

SB

55

<TARGET><BILL>SB 55</BILL><SUBJECT>SB
55</SUBJECT><COMM>SHSS29</COMM></TARGET>

Fiscal Note

State of Alaska
2015 Legislative Session

Bill Version: SB 55
Fiscal Note Number: _____
() Publish Date: _____

Identifier: SB055-DCCED-CBPL-03-13-15
Title: OPTOMETRY & OPTOMETRISTS
Sponsor: GIESSEL BY REQUEST
Requester: (S) Health and Social Services

Department: Department of Commerce, Community and
Economic Development
Appropriation: Corporations, Business and Professional
Licensing
Allocation: Corporations, Business and Professional
Licensing
OMB Component Number: 2360

Expenditures/Revenues

Note: Amounts do not include inflation unless otherwise noted below. (Thousands of Dollars)

	FY2016 Appropriation Requested	Included in Governor's FY2016 Request	Out-Year Cost Estimates				
			FY 2017	FY 2018	FY 2019	FY 2020	FY 2021
OPERATING EXPENDITURES	FY 2016	FY 2016					
Personal Services							
Travel							
Services	2.5						
Commodities							
Capital Outlay							
Grants & Benefits							
Miscellaneous							
Total Operating	2.5	0.0	0.0	0.0	0.0	0.0	0.0

Fund Source (Operating Only)

1156 Rcpt Svcs	2.5						
Total	2.5	0.0	0.0	0.0	0.0	0.0	0.0

Positions

Full-time							
Part-time							
Temporary							

Change in Revenues	2.5						
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Estimated SUPPLEMENTAL (FY2015) cost: 0.0 *(separate supplemental appropriation required)*
(discuss reasons and fund source(s) in analysis section)

Estimated CAPITAL (FY2016) cost: 0.0 *(separate capital appropriation required)*
(discuss reasons and fund source(s) in analysis section)

ASSOCIATED REGULATIONS

Does the bill direct, or will the bill result in, regulation changes adopted by your agency? Yes
If yes, by what date are the regulations to be adopted, amended or repealed? 07/01/16

Why this fiscal note differs from previous version:

Not applicable, initial version.

Prepared By: <u>Janey Hovenden, Division Director</u>	Phone: (907)465-2536
Division: <u>Corporations, Business and Professional Licensing</u>	Date: 03/13/2015 11:25 AM
Approved By: <u>Catherine Reardon, Director</u>	Date: 03/13/15
Agency: <u>Division of Administrative Services, DCCED</u>	

FISCAL NOTE ANALYSIS

STATE OF ALASKA
2015 LEGISLATIVE SESSION

BILL NO. SB 55

Analysis

SB 55 expands the practice of optometry to include prescriptive authority, including authority to prescribe controlled substances. It authorizes the board to establish continuing education standards and prescriptive standards in regulation. In addition, it restricts the practice of optometry by clarifying that invasive surgery and intravitreal injection are not permissible by licensees.

If the bill passes the division will require \$2.5 to cover legal costs to amend regulations, printing, and postage.

Professional licensing programs within the Division of Corporations, Business and Professional Licensing are funded by receipt supported services, fund source 1156 Rcpt Svcs (DGF). Licensing fees for each program are set per AS 08.01.065 so the revenue collected approximately equals the occupation's actual regulatory costs.

ALASKA STATE LEGISLATURE

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Juneau AK 99801-1182
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North to the Future

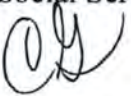
Senator Cathy Giessel

Senate District N

MEMORANDUM

DATE: February 19, 2015

TO: Senator Bert Stedman
Chair, Senate Health & Social Services Committee

FROM: Senator Cathy Giessel 

RE: Request for Hearing, Senate Bill 55, Optometry & Optometrists

I respectfully request that **Senate Bill 55** "Optometry and Optometrists" be scheduled for the Senate Health & Social Services Committee at your earliest convenience.

SB 55 modernizes and updates the Alaska Optometry Statute. It moves the continuing education (CE) requirements back into regulation. Continuing education is still required by current statute, but the hours and subjects will be determined by the Board of Optometry, as with other professions.

SB 55 allows the board to determine prescribed drug schedules anticipating federal regulations that may change again in the future. This bill updates the optometry definition to reflect current education and training, but specifically prohibits invasive surgery. It also defines that optometrists must be qualified for any procedure that they perform.

This bill also further defines and clarifies the prohibited surgical procedures under an "invasive surgery" definition. Alaska optometrists already do superficial surgical procedures such as removal of corneal foreign bodies under current statute, but nothing invasive would be allowed.

Attached you will find:

1. SB 55 version E
2. SB 55 Sponsor Statement
3. SB 55 Sectional Analysis Forthcoming
4. SB 55 Letters of Support Forthcoming

Please contact Jane Conway, 465-3623, in my office if you need any further information.

[Senator Cathy Giessel@akleg.gov](mailto:Senator.Cathy.Giessel@akleg.gov)

SENATE COMMITTEE REPORT First Committee of Referral

DATE: 2/18/15

FURTHER: Labor and Commerce

Date of 5-Day Notice: _____
(in accordance with Uniform Rule 23)

DATE TURNED IN TO OFFICE: 2/8/16

Health and Social Services Committee considered SENATE BILL NO. 55

SB 55 OPTOMETRY & OPTOMETRISTS

"An Act relating to the practice of optometry."

and recommends:

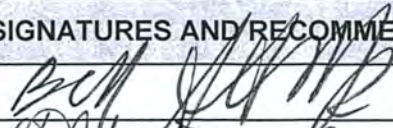
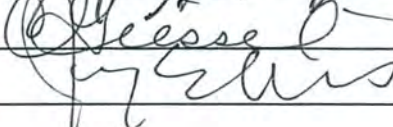
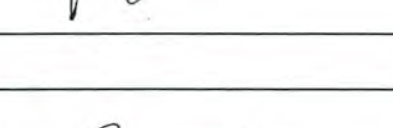

- be replaced with CS _____ (_____) Same Title New Title
- adopt previous CS _____ (_____) Same Title New Title
- attached amendment(s)
- adopt _____ Letter of Intent
- further referral to _____ Committee

Dept Abbr.	
ADM	LWF
CED	LAW
COR	LEG
CRT	MVA
EED	DNR
DEC	DPS
DFG	REV
GOV	DOT
DHS	UA

NEW FISCAL NOTE(S)				
Dept.	Fiscal	Indet.	Zero	FN #
CED	✓			

PREVIOUS FISCAL NOTE(S)				
Dept.	Fiscal	Indet.	Zero	FN #

APPROPRIATION - no fiscal note

SIGNATURES AND RECOMMENDATIONS:	PRINTED LAST NAME	Do PASS	Do NOT PASS	No REC	AMEND
	Stolte	✓			
	Giessel	✓			
	Ellis			✓	
CHAIR: 	STEGMAN	✓			

LEGAL SERVICES

DIVISION OF LEGAL AND RESEARCH SERVICES
LEGISLATIVE AFFAIRS AGENCY
STATE OF ALASKA

(907) 465-3867 or 465-2450
FAX (907) 465-2029
Mail Stop 3101

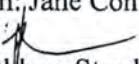
State Capitol
Juneau, Alaska 99801-1182
Deliveries to: 129 6th St., Rm. 329

MEMORANDUM

March 4, 2015

SUBJECT: Practice of Optometry
(SB 55; Work Order No. 29-LS0524\E)

TO: Senator Cathy Giessel
Attn: Jane Conway

FROM: 
Kathleen Strasbaugh
Legislative Counsel

You have requested a sectional summary of the above-described bill. Please note that a sectional summary of a bill should not be considered an authoritative interpretation of the bill and the bill itself is the best statement of its contents. If you would like an interpretation of the bill as it may apply to a particular set of circumstances, please advise.

Section 1 requires the Board of Examiners in Optometry (board) to adopt regulations governing prescription and use of pharmaceutical agents.

Section 2 amends AS 08.72.181(d) by removing specified hours and period of continuing education requirements for the renewal of an optometrist's license but retains delegation of those requirements to the board in regulation.

Section 3 repeals and reenacts AS 08.72.272(a) to provide that pharmaceutical agents, including controlled substances, may be used by a licensed optometrist if consistent with standards adopted by the board and any limitations on practice under section 5 of the bill.

Section 4 reenacts and modifies the prohibition by a licensee to perform an intravitreal injection.

Section 5 provides that a licensee may perform only services within the licensee's training and experience as provided by board regulation.

Section 6 revises the definition of optometry.

Section 7 adds a definition of "invasive surgery."

KJS:lem
15-147.lem

SENATE BILL NO. 55

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-NINTH LEGISLATURE - FIRST SESSION

BY SENATOR GIESSEL BY REQUEST

Introduced: 3/18/15

Referred:

A BILL

FOR AN ACT ENTITLED

1 **"An Act relating to the practice of optometry."**

2 **BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:**

3 * **Section 1.** AS 08.72.050 is amended to read:

4 **Sec. 08.72.050. Regulations.** The board shall adopt regulations

5 (1) necessary for the proper performances of its duties;

6 (2) governing the applicants and applications for licensing;

7 (3) for the licensing of optometrists;

8 (4) necessary to govern the practice of optometry, including the
9 prescription and use of pharmaceutical agents;

10 (5) prescribing requirements that a person licensed under this chapter
11 must meet to demonstrate continued professional competency.

12 * **Sec. 2.** AS 08.72.181(d) is amended to read:

13 (d) Before a license may be renewed, the licensee shall submit to the board
14 evidence that, during the preceding licensing period [IN THE FOUR YEARS
15 PRECEDING THE APPLICATION FOR RENEWAL], the licensee has


1 [(1) COMPLETED EIGHT HOURS OF CONTINUING
2 EDUCATION, APPROVED BY THE BOARD, CONCERNING THE USE AND
3 PRESCRIPTION OF PHARMACEUTICAL AGENTS;

4 (2) COMPLETED SEVEN HOURS OF CONTINUING
5 EDUCATION, APPROVED BY THE BOARD, CONCERNING THE INJECTION
6 OF NONTOPICAL THERAPEUTIC PHARMACEUTICAL AGENTS; AND

7 (3)] met [OTHER] continuing education requirements as may be
8 prescribed by regulations of the board to ensure the continued protection of the public.

9 * **Sec. 3.** AS 08.72.272(a) is repealed and reenacted to read:

10 (a) Except as provided in (e) of this section, a licensee may prescribe and use a
11 pharmaceutical agent, including a controlled substance, in the practice of optometry if
12 the pharmaceutical agent is used in a manner consistent with standards adopted by the
13 board in regulation; the standards must include limitations on practice adopted under
14 AS 08.72.278.

15 * **Sec. 4.** AS 08.72.272 is amended by adding a new subsection to read: 

16 (e) A licensee may not perform an intravitreal injection.

17 * **Sec. 5.** AS 08.72 is amended by adding a new section to read:

18 **Sec. 08.72.278. Limitation on practice.** (a) A licensee may perform the
19 services of optometry as defined in AS 08.72.300 only if the services are within the
20 scope of the licensee's education, training, and experience as established by
21 regulations adopted by the board.

22 (b) A licensee may not perform invasive surgery.

23 * **Sec. 6.** AS 08.72.300(3) is repealed and reenacted to read:

24 (3) "optometry" means the examination, evaluation, diagnosis,
25 treatment, and performance of preventive procedures related to diseases, disorders, or
26 conditions of the human eyes or adjacent and associated structures, consistent with this
27 chapter and regulations adopted by the board;

28 * **Sec. 7.** AS 08.72.300 is amended by adding a new paragraph to read:

29 (6) "invasive surgery" means surgery requiring penetration through the
30 globe of the eye, extraocular muscle surgery, retina surgery, corneal transplantation,
31 refractive surgery, or cosmetic lid surgery; in this paragraph, "refractive surgery"

←? what changed.

- 1 includes laser-assisted in situ keratomileusis (LASIK) and photorefractive
- 2 keratectomy (PRK).

ALASKA STATE LEGISLATURE

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North to the Future

Senator Cathy Giessel
Senate District N

Senate Bill 55 Optometry Statute Update

Sponsor Statement

SB 55 modernizes and updates the Alaska Optometry Statute.

This bill moves the continuing education (CE) requirements back into regulation, as desired by the Department of Commerce, Community and Economic Development. Continuing education is still required by current statute, but the hours and subjects will be determined by the Board of Optometry, as with other professions. The current regulations require more CE hours than the statute subsection deleted by this bill.

SB 55 allows the board to determine prescribed drug schedules anticipating federal regulations that may change again in the future as they did in 2014; that regulation required another statute change, and this bill would allow the board to move in step with its industry.

This bill updates the optometry definition to reflect current education and training, but specifically prohibits invasive surgery. This allows for future new and improved diagnostic and therapeutic procedures as determined by the board, while not having to return to the legislature for every new technological advance. It also defines that optometrists must be qualified for any procedure that they perform.

This bill also further defines and clarifies the prohibited surgical procedures under an "invasive surgery" definition. Alaska optometrists already do superficial surgical procedures such as removal of corneal foreign bodies under current statute, but nothing invasive would be allowed.

Sec. 08.72.010. Creation and purpose of board. There is created the Board of Examiners in Optometry to regulate and control the practice of optometry and to protect and promote the public health, welfare, and safety.

Sec. 08.72.020. Membership of board. The board consists of five persons.

Sec. 08.72.025. Removal of board members. [Repealed, Sec. 49 ch 94 SLA 1987. For current law, see AS 08.01.020]. Repealed or Renumbered

Sec. 08.72.030. Vacancies. [Repealed, Sec. 49 ch 94 SLA 1987. For current law, see AS 08.01.035]. Repealed or Renumbered

Sec. 08.72.040. Qualifications. Four board members shall be licensed, practicing optometrists who have been residents for at least three years. One board member shall be a public member.

Sec. 08.72.050. Regulations. The board shall adopt regulations

- (1) necessary for the proper performances of its duties;
- (2) governing the applicants and applications for licensing;
- (3) for the licensing of optometrists;
- (4) necessary to govern the practice of optometry;
- (5) prescribing requirements that a person licensed under this chapter

must meet to demonstrate continued professional competency.

Sec. 08.72.060. Miscellaneous powers and duties of board. (a) The board or a member designated by the board may issue subpoenas, administer oaths, and take testimony concerning any matter within the board's jurisdiction.

(b) The board may

- (1) adopt a seal;
- (2) define professional conduct and adopt rules of professional

conduct.

(c) The board shall

- (1) elect a chair and secretary from among its members;
- (2) order a licensee to submit to a reasonable physical examination if

the licensee's physical capacity to practice safely is at issue.

(d) *[Repealed by Sec. 3 ch 59 SLA 1966].*

(e) *[Repealed by Sec. 23 ch 75 SLA 1980].*

(f) *[Repealed by Sec. 3 ch 59 SLA 1966].*

Sec. 08.72.070. Applicability of Administrative Procedure Act. [Repealed, Sec. 23 ch 75 SLA 1980]. Repealed or Renumbered

Sec. 08.72.080. Compensation of board and secretary. [Repealed, Sec. 3 ch 59 SLA 1966]. Repealed or Renumbered

Sec. 08.72.090. Record of proceedings. [Repealed, Sec. 23 ch 75 SLA 1980]. Repealed or Renumbered

Sec. 08.72.100. Bond of secretary. [Repealed, Sec. 3 ch 59 SLA 1966]. Repealed or Renumbered

Article 02. LICENSING Sec. 08.72.110. License required. (a) A person may not practice, attempt to practice, or offer to practice optometry without first obtaining a license from the board.

(b) A person not licensed as an optometrist may not fit, sell, or dispose of or take, receive, or solicit an order for fitting, sale, or disposition of spectacles, eyeglasses, or lenses for the correction or relief of an optical or visual defect of the human eye or sell spectacles, eyeglasses, or lenses from house to house, or in the streets or highways. This chapter does not apply to the sale of toy glasses, goggles consisting of plano-white or plano-colored lenses or ordinary colored glasses, or complete ready-made spectacles and eyeglasses sold only as merchandise, or the sale or repair of eyeglass frames, or repair or replacement of lenses without pretense of adapting them to the eyes.

Sec. 08.72.115. Malpractice insurance. [Repealed, Sec. 40 ch 117 SLA 1978]. Repealed or Renumbered

Sec. 08.72.120. Registration. [Repealed Sec. 9 ch 50 SLA 1988]. Repealed or Renumbered

Sec. 08.72.125. Licensing of branch offices. [Repealed, Sec. 3 ch 94 SLA 1996]. Repealed or Renumbered

Sec. 08.72.130. Optometry register. [Repealed, Sec. 13 ch 37 SLA 1986]. Repealed or Renumbered

Sec. 08.72.140. Qualifications for licensure. An applicant for licensure as an optometrist

(1) shall be a graduate of a school or college of optometry recognized by the board;

(2) may not have committed an act in any jurisdiction that would have constituted a violation of this chapter or regulations adopted under this chapter at the time the act was committed;

(3) may not have been disciplined by an optometry licensing entity in another jurisdiction and may not be the subject of a pending disciplinary proceeding conducted by an optometry licensing entity in another jurisdiction; however, the board may consider the disciplinary action and, in the board's discretion, determine if the person is qualified for licensure;

(4) shall have successfully completed

(A) the written and practical portions of an examination on ocular pharmacology approved by the board that tests the licensee's or applicant's knowledge of the characteristics, pharmacological effects, indications, contraindications, and emergency care associated with the prescription and use of pharmaceutical agents;

(B) a nontopical therapeutic pharmaceutical agent course of at least 23 hours approved by the board or an examination approved by the board on the treatment and management of ocular disease; and

(C) an optometry and nontopical therapeutic pharmaceutical agent injection course of at least seven hours approved by the board or equivalent training acceptable to the board; and

(5) shall meet other qualifications for licensure as established under this chapter and regulations adopted by the board under AS 08.72.050.

Sec. 08.72.150. Application for examination and issuance of license.

An applicant shall apply for the examination by filing an application with the department together with the examination fee by the deadline established by the department in regulations. The department may require the applicant to submit a photograph of the applicant for its files; however, the photograph may not be forwarded with the application to the board for review. Upon successful completion of the examination by the applicant and payment of the license fee, the board shall issue a license to the successful applicant. The applicant may practice optometry in the state upon receipt of the license.

Sec. 08.72.160. Examination. (a) The examination must consist of two sections: (1) all or part of a national or international examination designated by regulation by the board; and (2) an examination approved by the board that is designed to test the applicant's knowledge of the laws of Alaska governing the practice of optometry and the regulations adopted under those laws.

(b) *[Repealed, Sec. 9 ch 49 SLA 1988]*.

(c) An applicant who fails the examination may retake the examination upon payment of a fee established under AS 08.01.065.

(d) *[Repealed, Sec. 7 ch 27 SLA 2010]*.

Sec. 08.72.170. Licensure by credentials. The board shall issue a license by credentials to an applicant who

(1) is a graduate of a school or college of optometry recognized by the board;

(2) has passed a written examination approved by the board that is designed to test the applicant's knowledge of the laws of Alaska governing the practice of optometry and the regulations adopted under those laws;

(3) holds a current license to practice optometry in another state or territory of the United States or in a province of Canada that has licensure requirements that the board determines are equivalent to those established under this chapter;

(4) at some time in the past, received a license to practice optometry from another state or territory of the United States or from a province of Canada that required the person to have passed the National Board of Examiners in Optometry examination to qualify for licensure;

(5) was engaged in the active licensed clinical practice of optometry in a state or territory of the United States or in a province of Canada for at least 3,120 hours during the 36 months preceding the date of application under this section;

(6) has not committed an act in any jurisdiction that would have constituted a violation of this chapter or regulations adopted under this chapter at the time the act was committed; and

(7) has not been disciplined by an optometry licensing entity in another jurisdiction and is not the subject of a pending disciplinary proceeding conducted by an optometry licensing entity in another jurisdiction; however, the board may consider the disciplinary action and, in the board's discretion, determine if the person is qualified for licensure.

Sec. 08.72.175. License endorsement. [Repealed, Sec. 7 ch 27 SLA 2010]. Repealed or Renumbered

Sec. 08.72.180. Annual renewal of license. [Repealed, Sec. 7 ch 94 SLA 1968]. Repealed or Renumbered

Sec. 08.72.181. Renewal of license. (a) [Repealed, Sec. 49 ch 94 SLA 1987].

(b) An optometrist licensed in this state and serving in the military service of the United States, while in the discharge of official duties, may maintain eligibility to practice in this state without paying a renewal fee by registering the optometrist's name and place of residence with the department.

(c) An application for license renewal must contain the name, office and post office address, date and license number of the licensee, and other information the board considers necessary.

(d) Before a license may be renewed, the licensee shall submit to the board evidence that, in the four years preceding the application for renewal, the licensee has

(1) completed eight hours of continuing education, approved by the board, concerning the use and prescription of pharmaceutical agents;

(2) completed seven hours of continuing education, approved by the board, concerning the injection of nontopical therapeutic pharmaceutical agents; and

(3) met other continuing education requirements as may be prescribed by regulations of the board to ensure the continued protection of the public.

(e) Before a license may be renewed, the licensee shall provide evidence of continued professional competency in accordance with the regulations adopted by the board under AS 08.72.050(5).

Sec. 08.72.185. Retired license status. (a) On retiring from practice and on payment of an appropriate one-time fee, a licensee in good standing with the board may apply for the conversion of an active or inactive license to a retired status license. A person holding a retired status license may not practice optometry in the state. A retired status license is valid for the life of the license holder and does not require renewal. A person holding a retired status license is exempt from license renewal requirements of AS 08.72.181.

(b) A person with a retired status license may apply for active licensure. Before issuing an active license under this subsection, the board may require

the applicant to meet reasonable criteria, as determined under regulations of the board.

Sec. 08.72.190. Fee for license by reciprocity. [Repealed, Sec. 10 ch 76 SLA 1969]. Repealed or Renumbered

Sec. 08.72.191. Fees. The department shall set fees under AS 08.01.065 for the following:

- (1) examination;
- (2) reexamination;
- (3) licensure by credentials;
- (4) license;
- (5) renewal.

Sec. 08.72.200. - 08.72.220. Examination, certificate and renewal fees. [Repealed, Sec. 10 ch 76 SLA 1969]. Repealed or Renumbered

Sec. 08.72.230. Fees and disbursements. The department shall collect all fees and keep a record of each transaction, and shall remit to the Department of Revenue all money received.

Sec. 08.72.240. Grounds for imposition of disciplinary sanctions. The board may impose disciplinary sanctions when the board finds after a hearing that a licensee

- (1) secured a license through deceit, fraud, or intentional misrepresentation;
- (2) engaged in deceit, fraud, or intentional misrepresentation in the course of providing professional services or engaging in professional activities;
- (3) advertised professional services in a false or misleading manner;
- (4) has been convicted of a felony or other crime which affects the licensee's ability to continue to practice competently and safely;
- (5) intentionally or negligently engaged in or permitted the performance of patient care by persons under the licensee's supervision which does not conform to minimum professional standards regardless of whether actual injury to the patient occurred;
- (6) failed to comply with this chapter, with a regulation adopted under this chapter, or with an order of the board;
- (7) continued to practice after becoming unfit due to
 - (A) professional incompetence;
 - (B) failure to keep informed of or use current professional theories or practices;
 - (C) addiction or severe dependency on alcohol or other drugs which impairs the licensee's ability to practice safely;
 - (D) physical or mental disability;
- (8) engaged in lewd or immoral conduct in connection with the delivery of professional service to patients;
- (9) failed to refer a patient to a physician after ascertaining the

presence of ocular or systemic conditions requiring management by a physician.

Sec. 08.72.250. , 08.72.255. Disciplinary sanctions; limits or conditions on license; discipline. [Repealed, Sec. 49 ch 94 SLA 1987. For current law, see AS 08.01.075]. Repealed or Renumbered

Sec. 08.72.260. Revocation of license by court. A license may be revoked by the superior court upon proof of violation of law or for a cause for which the board may refuse admittance to its examination. The attorney general shall prosecute appropriate judicial proceedings upon request of a member of the board.

Sec. 08.72.270. Practice not at place of business. (a) A licensed optometrist who temporarily practices optometry away from the optometrist's regular place of business shall display a license and deliver to each patient or person fitted or supplied with glasses or contact lenses a receipt showing the optometrist's permanent place of business or post office address and the amount charged.

(b) This section may not be construed as permitting peddling or canvassing by licensed optometrists.

Article 03. MISCELLANEOUS PROVISIONS Sec. 08.72.272.

Pharmaceutical agents. (a) A licensee may prescribe and use a pharmaceutical agent, including a controlled substance, in the practice of optometry if

(1) the pharmaceutical agent

(A) is prescribed and used for the treatment of ocular disease or conditions, ocular adnexal disease or conditions, or emergency anaphylaxis;

(B) is not a schedule IA, IIA, or VIA controlled substance; however, notwithstanding this subparagraph, a licensee may prescribe and use a pharmaceutical agent containing hydrocodone;

(C) is prescribed in a quantity that does not exceed four days of prescribed use if it is a controlled substance;

(D) is not injected into the ocular globe of the eye; and

(E) is not a derivative of clostridium botulinum; and

(2) the licensee

(A) has a physician-patient relationship, as defined by the board in regulations adopted under this chapter, with the person to whom the pharmaceutical agent is prescribed; and

(B) has on file with the department the licensee's current federal Drug Enforcement Administration registration number that is valid for the controlled substance prescribed or used.

(b) [Repealed, Sec. 7 ch 27 SLA 2010].

(c) [Repealed, Sec. 7 ch 27 SLA 2010].

(d) In this section, "controlled substance" has the meaning given in AS 11.71.900.

Sec. 08.72.273. Removal of foreign bodies. A licensee may remove superficial foreign bodies from the eye and its appendages. This section is not intended to permit a licensee to perform invasive surgery.

Sec. 08.72.274. Exemption. Except for AS 08.72.275, this chapter and regulations adopted under this chapter do not limit the practice of an optician licensed under AS 08.71.

Sec. 08.72.275. Lenses and frames for eyeglasses and sunglasses.

(a) A person may not fabricate, distribute, sell, exchange, deliver or possess with intent to distribute, sell, exchange or deliver eyeglasses or sunglasses unless they are fitted with plastic lenses, laminated lenses, heat-treated glass lenses, or glass lenses made impact resistant by other methods. All plastic and heat-treated glass lenses, before they are mounted in frames, shall be capable of withstanding the impact of a five-eighths inch steel ball dropped on the lens from a height of 50 inches. The impact test shall be conducted at room temperature, with the lens supported by a plastic tube one inch inside diameter, one and one-fourth inch outside diameter, with a one-eighth inch by one-eighth inch neoprene gasket on the top edge.

(b) A person may not fabricate, distribute, sell, exchange, deliver or possess with intent to distribute, sell, exchange or deliver eyeglasses or sunglasses having frames manufactured from cellulose nitrate or other highly flammable materials.

(c) A licensee may sell, exchange, or deliver eyeglasses or sunglasses that do not meet the requirements of (a) of this section if the sale, exchange, or delivery is authorized in a written request signed by the patient.

(d) A person who violates this section is punishable by a fine of not less than \$50 nor more than \$100.

Sec. 08.72.280. Prohibited acts. A person may not falsely personate a licensed optometrist, or buy, sell, or fraudulently obtain a license issued to another or advertise the practice of optometry in violation of regulations of the board. Practicing or offering to practice optometry without a license is sufficient evidence of a violation of this chapter.

Sec. 08.72.290. Criminal penalty. A person who violates this chapter is guilty of a misdemeanor and is punishable by a fine of not less than \$50 nor more than \$500, or by imprisonment for a term of not less than 10 days nor more than 90 days, or by both.

Article 04. GENERAL PROVISIONS Sec. 08.72.300. Definitions. In this chapter,

- (1) "board" means the Board of Examiners in Optometry;
- (2) "department" means the Department of Commerce, Community, and Economic Development;
- (3) "optometry" means the examination, diagnosis, and treatment of conditions of the human eyes and visual system, other than by use of laser, x-rays, surgery, or pharmaceutical agents, other than those permitted under

AS 08.72.272; "optometry" includes the employment of methods that a person licensed under this chapter is educationally qualified to use, as established by the board;

(4) "practicing optometry" means the performance of, or offer to perform, optometry for compensation;

(5) "recognized school or college of optometry" means a school or college approved by the American Optometric Association or a committee of the American Optometric Association.

Sec. 08.72.310. Short title. This chapter may be cited as the Optometry Law.

Statutes and Regulations **Medical**

December 2014

(Centralized Statutes and Regulations not included)



DEPARTMENT OF COMMERCE, COMMUNITY,
AND ECONOMIC DEVELOPMENT

***DIVISION OF CORPORATIONS, BUSINESS
AND PROFESSIONAL LICENSING***

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**CHAPTER 64.
MEDICINE.**

Article

1. **State Medical Board (§§ 08.64.010—08.64.160)**
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3. **Miscellaneous Provisions (§§ 08.64.366—08.64.369)**
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**ARTICLE 1.
STATE MEDICAL BOARD.**

Section

10. **Creation and membership of State Medical Board**
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160. **Applicability of Administrative Procedure Act**

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

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

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

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

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

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

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

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

Sec. 08.64.101. Duties. The board shall

- (1) examine and issue licenses to applicants;
- (2) develop written guidelines to ensure that licensing requirements are not unreasonably burdensome and the issuance of licenses is not unreasonably withheld or delayed;
- (3) submit an annual report of its proceedings to the governor, including a statement of money received and disbursed;
- (4) after a hearing, impose disciplinary sanctions on persons who violate this chapter, or the regulations or orders of the board;
- (5) adopt regulations ensuring that renewal of licenses is contingent upon proof of continued competency on the part of the licensee; and

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

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

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

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

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

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

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

- (1) educational and other qualifications;
- (2) application and registration procedures;
- (3) scope of activities authorized; and
- (4) responsibilities of the supervising or training physician.

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

Sec. 08.64.130. Board records. (a) The board shall preserve a record of its proceedings, which must contain the name, age, residence and duration of residence of each applicant for a license, the time spent by the applicant in medical study, the place of medical study, and the year and school from which degrees were granted. The record must also show whether the applicant was granted a license or rejected.

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

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

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

ARTICLE 2. LICENSING.

Section

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

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

(2) a mobile intensive care paramedic may render emergency lifesaving service; and

(3) a person who is licensed or authorized under another chapter of this title may engage in a practice that is authorized under that chapter.

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

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

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

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

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

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

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

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

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

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

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

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

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

Sec. 08.64.205. Qualifications for osteopath applicants. Each osteopath applicant shall meet the qualifications prescribed in AS 08.64.200(a)(3) and (4) and shall

- (1) submit a certificate of graduation from the legally chartered school of osteopathy approved by the board;
- (2) submit a certificate from a hospital approved by the American Medical Association or the American Osteopathic Association that certifies that the osteopath has satisfactorily completed and performed the duties of intern or resident physician for

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

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

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

Sec. 08.64.209. Qualifications for podiatry applicants. (a) Each applicant who desires to practice podiatry shall meet the qualifications prescribed in AS 08.64.200(a)(3) and (4) and shall

- (1) submit a certificate of graduation from a legally chartered school of podiatry approved by the board;
- (2) take the examination required by AS 08.64.210; the State Medical Board shall call to its aid a podiatrist of known ability who is licensed to practice podiatry to assist in the examination and licensure of applicants for a license to practice podiatry;
- (3) meet other qualifications of experience or education which the board may require.

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

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

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

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

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

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

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

- (1) meet the requirements of AS 08.64.200(a)(3) and (4) and 08.64.255;
- (2) have successfully completed

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

(B) other requirements establishing proof of competency and professional qualifications as the board considers necessary to ensure the continued protection of the public adopted at the discretion of the board by regulation; and

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

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

- (1) current licensure in another state and an active medical practice in that state for at least three years; or
- (2) current board certification in a practice specialty by the American Board of Medical Specialties.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(e) A permit issued under this section is initially valid for 90 consecutive calendar days. Upon request by a permittee, a permit issued under this section shall be extended for 60 calendar days by the board or its designee if, before the expiration of the initial 90-day permit, the permittee submits to the department a completed application form and the fee required for licensure under this chapter, except that the board may refuse to grant a request for an extension for the same reasons the board may refuse to grant a license under AS 08.64.240. Permits and extensions of permits issued to an individual under this section are not valid for more than 240 calendar days during any consecutive 24 months.

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

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

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

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

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

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

(b) Before a license may be renewed the licensee shall submit evidence to the board or its designee that continuing education requirements prescribed by regulations adopted by the board have been met.

(c) The board or its designee may exempt a physician from the requirements of (b) of this section upon an application by the physician giving evidence satisfactory to the board or its designee that the physician is unable to comply with the requirements because of extenuating circumstances. However, a person may not be exempted from more than 15 hours of continuing education in a five-year period.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(8) has demonstrated

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

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

(C) unfitness because of physical or mental disability;

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

(10) has violated AS 18.16.010;

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

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

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

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

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

(1) permanently revoke a license to practice;

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

(3) censure a licensee;

(4) issue a letter of reprimand;

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

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

(B) limit practice to those areas prescribed;

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

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

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

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

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

(c) The board may summarily suspend a license before final hearing or during the appeals process if the board finds that the licensee poses a clear and immediate danger to the public health and safety if the licensee continues to practice. A person whose license is suspended under this section is entitled to a hearing by the board no later than seven days after the effective date of the order and the person may appeal the suspension after a hearing to a court of competent jurisdiction.

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

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

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

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

Sec. 08.64.334. Voluntary surrender. The board, at its discretion, may accept the voluntary surrender of a license. A license may not be returned unless the board determines, under regulations adopted by it, that the licensee is competent to resume practice. However, a license may not be returned to the licensee if the voluntary surrender resulted in the dropping or suspension of civil or criminal charges against the physician.

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

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

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

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

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

(e) A physician, hospital, hospital committee, or private professional organization contracted with under AS 08.64.101(6) to identify, confront, evaluate, and treat individuals licensed under this chapter who abuse addictive substances that in good faith submits a report under this section or participates in an investigation or judicial proceeding related to a report submitted under this section is immune from civil liability for the submission or participation.

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

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

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

Sec. 08.64.338. Medical and psychiatric exams. For the purposes of an investigation under this chapter, the board may order a person to whom it has issued a license or permit to submit to a medical or psychiatric examination by a physician or other practitioner of the healing arts appointed by the board. An examination shall be

at the board's expense. An examination may include the required submission of biological specimens requested by the examining physician or practitioner.

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

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

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

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

ARTICLE 3. MISCELLANEOUS PROVISIONS.

Section

- 364. Prescription of drugs without physical examination
- 366. Liability for services rendered by a mobile intensive care paramedic
- 367. Prescription or administration of laetrile by physicians
- 369. Health care professionals to report certain injuries

Sec. 08.64.364. Prescription of drugs without physical examination. (a) The board may not impose disciplinary sanctions on a physician for prescribing, dispensing, or administering a prescription drug to a person without conducting a physical examination if

- (1) the prescription drug is
 - (A) not a controlled substance; or
 - (B) a controlled substance and is prescribed, dispensed, or administered by a physician when an appropriate licensed health care provider is present with the patient to assist the physician with examination, diagnosis, and treatment;
- (2) the physician is located in this state and the physician or another licensed health care provider or physician in the physician's group practice is available to provide follow-up care; and
- (3) the person consents to sending a copy of all records of the encounter to the person's primary care provider if the prescribing physician is not the person's primary care provider, and the physician sends the records to the person's primary care provider.

(b) In this section,

- (1) "controlled substance" has the meaning given in AS 11.71.900;
- (2) "prescription drug" has the meaning given in AS 08.80.480;
- (3) "primary care provider" has the meaning given in AS 21.07.250.

Sec. 08.64.366. Liability for services rendered by a mobile intensive care paramedic. An act or omission of a mobile intensive care paramedic done or omitted in good faith while rendering emergency service to a person who is in need of immediate aid in order to avoid serious harm or loss of life does not impose any liability upon the physician-trained mobile intensive care paramedic, the supervising physician, a hospital, the officers, members of the staff, nurses, or other employees of a hospital or upon a federal, state, borough, city or other local governmental unit or upon other employees of a governmental unit; however, this section does not relieve a physician or a hospital of a duty otherwise imposed by law upon the physician or hospital for the designation or training of a mobile intensive care paramedic or for the provision or maintenance of equipment to be used by the mobile intensive care paramedic.

Sec. 08.64.367. Prescription or administration of laetrile by physicians. (a) A physician may not be subject to disciplinary action by the State Medical Board for prescribing or administering amygdalin (laetrile) to a patient under the physician's care who has requested the substance unless the State Medical Board in a hearing conducted under the Administrative Procedure Act (AS 44.62) has made a formal finding that the substance is harmful.

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

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

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

- (1) second or third degree burns to five percent or more of a patient's body;
- (2) a burn to a patient's upper respiratory tract or laryngeal edema due to the inhalation of super-heated air;
- (3) a bullet wound, powder burn, or other injury apparently caused by the discharge of a firearm;
- (4) an injury apparently caused by a knife, axe, or other sharp or pointed instrument, unless the injury was clearly accidental; and

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

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

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

ARTICLE 4. GENERAL PROVISIONS.

Section

370. Exceptions to application of chapter

380. Definitions

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

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

(2) a physician or osteopath who is not a resident of this state, who is asked by a physician or osteopath licensed in this state to help in the diagnosis or treatment of a case;

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

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

(5) a person who is certified as a direct-entry midwife by the department under AS 08.65 or who is excluded from registration under AS 08.65.170(3) and (4) while engaged in the practice of midwifery whether or not the person accepts compensation for those services.

Sec. 08.64.380. Definitions. In this chapter,

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

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

(3) "emergency lifesaving service" means medical assistance given to a person whose physical condition, in the opinion of a reasonably prudent person, is such that the person's life is endangered;

(4) "mobile intensive care paramedic" means an individual licensed by the board who has successfully completed a paramedic training program certified under AS 18.08 and is authorized by law to provide advanced life support under the direct or indirect supervision of a physician;

(5) "practice of medicine" or "practice of osteopathy" means:

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

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

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

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

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

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

**CHAPTER 40.
STATE MEDICAL BOARD.**

Articles

1. **Licensing**
(12 AAC 40.010 – 12 AAC 40.058)
2. **Abortions**
(12 AAC 40.060 – 12 AAC 40.140)
3. **Continuing Medical Education**
(12 AAC 40.200 – 12 AAC 40.240)
4. **Mobile Intensive Care Paramedics**
(12 AAC 40.300 – 12 AAC 40.390)
5. **Physician Assistants**
(12 AAC 40.400 – 12 AAC 40.490)
6. **General Provisions**
(12 AAC 40.910 – 12 AAC 40.990)

**ARTICLE 1.
LICENSING.**

Section

10. **Application for license by credentials**
15. **Application for license by examination**
16. **Application for license by foreign medical graduates**
17. **Denial of application**
20. **License by examination**
21. **Acceptable examination combinations**
22. **Postgraduate training and active duty military service**
23. **Residency training requirements for podiatry applicant**
24. **Licensing requirements for applicants from fifth pathway programs**
25. **Lapsed physician licenses**
30. **(Repealed)**
31. **Activating a retired status license**
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35. **Temporary permit application requirements**
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38. **Residency permit**
40. **Recognized hospital**
45. **Courtesy license**
50. **Biographical data**
55. **Interview**
58. **Review of applications**

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

- (1) file a complete application; and
 - (2) if required under 12 AAC 40.055, be interviewed in accordance with AS 08.64.255.
- (b) A complete application must include the following items
- (1) submitted by the applicant:
 - (A) a completed application on a form provided by the department, including a photograph of the applicant and the applicant's notarized signature;
 - (B) a completed authorization for release of records on a form provided by the department and signed by the applicant;
 - (C) *repealed 4/2/2004*;
 - (D) a statement listing each hospital at which the applicant has held privileges within the five years immediately before the date that the applicant signs the application form;
 - (E) all required application and licensing fees;
 - (F) a certified true copy of the applicant's medical, osteopathy, or podiatry school diploma or certificate;
 - (G) if applicable, verification of the applicant's post-graduate training that meets the requirements of (h) of this section;
 - (2) requested by the applicant from appropriate agencies and sent directly to the division office:
 - (A) evidence satisfactory to the board that the applicant has passed an appropriate examination as described in (c) of this section;

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

(C) original letters of verification of hospital privileges from each of the hospitals listed by the applicant as required in (1)(D) of this subsection; the letters of verification must include

- (i) confirmation of the date of privileges held by the applicant;
- (ii) information on any disciplinary action taken against the applicant;
- (iii) any derogatory information on record about the applicant; and
- (iv) any reason for which the applicant would not be readmitted to privileges in that facility;

(D) clearance from the federal Drug Enforcement Administration (DEA);

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

(F) a Physician Profile from the American Medical Association (AMA) or American Osteopathic Association (AOA), if applicable;

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

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

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

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

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

(2) an official transcript from

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

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

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

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

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

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

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

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

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

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

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

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

(h) An applicant for licensure under this section who graduated from a medical school described in AS 08.64.200(a)(1) or a school of osteopathy described in AS 08.64.205(1), must submit a certified true copy of a certificate documenting successful completion of the post-graduate training required under AS 08.64.200(a)(2) or AS 08.64.205(2). Any other applicant must submit a certified true copy of a certificate documenting successful completion of the post-graduate training required under AS 08.64.225(a)(2)(A), if applicable. Training periods of less than 12 months will not be accepted. An original letter with an original signature submitted on program letterhead will be accepted in lieu of a certified true copy of a certificate if the letter is submitted directly to the board by the recognized hospital or facility.

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

(j) If a foreign medical graduate applicant for licensure in this state took the FLEX examination series before the implementation of the USMLE examination series, but did not achieve a minimum standard score of 75 for each component of the examination series, and has not otherwise provided evidence satisfactory to the board that the applicant has passed an appropriate examination as described in (c) of this section, the applicant may submit an

official transcript from the Federation of State Medical Boards documenting that the applicant achieved a weighted average score of 75 or higher. The board will not accept a weighted average score if the applicant

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

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

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

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

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

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

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

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

(1) submitted by the applicant:

(A) a completed application on a form provided by the department, including a photograph of the applicant and the applicant's notarized signature;

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

(C) *repealed 4/2/2004;*

(D) a statement listing each hospital at which the applicant has held privileges within the five years immediately before the date the applicant signs the application form;

(E) all required application and licensing fees;

(F) a certified true copy of the applicant's medical, osteopathy, or podiatry school diploma or certificate;

(G) if applicable, a certified true copy of each of the applicant's post-graduate training program certificates;

(2) requested by the applicant from appropriate agencies and sent directly to the division office:

(A) original letters of verification of hospital privileges from each of the hospitals listed by the applicant in (1)(D) of this subsection; the letters of verification must include

(i) confirmation of the date of privileges held by the applicant;

(ii) information on any disciplinary action taken against the applicant;

(iii) any derogatory information on record about the applicant; and

(iv) any reason for which the applicant would not be readmitted to privileges in that facility;

(B) clearance from the federal Drug Enforcement Administration (DEA);

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

(D) a Physician Profile from the American Medical Association (AMA) or the American Osteopathic Association (AOA), if applicable;

(E) for foreign medical graduates, a certified true copy of the applicant's certificate from the Educational Commission for Foreign Medical Graduates (ECFMG);

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

(G) if applicable, verification of completion of the first year of post-graduate training from the facility where the applicant completed the first year of internship or residency program.

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

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

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

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

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

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

(2) this chapter.

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

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

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

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

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

(1) have graduated from a school on the list titled *Medical Schools Recognized by the Medical Board of California*, effective on October 11, 2006, adopted by reference; and

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

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

(1) have graduated from a school on the list titled *Medical Schools Recognized by the Medical Board of California*, effective on October 11, 2006, adopted by reference; and

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

(c) In addition to meeting the requirements of either (a) or (b) of this section, an applicant for licensure who is a graduate of a medical college not accredited by the Association of American Medical Colleges and the Council on Medical Education of the American Medical Association shall establish proof of competency and professional qualifications by meeting one of the following requirements:

(1) successful completion of three years of postgraduate training that meets the requirements of AS 08.64.225(a)(2)(A); a year of full-time employment as a faculty member at a medical college accredited by the Association of American Medical Colleges and the Council on Medical Education of the American Medical Association may be substituted for a year of required postgraduate training, up to the maximum required;

(2) hold a current, active, unrestricted license to practice medicine in another state and have engaged in the active practice of medicine in that state for at least three years before the date of application for licensure in this state;

(3) hold a current certification in a practice specialty issued by the American Board of Medical Specialties.

(d) If necessary to determine whether an applicant for licensure who is a graduate of a medical college not accredited by the Association of American Medical Colleges and the Council on Medical Education of the American Medical Association is competent and able to safely practice medicine in this state, the board may require the applicant to pass the Special Purpose Examination (SPEX) administered by the Federation of State Medical Boards or to undergo a formal assessment of professional competency by a program approved by the board for that purpose.

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

Editor's note: Copies of Medical Schools Recognized by the Medical Board of California, adopted by reference in 12 AAC 40.016, may be obtained from the Department of Commerce, Community, and Economic Development, Division of Corporations, Business and Professional Licensing, State Medical Board, 550 W. 7th Avenue, Suite 1500, Anchorage, Alaska 99501-3567; telephone: (907) 269-8163.

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

Authority:	AS 08.64.100	AS 08.64.240
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12 AAC 40.020. LICENSE BY EXAMINATION. (a) The physician qualification examination required for licensure in this state is the most current version of the United States Medical Licensing Examination (USMLE).

(b) The minimum passing score for

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

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

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

(c) *Repealed 4/27/97.*

(d) *Repealed 4/27/97.*

(e) *Repealed 4/27/97.*

(f) *Repealed 4/27/97.*

(g) *Repealed 9/1/2007.*

(h) *Repealed 9/1/2007.*

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

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

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

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

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

Authority: AS 08.64.100 AS 08.64.210 AS 08.64.220

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

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

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

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

Authority: AS 08.64.100 AS 08.64.210 AS 08.64.220

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

Authority: AS 08.01.064 AS 08.64.200 AS 08.64.205
AS 08.64.100

12 AAC 40.023. RESIDENCY TRAINING REQUIREMENT FOR PODIATRY APPLICANT. In addition to meeting the application requirements in AS 08.64.209, an applicant for a license to practice podiatry shall submit to the board a certified true copy of a certificate verifying the applicant's successful completion of at least one year of surgical residency training in a hospital accredited by the American Podiatric Medical Association Council on Podiatric Medical Education or the American Board of Podiatric Surgery.

Authority: AS 08.64.100 AS 08.64.190 AS 08.64.209

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

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

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

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

Authority: AS 08.64.100 AS 08.64.200 AS 08.64.225

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

- (1) submits a completed renewal application on a form provided by the department;
- (2) pays the applicable biennial license renewal fee established in 12 AAC 02.250(a);
- (3) submits proof of meeting the continuing medical education requirements in 12 AAC 40.200 - 12 AAC 40.220; and
- (4) receives clearance from the Federation of State Medical Boards and documentation of the clearance is sent directly to the division by that federation.

(b) A physician license that has been lapsed for at least one year but less than five years will be reinstated if the applicant meets the requirements in (a)(2), (3), and (4) of this section and

- (1) submits a completed reinstatement application on a form provided by the department;
- (2) receives clearance from the federal Drug Enforcement Administration (DEA) and documentation of the clearance is sent directly to the division by the DEA;
- (3) arranges for verification of licensure to be sent directly to the division from each state other than Alaska where the applicant is or has been licensed as a physician;
- (4) is qualified for a license under AS 08.64.230 and is not disqualified by AS 08.64.240; and
- (5) arranges for a verification of hospital privileges to be sent directly to the division, from each hospital where the applicant has held privileges within the five years immediately before the date that the applicant signs the application form.

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

Authority: AS 08.01.100 AS 08.64.100 AS 08.64.240

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

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

- (1) submits a new and complete application as required by 12 AAC 40.010, documenting compliance with
 - (A) AS 08.64.200 and 08.64.250, if a physician applicant;
 - (B) AS 08.64.209 and 08.64.250, if a podiatry applicant; or
 - (C) AS 08.64.205, if an osteopath applicant;
- (2) submits evidence of at least 50 hours of continuing medical education credits earned within the two years immediately before the date of application;
- (3) submits evidence of successful completion of the Special Purpose Examination (SPEX) prepared by the Federation of State Medical Boards;
- (4) submits, at the request of the board, physical and mental examination reports from practitioners approved by the board indicating that, at the time of the examination, the applicant is mentally and physically capable of practicing medicine, podiatry, or osteopathy safely;
- (5) submits information from the disciplinary data bank of the Federation of State Medical Boards;
- (6) is interviewed by a member of the board; and
- (7) pays the fees established in 12 AAC 02.250.

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

Authority: AS 08.64.100 AS 08.64.180 AS 08.64.276

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

- (b) A physician may apply for an inactive license at the time of license renewal by
- (1) indicating on the form for license renewal that the physician is requesting an inactive license;
 - (2) paying the inactive biennial license fee established in 12 AAC 02.250; and
 - (3) submitting proof of meeting the continuing medical education requirements in 12 AAC 40.200 - 12 AAC 40.220.
- (c) A physician licensed as inactive may not practice as a physician in the state.
- (d) A physician licensed as inactive who wishes to resume active practice as a physician in the state must
- (1) *repealed 12/7/2006*;
 - (2) submit a written request for reactivation;
 - (3) request a clearance report from the Federation of State Medical Boards's Board Action Data Bank be sent directly to the board;
 - (4) pay the physician biennial license renewal fee established in 12 AAC 02.250, less any inactive license fee previously paid for the same licensing period;
 - (5) submit proof of meeting the continuing medical education requirements in 12 AAC 40.200 - 12 AAC 40.220;
 - (6) arrange for verification of licensure to be sent directly to the division from each state other than this state where the applicant is or has been licensed as a physician; and
 - (7) receive clearance from the federal Drug Enforcement Administration (DEA) and arrange for documentation of the clearance to be sent directly to the division by the DEA.
- (e) Notwithstanding (a) and (b) of this section, the board may refuse to reactivate a physician license for the same reasons that it may impose disciplinary sanctions against a licensee under AS 08.64.326 and this chapter.

Authority: AS 08.64.100 AS 08.64.240 AS 08.64.313

12 AAC 40.035. TEMPORARY PERMIT APPLICATION REQUIREMENTS. (a) A member of the board, will, in the member's discretion, issue a temporary physician permit to an applicant who

- (1) meets the requirements of AS 08.64.270; and
 - (2) has a complete application under 12 AAC 40.010 or 12 AAC 40.015 on file with the division; and
 - (3) if an interview is required under 12 AAC 40.055, is interviewed in accordance with AS 08.64.279.
- (b) *Repealed 8/9/00.*
- (c) *Repealed 8/9/00.*

Authority: AS 08.64.100 AS 08.64.270 AS 08.64.279
AS 08.64.180

12 AAC 40.036. LOCUM TENENS PERMIT APPLICATION REQUIREMENTS. (a) A member of the board, will, in the member's discretion, issue a locum tenens permit to an applicant who

- (1) meets the requirements of AS 08.64.275;
 - (2) has a complete application on file with the division;
 - (3) if an interview is required under 12 AAC 40.055, is interviewed in accordance with AS 08.64.279; and
 - (4) if the applicant is a foreign medical graduate, meets the requirements of 12 AAC 40.016.
- (b) A complete application must include
- (1) a certified true copy of a medical school diploma;
 - (2) verification of the applicant's completion of post-graduate training that meets the requirements of 12 AAC 40.010(h);
 - (3) verification of licensure from the appropriate licensing authority in each state, territory, or province where the applicant holds or has ever held a license, requested by the applicant and sent directly to the division from the licensing jurisdiction;
 - (4) all required application fees for a locum tenens permit;
 - (5) clearance from the Federation of State Medical Boards sent directly to the division.
- (c) *Repealed 6/15/2001.*
- (d) A physician who is not currently licensed in this state may apply for a locum tenens permit for the purpose of substituting for a physician licensed in this state who is
- (1) temporarily absent from the practice location at which the applicant will practice; or
 - (2) not expected to return to the practice location, if issuance of a locum tenens permit is necessary to temporarily provide essential medical services to the public or to protect the public health and safety.
- (e) Notwithstanding (a) of this section, the board's designee, as identified under 12 AAC 40.910, will perform the duties described in this section, as delegated by the board.

Authority: AS 08.64.100 AS 08.64.275 AS 08.64.279

12 AAC 40.038. RESIDENCY PERMIT. (a) A member of the board will, in the member's discretion, issue a residency permit to an applicant who

- (1) meets the requirements of AS 08.64.272;
- (2) if an interview is required under 12 AAC 40.055, is interviewed in accordance with AS 08.64.279;
- (3) provides a complete application;
- (4) if the applicant is a foreign medical graduate, meets the requirements of 12 AAC 40.016(a)(1).

(b) A complete application must include the following:

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

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

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

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

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

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

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

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

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

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

Authority: AS 08.64.100 AS 08.64.272 AS 08.64.279

12 AAC 40.040. RECOGNIZED HOSPITAL. For the purpose of AS 08.64.200(a)(2) a recognized hospital is one which has been approved for internship or residency training by the Accreditation Council for Graduate Medical Education (ACGME) or the Royal College of Physicians and Surgeons of Canada.

Authority: AS 08.64.100 AS 08.64.200

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

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

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

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

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

(4) physicians who come to the state to provide emergency medical care or emergency mental health care if

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

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

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

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

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

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

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

(d) The board will issue a courtesy license to an applicant who

- (1) submits a complete application on a form provided by the department;
- (2) pays the application and licensing fees established in 12 AAC 02.250;
- (3) submits verification, to the board's satisfaction, of a current license to practice medicine in good standing and not under investigation in the state or territory, or a province of Canada in which the applicant resides;
- (4) submits curriculum vitae;
- (5) describes, to the board's satisfaction, the circumstances under which the applicant will be practicing, including the name and license number of the supervising physician if the applicant is working in a supervised hospital fellowship;
- (6) describes the scope of medical practice required to perform the duties for which the courtesy license is issued; the description must include the practice location, duration of practice, and patient population to be seen; the applicant must demonstrate, to the board's satisfaction, that the scope of medical practice is for a limited purpose set out in (b) of this section;
- (7) submits a signed, notarized authorization for the release of records;
- (8) submits a certified true copy of an accredited medical school diploma;
- (9) submits a certified true copy of all accredited postgraduate training certificates;
- (10) submits a certified true copy of an American Board of Medical Specialties member board certificate; this requirement may be waived by the board if the courtesy license is intended to be used for a fellowship; and
- (11) submits a Federation of State Medical Board's Board Action Data Bank clearance report.

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

- (1) the duration of the activity as listed in (b) of this section;
- (2) a period not to exceed
 - (A) one year after the date the courtesy license is issued under (b)(1)-(b)(3) or (b)(5)-(b)(6) of this section;
 - (B) 90 days after the date the courtesy license is issued under (b)(4) of this section.

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

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

- (1) for purposes of locum tenens coverage;
- (2) to serve in place of a temporary license; or
- (3) for purposes of employment consideration.

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

Authority: AS 08.01.062 AS 08.64.100 AS 08.64.240

12 AAC 40.050. BIOGRAPHICAL DATA. An application for licensure by credentials or examination will not be considered complete until the applicant has requested the following documents and they are on file in the division office:

- (1) a physician profile from the American Medical Association or American Osteopathic Association;
- (2) clearance from the United States Department of Justice, Drug Enforcement Administration;
- (3) clearance from the Federation of State Medical Boards regarding previous or pending disciplinary actions against the applicant by another jurisdiction.

Authority: AS 08.64.100 AS 08.64.190 AS 08.64.200

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

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

- (1) the applicant's disciplinary history with any medical board, licensing agency, credentialing authority, medical or professional school, internship program, residency program, or military authority;
- (2) the applicant's charges or convictions of a felony, misdemeanor, or violation of a law, statute, or regulations of this or another jurisdiction, including the United States or another country, that relate to the grounds for the applicable license or permit denial or imposition of disciplinary sanctions under AS 08.64 or this chapter; the applicant's charges or convictions

- (A) include those crimes involving alcohol or narcotics or other controlled substances; but
- (B) exclude minor traffic violations;

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

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

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

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

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

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

Authority: AS 08.64.100 AS 08.64.255 AS 08.64.279
AS 08.64.240

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

(b) The form titled *Alaska State Medical Board Checklist — Temporary Permit*, dated July 2012, is adopted by reference. This form is established by the board for the use by the executive secretary or another employee of the division in completing the application processing for a temporary permit under AS 08.64.270.

(c) The form titled *Alaska State Medical Board Checklist — Resident Permit*, dated July 2012, is adopted by reference. This form is established by the board for the use by the executive secretary or another employee of the division in completing the application processing for a residency permit under AS 08.64.272.

(d) The form titled *Alaska State Medical Board Courtesy License Checklist*, dated July 2012, is adopted by reference. This form is established by the board for the use by the executive secretary or another employee of the division in completing the application processing for a courtesy license under AS 08.01.062 and 12 AAC 40.045.

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

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

ARTICLE 2. ABORTIONS.

Section

60. Termination of pregnancy

70. Informed consent

80. Medical procedures

90. Evaluation

100. Consultation requirements

110. Abortion procedures

120. Standards for hospitals and facilities

130. Records

140. Limitation

12 AAC 40.060. TERMINATION OF PREGNANCY. Termination of pregnancy must be requested by the pregnant woman, unless she has been adjudged mentally incompetent or is unmarried and under 18 years of age, in which case the request must be made by her parent or guardian.

Authority: AS 11.15.060(a) AS 08.64.105

12 AAC 40.070. INFORMED CONSENT. Unless otherwise provided in 12 AAC 40.060, a written informed consent shall be obtained from the patient or from any other person whose consent is required before termination of

a pregnancy. Such written informed consent shall be on the patient's chart. The patient and other persons whose consent is required shall be advised of the medical implications and the possible emotional and physical sequelae of the procedure.

Authority: AS 08.64.105

12 AAC 40.080. MEDICAL PROCEDURES. The patient shall be examined by a physician licensed in Alaska, and a written record of the patient's physical and emotional health shall be prepared before performing an abortion procedure as set out in 12 AAC 40.110.

Authority: AS 08.64.105

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

Authority: AS 08.64.105

12 AAC 40.100. CONSULTATION REQUIREMENTS. Abortions interrupting a pregnancy up to and including the twelfth week of gestation may be performed without consultation. Abortions performed after the twelfth week of gestation shall be preceded by consultation with another physician. The consultation shall include an opinion as to the preferred method of termination of pregnancy.

Authority: AS 08.64.105

12 AAC 40.110. ABORTION PROCEDURES. During the second or third trimester of a pregnancy, acceptable procedures include dilation and curettage, suction aspiration of the uterus, injection of pharmacological agents, hysterectomy and hysterotomy. The exact procedure to be used will depend upon the patient's total health, age, associated disease and pathology, and anomalies such as skeletal defects and other medical indications.

Authority: AS 08.64.105

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

(b) During the second or third trimester of a pregnancy, blood, blood derivatives, blood substitutes or plasma expanders shall be immediately available when an abortion is performed, and an operating room appropriately staffed and equipped for major surgery in accordance with regulations adopted under AS 18.20.060 shall be immediately available.

Authority: AS 08.64.105

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

Authority: AS 08.64.105

12 AAC 40.140. LIMITATION. A fetus which has not developed beyond 150 days after the first day of the last menstrual period may be considered nonviable for purposes of AS 11.15.060(a). In the performance of an abortion after that date, the physician shall be guided by a reasonable judgment as to whether the fetus is viable in fact.

Authority: AS 08.64.105 AS 11.15.060(a)

ARTICLE 3. CONTINUING MEDICAL EDUCATION.

Section

- 200. General requirements
- 210. Credit hours
- 220. Certification of compliance
- 240. Exemption from continuing medical education requirements

12 AAC 40.200. GENERAL REQUIREMENTS. (a) A physician seeking renewal of a license shall obtain an average of 25 credit hours of continuing medical education during each year of the previous license period.

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

Authority: AS 08.01.100 AS 08.64.100 AS 08.64.312
AS 08.64.075

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

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

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

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

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

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

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

Authority: AS 08.64.100 AS 08.64.312

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

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

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

Authority: AS 08.64.075 AS 08.64.312 AS 08.64.326
AS 08.64.100

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

Authority: AS 08.64.100 AS 08.64.101 AS 08.64.312

ARTICLE 4.
MOBILE INTENSIVE CARE PARAMEDICS.

Section

- 300. Application for license
- 310. Qualifications for initial license
- 315. Sponsorship
- 320. Approved curriculum
- 325. Internship requirements
- 330. (Repealed)
- 340. License issuance and expiration
- 350. Renewal of license
- 352. Lapsed mobile intensive paramedic licenses
- 355. Temporary permits
- 356. Provisional license
- 360. Grounds for suspension, revocation or refusal to issue a license
- 370. Scope of authorized activities
- 380. Prohibited acts
- 390. Identification

12 AAC 40.300. APPLICATION FOR LICENSE. (a) An applicant for a license as a mobile intensive care paramedic shall apply in writing to the board.

(b) The application will be provided by the board and must contain the name, age, mailing and geographical address (if different), the time spent in study, the place, year and school from which the degrees or certificates were granted, evidence that the applicant meets the requirements of 12 AAC 40.310, and any other information the board considers necessary.

(c) *Repealed 6/15/2001.*

Authority: AS 08.64.100 AS 08.64.107

12 AAC 40.310. QUALIFICATIONS FOR INITIAL LICENSE. (a) An applicant for a mobile intensive care paramedic license must

- (1) be 19 years of age or older;
- (2) be a high school graduate;
- (3) provide a letter from the applicant's physician sponsor verifying that the applicant will, at all times, be under the supervision of a physician sponsor approved by the board, as required by 12 AAC 40.315;
- (4) submit a certified copy of the applicant's paramedic education program certificate or an original letter, signed by the education program director and sent directly to the division from the program director, verifying completion of a training program that meets the requirements of 12 AAC 40.320;
- (5) following the successful completion of the classroom and clinical portions of the board approved curriculum, have satisfactorily completed a 480-hour internship that meets the requirements of 12 AAC 40.325;
- (6) pass the written and practical examination for emergency medical technician-paramedic administered by the National Registry of Emergency Medical Technicians; and
- (7) submit verification of licensure from the appropriate licensing authority in each state, territory, or province where the applicant holds or has ever held a license as a paramedic or other health care professional; and
- (8) submit the applicable fees established in 12 AAC 02.250.

(b) An applicant for licensure as a mobile intensive care paramedic who is currently licensed in another state must fulfill the requirements of (a)(1) – (4) and (6) – (8) of this section and

(1) may not be currently under suspension or revocation as a mobile intensive care paramedic, or emergency medical technician- paramedic, or the equivalent, and may not be the subject of an unresolved investigation, complaint review procedure, or disciplinary proceeding undertaken by a certifying or licensing agency in another state; and

(2) must submit written verification from the applicant's previous physician sponsor, on a form approved by the department, attesting that the applicant is capable of performing the activities listed in 12 AAC 40.370(a) plus any other specific emergency procedures authorized by the physician sponsor.

(c) The board will, in its discretion, require an applicant to provide additional documentation necessary to verify the applicant's education or experience.

Authority: AS 08.64.100 AS 08.64.107 AS 08.64.240

12 AAC 40.315. SPONSORSHIP. (a) A person licensed as a mobile intensive care paramedic shall immediately report to the board, in writing, any change of sponsorship.

(b) When a sponsor withdraws sponsorship of a mobile intensive care paramedic, the paramedic is not authorized to practice until a new physician sponsor is approved by the board.

Authority: AS 08.64.100 AS 08.64.107

12 AAC 40.320. APPROVED CURRICULUM. (a) The approved curriculum for license as a mobile intensive care paramedic is the U.S. Department of Transportation National Training Course Emergency Medical Technician Paramedic, in effect at the time of training.

(b) The training program must be under the direction of a physician licensed in the state where the training takes place.

Authority: AS 08.64.100 AS 08.64.107

12 AAC 40.325. INTERNSHIP REQUIREMENTS. An internship for a mobile intensive care paramedic must meet the following requirements:

(1) all procedures performed by an intern must be under the direct supervision of a physician sponsor or another physician, physician assistant, registered nurse, or mobile intensive care paramedic, licensed or certified in the state where the internship takes place, who has been designated the responsibility of supervision by the physician sponsor;

(2) the successful completion of the internship must be verified, on a form approved by the board, by the physician sponsor, attesting that the mobile intensive care paramedic intern is capable of performing the activities listed in 12 AAC 40.370(a) including any other specific emergency procedures authorized by the physician sponsor under 12 AAC 40.370(a)(8); and

(3) verification from the supervising physician of the successful completion of 20 twenty-four hour shifts, or the equivalent number of hours, completed at a location approved in advance by the board.

Authority: AS 08.64.100 AS 08.64.107

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

12 AAC 40.340. LICENSE ISSUANCE AND EXPIRATION. Upon documentation of successful completion of the requirements of this chapter, a license will be issued by the department to an applicant to practice as a mobile intensive care paramedic. A license expires biennially on a date set by the department. A license must be renewed under 12 AAC 40.350.

Authority: AS 08.64.100 AS 08.64.107

12 AAC 40.350. RENEWAL OF LICENSE. (a) An applicant for renewal of a mobile intensive care paramedic license shall submit

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

(2) satisfactory evidence of completion of continuing medical education consisting of not less than 60 classroom or clinical hours, or combination of classroom and clinical hours, for each complete 12-month period the applicant has held a mobile intensive care paramedic license during the concluding license period; not more than one-quarter of the total hours of continuing medical education required under this paragraph may be awarded for completion of a formal correspondence or other individual study program; at least six hours of the total hours of continuing medical education required under this paragraph must be specific to pediatrics emergency education;

(3) evidence of current successful completion of a course as either a provider or instructor in advanced cardiac life support from the American Heart Association or the American Safety and Health Institute; the board will accept the hours satisfied under this paragraph as a portion of the hours required in (2) of this subsection;

(4) evidence of current successful completion of a course in basic life support, including adult, child, and infant CPR and airway obstruction maneuvers from a program approved by the board; the board will accept the hours satisfied under this paragraph as a portion of the hours required in (a)(2) of this section; programs approved by the board include the following:

(A) Basic Life Support for Healthcare Providers – American Heart Association;

(B) CPR for the Professional Rescuer – American Red Cross;

(C) CPR component of Medic First Aid, Advanced – Medic First Aid International, Inc.;

(D) Basic Life Support for Professionals – EMP America;

(E) CPR for the Professional Rescuer – American Safety and Health Institute;

(F) Respond Systems AED/CPR;

(G) Emergency Care and Safety Institute's Professional Rescuer CPR;

(5) a written recommendation as to the applicant's fitness to practice as a mobile intensive care paramedic, made by the applicant's sponsor physician; the recommendation must include verification of skills performance in those authorized activities set out in 12 AAC 40.370(a); and

(6) the license renewal fee established by 12 AAC 02.250.

(b) If an applicant for renewal cannot meet the requirements for renewal under (a) of this section, the applicant must apply and meet the requirements for initial licensure under 12 AAC 40.300 — 12 AAC 40.310.

(c) The board will, in its discretion, exempt a mobile intensive care paramedic from the requirements of (a)(2) of this section upon application giving evidence satisfactory to the board that the applicant is unable to comply with the requirements because of extenuating circumstances. The board will not exempt a person from more than 60 hours of continuing medical education in a four-year period.

Authority: AS 08.01.100 AS 08.64.100 AS 08.64.107

12 AAC 40.352. LAPSED MOBILE INTENSIVE PARAMEDIC LICENSES. (a) A mobile intensive care paramedic license that has been lapsed for at least 60 days but less than one year will be reinstated if the applicant submits

- (1) documentation that the continuing medical education requirements of 12 AAC 40.350 have been met; and
- (2) the renewal fees required by 12 AAC 02.250.

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

- (1) a complete renewal application on a form provided by the department;
- (2) documentation that the continuing medical education requirements of 12 AAC 40.350(a)(2) have been met for the entire period during which the license has been lapsed;
- (3) verification of licensure from each state, territory, or province where the applicant holds or has ever held a mobile intensive paramedic license or other health care professional license;
- (4) the applicable fees required by 12 AAC 02.250.

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

Authority: AS 08.01.100 AS 08.64.107 AS 08.64.380
AS 08.64.100 AS 08.64.240

12 AAC 40.355. TEMPORARY PERMITS. (a) A member or designee, of the board may issue a temporary mobile intensive care paramedic permit to an applicant who meets the requirements of 12 AAC 40.310.

(b) A temporary permit is valid for eight months or until the board meets and considers the application, whichever occurs first.

(c) The board will, in its discretion, renew a temporary permit for good cause, one time only.

(d) A temporary permit will be withdrawn by the board if the physician sponsorship is withdrawn.

(e) In this section, "temporary permit" means a permit issued by a member or designee, of the board to an individual who has applied for licensure, has fulfilled the requirements set out in 12 AAC 40.310 and is awaiting the next meeting of the board for consideration of the application.

Authority: AS 08.64.100 AS 08.64.107

12 AAC 40.356. PROVISIONAL LICENSE. (a) The board will, in its discretion, issue a provisional license to an applicant for initial licensure who has met all requirements of 12 AAC 40.310 except for passing the examination required in 12 AAC 40.310(6). The applicant shall submit written verification from the National Registry of Emergency Medical Technicians that he or she is awaiting examination results or is scheduled to take the next examination.

(b) A provisional license is valid until the first meeting of the board after the results of the examination for licensure have been issued, or until the physician sponsor withdraws sponsorship, or until the board is notified that the provisional licensee has failed the examination for licensure, whichever occurs first.

(c) A provisional license is not renewable.

Authority: AS 08.64.100 AS 08.64.107

12 AAC 40.360. GROUNDS FOR SUSPENSION, REVOCATION OR REFUSAL TO ISSUE A LICENSE. The board, after compliance with the Administrative Procedure Act (AS 44.62), will, in its discretion, revoke, suspend, or refuse to issue a license for

- (1) fraud or deceit in obtaining a license required by this chapter;
- (2) habitual abuse of alcoholic beverages or depressants, or illegal use of hallucinogenic or stimulant drugs as defined by AS 17.12.150(3) or the use of narcotic drugs as defined by AS 17.10.230(13);
- (3) violation of the Controlled Substances Act (PL 91-513; 84 Stat. 1242) or any other federal law pertaining to medical practice and drugs;
- (4) gross misconduct by a licensee in the performance of his or her duties as a mobile intensive care paramedic which tends to endanger life or limb;
- (5) practice beyond the scope authorized by the sponsor physician;
- (6) practice without physician sponsorship.

Authority: AS 08.64.100

AS 08.64.107

12 AAC 40.370. SCOPE OF AUTHORIZED ACTIVITIES. (a) A licensed mobile intensive care paramedic, when under the supervision of a sponsor physician, may perform the activities listed in this subsection. The direct supervision of an activity may be delegated to another physician when the mobile intensive care paramedic is caring for a patient in a hospital, at the scene of a medical emergency when voice contact is monitored by a physician and direct communication is maintained, or when under the specific written standing order of a physician. The activities are

- (1) electrocardiographic monitoring and defibrillation;
- (2) initiating and maintaining intravenous routes using approved intravenous techniques and solutions;
- (3) performing endotracheal intubation and pulmonary ventilation by approved methods;
- (4) performing gastric suction by intubation;
- (5) obtaining blood for laboratory analysis;
- (6) administering parenterally, orally, or topically any approved agents or solutions;
- (7) use of pneumatic antishock devices; and
- (8) performing other emergency procedures authorized by a sponsoring physician.

(b) A person enrolled in a mobile intensive care paramedic training program may perform the activities set out in (a) of this section insofar as:

- (1) the activities are required as part of the training program;
- (2) the activities that take place in a hospital are supervised by a physician, physician assistant, mobile intensive care paramedic, or nurse; and
- (3) the activities that take place outside a hospital are supervised by a licensed mobile intensive care paramedic, or a physician sponsor, or the physician sponsor's designee.

(c) While functioning as an intern in Alaska, a person may not perform the activities listed in (a) of this section for more than 480 hours, or for more than six calendar months, without becoming licensed as a mobile intensive care paramedic by the board.

(d) The scope of authorized activities for a mobile intensive care paramedic does not include primary patient care, such as dispensing nonemergency medications, performing physical examinations for nonemergency purposes, and treatment of nonemergency medical conditions included in the scope of practice for a physician, physician assistant, or nurse, unless specifically authorized by the board.

Authority: AS 08.64.100

AS 08.64.107

12 AAC 40.380. PROHIBITED ACTS. No person may represent himself or herself as a paramedic, mobile intensive care paramedic, or emergency medical technician-paramedic unless he or she is licensed as a mobile intensive care paramedic under this chapter.

Authority: AS 08.64.100

AS 08.64.107

12 AAC 40.390. IDENTIFICATION. While performing the duties of a mobile intensive care paramedic, the licensee shall be clearly identified by nameplate, uniform, or other apparent means to distinguish him or her from other health care professionals, workers, and students.

Authority: AS 08.64.100

AS 08.64.107

ARTICLE 5. PHYSICIAN ASSISTANTS.

Section

400. Physician assistant license
405. Temporary license
406. (Repealed)
408. (Repealed)
410. Collaborative relationship and plan
415. Remote practice location
420. (Repealed)
430. Performance and assessment of practice
440. (Repealed)
445. Graduate physician assistant license
447. (Repealed)
450. Authority to prescribe, order, administer, and dispense medications
460. Identification
470. Renewal of a physician assistant license

- 473. Inactive physician assistant license
- 475. Lapsed physician assistant license
- 480. Exemptions
- 490. Grounds for suspension, revocation, or denial of license

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

- (1) shall apply for a permanent renewable license on a form provided by the department;
- (2) shall pay the appropriate fees established in 12 AAC 02.250; and
- (3) must be approved by the board.

(b) The application must contain documented evidence of

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

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

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

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

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

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

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

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

(c) *Repealed 9/1/2007.*

Authority: AS 08.64.100 AS 08.64.107

12 AAC 40.405. TEMPORARY LICENSE. (a) A member or designee of the board may approve a temporary physician assistant license of an applicant who meets the requirements of 12 AAC 40.400 or 12 AAC 40.445 and pays the fee set out in 12 AAC 02.250.

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

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

(d) *Repealed 07/25/2008.*

(e) An applicant who meets the requirements on the checklist established in this section has demonstrated the necessary qualifications for the temporary permit applied for and will be approved by the board or the board's designee for issuance of that permit. An applicant who does not meet the requirements on the checklist established in this section for that permit will not be issued a temporary permit unless the board further reviews the application and determines that the applicant meets the qualifications in AS 08.64 and this chapter for that permit. The form titled *Alaska State Medical Board – Checklist, Temporary Permit for Physician Assistant*, dated July 2012, is adopted by reference. This form is established by the board for the use by the executive secretary or another employee of the division in completing the application processing for a temporary permit under this section.

Authority: AS 08.64.100 AS 08.64.107

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

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

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

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

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

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

(3) the beginning date of employment under the collaborative plan and the physical location of practice;
(4) compliance with 12 AAC 40.415 if the practice location is a remote practice location; and
(5) prescriptive authority being granted to the physician assistant by the collaborating physician under the collaborative plan.

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

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

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

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

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

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

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

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

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

Authority: AS 08.64.100

AS 08.64.107

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

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

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

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

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

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

Authority: AS 08.64.100

AS 08.64.107

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

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

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

(c) *Repealed 3/27/03.*

(d) *Repealed 3/27/03.*

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

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

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

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

(i) Collaborative plans, regardless of duration, must include at least monthly telephone, radio, electronic, or direct personal contact between the physician assistant and the primary or alternate collaborating physician. Monthly contact must be documented.

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

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

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

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

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

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

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

(o) *Repealed 5/8/2013.*

(p) *Repealed 5/8/2013.*

(q) *Repealed 5/8/2013.*

Authority: AS 08.64.100 AS 08.64.107

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

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

- (1) shall apply on a form provided by the department;
- (2) shall pay the fees established in 12 AAC 02.250; and
- (3) must be approved by the board.

(b) The application must include

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

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

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

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

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

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

Authority: AS 08.64.100 AS 08.64.107

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

12 AAC 40.450. AUTHORITY TO PRESCRIBE, ORDER, ADMINISTER, AND DISPENSE MEDICATIONS. (a) A physician assistant who prescribes, orders, administers, or dispenses controlled substances must have a current Drug Enforcement Administration (DEA) registration number, valid for that handling of that controlled substance on file with the department.

(b) *Repealed 9/1/2007.*

(c) A physician assistant with a valid DEA registration number may order, administer, dispense, and write a prescription for a schedule II, III, IV, or V controlled substance only with the authorization of the physician assistant's primary collaborating physician. The authorization must be documented in the physician assistant's current collaborative plan on file with the division.

(d) The physician assistant's authority to prescribe may not exceed that of the primary collaborating physician as documented in the collaborative plan on file with the division.

(e) A physician assistant with a valid DEA registration number may request, receive, order, or procure schedule II, III, IV, or V controlled substance supplies from a pharmaceutical distributor, warehouse, or other entity only with the authorization of the physician assistant's primary collaborating physician. If granted this authority, the physician assistant is responsible for complying with all state and federal inventory and record keeping requirements. The authorization must be documented in the physician assistant's current collaborative plan on file with the division. Within 10 days after the date of issue on the form, the physician assistant shall provide to the primary collaborating physician a copy of each DEA Form 222 official order form used to obtain controlled substances.

(f) A physician assistant may prescribe, order, administer, or dispense a medication that is not a controlled substance only with the authorization of the physician assistant's primary collaborating physician. The authorization must be documented in the physician assistant's current collaborative plan on file with the division.

(g) A graduate physician assistant licensed under this chapter may not prescribe, order, administer, or dispense a controlled substance.

(h) Termination of a collaborative plan terminates a physician assistant's authority to prescribe, order, administer, and dispense medication under that plan.

(i) A prescription written under this section by a physician assistant must include the

- (1) primary collaborating physician's name;
- (2) primary collaborating physician's DEA registration number;
- (3) physician assistant's name; and
- (4) physician assistant's DEA registration number.

(j) In this section, unless the context requires otherwise,

(1) "order" means writing instructions on an order sheet to dispense a medication to a patient from an on-site pharmacy or drug storage area; for purposes of this paragraph, "on-site pharmacy" means a secured area that provides for the storage and dispensing of controlled substances and other drugs and is located in the facility where the physician assistant is practicing;

(2) "prescription" means a written document regarding a medication, prepared for transmittal to a licensed pharmacy for the dispensing of the medication;

(3) "schedule" used in conjunction with a controlled substance, means the relevant schedule of controlled substances under 21 U.S.C. 812 (Sec. 202, Federal Controlled Substances Act).

Authority: AS 08.64.100 AS 08.64.107

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

(1) a current state license; and

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

Authority: AS 08.64.100 AS 08.64.107

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

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

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

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

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

Authority: AS 08.64.100 AS 08.64.107 AS 08.64.315

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

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

- (1) indicating on the form for license renewal that the physician assistant is requesting an inactive license; and
- (2) paying the inactive biennial license fee established in 12 AAC 02.250.

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

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

- (1) submit a completed renewal application form indicating request for reactivation;
- (2) pay the physician assistant biennial license renewal fee established in 12 AAC 02.250, less any inactive license fee previously paid for the same licensing period;
- (3) submit a copy of a current certificate issued by the National Commission on Certification of Physician Assistants; and
- (4) request a clearance report from the Federation of State Medical Boards's Board Action Data Bank be sent directly to the board.

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

Authority: AS 08.64.100 AS 08.64.240 AS 08.64.313
AS 08.64.107

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

- (1) a complete renewal application form;
- (2) documentation that the continuing medical education requirements of 12 AAC 40.470(b)(2) have been met; and
- (3) the renewal fees required by 12 AAC 02.250.

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

- (1) a complete renewal application on a form provided by the department;
- (2) documentation that the continuing medical education requirements of 12 AAC 40.470(b)(2) have been met for the entire period that the authorization has been lapsed;
- (3) verification of licensure from the appropriate licensing authority in each state, territory, or province where the applicant holds or has ever held a license as a physician assistant or other health care professional;
- (4) clearance from the Federation of State Medical Boards sent directly to the division;
- (5) clearance from the federal Drug Enforcement Administration (DEA); and
- (6) the applicable fees required in 12 AAC 02.250.

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

Authority: AS 08.01.100 AS 08.64.100 AS 08.64.107

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

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

Authority: AS 08.64.100 AS 08.64.107

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

- (1) fails to pay the fees established in 12 AAC 02.250;
- (2) has obtained, or attempted to obtain, a license or authorization to practice as a physician assistant by fraud, deceit, material misrepresentation, or false statement;
- (3) habitually abuses alcoholic beverages, or illegally uses depressants, hallucinogenic or stimulant drugs as defined by AS 17.12.150(3) or uses narcotic drugs as defined by AS 17.10.230(13);
- (4) consistently fails to comply with 12 AAC 40.460;
- (5) practices without the required collaborative plan as required by 12 AAC 40.410;
- (6) represents or uses any signs, figures, or letters to represent himself or herself as a physician, surgeon, doctor, or doctor of medicine;
- (7) violates any section of this chapter;
- (8) is found to have demonstrated professional incompetence as defined in 12 AAC 40.970;

- (9) in a clinical setting,
 - (A) fails to clearly identify oneself as a physician assistant to a patient;
 - (B) uses or permits to be used on the physician assistant's behalf the term "doctor," "Dr.," or "doc"; or
 - (C) holds oneself out in any way to be a physician or surgeon;
- (10) practices without maintaining certification by the National Commission on Certification of Physician Assistants (NCCPA).

Authority: AS 08.64.100 AS 08.64.107

**ARTICLE 6.
GENERAL PROVISIONS.**

Section

- 910. Delegation of authority to the board's designee
- 930. Requirements for reporting the outcome of malpractice claims or actions
- 940. Standards of practice for record keeping
- 945. Performance of independent medical evaluations
- 946. Application made under oath or affirmation; disciplinary sanctions
- 950. Contract for impaired professionals program
- 955. Ethical standards
- 960. Current address
- 963. Application form and verifications for licensure
- 965. Reinstatement of a surrendered license
- 967. Unprofessional conduct
- 970. Professional incompetence
- 975. Prescribing controlled substances
- 980. (Repealed)
- 983. Cooperative practice agreements with pharmacists
- 985. General anesthetic
- 986. Withdrawal of application
- 987. Retention of abandoned applications
- 990. Definitions

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

Authority: AS 08.64.075 AS 08.64.100 AS 08.64.101

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

- (b) Malpractice reports shall include the
 - (1) name and address of the licensee;
 - (2) telephone number of the licensee;
 - (3) date of the occurrence;
 - (4) summary of the alleged malpractice;
 - (5) summary of the licensee's response to the allegations;
 - (6) case, claim, or court number of the malpractice claim or action; if a court action was not filed, the medical record or chart number, and the location of the records relating to the alleged malpractice;
 - (7) amount of the award or settlement paid or to be paid by or on behalf of the licensee;
 - (8) date of award or settlement;
 - (9) following type of resolution of the claim or action:
 - (A) court or jury award;
 - (B) settlement following initiation of civil court action;
 - (C) settlement before the initiation of civil court action;
 - (D) other private compromise.

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

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

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

- (b) Each patient record shall meet the following minimum requirements:
- (1) be legible;
 - (2) contain only those terms and abbreviations that are or should be comprehensible to similar licensees;
 - (3) contain adequate identification of the patient;
 - (4) indicate the dates that professional services were provided to the patient;
 - (5) reflect what examinations, vital signs, and tests were obtained, performed, or ordered concerning the patient and the findings and results of each;
 - (6) indicate the chief complaint of the patient;
 - (7) indicate the licensee's diagnostic impressions of the patient;
 - (8) indicate the medications prescribed for, dispensed to, or administered to the patient and the quantity and strength of each medication;
 - (9) reflect the treatment provided to or recommended for the patient;
 - (10) document the patient's progress during the course of treatment provided by the licensee.
- (c) Each entry in the patient record shall reflect the identity of the individual making the entry.
- (d) Each patient record shall include any writing intended to be a final record. This subsection does not require the maintenance of preliminary drafts, notes, other writings, or recordings once this information is converted to final form and placed in the patient record.

Authority: AS 08.64.100 AS 08.64.107

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

Authority: AS 08.64.100 AS 08.64.170 AS 08.64.370

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

Authority: AS 08.64.100 AS 08.64.190 AS 08.64.326
AS 08.64.107

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

- (1) qualifications of the contracting agency or agent;
- (2) record keeping;
- (3) responsibility to report to the board;
- (4) confidentiality;
- (5) chemical and behavioral monitoring components; and
- (6) costs.

Authority: AS 08.64.100 AS 08.64.101

12 AAC 40.955. ETHICAL STANDARDS. (a) The Principles of Medical Ethics of the American Medical Association on page xiv of the 2002 – 2003 Edition of the Council on Ethical and Judicial Affairs, *Code of Medical Ethics*, published by the American Medical Association are adopted by reference as the ethical standards for physicians and applies to all physicians subject to this chapter.

(b) The 1996 edition of the *Code of Ethics* of the American Osteopathic Association is adopted by reference as the ethical standards for osteopaths and applies to all osteopaths subject to this chapter.

(c) The 1998 edition of the *Code of Ethics* of the American Podiatric Medical Association is adopted by reference as the ethical standards for podiatrists and applies to all podiatrists subject to this chapter.

(d) The June 2006 edition of the *Code of Ethics of the Physician Assistant Profession of the American Academy of Physician Assistants* is adopted by reference as the ethical standards for physician assistants and applies to all physician assistants subject to this chapter.

(e) The third edition of the *EMT Code of Ethics* of the National Association of EMT's is adopted by reference as the ethical standards for mobile intensive care paramedics and applies to all mobile intensive care paramedics subject to this chapter.

Authority: AS 08.01.070 AS 08.64.107 AS 08.64.326
AS 08.64.100

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

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

Authority: AS 08.64.100 AS 08.64.107

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

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

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

(d) In this section, "application form or verification" means

- (1) an application for a license or permit;
- (2) a verification of licensure from an appropriate licensing authority in a state, territory, province, or other country;
- (3) a clearance report from the Federation of State Medical Boards Board Action Data Bank;
- (4) a clearance from the federal Drug Enforcement Administration (DEA).

Authority: AS 08.64.100

12 AAC 40.965. REINSTATEMENT OF A SURRENDERED LICENSE. (a) A license issued under this chapter that was voluntarily surrendered under AS 08.64.334 will be reinstated, if

- (1) the board determines that
 - (A) the requirements of AS 08.64.334 have been met;
 - (B) the applicant continues to qualify under AS 08.64 and this chapter for the license requested to be reinstated;
 - (C) the applicant has committed no grounds for imposition of disciplinary sanction under AS 08.64.326 or this chapter; and
 - (D) the applicant has satisfied any conditions imposed by the board to accept the surrendered license.
- (2) the applicant submits
 - (A) a new and complete application as required by 12 AAC 40.010, documenting compliance with
 - (i) AS 08.64.200 and AS 08.64.250, if a physician applicant;
 - (ii) AS 08.64.209 and AS 08.64.250, if a podiatrist applicant;
 - (iii) AS 08.64.205, if an osteopath applicant; or
 - (iv) AS 08.64.107, if a physician assistant or mobile intensive care paramedic;
 - (B) evidence of at least 50 hours of continuing medical education credits earned within the two years immediately before the date of application for reinstatement of the surrendered license for a physician, a podiatrist, or an osteopath;
 - (C) evidence of at least 120 hours of continuing medical education credits earned within the two years immediately before the date of application for reinstatement of the surrendered license for a physician assistant or a mobile intensive care paramedic;
 - (D) for a physician assistant, evidence of current certification issued by the National Commission on Certification of Physician Assistants; and
 - (E) at the request of the board,

- (i) a report of medical or psychiatric examination from a physician or another practitioner of the healing arts appointed by the board indicating that, at the time of the examination, the applicant is mentally and physically capable to resume practice under this chapter; and
- (ii) any other report that the board determines is necessary to evaluate whether the applicant is competent to resume practice under this chapter.

(b) If the board determines that a limitation or condition on an applicant's license is necessary for the applicant to be competent to resume practice, the board will require that the applicant for reinstatement under this section enter into an agreement with the board to limit or condition the applicant's license.

(c) If the board determines that probation is necessary to evaluate or monitor the practice for competency under this chapter of an applicant whose license is reinstated under this section, the board will impose a period of probation and notify the applicant of the terms to be met to successfully complete the probation.

Authority: AS 08.01.075 AS 08.64.100 AS 08.64.331
AS 08.01.100 AS 08.64.107 AS 08.64.334

12 AAC 40.967. UNPROFESSIONAL CONDUCT. For purposes of AS 08.64.240(b) and AS 08.64.326, "unprofessional conduct" means an act or omission by an applicant or licensee that does not conform to the generally accepted standards of practice for the profession for which the applicant seeks licensure or a permit under AS 08.64 or which the licensee is authorized to practice under AS 08.64. "Unprofessional conduct" includes the following:

- (1) submitting or causing the submission of testimony, a statement, or a document for consideration by the board knowing it contained false, misleading, or omitted material information or was fraudulently obtained; for purposes of this paragraph, "document" includes an affidavit, certificate, transcript, diploma, board certification information, reference letters, or translation of a foreign language document;
- (2) misrepresenting, concealing, or failing to disclose material information to
 - (A) obtain a license or permit under AS 08.64; or
 - (B) renew a license under AS 08.64;
- (3) purchase, sale, barter, or alteration of a license or permit issued under AS 08.64;
- (4) the use of a license or permit obtained as described in (3) of this section;
- (5) committing, or attempting to commit, fraud or deception, or attempting to subvert the process relating to an examination required under AS 08.64;
- (6) practicing a profession licensed under AS 08.64 without a required license or permit or with a lapsed, expired, retired, or inactive license or permit;
- (7) permitting or employing an unlicensed person to practice a profession licensed under AS 08.64
 - (A) without the required license or permit under AS 08.64; or
 - (B) while the person's license or permit was revoked, suspended, surrendered, or canceled in this state;
- (8) delegating professional practice responsibilities that require a license or permit under AS 08.64 to a person who does not possess the appropriate education, training, or licensure to perform the responsibilities;
- (9) failing to prepare and maintain accurate, complete, and legible records in accordance with generally accepted standards of practice for each patient and to make those records available to the board and the board's representatives for inspection for investigation purposes;
- (10) falsifying, intentionally making an incorrect entry, destroying or failing to maintain patient or facility medical records for at least seven years from the date of the last entry;
- (11) failing to provide copies of complete patient records in the licensee's custody and control within 30 days after receipt of a written request from the patient or the patient's guardian;
- (12) intentionally or negligently releasing or disclosing confidential patient information; this paragraph does not apply to disclosures required under state or federal law or when disclosure is necessary to prevent an imminent risk of harm to the patient or others;
- (13) offering, giving, soliciting, or receiving fees or other benefits, in whole or in part, to a person for bringing in or referring a patient;
- (14) harassing, disruptive, or abusive behavior by a licensee directed at staff or a patient, a patient's relative, or a patient's guardian;
- (15) disruptive behavior by a licensee at the workplace that interferes with the provision of patient care;
- (16) discriminating on the basis of the patient's race, religion, color, national origin, ancestry, or sex in the provision of professional services;
- (17) conviction of a felony or a crime involving moral turpitude; under this paragraph, a "crime involving moral turpitude" includes the following:
 - (A) homicide;
 - (B) manslaughter;
 - (C) assault;
 - (D) stalking;
 - (E) kidnapping;
 - (F) sexual assault;
 - (G) sexual abuse of a minor;

- (H) unlawful exploitation of a minor, including possession or distribution of child pornography;
- (I) indecent exposure;
- (J) unlawful distribution or possession for distribution of a controlled substance; for purposes of this subparagraph, "controlled substance" has the meaning given in AS 11.71.900;
- (18) using alcohol or other drugs
 - (A) to the extent that the use interferes with professional practice functions of the licensee or endangers the safety of patients; or
 - (B) that is illegal under state or federal law;
- (19) failing
 - (A) to comply with AS 08.64.336; or
 - (B) to report to the board or the board's representatives facts known to the licensee regarding incompetent or repeated negligent conduct, gross negligence, unprofessional conduct, sexual misconduct, or other illegal conduct by another licensee under AS 08.64.326;
- (20) failing to report to the board or the board's representatives that the licensee's hospital privileges have been denied, revoked, suspended, or limited by a hospital or other health care facility for disciplinary reasons by the physician in charge; this paragraph does not apply to a temporary suspension pending completion of medical records by the governing body of the hospital or other health care facility;
- (21) facilitating the practice of a profession licensed under AS 08.64 by a person who is not licensed, incompetent, or mentally, emotionally, or physically unable to practice safely;
- (22) failing to fulfill the responsibility and duties of a collaborating physician in any collaborative relationship entered into under AS 08.64 with a physician assistant;
- (23) violating provisions of any disciplinary sanction issued under AS 08.64;
- (24) failing to cooperate with an official investigation by the board or the board's representatives, including failing to timely provide requested information;
- (25) failing to allow the board or the board's representative, upon written request, to examine and have access to records maintained by the licensee that relate to the licensee's practice under AS 08.64;
- (26) failing to report to the board, no later than 30 days after
 - (A) the effective date of the action, any disciplinary action against the licensee taken by another licensing jurisdiction, health care entity, or law enforcement agency;
 - (B) the date of conviction, any conviction of a crime referred to in AS 08.64.326(a)(4);
- (27) providing treatment, rendering a diagnosis, or prescribing medications based solely on a patient-supplied history that a physician licensed in this state received by telephone, facsimile, or electronic format;
- (28) after performing surgery, failing to continue care of a surgical patient of the licensee through a post-surgical recovery and healing period, either by providing the care directly, delegating the care to one or more individuals who have the appropriate education, training, and licensure or certification to provide definitive care, or coordinating with another qualified physician or other medical professional who agrees to assume responsibility for managing the patient's post-surgical care;
- (29) prescribing, dispensing, or furnishing a prescription medication to a person without first conducting a physical examination of that person, unless the licensee has a patient-physician or patient-physician assistant relationship with the person; this paragraph does not apply to prescriptions written or medications issued
 - (A) for use in emergency treatment;
 - (B) for expedited partner therapy for sexually transmitted diseases; or
 - (C) in response to an infectious disease investigation, public health emergency, infectious disease outbreak, or act of bioterrorism;
- (30) failing to notify the board of the location of patient records within 30 days after a licensee has retired or closed a practice;
- (31) knowingly delegating a function, task, or responsibility to another person if the delegation would be reasonably likely to pose a substantial risk of harm to a patient;
- (32) any conduct described in (1) – (31) of this section that occurred in another licensing jurisdiction and is related to the applicant's or licensee's qualifications to practice.

Authority: AS 08.01.070 AS 08.64.100 AS 08.64.326

12 AAC 40.970. PROFESSIONAL INCOMPETENCE. As used in AS 08.64 and these regulations, "professional incompetence" means lacking sufficient knowledge, skills, or professional judgement in that field of practice in which the physician or physician assistant concerned engages, to a degree likely to endanger the health of his or her patients.

Authority: AS 08.64.100 AS 08.64.326

12 AAC 40.975. PRESCRIBING CONTROLLED SUBSTANCES. When prescribing a drug that is a controlled substance, as defined in AS 11.71.900, an individual licensed under this chapter shall create and maintain a complete, clear, and legible written record of care that includes, at a minimum,

- (1) a patient history and evaluation sufficient to support a diagnosis;

- (2) a diagnosis and treatment plan for the diagnosis;
- (3) monitoring the patient for the primary condition that necessitates the drug, side effects of the drug, and results of the drug, as appropriate;
- (4) a record of drugs prescribed, administered, or dispensed, including the type of drug, dose, and any authorized refills.

Authority: AS 08.64.100 AS 08.64.107 AS 08.64.380

12 AAC 40.980. COLLABORATING PHYSICIAN. *Repealed 9/1/2007.*

12 AAC 40.983. COOPERATIVE PRACTICE AGREEMENTS WITH PHARMACISTS. (a) A physician may enter into a cooperative practice agreement with a pharmacist licensed under AS 08.80 as provided in this section. The initial agreement may not exceed two years and is subject to renewal under (j) of this section.

(b) A physician planning to enter into a cooperative practice agreement with a pharmacist must submit to the board a written proposed agreement that meets the requirements of this section. The proposed agreement must be approved by the board before cooperative practice under the agreement, if approved, begins. A proposed modification to an agreement must be submitted to the board for approval, before the modification, if approved, is implemented. The board will approve a proposed agreement or modification if it is medically appropriate and provides for the safety of the patient. If the board disapproves a proposed agreement or modification, the board shall state the reasons for its action.

(c) A cooperative practice agreement between a physician and a pharmacist must include

(1) the physician's authorization to a pharmacist or group of pharmacists to manage a patient's medication therapy;

(2) the full name, medical license number, date of issuance of license, and specialty, if any, of each physician who is a party to the agreement;

(3) the full name, place of employment, mailing address, pharmacist license number, and date of issuance of license, of each pharmacist who is a party to the agreement;

(4) a statement of the duration of the agreement, which may not exceed two years;

(5) the types of cooperative practice decisions that the physician is authorizing the pharmacist to make under the agreement, including

(A) types of diseases, medications, or medication categories involved and the type of cooperative authority to be exercised in each case; and

(B) procedures, decision criteria, or plans the pharmacist must follow when making therapeutic decisions, particularly when initiating or modifying medication;

(6) requirements that a pharmacist must follow when exercising cooperative authority, including documentation of decisions made, and a plan for communication and feedback to the physician concerning specific decisions made;

(7) a plan for the physician to review the decisions made by the pharmacist at least once every three months;

(8) a plan for providing to the physician patient records created under the agreement;

(9) a provision that allows the physician to override the agreement if the physician considers it medically necessary or appropriate;

(10) an acknowledgement that the physician will not receive any compensation from a pharmacist or pharmacy as a result of the care or treatment of any patient under the agreement;

(11) a prohibition on the administration or dispensing of any schedule I, II, III, or IV controlled substances.

(d) The physician, or a physician assistant under the supervision of the physician, must physically examine and evaluate a patient before that patient may be included under a cooperative practice agreement to which that physician is a party. The physician must issue a prescription or medication order for each patient valid for up to one year. The physician, or a physician assistant under the supervision of the physician, must conduct a physical examination of a patient at least once a year while that patient is included under a cooperative practice agreement to which that physician is a party. The requirements of this subsection do not apply to a cooperative practice agreement allowing the administration of emergency contraception, immunizations of persons 18 years of age or older, and those immunizations recommended to be given on a yearly basis by the United States Department of Health and Human Services Centers for Disease Control and Prevention.

(e) Only a physician in active practice in this state may enter into a cooperative practice agreement under this section. An authority authorized by a physician must be within the physician's current scope of practice.

(f) A physician who enters into a cooperative practice agreement shall keep a copy of the written agreement and the records of all patients treated under it during the period of the agreement. The physician shall retain the agreement and records required by this subsection for at least seven years after the termination of the agreement.

(g) A cooperative practice agreement is terminated upon written notice by either the physician or the pharmacist. The physician shall notify the board in writing within 30 days after an agreement is terminated.

(h) The board may periodically review cooperative practice agreements approved under this section.

(i) The requirements of this section do not apply to cooperative practice agreements adopted by the physicians on medical staff of a hospital or nursing facility licensed under AS 47.32 for treatment of patients of that facility.

(j) The physician may seek renewal of a cooperative practice agreement for additional two-year periods.

(k) Notwithstanding the requirements of (b) of this section, a physician who, before the effective date of this section, has entered into a collaborative practice agreement with a pharmacist that has been approved by the Board of Pharmacy under 12 AAC 52.240 and is still current, must obtain the board's approval of that agreement under this section within six months after this section takes effect. After that time, a physician may not participate in a cooperative practice agreement with a pharmacist except as allowed under this section.

(l) In this section, "cooperative practice agreement" means an agreement between a physician and a pharmacist by which a physician authorizes the pharmacist to manage a patient's medication therapy as specified in the agreement.

Authority: AS 08.64.100 AS 08.64.326

12 AAC 40.985. GENERAL ANESTHETIC. A commercially prepared mixture of 50 percent oxygen and 50 percent nitrous oxide, when self-administered by a patient as a part of the outpatient care provided by a licensed podiatrist, is an analgesic and not a general anesthetic referred to in AS 08.64.380(9)(B).

Authority: AS 08.64.100 AS 08.64.107 AS 08.64.380(9)

12 AAC 40.986. WITHDRAWAL OF APPLICATION. (a) An application for a permit or license may be withdrawn from consideration by the board at the applicant's request. To withdraw an application, the applicant must submit a request for withdrawal in writing signed by the applicant. The request for withdrawal must be received by the division no later than five business days before the board's meeting where the application is to be initially considered.

(b) The board will not approve a request for the withdrawal of an application under this section for an application that has been reviewed and considered by the board, or considered abandoned under 12 AAC 02.910.

(c) An application approved for withdrawal under this section will be reported to the Federation of State Medical Boards's Board Action Data Bank.

(d) An application that is approved for withdrawal under this section will be retained on file in the department for at least 10 years after the date of withdrawal and will be returned to the board if the applicant reapplies for a permit or license.

Authority: AS 08.64.100

12 AAC 40.987. RETENTION OF ABANDONED APPLICATIONS. (a) An application that is abandoned under 12 AAC 02.910 will be retained on file in the department for at least 10 years after the date of abandonment. If an applicant with an abandoned application reapplies for a permit or license, that abandoned application will be returned to the board for review and consideration.

(b) The application of an applicant who has been issued a temporary permit before abandoning the application under 12 AAC 02.910 will be reported to the Federation of State Medical Boards as denied without prejudice.

Authority: AS 08.01.050 AS 08.64.100

12 AAC 40.990. DEFINITIONS. (a) In this chapter

(1) "acceptable moral character" means having not been convicted of a felony or any morally reprehensible crime during the five years immediately preceding application;

(2) "board" means State Medical Board;

(3) "certified true copy" means a copy of a document that includes a statement of certification, signed under penalty of unsworn falsification before a notary public, that the document is a true copy of the original document;

(4) "collaborating physician" means a person who is actively licensed in the state as a physician or osteopath, who enters into a consultative relationship with a nonphysician health care provider who undertakes the practice of medicine, medical diagnosis and treatment;

(5) "collaborative relationship" means a consultative relationship between a physician and nonphysician health care provider which uses their respective areas of expertise to meet the common goal of providing comprehensive care for the patient;

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

(7) "flex examination" means the written examination prepared by the Federation of State Medical Boards of the United States;

(8) "internship" means 480 hours of full-time supervised field training as a mobile intensive care paramedic;

(9) "mobile intensive care paramedic" means a physician-trained mobile intensive care paramedic as defined in AS 08.64.380(7);

(10) "NBME examination" means the written examination prepared by the National Board of Medical Examiners;

(11) "pharmacological agents" means saline, glucose, prostglandins and pitocin;

(12) "physician" means a person licensed under AS 08.64 to practice medicine or surgery;

(13) "physician assistant" means a person specially trained to perform many of the functions and duties of the physician, including examination, diagnosis and treatment, and who is licensed under this chapter to do so;

(14) "sponsor physician" means

(A) a physician licensed to practice medicine in the State of Alaska who is approved by the board to be responsible for the activities of a mobile intensive care paramedic;

(B) the chairperson of a local medical advisory board which takes responsibility for the supervision of mobile intensive care paramedics as defined in (A) of this paragraph, and whose membership consists of a majority of physicians; the chairperson must be a physician licensed to practice in the State of Alaska; or

(C) a physician working in the regular medical service of the United States armed services or the United States Public Health Service.

(15) "sponsor physician supervision" means responsibility for the medical care provided by the mobile intensive care paramedics, including but not limited to

(A) establishment and periodic review of treatment protocols;

(B) approval of medical standing orders which delineate those advanced life-support techniques which may be carried out by the mobile intensive care paramedic and under what circumstances;

(C) assuring that the mobile intensive care paramedics have 24-hour access to voice contact with a physician;

(D) responsibility for provisions for periodic physician critiques of patient care provided by the mobile intensive care paramedic for selected cases;

(E) approval of a program of continuing medical education for each mobile intensive care paramedic under his supervision; the program must meet the requirements of 12 AAC 40.350(a)(1);

(16) *repealed 3/12/89;*

(17) *repealed 3/12/89;*

(18) *repealed 3/12/89;*

(19) *repealed 3/12/89;*

(20) "USMLE" means the United States medical licensing examination sponsored jointly by the Federation of State Medical Boards of the United States, Inc. and the National Board of Medical Examiners;

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

(22) "division" means the division assigned occupational licensing functions in the department;

(23) "COMLEX examination" means the Comprehensive Osteopathic Medical Licensing Examination administered by the National Board of Osteopathic Medical Examiners;

(24) "post-graduate training" for physicians includes internship, residency, and advanced forms of residency including fellowships;

(25) "health care professional" includes chiropractors, mental health counselors, social workers, dental hygienists, dentists, health aides, nurses, nurse practitioners, certified nurse aides, occupational therapists, occupational therapy assistants, optometrists, osteopaths, naturopaths, physical therapists, physical therapy assistants, physicians, physician assistants, psychiatrists, psychologists, psychological associates, audiologists licensed under AS 08.11, hearing aid dealers licensed under AS 08.55, marital and family therapists licensed under AS 08.63, religious health practitioners, acupuncturists, and surgeons;

(26) "business day" means a day other than Saturday, Sunday, or a state holiday;

(27) "DEA" means the federal Drug Enforcement Administration;

(28) "FCVS" means the Federal Credentials Verification Service of the Federation of State Medical Boards of the United States, Inc.

(b) In AS 08.64.326(a)(9),

(1) "attempted sexual contact" means engaging in conduct that constitutes a substantial step towards sexual contact;

(2) "sexual contact"

(A) means touching, directly or through clothing, a patient's genitals, anus, or female breast, or causing the patient to touch, directly or through clothing, the licensee's or patient's genitals, anus, or female breast;

(B) includes sexual penetration;

(C) does not include acts

(i) that may reasonably be construed to be normal caretaker responsibilities for a child, interactions with a child, or affection for a child; or

(ii) performed for the purpose of administering a recognized and lawful form of examination or treatment that is reasonably adapted to promoting the physical or mental health of the person being treated; in this paragraph, "sexual penetration" means genital intercourse, cunnilingus, fellatio, anal intercourse, or an intrusion, however slight, of an object or any part of a person's body into the genitals or anus of another person's body; each party to any of the acts defined as "sexual penetration" is considered to be engaged in sexual penetration; "sexual penetration" does not include acts performed for the purpose of administering a recognized and lawful form of examination or treatment that is reasonably adapted to promoting the physical health of the person being treated;

(3) "sexual impropriety" means behavior, a gesture, or an expression that is seductive, sexually suggestive, or sexually demeaning to a patient; "sexual impropriety" includes

(A) encouraging the patient to masturbate in the presence of the licensee or masturbation by the licensee while the patient is present;

- (B) offering to provide controlled substances or other drugs in exchange for sexual contact;
 - (C) disrobing or draping practice that is seductive, sexually suggestive, or sexually demeaning to a patient, such as deliberately watching a patient dress or undress or failing to provide privacy for disrobing;
 - (D) making a comment about or to the patient that is seductive, sexually suggestive, or sexually demeaning to a patient, including
 - (i) sexual comment about a patient's body or underclothing;
 - (ii) sexualized or sexually-demeaning comment to a patient;
 - (iii) demeaning or degrading comments to the patient about the patient's sexual orientation, regardless of whether the patient is homosexual, heterosexual, or bisexual;
 - (iv) comments about potential sexual performance of the patient during an examination or consultation, except when the examination or consultation is pertinent to the issue of sexual function or dysfunction;
 - (v) requesting details of sexual history or sexual likes or dislikes of the patient if the details are not clinically indicated for the type of examination or consultation;
 - (E) performing an internal pelvic examination or rectal examination of the patient without the use of gloves;
 - (F) initiation by the licensee of conversation with a patient regarding the sexual problems, preferences, or fantasies of the licensee;
 - (G) using the medical or professional relationship with the patient to solicit sexual contact or a romantic relationship with the patient or another;
 - (H) kissing a patient in a romantic or sexual manner;
- (4) "sexual misconduct" includes sexual impropriety;
- (5) "in connection with the delivery of professional services to patients" includes sexual misconduct directed at patients or key third parties; in this paragraph, "key third parties" means individuals who have influence over the patient, including the patient's spouse, children, parents, legal guardian, or surrogate.

Authority: AS 08.64.100 AS 08.64.107 AS 08.64.326

APPENDIX A

HEALTH AND SAFETY

CHAPTER 20. HOSPITALS.

Sec. 18.16.010. Abortions. (a) An abortion may not be performed in this state unless

(1) the abortion is performed by a physician or surgeon licensed by the State Medical Board under AS 08.64.200;

Sec. 18.20.050. Denial, suspension, or revocation of license. The department may deny, suspend, or revoke a license in a case in which it finds that there has been a substantial failure to comply with the requirements established under AS 08.64.336 or AS 18.20.060—18.20.080.

CHAPTER 23. HEALTH CARE SERVICES INFORMATION.

Sec. 18.23.030. Confidentiality of records of review organization. (a) Except as provided in (b) of this section, all data and information acquired by a review organization, in the exercise of its duties and functions, shall be held in confidence and may not be disclosed to anyone except to the extent necessary to carry out the purposes of the review organization, and is not subject to subpoena or discovery. Except as provided in (b) of this section, a person described in AS 18.23.020 may not disclose what transpired at a meeting of a review organization except to the extent necessary to carry out the purposes of a review organization, and the proceedings and records of a review organization are not subject to discovery or introduction into evidence in a civil action against a health care provider arising out of the matter that is subject of consideration by the review organization. Information, documents, or records otherwise available from original sources are not immune from discovery or use in a civil action merely because they were presented during proceedings of a review organization, nor may a person who testified before a review organization or who is a member of it be prevented from testifying as to matters within the person's knowledge, but a witness may not be asked about the witness' testimony before a reviewing organization or opinions formed by the witness as a result of its hearings, except as provided in (b) of this section.

(b) Testimony, documents, proceedings, records, and other evidence adduced before a review organization that are otherwise accessible under this section may be obtained by a health care provider who claims that denial is unreasonable, or may be obtained under subpoena or discovery proceedings brought by a plaintiff who claims that information provided to a review organization was false and claims that the person providing the information knew or had reason to know the information was false.

(c) Nothing in AS 18.23.005 - 18.23.070 prevents a person whose conduct or competence has been reviewed under this chapter from obtaining, for the purpose of appellate review of the action of the review organization, any testimony, documents, proceedings, records and other evidence adduced before the review organization.

(d) Notwithstanding the provisions of (b) and (c) of this section, information contained in a report submitted to the State Medical Board, and information gathered by the board during an investigation, under AS 08.64.336 is not subject to subpoena or discovery unless and until the board takes action to suspend, revoke, limit, or condition a license of the person who is the subject of the report or investigation.

APPENDIX B

ALASKA RULES OF THE COURT
RULES OF EVIDENCE
ARTICLE V. PRIVILEGES

Rule 504. Physician and Psychotherapist-Patient Privilege.

(a) **Definitions.** As used in this rule:

(1) A patient is a person who consults or is examined or interviewed by a physician or psychotherapist.

(2) A physician is a person authorized to practice medicine in any state or nation, or reasonably believed by the patient so to be.

(3) A psychotherapist is (A) a person authorized to practice medicine in any state or nation, or reasonably believed by the patient so to be, while engaged in the diagnosis or treatment of a mental or emotional condition, including alcohol or drug addiction, or (B) a person licensed or certified as a psychologist or psychological examiner under the laws of any state or nation or reasonably believed by the patient so to be, while similarly engaged.

(4) A communication is confidential if not intended to be disclosed to third persons other than those present to further the interest of the patient in the consultation, examination, or interview, or persons reasonably necessary for the transmission of the communication, or persons who are participating in the diagnosis and treatment under the direction of the physician or psychotherapist, including members of the patient's family.

(b) **General Rule of Privilege.** A patient has a privilege to refuse to disclose and to prevent any other person from disclosing confidential communications made for the purpose of diagnosis or treatment of his physical, mental or emotional conditions, including alcohol or drug addiction, among himself, his physician or psychotherapist, or persons who are participating in the diagnosis or treatment under the direction of the physician or psychotherapist, including members of the patient's family.

(c) **Who May Claim the Privilege.** The privilege may be claimed by the patient, by his guardian, guardian ad litem or conservator, or by the personal representative of a deceased patient. The person who was the physician or psychotherapist at the time of the communication is presumed to have authority to claim the privilege but only on behalf of the patient.

(d) **Exceptions.** There is no privilege under this rule:

(1) *Condition and Element of Claim or Defense.* As to communications relevant to the physical, mental or emotional condition of the patient in any proceeding in which the condition of the patient is an element of the claim or defense of the patient, of any party claiming through or under the patient, of any person raising the patient's condition as an element of his own case, or of any person claiming as a beneficiary of the patient through a contract to which the patient is or was a party; or after the patient's death, in any proceeding in which any party puts the condition in issue.

(2) *Crime or Fraud.* If the services of the physician or psychotherapist were sought, obtained or used to enable or aid anyone to commit or plan a crime or fraud or to escape detection or apprehension after the commission of a crime or a fraud.

(3) *Breach of Duty Arising Out of Physician-Patient Relationship.* As to a communication relevant to an issue of breach, by the physician, or by the psychotherapist, or by the patient, of a duty arising out of the physician-patient or psychotherapist-patient relationship.

(4) *Proceedings for Hospitalization.* For communications relevant to an issue in proceedings to hospitalize the patient for physical, mental or emotional illness, if the physician or psychotherapist, in the course of diagnosis or treatment, has determined that the patient is in need of hospitalization.

(5) *Required Report.* As to information that the physician or psychotherapist or the patient is required to report to a public employee, or as to information required to be recorded in a public office, if such report or record is open to public inspection, or as to information or matters contained in or reasonably raised by a report submitted under AS 08.64.336, other than information that would establish the identity of a patient, unless the court finds that it is necessary to admit the identifying information in order to serve the interests of justice.

(6) *Examination by Order of Judge.* As to communications made in the course of an examination ordered by the court of the physical, mental or emotional condition of the patient, with respect to the particular purpose for which the examination is ordered unless the judge orders otherwise. This exception does not apply where the examination is by order of the court upon request of the lawyer for the defendant in a criminal proceeding in order to provide the lawyer with information needed so that he may advise the defendant whether to enter a plea based on insanity or to present a defense based on his mental or emotional condition.

(7) *Criminal Proceeding.* For physician-patient communications in a criminal proceeding. This exception does not apply to the psychotherapist-patient privilege. (Added by Supreme Court Order 364 effective August 1, 1979; amended by Supreme Court Order 850 effective January 15, 1988)



AMERICAN SOCIETY OF
PLASTIC SURGEONS®



THE PLASTIC SURGERY
FOUNDATION®

Executive Office

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847-228-9900 • Fax: 847-228-9131 • www.plasticsurgery.org

March 27, 2015

The Honorable Chairman Bert Stedman
State Capitol, Room 30
Juneau, AK 99801

RE: Opposition of SB 55

Dear Chairman Stedman and Honorable Members of the Health and Social Services Committee:

On behalf of the American Society of Plastic Surgeons (ASPS), I am writing to express serious opposition to Alaska Senate Bill 55, which would expand the scope of practice for optometrists beyond their professional training. ASPS was founded in 1931 and represents over 7,000 physicians certified by the American Board of Plastic Surgery. This legislation raises considerable patient safety concerns that would compromise quality medical care for patients in Alaska.

If passed, SB 55 would allow non-physician optometrists to perform surgical procedures on the face. This includes complex procedures that fall squarely within the practice of medicine. These procedures are neither “superficial” nor “not invasive” as the bill describes them. Allowing optometrists to practice medicine without the requisite medical school and residency training would jeopardize patient safety and lower the standard of surgical care in the state.

SB 55 also gives optometrists the authority to use a wide range of pharmaceuticals that require a fundamental and systematic medical understanding of the human body. This understanding is gained through the clinical and educational rigor of a physician’s training. Physicians are uniquely qualified to treat patients in the rare instance when an allergic reaction or some other life-threatening complication arises when these drugs are administered. Optometrists do not receive the same education and training ophthalmologists and plastic surgeons receive. Ophthalmologists and plastic surgeons must attain a core medical and surgical education while completing seven to ten years of training, which includes increasing responsibility and decision-making authority in the hospital setting. Optometrists only complete four to five years of education with significantly less clinical exposure and responsibility.

Due to patient safety issues, such as the possibility of complications arising from surgery, it is critical that such procedures are performed by physician surgeons who have the comprehensive training and board certification to handle those complications when they do occur. I again urge you to **OPPOSE** Senate Bill 55 in order to protect the high standard of patient safety in Alaska. If you have any questions or need further assistance, please feel free to contact Patrick Hermes, Senior Manager of Government Affairs and Advocacy at phermes@plasticsurgery.org.

Sincerely,

Scot Bradley Glasberg, MD
President, American Society of Plastic Surgeons

Alaska State Medical Board
Board Issued Guidelines

Subject:	<i>Guidelines Regarding the Use of Lasers and Laser Surgery</i>
Implemented:	January 16, 2004
Revised:	October 25, 2007
<p>The Alaska State Medical Board has adopted the policies of the American Medical Association, following, to be its guidelines to its licensees in Alaska with regard to who may perform laser surgery.</p> <p style="text-align: center;"><u>Performance of Laser Surgery</u></p> <p>American Medical Association's Policy H-475.989, Laser Surgery, reads:</p> <p style="padding-left: 40px;">"Laser surgery should be performed only by individuals licensed to practice medicine and surgery or by those categories of practitioners currently licensed by the state to perform surgical services."</p> <p>American Medical Association's Policy H-475.988, Laser Surgery, reads:</p> <p style="padding-left: 40px;">"The board opines that revision, destruction, incision or other structural alteration of human tissue using laser is surgery."</p> <p>The board has further adopted into its policy the American College of Surgeons' "<i>Statement on Surgery Using Lasers, Pulsed Light, Radiofrequency Devices, or Other Techniques</i>" adopted February 9, 2007 by the ACS Board of Regents attached hereto.</p>	

Support Emails for SB 55 Optometry

Compiled 2-20-15

Dear Senator Cathy Giessel,

Please support SB 55! SB 55 updates the Alaska Optometry statutes, allowing the board to determine the regulatory details of practice.

SB 55 places the details of the continuing education requirements back into regulation where they belong, as the Department indicated they desired many years ago.

SB 55 leaves the details of the current pharmaceutical prescribing authority up to the board, through regulation, as with the other prescribing professions. The bill does clearly prohibit injections into the vitreous body of the eye, which is done by specialty ophthalmologists.

SB 55 brings the definition of optometry into 2015. Optometrists are trained to perform far more advanced procedures than many years ago. The new definition clearly defines how optometrists are already practicing and allows the board the flexibility to assure protection of the public. And there is a section on limitations on practice which excludes any invasive surgery, and a section clearly defining all the excluded surgery reserved for ophthalmology, including laser PRK, even though many optometrists can perform this in a few other states, it is still prohibited in SB 55.

Sincerely,

Kathleen Rice, OD

Kenai, AK

Dear Senator Giessel,

My wife and I have practiced optometry in Fairbanks for the past fifteen years. We initially arrived in Alaska as an active duty family at Bassett Army hospital, but found that the kindness of the people that make up the community of Fairbanks encouraged us to make Alaska our home.

During our time serving the community of Fairbanks as optometrists we have always appreciated the Alaskan legislature's willingness to adjust the state's statutes to reflect the advances in technology available to our profession and the ever evolving scope of optometric practice. Optometrists provide the majority of primary eye care in our community and the increased scope of practice over the years has definitely improved our patients access to timely therapeutic intervention.

Thank you for supporting SB 55, as this bill would allow the Alaska Board of Optometry to regulate our continued education requirements and scope of medical prescribing to reflect the current advances in optometric education and technology. This bill would allow the board of optometry to insure proper protection of the public as is the case for many of the other board regulated professions in Alaska. We are blessed to practice in a state that has always recognized the advancements in optometric patient care.

Thank you,

Drs. Chad and Colleen Personett
Fairbanks, AK

Dear Ms. Conway:

As an optometrist with 26 years experience (20 in Alaska), I strongly support DROPPING the injections course requirement. We optometrists DO NOT DO INJECTIONS. It is a hostile requirement introduced to HARM optometry.

D J Kosterman OD

Sen. Giessel:

As an optometrist with 26 years experience (20 in Alaska), I strongly support the repeal of the requirement for a seven hours injection course. It is an unnecessary burden, unrelated to the actual practice of optometry.

Daniel Kosterman, OD

February 19, 2015

Senator Cathy Giessel:

I am your constituent asking you to please support SB 55.

SB 55 updates the Alaska Optometry statutes in several areas, making it similar to the dental and nurse practitioner statutes, whereas the board determines the regulatory details of practice. This allows more flexibility as technology advances.

It places the details of the continuing education requirements back into regulation where they belong, as the Department indicated they desired many years ago when I was on the Optometry Board. Current regulations already require 36 hours per license period, and the deleted hours shown are redundant and require unnecessary work for Occupational Licensing to track.

SB 55 leaves the details of the current pharmaceutical prescribing authority up to the board through regulation, as with the other prescribing professions. But the bill does clearly prohibit injections into the vitreous body of the eye, which is done by specialty ophthalmologists. Alaska optometrists currently prescribe scheduled drugs including schedule 2 hydrocodone as approved last legislative session.

SB 55 re-writes the optometry definition which is currently over 40 years old. Optometrists are trained and currently perform far more advanced procedures than many years ago, such as diagnostic imaging, laser imaging, and prescribing pharmaceuticals. This new definition clearly defines modern optometry, and allows the board the flexibility to assure protection of the public. There is also a section on limitations on practice which excludes any invasive surgery, and a section clearly defining all the excluded surgery reserved for ophthalmology, including laser PRK, even though many optometrists can perform this in a few other states, it is still prohibited in SB 55.

Sincerely,

Jeffrey A. Gonnason, OD

drjeffg@gmail.com

Past Chair, Alaska Board of Optometry
Past President, Alaska Optometric Association

Support Emails for SB 55 Optometry

Compiled Feb. 20-24, 2015

Dear Senator Cathy Giessel,

Please support SB 55! SB 55 updates the Alaska Optometry statutes, allowing the board to determine the regulatory details of practice.

SB 55 places the details of the continuing education requirements back into regulation where they belong, as the Department indicated they desired many years ago.

SB 55 leaves the details of the current pharmaceutical prescribing authority up to the board, through regulation, as with the other prescribing professions. The bill does clearly prohibit injections into the vitreous body of the eye, which is done by specialty ophthalmologists.

SB 55 brings the definition of optometry into 2015. Optometrists are trained to perform far more advanced procedures than many years ago. The new definition clearly defines how optometrists are already practicing and allows the board the flexibility to assure protection of the public. And there is a section on limitations on practice which excludes any invasive surgery, and a section clearly defining all the excluded surgery reserved for ophthalmology, including laser PRK, even though many optometrists can perform this in a few other states, it is still prohibited in SB 55.

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During our time serving the community of Fairbanks as optometrists we have always appreciated the Alaskan legislature's willingness to adjust the state's statutes to reflect the advances in technology available to our profession and the ever evolving scope of optometric practice. Optometrists provide the majority of primary eye care in our community and the increased scope of practice over the years has definitely improved our patients access to timely therapeutic intervention.

Thank you for supporting SB 55, as this bill would allow the Alaska Board of Optometry to regulate our continued education requirements and scope of medical prescribing to reflect the current advances in optometric education and technology. This bill would allow the board of optometry to insure proper protection of the public as is the case for many of the other board regulated professions in Alaska. We are blessed to practice in a state that has always recognized the advancements in optometric patient care.

Thank you,

Drs. Chad and Colleen Personett
Fairbanks, AK

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As an optometrist with 26 years experience (20 in Alaska), I strongly support DROPPING the injections course requirement. We optometrists DO NOT DO INJECTIONS. It is a hostile requirement introduced to HARM optometry.

D J Kosterman OD

Sen. Giessel:

As an optometrist with 26 years experience (20 in Alaska), I strongly support the repeal of the requirement for a seven hours injection course. It is an unnecessary burden, unrelated to the actual practice of optometry.

Daniel Kosterman, OD

Senator Giessel and members of the Senate HSS committee,

I am asking for your support of SB 55.

This bill updates the Alaska Optometry statutes in several areas, making it similar to the dental and nurse practitioner statutes, whereas the board determines the regulatory details of practice. This allows more flexibility as technology advances thus avoiding repeated trips to the legislature to continue to patch together an almost 40 year old existing law in a profession that has changed immensely in even the past 10 years.

It places the details of the continuing education requirements back into regulation where they belong, as the Department of Commerce, Community, and Economic Development indicated they desired many years ago.

Sincerely,

David Karpik, OD

Kenai Vision Center

Immediate Past President, Alaska Optometric Association.

From: Ladd Nolin <dr.nolin@alaskaeyecare.com>

Date: February 20, 2015 at 9:43:25 AM AKST

To: <Sen.Cathy.Giessel@akleg.gov>

Subject: HB55

Senator Cathy Giessel

February 19, 2015

Dear Senator Giessel,

I am writing to encourage your support of SB 55, which will improve access to eye care for Alaskans. It will be particularly valuable to those patients in rural areas.

Thank you for your support and hard work in the Senate!

Sincerely,

Ladd Nolin O.D.

From: victoria_blower@hotmail.com
To: sen.cathy.giessel@akleg.gov
Subject: SB 55
Date: Fri, 20 Feb 2015 16:56:52 -0900

February 20, 2015

Senator Giessel:

I am writing to ask you to please support SB 55.

This bill updates the Alaska Optometry Statute moving continuing education requirements back into regulation. Therefore allowing the Optometric board to determine the regulatory details of practice as other healthcare professions do. This I believe is also the desire of the Department of Commerce, Community and Economic Development and will decrease administrative tasks for Occupational Licensing.

As our industry and federal drug schedules have changed over the years, and will continue to from time to time, it has been necessary to return to the legislature for statute changes. This seems an unnecessary burden placed on the legislature which could more effectively be handled by board regulation as with other prescribing professions.

SB 55 updates the optometry definition to reflect current education and training. Allowing for improvements in diagnostic and therapeutic procedures as they develop and as determined by the board while safeguarding the public by specifying that optometrists must be qualified for any procedures they perform. It clearly defines limitations on practice which prohibit surgical procedures under an "invasive surgery" definition.

Sincerely,

Victoria A. Blower, OD
Treasurer, Alaska Optometric Association

Victoria Blower, O.D.
Accurate Vision Clinic
Care as Personal as it is Effective
207 E. Northern Lights Blvd
Suite 101
Anchorage, AK 99503
907-272-9800
victoria_blower@hotmail.com

Please support SB 55.

This bill updates the Alaska Optometry statutes in several areas, making it similar to the dental and nurse practitioner statutes, whereas the board determines the regulatory details of practice. This allows more flexibility as technology advances.

It places the details of the continuing education requirements back into regulation where they belong, as the Department indicated they desired many years ago. Current regulations already require 36 hours per license period, and the deleted hours shown are redundant and require unnecessary work for Occupational Licensing.

SB 55 leaves the details of the current pharmaceutical prescribing authority up to the board through regulation, as with the other prescribing professions. But the bill does clearly prohibit injections into the vitreous body of the eye, which is done by specialty ophthalmologists.

SB 55 re-writes the optometry definition which is currently over 40 years old. Optometrists are trained to perform far more advanced procedures than many years ago. The new definition clearly defines modern optometry, and allows the board the flexibility to assure protection of the public. And there is a section on limitations on practice which excludes any invasive surgery, and a section clearly defining all the excluded surgery reserved for ophthalmology, including laser PRK, even though many optometrists can perform this in a few other states, it is still prohibited in SB 55.

Thank you for your attention.....Dr. Jerimiah Myers "Doc"

PO Box 1948

Kodiak, AK 99615

(907) 539-2010 cell

(907) 486-6117 office

Dear Senator Giessel,

I am writing to ask you to please support SB 55.

SB 55 updates the Alaska Optometry Statute in several key areas.

SB 55 addresses the will of the Department of Commerce, Community and Economic Development to put the continuing education requirements back into regulation--where they belong.

SB 55 will allow the optometric board to determine the regulatory details of practice similar to dental and nurse practitioners. This flexibility is important if we are to continue to bring quality, timely advances in eye care technology to our patients throughout Alaska.

SB 55 updates and clearly defines modern day optometry. In Alaska and around the country, today's optometrist, unlike generations ago, in addition to utilizing pharmaceuticals, employ the use of sophisticated lasers and imaging equipment to best diagnose, manage and treat ocular conditions ranging from glaucoma, corneal disease, to diseases of the retina.

SB 55 safeguards the public by requiring optometrists to be qualified for any procedures they perform.

SB 55 defines limitations of practice. Invasive surgery is expressly prohibited and "invasive" is clearly defined.

Thank you for your support.

Sincerely,

Steven S. Dobson, O.D.

President, Alaska Optometric Association

Past Chair, Alaska Board of Optometry

Melissa Kookesh

From: Randy Ruaro
Sent: Tuesday, March 31, 2015 2:27 PM
To: Melissa Kookesh
Subject: FW: SB55

SB 55 file.

-----Original Message-----

From: Andrew Peter O.D. [mailto:homereyecare@gmail.com]
Sent: Friday, March 20, 2015 11:40 AM
To: Sen. Bert Stedman
Subject: SB55

I am writing you regarding a recent Senate bill hearing in the Health & Human Services committee. I kindly ask you please forward my email to Mr. Stedman. If possible, could you please confirm it has been forwarded?

Dear Mr. Stedman,

Recently I listened in on the Health & Human Services Committee hearing on Senate Bill 55; An Act Relating to the practice of optometry. As with many discussions, there are always differing viewpoints. As I was not overly familiar with the presented bill, I listened to arguments made both in favor and opposition of the bill. In fairness, all parties had good points.

I understand the concern for patient safety; it is paramount. The argument that this legislation might increase undesirable outcomes intrigued me. Considering similar legislation has been passed in Oklahoma, Kentucky, and Louisiana; all rural states, I decided to ask them. So I called optometric board members from these three states to ask if there has been an increase in formal complaints regarding undesirable patient outcomes. The feedback I received surprised me; there has been no increase in formal complaints to each respective optometric board. In other words, passage of similar legislation has not been associated with optometrists performing procedures poorly or out of their scope of practice.

I have personal bias toward this bill, but I will refrain from expressing my opinion. I simply wanted to pass along some facts from other rural states that have enacted similar legislation. If you have any additional questions, I would be more than happy to field a quick telephone call.

Andrew Peter O.D.
Homer Eyecare

Melissa Kookesh

From: Randy Ruaro
Sent: Tuesday, March 31, 2015 2:05 PM
To: Melissa Kookesh
Subject: FW: House Bill SB 55

Another email on SB 55.

-----Original Message-----

From: Anne Sharclane [mailto:bingo_queen_81879@yahoo.com]
Sent: Tuesday, March 17, 2015 11:36 PM
To: Sen. Bert Stedman
Subject: House Bill SB 55

Please vote No on house bill SB 55 I heard the bill will allow optometrists who are not qualified to perform surgery will be allowed to do so with only 15 hours of training versus the 4yrs +1 yr intern which is required this is not only absurd but needs to be taken seriously in this legislative vote please VOTE NO the question you have to ask yourself is which Dr would you feel most comfortable seeing please Vote No on house bill 55.

Sent from my iPhone

Good afternoon Chairman Stedman, Vice-Chair Giessel, and distinguished members of the Committee.

My name is Dr. Rachel Reinhardt, M.D. I am a board-certified ophthalmologist from the Seattle, WA area and have been in practice for 11 years. I earned my M.D. from the University of Washington in Seattle. I completed my surgical internship at VMMC and my ophthalmology residency at the Univ of WA. I am honored to testify today on behalf of the American Academy of Ophthalmology and its worldwide membership of over 31,000 eye physicians and surgeons, **asking for your opposition to SB 55**. This legislation would permit optometrists, who are non-medical doctors who have completed NEITHER medical school NOR surgical residency, to perform surgery on and around the eye.

SB 55 lowers the current standards of medical and surgical education required to perform eye surgery. Lowering the surgical standards—as optometry is requesting—creates two separate educational and credentialing requirements to perform the same surgery. This dual surgical standard authorized by SB 55 could have a profound effect on patient safety in Alaska.

SB 55 would **also** allow the Alaska Optometry Board to set its **own** educational and licensure requirements and REMOVE the Alaska State Medical Board as the governing body. As an M.D. I am policed by the Board of Medicine, but SB 55 would mean that optometrists doing eye surgery would not be. This alone is grounds for rejecting this legislation.

Our biggest concern is how SB 55 relates to eye surgeries. SB 55 states that optometrists cannot perform "invasive surgery" and they provide a short list of surgeries that are prohibited. At first glance you may think this sounds as if optometrists will be prevented from doing eye surgery, but the language is **grossly misleading** and in fact the language would actually ALLOW optometrists to do any surgical procedure NOT listed on their short list. And they have provided an arbitrary definition of "invasive surgery" as "penetration through the globe of the eye." Well, there are close to 100 ocular and lid surgeries that are not considered "penetration through the globe" that optometrists could do. For instance, even though on their short list they say "corneal transplantation" is prohibited, there are partial thickness corneal surgeries called lamellar keratoplasties that would not be prohibited. A pterygium excision is another example. This involves using a scalpel to excise and peel a fibrovascular membrane off of the conjunctiva and cornea, then using a drill to sand down the corneal surface and finally harvesting conjunctiva from another part of the eye to suture or glue onto the surgical site. These are just a few examples of surgeries that would NOT be prohibited since they do not meet their arbitrary definition of "invasive surgery."

SB 55 also states they cannot do "cosmetic lid surgery." There are dozens and dozens of orbital and eyelid surgeries that are NOT cosmetic and they don't "penetrate the globe." I could name a dozen of these delicate surgeries, including ptosis repair, entropion repair, punctoplasty, blepharoplasty, chalazion I&C, excisions of malignant tumors such as sebaceous cell carcinoma and even lacrimal gland biopsies. By saying they can't do "cosmetic lid surgery" does not prohibit them from doing scores of very delicate surgeries that often advanced fellowship trained ophthalmologists tend to do. And the risks of eyelid surgeries are not trivial. As an example, when operating on the lid there is a very serious potential risk of retrobulbar hemorrhage that can cause immediate blindness.

Along the same lines, SB 55 states that they cannot do "refractive surgery" which THEY have defined as **only** two types of refractive surgery – namely LASIK or PRK. The problem is there are at least 7-8 **other** refractive surgeries, some with lasers and some with

scalpels, that they COULD do. There is a cousin to LASIK surgery called LASEK for instance. They would be able to do Conductive Keratoplasty and Phototherapeutic Keratectomy to name just a few. And, they could do refractive surgeries that involve scalpels, such as Limbal Relaxing Incisions, which is when a partial thickness cut is made through the cornea to change the shape of the eye.

And SB 55 would NOT prohibit optometrists from doing Laser Surgeries. Lasers are *surgical instruments* that can cut as deeply and sharply as any scalpel. SB 55 would allow optometrists to perform dozens of laser surgeries for very serious eye diseases, including a Laser Peripheral Iridotomy, Selective Laser Trabeculoplasty, Yag capsulotomy to name only a few. The lasers can cause vision-threatening spikes in eye pressure which may require an immediate operating room surgery to fix. Lasers also increase patients' risk of hemorrhage, retinal detachment, cataract or blindness. You will likely here testimony from proponents of the bill that patients in remote areas of Alaska may not have access to care and if they developed acute angle closure glaucoma, that they would go blind without the laser treatment. But, these patients tend to be treated with topical drops and oral medications first and a laser is often deferred several days to weeks. There is time for patients to see an ophthalmologist.

SB 55 also would remove the existing safeguard against injections in and around the eye. Even though SB 55 prohibits performing an intravitreal injection, this does not prohibit them from injecting medications with a needle directly into the delicate structures of the front part of the eye, or the eye wall, eye muscles, lids or orbit. A subtenon's injection is an example of this. It requires threading a tiny needle under the episclera which is a thin layer surrounding the globe. Pressing that needle tip a fraction of a millimeter too far risks puncturing the eyeball. So, again, by simply listing what they CAN'T do, in this case "intravitreal injections," it opens the door for dozens of OTHER delicate injections in and around the eye.

Not only do these scalpel surgeries, laser surgeries and injections EXCEED the skill of optometrists to perform, the complications that could result from these surgeries is beyond the skill and experience of optometrists to handle. When you hear from the optometrists next they may state that they do not intend to do all these surgeries, but it is very important to understand that SB 55 creates loopholes that would make it impossible to STOP them from doing these surgeries.

The bottom line is there is no such thing as a "non-invasive" surgery and there are no *shortcuts* for learning how to safely perform surgery. Expertise in performing these surgeries AND managing serious complications is achieved through years of medical school and surgical residency. It **cannot** be obtained in 8 hours of a special add-on course. All ophthalmologists, who are M.D.s, train for 4 years in college, 4 years in medical school and 4 years in residency. This totals to more than 17,000 hours of combined education and training hours—before they can treat patients on their own. Medical school and residency teach M.D.s about the body and diseases as a whole, not just the eye. This allows ophthalmologists, and not optometrists, the unique ability to place the eye in context with ALL organ systems and allows M.D.s to recognize and treat potential SYSTEMIC complications that can arise from EYE surgery.

In addition to the surgical provisions, SB 55 would lift restrictions on optometrists to prescribe restricted medications. As you know the DEA moved hydrocodone containing narcotics from a Schedule 3 to a schedule 2 class. In response to that, just one year ago SB 162 passed into law that allows optometrists to prescribe hydrocodone containing narcotics that had been changed to a more restrictive class. Just 1 year ago, optometrists

testified to this committee that in order to ensure patient safety in Alaska, that an optometrist's authority to prescribe these narcotics WILL BE LIMITED TO four-days AND that they cannot prescribe any other Schedule II narcotics. Well, not only would SB 55 **remove the 4 day restriction** on hydrocodone narcotics, it would also **expand** optometry's authority to prescribe **all Schedule Ia and IIa controlled substances, without limitations**. Not even all M.D.s have the authority to prescribe all these restrictive medications. Now that prescription narcotic deaths have surpassed car accidents as the leading cause of accidental death in the United States, this is reason alone to reject SB 55.

Patient safety is paramount. It is our duty, both as ophthalmologists AND legislators, to do everything we can to protect our patients. Only 3 states in the entire country have enacted legislation as expansive and radical as SB 55. Alaskans deserve to KEEP the state's high standards of surgical safety.

Once again, we ask that you to vote "NO" on SB 55.

Thank you for very much for your time. I am grateful for this opportunity.

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Eyeball Wars Heat Up In Senate

March 23, 2015 9:23 PM

Filed Under: Brecht Heuchan, Capital City Consulting, Cary Samourkachian, Costco Optical, David Daniel, David Ramba, Denise Mogil, Eric Helms, House Majority Leader Bill Galvano, Jeff Hartley, Johnson & Johnson, Laura Angelini, Marc Reichelderfer, Matt Bryan, Missy Timmins, Nick Iarossi, Ophthalmologists, Optometrists, Rep. Eric Eisnaugle, Rich Heffley, Richard Coates, Senate Appropriations Chairman Tom Lee, Senate Health Policy Committee, Unilateral Pricing Policy, UPP



(Source: CBS4)

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TALLAHASSEE (NSF) – Capitol insiders may have thought they'd seen the last of eye wars, which for years were a perennial fight between optometrists and ophthalmologists over scope-of-practice issues.



But a new twist, with new players, in the turf battle over eye care surfaced Monday in a debate about contact-lens prices that pitted a former Senate president against the current Senate majority leader.

The issue focuses on whether contact-lens manufacturers should be able to set minimum prices — known in the industry as "unilateral pricing policy," or UPP — for their products.

Senate Appropriations Chairman Tom Lee, a former Senate president who wields considerable clout as he presides over the upper chamber's budget, is backing a measure that would do away with the pricing restrictions, which contact-lens discounters say are anti-competitive and could cost Florida's 2.1 million contact-lens wearers an extra \$125 million a year.

Manufacturers counter that pricing standards have reduced costs for contact-lens wearers and are commonly used for other products, such as Apple iPads.

Both sides have assembled a who's who of lobbyists to campaign for or against the proposal (SB 1400), which was approved in a 6-3 vote Monday by the Senate Health Policy Committee.

Influential Tallahassee lobbyist Marc Reichelderfer, a GOP strategist representing 1-800-CONTACTS, is leading the effort to do away with the pricing policies. He's cobbled together a team of more than a dozen lobbying powerhouses, including Rich Heffley, Brecht Heuchan, Missy Timmins and Richard Coates.

Johnson & Johnson, a manufacturer targeted in several lawsuits for its price-setting policies, is represented by Matt Bryan and colleagues, including Jeff Hartley and David Daniel, and the prominent lobbyist Nick Iarossi and several of his Capital City Consulting associates. Joining the manufacturers are the optometrists, represented by David Ramba.

People on both sides of the pricing policy use competing economic analyses to prove that it either works for or against consumers.

Optometrists — most of whom also sell contact lenses — write contact-lens prescriptions for specific brands. The price-setting by the manufacturers is aimed at inducing optometrists to write more prescriptions for their products and, critics say, to keep patients from going elsewhere to purchase their lenses.

The UPP "gives the optometrist the ability to improve his or her capture rate in the office," Johnson & Johnson's president Laura Angelini said last year in an interview widely distributed by opponents of the policy. "Now the patient has no incentive to shop around."

Proponents of the measure jetted in from as far as Las Vegas to plead with lawmakers to do away with the pricing structure, which online contact-lens sellers and discounters like Costco said are aimed at keeping consumers from shopping around for better prices.

"Our data on net cost showed dramatic increase to consumers," Cary Samourkachian, owner of lens.com, told the panel.

Denise Mogil, director of professional services for Costco Optical, told the committee that "if this bill passed, it would allow us to immediately lower our prices." Costco earlier this month filed a lawsuit in California against Johnson & Johnson challenging the pricing policy.

But Johnson & Johnson Manager of Pricing Strategy Eric Helms defended the policy.

"You're being asked to ban a business decision that has successfully reduced costs for 60 percent of Florida consumers since we implemented this policy last summer. We expect even more consumers to pay lower prices going forward as retailers continue to lower prices," he said.

And Helms also reminded the committee of his company's Sunshine State footprint.

"Johnson & Johnson has a long history in Florida. We have about 3,000 employees in the state. Our global headquarters for vision care is in Jacksonville. We have about 2,000 employees," Helms said, adding that the company recently approved a \$100 million investment project at the Jacksonville facility.

After the testimony, House Majority Leader Bill Galvano said that his "serious concerns" about the bill caused him some discomfort, for a reason unrelated to eye care.

"It's never a comfortable position to oppose our appropriations chair but I guess the budget's already being printed somewhere," Galvano, R-Bradenton said.

But an obviously rankled Lee said he shared Galvano's uneasiness.

"It's equally as awkward. I've been in the Legislature for 12 years and I don't think I've ever had a Republican leader lobby against a Republican piece of legislation that I've filed," Lee, R-Brandon, said.

Galvano's objections included "stepping into litigation" already underway and the possibility the state's actions could be in conflict with federal law regulating interstate commerce.

The measure equates to "an attempt to take away the freedom that a manufacturer has to determine the value of his or her product," Galvano said.

"I can't participate in that type of new regulation or that type of divestment of an existing freedom," he said.

But Lee argued that, unlike Apple products, consumers can't choose which contact lenses they want to purchase because they are restricted to the brand in their prescription.

"Go buy another phone. You have consumer choice. Here's the problem. There is no other product ... where the consumer is forced to buy that product and then is prohibited by law from shopping for the lowest price," Lee said. "In a free market society, sir, that is neither free, nor is it a market."

The eye-care industry was roiled for years by legislative and lobbying fights between optometrists and ophthalmologists about how much power optometrists should have to prescribe medications. A compromise reached in 2013 was hailed by then-Senate President Don Gaetz, R-Niceville, who declared that the "eyeballs wars have ended."

It remains unclear how long the contact-lens war will continue. A House companion (HB 1119) to Lee's bill has not been heard in committee yet,

and Rep. Eric Eisnaugle, the measure's sponsor, acknowledged that passage this year might be difficult.

"It often takes more than a year to get a heavy lift through," Eisnaugle, R-Orlando, said.

The News Service of Florida's Dara Kam contributed to this report.

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Eye doctors see long fight in 'eyeball wars'

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February 10, 2013 | By Kathleen Haughney, Tallahassee Bureau

TALLAHASSEE — A long-standing battle between the state's ophthalmologists and optometrists, known as the "eyeball wars," is once again ramping up in Tallahassee.

At stake, according to both sides, is the health of Florida's 38 million eyeballs.

It may seem an arcane issue — but not in Tallahassee, where political contributions and the right lobbyists tend to grab legislators' attention.

Involved are two groups with varying degrees of political capital, lobbyists and public-relations firms.

The optometrists — the health-care professionals who perform eye exams and fit you for eyeglasses — are a political powerhouse that gave more than \$1 million to political candidates in the 2012 election cycle.

Just last week, the Republican Party of Florida picked up the dinner tab at a swanky Tallahassee restaurant for the legislative chair of the Florida Optometric Association and six Republican lawmakers as thanks for the group's financial support.

On the other side are the ophthalmologists — the medical doctors who perform surgery and prescribe drugs for eye problems. They gave far less — just \$235,016 during the 2012 cycle — and are trying to compensate by hiring two of the top lobbyists in Tallahassee, Brian Ballard and Nick Iarossi.

Both sides are hoping to end a decades-long fight over whether optometrists can prescribe drugs for eye patients.

So far, the optometrists are winning.

On Thursday, a House panel approved a bill that would allow optometrists to prescribe oral medication, something they're now allowed to do in 47 other states. To qualify, optometrists licensed before 1990 would have to get 50 hours of training. More-recent grads would require 20 hours.

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Rep. Matt Caldwell, R-Lehigh Acres, argued that optometrists go through four years of schooling, similar to dentists, and that dentists are allowed to prescribe medication. This would simply let optometrists use the "full extent of their training," he said.

"All we're talking about today is expanding the option of oral medication," he said.

Optometrists argued that this move would also save patients time and money. Ophthalmologists typically charge higher fees, reflecting their M.D. education.

Barry J. Frauens, a Nova Southeastern University optometry-school faculty member, noted that he had a condition that was essentially shingles in his eye. His faculty colleagues made the diagnosis — but they were unable to actually treat him.

"I had to leave work, be seen by an ophthalmologist," he said. 50%

And that's as it should be, ophthalmologists say. Because optometrists don't have a medical-school education, they say, they risk harming the patient if they prescribe medicine.

David Eichenbaum, a Tampa Bay-area ophthalmologist, told lawmakers that it took him years to learn how to best prescribe medicine and medication levels. Even now, he said, he still consults with other doctors, particularly if the patient is a child. The optometrists' proposal would let them prescribe high-powered drugs including Vicodin and Xanax, Tylenol with codeine, and anabolic steroids.

Eichenbaum said that, in light of the state's fight against prescription-drug abuse, giving roughly 8,000 more people prescribing power seemed dangerous.

"We just won our long, hard fight to reduce distribution of these drugs, shut down pill mills," he said.

Though the ophthalmologists aren't considered a terribly potent political force, they're allied with one that is: the Florida Medical Association, which gave \$1.1 million in the past cycle. And the eye doctors are fighting back on another front.

They're are pushing legislation, HB 443, that would ban optometrists from calling themselves physicians and also require them to report any adverse incidents with patients, as medical doctors do now. And it requires optometrists diagnosing severe cases of glaucoma to immediately refer a patient to an ophthalmologist.

The bill would also require disclosure of what critics say amounts to fee-splitting: a Medicare rule that allows an optometrist to provide post-surgical care for an ophthalmologist's cataract-surgery patient for a percentage of the doctor's Medicare fee.

It's a major issue between the two groups.

The Florida Society of Ophthalmology has condemned the practice, saying it was intended as a convenience for patients living in extremely remote areas who couldn't get back to a doctor for a post-surgical checkup. But in Florida, they say, that's rarely an issue.

The current rule allows optometrists to collect 20 percent of the surgical fee for postop care of cataract patients. Ophthalmologists said this occurs in about 14 percent of cataract surgeries nationwide and, though they have no Florida numbers, they suspect it's more common here because of the high elderly population.

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Alaska Drivers With No Tickets In 3 Years Are Surprised By This New Rule

TO: Senator Pete Kelly
FROM: Scott A. Limstrom, MD, President, Alaska Society of Eye Physicians and Surgeons
3500 Latouche St., #250, Anchorage, Ak 99508
Date: March 20, 2015
RE: SB 55 White Paper as requested

SB 55 Surgery Provision – SB 55 states – “A licensee may not perform invasive surgery.” And then defines the term invasive surgery – “invasive surgery means surgery requiring penetration through the globe of the eye, extraocular muscle surgery, retina surgery, cornea transplantation, refractive surgery, or cosmetic lid surgery.” And also then defines the term – “refractive surgery” “in this paragraph, “refractive surgery” includes laser-assisted in situ keratomileusis (LASIK) and photorefractive keratectomy (PRK).

With this language, one could be led to believe that if SB 55 were to be enacted, optometrists would not have the authority to perform “invasive” surgery. **This statement is misleading and incorrect.** The surgical procedures above are only a short list of surgeries optometrists would not be allowed to perform. **If SB 55 were to be enacted, optometrists through regulations promulgated by the Board of Examiners in Optometry (Board) would be able to perform hundreds of scalpel and laser surgeries.**

Example of Cornea (the transparent front part of the eye that covers the iris and pupil) Surgeries Authorized Through SB 55:

- Surgery Example 1 - Scalpel is used to cut off abnormal tissue growth on the cornea;
- Surgery Example 2 - Laser is used to remove scar tissue from the cornea;
- Surgery Example 3 - Cornea tissue is transplanted from cadaver to damaged eye cornea; and
- Surgery Example 4 - A small incision is made in the cornea of the eye, and two crescent or semi-circular shaped ring segments are inserted between the layers of the cornea on each side of the pupil.

Example of Laser Surgeries (Use of an intense precisely focused beam of light to cut, remove or vaporize tissue), Authorized Through SB 55. The surgery procedure examples below do not “penetrate through the globe:”

- Surgery Example 1 - Laser is fired to create a small hole in the iris (the colored part to the eye) to relieve excessive pressure build-up in the eye;
- Surgery Example 2 - Laser is fired to create a small hole in the membrane that holds a transplanted lens of the eye in place. The membrane sometimes becomes “cloudy” following cataract surgery. The laser creates an opening in the capsule and clears path for light to enter the eye;
- Surgery Example 3 - Laser is fired to treat areas of tissue at the base of the cornea that is responsible for draining the aqueous (fluid) in the eye. The laser is fired to increase the flow of the fluid to reduce the eye pressure. Several different types of laser may be used to perform this type of surgery; and
- SB 55 contains a provision that prohibits “refractive surgery.” However, by only specifying “LASIK and PRK” which are two types of refractive surgery, SB 55 would allow at least 7 other optometric refractive surgeries of the eye.

In conclusion, the above examples represent just a fraction of the surgical authority that could be granted to optometrists if SB 55 were enacted.

SB 55 provisions prohibit “cosmetic lid surgery,” however SB 55 through Board of Optometry regulation would allow NON-cosmetic lid surgeries since these types of surgeries do not “penetrate through the globe.” Examples:

- Cut malignant tumors on the eye surface and around the eye on the lid using a scalpel or laser;
- Cut off the excess skin of an upper eyelid or cut and shorten the lower eyelid using a scalpel or laser;
- Cut the eye tear drainage system using a scalpel; and

SB 55 Optometric Injection Authority Expansion – Existing law specifically prohibits Botox injections and injections into the globe of the eye. Instead of those prohibitions, SB 55 prohibits **only** intravitreal injections (into the fluid part of the eye). This means that SB 55 only prohibits injections into the rear two-thirds of the eyeball. For example, **SB 55 would allow optometrists to inject a needle into the front of the eye to drain fluid; to inject a needle into the tissue covering the wall of the eye; and Botox injections.**

SB 55 Optometric Prescription Authority Expansion - Existing law prohibits IA, IIA and VIA controlled substances, except for an agent containing hydrocodone. Existing law also limits prescriptions to a four-day supply. SB 55 contains no limitations on the prescription of controlled substances and no limitations on supply. Controlled substance medications have and continue to cause state and federal law enforcement problems. At a time when these officials are actively working to tighten the access points to these types of medications, SB 55 creates a new class of prescribers.

To: Senate Health & Social Services Committee
From: Scott A. Limstrom, MD, president of Alaska Society of Eye Physicians & Surgeons
3500 Latouche St., #250, Anchorage, Alaska 99508, 907-561-1530

Geographic Outreach of Ophthalmologists in Alaska

Response to Request from Senator Stoltze, Senate Health and Social Services Committee

Alaskans have access to the highest quality of medical and surgical eye care through a highly trained cadre of dedicated ophthalmologists – medical and surgical eye physicians. There is approximately one ophthalmologist per 27,000 Alaskans, which is comparable to Washington State's ophthalmologists/citizens ratio of one ophthalmologist per 20,000 citizens.

Most recent data (through 2014) shows that 41% of the state's population lives in Anchorage. The Fairbanks North Star Borough and the Matanuska-Susitna Borough combined comprise an additional 27% of Alaska's total population (roughly 13% in each borough). So, nearly 70% of the state's population lives in those three areas, which have excellent access to highly trained ophthalmologists. With ophthalmology practices based in Anchorage, Juneau, Fairbanks, Kenai, Soldotna, and Wasilla, and through the Alaska Native Medical Center's field clinics (held two-to-four times a year) in Sitka, Juneau, Bethel, Ketchikan, Barrow, Kotzebue, Nome, Kodiak, and Dillingham, ophthalmologists efficiently serve the entire population of Alaska.

Ophthalmology practices are not limited to brick and mortar in Alaska. The Alaska Native Health System provides much rural eye care in the state. Three ophthalmologists based in Anchorage travel throughout the state with several optometrists providing needed eye care services. Many eye surgeries are performed in Anchorage. If a patient encounters an eye emergency, trauma or detached retina in a community like Kodiak, an emergency room doctor (or whoever is currently treating the patient) will immediately contact an ophthalmologist. The ophthalmologist uses skills and experience to assess the immediate treatment needed, whether the patient requires further medical eye treatment, and if so, how quickly the patient needs to be seen. As with other specialty surgeries such as cardiovascular surgery or neurosurgery, a patient requiring complex eye surgery is flown to Anchorage because these surgeries require sophisticated instrumentation only available in Anchorage.

Finally, telemedicine is also enhancing the delivery of eye care by ophthalmologists in Alaska. Telemedicine delivers eye care through digital medical equipment and telecommunications technology, providing patients in remote areas access to highly trained eye physicians and surgeons—ophthalmologists. These patients receive ophthalmic disease screening, diagnosis and monitoring. New and innovative diagnostic technologies have recently proliferated, based on wide availability of the Internet, smartphones, tablets, and other devices. Telemedicine technology allows ophthalmologists to take images of the patient's eyes, without requiring expensive equipment, and often times without the patient leaving home. This technological transformation has enhanced patient understanding and management of conditions, made diagnostic tools available in more remote settings, permitted remote diagnosis and interpretation by ophthalmologists, and has helped lower healthcare costs by reducing patient visits.

3/24/15

To: Senate Health & Social Services Committee

From: Scott A. Limstrom, MD, President of Alaska Society of Eye Physicians & Surgeons 3500 Latouche St., #250, Anchorage, Alaska 99508, 907-561-1530

Re: SB 55

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Why the ophthalmologist and optometrist conflict should concern patients

FORD VOX, MD | PHYSICIAN | MAY 10, 2011

If you need laser eye surgery in the state of Kentucky, or a little cosmetic work around the eyelids, it now behooves you to ask your prospective surgeon the following question before signing the operative consent form:

“Say doc, did you go to medical school?”



Kentucky joined the company of Oklahoma earlier this year as the second state to conflate optometrists and ophthalmologists. Only ophthalmologists are the sort of doctors who graduated from medical school, did an internship, completed a three-year residency in eye surgery, possibly a fellowship after that, and have achieved and maintained national board certification through a program of lifelong learning in their specialty.

Optometry schools (four-year programs focused on optics to prescribe glasses and contacts and the diagnosis and management of certain eye-related diseases) have a tough application process too, and many of the same students going into optometry could have chosen medicine. But nobody ever really faces a clear-cut choice of going into optometry or ophthalmology. Even if you do exceedingly well in medical school, you could easily miss out on an ophthalmology residency slot. Ophthalmology is among the most selective specializations in medicine. Yet despite having earned a reputation within medical science as one of its most advanced and storied fields, these days ophthalmology is challenged with its branding, of all things. Perhaps it's the funny spelling?

Nationwide, about 30 percent of consumers don't know the difference between the two types of eye doctors, according to a survey conducted by the National Consumer's League (the NCL designed the study independently, then applied for and received unrestricted funding from the American Academy of Ophthalmology, which did not commission the study). Ninety-five percent of the 600 Americans surveyed wanted an M.D. wielding the scalpel or the laser if they needed eye surgery. Regular everyday people seem to sense that the eyes are part of the body, that serious disease might have something to do with the whole, and that at the very least, you might want a full-service clinician involved if something becomes complicated enough for an invasive procedure.

Proponents of optometry's expansion argued that having optometrists perform in-office laser eye procedures, inject medications into eyes, and cut out "lumps and bumps" around the eyes increases health care access for Kentucky's rural citizens (Kentucky's Medicaid program can spend \$150 in transportation credits for a \$50 ophthalmology check-up). Optometrists outnumber ophthalmologists by a ration of four to one and can be found in most Kentucky counties.

But while you could easily be forgiven for imagining that Kentucky's leadership must now be hot on the trail of other ways to foster health care accessibility, like chiropractic spine surgery or cosmetic surgery parlors, do not expect the complete democratization of medicine until back adjusters and cosmetologists can pay to play with the same skill as optometrists. Mistaking optometry for ophthalmology was no Mr. Magoo moment.

"If you go back and look at our involvement in politics in terms of contributions, we've always been involved," says Dr. Ian Benjamin Gaddie, president-elect of the Kentucky Optometric Association. "We work hand-in-hand in the community with these people and that makes a huge difference."

Efforts included lobbying state legislators while they were immobilized in the optometric examining chair, reports indicate.

"In many states it's just how the stars line up, and how your luck goes as you run the gamut through the political process," Dr. Gaddie told me.

The Louisville *Courier-Journal's* Frankfort bureau chief Tom Loftus followed the blue grass stardust:

"Kentucky optometrists and their political action committee have given campaign money to 137 of the 138 members of the state legislature and Gov. Steve Beshear, contributing more than \$400,000 as they push for a bill to expand their practices.

Members of the Kentucky Optometric Association and its PAC have given at least \$327,650 to legislative candidates in the last two years alone and have hired 18 lobbyists to help them make their case.

They also gave a total of at least \$74,000 more to Beshear's re-election campaign, the Republican gubernatorial campaign of Senate President David Williams and the House and Senate political caucuses."

Optometry waged state-by-state expansion of practice battles for four decades on its way to where the profession stands now, which is increasingly nebulous. The American Academy of Ophthalmology and the American Medical Association have challenged optometry every step as optometry blurs its boundaries with medicine. A patchwork quilt of legislation around the country variably delineates optometric practice. Now two patches have little pockets for scalpels and lasers.

For optometrists, serving us as the "primary health care professional for the eye" means what the state says it does, and that can vary widely, creating confusion among patients and the rest of the medical world. Citing how in some states optometrists must obtain certifications for medications they have no intention of ever using, the American Society of Health-System Pharmacists pointed to optometrist licensure as an example to avoid.

Optometrists have been dilating eyes since the 1970s to better diagnose eye diseases, and have been using local medications in most states since the 1980s. They no longer face opposition from ophthalmology on these fronts. "We draw the philosophical line in the sand with surgery," says Dr. David Parke, chief executive officer of the American Academy of Ophthalmology.

Ophthalmologists have successfully fought back in 25 other state battles where optometrists asked legislatures to let them perform surgery, he says, by pointing out the difference in quality of training and management of adverse events.

While chair of the University of Oklahoma's Department of Ophthalmology for 17 years, Dr. Parke dealt with the aftermath of upgraded optometric licensure in that state. He says the problems he saw were the result of "not knowing what you don't know."

Dr. Parke's experience included treating a man whose "skin tag" was excised by an optometrist. Nine months later the patient came to the university medical center with an invasive, substantive squamous cell carcinoma that required a massive reconstructive surgery. "We asked the patient, 'Why'd you let him do that?' He replied, 'Well he's a doctor, he had on a white coat and he said he could.'"

In another case, an elderly patient with severe end-stage glaucoma could only be controlled surgically through a technique called filtering blebs. "She went to an optometrist who said to the patient, 'Mrs. Jones, you have cysts on your eyes, I should take care of those now,' and he proceeded to excise them, completely undoing the surgery."

"In the end it scares me, quite frankly," says Dr. Parke.

The most common laser procedure Kentucky optometrists will perform involves using a YAG laser to clear a membrane that becomes cloudy in some patients after lens replacement surgery (it's something ophthalmologists do as needed on post-cataract surgery follow-up appointments). The procedure may take only 20 minutes to learn and looks as simple as a video game. But complications can occur.

"You can be a pilot, and say, 'I'm just going to fly in good weather' — but you never know when it's gonna get dark, or when the storm's gonna come up," says Dr. Woodford Van Meter, president of the Kentucky Academy of Eye Physicians and Surgeons. "You can go get an amateur pilot's license, but that doesn't mean you should fly a jetliner full of passengers down to Florida."

But ophthalmologists can only convey their concerns when they're given enough time. By the immaculate design of 18 lobbyists, the ophthalmologists knew about the Kentucky bill just 12 hours before it entered a Senate committee (bypassing a customary 72-hour holding period), and sailed through that committee to the Senate floor the next day. The whole process, from the bill's first public posting to the Governor signing it into law, took 17 days, bypassing hundreds of other bills filed well before it. "It was a juggernaut. It was an advancing force that seemed to crush everything under its path," Tom Loftus said on the KET program [Comment on Kentucky](#).

Dr. Van Meter says he and his colleagues got 10 minutes total to make their case at an informational hearing put together at the last minute in the Kentucky Senate.

"The people pushing the bill to me looked like your dog when you come into the kitchen and he's taken a piece of meat of your plate," Dr. Van Meter told me. "He just looks guilty as sin, but he's sitting there smiling with big eyes like nothing in the world ever happened."

The bill itself looks like a rush job. It even includes an anatomical error. It prohibits optometrists from injecting into the posterior chamber of the eye (nobody can, it's too small a space). Presumably that line meant to state that optometrists cannot inject into the posterior segment of the eye, which includes the vitreous. Because of the sloppy writing, now optometrists can inject into the posterior segment, using drugs like Lucentis to treat macular degeneration. The bill also excludes optometrists from performing two common excimer laser corrective vision procedures, LASIK and PRK, but leaves out another common procedure, LASEK.

Dr. Ben Gaddie admits the LASEK loophole exists, but he expects the optometry board won't allow excimer laser procedures at all, following the spirit of the legislation if not its wording. However, he's not on the optometry board.

Dr. Van Meter and other state ophthalmology leaders sat down with Kentucky's governor to make their case as he weighed whether to sign the bill that had arrived on his desk with such urgency. They were a little flummoxed when it became apparent the governor had little issue with the idea that providers who didn't go to medical school would be doing surgery. "He seemed to think that was okay," Dr. Van Meter observes.

I asked the governor, who was on the road attending the National Governor's Association Winter Meeting in D.C. this weekend, whether he was now pioneering the way for other states in redefining optometry. He's making no such stand. Beshear based his decision "solely on what is best for the people of Kentucky. Under that framework, improving access to health care of all kinds is a priority for Kentuckians. Other states must make their own determinations for what is best for their citizens," he wrote in an email.

Elaborating on the access issue, Beshear wrote, "there are fewer ophthalmologists in Kentucky than optometrists and at times, it may be easier for residents (especially in rural areas) to get access to an optometrist for needed eye care. There will be times when citizens will require the services of an ophthalmologist; however, this legislation will allow Kentuckians to have more options in accessing proper eye care."

Naturally I wanted to know whether the governor would choose the care of an ophthalmologist or an optometrist should he need an eye surgery now in the optometry's purview. Maybe he'll simply pick the geographically closest provider, like he expects the disadvantaged Appalachian citizens of his state will do? He didn't answer that one.

What's optometry's end game, if the field sees itself as the primary care providers for the eye? "It's hard for me to fathom that the end goal of the organized profession of optometry is to go in and do routine intraocular surgery like retinal disease or cataract surgery or incisional glaucoma surgery," says Dr. Ben Gaddie. He believes that the minor surgical procedures with scalpels and lasers Kentucky now allows fit into the "primary care" mold.

It sure sounds specialized to me. The eye is part of the central nervous system. I don't know too many primary care docs who do a little bit of neurosurgery or plastic surgery on the side. There's a reason the rest of medicine organizes itself into cardiologists and cardiovascular surgeons, neurologists and neurosurgeons, and so on. There's a reason you want a surgeon to do surgery. They do a lot, and they do it well. It's worth a little drive.

"I give the optometrists an A+ in politics," says Dr. Parke of the ophthalmology association. "I may give them an F in being an effective advocate for patient safety and quality of care."

Ford Vox is a physician and medical journalist who has written for Reuters, U.S. News & World Report, and Newsweek. This piece originally appeared in [The Atlantic](#), and is reprinted with the author's permission.



AMA Journal of Ethics

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Virtual Mentor. December 2010, Volume 12, Number 12: 941-945.

Policy Forum

Ophthalmologists, Optometrists, and Scope of Practice Concerns

Kristin E. Schleiter, JD, LLM

Introduction

The average person may not think much of the difference in practice and training of psychiatrists and psychologists, or of ophthalmologists and optometrists. Yet a key distinction exists within each pair: a medical degree. As nonphysician practitioners advocate for expansion of their scope of practice into areas long considered the purview of medicine, physicians have fought back, arguing that their experience and training are central to patient safety. In the last decade, the clash between ophthalmologists and optometrists has focused on eye surgery.

Education and training are the primary differences between ophthalmologists and optometrists [1]. An ophthalmologist is a physician who "specializes in the refractive, medical and surgical care of the eyes and visual system and in the prevention of disease and injury" [2]. After obtaining an undergraduate degree, ophthalmologists must complete four years of schooling at an accredited medical school and a 3- or 4-year residency program, 3 years of which must be in ophthalmology. Only after this can ophthalmologists become licensed to practice medicine and perform surgery. Ophthalmologists may become certified by the American Board of Ophthalmology, which requires, in addition to the aforementioned schooling, serving as primary surgeon or first assistant to the primary surgeon on a minimum of 364 eye surgeries and performing well on the state licensing examinations, both written and oral [1].

Optometry differs on several accounts. The practice of optometry commonly includes examining the eye for vision prescription and corrective lenses and examining, diagnosing, treating, and managing disorders of the eye and visual system. But optometrists' education does not include medical school. After undergraduate education, optometrists must complete 4 years of an accredited optometry college, after which they are awarded the Doctor of Optometry degree. Some optometrists also undertake an optional 1-year residency program to enhance their experience in a particular area [1].

Optometrists are licensed by their states to provide primary vision care and nonsurgical management of certain eye diseases and must pass the licensing exam of the National Board of Examiners in Optometry. In some states, optometrists have attempted to expand their scope of practice to include the performance of laser and nonlaser eye surgery [1]. Organizations including the American Medical Association (AMA) have expressed concern that optometrists are using the legislature to expand their scope of practice into areas of medicine [3, 4].

Most states prohibit optometrists from performing surgery, and statutes often specify that the license to practice optometry does not include the right to practice medicine. Meanwhile, the licensing statutes of such

states as Colorado and North Carolina specifically exclude surgery from their definitions of the practice of optometry [5]. In some states, the law on optometrists' right to perform surgery is evolving. Some of these statutes delineate between laser and nonlaser surgery. And since 1997, for example, there have been 46 attempts in 21 states by optometry organizations to legislate surgery privileges [5]. All but one of these attempts were blocked.

Oklahoma

After an unsuccessful attempt by the Oklahoma board of optometry to issue regulations extending optometrists' scope of practice to include the performance of surgery, the Oklahoma state legislature enacted a law in 1998 authorizing optometrists to perform laser surgery procedures [1, 3, 6]. This bill also granted the Oklahoma Board of Examiners in Optometry the sole authority to determine what constitutes the practice of optometry [3].

The issue was revisited in 2004, after the Oklahoma attorney general issued an opinion addressing the state board of optometry's authority to expand optometrists' scope of practice past statutory limits [1, 5]. The opinion said that the Oklahoma Board of Examiners in Optometry "would need 'statutory authority' from the Oklahoma legislature before it could certify optometrists" to do more than the procedures endorsed by the 1998 law [7].

Oklahoma lawmakers reacted to the attorney general's opinion by passing legislation that allowed the state board of optometry to authorize optometrists to perform certain nonlaser surgery procedures, in effect stripping traditional oversight bodies (e.g., the governor, attorney general, or state medical board) of their ability to regulate the practice of optometry [1, 3, 5, 8]. The medical and osteopathic communities strongly opposed this bill. Testimony to the Oklahoma state legislature emphasized that, while certain scope of practice expansions were appropriate—ophthalmologists had previously supported optometry's efforts to "get privileges for punctual plugs, corneal foreign body removal, and last epilation," to name a few—optometrists had not proven that they possessed the education and training necessary to perform surgery [9].

Shortly after the bill was passed, the Oklahoma Board of Optometry used their newfound authority to pass a rule that further expanded optometrists' scope of practice, allowing optometrists to perform nonlaser surgical procedures, including the use of scalpels and insertion of needles directly into the eye within the state [1, 3]. At the time, the AMA opposed the legislation, arguing that, without education or training in surgical skills or incisions and subsequent tissue reactions, the scope of practice expansion put patients at serious risk [3]. Moreover, the AMA argued, ophthalmologists' understanding of the patient as a whole might allow them to recognize an eye condition optometrists may consider routine as an indication of something serious (e.g. malignant tumor, AIDS, multiple sclerosis) [3]. Despite strong objection by the AMA and other organizations, the rule stood, making Oklahoma the only state to date that allows nonphysicians to perform laser surgery [1].

West Virginia

A similar attempt to expand optometrists' scope of practice was recently made in West Virginia. After the state legislature amended its law regulating optometrists [10], the West Virginia Board of Optometry proposed amendments to its rule on optometrists' prescriptive authority [11]. The board stated that the amendment was necessary to clarify its rules, but it went far beyond this stated purpose.

According to analysis by the AMA, the American Association of Ophthalmology, and the West Virginia State Medical Association, the board's amendment expanded optometric scope of practice to include the prescribing of pharmaceuticals that have systemic effects—an expansion beyond the intent of the West Virginia legislature [4, 13, 14]. For example, the proposed amendment includes language "extensively debated and specifically rejected" by the state legislature that would have given the board open-ended authority to determine which injectable pharmaceutical agents West Virginia optometrists would be allowed to administer [12]. In contrast, the state legislature's existing language specifically limited injections to the administration of epinephrine to treat emergency cases of anaphylaxis or anaphylactic shock [12]. The proposed rule would also allow the board to authorize optometrists to sell pharmaceuticals by injection directly to the patient, a practice prohibited in the case of oral or topical agents [13].

The board's actions were characterized as attempts to circumvent the legislative process, using its regulatory authority to pass provisions that had been removed or amended in the state legislature's

deliberations over the optometry practice act bill [12]. The debate over the West Virginia Board of Optometry's proposed amendments is ongoing.

The Future

While some suggest that the trend is toward an expanded scope of optometric practice, history suggests that Oklahoma is an outlier. Most states—including those that have entertained proposals by optometrists to expand their scope of practice—have chosen not to allow optometry's practice to expand into surgery and other areas of medicine. Government facilities such as the Veterans Affairs Palo Alto Health Care System are considering changes to policy after scope expansions resulted in litigation due to preventable medical error [14]. In 2010 alone, however, there have been state efforts by Alaska, New Mexico, and Oklahoma to expand optometrists' scope of practice to include surgery [15]. It is highly unlikely that these efforts will be the last.

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March 2011

NEWS & OPINION



Woodford Van Meter, M.D.



Ben Mackey, M.D.

Kentucky governor signs law to expand optometric scope of practice

by Jena Passut EyeWorld Staff Writer

A controversial bill that allows optometrists in Kentucky to perform laser and scalpel procedures as well as injections has been signed into law by Gov. Steve Beshear, despite fierce opposition from the state's top ophthalmologists.

The governor said he signed the bill to give Kentuckians greater access to eyecare. "I believe this new law will mean more Kentuckians can get the eyecare they need," Gov. Beshear said in a prepared statement. Senate Bill 110 grants optometrists authority to perform laser procedures, including laser trabeculoplasty, peripheral iridotomy, iridoplasty and capsulotomy, YAG capsulotomies, LASEK, and laser "only" clear-lens extraction. The bill will also allow optometrists to perform some scalpel procedures and administer pharmaceutical agents, including by injection into the vitreous. "The law is dangerous, expensive, and will allow optometrists to perform surgery on unsuspecting patients who don't know the difference between ophthalmologists and optometrists," said Woodford Van Meter, M.D., president, Kentucky Academy of Eye Physicians and Surgeons, and professor of ophthalmology, University of Kentucky, Lexington. "Optometrists have limited surgical experience, and this legislation unfortunately grants surgical privileges in front of training and education, the reverse of what usually happens. Another problem is that optometrists have not asked to perform specific procedures but to perform all procedures except for certain exclusions." SB 110 also includes the creation of an independent optometric board that would solely decide scope of practice for the profession.

"No other board or state agency will have any authority to question what constitutes the practice of optometry," Dr. Van Meter said. "There's no national optometric standardized test to determine competency. This board could expand the optometric practice as it solely determines, outside the influence of the Kentucky Board of Medical Licensure."

SB 110 moved at warp speed through both the state Senate and House. It was introduced on Feb. 7, passed the state Senate 33-3 on Feb. 11, and passed the state House on Feb. 18 by a vote of 81-14. SB 110 easily cleared the House, after being discussed in the committee on licensing and occupations.

"That was a little bit suspicious," Dr. Van Meter said about the committee choice. "That committee deals with air conditioning regulations and fishing licenses." The timing of the Senate and House votes also caused some to question the influence of monetary contributions to the state's legislative process. Members of the General Assembly received more than \$400,000 in campaign contributions from optometrists and their political action committee, according to a story published in The Courier-Journal of Louisville. Money was donated to the campaigns of 137 of the 138 members of the state legislature, as well as to the governor's re-election campaign.

The Legislative Ethics Commission said the Kentucky Optometric Association had increased its lobbying force at the capitol from four to 18 lobbyists this session. Thirteen of those lobbyists started working on Feb. 1, the Commission said.

"We were told by the legislature that this bill had a lot of support, but there has not been one consumer, patient, or advocacy group saying it is a good idea," Dr. Van Meter said. "My fear is that this bill is going to make Kentucky look bad on the national scene. I am embarrassed." Ben Mackey, M.D., Corbin, Ky., is one of the state's many ophthalmologists who spoke out against the legislation. "My basic problem with the bill is that it lowers the standard of healthcare in general," Dr. Mackey said. "I don't think optometrists are qualified, and I don't think they meet the standard that should be there to perform this sort of procedure, which should be performed by a licensed physician." Dr. Mackey, whose father and brother are optometrists and did not campaign for the bill, pointed out that ophthalmologists spend thousands of hours training to do surgical procedures and have to go through a residency program. Gov. Beshear said that more training for optometrists would be a priority. "In order to ensure the highest degree of oversight, I will be meeting with the Board of Optometric Examiners to make sure that providers of these services undergo extensive training," he said.

Dr. Van Meter said the Kentucky law is the same as the 1998 bill in Oklahoma that allowed optometrists there to perform surgical procedures. Since then, similar legislation has been presented and rejected in 25 other states. "The American Medical Association (AMA), the American College of Surgeons (ACS), and the American Academy of Ophthalmology (AAO) have all issued policy statements advising that surgery should be performed by surgeons," Dr. Van Meter said, adding he disagrees with the argument that allowing the privileges will give Kentuckians better access to surgical care. "There is no backlog of eye surgery in Kentucky," he said. "We have statistics that

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show 95% of Kentuckians live within an hour of an ophthalmologist. There are more than enough ophthalmologists to do all the surgery that needs to be done." Dr. Van Meter said he is worried that since Kentucky has adopted the same law as Oklahoma, other states will be pressured to follow suit.

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Ophthalmology and Optometry Law Blog

TAG ARCHIVES: FLORIDA HOUSE BILL 239

Optometrists and Ophthalmologists Come to an Agreement-Optometrists Can to Prescribe Some Medications

Posted on April 11, 2013



By George F. Indest III, J.D., M.P.A., LL.M., Board Certified by The Florida Bar in Health Law

On April 4, 2013, the Florida Senate passed Florida Governor Rick Scott a hard-fought bill that would expand the drug-prescribing practices of optometrists, according to the Associated Press. House Bill 239 has pitted optometrists against ophthalmologists for years in what was called the "eyeball wars." (Click here to read House Bill 239.) The Senate sent a measure to the governor that would allow optometrists to prescribe some medications, while adding new patient protections.

To read the article from the Associated Press, click here.

I previously blogged about this topic when the bill was still being voted on in the House.

Click here to read what supporters and opponents of House Bill 239 had to say about it.

Ophthalmology and Optometry Law Blog

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Optometrists Have to Ability to Prescribe Some Medications.

According to an article in the Orlando Sentinel, the final bill was an agreement between the Florida Society of Ophthalmologists and the Florida Optometric Association. Optometrists wanted to ability to prescribe medications other than ointments and creams. Ophthalmologists argued optometrists are not doctors and did not receive the proper training to prescribe medicine.

The compromise under the final bill says optometrists would be allowed to prescribe 14 oral drugs, including antibiotics. However, optometrists will not be allowed to prescribe controlled substances. The measure clarifies that optometrists cannot perform surgeries and requires them to report any bad medical outcomes to the state, as ophthalmologists are required to do.

[Click here](#) to read the entire article from the Orlando Sentinel.

House Bill 239 May Reduce Costs for Patients.

State Senators voted 40-0 to pass the bill. Optometrists believed that House Bill 239 will help Floridians get the most appropriate eye treatment. This bill will also allegedly help cut down on duplicate services, and in return, reduce costs for patients.

If Governor Scott signs the bill, it will officially put an end this turf war over eyes.

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To contact The Health Law Firm, please call (407) 331-6620 or (850) 439-1001 and visit our website at www.TheHealthLawFirm.com.

What Do You Think?

What do you think of the new bill? Do you think optometrists prescribing medication is a good idea or a bad idea? Please leave any thoughtful comments below.

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Florida Legislature Has Optometrists and Ophthalmologists Seeing Red Over Proposed Law Allowing Prescribing

Posted on **March 12, 2013**

By George F. Indest III, J.D., M.P.A., LL.M., Board
Certified by The Florida Bar in Health Law

Ophthalmology and Optometry Law Blog

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This year Florida House Bill 239 and Florida Senate Bill 278 has been reignited in the Florida Legislature. This legislation is pitting optometrists and ophthalmologists against each other in what is being called the “eyeball wars,” according to the Fort Myers News-Press. These bills would expand the authority of optometrists to prescribe certain medications and treat some eye conditions. Optometrists and ophthalmologists are both trying to gain support for their respective viewpoints.

[Click here to read the article from Fort Myers News-Press.](#)

Elements of Florida House Bill 239 and Florida Senate Bill 278.

Most notably, the bills would expand the scope of practice for optometrists. Optometrists would have prescribing authority of oral medications. However, they would not have the ability to prescribe Schedule I and II narcotics. Optometrists would also be allowed to perform clinical laboratory studies. [Click here to read Florida House Bill 239](#), and [click here to read Florida Senate Bill 278](#).

Supporters Believe This Legislation Will Help Reduce Health Care Costs.

The backers of expanding prescribing authority to optometrists say it will help reduce health care costs and make treatment more available to communities short on ophthalmologists. According to a statement by the Florida Optometric Association, expanding the ability for optometrists to prescribe oral medications saves money, increases access to eye care, and saves people from losing vision due to treatment delays. According to the Fort Myers News-Press, this authority has been granted to optometrists in 48 states.

Opponents Believe Patients' Safety is at Stake.

According to the Florida Society of Ophthalmology, allowing an expansion of prescribing authority is a dangerous move for patients. A letter from the American Academy of Ophthalmology states that the language in the legislature is vague, broad and misleading. It also states that the training ophthalmologists receive provides them with not only technical skills, but instills the judgment one needs to determine when (and when not) to prescribe specific medications. To read the entire letter, [click here](#).

Other associations opposed to the bill include Florida Society of Interventional Pain

Ophthalmology and Optometry Law Blog atology, Florida Society of Anesthesiologists, [Create a free website](#)

Hillsborough County Medical Association. Letters written by each of these societies can be read by clicking [here](#).

Where are The Bills Now?

Florida House Bill 239 was passed by the House Health and Human Services Committee on March 7, 2013, and is now ready for the House Floor. On March 6, 2013, a Florida Senate panel voted 10-3 to approve Senate Bill 278. The bill has now been handed over to the Appropriation Committee.

Contact Health Law Attorneys Experienced with Investigations of Optometrists and Ophthalmologists.

The attorneys of The Health Law Firm provide legal representation to optometrists, ophthalmologists and other health providers in Department of Health (DOH) investigations, Drug Enforcement Administration (DEA) investigations, FBI investigations, Medicare investigations, Medicaid investigations and other types of investigations of health professionals and providers.

To contact The Health Law Firm, please call (407) 331-6620 or (850) 439-1001 and visit our website at www.TheHealthLawFirm.com.

Comments?

What do you think of optometrists being able to prescribe oral medication? Are you for or against this legislature? Please leave any thoughtful comments below.

Sources:

Gluck, Frank. "Not Seeing Eye to Eye: Optometrists, Ophthalmologists Differ on Bills." Fort Myers News-Press. (March 7, 2013). From: http://www.news-press.com/apps/pbcs.dll/article?AID=2013303070027&nclick_check=1

Corcoran, Richard. Letter Opposing HB 239 and SB 278. American Academy of Ophthalmology. (February 4, 2013). From: <http://www.mdeye.org/pdfs/AAOHB239OppositionLetter.pdf>

About the Author: George F. Indest III, J.D., M.P.A., LL.M., is Board Certified by The Florida Bar in Health Law. He is the President and Managing Partner of The Health Law Firm, which has a national practice. Its main office is in the Orlando, Florida, area. www.TheHealthLawFirm.com The Health Law Firm, 1101 Douglas Ave., Altamonte Springs, FL 32714, Phone: (407) 331-6620.

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Posted in **Ophthalmology, Optometry** | Tagged **Appropriation Committee, defense attorney, defense lawyer, eye care, eyeball wars, Florida health care lawyer, Florida health law attorney, Florida House Bill 239, Florida Legislature, Florida Medical Association, Florida ophthalmologist, Florida Optometric Association, Florida optometrist, Florida Senate Bill 278, Florida Society of Ophthalmology, Health and Humans Services (HHS), medical doctor, ophthalmologist, ophthalmologist attorney, ophthalmologist lawyer, Optometrist, optometrist attorney, optometrist lawyer, optometrist prescribing, optometrist prescribing authority, oral medication, physician** | [Leave a reply](#)

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March 5, 2015

Senator Cathy Giessel
716 W. 4th Ave., Ste. 511
Anchorage, AK 99501

Dear Senator Giessel:

This letter is intended to request your support for SB 55 and to explain why it is a positive change, as well as negate potential reservations for the bill.

SB 55 allows for the regulation of licensing and continuing education requirements to be policed by the Optometric board. This makes intuitive sense since we understand our profession well and will have a better grasp on how to adapt - just as all medical professions have to do - with time and advancements. SB 55 will favorably impact the citizens of Alaska by allowing for timely and quality advancements of regulations, while simultaneously lessening the burden for Occupational Licensing.

The profession of Optometry has changed drastically over the last several decades, as I dare say most medical professions have. The current legislation is grossly outdated and SB 55 defines modern optometry. Not only are we experts in optics, but we receive extensive training with respect to systemic and ocular health. We are trained to diagnose and manage ocular diseases with various imaging equipment and lasers, prescribe pharmaceuticals, and perform minor procedures. Despite the fact that we have this training, my colleagues and I are currently not allowed to use it to its full capacity. This is a travesty and certainly not beneficial to the Alaskan public. SB 55 provides a safeguard by requiring specific qualifications for any procedures performed and it clearly defines limitations of practice. I am not a surgeon, nor do I want to be, and desiring to use the education I earned to be the best clinician I can be seems perfectly logical and reasonable.

As our profession evolves, so do other aspects of medicine, such as pharmaceuticals. These evolutions have historically required legislature for statute changes. SB 55 allows the details of the current pharmaceutical prescribing authority to be regulated by the board, which will likely be more effective, as seen with other prescribing professions.

In summary, SB 55 will increase efficiency and effectiveness of regulating optometric physicians in the state of Alaska. It also accurately defines the profession and our scope of practice.

Thank you for listening, and on behalf of my fellow colleagues and myself, I appreciate your consideration of SB 55.

Very respectfully,

Kara Reynolds, OD
Vice President, Alaska Optometric Association



Emails of Support for SB 55 Optometry Compiled Feb. 25 – March 4, 2105


Senator Giessel's office

Please support SB 55.

This bill updates the Alaska Optometry statutes in several areas, making it similar to the dental and nurse practitioner statutes, whereas the board determines the regulatory details of practice. This allows more flexibility as technology advances.

It places the details of the continuing education requirements back into regulation where they belong, as the Department indicated they desired many years ago. Current regulations already require 36 hours per license period, and the deleted hours shown are redundant and require unnecessary work for Occupational Licensing. We do not need the additional seven hours of injectables training every four years. It is an added cost and requires travel outside of Alaska which results in less days in our clinics treating patients.

SB 55 leaves the details of the current pharmaceutical prescribing authority up to the board through regulation, as with the other prescribing professions. But the bill does clearly prohibit injections into the vitreous body of the eye, which is done by specialty ophthalmologists.



SB 55 re-writes the optometry definition which is currently over 40 years old. Optometrists are trained to perform far more advanced procedures than many years ago. The new definition clearly defines modern optometry, and allows the board the flexibility to assure protection of the public. And there is a section on limitations on practice which excludes any invasive surgery, and a section clearly defining all the excluded surgery reserved for ophthalmology, including laser PRK, even though many optometrists can perform this in a few other states, it is still prohibited in SB 55.

CDR Sarah Stienbarger, OD, FAAO


4341 Tudor Centre Drive


Anchorage, AK 99508

907-729-8533 office

907-729-8501 fax

Please support SB 55.





This bill updates the Alaska Optometry statutes in several areas, making it similar to the dental and nurse practitioner statutes, whereas the board determines the regulatory details of practice. This allows more flexibility as technology advances.

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Thank you.



Marilyn Holm, OD

Agape Peninsula Eye Care, LLC

43843 Sterling Hwy, Ste. 100

Soldotna, AK 99669


907-262-2200


Mrs. Conway,

Please support SB 55.

This bill updates the Alaska Optometry statutes in several areas, making it similar to the dental and nurse practitioner statutes, whereas the board determines the regulatory details of practice. This allows more flexibility as technology advances and in today's ever changing healthcare environment it is important to be able to adapt quickly.

It places the details of the continuing education requirements back into regulation where they belong, as the Department indicated they desired many years ago. Current regulations already





require 36 hours per license period, and the deleted hours shown are redundant and require unnecessary work for Occupational Licensing. It has been my personal experience that working with the State Licensing Department is cumbersome at best. When I was first applying for my Alaska license in 2010, there was not even a person designated to handle Optometry licenses which caused unnecessary delay.

SB 55 re-writes the optometry definition which is currently over 40 years old. Optometrists are trained to perform far more advanced procedures than many years ago. The new definition clearly defines modern optometry, and allows the board the flexibility to assure protection of the public. And there is a section on limitations on practice which excludes any invasive surgery, and a section clearly defining all the excluded surgery reserved for ophthalmology, including laser PRK, even though many optometrists can perform this in a few other states, it is still prohibited in SB 55.

Sincerely,

Benjamin Crawford, O.D.

Accurate Vision Clinic

207 E Northern Lights Blvd, Suite 101

Anchorage, AK 99503

Office 907-272-9800 | Fax 907-277-1398 | Mobile 907-717-1038


Dear Senator Giessel,

I am writing to you in support of SB 55 regarding the practice of Optometry. As a former chair of the State of Alaska Board of Examiners, I have spent a lot of time reviewing and working with both the Optometry statutes and regulations. SB 55 should be supported because it not only removes the required continuing education requirements from the statute and puts it back in regulation, but also because it redefines Optometry and defines invasive surgery.

I feel these changes would enable the board to react, via the regulatory process, to changes as technology advances. This is more consistent with other prescribing professions in the state. Having the definitions of Optometry and invasive surgery in statute provides safety to the public in that these definitions clearly define modern Optometry and limits invasive surgery. While the Board would be confined to these definitions and restrictions, I feel SB 55 allows the Board enough room to update the regulations to coincide with advancements in the field of Optometry for the foreseeable future.

Thank you for your consideration of this bill.





Sincerely,

Jill Geering Matheson, OD

Alaska Vision Center, Inc.

VISION SOURCE

800 Glacier Avenue

Juneau AK 99801

P: (907) 586-9864

F: (907) 586-9864

www.visionsource-alaskavision.com





ALASKA VISION CENTER, INC.

A MEMBER OF

Geering Matheson, OD • :

Bixby-DuBois, OD

Dear Legislators,

Please support SB 55.

This bill updates the Alaska Optometry statutes, making it similar to the dental and nurse practitioner statutes, whereas the board determines the regulatory details of practice. It places the details of the continuing education requirements back into regulation. Current regulations already require 36 hours per license period. SB 55 leaves the details of the current pharmaceutical prescribing authority up to the board through regulation, which is more consistent with other prescribing professions in our state.

SB 55 re-writes the optometry definition which is currently over 40 years old. As a recent graduate, I have been exposed to diagnostic techniques and treatment options that have been established in other states. I believe SB 55 will allow our state the flexibility it needs to ensure the protection of the public while defining the exclusions in invasive surgery. SB 55 will be best for the future of the Alaskan field of Optometry.

Sincerely,

Dr. Sarah Bixby-DuBois, Optometrist
Alaska Vision Center, Inc.
Juneau, AK 99801
sarahbixbydubois@gmail.com

Melissa Kookesh

From: Randy Ruaro
Sent: Tuesday, March 17, 2015 2:24 PM
To: Melissa Kookesh
Subject: FW: Senate Bill 55

FYI. For bill packets on SB 55.

From: David Zumbro [mailto:dzeyemd@mail.com]
Sent: Monday, March 16, 2015 5:49 PM
To: Sen. Bert Stedman
Subject: Senate Bill 55

Dear Senator Stedman,

My name is David Zumbro. I am a Board Certified Ophthalmologist with fellowship training in Vitreoretinal Disease and Surgery. I am a partner with Alaska Retinal Consultants, which is the only retina specialty group in the state. I am writing to you about the issues associated with Senate Bill 55. I hope that you can take the time to review this letter and accept my thoughts and comments as genuine given my unique training and experience. There are only a handful of Board Certified Ophthalmologists in the State of Alaska, so our voice is not a loud one. The primary concern for us is patient safety.

I am a retired COL from the US Army and spent several years teaching resident physicians at Brooke Army Medical Center and Wilford Hall Air Force Medical Center in San Antonio, Texas. This is relevant because I have experience in training individuals to perform surgical, laser and invasive procedures on an eye. As you may know, the pathway to become an eye surgeon is well established. People who desire to practice ophthalmology complete 4 years of medical school and then enter a 4 year residency training program. During residency, the individual in training is constantly supervised. No procedure; be it laser, periocular or intravitreal injection, simple excision of a corneal foreign body or eyelid lesion or even complex intraocular surgery is performed without the knowledge or presence of someone with great experience in the given procedure. During my teaching tenure, I discovered that the most difficult part of learning surgical and laser procedures is the decision making process. What to do, what NOT to do, how to best approach a procedure to maximize the safety for the patient. During this time, there were inexperienced individuals who thought they knew the best course of action and were wrong. We had a weekly "morbidity and mortality" conference to discuss these issues. This was a great teaching tool for all involved, including my seasoned colleagues. At the end of 4 years, most individuals would meet the requirements for graduation and move on to the Board Certification process. The common denominator for the few who did not meet the requirements was hubris. Persons who exaggerate their self-confidence and minimize the possible side effects of any procedure are not safe surgeons, and patients will suffer.

Another interesting fact about my experience is that I had 3 staff members who were optometrists prior to going to medical school and completing ophthalmology training. Two of them had completed extra training (fellowship) in glaucoma and one completed a fellowship in pediatric eye disease. I had several discussions with them regarding the issue of optometric expansion of practice. They all said the same things. First, their optometric training did not give them any surgical or laser experience. It did not train them properly about risks and complications of surgical and laser procedures and when they were admitted into medical school, their optometric training counted for zero credits in medical school. In other words, they were required to participate in the entire academic program, despite the fact that they were already "optometric physicians".

There are only two groups who will benefit from the passage of this bill. The optometrists of course are

one. We (ophthalmologists) will be the second group because of the very real necessity for us to fix complications of ill conceived procedures by inexperienced optometric providers. In the course of my practice, I have seen patients with intraocular fungus infections receive periocular steroid injections. It is often difficult to distinguish between noninfectious and infectious causes of inflammation in the eye and the treatments are radically different. Treating an infection with steroids is like pouring kerosene on a fire. Patients often need removal of the eye after inappropriate steroid treatment.

There is no urgency for Senate Bill 55 to be passed. We already have experts in the state who can perform the needed surgeries and lasers and have completed a well established rigorous training program and board certification process. Patients who require these treatments already get in to see the correct physician and receive this treatment. The notion that residents in the bush do not have access to care is incorrect. Patients are routinely flown in to Anchorage where the board certified ophthalmologists can provide the treatment. If you had patients clamoring at your door saying they couldn't get care, then you would know that this issue was real. Otherwise, it is simply contrived by the optometry lobby.

The proposed wording in Sec. 6. AS 08.72.300(3) concerns me. Not a clinic day goes by without a new patient coming in for evaluation with an inaccurate diagnosis by an optometrist. How can you expect an optometrist to establish and execute a proper course of treatment when they can't make the correct diagnosis? Senate Bill 55 does not benefit the people of Alaska. It is poorly conceived, nebulous in its wording and downright frightening to the experts in this field. During a casual lunch with one of the optometrists who admittedly crafted this proposed legislation, he said to me and my partners, "we can help you with intravitreal injections". It took 10 years of rigorous training to include medical school, residency and fellowship for me and my partners to become qualified to perform this procedure and others like it. That should give you pause when you consider passing this legislation. It becomes clear that the optometry lobby is trying to legislate an expansion to its scope of practice without the proper training or supervision.

David S. Zumbro, MD
Retiree Retinal Surgeon
Alaska Retinal Consultants



March 14, 2015

The Honorable Bert Stedman
Chairman, Health and Social Services Committee
Alaska Senate
State Capitol Room 30
Juneau, AK 99801

Dear Chairman

I am writing on behalf of the Interior Independent Practice Association regarding SB 55. We are an organization comprised of independently practicing physicians and associate providers in the Alaskan Interior. Our group represents the majority of all the specialist providers within the Interior. We are dedicated to the goal of providing access to high quality, safe medical care to all residents of the Interior. As such, we respectfully ask that you oppose SB 55. As you are aware, this bill would expand the scope of practice privileges to Optometrists. This would allow a group of providers who have neither completed medical school nor residency training to both perform surgical procedures and use medications with potentially toxic and life-threatening side effects. We do not feel that this would be compatible with the goal of providing safe and high quality care. The practice of establishing and upholding high standards for medical practice has been in place in the United States for over 80 years. The American Board of Medical Specialties and the individual national specialty groups make painstaking effort to ensure that member physicians demonstrate high levels of competency, judgment, and safety in caring for patients. To allow equivalent practice privileges to providers who have not been trained and certified in accordance with these standards both undermines this effort and creates increased potential for significant harm to patients. Please help us in our effort to maintain high standards for patient care and safety in Alaska by voting "no" on SB 55. Thank you for your kind consideration in this matter.

Sincerely,

Christopher Jensen, M.D.
President
Interior Independent Practice Association

*Alaska Society of
Eye Physicians and Surgeons*

3500 Latouche St. #250
Anchorage, Alaska 99508
907-561-1530



20 F Street, NW
Washington, D.C. 20001 -6701
202-737-6662

February 26, 2015

The Honorable Bert Stedman
Chairman, Health and Social Services Committee
Alaska Senate
State Capitol Room 30
Juneau AK, 99801

Dear Chairman Stedman:

We are writing today on behalf of the American Academy of Ophthalmology, the world's largest association of eye physicians and surgeons, serving more than 31,000 members worldwide, and on behalf of the Alaska Society of Eye Physicians and Surgeons, to ask for your opposition to SB 55. This legislation would permit optometrists, non-medical doctors who have neither completed medical school nor surgical residency, to perform surgery on and around the eye.

Our members strongly feel that SB 55 compromises the safety and surgical care of Alaska's eye patients by lowering the current standards of medical education and clinical training required to perform eye surgery. Lowering the surgical standards (as optometry is requesting) creates two separate and inconsistent sets of proficiency and credentialing requirements to perform the same surgery. This dual surgical standard authorized by SB 55 is not in the best interest of patient safety or quality of patient surgical care. Additionally, by allowing the Alaska Board of Examiners in Optometry to set its own licensure requirements, SB 55 would remove the Alaska State Medical Board's ability to fully ensure patient safety standards when it comes to operating on and around a patient's eyes. As a result, these provisions would place patients in harm's way and should be grounds for rejecting the legislation. The eyes of Alaska's citizens deserve better.

Although the legislation purports to prohibit optometrists from performing "invasive surgery," the bill's language is grossly misleading. SB 55 authorizes optometrists to perform surgeries using many different surgical techniques on the delicate structures of the eye. The bill's definition of "invasive surgery" is at odds with the surgery definition of both the American Medical Association and the American College of Surgeons. The supposed prohibition against invasive surgery as outlined in SB 55 is merely a short list of procedures optometrists could not perform, ignoring the fact that the language allows optometrists to perform any surgical procedure not listed. This would open the door for optometrists to perform dozens of surgeries—all of which are invasive—on the eye and surrounding tissues using scalpels, lasers, needles, ultrasound and other means.

There are no shortcuts for learning how to safely perform surgery. All ophthalmologists—medical doctors and surgeons specializing in comprehensive eye care—train for four years in medical school, perform a one-year hospital internship, and train for three additional years (approximately 9,000 hours of hands-on training) in a surgical residency program before they can treat on their own. This training provides not only technical skills, but just as important, it instills the judgment to determine when not to operate. Moreover, ophthalmologists' clinical training prepares them how to manage potentially blinding or even fatal surgical complications that may arise. The fact that optometrists—non-physicians—would be able to perform all the surgeries authorized in this bill without ever having completed medical school and surgical residency is alarming, and puts Alaska's eye surgery patients at severe risk.

*Alaska Society of
Eye Physicians and Surgeons*



In addition to the surgical provisions, SB 55 would also remove existing safeguards placed upon the practice of optometry by the state legislature, which pertain to the prescription and administration of pharmaceuticals. SB 55 removes the existing safeguard against injections into the globe of the eye. For example, optometrists would now be authorized to inject medications directly into the small and delicate structures of the eyeball's anterior segment. Additionally, SB 55 would also authorize optometrists to inject Botox for therapeutic purposes and to alter or enhance cosmetic appearance. Both of these procedures have significant potential for causing harm; for instance, fatal anaphylaxis has been reported after Botox injections. Optometrists do not have medical training to cope with these sorts of complications.

In 2014, the Alaska State Legislature passed legislation allowing optometrists the continued authority to prescribe controlled substances containing hydrocodone. To ensure patient safety, the legislature determined that an optometrist's authority to prescribe these potent medications was restricted to a four-day limitation. Not only would SB 55 remove all restrictions on the authority to prescribe these and other controlled substances, but it would also expand optometry's authority to prescribe all Schedule Ia and IIa controlled substances, without limitations. These sets of drug classifications contain many powerful and highly addictive substances. This particular section of the bill would even remove the requirement of a physician-patient relationship in order to prescribe such potent drugs.

We respectfully ask that you uphold Alaska's current, high standard of patient safety by voting "no" on SB 55. Thank you for your strong consideration on this matter.

Sincerely,

Scott A. Linstrom, MD
President
Alaska Society of Eye Physicians and Surgeons

Russell N. Van Gelder, MD, PhD
President
American Academy of Ophthalmology

Cc: The Honorable Cathy Giessel, Vice Chair
The Honorable Pete Kelly
The Honorable Bill Stoltze
The Honorable Johnny Ellis

2015 Optometry/Ophthalmology Educational and Training Comparison Chart

Degree/Qualification	Optometrist (OD)	Ophthalmologist (MD)
	Optometry School	Medical School
Education	<ul style="list-style-type: none"> • 4 Years in length • Hours of coursework based on SUNY Optometry School are 597.3 hours of basic sciences. 	<ul style="list-style-type: none"> • 4 years in length • Average hours of coursework based on average across medical schools are 1,436 hours of basic sciences.
	Optometry Post Graduate Training	Ophthalmology Residency
Mandatory Post-Graduate Training	<ul style="list-style-type: none"> • There is no mandatory post graduate training. About 15% go on to an optional 1 year training program. 	<ul style="list-style-type: none"> • Mandatory additional 4 years in training • Must complete 1 year of general medical or surgical internship. • Must complete 3 years of an ophthalmology residency training program. • 40% of ophthalmologists participate on a 1 or 2 year fellowship program. • Additional ophthalmology instruction and lab on ocular disease and management of a minimum 626 hours during residency.
Clinical Experience During Mandatory Education and Training	<ul style="list-style-type: none"> • Hours of clinical experience based on SUNY Optometry School are 1,910 hours. • Optometrists have no minimum requirements for number of patient visits with ocular diseases or ocular surgical operative experience. 	<ul style="list-style-type: none"> • Estimate of an average 60 hours per week, with at least 17,280 hours for clinical experience. • Accreditation Council on Graduate Medical Education requirements: 3,000 outpatient visits; minimum operative numbers as primary surgeon and as assistant; experience in the entire spectrum of ophthalmic disease and ocular surgery.
Profession Regulation	<ul style="list-style-type: none"> • State licensure • Several national boards with highly variable standards. None qualify for membership in the American Board of Medical Specialties. 	<ul style="list-style-type: none"> • State licensure • National board certification by the American Board of Ophthalmology, a member of the American Board of Medical Specialties. • Recertification mandatory every 10 years for Ophthalmologists certified in 1992 or later.

MAR 1 8 2015

Alaska State Medical Association

4107 Laurel Street • Anchorage, Alaska 99508 • (907) 562-0304 • (907) 561-2063 (fax)

March 16, 2015

Honorable Bert Stedman
Alaska State Senate
State Capitol Room 30
Juneau, AK 99801

RE: Senate Bill 55

Dear Senator Stedman:

The Alaska State Medical Association (ASMA) represents physicians statewide and is primarily concerned with the health of all Alaskans.

ASMA strongly opposes SB 55 which would expand the scope of practice for optometrists beyond their professional training, lower standards of care and put patients health at risk.

Although the bill appears to be short the expansion to the scope of practice is monumental.

One concern is the expansion of practice to include invasive e surgery. The Alaska State Medical Board has an official position on "Guidelines Regarding the Use of Lasers and Laser Surgery" and ASMA supports and endorses those guidelines. (Attached) Specifically the Alaska State Medical Board adopted the American Medical Association's Policy H-475.989:

"Laser surgery should be performed only by individuals licensed to practice medicine and surgery or by those categories of practitioners currently licensed by the state to perform surgical services."

Not only do optometry schools not currently provide the education and training to perform surgery safely that is comparable to ophthalmology residency programs but even if they started optometrists who have already graduated have not acquired that education and training. The surgeries included in SB 55 include dozens of surgeries with lasers, scalpels, needles, ultrasound and other techniques. None of these surgeries are “superficial” or “not invasive.”

Quite simply, expanding the scope of practice for optometrists to include laser surgeries is inappropriate given optometrists’ level of training.

In addition to the allowing surgery SB 55 would remove patient protections regarding prescription and administration of pharmaceuticals. Optometrists are not physicians and do not receive training necessary to perform injections into the globe of the eye. Furthermore, this legislation allows optometrists to inject Botox for either cosmetic or therapeutic purposes. Optometrists simply are not trained to perform such procedures.

With regard to prescriptions SB 55 would allow non-physician optometrists to prescribe all Schedule Ia and IIa controlled substances. In 2014, after much deliberation the Alaska Legislature allowed the temporary prescription of substances containing hydrocodone to be prescribed by optometrists. Even this small expansion drew great deliberation and concern. Allowing controlled substances to be prescribed by individuals without appropriate training jeopardizes the health of Alaska patients.

ASMA requests that SB 55 not move from your committee.

Sincerely,

A handwritten signature in black ink, appearing to read "Michael Haugen", with a long, sweeping horizontal line extending to the right.

Michael Haugen
Executive Director
Alaska State Medical Association