

Meeting of the Virginia Board of Medicine



October 15, 2026
8:30 a.m.

Board of Medicine
Thursday, October 15, 2026 @ 8:30 a.m.
Perimeter Center
9960 Mayland Drive, Suite 201
Board Room 2
Henrico, VA 23233

Call to Order

Emergency Egress Procedures i

Roll Call

Introduction of New Board Members

Approval of Full Board and Nominating Committee Minutes from June 4, 2026 1

Adoption of Agenda

Public Comment on Agenda Items..... 13

DHP Director’s Report 14

Reports of Officers and Executive Director 15

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

Committee and Advisory Board Reports 16

- ♦ List of Committee Appointments 17
- ♦ Advisory Board on Physician Assistants – October 1, 2026 18

Other Reports 22

- ♦ Board Counsel ----
 - ♦ Podiatry Report ----
 - ♦ Chiropractic Report ----
 - ♦ Committee of the Joint Boards of Nursing and Medicine 23
 - ♦ Board of Medicine and Nursing Workgroup Meeting – July 8, 2026 25
 - ♦ Board of Medicine and Nursing Workgroup Meeting – August 28, 2026 27
- 

New Business:

1. Consideration of HCA surgical technologist training program.....	32
2. Current Regulatory Chart	35
3. Regulatory Process Chart	38
4. Exempt action to implement HB746 regarding PA practice	39
5. NOIRA for implicit bias training	51
6. NOIRA for foreign chiropractors (HB1026).....	54
7. Revisions to Guidance Document 85-12 (telemedicine).....	56
8. Exempt action to create licensure by endorsement for chiropractors	65
9. Fast track action to remove 10-year requirement to take and pass USMLE	69
10. Licensing Report- Ms. Opher /Mr. Sobowale.....	72
11. Discipline Report – Ms. Deschenes	73
Announcements/Reminders	74

Adjournment

PERIMETER CENTER CONFERENCE CENTER
EMERGENCY EVACUATION OF BOARD AND TRAINING ROOMS
(Script to be read at the beginning of each meeting.)

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Board Room 2

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Agenda Item: Approval of Minutes of the June 4, 2026

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

Action: Review and approve with or without corrections.

DRAFT - UNAPPROVED

**NOMINATING COMMITTEE
PERIMETER CENTER - HEARING ROOM 5**

Thursday, June 4, 2026, at 7:45 AM Perimeter Center 9960 Mayland Drive, Henrico

Members present: Peter Apel, MD - Chair
Randy Clements, DPM
Jennifer Rathmann-Johnson, DC

The meeting of the Nominating Committee was called to order at 7:55 AM by Dr. Apel.

Candidates

President

Bo Vaughan, MD was interviewed for the office of President. Dr. Vaughan expressed how much he has enjoyed his work at the Board and how much he has learned from the veteran members on the Board. He said he has arranged his schedule to be available to Board staff and Board counsel. He can handle phone calls, other assorted tasks, and continue to do probable cause reviews. He was asked about his general approach to standard of care cases.

Secretary-Treasurer

Michele Nedelka, MD indicated that she has become more engaged with her work at the Board and looks forward to a leadership position. She asked questions about the duties expected of her as Secretary-Treasurer. She indicated that she will have more time for the Board now that she has a new partner joining her practice.

Discussion

The Committee discussed the most promising slate for the coming year.

- President – Dr. Vaughan
- Vice-President – Dr. McDowell
- Secretary-Treasurer – Dr. Nedelka

The meeting was adjourned at 8:20 AM.

William L. Harp, MD
Executive Director

VIRGINIA BOARD OF MEDICINE FULL BOARD MINUTES

June 4, 2026

Department of Health Professions

Henrico, VA 23233

CALL TO ORDER: Dr. Apel called the meeting to order at 8:38 a.m.

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

MEMBERS PRESENT: Peter J. Apel, MD – President & Chair
The Honorable David Christian, RPh
John R. Clements, DPM
Kamlesh Dave, MD
Hazem Elariny, MD
Deborah DeMoss Fonseca
William Hutchens, MD
Elliott Lucas, MD
Krishna P. Madiraju, MD
L. Blanton Marchese
Patrick McManus, MD
Michele Nedelka, MD
Jennifer Rathmann, DC
Gertude Shahady, MD
Mark Simcox, MD
Leroy Brown Vaughan, Jr., MD– Vice-President

MEMBERS ABSENT: Ken McDowell, DO – Secretary-Treasurer

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

STAFF PRESENT: William L. Harp, MD - Executive Director
Jennifer Deschenes, JD - Deputy Exec. Director for Discipline
Michael Sobowale, LLM - Deputy Exec. Director for Licensure of Allied Professions
Colanthia Opher - Deputy Exec. Director for Administration & Licensure of Doctors
Barbara Matusiak, MD - Medical Review Coordinator
David Bown, DC – DHP Agency Director
Erin Barrett – Director of DHP Legislative and Regulatory Affairs
Matt Novak - DHP Policy and Economic Analyst
Deirdre Brown - Executive Assistant

Shelby Smith – Licensing Specialist

OTHERS PRESENT:

Allyson Flinn – Medical Society of Virginia
Tamika Hines – Discipline and Compliance Case Manager
Roslyn Nickens – Licensing Supervisor
Coralyn Kirby – Discipline Support Specialist
Allison Still – Discipline Administrative Assistant
Denise Christian – Licensing Specialist
Erin Pollard - Licensing Specialist
Sabrina Harris - Licensing Specialist
Joshlynn Jones - Licensing Specialist
Jamie Culp - Licensing Specialist
Sonya Armstead - Licensing Specialist

EMERGENCY EGRESS INSTRUCTIONS

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

APPROVAL OF MINUTES OF FEBRUARY 19, 2026

Dr. McManus moved to approve the minutes of the February 19, 2026, meeting. The motion was properly seconded by Dr. Lucas and carried unanimously.

ADOPTION OF AGENDA

Dr. Vaughan moved to approve the agenda with the amendment to remove guest speaker Deputy Secretary Lauryn Walker of Health and Human Resources. The motion was properly seconded by Dr. Nedelka and carried unanimously.

PUBLIC COMMENT

No public comment.

DHP DIRECTOR'S REPORT

Dr. Brown shared that Governor Spanberger's administration will continue the work initiated under Governor Youngkin's administration on the Rural Health Transformation Fund, for which Virginia was awarded \$189 million in 2025. He noted that the funding must be expended within a specified timeframe.

Dr. Brown said that the Healthcare Workforce Initiative aims to make healthcare more affordable by using data to identify areas of need, particularly shortages of specialists in rural communities. He noted that Behavioral Health is a significant area of concern.

REPORTS OF OFFICERS AND EXECUTIVE DIRECTOR**PRESIDENT**

None.

VICE-PRESIDENT

None.

SECRETARY-TREASURER

None.

EXECUTIVE DIRECTOR**1. Budget Report**

Dr. Harp said that the numbers he would share were for FY2026. He reminded the Board members that FY2026 runs from July 1, 2025 to June 30, 2026. The expected revenue for FY2026 is \$12.7 million, noting that this is an even year which generates more renewal revenue than odd years.

Dr. Harp pointed out that from July 2025 through April 2026 was a 10-month period representing 83% of the fiscal year. Therefore, 17% of FY2026 remained. He said that the April numbers showed that 21% of the FY2026 funds remained indicating the Board is operating in the black. Most likely, the Board will finish FY2026 with a surplus of approximately \$300,000.

He concluded by noting that the FY2027 budget has been submitted to Finance for review, with the new budget scheduled to take effect on July 1.

2. Senate Bill and House Bill Updates

- **SB194** - Dr. Harp said that this bill establishes a requirement for continuing education on the Electronic Death Registration System for physicians, physician assistants, and advanced practice registered nurses. The Board is required to ask about completing death certificates in one's practice and whether the applicant/licensee has viewed the VDH physician tutorial. These 2 questions will be on new applications and renewals beginning in July/August 2026.
- **SB332** - Dr. Harp explained that this law will permit certified hospitals and medical care facilities to administer cannabis oil to patients with chronic illnesses. He noted

that the Virginia Department of Health (VDH) is forming a work group to support implementation. Dr. McManus has volunteered to serve on this work group.

- **HB452** – Dr. Harp noted that this bill extends the waiver for licensure to Radiologic Technologists, Limited Radiologic Technologists, and Radiologist Assistants working in hospitals and healthcare systems, including urgent care centers affiliated with a hospital or healthcare system.
- **HB573** – Dr. Harp noted that the Board of Medicine is required to develop educational materials for patients considering breast implants by January 1, 2027. He added that a work group is being assembled to support this effort. Dr. Shahady has volunteered to serve on this work group set for October 30th.
- **HB1139** – Dr. Harp explained that the bill removes the geographical residency requirements for Board members. Each Congressional District no longer must have an MD Board member, and citizen members are no longer prohibited from residing in the same Congressional District.
- **Item 288 #4s** – Dr. Harp stated that a work group will be convened with the Joint Boards of Nursing and Medicine to modernize the regulatory framework for advanced practice registered nurses on July 8th. Dr. Vaughan will serve on this work group.
- **HB768** – Dr. Harp said this bill addresses the concerns of mental health professionals who appear as child custody experts in court. He noted that a work group will be convened on July 20, in consultation with the Board of Medicine, and that representation from the Board of Medicine was still needed.
- **Item 288 #4** - This action calls for a work group to revisit the issue of psychologists prescribing on August 18th. Dr. Lucas served on this work group and has volunteered to do so again.

3. FSMB Annual Meeting

Dr. Harp noted that Mr. Marchese, Dr. Simcox, Dr. McDowell, and he attended the FSMB Annual Meeting in late April and early May 2026. He commented on 2 sessions from the meeting. The first was Artificial Intelligence. The Director of the Office of AI for the state of

Utah and the Co-CEO of Doctrone spoke about a pilot program that will provide AI healthcare visits from start to finish without a physician, to include the issuance of prescriptions. The second was a session on psychedelic drugs and their emerging use in psychiatric patients. The speaker mentioned cannabis, ketamine, psilocybin, and noted that LSD is currently being evaluated for treatment of several psychiatric syndromes. It was suggested that boards may wish to get ahead of these new treatments with some guidance to practitioners.

COMMITTEE AND ADVISORY BOARD REPORTS

No report.

OTHER REPORTS

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

Mr. Saunders provided updates on 8 ongoing legal cases.

Podiatry Report

No report.

Chiropractic Report

No report.

Committee of the Joint Boards of Nursing and Medicine

No report.

NEW BUSINESS

1. Regulatory Chart

Mr. Novak presented the chart of regulatory actions as of May 8, 2026, stating that there are currently only 5 regulatory actions in the Secretary's Office.

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

2. Final action regarding physician assistant prescriptions

Mr. Novak reviewed the final-stage regulatory action concerning the requirement to include the physician's name on prescriptions written by physician assistants.

MOTION: Mr. Marchese moved to adopt final regulatory language regarding physician assistant prescriptions. Dr. Vaughan seconded, and the motion carried unanimously.

3. Exempt regulatory action to implement HB712/SB641

Ms. Barrett reviewed the draft regulatory language implementing HB712.

MOTION: Mr. Marchese moved to adopt the regulatory amendment as an exempt action. Dr. Vaughan seconded, and the motion carried unanimously.

4. Fast-track regulatory action to change national certification body name for athletic trainers

Ms. Barrett reviewed the draft of fast-track changes to 18VAC85-120, which will change “National Athletic Trainers’ Association Board of Certification,” or “NATABOC,” to “Board of Certification for the Athletic Trainer,” or “BOC.”

MOTION: Dr. Rathmann moved amend 18VAC85-120 by fast-track regulatory action as presented. Dr. Clements seconded, and the motion carried unanimously.

5. Fast-track regulatory action to change national certification body name for acupuncturists.

Ms. Barrett reviewed the draft of fast-track changes to 18VAC85-110 changing “National Certification Commission for Acupuncture and Oriental Medicine,” or “NCCAOM,” to “National Certification Board for Acupuncture and Herbal Medicine,” or “NCBAHM.”

MOTION: Mr. Christian moved to amend 18VAC85-110 by fast-track regulatory action as presented. Dr. Rathmann seconded, and the motion carried unanimously.

Ms. Barrett reviewed with the Board members the three stages of the regulatory process: the Notice of Intended Regulatory Action (NOIRA), posting to Town Hall for public comment, and the final stage.

6. Petition for rulemaking - Mountcastle

After discussion of the petition for rulemaking to establish regulations on cosmetic injections, Dr. Hutchens recommended that the Board pursue a guidance document rather than a regulation. Dr. Vaughan noted that, given the variations of Botox, a guidance document would likely be lengthy. Ms. Barrett added that a draft guidance document on this topic is already in development with 2 other boards.

MOTION: Dr. Nedelka moved to deny the petition because a comprehensive guidance document is already being developed. The motion was seconded by Dr. Hutchens. With a vote of 16-1, the motion passed; Dr. Madiraju voted nay.

7. Petition for rulemaking - Lozano

Ms. Barrett reviewed the petition for rulemaking requesting amendments to the Board's regulations to require physicians to record the serial numbers of implanted medical devices. She stated that the Legislative Committee, as noted in its minutes, declined to recommend that the full Board initiate regulatory action regarding this issue, as did the Executive Committee.

Dr. Vaughan informed the Board that FDA regulations (21 CFR Parts 821 and 801) and the Centers for Medicare & Medicaid Services (CMS) require hospitals and facilities to maintain records for tracking medical devices implanted in patients.

MOTION: Ms. DeMoss Fonseca moved to accept the recommendation of the Executive Committee, denying the petition for the reasons stated by the Executive Committee. The motion was seconded by Dr. Nedelka. With a vote of 16-1, the motion passed; Dr. Madiraju voted nay.

8. Closure of periodic reviews for 18VAC90-30 and 18VAC90-40 with a decision to amend and adoption of a notice of intended regulatory action for periodic review changes to 18VAC90-30 and 18VAC90-40.

Mr. Novak reviewed the recommendations from the Committee of the Joint Boards of Nursing and Medicine to close the periodic review of Chapters 30 and 40 with the decision to retain the chapters with the intent to amend.

MOTION: Mr. Marchese moved to accept the recommendations by the Committee of the Joint Boards to close the periodic reviews of Chapters 30 and 40 and to issue a notice of intended regulatory action. Dr. Nedelka seconded and the motion carried unanimously.

9. Consideration of Amendments for Licensure by Endorsement Pursuant to SB1438 – Respiratory Therapy

Mr. Novak informed the Board that the General Assembly passed SB1438 (2025) which mandates that health regulatory boards under the Department of Health Professions (DHP) establish licensure by endorsement pathways. He stated that the Advisory Board on Respiratory Therapy met on May 12, 2026, and the members who were in attendance did not have any comments or feedback about the proposed regulations.

MOTION: Mr. Marchese moved to adopt an exempt regulatory action to amend regulations regarding respiratory therapists. Dr. Nedelka seconded and the motion carried unanimously.

10. Consideration of Amendments for Licensure by Endorsement Pursuant to SB1438 – Surgical Assisting

Mr. Novak stated that the Advisory Board of Surgical Assisting met on May 18, 2026, and the members who were in attendance voiced their support regarding the amendments as proposed.

MOTION: Dr. Nedelka moved to adopt an exempt regulatory action to amend regulations regarding surgical assisting. Mr. Marchese seconded and the motion carried unanimously.

LICENSING REPORTS

1. Medical Licensing Division for Allopathic, Osteopathic, Chiropractic, and Podiatric Professions

Ms. Opher announced that this month marks the one-year anniversary of the Licensing Section's transition into two separate units: Medical and Allied Professions. She provided an overview of the Medical licensing statistics noting that from June 2024 to June 2025, a total of 6,050 licenses were issued with an average processing time of 41.6 days. From June 2025 to June 2026, the number of licenses issued increased to 6,300 with the average processing time dropping to 34.6 days.

Ms. Opher further reported that from January 2026 through June 2026, the Medical Unit has issued 3,000 licenses, achieving an average processing time of 26 days. She expressed her appreciation for the team's hard work and dedication, especially during the Intern/resident/fellow training license surge.

2. Allied Licensing Division

Mr. Sobowale presented the Allied Licensing Unit's FY2025–FY2026 report as of June 3, 2026. He noted that in FY2025, just under 5,000 licenses were issued with an average processing time of 47 days. So far in FY2026, the Board has issued approximately 2,600 allied licenses with an average processing time of 27 days.

Mr. Sobowale also highlighted Virginia's leadership in licensure compacts. He reminded the Board that in 2021, Virginia was the first state to enact the Occupational Therapy Licensure Compact which now has 35 participating states. He further reported that Virginia entered

the Physician Assistant (PA) Licensure Compact in 2024, and that effective July 1, 2026, Virginia will join the Athletic Trainer Licensure Compact and the Respiratory Care Interstate Compact.

DISCIPLINE REPORT

Ms. Deschenes provided a brief report on the status of open cases as of May 15, 2026, stating that there are a total of 860 cases across all stages. During the 1st Quarter of FY2026, the Board received 643 cases and closed 472.

APPROVAL OF THE DRAFT 2027 MEETING CALENDAR

MOTION: Dr. Nedelka moved to accept or recommend alternate dates. Dr. Rathmann seconded and the motion carried unanimously.

REPORT OF NOMINATING COMMITTEE

Dr. Apel reported that the Nominating Committee met this morning at 7:55 a.m. and developed the following slate of officers for the Board's consideration:

- Dr. Vaughan – President
- Dr. McDowell – Vice-President
- Dr. Nedelka – Secretary-Treasurer

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

EXPIRING BOARD MEMBER TERMS

Dr. Apel announced that the following Board member terms would expire on June 30, 2026:

- Dr. Apel – completing 1st term
- Dr. Clements – completing 1st term
- Dr. Elariny – completing 1st term
- Dr. Hutchens – completing 1st term
- Dr. Madiraju – completing 1st term

Dr. Apel said that he will not be seeking reappointment and expressed his sincere appreciation to the Board. Ms. Deschenes acknowledged Dr. Apel's outstanding leadership, noting that he has given 200% in his role as President and will be greatly missed.

Dr. Apel passed the gavel to the new President, Dr. Vaughan, to formally adjourn the meeting.

ANNOUNCEMENTS

Dr. Vaughan noted that the next Full Board meeting will be held October 15, 2026, at 8:30 a.m.

ADJOURNMENT

With no additional business, Dr. Vaughan adjourned the meeting at 10:22 a.m.

William L. Harp, MD
Executive Director

DRAFT

Agenda Item: Public Comment on Agenda Items

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

Staff Note: All items for information only

Action: None.

Agenda Item: Report of Officers

- Staff Note:**
- ♦ President
 - ♦ Vice-President
 - ♦ Secretary-Treasurer
 - ♦ Executive Director

Action: Informational presentations. No action required.

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

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

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

VIRGINIA BOARD OF MEDICINE

Committee Appointments

FY2027

EXECUTIVE COMMITTEE (8)

Leroy Vaughan, Jr., MD - President, Chair
Ken McDowell, DO - Vice-President
Michele Nedelka, MD-Secretary/Treasurer
Randy Clements, DPM
Deborah DeMoss Fonseca
L. Blanton Marchese
Patrick McManus, MD
Mark Simcox, MD

LEGISLATIVE COMMITTEE (7)

Ken McDowell, DO - Vice-President, Chair
Leroy Vaughan, Jr., MD – President
Michele Nedelka, MD-Secretary/Treasurer
David Christian
William Hutchens, MD
Elliott Lucas, MD
Jennifer Rathmann, DC

CREDENTIALS COMMITTEE (9)

Patrick McManus, MD- Chair
David Christian
Jeffrey Feit, MD
Elliott Lucas, MD
L. Blanton Marchese
Barbra McCabe, MD
Ken McDowell, DO
Gertrude Shahady, MD
Mark Simcox, MD

FINANCE COMMITTEE

Leroy Vaughan, Jr., MD – President, Chair
Ken McDowell, DO – Vice-President
Michelle Nedelka – Secretary/Treasurer

BOARD BRIEFS COMMITTEE

William L. Harp, M.D., Ex Officio

CHIROPRACTIC COMMITTEE

Jennifer Rathmann, DC

COMMITTEE OF THE JOINT BOARDS OF NURSING AND MEDICINE

Leroy Vaughan, Jr., MD - President
Blanton Marchese
Gertrude Shahady, MD

<< DRAFT >>

ADVISORY BOARD ON PHYSICIAN ASSISTANTS

Minutes

October 1, 2026

The Advisory Board on Physician Assistants met on Thursday, October 1, 2026, at the Department of Health Professions, Perimeter Center, 9960 Mayland Drive, Henrico, Virginia.

MEMBERS PRESENT: Justin Hepner, PA-C, Chair
Tracey Dunn - citizen
Bobby Cockram, PA-C
Robert Glasgow, PA-C

MEMBERS ABSENT: Brian Hanrahan, MD

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

GUESTS PRESENT: Drew Densmore
Jonathan Williams

Call to Order

Justin Hepner called the meeting to order at 1:02 p.m.

Emergency Egress Procedures

Kathleen LaMotte announced the emergency egress instructions.

Roll Call

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

Approval of Minutes

Mr. Glasgow moved to approve the minutes from the May 14, 2026 meeting as amended. Mr. Cockram seconded the motion. The motion passed unanimously.

Adoption of Agenda

Ms. Dunn motioned to adopt the agenda. The motion was seconded by Mr. Cockram. The motion passed unanimously.

Public Comment

No public comment was received

New Business

Regulatory update

Mr. Novak reported that the NOIRA for the Physician Assistant Compact was approved by the Governor's Office earlier this morning. He noted that staff are unsure when it will be scheduled for publication. He also stated that licensure by endorsement has now been fully implemented and is live.

Mr. Novak introduced a chart outlining the regulatory processes used by the Department of Health Professions, providing members with a general overview of the rulemaking pathways and how regulations move through the system. Board members were encouraged to contact staff with any questions regarding the regulatory process.

Review and Recommendation of Language to Conform with HB746

Mr. Novak then reviewed HB746, enacted by the General Assembly, which follows the nurse practitioner model and authorizes physician assistants with sufficient experience to practice without a practice agreement. He explained that the Board must promulgate regulations to align with this law and ensure conformity with other professions. The Advisory Board's recommendation on this matter will proceed to the full Board for approval.

He noted that the regulatory package establishes a fee for autonomous practice, consistent with fees set by other Boards. A new Code section has been added to permit practice without a practice agreement and to outline exceptions requiring one. Additionally, new Section 118 establishes requirements and documentation standards for authorization to practice autonomously. Sections 140 and 160 also include new language to ensure compliance with the practice-without-an-agreement framework.

A motion was made by Mr. Cockram and seconded by Mr. Glasgow to recommend that the Board adopt the proposed regulatory action to conform regulations with HB746. The motion passed unanimously.

Update to Physician Assistant Compact – Justin Hepner, PA-C, Chair

Mr. Hepner provided an update on recent activity related to the Physician Assistant Compact. He reported that there are currently 29 member states participating in the Compact, and that committee work continues steadily. Development of the Compact's centralized database remains on track, with anticipated completion in 2027.

Mr. Hepner noted that Virginia is still in need of a backup delegate to the PA Compact Commission. The Board agreed that Mr. Glasgow's name will be advanced to serve in that role.

Review and Comment on PA Compact Commission Draft Rule 2 (Definitions) and Draft Rule 8 (Records Exempt from Disclosure) – Michael Sobowale

Mr. Sobowale reviewed the draft rules issued by the PA Licensure Compact Commission concerning definitions and records exempt from disclosure. He explained that compact legislation requires each member state to appoint a delegate to the PA Compact, and that the Commission subsequently assigns delegates to its committees. Mr. Hepner currently serves on the Executive Committee. The Rules Committee is responsible for completing draft rules for consideration by the Executive Committee and final approval by the full Commission. Each participating state is expected to follow these rules in administering Compact licensure.

Mr. Sobowale noted that the final day for public comment on the draft rules is Sunday, October 4. After the comment period closes, the Rules Committee will determine whether to advance the rules as drafted or make amendments based on the feedback received.

He further explained that Virginia will not need to incorporate Compact rules directly into its regulations; however, the Commonwealth will be required to follow these rules for all Compact-related licensure matters, provided that no provisions conflict with state law.

Licensing Report

Total PA licenses issued in 2025: 968

- **By reciprocity:** 106

Applications processed in 2026 (to date): 896

- **By reciprocity:** 85

Current processing time: 25 days

Total number of licensed PAs in the Commonwealth: 8,118

Announcements

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

Next Scheduled Meeting

The next meeting scheduled is Thursday, February 4, 2027, at 1:00 p.m.

Adjournment

Justin Hepner adjourned the meeting at 1:41 p.m.

William L. Harp, MD, Executive Director

DRAFT

Agenda Item: Other Reports

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

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

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

**VIRGINIA COMMITTEE OF THE JOINT BOARDS OF NURSING AND MEDICINE
BUSINESS MEETING MINUTES
June 17, 2026**

TIME AND PLACE: The meeting of the Committee of the Joint Boards of Nursing and Medicine was called to order at 9:00 A.M., June 17, 2026, in Board Room 2, Department of Health Professions, Perimeter Center, 9960 Mayland Drive, Suite 201, Henrico, Virginia.

MEMBERS' PRESENT: Helen M. Parke, DNP, FNP-BC; Board of Nursing - **Chair**
Carol Cartte, RN, BSN; Board of Nursing
Blanton Marchese; Board of Medicine Bo
Vaughan, Jr., MD; Board of Medicine

STAFF PRESENT: Claire Morris, R.N., L.N.H.A.; Executive Director; Board of Nursing
William L. Harp, MD; Executive Director; Board of Medicine
Randall Mangrum, DNP, R.N.; Deputy Executive Director for Advanced Practice
Shannon Alexander, Senior Licensing and Discipline Case Specialist

OTHERS PRESENT: Sarah Blose, Assistant Attorney General; Board Counsel

IN THE AUDIENCE: Dr. Yetty Shobo, Healthcare Workforce Data Center
Dr. Barbara Hodgdon, Healthcare Workforce Data Center

INTRODUCTIONS: Committee members and staff members introduced themselves.

ESTABLISHMENT OF A QUORUM: Dr. Parke called the meeting to order and established that a quorum was present.

PUBLIC COMMENT: No public comments were received.

PRESENTATION: Drs. Shobo and Hodgdon presented the Healthcare Workforce Date Center Advanced Practice Registered Nurse Workforce Survey Reports:

- Virginia's Licensed Advanced Practice Registered Nurse Workforce: 2025
- Virginia's Licensed Advanced Practice Registered Nurse Workforce: Comparison by Specialty

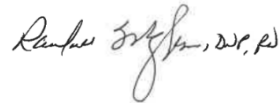
ACTION ITEM: Mr. Marchese moved to accept the HWDC reports as presented. The motion was seconded by Ms. Cartte and carried unanimously.

Dr. Parke thanked Dr. Shobo and Dr. Hodgdon for the report.

Virginia Committee of the Joint Boards of Nursing and Medicine – Business Meeting June 17, 2026

NEW BUSINESS: No new business

ADJOURNMENT: As there was no additional business, the meeting was adjourned at 9:41 A.M.



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

BOARDS OF MEDICINE AND NURSING WORKGROUP MEETING

July 8, 2026

The meeting of the Boards of Medicine and Nursing Workgroup was called to order at 10:15 A.M., July 8, 2026, in Board Room 4, Department of Health Professions, Perimeter Center, 9960 Mayland Drive, Suite 201, Henrico, Virginia

The Workgroup members participating in the meeting were:

Helen Parke, DNP, FNP-BC; Committee of Joint Boards of Nursing and Medicine Chair
Bo Vaughan, Jr., MD; Board of Medicine President
Richard Szucs, MD, Medical Society of Virginia (MSV)
Karen Ransone, MD; MSV
Cathy Harrison, DNAP, CRNA; VANA's Government Relations Committee Chair
Alysia Pack, DNP, APRN, FNP-C; Virginia Council of Nurse Practitioner (VCNP)
Aimee P. Seibert; Virginia College of Emergency Physicians
David May; VA Academy of Family Physicians
Phyllis Whitehead, PhD, APRN, Associate Professor at Virginia Tech Carilion School of Medicine,
Virginia Nurses Association (VNA) – **joined the meeting via TEAMS**

Staff participating in the meeting were:

William Harp, MD; Board of Medicine Executive Director
Claire Morris, RN, LNHA, Board of Nursing Executive Director
Randall Mangrum, DNP, RN; Deputy Executive Director for Advance Practice
Matt Novak, DHP Regulatory Coordinator
Huong Vu, Operations Manager, Board of Nursing

In the Audience:

Valerie Wrobel; VCNP
Patrice Lewis; Virginia Association of Nurse Anesthesiology (VANA), Gentry Locke Attorneys
Allyson Flinn; MSV
Emily White; VCNP
Amira Williams; VCNP, VECTRE Corporation
Sara Thomas; VCNP, VECTRE Corporation
Benjamin Trayham; Hancock, Daniel & Johnson, PC
Brittany Whitely; American College of Nurse Midwives (ACNM)

The meeting was called to order by Ms. Morris.

Dr. Parke moved to accept the agenda as presented. The motion was seconded and carried unanimously.

Mr. Novak noted that the correct bill is HB30 item 488 # 3C. Mr. Novak stated that the charge of the DHP is to convene a stakeholder workgroup to review the structure and purpose of the Committee of the Joint Boards of Nursing and Medicine and the workgroup will report its findings to the General Assembly by November 1, 2026.

Staff provided the following information to the Workgroup:

- The Committee of the Joint Boards of Nursing and Medicine's composition and the Committee of the Joint Boards meet five times a year.

Boards of Medicine and Nursing Workgroup Meeting
July 8, 2026

- The last time the Committee of Joint Boards of Nursing and Medicine recommended legislative or regulatory action to the Boards of Nursing and Medicine for consideration was in April 2026.
- Current count of APRN licenses and numbers of APRN complaints received. Board of Nursing licenses APRNs.
- Cases received from Enforcement regarding APRNs are reviewed by Dr. Mangrum and APRN Agency Subordinates.
- Most APRN cases are heard at the informal conferences, which conducted by Board of Nursing APRN Agency Subordinates, and recommendations are presented to the Committee of the Joint Boards of Nursing and Medicine for consideration. The Committee of the Joint Boards of Nursing and Medicine usually accept the Agency Subordinate recommendations.
- Some APRN cases are heard by the Special Conference Committee of the Joint Boards of Nursing and Medicine, which consists of three Committee Members.
- The formal hearings are heard by a quorum of the Committee of the Joint Boards of Nursing and Medicine, which consists of four Committee members.
- §54.1-2957 of the Code of Virginia.
- Review of Regulatory Process Chart and Joint Boards Regulatory Process.

The Workgroup discussion included the following:

- Using Physicians' expertise in disciplinary process instead of their oversight of the regulatory process.
- The Committee of the Joint Boards of Nursing and Medicine has institutional knowledge regarding standard of care for APRNs. It would be inconsistent if Board of Nursing was a solely regulator for APRNs without Board of Medicine.
- Possibility Advisory Board where Physicians are part of disciplinary hearings, such as informal and formal hearings. The Workgroup was reminded that Advisory Board is a regulatory process, which will require legislation, and Advisory Board Members are appointed by the Governor.
- The Workgroup voted against recommending dissolution of the Committee of the Joint Boards of Nursing and Medicine → four members were in favor and five members opposed.

After discussion, the Workgroup decided on the following for the next meeting:

- One more meeting should be convened before September 2026 – staff will poll members for their availability to participate.
- APRN Compact

Mr. Novak reminded the Workgroup that the report is due to the General Assembly by November 1, 2026.

The meeting was adjourned at 12:00 P.M.

BOARDS OF MEDICINE AND NURSING WORKGROUP MEETING

August 28, 2026

The meeting of the Boards of Medicine and Nursing Workgroup was called to order at 9:04 A.M., August 28, 2026, in Board Room 4, Department of Health Professions, Perimeter Center, 9960 Mayland Drive, Suite 201, Henrico, Virginia

The Workgroup members participating in the meeting were:

Helen Parke, DNP, FNP-BC; Committee of Joint Boards of Nursing and Medicine Chair

Bo Vaughan, Jr., MD; Board of Medicine President – **joined the meeting via TEAMS**

Robin N. Anderson, BSN, MD, FAAFP, Medical Society of Virginia (MSV)

Karen Ransone, MD; MSV

Cathy Harrison, DNAP, CRNA; VANA's Government Relations Committee Chair – **joined the meeting via TEAMS**

Alysia Pack, DNP, APRN, FNP-C; Virginia Council of Nurse Practitioner (VCNP)

Aimee P. Seibert; Virginia College of Emergency Physicians

David May; VA Academy of Family Physicians

Phyllis Whitehead, PhD, APRN, Associate Professor at Virginia Tech Carilion School of Medicine, Virginia Nurses Association (VNA) – **joined the meeting via TEAMS**

Staff participating in the meeting were:

William Harp, MD; Board of Medicine Executive Director

Claire Morris, RN, LNHA, Board of Nursing Executive Director

Randall Mangrum, DNP, RN; Deputy Executive Director for Advance Practice

Matt Novak, DHP Regulatory Coordinator

Huong Vu, Executive Assistant, Board of Nursing

In the Audience:

Valerie Wrobel; VCNP

Zach LeMaster; Virginia Association of Nurse Anesthesiology (VANA), Gentry Locke Attorneys

Colleen Grady; MSV

Clark Barrineau; MSV

Lindsey Cardwell, MSN, RN, NPD-BC; VNA

Mary Lindsay White; VA Academy of Family Physicians

Benjamin Trayham; Hancock, Daniel & Johnson, PC

Lauren Schmitt; Virginia Society of Anesthesiologists

The meeting was called to order by Ms. Morris.

Dr. Parke moved to accept the agenda as presented. The motion was seconded by Ms. Seibert and carried unanimously.

There were no public comments received in person.

The following written public comments were received prior to the meeting and provided to the Workgroup Members in advance:

- Medical Society of Virginia - dated August 17, 2026
- Virginia Academy of Family Physicians - dates August 21, 2026

Boards of Medicine and Nursing Workgroup Meeting
August 28, 2026

- Robin N. Anderson, BSN, MD, FAAFP - dated August 21, 2026
- Virginia Council of Nurse Practitioners - dated August 25, 2026
- **Exhibit A:** House Document No. 18 (2021), Report on Advanced Practice Registered Nurses, Virginia Department of Health Professions
- **Exhibit B:** NCSBN Consensus Model materials and state-by-state comparison of APRN regulatory structures, as included in the Meeting #1 agenda packet, supplemented with the current count of sole board-of-nursing jurisdictions
- Virginia College of Emergency Physicians – dated August 26, 2026
- Virginia Nurses Association – dated August 27, 2026

Mr. Novak stated that the workgroup is to consider pathways to modernize the Committee of the Joint Boards of Nursing and Medicine's structure and governance of the advanced practice registered nurses (APRNs).

Ms. Novak presented options for consideration of the workgroup and noted that workgroup members would vote on support for options, which can be more than one option. Workgroup members presented additional options for consideration.

Dr. Mangrum shared that currently the Board of Nursing receives about 125 APRN cases per month, of which 10 to 12 cases are scheduled for informal conferences. Dr. Mangrum added that he has three Probable Cause Reviewers and an Administrative Assistant under him to process APRN cases.

The Workgroup recessed at 10:00 A.M.

The Workgroup reconvened at 10:14 A.M.

The Workgroup considered and voted on pathway options for modernization of joint regulations of APRNs as follows:

Option # 1 - Advisory Board for APRNs

- Governor-appointed advisory board created in statute for the purpose of advising the Board of Nursing on the regulation and discipline of APRNs.
- Members possibly made up of each type of APRN, physicians/podiatrists, citizens.
- Regulation and discipline would be solely handled by Board of Nursing, with recommendations provided as needed from advisory board.
- A member of the advisory board would be required to sit on any disciplinary panel adjudicating the conduct of an APRN. (Va. Code § 54.1-2409.3)
- Dedicated APRN positions on the Board of Nursing would revert to RN or LPN positions. Those members could be APRNs, but the requirement for appointment would be limited to holding an RN or LPN license.

Boards of Medicine and Nursing Workgroup Meeting
August 28, 2026

- Could cause issues for disciplinary panels. If member of advisory board fails to attend disciplinary hearing, could delay disciplinary action. Potential impact for public safety.

In favor of #1 → Dr. Pack and Dr. Whitehead (2 votes)

Opposed # 1 → Dr. Parke, Dr. Vaughan, Dr. Anderson, Dr. Ransone, Dr. Harrison, Ms. Seibert and Mr. May (7 votes)

Option # 2 – APRNs are solely governed by Board of Nursing with physician-required participation in discipline

- APRNs solely governed by Board of Nursing. This streamlines the regulatory process for APRNs.
- Statute would require physician/podiatrist member(s) of the Board of Medicine participate in disciplinary panels for APRNs.
- This would require a statutory language change.
- President of Board of Medicine could appoint members to serve as needed and available.
- Could cause issues obtaining appropriate quorum for disciplinary panels, similar to option 1. If 1 or 2 Board of Medicine members are required to proceed and the appointed members cannot attend, disciplinary action may be delayed. Potential impact to public safety.

In favor of # 2 → Dr. Parke (1 vote)

Opposition of # 2 → Dr. Vaughan, Dr. Anderson, Dr. Ransone, Dr. Harrison, Dr. Pack, Dr. Whitehead, Ms. Seibert and Mr. May (8 votes)

Option # 3 - APRNs governed solely by Board of Nursing with no specific disciplinary requirement

- APRNs solely governed by Board of Nursing. This streamlines the regulatory process for APRNs.
- Board of Nursing handles disciplinary cases as needed.
- No statutory requirements for makeup of disciplinary panel, similar to Board of Medicine.
- Board of Nursing obtains expert testimony as needed, similar to Board of Medicine.

In favor of # 3 → Dr. Parke, Dr. Harrison, Dr. Pack and Dr. Whitehead (4 votes)

Opposition of # 3 → Dr. Vaughan, Dr. Anderson, Dr. Ransone, Ms. Seibert and Mr. May (5 votes)

Option # 4 – APRNs are regulated jointly by the Boards of Medicine and Nursing

- No change to current the process and makeup

In favor of # 4 → none

Opposition of # 4 → Dr. Parke, Dr. Harrison, Dr. Ransone, Dr. Anderson, Dr. Pack and Dr. Whitehead (6 votes)

Boards of Medicine and Nursing Workgroup Meeting
August 28, 2026

Dr. Vaughan, Ms. Seibert and Mr. May abstained from voting

Option # 5 – APRNs are solely regulated by the Board of Medicine

All Workgroup Members opposed option # 5 (9 votes)

Option # 6 – Increase APRN representation

- Increase APRN seats on the Board of Nursing and also on the Committee of the Joint Boards of Nursing and Medicine
- Amend statute to permit more electronic meetings and loosen current requirements concerning electronic participation by Board Members
- Emphasize sharing of meeting materials by electronic means. This would not require a statutory change.

In favor of # 6 → Dr. Vaughan, Dr. Anderson, Dr. Ransone, Ms. Seibert and Mr. May (5 votes)

Opposition of # 6 → Dr. Parke, Dr. Harrison, Dr. Pack and Dr. Whitehead (4 votes)

Option # 7 – APRN Board

- Would create a separate Board solely regulating APRNs
- Will require statutory change
- Would be logistically and operationally expensive, and would likely require additional staff and resources at the agency
- Amend statute to permit more electronic meetings and loosen current requirements concerning electronic participation by Board Members
- Emphasize sharing of meeting materials by electronic means. This would not require a statutory change

In favor of # 7 → none

Opposition of # 7 → Dr. Parke, Dr. Vaughan, Dr. Harrison, Dr. Ransone, Dr. Whitehead, Ms. Seibert and Mr. May (7 votes)

Dr. Anderson and Dr. Pack abstained from voting

Option # 8 – Increase APRN representation on the Board of Nursing and eliminate joint regulations with the Board of Medicine

- Elimination of the joint boards and joint regulation of APRNs
- Increase APRN seats on the Board of Nursing
- Amend statute to permit more electronic meetings and loosen current requirements concerning electronic participation by Board Members
- Emphasize sharing of meeting materials by electronic means. This would not require a statutory change
- Board of Nursing obtains expert testimony as needed, similar to the Board of Medicine

Boards of Medicine and Nursing Workgroup Meeting
August 28, 2026

In favor of # 8 → Dr. Parke, Dr. Harrison, Dr. Pack and Dr. Whitehead (**4 votes**)

Opposition of # 8 → Dr. Vaughan, Dr. Anderson, Dr. Ransone, Ms. Seibert and Mr. May (**5 votes**)

Mr. Novak noted that staff will prepare the report, which is due to the General Assembly by November 1, 2026.

The meeting was adjourned at 10:58 A.M.

Agenda Item: Consideration of approval of HCA surgical technologist training program

Included in your agenda package:

- Va. Code § 54.1-2956.12

Staff Note: Official request of HCA for approval and program specifics will be provided at the meeting as a handout.

Action needed:

- Discussion and approval of HCA training program for surgical technologists pursuant to Virginia Code § 54.1-2956.12.

Code of Virginia

Title 54.1. Professions and Occupations

Subtitle III. Professions and Occupations Regulated by Boards within the Department of Health Professions

Chapter 29. Medicine and Other Healing Arts

Article 4. Licensure and Certification of Other Practitioners of the Healing Arts

§ 54.1-2956.12. Registered surgical technologist; use of title; registration

A. No person shall hold himself out to be a surgical technologist or use or assume the title of "surgical technologist" or "certified surgical technologist," or use the designation "S.T." or any variation thereof, unless such person is certified by the Board. No person shall use the designation "C.S.T." or any variation thereof unless such person (i) is certified by the Board and (ii) has successfully completed an accredited surgical technologist training program and holds a current credential as a certified surgical technologist from the National Board of Surgical Technology and Surgical Assisting or its successor.

B. The Board shall certify as a surgical technologist any applicant who presents satisfactory evidence that he (i) has successfully completed an accredited surgical technologist training program and holds a current credential as a certified surgical technologist from the National Board of Surgical Technology and Surgical Assisting or its successor, (ii) has successfully completed a training program for surgical technology during the person's service as a member of any branch of the armed forces of the United States, (iii) has successfully completed a surgical technologist apprenticeship program registered with the U.S. Department of Labor, (iv) has successfully completed a hospital-based surgical technologist training program approved by the Board, (v) has successfully completed a surgical technologist training program through an institution or program accredited by a nationally recognized accreditation organization and holds a current credential as a surgical technologist from an entity approved by the Board, or (vi) has practiced as a surgical technologist or attended a surgical technologist training program at any time prior to October 1, 2022, provided he registers with the Board by December 31, 2023.

2014, c. [531](#); 2016, c. [99](#); 2021, Sp. Sess. I, c. [230](#); 2022, c. [71](#); 2023, c. [792](#).

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

Agenda Item: Current Regulatory Actions

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

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

Board of Medicine
Regulatory Actions
As of September 18, 2026

In the Governor's Office

VAC	Stage	Subject Matter	Submitted from agency	Time in current location	Notes
18VAC85-20	Proposed	Licensure of foreign physicians through provisional and restricted licenses	11/14/2025	32 days	Creates a provisional and restricted license pathway for foreign physicians as required by HB995 of the 2024 General Assembly.
18VAC85-40	Proposed	Implementation of 2022 Periodic Review for Chapter 40	4/8/2025	43 days	Implements changes following 2022 periodic review. Fast-track received an objection from a legislator pursuant to Va. Code § 2.2-4012.1., which converted the fast-track into a NOIRA. This action will now undergo the full regulatory process.
18VAC85-50	Final	Removal of patient care team physician or podiatrist name from prescriptions issued by physician assistants	6/22/2026	42 days	Result of a petition for rulemaking
18VAC85-50	NOIRA	Implementation of the PA Compact	4/14/2025	8 days	Facilitates entry into the PA Compact
18VAC85-50	Proposed	Amendment to requirements for patient care team physician or podiatrist	2/25/2026	42 days	Regulatory change pursuant to a petition for rulemaking received by the Board.

		consultation and collaboration			
18VAC85-180	NOIRA	Licensure of Anesthesiologist Assistants	8/18/2025	42 days	Begins the process to license Anesthesiologist Assistants as required by legislation

In the Secretary's Office

None.

At DPB

None.

At OAG

None.

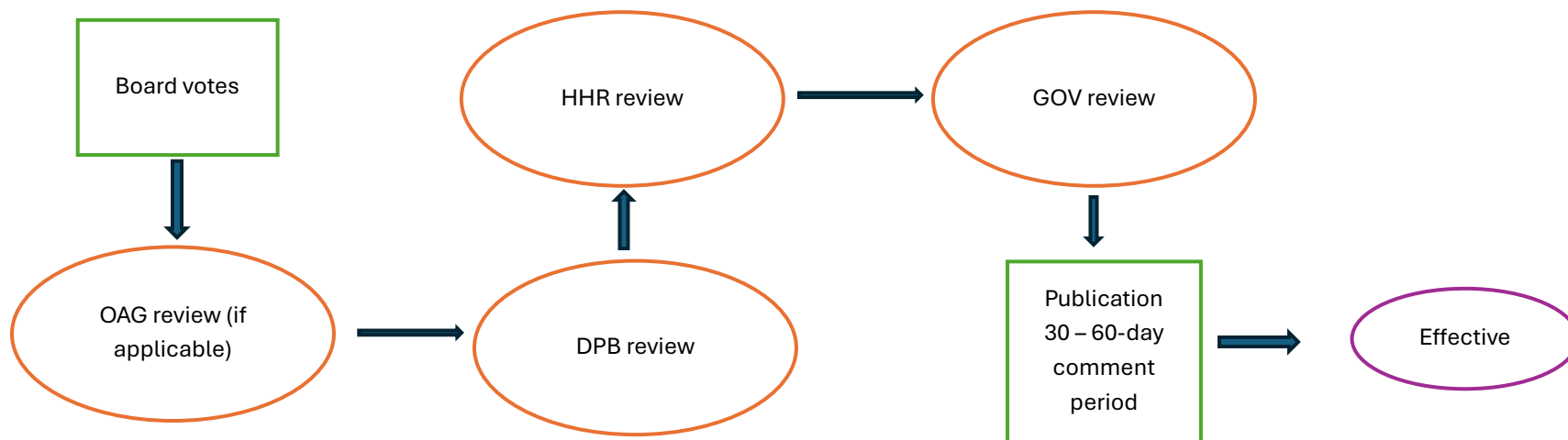
Recently effective/awaiting publication

VAC	Stage	Subject Matter	Submitted for Publication	Publication Date	Effective Date and Notes
18VAC85-20	Fast-Track	Clean up of continuing education requirement references following regulatory reduction	8/17/2026	9/17/2026	Removes references to CE requirements that were removed in a previous regulatory action
18VAC85-21	Exempt/Final	Exempt action to comply with HB712 of the 2026 General Assembly	7/29/2026	9/23/2026	Conforms to 2026 legislation regarding opioid counseling
18VAC85-40	Exempt/Final	Licensure by endorsement for	7/30/2026	8/24/2026	Effective 9/23/2026

		respiratory therapists			
18VAC85-50	Exempt/Final	Licensure by endorsement for physician assistants	5/12/2026	6/1/2026	Effective 7/1/2026
18VAC85-101	Exempt/Final	Licensure by endorsement for radiologic technologists et al.	5/12/2026	6/1/2026	Effective 7/1/2026
18VAC85-110	Exempt/Final	Licensure by endorsement for acupuncturists	5/12/2026	6/1/2026	Effective 7/1/2026
18VAC85-120	Exempt/Final	Licensure by endorsement for athletic trainers	5/12/2026	6/1/2026	Effective 7/1/2026
18VAC85-110	Fast-Track	Update of terminology for national certifying body	9/21/2026	10/19/2026	Effective 11/19/2026
18VAC85-120	Fast-Track	Update of terminology for national certifying body for athletic trainers	9/21/2026	10/19/2026	Effective 11/19/2026
18VAC85-160	Exempt/Final	Licensure by endorsement for surgical assistants and surgical technologists	7/30/2026	8/24/2026	Effective 9/23/2026

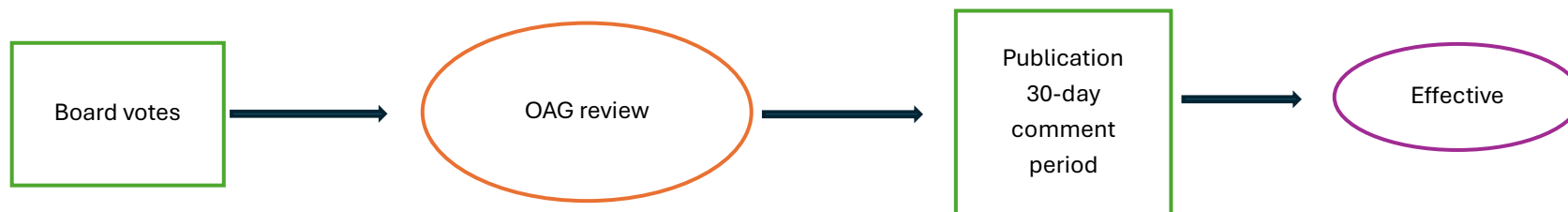
Regulatory Process

Standard rulemaking and fast-track



*Standard rulemaking includes three steps: notice of intended regulatory action (“NOIRA”), proposed stage, and final stage. Fast-track rulemaking includes one step.

Exempt regulations



Action Item: Consideration of Exempt Regulatory Action to Conform with HB746

Included in your Agenda Package:

- Draft regulatory language for an exempt action to conform with HB746; and
- HB746

Staff Note: This draft was viewed by the PA advisory board who recommended the Board adopt this action.

Action Needed:

- Motion to accept the recommendation of the advisory board and adopt an exempt regulatory action to conform regulations with HB746.

Project 8666 - Exempt Final

Board of Medicine

Conformity to HB746 of the 2026 General Assembly Session

18VAC85-50-35. Fees.

Unless otherwise provided, the following fees shall not be refundable:

1. The initial application fee for a license, payable at the time application is filed, shall be \$130.
2. The biennial fee for renewal of an active license shall be \$135 and for renewal of an inactive license shall be \$70, payable in each odd-numbered year in the birth month of the licensee.
3. The additional fee for late renewal of licensure within one renewal cycle shall be \$50.
4. The fee for authorization to practice without a practice agreement shall be \$100.
5. A restricted volunteer license issued pursuant to § 54.1-2951.3 of the Code of Virginia shall expire 12 months from the date of issuance and may be renewed without charge by receipt of a renewal application that verifies that the physician assistant continues to comply with provisions of § 54.1-2951.3 of the Code of Virginia.
- ~~5.~~ 6. The fee for reinstatement of a license pursuant to § 54.1-2408.2 of the Code of Virginia shall be \$2,000.
- ~~6.~~ 7. The fee for reinstatement of a license that has been expired for a period of two years or more shall be \$180.
- ~~7.~~ 8. The fee for a duplicate license shall be \$5.00, and the fee for a duplicate wall certificate shall be \$15.

~~8.~~ 9. The handling fee for a returned check or a dishonored credit card or debit card shall be \$50.

~~9.~~ 10. The fee for a letter of good standing or verification to another jurisdiction shall be \$10.

~~10.~~ 11. The fee for an application or for the biennial renewal of a restricted volunteer license pursuant to 18VAC85-50-61 shall be \$35, due in the licensee's birth month. An additional fee for late renewal of licensure shall be \$15 for each renewal cycle.

18VAC85-50-40. General requirements.

A. No person shall practice as a physician assistant in the Commonwealth of Virginia except as provided in this chapter.

B. Except as provided in §§ 54.1-2952 C and 54.1-2952.01 of the Code of Virginia, all services rendered by a physician assistant shall be performed only in accordance with a practice agreement with one or more doctors of medicine, osteopathy, or podiatry licensed by this board to practice in the Commonwealth.

18VAC85-50-57. Discontinuation of employment.

~~If~~ Except as provided in § 54.1-2952.01 of the Code of Virginia, if for any reason the physician assistant discontinues working with a patient care team physician or podiatrist, a new practice agreement shall be entered into in order for the physician assistant either to be reemployed by the same practitioner or to accept new employment with another patient care team physician or podiatrist.

18VAC85-50-101. Requirements for a practice agreement.

A. ~~Prior~~ Except as provided in § 54.1-2952.01, prior to initiation of practice, a physician assistant and one or more patient care team physicians or podiatrists shall enter into a written or

electronic practice agreement that spells out the roles and functions of the physician assistant and is consistent with provisions of § 54.1-2952 of the Code of Virginia.

1. Any such practice agreement shall take into account such factors as the physician assistant's level of competence, the number of patients, the types of illness treated by the physicians or podiatrists, the nature of the treatment, special procedures, and the nature of the physician's or podiatrist's availability in ensuring direct physician or podiatrist involvement at an early stage and regularly thereafter.

2. The practice agreement shall also provide an evaluation process for the physician assistant's performance, including a requirement specifying the time period, proportionate to the acuity of care and practice setting, within which the physicians or podiatrists shall review the record of services rendered by the physician assistant.

3. The practice agreement may include requirements for periodic site visits by licensees who supervise and direct the patient care team physicians or podiatrists to collaborate and consult with physician assistants who provide services at a location other than where the physicians or podiatrists regularly practice.

B. The board may require information regarding the degree of collaboration and consultation by the patient care team physicians or podiatrists. The board may also require a patient care team physician or podiatrist to document the physician assistant's competence in performing such tasks.

C. If the role of the physician assistant includes prescribing drugs and devices, the written practice agreement shall include those schedules and categories of drugs and devices that are within the scope of practice and proficiency of the patient care team physicians or podiatrists.

D. If the initial practice agreement did not include prescriptive authority, there shall be an addendum to the practice agreement for prescriptive authority.

E. If there are any changes in consultation and collaboration, authorization, or scope of practice, a revised practice agreement shall be entered into at the time of the change.

F. Physician assistants appointed as medical examiners pursuant to § 32.1-282 of the Code of Virginia may practice without a written or electronic practice agreement.

G. Physician assistants employed by (i) a hospital as defined by § 32.1-123 of the Code of Virginia, (ii) a state facility as defined by § 37.2-100 of the Code of Virginia, or (iii) a federally qualified health center designated by the Centers for Medicare and Medicaid Services may practice without a written or electronic practice agreement consistent with the requirements contained in § 54.1-2951.1 E of the Code of Virginia.

18VAC85-50-115. Responsibilities of the physician assistant.

A. ~~The~~ Except as provided in § 54.1-2952.01, the physician assistant shall not render independent health care and shall:

1. Perform only those medical care services that are within the scope of the practice and proficiency of the patient care team physicians or podiatrists as prescribed in the physician assistant's practice agreement. When a physician assistant is working outside the scope of specialty of the patient care team physicians or podiatrists, the physician assistant's functions shall be limited to those areas not requiring specialized clinical judgment, unless a separate practice agreement has been executed for an alternate patient care team physician or podiatrist.
2. Prescribe only those drugs and devices as allowed in Part V (18VAC85-50-130 et seq.) of this chapter.
3. Wear during the course of performing physician assistant duties identification showing clearly status as a physician assistant.

B. If, due to illness, vacation, or unexpected absence, a patient care team physician or podiatrist or alternate physician or podiatrist is unable to collaborate or consult with the physician assistant, such patient care team physician or podiatrist may temporarily delegate the responsibility to another doctor of medicine, osteopathic medicine, or podiatry.

Temporary coverage may not exceed four weeks unless special permission is granted by the board.

C. With respect to physician assistants employed by institutions, the following additional provisions shall apply:

1. No physician assistant may render care to a patient unless the physician or podiatrist responsible for that patient is available for collaboration and consultation with that physician assistant.

2. Any such practice agreement as described in subdivision A 1 of this section shall delineate the duties that the patient care team physician or podiatrist authorizes the physician assistant to perform.

D. Practice by a physician assistant in a hospital, including an emergency department, shall be in accordance with § 54.1-2952 of the Code of Virginia.

18VAC85-50-118. Authorized practice without a practice agreement.

A. A physician assistant with a current, unrestricted license may qualify for practice without a practice agreement within a specific clinical specialty or practice area upon completion of three years of full-time clinical experience in that specialty or practice area.

B. Pursuant to subsection A of § 54.1-2952.01 of the Code of Virginia, full-time clinical experience means 1,800 hours per year of clinical experience.

C. Pursuant to subsection A of § 54.1-2952.01 of the Code of Virginia, clinical experience means the postgraduate delivery of health care directly to patients pursuant to a practice agreement with a patient care team physician.

D. An applicant to practice without a practice agreement shall submit the following:

1. The fee specified in 18VAC85-50-35; and

2. An attestation from a physician licensed by the board as defined in subsection A of § 54.1-2952.01 of the Code of Virginia. The applicant may submit attestations from more than one physician with whom the applicant practiced during the required three years of clinical experience, but all attestations must be submitted at the same time.

E. In the event that a physician assistant is unable to obtain the attestation required by subsection B of § 54.1-2952.01 of the Code of Virginia, the board may accept other evidence demonstrating that the physician assistant has met the requirements of subsection B of § 54.1-2952.01 of the Code of Virginia.

F. A physician assistant authorized to practice without a practice agreement shall comply with all provisions of § 54.1-2952.01 of the Code of Virginia.

18VAC85-50-140. Approved drugs and devices.

A. The approved drugs and devices which the physician assistant with prescriptive authority may prescribe, administer, or dispense manufacturer's professional samples shall be in accordance with provisions of § 54.1-2952.1 of the Code of Virginia.

B. ~~The~~ Unless the physician assistant is authorized to practice without a practice agreement pursuant to § 54.1-2952.01 of the Code of Virginia, the physician assistant may prescribe only those categories of drugs and devices included in the practice agreement. The patient care team physician or podiatrist retains the authority to restrict certain drugs within these approved categories.

C. The physician assistant, pursuant to § 54.1-2952.1 of the Code of Virginia, shall only dispense manufacturer's professional samples or administer controlled substances in good faith for medical or therapeutic purposes within the course of his professional practice.

18VAC85-50-160. Disclosure.

A. Each prescription for a Schedule II through V drug shall bear the name of the patient care team physician or podiatrist and of the physician assistant.

B. The physician assistant shall disclose to the patient that he is a licensed physician assistant, ~~and also~~ Unless the physician assistant is authorized to practice without a practice agreement pursuant to § 54.1-2952.01 of the Code of Virginia, the physician assistant shall also disclose the name, address and telephone number of the patient care team physician or podiatrist. Such disclosure shall either be included on the prescription or be given in writing to the patient.

==47==
VIRGINIA ACTS OF ASSEMBLY - 2026 SESSION

CHAPTER 418

An Act to amend and reenact §§ 54.1-2951.1, 54.1-2952, and 54.1-2952.1 of the Code of Virginia and to amend the Code of Virginia by adding a section numbered 54.1-2952.01, relating to physician assistants; authorization to practice without a practice agreement.

[H 746]

Approved April 8, 2026

Be it enacted by the General Assembly of Virginia:

1. That §§ 54.1-2951.1, 54.1-2952, and 54.1-2952.1 of the Code of Virginia is amended and reenacted and that the Code of Virginia is amended by adding a section numbered 54.1-2952.01 as follows:

§ 54.1-2951.1. Requirements for licensure and practice as a physician assistant; licensure by endorsement.

A. The Board shall promulgate regulations establishing requirements for licensure as a physician assistant that shall include the following:

1. Successful completion of a physician assistant program or surgical physician assistant program accredited by the Accreditation Review Commission on Education for the Physician Assistant;

2. Passage of the certifying examination administered by the National Commission on Certification of Physician Assistants; and

3. Documentation that the applicant for licensure has not had his license or certification as a physician assistant suspended or revoked and is not the subject of any disciplinary proceedings in another jurisdiction.

B. The Board may issue a license by endorsement to an applicant for licensure as a physician assistant if the applicant (i) is the spouse of an active duty member of the Armed Forces of the United States or the Commonwealth, (ii) holds current certification from the National Commission on Certification of Physician Assistants, and (iii) holds a license as a physician assistant that is in good standing, or that is eligible for reinstatement if lapsed, under the laws of another state.

C. Except as provided in subsection E or permitted pursuant to § 54.1-2952.01, every physician assistant shall practice as part of a patient care team and shall provide care in accordance with a written or electronic practice agreement with one or more patient care team physicians or patient care team podiatrists.

A practice agreement shall include acts pursuant to § 54.1-2952, provisions for the periodic review of patient charts or electronic health records, guidelines for collaboration and consultation among the parties to the agreement and the patient, periodic joint evaluation of the services delivered, and provisions for appropriate physician input in complex clinical cases, in patient emergencies, and for referrals.

A practice agreement may include provisions for periodic site visits by a patient care team physician or patient care team podiatrist who is part of the patient care team at a location other than where the licensee regularly practices. Such visits shall be in the manner and at the frequency as determined by the patient care team physician or patient care team podiatrist who is part of the patient care team.

D. Except as provided in subsection E, evidence of a practice agreement shall be maintained by the physician assistant and provided to the Board upon request. The practice agreement may be maintained in writing or electronically and may be a part of credentialing documents, practice protocols, or procedures.

E. Physician assistants employed by a hospital as defined in § 32.1-123 or employed in (i) a state facility as defined in § 37.2-100 operated by the Department of Behavioral Health and Developmental Services or (ii) a federally qualified health center designated by the Centers for Medicare and Medicaid Services may practice without a separate practice agreement if the credentialing and privileging requirements of the applicable facility include a practice arrangement that incorporates the components of a practice agreement set forth in the provisions of subsection C, including requiring and designating a patient care team physician or podiatrist, and the patient care team requirements of § 54.1-2952. Such physician assistants shall continue to practice as part of a patient care team in collaboration and consultation with patient care team physicians or patient care team podiatrists.

§ 54.1-2952. Role of patient care team physician or patient care team podiatrist on patient care teams; services that may be performed by physician assistants; responsibility of licensee; employment of physician assistants.

A. A patient care team physician or patient care team podiatrist licensed under this chapter may serve on a patient care team with physician assistants and shall provide collaboration and consultation to such physician assistants. No patient care team physician or patient care team podiatrist shall be allowed to collaborate or consult with more than six physician assistants on a patient care team at any one time.

Service as part of a patient care team by a patient care team physician or patient care team podiatrist shall not, by the existence of such service alone, establish or create vicarious liability for the actions or inactions of other team members.

B. Physician assistants may practice medicine to the extent and in the manner authorized by the Board. A patient care team physician or patient care team podiatrist shall be available at all times to collaborate and consult with physician assistants, *except physician assistants who are authorized to practice without a practice agreement pursuant to § 54.1-2952.01*. Each patient care team shall identify the relevant physician assistant's scope of practice and an evaluation process for the physician assistant's performance.

C. Physician assistants appointed as medical examiners pursuant to § 32.1-282 may practice without a written or electronic practice agreement.

D. Any professional corporation or partnership of any licensee, any hospital and any commercial enterprise having medical facilities for its employees that are supervised by one or more physicians or podiatrists may employ one or more physician assistants in accordance with the provisions of this section.

Activities shall be performed in a manner consistent with sound medical practice and the protection of the health and safety of the patient. Such activities shall be set forth in a practice agreement or by the credentialing and privileging practice arrangement requirements of a facility described in subsection E of § 54.1-2951.1 and may include health care services that are educational, diagnostic, therapeutic, or preventive, including establishing a diagnosis, providing treatment, and performing procedures. Prescribing or dispensing of drugs may be permitted as provided in § 54.1-2952.1. In addition, a physician assistant may perform initial and ongoing evaluation and treatment of any patient in a hospital, including its emergency department, in accordance with the practice agreement or the credentialing and privileging practice arrangement requirements of a facility described in subsection E of § 54.1-2951.1, including tasks performed, relating to the provision of medical care in an emergency department.

A patient care team physician or the on-duty emergency department physician shall be available at all times for collaboration and consultation with both the physician assistant and the emergency department physician. No person shall have responsibility for any physician assistant who is not employed by the person or the person's business entity.

E. No physician assistant shall perform any acts beyond those set forth in the practice agreement or authorized as part of the patient care team *unless such physician assistant is authorized to practice without a practice agreement pursuant to § 54.1-2952.01*. No physician assistant practicing in a hospital shall render care to a patient unless the physician responsible for that patient is available for collaboration or consultation, pursuant to regulations of the Board.

F. Notwithstanding the provisions of § 54.1-2956.8:1, a licensed physician assistant who (i) is working in the field of radiology or orthopedics as part of a patient care team, (ii) has been trained in the proper use of equipment for the purpose of performing radiologic technology procedures consistent with Board regulations, and (iii) has successfully completed the exam administered by the American Registry of Radiologic Technologists for physician assistants for the purpose of performing radiologic technology procedures may use fluoroscopy for guidance of diagnostic and therapeutic procedures.

§ 54.1-2952.01. Physician assistants; authorization to practice without a practice agreement.

A. For the purposes of this section:

"Attestation" means a written certification, signed and stated by a physician licensed by the Board, affirming that the physician assistant completed the equivalent of at least three years of full-time clinical experience in a specific clinical specialty or practice area in collaboration and consultation with the physician, practiced in accordance with applicable standards of care, had on-call experience as applicable, and has the necessary experience to fulfill the duties set forth in subsection F.

"Clinical experience" means the postgraduate delivery of health care directly to patients pursuant to a practice agreement with a patient care team physician.

"Full-time clinical experience" means 1,800 hours per year of clinical experience.

B. A physician assistant who has completed the equivalent of at least three years of full-time clinical experience may practice within the specific clinical specialty or practice area of that experience without a written or electronic practice agreement upon receipt by the physician assistant of an attestation from the patient care team physician or patient care team podiatrist who provided collaboration and consultation to the physician assistant on a patient care team pursuant to subsection A of § 54.1-2952 stating:

1. That the patient care team physician or patient care team podiatrist has served as a patient care team physician or patient care team podiatrist, respectively, on a patient care team with the physician assistant pursuant to a practice agreement meeting the requirements of §§ 54.1-2952 and 54.1-2952.1;

2. That while a party to such practice agreement, the patient care team physician or patient care team podiatrist routinely practiced with a patient population and in a practice area included within the physician assistant's scope of practice; and

3. The period of time for which the patient care team physician or patient care team podiatrist practiced with the physician assistant under such a practice agreement.

C. A copy of the attestation required pursuant to subsection B shall be submitted to the Board together with a fee established by the Board. A physician assistant may submit attestations from more than one patient care team physician with whom the physician assistant practiced during the equivalent of three years of full-time clinical experience required pursuant to subsection B, provided that all attestations are submitted to the

Board at the same time. Upon receipt of such attestation or attestations and verification that a physician assistant satisfies the requirements of this section, the Board shall issue to the physician assistant a new license that includes a designation indicating that the physician assistant is authorized to practice without a practice agreement.

D. In the event that a physician assistant is unable to obtain the attestation required by subsection B, the Board may accept other evidence demonstrating that the physician assistant has met the requirements of subsection B in accordance with regulations adopted by the Board.

E. A physician assistant who obtains licensure by endorsement pursuant to § 54.1-2951.1 or who exercises a privilege to practice pursuant to the Physician Assistant Licensure Compact (§ 54.1-2953.1) shall only be authorized to practice without a practice agreement pursuant to the requirements of this section if he submits an attestation to the Board confirming he has completed the equivalent of three years of full-time clinical experience in a specific clinical specialty or practice area as required pursuant to this section. A physician assistant who does not meet the specific requirement of this section for independent practice in the Commonwealth shall remain subject to the practice agreement requirement of § 54.1-2952 regardless of his independent status in another jurisdiction.

F. A physician assistant authorized to practice without a practice agreement pursuant to this section shall:

1. Practice (i) within the scope of the physician assistant's clinical and professional training, (ii) within the limits of the physician assistant's knowledge and experience, and (iii) in a manner consistent with the applicable standards of care;

2. Consult and collaborate with other health care providers based on the clinical conditions of the patient to whom health care is provided; and

3. Establish a plan for referral of complex medical cases and emergencies to physicians or other appropriate health care providers.

§ 54.1-2952.1. Prescription of certain controlled substances and devices by licensed physician assistants.

A. In accordance with the provisions of this section and pursuant to the requirements of Chapter 33 (§ 54.1-3300 et seq.), a licensed physician assistant shall have the authority to prescribe controlled substances and devices as set forth in Chapter 34 (§ 54.1-3400 et seq.) and (i) as provided in a practice agreement or, (ii) as provided by the credentialing and privileging practice arrangement requirements of a facility described in subsection E of § 54.1-2951.1, or (iii) in accordance with such physician assistant's authorization to practice without a practice agreement pursuant to § 54.1-2952.01. Such practice agreements or arrangements, if necessary, shall include a statement of the controlled substances the physician assistant is or is not authorized to prescribe and may restrict such prescriptive authority as deemed appropriate by the patient care team physician or patient care team podiatrist.

B. It is unlawful for the physician assistant to prescribe controlled substances or devices pursuant to this section unless such prescription is authorized by the requirements of this section and (i) authorized by the practice agreement or, (ii) authorized by the credentialing and privileging practice arrangement requirements of a facility described in subsection E of § 54.1-2951.1 and the requirements in this section, or (iii) made in accordance with such physician assistant's authorization to practice without a practice agreement pursuant to § 54.1-2952.01.

C. The Board of Medicine, in consultation with the Board of Pharmacy, shall promulgate such regulations governing the prescriptive authority of physician assistants as are deemed reasonable and necessary to ensure an appropriate standard of care for patients.

The regulations promulgated pursuant to this section shall include, at a minimum, (i) such requirements as may be necessary to ensure continued physician assistant competency, which may include continuing education, testing, and any other requirement and shall address the need to promote ethical practice, an appropriate standard of care, patient safety, the use of new pharmaceuticals, and appropriate communication with patients, and (ii) a requirement that the physician assistant disclose to his patients his name, address, and telephone number and that he is a physician assistant. If a patient or his representative requests to speak with the patient care team physician or patient care team podiatrist, the physician assistant shall arrange for communication between the parties or provide the necessary information unless the physician assistant is authorized to practice without a practice agreement pursuant to § 54.1-2952.01.

D. This section shall not prohibit a licensed physician assistant from administering controlled substances in compliance with the definition of "administer" in § 54.1-3401 or from receiving and dispensing manufacturers' professional samples of controlled substances in compliance with the provisions of this section.

2. That the Board of Medicine shall adopt regulations implementing the provisions of this act and establishing processes for granting authorization to physician assistants to practice without a practice agreement within the physician assistant's current scope of practice in accordance with § 54.1-2952.01 of the Code of Virginia, as created by this act. Such initial adoption of regulations by the Board of Medicine shall be exempt from the provisions of the Administrative Process Act (§ 2.2-4000 et seq. of

the Code of Virginia).

3. That the provisions of the first enactment of this act shall not become effective until the Board of Medicine adopts regulations in accordance with the second enactment of this act. The Board of Medicine shall certify in writing to the Virginia Code Commission the date on which it meets such requirement.

Action Item: Consideration of NOIRA to Implement Legislative Mandates Regarding Implicit Bias Training

Included in your Agenda Package:

- Chapter 451 of the 2026 Acts of Assembly

Staff Note: Chapter 451 of the 2026 Acts of Assembly directs both the Board of Medicine and the Board of Nursing to require specific continuing education regarding implicit bias. The Board is required to promulgate regulations to implement those requirements. The first step for implementation is the issuance of a NOIRA.

Action Needed:

- Motion to initiate a Notice of Intended Regulatory Action to implement the implicit bias legislative mandate.

==52==
VIRGINIA ACTS OF ASSEMBLY - 2026 SESSION

CHAPTER 451

An Act to direct the Board of Medicine and Board of Nursing to require certain licensees to complete bias reduction training as part of their continuing education and continuing competency requirements for licensure and to amend and reenact § 54.1-3011 of the Code of Virginia, relating to Board of Nursing continuing education requirements.

[S 22]

Approved April 8, 2026

Be it enacted by the General Assembly of Virginia:

1. *§ 1. That the Board of Medicine, pursuant to its authority under § 54.1-2928.3 of the Code of Virginia, and the Board of Nursing, pursuant to its authority under § 54.1-3011 of the Code of Virginia, as amended by this act, shall require persons licensed by the Board of Medicine and the Board of Nursing (the Boards) to complete continuing learning activities on the topics that mitigate implicit and explicit bias in health care (bias reduction training). The Boards shall promulgate regulations requiring that the continuing education requirements for renewal of an active license shall include completion of such bias reduction training. The Boards shall designate organizations that identify and facilitate evidence-based curricula to comply with this act. Such bias reduction training shall be required for every license renewal period for licensees of the Boards but not more often than every two years.*

§ 2. That the first bias reduction training topic required pursuant to § 1 of this act shall be comprehensive and include how unconscious and conscious racial bias affects care during pregnancy, labor and delivery, and the postpartum period. Subsequent bias reduction training shall provide relevant practice-related content as determined by the Boards and shall include training on diseases and conditions, including sickle cell disease, that are often racialized in clinical practice. This training shall address how the inappropriate substitution of race-based assumptions for individualized clinical assessment, combined with implicit bias, leads to delayed diagnosis, inadequate treatment, and disparate health outcomes. The Boards shall update the list of available trainings as they identify additional needs.

§ 3. That the Boards shall report the number and type of licensees who have successfully completed such training to the Department of Health and the Virginia Neonatal Perinatal Collaborative to be included in their annual reports. The Virginia Neonatal Perinatal Collaborative shall, for licensees who provide fertility care, prenatal care, birth care, and postpartum care, evaluate the impact of such training, develop a method for assessment of its effectiveness, and make recommendations for training improvements.

§ 4. As used in this section:

"Explicit bias" means attitudes and beliefs about a person or group on a conscious level.

"Implicit bias" means a bias in judgment or behavior that results from subtle cognitive processes, including implicit prejudice and implicit stereotypes, that often operate at a level below conscious awareness and without intentional control.

2. That § 54.1-3011 of the Code of Virginia is amended and reenacted as follows:

§ 54.1-3011. Renewal of licenses; continuing education; lapsed licenses; reinstatement; penalties.

A. Every license issued under the provisions of this chapter shall be renewed biennially by such time as the Board may prescribe by regulation. The Board shall mail or send electronically a notice for renewal to every licensee, but the failure to receive such notice shall not excuse any licensee from the requirements for renewal. The person receiving such notice shall furnish the requested information and return the form to the Board with the renewal fee.

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

C. Any licensee who allows his license to lapse by failing to renew the license may be reinstated by the Board upon submission of satisfactory evidence that he is prepared to resume practice in a competent manner and upon payment of the fee.

~~**G. D.**~~ Any person practicing nursing during the time his license has lapsed shall be considered an illegal practitioner and shall be subject to the penalties provided for violations of this chapter.

~~**D. E.**~~ When the Board of Health has issued an emergency order pursuant to § 32.1-13, the Board may waive (i) the requirement for submission of a fee for renewal of a license or (ii) the requirement for submission of evidence satisfactory to the Board that a licensee whose license was allowed to lapse by failing to renew his license is prepared to resume practice in a competent manner for any person who held a valid, unrestricted, active license to practice nursing within the four-year period immediately prior to the application

for renewal of such license.

Action Item: Consideration of NOIRA to Implement Provisions of HB1026

Included in your Agenda Package:

- Chapter 724 (HB1026) of the 2026 Acts of Assembly

Staff Note: Chapter 724 of the 2026 Acts of Assembly creates a pathway for foreign trained chiropractors to obtain a license to Practice in Virginia. Regulations will be necessary to implement this pathway.

Action Needed:

- Motion to initiate a Notice of Intended Regulatory Action to implement provisions of HB1026.

==55==
VIRGINIA ACTS OF ASSEMBLY - 2026 SESSION

CHAPTER 724

An Act to amend the Code of Virginia by adding a section numbered 54.1-2936.1, relating to foreign-trained chiropractors; licensure by endorsement.

[H 1026]

Approved April 13, 2026

Be it enacted by the General Assembly of Virginia:

1. That the Code of Virginia is amended by adding a section numbered 54.1-2936.1 as follows:

§ 54.1-2936.1. Licensure by endorsement of foreign chiropractors.

The Board may issue a license to practice chiropractic to an applicant who:

1. Holds a degree in chiropractic from an institution located outside the United States that is accredited by the appropriate national or regional accrediting organization recognized in that country;

2. Either (i) holds a current, unrestricted license to practice chiropractic issued by a foreign jurisdiction whose educational and professional standards are substantially equivalent to those of the Commonwealth, as determined by the Board, or (ii) has held an unrestricted license to practice chiropractic issued by a foreign jurisdiction whose educational and professional standards are substantially equivalent to those of the Commonwealth, as determined by the Board, and has not had such unrestricted license revoked, suspended, or otherwise restricted as a result of disciplinary action;

3. Has actively practiced chiropractic for at least two years;

4. Has no history of professional discipline, impairment, or criminal conviction that would pose a risk to the health and safety of patients;

5. Is legally authorized to reside and work in the United States; and

6. Has passed Parts I, II, and III of the National Board of Chiropractic Examiners examination and the Special Purposes Examination for Chiropractic administered by the National Board of Chiropractic Examiners.

Action Item: Consideration of Revision to Guidance Document 85-12 (Telemedicine)

Included in your Agenda Package:

- Draft changes to 85-12

Action Needed:

- Motion to amend Guidance Document 85-12

Virginia Board of Medicine

Telemedicine

***NOTE: DOES NOT REFLECT RECENT
FEDERAL GUIDANCE ON HIPAA COMPLIANCE*
(See link on BOM website for current federal guidance)**

Section One: Preamble.

The Virginia Board of Medicine ("Board") recognizes that using telemedicine services in the delivery of medical services offers potential benefits in the provision of medical care. The appropriate application of these services can enhance medical care by facilitating communication between practitioners, other health care providers, and their patients, prescribing medication, medication management, obtaining laboratory results, scheduling appointments, monitoring chronic conditions, providing health care information, and clarifying medical advice. With the exception of prescribing controlled substances, the Virginia General Assembly has not established statutory parameters regarding the provision and delivery of telemedicine services. Therefore, practitioners must apply existing laws and regulations to the provision of telemedicine services. The Board issues this guidance document to assist practitioners with the application of current laws to telemedicine service practices.

These guidelines should not be construed to alter the scope of practice of any health care provider or authorize the delivery of health care services in a setting, or in a manner, not authorized by law. In fact, these guidelines support a consistent standard of care and scope of practice notwithstanding the delivery tool or business method used to enable practitioner-to-patient communications. For the purpose of prescribing controlled substances, a practitioner using telemedicine services in the provision of medical services to a patient (whether existing or new) must take appropriate steps to establish the practitioner-patient relationship as defined in Virginia Code § 54.1-3303. A practitioner should conduct all appropriate evaluations and history of the patient consistent with traditional standards of care for the particular patient presentation. As such, some situations and patient presentations are appropriate for the utilization of telemedicine services as a component of, or in lieu of, in-person provision of medical care, while others are not. The practitioner is responsible for making this determination, and in doing so must adhere to applicable laws and standards of care.

The Board has developed these guidelines to educate licensees as to the appropriate use of telemedicine services in the practice of medicine. The Board is committed to ensuring patient access to the convenience and benefits afforded by telemedicine services, while promoting the responsible provision of health care services.

It is the expectation of the Board that practitioners who provide medical care, electronically or otherwise, maintain the highest degree of professionalism and should:

- Place the welfare of patients first;

- Maintain acceptable and appropriate standards of practice;
- Adhere to recognized ethical codes governing the applicable profession;
- Adhere to applicable laws and regulations;
- In the case of physicians, properly supervise non-physician clinicians when required to do so by statute; and
- Protect patient confidentiality.

Section Two: Establishing the Practitioner-Patient Relationship.

The practitioner-patient relationship is fundamental to the provision of acceptable medical care. It is the expectation of the Board that practitioners recognize the obligations, responsibilities, and patient rights associated with establishing and maintaining a practitioner-patient relationship.

Where an existing practitioner-patient relationship is not present,¹ a practitioner must take appropriate steps to establish a practitioner-patient relationship consistent with the guidelines identified in this document, with Virginia law, and with any other applicable law.² While each circumstance is unique, such practitioner-patient relationships may be established using telemedicine services provided the standard of care is met.

A practitioner is discouraged from rendering medical advice and/or care using telemedicine services without (1) fully verifying and authenticating the location and, to the extent possible, confirming the identity of the requesting patient; (2) disclosing and validating the practitioner's identity and applicable credential(s); and (3) obtaining appropriate consents from requesting patients after disclosures regarding the delivery models and treatment methods or limitations, including any special informed consents regarding the use of telemedicine services. An appropriate practitioner-patient relationship has not been established when the identity of the practitioner may be unknown to the patient.

Section Three: Guidelines for the Appropriate Use of Telemedicine Services.

The Board has adopted the following guidelines for practitioners utilizing telemedicine services in the delivery of patient care, regardless of an existing practitioner-patient relationship prior to an encounter.

Licensure:

The practice of medicine occurs where the patient is located at the time telemedicine services are used, and insurers may issue reimbursements based on where the practitioner is located. Therefore, a practitioner must be licensed by, or under the jurisdiction of, the regulatory board of the state where the patient is located and ~~the state where the practitioner is located.~~ and should research insurer licensure requirements to determine if additional licensure may be needed. Practitioners who treat or prescribe through online service sites must possess appropriate licensure in all jurisdictions where patients receive care. To ensure appropriate insurance coverage, practitioners

¹ This guidance document is not intended to address existing patient-practitioner relationships established through in-person visits.

² The practitioner must adhere not only to Virginia law defining a practitioner-patient relationship, but the law in any state where a patient is receiving services that defines the practitioner-patient relationship.

must make certain that they are compliant with federal and state laws and policies regarding reimbursements.

Evaluation and Treatment of the Patient:

A documented medical evaluation and collection of relevant clinical history commensurate with the presentation of the patient to establish diagnoses and identify underlying conditions and/or contra-indications to the treatment recommended/provided must be obtained prior to providing treatment, which treatment includes the issuance of prescriptions, electronically or otherwise. Treatment and consultation recommendations made in an online setting, including issuing a prescription via electronic means, will be held to the same standards of appropriate practice as those in traditional, in-person encounters. Treatment, including issuing a prescription based solely on an online questionnaire, does not constitute an acceptable standard of care.

Informed Consent:

Evidence documenting appropriate patient informed consent for the use of telemedicine services must be obtained and maintained. Appropriate informed consent should, as a baseline, include the following:

- Identification of the patient, the practitioner, and the practitioner's credentials;
- Types of activities permitted using telemedicine services (e.g. prescription refills, appointment scheduling, patient education, etc.);
- Agreement by the patient that it is the role of the practitioner to determine whether or not the condition being diagnosed and/or treated is appropriate for a telemedicine encounter;
- Details on security measures taken with the use of telemedicine services, such as encrypting date of service, password protected screen savers, encrypting data files, or utilizing other reliable authentication techniques, as well as potential risks to privacy notwithstanding such measures;
- Hold harmless clause for information lost due to technical failures; and
- Requirement for express patient consent to forward patient-identifiable information to a third party.

Medical Records:

The medical record should include, if applicable, copies of all patient-related electronic communications, including patient-practitioner communication, prescriptions, laboratory and test results, evaluations and consultations, records of past care, and instructions obtained or produced in connection with the utilization of telemedicine services. Informed consents obtained in connection with an encounter involving telemedicine services should also be filed in the medical record. The patient record established during the use of telemedicine services must be accessible to both the practitioner and the patient, and consistent with all established laws and regulations governing patient healthcare records.

Privacy and Security of Patient Records and Exchange of Information:

Written policies and procedures should be maintained for documentation, maintenance, and transmission of the records of encounters using telemedicine services. Such policies and procedures should address (1) privacy, (2) health-care personnel (in addition to the practitioner addressee) who will process messages, (3) hours of operation, (4) types of transactions that will be permitted electronically, (5) required patient information to be included in the communication, such as patient name, identification number and type of transaction, (6) archival and retrieval, and (7) quality oversight mechanisms. Policies and procedures should be periodically evaluated for currency and be maintained in an accessible and readily available manner for review.

Section Four: Prescribing.

Prescribing controlled substances requires the establishment of a bona fide practitioner-patient relationship in accordance with § 54.1-3303 (A) of the Code of Virginia. Prescribing controlled substances, in-person or via telemedicine services, is at the professional discretion of the prescribing practitioner. The indication, appropriateness, and safety considerations for each prescription provided via telemedicine services must be evaluated by the practitioner in accordance with applicable law and current standards of practice and consequently carries the same professional accountability as prescriptions delivered during an in-person encounter. Where such measures are upheld, and the appropriate clinical consideration is carried out and documented, the practitioner may exercise their judgment and prescribe controlled substances as part of telemedicine encounters in accordance with applicable state and federal law.

Prescriptions must comply with the requirements set out in Virginia Code §§ 54.1-3408.01 and 54.1-3303(A). Prescribing controlled substances in Schedule II through V via telemedicine also requires compliance with federal rules for the practice of telemedicine. Practitioners issuing prescriptions as part of telemedicine services should include direct contact for the prescriber or the prescriber's agent on the prescription. This direct contact information ensures ease of access by pharmacists to clarify prescription orders, and further facilitates the prescriber-patient-pharmacist relationship.

For the purpose of prescribing Schedule VI controlled substances, “telemedicine services” is defined as it is in § 38.2-3418.16 of the Code of Virginia. Under that definition, “*telemedicine services*,” as it pertains to the delivery of health care services, means the use of electronic technology or media, including interactive audio or video, for the purpose of diagnosing or treating a patient or consulting with other health care providers regarding a patient’s diagnosis or treatment. “Telemedicine services” does not include an audio-only telephone, electronic mail message, facsimile transmission, or online questionnaire.

Section Five: Electronic Medical Services That Do Not Require Licensure.

The Code of Virginia has two sections of law that are pertinent to telemedicine and the requirement of a Virginia license to provide services to a patient residing in the Commonwealth.

The first is the “consultant exemption” found in § 54.1-2901 which lists Exceptions and Exemptions Generally to licensure. Subsection (A)(15) reads as follows: “*Any legally qualified out-of-state or foreign practitioner from meeting in consultation with legally licensed*

practitioners in this Commonwealth.” This statute is intended to have a Virginia practitioner involved in the care of the patient when a practitioner in another state/country consults with the Virginia practitioner or the patient. It provides an opportunity for Virginia residents to benefit from the expertise of practitioners known for specializing in certain conditions. There must be regular communication between the consultant and the Virginia practitioner while the consultation/care is being provided.

The second section of the Code of Virginia pertinent to telemedicine is § 38.2-3418.16 of the Code of Virginia, which provides the definition of telemedicine in the Insurance Title. The section enumerates what does and what does not constitute telemedicine. Section 38.2-3418.16 defines telemedicine as *“the use of electronic technology or media, including interactive audio or video, for the purpose of diagnosing or treating a patient, providing remote patient monitoring services, or consulting with other health care providers regarding a patient's diagnosis or treatment, regardless of the originating site and whether the patient is accompanied by a health care provider at the time such services are provided.”* To practice telemedicine into Virginia requires a license from the Board of Medicine. The Board notes that § 38.2-3418.16 states "Telemedicine services" does not include an audio-only telephone, electronic mail message, facsimile transmission, or online questionnaire. The Board believes that these communications do not constitute telemedicine, and therefore do not require licensure, when used in the follow-up care of a Virginia resident with whom a bona fide practitioner-patient relationship has been previously established. The establishment of a new practitioner-patient relationship requires a Virginia license and must comport with the requirements for telemedicine found in § 54.1-3303 of the Code of Virginia.

Section six: Guidance Document Limitations.

Nothing in this document shall be construed to limit the authority of the Board to investigate, discipline, or regulate its licensees pursuant to applicable Virginia statutes and regulations. Additionally, nothing in this document shall be construed to limit the Board's ability to review the delivery or use of telemedicine services by its licensees for adherence to the standard of care and compliance with the requirements set forth in the laws and regulations of the Commonwealth of Virginia. Furthermore, this document does not limit the Board's ability to determine that certain situations fail to meet the standard of care or standards set forth in laws and regulations despite technical adherence to the guidance produced herein.

Statutory references:

§ 54.1-3303. Prescriptions to be issued and drugs to be dispensed for medical or therapeutic purposes only.

A. A prescription for a controlled substance may be issued only by a practitioner of medicine, osteopathy, podiatry, dentistry or veterinary medicine who is authorized to prescribe controlled substances, a licensed nurse practitioner pursuant to § [54.1-2957.01](#), a licensed certified midwife pursuant to § [54.1-2957.04](#), a licensed physician assistant pursuant to § [54.1-2952.1](#), or a TPA-certified optometrist pursuant to Article 5 (§ [54.1-3222](#) et seq.) of Chapter 32.

B. A prescription shall be issued only to persons or animals with whom the practitioner has a bona fide practitioner-patient relationship or veterinarian-client-patient relationship. If a practitioner is providing expedited partner therapy consistent with the recommendations of the Centers for Disease Control and Prevention, then a bona fide practitioner-patient relationship shall not be required.

A bona fide practitioner-patient relationship shall exist if the practitioner has (i) obtained or caused to be obtained a medical or drug history of the patient; (ii) provided information to the patient about the benefits and risks of the drug being prescribed; (iii) performed or caused to be performed an appropriate examination of the patient, either physically or by the use of instrumentation and diagnostic equipment through which images and medical records may be transmitted electronically; and (iv) initiated additional interventions and follow-up care, if necessary, especially if a prescribed drug may have serious side effects. Except in cases involving a medical emergency, the examination required pursuant to clause (iii) shall be performed by the practitioner prescribing the controlled substance, a practitioner who practices in the same group as the practitioner prescribing the controlled substance, or a consulting practitioner.

A practitioner who has established a bona fide practitioner-patient relationship with a patient in accordance with the provisions of this subsection may prescribe Schedule II through VI controlled substances to that patient.

A practitioner who has established a bona fide practitioner-patient relationship with a patient in accordance with the provisions of this subsection may prescribe Schedule II through VI controlled substances to that patient via telemedicine if such prescribing is in compliance with federal requirements for the practice of telemedicine and, in the case of the prescribing of a Schedule II through V controlled substance, the prescriber maintains a practice at a physical location in the Commonwealth or is able to make appropriate referral of patients to a licensed practitioner located in the Commonwealth in order to ensure an in-person examination of the patient when required by the standard of care.

A prescriber may establish a bona fide practitioner-patient relationship for the purpose of prescribing Schedule II through VI controlled substances by an examination through face-to-face interactive, two-way, real-time communications services or store-and-forward technologies when all of the following conditions are met: (a) the patient has provided a medical history that is available for review by the prescriber; (b) the prescriber obtains an updated medical history at the time of prescribing; (c) the prescriber makes a diagnosis at the time of prescribing; (d) the prescriber conforms to the standard of care expected of in-person care as appropriate to the patient's age and presenting condition, including when the standard of care requires the use of diagnostic testing and performance of a physical examination, which may be carried out through the use of peripheral devices appropriate to the patient's condition; (e) the prescriber is actively licensed in the Commonwealth and authorized to prescribe; (f) if the patient is a member or enrollee of a health plan or carrier, the prescriber has been credentialed by the health plan or carrier as a participating provider and the diagnosing and prescribing meets the qualifications for reimbursement by the health plan or carrier pursuant to § [38.2-3418.16](#); (g) upon request, the prescriber provides patient records in a timely manner in accordance with the provisions of § [32.1-127.1:03](#) and all other state and federal laws and regulations; (h) the establishment of a bona fide practitioner-patient relationship via telemedicine is consistent with the standard of care, and the standard of care does not require an in-person examination for the purpose of diagnosis; and (i) the establishment of a bona fide practitioner patient relationship via telemedicine is consistent with federal law and regulations and any waiver thereof. Nothing in this paragraph shall apply to (1) a prescriber providing on-call coverage per an agreement with another prescriber or his prescriber's professional entity or employer; (2) a prescriber consulting with another prescriber regarding a patient's care; or (3) orders of prescribers for hospital out-patients or in-patients....

C. A prescription shall only be issued for a medicinal or therapeutic purpose in the usual course of treatment or for authorized research. A prescription not issued in the usual course of treatment or for authorized research is not a valid prescription. A practitioner who prescribes any controlled substance with the knowledge that the controlled substance will be used otherwise than for medicinal or therapeutic purposes shall be subject to the criminal penalties provided in § 18.2-248 for violations of the provisions of law relating to the distribution or possession of controlled substances.

§ 54.1-3408.01. Requirements for prescriptions.

A. The written prescription referred to in § 54.1-3408 shall be written with ink or individually typed or printed. The prescription shall contain the name, address, and telephone number of the prescriber. A prescription for a controlled substance other than one controlled in Schedule VI shall also contain the federal controlled substances registration number assigned to the prescriber. The prescriber's information shall be either preprinted upon the prescription blank, electronically printed, typewritten, rubber stamped, or printed by hand.

The written prescription shall contain the first and last name of the patient for whom the drug is prescribed. The address of the patient shall either be placed upon the written prescription by the prescriber or his agent, or by the dispenser of the prescription. If not otherwise prohibited by law, the dispenser may record the address of the patient in an electronic prescription dispensing record for that patient in lieu of recording it on the prescription. Each written prescription shall be dated as of, and signed by the prescriber on, the day when issued. The prescription may be prepared by an agent for the prescriber's signature.

This section shall not prohibit a prescriber from using preprinted prescriptions for drugs classified in Schedule VI if all requirements concerning dates, signatures, and other information specified above are otherwise fulfilled.

No written prescription order form shall include more than one prescription. However, this provision shall not apply (i) to prescriptions written as chart orders for patients in hospitals and long-term-care facilities, patients receiving home infusion services or hospice patients, or (ii) to a prescription ordered through a pharmacy operated by or for the Department of Corrections or the Department of Juvenile Justice, the central pharmacy of the Department of Health, or the central outpatient pharmacy operated by the Department of Behavioral Health and Developmental Services; or (iii) to prescriptions written for patients residing in adult and juvenile detention centers, local or regional jails, or work release centers operated by the Department of Corrections.

B. Prescribers' orders, whether written as chart orders or prescriptions, for Schedules II, III, IV, and V controlled drugs to be administered to (i) patients or residents of long-term care facilities served by a Virginia pharmacy from a remote location or (ii) patients receiving parenteral, intravenous, intramuscular, subcutaneous or intraspinal infusion therapy and served by a home infusion pharmacy from a remote location, may be transmitted to that remote pharmacy by an electronic communications device over telephone lines which send the exact image to the receiver in hard copy form, and such facsimile copy shall be treated as a valid original prescription order. If the order is for a radiopharmaceutical, a physician authorized by state or federal law to possess and administer medical radioactive materials may authorize a nuclear medicine technologist to transmit a prescriber's verbal or written orders for radiopharmaceuticals.

C. The oral prescription referred to in § 54.1-3408 shall be transmitted to the pharmacy of the patient's choice by the prescriber or his authorized agent. For the purposes of this section, an authorized agent of

the prescriber shall be an employee of the prescriber who is under his immediate and personal supervision, or if not an employee, an individual who holds a valid license allowing the administration or dispensing of drugs and who is specifically directed by the prescriber.

DRAFT

Agenda Item: Consideration of licensure by endorsement for chiropractors

Included in your agenda package:

- HB1861 from the 2025 General Assembly Session; and
- Draft regulatory changes to implement a licensure by endorsement pathway for chiropractors.

Action needed:

- Discussion of regulatory language;
- Vote to adopt exempt regulatory action for licensure by endorsement of chiropractors as presented or as amended by the Board.

==66==
VIRGINIA ACTS OF ASSEMBLY - 2025 SESSION

CHAPTER 553

An Act to direct each health regulatory board regulated by the Department of Health Professions to establish a licensure by endorsement pathway for qualified applicants of the professions regulated by such board.

[H 1861]

Approved March 24, 2025

Be it enacted by the General Assembly of Virginia:

1. § 1. *That each health regulatory board regulated by the Department of Health Professions shall enact regulations to establish a licensure by endorsement pathway for qualified applicants as practitioners of the particular profession or professions regulated by such board. Each such health regulatory board's initial adoption of regulations necessary to implement a licensure by endorsement pathway shall be exempt from the provisions of the Administrative Process Act (§ 2.2-4000 et seq. of the Code of Virginia), except that the enacting health regulatory board shall provide an opportunity for public comment on the regulations prior to adoption of such regulations.*

§ 2. *That the Board of Medicine shall be the first health regulatory board to enact regulations to provide a licensure by endorsement pathway pursuant to this act.*

Project 8773 - Exempt Final

Board of Medicine

Chiropractor licensure by endorsement

18VAC85-20-141. Licensure by endorsement for physicians and podiatrists.

To be licensed by endorsement as a physician or podiatrist, an applicant shall:

1. Hold at least one current, active license in a United States jurisdiction or Canada;
2. Have been engaged in active practice, defined as two out of the last five years immediately preceding application, where such practice is not required to be consecutive;
3. Verify that the most recent license held in another United States jurisdiction or in Canada is in good standing, defined as current and unrestricted, or if lapsed, eligible for renewal or reinstatement;
4. Hold current certification by one of the following:
 - a. American Board of Medical Specialties;
 - b. Bureau of Osteopathic Specialists;
 - c. American Board of Foot and Ankle Surgery;
 - d. American Board of Podiatric Medicine;
 - e. Fellowship of Royal College of Physicians of Canada;
 - f. Fellowship of the Royal College of Surgeons of Canada; or
 - g. College of Family Physicians of Canada;
5. Submit a current report from the U.S. Department of Health and Human Services National Practitioner Data Bank; and

6. Have no grounds for denial based on provisions of § 54.1-2915 of the Code of Virginia or regulations of the board nor any disciplinary restrictions on a current, active license.

18VAC85-20-142. Licensure by endorsement for chiropractors.

To obtain licensure by endorsement as a chiropractor, an applicant shall:

1. Hold at least one current, active license in a United States jurisdiction or Canada;
2. Verify that the most recent license held in another United States jurisdiction or Canada is in good standing, defined as current and unrestricted, or if lapsed, eligible for renewal or reinstatement;
3. Submit a current report from the U.S. Department of Health and Human Services National Practitioner Data Bank;
4. Have no grounds for denial based on provisions of § 54.1-2915 of the Code of Virginia or regulations of the board; and
5. Have no disciplinary restrictions on a current, active license.

Agenda Item: Consideration of fast-track amendment to remove 10-year limitation on passage of all stages of the USMLE or COMPLEX-USA

Included in your agenda package:

- Draft fast-track regulatory amendment to remove 18VAC85-20-140(E) which currently requires all steps of USMLE and COMPLEX-USA be completed in 10 years to be eligible for licensure as a physician.

Staff note: Years ago, the Board followed a nationwide trend of requiring completion of all USMLE Steps in 7 years to accommodate physicians in MD/PhD programs. Later, data from the Credentials Committee on applicants that exceeded the 7 years showed most of those applicants were issued licenses. Due to that data, the time for completion of all USMLE Steps was increased to 10 years. board certification was required for any applicant who took more than 10 years. The Board has received applications from very qualified individuals who took more than 10 years to pass all steps but were not board certified.

Action needed:

- Vote to adopt fast-track regulatory action to delete 18VAC85-20-140(E).

Project 8825 - Fast-Track

Board of Medicine

**Removal of 10-year limitation to pass all stages of the USMLE or COMPLEX-USA for
licensure as a physician**

18VAC85-20-140. Examinations, general.

A. The Executive Director of the Board of Medicine or the executive director's designee shall review each application for licensure and in no case shall an applicant be licensed unless there is evidence that the applicant has passed an examination equivalent to the examination required by the board at the time the applicant was examined and meets all requirements of Part III (18VAC85-20-120 et seq.) of this chapter. If the executive director or the executive director's designee is not fully satisfied that the applicant meets all applicable requirements of Part III of this chapter and this part, the executive director or the executive director's designee shall refer the application to the Credentials Committee for a determination on licensure.

B. A doctor of medicine or osteopathic medicine who has passed the examination of the National Board of Medical Examiners or of the National Board of Osteopathic Medical Examiners, Federation Licensing Examination, or the United States Medical Licensing Examination, or the examination of the Licensing Medical Council of Canada or other such examinations as prescribed in § 54.1-2913.1 of the Code of Virginia may be accepted for licensure.

C. A doctor of podiatry who has passed the National Board of Podiatric Medical Examiners examination and has passed a clinical competence examination acceptable to the board may be accepted for licensure.

D. A doctor of chiropractic who has met the requirements of one of the following may be accepted for licensure:

1. An applicant who graduated after January 31, 1996, shall document successful completion of Parts I through IV of the National Board of Chiropractic Examiners examination (NBCE).

2. An applicant who graduated from January 31, 1991, to January 31, 1996, shall document successful completion of Parts I, II, and III of the National Board of Chiropractic Examiners examination (NBCE).

3. An applicant who graduated from July 1, 1965, to January 31, 1991, shall document successful completion of Parts I, II, and III of the NBCE, or Parts I and II of the NBCE and the Special Purpose Examination for Chiropractic (SPEC), and document evidence of licensure in another state for at least two years immediately preceding application.

4. An applicant who graduated prior to July 1, 1965, shall document successful completion of the SPEC and document evidence of licensure in another state for at least two years immediately preceding application.

~~E. Applicants who sat for the United States Medical Licensing Examination (USMLE) or the Comprehensive Osteopathic Medical Licensure Examination (COMLEX-USA) shall provide evidence of passing all steps within a 10-year period unless the applicant is board certified in a specialty approved by the American Board of Medical Specialties or the Bureau of Osteopathic Specialists of the American Osteopathic Association.~~

~~F. Applicants for licensure in podiatry shall provide evidence of having passed the National Board of Podiatric Medical Examiners Examination to be eligible to sit for the Podiatric Medical Licensing Examination (PMLEXIS) in Virginia.~~

Agenda Item: Licensing Report

Staff Note: Ms. Opher will provide information on noteworthy medical
licensing matters.

Mr. Sobowale will provide information on note-worthy allied
licensing matters.

Action: None anticipated.

Agenda Item: Discipline Report

Staff Note: Ms. Deschenes will provide information on discipline matters.

Action: None anticipated.



- Next Meeting Date of the Full Board is **February 18-20, 2027**. Please check your calendars and advise staff of any known conflicts that may affect your attendance.
- The travel regulations require that “travelers must submit the Travel Expense Reimbursement Voucher within 30 days after completion of their trip”. (CAPP Topic 20335, State Travel Regulations, p.7). If you submit your reimbursement after the 30-day deadline, please be aware that it cannot be approved.
- In order for the agency to be in compliance with the travel regulations, please submit your request for today's meeting no later than

November 13, 2026

VIRGINIA BOARD OF MEDICINE

MEETING CALENDAR

Meeting	Date	Location
Full Board	February 18-20	Board Room 2, 4, TR1
	June 24-26	Board Room 2, 4, TR2
	October 21-23	Board Room 4, TR2, HR5
Executive	April 2	Board Room 4
	August 6	Board Room 4
	December 3	Board Room 4
Legislative	January 8	Board Room 4
	May 7	Board Room 4
	September 10	Board Room 4

Behavioral Analysts			10:00 a.m.
Mon - February 1	June 7	September 27	
Genetic Counseling			1:00 p.m.
Mon - February 1	June 7	September 27	
Occupational Therapy			10:00 a.m.
Tues - February 2	June 8	September 28	
Respiratory Care			1:00 p.m.
Tues - February 2	June 8	September 28	
Acupuncture			10:00 a.m.
Wed - February 3	June 9	September 29	
Radiological Technology			1:00 p.m.
Wed - February 3	June 9	September 29	
Athletic Training			10:00 a.m.
Thurs - February 4	June 10	September 30	
Physician Assistants			1:00 p.m.
Thurs - February 4	June 10	September 30	
Midwifery			10:00 a.m.
Fri - February 5	June 11	October 1	
Polysomnographic Technology			2:30 p.m.
Fri - February 5	June 11	October 1	
Surgical Assisting			10:00 a.m.
Mon - February 8	June 14	October 4	