Advisory Board on Respiratory Care

Virginia Board of Medicine

October 5, 2021
1:00 p.m.

Advisory Board on Respiratory Therapy

Board of Medicine

Tuesday, October 5, 2021 @ 1:00 p.m.

9960 Mayland Drive, Suite 201

Henrico, VA

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

PLEASE LISTEN TO THE FOLLOWING INSTRUCTIONS ABOUT EXITING THESE PREMISES IN THE EVENT OF AN EMERGENCY.

Training Room 2

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<<<DRAFT UNAPPROVED>>>

ADVISORY BOARD ON RESPIRATORY THERAPY

Minutes

January 26, 2021

Electronic Meeting

The Advisory Board on Respiratory Therapy held a virtual meeting on Tuesday, January 26, 2021 hosted at the Department of Health Professions, Perimeter Center, 9960 Mayland Drive, Henrico, Virginia.

MEMBERS PRESENT: Daniel Gochenour, RRT, Chair
Santiera Brown-Yearling, RRT, Vice-Chair
Bruce K. Rubin, MD
Denver Supinger, Citizen Member

MEMBERS ABSENT: Shari Toomey, RRT

STAFF PRESENT: William L. Harp, M.D., Executive Director
Michael Sobowale, LLM, Deputy Director, Licensure
Colanthia M. Opher, Deputy Director, Administration
Elaine Yeatts, DHP Senior Policy Analyst
Delores Cousins, Licensing Specialist

GUESTS PRESENT: None

Call to Order

Daniel Gochenour, RRT and Chair, called the meeting to order at 1:05 pm.

Emergency Egress Procedures

Dr. Harp announced the emergency egress instructions for those individuals that may be attending the virtual meeting in the Perimeter Center.

Roll Call

The roll was called, and a quorum was declared.

Approval of Minutes

Bruce Rubin moved to approve the minutes of October 6, 2020 meeting. Santiera Brown-Yearling seconded. By roll call vote, the motion was approved.

Adoption of Agenda

Bruce Rubin moved to adopt the agenda. Santiera Brown-Yearling seconded. By roll call vote, the motion carried.

Public Comment on Agenda Items

None

New Business

1. **Report of the 2021 General Assembly**

   Elaine Yeatts provided a report from the 2021 General Assembly and discussed bills that were of interest to the Advisory Board.

2. **Advanced Practice Respiratory Therapist Credential**

   Daniel Gochenour discussed the need for the Advisory Board to follow up on the presentation it heard on this topic at its October 6, 2020 meeting.

   It was recommended that the Board of Medicine put together a legislative proposal to be carried by a sponsor for consideration at the 2022 General Assembly.

Announcements

Delores Cousins provided the licensing report. The Board of Medicine has 3,166 Virginia active respiratory therapist licenses and 922 out-of-state active licenses.

Next Scheduled Meeting:

Next scheduled meeting date: May 25, 2021.

Adjournment

With no other business to conduct, Daniel Gochenour adjourned the meeting at 2:02 p.m.

Daniel Gochenour, RRT, Chair

William L. Harp, MD, Executive Director

Delores Cousins, Licensing Specialist

Department of Health Professions
Regulatory/Policy Actions – 2021 General Assembly
Board on Medicine/Advisory Boards

EMERGENCY REGULATIONS:

Legislative source	Mandate	Promulgating agency	Board adoption date	Effective date Within 280 days of enactment
SB1189	Occupational therapy compact	Medicine	8/6/21	**By 12/23/21**

EXEMPT REGULATORY ACTIONS

Legislative source	Mandate	Promulgating agency	Adoption date	Effective date
HB2039	Conform PA regs to Code	Medicine	6/24/21	9/15/21
HB2220	Change registration of surgical technologists to certification	Medicine	6/21/21	9/1/21
SB1178	Delete reference to conscience clause in regs for genetic counselors	Medicine	6/24/21	

APA REGULATORY ACTIONS

Legislative source	Mandate	Promulgating agency	Adoption date	Effective date
HB1953	Licensure of certified midwives	Nursing & Medicine	NOIRA Nursing – 7/20/21 Medicine – 8/6/21	Unknown

NON-REGULATORY ACTIONS

Legislative source	Affected agency	Action needed	Due date
HB793 (2018)	Medicine & Nursing	To report data on the number of nurse practitioners who have been authorized to practice without a practice agreement, the geographic and specialty areas in which nurse practitioners are practicing without a practice agreement, and any complaints or disciplinary actions taken against such nurse practitioners, along with any recommended modifications to the requirements of this act including any modifications to the clinical experience requirements for practicing without a practice agreement	November 1, 2021
Budget bill	Department	To study and make recommendations regarding the oversight and regulation of advanced practice registered nurses (APRNs). The department shall review recommendations of the National Council of State Boards of Nursing, analyze the oversight and regulations governing the practice of APRNs in other states, and review research on the impact of statutes and	November 1, 2021

		regulations on practice and patient outcomes.	
HB1953	Department	To convene a work group to study and report on the licensure and regulation of certified nurse midwives, certified midwives, and certified professional midwives to determine the appropriate licensing entity for such professionals.	November 1, 2021

Future Policy Actions:

HB2559 (2019) - requires the Secretary of Health and Human Resources to convene a work group to identify successes and challenges of the electronic prescription requirement and offer possible recommendations for increasing the electronic prescribing of controlled substances that contain an opioid and to report to the Chairmen of the House Committee on Health, Welfare and Institutions and the Senate Committee on Education and Health by **November 1, 2022**.

The Virginia Society for Respiratory Care
http://www.vsrc.org

To: Virginia Board of Health Professions

From: Virginia Society for Respiratory Care Executive Board & Medical Advisor

Date: June 15th, 2021

Subject: Request for APRT New Profession Assessment

Distinguished Board of Health Profession Members,

The Virginia Society for Respiratory Care requests a new profession study into the creation of an Advanced Practice Respiratory Therapist (APRT). The request is to see if there is a need for regulation by registration and licensure as stated by Virginia Code 54.1-2510. The APRT would function as a mid-level provider to care for patients as a Licensed Independent Practitioner (LIP). This would fill potential provider shortages to improve access to care for patients in Virginia. The APRT also has the potential to attract career seekers to the respiratory therapy profession. This could improve attrition in the profession with the ability to advance skill-set and education that leads to greater autonomy. This would be similar to our nursing colleagues with the ability to become mid-level providers.

The American Association for Respiratory Care has provided information on their support of the APRT profession (https://www.aarc.org/careers/advanced-practice-respiratory-therapist/). The AARC website states by 2030, the United States expects a shortfall of 1,300 to 12,000 cardiologists and pulmonologists. The AARC also recognizes the alarming prediction from the CDC which identifies 3 of the top 5 leading causes of death as diseases of the cardiopulmonary system. The AARC has advocated for cardiopulmonary health for nearly 80 years through its support of the profession and the respiratory therapists which aim to improve patient lives every day. It is this constant growth and goal to improve patient care and outcomes that lead us to the APRT.

The VSRC supports the development and licensure of an APRT to fill potential shortages in access to care for our patients. APRT licensure would require experience as an RRT, completion of a graduate program which requires clinical hours sufficient to function as a mid-level provider, and the eventual passing of an APRT board credential upon its creation. Ohio State University has a Master of Respiratory Therapy (MRT) program accredited by the Commission on Accreditation for Respiratory Care (CoARC) to train their graduates as APRTs. The VSRC acknowledges the infancy of the APRT profession but request the Virginia Board of Medicine to help facilitate this profession creation.

Sincerely,

Virginia Society for Respiratory Care Executive Board & Medical Advisor

Daniel Gochenour, Past President
Chase Poulsen, Treasurer
Hanns Billmayer, Delegate
Bruce Rubin, Medical Advisor
Connie Lloyd, Secretary
Bessie Brooks, Delegate

From: Brown, David <david.brown@dhp.virginia.gov>
Sent: Monday, September 20, 2021 12:36 PM
To: info@vsrc.org; Leslie Knachel <leslie.knachel@dhp.virginia.gov>
Subject: Request for APRT New Profession Assessment

To: Executive Board and Medical Advisor of the Virginia Society for Respiratory Care

Re: Request for APRT New Profession Assessment

The Virginia Board of Health Professions (BHP) received the Virginia Society for Respiratory Care's request for a sunrise review of the need to license Advanced Practice Respiratory Therapists (APRT). The BHP serves in an advisory capacity to the Virginia General Assembly in matters related to the state regulation of a health occupation, and is one of 14 Boards within the Department of Health Professions.

We believe that this review is premature. To date the BHP has evaluated the need for regulation of professions that are well-established and regulated in other states. According to Ohio State University, the only preparatory program in the country, there is not yet an official APRT credential. It is my understanding that OSU graduated their first class this year and that a bill to license APRTs in Ohio did not move forward in 2020. Currently, there are no APRTs in the United States.

While cardio-respiratory care may include advanced practice therapists sometime in the future, at this time there are an insufficient number of practitioners, no recognized credential, and no experience with the role that would allow us to study the issue fully (see Guidance Document75-2). Therefore we are unable to conduct a study at this time.

Respectfully,

David E. Brown, DC
Director, Virginia Department of Health Professions
804-367-4648

Virginia Department of
Health Professions
Board of Health Professions

Policies and Procedures for the Evaluation of the Need to Regulate Health Occupations and Professions

2019

Table of Contents

Introduction

In 1992, the Virginia Board of Health Professions published *Policies and Procedures for the Evaluation of the Need to Regulate Health Occupations and Professions*, a standard reference that defines the evaluative criteria and methodologies to assess objectively the public's need for state protection through practitioner regulation. Its approach dates back to 1983.

In 1998, the Board updated the 1992 version in response to an independent analysis of its approach pursuant to *Code of Virginia* §54.1-2409.2.[1] The study reaffirmed the Board's policies and procedures but offered that additional sources of objective data could strengthen the approach. Hence, the Board added malpractice insurance information and job analysis data to the methodology.

Nearly twenty years have passed between updates. The Board undertook an environmental scan of the literature and relevant statutes, policies, and procedures of other states.[2] As of this publication, there are 12 other states with formal policies. The existing literature pertains to those states systems. There are differences among the states with regard to the empowered organizational structure and minor logistics, but the principles, criteria and policies employed essentially mirror Virginia's current practice. The 2019 revision updates statutory references, provides hyperlinks to cited materials, and clarifies language that has become outdated otherwise but does not reflect a significant change in overall procedure.

The remainder of this document references the Board's authority to conduct evaluative reviews and details specific policies and procedures.

Authority

In 1977, the General Assembly established the Virginia Board of Health Professions to advise the Governor and the General Assembly on matters pertaining to the regulation of health occupations and professions and to provide policy coordination for the boards administered within the Virginia Department of Health Professions.

Currently, the Board is comprised of 18 members appointed by the Governor: five citizen members and a member from each of the thirteen licensing boards.

Code of Virginia § 54.1-2510 provides that

> **. . . [The Board shall] evaluate all health care professions and occupations in the Commonwealth, including those regulated and those not regulated by other provisions [of Title 54] *to consider whether each such profession or occupation should be regulated and the degree of regulation to be imposed* [emphasis added]. Whenever the Board determines that the public interest requires that a health care profession or occupation which is not regulated by law should be regulated, the Board shall recommend to the General Assembly a regulatory system to establish the appropriate degree of regulation.**

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[1] Accessible at (https://law.lis.virginia.gov/vacode/title54.1/chapter24/section54.1-2409.2/). The 1998 report, *Study of the Appropriate Criteria in Determining the Need for Regulation of Any Health Care Occupation or Profession* is accessible in executive summary and full report form from the Virginia General Assembly's House Document sites (https://rga.lis.virginia.gov/Published/1998/HD8) and https://rga.lis.virginia.gov/Published/1998/HD8/PDF, respectively.

[2] See the Appendix for References

The General Assembly, and not the Board, is the body empowered to make the final determination of the need for state regulation of a health care profession or occupation. Only the General Assembly has the authority to enact legislation specifying the profession to be regulated, the degree of regulation to be imposed and the organizational structure to be used to manage the regulatory program (e.g., board, advisory committee, or registry).

The Board's role is purely advisory. It has the authority and responsibility to study and make recommendations concerning the need to regulate new (i.e., currently unregulated) occupations and professions (i.e., a "sunrise" review) as well as to routinely re-examine the appropriateness of the regulatory schemes for currently regulated professions and occupations.

Policies

The Board's evaluation policies are grounded in the Commonwealth's philosophy on occupational regulation as expressed in statute and in the Board's own *Criteria for Evaluating the Need for Regulation* (i.e., the Criteria). Alternatives to regulation are also always considered.

Statute

The following statement epitomizes the Commonwealth's philosophy on the regulation of professions and occupations. ***The occupational property rights of the individual may be abridged only to the degree necessary to protect the public.*** This tenet is clearly stipulated in statute and serves as the Board's overarching philosophy in its approach to all its reviews of professions or occupations:

> **. . . the right of every person to engage in any lawful profession, trade or occupation of his choice is clearly protected by both the Constitution of the United States and the Constitution of the Commonwealth of Virginia. The Commonwealth cannot abridge such rights except as a reasonable exercise of its police powers when *(i)* it is found that such abridgement is necessary for the *protection or* preservation of the health, safety and welfare of the public *and (ii) any such abridgement is no greater than necessary to protect or preserve the public health, safety, and welfare.* (*Code of Virginia* 54.1-100 – amended by 2016 Acts of the Assembly Chapter 467)[3]**

Additional statutory guidance is provided in the same *Code* section. The following conditions must be met before the state may impose regulation on a profession or occupation:

1. **The unregulated practice of a profession or occupation can endanger the health, safety or welfare of the public, and the potential for harm is recognizable and not remote or dependent upon tenuous argument;**
2. **The practice of the profession or occupation has inherent qualities peculiar to it that distinguish it from ordinary work or labor:**
3. **The practice of the profession or occupation requires specialized skill or training and the public needs, and will benefit by, assurances of initial and continuing professional and occupational ability; and**
4. **The public is not effectively protected by other means.**

[3] Accessible at http://leg1.state.va.us/cgi-bin/legp504.exe?161+ful+CHAP0467

In addition, although the General Assembly has established that the following factors be considered in evaluating the need for the regulation of *commercial* occupations and professions, the Board has determined that these factors should be considered in evaluating proposals for the regulation of *health* professions, as well.

1. **Whether the practitioner, if unregulated, performs a service for individuals involving a hazard to the public health.**
2. **The opinion of a substantial portion of the people who do not practice the particular profession. . . on the need for regulation.**
3. **The number of states which have regulatory provisions similar to those proposed.**
4. **Whether there is sufficient demand for the service for which there is no regulated substitute and this service is required by a substantial portion of the population.**
5. **Whether the profession or occupation requires high standards of public responsibility, character and performance of each individual engaged in the profession or occupation, evidenced by established and published codes of ethics.**
6. **Whether the profession requires such skill that the public generally is not qualified to select a competent practitioner without some assurance that he has met minimum qualifications.**
7. **Whether the professional or occupational associations do not adequately protect the public from incompetent, unscrupulous or irresponsible members of the profession or occupation.**
8. **Whether current laws which pertain to public health, safety and welfare generally are ineffective or inadequate.**
9. **Whether the characteristics of the population or occupation make it impractical or impossible to prohibit those practices of the profession or occupation which are detrimental to the public health, safety and welfare.**
10. **Whether the practitioner performs a service for others which may have a detrimental effect on third parties relying on the expert knowledge of the practitioner.**

(*Code of Virginia* §54.1-311(B)1-2,4-10)

In addition to amending §54.1-100, Chapter 467 also created a new section, §54.1-310.1[4] which governs the petitioning of state regulation for an unregulated commercial profession or occupation and details the Board of Professional and Occupational Regulation's sunrise review responsibilities. Subsection (A) mandates that evaluation requests be submitted no later than December 1 of any year for analysis and evaluation during the following year. Although the Board of Health Professions is not bound by this section, in order to allow sufficient time and resources for each study, preference for proposals submitted before December 1 will be considered.

[4] Accessible at: https://law.lis.virginia.gov/vacode/title54.1/chapter3/section54.1-310.1/

The Criteria and Their Application

Based on the principles of occupational and professional regulation established by the General Assembly, the Board has adopted the following criteria to guide the evaluation of the need for regulation of a health occupation or profession.

VIRGINIA BOARD OF HEALTH PROFESSIONS
CRITERIA FOR EVALUATING THE NEED FOR REGULATION
Initially Adopted 1991
Readopted 1998 and 2019

Criterion One: Risk for Harm to the Consumer
The unregulated practice of the health occupation will harm or endanger the public health, safety or welfare. The harm is recognizable and not remote or dependent on tenuous argument. The harm results from: (a) practices inherent in the occupation, (b) characteristics of the clients served, (c) the setting or supervisory arrangements for the delivery of health services, or (d) from any combination of these factors.

Criterion Two: Specialized Skills and Training
The practice of the health occupation requires specialized education and training, and the public needs to have benefits by assurance of initial and continuing occupational competence.

Criterion Three: Autonomous Practice
The functions and responsibilities of the practitioner require independent judgment and the members of the occupational group practice autonomously.

Criterion Four: Scope of Practice
The scope of practice is distinguishable from other licensed, certified and registered occupations, in spite of possible overlapping of professional duties, methods of examination, instrumentation, or therapeutic modalities.

Criterion Five: Economic Impact
The economic costs to the public of regulating the occupational group are justified. These costs result from restriction of the supply of practitioner, and the cost of operation of regulatory boards and agencies.

Criterion Six: Alternatives to Regulation
There are no alternatives to State regulation of the occupation which adequately protect the public. Inspections and injunctions, disclosure requirements, and the strengthening of consumer protection laws and regulations are examples of methods of addressing the risk for public harm that do not require regulation of the occupation or profession.

Criterion Seven: Least Restrictive Regulation
When it is determined that the State regulation of the occupation or profession is necessary, the least restrictive level of occupational regulation consistent with public protection will be recommended to the Governor, the General Assembly and the Director of the Department of Health Professions.

In the process of evaluating the need for regulation, the Board's seven criteria are applied differently depending upon the level of regulation which appears most appropriate for the occupational group. The following outline delineates the characteristics of licensure, certification, and registration (the three most commonly used methods of regulation) and specifies the criteria applicable to each level.

Licensure. Licensure confers a monopoly upon a specific profession whose practice is well defined. It is the most restrictive level of occupational regulation. It generally involves the delineation in statute of a scope of practice which is reserved to a select group based upon their possession of unique, identifiable, minimal competencies for safe practice. In this sense, state licensure typically endows a particular occupation or profession with a monopoly in a specified scope of practice.

RISK: High potential, attributable to the nature of the practice.
SKILL & TRAINING: Highly specialized accredited post-secondary education required; clinical proficiency is certified by an accredited body.
AUTONOMY: Practices independently with a high degree of autonomy; little or no direct supervision.
SCOPE OF PRACTICE: Definable in enforceable legal terms.
COST: High
APPLICATION OF THE CRITERIA: When applying for licensure, the profession must demonstrate that Criteria 1 - 6 are met.

Statutory Certification. Certification by the state is also known as "title protection." No scope of practice is reserved to a particular group, but only those individuals who meet certification standards (defined in terms of education and minimum competencies which can be measured) may title or call themselves by the protected title.

RISK: Moderate potential, attributable to the nature of the practice, client vulnerability, or practice setting and level of supervision.
SKILL & TRAINING: Specialized; can be differentiated from ordinary work. Candidate must complete education or experience requirements that are certified by a recognized accrediting body.
AUTONOMY: Variable; some independent decision-making; majority of practice actions directed or supervised by others.
SCOPE OF PRACTICE: Definable, but not stipulated in law.
COST: Variable, depending upon level of restriction of supply of practitioners.
APPLICATION OF CRITERIA: When applying for statutory certification, a group must satisfy Criterion 1, 2, 4, 5, and 6.

Registration. Registration requires only that an individual file his name, location, and possibly background information with the State. No entry standard is typically established for a registration program.

RISK: Low potential, but consumers need to know that redress is possible.
SKILL & TRAINING: Variable, but can be differentiated for ordinary work and labor.
AUTONOMY: Variable.
APPLICATION OF CRITERIA: When applying for registration, Criteria 1, 4, 5, and 6 must be met.

Alternatives to Occupational and Professional Regulation

When a risk or potential risk has been demonstrated but it is not substantiated that licensure, certification, or registration are appropriate remedies, other alternatives are available. Inspections and injunctions, disclosure requirements, and the strengthening of consumer protection laws and regulations are examples of methods for protecting the public that do not require the regulation of specific occupations or professions.

These alternatives are less restrictive means of addressing the need to adequately protect the public health, safety, and welfare than restricting the occupational property rights of individuals.

Procedures

The Board has established general guidelines and procedures for the conduct of evaluation studies. These procedures assure the fair and equitable assessment of the need to regulate a profession or occupation or to determine the need for changing a current regulatory approach. These procedures translate the Board's policies into operational terms. Three questions are addressed: Who may request a study and how? How is a study conducted? and What happens to the results?

Who may request a study and how?

Requests for the Board to conduct an evaluation may come from a number of sources:

- the General Assembly
  - as a legislative resolution
  - as a request from an individual member,
- the Governor,
- the Director of the Department of Health Professions,
- Professional or Occupational Associations and Organizations,
- Concerned Members of the Public.

Prior to filing a request, it is recommended that the responsible individual(s) meet with Director of the Department of Health Professions and the Executive Director for the Board. At this meeting, proposal preparation may be discussed in detail and a suggested timetable agreed upon.

For requests from organizations or individuals, the review process commences with a formal letter of intent proposing the study. Because the time frame for such studies can require over a year (from request to recommendations), it is preferred that requests be received by December 1 for consideration during the following year. It is important that a contact person or persons be identified in this letter who will provide continuity to the review process. It should be noted that this time frame does not include consideration of the Director's review or the Board's recommendations by the Governor or General Assembly. Nor does it take into account the extensive work that must be accomplished between the time the General Assembly may enact enabling legislation and the promulgation of regulations which would be required to implement such legislation.

When a request for study is presented to the Board, the Board may agree to go forward or it may ask for additional information from the professional or organizational group in question.

How is a study conducted?

If the Board agrees to go forward with the study, the matter is referred to the Regulatory Research Committee, which conducts the study and prepares a report with recommendations for the full Board's review and final recommendations.

The Committee reviews and approves a staff prepared workplan, which details the background for the study, its scope, and the specific methodology to be employed. The specific questions to be addressed are detailed and reflect those questions outlined in the Appendix. Traditional workplans include a comprehensive review of the relevant literature and provide opportunities for receipt of public comment. In some instances, further information is gathered through Board sponsored surveys of practitioners, other states, or other parties knowledgeable about the issues germane to the profession or occupation.

As discussed earlier, as a result of the Board's formal review of the Criteria conducted pursuant to §54.1-2409.2 of the *Code of Virginia*, the evidentiary basis for application of the Criteria was strengthened to include references to recent job analyses (or role delineation studies) and actuarial risk assessments of malpractice insurers.

Commonly used to develop credentialing examinations, a job analysis (or role delineation study) abstracts the knowledge, skills, and abilities that define a profession and help distinguish it from related professions. In its simplest terms, a job analysis provides a detailed job description. An occupation or profession is broken down into performance domains, which broadly define the profession being delineated. Then each performance domain is broken down further into tasks. The tasks are categorized further into knowledge, skills, and ability statements.

Malpractice insurance underwriters establish premium rates and the extent of coverage based upon their actuarial assessment of the risk posed by the insured group. Data on civil suits, assessments of the type of work and work settings involved in practice, and evaluations of similar professions' claim histories, among other factors are considered.

Job analyses and data derived from malpractice insurance were selected to strengthen the Board's evidentiary basis for three reasons. First, they are generally readily available. Most health occupations and professions have professionally developed examinations based on job analyses, and most professions have malpractice insurance. Second, because they were designed for purposes other than to promote the regulation of the respective profession, these sources are viewed as relatively objective. Third, and most important, they are viewed as providing insight into better applying the most crucial criterion, Criterion One – Risk of Harm to the Consumer.

It has often been difficult or impossible to obtain objective information about actual harm to consumers gathered collectively by profession, precisely because the group is unregulated. The literature is usually unavailing and evaluation of anecdotal evidence alone makes attributions to the profession (and not simply individuals) questionable. Thus, to make fair assessments about the *potential* risks to the public when actual data are lacking, the Board's evaluations of recent job analyses and actuarial risk predictions found in the rationale for malpractice insurance coverage are factored into the reasoning.

Job analyses and actuarial risk predictions are not only useful in applying Criterion One. To appropriately apply the entire Criteria, the Board must have a thorough understanding of what comprises the practice of the profession and the necessary educational and training background required for entry level competency.

To answer the questions posed by the Criteria, the Board reviews the job analysis information garnered

and may apply its own measures of importance or *criticality*. Criticality "generally refers to the extent to which the ability to perform the task is essential to the performance on the job." (National Organization for Competency Assurance (1996) p.54). Scales such as those on the next page may be used. Here, all major tasks are reviewed and data tabulated to provide an overall score on each criterion.

Sample Criticality Scales for Rating Risk of Harm

Using the occupation as veterinary technician as an example, the following are sample scales for rating the risk of harm.

TASK 1: Scaling teeth above the gum line.

What is the effect of poor performance on public health & safety?

1. No risk
2. Little risk
3. Some risk
4. Significant risk
5. Severe risk

TASK 2: Preparing patient for surgery by shaving surgical area.

Could this activity be omitted on some occasions without having a major impact on client well-being?

1. Can sometimes omit – This activity could sometimes be omitted for some clients without a substantial risk of unnecessary complications, impairment of function or serious distress.

2. Can never omit – This activity could NEVER be omitted without a substantial risk of unnecessary complications, impairment of function, or serious distress.

Based on Correspondence with Kara Schmidt October 30, 1997 11:35 a.m.

These scores, along with the malpractice insurance risk assessment, literature review, public comment, and any other sources of information the Committee would like to explore serve as the basis to answer the questions expressed in the workplan. The responses form the basis for the report and recommendations.

What happens to the results?

Once completed, the Committee's study report including recommendations goes to the full Board for review. Upon adoption or revision of the report, the Board prepares its report for the consideration of the Director of the Department, the Secretary of Health and Human Resources, the Governor, and the General Assembly.

Once the final draft is approved, the Board or the source of the study may disseminate the report as they deem appropriate.

Appendix

QUESTIONS TO BE CONSIDERED FOR THE EVALUATION OF THE NEED FOR REGULATION OF A HEALTH OCCUPATION OR PROFESSION

A. GENERAL INFORMATION

1. What occupational or professional group is seeking regulation?
2. What is the level or degree of regulation sought?
3. Identify by title the association, organization, or other group representing Virginia-based practitioners. (If more than one organization, provide the information requested below for each organization.)
4. Estimate the number of practitioners (members and nonmembers) in the Commonwealth.
5. How many of these practitioners are members of the group preparing the proposal? (If several levels or types of membership are relevant to this proposal, explain these level and provide the number of members, by type).
6. Do other organizations also represent practitioners of this occupation/profession in Virginia? If yes, provide contact information for these organizations.
7. Provide the name, title, organizational name, mailing address, and telephone number of the responsible contact person(s) for the organization preparing this proposal.
8. How was this organization and individual selected to prepare this proposal?
9. Are there other occupations/professions within the broad occupational grouping? What organization(s) represent these entities? (List those in existence and any that are emerging).
10. For each association or organization listed above, provide the name and contact information of the *national* organizations with which the state associations are affiliated.

B. QUESTIONS WHICH ADDRESS THE CRITERIA

Criterion One: Risk for Harm to the Consumer. *The unregulated practice of the health occupation will harm or endanger the public health, safety or welfare. The harm is recognizable and not remote or dependent on tenuous argument. The harm results from: (a) practices inherent in the occupation, (b) characteristics of the clients served, (c) the setting or supervisory arrangements for the delivery of health services, or (d) from any combination of these factors.*

1. Provide a description of the typical functions performed and services provided by members of this occupational group.
2. Has the public actually been harmed by unregulated providers or by providers who are regulated in other states? If so, how is the evidence of harm documented (i.e., court case or disciplinary or other administrative action)? Was is physical, emotional, mental, social, or financial?
3. If no evidence of actual harm is available, what aspects of the provider group's practice constitute a potential for harm?
4. To what can the harm be attributed? Elaborate as necessary.
    - lack of skills
    - lack of knowledge
    - lack of ethics

- lack of supervision
- practices inherent in the occupation
- characteristics of the client/patients being served
- characteristics of the practice setting
- other (specify)

5. Does a potential for fraud exist because of the inability of the public to make an informed choice in selecting a competent practitioner?
6. Does a potential for fraud exist because of the inability for third party payors to determine Competency?
7. Is the public seeking regulation or greater accountability of this group?

Criterion Two: Specialized Skills and Training. *The practice of the health occupation requires specialized education and training, and the public needs to have benefits by assurance of initial and continuing occupational competence.*

1. What are the educational or training requirements for entry into this occupation? Are these programs accredited? By whom?
    - Are sample curricula available?
    - Are there training programs in Virginia?
2. If no programs exist in Virginia, what information is available on programs elsewhere which prepare practitioners for practice in the Commonwealth? What are the minimum competencies (knowledge, skills, and abilities) required for entry into the profession? How were they derived?
3. Are there national, regional, and/or state examinations available to assess entry-level competency?
    - Who develops and administers the examination?
    - What content domains are tested?
    - Are the examinations psychometrically sound -- in keeping with *The Standards for Educational and Psychological Testing*?
4 Are there requirements and mechanisms for ensuring continuing competence? For example, are there mandatory education requirements, re-examination, peer review, practice audits, institutional review, practice simulations, or self-assessment models?
5. Why does the public require state assurance of initial and continuing competence? What assurances do the public have already through private credentialing or certification or institutional standards, etc.?
6. Are there currently recognized or emerging specialties (or levels or classifications) within the occupational grouping? If so,
    - What are these specialties? How are they recognized? (by whom and through what mechanisms – e.g., specialty certification by a national academy, society or other organization)?
    - What are the various levels of specialties in terms of the functions or services performed by each?
    - How can the public differentiate among these levels or specialties for classification of practitioners?
    - Is a "generic" regulatory program appropriate, or should classifications (specialties/levels) be regulated separately (e.g., basic licensure with specialty certification)?
    -

Criterion Three: The functions and responsibilities of the practitioner require independent judgment and the members of the occupational group practice autonomously.

1. What is the nature of the judgments and decisions which the practitioner must make in practice?
    - Is the practitioner responsible for making diagnoses?
    - Does the practitioner design or approve treatment plans?

- Does the practitioner direct or supervise patient care?
- Does the practitioner use dangerous equipment or substance in performing his functions?

If the practitioner is not responsible for diagnosis, treatment design or approval, or directing patient care, who is responsible for these functions?

2. Which functions typically performed by this practitioner group are **unsupervised**, i.e., neither directly monitored or routinely checked?
   - What proportion of the practitioner's time is spent in unsupervised activity?
   - Who is legally accountable/liable for acts performed with no supervision?
3. Which functions are performed **only under supervision**?
   - Is the supervision *direct* (i.e., the supervisor is on the premises and responsible) or *general* (i.e., supervisor is responsible but not necessarily on the premises)?
   - Who provides the supervision? How frequently? Where? For what purpose?
   - Who is legally accountable/liable for acts performed under supervision?

Is the supervisor a member of a regulated profession (please elaborate)?

- What is contained in a typical supervisory or collaborative arrangement protocol?

3. Does the practitioner of this occupation supervise others? Describe the nature of this supervision (as in #3 above).
4. What is a typical work setting like, including supervisory arrangements and interaction of the practitioner with other regulated/unregulated occupations and professions?
5. Does this occupational group treat or serve a specific consumer/client/patient population?
6. Are clients/consumers/patients referred to this occupational group for care or services? If so, by whom? Describe a typical referral mechanism.
7. Are clients/consumers/patients referred from this occupational group for care or services? If so, to what practitioners are such referrals made? Describe a typical referral mechanism. How and on what basis are decisions to refer made?

Criterion Four: The scope of practice is distinguishable from other licensed, certified and registered occupations, *in spite of possible overlapping of professional duties, methods of examination, instrumentation, or therapeutic modalities.*

1. Which functions of this occupation are **similar to** those performed by other health occupational groups?
   - Which group(s)?
   - Are the other groups regulated by the state?
   - If so, why might the applicant group be considered different?
2. Which functions of this occupation are **distinct from** other similar health occupational groups?
   - Which group(s)?
   - Are the other groups regulated by the state?
3. How will the regulation of this occupational group affect the scope of practice, marketability, and economic and social status of the other, similar groups (whether regulated or unregulated)?

Criterion Five: The economic costs to the public of regulating the occupational group are justified. *These costs result from restriction of the supply of practitioner, and the cost of operation of regulatory boards and agencies.*

1. What are the range and average incomes of members of this occupational group in the Commonwealth? In adjoining states? Nationally?
2. What are the typical current fees for services provided by this group in the Commonwealth? In adjoining states? Nationally?

3. Is there any evidence that cost for services provided by this occupational group will increase if the group becomes state regulated? In other states, have there been any effects on fees/salaries attributable to state regulation?
4. Would state regulation of this occupation restrict other groups from providing care given by this group?
    - Are any of the other groups able to provide similar care at lower costs?
    - How is it that this lower cost is possible?
5. Are there current shortages/oversupplies of practitioners in Virginia? In the region? Nationally?
6. Are third-party payers in Virginia currently reimbursing services of the occupational group? By whom? For what?
    - If not in Virginia, elsewhere in the country?
    - Are similar services provided by another occupational group reimbursed by third-party payers in Virginia? Elsewhere? Elaborate.
7. If third-party payment does not currently exist, will the occupation seek it subsequent to state regulation?

Criterion Six: There are no alternatives to State regulation of the occupation which adequately protect the public. *[Inspections and injunctions, disclosure requirements, and the strengthening of consumer protection laws and regulations are examples of methods of addressing the risk for public harm that do not require regulation of the occupation or profession.]*

1. What laws or regulations currently exist to govern:
    - Facilities in which practitioners practice or are employed?
    - Devices and substances used in the practice?
    - Standards or practice?
2. Does the institution or organization where the practitioners practice set and enforce standards of care? How?
3. Does the occupational group participate in a nongovernmental credentialing program, either thorough a national certifying agency or professional association (e.g., Institute for Credentialing Excellence National Commission for Certifying Agencies).
    - How are the standards set and enforced in the program?
    - What is the extent of participation of practitioners in the program?
4. Does a Code of Ethics exist for this profession?
    - What is it?
    - Who established the Code?
    - How is it enforced?
    - Is adherence mandatory?
5. Does any peer group evaluation mechanism exist in Virginia or elsewhere? Elaborate.
6. How is a practitioner disciplined and for what causes?
    - Violation of standards of care?
    - Unprofessional conduct?
    - Other causes?
7. Are there specific legal offenses which, upon conviction, preclude a practitioner from practice?
8. Does any other means exist within the occupational group to protect the consumer from negligence or incompetence (e.g., malpractice insurance, review boards that handle complaints)?
    - How are challenges to a practitioner's competency handled?
9. What is the most appropriate level of regulation?

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VIRGINIA ADVISORY BOARD FOR RESPIRATORY CARE

Respiratory Therapy Workforce Concern

2021

Informal Poll of RT Staffing in Virginia

- 8 Hospital Directors/Managers Contacted
  - *7 Responded*
    - 6 summited answers to questions
    - 1 did not respond
  - *Hospital department leaders that were contacted*
    - HCA Chippenham, INOVA, Martha Jefferson, Norfolk General, Roanoke Memorial, UVA Health, and Winchester Memorial
      - *Attempted to contact Lynchburg General but email undeliverable*
    - Identified information removed from answers to protect anonymity

Question 1: How many open positions do you have that you are having difficulty filling?

- 1. Currently I have a 12.7% vacancy to budget, I am fortunate to have been able fill hard to fill positions but the applicant pool has been extremely small.
- 2. We have a total of 19 open positions. Which is a 20% vacancy
- 3. I've been running 38 FTEs, but budgeted for 44. At one point last winter we were at a 28% vacancy rate. I'm currently at a 14% vacancy rate.
- 4. Currently have about 13.6 FTE, or 24% shortage
- 5. 50 %
- 6. I am running over a 20% operational vacancy. Of 150 FTE's, we have ~18 FTE's positions open.

Question 2: Have you needed to alter the way your department provides RT services due to staffing?

- 1. Yes
- 2. We have altered our service to include Travelers and OT. Managers have also went into staffing at high volume. We have not given away or closed any services.
- 3. Yes
- 4. Currently we are looking at alternative ways to provide care to our patients.
- 5. Yes
- 6. Yes, we are looking at a nursing models including using LPNs to take on general care therapy with an RT assessment model. According to BOM, LPNs can be directly supervised by RTs. I don't want to do this, but the national shortage and regional competition is driving us to look at different models of care. I would like to see additional language to our licensure law that allows student RTs to have temporary licenses. We have started reaching out to area programs to develop Respiratory Therapy Assistant (RTA) positions. This had helped during our previous surges, by offering students to assist with equipment turnaround and be available to the RT for errands/equipment/etc. This allowed us to gain understanding of each individual and their engagement within the department and if they would be a good fit when they graduated.

Question 3: Do you feel confident in your ability to provide RT coverage to areas of need?

- 1. Yes to normal volumes, No to increased volumes. I have no extra staff to flex up.
- 2. Not 100% confident, but we have managed well. People are tired and feel underpaid in times like this, but my staff has done a phenomenal job taking care of the patients and each other.
- 3. We will need to prioritize services if this current surge continues to grow at this rate.
- 4. While we are maintaining at the current time we are not providing as much coverage as needed
- 5. NO
- 6. No. Staffing is of great concern and the influx of returning to normal operations is challenging with abnormal admissions to the hospital.

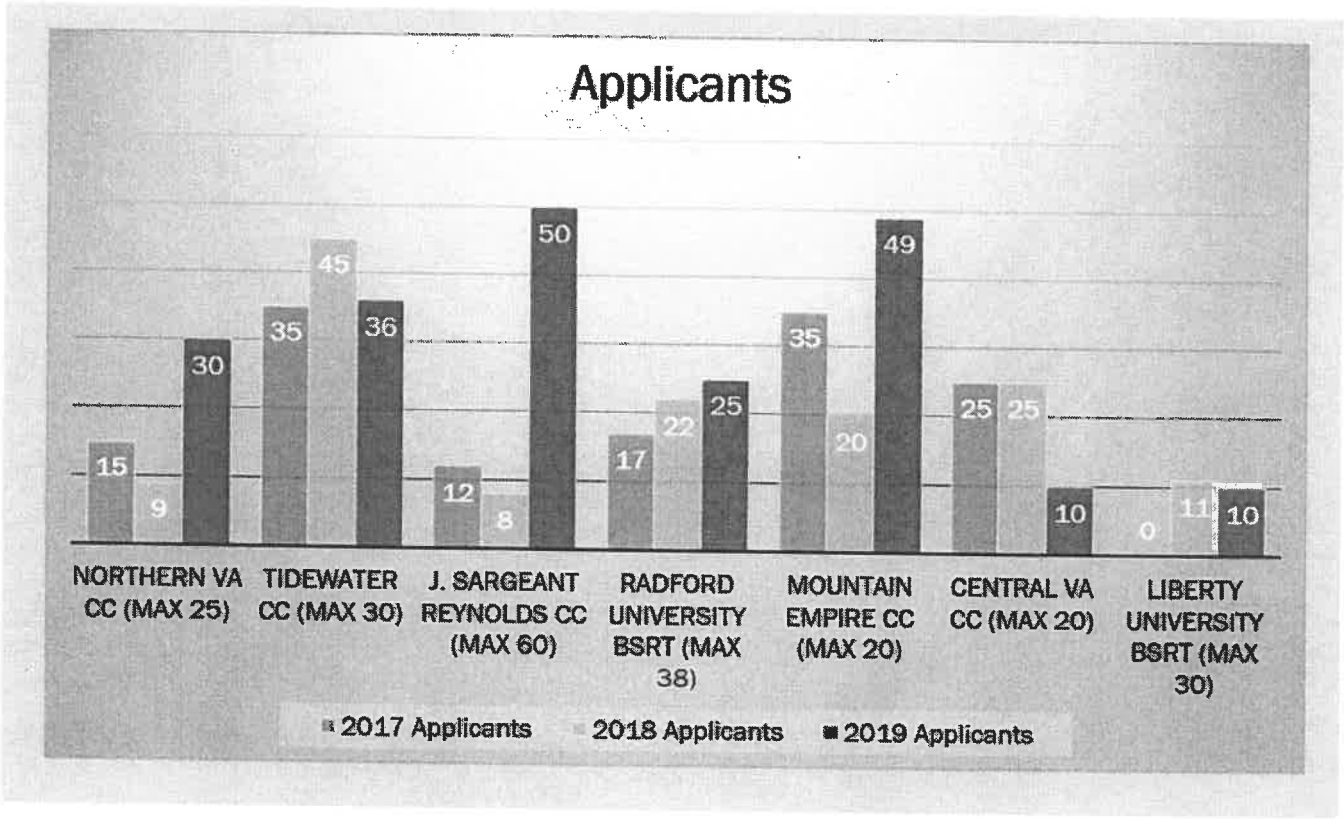
Question 4: Do you see staffing levels returning to normal within a year or 5 years?

- 1. No
- 2. When or if COVID subsides, we could recover if people would return to working FT/PT or PRN jobs versus traveling.
- 3. No, the healthcare system seems to be in a catch 22. We had vacant positions prior to the pandemic. As more people left for agency, coupled with individuals retiring, and others making career moves (going to Epic, teaching, etc) this creates a larger void. Essentially we are trading out agency therapists with different healthcare systems at this point. Until we can retain those individuals, we will continue this slippery slope. We are currently offering 25k sign on bonus to counter this.
- 4. No, I am very concerned about the future. Schools are only enrolling about 60% of capacity. There are only 7 schools in the state of VA producing RT's, with enrollment at 54% decrease from 2014. 789 RT's in the state of VA in 2019 were 55+ (18%) and people <30 years old only made up 9% of all RT's in VA.
- 5. Possibly 5
- 6. Maybe. I have heard some first year numbers are up in enrollment in area RT schools

Question 5: Please comment on any additional questions or concerns.

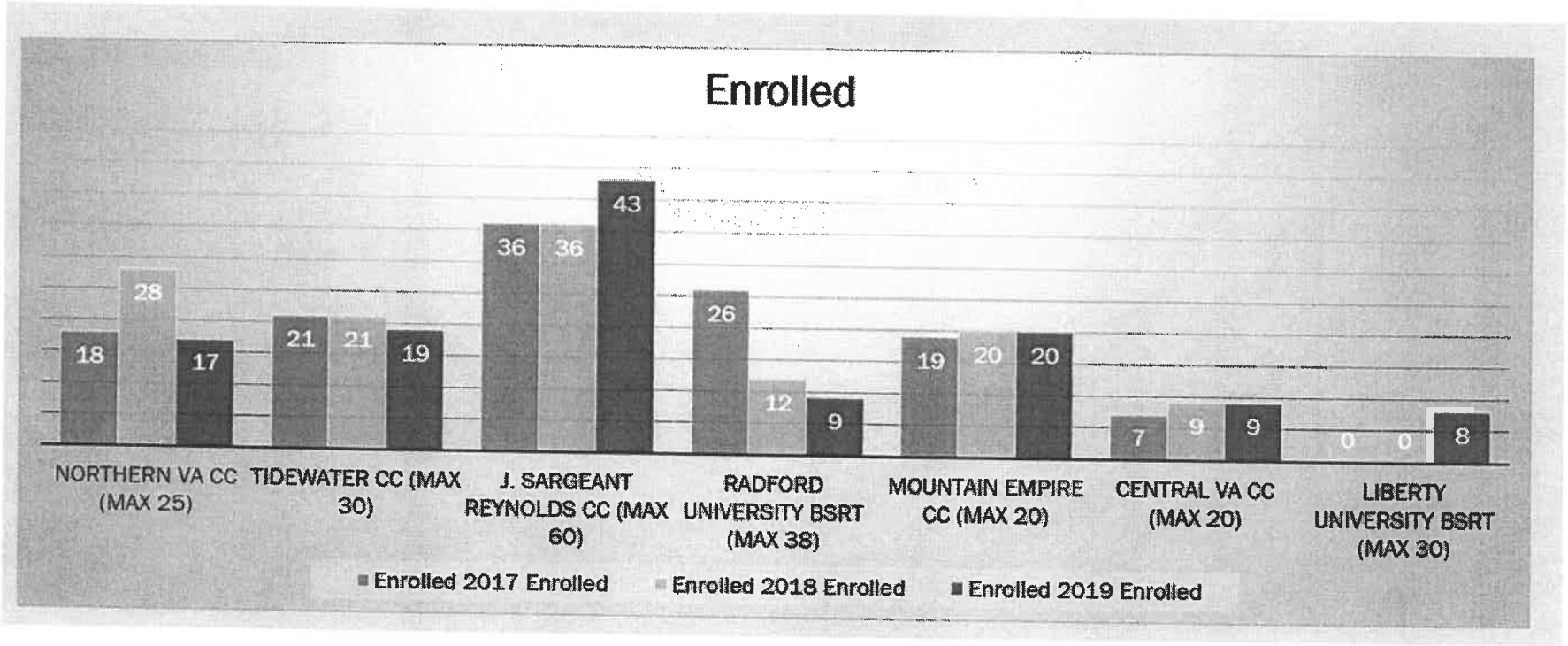
- 1. (No Answer)
- 2. Companies have struggled with salaries and bonuses to keep staff. It's been a learning experience from many levels. I would like to see the Board of Medicine improve the amount of time it takes for a new graduate to receive licensure. They announced less than a week from application, but it was certainly far from that. It would also be beneficial to see them take a more open approach to allowing RT's to work as students performing low risks procedures such as oxygen rounds and/or neb/MDI treatments. Facilities have struggled with a shortage of RT's even before COVID.
- 3. Utilizing students in their final semester would be beneficial. Advocating for RT to be seen as a professional and not technical would help. A reciprocal license so we can share staff, especially in our area, would be a great benefit. We have staff from WV, PA, and MD.
- 4. See additional slides
- 5. (No Answer)
- 6. I have major concerns in regards to the BOM in approving RT licenses. The last year was extremely difficult. Waiting for students to receive their licenses. The BOM need to invest or update to a more automative approach. I have horror stories of Student RT calling the BOM to get updates, being put on hold for long periods of time and then to be hung up on. We are at our whits in and we will be conversing more with our government relations team to find out what the deal is. This has been an ongoing issue for years, the turnaround time for licenses has been terrible. I have conversed over the years, only to be told that their metric for turning around licenses is within their standard. Just frustrating.

Virginia Program Data



CoARC Provided Data

Virginia Program Data



CoARC Provided Data

Recommendations

- Awareness of Respiratory Therapy Profession
- Support for those interested in the field
- Incentives for schools to offer RT programs

--- DRAFT UNAPPROVED ---

VIRGINIA BOARD OF MEDICINE

CREDENTIALS COMMITTEE BUSINESS MEETING

Monday, September 20, 2021 Department of Health Professions Henrico, VA

CALL TO ORDER: Dr. Miller called the meeting to order at 9:00 a.m.

MEMBERS PRESENT:
Jacob Miller, DO - Chair
Joel Silverman, MD
Janet Hickey, JD
Blanton Marchese
Alvin Edwards, PhD

STAFF PRESENT:
William L. Harp, MD - Executive Director
Michael Sobowale, LLM - Deputy Executive Director, Licensing
Colanthia M Opher - Deputy Executive Director, Administration
Elaine Yeatts - DHP Senior Policy Analyst

GUESTS PRESENT:
W. Scott Johnson, Esq. – Medical Society of Virginia
Clark Barrineau – Medical Society of Virginia
Christy Evanko - Virginia Association for Behavior Analysis

Dr. Miller read the emergency egress instructions.

Mr. Sobowale called the roll; a quorum was declared.

Approval of the Agenda

Dr. Silverman moved approval of the agenda as presented with Dr. Edwards seconding. The agenda was approved unanimously.

Public Comment

The Committee received public comment from Christ Evanko, Administrative Director for the Virginia Association for Behavior Analysis (VABA). VABA would like to request that the Committee recommend that Board staff run National Practitioner Data Bank (NPDB) queries on behalf of license applicants. Other issues pertaining to the licensing of Behavior Analysts and Assistant Behavior Analysts will be presented to the Advisory Board on Behavior Analysis at its October 4th meeting.

NEW BUSINESS

Overview

Dr. Harp provided brief comments on the purpose of the meeting. He said that during the pandemic, the Board made accommodations in the licensing processes of 5 professions considered essential to combatting COVID-19. Governor Northam declared the pandemic over June 30th. Given the success of expedited licensing during the pandemic, discussion has occurred about simplifying the process for applicants while still protecting the public. Part of the Committee's task will be to review and recommend which documents required in the licensing process must be primary-source verified, or submitted as copies, and those that may no longer be useful in the licensing process. He reminded the Committee that the Board voted to cease requiring FORM B's (employment verifications) as part of the licensing process. If an applicant has been licensed in multiple states and jurisdictions, the applicant is currently required to ensure a primary-source license verification from each state. It can be challenging for licensing boards to respond in a timely fashion to an applicant's request, producing significant delays in the licensing process. Also, during the pandemic, transcripts were not required to be primary-sourced. So if time permits, the Committee is tasked to review the documents required for licensing applicants in the 22 professions at the Board of Medicine and make recommendations on how the licensing process can be further streamlined.

New Business:

1. **Review of Licensure Requirements and Documents required for Submission**

   The Committee began by reviewing the licensure requirements and documents required of applicants prior to the waivers and accommodations implemented in concert with the Governor's Executive Order 57 on March 12, 2020. The waivers and accommodations enabled the Board to waive verification of certain primary-sourced documents and make certain accommodations in the licensing processes for five (5) expedited professions in order to streamline the licensure of health care providers during COVID-19. The 5 expedited professions were Medical Doctor (MD), Doctor of Osteopathy (DO), Doctor of Podiatric Medicine (DPM), Physician Assistant (PA), and Respiratory Therapy (RT).

   #### MD, DO, DPM

   After review and extensive discussion of the licensure requirements for MDs, DOs, and DPMs, and upon a motion by Mr. Marchese, seconded by Dr. Edwards, the Committee unanimously approved that the following recommendation to be made to the Board: that, for MDs, DOs, and DPMs, the Board should continue to require that an applicant submit primary-source verification transcripts, national board examination scores, evidence of completion of postgraduate training, the National Practitioner Data Bank (NPDB) self-query report, and one state license verification. The Committee agreed that a digitally-certified electronic copy of the NPDB report provided by an applicant is acceptable.

   For verification of completion of postgraduate training, the Board can accept a copy of the completion certificate issued by the training program or a program director's letter of completion, or other verification submitted by an applicant as proof of completion of postgraduate training when the applicant has finished postgraduate training at least 5 years prior to submitting an application to the Board. An applicant who is within 5 years of completing postgraduate training when an application is submitted to the Board would have to provide primary source verification

of proof of completion directly from the training program.

PA

After review and discussion, and upon a motion by Mr. Marchese, seconded by Dr. Edwards, the Committee voted unanimously to recommend to the full Board to continue to request that applicants submit primary-source verification of passage of the National Commission on Certification of Physician Assistants (NCCPA) certifying examination, proof of completion of education, the NPDB self-query report, and one current state license verification. The Board can accept a digitally-certified electronic copy of the NPDB report provided by an applicant, in lieu of a mailed report. In addition, the Committee recommended that the Board dispense with using "Form L" and place the question about successful completion of 35 hours of pharmacology in the application form.

RT

After review and discussion, and upon a motion by Mr. Marchese, seconded by Dr. Edwards, the Committee voted unanimously to recommend to the full Board for the Board to continue to request that applicants submit primary-source verification of passage of the National Board for Respiratory Care (NBRC) certifying examination, proof of completion of education, NPDB self-query report, and one current state license verification. The Board can accept a digitally-certified electronic copy of the NPDB report provided by an applicant, in lieu of a mailed report.

The Committee decided to defer review and discussion of the licensure requirements for other allied professions, and asked that the various advisory boards for each profession review their licensing requirements and application questions to determine if they are in line with current practice. The Committee asked that the findings be reported back to the Committee at its next meeting.

2. Guidance Document 85-9 on USMLE Attempts Limit

The Committee reviewed guidance document 85-9 and discussed whether a recommendation needed to be made to change the number of attempts written in the Board's guidance document for applicants taking the USMLE in light of the recent change made by FSMB to its policy regarding the total number of attempts that will be allowed a candidate on each Step of the exam. Effective July 1, 2021, FSMB reduced the total number of attempts a candidate may take per Step from six (6) to four (4). Upon a motion by Dr. Silverman, seconded by Dr. Edwards, the Committee voted unanimous approval of recommendation to change the total number of USMLE attempts limit listed in the Board's guidance document to bring it in line with the current FSMB's USMLE attempts limit.

3. Award of Continuing Education Credit for Board Members' Service

Dr. Miller led the discussion. Dr. Miller stated that Board members should be able to claim continuing education (CE) credit for their service on the Board, including attendance at meetings and case review. Mr. Marchese stated that he is aware that other states' licensing board members are able to receive CE credit for their service on the Board, but he is not sure how many credit hours should be claimed and in what category. Ms. Yeatts advised that currently, Board members should be able to claim credit for those types of activities, but they would be Type 2 CE.

Upon a motion by Dr. Edwards, seconded by Dr. Silverman, the Committee voted to recommend to the full Board that Board members be allowed to claim up to thirty (30) hours of Type 2 CE per biennium for time spent on licensing, discipline and policy issues. Two members abstained from the vote. The motion passed.

With no additional business, the meeting adjourned 12:35 p.m.

Jacob Miller, DO
Chair

William L. Harp, MD
Executive Director

Michael Sobowale, LL.M.
Deputy Executive Director, Licensing

Profession * Expedited Profession	Board Requirements Pre-COVID	COVID Process per Executive Order 57 Effective March 12, 2020	Credentials Committee Recommendation(s) - 9/20/21
*Respiratory Therapist	• Form B / Employment Verification • NBRC Credential Verification – **Primary source verified or** • Verification of Professional Education (school Transcripts) – **Primary source verified** • Other state license verification – **primary source only** • NPDB Self- Query Report – **Mailed and primary source only** • Non-routine questions 5-18 answered on application require supporting documentation from the applicant. • Required documents received at the Board must be primary source verified, and may be electronically transmitted from the source to the licensing specialist	**WAIVED** • Form B / Employment Verification • State license verifications waived • NPDB Self-Query accepted electronically	**NBRC credential verification – primary source verified**, or **Professional Education – primary Source verified** **1 state license verification plus NPDB report needed. Need to be primary source verified.** **Digitally-certified copy of NPDB self-query report can be accepted from an applicant.**

Commonwealth of Virginia

REGULATIONS

GOVERNING THE PRACTICE OF RESPIRATORY THERAPISTS

VIRGINIA BOARD OF MEDICINE

Title of Regulations: 18 VAC 85-40-10 et seq.

Statutory Authority: § 54.1-2400 and Chapter 29 of Title 54.1 of the *Code of Virginia*

Revised Date: March 5, 2020

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TABLE OF CONTENTS

Part I. General Provisions.

18VAC85-40-10. Definitions.

A. The following words and terms when used in this chapter shall have the meanings ascribed to them in §54.1-2900 of the Code of Virginia:

"Board"

"Qualified medical direction"

B. The following words and terms when used in this chapter shall have the following meanings unless the context clearly indicates otherwise:

"AARC" means the American Association for Respiratory Care.

"Accredited educational program" means a program accredited by the Commission on Accreditation for Respiratory Care or any other agency approved by the NBRC for its entry level certification examination.

"Active practice" means a minimum of 160 hours of professional practice as a respiratory therapist within the 24-month period immediately preceding renewal or application for licensure if previously licensed or certified in another jurisdiction. The active practice of respiratory care may include supervisory, administrative, educational or consultative activities or responsibilities for the delivery of such services.

"Advisory board" means the Advisory Board on Respiratory Care to the Board of Medicine as specified in §54.1-2956 of the Code of Virginia.

"NBRC" means the National Board for Respiratory Care, Inc.

"Respiratory therapist" means a person as specified in §54.1-2954 of the Code of Virginia.

18VAC85-40-20. Public participation.

A separate board regulation, 18VAC85-11, entitled Public Participation Guidelines, provides for involvement of the public in the development of all regulations of the Virginia Board of Medicine.

18VAC85-40-25. Current name and address.

Each licensee shall furnish the board his current name and address of record. All notices required by law or by this chapter to be given by the board to any such licensee shall be validly given when sent to the latest address of record provided or served to the licensee. Any change of name or address of record or public address, if different from the address of record, shall be furnished to the board within 30 days of such change.

18VAC85-40-30. Violations.

Any violation of Chapter 29 of Title 54.1 of the Code of Virginia shall be subject to the statutory sanctions as set forth in the Act.

18VAC85-40-35. Fees.

The following fees are required:

1. The application fee, payable at the time the application is filed, shall be $130.

2. The biennial fee for renewal of active licensure shall be $135 and for renewal of inactive licensure shall be $70, payable in each odd-numbered year in the license holder's birth month. For 2021, the fee for renewal of an active license shall be $108 and the fee for renewal of an inactive license shall be $54.

3. The additional fee for late renewal of licensure within one renewal cycle shall be $50.

4. The fee for reinstatement of a license issued by the Board of Medicine pursuant to §54.1-2904 of the Code of Virginia, which has lapsed for a period of two years or more, shall be $180 and must be submitted with an application for licensure reinstatement.

5. The fee for reinstatement of a license pursuant to §54.1-2408.2 of the Code of Virginia shall be $2,000.

6. The fee for a duplicate license shall be $5, and the fee for a duplicate wall certificate shall be $15.

7. The handling fee for a returned check or a dishonored credit card or debit card shall be $50.

8. The fee for a letter of good standing/verification to another jurisdiction shall be $10; the fee for certification of grades to another jurisdiction shall be $25.

9. The fee for an application or for the biennial renewal of a restricted volunteer license 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.

Part II. Requirements for Licensure as a Respiratory Therapist.

18VAC85-40-40. Licensure requirements.

An applicant for licensure shall submit the following on forms provided by the board:

1. A completed application and a fee as prescribed in 18VAC85-40-35.

2. Verification of professional education in respiratory care as required in 18VAC85-40-45.

3. Verification of practice as required on the application form.

4. Evidence of passage of the national examination as required in 18VAC85-40-50.

5. If licensed or certified in any other jurisdiction, documentation of active practice as a respiratory therapist or documentation of 20 hours of continuing education within the 24-month period immediately preceding application and verification that there has been no disciplinary action taken or pending in that jurisdiction.

18VAC85-40-45. Educational requirements.

An applicant for licensure shall:

1. Be a graduate of an accredited educational program for respiratory therapists; or

2. Hold current credentialing as a Certified Respiratory Therapist (CRT) or a Registered Respiratory Therapist (RRT) from the NBRC or any other credentialing body determined by the board to be equivalent.

18VAC85-40-50. Examination requirements.

An applicant for a license to practice as a licensed respiratory therapist shall submit to the board evidence that the applicant has passed the NBRC entry level examination for respiratory care, or its equivalent as approved by the board.

18VAC85-40-55. Registration for voluntary practice by out-of-state licensees.

Any respiratory therapist who does not hold a license to practice in Virginia and who seeks registration to practice under subdivision 27 of §54.1-2901 of the Code of Virginia on a voluntary basis under the auspices of a publicly supported, all volunteer, nonprofit organization that sponsors the provision of health care to populations of underserved people shall:

1. File a complete application for registration on a form provided by the board at least five business days prior to engaging in such practice. An incomplete application will not be considered;

2. Provide a complete record of professional licensure in each state in which he has held a license and a copy of any current license;

3. Provide the name of the nonprofit organization, the dates and location of the voluntary provision of services;

4. Pay a registration fee of $10; and

5. Provide a notarized statement from a representative of the nonprofit organization attesting to its compliance with provisions of subdivision 27 of §54.1-2901 of the Code of Virginia.

Part III. Renewal and Reinstatement.

18VAC85-40-60. Renewal of license.

A. Every licensed respiratory therapist intending to continue his licensure shall biennially in each odd-numbered year in his birth month:

1. Register with the board for renewal of his license;

2. Pay the prescribed renewal fee at the time he files for renewal;

3. Attest that he has engaged in active practice as defined in 18VAC85-40-10 or present other documented evidence acceptable to the board that he is prepared to resume practice; and

4. Attest to having met the continuing education requirements of 18VAC85-40-66.

B. A respiratory therapist whose licensure has not been renewed by the first day of the month following the month in which renewal is required shall pay a late fee as prescribed in 18VAC85-40-35.

18VAC85-40-61. Inactive license.

A licensed respiratory therapist who holds a current, unrestricted license in Virginia shall, upon a request on the renewal application and submission of the required fee, be issued an inactive license. The holder of an inactive license shall not be entitled to perform any act requiring a license to practice respiratory care in Virginia.

18VAC85-40-65. Reactivation or reinstatement.

A. To reactivate an inactive license or to reinstate a license that has been lapsed for more than two years, a respiratory therapist shall submit evidence of competency to return to active practice to include one of the following:

1. Information on continued practice in another jurisdiction during the period in which the license has been inactive or lapsed;

2. Ten hours of continuing education for each year in which the license has been inactive or lapsed, not to exceed three years; or

3. Recertification by passage of an examination from NBRC.

B. To reactivate an inactive license, a respiratory therapist shall pay a fee equal to the difference between the current renewal fee for inactive licensure and the renewal fee for active licensure.

C. To reinstate a license which has been lapsed for more than two years, a respiratory therapist shall file an application for reinstatement and pay the fee for reinstatement of his licensure as prescribed in 18VAC85-40-35. The board may specify additional requirements for reinstatement of a license so lapsed to include education, experience or reexamination.

D. A respiratory therapist whose licensure has been revoked by the board and who wishes to be reinstated shall make a new application to the board, fulfill additional requirements as specified in the order from the board and make payment of the fee for reinstatement of his licensure as prescribed in 18VAC85-40-35 pursuant to §54.1-2408.2 of the Code of Virginia.

E. The board reserves the right to deny a request for reactivation or reinstatement to any licensee who has been determined to have committed an act in violation of §54.1-2915 of the Code of Virginia or any provisions of this chapter.

18VAC85-40-66. Continuing education requirements.

A. In order to renew an active license as a respiratory therapist, a licensee shall attest to having completed 20 hours of continuing education within the last biennium as follows:

1. Courses approved and documented by a sponsor recognized by the AARC;

2. Courses directly related to the practice of respiratory care as approved by the American Medical Association for Category 1 CME credit; or

3. A credit course of post-licensure academic education relevant to respiratory care offered by a college or university accredited by an agency recognized by the U.S. Department of Education.

Up to two continuing education hours may be satisfied through delivery of respiratory therapy services, without compensation, to low-income individuals receiving services through a local health department or a free clinic organized in whole or primarily for the delivery of health services. One hour of continuing education may be credited for three hours of providing such volunteer services. For the purpose of continuing education credit for voluntary service, the hours shall be approved and documented by the health department or free clinic.

B. A practitioner shall be exempt from the continuing education requirements for the first biennial renewal following the date of initial licensure in Virginia.

C. The practitioner shall retain in his records the completed form with all supporting documentation for a period of four years following the renewal of an active license.

D. The board shall periodically conduct a random audit of its active licensees to determine compliance. The practitioners selected for the audit shall provide all supporting documentation within 30 days of receiving notification of the audit.

E. Failure to comply with these requirements may subject the licensee to disciplinary action by the board.

F. The board may grant an extension of the deadline for continuing competency requirements, for up to one year, for good cause shown upon a written request from the licensee prior to the renewal date.

G. The board may grant an exemption for all or part of the requirements for circumstances beyond the control of the licensee, such as temporary disability, mandatory military service, or officially declared disasters.

18VAC85-40-67. Restricted volunteer license.

A. A respiratory therapist who held an unrestricted license issued by the Virginia Board of Medicine or by a board in another state as a licensee in good standing at the time the license expired or became inactive may be issued a restricted volunteer license to practice without compensation in a clinic that is organized in whole or in part for the delivery of health care services without charge in accordance with §54.1-106 of the Code of Virginia.

B. To be issued a restricted volunteer license, a respiratory therapist shall submit an application to the board that documents compliance with requirements of §54.1-2928.1 of the Code of Virginia and the application fee prescribed in 18VAC85-40-35.

C. The licensee who intends to continue practicing with a restricted volunteer license shall renew biennially during his birth month, meet the continued competency requirements prescribed in subsection D of this section, and pay to the board the renewal fee prescribed in 18VAC85-40-35.

D. The holder of a restricted volunteer license shall not be required to attest to hours of continuing education for the first renewal of such a license. For each renewal thereafter, the licensee shall attest to obtaining 10 hours of continuing education as approved and documented by a sponsor recognized by the AARC or in courses directly related to the practice of respiratory care as approved by the American Medical Association for Category 1 CME credit within the last biennium.

Part IV. Scope of Practice.

18VAC85-40-70. Individual responsibilities.

Practice as a licensed respiratory therapist means, upon receipt of written or verbal orders from a qualified practitioner and under qualified medical direction, the evaluation, care and treatment of patients with deficiencies and abnormalities associated with the cardiopulmonary system. This practice shall include, but not be limited to, ventilatory assistance and support; the insertion of artificial airways without cutting tissue and the maintenance of such airways; the administration of medical gases exclusive of general anesthesia; topical administration of pharmacological agents to the respiratory tract; humidification; and administration of aerosols. The practice of respiratory care shall include such functions shared with other health professionals as cardiopulmonary resuscitation; bronchopulmonary hygiene; respiratory rehabilitation; specific testing techniques required to assist in diagnosis, therapy and research; and invasive and noninvasive cardiopulmonary monitoring.

18VAC85-40-80. [Repealed]

Part V. Standards of Professional Conduct.

18VAC85-40-85. Confidentiality.

A practitioner shall not willfully or negligently breach the confidentiality between a practitioner and a patient. A breach of confidentiality that is required or permitted by applicable law or beyond the control of the practitioner shall not be considered negligent or willful.

18VAC85-40-86. Patient records.

A. Practitioners shall comply with provisions of § 32.1-127.1:03 related to the confidentiality and disclosure of patient records.

B. Practitioners shall provide patient records to another practitioner or to the patient or his personal representative in a timely manner in accordance with provisions of § 32.1-127.1:03 of the Code of Virginia.

C. Practitioners shall properly manage and keep timely, accurate, legible and complete patient records;

D. Practitioners who are employed by a health care institution or other entity, in which the individual practitioner does not own or maintain his own records, shall maintain patient records in accordance with the policies and procedures of the employing entity.

E. Practitioners who are self-employed or employed by an entity in which the individual practitioner owns and is responsible for patient records shall:

1. Maintain a patient record for a minimum of six years following the last patient encounter with the following exceptions:

a. Records of a minor child, including immunizations, shall be maintained until the child reaches the age of 18 or becomes emancipated, with a minimum time for record retention of six years from the last patient encounter regardless of the age of the child;

b. Records that have previously been transferred to another practitioner or health care provider or provided to the patient [or his personal representative; or

c. Records that are required by contractual obligation or federal law may need to be maintained for a longer period of time.

2. From October 19, 2005, post information or in some manner inform all patients concerning the time frame for record retention and destruction. Patient records shall only be destroyed in a manner that protects patient confidentiality, such as by incineration or shredding.

3. When a practitioner is closing, selling or relocating his practice, he shall meet the requirements of § 54.1-2405 of the Code of Virginia for giving notice that copies of records can be sent to any like-regulated provider of the patient's choice or provided to the patient.

18VAC85-40-87. Practitioner-patient communication; termination of relationship.

A. Communication with patients.
1. Except as provided in § 32.1-127.1:03 F of the Code of Virginia, a practitioner shall accurately present information to a patient or his legally authorized representative in understandable terms and encourage participation in decisions regarding the patient's care.

2. A practitioner shall not deliberately make a false or misleading statement regarding the practitioner's skill or the efficacy or value of a medication, treatment, or procedure provided or directed by the practitioner in the treatment of any disease or condition.

3. Before an invasive procedure is performed, informed consent shall be obtained from the patient in accordance with the policies of the health care entity. Practitioners shall inform patients of the risks, benefits, and alternatives of the recommended procedure that a reasonably prudent practitioner practicing respiratory care in Virginia would tell a patient.

a. In the instance of a minor or a patient who is incapable of making an informed decision on his own behalf or is incapable of communicating such a decision due to a physical or mental disorder, the legally authorized person available to give consent shall be informed and the consent documented.

b. An exception to the requirement for consent prior to performance of an invasive procedure may be made in an emergency situation when a delay in obtaining consent would likely result in imminent harm to the patient.

c. For the purposes of this provision, "invasive procedure" shall mean any diagnostic or therapeutic procedure performed on a patient that is not part of routine, general care and for which the usual practice within the health care entity is to document specific informed consent from the patient or surrogate decision-maker prior to proceeding.

4. Practitioners shall adhere to requirements of § 32.1-162.18 of the Code of Virginia for obtaining informed consent from patients prior to involving them as subjects in human research with the exception of retrospective chart reviews.

B. Termination of the practitioner/patient relationship.

1. The practitioner or the patient may terminate the relationship. In either case, the practitioner shall make the patient record available, except in situations where denial of access is allowed by law.

2. A practitioner shall not terminate the relationship or make his services unavailable without documented notice to the patient that allows for a reasonable time to obtain the services of another practitioner.

18VAC85-40-88. Practitioner responsibility.

A. A practitioner shall not:

1. Perform procedures or techniques that are outside the scope of his practice or for which he is not trained and individually competent;

2. Knowingly allow subordinates to jeopardize patient safety or provide patient care outside of the subordinate's scope of practice or area of responsibility. Practitioners shall delegate patient care only to subordinates who are properly trained and supervised;

3. Engage in an egregious pattern of disruptive behavior or interaction in a health care setting that interferes with patient care or could reasonably be expected to adversely impact the quality of care rendered to a patient; or

4. Exploit the practitioner/patient relationship for personal gain.

B. Advocating for patient safety or improvement in patient care within a health care entity shall not constitute disruptive behavior provided the practitioner does not engage in behavior prohibited in A 3 of this section.

18VAC85-40-89. Solicitation or remuneration in exchange for referral.

A practitioner shall not knowingly and willfully solicit or receive any remuneration, directly or indirectly, in return for referring an individual to a facility or institution as defined in §37.2-100 of the Code of Virginia, or hospital as defined in §32.1-123 of the Code of Virginia.

Remuneration shall be defined as compensation, received in cash or in kind, but shall not include any payments, business arrangements, or payment practices allowed by Title 42, §1320a-7b(b) of the United States Code, as amended, or any regulations promulgated thereto.

18VAC85-40-90. Sexual contact.

A. For purposes of § 54.1-2915 A 12 and A 19 of the Code of Virginia and this section, sexual contact includes, but is not limited to, sexual behavior or verbal or physical behavior which:

1. May reasonably be interpreted as intended for the sexual arousal or gratification of the practitioner, the patient, or both; or

2. May reasonably be interpreted as romantic involvement with a patient regardless of whether such involvement occurs in the professional setting or outside of it.

B. Sexual contact with a patient.

1. The determination of when a person is a patient for purposes of § 54.1-2915 A 19 of the Code of Virginia is made on a case-by-case basis with consideration given to the nature, extent, and context of the professional relationship between the practitioner and the person. The fact that a person is not actively receiving treatment or professional services from a practitioner is not determinative of this issue. A person is presumed to remain a patient until the patient-practitioner relationship is terminated.

2. The consent to, initiation of, or participation in sexual behavior or involvement with a practitioner by a patient does not change the nature of the conduct nor negate the statutory prohibition.

C. Sexual contact between a practitioner and a former patient.

Sexual contact between a practitioner and a former patient after termination of the practitioner-patient relationship may still constitute unprofessional conduct if the sexual contact is a result of the exploitation of trust, knowledge, or influence of emotions derived from the professional relationship.

D. Sexual contact between a practitioner and a key third party shall constitute unprofessional conduct if the sexual contact is a result of the exploitation of trust, knowledge or influence derived from the professional relationship or if the contact has had or is likely to have an adverse effect on

patient care. For purposes of this section, key third party of a patient shall mean: spouse or partner, parent or child, guardian, or legal representative of the patient.

E. Sexual contact between a supervisor and a trainee shall constitute unprofessional conduct if the sexual contact is a result of the exploitation of trust, knowledge or influence derived from the professional relationship or if the contact has had or is likely to have an adverse effect on patient care.

18VAC85-40-91. Refusal to provide information.

A practitioner shall not willfully refuse to provide information or records as requested or required by the board or its representative pursuant to an investigation or to the enforcement of a statute or regulation.

Rev. 08/21 Respiratory Therapy

Virginia Department of Health Professions

Board of Medicine
9960 Mayland Drive, Suite 300
Henrico, Virginia 23233-1463
Phone: (804) 367-4600
Fax: (804) 527-4426
Email: medbd@dhp.virginia.gov

Application for License to Practice as a Respiratory Therapist

To the Board of Medicine of Virginia:

I hereby make application for a license to practice as a respiratory therapist in the Commonwealth of Virginia and submit the following statements:

1. Name in Full (Please Print or Type)

Last	First	Middle
Date of Birth ____ ____ ____ MO DAY YEAR	Social Security No. or VA Control No.*	Maiden Name if applicable
Public Address: This address will be public information:	House No. Street or PO Box	City State and Zip
Board Address: This address will be used for Board Correspondence and may be the same or different from the public address.	House No. Street or PO Box	City State and Zip
Work Phone Number	Home/Cell Phone Number	Email Address

Please submit address changes in writing immediately to medbd@dhp.virginia.gov

Please attach check or money order payable to the Treasurer of Virginia for $130.00. Applications will not be processed without the fee. Do not submit fee without an application. **IT WILL BE RETURNED.**

APPLICANTS DO NOT USE SPACES BELOW THIS LINE – FOR OFFICE USE ONLY

APPROVED BY

_____

Date

LICENSE NUMBER	PROCESSING NUMBER	FEE
0117-		**$130.00**

*In accordance with §54.1-116 Code of Virginia, you are required to submit your Social Security Number or your control number** issued by the *Virginia* Department of Motor Vehicles. If you fail to do so, the processing of your application will be suspended and fees will not be refunded. This number will be used by the Department of Health Professions for identification and will not be disclosed for other purposes except as provided by law. Federal and state law requires that this number be shared with other state agencies for child support enforcement activities. NO LICENSE WILL BE ISSUED TO ANY INDIVIDUAL WHO HAS FAILED TO DISCLOSE ONE OF THESE NUMBERS.

**In order to obtain a Virginia driver's license control number, it is necessary to appear in person at an office of the Department of Motor Vehicles in Virginia. A fee and disclosure to DMV of your Social Security Number will be required to obtain this number.

2. List in chronological order all professional practices including each location of service since graduation, including internships, residencies, hospital affiliations and absences from work. Also list all periods of non-professional activity or employment. **PLEASE ACCOUNT FOR ALL TIME**. If engaged in private practice, list all clinical affiliations.

From	To	Name and Address of Location Where Service was Provided	Position Held
________	________	________________________________	____________
________	________	________________________________	____________
________	________	________________________________	____________
________	________	________________________________	____________
________	________	________________________________	____________
________	________	________________________________	____________
________	________	________________________________	____________
________	________	________________________________	____________

3. Do you intend to engage in the active practice of respiratory therapy in the Commonwealth of Virginia? ☐ Yes ☐ No

If Yes, give location _____

4. List all jurisdictions in which you have been issued a license to practice respiratory therapy: include all active, inactive, expired, suspended or revoked licenses. Indicate number and date issued.

Jurisdiction	Number Issued	Active/Inactive/Expired

	Yes	No
QUESTIONS MUST BE ANSWERED. If any of the following questions (5-17) is answered **Yes**, explain and substantiate with documentation.		
5. Have you ever been denied a license or the privilege of taking a licensure/competency examination by any testing entity or licensing authority?	☐	☐
6. Have you ever been convicted of a violation of/or pled Nolo Contendere to any federal, state, or local statute, or regulation or ordinance, or entered into an plea bargaining relating to a felony or misdemeanor? (Excluding traffic violations, except convictions for driving under the influence.) **Additionally, any information concerning an arrest, charge, or conviction that has been sealed, including arrests, charges, or convictions for possession of marijuana, does not have to be disclosed.**	☐	☐
7. Have you ever been denied clinical privileges or voluntarily surrendered your clinical privileges for any reason while under investigation, been censured or warned or been requested to withdraw from any professional school, training program, hospital, healthcare facility, healthcare provider, or been terminated from employment or resigned in lieu of termination?	☐	☐
8. Have you requested a current report (Self Query) from NPDB?	☐	☐
9. Have you requested a certification of credentials from the National Board of Respiratory Care, Inc.? Certification should be requested from the NBRC. You may do so at http://www.nbrc.org/.	☐	☐
10. Do you have any pending disciplinary actions against your professional license/certification/permit/registration related to your practice of respiratory therapy?	☐	☐
11. Have you voluntarily withdrawn from any professional society while under investigation?	☐	☐
12. Within the past five years, have you exhibited any conduct or behavior that could call into question your ability to practice in a competent and professional manner?	☐	☐
13. Within the past five years, have you been disciplined by any entity?	☐Yes	☐No
14. Do you currently have any physical condition or impairment that affects or limits your ability to perform any of the Obligations and responsibilities of professional practice in a safe and competent manner? "Currently" means recently enough so that the condition could reasonably have an impact on your ability to function as a practicing respiratory therapist.	☐	☐
15. Do you currently have any mental health condition or impairment that affects or limits your ability to perform any of the obligations and responsibilities of professional practice in a safe and competent manner? "Currently" means recently enough so that the condition could reasonably have an impact on your ability to function as a practicing respiratory therapist.	☐	☐

16. Do you currently have any condition or impairment related to alcohol or other substance use that affects or limits your ability to perform any of the obligations and responsibilities of professional practice in a safe and competent manner? "Currently" means recently enough so that the condition could reasonably have an impact on your ability to function as a practicing respiratory therapist. ☐ ☐

17. Within the past 5 years, have any condition or restrictions been imposed upon you or your practice to avoid disciplinary action by any entity? ☐ ☐

18. Have you had any malpractice suits brought against you in the past ten (10) years? If so, please provide a narrative for each closed or pending case during this time period. ☐ ☐

Military Service:

19. Are you the spouse of someone who is on a federal active duty orders pursuant to Title 10 of the U.S. Code or of a veteran who has left active-duty service within one year of submission of this application and who is accompanying your spouse to Virginia or an adjoining state or the District of Columbia? ☐ ☐

20. Are you active duty military? ☐ ☐

21. AFFIDAVIT OF APPLICANT

I, _____, am the person referred to in the foregoing application and supporting documents.

I hereby authorize all hospitals, institutions, or organizations, my references, personal physicians, employers (past and present), business and professional associates (past and present), and all governmental agencies and instrumentalities (local, state, federal, or foreign) to release to the Virginia Board of Medicine any information, files or records requested by the Board in connection with the processing of individuals and groups listed above, any information which is material to me and my application.

I have carefully read the questions in the foregoing application and have answered them completely, without reservations of any kind, and I declare under penalty of perjury that my answers and all statements made by me herein are true and correct. Should I furnish any false information in this application, I hereby agree that such act shall constitute cause for the denial, suspension, or revocation of my license to practice respiratory therapy in the Commonwealth of Virginia.

I have carefully read the laws and regulations related to the practice of my profession which are available at www.dhp.virginia.gov and I understand that fees submitted as part of the application process shall not be refunded.

_____

Signature of Applicant

Advisory Board on:

Behavioral Analysts		10:00 a.m.
Mon –January 31	May 23	September 19
Genetic Counseling		1:00 p.m.
Mon - January 31	May 23	September 19
Occupational Therapy		10:00 a.m.
Tues – February 1	May 24	September 20
Respiratory Care		1:00 p.m.
Tues - February 1	May 24	September 20
Acupuncture		10:00 a.m.
Wed - February 2	May 25	September 21
Radiological Technology		1:00 p.m.
Wed - February 2	May 25	September 21
Athletic Training		10:00 a.m.
Thurs - February 3	May 26	September 22
Physician Assistants		1:00 p.m.
Thurs - February 3	May 26	September 22
Midwifery		10:00 a.m.
Fri - February 4	May 27	September 23
Polysomnographic Technology		1:00 p.m.
Fri - February 4	May 27	September 23
Surgical Assisting		10:00 a.m.
Mon - February 7	Tues – May 31	September 26