CONSIDERATION AND POSSIBLE ACTION ON LEGISLATION TO LICENSE ATHLETIC TRAINERS.

The following are attached for review:

- Assembly Bill 1510 (Dababneh)
- Athletic Trainer (AT) state regulatory models
- Athletic training education competencies
- Executive Summary from recent Board of Certification (BOC) Practice Analysis
- AT scopes of practice (FL, IL, NY, OH, PA, TX)
- BOC Professional Practice and Discipline Guidelines (1/2014)
- Texas AT statutory language (effect 9/1/2015)
- "Changes in Healthcare Professions' Scope of Practice: Legislative Considerations"
- BOC newsletter (Fall 2016)

AB-1510 Athletic trainers. (2017-2018)

Date Published: 02/17/2017 09:00 PM

CALIFORNIA LEGISLATURE— 2017–2018 REGULAR SESSION

ASSEMBLY BILL No. 1510

Introduced by Assembly Member Dababneh

February 17, 2017

An act to add and repeal Chapter 5.8 (commencing with Section 2697) of Division 2 of the Business and Professions Code, relating to athletic trainers.

LEGISLATIVE COUNSEL'S DIGEST

AB 1510, as introduced, Dababneh. Athletic trainers.

Existing law provides for the regulation of various professions and vocations, including those of an athlete agent.

This bill would enact the Athletic Training Practice Act, which would, after a determination is made that sufficient funds have been received to pay initial costs of this bill, provide for the licensure and regulation of athletic trainers, as defined. The bill would, after that determination, establish the Athletic Trainer Licensing Committee within the California Board of Occupational Therapy to implement these provisions, including issuing and renewing athletic training licenses and imposing disciplinary action. Under the bill, the committee would be comprised of 7 members, to be appointed to 4-year terms, except as specified. Commencing 6 months after the committee is established by this bill, the bill would prohibit a person from practicing as an athletic trainer or using certain titles without a license issued by the committee, except as specified. The bill would prohibit, except in specified cases for a specified period, a person from using the title "athletic trainer," unless the person is licensed by the committee. The bill would specify the requirements for licensure, including education, examination, and the payment of a license application fee established by the committee. The bill would define the practice of athletic training and prescribe supervision requirements on athletic trainers.

The bill would also establish the Athletic Trainers' Fund for the deposit of license application and renewal fees,

and would make those fees available to the committee for the purpose of implementing these provisions upon appropriation by the Legislature. The bill would authorize the Director of Consumer Affairs to seek and receive donations from the California Athletic Trainers Association for purposes of obtaining funds for the startup costs of implementing the act. The bill would require the director to determine that sufficient funds for that purpose have been obtained and to provide notice to the Legislature, the Governor, and on the department's Internet Web site of the determination, as specified. This bill would repeal these provisions on January 1, 2025.

Vote: majority Appropriation: no Fiscal Committee: yes Local Program: no

THE PEOPLE OF THE STATE OF CALIFORNIA DO ENACT AS FOLLOWS:

SECTION 1. The Legislature finds and declares the following:

(a) California is ~~one of~~ THE only ~~two~~ states that does not currently regulate the practice of athletic training. This lack of regulation creates the risk that individuals who have lost or are unable to obtain licensure in another state will come to California to practice, thereby putting the public in danger and degrading the standards of the profession as a whole.

(b) There is a pressing and immediate need to regulate the profession of athletic training in order to protect the public health, safety, and welfare. This need is particularly important because athletic trainers often work with schoolage children.

(c) There is also a pressing and immediate need to regulate the profession of athletic training because the absence of regulation puts California businesses, colleges, universities, and other organizations at risk of liability solely because of the unlicensed status of athletic trainers in the state.

SEC. 2. Chapter 5.8 (commencing with Section 2697) is added to Division 2 of the Business and Professions Code, to read:

CHAPTER 5.8. Athletic Trainers
Article 1. Administration

2697. This chapter shall be known, and may be cited, as the Athletic Training Practice Act.

2697.1. For the purposes of this chapter, the following definitions apply:

(a) "Athletic trainer" means a person who meets the requirements of this chapter, is licensed by the committee, and practices under the direction of a licensed physician or surgeon.

(b) "Board" means the California Board of Occupational Therapy.

(c) "Committee" means the Athletic Trainer Licensing Committee.

(d) "Director" means the Director of Consumer Affairs.

2697.2. (a) There is established the Athletic Trainer Licensing Committee within the California Board of Occupational Therapy. The committee shall consist of seven members.

(b) The seven committee members shall include the following: (a+b) OF SECTION 2697.4 & 2697.5

(1) Four licensed athletic trainers. Initially, the committee shall include four athletic trainers who have graduated from a professional degree program described in subdivision (a) of Section 2697.5 prior to approval by the committee and who will satisfy the remainder of the licensure requirements, including submission of an application, described in Section 2697.5 as soon as it is practically possible.

(2) One public member.

(3) One physician and surgeon licensed by the Medical Board of California or one osteopathic physician and

surgeon licensed by the Osteopathic Medical Board of California.

(4) One occupational therapist licensed by the board.

(c) Subject to confirmation by the Senate, the Governor shall appoint two of the licensed athletic trainers, the public member, the physician and surgeon or osteopathic physician and surgeon, and the licensed occupational therapist. The Senate Committee on Rules and the Speaker of the Assembly shall each appoint a licensed athletic trainer.

(d) (1) All appointments are for a term of four years and shall expire on June 30 of the year in which the term expires. Vacancies shall be filled for any unexpired term.

(2) Notwithstanding paragraph (1), for initial appointments to the committee, the public member appointed by the Governor and two of the athletic trainers shall serve terms of two years, and the remaining members shall serve terms of four years.

(e) Each member of the committee shall receive per diem and expenses as provided in Section 103.

2697.3. (a) (1) The committee shall adopt, repeal, and amend regulations as may be necessary to enable it to administer this chapter. All regulations shall be in accordance with this chapter.

(2) Before adopting regulations, the committee may consult the professional standards issued by the National Athletic Trainers Association, the Board of Certification, Inc., the Commission on Accreditation of Athletic Training Education, or any other nationally recognized professional athletic training organization.

(b) The committee shall approve programs for the education and training of athletic trainers.

(c) The committee shall investigate each applicant, before a license is issued, in order to determine whether the applicant meets the qualifications required by this chapter.

(d) Protection of the public shall be the highest priority for the committee in exercising its licensing, regulatory, and disciplinary functions. Whenever the protection of the public is inconsistent with other interests sought to be promoted, the protection of the public shall be paramount.

2697.4. Except as otherwise provided in this chapter, the committee shall issue an athletic training license to an applicant who meets all of the following requirements:

(a) ~~Has submitted an application developed by the committee that includes~~ FURNISHES evidence that the applicant has graduated from a professional degree program in athletic training accredited by the Commission on Accreditation of Athletic Training Education, or its predecessors or successors, and approved by the committee, at an accredited postsecondary institution or institutions approved by the committee. The professional degree program shall consist of didactic, clinical, and research experiences in athletic training using critical thinking and weighing of evidence.

(b) Has passed an athletic training certification examination offered by the Board of Certification, Inc., its predecessors or successors, or another nationally accredited athletic trainer certification agency approved and recognized by the committee.

REMOVE SECTION (c) Possesses a certificate in Cardio Pulmonary Resuscitation (CPR) and Automated External Defibrillator (AED) for professional rescuers and health care providers from a certification body, approved by the committee, that adheres to the most current international guidelines for cardiopulmonary resuscitation and emergency cardiac care.

(C) FINGERPRINT LANGUAGE

(d) Has paid the application fee established by the committee.

2697.5. Notwithstanding Section 2697.4, the committee shall issue an athletic training license to an applicant who did not graduate from an accredited athletic training education program described in subdivision (a) of Section 2697.4, but who received athletic training via an internship, if the applicant meets all of the following

requirements:

(a) Furnishes evidence satisfactory to the committee of completion of a degree at an accredited postsecondary institution that included instruction in basic sciences related to, and on the practice of, athletic training.

(b) Passes the examination described in subdivision (b) of Section 2697.4.

(c) Completes at least 1,500 hours of clinical experience under an athletic trainer certified by a certification agency described in subdivision (b) of Section 2697.4.

REMOVE SECTION (d) Possesses a certificate in CPR and AED for professional rescuers and health care providers from a certification body, approved by the committee, that adheres to the most current international guidelines for cardiopulmonary resuscitation and emergency cardiac care.

(d) FINGERPRINT LANGUAGE

(e) Has paid the application fee established by the committee.

2697.6. A license issued by the committee pursuant to Section 2697.4 or 2697.5 is valid for two years and thereafter is subject to the renewal requirements described in Sections 2697.7 and 2697.8.

2697.7. The committee shall establish license application and renewal fees in an amount sufficient to cover the reasonable regulatory costs of administering this chapter.

2697.8. The committee shall renew a license if an applicant meets all of the following requirements:

(a) Pays the renewal fee as established by the committee.

(b) Submits proof of all of the following:

(1) Satisfactory completion of continuing education, as determined by the committee.

(2) Current athletic training certification from a certification body approved by the committee, including, but not limited to, the Board of Certification, Inc., or its predecessors or successors.

REMOVE SUBMITTALS (3) Current certification described in subdivision (c) of Section 2697.4.

2697.9. (a) The committee may deny a license or the renewal of a license for an applicant or licensee who is described by any of the following:

(1) Does not meet the requirements of this chapter.

(2) Has had an athletic training license, certification, or registration revoked or suspended by an accredited organization, state, or territory.

(3) Has been convicted of a felony or any other crime that substantially relates to the functions or duties of an athletic trainer.

(4) Has committed unprofessional conduct, as described in subdivision (b).

(b) The committee may order any of the following actions relative to an athletic training license after a hearing for unprofessional conduct, which includes, but is not limited to, a violation of this chapter, any regulation adopted by the committee pursuant to this chapter, and revocation or suspension of an athletic training license, certification, or registration by an accredited organization, state, or territory:

(1) Issuance of the athletic training license subject to terms and conditions.

(2) Suspension or revocation of the athletic training license.

(3) Imposition of probationary conditions upon the athletic training license.

Article 2. Athletic Training

2697.10. (a) A person shall not engage in the practice of athletic training unless licensed pursuant to this chapter.

(b) A person shall not use the title "athletic trainer," "licensed athletic trainer," "certified athletic trainer," "athletic trainer certified," "a.t.," "a.t.l.," "c.a.t.," "a.t.c.," or any other variation of these terms, or any other similar terms indicating that the person is an athletic trainer unless that person is licensed pursuant to this chapter.

(c) Notwithstanding subdivisions (a) and (b), a person who practiced athletic training in California for a period of 20 consecutive years prior to July 1, 2018, and is not eligible on that date for an athletic training license may engage in the practice of athletic training and use the title "athletic trainer" without being licensed by the committee, upon registration with the committee. However, on and after January 1, 2021, a person shall not engage in the practice of athletic training or use the title "athletic trainer" unless he or she is licensed by the committee pursuant to this chapter.

2697.11. (a) The practice of athletic training includes all of the following:

(1) Risk management and injury or illness prevention.

(2) The clinical evaluation and assessment of an injury sustained or exacerbated while participating in physical activity. OR A CONDITION EXACERBATED WHILE PARTICIPATING IN PHYSICAL ACTIVITY

(3) The immediate care of an injury sustained or exacerbated while participating in physical activity or a condition exacerbated while participating in physical activity.

(4) The rehabilitation and reconditioning from an injury ~~or an illness~~ sustained or exacerbated while participating in physical activity.

(b) The practice of athletic training does not include grade 5 spinal manipulations.

(c) An athletic trainer shall refer a patient to an appropriate licensed health care provider when the ~~treatment or~~ management of the injury or condition does not fall within the practice of athletic training.

(d) An athletic trainer shall not provide, offer to provide, or represent that he or she is qualified to provide any treatment that he or she is not qualified to perform by his or her education, training, ~~or experience~~, or that he or she is otherwise prohibited by law from performing. SCOPE OF OR

(e) (1) For purposes of this section, "injury" means an injury sustained as a result of, or exacerbated by, participation in athletics or physical activity for which the athletic trainer has had formal training during his or her professional education program or advanced postprofessional study and falls within the practice of athletic training.

(2) For purposes of this section, "condition" means a condition acutely exacerbated while participating in athletics or physical activity for which the athletic trainer has had formal training during his or her professional education program or advanced postprofessional study and falls within the practice of athletic training.

2697.12. (a) An athletic trainer shall render treatment within his or her scope of practice under the direction of a physician and surgeon licensed by the Medical Board of California or an osteopathic physician and surgeon licensed by the Osteopathic Medical Board of California. This direction shall be provided by verbal or written order by the directing physician and surgeon or osteopathic physician and surgeon or by athletic training treatment plans or protocols established by the physician and surgeon or osteopathic physician and surgeon.

(b) Notwithstanding any other law, and consistent with this chapter, the committee may establish other alternative mechanisms for the adequate direction of an athletic trainer.

2697.13. The requirements of this chapter do not apply to the following:

(a) An athletic trainer licensed, certified, or registered in another state or country who is in California temporarily, traveling with a team or organization, to engage in the practice of athletic training for, among other things, an athletic or sporting event.

OR COUNTRY

(b) An athletic trainer licensed, certified, or registered in another state who is invited by a sponsoring organization, such as the United States Olympic Committee, to temporarily provide athletic training services under his or her state's scope of practice for athletic training.

(c) A student enrolled in an athletic training education program, while participating in educational activities during the course of his or her educational rotations under the supervision and guidance of an athletic trainer licensed under this chapter, a physician and surgeon licensed by the Medical Board of California, an osteopathic physician and surgeon licensed by the Osteopathic Medical Board of California, or other licensed health care provider.

(d) A member or employee of the United States Armed Forces, licensed, certified, or registered in another state, as part of his or her temporary federal deployment or employment in California for a limited time.

2697.14. This chapter does not limit, impair, or otherwise apply to the practice of any person licensed and regulated under any other chapter of Division 2 (commencing with Section 500).

2697.15. This chapter does not require new or additional third-party reimbursement for services rendered by an individual licensed under this chapter.

Article 3. Athletic Trainers' Fund

2697.16. The Athletic Trainers' Fund is hereby established. All fees collected pursuant to this chapter shall be paid into the fund. These fees shall be available to the committee, upon appropriation by the Legislature, for the regulatory purpose of implementing this chapter.

2697.17. (a) Notwithstanding any other law, including Section 11005 of the Government Code, the Director of Consumer Affairs may seek and receive funds from the California Athletic Trainers Association for the initial costs of implementing this chapter.

AS A LOAN

(b) Articles 1 (commencing with Section 2697) and 2 (commencing with Section 2697.10) shall not become operative unless the director determines, on or before January 1, 2019, that sufficient funds to pay for the initial costs of this chapter have been received from the California Athletic Trainers Association, or some other source of funding, and the funds are deposited in the Athletic Trainers' Fund, in which case Article 1 shall become operative on the first January 1 or July 1, whichever occurs first, immediately following this determination. Article 2 shall become operative on the first January 1 or July 1, whichever occurs first, immediately following the operative date of Article 1. If the director finds that sufficient funds are not available by January 1, 2019, the director shall reexamine the funding status by June 30 of each subsequent year until either the director determines that sufficient funds have been received and deposited or until January 1, 2021, whichever occurs first.

(c) The director shall provide written notification to the Legislature and the Governor when the determination described in subdivision (b) has been made, and shall concurrently post a notice on the Department of Consumer Affairs Internet Web site that the determination has been made.

(d) A failure of the director to comply with subdivision (c) shall not affect the validity of a determination made pursuant to subdivision (b).

2697.18. This chapter shall remain in effect only until January 1, 2025, and as of that date is repealed, UNLESS SUBSEQUENT STATUTE IS ENACTED BEFORE THAT DATE THAT DELETES OR EXTENDS THAT DATE.

AB-1510 Athletic trainers. (2017-2018)

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Existing law provides for the regulation of various professions and vocations, including those of an athlete agent.

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The bill would also establish the **Athletic Trainers**' Fund for the deposit of license application and renewal fees, and would make those fees available to the committee for the purpose of implementing these provisions upon appropriation by the Legislature. The bill would authorize the Director of Consumer Affairs to seek and receive donations from the California **Athletic Trainers** Association for purposes of obtaining funds for the startup costs of implementing the act. The bill would require the director to determine that sufficient funds for that purpose have been obtained and to provide notice to the Legislature, the Governor, and on the department's Internet Web site of the determination, as specified. This bill would repeal these provisions on January 1, 2025.

Vote: majority Appropriation: no Fiscal Committee: yes Local Program: no

THE PEOPLE OF THE STATE OF CALIFORNIA DO ENACT AS FOLLOWS:

SECTION 1. The Legislature finds and declares the following:

(a) California is one of only two states that does not currently regulate the practice of athletic training. This lack of regulation creates the risk that individuals who have lost or are unable to obtain licensure in another state will come to California to practice, thereby putting the public in danger and degrading the standards of the profession as a whole.

(b) There is a pressing and immediate need to regulate the profession of athletic training in order to protect the public health, safety, and welfare. This need is particularly important because **athletic trainers** often work with schoolage children.

(c) There is also a pressing and immediate need to regulate the profession of athletic training because the absence of regulation puts California businesses, colleges, universities, and other organizations at risk of liability solely because of the unlicensed status of **athletic trainers** in the state.

SEC. 2. Chapter 5.8 (commencing with Section 2697) is added to Division 2 of the Business and Professions Code, to read:

CHAPTER 5.8. Athletic Trainers
Article 1. Administration

2697. This chapter shall be known, and may be cited, as the Athletic Training Practice Act.

2697.1. For the purposes of this chapter, the following definitions apply:

(a) "**Athletic trainer**" means a person who meets the requirements of this chapter, is licensed by the committee, and practices under the direction of a licensed physician or surgeon.

(b) "Board" means the California Board of Occupational Therapy.

(c) "Committee" means the **Athletic Trainer** Licensing Committee.

(d) "Director" means the Director of Consumer Affairs.

2697.2. (a) There is established the **Athletic Trainer** Licensing Committee within the California Board of Occupational Therapy. The committee shall consist of seven members.

(b) The seven committee members shall include the following:

(1) Four licensed **athletic trainers**. Initially, the committee shall include four **athletic trainers** who have graduated from a professional degree program described in subdivision (a) of Section 2697.5 prior to approval by the committee and who will satisfy the remainder of the licensure requirements, including submission of an application, described in Section 2697.5 as soon as it is practically possible.

(2) One public member.

(3) One physician and surgeon licensed by the Medical Board of California or one osteopathic physician and surgeon licensed by the Osteopathic Medical Board of California.

(4) One occupational therapist licensed by the board.

(c) Subject to confirmation by the Senate, the Governor shall appoint two of the licensed **athletic trainers**, the public member, the physician and surgeon or osteopathic physician and surgeon, and the licensed occupational therapist. The Senate Committee on Rules and the Speaker of the Assembly shall each appoint a licensed **athletic trainer**.

(d) (1) All appointments are for a term of four years and shall expire on June 30 of the year in which the term expires. Vacancies shall be filled for any unexpired term.

(2) Notwithstanding paragraph (1), for initial appointments to the committee, the public member appointed by the Governor and two of the **athletic trainers** shall serve terms of two years, and the remaining members shall

serve terms of four years.

(e) Each member of the committee shall receive per diem and expenses as provided in Section 103.

2697.3. (a) (1) The committee shall adopt, repeal, and amend regulations as may be necessary to enable it to administer this chapter. All regulations shall be in accordance with this chapter.

(2) Before adopting regulations, the committee may consult the professional standards issued by the National **Athletic Trainers** Association, the Board of Certification, Inc., the Commission on Accreditation of Athletic Training Education, or any other nationally recognized professional athletic training organization.

(b) The committee shall approve programs for the education and training of **athletic trainers**.

(c) The committee shall investigate each applicant, before a license is issued, in order to determine whether the applicant meets the qualifications required by this chapter.

(d) Protection of the public shall be the highest priority for the committee in exercising its licensing, regulatory, and disciplinary functions. Whenever the protection of the public is inconsistent with other interests sought to be promoted, the protection of the public shall be paramount.

2697.4. Except as otherwise provided in this chapter, the committee shall issue an athletic training license to an applicant who meets all of the following requirements:

(a) Has submitted an application developed by the committee that includes evidence that the applicant has graduated from a professional degree program in athletic training accredited by the Commission on Accreditation of Athletic Training Education, or its predecessors or successors, and approved by the committee, at an accredited postsecondary institution or institutions approved by the committee. The professional degree program shall consist of didactic, clinical, and research experiences in athletic training using critical thinking and weighing of evidence.

(b) Has passed an athletic training certification examination offered by the Board of Certification, Inc., its predecessors or successors, or another nationally accredited **athletic trainer** certification agency approved and recognized by the committee.

(c) Possesses a certificate in Cardio Pulmonary Resuscitation (CPR) and Automated External Defibrillator (AED) for professional rescuers and health care providers from a certification body, approved by the committee, that adheres to the most current international guidelines for cardiopulmonary resuscitation and emergency cardiac care.

(d) Has paid the application fee established by the committee.

2697.5. Notwithstanding Section 2697.4, the committee shall issue an athletic training license to an applicant who did not graduate from an accredited athletic training education program described in subdivision (a) of Section 2697.4, but who received athletic training via an internship, if the applicant meets all of the following requirements:

(a) Furnishes evidence satisfactory to the committee of completion of a degree at an accredited postsecondary institution that included instruction in basic sciences related to, and on the practice of, athletic training.

(b) Passes the examination described in subdivision (b) of Section 2697.4.

(c) Completes at least 1,500 hours of clinical experience under an **athletic trainer** certified by a certification agency described in subdivision (b) of Section 2697.4.

(d) Possesses a certificate in CPR and AED for professional rescuers and health care providers from a certification body, approved by the committee, that adheres to the most current international guidelines for cardiopulmonary resuscitation and emergency cardiac care.

(e) Has paid the application fee established by the committee.

2697.6. A license issued by the committee pursuant to Section 2697.4 or 2697.5 is valid for two years and thereafter is subject to the renewal requirements described in Sections 2697.7 and 2697.8.

2697.7. The committee shall establish license application and renewal fees in an amount sufficient to cover the reasonable regulatory costs of administering this chapter.

2697.8. The committee shall renew a license if an applicant meets all of the following requirements:

(a) Pays the renewal fee as established by the committee.

(b) Submits proof of all of the following:

(1) Satisfactory completion of continuing education, as determined by the committee.

(2) Current athletic training certification from a certification body approved by the committee, including, but not limited to, the Board of Certification, Inc., or its predecessors or successors.

(3) Current certification described in subdivision (c) of Section 2697.4.

2697.9. (a) The committee may deny a license or the renewal of a license for an applicant or licensee who is described by any of the following:

(1) Does not meet the requirements of this chapter.

(2) Has had an athletic training license, certification, or registration revoked or suspended by an accredited organization, state, or territory.

(3) Has been convicted of a felony or any other crime that substantially relates to the functions or duties of an **athletic trainer**.

(4) Has committed unprofessional conduct, as described in subdivision (b).

(b) The committee may order any of the following actions relative to an athletic training license after a hearing for unprofessional conduct, which includes, but is not limited to, a violation of this chapter, any regulation adopted by the committee pursuant to this chapter, and revocation or suspension of an athletic training license, certification, or registration by an accredited organization, state, or territory:

(1) Issuance of the athletic training license subject to terms and conditions.

(2) Suspension or revocation of the athletic training license.

(3) Imposition of probationary conditions upon the athletic training license.

Article 2. Athletic Training

2697.10. (a) A person shall not engage in the practice of athletic training unless licensed pursuant to this chapter.

(b) A person shall not use the title "**athletic trainer**," "licensed **athletic trainer**," "certified **athletic trainer**," "**athletic trainer** certified," "a.t.," "a.t.l.," "c.a.t.," "a.t.c.," or any other variation of these terms, or any other similar terms indicating that the person is an **athletic trainer** unless that person is licensed pursuant to this chapter.

(c) Notwithstanding subdivisions (a) and (b), a person who practiced athletic training in California for a period of 20 consecutive years prior to July 1, 2018, and is not eligible on that date for an athletic training license may engage in the practice of athletic training and use the title "**athletic trainer**" without being licensed by the committee, upon registration with the committee. However, on and after January 1, 2021, a person shall not engage in the practice of athletic training or use the title "**athletic trainer**" unless he or she is licensed by the committee pursuant to this chapter.

2697.11. (a) The practice of athletic training includes all of the following:

(1) Risk management and injury or illness prevention.

(2) The clinical evaluation and assessment of an injury sustained or exacerbated while participating in physical activity.

(3) The immediate care of an injury sustained or exacerbated while participating in physical activity or a condition exacerbated while participating in physical activity.

(4) The rehabilitation and reconditioning from an injury or an illness sustained or exacerbated while participating in physical activity.

(b) The practice of athletic training does not include grade 5 spinal manipulations.

(c) An **athletic trainer** shall refer a patient to an appropriate licensed health care provider when the treatment or management of the injury or condition does not fall within the practice of athletic training.

(d) An **athletic trainer** shall not provide, offer to provide, or represent that he or she is qualified to provide any treatment that he or she is not qualified to perform by his or her education, training, or experience, or that he or she is otherwise prohibited by law from performing.

(e) (1) For purposes of this section, "Injury" means an injury sustained as a result of, or exacerbated by, participation in athletics or physical activity for which the **athletic trainer** has had formal training during his or her professional education program or advanced postprofessional study and falls within the practice of athletic training.

(2) For purposes of this section, "condition" means a condition acutely exacerbated while participating in athletics or physical activity for which the **athletic trainer** has had formal training during his or her professional education program or advanced postprofessional study and falls within the practice of athletic training.

2697.12. (a) An **athletic trainer** shall render treatment within his or her scope of practice under the direction of a physician and surgeon licensed by the Medical Board of California or an osteopathic physician and surgeon licensed by the Osteopathic Medical Board of California. This direction shall be provided by verbal or written order by the directing physician and surgeon or osteopathic physician and surgeon or by athletic training treatment plans or protocols established by the physician and surgeon or osteopathic physician and surgeon.

(b) Notwithstanding any other law, and consistent with this chapter, the committee may establish other alternative mechanisms for the adequate direction of an athletic trainer.

2697.13. The requirements of this chapter do not apply to the following:

(a) An **athletic trainer** licensed, certified, or registered in another state or country who is in California temporarily, traveling with a team or organization, to engage in the practice of athletic training for, among other things, an athletic or sporting event.

(b) An **athletic trainer** licensed, certified, or registered in another state who is invited by a sponsoring organization, such as the United States Olympic Committee, to temporarily provide athletic training services under his or her state's scope of practice for athletic training.

(c) A student enrolled in an athletic training education program, while participating in educational activities during the course of his or her educational rotations under the supervision and guidance of an **athletic trainer** licensed under this chapter, a physician and surgeon licensed by the Medical Board of California, an osteopathic physician and surgeon licensed by the Osteopathic Medical Board of California, or other licensed health care provider.

(d) A member or employee of the United States Armed Forces, licensed, certified, or registered in another state, as part of his or her temporary federal deployment or employment in California for a limited time.

2697.14. This chapter does not limit, impair, or otherwise apply to the practice of any person licensed and regulated under any other chapter of Division 2 (commencing with Section 500).

2697.15. This chapter does not require new or additional third-party reimbursement for services rendered by an individual licensed under this chapter.

Article 3. Athletic Trainers' Fund

2697.16. The **Athletic Trainers'** Fund is hereby established. All fees collected pursuant to this chapter shall be paid into the fund. These fees shall be available to the committee, upon appropriation by the Legislature, for the regulatory purpose of implementing this chapter.

2697.17. (a) Notwithstanding any other law, including Section 11005 of the Government Code, the Director of Consumer Affairs may seek and receive funds from the California **Athletic Trainers** Association for the initial

costs of implementing this chapter.

(b) Articles 1 (commencing with Section 2697) and 2 (commencing with Section 2697.10) shall not become operative unless the director determines, on or before January 1, 2019, that sufficient funds to pay for the initial costs of this chapter have been received from the California **Athletic Trainers** Association, or some other source of funding, and the funds are deposited in the **Athletic Trainers'** Fund, in which case Article 1 shall become operative on the first January 1 or July 1, whichever occurs first, immediately following this determination. Article 2 shall become operative on the first January 1 or July 1, whichever occurs first, immediately following the operative date of Article 1. If the director finds that sufficient funds are not available by January 1, 2019, the director shall reexamine the funding status by June 30 of each subsequent year until either the director determines that sufficient funds have been received and deposited or until January 1, 2021, whichever occurs first.

(c) The director shall provide written notification to the Legislature and the Governor when the determination described in subdivision (b) has been made, and shall concurrently post a notice on the Department of Consumer Affairs Internet Web site that the determination has been made.

(d) A failure of the director to comply with subdivision (c) shall not affect the validity of a determination made pursuant to subdivision (b).

2697.18. This chapter shall remain in effect only until January 1, 2025, and as of that date is repealed.

State	Regulating Agency	Gov Body Type	Board/Dept Regulating Agency It Falls Under (if not autonomous)
Alabama	Board of Athletic Trainers	AT Board	
Alaska	Division of Corporations, Business and Professional Licensing		
Arizona	Arizona Board of Athletic Training	AT Board	
Arkansas	Arkansas State Board of Athletic Training	AT Board	
California			
Colorado	Department of Regulatory Agencies, Division of Registration and Occupations	Admin Agency	Department of Regulatory Agencies, Division of Registrations
Connecticut	CT Department of Public Health	Admin Agency	Connecticut Department of Public Health
Delaware	Examining Board of Physical Therapy & Athletic Trainers	AT/PT Board	Division of Professional Regulation
DC			
Florida	Department of Health Board of Athletic Trainers	AT Board	Department of Health
Georgia	Georgia Board of Athletic Trainers	AT Board	
Hawaii	State of Hawaii	Admin Agency	Professional and Vocational Licensing
Idaho	State Board of Medicine	AT Board	BOM
Illinois	Illinois Department of Professional Regulation	AT Board	Illinois Department of Professional Regulation
Indiana	Professional Licensing Agency	AT Board	Indiana Professional Licensing Agency
Iowa	Iowa Board of Athletic Training	AT Board	Bureau of Professional Licensure
Kansas	State Board of Healing Arts	Advisory Group	State Board of Healing Arts
Kentucky	Kentucky Board of Medical Licensure	Advisory Group	BOM
Louisiana	State Board of Medical Examiners	Advisory Group	BOM
Maine	Athletic Trainer Program	Admin Agency	Office of Professional and Occupational Regulation
Maryland	Maryland Board of Physicians	Advisory Group	BOM
Massachusetts	Division of Professional Licensure	Other	Consumer Affairs & Business Regulation Board of Allied Health Professions

Michigan	Bureau of Professional Licensing	AT Board	Bureau of Health Professions
Minnesota	MN Board of Medical Practice	Advisory Group	BOM
Mississippi	Mississippi State Department of Health	Admin Agency	State Department of Health
Missouri	State of Missouri	Advisory Group	Board of Registration for the Healing Arts
Montana	Montana Board of Athletic Trainers	AT Board	Department of Labor & Industry - Business Standards
Nebraska	DHHS	AT Board	Dept. of HHS Regulation & Licensure
Nevada	Nevada State Board of Athletic Trainers	AT Board	
New Hampshire	Office of Allied Health Professionals	AT Board	Office of Allied Health Professionals
New Jersey	NJ State Board of Medical Examiners	Advisory Group	Division of Consumer Affairs
New Mexico	New Mexico Athletic Trainers Practice Board	AT Board	Regulation & Licensing Dept
New York	Office of the Professions-AT Unit	Advisory Group	Office of the Professions
North Carolina	N.C. Board of Athletic Training Examiners	AT Board	
North Dakota	North Dakota Board of Athletic Trainers	AT Board	
Ohio	Athletic Trainers Section	AT/PT/OT Board	
Oklahoma	State Board of Medical Licensure and Supervision	Advisory Group	BOM
Oregon	Oregon Health Licensing Agency	AT Board	Health Licensing Agency
Pennsylvania	State Board of Medicine	Other	BOM
Rhode Island	RI Department of Health	AT Board	Department of Health
South Carolina	SC Department of Health and Environmental Control	Advisory Committee	Department of Health and Environmental Control - Division of EMS and Trauma
South Dakota	SD Board of Medical & Osteopathic Examiners		BOM
Tennessee	Tennessee Board of Athletic Trainers	AT Board	Department of Health
Texas	Texas Department of Licensing and Regulation	Advisory Board	Professional Licensing and Certification Unit

Utah	Utah Division of Occupational & Professional Licensing	AT Board	Division of Occupational & Professional Licensing
Vermont	Vermont Secretary of State	Advisory Group	Office of Professional Regulation
Virginia	Virginia Board of Medicine	Advisory Board	BOM
Washington	Health Systems Quality Assurance	Advisory Committee	Health Systems Quality Assurance
West Virginia	WV Board of Physical Therapy	Other	West Virginia Board of Physical Therapy
Wisconsin	Department of Regulation & Licensing	AT Board	Department of Safety and Professional Services - Division of Professional Credentialing
Wyoming	WY Board of Athletic Training	AT Board	Wyoming State Board of Athletic Training

Athletic Training Education Competencies

5th Edition

Table of Contents

Preface

The 5th edition of the Athletic Training Education Competencies (Competencies) provides educational program personnel and others with the knowledge, skills, and clinical abilities to be mastered by students enrolled in professional athletic training education programs. Mastery of these Competencies provides the entry–level athletic trainer with the capacity to provide athletic training services to clients and patients of varying ages, lifestyles, and needs.

The Commission on Accreditation of Athletic Training Education (CAATE) requires that the Competencies be instructed and evaluated in each accredited professional athletic training education program. The Competencies serve as a companion document to the accreditation standards, which identify the requirements to acquire and maintain accreditation, published by CAATE.

The Professional Education Council (PEC) of the NATA was charged with creating the 5th edition of the Competencies. The PEC developed and executed a systematic plan to draft the Competencies and to solicit and integrate feedback from multiple sources as the draft was revised. First, the PEC orchestrated an initial open call for feedback on the 4th edition of the Competencies. Next, groups of subject-matter experts, including practicing athletic trainers, educators, and administrators, were identified. In addition to the feedback on the 4th edition, these subject-matter experts considered today's healthcare system, current best practice in athletic training, and their own expertise in creating an initial draft of the 5th edition. Many conversations ensued and subsequent drafts were submitted. Following revision for form and consistency of language, a draft of the Competencies was again posted for open feedback. This valuable feedback was considered in its entirety by the PEC, and final revisions were made.

We thank the members of the PEC for their untiring efforts in revising this document to reflect the changing needs of athletic training education. The advice, cooperation, and feedback from the Board of Certification and the CAATE have also been instrumental in this process. Finally, the diligent and perceptive feedback that was received from stakeholders during the public comment periods was instrumental in creating a document that ensures that entry-level athletic trainers are prepared to work in a changing healthcare system. Together we are improving healthcare by improving the education of athletic trainers.

— NATA Executive Committee for Education, December 2010

Introduction

This document is to be used as a guide by administrative, academic, and clinical program personnel when structuring all facets of the education experience for students. Educational program personnel should recognize that the Competencies are the ***minimum requirements*** for a student's professional education. Athletic training education programs are encouraged to exceed these minimums to provide their students with the highest quality education possible. In addition, programs should employ innovative, student-centered teaching and learning methodologies to connect the classroom, laboratory and clinical settings whenever possible to further enhance professional preparation.

The acquisition and clinical application of knowledge and skills in an education program must represent a defined yet flexible program of study. Defined in that knowledge and skills must be accounted for in the more formal classroom and laboratory educational experience. Flexible in that learning opportunities are everywhere. Behaviors are identified, discussed, and practiced throughout the educational program. Whatever the sequence of learning, patient safety is of prime importance; students must demonstrate competency in a particular task before using it on a patient. This begins a cycle of learning, feedback, refinement, and more advanced learning. Practice with concepts by gaining clinical experience with real life applications readies the student for opportunities to demonstrate decision-making and skill integration ability, Clinical Integrated Proficiencies (CIP). CIPs are designed to measure of real life application. Students should be assessed in their performance of CIPs on actual patients. If this is not possible, standardized/simulated patients or scenarios should be used to measure student proficiency.

Also, inherent in this document is the understanding that a comprehensive basic and applied science background is needed for students to develop appropriate levels of professional competence in the discipline-specific knowledge and skills described in this document.

All facets of the educational programs must incorporate current knowledge and skills that represent best practice. Programs must select such content following careful review of the research literature and consideration of the needs for today's entry-level practitioner. Because the knowledge within a profession is dynamic, information regarding current best practice is fluid and requires on-going examination and reflection.

Summary of Major Changes included in 5th Edition

- The 12 content areas of the previous edition have been reorganized into 8 to eliminate redundancies and better reflect current practice.
  - The pathology content area was eliminated, and these competencies are addressed throughout other content areas.
  - The risk management/prevention and nutritional considerations content areas were combined to form the new **Prevention and Health Promotion (PHP)** content area. This change was made to reflect the current emphasis on prevention and wellness across health care and the lifespan.
  - The orthopedic clinical exam/diagnosis and medical conditions/disabilities content areas were combined to form the **Clinical Examination and Diagnosis (CE)** content area. This change was made to emphasize that athletic trainers use one standard clinical examination model that changes based on the findings and needs of the patient.
  - The therapeutic modalities, conditioning and rehabilitative exercise and pharmacology content areas were combined to form one content area that incorporates all aspects of **Therapeutic Interventions (TI)**.
  - A new content area was added to provide students with the basic knowledge and skills related to **Evidence-Based Practice (EBP).** The importance of using EBP concepts and principles to improve patient outcomes is being emphasized throughout the health care system and is reflected within this new content area.
- The **Acute Care (AC)** content area has been substantially revised to reflect contemporary practice.
  - The addition of skill in assessing rectal temperature, oxygen saturation, blood glucose levels, and use of a nebulizer and oropharyngeal and nasopharyngeal airways reflects recommendations of NATA position statements that are published or in development.
- The content areas now integrate knowledge and skills, instead of separate sections for cognitive and psychomotor competencies. The action verb used in each competency statement identifies the expected outcome. In some places, knowledge is the expectation and not skill acquisition. For example, acute care competency #9 (AC-9) requires that athletic training students be knowledgeable about the various types of airway adjuncts including oropharyngeal airways (OPA), nasopharyngeal airways (NPO) and supraglottic airways. However, the accompanying skill competency AC-10 does not require skill acquisition in the use of the supraglottic airways.
- The **Clinical Integration Proficiencies (CIP)**, which are ideally assessed in the context of real patient care, have been removed from the individual content areas and reorganized into a separate section. This reorganization reflects clinical practice and demonstrates the global nature of the Proficiencies. For example, rather than just assessing students' ability to examine a real patient in a real clinical setting, the new CIPs require that students demonstrate the ability to examine and diagnose a patient, provide appropriate acute/emergent care, plan and implement appropriate therapeutic interventions, and make decisions pertaining to safe return to participation. This approach to student assessment better reflects the comprehensive nature of real patient care.

Comparison of the Role Delineation Study/Practice Analysis, 6th Ed and the Competencies

The Role Delineation Study/Practice Analysis, 6th ed (RDS/PA) of the Board of Certification serves as the blue print for the certification examination. As such, the Competencies must include all tasks (and related knowledge and skills) included in the RDS/PA. Working with the BOC, we compared the RDS/PA with this version of the Competencies and can confidently state that the content of the RDS /PA is incorporated in this version.

5th Edition Competencies – Project Team Members

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Foundational Behaviors of Professional Practice

These basic behaviors permeate professional practice and should be incorporated into instruction and assessed throughout the educational program.

Primacy of the Patient

- Recognize sources of conflict of interest that can impact the client's/patient's health.
- Know and apply the commonly accepted standards for patient confidentiality.
- Provide the best healthcare available for the client/patient.
- Advocate for the needs of the client/patient.

Team Approach to Practice

- Recognize the unique skills and abilities of other healthcare professionals.
- Understand the scope of practice of other healthcare professionals.
- Execute duties within the identified scope of practice for athletic trainers.
- Include the patient (and family, where appropriate) in the decision-making process.
- Work with others in effecting positive patient outcomes.

Legal Practice

- Practice athletic training in a legally competent manner.
- Identify and conform to the laws that govern athletic training.
- Understand the consequences of violating the laws that govern athletic training.

Ethical Practice

- Comply with the NATA's *Code of Ethics* and the BOC's *Standards of Professional Practice.*
- Understand the consequences of violating the NATA's *Code of Ethics* and BOC's *Standards of Professional Practice.*
- Comply with other codes of ethics, as applicable.

Advancing Knowledge

- Critically examine the body of knowledge in athletic training and related fields.
- Use evidence-based practice as a foundation for the delivery of care.
- Appreciate the connection between continuing education and the improvement of athletic training practice.
- Promote the value of research and scholarship in athletic training.
- Disseminate new knowledge in athletic training to fellow athletic trainers, clients/patients, other healthcare professionals, and others as necessary.

Cultural Competence

- Demonstrate awareness of the impact that clients'/patients' cultural differences have on their attitudes and behaviors toward healthcare.
- Demonstrate knowledge, attitudes, behaviors, and skills necessary to achieve optimal health outcomes for diverse patient populations.
- Work respectfully and effectively with diverse populations and in a diverse work environment.

Professionalism

- Advocate for the profession.
- Demonstrate honesty and integrity.
- Exhibit compassion and empathy.
- Demonstrate effective interpersonal communication skills.

Evidence-Based Practice (EBP)

Evidence-based practitioners incorporate the best available evidence, their clinical skills, and the needs of the patient to maximize patient outcomes. An understanding of evidence-based practice concepts and their application is essential to sound clinical decision-making and the critical examination of athletic training practice.

Practicing in an evidence-based manner should not be confused with conducting research. While conducting research is important to the profession of athletic training, developing the ability to conduct a research project is not an expectation of professional education. This section focuses on the knowledge and skills necessary for entry-level athletic trainers to use a systematic approach to ask and answer clinically relevant questions that affect patient care by using review and application of existing research evidence. One strategy, among others, is to use a five-step approach: 1) creating a clinically relevant question; 2) searching for the best evidence; 3) critically analyzing the evidence; 4) integrating the appraisal with personal clinical expertise and patients' preferences; and 5) evaluating the performance or outcomes of the actions. Each competency listed below is related to such a systematic approach and provides the building blocks for employing evidence-based practice. Other specific evidence-based practice competencies have also been included in appropriate content areas.

All items listed in parentheses (eg) are intended to serve as examples and are not all encompassing or the only way to satisfy the competency.

Knowledge and Skills

EBP-1. Define evidence-based practice as it relates to athletic training clinical practice.

EBP-2. Explain the role of evidence in the clinical decision making process.

EBP-3. Describe and differentiate the types of quantitative and qualitative research, research components, and levels of research evidence.

EBP-4. Describe a systematic approach (eg, five step approach) to create and answer a clinical question through review and application of existing research.

EBP-5. Develop a relevant clinical question using a pre-defined question format (eg, PICO= Patients, Intervention, Comparison, Outcomes; PIO = Patients, Intervention, Outcomes).

EBP-6. Describe and contrast research and literature resources including databases and online critical appraisal libraries that can be used for conducting clinically-relevant searches.

EBP-7. Conduct a literature search using a clinical question relevant to athletic training practice using search techniques (eg, Boolean search, Medical Subject Headings) and resources appropriate for a specific clinical question.

EBP-8. Describe the differences between narrative reviews, systematic reviews, and meta-analyses.

EBP-9. Use standard criteria or developed scales (eg, Physiotherapy Evidence Database Scale [PEDro], Oxford Centre for Evidence Based Medicine Scale) to critically appraise the structure, rigor, and overall quality of research studies.

EBP-10. Determine the effectiveness and efficacy of an athletic training intervention utilizing evidence-based practice concepts.

EBP-11. Explain the theoretical foundation of clinical outcomes assessment (eg, disablement, health-related quality of life) and describe common methods of outcomes assessment in athletic training clinical practice (generic, disease-specific, region-specific, and dimension-specific outcomes instruments).

EBP-12. Describe the types of outcomes measures for clinical practice (patient-based and clinician-based) as well as types of evidence that are gathered through outcomes assessment (patient-oriented evidence versus disease-oriented evidence).

EBP-13. Understand the methods of assessing patient status and progress (eg, global rating of change, minimal clinically important difference, minimal detectable difference) with clinical outcomes assessments.

EBP-14. Apply and interpret clinical outcomes to assess patient status, progress, and change using psychometrically sound outcome instruments.

Prevention and Health Promotion (PHP)

Athletic trainers develop and implement strategies and programs to prevent the incidence and/or severity of injuries and illnesses and optimize their clients'/patients' overall health and quality of life. These strategies and programs also incorporate the importance of nutrition and physical activity in maintaining a healthy lifestyle and in preventing chronic disease (eg, diabetes, obesity, cardiovascular disease).

Knowledge and Skills

General Prevention Principles

PHP-1. Describe the concepts (eg, case definitions, incidence versus prevalence, exposure assessment, rates) and uses of injury and illness surveillance relevant to athletic training.

PHP-2. Identify and describe measures used to monitor injury prevention strategies (eg, injury rates and risks, relative risks, odds ratios, risk differences, numbers needed to treat/harm).

PHP-3. Identify modifiable/non-modifiable risk factors and mechanisms for injury and illness.

PHP-4. Explain how the effectiveness of a prevention strategy can be assessed using clinical outcomes, surveillance, or evaluation data.

PHP-5. Explain the precautions and risk factors associated with physical activity in persons with common congenital and acquired abnormalities, disabilities, and diseases.

PHP-6. Summarize the epidemiology data related to the risk of injury and illness associated with participation in physical activity.

Prevention Strategies and Procedures

PHP-7. Implement disinfectant procedures to prevent the spread of infectious diseases and to comply with Occupational Safety and Health Administration (OSHA) and other federal regulations.

PHP-8. Identify the necessary components to include in a preparticipation physical examination as recommended by contemporary guidelines (eg, American Heart Association, American Academy of Pediatrics Council on Sports Medicine & Fitness).

PHP-9. Explain the role of the preparticipation physical exam in identifying conditions that might predispose the athlete to injury or illness.

PHP-10. Explain the principles of the body's thermoregulatory mechanisms as they relate to heat gain and heat loss.

PHP-11. Explain the principles of environmental illness prevention programs to include acclimation and conditioning, fluid and electrolyte replacement requirements, proper practice and competition attire, hydration status, and environmental assessment (eg, sling psychrometer, wet bulb globe temperatures [WBGT], heat index guidelines).

PHP-12. Summarize current practice guidelines related to physical activity during extreme weather conditions (eg, heat, cold, lightning, wind).

PHP-13. Obtain and interpret environmental data (web bulb globe temperature [WBGT], sling psychrometer, lightning detection devices) to make clinical decisions regarding the scheduling, type, and duration of physical activity.

PHP-14. Assess weight loss and hydration status using weight charts, urine color charts, or specific gravity measurements to determine an individual's ability to participate in physical activity in a hot, humid environment.

PHP-15. Use a glucometer to monitor blood glucose levels, determine participation status, and make referral decisions.

PHP-16. Use a peak-flow meter to monitor a patient's asthma symptoms, determine participation status, and make referral decisions.

PHP-17. Explain the etiology and prevention guidelines associated with the leading causes of sudden death during physical activity, including but not limited to:

- **PHP-17a.** Cardiac arrhythmia or arrest
- **PHP-17b.** Asthma
- **PHP-17c.** Traumatic brain injury
- **PHP-17d.** Exertional heat stroke
- **PHP-17e.** Hyponatremia
- **PHP-17f.** Exertional sickling
- **PHP-17g.** Anaphylactic shock
- **PHP-17h.** Cervical spine injury
- **PHP-17i.** Lightning strike

PHP-18. Explain strategies for communicating with coaches, athletes, parents, administrators, and other relevant personnel regarding potentially dangerous conditions related to the environment, field, or playing surfaces.

PHP-19. Instruct clients/patients in the basic principles of ergodynamics and their relationship to the prevention of illness and injury.

Protective Equipment and Prophylactic Procedures

PHP-20. Summarize the basic principles associated with the design, construction, fit, maintenance, and reconditioning of protective equipment, including the rules and regulations established by the associations that govern its use.

PHP-21. Summarize the principles and concepts related to the fabrication, modification, and appropriate application or use of orthotics and other dynamic and static splints.

PHP-22. Fit standard protective equipment following manufacturers' guidelines.

PHP-23. Apply preventive taping and wrapping procedures, splints, braces, and other special protective devices.

Fitness/Wellness

PHP-24. Summarize the general principles of health maintenance and personal hygiene, including skin care, dental hygiene, sanitation, immunizations, avoidance of infectious and contagious diseases, diet, rest, exercise, and weight control.

PHP-25. Describe the role of exercise in maintaining a healthy lifestyle and preventing chronic disease.

PHP-26. Identify and describe the standard tests, test equipment, and testing protocols that are used for measuring fitness, body composition, posture, flexibility, muscular strength, power, speed, agility, and endurance.

PHP-27. Compare and contrast the various types of flexibility, strength training, and cardiovascular conditioning programs to include expected outcomes, safety precautions, hazards, and contraindications.

PHP-28. Administer and interpret fitness tests to assess a client's/patient's physical status and readiness for physical activity.

PHP-29. Explain the basic concepts and practice of fitness and wellness screening.

PHP-30. Design a fitness program to meet the individual needs of a client/patient based on the results of standard fitness assessments and wellness screening.

PHP-31. Instruct a client/patient regarding fitness exercises and the use of muscle strengthening equipment to include correction or modification of inappropriate, unsafe, or dangerous lifting techniques.

General Nutrition Concepts

PHP-32. Describe the role of nutrition in enhancing performance, preventing injury or illness, and maintaining a healthy lifestyle.

PHP-33. Educate clients/patients on the importance of healthy eating, regular exercise, and general preventative strategies for improving or maintaining health and quality of life.

PHP-34. Describe contemporary nutritional intake recommendations and explain how these recommendations can be used in performing a basic dietary analysis and providing appropriate general dietary recommendations.

PHP-35. Describe the proper intake, sources of, and effects of micro- and macronutrients on performance, health, and disease.

PHP-36. Describe current guidelines for proper hydration and explain the consequences of improper fluid/electrolyte replacement.

PHP-37. Identify, analyze, and utilize the essential components of food labels to determine the content, quality, and appropriateness of food products.

PHP-38. Describe nutritional principles that apply to tissue growth and repair.

PHP-39. Describe changes in dietary requirements that occur as a result of changes in an individual's health, age, and activity level.

PHP-40. Explain the physiologic principles and time factors associated with the design and planning of pre-activity and recovery meals/snacks and hydration practices.

PHP-41. Identify the foods and fluids that are most appropriate for pre-activity, activity, and recovery meals/snacks.

Weight Management and Body Composition

PHP-42. Explain how changes in the type and intensity of physical activity influence the energy and nutritional demands placed on the client/patient.

PHP-43. Describe the principles and methods of body composition assessment to assess a client's/patient's health status and to monitor changes related to weight management, strength training, injury, disordered eating, menstrual status, and/or bone density status.

PHP-44. Assess body composition by validated techniques.

PHP-45. Describe contemporary weight management methods and strategies needed to support activities of daily life and physical activity.

Disordered Eating and Eating Disorders

PHP-46. Identify and describe the signs, symptoms, physiological, and psychological responses of clients/patients with disordered eating or eating disorders.

PHP-47. Describe the method of appropriate management and referral for clients/patients with disordered eating or eating disorders in a manner consistent with current practice guidelines.

Performance Enhancing and Recreational Supplements and Drugs

PHP-48. Explain the known usage patterns, general effects, and short- and long-term adverse effects for the commonly used dietary supplements, performance enhancing drugs, and recreational drugs.

PHP-49. Identify which therapeutic drugs, supplements, and performance-enhancing substances are banned by sport and/or workplace organizations in order to properly advise clients/patients about possible disqualification and other consequences.

Clinical Examination and Diagnosis (CE)

Athletic trainers must possess strong clinical examination skills in order to accurately diagnosis and effectively treat their patients. The clinical examination is an on-going process, repeated to some extent each time the patient is treated. The development of these skills requires a thorough understanding of anatomy, physiology, and biomechanics. Athletic trainers must also apply clinical-reasoning skills throughout the physical examination process in order to assimilate data, select the appropriate assessment tests, and formulate a differential diagnosis.

The competencies identified in this section should be considered in the context of the competencies identified in other domains. For example, the knowledge and skills associated with acute care and therapeutic interventions, while applicable for this domain, are not repeated here.

The clinical examination process is comprehensive and may include a review of the systems and regions identified below based on the patient's relevant history and examination findings. Consideration must also be given to the patient's behavioral and cognitive status and history; competencies addressing this content area are included elsewhere.

Systems and Regions

a. Musculoskeletal
b. Integumentary
c. Neurological
d. Cardiovascular
e. Endocrine
f. Pulmonary
g. Gastrointestinal
h. Hepatobiliary
i. Immune
j. Renal and urogenital
k. The face, including maxillofacial region and mouth
l. Eye, ear, nose, and throat

Knowledge and Skills

CE-1. Describe the normal structures and interrelated functions of the body systems.

CE-2. Describe the normal anatomical, systemic, and physiological changes associated with the lifespan.

CE-3. Identify the common congenital and acquired risk factors and causes of musculoskeletal injuries and common illnesses that may influence physical activity in pediatric, adolescent, adult, and aging populations.

CE-4. Describe the principles and concepts of body movement, including normal osteokinematics and arthrokinematics.

CE-5. Describe the influence of pathomechanics on function.

CE-6. Describe the basic principles of diagnostic imaging and testing and their role in the diagnostic process.

CE-7. Identify the patient's participation restrictions (disabilities) and activity limitations (functional limitations) to determine the impact of the condition on the patient's life.

CE-8. Explain the role and importance of functional outcome measures in clinical practice and patient health-related quality of life.

CE-9. Identify functional and patient-centered quality of life outcome measures appropriate for use in athletic training practice.

CE-10. Explain diagnostic accuracy concepts including reliability, sensitivity, specificity, likelihood ratios, prediction values, and pre-test and post-test probabilities in the selection and interpretation of physical examination and diagnostic procedures.

CE-11. Explain the creation of clinical prediction rules in the diagnosis and prognosis of various clinical conditions.

CE-12. Apply clinical prediction rules (eg, Ottawa Ankle Rules) during clinical examination procedures.

CE-13. Obtain a thorough medical history that includes the pertinent past medical history, underlying systemic disease, use of medications, the patient's perceived pain, and the history and course of the present condition.

CE-14. Differentiate between an initial injury evaluation and follow-up/reassessment as a means to evaluate the efficacy of the patient's treatment/rehabilitation program, and make modifications to the patient's program as needed.

CE-15. Demonstrate the ability to modify the diagnostic examination process according to the demands of the situation and patient responses.

CE-16. Recognize the signs and symptoms of catastrophic and emergent conditions and demonstrate appropriate referral decisions.

CE-17. Use clinical reasoning skills to formulate an appropriate clinical diagnosis for common illness/disease and orthopedic injuries/conditions.

CE-18. Incorporate the concept of differential diagnosis into the examination process.

CE-19. Determine criteria and make decisions regarding return to activity and/or sports participation based on the patient's current status.

CE-20. Use standard techniques and procedures for the clinical examination of common injuries, conditions, illnesses, and diseases including, but not limited to:

- **CE-20a.** history taking
- **CE-20b.** inspection/observation
- **CE-20c.** palpation
- **CE-20d.** functional assessment
- **CE-20e.** selective tissue testing techniques / special tests
- **CE-20f.** neurological assessments (sensory, motor, reflexes, balance, cognitive function)
- **CE-20g.** respiratory assessments (auscultation, percussion, respirations, peak-flow)
- **CE-20h.** circulatory assessments (pulse, blood pressure, auscultation)
- **CE-20i.** abdominal assessments (percussion, palpation, auscultation)
- **CE-20j.** other clinical assessments (otoscope, urinalysis, glucometer, temperature, opthalmoscope)

CE-21. Assess and interpret findings from a physical examination that is based on the patient's clinical presentation. This exam can include:

- **CE-21a.** Assessment of posture, gait, and movement patterns
- **CE-21b.** Palpation
- **CE-21c.** Muscle function assessment
- **CE-21d.** Assessment of quantity and quality of osteokinematic joint motion
- **CE-21e.** Capsular and ligamentous stress testing
- **CE-21f.** Joint play (arthrokinematics)
- **CE-21g.** Selective tissue examination techniques / special tests
- **CE-21h.** Neurologic function (sensory, motor, reflexes, balance, cognition)
- **CE-21i.** Cardiovascular function (including differentiation between normal and abnormal heart sounds, blood pressure, and heart rate)
- **CE-21j.** Pulmonary function (including differentiation between normal breath sounds, percussion sounds, number and characteristics of respirations, peak expiratory flow)
- **CE-21k.** Gastrointestinal function (including differentiation between normal and abnormal bowel sounds)
- **CE-21l.** Genitourinary function (urinalysis)
- **CE-21m.** Ocular function (vision, ophthalmoscope)
- **CE-21n.** Function of the ear, nose, and throat (including otoscopic evaluation)
- **CE-21o.** Dermatological assessment
- **CE-21p.** Other assessments (glucometer, temperature)

CE-22. Determine when the findings of an examination warrant referral of the patient.

CE-23. Describe current setting-specific (eg, high school, college) and activity-specific rules and guidelines for managing injuries and illnesses.

Acute Care of Injuries and Illnesses (AC)

Athletic trainers are often present when injuries or other acute conditions occur or are the first healthcare professionals to evaluate a patient. For this reason, athletic trainers must be knowledgeable and skilled in the evaluation and immediate management of acute injuries and illnesses.

The competencies identified in this section should be considered in the context of the competencies identified in other domains. For example, the knowledge and skills associated with the process of examination and documentation, while applicable for this domain, are not repeated here. Likewise, the knowledge and skills associated with the administrative and risk management aspects of planning for an emergency injury/illness situation are not repeated here.

Knowledge and Skills

Planning

AC-1. Explain the legal, moral, and ethical parameters that define the athletic trainer's scope of acute and emergency care.

AC-2. Differentiate the roles and responsibilities of the athletic trainer from other pre-hospital care and hospital-based providers, including emergency medical technicians/paramedics, nurses, physician assistants, and physicians.

AC-3. Describe the hospital trauma level system and its role in the transportation decision-making process.

Examination

AC-4. Demonstrate the ability to perform scene, primary, and secondary surveys.

AC-5. Obtain a medical history appropriate for the patient's ability to respond.

AC-6. When appropriate, obtain and monitor signs of basic body functions including pulse, blood pressure, respiration, pulse oximetry, pain, and core temperature. Relate changes in vital signs to the patient's status.

AC-7. Differentiate between normal and abnormal physical findings (eg, pulse, blood pressure, heart and lung sounds, oxygen saturation, pain, core temperature) and the associated pathophysiology.

Immediate Emergent Management

AC-8. Explain the indications, guidelines, proper techniques, and necessary supplies for removing equipment and clothing in order to access the airway, evaluate and/or stabilize an athlete's injured body part.

AC-9. Differentiate the types of airway adjuncts (oropharygneal airways [OPA], nasopharyngeal airways [NPA] and supraglottic airways [King LT-D or Combitube]) and their use in maintaining a patent airway in adult respiratory and/or cardiac arrest.

AC-10. Establish and maintain an airway, including the use of oro- and nasopharygneal airways, and neutral spine alignment in an athlete with a suspected spine injury who may be wearing shoulder pads, a helmet with and without a face guard, or other protective equipment.

AC-11. Determine when suction for airway maintenance is indicated and use according to accepted practice protocols.

AC-12. Identify cases when rescue breathing, CPR, and/or AED use is indicated according to current accepted practice protocols.

AC-13. Utilize an automated external defibrillator (AED) according to current accepted practice protocols.

AC-14. Perform one- and two- person CPR on an infant, child and adult.

AC-15. Utilize a bag valve and pocket mask on a child and adult using supplemental oxygen.

AC-16. Explain the indications, application, and treatment parameters for supplemental oxygen administration for emergency situations.

AC-17. Administer supplemental oxygen with adjuncts (eg, non-rebreather mask, nasal cannula).

AC-18. Assess oxygen saturation using a pulse oximeter and interpret the results to guide decision making.

AC-19. Explain the proper procedures for managing external hemorrhage (eg, direct pressure, pressure points, tourniquets) and the rationale for use of each.

AC-20. Select and use the appropriate procedure for managing external hemorrhage.

AC-21. Explain aseptic or sterile techniques, approved sanitation methods, and universal precautions used in the cleaning, closure, and dressing of wounds.

AC-22. Select and use appropriate procedures for the cleaning, closure, and dressing of wounds, identifying when referral is necessary.

AC-23. Use cervical stabilization devices and techniques that are appropriate to the circumstances of an injury.

AC-24. Demonstrate proper positioning and immobilization of a patient with a suspected spinal cord injury.

AC-25. Perform patient transfer techniques for suspected head and spine injuries utilizing supine log roll, prone log roll with push, prone log roll with pull, and lift-and-slide techniques.

AC-26. Select the appropriate spine board, including long board or short board, and use appropriate immobilization techniques based on the circumstance of the patient's injury.

AC-27. Explain the role of core body temperature in differentiating between exertional heat stroke, hyponatremia, and head injury.

AC-28. Differentiate the different methods for assessing core body temperature.

AC-29. Assess core body temperature using a rectal probe.

AC-30. Explain the role of rapid full body cooling in the emergency management of exertional heat stroke.

AC-31. Assist the patient in the use of a nebulizer treatment for an asthmatic attack.

AC-32. Determine when use of a metered-dose inhaler is warranted based on a patient's condition.

AC-33. Instruct a patient in the use of a meter-dosed inhaler in the presence of asthma-related bronchospasm.

AC-34. Explain the importance of monitoring a patient following a head injury, including the role of obtaining clearance from a physician before further patient participation.

AC-35. Demonstrate the use of an auto-injectable epinephrine in the management of allergic anaphylaxis. Decide when auto-injectable epinephrine use is warranted based on a patient's condition.

AC-36. Identify the signs, symptoms, interventions and, when appropriate, the return-to-participation criteria for:

- **AC-36a.** sudden cardiac arrest
- **AC-36b.** brain injury including concussion, subdural and epidural hematomas, second impact syndrome and skull fracture
- **AC-36c.** cervical, thoracic, and lumbar spine trauma
- **AC-36d.** heat illness including heat cramps, heat exhaustion, exertional heat stroke, and hyponatremia
- **AC-36e.** exertional sickling associated with sickle cell trait
- **AC-36f.** rhabdomyolysis
- **AC-36g.** internal hemorrhage
- **AC-36h.** diabetic emergencies including hypoglycemia and ketoacidosis
- **AC-36i.** asthma attacks
- **AC-36j.** systemic allergic reaction, including anaphylactic shock
- **AC-36k.** epileptic and non-epileptic seizures
- **AC-36l.** shock
- **AC-36m.** hypothermia, frostbite
- **AC-36n.** toxic drug overdoses
- **AC-36o.** local allergic reaction

Immediate Musculoskeletal Management

AC-37. Select and apply appropriate splinting material to stabilize an injured body area.

AC-38. Apply appropriate immediate treatment to protect the injured area and minimize the effects of hypoxic and enzymatic injury.

AC-39. Select and implement the appropriate ambulatory aid based on the patient's injury and activity and participation restrictions.

Transportation

AC-40. Determine the proper transportation technique based on the patient's condition and findings of the immediate examination.

AC-41. Identify the criteria used in the decision-making process to transport the injured patient for further medical examination.

AC-42. Select and use the appropriate short-distance transportation methods, such as the log roll or lift and slide, for an injured patient in different situations.

Education

AC-36. Instruct the patient in home care and self-treatment plans for acute conditions.

Therapeutic Interventions (TI)

Athletic trainers assess the patient's status using clinician- and patient-oriented outcome measures. Based on this assessment and with consideration of the stage of healing and goals, a therapeutic intervention is designed to maximize the patient's participation and health-related quality of life.

A broad range of interventions, methods, techniques, equipment, activities using body movement, and medications are incorporated into this domain. These interventions are designed to enhance function by identifying, remediating, and preventing impairments and activity restrictions (functional limitations) to maximize participation. Rehabilitation is conducted in a wide variety of settings (eg, aquatic, clinic) with basic and contemporary equipment/modalities and on a wide range of patients with respect to age, overall health, and desired level of activity. Therapeutic interventions also include the use of prescription and nonprescription medications. For this reason, the athletic trainer needs to be knowledgeable about common prescription and nonprescription drug indications, adverse reactions, and interactions.

The competencies identified in this section should be considered in the context of the competencies identified in other content areas. For example, the knowledge and skills associated with the process of examination and documentation, while applicable for this content area, are not included here.

Therapeutic interventions include:

- Techniques to reduce pain
- Techniques to limit edema
- Techniques to restore joint mobility
- Techniques to restore muscle extensibility
- Techniques to restore neuromuscular function
- Exercises to improve strength, endurance, speed, and power
- Activities to improve balance, neuromuscular control, coordination, and agility
- Exercises to improve gait, posture, and body mechanics
- Exercises to improve cardiorespiratory fitness
- Functional exercises (eg, sports- or activity-specific)
- Exercises which comprise a home-based program
- Aquatic therapy
- Therapeutic modalities
  - superficial thermal agents (eg, hot pack, ice)
  - electrical stimulation
  - therapeutic ultrasound
  - diathermy
  - therapeutic low-level laser and light therapy
  - mechanical modalities
    - traction
    - intermittent compression
    - continuous passive motion
    - massage
    - biofeedback
- Therapeutic medications (as guided by applicable state and federal law)

Knowledge and Skills

Physical Rehabilitation and Therapeutic Modalities

TI-1. Describe and differentiate the physiological and pathophysiological responses to inflammatory and non-inflammatory conditions and the influence of these responses on the design, implementation, and progression of a therapeutic intervention.

TI-2. Compare and contrast contemporary theories of pain perception and pain modulation.

TI-3. Differentiate between palliative and primary pain-control interventions.

TI-4. Analyze the impact of immobilization, inactivity, and mobilization on the body systems (eg, cardiovascular, pulmonary, musculoskeletal) and injury response.

TI-5. Compare and contrast the variations in the physiological response to injury and healing across the lifespan.

TI-6. Describe common surgical techniques, including interpretation of operative reports, and any resulting precautions, contraindications, and comorbidities that impact the selection and progression of a therapeutic intervention program.

TI-7. Identify patient- and clinician-oriented outcomes measures commonly used to recommend activity level, make return to play decisions, and maximize patient outcomes and progress in the treatment plan.

TI-8. Explain the theory and principles relating to expected physiological response(s) during and following therapeutic interventions.

TI-9. Describe the laws of physics that (1) underlay the application of thermal, mechanical, electromagnetic, and acoustic energy to the body and (2) form the foundation for the development of therapeutic interventions (eg, stress-strain, leverage, thermodynamics, energy transmission and attenuation, electricity).

TI-10. Integrate self-treatment into the intervention when appropriate, including instructing the patient regarding self-treatment plans.

TI-11. Design therapeutic interventions to meet specified treatment goals.

- **TI-11a.** Assess the patient to identify indications, contraindications, and precautions applicable to the intended intervention.
- **TI-11b.** Position and prepare the patient for various therapeutic interventions.
- **TI-11c.** Describe the expected effects and potential adverse reactions to the patient.
- **TI-11d.** Instruct the patient how to correctly perform rehabilitative exercises.
- **TI-11e.** Apply the intervention, using parameters appropriate to the intended outcome.
- **TI-11f.** Reassess the patient to determine the immediate impact of the intervention.

TI-12. Use the results of on-going clinical examinations to determine when a therapeutic intervention should be progressed, regressed or discontinued.

TI-13. Describe the relationship between the application of therapeutic modalities and the incorporation of active and passive exercise and/or manual therapies, including therapeutic massage, myofascial techniques, and muscle energy techniques.

TI-14. Describe the use of joint mobilization in pain reduction and restoration of joint mobility.

TI-15. Perform joint mobilization techniques as indicated by examination findings.

TI-16. Fabricate and apply taping, wrapping, supportive, and protective devices to facilitate return to function.

TI-17. Analyze gait and select appropriate instruction and correction strategies to facilitate safe progression to functional gait pattern.

TI-18. Explain the relationship between posture, biomechanics, and ergodynamics and the need to address these components in a therapeutic intervention.

TI-19. Identify manufacturer, institutional, state, and/or federal standards that influence approval, operation, inspection, maintenance and safe application of therapeutic modalities and rehabilitation equipment.

TI-20. Inspect therapeutic equipment and the treatment environment for potential safety hazards.

Therapeutic Medications

TI-21. Explain the federal, state, and local laws, regulations and procedures for the proper storage, disposal, transportation, dispensing (administering where appropriate), and documentation associated with commonly used prescription and nonprescription medications.

TI-22. Identify and use appropriate pharmaceutical terminology for management of medications, inventory control, and reporting of pharmacological agents commonly used in an athletic training facility.

TI-23. Use an electronic drug resource to locate and identify indications, contraindications, precautions, and adverse reactions for common prescription and nonprescription medications.

TI-24. Explain the major concepts of pharmacokinetics and the influence that exercise might have on these processes.

TI-25. Explain the concepts related to bioavailability, half-life, and bioequivalence (including the relationship between generic and brand name drugs) and their relevance to the patient, the choice of medication, and the dosing schedule.

TI-26. Explain the pharmacodynamic principles of receptor theory, dose-response relationship, placebo effect, potency, and drug interactions as they relate to the mechanism of drug action and therapeutic effectiveness.

TI-27. Describe the common routes used to administer medications and their advantages and disadvantages.

TI-28. Properly assist and/or instruct the patient in the proper use, cleaning, and storage of drugs commonly delivered by metered dose inhalers, nebulizers, insulin pumps, or other parenteral routes as prescribed by the physician.

TI-29. Describe how common pharmacological agents influence pain and healing and their influence on various therapeutic interventions.

TI-30. Explain the general therapeutic strategy, including drug categories used for treatment, desired treatment outcomes, and typical duration of treatment, for the following common diseases and conditions: asthma, diabetes, hypertension, infections, depression, GERD, allergies, pain, inflammation, and the common cold.

TI-31. Optimize therapeutic outcomes by communicating with patients and/or appropriate healthcare professionals regarding compliance issues, drug interactions, adverse drug reactions, and sub-optimal therapy.

Psychosocial Strategies and Referral (PS)

Athletic trainers must be able to recognize clients/patients exhibiting abnormal social, emotional, and mental behaviors. Coupled with recognition is the ability to intervene and refer these individuals as necessary. Additionally, athletic trainers appreciate the role of mental health in injury and recovery and use interventions to optimize the connection between mental health and restoration of participation.

Knowledge and Skills

Theoretical Background

PS-1. Describe the basic principles of personality traits, trait anxiety, locus of control, intrinsic and extrinsic motivation, and patient and social environment interactions as they affect patient interactions.

PS-2. Explain the theoretical background of psychological and emotional responses to injury and forced inactivity (eg, cognitive appraisal model, stress response model).

PS-3. Describe how psychosocial considerations affect clinical decision-making related to return to activity or participation (eg, motivation, confidence).

PS-4. Summarize and demonstrate the basic processes of effective interpersonal and cross-cultural communication as it relates to interactions with patients and others involved in the healthcare of the patient.

PS-5. Summarize contemporary theory regarding educating patients of all ages and cultural backgrounds to effect behavioral change.

Psychosocial Strategies

PS-6. Explain the importance of educating patients, parents/guardians, and others regarding the condition in order to enhance the psychological and emotional well-being of the patient.

PS-7. Describe the psychological techniques (eg, goal setting, imagery, positive self-talk, relaxation/anxiety reduction) that the athletic trainer can use to motivate the patient during injury rehabilitation and return to activity processes.

PS-8. Describe psychological interventions (eg, goal setting, motivational techniques) that are used to facilitate a patient's physical, psychological, and return to activity needs.

PS-9. Describe the psychosocial factors that affect persistent pain sensation and perception (eg, emotional state, locus of control, psychodynamic issues, sociocultural factors, personal values and beliefs) and identify multidisciplinary approaches for assisting patients with persistent pain.

PS-10. Explain the impact of sociocultural issues that influence the nature and quality of healthcare received (eg, cultural competence, access to appropriate healthcare providers, uninsured/underinsured patients, insurance) and formulate and implement strategies to maximize client/patient outcomes.

Mental Health and Referral

PS-11. Describe the role of various mental healthcare providers (eg, psychiatrists, psychologists, counselors, social workers) that may comprise a mental health referral network.

PS-12. Identify and refer clients/patients in need of mental healthcare.

PS-13. Identify and describe the basic signs and symptoms of mental health disorders (eg, psychosis, neurosis; sub-clinical mood disturbances (eg, depression, anxiety); and personal/social conflict (eg, adjustment to injury, family problems, academic or emotional stress, personal assault or abuse, sexual assault or harassment) that may indicate the need for referral to a mental healthcare professional.

PS-14. Describe the psychological and sociocultural factors associated with common eating disorders.

PS-15. Identify the symptoms and clinical signs of substance misuse/abuse, the psychological and sociocultural factors associated with such misuse/abuse, its impact on an individual's health and physical performance, and the need for proper referral to a healthcare professional.

PS-16. Formulate a referral for an individual with a suspected mental health or substance abuse problem.

PS-17. Describe the psychological and emotional responses to a catastrophic event, the potential need for a psychological intervention and a referral plan for all parties affected by the event.

PS-18. Provide appropriate education regarding the condition and plan of care to the patient and appropriately discuss with others as needed and as appropriate to protect patient privacy.

Healthcare Administration (HA)

Athletic trainers function within the context of a complex healthcare system. Integral to this function is an understanding of risk management, healthcare delivery mechanisms, insurance, reimbursement, documentation, patient privacy, and facility management.

Knowledge and Skills

HA-1. Describe the role of the athletic trainer and the delivery of athletic training services within the context of the broader healthcare system.

HA-2. Describe the impact of organizational structure on the daily operations of a healthcare facility.

HA-3. Describe the role of strategic planning as a means to assess and promote organizational improvement.

HA-4. Describe the conceptual components of developing and implementing a basic business plan.

HA-5. Describe basic healthcare facility design for a safe and efficient clinical practice setting.

HA-6. Explain components of the budgeting process including: purchasing, requisition, bidding, request for proposal, inventory, profit and loss ratios, budget balancing, and return on investments.

HA-7. Assess the value of the services provided by an athletic trainer (eg, return on investment).

HA-8. Develop operational and capital budgets based on a supply inventory and needs assessment; including capital equipment, salaries and benefits, trending analysis, facility cost, and common expenses.

HA-9. Identify the components that comprise a comprehensive medical record.

HA-10. Identify and explain the statutes that regulate the privacy and security of medical records.

HA-11. Use contemporary documentation strategies to effectively communicate with patients, physicians, insurers, colleagues, administrators, and parents or family members.

HA-12. Use a comprehensive patient-file management system for appropriate chart documentation, risk management, outcomes, and billing.

HA-13. Define state and federal statutes that regulate employment practices.

HA-14. Describe principles of recruiting, selecting, hiring, and evaluating employees.

HA-15. Identify principles of recruiting, selecting, employing, and contracting with physicians and other medical and healthcare personnel in the deployment of healthcare services.

HA-16. Describe federal and state infection control regulations and guidelines, including universal precautions as mandated by the Occupational Safety and Health Administration (OSHA), for the prevention, exposure, and control of infectious diseases, and discuss how they apply to the practicing of athletic training.

HA-17. Identify key regulatory agencies that impact healthcare facilities, and describe their function in the regulation and overall delivery of healthcare.

HA-18. Describe the basic legal principles that apply to an athletic trainer's responsibilities.

HA-19. Identify components of a risk management plan to include security, fire, electrical and equipment safety, emergency preparedness, and hazardous chemicals.

HA-20. Create a risk management plan and develop associated policies and procedures to guide the operation of athletic training services within a healthcare facility to include issues related to security, fire, electrical and equipment safety, emergency preparedness, and hazardous chemicals.

HA-21. Develop comprehensive, venue-specific emergency action plans for the care of acutely injured or ill individuals.

HA-22. Develop specific plans of care for common potential emergent conditions (eg, asthma attack, diabetic emergency).

HA-23. Identify and explain the recommended or required components of a pre-participation examination based on appropriate authorities' rules, guidelines, and/or recommendations.

HA-24. Describe a plan to access appropriate medical assistance on disease control, notify medical authorities, and prevent disease epidemics.

HA-25. Describe common health insurance models, insurance contract negotiation, and the common benefits and exclusions identified within these models.

HA-26. Describe the criteria for selection, common features, specifications, and required documentation needed for secondary, excess accident, and catastrophic health insurance.

HA-27. Describe the concepts and procedures for revenue generation and reimbursement.

HA-28. Understand the role of and use diagnostic and procedural codes when documenting patient care.

HA-29. Explain typical administrative policies and procedures that govern first aid and emergency care.

HA-30. Describe the role and functions of various healthcare providers and protocols that govern the referral of patients to these professionals.

Professional Development and Responsibility (PD)

The provision of high quality patient care requires that the athletic trainer maintain current competence in the constantly changing world of healthcare. Athletic trainers must also embrace the need to practice within the limits of state and national regulation using moral and ethical judgment. As members of a broader healthcare community, athletic trainers work collaboratively with other healthcare providers and refer clients/patients when such referral is warranted.

Knowledge and Skills

PD-1. Summarize the athletic training profession's history and development and how current athletic training practice has been influenced by its past.

PD-2. Describe the role and function of the National Athletic Trainers' Association and its influence on the profession.

PD-3. Describe the role and function of the Board of Certification, the Commission on Accreditation of Athletic Training Education, and state regulatory boards.

PD-4. Explain the role and function of state athletic training practice acts and registration, licensure, and certification agencies including (1) basic legislative processes for the implementation of practice acts, (2) rationale for state regulations that govern the practice of athletic training, and (3) consequences of violating federal and state regulatory acts.

PD-5. Access, analyze, and differentiate between the essential documents of the national governing, credentialing and regulatory bodies, including, but not limited to, the NATA *Athletic Training Educational Competencies*, the BOC *Standards of Professional Practice*, the NATA *Code of Ethics*, and the BOC *Role Delineation Study/Practice Analysis*.

PD-6. Explain the process of obtaining and maintaining necessary local, state, and national credentials for the practice of athletic training.

PD-7. Perform a self-assessment of professional competence and create a professional development plan to maintain necessary credentials and promote life-long learning strategies.

PD-8. Differentiate among the preparation, scopes of practice, and roles and responsibilities of healthcare providers and other professionals with whom athletic trainers interact.

PD-9. Specify when referral of a client/patient to another healthcare provider is warranted and formulate and implement strategies to facilitate that referral.

PD-10. Develop healthcare educational programming specific to the target audience (eg, clients/patients, healthcare personnel, administrators, parents, general public).

PD-11. Identify strategies to educate colleagues, students, patients, the public, and other healthcare professionals about the roles, responsibilities, academic preparation, and scope of practice of athletic trainers.

PD-12. Identify mechanisms by which athletic trainers influence state and federal healthcare regulation.

Clinical Integration Proficiencies (CIP)

The clinical integration proficiencies (CIPs) represent the synthesis and integration of knowledge, skills, and clinical decision-making into actual client/patient care. The CIPs have been reorganized into this section (rather than at the end of each content area) to reflect their global nature. For example, therapeutic interventions do not occur in isolation from physical assessment.

In most cases, assessment of the CIPs should occur when the student is engaged in real client/patient care and may be necessarily assessed over multiple interactions with the same client/patient. In a few instances, assessment may require simulated scenarios, as certain circumstances may occur rarely but are nevertheless important to the well-prepared practitioner.

The incorporation of evidence-based practice principles into care provided by athletic trainers is central to optimizing outcomes. Assessment of student competence in the CIPs should reflect the extent to which these principles are integrated. Assessment of students in the use of Foundational Behaviors in the context of real patient care should also occur.

Prevention & Health Promotion

CIP-1. Administer testing procedures to obtain baseline data regarding a client's/patient's level of general health (including nutritional habits, physical activity status, and body composition). Use this data to design, implement, evaluate, and modify a program specific to the performance and health goals of the patient. This will include instructing the patient in the proper performance of the activities, recognizing the warning signs and symptoms of potential injuries and illnesses that may occur, and explaining the role of exercise in maintaining overall health and the prevention of diseases. Incorporate contemporary behavioral change theory when educating clients/patients and associated individuals to effect health-related change. Refer to other medical and health professionals when appropriate.

CIP-2. Select, apply, evaluate, and modify appropriate standard protective equipment, taping, wrapping, bracing, padding, and other custom devices for the client/patient in order to prevent and/or minimize the risk of injury to the head, torso, spine, and extremities for safe participation in sport or other physical activity.

CIP-3. Develop, implement, and monitor prevention strategies for at-risk individuals (eg, persons with asthma or diabetes, persons with a previous history of heat illness, persons with sickle cell trait) and large groups to allow safe physical activity in a variety of conditions. This includes obtaining and interpreting data related to potentially hazardous environmental conditions, monitoring body functions (eg, blood glucose, peak expiratory flow, hydration status), and making the appropriate recommendations for individual safety and activity status.

Clinical Assessment & Diagnosis / Acute Care / Therapeutic Intervention

CIP-4. Perform a comprehensive clinical examination of a patient with an upper extremity, lower extremity, head, neck, thorax, and/or spine injury or condition. This exam should incorporate clinical reasoning in the selection of assessment procedures and interpretation of findings in order to formulate a differential diagnosis and/or diagnosis, determine underlying impairments, and identify activity limitations and participation restrictions. Based on the assessment data and consideration of the patient's goals, provide the appropriate initial care and establish overall treatment goals. Create and implement a therapeutic intervention that targets these treatment goals to include, as appropriate, therapeutic modalities, medications (with physician involvement as necessary), and rehabilitative techniques and procedures. Integrate and interpret various forms of standardized documentation including both patient-oriented and clinician-oriented outcomes measures to recommend activity level, make return to play decisions, and maximize patient outcomes and progress in the treatment plan.

CIP-5. Perform a comprehensive clinical examination of a patient with a common illness/condition that includes appropriate clinical reasoning in the selection of assessment procedures and interpretation of history and physical examination findings in order to formulate a differential diagnosis and/or diagnosis. Based on the history, physical examination, and patient goals, implement the appropriate treatment strategy to include medications (with physician involvement as necessary). Determine whether patient referral is needed, and identify potential restrictions in activities and particpa-tion. Formulate and communicate the appropriate return to activity protocol.

CIP-6. Clinically evaluate and manage a patient with an emergency injury or condition to include the assessment of vital signs and level of consciousness, activation of emergency action plan, secondary assessment, diagnosis, and provision of the appropriate emergency care (eg, CPR, AED, supplemental oxygen, airway adjunct, splinting, spinal stabilization, control of bleeding).

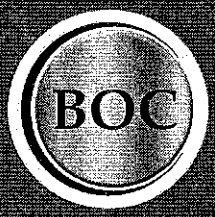
Psychosocial Strategies and Referral

CIP-7. Select and integrate appropriate psychosocial techniques into a patient's treatment or rehabilitation program to enhance rehabilitation adherence, return to play, and overall outcomes. This includes, but is not limited to, verbal motivation, goal setting, imagery, pain management, self-talk, and/or relaxation.

CIP-8. Demonstrate the ability to recognize and refer at-risk individuals and individuals with psychosocial disorders and/or mental health emergencies. As a member of the management team, develop an appropriate management plan (including recom-mendations for patient safety and activity status) that establishes a professional helping relationship with the patient, ensures interactive support and education, and encourages the athletic trainer's role of informed patient advocate in a manner consistent with current practice guidelines.

Healthcare Administration

CIP-9. Utilize documentation strategies to effectively communicate with patients, physicians, insurers, colleagues, administrators, and parents or family members while using appropriate terminology and complying with statues that regulate privacy of medical records. This includes using a comprehensive patient-file management system (including diagnostic and procedural codes) for appropriate chart documentation, risk management, outcomes, and billing.



Board of Certification, Inc.

PRACTICE ANALYSIS, 7TH EDITION

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Report of Findings from the 2015 Athletic Trainer Practice Analysis Study

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EXECUTIVE SUMMARY

INTRODUCTION

The Board of Certification, Inc. (BOC) was incorporated in 1989 to provide a certification program for entry-level Athletic Trainers. The BOC establishes and regularly reviews both the standards for the practice of athletic training and the continuing education requirements for BOC Certified Athletic Trainers. The BOC has the only accredited certification program for Athletic Trainers in the United States. The BOC's mission is to provide exceptional credentialing programs for healthcare professionals to ensure protection of the public.

Athletic trainers are healthcare professionals who collaborate with physicians. The services provided by Athletic Trainers comprise prevention, emergency care, clinical diagnosis, therapeutic intervention and rehabilitation of injuries and medical conditions. Athletic training is recognized by the American Medical Association (AMA) as a healthcare profession. Individuals become eligible for BOC certification through a bachelor's or master's professional athletic training program accredited by the Commission on Accreditation of Athletic Training Education (CAATE).

Consistent with its mission and to ensure that the examination bears a close relationship to current practice, the BOC conducts periodic studies of the profession. Doing so maintains close alignment with best practices in certification. The BOC identified a qualified group of Certified Athletic Trainers to meet with Castle Worldwide, Inc. (Castle) for two days in Omaha, Nebraska, to define performance domains, tasks and the knowledge and skill required for the competent performance of the tasks. The group delineated these elements of the role through intense analysis of the practice of newly certified Athletic Trainers, with particular attention to the divergent ways that it applies in different settings and with different patient conditions.

The purpose of BOC certification is to identify for the public those individuals who possess proficiency at a level that is required for entry to the athletic training profession. The BOC examination serves regulatory purposes in nearly all jurisdictions of the United States. For these reasons, it is essential that the examination have practice-related validity. Accordingly, the analysis concentrated on entry-level practice. Collecting data in a validation survey from a large sample of newly certified Athletic Trainers, the study identified the point in time that Athletic Trainers are expected to perform the tasks (Performance Expectation), the amount of harm that an inability to perform the tasks competently might bring about (Consequence) and how often newly certified Athletic Trainers perform the tasks (Frequency). The practice analysis consisted of the following major phases:

I. Initial Development and Validation. The panel of Certified Athletic Trainers identified the essential domains, tasks, knowledge and skill. Based on this work, Castle developed a validation survey.

II. Pilot Study. A sample of 200 newly certified Athletic Trainers was invited to review and validate the work of the panel by means of a pilot of the validation survey. The input of participants in this project was used to identify a number of changes in the survey and data collection strategy.

III. Validation Study. A large sample of newly certified Athletic Trainers was invited to participate in the BOC's large-scale national validation survey. The names and contact information for participants in the survey were drawn from BOC certification databases. A qualified group of participants representative of newly certified Athletic Trainers provided data in this phase.

The Practice Analysis Task Force provided oversight for the practice analysis study and wrote the literature reviews published as part of it. The task force is listed here:

NAME	RESPONSIBILITY
Christine Odell, PhD, ATC	Chair
Paul Bruning, DHA, ATC	Healthcare Administration and Professional Responsibility
Darryl Conway, MA, ATC	Immediate and Emergency Care
Peggy Houglum, PhD, ATC	Therapeutic Intervention
David Ruiz, MS, ATC, Cert. MDT	Examination, Assessment and Diagnosis
Jay Sedory, MEd, ATC, EMT-T	Injury and Illness Prevention and Wellness Promotion
Ericka Zimmerman, EdD, ATC, CES, PES	Program Director

The panel of experts appointed by the BOC defined the essential framework of the practice analysis study. The panel and other project personnel are listed here:

NAME	LOCATION
Esther Chou, MEd, L-AT, CSCS	Virginia
Jill Dale, MS, ATC	New York
Tiffany Duran, MS, LAT, ATC	Texas
Linda Fabrizio Mazzoli, MS, ATC, PTA, PES	Pennsylvania
Jena Hansen-Honeycutt, MS, LAT, ATC, PES	California
David Manning, MS, ATC, LAT	New Mexico
Marty Matney, MBA, AT/L, ATC, PTA/L, CEAS	Washington
Dani Moffit, PhD, ATC	Idaho
Kiley Nave, MEd, ATC	Florida
Forrest Pecha, MS, LAT, ATC, CSCS, OTC	Idaho
Kelvin Phan, MSEd, ATC, PES	West Virginia
Daniel Sonday, MS, ATR, ATC	Wisconsin/Minnesota
Bridget Spooner, MS, LAT, ATC	Pennsylvania
Jessica Viana, MEd, LAT, ATC	New Jersey
Rebecca Wardlaw, MA, LAT, ATC	Nebraska
Amanda Webster, ATC	South Carolina
Nathan Welever, MS, AT/L, ATC	Washington

EXECUTIVE SUMMARY

BOC STAFF

Denise Fandel, MBA, CAE, Executive Director

Shannon Leftwich, MA, ATC, Director of Credentialing and Regulatory Affairs

CASTLE STAFF

James P. Henderson, PhD, Senior Psychometrician

The practice analysis study began with a preliminary review of documents and preparatory discussions in June and July 2014 and a meeting October 3-5, 2014, in Omaha, Nebraska, of the practice analysis panel. Assisted by Castle, the panel outlined domains, tasks and knowledge and skill statements that are essential to the proficient performance of newly certified Athletic Trainers. The validation survey resulting from this meeting was assessed by means of a pilot project, with changes incorporated as approved by the Practice Analysis Task Force. A large-scale validation study conducted March 18 through April 20, 2015, provided information that was used to assess the appropriateness of the domains and tasks as delineated by the panel of experts.

The panel of experts reviewed and reached consensus on the target audience definition. After this discussion, panelists expressed clear understanding that the purpose of certification was to ensure proficiency for the newly certified Athletic Trainer. The panel then focused on the existing content outline, in place since 2010, and the updates that would ensure its currency and adequacy for the upcoming five-year period. Through facilitated discussion, participants reached consensus on five domains appropriately expected of newly certified Athletic Trainers.

The domains are as follows:

I. Injury and Illness Prevention and Wellness Promotion;
II. Examination, Assessment and Diagnosis;
III. Immediate and Emergency Care;
IV. Therapeutic Intervention; and
V. Healthcare Administration and Professional Responsibility.

For each domain, panel experts worked in separate focus groups to draft tasks, which the whole group then reviewed and refined through a consensus process. The participants' diversity led to discussions that challenged terminology, phrasing and every aspect of the draft statements, with the resulting consensus on revisions representing a position that all members of the panel believed to be valid. The panel also developed a set of knowledge and skill statements for each task, making refinements and reaching consensus through additional small-group work and whole-group discussion.

Based on the work of the expert panel and in consultation with the BOC Practice Analysis Task Force and BOC staff, Castle developed an online questionnaire to be completed by BOC Certified Athletic Trainers. The purpose of the questionnaire was to collect data on the tasks that were developed by the panel of experts. The questionnaire phase of the practice analysis study was important because Certified Athletic Trainers should have input into the delineation of their field. The process for reviewing the survey with the BOC Practice Analysis Task Force and staff resulted in revisions and led to the pilot study that involved a sample of 200 recently certified Athletic Trainers. Castle collected data from this group from January 29 through February 18,

2015, with sufficient responses (≥ 15% of ratings for tasks and domains) from 31 participants. Castle summarized the ratings and other data (Appendix B) and made recommendations to the BOC Practice Analysis Task Force, which approved several minor modifications to the survey. The experience of collecting pilot data also led to a number of suggestions for collecting data, and the BOC and Castle implemented these changes together.

VALIDATION STUDY

The sampling plan for the large-scale validation study was quite simple—all individuals who had been certified in 2013 and working back in time to 2009 certificants until the desired sample size was achieved (n = 5,000) all were included and invited to participate in the study. Castle survey administration staff sent an invitation letter by email to this group on March 18, 2015, and data were collected through midnight on April 20. Castle monitored responses and sent email follow-up correspondence as appropriate.

To be included in the data set for analysis, respondents had to provide at least 15% of the ratings requested. Ultimately, Castle received 903 qualified, usable responses for most tasks. The 18% response rate accounting for this group is substantial, especially considering the survey's length and complexity. Also, the rate compares favorably to the level of participation for most practice analysis studies.

The BOC had two objectives for collecting demographic data from survey participants: to ensure that the people who participated in evaluating the domains and tasks were qualified to do so by virtue of their standing as newly certified Athletic Trainers and to support generalization from respondents to the newly certified population. To assess these objectives, the survey included 17 demographic questions, consistent with previous BOC surveys.

Responses to the demographic portion of the survey provide information that may be used to understand the characteristics of respondents. The substantial majority of the group was female. More than 85% of the respondents indicated that they were between 20 and 30 years of age. About one-third of the respondents are in the Midwestern states, although all regions were well represented. Respondents were largely of Caucasian descent. About one-third reported a bachelor's degree with athletic training as their major. About half report having a master's degree, but the major field was divided between athletic training and other disciplines.

Given the sampling strategy, it is not surprising that almost 80% of the respondents have been certified for five years or less. About 85% of the respondents have been in practice for five years or less. A small percentage of respondents are qualified in other fields in healthcare. When respondents hold credentials in other fields, the largest number are in physical therapy and emergency medical technology. The most frequent work settings are secondary schools (athletic training), universities and colleges (athletic training), and clinics and hospitals (athletic training).

Respondents were asked the number of Athletic Trainers who are employed in their current work setting. Overwhelmingly, most settings employ from one to five Athletic Trainers. Only about 15% indicated that they were the first Athletic Trainer to be employed in their workplace. The largest number of respondents reported their title as Athletic Trainer. About three-fourths of the respondents reported that there was an Emergency Action Plan in place at the time they were first employed in their current position. Given the request to report the portion of their work time that is devoted to athletic training, about half of the respondents reported that these responsibilities are 90% or more of their jobs. Well more than half reported that they spend more than 70% of their time in the delivery of patient care.

Most respondents reported that they do not supervise anyone who provides direct patient care, although about 30% do, to varying degrees. Finally, the survey asked respondents to provide information about their annual earnings from their work in athletic training. More than half of the respondents indicated that their athletic training income is between $30,000 and $50,000 annually.

Validation of the Domains and Tasks

Respondents were asked to evaluate each task using scales for Performance Expectation, Consequence and Frequency. A three-point scale was used for Performance Expectation, with the most desired response being "2" (within the first six months after certification). The Consequence scale employed five units (1 to 5), with a "5" indicating the potential for extreme harm. A five-point scale (1 to 5) was used for the Frequency scale, with a response of "5" representing the highest rating. The scales are listed below as a reference:

- **Performance Expectation:** At what point are newly certified Athletic Trainers first expected to perform the domain or task?
- **Consequence:** To what degree may the newly certified Athletic Trainer's lack of proficiency to perform duties in each domain or task be seen as causing harm to stakeholders? (Harm may be seen as physical, psychological, emotional, legal, financial, etc.)
- **Frequency:** Frequency refers to how often newly certified Athletic Trainers perform duties in each domain or task, considering a one-year period.

After rating the tasks, participants in the survey were asked to evaluate the domains as a whole, considering all tasks in the domain taken together. The evidence that newly certified Athletic Trainers are expected to perform the domains within the first six months after earning certification is very strong, with at least 88% of respondents attaching a "2" for all domains. See Table 1.1 for the details.

Table 1.1. Counts and Percentages for Performance Expectation of Domains

Domain	N	1	% 1	2	% 2	3	% 3
Injury and Illness Prevention and Wellness Promotion	898	5	0.6%	844	94.0%	898	5
Examination, Assessment and Diagnosis	840	4	0.5%	811	96.5%	840	4
Immediate and Emergency Care	819	5	0.6%	758	92.6%	819	5
Therapeutic Intervention	799	2	0.3%	755	94.5%	799	2
Healthcare Administration and Professional Responsibility	788	4	0.5%	696	88.3%	788	4

Performance Expectation: 1 = Not at all, 2 = Within first six months, 3 = Only after first six months

Consequence ratings suggest that the third domain (Immediate and Emergency Care) has the greatest criticality (substantial harm), and the degree to which harm might result from improper performance for the other domains ranges close to moderate. Domain-level responses for Consequence are summarized in Tables 1.2 and 1.3.

Examination, Assessment and Diagnosis is the domain that entry-level Athletic Trainers perform most frequently. Immediate and Emergency Care is performed about monthly, and the other domains are performed on at least a weekly basis. See Tables 1.4 and 1.5 for the detail on Frequency ratings.

Table 1.2. Counts and Percentages for Consequence of Domains

Domain	N	1	% 1	2	% 2	3	% 3	4	% 4	5	% 5
Injury and Illness Prevention and Wellness Promotion	873	47	5.4%	181	20.7%	386	44.2%	194	22.2%	65	7.4%
Examination, Assessment and Diagnosis	820	35	4.3%	96	11.7%	297	36.2%	284	34.6%	108	13.2%
Immediate and Emergency Care	795	24	3.0%	44	5.5%	102	12.8%	256	32.2%	369	46.4%
Therapeutic Intervention	781	30	3.8%	206	26.4%	416	53.3%	110	14.1%	19	2.4%
Healthcare Administration and Professional Responsibility	767	77	10.0%	241	31.4%	308	40.2%	104	13.6%	37	4.8%

Consequence: 1 = No harm, 2 = Minimal harm, 3 = Moderate harm, 4 = Substantial Harm, 5 = Extreme Harm

Table 1.3. Descriptive Statistics for Consequence of Domains

Domain	N	Median	Mean	SE Mean	Std Dev
Injury and Illness Prevention and Wellness Promotion	873	3	3.1	0.00	1.0
Examination, Assessment and Diagnosis	820	3	3.4	0.00	1.0
Immediate and Emergency Care	795	4	4.1	0.00	1.0
Therapeutic Intervention	781	3	2.8	0.00	0.8
Healthcare Administration and Professional Responsibility	767	3	2.7	0.00	1.0

Consequence: 1 = No harm, 2 = Minimal harm, 3 = Moderate harm, 4 = Substantial Harm, 5 = Extreme Harm

Table 1.4. Counts and Percentages for Frequency of Domains

Domain	N	1	% 1	2	% 2	3	% 3	4	% 4	5	% 5
Injury and Illness Prevention and Wellness Promotion	870	4	0.5%	41	4.7%	201	23.1%	255	29.3%	369	42.4%
Examination, Assessment and Diagnosis	816	4	0.5%	9	1.1%	23	2.8%	104	12.7%	676	82.8%
Immediate and Emergency Care	793	6	0.8%	202	25.5%	336	42.4%	135	17.0%	114	14.4%
Therapeutic Intervention	780	3	0.4%	7	0.9%	60	7.7%	204	26.2%	506	64.9%
Healthcare Administration and Professional Responsibility	769	7	0.9%	48	6.2%	141	18.3%	187	24.3%	386	50.2%

Frequency: 1 = Never, 2 = Once per year, 3 = Once per month, 4 = Once per week, 5 = Daily

Table 1.5. Descriptive Statistics for Frequency of Domains

Domain	N	Median	Mean	SE Mean	Std Dev
Injury and Illness Prevention and Wellness Promotion	870	4	4.1	0.0	0.9
Examination, Assessment and Diagnosis	816	5	4.8	0.0	0.6
Immediate and Emergency Care	793	3	3.2	0.0	1.0
Therapeutic Intervention	780	5	4.5	0.0	0.7
Healthcare Administration and Professional Responsibility	769	5	4.2	0.0	1.0

Frequency: 1 = Never, 2 = Once per year, 3 = Once per month, 4 = Once per week, 5 = Daily

Reliability Analysis for Domains

Reliability, reported in Table 1.6, was measured by estimating internal consistency (Cronbach's alpha) using the respondents' ratings for Consequence and Frequency for the tasks in each domain or subdomain. This procedure calculates the extent to which the task ratings within a domain consistently measure what other tasks within that performance domain measure. Reliability coefficients range from 0 to 1 and should be above 0.70 to be judged as adequate. The reliability coefficients obtained for this study were strong, especially for Therapeutic Intervention, and were almost as strong for Examination, Assessment and Diagnosis.

Table 1.6. Reliability

Reliability	Consequence	Frequency
Injury and Illness Prevention and Wellness Promotion	0.86	0.71
Examination, Assessment and Diagnosis	0.92	0.83
Immediate and Emergency Care	0.88	0.78
Therapeutic Intervention	0.93	0.88
Healthcare Administration and Professional Responsibility	0.81	0.58

CONCLUSION

The process for developing the outline of domains, tasks and knowledge and skill statements was drawn from established methodology for practice analysis studies. Panelists were well informed about the professional expectations of newly certified Athletic Trainers, and they participated in group discussions to clarify understanding, negotiate language and express opinions about all elements of the system. This work provided a strong basis for the validation study to follow.

Demographic data collected in the validation study indicate that respondents were qualified to participate in the survey and were aligned to the major characteristics of newly certified Athletic Trainers. They are distributed across practice settings, regions and other variables in ways that are consistent with previous BOC surveys.

Almost across the board, task validation data indicate strong support for the inference that tasks are valid with respect to entry-level practice. Additionally, ratings indicate that tasks are consequential to the safety and effectiveness of athletic training services and that they are performed often by newly certified Athletic Trainers. The only real disparity in opinion concerned the first two tasks in Healthcare Administration and Professional Responsibility, where it may be said that Athletic Trainers are responsible for the tasks but that not all settings require newly certified Athletic Trainers to perform them directly. Ratings for domains indicate their validity to the practice of Certified Athletic Trainers.

The purpose of the practice analysis study was to develop a current outline of domains, tasks and knowledge and skill statements that characterize the work of newly certified Athletic Trainers and define what proficiencies they should be expected to possess. Data collected in the validation study support the conclusion that this purpose was achieved and that the BOC may use the outline as the basis for its certification examination.

AT Scopes
(FL, IL, NY, OH, PA, TX)

FLORIDA

468.701 Definitions.--As used in this part, the term:
(1) "Athlete" means a person who participates in an athletic activity.
(2) "Athletic activity" means the participation in an activity, conducted by an educational institution, a professional athletic organization, or an amateur athletic organization, involving exercises, sports, games, or recreation requiring any of the physical attributes of strength, agility, flexibility, range of motion, speed, and stamina.
(3) "Athletic injury" means an injury sustained which affects the athlete's ability to participate or perform in athletic activity.
(4) "Athletic trainer" means a person licensed under this part.
(5) "Athletic training" means the recognition, prevention, and treatment of athletic injuries.
(6) "Board" means the Board of Athletic Training.
(7) "Department" means the Department of Health.
(8) "Direct supervision" means the physical presence of the supervisor on the premises so that the supervisor is immediately available to the trainee when needed.
(9) "Supervision" means the easy availability of the supervisor to the athletic trainer, which includes the ability to communicate by telecommunications.

ILLINOIS

(225 ILCS 5/3) (from Ch. 111, par. 7603)
(Section scheduled to be repealed on January 1, 2026)
Sec. 3. Definitions. As used in this Act:
(1) "Department" means the Department of Financial and Professional Regulation.
(2) "Secretary" means the Secretary of Financial and Professional Regulation.
(3) "Board" means the Illinois Board of Athletic Trainers appointed by the Secretary.
(4) "Licensed athletic trainer" means a person licensed to practice athletic training as defined in this Act and with the specific qualifications set forth in Section 9 of this Act who, upon the direction of his or her team physician or consulting physician, carries out the practice of prevention/emergency care or physical reconditioning of injuries incurred by athletes participating in an athletic program conducted by an educational institution, professional athletic organization, or sanctioned amateur athletic organization employing the athletic trainer; or a person who, under the direction of a physician, carries out comparable functions for a health organization-based extramural program of athletic training services for athletes. Specific duties of the athletic trainer include but are not limited to:
A. Supervision of the selection, fitting, and maintenance of protective equipment;
B. Provision of assistance to the coaching staff in the development and implementation of conditioning programs;
C. Counseling of athletes on nutrition and hygiene;
D. Supervision of athletic training facility and inspection of playing facilities;

E. Selection and maintenance of athletic training equipment and supplies;
F. Instruction and supervision of student trainer staff;
G. Coordination with a team physician to provide:
(i) pre-competition physical exam and health history updates,
(ii) game coverage or phone access to a physician
(ii) game coverage or phone access to a physician or paramedic,
(iii) follow-up injury care,
(iv) reconditioning programs, and
(v) assistance on all matters pertaining to the health and well-being of athletes.
H. Provision of on-site injury care and evaluation as well as appropriate transportation, follow-up treatment and rehabilitation as necessary for all injuries sustained by athletes in the program;
I. With a physician, determination of when an athlete may safely return to full participation post-injury; and
J. Maintenance of complete and accurate records of all athletic injuries and treatments rendered.
To carry out these functions the athletic trainer is authorized to utilize modalities, including, but not limited to, heat, light, sound, cold, electricity, exercise, or mechanical devices related to care and reconditioning.

NEW YORK

§8351. Definition.
As used in this article "athletic trainer" means any person who is duly certified in accordance with this article to perform athletic training under the supervision of a physician and limits his or her practice to secondary schools, institutions of postsecondary education, professional athletic organizations, or a person who, under the supervision of a physician, carries out comparable functions on orthopedic athletic injuries, excluding spinal cord injuries, in a health care organization. Supervision of an athletic trainer by a physician shall be continuous but shall not be construed as requiring the physical presence of the supervising physician at the time and place where such services are performed.
The scope of work described herein shall not be construed as authorizing the reconditioning of neurologic injuries, conditions or disease.

§8352. Definition of practice of athletic training.
The practice of the profession of athletic training is defined as the application of principles, methods and procedures for managing athletic injuries, which shall include the preconditioning, conditioning and reconditioning of an individual who has suffered an athletic injury through the use of appropriate preventative and supportive devices, under the supervision of a physician and recognizing illness and referring to the appropriate medical professional with implementation of treatment pursuant to physician`s orders. Athletic training includes instruction to coaches, athletes, parents, medical personnel and communities in the area of care and prevention of athletic injuries.

The scope of work described herein shall not be construed as authorizing the reconditioning of neurologic injuries, conditions or disease.

OHIO

[ATHLETIC TRAINERS SECTION]
4755.60 Definitions. As used in sections 4755.60 to 4755.65 and 4755.99 of the Revised Code:
(A) "Athletic training" means the practice of prevention, recognition, and assessment of an athletic injury and the complete management, treatment, disposition, and reconditioning of acute athletic injuries upon the referral of an individual authorized under Chapter 4731. of the Revised Code to practice medicine and surgery, osteopathic medicine and surgery, or podiatry, a dentist licensed under Chapter 4715. of the Revised Code, a physical therapist licensed under this chapter, or a chiropractor licensed under Chapter 4734. of the Revised Code. Athletic training includes the administration of topical drugs that have been prescribed by a licensed health care professional authorized to prescribe drugs, as defined in section 4729.01 of the Revised Code. Athletic training also includes the organization and administration of educational programs and athletic facilities, and the education of and consulting with the public as it pertains to athletic training.
(B) "Athletic trainer" means a person who meets the qualifications of this chapter for licensure and who is employed by an educational institution, professional or amateur organization, athletic facility, or health care facility to practice athletic training.
(C) "The national athletic trainers association, inc." means the national professional organization of athletic trainers that provides direction and leadership for quality athletic training practice, education, and research.
(D) "Athletic injury" means any injury sustained by an individual that affects the individual's participation or performance in sports, games, recreation, exercise, or other activity that requires physical strength, agility, flexibility, speed, stamina, or range of motion. Effective 4/10/01

PENNSYLVANIA

§ 18.502. Definitions

The following words and terms, when used in this subchapter, have the following meanings, unless the context clearly indicates otherwise:
Approved athletic training education programs - An athletic training education program that is accredited by a Board-approved Nationally recognized accrediting agency.
Athletic training services -The management and provision of care of injuries to a physically active person, with the direction of a licensed physician.
(i) The term includes the rendering of emergency care, development of injury prevention programs and providing appropriate preventative and supportive devices for the physically active person.

(ii) The term also includes the assessment, management, treatment, rehabilitation and reconditioning of the physically active person whose conditions are within the professional preparation and education of a licensed athletic trainer.
(iii) The term also includes the use of modalities such as: mechanical stimulation, heat, cold, light, air, water, electricity, sound, massage and the use of therapeutic exercise, reconditioning exercise and fitness programs.
(iv) The term does not include surgery, invasive procedures or prescription of any medication or controlled substance.

BOC - The Board of Certification, Inc., a National credentialing organization for athletic trainers.

Direction - Supervision over the actions of a licensed athletic trainer by means of referral by prescription to treat conditions for a physically active person from a licensed physician, dentist or podiatrist or written protocol approved by a supervising physician, except that the physical presence of the supervising physician, dentist or podiatrist is not required if the supervising physician, dentist or podiatrist is readily available for consultation by direct communication, radio, telephone, facsimile, telecommunications or by other electronic means.

Licensed athletic trainer - A person who is licensed to perform athletic training services by the Board or the State Board of Osteopathic Medicine.

Physically active person - An individual who participates in organized, individual or team sports, athletic games or recreational sports activities.

Referral - An order from a licensed physician, dentist or podiatrist to a licensed athletic trainer for athletic training services. An order may be written or oral, except that an oral order must be reduced to writing within 72 hours of issuance.

Standing written prescription - A portion of the written protocol or a separate document from a supervising physician, which includes an order to treat approved individuals in accordance with the protocol.

Written protocol - A written agreement or other document developed in conjunction with one or more supervising physicians, which identifies and is signed by the supervising physician and the licensed athletic trainer, and describes the manner and frequency in which the licensed athletic trainer regularly communicates with the supervising physician and includes standard operating procedures, developed in agreement with the supervising physician and licensed athletic trainer, that the licensed athletic trainer follows when not directly supervised onsite by the supervising physician.

TEXAS

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 451.001. Definitions.

In this chapter:

(1) "Athletic injury" means an injury sustained by a person as a result of the person's participation in an organized sport or sport-related exercise or activity, including interscholastic, intercollegiate, intramural, semiprofessional, and professional sports activities.

(2) "Athletic trainer" means a person who practices athletic training, is licensed by the department, and may use the initials "LAT," "LATC," and "AT" to designate the person as an athletic trainer. The terms "sports trainer" and "licensed athletic trainer" are equivalent to "athletic trainer."

(3) "Athletic training" means the form of health care that includes the practice of preventing, recognizing, assessing, managing, treating, disposing of, and reconditioning athletic injuries under the direction of a physician licensed in this state or another qualified, licensed health professional who is authorized to refer for health care services within the scope of the person's license.

(4) "Board" means the Advisory Board of Athletic Trainers.

(5) "Commission" means the Texas Commission of Licensing and Regulation.

(6) "Department" means the Texas Department of Licensing and Regulation.

(7) "Executive director" means the executive director of the department.