Standards for the Accreditation of

Post-Professional Athletic Training Degree Programs

© Commission on Accreditation of Athletic Training Education

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The purpose of the Commission on Accreditation of Athletic Training Education (CAATE) is to develop, maintain, and promote appropriate minimum education standards for quality for athletic training programs. The CAATE is sponsored by the American Academy of Family Physicians, the American Academy of Pediatrics, the American Orthopaedic Society for Sports Medicine, and the National Athletic Trainers' Association (NATA).

The *Standards for the Accreditation of Post-Professional Athletic Training Degree Programs (Standards)* are used to prepare athletic trainers for advanced clinical practice through a structured didactic and clinical experience. Each institution is responsible for demonstrating compliance with these *Standards* to obtain and maintain recognition as a CAATE-accredited post-professional athletic training degree program. A list of accredited programs is published and available to the public.

These *Standards* are to be used for the development, evaluation, analysis, and maintenance of post-professional athletic training degree programs. Via comprehensive and annual review processes, the CAATE is responsible for the evaluation of a program's compliance with the *Standards*. The *Standards* provide minimum academic requirements; institutions are encouraged to develop sound innovative educational approaches that substantially exceed these *Standards*. The *Standards* include two different types of accreditation standards that are important to differentiate. The majority of the standards are *Compliance Standards,* which are denoted by the verb "must". *Compliance Standards* represent the minimum education standards for quality that are required to demonstrate accreditation compliance. Accreditation decisions are only made by the CAATE based upon program compliance with *Compliance Standards*. Standards denoted by the verb "should" are *Aspirational Standards*. In contrast to *Compliance Standards, Aspirational Standards* are not required to ensure minimum educational quality. Instead, *Aspirational Standards* are provided in instances where the CAATE feels that it is important to note a desired state beyond the minimum required for accreditation compliance. While *Compliance Standards* must be attained to ensure minimum educational quality and compliance, *Aspirational Standards* are only recommendations and are NOT utilized to determine program compliance and are NOT used to make accreditation decisions. However, *Aspirational Standards* are important and any non-compliance with an *Aspirational Standard* must be justified. To assist in the interpretation of individual standards a glossary of terms is provided at the end of this document.

Description of the Profession

Athletic Trainers are healthcare professionals who collaborate with physicians to optimize activity and participation of patients and clients. Athletic training encompasses the prevention, diagnosis and intervention of emergency, acute and chronic medical conditions involving impairment, functional limitations and disabilities. Athletic

Training is recognized by the American Medical Association (AMA) as a healthcare profession.

The athletic trainer's post-professional preparation is based on developing students' knowledge, skills, and abilities, beyond the professional level, as determined by the Commission. Post-Professional athletic training degree programs incorporate core competencies required for advanced clinical practice. The Post-Professional core competencies are listed and defined here:

- Evidence-Based Practice
- Interprofessional Education and Collaborative Practice
- Quality Improvement
- Healthcare Informatics
- Professionalism
- Patient-Centered Care

CAATE accredited post-professional athletic training degree programs must ensure that students attain specific **core competencies** that relate to professional behaviors. There is an important conceptual difference between the meaning of the term **core competencies** as it relates to post-professional education and its meaning in the context of professional education. The National Athletic Trainers' Association (NATA) *Athletic Training Education Competencies* and the CAATE *Standards for the Accreditation of Professional Athletic Training Programs* use the term **"competencies"** to refer to the specific knowledge that must be attained and the specific skills that must be developed by students in a professional education program. The post-professional *Standards* have been developed to enhance the competence of athletic trainers who have already attained the necessary credentials for entry-level professional practice. For the post-professional education of athletic trainers, educational **"core competencies"** are broadly defined as professional behavior that involves *the habitual and judicious use of communication, knowledge, clinical skills, clinical reasoning, emotions, values, and reflection in daily practice.*

The Institute of Medicine (IOM) has identified five core competencies for all healthcare providers, regardless of discipline, and similar concepts are represented in six competencies defined by the Accreditation Council for Graduate Medical Education (ACGME) and the American Board of Medical Specialties (ABMS) for all graduate medical education, regardless of specialty. Post-professional education core competencies are consistent with those specified by IOM and ACGME/ABMS, and they are consistent with seven foundational behaviors of professional practice identified within the NATA Education Competencies for professional education. The six core competencies that a CAATE accredited post-professional athletic training degree program must be designed to address are: 1) patient-centered care, 2) interprofessional education and collaboration, 3) evidence-based practice, 4) quality improvement, 5) use of healthcare informatics, and 6) professionalism. Descriptions of the six core competencies are provided:

1. Patient-Centered Care

Patient-centered care is characterized by efforts to clearly inform, educate, and communicate with patients in a compassionate manner. Shared decision-making and management are emphasized, as well as continuous advocacy of injury and disease prevention measures and promotion of a healthy lifestyle. Although the phrase "patient-centered care" is widely used, its meaning is not interpreted in a consistent manner within and across health professions. The American healthcare delivery system is characterized by clinician-centered and disease-focused care, which empowers the healthcare professional to function as the primary source of control, and which involves treatment of a condition without adequate attention to the needs, concerns, and preferences of the patient.

Competency in patient-centered care relates to the athletic trainer's ability to serve as an advocate for a patient's best interests, to educate the patient about health-related concerns and intervention options, to recognize any conflict of interest that could adversely affect the patient's health, and to facilitate collaboration among the patient, physician, family, and other members of the patient's social network or healthcare system to develop an effective treatment plan that includes agreed-upon implementation steps, short-term goals and long-term goals.

2. Interprofessional Education and Collaborative Practice

Coordinated cooperation among clinicians who provide care for a patient is far more important than professional prerogatives and roles. Different health professions often perform a subset of overlapping functions, but separate scopes of practice, governance structures, and standards maintained by licensing agencies for the different health professions present obstacles to the delivery of optimum patient care by an interprofessional team. Interprofessional Education occurs when two or more professions learn with, from and about each other to improve collaboration and the quality of care. Competency in interprofessional education and collaborative practice relates to the athletic trainer's ability to interact with other health professionals in a manner that optimizes the quality of care provided to individual patients.

In many healthcare settings, authoritative organizational policies establish strict practice boundaries and separation of professional disciplines that are strongly reinforced by third-party reimbursement procedures. Efforts to change scope of practice legislation often produce conflict that results in distrust and hostility among professions. Health professions education is often provided by separate professional schools or separate academic units within an educational institution, which are often housed in separate facilities. Administrative governance by separate deans, directors, or department chairs often results in the protection of the special interests of a particular health profession. Some fear that

professional identity will be lost, advantageous organizational hierarchy will be altered, and political clout will be weakened by interprofessional health professions education and clinical collaboration. Each program should strive to remove barriers to interprofessional education and collaborative practice within its educational institution. Athletic training students should be provided with as many opportunities as possible for intentional interprofessional collaboration with educators, practicing clinicians, and students from other health professions.

3. Evidence-Based Practice

Evidence-based practice is the integration of best research evidence with clinical expertise and patient values and circumstances to make decisions about the care of individual patients. ***Best research evidence*** includes evidence from randomized controlled trials, laboratory experiments, clinical trials, epidemiological research, outcomes research, qualitative research, and the knowledge of experts. ***Clinical expertise*** is derived from the knowledge and experience developed over time from practice, including inductive reasoning. ***Patient values and circumstances*** are the unique preferences, concerns, financial resources, and social supports that are brought by each patient to a clinical encounter. Evidence-based practice does not dictate that all clinical decisions must be based on the results of randomized controlled trials, because such results are often unavailable or insufficiently relevant to the specific clinical circumstance.

Traditional health professions education has been heavily compartmentalized, i.e., lecture presentation of highly focused subject matter pertaining to the diagnosis and treatment of specific conditions, which has not been directly related to ethical considerations or acquisition of clinical skills. Students should not be expected to independently assimilate, retain, and integrate knowledge derived from course lectures with subsequent clinical skill instruction and patient interactions. A post-professional athletic training degree program curriculum must reflect an intentional effort to link didactic content to clinical decision-making. Competency in evidence-based practice relates to the athletic trainer's ability to integrate the best available research evidence with clinical expertise and consideration of patient values and circumstances to optimize patient outcomes.

4. Quality Improvement

Healthcare organizations are increasingly adopting quality assessment methods that originated in the industrial manufacturing sector to minimize waste, decrease errors, increase efficiency, and improve quality of care. Total quality management (TQM) and continuous quality improvement (CQI) are terms used to designate a systematic approach to optimization of processes to ensure that high-quality products and services are consistently delivered to consumers. Emerging technologies are enhancing the process of clinical

decision-making through rapid access to relevant patient data, more extensive communication between clinician and patient, and improved communication between different clinicians treating the patient.

Competency in quality improvement relates to the athletic trainer's recognition of the need for constant self-evaluation and life-long learning, and it includes the ability to identify a quality improvement objective, specify changes that are expected to produce an improvement, and quantitatively confirm that an improvement resulted from implementation of the change (e.g., improved patient outcomes from administration of a specific intervention or utilization of a specific protocol).

5. Use of Healthcare Informatics

Competency in the use of healthcare informatics relates to the athletic trainer's ability to: 1) search, retrieve, and utilize information derived from online databases and/or internal databases for clinical decision support, 2) properly protect the security of personal health information in a manner that is consistent with legal and ethical considerations for use of such data, including control of data access, utilization of patient identity coding, de-identification of aggregated data, and encryption of electronically transmitted data, 3) guide patients to online sources of reliable health-related information, 4) utilize word processing, presentation, and data analysis software, and 5) communicate through email, text messaging, listservs, and emerging modes of interactive electronic information transfer.

The assumption that health professionals can identify and treat conditions, evaluate new clinical tests and therapeutic procedures, and develop clinical practice guidelines solely through reliance on knowledge gained from academic preparation and practice experience is no longer valid. Human memory is an unreliable means for maintaining familiarity with the rapidly expanding body of knowledge in healthcare. Clinicians must increasingly use information technology to manage clinical data and access the most recent evidence pertaining to optimum patient care.

6. Professionalism

Elements of professionalism are clearly exhibited through the delivery of patient-centered care, effective participation as a member of an interdisciplinary team, and commitment to continuous quality improvement, but its importance makes it worthy of designation as another distinct competency. Professionalism relates to personal qualities of honesty, reliability, accountability, patience, modesty, and self-control. It is exhibited through ethical behavior, a respectful demeanor toward all persons, compassion, a willingness to serve others, sensitivity to the concerns of diverse patient populations, a conscientious approach

to performance of duties, a commitment to continuing education, contributions to the body of knowledge in the discipline, appropriate dress, and maintenance of a healthy lifestyle.

Recognition of the need for continuous self-evaluation and personal growth is essential for attainment of a high level of professionalism. Competency in professionalism relates to the athletic trainer's adherence to the NATA *Code of Ethics* and the Board of Certification *Standards of Practice*, and includes intrinsic motivation to continuously exhibit the manifestations of professionalism in all aspects of clinical practice and personal conduct.

2013 CAATE Post-Professional Athletic Training Degree Standards

Sponsorship

1. The sponsoring institution **must** be accredited by an agency recognized by the United States Department of Education or by the Council for Higher Education Accreditation and must be legally authorized to provide a program of post-baccalaureate education. For programs outside of the United States, the institution **must** be accredited by a recognized post-baccalaureate accrediting agency.
2. The program **must** lead to a post-baccalaureate (post-professional) masters or doctoral degree.
3. The name "Athletic Training" **must** appear on the transcript as the major, specialization, concentration, emphasis, or track
4. The institution **should** grant a post-baccalaureate (post-professional) degree in athletic training.
5. All sites where students are involved in patient care (excluding the Program's sponsoring institution) **must** have an affiliation agreement or memorandum(s) of understanding that is endorsed by the appropriate administrative authority (i.e. those bearing signature authority) at both the sponsoring institution and site. In the case where the administrative oversight of the student differs from the affiliate site, formal agreements **must** be obtained from all parties.

6. In certain instances, the school/college or university sponsoring the program may establish affiliation with other units within the institution or at other institutions, to provide instruction, research, or administrative experiences. If such affiliations are made there **must** be formal administrative arrangements for use of all affiliated settings.
7. The program **should** be housed within the school of health sciences, health professions, medicine or similar health-related academic unit.

Outcomes

8. Develop a Plan: The program's outcomes and objectives guide the program, and **must** be consistent with the missions of the university, school/college, and department in which the program is housed.
9. Develop a Plan: All aspects of the program (didactic, scholarly experience, advanced clinical practice) **must** have corresponding program outcomes and objectives.
10. Develop a Plan: The program's outcomes and objectives **must** reflect its faculty expertise and resources.
11. Develop a Plan: The program's outcomes **must** increase students' depth and breadth of understanding of athletic training subject matter areas, skills, and *Post-Professional Core-Competencies,* beyond the knowledge, skills, and abilities required of the professional preparation program.
12. Develop a Plan: There **must** be a comprehensive assessment plan to evaluate all aspects of the educational program. Assessments used for this purpose **must** include those defined in Standards 10 and 11. Additional assessments may include,

but are not limited to, clinical site evaluations, preceptor evaluations, academic course performance, retention and graduation rates, graduating student exit evaluations, and alumni placement rates one year post graduation.

13. Develop a Plan: The plan **must** be ongoing and document regular assessment of the educational program.
14. Assessment Measures: The program's assessment measures **must** include those stated in Standards 10 and 11 in addition to any unique metrics that reflect the specific program, department, or college. The specific volume and nature of this information is influenced by the individual character of the institution and should be in keeping with other similar academic programs within the institution. The assessment tools **must** relate the program's stated educational mission, goals and objectives to the quality of instruction all identified, student learning, and overall program effectiveness.
15. Assessment Measures: The program's aggregate institutional data (as defined by the CAATE) for the most recent three years **must** be provided.
16. Assessment Measures: Programs **must** post the aggregate institutional data (as defined by the CAATE) on the program's home page or a direct link to the data **must** be on the program's home webpage.
17. Collect the Data: Programs **must** obtain data to determine all identified program outcomes.
18. Data Analysis: Programs **must** analyze the outcomes data to determine the extent to which the program is meeting its stated mission, goals, and objectives.
19. Action Plan: The results of the data analysis are used to develop a plan for continual program improvement. This plan **must**:
    a. Develop targeted goals and action plans if the program and student learning outcomes are not met; and
    b. State the specific timelines for reaching those outcomes; and
    c. Identify the person(s) responsible for those action steps; and
    d. Provide evidence of periodic updating of action steps as they are met or circumstances change.

Personnel

20. Program Director **must** be a full-time employee of the sponsoring institution.
21. The Program Director **must** possess a terminal degree (e.g., PhD, EdD) from a regionally accredited institution.
22. The Program Director **must** be a member of the graduate faculty, where applicable, as defined by institutional policy.
23. Program Director **must** have faculty status, with full faculty rights, responsibilities, privileges, and full college voting rights as defined by institution policy and that are consistent with similar positions at the institution necessary to provide appropriate program representation in institutional decisions.
24. The Program Director **should** be tenured and hold the rank of associate professor or higher.
25. The Program Director **must** have an ongoing involvement in the athletic training profession as evidenced by scholarly publications/presentations and involvement in the profession.
26. Program Director **must** have programmatic administrative and supervisory

assignment that is consistent with other similar assignments within the degree-granting unit at the institution.

27. Program Director **must** have administrative release time. The Program Director's release time **must** be equivalent to similar health care programs in the institution. If no such similar program exists at the institution, then benchmark with peer institutions.
28. Program Director Responsibilities **must** include input to and assurance of the following program features:
    a. Ongoing compliance with the Standards;
    b. Planning, development, implementation, delivery, documentation, and assessment of all components of the curriculum;
    c. Advanced clinical practice experiences;
    d. Programmatic budget.
29. Program Director Qualifications: The Program Director **must** be certified and be in good standing with the Board of Certification (BOC).
30. Program Director Qualifications: The Program Director **must** possess a current state athletic training credential and be in good standing with the state regulatory agency (where applicable).
31. Athletic Training Faculty Qualifications: All faculty assigned and responsible for the instruction of the required program content **must** be qualified through professional preparation and experienced in their respective academic areas as determined by the institution.
32. Athletic Training Faculty Qualifications: All faculty assigned and responsible for the instruction of the required program content **must** be recognized by the institution as having instructional responsibilities.
33. Athletic Training Faculty Qualifications: All faculty assigned and responsible for the instruction of required program content must incorporate the most current athletic training knowledge, skills, and abilities as they pertain to their respective teaching areas.
34. Athletic Training Faculty **must** have an ongoing involvement in the athletic training profession as evidenced by scholarly publications/presentations and involvement in the profession.
35. Athletic Training Faculty Qualifications: All faculty assigned and responsible for instruction of the required program content **must** possess a current state credential and be in good standing with the state regulatory agency (where and when applicable) when teaching hands on athletic training patient care techniques with an actual patient population.
36. Athletic Training Faculty Number: In addition to the Program Director, there **must** be a minimum of one full-time (1.0 FTE) core faculty member as defined in the glossary, dedicated (100% of 1 FTE) to the athletic training program. The faculty members **must** have full faculty rights, responsibilities, privileges, and full college voting rights as defined by institution policy and that are consistent with similar positions at the institution necessary to provide appropriate program representation in institutional decisions.
37. Athletic Training Faculty: Based on the program's student enrollment, the number of athletic training faculty **must** be sufficient to advise and mentor students.

38. Athletic Training Faculty: Based on the program's student enrollment, the number of athletic training faculty **must** be sufficient to meet program outcomes.
39. Medical Director: The program must have a Medical Director. This individual **must** be an MD/DO who is licensed to practice in the state sponsoring the program.
40. Medical Director: The Medical Director **must**, in coordination with the Program Director, serve as a resource and medical content expert for the program.

Program Delivery: Program delivery includes didactic, laboratory, and advanced clinical practice courses.

41. The program **must** assure that the *Post-Professional Core Competencies* are integrated within the program.
42. Clearly written current course syllabi are required for all courses that deliver content related to the *Post-Professional Core Competencies* and **must** be written using clearly stated objectives.
43. Clinical placements **must** be non-discriminatory with respect to race, color, creed, religion, ethnic origin, age, sex, disability, sexual orientation, or other unlawful basis.
44. All clinical education sites **must** be evaluated by the program on an annual and planned basis and the evaluations **must** serve as part of the program's comprehensive assessment plan.
45. The program's students **must** be credentialed and be in good standing with the Board of Certification (BOC) prior to providing athletic training services.
46. The program's students **must** possess a current state athletic training credential and be in good standing with the state regulatory agency (where applicable) prior to providing athletic training services.
47. Course credit **must** be consistent with institutional policy or institutional practice.
48. The number of work hours performed during clinical experiences and graduate assistantship experiences **must** be in compliance with institutional and Federal policy.
49. The program **must** include scholarly experiences designed to improve student critical thinking and decision making.
50. The athletic training faculty **must** be actively involved in advising students in scholarly experiences by providing mentorship and serving as role models.
51. Sufficient time and opportunity **must** be provided within the program for students to engage in scholarly experiences.
52. The program's scholarly experiences **should** lead to dissemination of new knowledge in athletic training.
53. The program's scholarly experiences **should** emphasize clinical research designed to inform athletic training practice.
54. The program **must** include advanced clinical practice experiences designed to improve the students' ability to provide patient care.
55. Sufficient time and opportunity **must** be provided within the program for students to engage in advanced clinical practice experiences.
56. Assessment of student achievement of the advanced clinical practice outcomes and objectives **must** be accounted for via formal academic coursework.
57. Students **must** receive formal and informal feedback regarding their advanced clinical practice performance at regular intervals.

58. The advanced clinical practice experiences must integrate the *Post-Professional Core Competencies.*
59. There **must** be an individualized advanced clinical education plan (individual goals and/or objectives) for each student to improve the students' ability to provide patient care.

Financial Resources

60. The program **must** receive adequate, equitable, and annually available resources necessary to meet the program's needs based on the program's size and documented mission and outcomes. Funding **must** be commensurate with other comparable health care programs. If no such similar program exists at the institution, then benchmark with health care programs at peer institutions.

Facilities and Instructional Resources

61. The classroom and laboratory space **must** be sufficient to deliver the curriculum and must be available for exclusive use during normally scheduled class times.
62. The number and quality of instructional aids **must** meet the needs of the program.
63. The equipment and supplies needed to instruct students in the required program content **must** be available for formal instruction, practice, and clinical education.
64. Library and other Information Sources: Students must have reasonable access to the information resources needed to adequately prepare them for advanced practice and to support the *Post-Professional Core Competencies*. This includes current electronic or print editions of books, periodicals, and other reference materials and tools related to the program outcomes.
65. Offices **must** be provided for program staff and faculty on a consistent basis to allow program administration and confidential student counseling.

Operational Policies and Fair Practices

66. Program Admission, Retention and Advertisement: standards and criteria **must** be identified and publicly accessible.
67. Student, faculty recruitment, student admission, and faculty employment practices **must** be non-discriminatory with respect to race, color, creed, religion, ethnic origin, age, sex, disability, sexual orientation, or other unlawful basis.
68. The program **must** assure equal opportunity for classroom instruction, clinical experience, and other educational activities for all students in the program.
69. All program documents **must** use accurate terminology of the profession and program offered (e.g., BOC certification, accreditation status, and the program title of athletic training).
70. Academic tuition, fees, and other required program specific costs incurred by the student **must** be publicly accessible in official institutional documents.
71. Full financial responsibilities and benefits (e.g., tuition and fees, tuition waivers, financial aid, graduate assistantships) must be provided to the student, in writing, prior to the student committing to attend the institution.

Program Description and Requirements

72. Athletic training faculty and students **must** have a clearly written and consistent description of the academic curriculum available to them.
73. Athletic training faculty and students **must** have a clearly written and consistent

description of the academic curriculum available to them. This description must include program mission, outcomes and objectives.

74. Athletic training faculty and students must have a clearly written and consistent description of the academic curriculum available to them. This description **must** include curriculum and course sequence.
75. Athletic training faculty and students **must** have a clearly written and consistent description of the academic curriculum available to them. This description **must** include program requirements for completion of the degree.
76. The institution **must** have a published procedure available for processing student and faculty grievances.
77. Policies and processes for student withdrawal and for refund of tuition and fees **must** be published in official institutional publications or other announced information sources and made available to applicants.
78. Policies and procedures governing the award of available funding for scholarships administered by the program **must** be accessible by eligible students.

Student Records

79. Program **must** maintain appropriate student records demonstrating progression through the curriculum.
80. Program **must** maintain appropriate student records. These records, at a minimum, **must** include program admission application and supporting documents.
81. Program **must** maintain appropriate student records. These records, at a minimum, **must** include remediation and disciplinary actions (when applicable).
82. Program **must** maintain appropriate student records. These records, at a minimum, **must** include advanced clinical practice experiences.
83. Student records **must** be stored in a secure location(s), either electronic or in print, and be accessible to only designated program personnel.

Glossary:

Advanced clinical practice: the practice of athletic training at a level which requires substantial theoretical knowledge in athletic training and proficient clinical utilization of this knowledge in practice.
Adapted from:
https://www.ncsbn.org/1986_Position_Paper_on_Advanced_Clinical_Nursing_Practice.pdf

Affiliation agreement: formal, written document signed by administrative personnel, who have the authority to act on behalf of the institution or affiliate, from the sponsoring institution and affiliated site. This agreement defines the roles and responsibilities of the host site, the affiliate, and the student. Same as the memorandum of understanding.

Appropriate administrative authority: Individuals identified by the host institution and, when applicable, the affiliate who have been authorized to enter an agreement on behalf of the institution or affiliate. The individuals having appropriate administrative authority may vary based on the nature of the agreement.

Aspirational Standards: Standards denoted by the verb "should" are *Aspirational Standards*. In contrast to *Compliance Standards, Aspirational Standards* are not required to ensure minimum educational quality. Instead, *Aspirational Standards* are provided in instances where the CAATE feels that it is important to note a desired state beyond the minimum required for accreditation compliance. *Aspirational Standards* are only recommendations and are NOT utilized to determine program compliance and are NOT used to make accreditation decisions. However, *Aspirational Standards* are important and any non-compliance with an *Aspirational Standard* must be justified.

Assessment plan: See Comprehensive Assessment Plan

Clinical site: A physical area where clinical education occurs.

Compliance Standards: *Compliance Standards* represent the minimum education standards for quality that are required to demonstrate accreditation compliance. Accreditation decisions are only made based upon program compliance with *Compliance Standards*.

Comprehensive Assessment Plan: The process of identifying program outcomes, collecting relevant data, and analyzing those data, then making a judgment on the efficacy of the program in meeting its goals and objectives. When applicable, remedial or corrective changes are made in the program.

Course/coursework: Courses involve classroom (didactic), laboratory, and clinical learning experience.

Degree: The award conferred by the college or university that indicates the level of education (masters or doctorate) that the student has successfully completed in athletic training.

Faculty: An individual who has full faculty status, rights, responsibilities, privileges, and full college voting rights as defined by institution policy and that are consistent with similar positions at the institution necessary to provide appropriate program representation in institutional decisions. Additional faculty are defined as follows:

> **Core Faculty:** Administrative or teaching faculty devoted to the program that has full faculty status, rights, responsibilities, privileges, and full college voting rights as defined by the institution. This person is appointed to teach athletic training courses, advise and mentor students in the AT program. At minimum, the **core faculty** must include the Program Director and one (1) additional faculty member. **Core faculty** report to and are evaluated and assigned responsibilities exclusively by the administrator (Chair or Dean) of the academic unit in which the program is housed.
>
> **Associated Faculty:** Individual(s) with a split appointment between the program and another institutional entity (e.g., athletics or another institutional department). These faculty members are evaluated and assigned responsibilities by two different supervisors.
>
> **Adjunct Faculty:** Individual contracted to provide course instruction on a full-course or partial-course basis, but whose primary employment is elsewhere inside or outside the institution. Adjunct faculty may be paid or unpaid.

Fees: Institutional charges incurred by the student other than tuition and excluding room and board.

Goals: The primary or desired results needed to meet an outcome. These are usually larger and longer term than objectives.

Health Care Professional: Athletic Trainer, Chiropractor, Dentist, Registered Dietician, Emergency Medical Technician, Nurse Practitioner, Nutritionist, Paramedic, Occupational Therapist, Optometrist, Orthotist, Physician (MD/DO), Pharmacist, Physical Therapist, Physician Assistant, Podiatrist, Prosthetist, Psychologist, Registered Nurse or Social Worker who hold a current active state or national practice credential and/or certification in the discipline and whose discipline provides direct patient care in a field that has direct relevancy to the practice and discipline of Athletic Training. These individuals may or may not hold formal appointments to the instructional faculty.

Higher education accrediting agency: An organization that evaluates post-secondary educational institutions.

Institutional Aggregate data: Institutional aggregate data must include, but is not limited to: retention rate, graduation rates, transfer-out rates, graduation rates for students receiving athletically related student aid, transfer-out rates for students receiving athletically related

student aid, job placement for graduates, job placement rates for graduates, graduate and professional education placement for graduates.

Laboratory: A setting where students practice skills on a simulated patient (i.e., role playing) in a controlled environment.

Medical director: The physician who serves as a resource regarding the program's medical content. There is no requirement that the medical director participates in the clinical delivery of the program.

Memorandum of understanding (MOU): Similar to an affiliation agreement, but tends not to include legally-binding language or intent. must

Must: A verb used to denote that a standard is a *Compliance Standard* that is required to ensure minimal educational quality.

Objectives: Sub-goals required to meet the larger goal. Generally objectives are more focused and shorter-term than the overriding goal.

Outcome (program): The quantification of the program's ability to meet its published mission. The outcome is generally formed by multiple goals and objectives. For example, based on the evaluation of the goals associated with the outcomes, each outcome may be measured as "met," "partially met," or "not met."

Outcome assessment instruments: A collection of documents used to measure the program's progress towards meeting its published outcomes. Examples of outcomes assessment instruments include course evaluation forms, employer surveys, alumni surveys, student evaluation forms, preceptor evaluation forms, and so on.

Physician: A medical doctor (MD) or doctor of osteopathic medicine (DO) who possesses the appropriate state licensure.

Preceptor: A certified/licensed professional who teaches and evaluates students in a clinical setting using an actual patient base.

Professional development: Continuing education opportunities and professional enhancement, typically is offered through the participation in symposia, conferences, and in-services that allow for the continuation of eligibility for professional credentials.

Program Director: The full-time faculty member of the host institution and a BOC Certified Athletic Trainer responsible for the implementation, delivery, and administration of the AT program.

Release time (reassigned work load): A reduction in the base teaching load to allow for the coordinator [illegible]

Required program content: Required content that encompasses the *Post-Professional Core Competencies* and content necessary to achieve all aspects of the program's (didactic, scholarly experience, advanced clinical practice) outcomes.

Retention: Matriculating through the AT program culminating in graduation.

Retention rate: A time-based measure of the number of students who are enrolled at the start of the period being studied (e.g., 1 year, 4 years) versus those enrolled at the end of the period. Retention rate is calculated as: number at end/number at start * 100.

Scholarly experiences: Any activity that promotes the intellectual and creative process and involves generating, transmitting, applying, and preserving knowledge for the benefit of external audiences.

Should: A verb used to denote that a standard is an *Aspirational Standard* that is recommended to achieve a desired state that is beyond minimal educational quality.

Similar academic institution (Syn: Peer institution): Institutions of comparable size, academic mission, and other criteria used for comparing metrics. Many institutions publish a list of peer institutions.

Sponsoring institution: The college or university that offers the academic program and awards the degree associated with the athletic training program.

Stakeholder: Those who are affected by the program's outcomes. Examples include the public, employers, the Board of Certification, Inc., and alumni.

BOARD OF CERTIFICATION
FOR THE ATHLETIC TRAINER

Be Certain.™

Crosswalk Analysis:

BOC Role Delineation Study/Practice Analysis, Sixth Edition
and
NATA Athletic Training Education Competencies, Fifth Edition

The Board of Certification, Inc. (BOC) regularly conducts a role delineation study/practice analysis (RD/PA) within a sample of the population of BOC certified athletic trainers. When the RD/PA has been approved for publication, the BOC shares the document with the NATA Executive Committee on Education (ECE) who publishes the *NATA Athletic Training Education Competencies (Competencies).* The *Competencies* define the educational content that is expected of students enrolled in an athletic training education program accredited by the Commission on Accreditation of Athletic Training Education (CAATE). The RD/PA serves as the blueprint for the certification exam that students must pass to become a certified athletic trainer. As such, care has been taken to assure that the content of the RD/PA has been included in the *Competencies*. BOC staff and subject matter experts perform a "crosswalk" analysis between the RD/PA and the most current version of the *Competencies* to determine if any tasks, knowledge or skills that have been validated for inclusion in the RD/PA, and therefore mapped to the BOC exam, may be missing in the *Competencies*. Through this cooperative effort, the BOC provides another level of quality assurance to the public. However, close review of the two documents will indicate that the *Competencies* are broader and more specific than the knowledge and skills presented in the RD/PA. The basic premise of the *Competencies* is that of preparing entry-level athletic trainers for current practices verified by the RD/PA. Although these are two distinctly individual documents, both hold a major role in the preparation and evaluation of entry-level athletic trainers.

BOC Domains

- Injury/Illness Prevention and Wellness Protection
- Clinical Evaluation and Diagnosis
- Immediate and Emergency Care
- Treatment and Rehabilitation
- Organizational and Professional Health and Well-being

NATA Competencies

EBP = Evidence-Based Practice
PHP = Prevention and Health Promotion
CE = Clinical Examination and Diagnosis
AC = Acute Care of Injuries and Illnesses
TI = Therapeutic Interventions
PS = Psychosocial Strategies and Referral
HA = Healthcare Administration
PD = Professional Development and Responsibility
CIP = Clinical Integration Proficiencies

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	BOC RD/PA Classification	NATA Competencies
I. Injury/illness prevention and wellness protection – Educating participants and managing risk for safe performance and function.		
A. Minimize risk of injury and illness of individuals and groups impacted by or involved in a specific activity through awareness, education, and intervention.	**010100**	**PHP,CE,AC, PS,HA,CIP**
Knowledge of:	---	---
1. Roles of appropriate individuals (e.g., administrators, management, parents/guardians/family members, coaches, participants, and members of the health care team)in risk and illness prevention	010101	PHP 18 AC 2 HA 24
2. Behavioral risks (e.g., nutritional, sexual, substance abuse, blood-borne pathogens, sedentary lifestyle, and overtraining)	010102	PHP 5,24,25
3. Catastrophic risks (e.g., cardiorespiratory, neurological, thermoregulatory, endocrinological, and immunological)	010103	PHP 10,11 PS 16
4. Common risks (e.g., musculoskeletal, integumentary, neurological, respiratory, and medical)	010104	PHP 6 CE 3
5. Effective communication techniques (e.g., multimedia videos, pamphlets, posters, models, handouts, and oral communication)	010105	PHP 18
6. Environmental risks (e.g. heat, cold, altitude, sunburn, insects, visibility/lighting, and lightning)	010106	PHP 10,11
7. Mechanisms of common and catastrophic injury	010107	PHP 3
8. Preventive measures (e.g., safety rules, accepted biomechanical techniques, ergonomics, and nutritional guidelines)	010108	PHP 4
Skill in:	---	---
9. Communicating effectively	010109	CIP 9
10. Identifying appropriate resources	010110	CIP 3
11. Identifying risks	010111	PHP 1,5,17 CIP 3
B. Interpret individual and group pre-participation and other relevant screening information (e.g., verbal, observed, written) in accordance with accepted and applicable guidelines to minimize the risk of injury and illness.	**010200**	**PHP, AC,HA,PD,CIP**
Knowledge of:	---	---
1. Established laws, regulations, and policies (e.g; institutional, state, and national)	010201	PD 3-5 AC 1
2. Established guidelines for recommended participation	010202	PD 5,8,9
3. Pre-participation evaluation process and procedures	010203	HA 23
4. Privacy laws	010204	PD 3

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	BOC RD/PA Classification	NATA Competencies
Skill in:	---	---
5. Applying appropriate pre-participation screening information	010205	HA 23 CIP 1
6. Applying established guidelines and regulations	010206	PD 3-5
7. Collecting appropriate pre-participation screening information	010207	AC 5
8. Identifying appropriate resources	010208	CIP 1,3
9. Identifying health-related conditions that may limit or compromise participation	010209	PHP 5
10. Identifying established guidelines and regulations	010210	PD 4,5 PHP 12
C. Identify and educate individual(s) and groups through appropriate communication methods (e.g., verbal, written) about the appropriate use of personal protective equipment (e.g., clothing, shoes, protective gear, and braces) by following accepted procedures and guidelines.	**010300**	**PHP,PD,CIP**
Knowledge of:	---	---
1. Commercially available protective products	010301	PHP 20-22
2. Effective communication techniques (e.g., multimedia videos, pamphlets, posters, models, handouts, and oral communication)	010302	PHP 18
3. Effective use of prophylactic/protective measures	010303	PHP 2,23
4. Established standards pertaining to protective equipment (e.g., NOCSAE and ASTM)	010304	PHP 20 PD 5
5. Intended purpose, limitations, and capabilities of protective equipment	010305	PHP 20,21
6. Legal risks and ramifications of making equipment modifications	010306	PHP 20,21 PD 3-5
7. Legal and safety risks involved in the construction and use of custom and commercial protective devices	010307	PHP 20,21 PD 3-5
8. Manufacturer's guidelines regarding selection, fit, inspection, and maintenance of equipment	010308	PHP 20,21,22
9. Materials and methods for fabricating custom-made protective devices	010309	PHP 21
10. Physical properties of the protective equipment materials (e.g., absorption, dissipation, and transmission of energy)	010310	PHP 20-22
Skill in:	---	---
11. Educating individuals on the selection of standard protective equipment	010311	CIP 1,2
12. Fabricating and fitting custom-made devices	010312	PHP 21
13. Fitting standard protective equipment	010313	PHP 22
14. Interpreting rules regarding protective equipment	010314	PHP 20 PD 5

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	BOC RD/PA Classification	NATA Competencies
15. Identifying injuries, illnesses, and health-related conditions that warrant the application of custom-made or commercially available devices	010315	CIP 1,2
16. Selecting and applying commercial devices	010316	CIP 1,2
D. Maintain physical activity, clinical treatment, and rehabilitation areas by complying with regulatory standards to minimize the risk of injury and illness.	**010400**	**PHP,TI,PD**
Knowledge of:	---	---
1. Laws, regulations, and policies (e.g., institutional , state, and national) regarding safety and sanitation	010401	PHP 7,20 TI 19 PD 3-5
2. Manufacturer's guidelines for maintaining equipment and devices	010402	PHP 22 TI 19
3. Health-related conditions that pose risk	010403	PHP 5
Skill in:		
4. Complying with manufacturer's recommendations for maintenance of equipment	010404	PHP 20
5. Maintaining a safe and sanitary environment in compliance with established standards (e.g., OSHA, universal precautions, local health department, and institutional policy)	010405	PHP 22 TI 19,20 PD 4,5,7
6. Recognizing noncompliance with safety and sanitation standards	010406	PHP 7
7. Recognizing malfunction or disrepair of therapeutic modalities, rehabilitation equipment, or furnishings in clinical and treatment areas	010407	TI 20
E. Monitor environmental conditions (e.g., weather, surfaces, client work-setting) using appropriate methods and guidelines to facilitate individual and group safety.	**010500**	**PHP,HA,PD,CIP**
Knowledge of:	---	---
1. Health-related conditions of participants that predispose them to environmentally caused illness (e.g., prior heat illness, sickle cell trait, asthma, recent viral infection, use of medication, ergogenic aids, obesity, and dehydration)	010501	PHP 29
2. Emergency communication systems	010502	HA 24
3. Environmental conditions that create risk (e.g., heat, humidity, cold, altitude, pollution, weather extremes, insect swarms, infectious pathogens, and ergonomic conditions)	010503	PHP 10
4. Ergonomic and epidemiological risk factors as they related to participation	010504	PHP 19
5. Established standards regarding environmental risks (e.g., governing body rules/regulations, NATA, NCAA, ACSM, etc.)	010505	PHP 12 HA 15,16 PD 3-5
6. Hazards common in activity areas (e.g., surface irregularities, obstructions, inadequate offsets, moisture and other foreign objectives, inadequate lighting, inadequate ingress and egress)	010506	PHP 18

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7. Hazards common to equipment (e.g., shoulder pads, goal posts, computer keyboards, desk chairs, hand trucks)	010507	PHP 18,19
8. Methods for reducing risk from environmental conditions (e.g., activity scheduling, clothing selection, and fluid replacement)	010508	PHP 10-12
9. Policies and procedures for removing participants from environmental risk situations (e.g., heat index, lightning and activity scheduling)	010509	PHP 11
10. Policy statements and guidelines pertaining to safety hazards (e.g., NATA and NCAA)	010510	PD 4
11. Rules governing play and established standards and practices	010511	PD 4
Skill in:	---	---
12. Conducting inspections and recognizing hazards	010512	PHP 18
13. Monitoring techniques (e.g., weight charts, fluid intake, and body composition)	010513	PHP 14
14. Recognizing environmental and ergonomic risks	010514	PHP 13
15. Recognizing characteristics in participants that would predispose them to environmental and ergonomic risks	010515	PHP 18,19
16. Recommending and implementing appropriate methods for addressing hazards	010516	CIP 3
17. Using available resources to gather/interpret information regarding environmental data	010517	PHP 13
F. Maintain or improve physical conditioning for the individual or group by designing and implementing programs (e.g., strength, flexibility, CV fitness) to minimize the risk of injury and illness.	**010600**	**PHP**
Knowledge of:	---	---
1. Components of a physical conditioning program	010601	PHP 25,29,30
2. Current strength and conditioning techniques	010602	PHP 26,29,31
3. Ergonomics	010603	PHP 19
4. Human physiology	010604	PHP 25
5. Physiological adaptation to exercise (e.g., space and altitude)	010605	PHP 28,30
6. Various conditioning stages and program intervals	010606	PHP 28,30
Skill in:	---	---
7. Addressing the components of a comprehensive conditioning program (e.g., strength, flexibility, endurance, sport requirements, and individual needs)	010607	PHP 27,29,30,44
8. Assessing appropriateness of individual or group participation in conditioning programs	010608	PHP 27,29,30
9. Correcting or modifying inappropriate, unsafe, or dangerous activities undertaken in conjunction with physical conditioning programs	010609	PHP 26,28,31
10. Educating appropriate individuals in the effective application of conditioning programs (e.g., guardian, coaches, participants, and administration)	010610	PHP 29

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	BOC RD/PA Classification	NATA Competencies
11. Instructing in the use of appropriate conditioning equipment (e.g., bikes, weight machines, and treadmills)	010611	PHP 29-31
G. Promote healthy lifestyle behaviors using appropriate education and communication strategies to enhance wellness and minimize the risk of injury and illness.	**010700**	**PHP,CE,PS,PD**
Knowledge of:	---	---
1. Accepted guidelines for exercise prescription	010701	PHP 27,29
2. Accepted nutritional practices	010702	PHP 32-35,38,39,45
3. Effective communication techniques (e.g., multimedia videos, pamphlets, posters, models, handouts, and oral communication)	010703	PHP 33
4. Predisposing factors for nutritional and stress-related disorders	010704	PHP 32,45 PS 13
5. Professional resources for addictions (e.g., tobacco, alcohol, and narcotics)	010705	PS 13
6. Professional resources for stress management and behavior modification (e.g., anger management, HIV/STD prevention, and operational stress control)	010706	CE 22 PS 11
7. Related nutritional disorders, inactivity-related diseases, overtraining issues, and stress-related disorders	010707	PHP 24,32,33,35,45 PS 12,13
Skill in:	---	---
8. Accessing information concerning accepted guidelines for nutritional practices	010708	PHP 35-37,39,40 PS 13
9. Addressing the issue of special nutritional needs in regard to competition or activity (e.g., pre- and post-game meals and nutritional supplements)	010709	PHP 33,40-42
10. Communicating with appropriate professionals regarding referral and treatment for individuals	010710	PHP 43,47 PS 11,14 PD 10
11. Educating appropriate individuals on nutritional disorders, maladaptation, substance abuse, and overtraining	010711	PHP 32 PS 18
12. Recognizing signs and symptoms of nutritional, addiction, and stress-related disorders	010712	PHP 43,46 PS 14
II. Clinical evaluation and diagnosis – Implementing standard evaluation techniques and formulating a clinical impression for the determination of a course of action.		
A. Obtain an individual's history through observation, interview, and/or review of relevant records to assess injury, illness, or health-related condition.	**020100**	**CE,PS,CIP**
Knowledge of:	---	---
1. Biomechanical factors associated with specific activities	020101	CE 4,21
2. Communication techniques in order to elicit information	020102	PS 17

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	BOC RD/PA Classification	NATA Competencies
3. Injuries, illnesses, and health-related conditions associated with specific activities	020103	CE 7,20,21
4. Medical records as a source of information	020104	CE 21
5. Pathomechanics of injury	020105	CE 5,20,21
6. Pathophysiology of illnesses and health-related conditions	020106	CE 5,20,21
7. Relationships between injuries, illnesses, and health-related conditions and outside factors (e.g., predisposing, nutritional, ergogenic aids, infectious agents, and medications)	020107	CE 20,21 PS 14
8. Signs and symptoms of injuries, illnesses, and health-related conditions	020108	CE 13,20,21 PS 12
9. Standard medical nomenclature and terminology	020109	CE 1,2
10. The body's immediate and delayed physiological response to injuries, illnesses, and health-related conditions	020110	CE 2,20
Skill in:	---	---
11. Obtaining and recording information related to injuries, illnesses, and health related conditions	020111	CE 13,20,21 PS 12
12. Identifying anatomical structures involved in injuries, illnesses, and health-related conditions	020112	CE 1,2,20,21
13. Identifying nutritional factors related to injuries, illnesses, and health-related conditions	020113	CIP 1
14. Identifying psychosocial factors associated with injuries, illnesses, and health-related conditions	020114	CE 21
15. Identifying the extent and severity of injuries, illnesses, and health-related conditions	020115	CE 13
16. Identifying the impact of supplements and prescription and nonprescription medications associated with injuries, illnesses, and health-related conditions	020116	CIP 1,5
17. Interpreting medical records and related reports	020117	CIP 9
18. Recognizing predisposing factors to specific injuries, illnesses, and health-related conditions	020118	CE 21
19. Relating signs and symptoms to specific injuries, illnesses, and health-related conditions	020119	CE 13,21
B. Utilize appropriate visual and palpation techniques to determine the type and extent of the injury, illness, or health-related condition.	**020200**	**CE,PS**
Knowledge of:	---	---
1. Human anatomy with emphasis on bony landmarks and soft tissue structures	020201	CE 2,21
2. Immediate and delayed physiological response to injuries, illnesses, and health-related conditions	020202	CE 20
3. Normal and abnormal structural relationships to the pathomechanics of injuries and health-related conditions	020203	CE 20
4. Principles of palpation techniques and visual inspection	020204	CE 20
5. Response to injuries, illnesses, and health-related conditions	020205	CE 20
6. Signs of injuries, illnesses, and health-related conditions	020206	CE 20 PS 12

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	BOC RD/PA Classification	NATA Competencies
7. Standard medical nomenclature and terminology	020207	CE 20
Skill in:	---	---
8. Assessing immediate and delayed physiological responses to injuries, illnesses, and health-related conditions	020208	CE 20
9. Assessing pre-existing structural abnormalities and relating them to pathomechanics of injuries, illnesses, and health-related conditions	020209	CE 20
10. Identifying bony surface landmarks and soft tissue abnormalities of specific/ injuries, illnesses, and health-related conditions	020210	CE 1,20 PS 12
11. Identifying the relationship and severity of pathological signs of injuries, illnesses, and health-related conditions	020211	CE 20
12. Locating and palpating bony landmarks, articulations, ligamentous structures, musculotendinous units, and other soft tissues	020212	CE 1,20,21
13. Palpating appropriate structures in order to assess the integrity of human anatomical/physiological systems	020213	CE 1,20,21
14. Recognizing severity of pathological signs and symptoms of injuries, illnesses, and health-related conditions	020214	CE 20,21
C. Utilize appropriate tests (e.g., ROM, special tests, neurological tests) to determine the type and extent of the injury, illness, or health-related condition.	**020300**	**PHP,CE**
Knowledge of:	---	---
1. Mechanics, principles, and techniques of specific/special tests (ligamentous, neurological, manual, fracture, and functional tests)	020301	CE 20,21
2. Signs and symptoms of systemic failure during exercise	020302	CE 20,21
3. Signs, symptoms, and interpretations of specific/special tests	020303	CE 20,21
4. Standard/individual special tests for range of motion, muscular strength, structural integrity, and functional capacity	020304	PHP 26 CE 20,21
Skill in:	---	---
5. Assessing muscular strength through the use of manual or non-manual muscle tests	020305	PHP 26 CE 20,21
6. Assessing neurological function	020306	CE 20,21
7. Assessing joint range of motion using test and measurement techniques	020307	CE 20,21
8. Identifying appropriate specific/special tests	020308	PHP 26 CE 20,21
9. Identifying location, type, function, and action of each joint	020309	CE 20,21

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	BOC RD/PA Classification	NATA Competencies
10. Identifying structural and functional integrity of anatomical structures	020310	PHP 26 CE 20,21
11. Interpreting the information gained from specific/special tests	020311	CE 21
12. Performing specific/special tests	020312	PHP 26 CE 20,21
13. Using equipment associated with specific/special tests	020313	PHP 26 CE 20
D. Formulate a clinical diagnosis by interpreting the signs, symptoms, and predisposing factors of the injury, illness, or health-related condition to determine the appropriate course of action.	**020400**	**CE,TI,PS,PD,CIP**
Knowledge of:	---	---
1. Basic pharmacology associated with diagnosis and courses of action	020401	TI 24-31
2. Signs, symptoms, and predisposing factors related to injuries, illnesses, and health-related conditions	020402	CE 21
3. Guidelines for return to participation	020403	CE 7
4. Indications for referral	020404	CE 16 PD 10
5. Standard medical terminology and nomenclature	020405	CE 1
6. Pathomechanics of injuries and/or health-related conditions	020406	CE 21
7. Psychosocial dysfunction and implications associated with injuries, illnesses, and health-related conditions	020407	PS 7,9
Skill in:	---	---
8. Identifying appropriate courses of action (e.g., treatment plan, referral)	020408	CE 12,16 PD 10
9. Interpreting the pertinent information from the evaluation	020409	CE 17,18,21
10. Synthesizing applicable information from an evaluation	020410	CE 17,18,21 CIP 2,10,11
E. Educate the appropriate individual(s) about the clinical evaluation by communicating information about the injury, illness, or health-related condition to encourage compliance with recommended care.	**020500**	**CE,AC,PS,PD,CIP**
Knowledge of:	---	---
1. Commonly accepted practices regarding the care and treatment of injuries, illnesses, and health-related conditions	020501	PS 4,6
2. Effective communication techniques (e.g., multimedia videos, pamphlets, posters, models, handouts, and oral communication)	020502	PS 4,6

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	BOC RD/PA Classification	NATA Competencies
3. Patient confidentiality rules and regulations	020503	PS 18 PD 3-5
4. Potential health-related complications and expected outcomes	020504	CE 8
5. Role and scope of practice of various health care professionals	020505	AC 2 PS 10 PD 1,2,8,9
6. Standard medical terminology and nomenclature	020506	CE 1
Skill in:	---	---
7. Communicating with appropriate professionals regarding referral and treatment for individuals	020507	PS 11,14
8. Directing a referral to the appropriate professionals	020508	CE 16 PD 10
9. Interpreting standard medical terminology and nomenclature and describing the nature of injuries, illnesses, and health-related conditions in basic terms	020509	CE 1
10. Utilizing appropriate counseling techniques	020510	CIP 7
11. Using standard medical terminology and nomenclature	020511	CIP 9
III. Immediate and emergency care – Employing standard care procedures and communicating outcomes for efficient and appropriate care of the injured.		
A. Coordinate care of individual(s) through appropriate communication (e.g., verbal, written, demonstrative) of assessment findings to pertinent individual(s).	**030100**	**AC,PS,HA,PD,CIP**
Knowledge of:	---	---
1. Components of the emergency action plan(s)	030101	AC 2-4,8 HA 21
2. Effective communication techniques (e.g., multimedia videos, pamphlets, posters, models, handouts, and oral communication)	030102	PS 4
3. Roles of individual members of the medical management team	030103	AC 2 PD 8,10
Skill in:	---	---
4. Communicating effectively with appropriate individuals (e.g., medical providers, patients, parents, administrators)	030104	AC 2 PD 14 CIP 20
5. Educating individuals regarding standard emergency care procedures	030105	AC 2,3 PD 14
6. Implementing the emergency action plan(s)	030106	CIP 15

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	BOC RD/PA Classification	NATA Competencies
B. Apply appropriate immediate and emergency care procedures to prevent the exacerbation of health-related conditions to reduce the risk factors for morbidity and mortality.	**030200**	**PHP,CE,AC,TI, HA,PD,CIP**
Knowledge of:	---	---
1. Appropriate management techniques for life-threatening health-related conditions (e.g., respiratory, cardiac and central nervous)	030201	AC 5-7,19,20,22, 27,28,30,33,34,38
2. Appropriate use of emergency equipment and techniques (e.g., AED, CPR masks, and BP cuff)	030202	PHP 15,16 CE 23 AC 6-10,29,31,32,35 TI 28
3. Mechanisms (biomechanics/kinesiology)of catastrophic conditions	030203	AC 23,24
4. Common life-threatening medical situations (e.g., respiratory, central nervous, and cardiovascular)	030204	AC 7,27,36
5. Emergency action plan(s)	030205	HA 20
6. Federal and state occupational, safety, and health guidelines	030206	AC 21 PD 4,5
7. Human physiology: normal and compromised functions	030207	AC 7
8. Physiologic reactions to life-threatening conditions	030208	AC 36
9. Pharmacological and therapeutic modality usage for acute health-related conditions	030209	AC 27,31,32,35 TI 30
10. Signs and symptoms of common medical conditions	030210	AC 27,36
11. Standard protective equipment and removal devices and procedures	030211	AC 10
Skill in:	---	---
12. Applying pharmacological agents	030212	CIP 4,6
13. Applying therapeutic modalities	030213	CIP 4
14. Performing cardio-pulmonary resuscitation techniques and procedures	030214	AC 12-18
15. Implementing emergency action plan(s)	030215	AC 4 CIP 6
16. Implementing federal and state occupational, safety, and health guidelines	030216	PD 4,5
17. Implementing immobilization and transfer techniques	030217	AC 23-26
18. Managing common non-life-threatening and life-threatening emergency situations/health-related conditions (e.g., evaluation, monitoring, and provision of care)	030218	AC 1,2,7,11-18
19. Measuring, monitoring, and interpreting vital signs	030219	AC 6,7,28,29,32
20. Removing protective equipment using appropriate removal devices and/or manual techniques	030220	CIP 6
21. Transferring care to appropriate medical and/or allied health professionals and/or facilities	030221	PD 10

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	BOC RD/PA Classification	NATA Competencies
22. Using standard medical equipment	030222	AC 31,32 TI·28
23. Utilizing emergency equipment	030223	CIP 6
C. Implement appropriate referral strategies, while stabilizing and/or preventing exacerbation of the condition(s), to facilitate the timely transfer of care for health-related conditions beyond the scope of practice of the Athletic Trainer.	**030300**	**AC,PS,HA,CIP**
Knowledge of:	---	---
1. Common management strategies for life- and non-life-threatening health-related conditions	030301	AC 36-39
2. Emergency action plan(s)	030302	AC 1,2
3. Health-related conditions beyond the scope of the athletic trainer	030303	PS 11
4. Indications for referral to other health care providers	030304	PS 11,14,15
5. Roles of medical and allied health care providers	030305	AC 2 HA 31
Skill in:	---	---
6. Communicating with appropriate professionals regarding referral and treatment for individuals	030306	PS 18
7. Directing a referral to the appropriate professionals	030307	PS 11
8. Immobilization, splinting and transfer techniques	030308	AC 37
9. Implementing the emergency action plan(s)	030309	CIP 6
10. Managing common non-life-threatening and life-threatening emergency situations/health-related conditions until transfer to appropriate medical providers and facilities	030310	AC 37
11. Recognizing acute health-related conditions beyond the scope of the athletic trainer	030311	CIP 5,6
D. Demonstrate how to implement and direct immediate care strategies (e.g., first aid, Emergency Action Plan) using established communication and administrative practices to provide effective care.	**030400**	**EBP,AC,PS,HA,CIP**
Knowledge of:	---	---
1. Effective communication techniques (e.g., multimedia videos, pamphlets, posters, models, handouts, and oral communication)	030401	PS 4
2. Emergency action plan(s)	030402	HA 20
3. Evidence based practice	030403	EBP 1-14
4. Pertinent administrative practices	030404	HA 29
5. Roles of medical and allied health care providers	030405	HA 31
Skill in:	---	---
6. Implementing the emergency action plan(s)	030406	HA 20
7. Implementing relevant administrative practices (e.g., Injury reports, documentation, case reports)	030407	CIP 9
8. Instruction of emergency care techniques	030408	AC 43

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	BOC RD/PA Classification	NATA Competencies
IV. Treatment and rehabilitation – Reconditioning participants for optimal performance and function.		
A. Administer therapeutic and conditioning exercise(s) using appropriate techniques and procedures to aid recovery and restoration of function.	**040100**	**CE,TI,PS**
Knowledge of:	---	---
1. Adaptation of the cardiovascular and muscular systems related to treatment, rehabilitation, and reconditioning	040101	TI 4,8
2. Age-specific considerations related to treatment, rehabilitation, and reconditioning	040102	TI 5,8
3. Available equipment and tools related to treatment, rehabilitation, and reconditioning	040103	CE 6 TI 10
4. Functional criteria for return to activity	040104	CE 19 TI 7
5. Indications and contraindications related to treatment, rehabilitation, and reconditioning	040105	CE 7
6. Inflammatory process related to treatment, rehabilitation, and reconditioning	040106	TI 1
7. Neurology related to treatment, rehabilitation, and reconditioning	040107	TI 1,4,5
8. Pharmacology related to treatment, rehabilitation, and reconditioning	040108	TI 29,30
9. Principles of adaptation and overload of tissues	040109	TI 4,5,8
10. Principles of adaptation of systems	040110	TI 4,5,8
11. Principles of strength and conditioning exercises (e.g., plyometrics, core stabilization, speed, agility, and power)	040111	TI 8
12. Principles of therapeutic exercise (e.g., isometric, isotonic, isokinetic, work, power, and endurance)	040112	TI 8,13,17
13. Proprioception and kinesthesis related to treatment, rehabilitation, and reconditioning	040113	TI 8,17,24
14. Psychology related to treatment, rehabilitation, and reconditioning	040114	PS 7-10
15. Structure, growth, development, and regeneration of tissue	040115	TI 1,4,5
16. Surgical procedures and implications for treatment, rehabilitation, and reconditioning	040116	TI 6
Skill in:	---	---
17. Applying exercise prescription in the development and implementation of treatment, rehabilitation, and reconditioning (e.g., aquatics, isokinetics, and closed-chain)	040117	TI 11,17
18. Evaluating criteria for return to activity	040118	CE 19,20,22 TI 11 PS 3

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	BOC RD/PA Classification	NATA Competencies
B. Administer therapeutic modalities (e.g., electromagnetic, manual, mechanical) using appropriate techniques and procedures based on the individual's phase of recovery to restore functioning.	**040200**	**CE,TI,CIP**
Knowledge of:	---	---
1. Available therapeutic modalities related to treatment, rehabilitation, and reconditioning	040201	TI 10,14
2. Indications and contraindications for therapeutic modalities	040202	TI 11
3. Inflammatory process related to therapeutic modalities	040203	TI 1
4. Pharmacology related to therapeutic modalities	040204	TI 21-23
5. Physiological response to therapeutic modalities	040205	TI 3,5,8
6. Principles of mechanical, electromagnetic, and acoustical energy	040206	TI 8,9
7. Principles of therapeutic exercise (e.g., isometric, isotonic, isokinetic, work, power, and endurance)	040207	TI 8
8. Structure, growth, development, and regeneration of tissue	040208	TI 8
9. Theories of pain	040209	TI 2,3
Skill in:	---	---
10. Applying manual therapy techniques	040210	TI 13-15
11. Applying thermal, electrical, mechanical, and acoustical modalities	040211	TI 9
12. Communicating with appropriate professionals regarding referral and treatment for individuals	040212	CE 22 TI 11
13. Recognizing the status of systemic illnesses	040213	TI 11 CIP 5
14. Recognizing the status of bacterial, viral, fungal, and parasitic infections	040214	CIP 5
C. Apply braces, splints, or other assistive devices according to appropriate practices in order to facilitate injury protection to achieve optimal functioning for the individual.	**040300**	**PHP,CE,TI**
Knowledge of:	---	---
1. Commercially available soft goods	040301	TI 16
2. Functions of bracing	040302	TI 16
3. Legal risks and ramifications for bracing	040303	PHP 20
4. Pathomechanics of common and catastrophic injury	040304	CE 3,4
5. Materials and methods for fabricating custom-made devices	040305	TI 16
6. Pathomechanics of the injury or condition	040306	CE 3-5
Skill in:	---	---
7. Applying braces, splints, or assistive devices	040307	TI 16
8. Fabricating braces, splints, or assistive devices	040308	TI 16

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	BOC RD/PA Classification	NATA Competencies
D. Administer treatment for injury, illness, and/or health-related conditions using appropriate methods to facilitate injury protection, recovery, and/or optimal functioning for individual(s).	**040400**	**EBP,PHP,CE,TI, PS,HA,CIP**
Knowledge of:	---	---
1. Available reference sources related to injuries, illnesses, and health-related conditions	040401	EBP 6
2. Medical and allied health care professionals involved in the treatment of injuries, illnesses, and health-related conditions	040402	CE 22
3. Pathophysiology associated with systemic illness, communicable diseases, and infections (e.g., bacterial, viral, fungal, and parasitic)	040403	PHP 5,6 HA 15
4. Pharmacology related to the treatment of injuries, illnesses, and health-related conditions	040404	TI 25-30 PHP 48
5. Psychological reaction to injuries, illnesses, and health-related conditions	040405	TI 8 PS 1,2
6. Structure, growth, development, and regeneration of tissue	040406	TI 8
Skill in:	---	---
7. Applying topical wound or skin care products	040407	CIP 4,5
8. Applying thermal, electrical, mechanical, and acoustical modalities	040408	TI 9
9. Communicating with appropriate professionals regarding referral and treatment for individuals	040409	CE 22 TI 10,31 PS 6
10. Directing a referral to the appropriate professionals	040410	CE 22 PS 11
11. Indications for referral	040411	CE 22 PS 14
12. Recognizing the status of systemic illnesses	040412	CIP 5
13. Recognizing the status of bacterial, viral, fungal, and parasitic infections	040413	CIP 5
E. Reassess the status of injuries, illnesses, and/or health-related conditions using appropriate techniques and documentation strategies to determine appropriate treatment, rehabilitation, and/or reconditioning and to evaluate readiness to return to a desired level of activity.	**040500**	**CE,TI,PS,HA**
Knowledge of:	---	---
1. Adaptation of the cardiovascular and muscular systems related to rehabilitation, recovery, and performance	040501	TI 5,18
2. Age-specific considerations related to rehabilitation, recovery, and performance	040502	CE 7 TI 5
3. Appropriate documentation protocols	040503	HA 11,12

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	BOC RD/PA Classification	NATA Competencies
4. Functional criteria for return to activity	040504	CE 19 TI 7
5. Indications and contraindications related to rehabilitation, recovery, and performance	040505	TI 5,8
6. Inflammatory process related to rehabilitation, recovery, and performance	040506	TI 1
7. Neurology related to rehabilitation, recovery, and performance	040507	TI 5
8. Principles of adaptation and overload of tissues	040508	TI 4
9. Principles of strength and conditioning exercises (e.g., plyometrics, core stabilization, speed, agility, and power)	040509	TI 8
10. Principles of therapeutic exercise (e.g., isometric, isotonic, isokinetic, work, power, and endurance)	040510	TI 8
11. Proprioception and kinesthesis related to rehabilitation, recovery, and performance	040511	TI 8
12. Psychology effects related to rehabilitation, recovery, and performance	040512	PS 7
13. Structure, growth, development, and regeneration of tissue	040513	TI 5,8
14. Surgical procedures and implications for rehabilitation, recovery, and performance	040514	TI 6
Skill in:	---	---
15. Evaluating criteria for return to activity	040515	CE 9,19 TI 7
16. Interpreting assessment information necessary to modify, continue, or discontinue treatment plans	040516	CE 14,15 TI 4,7,10,12
F. Provide guidance and/or referral to specialist for individual(s) and groups through appropriate communication strategies (e.g., oral and education materials) to restore an individual(s) optimal functioning.	**040600**	**CE,TI,PS,HA,PD,CIP**
Knowledge of:	---	---
1. Applicable methods and materials for education	040601	PS 4,5
2. Appropriate documentation protocols	040602	HA 11
3. Available support systems (e.g., psychosocial, community, family, and health care) related to rehabilitation, recovery, and performance	040603	PS 11 HA 30
4. Effective communication techniques (e.g., multimedia videos, pamphlets, posters, models, handouts, and oral communication)	040604	PS 4,5
5. Learning process across the lifespan	040605	PD 7 PS 5
6. Psychology effects related to rehabilitation, recovery, and performance	040606	PS 3,7-9
7. Referral resources	040607	CE 22 PD 10

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	BOC RD/PA Classification	NATA Competencies
Skill in:	---	---
8. Communicating with appropriate professionals regarding referral and treatment for individuals	040608	CIP 9
9. Directing a referral to the appropriate professionals	040609	CE 22 PS 11 PD 10
10. Identifying appropriate individuals to educate	040610	TI 10 PS 18
11. Indications for referral	040611	CE 22 PS 14 PD 10
12. Providing guidance/counseling for the individual during the treatment, rehabilitation, and reconditioning process	040612	PS 4,7,8,10
V. Organizational and professional health and well-being – Understanding and adhering to approved organizational and professional practices and guidelines to ensure individual and organizational well-being.		
A. Apply basic internal business functions (e.g., business planning, financial operations, staffing) to support individual and organizational growth and development.	**050100**	**HA,PD**
Knowledge of:	---	---
1. Appropriate computer software applications	050101	HA 12
2. Credentialing systems and general requirements for pertinent professions	050102	PD 2,6
3. Facility design and operation	050103	HA 5,29
4. Human resource management	050104	HA 12-14
5. Institutional budgeting and procurement process	050105	HA 6,8
6. Institutional and federal employment regulations (e.g., EEOC, ADA, and Title IX)	050106	HA 15-17 PD 3
7. Management techniques	050107	HA 2,3
8. Leadership styles	050108	HA 2,3
9. Revenue generation strategies	050109	HA 7,25-28
10. Staff scheduling, patient flow, and allocation of resources	050110	HA 2,6,8
11. Storage and inventory procedures	050111	HA 6
12. Strategic planning and goal setting	050112	HA 3,4
Skill in:	---	---
13. Facility design, operation, and management (e.g., planning, organizing, designing, scheduling, coordinating, budgeting)	050113	HA 5
14. Managing financial resources (e.g., planning, budgeting, resource allocation, revenue generation)	050114	HA 6,8

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	BOC RD/PA Classification	NATA Competencies
15. Managing human resources (e.g., delegating, planning, staffing, hiring, firing, and conducting performance evaluations)	050115	HA 12-14
16. Using computer software applications (e.g., word processing, data base spreadsheet, and Internet applications)	050116	HA 6,8
B. Apply basic external business functions (e.g., marketing and public relations) to support organizational sustainability, growth, and development.	**050200**	**HA,PD**
Knowledge of:	---	---
1. Appropriate computer software applications	050201	HA 12
2. Credentialing systems and general requirements for pertinent professions	050202	PD 3
3. Facility design and operation	050203	HA 5,29
4. Human resource management	050204	HA 12-14
5. Institutional budgeting and procurement process	050205	HA 6,8
6. Institutional and federal employment regulations (e.g., EEOC, ADA, and Title IX)	050206	HA 15,16,17 PD 3
7. Management techniques	050207	HA 2,3
8. Leadership styles	050208	HA 2,3
9. Revenue generation strategies	050209	HA 7,25-28
10. Staff scheduling, patient flow, and allocation of resources	050210	HA 2
11. Storage and inventory procedures	050211	HA 6
12. Strategic planning and goal setting	050212	HA 3,4
Skill in:	---	---
13. Facility design, operation, and management (e.g., planning, organizing, designing, scheduling, coordinating, budgeting)	050213	HA 5
14. Managing financial resources (e.g., planning, budgeting, resource allocation, revenue generation)	050214	HA 6,8
15. Managing human resources (e.g., delegating, planning, staffing, hiring, firing, and conducting performance evaluations	050215	HA 12-14
16. Using computer software applications (e.g., word processing, data base spreadsheet, and Internet applications)	050216	HA 6,8
C. Maintain records and documentation that comply with organizational, association, and regulatory standards to provide quality of care and to enable internal surveillance for program validation and evidence-based interventions.	**050300**	**EBP,PHP,CE,AC, TI,HA,PD,CIP**
Knowledge of:	---	---
1. Appropriate computer software applications	050301	HA 11
2. Credentialing systems and general requirements for pertinent professions	050302	PD 3

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	BOC RD/PA Classification	NATA Competencies
3. Criteria for determining the legal standard of care in athletic training (e.g., state statutes and regulations, professional standards and guidelines, publications, customs, practices, and societal expectations)	050303	AC 1 TI 21
4. Evidence-based practice, epidemiology studies, and clinical outcomes assessment	050304	CE 10,11 TI 7
5. Federal and state statutes, regulations, and adjudication that apply to the practice and/or organization and administration of athletic training (e.g., OSHA, DEA, Title IX, Civil Rights Act, HIPAA, Buckley Amendment, labor practices, patient confidentiality, insurance, and record keeping)	050305	PD 3 HA 10
6. Guidelines and regulations for decreasing exposure to environmental hazards	050306	PD 3,5
7. Guidelines for development of risk management policies and procedures	050307	PD 3,5
8. Institutional drug testing and substance abuse policies	050308	PHP 17,18
9. Institutional, governmental, and appropriate organizational guidelines for safety, health care delivery, and legal compliance	050309	PD 3-5
10. Institutional review boards, policies, and procedures regarding informed consent guidelines	050310	PD 8
11. Institutional risk management policies and procedures	050311	PHP 18 HA 18
12. Prescreening participation guidelines	050312	HA 23
13. Relevant policy and position statements of appropriate organizations (e.g., ACSM, AOASM, AOSSM, AMSSM, NCAA, NATA, NFHSA, NAIA, USOC)	050313	PD 5
14. Standard medical terminology and nomenclature	050314	CE 1 TI 22
15. State statutes, regulations, and adjudication that directly govern the practice of athletic training (e.g, state practice and title acts, state professional conduct and misconduct acts, liability and negligence)	050315	PD 3-5
16. State statutes, regulations, and adjudication governing other professions which impact the practice of athletic training (e.g., medicine, physical therapy, nursing, pharmacology)	050316	PD 8
Skill in:	---	---
17. Creating and completing the documentation process	050317	HA 9,11
18. Obtaining, interpreting, evaluating, and applying relevant research data, literature, and/or other forms of information	050318	TI 7
19. Obtaining, interpreting, evaluating, and applying relevant policy and position statements	050319	PD 3,5
20. Interacting with appropriate administration leadership	050320	CIP 9
21. Researching practice methods and procedures	050321	EBP 1-14

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	BOC RD/PA Classification	NATA Competencies
22. Researching professional standards and guidelines (e.g., BOC, NATA, state organizations)	050322	HA 10 PD 3-6
23. Using computer software applications (e.g., word processing, data base spreadsheet, and Internet applications)	050323	CIP 9
D. Demonstrate appropriate planning for coordination of resources (e.g., personnel, equipment, liability, scope of service) in event medical management and emergency action plans.	**050400**	**EBP,PHP,AC,TI, PS,HA,PD,CIP**
Knowledge of:	---	---
1. Appropriate medical equipment and supplies	050401	AC 8-10,13,15,16,18 HA 19,20
2. Criteria for determining the legal standard of care in athletic training (e.g., state statutes and regulations, professional standards and guidelines, publications, customs, practices, and societal expectations)	050402	PD 3-6
3. Federal and state statutes, regulations, and adjudication that apply to the practice and/or organization and administration of athletic training (e.g., OSHA, DEA, Title IX, Civil Rights Act, HIPAA, Buckley Amendment, labor practices, patient confidentiality, insurance, and record keeping)	050403	TI 21 HA 15-17
4. Institutional drug testing and substance abuse policies	050404	PHP 49 PS 14,15
5. Institutional, governmental, and appropriate organizational guidelines for safety, health care delivery, and legal compliance	050405	HA 29 PD 3-6
6. Institutional review boards, policies, and procedures regarding informed consent guidelines	050406	PD 8
7. Institutional risk management policies and procedures	050407	HA 18,19
8. Prescreening participation guidelines	050408	HA 23
9. Reimbursement issues	050409	HA 25-28
10. Staff preparedness	050410	HA 20-22
11. State statutes, regulations, and adjudication that directly govern the practice of athletic training (e.g., state practice and title acts, state professional conduct and misconducts acts, liability and negligence)	050411	HA 15-17 PD 3-6
12. State statutes, regulations, and adjudication governing other professions that impact the practice of athletic training (e.g., medicine, physical therapy, nursing, pharmacology)	050412	HA 15-17 PD 8
13. Site-specific access issues	050413	HA 20
Skill in:	---	---
14. Creating and completing the documentation process	050414	CIP 9
15. Interacting with appropriate administration leadership	050415	CIP 9
16. Obtaining, interpreting, evaluating, and applying relevant policy and position statements	050416	PD 8

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	BOC RD/PA Classification	NATA Competencies
17. Researching practice methods and procedures	050417	EBP 1-14
18. Researching professional standards and guidelines (e.g., BOC, NATA, state organizations)	050418	PD 3-5
19. Using computer software applications (e.g., word processing, data base spreadsheet, and Internet applications)	050419	CIP 9
E. Demonstrate an understanding of statutory and regulatory provisions and professional standards of the practice of Athletic Training in order to provide for the safety and welfare of individual(s) and groups.	**050500**	**PHP,TI,PS,PD**
Knowledge of:	---	---
1. Appropriate equipment and facility inspection procedures and documentation	050501	PHP 18 TI 19,20
2. Criteria for determining the legal standard of care in athletic training (e.g., state statutes and regulations, professional standards and guidelines, publications, customs, practices, and societal expectations)	050502	PD 3-5
3. Federal and state statutes, regulations, and adjudication which apply to the practice and/or organization and administration of athletic training (e.g., OSHA, DEA, Title IX, Civil Rights Act, HIPAA, Buckley Amendment, labor practices, patient confidentiality, insurance, record keeping)	050503	TI 21 PS 18 PD 4,6
4. Institutional, professional, and governmental guidelines for maintenance of facilities and equipment	050504	PD 4
5. Manufacturer's operational guidelines	050505	PHP 20 TI 19
6. Safe playing and treatment environments	050506	PHP 12,18
7. State statutes, regulations, and adjudication that directly govern the practice of athletic training (e.g, state practice and title acts, state professional conduct and misconducts acts, liability and negligence)	050507	PD 4,6
8. State statutes, regulations, and adjudication governing other professions which impact the practice of athletic training (e.g., medicine, physical therapy, nursing, pharmacology)	050508	PD 4
Skill in:	---	---
9. Researching and applying state and federal statutes, regulations, and adjudications	050509	PD 4,6
10. Researching professional standards and guidelines (e.g., BOC, NATA, state organizations)	050510	PD 4,6
11. Researching practice methods and procedures	050511	PD 4-6
F. Develop a support/referral process for interventions to address unhealthy lifestyle behaviors.	**050600**	**AC,PS,HA,PD,CIP**
Knowledge of:	---	---
1. Appropriate professional behaviors	050601	PD 5,6
2. Credentialing systems and general requirements for health care professions	050602	PD 5,6

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	BOC RD/PA Classification	'A Conencies
3. Community resources	050603	110 2
4. Confidentiality policies	050604	18
5. Effective communication techniques (e.g., multimedia videos, pamphlets, posters, models, handouts, and oral communication)	050605	4
6. Effective meeting planning	050606	10
7. Federal and state statutes, regulations, and adjudication which apply to the practice and/or organization and administration of athletic training (e.g., OSHA, DEA, Title IX, Civil Rights Act, HIPAA, Buckley Amendment, labor practices, patient confidentiality, insurance, record keeping)	050607	31 4,6
8. Institutional and governmental regulations regarding drug use, substance abuse, and mental illness	050608	3-5
9. Institutional chain of command	050609	
10. Role and scope of practice of various health care professionals	050610	1 4-6
Skill in:	---	-
11. Communicating with appropriate professionals regarding referral and treatment for individuals	050611	10
12. Directing a referral to the appropriate professionals	050612	10 8
13. Identifying appropriate individuals to educate	050613	3,9
14. Indications for referral	050614	10
15. Interpreting standard medical terminology and nomenclature for appropriate individuals	050615	P 9
16. Mitigating conflict	050616	A 2
17. Networking and recruiting qualified medical team members	050617	11
18. Nurturing professional relationships	050618	11
19. Providing guidance/counseling for the individual during the treatment, rehabilitation, and reconditioning process	050619	P 7
20. Respecting diversity of opinions and positions	050620	S 5

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BOC STANDARDS OF PROFESSIONAL PRACTICE

Implemented January 1, 2006

BOARD OF CERTIFICATION
FOR THE ATHLETIC TRAINER

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Introduction

The mission of the Board of Certification Inc. (BOC) is to provide exceptional credentialing programs for healthcare professionals. The BOC has been responsible for the certification of Athletic Trainers since 1969. Upon its inception, the BOC was a division of the professional membership organization the National Athletic Trainers' Association. However, in 1989, the BOC became an independent non-profit corporation.

Accordingly, the BOC provides a certification program for the entry-level Athletic Trainer that confers the ATC® credential and establishes requirements for maintaining status as a Certified Athletic Trainer (to be referred to as "Athletic Trainer" from this point forward). A nine member Board of Directors governs the BOC. There are six Athletic Trainer Directors, one Physician Director, one Public Director and one Corporate/Educational Director.

The BOC is the only accredited certification program for Athletic Trainers in the United States. Every five years, the BOC must undergo review and re-accreditation by the National Commission for Certifying Agencies (NCCA). The NCCA is the accreditation body of the National Organization for Competency Assurance.

The *BOC Standards of Professional Practice* consists of two sections:

I. Practice Standards
II. Code of Professional Responsibility

I. Practice Standards

Preamble

The Practice Standards (Standards) establish essential practice expectations for all Athletic Trainers. Compliance with the Standards is mandatory.

The Standards are intended to:

- Assist the public in understanding what to expect from an Athletic Trainer
- Assist the Athletic Trainer in evaluating the quality of patient care
- Assist the Athletic Trainer in understanding the duties and obligations imposed by virtue of holding the ATC® credential

The Standards are NOT intended to:

- Prescribe services
- Provide step-by-step procedures
- Ensure specific patient outcomes

The BOC does not express an opinion on the competence or warrant job performance of credential holders; however, every Athletic Trainer and applicant must agree to comply with the Standards at all times.

Standard 1: Direction

The Athletic Trainer renders service or treatment under the direction of a physician.

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Standard 2: Prevention
The Athletic Trainer understands and uses preventive measures to ensure the highest quality of care for every patient.

Standard 3: Immediate Care
The Athletic Trainer provides standard immediate care procedures used in emergency situations, independent of setting.

Standard 4: Clinical Evaluation and Diagnosis
Prior to treatment, the Athletic Trainer assesses the patient's level of function. The patient's input is considered an integral part of the initial assessment. The Athletic Trainer follows standardized clinical practice in the area of diagnostic reasoning and medical decision making.

Standard 5: Treatment, Rehabilitation and Reconditioning
In development of a treatment program, the Athletic Trainer determines appropriate treatment, rehabilitation and/or reconditioning strategies. Treatment program objectives include long- and short-term goals and an appraisal of those which the patient can realistically be expected to achieve from the program. Assessment measures to determine effectiveness of the program are incorporated into the program.

Standard 6: Program Discontinuation
The Athletic Trainer, with collaboration of the physician, recommends discontinuation of the athletic training service when the patient has received optimal benefit of the program. The Athletic Trainer, at the time of discontinuation, notes the final assessment of the patient's status.

Standard 7: Organization and Administration
All services are documented in writing by the Athletic Trainer and are part of the patient's permanent records. The Athletic Trainer accepts responsibility for recording details of the patient's health status.

II. Code of Professional Responsibility

Preamble
The Code of Professional Responsibility (Code) mandates that BOC credential holders and applicants act in a professionally responsible manner in all athletic training services and activities. The BOC requires all Athletic Trainers and applicants to comply with the Code. The BOC may discipline, revoke or take other action with regard to the application or certification of an individual that does not adhere to the Code. The *Professional Practice and Discipline Guidelines and Procedures* may be accessed via the BOC website, www.bocatc.org.

Code 1: Patient Responsibility
The Athletic Trainer or applicant:

1.1 Renders quality patient care regardless of the patient's race, religion, age, sex, nationality, disability, social/economic status or any other characteristic protected by law
1.2 Protects the patient from harm, acts always in the patient's best interests and is an advocate for the patient's welfare
1.3 Takes appropriate action to protect patients from Athletic Trainers, other healthcare providers or athletic training students who are incompetent, impaired or engaged in illegal or unethical practice

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1.4 Maintains the confidentiality of patient information in accordance with applicable law

1.5 Communicates clearly and truthfully with patients and other persons involved in the patient's program, including, but not limited to, appropriate discussion of assessment results, program plans and progress

1.6 Respects and safeguards his or her relationship of trust and confidence with the patient and does not exploit his or her relationship with the patient for personal or financial gain

1.7 Exercises reasonable care, skill and judgment in all professional work

Code 2: Competency

The Athletic Trainer or applicant:

2.1 Engages in lifelong, professional and continuing educational activities

2.2 Participates in continuous quality improvement activities

2.3 Complies with the most current BOC recertification policies and requirements

Code 3: Professional Responsibility

The Athletic Trainer or applicant:

3.1 Practices in accordance with the most current BOC Practice Standards

3.2 Knows and complies with applicable local, state and/or federal rules, requirements, regulations and/or laws related to the practice of athletic training

3.3 Collaborates and cooperates with other healthcare providers involved in a patient's care

3.4 Respects the expertise and responsibility of all healthcare providers involved in a patient's care

3.5 Reports any suspected or known violation of a rule, requirement, regulation or law by him/herself and/or by another Athletic Trainer that is related to the practice of athletic training, public health, patient care or education

3.6 Reports any criminal convictions (with the exception of misdemeanor traffic offenses or traffic ordinance violations that do not involve the use of alcohol or drugs) and/or professional suspension, discipline or sanction received by him/herself or by another Athletic Trainer that is related to athletic training, public health, patient care or education

3.7 Complies with all BOC exam eligibility requirements and ensures that any information provided to the BOC in connection with any certification application is accurate and truthful

3.8 Does not, without proper authority, possess, use, copy, access, distribute or discuss certification exams, score reports, answer sheets, certificates, certificant or applicant files, documents or other materials

3.9 Is candid, responsible and truthful in making any statement to the BOC, and in making any statement in connection with athletic training to the public

3.10 Complies with all confidentiality and disclosure requirements of the BOC

3.11 Does not take any action that leads, or may lead, to the conviction, plea of guilty or plea of nolo contendere (no contest) to any felony or to a misdemeanor related to public health, patient care, athletics or education; this includes, but is not limited to: rape; sexual abuse of a child or patient; actual or threatened use of a weapon of violence; the prohibited sale or distribution of controlled substance, or its possession with the intent to distribute; or the use of the position of an Athletic Trainer to improperly influence the outcome or score of an athletic contest or event or in connection with any gambling activity

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3.12 Cooperates with BOC investigations into alleged illegal or unethical activities; this includes but is not limited to, providing factual and non-misleading information and responding to requests for information in a timely fashion

3.13 Does not endorse or advertise products or services with the use of, or by reference to, the BOC name without proper authorization

Code 4: Research

The Athletic Trainer or applicant who engages in research:

4.1 Conducts research according to accepted ethical research and reporting standards established by public law, institutional procedures and/or the health professions

4.2 Protects the rights and well being of research subjects

4.3 Conducts research activities with the goal of improving practice, education and public policy relative to the health needs of diverse populations, the health workforce, the organization and administration of health systems and healthcare delivery

Code 5: Social Responsibility

The Athletic Trainer or applicant:

5.1 Uses professional skills and knowledge to positively impact the community

Code 6: Business Practices

The Athletic Trainer or applicant:

6.1 Refrains from deceptive or fraudulent business practices

6.2 Maintains adequate and customary professional liability insurance

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VISION OF THE BOC
To be the worldwide leader in credentialing

MISSION OF THE BOC
To provide exceptional credentialing programs for healthcare professionals to assure protection of the public

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BOC PROFESSIONAL PRACTICE AND DISCIPLINE GUIDELINES

Effective March 22, 2007
Updated January 1, 2014

Certainty for the
BOC Certified Athletic Trainer

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Introduction

The *BOC Professional Practice and Discipline Guidelines and Procedures* are intended to inform BOC Certified Athletic Trainers, BOC exam applicants, consumers of athletic training services and members of the public of the disciplinary guidelines and procedures.

Section 1: Professional Practice and Discipline Committee

1.1 Function and Jurisdiction of the Professional Practice and Discipline Committee

The Professional Practice and Discipline Committee (referred to herein as "PPD Committee") is responsible for the oversight and adjudication of the *BOC Professional Practice and Discipline Guidelines and Procedures* (referred to herein as *Procedures*) and the *BOC Standards of Professional Practice*, which consists of the Practice Standards and the Code of Professional Responsibility. The PPD Committee has jurisdiction over all BOC Certified Athletic Trainers (referred to herein as AT or ATs) and both current and prospective BOC exam applicants.

1.2 Powers and Duties of the PPD Committee

The PPD Committee shall be authorized and empowered to:

1.2.1 Review and decide cases involving alleged violations of the *BOC Standards of Professional Practice* and impose sanctions as appropriate;

1.2.2 Review sanctions imposed for failure to comply with recertification requirements pursuant to Section 10;

1.2.3 Regularly report to the BOC Executive Director on the operation of the PPD Committee;

1.2.4 Propose amendments to the *Procedures*, subject to review and approval of the BOC Executive Director and BOC Legal Counsel, and adoption by the BOC Board of Directors; and

1.2.5 Adopt such other rules or procedures as may be necessary or appropriate to govern the internal operations of the PPD Committee.

1.3 Selection and Term Limits

The BOC Board of Directors, by a majority vote, shall appoint five persons who are ATs in good standing and two members of the public for a three year term to the PPD Committee with the ability to serve no more than a maximum of three consecutive terms. The terms shall be staggered. The BOC Board of Directors shall designate one AT member to serve as the Chair of the PPD Committee. The term for the Chair will be three years with the ability to serve no more than a maximum of two consecutive terms as Chair. The Chair must have previously served on the PPD Committee. The Chair will only vote when there is a tie vote among the other PPD Committee members.

When a vacancy on the PPD Committee occurs as a result of resignation, unavailability or disqualification, the BOC Executive Director shall designate a new member in coordination and compliance with the BOC Nominating Committee.

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Section 2: Investigation

2.1 Filing a Complaint

Individuals shall report possible violations of the *BOC Standards of Professional Practice* in a written and signed statement addressed to the BOC. This statement shall identify the persons alleged to be involved and the facts concerning the alleged conduct in as much detail as possible and should include any available documentation. You may file a complaint on the BOC website, www.bocatc.org, or you may contact the BOC office to obtain a complaint form.

The BOC may undertake an investigation or initiate a disciplinary proceeding without a complaint in the event it receives or discovers information indicating that a violation of the *BOC Standards of Professional Practice* may have occurred.

2.2 Procedures for Investigation

2.2.1 Preliminary Review

The BOC shall review all complaints and information concerning a possible violation of the *BOC Standards of Professional Practice*. In making a determination of whether to proceed, the BOC shall make such inquiry regarding the underlying facts as it deems appropriate. If the BOC chooses not to investigate a complaint, no file shall be opened and the Complainant shall be notified of the BOC's decision.

2.2.2 Investigation

If, upon completion of its preliminary review, the BOC determines that the information and allegations, if true, describe facts that would constitute a violation of the *BOC Standards of Professional Practice*, the BOC shall initiate an investigation. Notice: Upon initiation of an investigation, the BOC shall notify the Respondent as well as the Complainant that it has decided to conduct an investigation. This notification shall be in writing and shall include a description of the allegations or information received by the BOC and may request additional information from the Respondent and/or Complainant. The identity of the Complainant will remain confidential to the extent consistent with a proper and thorough investigation. The Respondent and/or Complainant shall have 15 calendar days from the date notification is sent to respond in writing to the complaint. The BOC may extend this period up to an additional 15 calendar days upon request, provided sufficient justification for the extension is given prior to the expiration of the original deadline.

2.2.2.1 Response: Upon receipt of a response admitting the allegations in the complaint, the BOC shall refer the matter to the PPD Committee and the Respondent may request, or be requested to, enter into a Consent Agreement as outlined in Section 4. All other responses will be considered in the investigation.

2.2.3 Probable Cause Determination Procedures

Upon the completion of its investigation, the BOC shall determine if there is probable cause to believe grounds for discipline exist and shall either:

2.2.3.1 Dismiss the case due to insufficient evidence, the matter being insufficiently serious, or other reasons as may be warranted;

2.2.3.2 Begin preparation and processing of a Charge against the Respondent in accordance with Section 3; or

2.2.3.3 Offer a Consent Agreement as outlined in Section 4.

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Section 3: Charge

3.1 Charge

A Charge letter shall be prepared by the BOC. The Charge letter shall contain a statement of the factual allegations constituting the alleged violation and the standard or code allegedly violated. The Charge letter shall also include a recitation of the Respondent's rights and shall enclose a copy of these *Procedures.*

3.2 Service of the Charge Letter

The Charge letter shall be transmitted to the Respondent by certified mail or tracked courier, return receipt requested.

3.3 Response

The Respondent shall have 30 calendar days from the date of receipt or delivery of the Charge in which to respond to the allegations, provide comments regarding appropriate sanctions or request a hearing. The BOC may extend this period up to an additional 15 calendar days upon request, provided sufficient justification for the extension is given prior to the expiration of the original deadline. All responses shall be in writing. Hearings are available only if the Respondent disputes the truth of the factual allegations underlying the Charge.

3.4 Failure to Respond

If the Respondent fails to respond within the period provided by Section 3.3, the Respondent shall be deemed to be in default and the allegations set forth in the Charge shall be deemed admitted. In such circumstance, the BOC shall serve upon the Respondent a notice of default specifying the form of discipline (see Section 8), if any, to be imposed and informing the Respondent of his/her right of appeal.

3.5 Consent Agreement

If the Respondent does not dispute the factual allegations outlined in the Charge letter, the Respondent shall be requested to enter into a Consent Agreement as outlined in Section 4.

Section 4: Consent Agreements

4.1 Consent Agreement

At any time during a disciplinary proceeding, the BOC may execute a Consent Agreement with the Respondent. A Consent Agreement is a voluntary and legally binding agreement between the BOC and the Respondent which formally resolves a Charge or investigation without further proceedings. Consent Agreements may be initiated by either the BOC or a Respondent. Consent Agreements may be entered into only with the consent of the Respondent, the PPD Committee and the Executive Director.

Any remedy, penalty or sanction that is otherwise available under these *Procedures* may be achieved by Consent Agreement, including long-term suspension. A Consent Agreement is not subject to review or appeal and may be modified only by a writing executed by all parties to the original Consent Agreement. A Consent Agreement may be enforced by either party in an action at law or equity.

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4.2 Offer of Consent Agreement

The BOC may propose entry into a Consent Agreement at any time during the disciplinary process, including but not limited to the conclusion of an investigation, at the time of service of a Charge letter, upon receipt of the Response to the Charge letter, or during the Hearing or Appeals process. Every Consent Agreement shall contain and describe in reasonable detail:

4.2.1 The act or practice which the Respondent is alleged to have engaged in or omitted;

4.2.2 The standard(s) or code(s) that such act, practice or omission to act is alleged to have been violated;

4.2.3 A statement that the Respondent does not contest the factual allegation(s) and violation(s) as outlined by 4.2.1 and/or the BOC's findings regarding the factual allegations;

4.2.4 The proposed action to be taken and a statement that the Respondent consents to the proposed action; and

4.2.5 The Respondent's waiver of all right of appeal within the BOC or the judicial system or to otherwise challenge or contest the validity of the Consent Agreement.

4.3 Publication

Although Consent Agreements typically remain confidential, the BOC may determine that circumstances exist in which publication is warranted. The terms of each Consent Agreement will specify the degree of confidentiality accorded each agreement.

Section 5: Conviction of a Crime or Professional Discipline

5.1 Duty to Report Criminal Charge, Conviction or Professional Discipline

5.1.1 Duty to Report Criminal Charge

An AT or BOC applicant who is charged with a serious crime as defined in Section 5.3.1 below, shall notify the BOC of such charge within 10 calendar days after the date on which the Respondent is notified of the charge.

5.1.2 Duty to Report Criminal Conviction or Professional Discipline

An AT or BOC applicant who is convicted of any crime (with the exception of misdemeanor traffic offenses or traffic ordinance violations that do not involve the use of alcohol or drugs), or who becomes subject to any professional discipline, shall notify the BOC in writing of such conviction or professional discipline within 10 calendar days after the date on which the Respondent is notified of the conviction or professional discipline.

5.2 Commencement of Disciplinary Proceedings Upon Notice of Charge, Conviction or Professional Discipline

Upon receiving notice that an AT or BOC applicant has been charged with a serious crime (as defined in Section 5.3.1) or convicted of a crime other than a serious crime or has been subject to professional discipline other than suspension (as defined in Section 5.3.2), the BOC shall commence an investigation. If the conviction is for a serious crime or if a Respondent has received a professional suspension, the BOC shall obtain the record of conviction or proof of suspension and initiate disciplinary proceedings against the Respondent as provided in Section 3. If the Respondent's criminal conviction or professional suspension is either admitted or proved as provided in Section 5.4, the Respondent shall have no right to a hearing before the Hearing Panel.

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5.3 Conviction of Serious Crime or Professional Suspension – Immediate Suspension

Upon receiving notification of a Respondent's conviction of a serious crime or professional suspension, the BOC may, at its discretion, issue a notice to the convicted or suspended AT or BOC applicant directing that the Respondent show cause why the Respondent's right to use the ATC® certification mark should not be immediately suspended or BOC exam eligibility be denied pursuant to Section 8.

5.3.1 Serious Crime Defined

The term serious crime as used in these rules shall include: 1) any felony; 2) a misdemeanor related to public health, patient care, athletics or education. This includes, but is not limited to: rape; sexual or physical abuse of a child or patient; actual or threatened use of a weapon of violence; the prohibited sale or distribution of controlled substance, or its possession with the intent to distribute; or the use of the position of an AT to improperly influence the outcome or score of an athletic contest or event or in connection with any gambling activity; and/or an attempt, conspiracy, aiding and abetting, or solicitation of another to commit such an offense.

5.3.2 Definition of a Professional Suspension

A professional suspension as used herein shall mean the Respondent's license to provide athletic training or other healthcare services has been suspended or barred by a governmental or industry self-regulatory authority.

5.4 Proof of Conviction or Professional Discipline

Except as otherwise provided in these *Procedures*, an original or authenticated copy of a certificate or other writing from the clerk of any court of criminal jurisdiction indicating that an AT or applicant has been convicted of a crime in that court, or an original or authenticated copy of a letter or other writing from a governmental or industry self-regulatory authority to the effect that an AT or applicant has been subject to professional discipline or suspension by such authority, shall constitute conclusive proof of the existence of such conviction or such professional discipline for purposes of these disciplinary proceedings.

5.5 Applicants with Prior Criminal Conviction or Professional Discipline

A BOC applicant who has a prior conviction of any crime (with the exception of misdemeanor traffic offenses or traffic ordinance violations that do not involve the use of alcohol or drugs), or who has been subject to any professional discipline, shall select "Yes" to Question 1 and/or Question 2 of the Affidavit section of the BOC Exam Application.

5.5.1 Commencement of Disciplinary Proceedings upon Notice of Prior Conviction or Professional Discipline to Determine Exam Eligibility

The BOC Applicant shall submit an explanation of the events that led to the conviction and copy of court document(s), including, but not limited to, an arrest report, sentence recommendation, proof of compliance of all court requirements and proof of payment for all related fines. The Committee may request additional documentation at any time during the proceedings.

5.5.1.1 The Committee will review each case to determine exam eligibility.

5.5.1.2 The Committee may grant exam eligibility and if necessary, may impose discipline once the Applicant is certified. Possible forms of discipline are outlined in Section 8.

5.5.1.3 The Committee may deny exam eligibility. If exam eligibility is denied the Applicant has 30 calendar days to appeal. See Section 7 for appeal procedures.

5.5.2 Predetermination of Applicant Eligibility

Individuals with a conviction and/or professional discipline may request a predetermination of eligibility at any time by submitting documentation, as outlined in 5.5.1, prior to submitting an application. Upon review, the Committee will provide the individual written notification of exam eligibility. In the event that additional information is discovered regarding the conviction and/or professional discipline the notification is null and void. The notification does not guarantee exam eligibility.

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Section 6: Hearings

Hearings are conducted only in cases where the Respondent disputes the truthfulness of the facts underlying the Charge. Respondents wishing to have a hearing must request a hearing in writing in Response to the Charge Letter. Hearings are conducted orally by telephone conference call. A hearing may be conducted in person at the BOC office in Omaha, Nebraska, if the BOC determines that exceptional circumstances exist which warrant such a hearing.

6.1 Notice

The BOC shall:

6.1.1 Forward any Response containing a valid request for a hearing and the Charge letter to the Hearing Panel;

6.1.2 Schedule a hearing before the Hearing Panel; and

6.1.3 Send by certified mail, return receipt requested, or tracked courier, a Notice of Hearing to the Respondent.

6.1.3.1 The Notice of Hearing shall include a statement of the date and time of the hearing. The BOC will endeavor to schedule the hearing on a mutually agreeable time and date.

6.2 Designation of a Hearing Panel

Upon receipt of a request for a hearing that complies with the requirements of Section 3.3, above, the BOC Executive Director shall appoint a Hearing Panel. The Panel shall comprise five members, including three ATs and two members of the public. The BOC Executive Director shall designate one of the AT members to serve as the Chair for the Hearing Panel. The Chair shall only vote in the event of a tie among the other Hearing Panel members.

6.2.1 The Hearing Panel may be established as a standing Panel.

6.2.2 The BOC Executive Director may also appoint up to eight non-voting substitute members.

6.2.3 When a vacancy of a full member occurs in the Hearing Panel as a result of resignation, unavailability or disqualification, the BOC Executive Director shall designate a substitute member to serve in the full member's place.

6.3 Procedure and Proof

6.3.1 The Hearing Panel shall maintain an audio-taped or written transcript of the proceedings.

6.3.2 The BOC and the Respondent or their agent(s) may make opening statements, present documents and testimony, examine and cross-examine witnesses under oath, make closing statements and present written briefs as scheduled by the Hearing Panel.

6.3.3 The Hearing Panel shall determine all matters relating to the hearing by majority vote. The hearing shall be conducted on the record. Formal rules of evidence shall not apply. Relevant evidence may be admitted.

6.4 Decision

6.4.1 Decisions by the Hearing Panel shall be in writing and shall include, as appropriate, factual findings, conclusions of law and any form(s) of discipline applied.

6.4.2 Decisions by the Hearing Panel shall be transmitted to the Respondent by certified mail or tracked courier, return receipt requested.

6.5 Expenses

Each party shall bear its own travel, legal and other expenses related to the hearing.

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Section 7: Appeals

The Respondent may appeal a decision by the Hearing Panel, a decision rendered by the PPD Committee regarding the imposition of discipline, or an entry of default by the BOC. Consent Agreements and any Orders accompanying them, are not subject to appeal. All appeals are based on the record before the Hearing Panel or PPD Committee. New or additional evidence is permitted only in exceptional circumstances and in the interests of justice.

7.1 Appeals Procedure

7.1.1 An appeal must be postmarked within 30 calendar days of the Respondent's receipt of a Hearing Panel or PPD Committee decision or a BOC entry of default through the submission of a written appeal statement to the BOC Executive Director. The appeal statement must set forth the grounds on which the appeal is based and the specific relief requested.

7.1.2 The BOC Executive Director may file a written response to the appeal statement of the Respondent.

7.1.3 The Appeals Panel shall render a decision on the record without oral hearing, although written briefing may be submitted.

7.2 Designation of Appeals Panel

Upon receipt of a valid appeal statement, the BOC Board of Directors shall select three of its members to serve on an Appeals Panel. The Appeals Panel shall include at least one Athletic Trainer Director and one Public Director.

7.3 Decision

The decision of the Appeals Panel shall be rendered in writing. A decision by the Appeals Panel shall contain, as appropriate, factual findings, conclusions of law and any form(s) of discipline applied. It shall be transmitted to the Respondent by certified mail or tracked courier, return receipt requested. The Appeals Panel decision shall be final. The Appeals Panel may make the following decisions:

7.3.1 Affirm PPD Committee/Hearing Panel decision; or

7.3.2 Reverse the PPD Committee/Hearing Panel decision; or

7.3.3 Refer the case back to the PPD Committee/Hearing Panel for further investigation and resolution with full right of appeal; or

7.3.4 Modify the decision but not in a manner that would be more adverse to the Respondent; or

7.3.5 Vacate an entry of default by the BOC.

Section 8: Forms of Discipline

A violation of the *BOC Standards of Professional Practice* may result in one or more of the Forms of Discipline listed below. In imposing discipline, the BOC may consider any aggravating and/or mitigating circumstances, including the underlying facts, decision and discipline imposed in any previous disciplinary or criminal proceeding before the PPD Committee, Hearing Panel, Appeals Panel or any other regulatory body or court. All forms of discipline may be appealed as set forth in Section 7.

8.1 Suspension

The BOC may suspend certification in an Order of Suspension. The Order of Suspension shall state clearly and with reasonable particularity the grounds for suspension. The Order of Suspension also shall state the time at which the Respondent may petition for reinstatement under Section 12 of these

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Procedures. It shall be standard procedure to publish Suspensions. Should the PPD Committee and/or BOC Executive Director determine that there is cause to believe that a threat of immediate and irreparable injury to the health of the public exists, the PPD Committee and/or BOC Executive Director shall immediately place the Respondent's certification on Suspension prior to a final disciplinary decision.

8.1.1 Should an individual voluntarily surrender certification as outlined in a Consent Agreement (Section 4), the certification is **Suspended**.

8.1.2 Should an individual have a petition for reinstatement from suspension denied two times, the certification is permanently **Revoked**.

8.2 Denial of Eligibility

The BOC may deny a BOC applicant eligibility to sit for the BOC exam either permanently or for a specified period of time in an Order of Denial. The Order of Denial shall state clearly and with reasonable particularity the grounds for the denial of eligibility.

8.3 Private Censure

The BOC may issue a Private Censure. A Private Censure shall be an unpublished written reprimand from the BOC to the Respondent.

8.4 Public Censure

The BOC may issue a Public Censure. A Public Censure shall be a written reprimand from the BOC to the Respondent. It shall be standard procedure to publish Public Censures.

8.5 Probation

The BOC may place a Respondent on Probation. Probation may include the setting of conditions that must be met in a specific period of time not to exceed three years. A Respondent on probation is required to complete an Annual Probation Report. A report form is provided at the time the Probation is issued.

8.6 Sanctions

The BOC may issue sanctions that include but are not limited to one or more of the following:

8.6.1 Mandatory audit participation of a specified reporting period;

8.6.2 Educational course requirements to be completed and reported by a specified date;

8.6.3 Other training, treatment and/or corrective action;

8.6.4 Payment of unpaid certification fee(s);

8.6.5 Annual reporting of a specified number of continuing education units to be submitted by a specified date.

Section 9: Impaired Practitioner *(section effective January 1, 2008)*

With regard to its charge to protect the public, it is the policy of the BOC to discipline and/or restrict the practice of any BOC Certified Athletic Trainer with an impairment that prevents him or her from practicing athletic training with reasonable skill.

9.1 Definitions

9.1.1 "Impaired practitioner" is defined as a person with a physical or mental condition, including deterioration through aging, loss of motor skill, or excessive use or abuse of drugs including alcohol, that prevents one from practicing athletic training with reasonable skill and safety to patients. (*Modified from definition of American Medical Association, 1972*)

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9.1.2 Types of impairments may include, but are not limited to:
- 9.1.2.1 Substance abuse;
- 9.1.2.2 Personality disorders – disruptive behavior;
- 9.1.2.3 Physical impairments;
- 9.1.2.4 Psychological impairments.

9.1.3 "Governing authority" is defined as the entity responsible for overseeing the practice regulations of the Athletic Trainer in question. In many cases the governing authority will be identified in the regulatory legislation of the state, province or jurisdiction in which the Athletic Trainer practices.

9.1.4 "Reasonable skill" is defined as entry-level competence.

9.2 Scope of BOC Responsibilities

9.2.1 Restrictions or discipline primarily shall be the responsibility of the governing authority; in general, the BOC will respond to the governing authority's actions.

9.2.2 The BOC shall act in the public's interest by forwarding all complaints or allegations of impairment to the appropriate governing authority.

9.2.2.1 The BOC will accept the determination of the governing authority of the validity of a complaint or allegation of impairment.

9.2.3 In the event the governing authority disciplines or restricts the practitioner's ability to provide AT services, the BOC generally shall likewise discipline or restrict the practitioner's certification.

9.2.3.1 Certification restrictions or discipline shall be established by the BOC in a manner consistent with the restrictions or sanctions rendered by the state governing authority. These restrictions may include:

9.2.3.1.1 Imposition of discipline as outlined in Section 8.

9.2.4 Where the governing authority has sanctioning authority, the BOC may restrict or discipline a practitioner's certification in the absence or presence of restriction or discipline by the governing authority.

9.2.5 In the absence of a governing authority, the BOC shall follow the *BOC Professional Practice and Discipline Guidelines and Procedures* with regard to complaints or allegations of impairment.

9.3 Reporting Guidelines

9.3.1 Early intervention for the impaired practitioner may enhance recovery and will protect the safety of the public. Thus, reporting should occur when there is a reasonable suspicion of impairment.

9.3.2 Decreased clinical judgment, inappropriate behavior or diminished psychomotor skills are the hallmarks of impairment and generally should lead to reporting.

9.3.3 Strict adherence to the definition of impaired practitioner should be followed; however, illnesses, disabilities or other conditions that do not hamper the practitioner's ability to competently practice as an AT should not be reported.

9.3.4 Reporting of an impaired practitioner may occur through:
- 9.3.4.1 Self-reporting;
- 9.3.4.2 Reporting from another practitioner;
- 9.3.4.3 Reporting from a patient;
- 9.3.4.4 Reporting from other sources with personal knowledge or reasonable suspicion of impairment.

9.3.5 Upon the development of a reasonable suspicion of impairment, complaints or allegations of impairment should be directed or sent promptly to the governing authority, with a copy to the BOC. Where there is no governing authority, complaints or allegations of impairment should be directed or sent promptly to the BOC.

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9.4 Purpose and Application of Discipline and Restrictions

9.4.1 Protect the public.

9.4.2 In response to action by an appropriate governing authority or on its own initiative, the BOC shall impose discipline or restrictions necessary to protect the public.

9.4.3 BOC discipline and/or restrictions shall be clearly associated with the practitioner's behavior demonstrating incompetence or the potential for endangerment to the public.

9.4.4 Protect the individual.

9.4.5 Discipline and/or restrictions shall not unduly restrict/penalize an individual in areas of practice where he/she is safely and competently performing duties or providing a service.

9.4.6 Discipline and/or restrictions shall afford the practitioner the opportunity for rehabilitation or retraining if possible or practicable. The practitioner may be required to participate in a recovery program related to the impairment. This program may be established by the employer, state or private sector but must be approved by the governing authority or the BOC.

9.4.6.1 Where a discipline includes mandatory participation in a recovery program, it is the responsibility of the impaired practitioner to enroll in the recovery program.

9.4.6.1.1 Recovery or treatment programs must include:

9.4.6.1.1.1 A monitoring system to track progress of the impaired practitioner.

9.4.6.1.1.2 The submission of reports of compliance and progress to the governing authority.

9.4.6.1.2 The BOC may require evidence or verification that the practitioner has completed a treatment program related to the impairment.

9.4.7 Following completion of any program or treatment requirements and demonstration of competence to practice, the BOC will adjust the certification status appropriately.

9.5 Professional Review and Monitoring

9.5.1 Upon receipt of a report or decision of impairment by the governing authority, the BOC will follow the *BOC Professional Practice and Discipline Guidelines and Procedures* to determine the appropriate discipline or restrictions that may be imposed upon the practitioner.

9.5.2 The BOC shall maintain confidentiality regarding impaired practitioners consistent with the law, its ability to investigate the reported alleged impairment and public safety.

9.5.3 Restrictions or discipline must be based on facts related to the impairment. Evidence of the impairment must be based on the absence of a level of competence to practice athletic training in a manner that protects the safety of the public.

9.5.3.1 If the AT is unable to practice competently and safely, practice restrictions must be established that will enable the AT to do so or the AT's BOC certification will be suspended. Appropriate restrictions may limit the practice setting, clientele or other job duties that may be performed by the AT.

9.5.4 Where the governing authority has ordered specific testing of the practitioner such as physical examination, psychological examination and/or drug testing, the BOC may require the submission of copies of any reports generated from the examinations/testing or confirmation from the governing authority as to the results.

9.5.5 Once it is identified that testing of the practitioner is needed, it is the responsibility of the practitioner to obtain the tests required by the governing authority.

9.5.6 The BOC shall establish a system for monitoring the impaired practitioner to ensure the practitioner is in compliance with sanctions or restrictions.

9.5.6.1 The monitoring system may be overseen by the employer or the governing authority; however, the practitioner is required to report any changes in status to the BOC.

9.5.6.2 Compliance with the monitoring system shall be a condition of BOC certification.

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Section 10: Required Action After Suspension

After the entry of Suspended, the Respondent shall promptly terminate any and all use of the ATC© certification mark and, in particular, shall not use the ATC© certification mark in any advertising material, announcement, letterhead or business card. The Respondent is required to return his/her BOC certification card to the BOC office within 10 calendar days of receipt of the order via traceable mail. Once the use of the ATC© certification mark has been terminated the Respondent may not:

10.1 Represent him/herself to the public as a practicing Certified Athletic Trainer or use the certification marks ATC© or C.A.T. following his/her name; or
10.2 Serve as an item writer for the BOC exam; or
10.3 Serve as a supervisor of students who are satisfying the athletic training requirements for certification eligibility.

Section 11: Status Definitions

The following status definitions are effective as of January 1, 2012.

11.1 Certified
Certification is in good standing. Individuals may practice as authorized by the BOC.

11.2 Expired
11.2.1 Certification is voluntarily resigned for reasons unrelated to disciplinary proceedings. ATs with an Expired status may not represent themselves as Certified Athletic Trainers or use the ATC© certification mark.
11.2.2 Certification is forfeited due to non-compliance with BOC certification fee and/or continuing education requirements. Respondents with an Expired status may not represent themselves as Certified Athletic Trainers or use the ATC® certification mark.

11.3 Suspended
Certification is not in good standing as a result of the imposition of a disciplinary action or the BOC Executive Director's decision that there is cause to believe that a threat of immediate and irreparable injury to the health of the public exists. Respondents with a Suspended status may not represent themselves as a Certified Athletic Trainer or use the ATC© certification mark.
11.3.1 Revoked
Certification is Suspended and individual has had two petitions for reinstatement denied; the certification is permanently revoked. Respondents with a Revoked status may not represent themselves as a Certified Athletic Trainer or use the ATC© certification mark.

Section 12: Reinstatement

12.1 Reinstatement After Expired
Failure to comply with fee, continuing education and/or emergency cardiac care requirements are direct violations of the *BOC Standards of Professional Practice* and result in an Expired status. The following steps are necessary for reinstatement:
12.1.1 The AT must complete a reinstatement application and pay the required fee.
12.1.2 The BOC may require an AT in Expired status to sit for the BOC certification exam.

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12.2 Reinstatement After Suspended

Respondents whose certification was suspended for disciplinary reasons under Section 8 of these Guidelines must petition for reinstatement before returning to practice. Such petition shall be submitted in writing and shall be accompanied by any supporting documentation the Respondent wishes to provide to the Reinstatement Panel. A petition fee may be assessed.

12.2.1 Designation of Reinstatement Panel

Upon receipt of a valid petition for reinstatement from Suspended status, the BOC Executive Director shall appoint a Reinstatement Panel. The Panel shall comprise five members, including three ATs and two members of the public. The BOC Executive Director shall designate one of the AT members to serve as the Chair for the Reinstatement Panel. The Chair shall only vote in the event of a tie among the other Reinstatement Panel members.

12.2.1.1 The Reinstatement Panel may be established as a standing Panel.

12.2.1.2 The BOC Executive Director may also appoint up to eight non-voting substitute members.

12.2.1.3 When a vacancy of a full member occurs in the Reinstatement Panel as a result of resignation, unavailability or disqualification, the BOC Executive Director shall designate a substitute member to serve in the full member's place.

12.2.2 Investigation

Immediately upon receipt of a petition for reinstatement, the BOC will initiate an investigation. The petitioner shall cooperate in any such investigation. Once the investigation is concluded, a report of the investigation shall be submitted to the Reinstatement Panel. The report shall contain the results of the investigation, information regarding the petitioner's past disciplinary record and any recommendation regarding reinstatement.

12.2.3 Successive Petitions

If the petition is denied, the Reinstatement Panel shall set a date upon which the Respondent may file a second petition for permission to reapply for reinstatement. The Reinstatement Panel will not consider petitions for permission to reapply for reinstatement from Respondents whose petitions have been denied twice. Once a Respondent has had two petitions denied, his/her certification status is Revoked. Denials of petitions for permission to reapply are not appealable under these Guidelines.

12.2.4 Conditions or Restrictions on Reinstatement

If the reinstatement petition is granted, the Reinstatement Panel may impose disciplinary sanctions as outlined in Section 8 following reinstatement. The Reinstatement Panel also may impose other conditions on reinstatement, including but not limited to a requirement that the Respondent sit for the BOC certification exam.

Section 13: Confidentiality of Proceedings

13.1 Confidentiality

Except as otherwise provided in these *Procedures*, all proceedings conducted pursuant to these *Procedures* shall be confidential and the records of the PPD Committee, Hearing Panel, Appeals Panel, Reinstatement Panel, BOC Legal Counsel and BOC staff shall remain confidential and shall not be made public.

13.2 Exceptions to Confidentiality

The subject matter and status of proceedings conducted pursuant to these *Procedures* may be disclosed if:

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13.2.1 The proceeding is predicated on criminal conviction or professional discipline as defined herein; or

13.2.2 The Respondent has waived confidentiality; or

13.2.3 Such disclosure is required by legal process of a court of law or other governmental body or agency having appropriate jurisdiction; or

13.2.4 The proceeding involves a consumer or consumers of athletic training services, wherein the BOC may contact the consumer(s) and/or the Respondent's current and/or former employer(s) to request documents relevant to the proceeding; or

13.2.4.1 The Respondent receives a form of discipline that is published. In such cases, all AT state regulatory bodies shall be notified and an announcement included in one or more publications of interest to persons engaged in, or otherwise interested in, the profession of athletic training. The BOC may also disclose its final decision to state regulatory bodies and others as it deems appropriate, including, but not limited to, persons inquiring about the status of a Respondent's certification, employers and the general public.

Section 14: General Provisions

14.1 Definitions

14.1.1 Respondent

For the purpose of these *Procedures*, "Respondent" shall mean a Certified Athletic Trainer, BOC applicant or BOC potential applicant who is the subject of a disciplinary complaint or proceeding.

14.1.2 Complainant

For the purpose of these *Procedures*, "Complainant" shall be any individual or organization who provides the BOC with information or allegations indicating that a violation of the *BOC Standards of Professional Practice* may have occurred.

14.2 Disqualification

PPD Committee, Hearing Panel, Appeals Panel and Reinstatement Panel members may not serve in any situation where their impartiality might reasonably be questioned or in which they have an apparent or actual conflict of interest. PPD Committee, Hearing Panel, Appeals Panel and Reinstatement Panel members shall refrain from participating in any proceeding in which they, a member of their immediate family, their employer or an organization to which they belong, have any interest. PPD Committee, Hearing Panel, Appeals Panel and Reinstatement Panel members may not consider any matter that came before them during their tenure on another BOC committee or panel. PPD Committee, Hearing Panel, Appeals Panel and Reinstatement Panel members may serve in only one capacity at a time.

14.3 Quorum

A quorum of the PPD Committee, a Hearing Panel, an Appeals Panel or a Reinstatement Panel consists of three full-voting members, one of which must be the public member. PPD Committee, Hearing Panel, Appeals Panel and Reinstatement Panel action shall be determined by a majority vote.

14.4 Waiver and Release

As a condition of certification and application, ATs and applicants agree to release, discharge and exonerate the BOC, its officers, directors, employees, committee members and agents from any and

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all liability of any nature and kind, arising out of any investigation, evaluation and/or communication regarding the individual's eligibility, certification or recertification. The foregoing waiver and release shall apply with equal force and effect to any person furnishing documents, records or other information to the BOC relating to the AT or applicant's eligibility, certification or recertification.

14.5 Notice and Service

Except as may otherwise be provided in these Procedures, notice shall be in writing and the giving of notice and/or service shall be sufficient when made either personally or by US regular mail, US certified mail or overnight mail sent to the last known address of the Respondent according to the records of the BOC.

14.6 Liberal Construction of *Procedures*

Time limitations are administrative and the BOC reserves the right to grant extensions for good cause, as determined by the BOC in its sole discretion. A Respondent's failure to observe time limits without proof of good cause may result in the forfeiture of rights or remedies under these Procedures. These Procedures shall be liberally construed for the protection of the public, the BOC, its ATs and applicants. No investigation or procedure shall be deemed invalid or insufficient by reason of any non-prejudicial irregularity or deviation.

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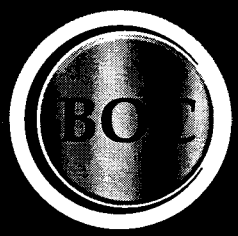
To be the worldwide leader in credentialing

MISSION OF THE BOC
To provide exceptional credentialing programs for healthcare professionals to assure protection of the public



BOARD OF CERTIFICATION
FOR THE ATHLETIC TRAINER

Be Certain.

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CONSENT AGREEMENT

This Consent Agreement is made by and between the National Athletic Trainers' Association Board of Certification, Inc., ("BOC"), a North Carolina non-profit corporation with a place of business at 1415 Harney Street, Suite 200, Omaha, Nebraska 68102, and Brittany Schreppel ("Respondent") of [redacted] South Williamsport, Pennsylvania, [redacted] referred to hereinafter collectively as the "Parties."

WHEREAS, Respondent has been certified by the BOC (Certification Number 2000004352) as having satisfied the requirements established by the BOC with regard to knowledge and professional competence in the area of entry-level athletic training; and

WHEREAS, the Parties stipulate to the truth and accuracy of the following:

1. On or about August 22, 2011, Respondent entered into a consent order with the State of Pennsylvania on August 5, 2013 admitting she had inappropriate physical contact with a student athlete where she was employed.

2. The Respondent's conduct violates the Code of Professional Responsibility ("Code") 3.2 of the BOC Standards of Professional Practice ("BOC Practice Standards"). Code section 3.2 states that an athletic trainer "Knows and complies with applicable local, state and/or federal rules, requirements, regulations and/or laws related to the practice of athletic training."

3. The Respondent's conduct also violated Code sections 1.6 and 1.7. Code section 1.6 states that an athletic trainer "[r]espects and safeguards his or her relationship of trust and confidence with the patient and does not exploit his or her relationship with the patient for personal or financial gain. Code section 1.7 states that an athletic trainer "[e]xercises reasonable care, skill and judgment in all professional work."

4. The above described Code violation constitutes grounds for disciplinary action pursuant to Section 9 of the BOC Professional Practice and Discipline Guidelines and Procedures ("BOC Discipline Procedures")."

WHEREAS, Respondent, in consideration of this Consent Agreement and for the purpose of terminating the BOC's investigation into his conduct, voluntarily admits that her actions as set forth above violate Code 3.2 of BOC Practice Standard violations and agrees that, for purposes of this or any future proceeding before the BOC, this Consent Agreement shall have the same effect as if ordered after a full hearing held pursuant to Section 7 of the BOC Discipline Procedures;

WHEREAS, Respondent understands and acknowledges Respondent's rights to a hearing and to appeal a decision by a hearing panel, but waives those rights and stipulates and agrees to the issuance of this Consent Agreement without further proceedings in this matter, and agrees to be fully bound by the terms and conditions specified herein; and

WHEREAS, the BOC Executive Director has consented to the execution of this Consent Agreement;

NOW, THEREFORE, pursuant to Section 5 of the BOC Discipline Procedures and in consideration of the mutual covenants contained herein, the receipt and sufficiency of which are hereby acknowledged, the Parties hereby stipulate and agree to the following:

1. The Parties agree that this Consent Agreement shall be and hereby is legally binding and is in full and complete settlement and resolution of any and all charges and/or claims that were or could have been brought by the BOC regarding the actions of Respondent as set forth above in Paragraphs 1 and 2 of Page 1, and shall constitute an admission by the Respondent that these actions violated Code 3.2 of the BOC Practice Standards.

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2. In exchange for the summary termination of the BOC's investigation into Respondent's conduct as described in Paragraphs 1 and 2 of Page 1 above, Respondent voluntarily admits: (1) the truthfulness of the factual allegation(s) set forth in Paragraphs 1 and 2 of Page 1 above; and (2) that Respondent's actions, as set forth in Paragraphs 1 and 2 of Page 1 above, violate Code 3.2 of the BOC Practice Standards. Respondent further agrees that for purposes of this or any future proceeding before the BOC, this Consent Agreement shall have the same effect as if ordered after a full hearing held pursuant to Section 7 of the BOC Discipline Procedures.

3. Respondent waives all right to a hearing on the merits of this matter as provided in Section 7 of the BOC Disciplinary Procedures.

4. Respondent waives all right to appeal the charges and/or claims set forth herein to the BOC or to any administrative, regulatory, judicial or other forum.

5. Respondent waives all right to challenge or otherwise contest the validity of this Consent Agreement to the BOC or to any administrative, regulatory, judicial or other forum. The Consent Agreement may be enforced by either party in an action at law or equity.

6. Respondent consents to and agrees that Respondent's certification status is considered Suspended. While suspended Respondent is not authorized to do the following:

a. Represent herself to the public as a practicing Certified Athletic Trainer or use the certification marks "ATC" or C.A.T." following your name; or

b. Serve as an item writer for the BOC certification exam; or

c. Serve as a supervisor of students who are satisfying the athletic training requirements for certification eligibility.

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7. Respondent may petition for reinstatement after suspension in accordance with Section 13 of the BOC Discipline Procedures. Such petition may be brought by Respondent no sooner than 2 years from January 13, 2014.

8. Any alleged breach of any provision of this Consent Agreement by Respondent may, at the sole and absolute discretion of the BOC, result in the following actions:

a. The BOC shall notify Respondent in writing by certified mail, return receipt requested or by tracked courier that the term(s) of this Consent Agreement have been breached and include a description of the acts or omission(s) constituting a breach the term(s) of this Consent Agreement.

b. Respondent shall be allowed fifteen (15) days from the date of the receipt of notification required in Paragraph 9(a) above to demonstrate to the sole satisfaction of the BOC that he has cured the breach in question.

c. Failure to cure the breach within the fifteen (15) day time period will terminate the BOC's obligations under this Consent Agreement and will cause the original matter, as outlined in Paragraphs 1 through 4 of Page 1, above, to be referred to the BOC Professional Practice and Discipline Committee ("PPD Committee") which shall make a final determination of the disciplinary action, if any, to be taken.

d. In addition, Respondent's breach of any term of this Consent Agreement may constitute an additional and independent Code violation and may provide separate grounds for the BOC to suspend, revoke, or otherwise take action with regard to his BOC certification.

9. Any notice by the BOC pertaining to this Consent Agreement shall be sufficient if sent to Respondent at the last address of record Respondent has reported to the BOC, or to an attorney designated by Respondent.

10. Respondent agrees that the factual and legal allegations as contained in this Consent Agreement shall be deemed true and admitted in any subsequent proceeding before the BOC in which his compliance with this Consent Agreement or the BOC Practice Standards is at issue.

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11. Any extension of time or grace period for reporting granted by the BOC in its sole and absolute discretion shall not be a waiver or preclude the BOC from taking action at a later time. The BOC shall not be required to grant any waiver, extensions of time, or grace periods.

12. This Consent Agreement shall be binding on and shall inure to the benefit of the Parties, their successors, assigns, or other legal representatives.

13. No waiver, change, amendment, or discharge of any term or condition hereof and no consent of either Party shall be of any force or effect unless made in writing and signed by both Parties or by duly authorized agents of the Parties. Any waiver granted by the BOC shall be at the sole and absolute discretion of the BOC and shall not function as a continuing waiver.

14. This Consent Agreement contains the entire understanding between the Parties and supersedes any and all pre-existing understandings, either oral or written, between the Parties relating to the subject matter hereof.

IN WITNESS WHEREOF, the Parties have executed this Consent Agreement, effective as of the 10th day of February, 2014.

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ATHLETIC TRAINERS GOVERNING BOARD
OFFICE OF LICENSED ALLIED HEALTH PROFESSIONALS
CONCORD, NEW HAMSPHIRE

In The Matter Of: **Docket #04-2013**

Nicole M. Bedard
(Application for Licensure)

DECISION AND ORDER

By the Board: Renee Kleszczynski, AT, Chair, George Tosatti, Public Member, Eric Glinas, AT

Also present: Tina M. Kelley, Administrator to the Board

Appearances: None

On September 19, 2013, the New Hampshire Athletic Trainers Governing Board ("Board") voted to DENY a request for reinstatement of Nicole M. Bedard ("Ms. Bedard" or "Applicant") license. See Order on Application Denial ("First Order"), dated September 19, 2013. Ms. Bedard petitioned the Board for a hearing on September 28, 2013 and the Board issued a "Notice of Hearing, Order to Show Cause" on October 23, 2013. On October 21, 2013 the Board received a letter of complaint submitted by Rolinda Mitchell, AT. The Board issued an Amended Notice of Hearing, Order to Show Cause on November 4, 2013.

On November 21, 2013, the hearing was held in accordance with RSA 328-F: 23 and 328-F:24; Aph 200 and Ath 200. Ms. Bedard appeared *pro se*.

At the time of the hearing, the Board reviewed the Order on Application Denial and supporting exhibits, the Notice of Hearing, Order to show Cause, and the Amended Notice of Hearing, Order to Show Cause and supporting exhibit. Ms. Bedard did not present any exhibits.

Ms. Bedard admitted that she had not changed her home address with the Board's office due to the fact that she had moved so many times over the past 4 years.

Ms. Bedard admitted that she had not provided the Board with the name and address of her current employer. She further stated that she had not listed it on the application for reinstatement

because she was planning on leaving employment at "Trinity High School". Ms. Bedard further admitted that she had been practicing at "Trinity High School" without a license from January 1, 2013 until May 25, 2013 and used the credentials in conjunction with her name during that period of time.

When asked why Ms. Bedard had not indicated in any of her letters of explanation to the Board that she had been practicing at Trinity High School without a license and stated to the Board in those letters that she had only been performing the duties of "Health Officer" she stated "I lied to cover up what I had done".

Ms. Bedard addressed the letter of complaint cited in the Amended Notice of Hearing, Order to Show Cause dated November 4, 2013. During testimony Ms. Bedard admitted to the Board that some of the student files she maintained were missing various pieces of documentation such as injury reports, documentation for the physician, return to play clearance notes, and injury follow- up notes. Ms. Bedard told the Board that she had no idea why allegations were made that she did not follow the standard concussion return to play protocol and that her knowledge and use of ImPACT testing is not at a based level.

Relevant Law:

RSA 328-F:21:

I. Licensees shall maintain their current business and home addresses on file with their governing boards. Any changes in address shall be provided to the office no later than 30 days from the date of the change.

RSA 328-F:23 II:

(a) Knowingly or negligently providing inaccurate material information to the board or failing to provide complete and truthful material information upon inquiry by the board, including during the process of applying for a license, license renewal, and license reinstatement.

RSA 328-F:23 II;

(c) Violation of the ethical standards adopted by the governing board.

RSA 328-F:23 II;

(e) Failure to provide care with reasonable skill, safety and regard for client or patient rights, whether or not the client or patient has suffered injury.

RSA 328-F:23 II:

(i) Practice without a currently valid license.

RSA 328-F:23 II:

(j) Violation of any provision of this chapter, or any governing board's practice act or rule adopted pursuant to RSA 541-A, or any state or federal law reasonably related to the licensee's authority to practice safely.

RSA 326-G:5:

I. Any person licensed to practice as an athletic trainer in this state may use the title "New Hampshire Licensed Athletic Trainer" and the abbreviation, "N.H.LAT" to designate such person's practice of athletic training and shall produce such person's license upon the request of the board.

II. Any person who uses the title or the abbreviation or otherwise states or implies by word or act that he or she is currently licensed to practice athletic training, and does so at a time when she or he does not possess a valid license, shall be guilty of a misdemeanor.

Ath 404.02(a):

Knowingly or negligently providing inaccurate material information to the board or failing to provide complete and truthful material information upon inquiry by the board, including during the process of applying for a license, license renewal, or license reinstatement;

ATh 404.02(d):

Violating Ath 500;

Ath 404.02(i):

Practicing athletic training when a previous license is not currently valid:

Ath 404.02(j):

Violating:

(1) Any provision of RSA 328-F;
(2) Any provision of RSA 326-G;
(3) Any rule adopted by the board; or
(4) Any state or federal law reasonably related to the licensee's authority to practice or the licensee's ability to practice safely.

Ath 501.02(g):

Licensees shall not misrepresent in any manner, either directly or indirectly, their skills, training, professional credentials, identity or services.

Findings of Fact and Rulings of Law:

- Ms. Bedard held a New Hampshire Athletic Trainers license from November 20, 2009 through December 31, 2012.
- Ms. Bedard let her licensed lapse by not renewing that license on December 31, 2012.
- Ms. Bedard practiced without a license at Trinity High School from January 1, 2013 until May 25, 2013 without a license in violation of RSA 328-F:23, II (a), (i), and (j), Ath 404.02(a), (d), (i), and (j).

- Ms. Bedard used the credentials "Athletic Trainer" in conjunction with her name without holding a license in New Hampshire between January 1, 2013 and May 25, 2013 in violation of RSA 328-F:23 II(c), RSA 328-F:23 II(c) and (i), RSA 326-G:5, Ath 404.02(d), Ath 404.02(i) and (j), and Ath 501.02(g).
- Ms. Bedard submitted her 2010 renewal application providing false information to the Board by marking "N/A" in the spaces designated for place of employment name, mailing address and phone number in violation of RSA 328-F:23, II(a) and (j), and Ath 404.02(d) and (j).
- By her own admission Ms. Bedard failed to update her home and business address with the Board's office in violation of RSA 328-F:21, RSA 328-F:23 II, and Ath 404.02(j).
- Ms. Bedard submitted an application for reinstatement failing to disclose to the Board that she was also practicing as an athletic trainer at Trinity High School as evidenced by the letter submitted by Denis J. Mailloux, Principal of Trinity High School in violation of RSA 328-F:23 II(a) and (j), and Ath 404.02(d) and (j).
- Ms. Bedard submitted a resume as part of her application for reinstatement providing inaccurate information regarding her employment history as evidenced by the letter submitted by Denis J. Mailloux, Principal of Trinity High School in violation of RSA 328-F:23 II(a) and (j), and Ath 404.02(d) and (j).
- By her own admission Ms. Bedard provided false information to the Board in numerous letter stating that she wished to cover up what she had done in violation of RSA 328-F:23 II(a), RSA 328-F:23 II, Ath 404.02(a), and Ath 404.02(j).
- By her own admission Ms. Bedard stated that student files were missing documentation and the Board finds that there is a high probability that Ms. Bedard improperly set-up athletic baselines and post-injuries, leaving out demographic information and pertinent dates of injury related to concussions in violation of RSA 328-F:23 II(e).
- The Petitioner has not demonstrated to the Board "sufficient evidence of good professional character and reliability" as evidenced by her practicing without a license, use of credentials implying that she was a licensed Athletic Trainer in the

State of New Hampshire from January, 1, 2013 until May 25, 2013, not maintaining a current home and business address on file with the Board's office, providing false information to the Board during renewal, reinstatement, and investigation failure to maintain student files, and failure to provide care to students with reasonable skill and safety in violation of RSA 328-F:21 I, RSA 328-F:23 II(a), (c), (e), (i), and (j), RSA 326-G:5, Ath 404.02(a), (d), (i), and (j), and Ath 501.02(g).

THEREFORE, IT IS HERBY ORDERED that the original "Order on Application Denial" is upheld and Ms. Bedard's **REQUEST FOR REINSTATEMENT OF LICENSURE IS DENIED FOR A PERIOD OF AT LEAST 12 MONTHS FROM THE DATE OF THIS ORDER.**

IT IS FURTHER ORDERED that before Ms. Bedard re-applies for licensure she must successfully complete the following:

1. A live 8 hour course pre-approved by the Board on Concussion's. The course must include evaluation, assessment and return to play guidelines.
2. A live 12 hour course pre-approved by the Board in Ethics.

IT IS FURTHER ORDERED that Ms. Bedard read RSA 328-F the Allied Health Professionals Governing Board's Practice Act, the Office of Licensed Allied health Professionals Governing Board's Administrative Rules, RSA 326-G the Athletic Trainers Practice Act, and the Athletic Trainers Administrative Rules. Upon completion Ms. Bedard shall submit to the Board a notarized statement attesting to the fact that she has read the rules and laws listed above and that if her license is reinstatement that she shall abide by them.

IT IS FURTHER ORDERED that if Ms. Bedard practices as an Athletic Trainer in another State she shall provide to the Board 2 letters of recommendation from the directing physician(s) and her direct supervisor(s) describing Ms. Bedards's responsibilities and attesting to her skills as an athletic trainer, character, and ethics while employed.

IT IS FURTHER ORDERED that at the time Ms. Bedard applies for reinstatement of her license the Board will consider, in addition to full licensure, a conditional period of licensure for a period of time to be determined by the Board.

IT IS FURTHER ORDERED that Ms. Bedard shall bear all costs of complying with the terms of this Decision and Order, but she shall be permitted to share such costs with third parties.

IT IS FURTHER ORDERED that the Board may consider Ms. Bedard's compliance with the terms and conditions herein in any subsequent proceeding before the Board.

IT IS FURTHER ORDERED that Ms. Bedard's breach of any terms and conditions of this Decision and Order shall constitute unprofessional conduct pursuant to RSA 328-F:23, II.

IT IS FURTHER ORDERED that this Decision and Order shall become a permanent part of Ms. Bedard's file, which is maintained by the Board as a public document.

IT IS FURTHER ORDERED that this Decision and Order shall take effect as a final Order of the Board on the date it is signed by an authorized representative of the Board.

BY ORDER OF THE BOARD

Date: December 19, 2013

Renee Kleszczynski, AT, Chair
Authorized Representative of the New Hampshire
Athletic Trainers Governing Board

In the Matter of:
Casey BISHOP
(Application for License)

ORDER OF CONDITIONAL DENIAL

Now before the New Hampshire Athletic Trainers Governing Board ("Board") is the September 22, 2006 Application for License of Casey Bishop, ATC ("the applicant" or "Ms. Bishop").

At the October 26, 2006 regularly scheduled Board meeting, the Board voted to conditionally deny Ms. Bishop's application to practice athletic training in New Hampshire. The grounds for the conditional denial are based upon a determination, under RSA 326-G:4, I, that Ms. Bishop has not demonstrated "sufficient evidence of good professional character and reliability to satisfy the Board that the applicant shall faithfully and conscientiously avoid professional misconduct and adhere to this chapter, 328-F, and the board's rules." Additional grounds are based upon a determination that pursuant to RSA 328-F:23, II(i), that Ms. Bishop has allegedly committed certain acts that would constitute grounds for discipline. ("Misconduct sufficient to support disciplinary proceedings shall include: practice without a currently valid license.").

It is alleged that on September 9, 2006, Ms. Bishop called the Office of Licensed Allied Health Professionals requesting an Athletic Training licensing application to be sent to Casey Bishop, 21Philbrook Road, Kittery ME 03904. An application was sent promptly to this address.

It is alleged that on or about July 2006, Ms. Bishop began engaging in the unauthorized practice of an allied health profession, contrary to RSA 328-F:27, and engaging in the unauthorized practice of athletic training, contrary to RSA 326-G:5, II.

It is alleged that on September 22, 2006, the Office of Licensed Allied Health Professionals received an incomplete application from Ms. Bishop. On September 28, 2006, the Office of Licensed Allied Health Professionals sent Ms. Bishop a letter acknowledging receipt of her Application for Initial License. This letter identified deficiencies in the application and requested that certain items be forwarded to the Board. This letter also contained the following language: "Candidates for licensure ***must not*** begin employment until you have received a license from the Office of Licensed Allied Health Professionals." (emphasis in original).

The conduct described above, if found to be true by the Athletic Trainers Governing Board, constitutes grounds for discipline pursuant to 328-F:23, II and RSA 328-F:5. In accordance with RSA 328-F:27, III, and/or RSA 326-G:5, II, this is a misdemeanor level offense.

Therefore, the present license application of Casey Bishop shall be denied at the next regularly scheduled Athletic Trainers Governing Board's meeting following sixty (60) days after the date of this order (specifically the Board's January 25, 2007 meeting) unless she meets the conditions set forth below or unless prior to 4:00 p.m. on December 6, 2006 (30 days from the date of this Order) the Board actually receives at the Office of Licensed Allied Health Professionals a written request for a hearing from the applicant. If a timely hearing request is received, the application shall not be denied unless, following the resulting hearing, the applicant fails to demonstrate that she is qualified for licensure. The burden of proof shall be on the applicant to demonstrate that she meets the professional character and competency requirements for licensure; and

Therefore, the applicant must abide by the following conditions for the Board to consider to remove the conditional denial and review the application:

1. The applicant will send a certified check in the amount of three hundred dollars ($300) payable to "Treasurer, State of New Hampshire" to the Office of Licensed Allied Health Professionals. This check shall not be credited toward the processing of this application or any renewal applications;
2. The applicant will read the laws governing the Athletic Trainers Governing Board, RSA 326-G; the laws governing the Allied Health Professional, RSA 328-F; their respective rules; and the BOC Standards of Professional Practice, enclosed with this order. The applicant will, before a notary public, certify that she has read the above statutes, rules, and standards, and that she will abide by them; and the applicant will return the attached notarized certification to the Office of Licensed Allied Health Professionals; and
3. The applicant will provide a copy of this Order of Conditional Denial to her current employer. The employer must state in writing on a copy of the Order of Conditional Denial that he/she has read it. It is the Applicant's responsibility to return the signed copy of this Order to the Office of Licensed Allied Health Professionals; and

Therefore, if the applicant meets the above conditions and provides the Office of Licensed Allied Health Professionals with the documents set forth above on or before 4:00 p.m. on Wednesday, November 29, 2006, the Board will review the completed application at its next regularly scheduled board meeting (specifically November 30, 2006).

Therefore, if the applicant does not meet the above conditions and/or does not provide the Office of Licensed Allied Health Professionals with the documents set forth above on or before sixty (60) days from the effective date of this Order of Conditional Denial, the Board will deny Ms. Bishop's application for licensure. Such a denial will be reportable to HIP-DB and/or BOC; and

THEREFORE IT IS ORDERED, that the license application of Casey Bishop, ATC be denied effective 12:01 a.m., January 25, 2007 unless prior to 4:00 p.m. on December 6, 2006, the Board receives a written request for a hearing; and

IT IS FURTHER ORDERED, that receipt of a timely filed hearing request shall automatically void this Order and a further Order shall be issued in due course in which the Board establishes a date and time of the hearing, and specifies the issues to be heard; and

IT IS FURTHER ORDERED, any hearing held in response to this Order shall be conducted pursuant to RSA 328-F:23, RSA 326-G, and RSA 541-A. The applicant may request to be heard on any relevant matter of law or fact, but evidentiary proceedings shall be conducted only to the extent the applicant has identified disputed factual issues which require resolution.

BY ORDER OF THE BOARD

November 6, 2006

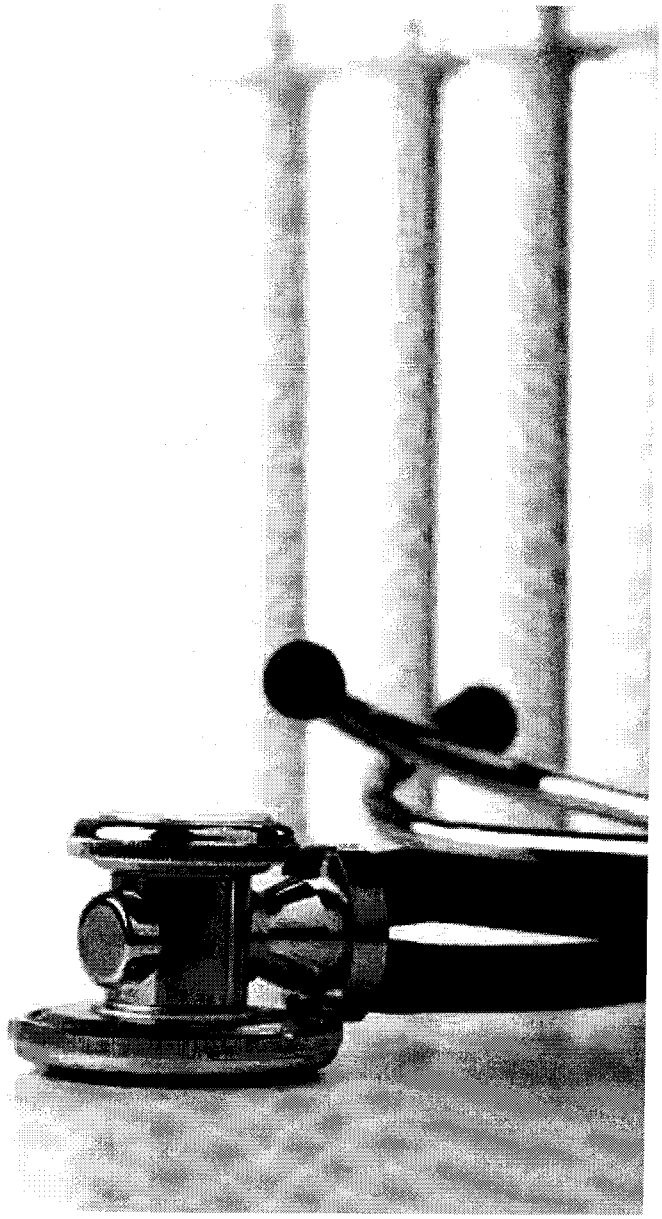
Maren M. Bicknell

Maren McElwee Bicknell, ATC, NHLAT
Chair, Athletic Trainers Governing Board

Alabama	Alabama Board of Athletic Trainers
Alaska	NO LICENSURE
Arizona	Arizona Board of Athletic Trainers
Arkansas	Arkansas State Board of Athletic Training (Prior to 2001, it appears to have been a Committee under the Physical Therapy Board and Governor)
California	NO LICENSURE
Colorado	Colorado Board of Medical Examiners Office of Athletic Trainer Registration (appears to be autonomous from Medical Board)
Connecticut	Department of Public Health/Athletic Trainer Licensure
Delaware	Examining Boards of Physical Therapists & Athletic Trainers
District of Columbia	NO LICENSURE
Florida	Board of Athletic Training
Georgia	Georgia Board of Athletic Trainers
Hawaii	Department of Commerce &Vocational Licensing/Athletic Trainer Program
Idaho	Board of Medicine/Board of Athletic Trainers
Illinois	Illinois Board of Athletic Trainers
Indiana	Indiana Athletic Trainers Board
Iowa	Iowa Board of Athletic Training
Kansas	Board of Healing Arts/Athletic Trainers Council
Kentucky	Kentucky Board of Medical Licensure
Louisiana	Louisiana State Board of Medical Examiners/Athletic Trainers Advisory Committee
Maine	Department of Professional & Financial Regulation
Maryland	Maryland Board of Physicians/Athletic Trainer Advisory Committee
Massachusetts	Board of Allied Health Professionals

Michigan	Michigan Board of Athletic Trainers
Minnesota	Minnesota Board of Medical Practice/Athletic Advisory Council
Mississippi	Mississippi State Department of Health/Professional Licensure Division
Missouri	Missouri Athletic Trainer Advisory Committee
Montana	Montana Board of Athletic Trainers
Nebraska	Nebraska Department of Health & Human Services
Nevada	Nevada State Board of Athletic Trainers
New Hampshire	Office of Licensed Allied Health Professional
New Jersey	State Board of Medical Examiners/Athletic Training Advisory Committee
New Mexico	Athletic Trainers Practice Board
New York	Office of Professions/Division of Professional Licensing Services
North Carolina	North Carolina Board of Athletic Trainer Examiners
North Dakota	North Dakota Board of Athletic Trainers
Ohio	Ohio Occupational Therapy, Physical Therapy, and Athletic Trainers Board
Oklahoma	Oklahoma Medical Board/Athletic Trainers Committee
Oregon	Board of Athletic Trainers
Pennsylvania	State Board of Medicine
Rohde Island	Board of Athletic Trainers
South Carolina	Department of Health and Environmental Control/Certified Athletic Trainer Program
South Dakota	Board of Medical & Osteopathic Examiners
Tennessee	Board of Athletic Trainers
Texas	Department of State Health Services/Advisory Board of Athletic Trainers
Utah	Division of Occupational & Professional Licensing/Athletic Trainer
Vermont	Office of Professional Regulation/Athletic Trainer

Virginia	Virginia Board of Medicine/Athletic Trainers Advisory Board
Washington	State Department of Health/Athletic Training Advisory Committee
West Virginia	West Virginia Board of Physical Therapy (Athletic Trainers are required to register with the Board)
Wisconsin	Department of Safety & Professional Services/Athletic Trainers Affiliated Credentialing Board
Wyoming	Wyoming State Board of Athletic Training



Changes in Healthcare Professions' Scope of Practice: Legislative Considerations

This document is the result of collaboration between the following organizations:

Association of Social Work Boards (ASWB)

Federation of State Boards of Physical Therapy (FSBPT)

Federation of State Medical Boards of the United States, Inc. (FSMB)

National Association of Boards of Pharmacy (NABP®)

National Board for Certification in Occupational Therapy, Inc. (NBCOT®)

National Council of State Boards of Nursing, Inc. (NCSBN®)

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A new era of healthcare reform is sweeping state and federal government in the U.S. During these difficult economic times policymakers are faced with many challenges, not the least of which are legislative and regulatory debates on how to maximize the use of all healthcare practitioners and the debate among healthcare practitioners regarding the continuous evolution of scopes of practice. Law and rule makers charged with consumer protection will find this document helpful in guiding discussions on how the most effective and efficient care can be delivered to the American public in an era of continuous changes in healthcare.

Executive Summary

This document is a result of a collaborative effort in 2006 by representatives from six healthcare regulatory organizations. It has been developed to assist legislators and regulatory bodies with making decisions about changes to healthcare professions' scopes of practice.

Proposed changes to a healthcare professions' scope of practice often elicit strongly worded comments from several professional interest groups. Typically, these debates are perceived as turf battles between two or more professions, with the common refrain of "this is part of my practice so it can't be part of yours." Often lost among the competing arguments and assertions are the most important issues of whether this proposed change will better protect the public and enhance consumers' access to competent healthcare services.

Healthcare education and practice have developed in such a way that most professions today share some skills or procedures with other professions. It is no longer reasonable to expect each profession to have a completely unique scope of practice, exclusive of all others. We believe that scope of practice changes should reflect the evolution of abilities of each healthcare discipline, and we have therefore attempted to develop a rational and useful way to make decisions when considering practice act changes.

Based on reports from the Institute of Medicine[1] and the Pew Healthcare Commission[2] we propose a process for addressing scope of practice, which is focused on patient safety. The question that healthcare professionals must answer today is whether their profession can provide this proposed service in a safe and effective manner. If an issue does not address this question, it has no relevance to the discussion.

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[1] *Crossing the Quality Chasm: A New Health System for the 21st Century,* The Institute of Medicine, National Academy Press, 2001.

[2] *Reforming Healthcare Workforce Regulation: Policy Considerations for the 21st Century,* Report of the Pew Health Professions Commission's Taskforce on Healthcare Workforce Regulation, December 1995, ix.

This process gets to the heart of regulation which, according to Schmitt and Shimberg[3], is intended to:

1. "Ensure that the public is protected from unscrupulous, incompetent and unethical practitioners";

2. "Offer some assurance to the public that the regulated individual is competent to provide certain services in a safe and effective manner"; and

3. "Provide a means by which individuals who fail to comply with the profession's standards can be disciplined, including the revocation of their licenses."

The argument for scope of practice changes should have a foundational basis within four areas: (1) an established history of the practice scope within the profession; (2) education and training; (3) supporting evidence; and (4) appropriate regulatory environment. If a profession can provide support evidence in these areas, the proposed changes in scope of practice are likely to be in the public's best interest.

[3] *Demystifying Occupational and Professional Regulation: Answers to Questions You May Have Been Afraid to Ask,* Schmitt, K. and Shimberg, B., Council on Licensure, Enforcement and Regulation, 1996.

Changes in Healthcare Professions' Scope of Practice: Legislative Considerations

A. Purpose

The purpose of this document is to provide information and guidance for legislative and regulatory agency decision making regarding changes in the scope of practice of healthcare professions. Specifically, the purpose is to:

- Promote better consumer care across professions and competent providers;
- Improve access to care; and
- Recognize the inevitability of overlapping scopes of practice.

We envision this document as an additional resource to be used by state legislatures, healthcare professions and regulatory boards in preparing proposed changes to practice acts and briefing legislators regarding those changes, just as various professions' model practice acts are used.

B. Background

This paper was a collaborative project developed by representatives of the regulatory boards of the following healthcare professions: medicine, nursing, occupational therapy, pharmacy, physical therapy and social work. It attempts to address scope of practice issues from a public protection viewpoint by determining whether a specific healthcare profession is capable of providing the proposed care in a safe and effective manner.

We believe that it is critical to review scope of practice issues broadly if our regulatory system is going to achieve the recommendations made by both the Institute of Medicine and the Pew Health Commission Taskforce on Healthcare Workforce Regulation. These reports urge regulators to allow for innovation in the use of all types of clinicians in meeting consumer needs in the most effective and efficient way, and to explore pathways to allow all professionals to provide services to the full extent of their current knowledge, training, experience and skills.

C. Historical Context

The history of professional licensure must be taken into account if one is to understand the current regulatory system governing scope of practice. Physicians were the first health professionals to obtain legislative recognition and protection of their practice authority. The practice of medicine was defined in broad and undifferentiated terms to include all aspects of an individual's care. Therefore, when other healthcare professions sought legislative recognition, they were seen as claiming the ability to do tasks which were already included in the universal and implicitly exclusive authority of medicine. This dynamic has fostered a view of scope of practice that is conceptually faulty and potentially damaging.

D. Introduction

The scope of practice of a licensed healthcare profession is statutorily defined in each state's laws in the form of a practice act. State legislatures have the authority to adopt or modify practice acts and therefore adopt or modify a particular scope of practice of a healthcare profession. Sometimes such modifications of practice acts are just the formalization of changes already occurring in education or practice within a profession due to the results of research, advances in technology, and changes in societal healthcare demands, among other things.

This process sometimes pits one profession against another before the state legislature. As an example, one profession may perceive another profession as "encroaching" into their area of practice. The profession may be economically or otherwise threatened and therefore opposes the other profession's legislative effort to change scope of practice. Proposed changes in scopes of practice that are supported by one profession but opposed by other professions may be perceived by legislators and the public as "turf battles." These turf battles are often costly and time consuming for the regulatory bodies, the professions and the legislators involved.[4] Aside from guidance on scope of practice issues, this document may assist in preventing costly legislative battles; promote better consumer care and collaboration among regulatory bodies, the professions and between competent providers; and improve access to care.

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[4] *Strengthening Consumer Protection: Priorities for Healthcare Workforce Regulation*, Report from Pew Health Professions Commission, 1998.

The Purpose of Regulation

Before providing information regarding scope of practice decisions, we must ask the very basic question, "What is the purpose of regulation?" According to Schmitt and Shimberg,[5] regulation is intended to:

1. "Ensure that the public is protected from unscrupulous, incompetent and unethical practitioners";
2. "Offer some assurance to the public that the regulated individual is competent to provide certain services in a safe and effective manner"; and
3. "Provide a means by which individuals who fail to comply with the profession's standards can be disciplined, including the revocation of their licenses."

A. Defining Scope of Practice

A 2005 Federation of State Medical Boards report defined scope of practice as the "Definition of the rules, the regulations, and the boundaries within which a fully qualified practitioner with substantial and appropriate training, knowledge, and experience may practice in a field of medicine or surgery, or other specifically defined field. Such practice is also governed by requirements for continuing education and professional accountability."[6]

B. Assumptions Related to Scope of Practice

In attempting to provide a framework for scope of practice decisions, basic assumptions can be made:

1. **The purpose of regulation — public protection — should have top priority in scope of practice decisions, rather than professional self-interest.** This encompasses the belief that the public should have access to providers who practice safely and competently.

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[5] *Demystifying Occupational and Professional Regulation: Answers to Questions You May Have Been Afraid to Ask*, Schmitt, K. and Shimberg, B., Council on Licensure, Enforcement and Regulation, 1996.

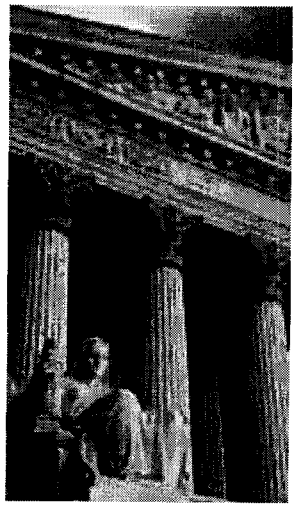
[6] *Assessing Scope of Practice in Health Care Delivery: Critical Questions in Assuring Public Access and Safety*, Federation of State Medical Boards, 2005.

2. **Changes in scope of practice are inherent in our current healthcare system.** Healthcare and its delivery are necessarily evolving. These changes relate to demographic changes (such as the aging of the "baby boomers"); advances in technology; decreasing healthcare dollars; advances in evidence-based healthcare procedures, practices and techniques; and many other societal and environmental factors. Healthcare practice acts also need to evolve as healthcare demands and capabilities change.

3. **Collaboration between healthcare providers should be the professional norm.** Inherent in this statement is the concept that competent providers will refer to other providers when faced with issues or situations beyond the original provider's own practice competency, or where greater competence or specialty care is determined as necessary or even helpful to the consumer's condition.

4. **Overlap among professions is necessary.** No one profession actually owns a skill or activity in and of itself. One activity does not define a profession, but it is the entire scope of activities within the practice that makes any particular profession unique. Simply because a skill or activity is within one profession's skill set does not mean another profession cannot and should not include it in its own scope of practice.

5. **Practice acts should require licensees to demonstrate that they have the requisite training and competence to provide a service.** No professional has enough skills or knowledge to perform all aspects of the profession's scope of practice. For instance, physicians' scope of practice is "medicine," but no physician has the skill and knowledge to perform every aspect of medical care. In addition, all healthcare providers' scopes of practice include advanced skills that are not learned in entry-level education programs and would not be appropriate for an entry-level practitioner to perform. As professions evolve, new techniques are developed, but not all practitioners are competent to perform these new techniques.



The Basis for Decisions Related to Changes in Scope of Practice

Arguments for scope of practice changes should have a foundational basis within four areas: (1) an established history of the practice scope within the profession; (2) education and training; (3) supportive evidence; and (4) appropriate regulatory environment. This foundation should provide the framework for analyzing and determining if a change in statutory scope of practice is warranted in a particular situation. If a profession can provide supporting evidence in these areas, the proposed changes in scope of practice should be adopted.

A. Historical Basis

The first of these relates to the history and evolution of the profession and its practice. This historical framework provides the basis for the essentials of the profession, including its theoretical basis, how it developed over the years and how it is presently defined. Changes in statutory scope of practice should fit within the historical, evolutionary and present practice context for the profession.

Questions to be considered in this area include:

1. Has there been an evolution of the profession towards the addition of the new skill or service?
2. What is the evidence of this evolution?
3. How does the new skill or service fit within or enhance a current area of expertise?

B. Education and Training

Tasks added to scopes of practice are often initially performed by professionals as advanced skills. Over time, as these new skills and techniques are utilized by a sufficient cohort of practitioners, they become entry-level skills and are taught as such in entry-level curricula. It is not realistic to require a skill or activity to be taught in an entry-level program before it becomes part of a profession's scope of practice. If this were the standard, there would be few, if any increases in scope of practice. However, the entry-level training program and its accompanying accrediting standards should provide the framework,

including the basic knowledge and skills needed, to acquire the new skill once out in the field. There should be appropriate accredited postprofessional training programs and competence assessment tools that indicate whether the practitioner is competent to perform the advanced skill safely.

Questions to be considered in this area include:

1. Does current entry-level education prepare practitioners to perform this skill as their experience increases?
2. If the change in scope is an advanced skill that would not be tested on the entry-level licensure examination, how is competence in the new technique assured?
3. What competence measures are available and what is the validity of these measures?
4. Are there training programs within the profession for obtaining the new skill or technique?
5. Are standards and criteria established for these programs?
6. Who develops these standards?
7. How and by whom are these programs evaluated against these standards?

C. Evidence

There should be evidence that the new skill or technique, as used by these practitioners, will promote access to quality healthcare. The base of evidence should include the best available clinical evidence, clinical expertise and research. Other forms of evidence include evolving concepts of disease/disability management, quality improvement and risk data, standards of care, infection control data, cost-effectiveness analysis and benchmarking data. Available evidence should be presented in an easy-to-understand format and in an objective and transparent manner.

Questions to be considered in this area include:

1. Is there evidence within the profession related to the particular procedures and skills involved in the changes in scope?
2. Is there evidence that the procedure or skill is beneficial to public health?

D. Regulatory Environment

A consideration in proposing changes in scope of practice is the regulatory environment. Often, it is the professional association that promotes and lobbies for scope of practice changes. The regulatory board should be involved in the process and be prepared to deal with the regulatory issues related to the proposed changes.

Questions to be considered in this area include:

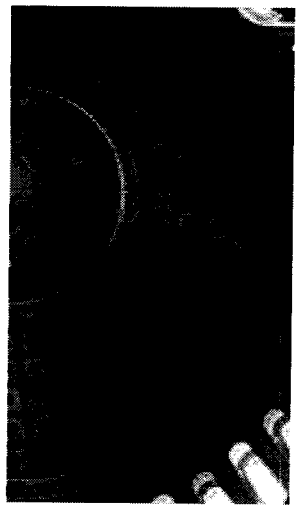
1. Is the regulatory board authorized to develop rules related to a changed or expanded scope?
2. Is the board able to determine the assessment mechanisms for determining if an individual professional is competent to perform the task?
3. Is the board able to determine the standards that training programs should be based on?
4. Does the board have sufficient authority to discipline any practitioner who performs the task or skill incorrectly or might likely harm a patient?
5. Have standards of practice been developed for the new task or skill?
6. How has the education, training and assessment within the profession expanded to include the knowledge base, skill set and judgments required to perform the tasks and skills?
7. What measures will be in place to assure competence?

Basis for Legislative Decision Making

Although the areas for decision making previously listed do not specifically mention public protection, supplying documentation in historical basis, education and training, evidence, and the regulatory environment is likely to ensure that the public will be protected when these changes are made.

Potential for harm to the consumer is difficult to prove or disprove relative to scope of practice. It is the very fact that there is potential for harm that necessitates regulation. If a strong basis for the redefined scope is demonstrated as described, this basis will be rooted in public protection.

This document rests on the premise that the only factors relevant to scope of practice decision making are those designed to ensure that all licensed practitioners be capable of providing competent care.



Conclusion

This document presents important issues for consideration by legislators and regulatory bodies when establishing or modifying a profession's scope of practice. The primary focus of this paper is public protection. When defining a profession's scope of practice, the goal of public protection can be realized when legislative and/or regulatory bodies include the following critical factors in their decision-making process:

- **Historical basis** for the profession, especially the evolution of the profession advocating a scope of practice change;
- Relationship of **education and training** of practitioners to scope of practice;
- **Evidence** related to how the new or revised scope of practice benefits the public; and
- The **capacity of the regulatory agency** involved to effectively manage modifications to scope of practice changes.

Overlapping scopes of practice are a reality in a rapidly changing healthcare environment. The criteria related to who is qualified to perform functions safely without risk of harm to the public are the only justifiable conditions for defining scopes of practice.

Appendix

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Related resource information:
www.fsmb.org/pdf/2005_grpol_scope_of_practice.pdf

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Related resource information:
www.ncsbn.org/NursingRegandInterpretationofSoP.pdf

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