Athletic Trainers
Occupations Code
Title 3. Health Professions
Chapter 451
Administered by the Texas Department of Licensing and Regulation
(Effective September 1, 2015)

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SUBCHAPTER A. GENERAL PROVISIONS

Sec. 451.001. Definitions.

In this chapter:

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

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

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

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

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

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

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

Sec. 451.002. Interpretation; Practice of Medicine.

This chapter does not authorize the practice of medicine by a person not licensed by the Texas Medical Board.

Sec. 451.003. Applicability.

This chapter does not apply to:

(1) a physician licensed by the Texas Medical Board;

(2) a dentist, licensed under the laws of this state, engaged in the practice of dentistry;

(3) a licensed optometrist or therapeutic optometrist engaged in the practice of optometry or therapeutic optometry as defined by statute;

(4) an occupational therapist engaged in the practice of occupational therapy;

(5) a nurse engaged in the practice of nursing;

(6) a licensed podiatrist engaged in the practice of podiatry as defined by statute;

(7) a physical therapist engaged in the practice of physical therapy;

(8) a registered massage therapist engaged in the practice of massage therapy;

(9) a commissioned or contract physician, physical therapist, or physical therapist assistant in the United States Army, Navy, Air Force, or Public Health Service; or

(10) an athletic trainer who does not live in this state, who is licensed, registered, or certified by an authority recognized by the department, and who provides athletic training in this state for a period determined by the department.

SUBCHAPTER B. ADVISORY BOARD OF ATHLETIC TRAINERS

Sec. 451.051. Board; Membership.

(b) The board consists of five members appointed by the presiding officer of the commission with the approval of the commission as follows:

(1) three members who are athletic trainers; and

(2) two members who represent the public.

(c) Each member of the board must be a citizen of the United States and a resident of this state for the five years preceding appointment.

(d) Appointments to the board shall be made without regard to the race, color, disability, sex, religion, age, or national origin of the appointee.

Sec. 451.0521. Duties of Board.

The board shall provide advice and recommendations to the department on technical matters relevant to the administration of this chapter.

Sec. 451.053. Terms; Vacancy.

(a) Board members serve staggered six-year terms with the terms of one or two members expiring on January 31 of each odd-numbered year.

(b) If a vacancy occurs on the board, the presiding officer of the commission, with the commission's approval, shall appoint a replacement who meets the qualifications for the vacant position to serve for the unexpired portion of the term.

Sec. 451.055. Presiding Officer.

The presiding officer of the commission shall designate a member of the board to serve as the presiding officer of the board for a one-year term. The presiding officer of the board may vote on any matter before the board.

Sec. 451.056. Meetings.

The board shall meet at the call of the presiding officer of the commission or the executive director.

SUBCHAPTER C. POWERS AND DUTIES

Sec. 451.101. General Powers and Duties.

(a) The executive director shall administer and enforce this chapter.

(a-1) The department shall:

(1) adopt an official seal;

(2) prescribe the application form for a license applicant;

(3) prescribe a suitable form for a license certificate;

(4) prepare and conduct an examination for license applicants;

(5) maintain a complete record of all licensed athletic trainers; and

(6) annually prepare a roster showing the names and addresses of all licensed athletic trainers.

(a-2) The department shall make a copy of the roster available to any person requesting it on payment of a fee established by the department in an amount sufficient to cover the cost of the roster.

Sec. 451.110. Confidentiality of Complaint and Disciplinary Information.

(h) All information and materials subpoenaed or compiled by the department in connection with a complaint and investigation are confidential and not subject to disclosure under Chapter 552, Government Code, and not subject to disclosure, discovery, subpoena, or other means of legal compulsion for their release to anyone other than the department or its employees or agents involved in discipline of the holder of a license, except that this information may be disclosed to:

(1) persons involved with the department in a disciplinary action against the holder of a license;

(2) athletic trainer licensing or disciplinary boards in other jurisdictions;

(3) peer assistance programs approved by the commission under Chapter 467, Health and Safety Code;

(4) law enforcement agencies; and

(5) persons engaged in bona fide research, if all individual-identifying information has been deleted.

(i) The filing of formal charges by the department against a holder of a license, the nature of those charges, disciplinary proceedings of the department, commission, or executive director, and final disciplinary actions, including warnings and reprimands, by the department, commission, or executive director are not confidential and are subject to disclosure in accordance with Chapter 552, Government Code.

SUBCHAPTER D. LICENSE REQUIREMENTS

Sec. 451.151. License Required.

A person may not hold the person out as an athletic trainer or perform any activity of an athletic trainer unless the person holds a license under this chapter.

Sec. 451.152. License Application.

An applicant for an athletic trainer license must submit to the department:

(1) an application in the manner and on a form prescribed by the executive director; and

(2) the required examination fee.

Sec. 451.153. Applicant Qualifications.

(a) An applicant for an athletic trainer license must:

(1) have met the athletic training curriculum requirements of a college or university approved by the commission and give proof of graduation;

(2) hold a degree or certificate in physical therapy and have completed:

(A) a basic athletic training course from an accredited college or university; and

(B) an apprenticeship described by Subsection (b); or

(3) have a degree in corrective therapy with at least a minor in physical education or health that includes a basic athletic training course and meet the apprenticeship requirement or any other requirement established by the commission.

(b) The apprenticeship required to be completed by an applicant consists of 720 hours completed in two years under the direct supervision of a licensed athletic trainer acceptable to the department. Actual working hours include a minimum of 20 hours a week during each fall semester.

Sec. 451.154. Out-of-State License Applicants.

(a) An out-of-state applicant must:

(1) satisfy the requirements under Section 451.153; and

(2) submit proof of active engagement as an athletic trainer in this state as described by Subsection (b).

(b) A person is actively engaged as an athletic trainer if the person:

(1) is employed on a salary basis by an educational institution for the institution's school year or by a professional or other bona fide athletic organization for the athletic organization's season; and

(2) performs the duties of athletic trainer as the major responsibility of that employment.

Sec. 451.156. Requirements for License Issuance.

An applicant for an athletic trainer license is entitled to receive the license if the applicant:

(1) satisfies the requirements of Section 451.153 or 451.154;

(2) passes the examination required by the department;

(3) pays the required license fee; and

(4) has not committed an act that constitutes grounds for refusal of a license under Section 451.251.

Sec. 451.157. Temporary License.

(a) The department may issue a temporary license to an applicant if the applicant satisfies:

(1) the requirements of Section 451.153 or 451.154; and

(2) any other requirement established by the commission.

(b) The commission by rule shall prescribe the time during which a temporary license is valid.

SUBCHAPTER E. LICENSE RENEWAL

Sec. 451.201. License Expiration; Renewal.

(a) A license issued under Section 451.156 expires on the second anniversary of the date of issuance and may be renewed biennially.

SUBCHAPTER F. DISCIPLINARY PROCEDURES

Sec. 451.251. Grounds for Denial of License or Disciplinary Action.

(a) The commission or executive director may refuse to issue a license to an applicant and shall reprimand a license holder or suspend, revoke, or refuse to renew a person's license if the person:

(1) has been convicted of a misdemeanor involving moral turpitude or a felony;

(2) obtained the license by fraud or deceit;

(3) violated or conspired to violate this chapter or a rule adopted under this chapter; or

(4) provided services outside the scope of practice of athletic training.

(b) For the purposes of Subsection (a)(1), the record of conviction is conclusive evidence of conviction.

SUBCHAPTER G. PENALTIES

Sec. 451.301. Criminal Penalty.

(a) A person commits an offense if the person violates this chapter.

(b) An offense under this section is a misdemeanor punishable by a fine of not less than $25 or more than $200.

SUBCHAPTER H. ADMINISTRATIVE PENALTY

Sec. 451.351. Amount of Administrative Penalty.

(c) The amount of an administrative penalty imposed for a violation of this chapter or a rule adopted or order issued under this chapter may not exceed $500 for each violation, and each day a violation continues or occurs is a separate violation for purposes of imposing a penalty. The total amount of the penalty assessed for a violation continuing or occurring on separate days under this subsection may not exceed $2,500.

(d) The amount shall be based on:

(1) the seriousness of the violation, including the nature, circumstances, extent, and gravity of the violation;

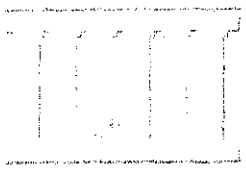
(2) the threat to health or safety caused by the violation;

(3) the history of previous violations;

(4) the amount necessary to deter a future violation;

(5) whether the violator demonstrated good faith, including, when applicable, whether the violator made good faith efforts to correct the violation; and

(6) any other matter that justice may require.



Changes in Healthcare Professions' Scope of Practice: Legislative Considerations

In 2009, a new era of health care 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 health care 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 health care.

Revised August 2009

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I. 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 therefore have 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.

This process gets to the heart of regulation which, according to Schmitt and Shimberg, 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."[3]

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.

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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.

[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.

II. 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
- 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 individuals' 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.

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

III. 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, 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."[5]

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.
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 competence, 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; not all practitioners are competent to perform these new techniques.

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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.

IV. 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 post-professional 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?

V. Basis for Legislative Decision Making

Although the areas for decision making listed above 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 above, this basis will be rooted in public protection.

This paper 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.

VI. Conclusion

This paper 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.

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(In May 2006)

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PO Box 619850
Dallas, TX 75261-9850
Main phone: 817.868.4000
www.fsmb.org

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

National Association of Boards of Pharmacy (NABP)
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Mount Prospect, IL 60056
Tel: 847.391.4406
www.nabp.net

National Board for Certification in Occupational Therapy, Inc. (NBCOT)
The Eugene B. Casey Building
800 South Frederick Avenue
Suite 200
Gaithersburg, MD 20877-4150
301.990.7979
www.nbcot.org

Related resource information:
Foundations of NBCOT Certification Examinations
www.nbcot.org/WebArticles/articlefiles/106-monograph_foundations_exams.pdf

Occupational Therapy State Regulatory Boards and NBCOT
www.nbcot.org/WebArticles/articlefiles/106-RegulatoryBoardsAndNBCOT_brochure.pdf

National Council of State Boards of Nursing, Inc. (NCSBN)
111 East Wacker Drive
Suite 2900
Chicago, Illinois 60601
312.525.3600
www.ncsbn.org

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

BOC REGULATORY UPDATE

A PUBLICATION FROM THE BOARD OF CERTIFICATION

FALL 2016

BOC Joins Coalition to Address Antitrust Liability for Boards

The BOC has joined with representatives from other national professional licensing board associations to form a coalition in response to a US Supreme Court decision affecting regulatory boards.

The Professional Licensing Coalition (PLC) has spearheaded federal efforts to eliminate the threat of antitrust liability from regulatory boards and their members when they are acting in their official capacity. In its 2015 ruling on *North Carolina State Board of Dental Examiners v. Federal Trade Commission*, the Supreme Court said state licensing boards composed of market participants do not necessarily have immunity from antitrust laws.

The PLC's strategy is to amend the 1984 Local Government Anti-Trust Act to include state regulatory boards.

(Continued on Page 3)

Professional Licensing Coalition Members

American Association of Veterinary State Boards (AAVSB)
Association of Social Work Boards (ASWB)
Association of State & Provincial Psychology Boards (ASPPB)
Board of Certification for the Athletic Trainer (BOC)
Council of Landscape Architectural Registration Boards (CLARB)
Federation of Associations of Regulatory Boards (FARB)
Federation of State Boards of Physical Therapy (FSBPT)
Federation of State Medical Boards (FSMB)
National Association of State Boards of Accountancy (NASBA)
National Board for Certification in Occupational Therapy (NBCOT)
National Council of Architectural Registration Boards (NCARB)

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- *State Regulatory News*
- *Requirements for AT License or Registration Renewal*
- *FARB Publishes Model for Identifying and Addressing Antitrust Issues*
- *Save the Date: BOC Regulatory Conference*
- *Board Advocates for ATs During Capitol Hill Day*
- *And More!*

FOLLOW US:

BOC NEWS IN BRIEF

Annual Exam Report
The annual exam report for the BOC's 2015-2016 testing year has been posted on the BOC website.

Regulatory Network
News affecting Athletic Trainer regulation happens every day. Are you up to speed on changes at the state and federal level?

The BOC State Regulatory Network collects news and provides a space for discussion among peers in the regulatory community. Don't miss it. Sign up or log in today!

Disciplinary Action Exchange
The Disciplinary Action Exchange (DAE) helps the BOC, states and consumers locate disciplinary actions in an efficient manner. The BOC posts all public disciplinary actions that have been deemed public.

We strongly encourage you to participate in the exchange. You can submit disciplinary actions via the online submission form, under the "Links" section of the State Regulatory Network home page.

Get the Word Out
Let us help you get the word out on important announcements you have for ATs. The BOC can post announcements on our website or in *Cert Update*, a biannual newsletter for ATs.

Read more:
- BOC Website
- *Cert Update*

New CAATE Standards Under Review

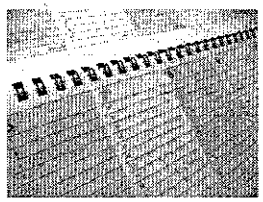
The Commission on Accreditation of Athletic Training Education (CAATE) recently closed public comment periods regarding proposed Operational and Curricular Content Standards. CAATE committees are now reviewing the many comments submitted and, if necessary, will make the appropriate modifications to the proposed Standards.

The Operational Standards, once adopted, will apply only to professional programs at the master's degree level.

The Curricular Content Standards, once revised and adopted, will comprise the new content that must be taught in all professional programs.

If an additional open comment period is warranted, the BOC will post the information on the BOC Regulatory Network.

Please visit the CAATE's website, www.caate.net, for more information.



CALENDAR OF EVENTS

41st Annual Federation of Associations of Regulatory Board (FARB) Forum
January 26-29, 2017
San Antonio, Texas
www.FARB.org

NATA Clinical Symposia & AT Expo
June 26-29, 2017
Houston, Texas
www.NATA.org

BOC Athletic Trainer Regulatory Conference
July 14-15, 2017
Omaha, Nebraska
www.bocatc.org/state-regulation/state-regulatory-conference

Council on Licensure, Enforcement and Regulation (CLEAR) Annual Education Conference
September 13-16, 2017
Denver, Colorado
www.CLEARhq.org

STATE REGULATORY NEWS

COLORADO
A bill reinstating Athletic Trainer regulation was signed into law in June. SB161 restored regulatory authority of ATs to the director of the Division of Professions and Occupations in the Department of Regulatory Agencies. The law was passed after the Colorado General Assembly, in 2015, did not enact legislation to continue the director's regulatory authority, thereby repealing regulation of ATs.

SB161 reinstates the director's authority in this area. Athletic Trainers are required to obtain a registration from the director in order to practice athletic training in Colorado. The bill restores the "Athletic Trainer Practice Act," as it existed on June 30, 2015, with a few changes.

NORTH DAKOTA
The North Dakota Board of Athletic Trainers (NDBAT) has partnered with the BOC to develop online systems for North Dakota licensees and the public. Services include:
- **2016 Renewal Applications** - ATs licensed in North Dakota renewed their North Dakota license using BOC Central™ (an online system ATs use to maintain their BOC certification). The BOC will perform the same service in 2017
- **Online Registry** - The BOC developed an online registry so that anyone can check the status of a North Dakota licensed AT
- **New License Applications** - ATs looking to be licensed for the first time in North Dakota now complete the initial license application using BOC Central™

Brad Reed, Secretary/Treasurer for the NDBAT, said the board has received only positive feedback about the new system.

The BOC staff "has been nothing but professional, helpful and very hardworking ... I wish everyone I worked with was this great, being treated like a person and not as a number, my hat's off to you," Reed said. "Thank you for a job well done."

If you are interested in learning more about what the BOC can do for you, please contact Shannon Fleming at ShannonF@bocatc.org.

WASHINGTON
Notice on Continuing Education
Athletic Trainers are now required to complete 50 hours of continuing education every 2 years.

BOC Joins Coalition *(Continued from Page 1)*

BOC Executive Director Denise Fandel is serving as the BOC's representative to the coalition to help shape legislation that will protect those who serve on state boards from potential litigation.

The BOC will provide updates from the coalition as they become available.

FOR FURTHER READING
- "SCOTUS Denies Boards Antitrust Immunity," *Regulatory Update*
- "Opinion analysis: No antitrust immunity for professional licensing boards," SCOTUSblog
- "The Federation of Associations of Regulatory Boards Publishes Model for Identifying and Addressing Antitrust Issues," FARB

STATE BY STATE: Requirements For AT License or Registration Renewal

The BOC recently conducted research to determine the current requirements for Athletic Trainers to renew their license or registration in each state. The following table provides detail on fees, renewal cycles, BOC certification requirements and acceptance, and continuing education (CE) requirements.

Maintaining competence is critical to Athletic Trainers, the profession and the public. Patients have come to expect that a healthcare provider's license to practice provides assurance of their current professional competence. Athletic Trainers want to know that their colleagues are competent as well.

States in red do not have continuing competence requirements such as CE or maintaining BOC certification. The BOC will work with these states to help them update their laws or rules and regulations.

States in green require BOC certification for renewal. This is recommended by the BOC as it is most efficient and cost effective for Athletic Trainers. The BOC requires continuing education to maintain BOC certification.

Please contact Shannon Fleming, ShannonF@bocatc.org, with corrections and updates.

State	Renewal Fee	Renewal Cycle	BOC Certification Required to Renew	CE Required	CE Amount	Accept BOC Certification to Renew
Alaska		Biennial	X	X		
Alabama	$75	Annual		X	26/year	X
Arkansas	$50	Annual		X	Prescribed by the BOC	X
Arizona	$175	Annual		X	15/year	X
California						
Colorado	$155	Biannual				
Connecticut	$200	Annual	X			
District of Columbia						
Delaware		Biennial		X	3.0(30 hours)/2 years	
Florida	$130	Biennial		X	24/2 years	X
Georgia	$100	Biennial		X	40/2 years	
Hawaii		Triennial	X			
Iowa	$120	Biennial		X	50/2 years	X
Idaho	$90	Annual		X	BOC or 80/3 years	X
Illinois	$100	Biennial		X	40/2 years	
Indiana	$50	Biennial		X	50/2 years	
Kansas	$67	Annual		X	20/year	

State	Renewal Fee	Renewal Cycle	BOC Certification Required to Renew	CE Required	CE Amount	Accept BOC Certification to Renew
Kentucky	$50	Triennial		X	60/3 years	
Louisiana	$100	Annual		X	24/2 year	
Massachusetts	$68	Biennial	X			
Maryland	$135	Biennial		X	50/2 years	X
Maine	$175	Annual	X	X	BOC	
Michigan	$600	Triennial		X	80/3years	X
Minnesota	$100	Annual		X	60/3 years	
Missouri	$50	Biennial				
Mississippi	$50	Annual		X		
Montana	$250	Annual	X	X	Prescribed by BOC	
North Carolina	$75	Annual		X	75/3 years	
North Dakota	$50	Annual		X	80/3 years or BOC	X
Nebraska	$117	Biennial		X	25/2 years or BOC	X
New Hampshire	$110	Biennial	X	X	Current BOC certification	
New Jersey	$80	Biennial		X	24/2 years	
New Mexico	$165	Annual	X	X	75/3 years	
Nevada	$150	Annual		X		
New York	$50	Triennial				
Ohio	$80	Biennial		X	25/2 years including ethics	
Oklahoma	$55	Annual				
Oregon	$225	Annual		X	10/year	
Pennsylvania	$37	Biennial		X	Prescribed by the BOC	
Rhode Island	$62.50	Biennial		X	Prescribed by the BOC	
South Carolina	$40	Biennial		X	2 courses (choose from list)/2 years	
South Dakota	$50	Annual		X	4/3 years (1 CEU = 10 contact hours)	
Tennessee	$150	Biennial		X	50/2 years	
Texas	$250	Biennial		X	40/2 years	
Utah	$47	Biennial	X			
Virginia	$135	Biennial	X			
Vermont	$200	Biennial	X			
Washington	$200	Annual		X	50/2 years	
Wisconsin	$75	Biennial		X	30/2 years	
West Virginia	$75	Biennial				
Wyoming	$200	Annual		X	50/2 years or BOC	X

FARB Publishes Model for Identifying And Addressing Antitrust Issues

The Federation of Associations of Regulatory Boards (FARB) recently released the following statement and guidance on antitrust issues for state professional licensing boards. The FARB Model for Identifying and Addressing Antitrust Issues appears on the next page.

As an organization that crosses jurisdictional and professional boundaries, FARB is in the unique position to provide guidance to the regulatory community. FARB stands behind the importance of professional regulation as a means of promoting the health, safety and welfare of the consuming public.

Northbrook, IL - The Federation of Associations of Regulatory Boards (FARB) is pleased to announce the development of the FARB Model for Identifying and Addressing Antitrust Issues. The Model provides a reasoned and balanced approach to regulation in response to the 2015 Supreme Court of the United States ruling in North Carolina State Board of Dental Examiners v. FTC. Legislative and legal responses exceeding those necessary to adequately address the issues have emerged, ignoring the foundation of the established administrative regulatory system. Examples of legislative responses range from the formation of oversight commissions to altering the board membership. The composition of state boards has become the focus of criticism, rather than the underlying nature of the contemplated board action.

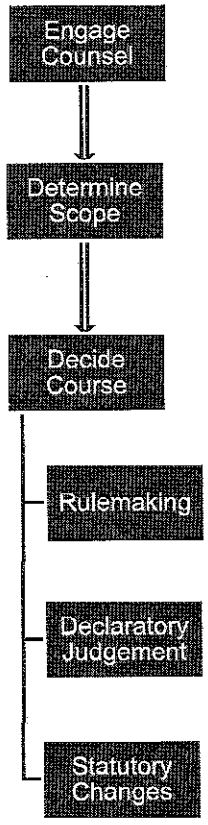
Supreme Court Ruling

The Supreme Court ruling has prompted varied legal and political reactions including challenges to the basic need for an administrative regulatory system; suggested additional bureaucratic layers of government decision makers; and modifications to the composition of the regulatory boards. The judicial decision characterized a state regulatory board as "non-sovereign" for purposes of applying the immunity principles under the state action doctrine. This state action doctrine is a common law defense and provides antitrust immunity to state actors. Based upon the involvement of licensees, referred to as "active market participants," the Supreme Court imposed the two part test generally reserved to private actors seeking immunity from antitrust liability. The two part test includes a clearly articulated state policy to displace competition and active supervision by the state. In spite of the checks and balances in place to curb self-serving interests and the existence and application of relevant ethics laws applicable to volunteer state board members, the Court found the need for satisfaction of the two prong test and focused on the state oversight requirement.

FARB offers the following Model as a method by which boards may address the concerns in the opinion, balancing economic factors and the public protection needs met by an effective and efficient state based licensure system.

FARB

FARB Model for Identifying and Addressing Antitrust Issues



STEP ONE: Engage legal counsel
It is strongly recommended that state licensing boards engage and regularly involve legal counsel. Attendance and participation by counsel at all board meetings provides ongoing opportunities for counsel to identify, research, and advise on important legal consequences to decisions. It is here where counsel can proactively identify board actions and relevant antitrust issues.

STEP TWO: Determine the scope of the proposed action
In conjunction with legal counsel, assess whether the proposed board action implicates antitrust laws. Decisions to grant or deny an individual applicant a license or pursue administrative prosecution of a licensee generally do not constitute anti-competitive behavior. Adoption of policy positions that may affect virtually all practitioners or preclude others from entering the market are the types of board actions which should not take place without prior assessment of compliance with antitrust laws.

STEP THREE: Choose the appropriate course of action
If a decision has potential antitrust implications and the issue is not addressed by current statute or rules, state licensing boards can seek the necessary oversight to satisfy the second prong of the immunity test. Such oversight can be addressed in one or more of the following options.

OPTION ONE: Rulemaking
Subject the licensing board determination to the rulemaking process, which involves notice, an opportunity for comment(s), and hearings. In many jurisdictions, legislative and/or executive approval is required before new rules are effectuated. Rulemaking involves oversight from multiple perspectives.

OPTION TWO: Declaratory judgement
Seek a declaratory ruling from a court regarding the encompassing position of the licensing board. The board will be required to substantiate its position to justify the entry of a court order. If successful, the judicial order would provide oversight and justification for the proposed action.

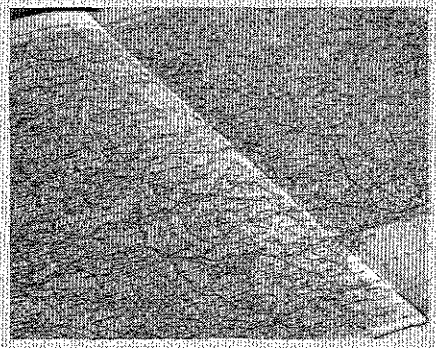
OPTION THREE: Statutory changes
Provide data to the legislature to stimulate statutory changes to address the encompassing issue(s). To the extent the practice act is in need of and does change, the board would clearly be acting under oversight of the legislative branch.

These options, individually and/or collectively, will involve time, costs, and effort, and may contain some uncertainty. However, such checks and balances provide state oversight while maintaining the expertise on the boards to promote effective and efficient public protection legislation.

Federation of Associations of Regulatory Boards (FARB) | 1466 Techny Road | Northbrook, IL 60062
Phone: 847-559-FARB (3272) | Fax: 847-714-9796 | E-mail: FARB@FARB.org

SAVE THE DATE: BOC Regulatory Conference to be July 14-15, 2017

The Advisory Panel met in October to discuss and develop the 2017 BOC Athletic Trainer Regulatory Conference. Conference topics may include deregulation, telehealth, portability, board issues and strategic planning. More information will be made available by March 2017.



As in previous years, invitations will be sent to the state association and state regulatory agency in each state. The BOC will fund up to 2 nights hotel for a representative from each state association and state regulatory agency. Registration and travel will be the responsibility of the attendee. The $250 registration fee will include breakfast, lunch and an evening reception on Friday and breakfast on Saturday.

The conference will begin at 8:00am on Friday, July 14, and will end at noon on Saturday, July 15.

Board Advocates for ATs During Capitol Hill Day

BOC leaders advocated for Athletic Trainers and student-athletes during a June visit to Washington D.C.

BOC Executive Director Denise Fandel and members of the BOC Board of Directors spent Capitol Hill Day discussing 2 proposed pieces of legislation with elected officials. BOC leaders urged support of the Sports Medicine Licensure Clarity Act and the Secondary School Student Athletes' Bill of Rights.

The Sports Medicine Licensure Clarity Act would protect ATs who provide services for their team in a secondary state. Many states do not provide legal protection for ATs who travel to another state with an athletic team solely to provide care for that team.

Learn more about the Sports Medicine Licensure Clarity Act, or H.R. 921 / S. 689, at the NATA website.

The Secondary School Student Athletes' Bill of Rights addresses the health and safety of youth athletes. Introduced in the U.S. House of Representatives in 2013 and in the U.S. Senate in 2015, the resolution contains 10 best practices that any school in the country can implement to make their student athletes safer. It also encourages secondary schools to take all available and reasonable efforts to ensure student athlete safety.

Learn more about the Secondary School Student Athletes' Bill of Rights, or H. Res. 72/ S. RES 83, at the NATA website.

New **BOC Practice Analysis** Published

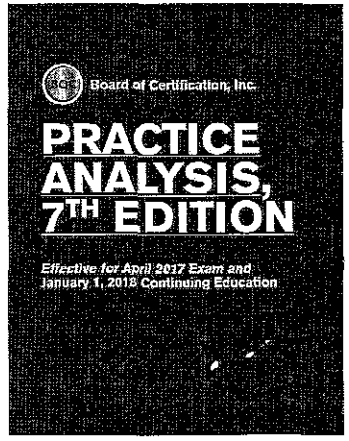
The BOC has published a new version of its practice analysis. BOC Practice Analysis, 7th Edition, will become effective for BOC exams beginning April 2017 and for continuing education beginning January 1, 2018.

PA7 identifies essential knowledge and skills for the athletic training profession and serves as a blueprint for exam development and continuing competence programming.

The following supporting documents are available at no cost from the BOC website:

- Content Outline for PA7
- Comparison of PA7 to RD/PA6
- How to Use PA7

If you need a full copy of PA7 for regulatory purposes, please contact the BOC office via email: ShannonL@bocatc.org.



Click for more about PA7

Updated Standards Document Now Available

The BOC Board of Directors has approved an updated version of the *BOC Standards of Professional Practice*, which became effective September 1, 2016. It was published in full in the summer edition of *Cert Update*.

The BOC Standards Committee's goal was to streamline the document with the understanding that the Professional Practice and Discipline Committee uses this document to determine practice violations. Last updated in 2006, the new version aligns with other healthcare professions while maintaining its relevance for Athletic Trainers.

A public comment period was open in fall 2015. The Standards Committee reviewed the feedback and made a few modifications. The *BOC Standards of Professional Practice* is reviewed by the BOC Standards Committee and recommendations are provided to the BOC Board of Directors. The BOC Standards Committee is composed of 5 Athletic Trainer members and 1 Public member.

Examples of language pertaining to hiring an Executive Officer, Administrative Personnel

107.

Pursuant to subdivision (e) of Section 4 of Article VII of the California Constitution, each board may appoint a person exempt from civil service and may fix his or her salary, with the approval of the Department of Human Resources pursuant to Section 19825 of the Government Code, who shall be designated as an executive officer unless the licensing act of the particular board designates the person as a registrar.
(Amended by Stats. 2012, Ch. 665, Sec. 1. Effective January 1, 2013.)

154.

Any and all matters relating to employment, tenure or discipline of employees of any board, agency or commission, shall be initiated by said board, agency or commission, but all such actions shall, before reference to the State Personnel Board, receive the approval of the appointing power.
To effect the purposes of Division 1 of this code and each agency of the department, employment of all personnel shall be in accord with Article XXIV of the Constitution, the law and rules and regulations of the State Personnel Board. Each board, agency or commission, shall select its employees from a list of eligibles obtained by the appointing power from the State Personnel Board. The person selected by the board, agency or commission to fill any position or vacancy shall thereafter be reported by the board, agency or commission, to the appointing power.
(Amended by Stats. 1945, Ch. 1276.)

2570.21. (Occupational Therapy)

Subject to Sections 107 and 154, the board may employ an executive officer and other officers and employees
(Added by Stats. 2000, Ch. 697, Sec. 3. Effective January 1, 2001.)

2531.75. (Speech Language)

(a) The board may appoint a person exempt from civil service who shall be designated as an executive officer and who shall exercise the powers and perform the duties delegated by the board and vested in him or her by this chapter.
(b) This section shall remain in effect only until January 1, 2018, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2018, deletes or extends that date.
(Amended by Stats. 2013, Ch. 516, Sec. 8. Effective January 1, 2014. Repealed as of January 1, 2018, by its own provisions.)

2607.5. (Physical Therapy)

(a) The board may employ an executive officer exempt from the provisions of the State Civil Service Act (Part 2 (commencing with Section 18500) of Division 5 of Title 2 of the Government Code) and may also employ investigators, legal counsel, physical therapist consultants, and other assistance as it may deem necessary to carry out this chapter. The board may fix the compensation to be paid for services and may incur other expenses as it may deem necessary. Investigators employed by the board shall be provided special training in investigating physical therapy practice activities.
(b) The Attorney General shall act as legal counsel for the board for any judicial and administrative proceedings and his or her services shall be a charge against it.
(c) This section shall remain in effect only until January 1, 2018, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2018, deletes or extends that date.
(Amended by Stats. 2013, Ch. 389, Sec. 12. Effective January 1, 2014. Repealed as of January 1, 2018, by its own provisions.)

Examples of language pertaining to disciplining licensees

2570.27. (Occupational Therapy)

(a) The board may discipline a licensee by any or a combination of the following methods:
(1) Placing the license on probation with terms and conditions.
(2) Suspending the license and the right to practice occupational therapy for a period not to exceed one year.
(3) Revoking the license.
(4) Suspending or staying the disciplinary order, or portions of it, with or without conditions.
(5) Taking other action as the board, in its discretion, deems proper.
(b) The board may issue an initial license on probation, with specific terms and conditions, to any applicant who has violated any provision of this chapter or the regulations adopted pursuant to it, but who has met all other requirements for licensure.
(Added by Stats. 2002, Ch. 1079, Sec. 6. Effective September 29, 2002.)

2570.28. (Occupational Therapy)

The board may deny or discipline a licensee for any of the following:
(a) Unprofessional conduct, including, but not limited to, the following:
(1) Incompetence or gross negligence in carrying out usual occupational therapy functions.
(2) Repeated similar negligent acts in carrying out usual occupational therapy functions.
(3) A conviction of practicing medicine without a license in violation of Chapter 5 (commencing with Section 2000), in which event a certified copy of the record of conviction shall be conclusive evidence thereof.
(4) The use of advertising relating to occupational therapy which violates Section 17500.
(5) Denial of licensure, revocation, suspension, restriction, or any other disciplinary action against a licensee by another state or territory of the United States, by any other government agency, or by another California health care professional licensing board. A certified copy of the decision, order, or judgment shall be conclusive evidence thereof.
(b) Procuring a license by fraud, misrepresentation, or mistake.
(c) Violating or attempting to violate, directly or indirectly, or assisting in or abetting the violation of, or conspiring to violate, any provision or term of this chapter or any regulation adopted pursuant to this chapter.
(d) Making or giving any false statement or information in connection with the application for issuance or renewal of a license.
(e) Conviction of a crime or of any offense substantially related to the qualifications, functions, or duties of a licensee, in which event the record of the conviction shall be conclusive evidence thereof.

(f) Impersonating an applicant or acting as proxy for an applicant in any examination required under this chapter for the issuance of a license.
(g) Impersonating a licensed practitioner, or permitting or allowing another unlicensed person to use a license.
(h) Committing any fraudulent, dishonest, or corrupt act that is substantially related to the qualifications, functions, or duties of a licensee.
(i) Committing any act punishable as a sexually related crime, if that act is substantially related to the qualifications, functions, or duties of a licensee, in which event a certified copy of the record of conviction shall be conclusive evidence thereof.
(j) Using excessive force upon or mistreating or abusing any patient. For the purposes of this subdivision, "excessive force" means force clearly in excess of that which would normally be applied in similar clinical circumstances.
(k) Falsifying or making grossly incorrect, grossly inconsistent, or unintelligible entries in a patient or hospital record or any other record.
(l) Changing the prescription of a physician and surgeon or falsifying verbal or written orders for treatment or a diagnostic regime received, whether or not that action resulted in actual patient harm.
(m) Failing to maintain confidentiality of patient medical information, except as disclosure is otherwise permitted or required by law.
(n) Delegating to an unlicensed employee or person a service that requires the knowledge, skills, abilities, or judgment of a licensee.
(o) Committing any act that would be grounds for denial of a license under Section 480.
(p) Except for good cause, the knowing failure to protect patients by failing to follow infection control guidelines of the board, thereby risking transmission of infectious diseases from licensee to patient, from patient to patient, or from patient to licensee.
(1) In administering this subdivision, the board shall consider referencing the standards, regulations, and guidelines of the State Department of Public Health developed pursuant to Section 1250.11 of the Health and Safety Code and the standards, guidelines, and regulations pursuant to the California Occupational Safety and Health Act of 1973 (Part 1 (commencing with Section 63001) of Division 5 of the Labor Code) for preventing the transmission of HIV, hepatitis B, and other blood-borne pathogens in health care settings. As necessary to encourage appropriate consistency in the implementation of this subdivision, the board shall consult with the Medical Board of California, the Board of Podiatric Medicine, the Dental Board of California, the Board of Registered Nursing, and the Board of Vocational Nursing and Psychiatric Technicians.
(2) The board shall seek to ensure that licensees are informed of their responsibility to minimize the risk of transmission of infectious diseases from health care provider to patient, from patient to patient, and from patient to health care provider, and are informed of the most recent scientifically recognized safeguards for minimizing the risks of transmission.
(Amended by Stats. 2009, Ch. 307, Sec. 26. Effective January 1, 2010.)

2570.29. (Occupational Therapy)

In addition to other acts constituting unprofessional conduct within the meaning of this chapter, it is unprofessional conduct for a person licensed under this chapter to do any of the following:
(a) Obtain or possess in violation of law, or prescribe, or, except as directed by a licensed physician and surgeon, dentist, optometrist, or podiatrist, to administer to himself or herself, or furnish or administer to another, any controlled substance as defined in Division 10 (commencing with Section 11000) of the Health and Safety Code or any dangerous drug or dangerous device as defined in Section 4022.
(b) Use to an extent or in a manner dangerous or injurious to himself or herself, to any other person, or to the public, or that impairs his or her ability to conduct with safety to the public the practice authorized by his or her license, of any of the following:
(1) A controlled substance as defined in Division 10 (commencing with Section 11000) of the Health and Safety Code.
(2) A dangerous drug or dangerous device as defined in Section 4022.
(3) Alcoholic beverages.
(c) Be convicted of a criminal offense involving the prescription, consumption, or self-administration of any of the substances described in subdivisions (a) and (b) of this section, or the possession of, or falsification of a record pertaining to, the substances described in subdivision (a) of this section, in which event the record of the conviction is conclusive evidence thereof.
(d) Be committed or confined by a court of competent jurisdiction for intemperate use of any of the substances described in subdivisions (a) and (b) of this section, in which event the court order of commitment or confinement is prima facie evidence of the commitment or confinement.
(e) Falsify, or make grossly incorrect, grossly inconsistent, or unintelligible entries in any hospital or patient record, or any other record, pertaining to the substances described in subdivision (a) of this section.
(Added by Stats. 2002, Ch. 1079, Sec. 8. Effective September 29, 2002.)

Standards of Practice (Oregon)

Athletic trainers shall adhere to the following standards of professional conduct:

(1) Physician Collaboration: Athletic trainers are required to collaborate with a physician in the treatment of an athletic injury as provided in OAR 331-160-0015.

(2) Registered Athletic Trainers shall be responsible for the conduct and performance of student assistants under their supervision.

(3) Documentation: All services are documented in writing by the Athletic Trainer and are part of the Athletic Trainer's record for the athlete. The Athletic Trainer accepts responsibility for chronologically recording details of the patient's health status and treatment, signing and dating each entry.

(4) The patient's record shall include, but not be limited to:

(a) Athlete's name and any other identifying information;

(b) Referral source, as applicable;

(c) Initial and subsequent assessments;

(d) Treatment plan, including methods used, results and plan revisions;

(e) Documentation of discontinuation of treatment and final summary.

(5) Records must be maintained for no less than seven years after discharge. All records are subject to review by the agency.

(6) All records must be legibly written or typed, dated and signed.

(7) Confidentiality: Athletic trainers are required to maintain confidentiality in accordance with all applicable laws.

(8) Initial Assessment: Prior to treatment, athletic trainers are required to assess the athlete's status, history, and level of functioning.

(9) Treatment Program Planning: The treatment program objectives must include goals, expectations and measures to determine the effectiveness of the program.

(10) Athletic trainers are required to observe the Occupational Safety and Health Act Blood Borne Pathogens Standards under 29 CFR 1910:1030 when providing services.

(11) Practicing athletic training or offering to perform services beyond the scope of practice permitted by law and defined in ORS 688.701, is prohibited.

(12) Performing services that have not been authorized by the athlete or the athlete's legal representative is prohibited.

32-4153. Grounds for disciplinary action **(Arizona)**

The following are grounds for disciplinary action:

1. Practicing athletic training in violation of this chapter or rules adopted pursuant to this chapter.

2. Practicing or offering to practice beyond the scope of the practice of athletic training.

3. Obtaining or attempting to obtain a license by fraud or misrepresentation.

4. Engaging in the performance of substandard care by an athletic trainer due to a deliberate or negligent act or failure to act, regardless of whether actual injury to the person cared for is established.

5. Failing to provide direct supervision in accordance with this chapter and rules adopted pursuant to this chapter.

6. Committing any felony or a misdemeanor involving moral turpitude. A conviction by a court of competent jurisdiction is conclusive evidence of the commission of the crime.

7. Practicing as an athletic trainer if the licensee's physical or mental abilities are impaired by the use of alcohol or any other substance that interferes with the ability to safely practice athletic training.

8. Having had a license or certificate revoked or suspended or any other disciplinary action taken or an application for licensure or certification refused, revoked or suspended by the proper authorities of another state, territory or country.

9. Engaging in sexual misconduct. For the purpose of this paragraph, "sexual misconduct" includes:

(a) Engaging in or soliciting sexual relationships, whether consensual or nonconsensual, while a provider relationship exists.

(b) Making sexual advances, requesting sexual favors or engaging in other verbal conduct or physical contact of a sexual nature with a person treated by the athletic trainer.

(c) Intentionally viewing a completely or partially disrobed patient in the course of treatment if the viewing is not related to treatment under current practice standards.

10. Failing to adhere to the recognized standards and ethics of the athletic training profession.

11. Making misleading, deceptive, untrue or fraudulent representations in violation of this chapter.

12. Charging unreasonable or fraudulent fees for services performed or not performed.

13. Having been adjudged mentally incompetent by a court of competent jurisdiction.

14. Aiding or abetting a person who is not licensed in this state and who directly or indirectly performs activities requiring a license.

15. Failing to report to the board any act or omission of a licensee or applicant or any other person who violates this chapter.

16. Interfering with an investigation or disciplinary proceeding by wilful misrepresentation of facts or by the use of threats or harassment against any person to prevent that person from providing evidence in a disciplinary proceeding or any legal action.

17. Failing to maintain confidentiality without prior written consent of the individual treated or unless otherwise required by law.

18. Failing to maintain adequate records regarding treatment. For the purposes of this paragraph, "adequate records" means legible records that contain at a minimum a determination of the nature of the injury and the referral and treatment required, the treatment plan, the treatment record, a final summary on conclusion of treatment and sufficient information to identify the person treated.

19. Promoting an unnecessary device, treatment or service for the financial gain of the athletic trainer or of a third party.

20. Providing unwarranted treatment or treatment beyond the point of reasonable benefit.

21. Providing athletic training services that are in any way linked to the financial gain of a referral source.

22. Violating this chapter, board rules or a written order of the board.

Example of language of other state regulatory agency scope of practice for Athletic Trainers

Scope of Practice (Oregon)

The scope of practice of athletic training by a registered athletic trainer shall consist of the following:

(1) The education, instruction, application and monitoring of facts and circumstances required to protect the athlete from athletic injury, including but not limited to:

(a) The identification, through physical examinations or screening processes, of conditions that may pose a risk of injury, illness or disease to an athlete.

(b) The supervision and maintenance of athletic equipment to assure safety.

(2) The recognition, evaluation and care of injuries and illness occurring during athletic events or in the practice for athletic events including but not limited to the following;

(a) Performance of strength testing using mechanical devices or other standard techniques;

(b) Application of tape, braces and protective devices to prevent or treat injury;

(c) Administration of standard techniques of first aid;

(d) Use of emergency care equipment to aid the injured athlete by facilitating safe transportation to an appropriate medical facility;

(e) Determination of the level of functional capacity of an injured athlete in order to establish the extent of an injury; and

(f) Determination of the level of functional capacity of an injured or ill athlete to participate.

(3) The gathering and accurate recording of all information required in the assessment of athletic injuries.

(4) The development and implementation of an appropriate course of rehabilitation or reconditioning by the use of therapeutic modalities, including but not limited to: water, cold, heat, electrical, mechanical and acoustical devices, massage, manual techniques, gait training exercise, and physical capacity functional programs which are determined to be needed to facilitate recovery, restore athletic function or performance;

(5) Dispensation of non-prescription medication and application of topical non-prescription medication;

(6) The determination and implementation of a plan for appropriate health care administration.

(7) Referral of an athlete to appropriate health care provider as needed.

(8) Organization of a medical care service delivery system for athletes when needed.

(9) Establishment of plans to manage an athlete's medical emergencies;

(10) The education or providing of athletic training guidance to athletes for the purpose of facilitating recovery, function and performance of the athlete.