MINUTES
Monthly Meeting
MEDICAL LICENSURE COMMISSION OF ALABAMA
Meeting Location: 848 Washington Avenue
Montgomery, Alabama 36104

December 17, 2025

MEMBERS PRESENT IN PERSON

Jorge Alsip, M.D., Chairman
Kenneth W. Aldridge, M.D., Vice-Chairman
Howard J. Falgout, M.D.
Paul M. Nagrodzki, M.D.
Nina Nelson-Garrett, M.D.
James R. Seale, Esq.

MEMBERS NOT PRESENT

Craig H. Christopher, M.D.
Pamela Varner, M.D.

MLC STAFF

Aaron Dettling, General Counsel, MLC
Rebecca Robbins, Operations Director (Recording)
Nicole Roque, Administrative Assistant (Recording)
Heather Lindemann, Licensure Assistant

OTHERS PRESENT

BME STAFF

Buddy Chavez, Investigator
Anthony Crenshaw, Investigator
Rebecca Daniels, Investigator
Amy Dorminey, Director of Operations
Alicia Harrison, Associate General Counsel
Chris Hart, Technology
Effie Hawthorne, Associate General Counsel
Wilson Hunter, General Counsel
Roland Johnson, Physician Monitoring
Sally Knight, Physician Monitoring
Stephen Lavender, Investigator
Christy Lawson, Paralegal
William Perkins, Executive Director
Tiffany Seamon, Director of Credentialing
Ben Schlemmer, Investigator
Scott Sides, Investigator

Call to Order: 9:00 a.m.

Prior notice having been given in accordance with the Alabama Open Meetings Act, and with a quorum of six members present, Commission Chairman, Jorge Alsip, M.D. convened the monthly meeting of the Alabama Medical Licensure Commission.

OLD BUSINESS

Minutes November 19, 2025

Commissioner Seale made a motion that the Minutes of November 19, 2025, be approved. A second was made by Commissioner Falgout. The motion was approved by unanimous vote.

NEW BUSINESS

Full License Applicants

	Name	Medical School	Endorsement
1.	Thaer S M Abdelfattah	Jordan University of Science & Technology	USMLE/PA
2.	Ahmed A M F Abdelhaleem	Menoufia University Faculty of Medicine	USMLE
3.	Abdulmoiz Kaiser Abdulwali	Alfaisal University College of Medicine	USMLE
4.	Mahmoud E M A Abodorra	University of Alexandria	USMLE
5.	Ahmed M Abouhamda	Ain Shams University Faculty of Medicine	USMLE
6.	Jacob Bradley Abshire	University of Alabama School of Medicine Birmingham	USMLE
7.	Monica Opeoluwa Adedeji	Howard University College of Medicine	USMLE/PA
8.	Rida Ahmad	Aga Khan Medical College, Aga Khan University	USMLE
9.	Shifa Batool Akhter	Fatima Jinnah Medical College for Women, University of the Punjab	USMLE
10.	Armon Do Amini	University of Texas Southwestern Medical Center at Dallas	USMLE
11.	Senthil Anand	S.R.M. Medical College Hospital and Research Centre	USMLE/AZ
12.	Bayley Delayne Atkins	University of Alabama School of Medicine Birmingham	USMLE
13.	Juhaina Saud Bajaman	Alfaisal University College of Medicine	USMLE
14.	Jarrett Alexander Barnes	University of South Alabama College of Medicine	USMLE
15.	Jon Thomas Beezley	University of North Texas Health Science Center	COMLEX/OH
16.	Christopher Michael Bell	University of Tennessee	USMLE/TN
17.	Clayton P M Bellam	Philadelphia College of Osteopathic Medicine	COMLEX/GA
18.	Jonathan Taylor Bergeron	Louisiana State University School of Medicine New Orleans	USMLE
19.	Vince Blaire Binondo	Lincoln Memorial Univ Debusk College of Osteopathic Medicine	COMLEX/TN
20.	Connor John Black	Idaho College of Osteopathic Medicine	COMLEX
21.	Ethan James Boyd	University of South Alabama College of Medicine	USMLE
22.	Kaitlin Jeniece Brittain	Edward Via College of Osteopathic Medicine Louisiana	COMLEX
23.	Sebrina Rene Burnett	Burrell College of Osteopathic Medicine	COMLEX
24.	Rebecca Jewel Burson	University of Mississippi School of Medicine	USMLE
25.	Taylor Ann Carter	Edward Via College of Osteopathic Medicine Auburn	COMLEX
26.	Rayen-Ayoub Chakra	St. Matthews University (Grand Cayman)	USMLE/GA

	Name	Medical School	Endorsement
27.	Sophie Hui-Ying Chang	Our Lady of Fatima University	USMLE/MN
28.	Joel Michael Cohen	University of South Florida College of Medicine	USMLE
29.	Haley Kathleen Cook	Edward Via College of Osteopathic Medicine, Carolinas Campus	COMLEX
30.	Anna Grace Coop	Edward Via College of Osteopathic Medicine Auburn	COMLEX
31.	Bailey Marie Creighton	Florida State University College of Medicine	USMLE
32.	Richard Clayton Davis	Tulane University School of Medicine	USMLE/NC
33.	Elliot Tyler Dawson	University of Illinois at Chicago	USMLE/MN
34.	Jordan Day-Caudill	Lincoln Memorial Univ Debusk College of Osteopathic Medicine	COMLEX
35.	Monica B Dhakar	B.J. Government Medical College, Pune	USMLE/MI
36.	Roshan Dinparastisaleh	Tabriz University of Medical Sciences Faculty of Medicine	USMLE
37.	Pankil Prakashchandra Doshi	University of Northern Philippines College of Medicine	USMLE/MO
38.	Carly Marie Duncan	Washington University School of Medicine	USMLE
39.	Humna Ellahi	Sahiwal Medical College	USMLE/TX
40.	Billy Alexander Essman	Edward Via College of Osteopathic Medicine Auburn	COMLEX
41.	Jovanna A Fazzini Tracz	Eastern Virginia Medical School	USMLE
42.	Karl Jacob Fischer	University of Kansas School of Medicine Wichita	USMLE
43.	Nathan David Flesher	University of Kansas School of Medicine Wichita	USMLE
44.	Fabiola Marie Fontanet Jaime	Universidad Central Del Caribe School of Medicine	USMLE
45.	Saurabh Gambhir	Ross University School of Medicine	USMLE/NJ
46.	Matthew Paul Garrett	Louisiana State University Medical Center in Shreveport	USMLE
47.	John Carl Goffigan	Keck School of Medicine of the University of Southern California	USMLE/CA
48.	Claire Webster Goode	Edward Via College of Osteopathic Medicine Auburn	COMLEX
49.	Connor Michael Griffin	University of Arkansas College of Medicine	USMLE
50.	Samuel Troupe Grimes	University of South Alabama College of Medicine	USMLE
51.	Sarah Jane Gross	University of South Alabama College of Medicine	USMLE
52.	Sydney Hartinger Grubb	Alabama College of Osteopathic Medicine	COMLEX
53.	Aysenur Gullu	Necmettin Erbakan University	USMLE
54.	Yuqing Guo	Nanjing University of Chinese Medicine	USMLE
55.	Amit Gupta	All India Institute of Medical Sciences	USMLE
56.	Tayyaba Haq	Nishtar Medical College, Bahuddin Zakaria University	USMLE
57.	LeAnthony Hardy	Augusta University	USMLE/GA
58.	Evan Kenneth Harmon	Univ of North Carolina School at Chapel Hill School of Medicine	USMLE/OH
59.	Kevin Andrew Hinson	Liberty University College of Osteopathic Medicine	COMLEX/KY
60.	Shauna-Kaye K Hunter	University of The West Indies, Jamaica	USMLE
61.	Ahmer Israr	Alabama College of Osteopathic Medicine	COMLEX
62.	Mia Michaela Jetsu	University of South Alabama College of Medicine	USMLE
63.	Aarti Joshi	Alabama College of Osteopathic Medicine	COMLEX
64.	Charitha Karanam Ramapathy	Dr. N.T.R. University of Health Sciences	USMLE/NM
65.	Usbah Khalid	Services Institute of Medical Sciences	USMLE
66.	Humam Manzoor Khan	Maulana Azad Medical College, University of Delhi	USMLE
67.	Tu Minh Khong	Emory University School of Medicine	USMLE
68.	Samer William Kirmiz	Michigan State University College of Human Medicine	USMLE/CA
69.	Ryan Jean Kronen	Washington University School of Medicine	USMLE/MA
70.	Xhensila Kycyku	Nova Southeastern University College of Osteopathic Medicine	COMLEX
71.	Michael Daniel Landis	University of Central Florida College of Medicine	USMLE/FL

	Name	Medical School	Endorsement
72.	Christopher S Laurent	Florida State University College of Medicine	USMLE
73.	Alyssa Renea Leibengood	University of Kansas School of Medicine	USMLE
74.	Jeffrey Yen Lin	Albany Medical College	NBME/NY
75.	Jiapeng Liu	Capital University of Medical Sciences	USMLE
76.	Stanley Shi-Dan Liu	Mayo Medical School	USMLE/MD
77.	Leslie Charles Lockridge	Rosalind Franklin University of Medicine and Science	USMLE/RI
78.	Travis Benjamin Lysaght	University of Toledo College of Medicine	USMLE
79.	Michael Joseph Maniaci	Saint Louis University School of Medicine	USMLE/FL
80.	Jack Gordon Mason	University of Mississippi School of Medicine	USMLE
81.	Ziad Rachid Mattar	First Moscow State Medical University	USMLE/OH
82.	Casey Lee Mcatee	University of Alabama School of Medicine Birmingham	USMLE/LA
83.	Natasha Mary McKay	Ross University School of Medicine	USMLE/VA
84.	Alexandra Diane McNeil	William Carey University College of Osteopathic Medicine	COMLEX
85.	Adriana A Montilla Hernandez	University of Carabobo, Faculty of Health Sciences Valencia	USMLE/PA
86.	James Ingemar Morrow	St. George's University School of Medicine	USMLE/FL
87.	Sheila Sharon Nazarian Mobin	Albert Einstein College of Medicine of Yeshiva University	USMLE/CA
88.	Ruben Ngnitewe Massa A	University of Missouri School of Medicine Columbia	USMLE/WI
89.	Matthew White Nottingham	Virginia Commonwealth University School of Medicine	USMLE/VA
90.	Usama Oguz	Gaziantep University Faculty of Medicine	USMLE
91.	Tumpa Patra	Bankura Sammilani Medical College, University of Calcutta	USMLE
92.	David Daniel Pfau	Case Western Reserve University School of Medicine	USMLE/CO
93.	Harvey Alan Pflanzer	New York Institute of Technology College of Osteopathic Medicine	COMLEX/FL
94.	Kiara Alicia Phelps	University of Medicine and Health Sciences, St. Kitts	USMLE/LA
95.	Indira Babu Poojary	Yenepoya Medical College	USMLE
96.	Soorya Gokulan Rajendran	University of Alabama School of Medicine Birmingham	USMLE
97.	Lekshmi Ravi	Kannur Medical College	USMLE
98.	Annie Emery Lewis Schilleci	Louisiana State University Medical Center in Shreveport	USMLE
99.	Iqra Shakoor	Peoples Med College for Girls, Liaquat Univ of Med & Health Sci	USMLE
100.	Dalton Michael Sheffield	Edward Via College of Osteopathic Medicine Auburn	COMLEX
101.	Muhammad D A Sheikh	Aga Khan Medical College, Aga Khan University	USMLE
102.	Sajan Parthiv Sheth	Alabama College of Osteopathic Medicine	COMLEX
103.	Mykel Rye Shiver	University of Alabama School of Medicine Birmingham	USMLE
104.	Rabi Shrestha	Nepal Medical College	USMLE
105.	Anna Sahreen Siddiq	Edward Via College of Osteopathic Medicine Auburn	COMLEX
106.	Sabina Siddiqui	University of Tennessee at Memphis	USMLE/MI
107.	Harleen Singh	St. George's University School of Medicine	USMLE/GA
108.	Mannat Singh	Kasturba Medical College, Manipal University	USMLE
109.	Neha Singh	Patna Medical College	USMLE
110.	Brice Alan Smoker	University of South Carolina School of Medicine	USMLE
111.	Danielle Shay Stephens	University of Louisville School of Medicine	USMLE
112.	Brett Anthony Stinger	Louisiana State University School of Medicine New Orleans	USMLE
113.	Siri Tadikonda	N.R.I. Medical College, Guntur	USMLE
114.	Yashwin Tah	Punjab Institute of Medical Sciences	USMLE
115.	Mina M Thabet Iskander	Ain Shams University Faculty of Medicine	USMLE
116.	Madison P H Thrower	Louisiana State University Medical Center in Shreveport	USMLE

Name	Medical School	Endorsement
117.Nitin Tiwari	Virginia Commonwealth University School of Medicine	USMLE/OH
118.Joseph Michel Trak	American University of The Caribbean	USMLE/NY
119.Akshay S Vakharia	B J Medical College, Gujarat University	FLEX/MI
120.Justine Josephine Vella	University of Medicine and Health Sciences, St. Kitts	USMLE
121.Jyoti Verma	Government Medical College Patiala	USMLE
122.Mitchell Douglas Vorce	Lake Erie College of Osteopathic Medicine	COMLEX/FL
123.Kamal Wahab	University Of Baghdad	USMLE/FL
124.Caitlin E Wainscott	University of South Alabama College of Medicine	USMLE/WY
125.Wei Wang	Edward Via College of Osteopathic Medicine Auburn	COMLEX
126.Benjamin Joseph Weigman	University of Wisconsin Medical School	USMLE
127.Michael David Whittendale	Edward Via College of Osteopathic Medicine, Carolinas Campus	COMLEX/VA
128.Erica Rene Wilt	Marshall University School of Medicine	USMLE/NC
129.Charles Parker Windham	University of Texas Southwestern Medical Center at Dallas	FLEX/CT
130.*Hannah H. Choi	American University of Antigua	USMLE
131.Martin J. Dib	University of Chile Faculty of Medicine	USMLE/MA
132.Junu Giri	Chitwan Medical College	USMLE
133.*Thamotharampillai Sivaraj	University of Colombo	FLEX/PA

**Approved pending acceptance and payment of NDC issued by the BME.*

A motion was made by Commissioner Aldridge with a second by Commissioner Nelson-Garrett to approve applicant numbers one through one hundred and thirty-three (1-133) for full licensure. The motion was approved by unanimous vote.

Limited License Applicants

	Name	Medical School	End.	Location	License
1.	Mahmoud Hassouba	Cairo University Faculty of Medicine	LL/AL	UAB Dept of Radiology	F
2.	Namra Qadeer Shaikh	Aga Khan Medical College	LL/AL	UAB General Surgery	R

A motion was made by Commissioner Aldridge with a second by Commissioner Falgout to approve applicant numbers one and two (1 & 2) for limited licensure. The motion was approved by unanimous vote.

IMLCC Report

The Commission received as information a report of the licenses that were issued via the Interstate Medical Licensure Compact from November 1, 2025, through November 30, 2025. A copy of this report is attached as Exhibit "A".

REPORTS

Physician Monitoring Report

The Commission received as information the physician monitoring report dated December 12, 2025. A copy of the report is attached as Exhibit "B".

APPLICANTS FOR REVIEW

Numair Ehtsham, M.D.

A motion was made by Commissioner Nagrodzki with a second by Commissioner Nelson-Garrett to approve Dr. Ehtsham's application for full licensure. The motion was approved by unanimous vote.

Kenneth Hau, M.D.

A motion was made by Commissioner Nagrodzki with a second by Commissioner Nelson-Garrett to approve Dr. Hau's application for full licensure. The motion was approved by unanimous vote.

Gabrielle Morris, M.D.

A motion was made by Commissioner Nelson-Garrett with a second by Commissioner Aldridge to approve Dr. Morris' application for full licensure. The motion was approved by unanimous vote.

Timothy Ramsden, M.D.

A motion was made by Commissioner Nagrodzki with a second by Commissioner Falgout to defer any action on Dr. Ramsden's application for licensure until the January 28, 2026 Commission meeting. The motion was approved by unanimous vote.

Muhammad Shehryar, M.D.

A motion was made by Commissioner Falgout with a second by Commissioner Nelson-Garrett to approve Dr. Shehryar's application for full licensure. The motion was approved by unanimous vote.

Bryan Smith, M.D.

A motion was made by Commissioner Nagrodzki with a second by Commissioner Nelson-Garrett to approve Dr. Smith's application for full licensure. The motion was approved by unanimous vote.

Andre Sullivan, M.D.

A motion was made by Commissioner Aldridge with a second by Commissioner Nelson-Garrett to approve Dr. Sullivan's application for full licensure. The motion was approved by unanimous vote.

Namitha Thotli, M.D.

A motion was made by Commissioner Nagrodzki with a second by Commissioner Nelson-Garrett to approve Dr. Thotli's application for full licensure. The motion was approved by unanimous vote.

Larry Zhao, M.D.

A motion was made by Commissioner Nelson-Garrett with a second by Commissioner Falgout to approve Dr. Zhao's application for full licensure. The motion was approved by unanimous vote.

DISCUSSION ITEMS

FSMB Call for Comments: Legislative Developments for Unmatched Medical Graduates in the United States

The Commission received as information the Federation of State Medical Boards Call for Comments: Legislative Developments for Unmatched Medical Graduates in the United States. A copy of the memorandum is attached as Exhibit "C".

BME Rules Approved for Publication: 540-X-10, Office Based Surgery

The Commission received as information the Alabama State Board of Medical Examiners Rules Approved for Publication: 540-X-10, Office Based Surgery. A copy of the rule is attached hereto as Exhibit "D".

REQUESTS

Kristin Dobay, M.D.

The Commission considered a request filed by Dr. Dobay to lift the restrictions placed on his Alabama medical license. A motion was made by Commissioner Nagrodzki with a second by Commissioner Falgout to lift the restrictions and to reinstate Dr. Dobay's license to a full and unrestricted status. The motion was approved by unanimous vote. A copy of the order is attached as Exhibit "E".

ADMINISTRATIVE FILINGS

Jonathan T. Miller, M.D.

The Commission received a proposed Joint Settlement Agreement and Consent Order between Dr. Miller and the Alabama State Board of Medical Examiners. A motion was made by Commissioner Seale with a second by Commissioner Falgout to accept the Joint Settlement Agreement and to enter a Consent Decree incorporating its terms. The motion was approved by unanimous vote. A copy of the Commission's order is attached hereto as Exhibit "F".

Gregory K. Parker, M.D.

A motion was made by Commissioner Seale with a second by Commissioner Aldridge to approve the Bill of Costs filed by the Alabama State Board of Medical Examiners. The motion was approved by unanimous vote. A copy of the Commission's order is attached hereto as Exhibit "G".

CLOSED SESSION UNDER ALA. CODE 34-24-361.1

At 10:08 a.m., the Commission entered closed session pursuant to Alabama Code § 34-24-361.1 to hear and consider the following matters:

Marcus D. Rushing, M.D.

At the conclusion of the hearing, a motion was made by Commissioner Seale with a second by Commissioner Nelson-Garrett to revoke Dr. Rushing's Alabama medical license and assess an administrative fine. The motion was approved by unanimous vote. A copy of the Commission's order is attached hereto as Exhibit "H".

Meeting adjourned at 11:00 a.m.

PUBLIC MEETING NOTICE: The next meeting of the Alabama Medical Licensure Commission was announced for Wednesday, January 28, 2026, beginning at 9:00 a.m.

JORGE ALSIP, M.D., Chairman
Alabama Medical Licensure Commission

Rebecca Robbins, Director of Operations
Recording Secretary
Alabama Medical Licensure Commission

01/28/2026
Date Signed

EXHIBIT

A

IMLCC Licenses Issued November 1, 2025 - November 30, 2025 (121)

Name	License Type	License Number	Status	Issue Date	Expiration Date	State of Primary Licensure
Raza Mushtaq	MD	52603	Active	11/4/2025	12/31/2025	Arizona
Steven Palter	MD	52607	Active	11/5/2025	12/31/2026	Arizona
Austin Kimball Traasdahl	DO	4386	Active	11/6/2025	12/31/2025	Arizona
Andrew Scott Huard	DO	4391	Active	11/20/2025	12/31/2025	Arizona
Christie Blanton	MD	52600	Active	11/4/2025	12/31/2026	Colorado
Ali abdulkareem Abbas Alsarah	MD	52627	Active	11/7/2025	12/31/2025	Colorado
Hellena Renee Scott-Okafor	MD	52591	Active	11/3/2025	12/31/2025	Florida
Divya Singh	MD	52613	Active	11/5/2025	12/31/2025	Florida
Katia Dieguez Otero	MD	52620	Active	11/6/2025	12/31/2025	Florida
Marcia Ann Radke	MD	52619	Active	11/6/2025	12/31/2025	Florida
Uche Prince Ike	MD	52622	Active	11/7/2025	12/31/2025	Florida
Sailaja Bondalapati	MD	52630	Active	11/18/2025	12/31/2025	Florida
Teji Dhami	MD	52634	Active	11/18/2025	12/31/2025	Florida
Ha Thuy Hatley	MD	52644	Active	11/18/2025	12/31/2025	Florida
Ali Kasraeian	MD	52631	Active	11/18/2025	12/31/2025	Florida
Adel Yazji	MD	52639	Active	11/18/2025	12/31/2025	Florida
Jennifer Ann Brown	MD	52654	Active	11/20/2025	12/31/2026	Florida
Veronica Nabizada	MD	52649	Active	11/20/2025	12/31/2025	Florida
Vito Petrozzino	MD	52650	Active	11/20/2025	12/31/2025	Florida
Michael Corey Zaplin	MD	52742	Active	11/21/2025	12/31/2025	Florida
Corey Alvarez	MD	52760	Active	11/24/2025	12/31/2025	Florida
Aleksei Belousov	MD	52754	Active	11/24/2025	12/31/2025	Florida
Zachary Edward Brown	MD	52764	Active	11/24/2025	12/31/2025	Florida
Jeffrey Wayne Crooms	MD	52772	Active	11/24/2025	12/31/2025	Florida
Frank Mohammed Fayz	MD	52770	Active	11/24/2025	12/31/2025	Florida
Octavia Lawton Graham	MD	52751	Active	11/24/2025	12/31/2025	Florida
Adeeb Rohani	MD	52771	Active	11/24/2025	12/31/2025	Florida
Gavin Wayne Sigle	MD	52752	Active	11/24/2025	12/31/2025	Florida
Patrick Wilson Domkowski	MD	52783	Active	11/25/2025	12/31/2025	Florida
John J Cortina	DO	4382	Active	11/3/2025	12/31/2025	Florida
Stephen Hugo Perez	DO	4389	Active	11/18/2025	12/31/2025	Florida
Temitayo Akinfenwa	MD	52592	Active	11/3/2025	12/31/2025	Georgia

Elizabeth Ann Atkinson	MD	52598	Active	11/3/2025	12/31/2025	Georgia
Andrew Krieger	MD	52605	Active	11/4/2025	12/31/2026	Georgia
Yasmin Zanjabil Ahmed	MD	52612	Active	11/5/2025	12/31/2026	Georgia
Naila D Avery	MD	52610	Active	11/5/2025	12/31/2025	Georgia
Zachary Alexis Adams	MD	52636	Active	11/18/2025	12/31/2026	Georgia
Sergio Naccarato	MD	52645	Active	11/18/2025	12/31/2026	Georgia
Mahaveer Vakharia	MD	52774	Active	11/24/2025	12/31/2025	Georgia
Meron Abraham Tesfay	MD	52782	Active	11/25/2025	12/31/2025	Georgia
Joshua Hattaway	DO	4415	Active	11/25/2025	12/31/2025	Georgia
Shoeb Mohiuddin	MD	52593	Active	11/3/2025	12/31/2025	Illinois
David Enscoe	MD	52745	Active	11/21/2025	12/31/2025	Illinois
Terrence Michael Chambers	MD	52758	Active	11/24/2025	12/31/2025	Illinois
Matthew Groenwald	MD	52750	Active	11/24/2025	12/31/2025	Illinois
Elena Morgan	MD	52609	Active	11/5/2025	12/31/2025	Indiana
Kristin Lyn Tielker	MD	52652	Active	11/20/2025	12/31/2025	Indiana
Tobias Benjamin Kulik	MD	52655	Active	11/20/2025	12/31/2026	Kansas
Christopher Fenzel	MD	52633	Active	11/18/2025	12/31/2025	Kentucky
Kevin James Croce	MD	52780	Active	11/25/2025	12/31/2025	Kentucky
Rachel Margaret Guarisco	MD	52744	Active	11/21/2025	12/31/2025	Louisiana
Renee Yvonne Meadows	MD	52761	Active	11/24/2025	12/31/2025	Louisiana
Kevin Michael Shahbazian	DO	4390	Active	11/18/2025	12/31/2025	Louisiana
Laura Leahy Caldwell	MD	52766	Active	11/24/2025	12/31/2025	Maine
Thomas Richard Pentzer	DO	4384	Active	11/3/2025	12/31/2025	Maine
Jason Ramirez	MD	52596	Active	11/3/2025	12/31/2025	Maryland
Ghazaleh Gigi Hafizi	MD	52624	Active	11/7/2025	12/31/2025	Maryland
Andrew Garff	MD	52638	Active	11/18/2025	12/31/2026	Maryland
Garry Ting-Guide Ng	MD	52589	Active	11/3/2025	12/31/2025	Michigan
Bhanu Ram Pai	MD	52585	Active	11/3/2025	12/31/2025	Michigan
Nooreldin N Elkosh	MD	52602	Active	11/4/2025	12/31/2026	Michigan
Wassim Mohamad Younes	MD	52608	Active	11/5/2025	12/31/2025	Michigan
Stacie Diane Vetitoe	MD	52617	Active	11/6/2025	12/31/2025	Michigan
Omer Ahmed Zaman	MD	52616	Active	11/6/2025	12/31/2025	Michigan
Laura Norton Petrovich	MD	52736	Active	11/20/2025	12/31/2025	Michigan
Lee Carl Rabinowitz	MD	52653	Active	11/20/2025	12/31/2025	Michigan

Daniel Holmberg	MD	52595	Active	11/3/2025	12/31/2025	Minnesota
Mohamed Manaa	MD	52597	Active	11/3/2025	12/31/2025	Minnesota
Scott Chasley Martin	MD	52741	Active	11/21/2025	12/31/2025	Mississippi
Gaurav Ashok Kulkarni	MD	52587	Active	11/3/2025	12/31/2025	Missouri
James M Schmitt	MD	52601	Active	11/4/2025	12/31/2025	Missouri
Shvetha Murthy Zarek	MD	52768	Active	11/24/2025	12/31/2025	Missouri
Ketan Jayantibhai Patel	MD	52781	Active	11/25/2025	12/31/2025	Missouri
Benjamin Robert Cook	DO	4413	Active	11/24/2025	12/31/2025	Missouri
Brandon Carl Bunker	MD	52628	Active	11/7/2025	12/31/2025	Nebraska
Pejman Kharazi	MD	52647	Active	11/20/2025	12/31/2025	Nevada
Paige Davis Clark	MD	52626	Active	11/7/2025	12/31/2026	New Hampshire
Angela Oh-Park Antipin	MD	52625	Active	11/7/2025	12/31/2026	New Jersey
Edward Shaoyou Liu	MD	52656	Active	11/20/2025	12/31/2026	New Jersey
Matthew Lederman	MD	52743	Active	11/21/2025	12/31/2026	New Jersey
Usman Ali	MD	52641	Active	11/18/2025	12/31/2025	North Dakota
Peter Meade Anderson	MD	52590	Active	11/3/2025	12/31/2025	Ohio
Tom Alex Stamatis	MD	52614	Active	11/6/2025	12/31/2025	Ohio
John Arjun Sharma	MD	52623	Active	11/7/2025	12/31/2026	Ohio
Ann jean Smith	MD	52740	Active	11/21/2025	12/31/2025	Ohio
Mindy Marie Labac	MD	52757	Active	11/24/2025	12/31/2025	Ohio
Eric Fete	DO	4383	Active	11/3/2025	12/31/2025	Ohio
Helene Glassberg	MD	52629	Active	11/18/2025	12/31/2026	Pennsylvania
Adam Christopher Lake	MD	52640	Active	11/18/2025	12/31/2025	Pennsylvania
Taura Long	MD	52594	Active	11/3/2025	12/31/2025	Tennessee
Laura Zabalgoitia	MD	52604	Active	11/4/2025	12/31/2026	Tennessee
William Charles Barrow	MD	52611	Active	11/5/2025	12/31/2025	Tennessee
Andrea Marie Orvik	MD	52606	Active	11/5/2025	12/31/2025	Tennessee
Emily Ager	MD	52621	Active	11/7/2025	12/31/2026	Tennessee
Harrison Tyler Klause	MD	52755	Active	11/24/2025	12/31/2025	Tennessee
William Neil McKee	MD	52779	Active	11/25/2025	12/31/2025	Tennessee
Janeeka Beatriz Benoit	DO	4392	Active	11/20/2025	12/31/2025	Tennessee
Brittani Amber Smith	MD	52586	Active	11/3/2025	12/31/2025	Texas
Julie Lynn Holroyd	MD	52646	Active	11/18/2025	12/31/2025	Texas
William Ryan Ince	MD	52642	Active	11/18/2025	12/31/2026	Texas

Abdul Rasheed Khan	MD	52632	Active	11/18/2025	12/31/2025	Texas
Ghulam Hussain Thaver	MD	52635	Active	11/18/2025	12/31/2026	Texas
Patrick Michael Weill	MD	52651	Active	11/20/2025	12/31/2025	Texas
Elena Nicole Zamora	MD	52648	Active	11/20/2025	12/31/2025	Texas
Fredricka Renee Barr	MD	52756	Active	11/24/2025	12/31/2025	Texas
Vineet Choudhry	MD	52765	Active	11/24/2025	12/31/2025	Texas
Katharina Laura Hill	MD	52759	Active	11/24/2025	12/31/2025	Texas
Patricia Colleen Lee	MD	52763	Active	11/24/2025	12/31/2025	Texas
Lady Aura Caridad Martinez Fernandez	MD	52767	Active	11/24/2025	12/31/2025	Texas
Sifau Yetunde Oladipo	MD	52773	Active	11/24/2025	12/31/2025	Texas
Caroline Leilani Valdes	MD	52769	Active	11/24/2025	12/31/2025	Texas
Shawn L White	MD	52753	Active	11/24/2025	12/31/2025	Texas
Vishal Pankaj Kapadia	DO	4385	Active	11/4/2025	12/31/2025	Texas
Rissa Alivnia Fedora	DO	4388	Active	11/18/2025	12/31/2025	Texas
Kevin Paul Feig	MD	52588	Active	11/3/2025	12/31/2025	Washington
Katie H Lee	MD	52584	Active	11/3/2025	12/31/2025	Washington
Javier Vargas Jr.	MD	52615	Active	11/6/2025	12/31/2026	Washington
Leila Mae Elder	MD	52618	Active	11/6/2025	12/31/2025	West Virginia
Stephen Scott Klos	MD	52637	Active	11/18/2025	12/31/2025	Wisconsin
Jenny Tumba	MD	52643	Active	11/18/2025	12/31/2025	Wisconsin
Melissa Sue Tuck-White	MD	52762	Active	11/24/2025	12/31/2025	Wyoming

**Total licenses issued since April 2017 - 6,324*

EXHIBIT

B

STATE *of* ALABAMA

MEDICAL LICENSURE COMMISSION

To: Medical Licensure Commission

From: Nicole Roque

Subject: December Physician Monitoring Report

Date: 12/12/2025

The physicians listed below are currently being monitored by the MLC.

Physician:	**Robert Bolling, M.D.**
Order Type:	MLC
Due Date:	Other
Order Date:	12/18/2024
License Status:	Active-Probation
Requirements:	Worksite Monitor Report
Received:	Report from Luis Pernia, M.D.

Physician:	**Richard E. Jones, M.D.**
Order Type:	MLC
Due Date:	Other
Order Date:	3/27/2024
License Status:	Active-Probation
Requirements:	Site visit to ensure compliance with Commission Order
Received:	Compliance memo from RK Johnson

Physician:	**Shakir Raza Meghani, M.D.**
Order Type:	BME/MLC
Due Date:	Monthly
Order Date:	11/20/2023
License Status:	Active
Requirements:	Check PDMP Monthly Site visit to verify dispensing records
Received:	PDMP Compliant Site visit conducted and Dr. Meghani was found to be in compliance

Physician:	**Kenneth Eugene Roberts, M.D.**
Order Type:	BME/MLC
Due Date:	Quarterly
Order Date:	2/6/2014
License Status:	Active
Requirements:	Chaperon
	Staff/Patient Surveys
	Limited Practice
Received:	Compliance Memo from RK Johnson

EXHIBIT

C

STATE *of* ALABAMA

MEDICAL LICENSURE COMMISSION

MEMORANDUM

To: Medical Licensure Commission

From: Rebecca Robbins

Date: December 5, 2025

Subject: FSMB Call for Comments: *Legislative Developments for Unmatched Medical Graduates in the United States*

Pursuant to legislation that has been enacted in several states establishing additional pathways to practice and/or licensure for medical graduates who have not been accepted into an accredited post-graduate training program, and similar legislation that has been introduced in several states, the FSMB has produced a draft report evaluating the status of unmatched medical graduates and the experience of states that have enacted relevant legislation.

The draft report, *Legislative Developments for Unmatched Medical Graduates in the United States*, has been reviewed by the FSMB Board of Directors and is now being distributed to member boards for comment. After the receipt and review of any comments, the final report will be presented to the FSMB House of Delegates at the 2026 annual meeting.

Comments are due by January 16, 2026. If the Commission does not wish to submit any comments, this item should be received as information.

Recommendation: Defer for discussion

Rebecca Robbins

From:	Beverly Shelton <BShelton@fsmb.org> on behalf of Humayun Chaudhry <hchaudhry@fsmb.org>
Sent:	Wednesday, December 3, 2025 10:04 AM
Cc:	Andrea Ciccone; Joe Knickrehm
Subject:	Feedback Requested on Draft Report

Dear Board Chairs, Presidents, and Executive Directors,

Since 2014, twelve (12) states have enacted legislation establishing additional pathways for medical graduates who have not been accepted into an accredited postgraduate training program, and eleven (11) additional states have had similar legislation introduced. The stated goal of these proposals is to address physician shortages, particularly in rural or underserved areas, and offer practice opportunities for unmatched medical graduates. While these proposals share a similar objective, the requirements within them vary greatly across jurisdictions.

There has been an increasing number of requests directed to FSMB from member boards to provide some assistance or guidance in response to such legislation being considered in their jurisdictions. **Neither FSMB nor its House of Delegates have taken a formal position in support or against the merits of this form of licensure as a best practice to address real health care workforce concerns.** Our assistance, when asked, continues to be limited to a state-by-state analysis of the various models that have been enacted, without any associated guidance or analysis.

During its July 2025 meeting, the FSMB Board of Directors discussed this issue and charged FSMB staff to develop a report, with guidance from the Advisory Council of Board Executives, to evaluate the status of unmatched medical graduates and the experience of states that have enacted relevant legislation. The draft report, *Legislative Developments for Unmatched Medical Graduates in the United States*, was reviewed by the Board of Directors in October 2025 and is now being distributed to member boards for comment.

Please review the draft report at your convenience and provide your comments and feedback by **January 16, 2026.** We greatly appreciate your willingness to participate so that a final report may be submitted to the FSMB House of Delegates for consideration at the 2026 Annual Meeting. Links to both the report and feedback instrument are provided below.

REVIEW THE DRAFT REPORT HERE

PROVIDE COMMENTS AND FEEDBACK HERE

If you have any questions about the report, please contact FSMB's Chief of Staff, Andrea Ciccone, copied on this email.

Sincerely,
Hank

Legislative Developments for Unmatched Medical Graduates in the United States

Section 1. Introduction

This report is intended to provide helpful information to U.S. state and territorial medical and osteopathic boards and policy makers who may be considering legislation in their jurisdictions to enable additional licensure pathways for unmatched medical graduates who have not yet completed postgraduate training (also known as graduate medical education or GME). It is not intended to be an endorsement of such approaches, and it should be noted that current FSMB policy does not recognize nor endorse an additional licensure pathway for unmatched medical graduates.

Since 2014, 12 states have enacted legislation establishing additional pathways for U.S. and international medical graduates (USMGs and IMGs, respectively) who have not yet completed Accreditation Council for Graduate Medical Education- (ACGME) accredited postgraduate training nor passed the United States Medical Licensing Examination (USMLE) Step 3 or the Comprehensive Osteopathic Medical Licensing Examination of the United States (COMLEX) Level 3. These measures are ostensibly designed to address physician shortages, offer practice opportunities for unmatched graduates, and increase healthcare access in medically underserved regions. Although nine distinct titles exist for this licensure class (*see* table on p. 3), "assistant physician" (AP) is the most common colloquial designation for this type of licensure and is the one which will be used as a general term in this report. There are two primary licensure pathways for APs: a repeatedly renewable license that creates a permanent physician class without requiring completion of standardized exams or residency, and a time-limited "bridge" license for graduates awaiting residency placement. All APs under enacted legislation in the 12 states are expected to practice under supervision and/or under collaborative agreements with supervising physicians, and no states currently permit direct conversion from an AP to an unrestricted medical license. As of October 1, 2025, FSMB records show approximately 354 medical graduates held active AP licenses, with concentrations greatest in Missouri and Arizona, 88 percent of which are IMGs (compared to 23 percent of the overall physician population) and 58 percent are under the age of 40 (compared to 24 percent of the overall physician population).[1]

Section 2. Background

FSMB policy currently states that the minimum requirements for full and unrestricted medical licensure for all physicians should include the completion of at least 36 months of progressive, accredited postgraduate medical training (also termed GME), as well as completion of USMLE Steps 1, 2, and 3

[1] Data accessed from FSMB's Physician Data Center (PDC).

or COMLEX Levels 1, 2, and 3,[2] among other requirements which are paramount to ensure that physicians have a baseline of skills and competence to ensure the safety of patients. More recently, an Advisory Commission on Additional Licensure Pathways that was co-chaired by FSMB, ACGME and Intealth advised completion of postgraduate training as a recommended requirement for internationally trained physicians seeking supervised employment leading to licensure eligibility.[3]

Context and Policy Drivers

The physician workforce shortage — projected in one widely-quoted estimate to reach up to 86,000 by 2036[4] — has prompted legislators in some states to develop additional licensure pathways for medical graduates who do not match into residency programs. Advocates for AP licensure include the Association of Medical Doctor Assistant Physicians, the American Legislative Exchange Council (ALEC), and policy research organizations such as the Cato Institute and Heartland Institute. These organizations argue that restricted residency growth since the Balanced Budget Act of 1997 and limited federal funding for training make additional licensure pathways essential for meeting public health needs, especially in medically underserved communities.

In 2025, nearly 47,200 medical graduates sought to match with one of approximately 37,600 residency positions, leaving roughly 9,600 positions unmatched. Contributing factors for not matching included poor test performance and/or interviews, length of time since medical school graduation[5], medical school reputation/ranking and location, competitive specialty selection, legislative caps on GME funding, and static residency slot growth. Data from the National Resident Matching Program (NRMP) demonstrate that there are significant disparities among the type of applicants and their acceptance rates (NRMP includes data about all residencies, regardless of funding source.[6]).

Breakdown of Residency Match Rate by Applicant Type			
Category	Number of Applicants	Number of Matches	Percent of Matching Applicants
U.S. MD Seniors	20,368	19,044	93.5%
U.S. DO Seniors	8,392	7,773	92.6%
U.S. MD Grads	1,751	803	45.9%
U.S. DO Grads	630	276	43.8%
U.S. IMGs	4,587	3,108	67.8%

[2] https://www.fsmb.org/siteassets/advocacy/policies/guidelines-for-structure-function-of-state-medical-and-osteopathic-board-2024.pdf
[3] https://www.fsmb.org/siteassets/communications/acalm-guidance.pdf
[4] https://www.aamc.org/news/press-releases/new-aamc-report-shows-continuing-projected-physician-shortage
[5] https://bmcmededuc.biomedcentral.com/articles/10.1186/s12909-025-07806-3
[6] https://www.nrmp.org/policy/main-residency-match-all-in-policy/

Non-U.S. IMGs	11,465	6,653	58.0%
Source: https://www.nrmp.org/match-data/2025/05/results-and-data-2025-main-residency-match/			

Both U.S. and non-U.S. IMGs have significantly lower match rates than active, domestic MD and DO applicants (called "U.S. MD Seniors" and "U.S. DO Seniors," respectively), as do prior MD and DO graduates (called "U.S. MD Grads" and "U.S. DO Grads," respectively). NRMP provides no further analysis on the duration of time between medical school graduation and successful matching for prior graduate cohorts. Unmatched graduates often face substantial educational debt and limited clinical opportunities as they typically wait another year to apply again. AP licensure may, in such circumstances, support interim participation in supervised clinical practice and is said to improve candidacy for a future residency match.

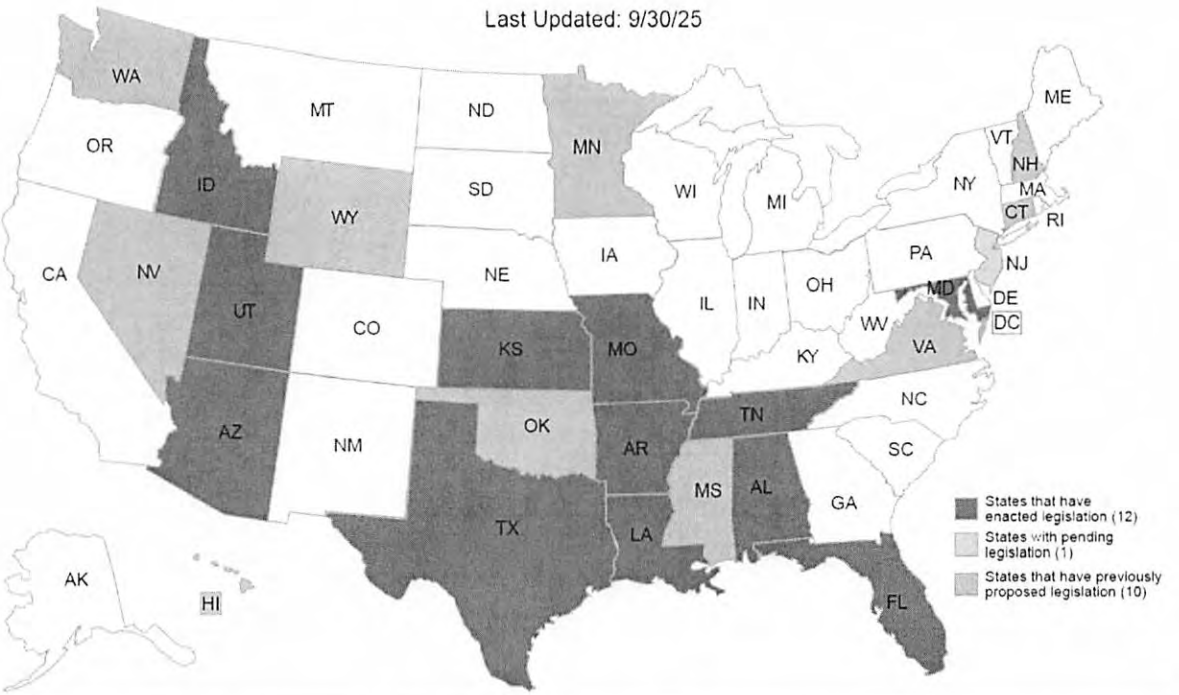
Between 2014 and 2025, 12 states enacted AP legislation, with eleven additional states introducing similar proposals that have not yet been enacted. Applicant requirements, scope of practice, and specific licensure titles vary by jurisdiction, but all share a core objective of permitting unmatched graduates to practice in supervised roles. Opposition from organizations such as the American Medical Association (AMA) and the Association of American Medical Colleges (AAMC) centers on concerns that bypassing residency training, especially if that bypass becomes enduring, undermines the training necessary for independent practice and may diminish support for federal GME funding.

Section 3. Components and Requirements of AP Licensure

Key Requirements

Each state's AP program has unique criteria; however, all require graduation from a recognized medical school, successful completion of USMLE Steps 1 and 2 (or COMLEX Levels 1 and 2), ongoing supervision, and absence of completion of ACGME-accredited residency training (although discrepancies exist on whether states will allow applicants who have ever been accepted into, or have begun, a residency). Applicants must typically apply for such a license within one to three years of their medical school graduation. Only some states limit AP practice to rural or medically underserved areas. Generally, AP licenses are designed to be time-limited.

States with AP Licensure



Components and Requirements of AP Licensure

State/ Component	Enacted	Title	Graduation from medical school (within _ years of application)	IMG eligibility	Require USMLE Steps 1+2 (time max after graduation, if applicable)	Allow COMLEX Levels 1 + 2	State residency requirement	In-state medical school requirement
Missouri + SB 718 ('18)	2014	Assistant physician	✓ (within last 3 years)	✓	✓ (3 years)	✓ (not specified)	✓	X
Arkansas	2015	Graduate registered physician	✓ (within last 2 years)	✓ (ECFMG certification)	✓ (2 years, within 3 attempts)	✓	X	X
Kansas	2015	Special permit(ee)	✓	X	*	X	X	✓
Utah	2017	Associate physician	✓ (within last 3 years)	X (LCME graduate)	✓ (2 years)	✓ (not specified)	X	X
Arizona	2021	Transitional training permit(ee)	✓ (within last 2 years)	✓	✓	X	X	X
Louisiana	2022	Bridge year graduate physician	✓ (within the previous year)	✓ (ECFMG certification)	*	X	X	X
Tennessee	2023	Graduate physician	✓ (within last 3 years)	✓	✓ (2 years)	✓	X	X
Alabama	2023	Bridge year graduate physician	✓ (within the previous year)	X (LCME/ COCA graduate)	✓	✓ (LMCC)	X	X
Idaho	2023	Bridge year physician	✓ (within the previous year)	✓	*	X	X	X
Florida	2024	Graduate assistant physician	✓ (within the previous year)	✓	✓ (Requires all Steps)	✓ (COMLEX – all Steps)	X	X
Maryland	2024	Supervised medical graduate	✓	✓	✓	✓	X	X
Texas	2025	Physician graduate	✓ (within last 2 years)	✓	✓	✓ (LMCC)	✓	X

State/ Component	Renewable license	Time limit, if applicable	Require collaborative practice agreement (CPA) and/or supervision	Practice in rural/ underserved area	Conversion to full license	SMB rulemaking authority	Issued rules	Licenses granted (active licenses)
Missouri + SB 718 ('18)	✓	Unlimited	✓	✓	X	✓	✓	838 (268)
Arkansas	✓	N/A	✓	X	X	✓	✓	14 (N/A)
Kansas	✓	2 years (1 year, 1 possible renewal)	✓	✓	X	✓	N/A	3 (N/A)
Utah	✓	6 years (2 years and 2 possible renewals)	✓	✓	X	✓	✓	11 (1)
Arizona	✓	3 years (1 year, 2 possible renewals)	✓	X	X	✓	✓ (MD) ✓ (DO)	N/A (85)
Louisiana	✓	3 years (1 year, 2 possible renewals)	✓	X	X	✓	✓	14 (N/A)
Tennessee	X	2 years	✓	✓	X	✓	✓ (MD) Not found (DO)	N/A
Alabama	✓	2 years (1 year and 1 possible renewal)	✓	X	X	✓	✓	0
Idaho	X	1 year	✓	X	X	✓	N/A	N/A
Florida	✓	3 years (2 years and 1 possible 1 year renewal)	✓	X	X	✓	✓ (MD) ✓ (DO)	N/A
Maryland	X	2 years	✓	X	X	✓	✓	0
Texas	✓	Unlimited	✓	✓	X	✓	✓	0

*: Indicates that the category was unstated or unaddressed in legislation or regulation.
N/A: Not available

Section 4. Regulatory Considerations

Pathways to Full Licensure

No state permits direct transition from AP licensure to full and unrestricted licensure without completion of postgraduate residency training and the successful completion of USMLE Step 3 or COMLEX Level 3. FSMB recognizes the importance of residency and examination completion in ensuring that physicians have the necessary skills to practice in an independent setting to enable them to provide quality healthcare to the patients they serve.

Licensure Structure: Time-Limited vs. Permanent Licenses

States vary in terms of offering time-limited versus permanent AP licenses, the level of regulatory oversight, supervision quality, and CME mandates. Time-limits imposed by states vary by duration of licensure, renewal cycles, and number of renewals possible; Missouri and Texas, unlike other jurisdictions, allow unlimited renewals.

Practice Setting

Five states require practice in rural or medically underserved areas. Some experts caution that APs practicing in these areas may risk contributing to the creation of a "second-class" of physician categories concentrated in socioeconomically disadvantaged or geographically isolated areas.[7] Resource and preceptor/supervision deficits, as well as difficulty retaining experienced supervisors in rural or medically underserved areas, will also present challenges to AP competency enhancement.[8]

Supervision

All states that have enacted this type of licensure pathway recognize that robust supervision via a supervision agreement is essential. They require that supervising physicians should be licensed in the same physical location, without prior discipline, and be capable of effectively assessing an AP's competence. However, limited supervision capacity and retention may impede AP practice initiation; in one study, only 25 percent of APs secured necessary supervision.[9]

Section 5. Licensure and Disciplinary Data

AP Licenses Issued in U.S.

Since 2016, a total of 870 AP licenses have been issued by five states, with the number of licenses issued by year shown below:[10]

AP Licenses Issued in the U.S. by Year										
Year	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025
Number	1	107	119	166	168	115	66	54	67	7

[7] https://www.advisory.com/daily-briefing/2022/08/04/assistant-physicians
[8] https://www.ruralhealthresearch.org/projects/1057
[9] https://www.goldwaterinstitute.org/policy-report/removing-barriers-for-associate-physicians-to-expand-healthcare-access/#:~:text=States%20demonstrated%20significant%20variation%20in,holders%20since%20its%20program%20began
[10] Data accessed from FSMB's Physician Data Center (PDC).

USMLE Performance

Comparative USMLE performance from 2010-2025 for MDs categorized as APs and licensed IMGs and USMGs are shown below:

	Assistant Physicians	IMGs	USMGs
Step 1			
Passing Rate on 1st Attempt	75%	96%	97%
Step 2 CK			
Passing Rate on 1st Attempt	65%	94%	98%
1st Attempt Average Passing Score (Std Dev)	222 (13)	234 (17)	243 (16)

APs typically require more attempts for examination passage and tend to score lower on the USMLE, on average, than their non-AP peers.[11] These findings have implications for training and supervision and appear to be correlated with a lower likelihood that such medical school graduates match into residency training.

AP Matriculation into Residency

A study of current licenses for individuals issued an AP license from 2016-2025 found that 38 percent had ultimately achieved full licensure, meaning that they had matched and subsequently completed GME training; eight percent were in residency training and possessed an active training license; 27 percent had continued practicing with an AP license; 22 percent had no license; and 6 percent had an active, non-physician license.[12]

Section 6. Legislative Considerations

The ongoing physician workforce shortage has prompted some states to expand licensure options for unmatched graduates, particularly to serve underserved communities. Other policy initiatives such as increased federal funding of residencies, the embrace of telemedicine, and the enactment of licensure compacts (i.e., Interstate Medical Licensure Compact and the PA Licensure Compact) may be more sensible and effective. If a state wishes to create an AP licensure pathway, however, consideration should be made to protect both the interests of the unmatched medical graduate and the public at large. Legislation, when proposed, should consider the following points of concern:

[11] Ibid.
[12] Ibid. Total does not add up to 100 due to rounding.

- Creating new and unfunded licensure categories may sow confusion among the public and create a two-tiered system of health care delivery by physicians possessing mixed skills and competencies.

- Eligibility should be reserved for applicants who have successfully graduated from an Liaison Committee on Medical Education- (LCME) or Commission on Osteopathic College Accreditation- (COCA) accredited medical school within the last two years and who have successfully completed USMLE Steps 1 and 2, or COMLEX Levels 1 and 2, but have not yet matched into a residency program.

- AP licensure should preferentially serve as an interim bridge option, with time limits, rather than as a permanent or enduring substitute for traditional residency training.

- Legislation should specify active supervision through the requirement of a supervision agreement with fully licensed physicians in the same physical location who have not had any disciplinary action or licensure infractions within the previous five years (A supervision agreement is a formal, written contract that outlines the scope of practice, responsibilities, and procedures that the AP is authorized to perform under physician supervision).

- There should be ongoing evaluation of the AP during the licensure period by the supervising physician and shared with the state medical board, beginning at the start of their practice period, to identify areas of strength as well as areas where additional support may be needed.

- Rulemaking authority should be delegated, and resources allocated, to the state medical board to implement and evaluate any AP licensure pathway.

- To obtain full licensure, the AP should meet the state's existing licensure requirements related to GME requirements and medical licensure examination completion.

- State medical boards should collect information that will facilitate evaluation of AP licensure in their jurisdiction to ensure it is meeting its intended purpose, including the number of APs who matriculate into residencies, and then full licensure, as well as the specialization and location of AP practice.

EXHIBIT
D

ALABAMA STATE BOARD OF MEDICAL EXAMINERS
WILLIAM M. PERKINS, EXECUTIVE DIRECTOR

P.O.BOX 946
MONTGOMERY, ALABAMA 36101-0946
848 WASHINGTON AVE.
MONTGOMERY, ALABAMA 36104

TELEPHONE: (334) 242-4116
E MAIL: bme@albme.gov

MEMORANDUM

To: Medical Licensure Commission

From: Mandy Ellis

Date: December 11, 2025

Re: Administrative Rules Approved for Publication

The Board of Medical Examiners, at its meeting November 13, 2025, approved the repeal and replace of the following rules to be published for public comment in the *Alabama Administrative Monthly*:

- Administrative Rules, Chapter 540-X-10, *Office-Based Surgery*

The Board, at its meeting September 18, 2025, approved for publication a second repeal and replace of the Office-Based Surgery Rules which addressed comments received after publication earlier in the year but were not adopted as final. The rules approved at the September meeting were published in the September 2025 *Alabama Administrative Monthly* with a comment period ending on November 4, 2025. Additional comments were received. Attached are the revised rules addressing the additional comments received and amendments approved by the Board at their meeting on November 13, 2025.

The rules were published on November 26, 2025. The public comment period ends January 1, 2026. The anticipated effective date is March 16, 2026.

Attachments:

- Repeal and Replace of Administrative Rules, Chapter 540-X-10, *Office-Based Surgery*

APA-1

TRANSMITTAL SHEET FOR NOTICE OF INTENDED ACTION

Control: 540

Department or Agency: Alabama Board of Medical Examiners

Rule No.: Chapter 540-X-10

Rule Title: Office-Based Surgery

Intended Action: Repeal and Replace

Would the absence of the proposed rule significantly harm or endanger the public health, welfare, or safety?	Yes
Is there a reasonable relationship between the state's police power and the protection of the public health, safety, or welfare?	Yes
Is there another, less restrictive method of regulation available that could adequately protect the public?	No
Does the proposed rule have the effect of directly or indirectly increasing the costs of any goods or services involved?	No

To what degree?: N/A

Is the increase in cost more harmful to the public than the harm that might result from the absence of the proposed rule?	NA
Are all facets of the rule-making process designed solely for the purpose of, and so they have, as their primary effect, the protection of the public?	Yes
Does the proposed action relate to or affect in any manner any litigation which the agency is a party to concerning the subject matter of the proposed rule?	No

Does the proposed rule have an economic impact? No

If the proposed rule has an economic impact, the proposed rule is required to be accompanied by a fiscal note prepared in accordance with subsection (f) of Section 41-22-23, Code of Alabama 1975.

Certification of Authorized Official

I certify that the attached proposed rule has been proposed in full compliance with the requirements of Chapter 22, Title 41, Code of Alabama 1975, and that it conforms to all applicable filing requirements of the Administrative Procedure Division of the Legislative Services Agency.

Signature of certifying officer: *William M. Perkins*

William M Perkins

Date: Tuesday, November 18, 2025

REC'D & FILED
NOV 18, 2025
LEGISLATIVE SVC AGENCY

APA-2

ALABAMA BOARD OF MEDICAL EXAMINERS

NOTICE OF INTENDED ACTION

AGENCY NAME: Alabama Board of Medical Examiners

RULE NO. & TITLE: Chapter 540-X-10 Office-Based Surgery

INTENDED ACTION: Repeal and Replace

SUBSTANCE OF PROPOSED ACTION:
Repeal and replace Chapter to update outdated rules, add sections on emergency plans, patient evaluation and selection, accreditation and quality assurance, and reporting.
This amendment meets the "protection of public health" exemption from the moratorium on rule amendments contained in Governor Ivey's Executive Order No. 735, Reducing "Red Tape" on Citizens and Businesses.

TIME, PLACE AND MANNER OF PRESENTING VIEWS:
All interested persons may submit data, views, or arguments concerning the proposed new rule(s) and regulation(s) in writing to: Effie Hawthorne, Office of the General Counsel, Alabama State Board of Medical Examiners, Post Office Box 946, Montgomery, Alabama 36101-0946, by mail or email (publiccomment@albme.gov), until and including January 2, 2026. Persons wishing to submit data, views, or comments in person should contact Effie Hawthorne by telephone (334-242-4116) during the comment period. Copies of proposed rules may be obtained at the Board's website: www.albme.gov.

FINAL DATE FOR COMMENT AND COMPLETION OF NOTICE:
Friday, January 2, 2026

CONTACT PERSON AT AGENCY:
Effie Hawthorne
(334) 242-4116
publiccomment@albme.gov

William M. Perkins
William M Perkins

(Signature of officer authorized
to promulgate and adopt
rules or his or her deputy)

ALABAMA BOARD OF MEDICAL EXAMINERS
ADMINISTRATIVE CODE

CHAPTER 540-X-10
OFFICE-BASED SURGERY

TABLE OF CONTENTS

540-X-10-.01 Preamble.

(1) Office-based surgery is surgery[1] performed outside a hospital or outpatient facility licensed by the Alabama Department of Public Health. It is the position of the Alabama Board of Medical

~~Examiners that the physician is responsible for providing a safe environment for office-based surgery. Surgical procedures in medicine have changed over the generations from procedures performed at home or at the surgeon's office to the hospital and, now, often back to outpatient locations. However, the premise for the surgery remains unchanged: that it be performed in the best interest of the patient and under the best circumstances possible for the management of disease and the well-being of the patient. Surgery that is performed in a physician's office at this time varies from a simple incision and drainage with topical anesthesia to semi-complex procedures under general anesthesia. It is imperative that the surgeon evaluate the patient, advise and assist the patient with a decision about the procedure and the location for its performance and, to the best of the surgeon's ability, assure that the quality of care be equal in any facility that the surgeon advises. If the physician performs surgery in the physician's office, it is expected that the physician will require office standards similar to those at other sites where the physician performs such procedures. It is also expected that any physician who performs a surgical procedure is knowledgeable about sterile technique, the need for pathological evaluation of certain surgical specimens, about any drug that the physician administers or orders administered, and about potential untoward reactions and complications and their treatment. Recognizing that there have been serious adverse events in office surgical settings, both in Alabama and in other states, the Board of Medical Examiners, in conjunction with an ad hoc committee representing various medical and surgical specialties, has developed guidelines for physicians who perform surgery in their offices. These guidelines are intended to remind the physician of the minimal suggested necessities for various levels of surgery in the office setting. The physician must decide on a case-by-case basis the location and level of service that is best for the physician's particular patient and procedure; this decision must always be made with the patient's best interest in mind.~~

~~[1] Definition of surgery: Surgery, which involves the revision, destruction, incision or structural alteration of human tissue performed using a variety of methods and instruments, is a discipline that includes the operative, and non-operative care of individuals in need of such intervention, and demands pre-operative assessment, judgment, technical skills, post-operative management and follow-up.~~

~~(2) The Alabama Board of Medical Examiners recommends the following general guidelines for office-based surgery/ procedures:~~

~~(a) Training: A procedure, whether done in an office, outpatient surgical facility or hospital, should be performed by physicians operating within their area of professional training. Appropriate training and continuing medical education should be documented and that documentation readily available to patients and the Alabama Board of Medical Examiners. Physicians who perform office-based procedures must have plans for managing emergency complications.~~

~~(b) Patient Selection: Patients must be individually evaluated for each procedure to determine if the office is an appropriate setting for the anesthesia required and for the surgical procedure to be performed.~~

~~(c) Patient Evaluation: Patients undergoing office-based surgery must have an appropriately documented history and physical examination as well as other indicated consultations and studies.~~

~~(d) Anesthesia: When deep sedation, major regional anesthesia or general anesthesia is provided in the office setting, it must be administered by a qualified person(s)[2] other than the person performing the procedure. Anesthesia personnel should be familiar with variations in technique based on the specifics of the patient and the procedure, particularly patients requiring large volumes of fluids and/or requiring airway management. Patients must be properly monitored before, during and after the procedure. Anesthesia personnel should be currently trained in ACLS.~~

~~(e) Office Setting: The office should be set up with patient safety as a primary consideration. Safety issues should include, but not be limited to, accessibility, sterilization and cleaning routines, storage of materials and supplies, supply inventory, emergency equipment, and infection control.~~

~~[2] The terms "qualified person(s)" and "qualified practitioner" are not defined precisely in these rules. Just as a physician is expected to determine if he is qualified to perform a certain procedure or treat a certain illness or whether he should refer his patient to someone whom he considers to be more qualified, he should assure, to the best of his ability, that the persons in his employ, whether directly or via contract, have the training, skills and ability to assist him as needed for the planned procedure. If questions arise about qualifications, he should explain his rationale as he would for questions about quality medical care.~~

~~(f) Emergency Planning: Planning should include, but not be limited to, emergency medicines, emergency equipment, and transfer protocols[3]. Practitioners should be trained and capable of recognizing and managing complications related to anesthesia that he/she administers and the procedures that he/she performs.~~

~~(g) Follow-up Care: As with any surgical treatment or procedure, follow-up care by the responsible surgeon is a requirement. Arrangements shall be made for follow-up care and for treatment of complications outside normal business hours. The patient, or a responsible adult, should be aware of these arrangements and of any medications prescribed after the procedure.~~

~~(h) Quality Improvement: Continuous quality improvement should be a goal.~~

~~(i) Facility accreditation is encouraged for those settings where deep sedation/analgesia (level 4) and general anesthesia (level 5) are provided.~~

~~(3) These rules shall not apply to an oral surgeon licensed to practice dentistry who is also a physician licensed to practice medicine, if the procedure is exclusively for the practice of dentistry. An oral surgeon licensed to practice dentistry who is also a physician licensed to practice medicine and who performs office based surgery other than the practice of dentistry shall comply with the requirements of these regulations for those procedures which fall outside the scope of practice of dentistry.~~

~~[3] **Definition of transfer protocols: Ensure the continuity of patient care is uninterrupted.**~~
~~**Author**: Alabama Board of Medical Examiners ad hoc Committee: Arthur F. Toole, III, M.D.; Jorge A. Alsip, M.D.; James G. Chambers, III, M.D.; Craig H. Christopher, M.D.; Alcus Ray Hudson, M.D.; Pamela D. Varner, M.D.; James E. West, M.D.; and Task Force Sub-Committee: Jeff Plagenhoef, M.D.; Eric Crum, M.D.; Dan J. Coyle, Jr., M.D.; Gary Monheit, M.D.; Robert Hurlbutt, IV, M.D.; C. Paul Perry, M.D.; W. Guinn Paulk, M.D.; Mark McIlwain, D.M.D., M.D.; Jerald Clanton, D.M.D., M.D.; Patrick J. Budny, M.D.; James W. Northington, M.D.; David Franco, M.D.; Thomas E. Moody, M.D.~~
~~**Statutory Authority**: Code of Ala. 1975, §34-24-53. 3 Definition of transfer protocols: Ensure the continuity of patient care is uninterrupted.~~

History: New Rule: Filed October 17, 2003; effective November 21, 2003.

540-X-10-.02 Definitions - Levels Of Anesthesia^4.

(1) Local Anesthesia. The administration of an agent which produces a localized and reversible loss of sensation in a circumscribed portion of the body.

(2) Minimal Sedation (anxiolysis). A drug-induced state during which patients respond normally to verbal commands. Although cognitive function and coordination may be impaired, ventilatory and cardiovascular functions are unaffected.

(3) Moderate Sedation/Analgesia ("Conscious Sedation"). A drug-induced depression of consciousness during which a patient responds purposefully to verbal commands, either alone or accompanied by light tactile stimulation. Reflex withdrawal from painful stimulation is **NOT** considered a purposeful response. No interventions are required to maintain a patent airway, and spontaneous ventilation is adequate. Cardiovascular function is usually maintained.

(4) Deep Sedation/Analgesia. A drug-induced depression of consciousness during which patients cannot be easily aroused but respond purposefully following repeated or painful stimulation. Reflex withdrawal from painful stimulation is **NOT** considered a purposeful response. The ability to independently maintain ventilatory function may be impaired. Patients may require assistance in maintaining a patent airway, and spontaneous ventilation may be inadequate. Cardiovascular function is usually maintained.

(5) General Anesthesia. A drug-induced loss of consciousness during which patients are not arousable, even by painful stimulation. The ability to independently maintain ventilatory function is often impaired. Patients often require assistance in maintaining a patent airway, and positive pressure ventilation may be required because of depressed spontaneous

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[4] **Reference: Appendix A - American Society of Anesthesiologists (ASA) definitions. This Appendix is included in these Rules only for information.**

ventilation or drug-induced depression of neuromuscular function. Cardiovascular function may be impaired.

~~(6) Regional Anesthesia ("Major conduction blockade") is considered in the same category as General Anesthesia.~~[5]

~~(7) Because sedation is a continuum, it is not always possible to predict how an individual patient will respond. Hence, practitioners intending to produce a given level of sedation should be able to rescue patients whose level of sedation becomes deeper than initially intended. Individuals administering Moderate Sedation/Analgesia ("Conscious Sedation") should be able to rescue patients who enter a state of Deep Sedation/Analgesia, while those administering Deep Sedation/ Analgesia should be able to rescue patients who enter a state of general anesthesia.~~
~~**Author:** Alabama Board of Medical Examiners ad hoc Committee: Arthur F. Toole, III, M.D.; Jorge A. Alsip, M.D.; James G. Chambers, III, M.D.; Craig H. Christopher, M.D.; Aleus Ray Hudson, M.D.; Pamela D. Varner, M.D.; James E. West, M.D.; and Task Force Sub-Committee: Jeff Plagenhoef, M.D.; Eric Crum, M.D.; Dan J. Coyle, Jr., M.D.; Gary Monheit, M.D.; Robert Hurlbutt, IV, M.D.; C. Paul Perry, M.D.; W. Guinn Paulk, M.D.; Mark McIlwain, D.M.D., M.D.; Jerald Clanton, D.M.D., M.D.; Patrick J. Budny, M.D.; James W. Northington, M.D.; David Franco, M.D.; Thomas E. Moody, M.D.~~
~~**Statutory Authority:** Code of Ala. 1975, §34-24-53.~~
~~**History: New Rule:** Filed October 17, 2003; effective November 21, 2003.~~

~~540-X-10-.03 Standards For Each Level Of Anesthesia - Preoperative Assessment.~~

~~A medical history, a physical examination consistent with the type and level of anesthesia and/or analgesia and the level of surgery to be performed, and the appropriate laboratory studies should be performed by a practitioner qualified to assess the impact of co-existing disease processes on surgery and anesthesia. A pre-anesthetic examination and evaluation should be conducted immediately prior to surgery by the physician or by a qualified person who will be administering or directing the anesthesia. If a qualified person will be administering the anesthesia, the physician shall review with the qualified person the~~

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[5] ~~Reference: Appendix A - American Society of Anesthesiologists (ASA) definitions.~~

~~pre-anesthesic examination and evaluation. The data obtained during the course of the pre-anesthesia evaluations (focused~~

history and physical, including airway assessment and significant historical data not usually found in a primary care or surgical history[6] that may alter care or affect outcome) should be documented in the medical record.

Author: Alabama Board of Medical Examiners ad hoc Committee: Arthur F. Toole, III, M.D.; Jorge A. Alsip, M.D.; James G. Chambers, III, M.D.; Craig H. Christopher, M.D.; Alcus Ray Hudson, M.D.; Pamela D. Varner, M.D.; James E. West, M.D.; and Task Force Sub-Committee: Jeff Plagenhoef, M.D.; Eric Crum, M.D.; Dan J. Coyle, Jr., M.D.; Gary Monheit, M.D.; Robert Hurlbutt, IV, M.D.; C. Paul Perry, M.D.; W. Guinn Paulk, M.D.; Mark McIlwain, D.M.D., M.D.; Jerald Clanton, D.M.D., M.D.; Patrick J. Budny, M.D.; James W. Northington, M.D.; David Franco, M.D.; Thomas E. Moody, M.D.

Statutory Authority: Code of Ala. 1975, §34-24-53.

History: New Rule: Filed October 17, 2003; effective November 21, 2003.

540-X-10-.04 Standards For Office-Based Procedures - Local Anesthesia.

(1) Equipment and supplies: Oral airway positive pressure ventilation device, epinephrine, and atropine should be available.

(2) Training required: The physician is expected to be knowledgeable in proper drug dosages, recognition and management of toxicity or hypersensitivity to local anesthetic and other drugs. It is recommended that the physician be currently trained in Basic Cardiac Life Support (BCLS).

(3) Assistance of other personnel: No other assistance is required, unless dictated by the scope of the surgical procedure.

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[6] **Reference: Appendix B -- Standards of the American Society of Anesthesiologists. This Appendix is included in these Rules only for information.**

Author: Alabama Board of Medical Examiners ad hoc Committee: Arthur F. Toole, III, M.D.; Jorge A. Alsip, M.D.; James G. Chambers, III, M.D.; Craig H. Christopher, M.D.; Alcus Ray Hudson, M.D.; Pamela D. Varner, M.D.; James E. West, M.D.; and Task Force Sub-Committee: Jeff Plagenhoef, M.D.; Eric Crum, 6 Reference: Appendix B -- Standards of the American Society of Anesthesiologists. This Appendix is included in these Rules only for information. M.D.; Dan J. Coyle, Jr., M.D.; Gary Monheit, M.D.; Robert Hurlbutt, IV, M.D.; C. Paul Perry, M.D.; W. Guinn

Paulk, M.D.; Mark McIlwain, D.M.D., M.D.; Jerald Clanton, D.M.D., M.D.; Patrick J. Budny, M.D.; James W. Northington, M.D.; David Franco, M.D.; Thomas E. Moody, M.D.
Statutory Authority: Code of Ala. 1975, §34-24-53.
History: **New Rule**: Filed October 17, 2003; effective November 21, 2003.

540-X-10-.05 Standards For Office-Based Procedures -- Minimal Sedation.

(1) Equipment and supplies: Oral airway positive pressure ventilation device, epinephrine, and atropine should be available.

(2) Training required: The physician is expected to be knowledgeable in proper drug dosages, recognition and management of toxicity or hypersensitivity to local anesthetic and other drugs. It is recommended that the physician be currently trained in Basic Cardiac Life Support (BCLS).

(3) Assistance of other personnel: Anesthesia should be administered only by licensed, qualified and competent practitioners who have training and experience appropriate to the level of anesthesia administered and function in accordance with their scope of practice. Practitioners must have documented competence and training to administer local anesthesia with sedation and to assist in any support or resuscitation measures as required. Scrub or Circulating nurse(s) and/or assistant(s) must be trained in their specific job skills as determined by the supervising physician.
Author: Alabama Board of Medical Examiners ad hoc Committee: Arthur F. Toole, III, M.D.; Jorge A. Alsip, M.D.; James G. Chambers, III, M.D.; Craig H. Christopher, M.D.; Alcus Ray Hudson, M.D.; Pamela D. Varner, M.D.; James E. West, M.D.; and Task Force Sub-Committee: Jeff Plagenhoef, M.D.; Eric Crum, M.D.; Dan J. Coyle, Jr., M.D.; Gary Monheit, M.D.; Robert Hurlbutt, IV, M.D.; C. Paul Perry, M.D.; W. Guinn Paulk, M.D.; Mark McIlwain, D.M.D., M.D.; Jerald Clanton, D.M.D., M.D.; Patrick J. Budny, M.D.; James W. Northington, M.D.; David Franco, M.D.; Thomas E. Moody, M.D.
Statutory Authority: Code of Ala. 1975, §34-24-53.
History: New Rule: Filed October 17, 2003; effective November 21, 2003.

~~540-X-10-.06~~ ~~Standards For Office-Based Procedures - Moderate Sedation/Analgesia.~~

~~(1) Physician Registration Requirement: The Alabama Board of Medical Examiners requires each physician who offers office-based surgery that requires moderate sedation, deep sedation or general anesthesia, as defined in these rules to register with the State Board of Medical Examiners as an office-based surgery physician.~~[7]

~~(2) Equipment and supplies: Emergency resuscitation equipment, emergency life-saving medications, suction, and a reliable source of oxygen with a backup tank must be readily available. When medication for sedation and/or analgesia is administered intravenously (IV), monitoring equipment should include: blood pressure apparatus, stethoscope, pulse oximetry, continuous EKG, and temperature monitoring for procedures lasting longer than thirty (30) minutes. Patient's vital signs, oxygen saturation, and level of consciousness should be documented prior to the procedure, during regular intervals throughout the procedure, and prior to discharge. Facility, in terms of general preparation, should have adequate equipment and supplies, provisions for proper record keeping, and the ability to recover patients after anesthesia.~~

~~(3) Training required: The physician must be able to document satisfactory completion of training such as being Board certified or being an active candidate for certification by a Board approved by the American Board of Medical Specialties or comparable formal training. Alternative credentialing for procedures outside the physician's core curriculum must be applied for through the Alabama Board of Medical Examiners and must be approved by the Board. The physician and at least one assistant must be currently trained in Advanced Cardiac Life Support (ACLS).~~

~~(4) Assistance of other personnel: Anesthesia should be administered only by licensed, qualified and competent practitioners. Practitioners must have documented competence and training to administer moderate sedation/analgesia and to assist in any support or resuscitation measures as required. The~~

~~[7] Reference: Appendix D -- Physician Registration Form~~

individual administering moderate sedation/analgesia and/or monitoring the patient cannot assist the physician in performing the surgical procedure. Scrub or Circulating nurse(s) and/or assistant(s) must be trained in their specific job skills as determined by the supervising physician. At least one physician currently trained in ACLS must be immediately and physically available until the last patient is past the first stage of recovery. At least one practitioner currently trained in ACLS must be immediately and physically available until the last patient is discharged from the facility.

Author: Alabama Board of Medical Examiners ad hoc Committee: Arthur F. Toole, III, M.D.; Jorge A. Alsip, M.D.; James G. Chambers, III, M.D.; Craig H. Christopher, M.D.; Aleus Ray Hudson, M.D.; Pamela D. Varner, M.D.; James E. West, M.D.; and Task Force Sub-Committee: Jeff Plagenhoef, M.D.; Eric Crum, M.D.; Dan J. Coyle, Jr., M.D.; Gary Monheit, M.D.; Robert Hurlbutt, IV, M.D.; C. Paul Perry, M.D.; W. Guinn Paulk, M.D.; Mark McIlwain, D.M.D., M.D.; Jerald Clanton, D.M.D., M.D.; Patrick J. Budny, M.D.; James W. Northington, M.D.; David Franco, M.D.; Thomas E. Moody, M.D.

Statutory Authority: Code of Ala. 1975, §34-24-53.

History: New Rule: Filed October 17, 2003; effective November 21, 2003.

540-X-10-.07 Standards For Office-Based Procedures -- Deep Sedation/Analgesia.

(1) Physician Registration Requirement: The Alabama Board of Medical Examiners requires each physician who offers office-based surgery that requires moderate sedation, deep sedation or general anesthesia, as defined in these rules to register with the State Board of Medical Examiners as an office-based surgery physician.[8]

(2) Equipment and supplies: Emergency resuscitation equipment, emergency life-saving medications, suction, and a reliable source of oxygen with a backup tank must be readily available. Monitoring equipment should include: blood pressure apparatus, stethoscope, pulse oximetry, continuous EKG, and temperature monitoring for procedures lasting longer than thirty (30) minutes. Patient's vital signs, oxygen saturation, and level of consciousness should be documented prior to the

[8] Reference: Appendix D -- Physician Registration Form

~~procedure, during regular intervals throughout the procedure, and prior to discharge. Facility, in terms of general preparation, should have adequate equipment and supplies, provisions for proper record keeping, and the ability to recover patients after anesthesia.~~

~~(3) Training required: The physician must be able to document satisfactory completion of training such as being Board certified or being an active candidate for certification by a Board approved by the American Board of Medical Specialties or comparable formal training. Alternative credentialing for procedures outside the physician's core curriculum must be applied for through the Alabama Board of Medical Examiners and must be approved by the Board. The physician and at least one assistant must be currently trained in Advanced Cardiac Life Support (ACLS).~~

~~(4) Assistance of other personnel: Anesthesia should be administered only by licensed, qualified and competent practitioners. Practitioners must have documented competence and training to administer deep sedation/analgesia and to assist in any support or resuscitation measures as required. The individual administering deep sedation/analgesia and/or monitoring the patient cannot assist the physician in performing the surgical procedure. Scrub or Circulating nurse(s) and/or assistant(s) must be trained in their specific job skills as determined by the supervising physician. At least one physician currently trained in ACLS must be immediately and physically available until the last patient is past the first stage of recovery. At least one practitioner currently trained in ACLS must be immediately and physically available until the last patient is discharged from the facility.~~

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~~**Statutory Authority:** Code of Ala. 1975, §34-24-53.~~

~~**History: New Rule:** Filed October 17, 2003; effective November 21, 2003.~~

540-X-10-.08 Standards For Office-Based Procedures -- General And Regional Anesthesia.

(1) Physician Registration Requirement: The Alabama Board of Medical Examiners requires each physician who offers office-based surgery that requires moderate sedation, deep sedation or general anesthesia, as defined in these rules to register with the State Board of Medical Examiners as an office-based surgery physician.[9]

(2) Equipment and supplies: Emergency resuscitation equipment, suction and a reliable source of oxygen with a backup tank must be readily available. When triggering agents are in the office, at least 12 ampules of dantrolene sodium must be readily available within 10 minutes with additional ampules available from another source. Monitoring equipment should include: blood pressure apparatus, stethoscope, pulse oximetry, continuous EKG, capnography, and temperature monitoring for procedures lasting longer than thirty (30) minutes. Monitoring equipment and supplies should be in compliance with currently adopted ASA standards[10]. Facility, in terms of general preparation, must have adequate equipment and supplies, provisions for proper record keeping, and the ability to recover patients after anesthesia.

(3) Training required: The physician must be able to document satisfactory completion of training such as being Board certified or being an active candidate for certification by a Board approved by the American Board of Medical Specialties or comparable formal training. Alternative credentialing for procedures outside the physician's core curriculum must be applied for through the Alabama Board of Medical Examiners and must be approved by the Board. The physician and at least one assistant must be currently trained in Advanced Cardiac Life Support (ACLS).

(4) Assistance of other personnel: Anesthesia should be administered only by licensed, qualified and competent practitioners. Practitioners must have documented competence and training to administer general and regional anesthesia and

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[9] Reference: Appendix D -- Physician Registration Form

[10] Reference: Appendix C -- Guidelines for Office-Based Anesthesia, section entitled "Monitoring and Equipment." This Appendix is included in these Rules only for information.

~~to assist in any support or resuscitation measures as required. The individual administering general and regional anesthesia and/or monitoring the patient cannot assist the physician in performing the surgical procedure. Scrub or Circulating nurse(s) and/or assistant(s) must be trained in their specific job skills as determined by the supervising physician. Direction of the sedation/analgesia component of the medical procedure should be provided by a physician who is immediately and physically present, who is licensed to practice medicine in the state of Alabama, and who is responsible for the direction of administration of the anesthetic. The physician providing direction should assure that an appropriate pre-anesthetic examination is performed, assure that qualified practitioners participate, be available for diagnosis treatment and management of anesthesia related complications or emergencies, and assure the provision of indicated post anesthesia care. At least one physician currently trained in ACLS must be immediately and physically available until the last patient is past the first stage of recovery. At least one practitioner currently trained in ACLS must be immediately and physically available until the last patient is discharged from the facility[11].~~

~~**Author:** Alabama Board of Medical Examiners ad hoc Committee: Arthur F. Toole, III, M.D.; Jorge A. Alsip, M.D.; James G. Chambers, III, M.D.; Craig H. Christopher, M.D.; Alcus Ray Hudson, M.D.; Pamela D. Varner, M.D.; James E. West, M.D.; and Task Force Sub-Committee: Jeff Plagenhoef, M.D.; Eric Crum, M.D.; Dan J. Coyle, Jr., M.D.; Gary Monheit, M.D.; Robert Hurlbutt, IV, M.D.; C. Paul Perry, M.D.; W. Guinn Paulk, M.D.; Mark McIlwain, D.M.D., M.D.; Jerald Clanton, D.M.D., M.D.; Patrick J. Budny, M.D.; James W. Northington, M.D.; David Franco, M.D.; Thomas E. Moody, M.D.~~

~~**Statutory Authority:** Code of Ala. 1975, §34-24-53.~~

~~**History: New Rule:** Filed October 17, 2003; effective November 21, 2003.~~

~~540-X-10-.09 Recovery Area And Assessment For Discharge With Moderate And Deep Sedation/General Anesthesia - Monitoring Requirement.~~

~~Monitoring in the recovery area should be performed by a **dedicated** person, trained in their specific job skills as determined by the supervising physician, and must include pulse oximetry and non-invasive blood pressure~~

~~11 Reference: Appendix D - Physician Registration Form and Appendix E - ASF Sterilization (Appendix E is included in these Rules only for information).~~

~~measurement. The patient must be assessed periodically for level of consciousness, pain relief, or any untoward complication. Each patient should meet discharge criteria as established by the practice, prior to leaving the facility. Documented recovery from anesthesia should include the following: 1) vital signs and oxygen saturation stable within acceptable limits; 2) no more than minimal nausea, vomiting or dizziness; and 3) sufficient time (up to 2 hours) should have elapsed following the last administration of reversal agents to ensure the patient does not become sedated after reversal effects have worn off. The patient should be given appropriate discharge instructions and discharge under the care of a responsible third party after meeting discharge criteria. Discharge instructions should include: 1) the procedure performed; 2) information about potential complications; 3) telephone numbers to be used by the patient to discuss complications or questions that may arise; 4) instructions for medications prescribed and pain management; 5) information regarding the follow-up visit date, time and location; and 6) designated treatment facility in the event of an emergency (office based physician's number, not the emergency room).~~

~~**Author:** Alabama Board of Medical Examiners ad hoc Committee: Arthur F. Toole, III, M.D.; Jorge A. Alsip, M.D.; James G. Chambers, III, M.D.; Craig H. Christopher, M.D.; Aleus Ray Hudson, M.D.; Pamela D. Varner, M.D.; James E. West, M.D.; and Task Force Sub-Committee: Jeff Plagenhoef, M.D.; Eric Crum, M.D.; Dan J. Coyle, Jr., M.D.; Gary Monheit, M.D.; Robert Hurlbutt, IV, M.D.; C. Paul Perry, M.D.; W. Guinn Paulk, M.D.; Mark McIlwain, D.M.D., M.D.; Jerald Clanton, D.M.D., M.D.; Patrick J. Budny, M.D.; James W. Northington, M.D.; David Franco, M.D.; Thomas E. Moody, M.D.~~

~~**Statutory Authority:** Code of Ala. 1975, §34-24-53.~~

~~**History: New Rule:** Filed October 17, 2003; effective November 21, 2003.~~

~~540-X-10-.10 Tumescent Liposuction And Similarly Related Procedures.~~

~~(1) In the performance of liposuction when infiltration methods such as the tumescent technique are used, they should be regarded as regional or systemic anesthesia because of the potential for systemic toxic effects.~~

(2) When infiltration methods such as the tumescent technique are used in the performance of liposuction, the Standards for Office Based Procedures -- General and Regional Anesthesia stated in Rule 540-X-10-.08 shall be met, including the physician registration requirement, the equipment and supplies requirement, the training requirement and the assistance of other personnel requirement.

(3) When infiltration methods such as the tumescent technique are used in the performance of liposuction, the monitoring requirement found in Rule 540-X-10-.09, Recovery Area and Assessment for Discharge with Moderate and Deep Sedation/General Anesthesia -- Monitoring Requirement, must be met.
Author: Alabama Board of Medical Examiners
Statutory Authority: Code of Ala. 1975, §34-24-53.
History: New Rule: Filed September 22, 2011; effective October 27, 2011.

540-X-10-.11 Reporting Requirement.

(1) Reporting to the Alabama Board of Medical Examiners is required within three (3) business days of the occurrence and will include all surgical related deaths and all events related to a procedure(s) that resulted in an emergency transfer of the surgical patient to the hospital, anesthetic or surgical events requiring CPR, unscheduled hospitalization related to the surgery, and surgical site deep wound infection.

(2) Office Administration. The following summarizes some of the important written documents and polices and procedures that office-based practices are encouraged to develop and implement. The policies and procedures should undergo periodic review and updating. Office-based surgery practices are encouraged to utilize on-site patient safety surveys that are performed by professional trade associations, nationally recognized accrediting agencies and/or other organizations experienced in providing emerging risk-reduction strategies associated with office-based surgery.

(a) Policies and Procedures. Written policies and procedures can assist office-based practices in providing safe and quality surgical care, assure consistent personnel performance, and promote an awareness and understanding of the inherent rights of patients. The following are important aspects of an office-based practice that should benefit from simple policy and procedure statements.

1. Emergency Care and Transfer Plan: A plan shall be developed for the provision of emergency medical care as

~~well as the safe and timely transfer of patients to a nearby hospital should hospitalization be necessary.~~

~~(i) Age appropriate emergency supplies, equipment and medication should be provided in accordance with the scope of surgical and anesthesia services provided at the practitioner's office.~~

~~(ii) In an office where anesthesia services are provided to infants and children, the required emergency equipment should be appropriately sized for a pediatric population, and personnel should be appropriately trained to handle pediatric emergencies (currently trained in APLS or PALS).~~

~~(iii) At least one physician currently trained in ACLS must be immediately and physically available until the last patient is past the first stage of recovery. A practitioner who is qualified in resuscitation techniques and emergency care should be present and available until all patients having more than local anesthesia or minor conductive block anesthesia have been discharged from the office (Advanced adult or pediatric life support certified).~~

~~(iv) In the event of untoward anesthetic, medical or surgical emergencies, personnel should be familiar with the procedures and plan to be followed, and able to take the necessary actions. All office personnel should be familiar with a documented plan for the timely and safe transfer of patients to a nearby hospital. This plan should include arrangements for emergency medical services, if necessary, or when appropriate escort of the patient to the hospital by an appropriate practitioner. If advanced cardiac life support is instituted, the plan should include immediate contact with emergency medical services.~~

~~2. Medical Record Maintenance and Security: The practice should have a procedure for initiating and maintaining a health record for every patient evaluated or treated. The record should include a procedure code or suitable narrative description of the procedure and should have sufficient information to identify the patient, support the diagnosis, justify the treatment and document the outcome and required follow-up care. For procedures requiring patient consent, there should be a documented informed written consent. If analgesia/sedation, minor or~~

~~major conduction blockade or general anesthesia are provided, the record should include documentation of the type of anesthesia used, drugs (type, time and dose) and fluids administered, the record of monitoring of vital signs, level of consciousness during the procedure, patient weight, estimated blood loss, duration of the procedure, and any complications related to the procedure or anesthesia. Procedures should also be established to assure patient confidentiality and security of all patient data and information.~~

~~3. Infection Control Policy: The practice should comply with state and federal regulations regarding infection control. For all surgical procedures, the level of sterilization should meet current OSHA requirements. There should be a procedure and schedule for cleaning, disinfecting and sterilizing equipment and patient care items. Personnel should be trained in infection control practices, implementation of universal precautions, and disposal of hazardous waste products. Protective clothing and equipment should be readily available[12].~~

~~4. Federal and State Laws and Regulations: Federal and state laws and regulations that affect the practice should be identified and procedures developed to comply with those requirements. The following are some of the key requirements upon which office-based practices should focus:~~

~~(i) Non-Discrimination (see Civil Rights statutes and the Americans with Disabilities Act).~~

~~(ii) Personal Safety (see Occupational Safety and Health Administration information)~~

~~(iii) Controlled Substance Safeguards.~~

~~(iv) Laboratory Operations and Performance (CLIA).~~

~~(v) Personnel Licensure Scope of Practice and Limitations~~

~~[12] Reference: Appendix E - American Association for Accreditation of Ambulatory Facilities, Inc., Guidelines for Sterilization. This Appendix is included in these Rules only for information.~~

~~**Author:** Alabama Board of Medical Examiners ad hoc Committee: Arthur F. Toole, III, M.D.; Jorge A. Alsip, M.D.; James G.~~

Chambers, III, M.D.; Craig H. Christopher, M.D.; Aleus Ray 12 Reference: Appendix E -- American Association for Accreditation of Ambulatory Facilities, Inc., Guidelines for Sterilization. This Appendix is included in these Rules only for information. Hudson, M.D.; Pamela D. Varner, M.D.; James E. West, M.D.; and Task Force Sub-Committee: Jeff Plagenhoef, M.D.; Eric Crum, M.D.; Dan J. Coyle, Jr., M.D.; Gary Monheit, M.D.; Robert Hurlbutt, IV, M.D.; C. Paul Perry, M.D.; W. Guinn Paulk, M.D.; Mark McIlwain, D.M.D., M.D.; Jerald Clanton, D.M.D., M.D.; Patrick J. Budny, M.D.; James W. Northington, M.D.; David Franco, M.D.; Thomas E. Moody, M.D.
Statutory Authority: Code of Ala. 1975, §34-24-53.
History: New Rule: Filed October 17, 2003; effective November 21, 2003.

540-X-10-.12 Registration Of Office-Based Surgery/Procedures Physician.

(1) Prior to performing any office-based surgery/procedures as defined in this rule, registration is required of any physician who is licensed to practice medicine in Alabama, who maintains a practice location in Alabama, and who performs or offers to perform the following:

(a) Any office-based surgery/procedure which requires moderate sedation, deep sedation or general anesthesia, as defined in these rules, or

(b) Liposuction when infiltration methods such as the tumescent technique are used, or

(c) Any procedure in which propofol is administered, given or used.

(2) Registration shall be accomplished on a form provided by the Board. After initially registering as an office-based surgery/procedures physician, it shall be the obligation of the registrant to advise the Board of any change in the practice location within the State of Alabama of that office-based surgery/procedures physician.

(3) The form for registration of an office-based surgery/procedures physician is incorporated as Appendix D to these rules.

(4) For the purposes of these rules an "office-based surgery/procedures physician" shall mean any physician licensed to practice medicine in Alabama who performs or offers to perform in an office setting within the state of Alabama, any procedure that

~~requires moderate sedation, deep sedation or general anesthesia, as defined in these rules, or who performs or offers to perform liposuction when infiltration methods such as the tumescent technique are used, or who performs or offers to perform any procedure in which propofol is administered, given, or used.~~

~~(5) In January 2012, the Board of Medical Examiners shall cause a notice to be mailed to every physician who is licensed in the State of Alabama notifying them of the requirements contained in this Chapter.~~

~~(6) Beginning January 2012, annual registration as an office-based surgery/procedures physician shall be required, and registration shall be by electronic means.~~

~~(7) Annual registration as an office-based surgery/procedures physician shall be due by January 31 of each year.~~
~~**Author:** Alabama Board of Medical Examiners ad hoc Committee: Arthur F. Toole, III, M.D.; Jorge A. Alsip, M.D.; James G. Chambers, III, M.D.; Craig H. Christopher, M.D.; Aleus Ray Hudson, M.D.; Pamela D. Varner, M.D.; James E. West, M.D.; and Task Force Sub-Committee: Jeff Plagenhoef, M.D.; Eric Crum, M.D.; Dan J. Coyle, Jr., M.D.; Gary Monheit, M.D.; Robert Hurlbutt, IV, M.D.; C. Paul Perry, M.D.; W. Guinn Paulk, M.D.; Mark McIlwain, D.M.D., M.D.; Jerald Clanton, D.M.D., M.D.; Patrick J. Budny, M.D.; James W. Northington, M.D.; David Franco, M.D.; Thomas E. Moody, M.D.~~
~~**Statutory Authority:** Code of Ala. 1975, §34-24-53.~~
~~**History: New Rule:** Filed October 17, 2003; effective November 21, 2003. **Amended (Rule and Appendix D):** Filed September 22, 2011; effective October 27, 2011. **Amended (Rule and Appendix D):** Filed August 15, 2018; effective September 29, 2018. **Amended:** Published February 26, 2021; effective April 12, 2021.~~

~~540-X-10-.13 Penalty.~~

~~(1) A physician may be guilty of unprofessional conduct within the meaning of Code of Ala. 1975, §34-24-360(2) if he fails to comply with the requirements of these rules concerning any of the following:~~

~~(a) Standards for office based procedures for moderate sedation/analgesia or general/regional anesthesia;~~

~~(b) Reporting;~~

~~(c) Emergency care and transfer;~~

~~(d) Registration.~~

~~(2) A physician who has been found to be not in compliance with the requirements of this Chapter 540-X-10 may have his license revoked, suspended or otherwise disciplined by the Medical Licensure Commission.~~

~~**Author:** Alabama Board of Medical Examiners ad hoc Committee: Arthur F. Toole, III, M.D.; Jorge A. Alsip, M.D.; James G. Chambers, III, M.D.; Craig H. Christopher, M.D.; Alcus Ray Hudson, M.D.; Pamela D. Varner, M.D.; James E. West, M.D.; and Task Force Sub-Committee: Jeff Plagenhoef, M.D.; Eric Crum, M.D.; Dan J. Coyle, Jr., M.D.; Gary Monheit, M.D.; Robert Hurlbutt, IV, M.D.; C. Paul Perry, M.D.; W. Guinn Paulk, M.D.; Mark McIlwain, D.M.D., M.D.; Jerald Clanton, D.M.D., M.D.; Patrick J. Budny, M.D.; James W. Northington, M.D.; David Franco, M.D.; Thomas E. Moody, M.D.~~

~~**Statutory Authority:** Code of Ala. 1975, §34-24-53.~~

~~**History: New Rule:** Filed October 17, 2003; effective November 21, 2003.~~

~~540-X-10-AA~~ ~~Appendix A Continuum Of Depth of Sedation.~~

~~STATE BOARD OF MEDICAL EXAMINERS~~
~~CHAPTER 540-X-10~~

~~APPENDIX A~~

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CONTINUUM OF DEPTH OF SEDATION: DEFINITION OF GENERAL ANESTHESIA AND LEVELS OF SEDATION/ANALGESIA*

Committee of Origin: Quality Management and Departmental Administration

(Approved by the ASA House of Delegates on October 13, 1999, and last amended on October 15, 2014)

	Minimal Sedation Anxiolysis	*Moderate Sedation/ Analgesia ("Conscious Sedation")*	*Deep Sedation/ Analgesia*	*General Anesthesia*
Responsiveness	Normal response to verbal stimulation	Purposeful** response to verbal or tactile stimulation	Purposeful** response following repeated or painful stimulation	Unarousable even with painful stimulus
Airway	Unaffected	No intervention required	Intervention may be required	Intervention often required
Spontaneous Ventilation	Unaffected	Adequate	May be inadequate	Frequently inadequate
Cardiovascular Function	Unaffected	Usually maintained	Usually maintained	May be impaired

Minimal Sedation (Anxiolysis) is a drug-induced state during which patients respond normally to verbal commands. Although cognitive function and physical coordination may be impaired, airway reflexes, and ventilatory and cardiovascular functions are unaffected.

Moderate Sedation/Analgesia ("Conscious Sedation") is a drug-induced depression of consciousness during which patients respond purposefully** to verbal commands, either alone or accompanied by light tactile stimulation. No interventions are required to maintain a patent airway, and spontaneous ventilation is adequate. Cardiovascular function is usually maintained.

* Monitored Anesthesia Care ("MAC") does not describe the continuum of depth of sedation, rather it describes "a specific anesthesia service in which an anesthesiologist has been requested to participate in the care of a patient undergoing a diagnostic or therapeutic procedure."

** Reflex withdrawal from a painful stimulus is NOT considered a purposeful response.

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Deep Sedation/Analgesia is a drug-induced depression of consciousness during which patients cannot be easily aroused but respond purposefully** following repeated or painful stimulation. The ability to independently maintain ventilatory function may be impaired. Patients may require assistance in maintaining a patent airway, and spontaneous ventilation may be inadequate. Cardiovascular function is usually maintained.

General Anesthesia is a drug-induced loss of consciousness during which patients are not arousable, even by painful stimulation. The ability to independently maintain ventilatory function is often impaired. Patients often require assistance in maintaining a patent airway, and positive pressure ventilation may be required because of depressed spontaneous ventilation or drug-induced depression of neuromuscular function. Cardiovascular function may be impaired.

Because sedation is a continuum, it is not always possible to predict how an individual patient will respond. Hence, practitioners intending to produce a given level of sedation should be able to rescue*** patients whose level of sedation becomes deeper than initially intended. Individuals administering Moderate Sedation/Analgesia ("Conscious Sedation") should be able to rescue*** patients who enter a state of Deep Sedation/Analgesia, while those administering Deep Sedation/Analgesia should be able to rescue*** patients who enter a state of General Anesthesia.

** Reflex withdrawal from a painful stimulus is NOT considered a purposeful response.

*** Rescue of a patient from a deeper level of sedation than intended is an intervention by a practitioner proficient in airway management and advanced life support. The qualified practitioner corrects adverse physiologic consequences of the deeper-than-intended level of sedation (such as hypoventilation, hypoxia and hypotension) and returns the patient to the originally intended level of sedation. It is not appropriate to continue the procedure at an unintended level of sedation.

~~Author:~~

~~Statutory Authority:~~
~~History:~~

~~540-X-10-AB~~ ~~Appendix B Standards Of The American Society Of Anesthesiologists.~~

~~STATE BOARD OF MEDICAL EXAMINERS~~
~~CHAPTER 540-X-10~~

~~APPENDIX B~~

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BASIC STANDARDS FOR PREANESTHESIA CARE

Committee of Origin: Standards and Practice Parameters

(Approved by the ASA House of Delegates on October 14, 1987, and last affirmed on October 28, 2015)

These standards apply to all patients who receive anesthesia care. Under exceptional circumstances, these standards may be modified. When this is the case, the circumstances shall be documented in the patient's record.

An anesthesiologist shall be responsible for determining the medical status of the patient and developing a plan of anesthesia care.

The anesthesiologist, before the delivery of anesthesia care, is responsible for:

1. Reviewing the available medical record.
2. Interviewing and performing a focused examination of the patient to:
   - 2.1 Discuss the medical history, including previous anesthetic experiences and medical therapy.
   - 2.2 Assess those aspects of the patient's physical condition that might affect decisions regarding perioperative risk and management.
3. Ordering and reviewing pertinent available tests and consultations as necessary for the delivery of anesthesia care.
4. Ordering appropriate preoperative medications.
5. Ensuring that consent has been obtained for the anesthesia care.
6. Documenting in the chart that the above has been performed.

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STATEMENT ON DOCUMENTATION OF ANESTHESIA CARE

Committee of Origin: Committee on Quality Management and Departmental Administration (QMDA)

(Approved by the ASA House of Delegates on October 15, 2003 and last amended on October 28, 2015)

Accurate and thorough documentation is an essential element of high quality and safe medical care, and accordingly a basic responsibility of physician anesthesiologists. Anesthesia care is a continuum including three general phases of care: preanesthesia, intraoperative/intraprocedural anesthesia and postanesthesia care. To contribute to accuracy in medical records and to facilitate any future necessary chart review, anesthesiologists should ensure that accurate and thorough documentation is accomplished in all three phases of anesthesia related care. Information that is relevant to the perioperative care of a patient that exists elsewhere in the medical record need not be duplicated in the preanesthesia evaluation, the anesthesia record or postanesthesia evaluation. Departments and practices should develop local policies that address how information may be provided when documenting patient evaluations. These policies may include how information should be referenced and incorporated in an evaluation without requiring duplication of information from elsewhere in the medical record.

Depending upon several local factors, documentation may be provided on a paper record or within an electronic record. Anesthesiologists may delegate to appropriately trained and credentialed anesthesia care team members any portion of the periprocedural record keeping, but they should play an active role to ensure that accurate and thorough medical record keeping is accomplished. Documentation should meet all applicable regulatory, legal and billing compliance requirements.

In specific circumstances (e.g. emergencies, rapidly developing critical events, time sensitive sequential clinical care activities) an anesthesiologist or anesthesia care team member may be in conflict between a primary obligation to ensure patient safety and best clinical care, and contemporaneous medical record documentation. In these circumstances, attention to clinical care requirements remains the primary obligation. Medical record documentation should be provided as soon as appropriate in view of competing, primary clinical care requirements. The record should include documentation of:

I. Preanesthesia Evaluation*

A. Patient interview to assess:
1. Patient and procedure identification
2. Anticipated disposition
3. Medical history – includes patient's ability to give informed consent
4. Surgical History (PSHx)
5. Anesthetic history
6. Current Medication List (preadmission and postadmission)

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7. Allergies/Adverse Drug Reaction (including reaction type)
8. NPO status
9. Documenting the presence of and the perioperative plan for existing advance directives.

B. Appropriate physical examination, including vital signs, height and weight and documentation of airway assessment and cardiopulmonary exam.

C. Review of objective diagnostic data (e.g., laboratory, ECG, X-ray) and medical records.

D. Medical consultations when applicable.

E. Assignment of ASA physical status, including emergent status when applicable.

F. The anesthetic plan – including plans for post-anesthesia care and pain management.

G. Documentation of informed consent (to include risks, benefits and alternatives) of the anesthetic plan and postoperative pain management plan.

H. Appropriate premedication and prophylactic antibiotic administrations (if indicated).

II. Intraoperative/procedural anesthesia (time-based record of events)

A. Immediately prior to the start of anesthesia care and anesthesia procedures:
1. Patient re-evaluation
2. Confirmation of availability of and appropriate function of all necessary equipment, medications and staff.

B. Physiologic monitoring data** (e.g., recording of results from routine and nonroutine monitoring devices).

C. Medications administered: dose, time, route, response (where appropriate).

D. Intravenous fluids: type, volume and time.

E. Technique(s) used.

F. Patient positioning and actions to reduce the chance of adverse patient effects/complications related to positioning.

G. Additional Procedures performed: vessel location, catheter type/size, specific insertion technique (e.g., sterile technique, use of ultrasound), actions to reduce the chance of related complications (ex., catheter based infection prevention measures), stabilization technique and dressing.

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H. Unusual or noteworthy events during surgery and anesthesia care.

I. Patient status at transfer of care to staff in a Postanesthesia Care Unit (PACU) or an area which provides equivalent postanesthesia care (e.g., ICU, SDS or floor nurse).

III. Postanesthesia (time-based record of events)

A. Patient status at transfer of care to staff in a Postanesthesia Care Unit (PACU) or an area which provides equivalent postanesthesia care (e.g. ICU, SDS or floor nurse).

B. If the PACU is bypassed, criteria demonstrating that patient status at transfer of care are appropriate.

C. It is not the responsibility of the anesthesiologist to document the patient's condition throughout the PACU stay or when leaving the PACU.

D. Significant or unexpected post-procedural events/complications.

E. Postanesthesia evaluation documenting physiologic condition and presence/absence of anesthesia related complications or complaints.

* See Basic Standards for Preanesthesia Care

** See Standards for Basic Anesthetic Monitoring

~~Author:~~

~~Statutory Authority:~~
~~History:~~

~~540-X-10-AC~~ ~~Appendix C Guidelines For Office-Based Anesthesia.~~

~~STATE BOARD OF MEDICAL EXAMINERS~~

~~CHAPTER 540-X-10~~

~~APPENDIX C~~

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American Society of Anesthesiologists®

GUIDELINES FOR OFFICE-BASED ANESTHESIA

Committee of Origin: Ambulatory Surgical Care

(Approved by the ASA House of Delegates on October 13, 1999; last amended on October 21, 2009; and reaffirmed on October 15, 2014)

These guidelines are intended to assist ASA members who are considering the practice of ambulatory anesthesia in the office setting: office-based anesthesia (OBA). These recommendations focus on quality anesthesia care and patient safety in the office. These are minimal guidelines and may be exceeded at any time based on the judgment of the involved anesthesia personnel. Compliance with these guidelines cannot guarantee any specific outcome. These guidelines are subject to periodic revision as warranted by the evolution of federal, state and local laws as well as technology and practice.

ASA recognizes the unique needs of this growing practice and the increased requests for ASA members to provide OBA for health care practitioners* who have developed their own office operatories. Since OBA is a subset of ambulatory anesthesia, the ASA "Guidelines for Ambulatory Anesthesia and Surgery" should be followed in the office setting as well as all other ASA standards and guidelines that are applicable.

There are special problems that ASA members must recognize when administering anesthesia in the office setting. Compared with acute care hospitals and licensed ambulatory surgical facilities, office operatories currently have little or no regulation, oversight or control by federal, state or local laws. Therefore, ASA members must satisfactorily investigate areas taken for granted in the hospital or ambulatory surgical facility such as governance, organization, construction and equipment, as well as policies and procedures, including fire, safety, drugs, emergencies, staffing, training and unanticipated patient transfers.

ASA members should be confident that the following issues are addressed in an office setting to provide patient safety and to reduce risk and liability to the anesthesiologist.

Administration and Facility

Quality of Care

- The facility should have a medical director or governing body that establishes policy and is responsible for the activities of the facility and its staff. The medical director or governing body is responsible for ensuring that facilities and personnel are adequate and appropriate for the type of procedures performed.
- Policies and procedures should be written for the orderly conduct of the facility and reviewed on an annual basis.
- The medical director or governing body should ensure that all applicable local, state and federal regulations are observed.

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- All health care practitioners* and nurses should hold a valid license or certificate to perform their assigned duties.
- All operating room personnel who provide clinical care in the office should be qualified to perform services commensurate with appropriate levels of education, training and experience.
- The anesthesiologist should participate in ongoing continuous quality improvement and risk management activities.
- The medical director or governing body should recognize the basic human rights of its patients, and a written document that describes this policy should be available for patients to review.

Facility and Safety

- Facilities should comply with all applicable federal, state and local laws, codes and regulations pertaining to fire prevention, building construction and occupancy, accommodations for the disabled, occupational safety and health, and disposal of medical waste and hazardous waste.
- Policies and procedures should comply with laws and regulations pertaining to controlled drug supply, storage and administration.

Clinical Care

Patient and Procedure Selection

- The anesthesiologist should be satisfied that the procedure to be undertaken is within the scope of practice of the health care practitioners and the capabilities of the facility.
- The procedure should be of a duration and degree of complexity that will permit the patient to recover and be discharged from the facility.
- Patients who by reason of pre-existing medical or other conditions may be at undue risk for complications should be referred to an appropriate facility for performance of the procedure and the administration of anesthesia.

Perioperative Care

- The anesthesiologist should adhere to the "Basic Standards for Preanesthesia Care," "Standards for Basic Anesthetic Monitoring," "Standards for Postanesthesia Care" and "Guidelines for Ambulatory Anesthesia and Surgery" as currently promulgated by the American Society of Anesthesiologists.
- The anesthesiologist should be physically present during the intraoperative period and immediately available until the patient has been discharged from anesthesia care.
- Discharge of the patient is a physician responsibility. This decision should be documented in the medical record.
- Personnel with training in advanced resuscitative techniques (e.g., ACLS, PALS) should be immediately available until all patients are discharged home.

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Monitoring and Equipment

- At a minimum, all facilities should have a reliable source of oxygen, suction, resuscitation equipment and emergency drugs. Specific reference is made to the ASA "Statement on Nonoperating Room Anesthetizing Locations."
- There should be sufficient space to accommodate all necessary equipment and personnel and to allow for expeditious access to the patient, anesthesia machine (when present) and all monitoring equipment.
- All equipment should be maintained, tested and inspected according to the manufacturer's specifications.
- Back-up power sufficient to ensure patient protection in the event of an emergency should be available.
- In any location in which anesthesia is administered, there should be appropriate anesthesia apparatus and equipment which allow monitoring consistent with ASA "Standards for Basic Anesthetic Monitoring" and documentation of regular preventive maintenance as recommended by the manufacturer.
- In an office where anesthesia services are to be provided to infants and children, the required equipment, medication and resuscitative capabilities should be appropriately sized for a pediatric population.

Emergencies and Transfers

- All facility personnel should be appropriately trained in and regularly review the facility's written emergency protocols.
- There should be written protocols for cardiopulmonary emergencies and other internal and external disasters such as fire.
- The facility should have medications, equipment and written protocols available to treat malignant hyperthermia when triggering agents are used.
- The facility should have a written protocol in place for the safe and timely transfer of patients to a prespecified alternate care facility when extended or emergency services are needed to protect the health or well-being of the patient.

*defined herein as physicians, dentists and podiatrists

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STATEMENT ON NONOPERATING ROOM ANESTHETIZING LOCATIONS

Committee of Origin: Standards and Practice Parameters

(Approved by the ASA House of Delegates on October 19, 1994, and last amended on October 16, 2013)

These guidelines apply to all anesthesia care involving anesthesiology personnel for procedures intended to be per-formed in locations outside an operating room. These are minimal guidelines which may be exceeded at any time based on the judgment of the involved anesthesia personnel. These guidelines encourage quality patient care but observing them cannot guarantee any specific patient outcome. These guidelines are subject to revision from time to time, as warranted by the evolution of technology and practice. ASA Standards, Guidelines and Policies should be adhered to in all nonoperating room settings except where they are not applicable to the individual patient or care setting.

1. There should be in each location a reliable source of oxygen adequate for the length of the procedure. There should also be a backup supply. Prior to administering any anesthetic, the anesthesiologist should consider the capabilities, limitations and accessibility of both the primary and backup oxygen sources. Oxygen piped from a central source, meeting applicable codes, is strongly encouraged. The backup system should include the equivalent of at least a full E cylinder.
2. There should be in each location an adequate and reliable source of suction. Suction apparatus that meets operating room standards is strongly encouraged.
3. In any location in which inhalation anesthetics are administered, there should be an adequate and reliable system for scavenging waste anesthetic gases.
4. There should be in each location: (a) a self-inflating hand resuscitator bag capable of administering at least 90 percent oxygen as a means to deliver positive pressure ventilation; (b) adequate anesthesia drugs, supplies and equipment for the intended anesthesia care; and (c) adequate monitoring equipment to allow adherence to the "Standards for Basic Anesthetic Monitoring." In any location in which inhalation anesthesia is to be administered, there should be an anesthesia machine equivalent in function to that employed in operating rooms and maintained to current operating room standards.
5. There should be in each location, sufficient electrical outlets to satisfy anesthesia machine and monitoring equipment requirements, including clearly labeled outlets connected to an emergency power supply. In any anesthetizing location determined by the health care facility to be a "wet location" (e.g., for cystoscopy or arthroscopy or a birthing room in labor and delivery), either isolated electric power or electric circuits with ground fault circuit interrupters should be provided.*
6. There should be in each location, provision for adequate illumination of the patient, anesthesia machine (when present) and monitoring equipment. In addition, a form of battery-powered illumination other than a laryngoscope should be immediately available.
7. There should be in each location, sufficient space to accommodate necessary equipment and personnel and to allow expeditious access to the patient, anesthesia machine (when present) and monitoring equipment.

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8. There should be immediately available in each location, an emergency cart with a defibrillator, emergency drugs and other equipment adequate to provide cardiopulmonary resuscitation
9. There should be in each location adequate staff trained to support the anesthesiologist. There should be immediately available in each location, a reliable means of two-way communication to request assistance.
10. For each location, all applicable building and safety codes and facility standards, where they exist, should be observed
11. Appropriate postanesthesia management should be provided (see Standards for Postanesthesia Care). In addition to the anesthesiologist, adequate numbers of trained staff and appropriate equipment should be available to safely transport the patient to a postanesthsia care unit.

*See National Fire Protection Association. Health Care Facilities Code 99; Quincy, MA: NFPA, 2012.

~~Author:~~
~~Statutory Authority:~~
~~History:~~

~~540-X-10-AD~~ ~~Appendix D Physician Registration Form.~~

~~STATE BOARD OF MEDICAL EXAMINERS~~
~~CHAPTER 540-X-10~~

~~APPENDIX D~~

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ALABAMA BOARD OF MEDICAL EXAMINERS
P. O. Box 946 – Montgomery, Alabama 36101
848 Washington Avenue - 36104

OFFICE-BASED SURGERY / PROCEDURES PHYSICIAN REGISTRATION FORM

Office-Based Surgery (OBS) Registration is required annually for any licensed physician who maintains a practice location in Alabama and perform or offer to perform any office-based surgery/procedure which requires moderate sedation, deep sedation or general anesthesia.

Name
License Number
Primary Specialty
List all Specialty Board Certification (List Specialty Boards approved by the American Board of Medical Specialties or the American Osteopathic Association)

Is your office currently accredited by one of the following organizations?
Accreditation Association for Ambulatory Health Care (AAAHC)
American Association for Accreditation of Ambulatory Surgery Facilities (AAAASF)
Joint Commission on Accreditation of Healthcare Organizations (JCAHO)

You answered yes, please check all that apply.

You answered no, do you plan to obtain accreditation within the next two years?

1. Do you perform any procedures in the office-based setting in which one or more of the following levels of anesthesia are utilized?

a. Moderate Sedation / Analgesia ("Conscious sedation") - drug-induced depression of consciousness during which a patient responds purposefully to verbal commands, either alone or accompanied by light tactile stimulation.

You answered yes, list procedures performed

b. Deep Sedation / Analgesia - drug-induced depression of consciousness during which patients cannot be easily aroused but respond purposefully following repeated or painful stimulation.

You answered yes, list procedures performed

c. General Anesthesia - drug-induced loss of consciousness during which patients are not arousable, even by painful stimulation. The ability to independently maintain ventilatory function is often impaired. Patients often require assistance in maintaining a patent airway, and positive pressure ventilation may be required because of depressed spontaneous ventilation or drug-induced depression of neuromuscular function. Cardiovascular function may be impaired. Regional Anesthesia ("Major conduction blockade") is considered in the same category as General Anesthesia.

You answered yes, list procedures performed

I (the physician) certify that I have read Board Rules 540-X-10-.06 through .08 and meet the training requirements set forth in the Alabama Board of Medical Examiners' Office-Based Surgery Rules for moderate sedation, deep sedation, and general anesthesia.

2. Do you perform liposuction when infiltration methods such as the tumescent technique are used?

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You answered yes, I (the physician) certify that I have read **Board Rule 540-X-10-.10**, and I meet the requirements and standards set forth in **Board Rule 540-X-.08**.

3. Do you perform any procedures in which propofol is administered, given, or used?

You answered yes, I (the physician) certify that I have read and meet the requirements and standards set forth in **Board Rule 540-X-.08**.

4. Do you perform any procedures which are outside of the core curriculum of your formal specialty training?

You answered yes, list procedures performed

You answered yes, upload documentation of the training you have received, which qualifies you to perform the procedure.

I swear (affirm) that the information set forth on this Office-Based Surgery / Procedures Registration Form is true and correct to the best of my knowledge, information and belief. I also understand that the Board of Medical Examiners may conduct an on-site inspection at any time.

I understand and agree that by typing my name, I am providing an electronic signature that has the same legal effect as a written signature pursuant to Ala. Code §§ 8-1A-2 and 8-1A-7. I attest that the foregoing information has been provided by me and is true and correct to the best of my knowledge, information and belief.

Knowingly providing false information to the Alabama Board of Medical Examiners or Medical Licensure Commission of Alabama could result in disciplinary action.

~~Author:~~
~~Statutory Authority:~~

~~History:~~

~~540-X-10-AE~~ ~~Appendix E American Association For Accreditation Of Ambulatory Facilities, Inc., Guidelines For Starilization.~~

~~STATE BOARD OF MEDICAL EXAMINERS~~
~~CHAPTER 540-X-10~~

~~APPENDIX E~~

200 PROCEDURE ROOM POLICY, ENVIRONMENT AND PROCEDURES

200.30 Procedures - Sterilization

200.030.010 A,B,C-M,C

The facility has at least one autoclave which uses high pressure steam and heat, or all sterile items are single use disposable.

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200 PROCEDURE ROOM POLICY, ENVIRONMENT AND PROCEDURES

200.030.015 A,B,C-M,C

Gas sterilizers and automated endoscope reprocessors (ARR) must be vented as per manufacturer's specifications.

200.030.020 A,B,C-M,C

All instruments used in patient care are sterilized, where applicable.

200.030.025 A,B,C-M,C

A room with acceptable ventilation and space that is separate from the procedure room is required for reprocessing of scopes. If the facility is unable to use two separate rooms they must be able to document that they are using a closed reprocessing system with ventilation that exchanges the room air 10 -12 times per hour or an active charcoal filtration system is in place. All situations must meet requisite standards (OSHA, CDC, Federal, State, etc.) for air exchange ratios and vapor particle standards.

200.030.026 A,B,C-M,C

A written protocol is in place and followed that specifically addresses and requires enumerated steps to accomplish the below goals:
- The cleaning of the scope. The location of the manual rinsing and cleaning of endoscopes prior to HLD may be carried out in the procedure room away from the patient. Specific steps must be in place to minimize spraying and aerosolizing of the bio-burden.
- Processing of the scopes must be in the location that meets requisite standards of air exchange ratios and vapor particle standards. For example, a room that is separate from the procedure room is required for manual HLD reprocessing of endoscopes. This room must be adequate sized and segregated from patient and staff. Necessary protective equipment for personnel performing this function must be included in the protocol as well as readily available.
- Scope cleaning functions should be limited to properly trained personnel.
- If there is not a separate room (see previous standard) being utilized for processing of the scopes, then the protocol must include steps that directs that the contaminated equipment will be cleaned and placed in the re-processor prior to bringing the next patient into the room. In addition, the clean scope coming out of the re-processor is to be removed only when the room is clean and free of dirty instruments.
- Cross contamination should be avoided no matter where cleaning and processing takes place. There must always be some distinct type of separation of clean and dirty areas in any location.
- Clean (reprocessed) endoscopes should be stored in a closed cabinet exclusively dedicated for scope storage to avoid contamination prior to use.

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200 PROCEDURE ROOM POLICY, ENVIRONMENT AND PROCEDURES

200.030.030 A,B,C-M,C

High-level disinfection is used only for non-autoclavable endoscopic equipment, and in areas that are categorized as semi-critical where contact will be made with mucus membrane or other body surfaces that are not sterile. At all times the manufacturer's recommendations for usage should be followed.

200.030.035 A,B,C-M,C

Monitoring records are retained for the sterilization or other disinfection process and should be reviewed and stored for a minimum of three (3) years.

200.030.040 A,B,C-M,C

A weekly spore test, or its equivalent, is performed on each autoclave and the results filed and kept for three (3) years. The sterility of each load in the autoclave is checked with indicator tape, chemical monitors, or other effective means both on the outside and inside of the pack.

200.030.045 A,B,C-M,C

If a spore test is positive, there is a protocol for remedial action to correct the sterilization process.

~~**Author:** Alabama Board of Medical Examiners~~
~~**Statutory Authority:** Code of Ala. 1975, §34-24-53.~~
~~**History: Repealed and New Rule (Appendices A - E):** Filed May 18, 2017; effective July 2, 2017. **Amended (Appendix D only):** Filed August 15, 2018; effective September 29, 2018.~~

ALABAMA BOARD OF MEDICAL EXAMINERS
ADMINISTRATIVE CODE

CHAPTER 540-X-10
OFFICE-BASED SURGERY

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540-X-10-.01 Preamble.

(1) Office-based surgery is surgery performed outside of a hospital or outpatient facility licensed by the Alabama Department of Public Health. It is the position of the Board that any physician performing office-based surgery is responsible for providing a safe environment. Surgical procedures in medicine have changed over the generations from procedures performed at home or at the surgeon's office to the hospital and, now, often back to outpatient locations. However, the premise for the surgery remains unchanged: that it be performed in the best interest of the patient and under the best circumstances possible for the management of disease and well-being of the patient.

(2) Surgery that is performed in a physician's office at this time varies from a simple incision and drainage with topical anesthesia to semi-complex procedures under general anesthesia. It is imperative that the surgeon evaluate the patient, advise and assist the patient with a decision about the procedure and the location for its performance and, to the best of the surgeon's ability, ensure that the quality of care be equal no matter the location. If the physician performs surgery in the physician's office, it is expected that the physician will require standards similar to those at other sites where the physician performs such procedures. It is also expected that any physician who performs a surgical procedure is knowledgeable about sterile technique, the need for pathological evaluation of certain surgical specimens, any drug that the physician administers or orders administered, and about potential untoward reactions, complications, and their treatment.

(3) Recognizing that there have been serious adverse events in office surgical settings, both in Alabama and in other states, the Board has developed guidelines for physicians who perform office-based surgeries. These guidelines are intended to remind the physician of the minimal requirements for various levels of surgery in the office setting. While the physician must decide on a case-by-case basis the location and level of service that is best for the physician's particular patient and procedure, this decision must always be made with the patient's best interest in mind.

(4) These rules shall not apply to an oral surgeon licensed to practice dentistry who is also a physician licensed to practice medicine if the procedure is exclusively for the practice of dentistry. An oral surgeon licensed to practice dentistry who is also a physician licensed to practice medicine and who performs office-based surgery other than the practice of dentistry shall comply with the requirements of these regulations for those procedures which fall outside the scope of practice of dentistry.

Author: Alabama Board of Medical Examiners
Statutory Authority: Code of Ala. 1975, §34-24-53. 3 Definition of transfer protocols: Ensure the continuity of patient care is uninterrupted.
History: New Rule: Filed October 17, 2003; effective November 21, 2003. **Repealed and New Rule:** Published ; effective .

540-X-10-.02 Definitions.

(1) Anesthesia. A drug or agent-induced loss of sensation or consciousness which occurs on a continuum[1] with common levels identified as local, minimal, moderate, deep, and general anesthesia.

(2) Deep Sedation / Analgesia. A drug-induced depression of consciousness during which patients cannot be easily aroused but respond purposefully following repeated or painful stimulation. Reflex withdrawal from painful stimulation is **NOT** considered a purposeful response. The ability to independently maintain ventilatory function may be impaired. Patients may require assistance in maintaining a patent airway, and spontaneous ventilation may be inadequate. Cardiovascular function is usually maintained. The use of propofol or its derivative and analogues is considered deep sedation.

(3) General Anesthesia. A drug-induced loss of consciousness during which patients are not arousable, even by painful stimulation. The ability to independently maintain ventilatory function is often impaired. Patients often require assistance in maintaining a patent airway, and positive pressure ventilation may be required because of depressed spontaneous ventilation or drug-induced depression of neuromuscular function. Cardiovascular function may be impaired.

(4) Local Anesthesia. The administration of an agent which produces a localized and reversible loss of sensation in a circumscribed portion of the body.

(5) Level I Office-Based Surgery. Any type of surgery or diagnostic procedure in which pre-operative medications are not required or used other than minimal pre-operative tranquilization/anxiolysis of the patient. There is no anesthesia, or it is a local, topical, appropriate block. No drug-induced alteration of consciousness other than minimal pre-operative tranquilization of the patient is permitted and the chances of complication requiring hospitalization are remote. Level I office based surgical procedures include, but are not limited to, excisions of skin lesions, moles, warts, cysts and lipomas; repair of lacerations or surgery limited to the skin and subcutaneous tissue; incision and drainage of superficial abscesses; limited endoscopies such as proctoscopies; skin biopsies, arthrocentesis, thoracentesis, paracentesis, and endometrial biopsy; insertions of IUD's and colposcopy; dilation

of urethra and cystoscopic procedures; and closed reductions of simple fractures or small joint dislocations.

(6) Level II Office-Based Surgery. Any type of surgery or diagnostic procedure using moderate sedation or higher, the use of intravenous medications to accomplish sedation, or a local or peripheral major nerve block, including Bier Block. Level II procedures shall constitute procedures in which the chance of complications requiring hospitalization is remote. Level II procedures include liposuction when infiltration methods such as the tumescent technique are used and diagnostic studies such as endoscopic and radiologic procedures where moderate sedation is used.

(7) Level III Office-Based Surgery. Any type of surgery or diagnostic procedure using deep sedation or general anesthesia, a major upper or lower extremity nerve block, such as an epidural, spinal, or caudal nerve block, or any procedure in which propofol is administered, given, or used. Level III procedures will not generally be emergent or life threatening in nature.

(8) Minimal Sedation (anxiolysis). A drug-induced state during which patients respond normally to verbal commands. Although cognitive function and coordination may be impaired, ventilatory and cardiovascular functions are unaffected.

(9) Moderate Sedation / Analgesia ("Conscious Sedation"). A drug-induced depression of consciousness during which a patient responds purposefully to verbal commands, either alone or accompanied by light tactile stimulation. Reflex withdrawal from painful stimulation is **NOT** considered a purposeful response. No interventions are required to maintain a patent airway, and spontaneous ventilation is adequate. Cardiovascular function is usually maintained.

(10) Office-based surgery. Any surgical or invasive medical procedure performed outside a hospital or outpatient facility licensed by the Alabama Department of Public Health.

(11) Physician Office. A facility, office, or laboratory where a registered physician performs office-based surgery.

(12) Registered Physician. A physician registered to perform office-based surgery.

(13) Surgery. A medical procedure which involves the revision, destruction, incision, or structural alteration of human tissue performed using a variety of methods and instruments, is a discipline that includes the operative and non-operative care of individuals in need of such intervention, and

which demands pre-operative assessment, judgment, technical skills, post-operative management, and follow-up.

(14) Regional Anesthesia (A major conduction blockade) is considered in the same category as General Anesthesia.

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[1] See Appendix A.

Author: Alabama Board of Medical Examiners
Statutory Authority: Code of Ala. 1975, §34-24-53.
History: **New Rule:** Filed October 17, 2003; effective November 21, 2003. **Repealed and New Rule:** Published ; effective .

540-X-10-.03 Registration of Physicians and Physician Offices.

(1) Level I Office-Based Surgery does not require registration.

(2) Registration is required of any physician who is licensed to practice medicine in Alabama, who maintains a practice location in Alabama, and who performs or offers to perform any Level II or Level III office-based surgery. Registration must be accomplished and approved by the Board prior to performing any Level II or Level III procedures.

(3) Registration shall be accomplished on a form provided by the Board. Initial registration shall not be automatic and must be approved by the Board, subject to compliance with Ala. Admin. Rules Chapter 540-X-10 and all other applicable laws. A physician office may register more than one physician using a form provided by the Board. The physician office must identify a registered physician who shall be responsible for the accuracy of the registration and all reporting requirements under Ala. Admin. Rules Chapter 540-X-10.

(4) Annual registration shall be due by January 31 of each year, and registration shall be by electronic means. It shall be the obligation of the registered physician to advise the Board of any change in the practice location within the State of Alabama or any other information required to be reported.

(5) On or before March 2, 2026, the Board shall cause a notice to be transmitted to every physician who is licensed in

the State of Alabama notifying them of the requirements contained in this Chapter.

(6) Full compliance with Ala. Admin. Rules Chapter 540-X-10 shall be required beginning on January 1, 2027.

Author: Alabama Board of Medical Examiners
Statutory Authority: Code of Ala. 1975, §34-24-53.
History: **New Rule:** Filed October 17, 2003; effective November 21, 2003. **Repealed and New Rule:** Published ; effective .

540-X-10-.04 General Requirements.

(1) Every physician who performs or proposes to perform office-based surgery or procedures shall be trained to perform the surgery or procedure and possess an active, unrestricted medical license.

(2) Evidence of the physician's training and continuing medical education shall be documented and readily available to patients and the Board.

(3) When evaluating whether a physician is properly trained to perform a certain surgical procedure, the Board shall consider the following criteria:

(a) Training or certification in the procedures to be performed; OR

(b) Specialty board certification by an American Board of Medical Specialties board, an American Osteopathic Association specialty board, or other credible certifying body; OR

(c) Possession of credentialing to perform the same surgery or procedure at a nearby hospital or ambulatory care facility with whom the physician has privileges or an emergency transfer agreement; OR

(d) Completion of an accredited residency or a fellowship relating to the surgery or procedure to be performed or in which the procedure was an integral part of the formal training program; OR

(e) Accreditation by a credentialing body chosen by the physician and approved by the Board.

(4) When a physician proposes to provide a new office-based surgical procedure, he or she shall conduct specific training for all personnel involved in the care of patients prior to performing the procedure. Education must be specifically tailored to the new procedure and must include, at a minimum:

(a) Formal training regarding a basic understanding of the procedure being introduced, including risks and benefits of the procedure;

(b) Signs and symptoms of postoperative complications; and

(c) A basic understanding of the management and care of patients by a review of the office's policies and protocols.

(5) Physicians performing office-based surgery shall have qualified call coverage at all times by a physician who is responsible for the emergency care of his or her patients in his or her absence.

(a) The physician providing call coverage must be trained to manage the full range of complications associated with the procedures being performed.

(b) Transfer agreements can be used to supplement call coverage but cannot be used as a substitute for a call schedule.

(6) Medical Record Maintenance and Security: Each physician office shall have a procedure for initiating and maintaining a health record for every patient evaluated or treated. The record shall include a procedure code or suitable narrative description of the procedure and must have sufficient information to identify the patient, support the diagnosis, justify the treatment, and document the outcome and required follow-up care. For procedures requiring patient consent, there shall be a documented informed written consent. If analgesia/sedation, minor or major conduction blockade, or general anesthesia are provided, the record shall include documentation of the type of anesthesia used, drugs (type, time and dose) and fluids administered, the record of monitoring of vital signs, level of consciousness during the procedure, patient weight, estimated blood loss, duration of the procedure, and any complications related to the procedure or anesthesia. Procedures shall also be established to ensure patient confidentiality and security of all patient data and information.

(7) Infection Control Policy: Each physician office shall comply with state and federal regulations regarding infection control. For all surgical procedures, the level of sterilization shall meet current OSHA requirements. There shall be a procedure

and schedule for cleaning, disinfecting, and sterilizing equipment and patient care items. Personnel shall be trained in infection control practices, implementation of universal precautions, and disposal of hazardous waste products. Protective clothing and equipment must be readily available.

(8) Federal and State Laws and Regulations: Federal and state laws and regulations that affect the practice shall be identified and procedures developed to comply with those requirements. The following are some of the key requirements upon which office-based practices should focus:

(a) Non-Discrimination (see Civil Rights statutes and the Americans with Disabilities Act).

(b) Personal Safety (see Occupational Safety and Health Administration information).

(c) Controlled Substance Safeguards.

(d) Laboratory Operations and Performance (CLIA).

(e) Personnel Licensure Scope of Practice and Limitations.

Author: Alabama Board of Medical Examiners
Statutory Authority: Code of Ala. 1975, §34-24-53.
History: **New Rule:** Filed October 17, 2003; effective November 21, 2003. **Repealed and New Rule:** Published ; effective .

540-X-10-.05 Emergency Plan.

(1) Every physician who performs office-based surgery shall maintain on-site a written emergency plan.

(2) The emergency plan shall include, but not be limited to, emergency medicines, emergency equipment, and transfer protocols that ensure the continuity of a patient's care remains uninterrupted during any adverse event or transfer.

(a) Age-appropriate emergency supplies, equipment, and medication shall be provided in accordance with the scope of surgical and anesthesia services provided at the physician's office.

(b) In a physician office where anesthesia services are provided to infants and children, the required emergency

equipment must be appropriately sized for a pediatric population, and personnel must be appropriately trained to handle pediatric emergencies, which shall include up to date training and certification in Pediatric Advanced Life Support ("PALS") or Advanced Pediatric Life Support ("APLS").

(c) At least one physician currently trained in Advanced Cardiac Life Support ("ACLS") must be immediately and physically available until the last patient is past the first stage of recovery. A practitioner who is qualified in resuscitation techniques and emergency care, including ACLS, APLS, or PALS, as appropriate, must be present and available until all patients having more than local anesthesia or minor conductive block anesthesia have been discharged from the physician office.

(3) All physicians and support personnel shall be trained and capable of recognizing and managing complications related to the procedures and anesthesia that they perform. In the event of anesthetic, medical, or surgical emergencies, personnel must be familiar with the procedures and plan to be followed and able to take the necessary actions. All personnel must be familiar with a documented plan for the timely and safe transfer of patients to a nearby hospital. This plan must include arrangements for emergency medical services, if necessary, or when appropriate, escorting the patient to the hospital by an appropriate practitioner. If advanced cardiac life support is instituted, the plan must include immediate contact with emergency medical services.

(4) The emergency plan shall include objective criteria that shall be used when evaluating a patient for activation of the emergency plan, the provision of emergency medical care, and the safe and timely transfer of a patient to a hospital located within a reasonable distance as determined by the nature of the surgical procedure and which is equipped to accept transfer and treatment of the complications that may be experienced by the registered physician's patients.

(5) Every registered physician shall possess the ability to emergently transfer patients to a hospital should hospitalization become necessary. This requirement may be satisfied by possession of:

(a) A written transfer agreement, OR

(b) A written agreement with another physician willing to accept the registered physician's patient, OR

(c) Admitting, courtesy, or consulting privileges at a hospital within a reasonable distance based on the nature of the surgical procedure.

Author: Alabama Board of Medical Examiners
Statutory Authority: Code of Ala. 1975, §34-24-53.
History: **New Rule:** Filed October 17, 2003; effective November 21, 2003. **Repealed and New Rule:** Published ; effective .

540-X-10-.06 Patient Evaluation and Selection.

(1) Patients must be individually evaluated using objective and subjective criteria for each procedure to determine if the physician office is an appropriate setting for the anesthesia required and for the surgical procedure to be performed. Patient selection shall occur pursuant to procedure-specific written criteria which shall be available for inspection by the Board and shall comply with any requirements issued by the physician office's credentialing entity. These criteria shall include both inclusionary and exclusionary criteria.

(2) Patients undergoing Level II or Level III office-based surgery must have an appropriately documented history and physical examination as well as other indicated consultations and studies, all occurring not more than thirty (30) days prior to the surgical procedure.

(3) In addition to the patient selection criteria required by the registered physician's credentialing entity, the Board requires adherence to the following safety parameters :

(a) Intra-peritoneal and intra-pleural procedures are not permitted to be performed in a physician's office without prior, written approval from the Board. Intravascular and intraluminal procedures, ventral hernia repair that does not open the peritoneal cavity, and rib harvest that does not enter the pleural space do not require Board approval.

(b) The registered physician must utilize written criteria for the inclusion and exclusion of pediatric patients.

(c) Patients with a history of solid organ transplant, excepting kidney transplant, are not appropriate candidates for an office-based surgical procedure.

(d) A physician shall not perform a Level III office-based surgical procedure on any patient with an American Society of Anesthesiologists ("ASA") Physical Status Classification greater than or equal to four (4).

(e) For Level III surgery, the registered physician must utilize written evidence-based frailty scoring tools and accompanying procedure-specific exclusion criteria for patients age 75 or older. Patients age 85 or older are not appropriate candidates for a Level III office-based surgical procedure except in emergency or urgent circumstances or without prior, written Board approval.

Author: Alabama Board of Medical Examiners
Statutory Authority: Code of Ala. 1975, §34-24-53.
History: **New Rule:** Filed October 17, 2003; effective November 21, 2003. **Repealed and New Rule:** Published ; effective .

540-X-10-.07 Accreditation and Quality Assurance.

(1) All Level II and Level III office-based surgical procedures shall be performed in a physician office that is appropriately equipped, registered with the Board, and accredited or certified by an accrediting entity approved by the Board.

(2) The Board may approve an accrediting entity that demonstrates to the satisfaction of the Board that it has all of the following:

(a) Standards pertaining to patient care, recordkeeping, equipment, personnel, facilities, and other related matters that are in accordance with acceptable and prevailing standards of care as determined by the Board;

(b) Processes that ensure a fair and timely review and decision on any applications for accreditation or renewals thereof;

(c) Processes that ensure a fair and timely review and resolution of any complaints received concerning accredited or certified physician offices; and

(d) Resources sufficient to allow the accrediting entity to fulfill its duties in a timely manner.

(3) A physician may perform procedures under this rule in a physician office that is not accredited or certified, provided that the physician office has submitted an application for accreditation by a Board-approved accrediting entity, and that the physician office is appropriately equipped and maintained to ensure patient safety such that the physician office meets the accreditation standards. If the physician office is not accredited or certified within one year of the physician's performance of the first procedure under this rule, the physician must cease performing procedures until the physician office is accredited or certified.

(4) Proof of accreditation shall be kept on file with the Board and on site at the physician office. If a physician office loses its accreditation or certification and is no longer accredited or certified by at least one Board-approved entity, the physician shall immediately cease performing procedures in that physician office. Any changes to a physician office's accreditation status shall be reported to the Board within five (5) business days.

(5) Each physician office shall implement a quality assurance program to periodically review the physician office's procedures and quality of care provided to patients.

(a) A physician office shall engage its quality assurance program not less than annually. The quality assurance program may be administered by the physician office's accrediting entity.

(b) A registered physician and his or her partners cannot provide peer review for each other.

(6) A quality assurance program shall include, but not be limited to:

(a) Review of all mortalities;

(b) Review of the patient selection, appropriateness, and necessity of procedures performed;

(c) Review of all emergency transfers;

(d) Review of surgical and anesthetic complications;

(e) Review of outcomes, including postoperative infections;

(f) Analysis of patient satisfaction surveys and complaints;

(g) Identification of undesirable trends, including diagnostic errors, poor outcomes, follow-up of abnormal test results, medication errors, and system problems; and

(h) Tracking of all deviations from the patient selection and procedure protocols, including identification of the patient, the basis for the deviation, a description of the medical decision-making supporting the deviation, a description of the outcome, and any remedial measures taken.

(7) Quality assurance program findings shall be documented and incorporated into the physician office's educational programming, protocols, and planning, as appropriate.

(8) Each physician shall attest in writing to the Board that a compliant quality assurance program has been implemented prior to performing any office-based surgery. Each physician shall be responsible for producing the plan to the Board upon demand.

Author: Alabama Board of Medical Examiners
Statutory Authority: Code of Ala. 1975, §34-24-53.
History: New Rule: Filed October 17, 2003; effective November 21, 2003. **Repealed and New Rule:** Published ; effective .

540-X-10-.08 Standards for Preoperative Assessment.

(1) A medical history, a physical examination consistent with the type and level of anesthesia and/or analgesia and the level of surgery to be performed, and the appropriate laboratory studies must be performed by a practitioner qualified to assess the impact of co-existing disease processes on surgery and anesthesia. A pre-anesthetic examination and evaluation must be conducted immediately prior to surgery by the physician or by a qualified person who will be administering or directing the anesthesia. If a qualified person will be administering the anesthesia, the physician shall review with the qualified person the pre-anesthetic examination and evaluation. The data obtained during the course of the pre-anesthesia evaluations (focused history and physical, including airway assessment and significant historical data not usually found in a primary care or surgical history that may alter care or affect outcome) must be documented in the medical record.

(2) Because sedation is a continuum, it is not always possible to predict how an individual patient will respond. Hence, practitioners intending to produce a given level of sedation must be able to rescue patients whose level of sedation becomes deeper than initially intended. Individuals administering Moderate Sedation / Analgesia ("Conscious Sedation") must be able to rescue patients who enter a state of Deep Sedation / Analgesia, while those administering Deep Sedation / Analgesia must be able to rescue patients who enter into a state of general anesthesia.

Author: Alabama Board of Medical Examiners
Statutory Authority: Code of Ala. 1975, §34-24-53.
History: New Rule: Filed October 17, 2003; effective November 21, 2003. **Repealed and New Rule:** Published ; effective .

540-X-10-.09 Standards for Moderate Sedation/Analgesia.

(1) Equipment and supplies: Emergency resuscitation equipment, emergency life-saving medications, suction, and a reliable source of oxygen with a backup tank must be readily available. When medication for sedation and/or analgesia is administered intravenously (IV), monitoring equipment must include: blood pressure apparatus, stethoscope, pulse oximetry, continuous EKG, and temperature monitoring for procedures lasting longer than thirty (30) minutes. The patient's vital signs, oxygen saturation, and level of consciousness must be documented prior to the procedure, during regular intervals throughout the procedure, and prior to discharge. During the procedure, the patient's ventilatory function must be continually monitored by observation of qualitative clinical signs, including but not limited to, capnography, unless precluded or invalidated by the nature of the patient, procedure, or equipment. All patients must be continuously monitored by pulse oximetry with appropriate alarms. The physician office, in terms of general preparation, must have adequate equipment and supplies, provisions for proper record keeping, and the ability to recover patients after anesthesia.

(2) Training required: The physician and at least one assistant must be currently trained in ACLS.

(3) Assistance of other personnel: Anesthesia may be administered only by a licensed, qualified, and competent anesthesiologist, certified registered nurse anesthetist (CRNA) practicing under the direction of or in coordination with a

licensed physician who is immediately available, anesthesiologist assistant (AA), who is practicing under the supervision of an anesthesiologist in accordance with Board rules (Chapter 540-X-7, et seq.), or registered nurse who has documented competence and training to administer Moderate Sedation / Analgesia ("Conscious Sedation") and to assist in any support or resuscitation measures as required.

(4) The individual administering Moderate Sedation / Analgesia ("Conscious Sedation") and/or monitoring the patient must be someone other than the physician performing the surgical procedure, nor can this person assist in the actual performance of the procedure. Scrub or circulating nurse(s) and/or assistant(s) must be trained in their specific job skills as determined by the registered physician.

(5) At least one physician currently trained in ACLS must be immediately and physically available until the last patient is past the first stage of recovery, and at least one practitioner currently trained in ACLS must be immediately and physically available until the last patient is discharged from the physician office.

Author: Alabama Board of Medical Examiners
Statutory Authority: Code of Ala. 1975, §34-24-53.
History: New Rule: Filed October 17, 2003; effective November 21, 2003. **Repealed and New Rule:** Published ; effective .

540-X-10-.10 Standards for Deep Sedation/Analgesia.

(1) Equipment and supplies: Emergency resuscitation equipment, emergency life-saving medications, suction, and a reliable source of oxygen with a backup tank must be readily available. Monitoring equipment must include: blood pressure apparatus, stethoscope, pulse oximetry, continuous EKG, and temperature monitoring for procedures lasting longer than thirty (30) minutes. The patient's vital signs, oxygen saturation, and level of consciousness must be documented prior to the procedure, during regular intervals throughout the procedure, and prior to discharge. During the procedure, the patient's ventilatory function must be continually monitored by observation of qualitative clinical signs, including but not limited to, capnography, unless precluded or invalidated by the nature of the patient, procedure, or equipment. All patients must be continuously monitored by pulse oximetry with appropriate alarms. The physician office, in terms of general preparation, must have

adequate equipment and supplies, provisions for proper record keeping, and the ability to recover patients after anesthesia.

(2) Training required: The physician and at least one assistant must be currently trained in Advanced Cardiac Life Support (ACLS).

(3) Assistance of other personnel: Anesthesia may be administered only by a licensed, qualified, and competent anesthesiologist, certified registered nurse anesthetist (CRNA) practicing under the direction of or in coordination with a licensed physician who is immediately available, or anesthesiologist assistant (AA), who is practicing under the supervision of an anesthesiologist in accordance with Board rules (Chapter 540-X-7, et. seq.), who has documented competence and training to administer Deep Sedation / Analgesia and to assist in any support or resuscitation measures as required.

(4) The individual administering deep sedation/analgesia and/or monitoring the patient must be someone other than the physician performing the surgical procedure, nor can this person assist in the actual performance of the procedure. Scrub or circulating nurse(s) and/or assistant(s) must be trained in their specific job skills as determined by the registered physician.

(5) At least one physician currently trained in ACLS must be immediately and physically available until the last patient is past the first stage of recovery, and at least one practitioner currently trained in ACLS must be immediately and physically available until the last patient is discharged from the physician office.

Author: Alabama Board of Medical Examiners
Statutory Authority: Code of Ala. 1975, §34-24-53.
History: **New Rule:** Filed September 22, 2011; effective October 27, 2011. **Repealed and New Rule:** Published ; effective .

540-X-10-.11 Standards for General and Regional Anesthesia.

(1) Equipment and supplies: Emergency resuscitation equipment, suction, and a reliable source of oxygen with a backup tank must be readily available. When triggering agents are in the office, at least twelve (12) ampules of dantrolene sodium must be readily available within ten (10) minutes with additional ampules available from another source. Monitoring equipment must include: blood pressure apparatus, stethoscope, pulse oximetry, continuous

EKG, capnography, and temperature monitoring for procedures lasting longer than thirty (30) minutes. Monitoring equipment and supplies must be in compliance with currently adopted ASA standards, including the most current version of the ASA Standard for Basic Anesthetic Monitoring. The physician office, in terms of general preparation, must have adequate equipment and supplies, provisions for proper record keeping, and the ability to recover patients after anesthesia.

(2) Training required: The physician and at least one assistant must be currently trained in Advanced Cardiac Life Support (ACLS).

(3) Assistance of other personnel: Anesthesia may be administered only by a licensed, qualified, and competent anesthesiologist, certified registered nurse anesthetist (CRNA) practicing under the direction of or in coordination with a licensed physician who is immediately available, or anesthesiologist assistant (AA), who is practicing under the supervision of an anesthesiologist in accordance with Board rules (Chapter 540-X-7, et seq.), who has documented competence and training to administer general and regional anesthesia and to assist in any support or resuscitation measures as required.

(4) The individual administering general and regional anesthesia and/or monitoring the patient must be someone other than the physician performing the surgical procedure, nor can this person assist in the actual performance of the procedure. Scrub or Circulating nurse(s) and/or assistant(s) must be trained in their specific job skills as determined by the registered physician.

(5) Direction of the sedation/analgesia component of the medical procedure must be provided by a physician who is immediately and physically present, who is licensed to practice medicine in the state of Alabama, and who is responsible for the direction of administration of the anesthetic. The physician providing direction must ensure that an appropriate pre-anesthetic examination is performed, ensure that qualified practitioners participate, be available for diagnosis, treatment, and management of anesthesia related complications or emergencies, and ensure the provision of indicated post anesthesia care.

(6) At least one physician currently trained in ACLS must be immediately and physically available until the last patient is past the first stage of recovery, and at least one practitioner currently trained in ACLS must be immediately and physically

available until the last patient is discharged from the physician office.

Author: Alabama Board of Medical Examiners
Statutory Authority: Code of Ala. 1975, §34-24-53.
History: **New Rule:** Filed October 17, 2003; effective November 21, 2003. **Repealed and New Rule:** Published ; effective .

540-X-10-.12 Monitoring Requirements for the Recovery Area and Assessment for Discharge with Moderate & Deep Sedation/General Anesthesia.

Monitoring in the recovery area shall be performed by **dedicated** personnel, trained in their specific job skills as determined by the registered physician, and must include pulse oximetry and non-invasive blood pressure measurement. The recovery area must be staffed by an appropriate number of people for the patients being monitored. The patient must be assessed periodically for level of consciousness, pain relief, or any untoward complication. Each patient must meet discharge criteria as established by the practice prior to leaving the physician office. Documented recovery from anesthesia must include the following: 1) vital signs and oxygen saturation stable within acceptable limits; 2) no more than minimal nausea, vomiting, or dizziness; and 3) sufficient time (up to two (2) hours) must have elapsed following the last administration of reversal agents to ensure the patient does not become sedated after reversal effects have worn off. After meeting discharge criteria, the patient shall be given appropriate discharge instructions, discharged under the direction of the physician performing the procedure, and discharged under the care of a responsible third party. Discharge instructions shall include: 1) the procedure performed; 2) information about potential complications; 3) telephone numbers to be used by the patient to discuss with the registered physician complications or questions that may arise; 4) instructions for medications prescribed and pain management; 5) information regarding the follow-up visit date, time, and location; and 6) designated treatment facility in the event of an emergency. The use of reversal agents such as Narcan and flumazenil should be used with caution in the outpatient setting. The registered physician must be fully educated on the duration of action of these medications.

Author: Alabama Board of Medical Examiners

Statutory Authority: Code of Ala. 1975, §34-24-53.
History: New Rule: Filed October 17, 2003; effective November 21, 2003. **Amended (Rule and Appendix D):** Filed September 22, 2011; effective October 27, 2011. **Amended (Rule and Appendix D):** Filed August 15, 2018; effective September 29, 2018. **Amended:** Published February 26, 2021; effective April 12, 2021. **Repealed and New Rule:** Published ; effective .

540-X-10-.13 Tumescent Liposuction and Similarly Related Procedures.

(1) In the performance of liposuction when infiltration methods such as the tumescent technique are used, they should be regarded as regional or systemic anesthesia because of the potential for systemic toxic effects. The registered physician is expected to be knowledgeable in proper drug dosages and the recognition and management of toxicity or hypersensitivity to local anesthetic and other drugs.

(2) When infiltration methods such as the tumescent technique are used in the performance of liposuction, the Standards for General and Regional Anesthesia stated in Rule 540-X-10-.11 must be met, including the physician registration requirement, the equipment and supplies requirement, the training requirement, and the assistance of other personnel requirement. Every person administering local anesthetics by infiltration, tumescent technique, and nerve blocks must be trained to respond to local anesthetic systemic toxicity ("LAST"). A LAST kit must be maintained on site.

(3) When infiltration methods such as the tumescent technique are used in the performance of liposuction, the monitoring requirement found in Rule 540-X-10-.12, Monitoring Requirements for the Recovery Area and Assessment for Discharge with Moderate and Deep Sedation / General Anesthesia, must be met.

Author: Alabama Board of Medical Examiners
Statutory Authority: Code of Ala. 1975, §34-24-53.
History: New Rule: Filed October 17, 2003; effective November 21, 2003. **Repealed and New Rule:** Published ; effective .

540-X-10-.14 Reporting Requirements.

(1) Reporting to the Board is required within five (5) business days of the occurrence and will include all surgical related deaths that occur within thirty (30) days of the procedure, anesthetic or surgical events requiring CPR, wrong site surgery, wrong patient surgery, and unplanned reoperation related to a prior office-based surgical procedure occurring within thirty (30) days of the procedure. However, (1) planned reoperations, (2) reoperations for minor complications, and (3) the transfer of a patient to a more acute setting or a hospital as a result of the physician's findings during the diagnostic portion of a procedure do not need to be reported.

(2) Each physician office shall execute agreements with its accrediting or certifying entities requiring the entity to report any suspension, restriction, termination, or adverse accreditation action, the findings of any surveys and complaint or incident investigations, and any data requested by the Board. The registered physician shall be responsible for submitting or causing the accrediting entity to submit annual outcome data to the Board for all procedures performed at a physician office on or before January 31 following renewal of the physician's registration.

(3) Each registered physician shall report to the Board annually in writing a comprehensive list of all procedures performed at each location; provided, the registered physician shall report the performance of any new Level III procedure within thirty (30) days of performing the procedure at a physician office.

(4) A physician office where more than one registered physician performs office-based surgery may make reports on behalf of the registered physicians.

Author: Alabama Board of Medical Examiners
Statutory Authority: Code of Ala. 1975 § 34-24-53
History: New Rule: Published ; effective .

540-X-10-.15 Denial of Registration: Process and Grounds.

(1) If, after examination of a physician's registration, and after consideration of any information developed by the Board

pursuant to an investigation into the qualifications of the physician for registration, the Board determines that there is probable cause to believe there exist grounds upon which the registration may be denied, the Board shall take the following actions:

(a) Defer final decision on the registration; and

(b) Notify the physician of the grounds for possible denial of the registration and the procedure for obtaining a hearing before the Board.

(2) The failure to request a hearing within the time specified in the notice shall be deemed a waiver of such hearing.

(3) If requested by the physician, a hearing shall be set before the Board on the registration.

(4) In the event that a hearing is not requested, the Board shall take action to approve or deny the registration.

(5) All hearings under this rule shall be conducted in accordance with the Alabama Administrative Procedure Act, Ala. Code §§ 41-22-1 et seq. and Ala. Admin. Code Chapter 540-X-6. A decision rendered by the Board at the conclusion of the hearing shall constitute final administrative action of the Board of Medical Examiners for the purposes of judicial review under Ala. Code § 41-22-20. The registering physician shall have the burden of demonstrating to the reasonable satisfaction of the Board that he or she meets all qualifications and requirements for registration to practice office-based surgery.

(6) The Board may deny a registration on the grounds that:

(a) The registering physician does not meet a requirement of this rule;

(b) The registering physician has failed to provide any information required under this rule;

(c) The registering physician, in the opinion of the Board, is not qualified to perform a specific surgery or is not qualified to perform office-based surgery with reasonable skill and safety to his or her patients;

(d) The registering physician has committed any of the acts or offenses constituting grounds to discipline the applicant in this state pursuant to, but not limited to, Ala. Code §§ 16-47-128, 34-24-360, and 34-24-57; or

(e) The registering physician has submitted or caused to be submitted false, misleading, or untruthful information to the Board in connection with his or her application.

Author: Alabama Board of Medical Examiners
Statutory Authority: Code of Ala. 1975 § 34-24-53
History: New Rule: Published ; effective .

540-X-10-.16 Penalties.

(1) A physician may be guilty of unprofessional conduct within the meaning of Ala. Code § 34-24-360(2) if he or she fails to comply with the requirements of Ala. Admin. Rules Chapter 540-X-10 or fails to make any mandatory report.

(2) A physician who has been found to be not in compliance with the requirements of Ala. Admin. Rules Chapter 540-X-10 may have his or her license revoked, suspended, fined, or otherwise disciplined by the Medical Licensure Commission.

(3) The Board may restrict, modify, suspend, deny issuance or renewal, or revoke a physician's registration based on a finding of non-compliance or violation of Ala. Admin. Rules Chapter 540-X-10.

Author: Alabama Board of Medical Examiners
Statutory Authority: Code of Ala. 1975 § 34-24-53
History: New Rule: Published ; effective .

540-X-10-AA **Appendix A Continuum of Depth of Sedation.**

[Added image:]

American Society of Anesthesiologists®

Statement on Continuum of Depth of Sedation: Definition of General Anesthesia and Levels of Sedation/Analgesia

Developed By: *Committee on Quality Management and Departmental Administration*
Last Amended: *October 23, 2024 (Original Approval: October 13, 1999)*

	Minimal Sedation Anxiolysis	**Moderate Sedation/ Analgesia ("Conscious Sedation")**	**Deep Sedation/ Analgesia**	**General Anesthesia**
Responsiveness	Normal response to verbal stimulation	Purposeful** response to verbal or tactile stimulation	Purposeful** response following repeated or painful stimulation	Unarousable even with painful stimulus
Airway	Unaffected	No intervention required	Intervention may be required	Intervention often required
Spontaneous Ventilation	Unaffected	Adequate	May be inadequate	Frequently inadequate
Cardiovascular Function	Unaffected	Usually maintained	Usually maintained	May be impaired

Note: The table above and definitions below are intended to guide the assessment of a patient's level of sedation at any moment which can change during the procedure.

Minimal Sedation (Anxiolysis) is a drug-induced state during which patients respond normally to verbal commands. Although cognitive function and physical coordination may be impaired, airway reflexes, and ventilatory and cardiovascular functions are unaffected. This is typically accomplished by a single oral dose of a sedative or an analgesic administered before the procedure.

Moderate Sedation/Analgesia ("Conscious Sedation") is a drug-induced depression of consciousness during which patients respond purposefully** to verbal commands, either alone or accompanied by light tactile stimulation. No interventions are required to maintain a patent airway, and spontaneous ventilation is adequate. Cardiovascular function is usually maintained. This is typically accomplished by titration of IV sedatives and/or analgesics during the procedure.†

Deep Sedation/Analgesia is a drug-induced depression of consciousness during which patients cannot be easily aroused but respond purposefully** following repeated or painful stimulation. The ability to independently maintain ventilatory function may be impaired. Patients may require assistance in maintaining a patent airway, and spontaneous ventilation may be inadequate. Cardiovascular function is usually maintained. This is typically accomplished by titration of IV sedatives and/or analgesics and/or anesthetics during the procedure.†

General Anesthesia is a drug-induced loss of consciousness during which patients are not arousable, even by painful stimulation. The ability to independently maintain ventilatory function is often impaired. Patients often require assistance in maintaining a patent airway, and positive pressure ventilation may be required because of depressed spontaneous ventilation or drug-induced depression of neuromuscular function. Cardiovascular function may be impaired.

Because sedation is a continuum, it is not always possible to predict how an individual patient will respond. Hence, practitioners intending to produce a given level of sedation should be able to rescue*** patients whose level of sedation becomes deeper than initially intended. Individuals administering Moderate Sedation/Analgesia ("Conscious Sedation") should be able to rescue*** patients who enter a state of Deep Sedation/Analgesia, while those administering Deep Sedation/Analgesia should be able to rescue*** patients who enter a state of General Anesthesia.

* Monitored Anesthesia Care ("MAC") does not describe the continuum of depth of sedation, rather it describes "a specific anesthesia service performed by a qualified anesthesia provider, for a diagnostic or therapeutic procedure." Indications for monitored anesthesia care include "the need for deeper levels of analgesia and sedation than can be provided by moderate sedation (including potential conversion to a general or regional anesthetic."

** Reflex withdrawal from a painful stimulus is NOT considered a purposeful response.

*** Rescue of a patient from a deeper level of sedation than intended is an intervention by a practitioner proficient in airway management and advanced life support. The qualified practitioner corrects adverse physiologic consequences of the deeper-than-intended level of sedation (such as hypoventilation, hypoxia and hypotension) and returns the patient to the originally intended level of sedation. It is not appropriate to continue the procedure at an unintended level of sedation.

† The effect of administering other drugs, including analgesics, may increase the depth of sedation.

1. American Society of Anesthesiologists. *Position on Monitored Anesthesia Care.* Last amended on October 17, 2018.

Last updated by: Governance

Date of last update: October 23, 2024

https://www.asahq.org/standards-and-practice-parameters/statement-on-continuum-of-depth-of-sedation-definition-of-general-anesthesia-and-levels-of-sedation-analgesia

Author: Alabama Board of Medical Examiners
Statutory Authority: Code of Ala. 1975 § 34-24-53
History: Repealed and New Rule: Published ; effective .

EXHIBIT
E

In re:

KRISTIN JOSEF DOBAY, M.D.,

Respondent.

BEFORE THE MEDICAL LICENSURE COMMISSION OF ALABAMA

ORDER

This matter is before the Medical Licensure Commission of Alabama on Respondent's request, submitted on November 23, 2025, for relief from all remaining license conditions imposed by our Findings of Fact and Conclusions of Law dated May 3, 2025. The Board does not oppose Respondent's request. The Commission is advised that Respondent has satisfactorily completed the supervised preceptorship, has complied with all other terms and conditions imposed by our order, and wishes to pursue recertification by the American Board of Obstetrics and Gynecology.

Upon due consideration by the full Commission, it is ordered that Respondent's request is granted, and the license to practice medicine and/or osteopathy of Kristin J. Dobay, M.D., No. MD.48792, is reinstated to full and unrestricted status.

DONE on this the 19th day of December, 2025.

THE MEDICAL LICENSURE
COMMISSION OF ALABAMA

By:

E-SIGNED by Jorge Alsip, M.D.
on 2025-12-19 06:09:33 CST

Jorge A. Alsip, M.D.
its Chairman

EXHIBIT

F

ALABAMA STATE BOARD OF MEDICAL EXAMINERS,

Complainant,

vs.

JONATHAN THOMAS MILLER, M.D.,

Respondent.

BEFORE THE MEDICAL LICENSURE COMMISSION OF ALABAMA

CASE NO. 2025-599

CONSENT DECREE

This matter comes before the Medical Licensure Commission of Alabama ("the Commission") on the Administrative Complaint ("the Administrative Complaint") filed by the Alabama State Board of Medical Examiners ("the Board") on December 5, 2025. The Board and the Respondent, Jonathan Thomas Miller, M.D. ("Respondent"), have entered into a Joint Settlement Agreement ("the Settlement Agreement"), and have asked the Commission to approve the Settlement Agreement and to embody it in this Consent Decree.

General Provisions

1. **Approval of the Settlement Agreement.** After review, the Commission finds that the Settlement Agreement represents a reasonable and appropriate disposition of the matters asserted in the Administrative Complaint. The Commission therefore approves the Settlement Agreement.

2. **Mutual Agreement and Waiver of Rights.** Respondent has consented and agreed to the entry of this Consent Decree, and has agreed to be bound by the findings of fact, conclusions of law, and terms and conditions stated herein. Respondent has validly waived all rights to an administrative hearing before the Commission, to be represented by an attorney at such hearing, and to further notice and formal adjudication by the Commission of the charges arising from the Administrative Complaint. Respondent has also validly waived all rights to judicial review of this Consent Decree pursuant to Ala. Code § 34-24-367, the Alabama Administrative Procedure Act, Ala. Code §§ 41-22-1, *et seq.*, by extraordinary writ, or otherwise.

3. **Public Documents.** The Administrative Complaint, the Settlement Agreement, and this Consent Decree shall constitute public records under the laws of the State of Alabama. The Administrative Complaint, the Settlement Agreement, and this Consent Decree may be published or disclosed by the Board and/or the Commission without further notice to Respondent.

4. **Additional Violations.** Any violation of the requirements of this Consent Decree, or any new violation of state or federal laws or regulations, may result in the Board filing a petition to discipline Respondent's medical license. Nothing in this Consent Decree precludes the Board from bringing new

administrative charges against Respondent based upon events and circumstances not raised in the Administrative Complaint.

5. **Retention of Jurisdiction.** The Commission retains jurisdiction for the purpose of entering such other and further orders and directives as may be required to implement the provisions of this Consent Decree.

6. **Official Notice.** Pursuant to Ala. Code § 41-22-13(4), Respondent is informed that the Board and/or the Commission may at any time take official notice of this Consent Decree, and/or any of the Findings of Fact herein, and may deem any of the findings or conclusions set forth in this Consent Decree to be conclusively established, all without further notice to Respondent.

Findings of Fact

1. Respondent has been licensed to practice medicine in the State of Alabama since July 25, 2007, having been issued license no. MD.28292. Respondent was so licensed at all relevant times.

2. On or about December 5, 2024, Respondent submitted or caused to be submitted an Alabama medical license renewal application for calendar year 2025. On that application, Respondent certified that the annual minimum continuing medical education requirement of 25 AMA PRA Category 1™ credits had been met or would be met by December 31, 2024. Respondent further represented that, if audited, Respondent would have supporting documents.

3. Respondent did not earn any valid continuing medical education credits during 2024.

Conclusions of Law

1. The Commission has jurisdiction over the subject matter of the Administrative Complaint, and over the parties, pursuant to Ala. Code § 34-24-310, *et seq.*

2. The Commission finds, as a matter of law, that the determined facts constitute violations of Ala. Code § 34-24-360(23), Ala. Admin. Code r. 545-X-5-.02, and Ala. Admin. Code r. 545-X-5-.10.

Order/Discipline

Based upon the foregoing Findings of Fact and Conclusions of Law, it is ORDERED, ADJUDGED, AND DECREED:

1. That Respondent is assessed an administrative fine in the amount of two thousand five hundred dollars ($2,500.00). In accordance with Ala. Admin. Code r. 545-X-3-.08(8)(d)(i), Respondent is ordered to pay the administrative fine within 30 days of this Order.[1]

---

[1] *See* Ala. Admin. Code r. 545-X-3-.08(8)(d)(i). Respondent is further advised that "[t]he refusal or failure by a physician to comply with an order entered by the Medical Licensure Commission" may be a separate instance of "unprofessional conduct." *See* Ala. Admin. Code r. 545-X-4-.06(6). Failure to timely pay the assessed costs and fines may therefore form an independent basis for further disciplinary action against Respondent.

2. That Respondent is ordered to obtain 25 ***additional*** credits of AMA PRA Category 1™ or equivalent continuing medical education, in addition to the 25 credits already required for calendar year 2025, for a combined total of 50 credits, during calendar year 2025.

3. That no costs of this proceeding are assessed against Respondent at this time.

DONE on this the 19th day of December, 2025.

THE MEDICAL LICENSURE
COMMISSION OF ALABAMA

By:

E-SIGNED by Jorge Alsip, M.D.
on 2025-12-19 06:09:58 CST

Jorge A. Alsip, M.D.
its Chairman

EXHIBIT

G

ALABAMA STATE BOARD OF MEDICAL EXAMINERS,

Complainant,

v.

GREGORY KEITH PARKER, M.D.,

Respondent.

BEFORE THE MEDICAL LICENSURE COMMISSION OF ALABAMA

CASE NO. 2025-063

ORDER

This matter is before the Medical Licensure Commission of Alabama on the Bill of Costs filed on November 20, 2025 by the Alabama State Board of Medical Examiners. Respondent had 10 days in which to file written objections to the Bill of Costs. *See* Ala. Admin. Code r. 545-X-3-.08(10)(c). No such objections have been filed. Upon review, the Board's Bill of Costs is approved, and the administrative costs of this proceeding are assessed against Respondent in the amount of $2,160.00. *See* Ala. Admin. Code r. 545-X-3-.08(9), (10).

DONE on this the 19th day of December, 2025.

THE MEDICAL LICENSURE COMMISSION OF ALABAMA

By:

E-SIGNED by Jorge Alsip, M.D.
on 2025-12-19 06:10:15 CST

Jorge A. Alsip, M.D.
its Chairman

EXHIBIT
H

ALABAMA STATE BOARD OF MEDICAL EXAMINERS,

Complainant,

v.

MARCUS D. RUSHING, M.D.,

Respondent.

BEFORE THE MEDICAL LICENSURE COMMISSION OF ALABAMA

CASE NO. 2025-167

FINDINGS OF FACT AND CONCLUSIONS OF LAW

This matter came before the Medical Licensure Commission of Alabama for a contested case hearing on December 17, 2025. After receiving and considering all of the relevant evidence and argument, we find the Respondent, Marcus D. Rushing, M.D., guilty of the disciplinary charges alleged by the Board and impose professional discipline as outlined below.

I. Introduction and Procedural History

The Respondent in this case is Marcus D. Rushing, M.D. ("Respondent"). Respondent is a licensee of this Commission who was first licensed in Alabama on May 30, 2024, having been issued license No. MD.48933.

This case began with the Board's filing of an Administrative Complaint and Petition for Summary Suspension of License ("the Administrative Complaint") with the Commission on or about August 4, 2025. In accordance with Ala. Code § 34-24-

361(f) and Ala. Admin. Code r. 545-X-3-.13(1)(a), on August 28, 2025, we entered an order summarily suspending Respondent's license to practice medicine and set this matter for a full evidentiary hearing.

The Administrative Complaint contains two counts. In Count One, the Board alleges that professional discipline in Alabama is warranted because, on March 21, 2025, Respondent's license to practice medicine in Illinois was indefinitely suspended, subjecting his Alabama medical license to reciprocal discipline pursuant to Ala. Code § 34-24-360(15). In Count Two, the Board alleges that Respondent is guilty of unprofessional conduct in transgression of Ala. Code § 34-24-360(2) and Ala. Admin. Code r. 545-X-4-.06(19). As grounds for Count Two, the Board alleges that Respondent failed to provide information requested by the Board as part of its investigation of the reasons for Illinois' suspension of his medical license in that state.

On grounds of these two counts, the Board urges the Commission, after a hearing, to "revoke the license to practice medicine of Respondent, assess the maximum fine, and/or take such other actions as the Commission may deem appropriate based upon the evidence presented for consideration."

On December 17, 2025, we conducted a contested case hearing as prescribed in Ala. Admin. Code r. 545-X-3. The case supporting disciplinary action was presented by the Alabama Board of Medical Examiners through its attorneys E. Wilson Hunter and Alicia Harrison. Respondent did not appear, and the hearing was held *in absentia*

as authorized by Ala. Code § 41-22-12(d). Pursuant to Ala. Admin. Code r. 545-X-3-.08(1), the Honorable William R. Gordon presided as Hearing Officer. Each side was offered the opportunity to present evidence and argument in support of its respective contentions, and to cross-examine the witnesses presented by the other side. Board Exhibits 1-14 were received into evidence. After careful review, we have made our own independent judgments regarding the weight and credibility to be afforded to the evidence, and the fair and reasonable inferences to be drawn from it. Having done so, and as prescribed in Ala. Code § 41-22-16, we enter the following Findings of Fact and Conclusions of Law.

II. Findings of Fact

1. Respondent was first licensed to practice medicine in Alabama on May 30, 2024, under license number MD.48933.

2. Respondent was licensed as a physician and surgeon in the State of Illinois on or about October 29, 2021, under license number 036.158662. (Board Ex. 12.)

3. On March 21, 2025, the Illinois Department of Financial and Professional Regulation ("IDFPR"), Division of Professional Regulation, entered a "Suspension Order Due to Delinquent Child Support." (Board Ex. 3.) In that Order, IDFPR indefinitely suspended Respondent's license to practice medicine in Illinois, based on the certification by the Illinois Department of Healthcare and Family Services ("IDHFS") that Respondent was more than 30 days delinquent in the payment of child

support payments, and based on the fact that Respondent had failed to adequately respond within 30 days of IDFPR's notice to him. (Board Ex. 3, 12.)

4. On May 8, 2025, Board Investigator Ben Schlemmer ("Investigator Schlemmer") emailed Respondent requesting that he make contact to discuss information that the Board had received about the suspension of Respondent's Illinois medical license. On May 11, 2025, Respondent replied:

> Hello Mr. Schlemmer and what a pleasure to be e-introduced. E-mail correspondence might prove best going forward. Would you mind clarifying the following:
>
> 1) From whom (ie, business entity, agency, patient, etc) did you receive information regarding me (Dr. Rushing)?
>
> 2) When did you receive information regarding me (Dr. Rushing)?

(Board Ex. 4.)

5. On May 12, 2025, Investigator Schlemmer sent the following e-mail to Respondent:

> Dr. Rushing, thank you for getting back with me. I agree email will probably be a more ideal communication platform for the transmission of documents and the such. With that said it is important that I speak with you initially, so I can explain exactly what is needed and required of you during this process.
>
> To answer your questions:
>
> 1. The Alabama Board of Medical Examiners (ALBME) received notification from the Physician Data Center (PDC) the State of Illinois Department of Financial and Professional Regulation indefinitely suspended your medical license due to delinquent child support payments.
>
> 2. The ALBME opened an official investigation into this suspension on May 7, 2025.

I know you probably have questions and I look forward to working with you to obtain answers.

Please let me know I [*sic*] good time for us to speak. At that time I can provide additional information/instructions and arrange to send you the documents associated with our case.

Again, I look forward to working with you to get this matter resolved in a timely manner.

(Board Ex. 4 at 1, 2.)

6. On May 14, 2025, Respondent replied:

Thank you for clarifying Mr. Schlemmer,

This is important information and is related to the following cases:

Case No. 2024 L 004444 | Circuit Court of Cook County, Law Division (Illinois) - see attached.

Case 2019D008356 | Circuit Court of Cook County, Domestic Relations Division (Illinois) - see attached.

Of note, on May 1, 2025, the Illinois Licensing Board (IDFPR) was named in a federal suit related to the aforementioned (Case No. 25 CV 1957, US District Court, Minnesota).

It may be beneficial to read the attached complaints in detail prior to a phone call. **I am very happy to comply with any investigation so long as my participation does not interfere with the related state and federal cases.** Please do not hesitate to reach out with any questions or concerns.

(Board Ex.4 at 2, 3 (emphasis added).)

7. On May 16, 2025, Investigator Schlemmer e-mailed the Board's formal Notice of Investigation, an explanation of the Board's investigation, and a copy of the

Physician Data Center report, emphasizing that it was imperative that he speak with Respondent:

> Dr. Rushing, thank you for sharing those documents. With that said, while I respect and encourage anyone to exercise their right to due process as you are, I want to be clear the ALBME's investigation is into what was reported by the PDC. Namely, the suspension of your medical license in Illinois and whether that suspension will have an effect on your Alabama license status.
>
> It is imperative I speak with you regarding this matter. Please let me know when we can schedule a time to discuss the ALBME's investigative process and what is required of you.
>
> To help, I have attached a brief explanation and a copy of the PDC report for you to review. I have also attached a Notice of Investigation I need you to sign and return to me (digital is fine).
>
> I look forward speaking with you soon, so we can work together towards a resolution.

(Board Ex. 4 at 3.)

8. The Board's formal Notice of Investigation explicitly informed Respondent that a "**written response . . . should be provided to the Board within *15* days of receiving this investigative package.**" (Board Ex. 5 at 2 (emphasis in original).) The fifteenth day from May 16 was May 31, 2025.

9. On May 27, 2025, Investigator Schlemmer followed up via e-mail, asking whether Respondent received the prior email and attachments. (Board Ex. 6.) Respondent did not respond to this e-mail.

10. On June 10, 2025, Investigator Schlemmer followed up with another e-mail to Respondent. A few hours later, Respondent replied:

Hello Mr. Schlemmer,

I thought that we were communicating via e-mail, as was requested. Please feel free to correspond with me here - or alternatively, is there a formal hearing date scheduled? What questions do you have for me - I am very much happy to address any and all questions.

(Board Ex. 7 at 2.)

11. A few hours later on June 10, 2025, Investigator Schlemmer replied:

Dr Rushing, you are correct about email communication and we can continue to utilize it for now; however, a conversation to discuss your plans/response would still be beneficial.

With that said, did you receive my email on May 16, 2025, that included attachments with instructions regarding the ALBME's Investigative process, what was needed from you, and the Notice of Investigation? If not please let me know so that I can resend those documents. **I need a written response from you by June 18, 2025.**

If I have not received your written response by June 18, 2025, your case will go before our Board without said document(s). Once our Board has completed this review, they will determine if a formal hearing is needed.

Again, I am here to work with you through this process so together we can provide our Board the information needed for an informed decision. Please let me know of any questions or concerns you may have.

(Board Ex. 7 at 2 (emphasis added).) Respondent did not respond to this e-mail.

12. On June 18, 2025, Investigator Schlemmer again requested the status of Respondent's written response:

Good morning, Dr. Rushing. I am checking in to see if you are planning on returning a written response for our Board to review regarding the action taken against your license in Illinois. Whether you choose to submit a written response or not, I will be including the previous information you provided regarding your ongoing legal filings. Please let me know what your intentions are, so we can work together to get this resolved.

(Board Ex. 8.) Respondent did not respond to this e-mail.

13. In sum, despite multiple good-faith attempts by Investigator Schlemmer to engage Respondent about the substance of the Board's investigation into the reasons for IDFPR's decision to suspend Respondent's license to practice medicine in Illinois, despite Respondent's conditional pledge to cooperate with the Board's investigation "so long as [his] participation does not interfere with the related state and federal cases," despite clear notice that Respondent was required to provide a written response to the Board's investigation no later than May 31, and despite Investigator Schlemmer's extension of that deadline through June 18, 2025, Respondent failed and/or refused to provide any substantive response to the Board's investigation.

III. Conclusions of Law

1. The Medical Licensure Commission of Alabama has jurisdiction over the subject matter of this cause pursuant to Act No. 1981-218, Ala. Code §§ 34-24-310, *et seq*. Under certain conditions, the Commission "shall have the power and duty to suspend, revoke, or restrict any license to practice medicine or osteopathy in the State of Alabama or place on probation or fine any licensee." Ala. Code § 34-24-360.

2. Respondent was notified of the time, date and place of the administrative hearing and of the charges against him in compliance with Ala. Code §§ 34-24-361(e) and 41-22-12, and Ala. Admin. Code r. 545-X-3-.03(3), (4), using both Respondent's

practice address of record, which state law requires Respondent to keep updated,[1] and the e-mail address he repeatedly stated was his preferred method of communication. At all relevant times, Respondent was a licensee of this Commission and was and is subject to the Commission's jurisdiction.

3. Before making any decision on a contested case such as this one, the Commission is required by law to "receive and consider" a recommendation from the Board. The Board's recommendation, however, is not binding upon the Commission. *See* Ala. Code § 34-24-361(h). The Commission has received and duly considered the Board's non-binding recommendation to "revoke the license to practice medicine of Respondent, assess the maximum fine, and/or take such other actions as the Commission may deem appropriate based upon the evidence presented for consideration."

4. The Commission may impose professional discipline upon any license to practice medicine and/or osteopathy in this state when it is shown, after notice and hearing, that "disciplinary action [has been] taken by another state against a licensee . . . , based upon acts by the licensee similar to acts described in this section . . . ." Ala. Code § 34-24-360(15). It is undisputed that, on March 21, 2025, the IDFPR did

[1] *See* Ala. Code § 34-24-338 ("If any registrant shall change his address during the year for which any certificate of registration shall have been issued by the commission, such registrant shall, within 15 days thereafter, notify the commission of such change . . .").

suspend indefinitely Respondent's license to practice medicine in Illinois.[2] We therefore conclude that Respondent is in violation of Ala. Code § 34-24-360(15) as charged in Count One of the Administrative Complaint.

5. The Commission has the power and duty to impose discipline upon any physician when the physician is shown, after notice and hearing, to have committed "[u]nprofessional conduct as defined herein or in the rules and regulations promulgated by the commission." Ala. Code § 34-24-360(2). Our rules generally define "unprofessional conduct" as "the commission or omission of any act that is detrimental or harmful to the patient of the physician or detrimental or harmful to the health, safety, and welfare of the public, and which violates the high standards of honesty, diligence, prudence and ethical integrity demanded from physicians and osteopaths licensed to practice in the State of Alabama." Ala. Admin. Code r. 545-X-4-.06. "Failing to furnish information in a timely manner to the board . . . if requested by the board" is one specific, nonexclusive example of conduct constituting "unprofessional conduct." Ala. Admin. Code r. 545-X-4-.06(19). Based on the facts presented, we conclude that Respondent engaged in unprofessional conduct by failing to furnish in a timely manner

[2] Respondent refused to provide any response to the Board's investigation, and did not participate in his hearing before the Commission. He has not, therefore, presented any argument that the reasons for the suspension of his Illinois medical license are not "similar to" reasons that would be applicable in Alabama. Even so, we conclude that Illinois' stated reasons for suspending Respondent's license in that state are at least "similar to" unprofessional conduct as defined in Alabama. *See, e.g.*, Ala. Admin. Code r. 545-X-4-.06(9), (10), (19).

information requested by the Board concerning the suspension of his Illinois license, as charged in Count Two.

6. We reach all of these decisions based on all of the facts presented, viewed through the lens of our professional experience, expertise, and judgment. *See* Ala. Code § 41-22-13(5) ("The experience, technical competence, and specialized knowledge of the agency may be utilized in the evaluation of the evidence.").

IV. Decision

Based on all of the foregoing, it is **ORDERED, ADJUDGED, AND DECREED:**

1. That the Respondent, Marcus D. Rushing, M.D., is adjudged **GUILTY** of disciplinary action taken by another state in violation of Ala. Code § 34-24-360(15), as charged in Count One of the Administrative Complaint;

2. That the Respondent, Marcus D. Rushing, M.D., is adjudged **GUILTY** of unprofessional conduct in violation of Ala. Code § 34-24-360(2) and Ala. Admin. Code r. 545-X-4-.06(19), as charged in Count Two of the Administrative Complaint;

3. That, separately and severally on account of Counts One and Two of the Administrative Complaint, Respondent's license to practice medicine and/or osteopathy in the State of Alabama is **REVOKED;**

4. That Respondent shall, within 30 days of this Order,[3] pay an administrative fine in the amount of $10,000.00 as to Count One of the Administrative Complaint, and $10,000.00 as to Count Two of the Administrative Complaint, for a total administrative fine of $20,000.00;

5. That within 30 days of this order, the Board shall file its bill of costs as prescribed in Ala. Admin. Code r. 545-X-3-.08(10)(b), and Respondent shall file any objections to the cost bill within 10 days thereafter, as prescribed in Ala. Admin. Code r. 545-X-3-.08(10)(c). The Commission reserves the issue of imposition of costs until after full consideration of the Board's cost bill and Respondent's objections, and this reservation does not affect the finality of this order. *See* Ala. Admin. Code r. 545-X-3-.08(10)(e).

DONE on this the 30th day of December, 2025.

THE MEDICAL LICENSURE
COMMISSION OF ALABAMA

By:

E-SIGNED by Jorge Alsip, M.D.
on 2025-12-30 14:02:28 CST

Jorge A. Alsip, M.D.
its Chairman

[3] *See* Ala. Admin. Code r. 545-X-3-.08(8)(d)(i). Respondent is further advised that "[t]he refusal or failure by a physician to comply with an order entered by the Medical Licensure Commission" may be a separate instance of "unprofessional conduct." *See* Ala. Admin. Code r. 545-X-4-.06(6).