BOARD MEETING MINUTES

March 18 - 20, 2026

3127 Smoketree Court
Raleigh, North Carolina

General Session Minutes of the North Carolina Medical Board (NCMB) Meeting held March 18 - 20, 2026.

The March 18-2-, 2026 meeting of the North Carolina Medical Board was held in person. meeting of the North Carolina Medical Board was held in person at 3127 Smoketree Court, Raleigh, NC 27604 and certain closed portions of the meeting were conducted virtually, including licensing and investigative interviews. Anuradha Rao-Patel, MD, President, called the meeting to order. Board members in attendance were Robert L. Rich, Jr., MD, President-Elect; Mark A. Newell, MD, MMM; Secretary/Treasurer; Earic R. Bonner, MD, MBA; J. Nelson Dollar, MA; Lisa Ehrler, DO; Vickie A. Harry; Sharona Y. Johnson, PhD, FNP-BC; Shannon R. Joseph; Gregory S. McCarty, MD; Miguel A. Pineiro, PA-C, MHPE; Anthony R. Plunkett, MD; Devdutta G. Sangvai, MD, JD, MBA.

PRESIDENTIAL REMARKS

Dr. Anuradha Rao-Patel reminded the Board members of their duty to avoid conflicts of interest with respect to any matters coming before the Board as required by the State Government Ethics Act. Reported conflicts were included within individual committee reports.

ANNOUNCEMENTS and UPDATES

Dr. Rao-Patel recognized new staff as they were introduced by their perspective manager. She also recognized staff with employment milestones. A staff promotion was recognized by their perspective manager.

INSTILLATION CEREMONY

Dr. Rao-Patel administered the New Board Member Oath to Dr. Lisa Ehrler. Dr. Rao-Patel read the Evaluation of Statement of Economic Interest for Dr. Lisa Ehrler.

NORTH CAROLINA PHYSICIAN HEALTH PROGRAM REPORTS (NCPHP)

Dr. Joseph Jordan gave the NCPHP Annual report.

A motion passed to close the session pursuant to Section 143-318.11(a) of the North Carolina General Statutes to prevent the disclosure of information that is confidential pursuant to Sections 90-8, 90-14, 90-16, and 90-21.22 of the North Carolina General Statutes and not considered a public record within the meaning of Chapter 132 of the General Statutes and/or to preserve attorney/client privilege.

Dr. Joseph Jordan gave the NCPHP Compliance Committee report. The specifics of this report are not included because the information contained in the report is confidential and non-public.

A motion passed to return to open session.

NCMB LEGAL DEPARTMENT REPORT

Mr. Brian Blankenship, Chief Legal Officer, gave the Legal Department Report on Friday, March 20, 2026.

Mr. Blankenship updated the Board on the schedule of June 2026 and October 2026 hearings and hearing assignments. Deputy General Counsel Marcus Jimison provided an updated regarding rules activity.

A motion passed to close the session pursuant to N.C. Gen Stat. §143-318.11(a) to prevent the disclosure of information that is confidential pursuant to Sections 90-8, 90-14, 90-16, and/or 90-21.22 of the North Carolina General Statutes and not considered public records within the meaning of Chapter 132 of the General Statutes and/or to preserve attorney/client privilege.

Mr. Blankenship provided information within the attorney-client privilege regarding work product occurring since the last Legal Department Report was presented.

The Legal Department Report was concluded.

The Board accepted the report as information.

A motion passed to return to open session.

NCMB COMMITTEE REPORTS

Executive Committee Report

Members present were: Anuradha Rao-Patel, MD, Chair; J. Nelson Dollar, MA; Mark A. Newell, MD, MMM; Robert L. Rich, MD. Member absent: Devdutta G. Sangvai, MD, JD, MBA

Financial Update

a. Year-To-Date Financials

The Committee reviewed the following financial reports through January 31, 2026: Balance Sheet, Profit & Loss versus Budget, and the Profit & Loss Comparison with the accounting team.

Committee Recommendation: Accept the financial information as reported.

Board Action: Accept Committee recommendation. Accept the financial information as reported.

b. FY25 Budget to Actuals

The Committee reviewed the Budget to Actuals Report, which compares actual income and expenses to budgeted income and expenses for the fiscal year ending October 31, 2025, with the accounting team.

Committee Recommendation: Accept the financial information as reported.

Board Action: Accept the Committee recommendation. Accept the investment statements as reported.

c. Investment Account Update

The Committee reviewed the investment statements for December 2025, January and February 2026 with the accounting team.

Committee Recommendation: Accept the investment statements as reported.

Board Action: Accept the Committee recommendation. Accept the investment statements as reported.

Old Business:

a. 2026 NCMB Retreat Update

The 2026 NCMB Retreat is set for August 7-9 at the Chetola Resort in Blowing Rock.

Possible topics at the retreat include a legislative update with elected officials and additional training on counter transference.

Staff will meet the Board President between now and the Board meeting to explore the possible topics for the retreat.

Committee Recommendation: Accept the NCMB Retreat update as information.

Board Action: Accept the Committee recommendation. Accept the NCMB Retreat update as information.

New Business:

a. Legislative Update

Staff presented the legislative update.

Committee Recommendation: Accept the legislative update as information.

Board Action: Accept the Committee recommendation. Accept the legislative update as information.

b. FSMB Annual Meeting Update

The 2026 Federation of State Medical Boards (FSMB) Annual Meeting will be held April 30-May 2, 2026 at the Baltimore Marriott Waterfront. Ms. Loney Johnson has reserved rooms for Board members going to the meeting.

NCMB will host a dinner for Board members and staff in attendance on Thursday, April 30th. We have up to 16 seats available for the FSMB Foundation luncheon on Friday, May 1st. We hope all Board members present will attend the lunch.

Ms. Johnson provided additional details for the FSMB annual meeting during the Committee

meeting.

Committee Recommendation: Accept the FSMB Annual Meeting update as information.

Board Action: Accept the Committee recommendation. Accept the FSMB Annual Meeting update as information.

Policy Committee Report

Members present were: Robert L. Rich, Jr., M.D., Chair; J. Nelson Dollar, M.A.; Gregory S. McCarty, M.D.; Anthony R. Plunkett, M.D. Member absent: Devdutta G. Sangvai, M.D., J.D., MBA.

Old Business:

a. 5.1.1: Office-Based Procedures (Appendix A)

After the January 2026 meeting, Committee members reviewed the requested revisions with no additional revisions requested. As the incorporated revisions are not substantive in nature, but instead are meant for clarification, the Committee agreed to adopt and publish the revised position statement without sending to the stakeholders for comment.

Committee recommendation: Adopt and publish the revised position statement.

Board Action: Accept Committee recommendation. Adopt and publish the revised position statement.

New Business:

b. 8.3.1: Advertising and Publicity

The Committee reviewed the revisions and comments received from Committee members prior to the meeting and after discussion instructed staff to incorporate discussed revisions, circulate to Committee members, and bring back for review at a later meeting.

Committee Recommendation: Staff to incorporate discussed revisions, circulate to Committee members, and bring back for review at a later meeting, with an anticipated date of July 2026.

Board Action: Accept Committee recommendation. Staff to incorporate discussed revisions, circulate to Committee members, and bring back for review at a later meeting, with an anticipated date of July 2026.

c. 10.1.1: Referral Fees and Fee Splitting

The Committee reviewed the one comment received from a Committee member prior to the meeting and after staff provided clarification on the phrase “Voucher Advertising” the Committee agreed to make no changes to the current position statement and accept the review as information.

Committee Recommendation: Accept review of the position statement as information.

Board Action: Accept Committee recommendation. Accept review of the position statement as information.

Position Statement Review Chart:

The Committee reviewed the position statement review chart noting that the Committee is ahead of the four-year review cycle of the current position statements. The Committee agreed that unless an urgent matter arises, the Committee will meet next in July 2026. The tentative agenda for that meeting would include discussing the revisions to 8.3.1: Advertising and Publicity and review of 9.1.3.: Licensee Employment.

Committee Recommendation: Accept as information.

Board Action: Accept Committee recommendation. Accept as information.

Licensing Committee Report

Members present were Earic R. Bonner, MD, MBA, Chair; Vickie A. Harry; Mark A. Newell, MD, MMM; Miguel A. Pineiro, PA-C, MHPE; Robert L. Rich, MD.

A motion passed to close the session pursuant to Section 143-318.11(a) of the North Carolina General Statutes to prevent the disclosure of information that is confidential pursuant to Sections 90-8, 90-14, 90-16, and 90-21.22 of the North Carolina General Statutes and not considered a public record within the meaning of Chapter 132 of the General Statutes and/or to preserve attorney-client privilege.

The License Committee reviewed eight cases. A written report was presented for the Board's review. The Board adopted the Committee's recommendation to approve the written report. The specifics of this report are not included because these actions are not public information.

A motion passed to return to open session.

Open Session:

a. Licensing Dashboard Update (Becky Powers Chief of Licensing and Registration)
The Committee received a presentation on the data in the Licensing Dashboard. The Chief Licensing and Registration Officer presented data on seven metrics developed for the Committee. The data presented was broken down into three areas: current status, workload, and licenses issued.

Current staffing: updates to staffing included adding the Registration and Corporations Coordinator positions to our report. Also added was the filling of the last three coordinator positions. This brought our Coordinator staff to 10.4. The Licensing Department has three Associates, one Sr. Associate, one Sr. Coordinator, one Licensing Coordinator Manager, one Corporations Coordinator, one Registration Coordinator, one Licensing Investigator and a Chief of Licensing and Registration.

The number of applications in the system is approximately 2,531 applications. Dashboard presentation, the board received over 1,980 applications within the first quarter ending January 31.

The sharp rise in applications in January included the Interstate Medical License Compact (IMLC) applications.

For the current fiscal year, more than 1,400 licenses have been issued. Approximately 16% of those applications were complex and required additional rounds of review. The time to license is an average of 81.7 days for the reporting period. This is a sharp decrease and may be due to the IMLC licenses had been part of this statistical data. IMLC licenses are completed in a shorter time frame.

The initial time to review has decreased significantly. Our current timeline is stated on our website for 15 business days. We are currently at 3.20 business days.

Board members discussed the report. Dr. Newell observed our current data and inquired about the separation of IMLC data. It was shared that we are working with our Data Analyst to update our statistical information reflecting the separation

Committee recommendation: Accept as information

Board Action: Accept as information

b. Resident Training License Conversion to a Full, Board Attorney
The Committee received a recommendation to adopt RTL Conversion Rule 21 NCAC 32b. 1403 allowing for RTL applications to be converted to a full license.

Committee Recommendation: Approve the proposed Rule as written. The vote was to move to the full board for approval.

Board Action: Approve the proposed Rule as written. The vote was to move to the full board for approval.

License Interview Report

A motion passed to close the session pursuant to Section 143-318.11(a) of the North Carolina General Statutes to prevent the disclosure of information that is confidential pursuant to Sections 90-8, 90-14, 90-16, and 90-21.22 of the North Carolina General Statutes and not considered a public record within the meaning of Chapter 132 of the General Statutes and/or to preserve attorney-client privilege.

Five licensure interviews were conducted virtually. A written report was presented for the Board's review. The Board adopted the Committee's recommendation to approve the written report. The specifics of this report are not included because these actions are not public information.

A motion passed to return to open session.

Disciplinary (Investigative) Committee Report

Members present were: Mark A. Newell, MD, MMM, Chair; J. Nelson Dollar, MA; Vicki A. Harry; Sharona Y. Johnson, PhD, FNP-BC; Shannon R. Joseph; Miguel A. Pineiro, PA-C, MHPE; Robert L. Rich, MD.
Member absent: Devdutta G. Sangvai, MD, JD, MBA

A motion passed to close the session pursuant to Section 143-318.11(a) of the North Carolina General Statutes to prevent the disclosure of information that is confidential pursuant to Sections 90-8, 90-14, 90-16, and 90-21.22 of the North Carolina General Statutes and not considered a public record within the meaning of Chapter 132 of the General Statutes and/or to preserve attorney-client privilege.

The Disciplinary (Investigative) Committee reviewed 56 investigative cases. A written report was presented for the Board's review. The Board adopted the recommendations and approved the written report. The specifics of this report are not included because these actions are not public information.

A motion passed to return to open session.

Disciplinary (Complaints) Committee Report

Members present were: Mark A. Newell, MD, MMM, Chair; J. Nelson Dollar, MA; Vicki A. Harry; Sharona Y. Johnson, PhD, FNP-BC; Shannon R. Joseph; Miguel A. Pineiro, PA-C, MHPE; Robert L. Rich, MD. Member absent: Devdutta G. Sangvai, MD, JD, MBA

A motion passed to close the session pursuant to Section 143-318.11(a) of the North Carolina General Statutes to prevent the disclosure of information that is confidential pursuant to Sections 90-8, 90-14, 90-16, and 90-21.22 of the North Carolina General Statutes and not considered a public record within the meaning of Chapter 132 of the General Statutes and/or to preserve attorney-client privilege.

The Disciplinary (Complaints) Committee reviewed 60 complaint cases. A written report was presented for the Board's review. The Board adopted the Committee's recommendation to approve the written report. The specifics of this report are not included because these actions are not public.

A motion passed to return to open session.

Disciplinary (Compliance) Committee Report

Members present were: Mark A. Newell, MD, MMM, Chair; J. Nelson Dollar, MA; Vicki A. Harry; Sharona Y. Johnson, PhD, FNP-BC; Shannon R. Joseph; Miguel A. Pineiro, PA-C, MHPE; Robert L. Rich, MD. Member absent: Devdutta G. Sangvai, MD, JD, MBA

A motion passed to close the session pursuant to Section 143-318.11(a) of the North Carolina General Statutes to prevent the disclosure of information that is confidential pursuant to Sections 90-8, 90-14, 90-16, and 90-21.22 of the North Carolina General Statutes and not considered a public record within the meaning of Chapter 132 of the General Statutes and/or to preserve attorney-client privilege.

The Disciplinary (Compliance) Committee reviewed four investigative cases. A written report was presented for the Board's review. The Board adopted the recommendations and approved the written report. The specifics of this report are not included because these actions are not public information.

A motion passed to return to open session.

Disciplinary (Malpractice) Committee Report

Members present were: Mark A. Newell, MD, MMM, Chair; J. Nelson Dollar, MA; Vicki A. Harry; Sharona Y. Johnson, PhD, FNP-BC; *Shannon R. Joseph;* Miguel A. Pineiro, PA-C, MHPE; Robert L. Rich, MD. Member absent: Devdutta G. Sangvai, MD, JD, MBA

A motion passed to close the session pursuant to Section 143-318.11(a) of the North Carolina General Statutes to prevent the disclosure of information that is confidential pursuant to Sections 90-8, 90-14, 90-16, and 90-21.22 of the North Carolina General Statutes and not considered a public record within the meaning of Chapter 132 of the General Statutes and/or to preserve attorney-client privilege.

The Disciplinary (Malpractice) Committee reviewed 40 cases. A written report was presented for the Board's review. The Board adopted the Committee's recommendation to approve the written report. The specifics of this report are not included because these actions are not public information.

A motion passed to return to open session.

Disciplinary (Department of Health and Human Services) DHHS Committee Report

Members present were: Mark A. Newell, MD, MMM, Chair; J. Nelson Dollar, MA; Vicki A. Harry; Sharona Y. Johnson, PhD, FNP-BC; *Shannon R. Joseph;* Miguel A. Pineiro, PA-C, MHPE; Robert L. Rich, MD. Member absent: Devdutta G. Sangvai, MD, JD, MBA

A motion passed to close the session pursuant to Section 143-318.11(a) of the North Carolina General Statutes to prevent the disclosure of information that is confidential pursuant to Sections 90-8, 90-14, 90-16, and 90-21.22 of the North Carolina General Statutes and not considered a public record within the meaning of Chapter 132 of the General Statutes and/or to preserve attorney-client privilege.

The Disciplinary (DHHS) Committee reviewed two cases. A written report was presented for the Board's review. The Board adopted the Committee's recommendation to approve the written report. The specifics of this report are not included because these actions are not public.

A motion passed to return to open session.

Investigative Interview Report

A motion passed to close the session pursuant to Section 143-318.11(a) of the North Carolina General Statutes to prevent the disclosure of information that is confidential pursuant to Sections 90-8, 90-14, 90-16, and 90-21.22 of the North Carolina General Statutes and not considered a public record within the meaning of Chapter 132 of the General Statutes and/or to preserve attorney-client privilege.

Five investigative interviews were conducted virtually. A written report was presented for the Board's review. The Board adopted the recommendations and approved the written report. The specifics of this report are not included because these actions are not public information.

A motion passed to return to open session.

Outreach Committee Report

Members present were: Anthony R. Plunkett, MD, Chair; Lisa Ehrler, DO; Vicki A. Harry; Sharona Y. Johnson, PhD, FNP-BC

Old Business:

a. Update on Presentations
    i. Professional and public presentations
    ii. Regulatory Immersion Series events
    iii. Update on presentations to Medical Executive Committees and Grand Rounds
    iv. Update on webinar presentations

The Communications Director gave an overview of professional and public outreach efforts, including the Regulatory Immersion Series mock disciplinary course. The Communications Director noted that NCMB will be tabling at several health fairs in the upcoming months. Some of these health fairs are in Eastern NC and in the Triad, as staff make progress in efforts to expand outreach outside of the Triangle. Staff have also added a few new RIMS program engagements to the schedule and are looking for Board Members to staff those sessions.

The Communications Director reported that staff have made progress in securing presentation opportunities to Medical Executive Committees and Grand Rounds, extending a special thank you to Dr. McCarty, Dr. Johnson, and Dr. Plunkett for reaching out to their contacts to assist with this effort. The Committee Chair advised that presentations lasting 10-15 minutes are preferred by MEC audience. Staff asked for Committee Members' input on key content to include in short presentations.

Finally, the Communications Director discussed continuing to explore the webinar model of presentations, as many organizations report that it can be challenging to get attendees to attend in person events. Continuing with the webinar model, staff are planning a live webinar on IMLC and other provisions of HB67 for some time this Spring.

Committee recommendation: Accept as information.

Board Action: Accept committee recommendation. Accept as information

b. Update on Board Member Awareness Efforts

The Communications Director updated the committee on continued efforts with Board Service Awareness. Staff have completed a new webpage on the NCMB website covering the opportunity to serve as a Board Member that covers qualifications, the application process, FAQs and more. This format will allow Board Members, Board alumni or staff to more easily share information about Board Service.

Committee recommendation: Accept as information.

Board Action: Accept committee recommendation. Accept as information.

New Business:

a. Proposed training/onboarding for NCMB speakers

The Communications Director proposed offering training on presentations to Board Members, with a goal of increasing Board Members' confidence in providing information about NCMB at events. Recognizing that a majority of Board Members have served for two years or less, staff felt that this would be a good time to talk about the process for participating in speaking engagements. The Communications Director indicated that staff support presenters by developing content, coordinating logistics and arranging prep sessions, if needed. The Communications Director noted that there are opportunities for Public Members to participate in presentations as well and suggested that public outreach be included in any training presented. The Committee discussed holding training during a Thursday afternoon at a future Board Meeting; staff will consult NCMB's training calendar and see when this might be possible. Board Members are invited to share specific training needs or ideas with staff.

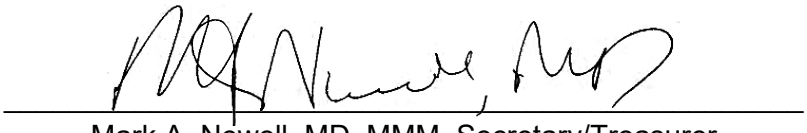
Committee recommendation: Direct staff to develop a training program suitable for Board Members or anyone who presents information about NCMB.

Board Action: Accept committee recommendation. Direct staff to develop a training program suitable for Board Members or anyone who presents information about NCMB.

ADJOURNMENT

The Medical Board officially adjourned at 11:38 a.m. on Friday, March 20, 2026.

The next meeting of the Medical Board will be in person, May 20-22, 2026



Mark A. Newell, MD, MMM, Secretary/Treasurer

5.1.1: Office-Based Procedures

Preface

This Position Statement on Office-Based Procedures is an interpretive statement that attempts to identify and explain the standards of practice for Office-Based Procedures in North Carolina. The Board's intention is to articulate existing professional standards and not to promulgate a new standard.

This Position Statement is in the form of guidelines designed to assure patient safety and identify the criteria by which the Board will assess the conduct of licensees in considering disciplinary action arising out of the performance of office-based procedures. Thus, it is expected that the licensee who follows the guidelines set forth below will avoid disciplinary action by the Board. However, this Position Statement is not intended to be comprehensive or to set out exhaustively every standard that might apply in every circumstance. The silence of the Position Statement on any particular matter should not be construed as the lack of an enforceable standard.

General Guidelines

The Licensee's Professional and Legal Obligation

The Board has adopted the guidelines contained in this Position Statement in order to assure patients have access to safe, high-quality office-based surgical and special procedures. The guidelines further assure that a licensee with appropriate qualifications takes responsibility for the supervision of all aspects of the perioperative surgical, procedural and anesthesia care delivered in the office setting, including compliance with all aspects of these guidelines.

These obligations are to be understood (as explained in the Preface) as existing standards identified by the Board in an effort to assure patient safety and provide licensees guidance to avoid practicing below the standards of practice in such a manner that the licensee would be exposed to possible disciplinary action for unprofessional conduct as contemplated in N.C. Gen. Stat. § 90-14(a)(6).

Procedure Level Definitions

Level I procedures – any surgical or special procedures:

1. That do not involve drug-induced alteration of consciousness;
2. Where preoperative medications are not required or used other than minimal anxiolysis of the patient;
3. Where the anesthesia required or used is local, topical, digital block, or none; and
4. Where the probability of complications requiring hospitalization is remote.

Level II procedures – any surgical or special procedures:

1. That require the administration of local or peripheral nerve block, minor conduction blockade, Bier block, minimal sedation, or conscious sedation; and
2. Where there is only a moderate risk of surgical and/or anesthetic complications and the need for hospitalization as a result of these complications is unlikely.

Level III procedures – any surgical or special procedures:

1. That require, or reasonably should require, the use of major conduction blockade, deep sedation/analgesia, or general anesthesia; and

2. Where there is only a moderate risk of surgical and/or anesthetic complications and the need for hospitalization as a result of these complications is unlikely.

(Additional definitions are provided at the end of this position statement.)

Exemptions

These guidelines do not apply to Level I procedures.

Written Policies and Procedures

Written policies and procedures should be maintained to assist office-based practices in providing safe and quality surgical or special procedure care, assure consistent personnel performance, and promote an awareness and understanding of the inherent rights of patients.

Emergency Procedure and Transfer Protocol

The licensee who performs the surgical or special procedure should assure that a transfer protocol is in place, preferably with a hospital that is licensed in the jurisdiction in which it is located and that is within reasonable proximity of the office where the procedure is performed. The transfer protocol should have guidelines on a "warm handoff" ensuring there has been direct communication from the transferring licensee's office to the receiving provider.

All office personnel should be familiar with and capable of carrying out written emergency instructions. The instructions should be followed in the event of an emergency, any untoward anesthetic, medical or surgical complications, or other conditions making transfer to an emergency department and/or hospitalization of a patient necessary. The instructions should include arrangements for immediate contact of emergency medical services when indicated and when advanced cardiac life support is needed. When emergency medical services are not indicated, the instructions should include procedures for timely escort of the patient to the hospital or to an appropriate licensed health care professional.

Infection Control

The practice should comply with state and federal regulations regarding infection control. For all surgical and special procedures, the level of sterilization should meet applicable industry and occupational safety 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.

Performance Improvement

A performance improvement program should be implemented to provide a mechanism to review yearly the current practice activities and quality of care provided to patients.

Performance improvement activities should include, but are not limited to, review of complications and mortalities; the appropriateness and necessity of procedures performed; emergency transfers; reportable complications, and resultant outcomes (including all postoperative infections); analysis of patient satisfaction surveys and complaints; and identification of undesirable trends (such as diagnostic errors, unacceptable results, follow-up of abnormal test results, medication errors, and system problems). Findings of the performance improvement program should be incorporated into the practice's educational activity.

Medical Records and Informed Consent

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.

Medical history, physical examination, lab studies obtained within 30 days of the scheduled procedure, and pre-anesthesia examination and evaluation information and data should be adequately documented in the medical record.

The medical records also should contain documentation of the intraoperative and postoperative monitoring required by these guidelines.

Written documentation of informed consent should be included in the medical record.

Credentialing of Licensees

A licensee who performs surgical or special procedures in an office requiring the administration of anesthesia services should be credentialed to perform that surgical or special procedure by a hospital, an ambulatory surgical facility, or substantially comply with criteria established by the Board.

Criteria to be considered by the Board in assessing a licensee's competence to perform a surgical or special procedure include, without limitation:

1. State licensure in North Carolina;
2. Procedure specific education, training, experience and successful evaluation appropriate for the patient population being treated (*i.e.*, pediatrics);
3. For licensees, board certification, board eligibility or completion of a training program in a field of specialization recognized by the ACGME or AOA or by a national medical specialty board that is recognized by the ABMS or AOA for expertise and proficiency in that field. For purposes of this requirement, board eligibility or certification is relevant only if the board in question is recognized by the ABMS, AOA, or equivalent board certification as determined by the Board;
4. Professional misconduct and malpractice history;
5. Participation in peer and quality review;
6. Participation in continuing education consistent with the statutory requirements and requirements of the licensee's professional organization;
7. To the extent such coverage is reasonably available in North Carolina, malpractice insurance coverage for the surgical or special procedures being performed in the office;
8. Procedure-specific competence (and competence in the use of new procedures and technology), which should encompass education, training, experience and evaluation, and which may include the following:
    - Adherence to professional society standards;
    - Credentials approved by a nationally recognized accrediting or credentialing entity; or
    - Didactic course complemented by hands-on, observed experience; training is to be followed by a specified number of cases supervised by a licensed health care professional already competent in the respective procedure, in accordance with professional society standards.

If the licensee administers the anesthetic as part of a surgical or special procedure (Level II only), he or she also should have documented competence to deliver the level of anesthesia administered.

Accreditation
After one year of operation following the adoption of these guidelines, any licensee who performs Level II or Level III procedures in an office should be able to demonstrate, upon request by the Board, substantial compliance with these guidelines, or should obtain accreditation of the office setting by an approved accreditation agency or organization. The approved accreditation agency or organization should submit, upon request by the Board, a summary report for the office accredited by that agency.

All expenses related to accreditation or compliance with these guidelines shall be paid by the licensee who performs the surgical or special procedures.

Patient Selection
The licensee who performs the surgical or special procedure should evaluate the condition of the patient and the potential risks associated with the proposed treatment plan. The licensee also is responsible for determining that the patient has an adequate support system to provide for necessary follow-up care. Patients with pre-existing medical problems or other conditions, who are at undue risk for complications, should be referred to an appropriate specialist for preoperative consultation.

ASA Physical Status Classifications
Patients that are considered high risk or are ASA physical status classification III, IV, or V and require a general anesthetic for the surgical procedure, should not have the surgical or special procedure performed in a licensee office setting.

C**andidates for Level II Procedures**
Patients with an ASA physical status classification I, II, or III may be acceptable candidates for office-based surgical or special procedures requiring conscious sedation/ analgesia. ASA physical status classification III patients should be specifically addressed in the operating manual for the office. They may be acceptable candidates if deemed so by a licensee qualified to assess the specific disability and its impact on anesthesia and surgical or procedural risks.

Candidates for Level III Procedures
Only patients with an ASA physical status classification I or II, who have no airway abnormality, and possess an unremarkable anesthetic history are acceptable candidates for Level III procedures.

Surgical or Special Procedure Guidelines

Patient Preparation
A medical history and physical examination to evaluate the risk of anesthesia and of the proposed surgical or special procedure should be performed by a licensee qualified to assess the impact of co-existing disease processes on surgery and anesthesia. Appropriate laboratory studies should be obtained within 30 days of the planned surgical procedure.

A pre-procedure examination and evaluation should be conducted prior to the surgical or special procedure by the licensee. The information and data obtained during the course of this evaluation should be documented in the medical record.

The licensee performing the surgical or special procedure also should:

1. Ensure that an appropriate pre-anesthetic examination and evaluation is performed proximate to the procedure;

2. Prescribe the anesthetic, unless the anesthesia is administered by an anesthesiologist in which case the anesthesiologist may prescribe the anesthetic;
3. Ensure that qualified health care professionals participate;
4. Remain physically present during the intraoperative period and be immediately available for diagnosis, treatment, and management of anesthesia-related complications or emergencies; and
5. Ensure the provision of indicated post-anesthesia care.

Discharge Criteria

Criteria for discharge for all patients who have received anesthesia should include the following:

1. Confirmation of stable vital signs;
2. Stable oxygen saturation levels;
3. Return to pre-procedure mental status;
4. Adequate pain control;
5. Minimal bleeding, nausea and vomiting;
6. Resolving neural blockade, resolution of the neuraxial blockade; and
7. Eligible to be discharged in the company of a competent adult.

Information to the Patient

The patient should receive verbal instruction understandable to the patient or guardian, confirmed by written post-operative instructions and emergency contact numbers. The 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 should questions arise;
4. Instructions for medications prescribed and pain management;
5. Information regarding the follow-up visit date, time and location; and
6. Designated treatment hospital in the event of emergency.

Reportable Complications

Licensees performing surgical or special procedures in the office should maintain timely records, which should be provided to the Board within three business days of receipt of a Board inquiry. Records of reportable complications should be in writing and should include:

1. Licensee's name and license number;
2. Date and time of the occurrence;
3. Office where the occurrence took place;
4. Name, date of birth, and address of the patient;
5. Surgical or special procedure involved;
6. Type and dosage of sedation or anesthesia utilized in the procedure; and
7. Circumstances involved in the occurrence.

Equipment Maintenance

All anesthesia-related equipment and monitors should be maintained to current operating room standards. All devices should have regular service/maintenance checks at least annually or per manufacturer recommendations. Service/maintenance checks should be performed by appropriately qualified biomedical personnel. Prior to the administration of anesthesia, all equipment/monitors should be checked using the current FDA recommendations as a guideline. Records of equipment checks should be maintained in a separate, dedicated log which must be made available to the Board upon request. Documentation of any criteria deemed to be substandard should include a clear description of

the problem and the intervention. If equipment is utilized despite the problem, documentation should clearly indicate that patient safety is not in jeopardy.

The emergency supplies should be maintained and inspected by qualified personnel for presence and function of all appropriate equipment and drugs at intervals established by protocol to ensure that equipment is functional and present, drugs are not expired, and office personnel are familiar with equipment and supplies. Records of emergency supply checks should be maintained in a separate, dedicated log and made available to the Board upon request.

A licensee should not permit anyone to tamper with a safety system or any monitoring device or disconnect an alarm system.

Compliance with Relevant Health Laws
Federal and state laws and regulations that affect the practice should be identified and procedures developed to comply with those requirements.

Nothing in this position statement affects the scope of activities subject to or exempted from the North Carolina health care facility licensure laws.

Patient Rights
Office personnel should be informed about the basic rights of patients and understand the importance of maintaining patients' rights. A patients' rights document should be readily available upon request.

Enforcement
In that the Board believes that these guidelines constitute the accepted and prevailing standards of practice for office-based procedures in North Carolina, failure to substantially comply with these guidelines creates the risk of disciplinary action by the Board.

Level II Guidelines

Personnel
The licensee who performs the surgical or special procedure or a health care professional who is present during the intraoperative and postoperative periods should be ACLS certified, and at least one other health care professional should be BLS certified. In an office where anesthesia services are provided to infants and children, personnel should be appropriately trained to handle pediatric emergencies (*i.e.*, APLS or PALS certified).

Recovery should be monitored by a registered nurse or other health care professional practicing within the scope of his or her license or certification who is BLS certified and has the capability of administering medications as required for analgesia, nausea/vomiting, or other indications.

Surgical or Special Procedure Guidelines

Intraoperative Care and Monitoring
The licensee who performs Level II procedures that require conscious sedation in an office should ensure that monitoring is provided by a separate health care professional not otherwise involved in the surgical or special procedure. Monitoring should include, when clinically indicated for the patient:

- Direct observation of the patient and, to the extent practicable, observation of the patient's responses to verbal commands;
- Pulse oximetry should be performed continuously (an alternative method of measuring oxygen saturation may be substituted for pulse oximetry if the method has been demonstrated to have at least equivalent clinical effectiveness);
- An electrocardiogram monitor should be used continuously on the patient;
- The patient's blood pressure, pulse rate, and respirations should be measured and recorded at least every five minutes; and
- The body temperature of a pediatric patient should be measured continuously.

Clinically relevant findings during intraoperative monitoring should be documented in the patient's medical record.

Postoperative Care and Monitoring
The licensee who performs the surgical or special procedure should evaluate the patient immediately upon completion of the surgery or special procedure and the anesthesia.

Care of the patient may then be transferred to the care of a qualified health care professional in the recovery area. A registered nurse or other health care professional practicing within the scope of his or her license or certification and who is BLS certified and has the capability of administering medications as required for analgesia, nausea/vomiting, or other indications should monitor the patient postoperatively.

At least one health care professional who is ACLS certified should be immediately available until all patients have met discharge criteria. Prior to leaving the operating room or recovery area, each patient should meet discharge criteria.

Monitoring in the recovery area should include pulse oximetry and non-invasive blood pressure measurement. The patient should be assessed periodically for level of consciousness, pain relief, or any untoward complication. Clinically relevant findings during post-operative monitoring should be documented in the patient's medical record.

Equipment and Supplies
Unless another availability standard is clearly stated, the following equipment and supplies should be present in all offices where Level II procedures are performed:

1. Full and current crash cart at the location where the anesthetizing is being carried out. (the crash cart inventory should include appropriate resuscitative equipment and medications for surgical, procedural or anesthetic complications);
2. Age-appropriate sized monitors, resuscitative equipment, supplies, and medication in accordance with the scope of the surgical or special procedures and the anesthesia services provided;
3. Emergency power source able to produce adequate power to run required equipment for a minimum of two (2) hours;
4. Electrocardiographic monitor;
5. Noninvasive blood pressure monitor;
6. Pulse oximeter;
7. Continuous suction device;
8. Endotracheal tubes, laryngoscopes;
9. Positive pressure ventilation device (e.g., Ambu);

10. Reliable source of oxygen;
11. Emergency intubation equipment;
12. Adequate operating room lighting;
13. Appropriate sterilization equipment; and
14. IV solution and IV equipment.

Level III Guidelines

Personnel
Anesthesia should be administered by an anesthesiologist or a CRNA supervised by a licensee. The licensee who performs the surgical or special procedure should not administer the anesthesia. The anesthesia provider should not be otherwise involved in the surgical or special procedure.

The licensee or the anesthesia provider should be ACLS certified, and at least one other health care professional should be BLS certified. In an office where anesthesia services are provided to infants and children, personnel should be appropriately trained to handle pediatric emergencies (*i.e.*, APLS or PALS certified).

Surgical or Special Procedure Guidelines

Intraoperative Monitoring
The licensee who performs procedures in an office that require major conduction blockade, deep sedation/analgesia, or general anesthesia should ensure that monitoring is provided as follows when clinically indicated for the patient:

- Direct observation of the patient and, to the extent practicable, observation of the patient's responses to verbal commands;
- Pulse oximetry should be performed continuously. Any alternative method of measuring oxygen saturation may be substituted for pulse oximetry if the method has been demonstrated to have at least equivalent clinical effectiveness;
- An electrocardiogram monitor should be used continuously on the patient;
- The patient's blood pressure, pulse rate, and respirations should be measured and recorded at least every five minutes;
- Monitoring should be provided by a separate health care professional not otherwise involved in the surgical or special procedure;
- End-tidal carbon dioxide monitoring should be performed on the patient continuously during any level of sedation beyond conscious sedation;
- An in-circuit oxygen analyzer should be used to monitor the oxygen concentration within the breathing circuit, displaying the oxygen percent of the total inspiratory mixture;
- A respirometer (volumeter) should be used to measure exhaled tidal volume whenever the breathing circuit of a patient allows;
- The body temperature of each patient should be measured continuously; and
- An esophageal or precordial stethoscope should be utilized on the patient.

Clinically relevant findings during intraoperative monitoring should be documented in the patient's medical record.

Postoperative Care and Monitoring

The licensee who performs the surgical or special procedure should evaluate the patient immediately upon completion of the surgery or special procedure and the anesthesia.

Care of the patient may then be transferred to the care of a qualified health care professional in the recovery area. Qualified health care professionals capable of administering medications as required for analgesia, nausea/vomiting, or other indications should monitor the patient postoperatively.

Recovery from a Level III procedure should be monitored by an ACLS certified (PALS or APLS certified when appropriate) health care professional using appropriate criteria for the level of anesthesia. At least one health care professional who is ACLS certified should be immediately available during postoperative monitoring and until the patient meets discharge criteria. Each patient should meet discharge criteria prior to leaving the operating or recovery area.

Monitoring in the recovery area should include pulse oximetry and non-invasive blood pressure measurement. The patient should be assessed periodically for level of consciousness, pain relief, or any untoward complication. Clinically relevant findings during postoperative monitoring should be documented in the patient's medical record.

Equipment and Supplies

Unless another availability standard is clearly stated, the following equipment and supplies should be present in all offices where Level III procedures are performed:

1. Full and current crash cart at the location where the anesthetizing is being carried out (the crash cart inventory should include appropriate resuscitative equipment and medications for surgical, procedural or anesthetic complications);
2. Age-appropriate sized monitors, resuscitative equipment, supplies, and medication in accordance with the scope of the surgical or special procedures and the anesthesia services provided;
3. Emergency power source able to produce adequate power to run required equipment for a minimum of two (2) hours;
4. Electrocardiographic monitor;
5. Noninvasive blood pressure monitor;
6. Pulse oximeter;
7. Continuous suction device;
8. Endotracheal tubes, and laryngoscopes;
9. Positive pressure ventilation device (*e.g.*, Ambu);
10. Reliable source of oxygen;
11. Emergency intubation equipment;
12. Adequate operating room lighting;
13. Appropriate sterilization equipment;
14. IV solution and IV equipment;
15. A malignant hyperthermia cart should be fully stocked and emergently available;
16. Esophageal or precordial stethoscope;
17. Emergency resuscitation equipment;
18. Temperature monitoring device;
19. End tidal CO2 monitor for any level of sedation beyond conscious sedation;
20. Appropriate operating or procedure table; and
21. Appropriate pediatric specific emergency cart for those locations giving anesthesia to pediatric patients.

Definitions

AAAASF – the American Association for the Accreditation of Ambulatory Surgery Facilities.
AAAHC – the Accreditation Association for Ambulatory Health Care
ABMS – the American Board of Medical Specialties
ACGME – the Accreditation Council for Graduate Medical Education
ACLS certified – a person who holds a current "ACLS Provider" credential certifying that they have successfully completed the national cognitive and skills evaluations in accordance with the curriculum of the American Heart Association for the Advanced Cardiovascular Life Support Program.
Advanced cardiac life support certified – a licensee that has successfully completed and recertified periodically an advanced cardiac life support course offered by a recognized accrediting organization appropriate to the licensee's field of practice. For example, for those licensees treating adult patients, training in ACLS is appropriate; for those treating children, training in PALS or APLS is appropriate.
Ambulatory surgical facility – a facility licensed under Article 6, Part D of Chapter 131E of the North Carolina General Statutes or if the facility is located outside North Carolina, under that jurisdiction's relevant facility licensure laws.
Anesthesia provider – an anesthesiologist or CRNA.
Anesthesiologist – a physician who has successfully completed a residency program in anesthesiology approved by the ACGME or AOA, or who is currently a diplomate of either the American Board of Anesthesiology or the American Osteopathic Board of Anesthesiology, or who was made a Fellow of the American College of Anesthesiology before 1982.
AOA – the American Osteopathic Association
APLS certified – a person who holds a current certification in advanced pediatric life support from a program approved by the American Heart Association.
Approved accrediting agency or organization – a nationally recognized accrediting agency (*e.g.*, AAAASF; AAAHC, JCAHO, and HFAP) including any agency approved by the Board.
ASA – the American Society of Anesthesiologists
BLS certified – a person who holds a current certification in basic life support from a program approved by the American Heart Association.
Board – the North Carolina Medical Board.
Conscious sedation – the administration of a drug or drugs in order to induce that state of consciousness in a patient which allows the patient to tolerate unpleasant medical procedures without losing defensive reflexes, adequate cardio-respiratory function and the ability to respond purposefully to verbal command or to tactile stimulation if verbal response is not possible as, for example, in the case of a small child or deaf person. Conscious sedation does not include an oral dose of pain medication or minimal pre-procedure tranquilization such as the administration of a pre-procedure oral dose of a benzodiazepine designed to calm the patient. "Conscious sedation" should be synonymous with the term "sedation/analgesia" as used by the American Society of Anesthesiologists.
Credentialed – a physician that has been granted, and continues to maintain, the privilege by a hospital or ambulatory surgical facility licensed in the jurisdiction in which it is located to provide specified services, such as surgical or special procedures or the administration of one or more types of anesthetic agents or procedures, or can show documentation of adequate training and experience.
CRNA – a registered nurse who is authorized by the North Carolina Board of Nursing to perform nurse anesthesia activities.
Deep sedation/analgesia – the administration of a drug or drugs which produces depression of consciousness during which patients cannot be easily aroused but can 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.
FDA – the Food and Drug Administration.

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.
Health care professional – any office staff member who is licensed or certified by a recognized professional or health care organization.
HFAP – the Health Facilities Accreditation Program, a division of the AOA.
Hospital – a facility licensed under Article 5, Part A of Chapter 131E of the North Carolina General Statutes or if the facility is located outside North Carolina, under that jurisdiction's relevant facility licensure laws.
Immediately available – within the office.
JCAHO – the Joint Commission for the Accreditation of Health Organizations
Local anesthesia – the administration of an agent which produces a transient and reversible loss of sensation in a circumscribed portion of the body.
Major conduction blockade – the injection of local anesthesia to stop or prevent a painful sensation in a region of the body. Major conduction blocks include, but are not limited to, axillary, interscalene, and supraclavicular block of the brachial plexus; spinal (subarachnoid), epidural and caudal blocks.
Minimal sedation (anxiolysis) – the administration of a drug or drugs which produces a state of consciousness that allows the patient to tolerate unpleasant medical procedures while responding normally to verbal commands. Cardiovascular or respiratory function should remain unaffected and defensive airway reflexes should remain intact.
Minor conduction blockade – the injection of local anesthesia to stop or prevent a painful sensation in a circumscribed area of the body (*i.e.*, infiltration or local nerve block), or the block of a nerve by direct pressure and refrigeration. Minor conduction blocks include, but are not limited to, intercostal, retrobulbar, paravertebral, peribulbar, pudendal, sciatic nerve, and ankle blocks.
Monitoring – continuous, visual observation of a patient and regular observation of the patient as deemed appropriate by the level of sedation or recovery using instruments to measure, display, and record physiologic values such as heart rate, blood pressure, respiration and oxygen saturation.
Office – a location at which incidental, limited ambulatory surgical procedures are performed and which is not a licensed ambulatory surgical facility pursuant to Article 6, Part D of Chapter 131E of the North Carolina General Statutes.
Operating room – that location in the office dedicated to the performance of surgery or special procedures.
OSHA – the Occupational Safety and Health Administration.
PALS certified – a person who holds a current certification in pediatric advanced life support from a program approved by the American Heart Association.
Physical status classification – a description of a patient used in determining if an office surgery or procedure is appropriate. For purposes of these guidelines, ASA classifications will be used. The ASA enumerates classification: I-normal, healthy patient; II-a patient with mild systemic disease; III a patient with severe systemic disease limiting activity but not incapacitating; IV-a patient with incapacitating systemic disease that is a constant threat to life; and V-moribund, patients not expected to live 24 hours with or without operation.
Physician – an individual holding an MD or DO degree licensed pursuant to the NC Medical Practice Act and who performs surgical or special procedures covered by these guidelines.
Reasonable Proximity**-**The Board recognizes that reasonable proximity is a somewhat ambiguous standard. The Board believes that the standard often used by hospitals of thirty (30) minutes travel time is a useful benchmark.

Recovery area – a room or limited access area of an office dedicated to providing medical services to patients recovering from surgical or special procedures or anesthesia.
Reportable complications – untoward events occurring at any time within forty-eight (48) hours of any surgical or special procedure or the administration of anesthesia in an office setting including, but not limited to, any of the following: paralysis, nerve injury, malignant hyperthermia, seizures, myocardial infarction, pulmonary embolism, renal failure, significant cardiac events, respiratory arrest, aspiration of gastric contents, cerebral vascular accident, transfusion reaction, pneumothorax, allergic reaction to anesthesia, unintended hospitalization for more than twenty-four (24) hours, or death.
Special procedure – patient care that requires entering the body with instruments in a potentially painful manner, or that requires the patient to be immobile, for a diagnostic or therapeutic procedure requiring anesthesia services; for example, diagnostic or therapeutic endoscopy; invasive radiologic procedures, pediatric magnetic resonance imaging; manipulation under anesthesia or endoscopic examination with the use of general anesthesia.
Surgical procedure – the revision, destruction, incision, or structural alteration of human tissue performed using a variety of methods and instruments and includes the operative and non-operative care of individuals in need of such intervention, and demands pre-operative assessment, judgment, technical skill, post-operative management, and follow-up.
Topical anesthesia – an anesthetic agent applied directly or by spray to the skin or mucous membranes, intended to produce a transient and reversible loss of sensation to a circumscribed area.

21 NCAC 32B .1403 is proposed for adoption as follows:

SECTION .1300 – GENERAL

21 NCAC 32B .1403 CONVERSION APPLICATION FOR PHYSICIAN LICENSE

(a) A resident training licensee who meets the qualifications listed in this Rule may apply to convert their resident training license to a full, unrestricted physician license.

(b) An applicant seeking to convert shall:

(1) complete the Board's online application for conversion and attest under oath or affirmation that the information on the application is true and complete, and authorizing the release to the Board of all information pertaining to the application;

(2) submit documentation of a legal name change, if applicable;

(3) supply a certified copy of the applicant's birth certificate if the applicant was born in the United States (U.S.) or a certified copy of a valid and unexpired U.S. passport. If the applicant does not possess proof of their U.S. citizenship, the applicant must provide information about the applicant's immigration status. Applicants who are not present in the U.S. and who do not plan to practice physically in the U.S. shall submit a statement to that effect;

(4) submit proof that the applicant has completed graduate medical education as required by G.S. 90-9.1 or 90-9.2, as follows:

(A) A graduate of a medical school approved by LCME, CACMS, or COCA shall have completed at least one year of graduate medical education approved by ACGME, CFPC, RCPSC, or AOA;

(B) A graduate of a medical school not approved by LCME shall have completed two years of graduate medical education approved by ACGME, CFPC, RCPSC, or AOA; or

(C) An applicant may satisfy the graduate medical education requirements of Parts (A) or (B) of this subparagraph by showing proof of current certification by a specialty board recognized by the ABMS, CCFP, FRCP, FRCS, or AOA;

(5) if the applicant applied for a resident training license on the basis of COMLEX or USMLE examination, he or she shall provide proof that that the applicant has taken and passed within three attempts:

(A) the COMLEX Level 3; or

(B) the USMLE Step 3.

(6) create an AMA Physician Profile and, if the applicant is an osteopathic physician, also create an AOA Physician Profile;

(7) submit a letter from the graduate medical education program director recommending the applicant for full licensure. The letter should indicate the applicant’s status in the graduate medical education program and attest that the applicant is currently in good standing with the program or was in good standing at the time of application. The letter should also include information about the applicant’s dates of participation in the program; any information pertaining to leaves of absence taken by the applicant; any investigations involving the applicant; any adverse actions taken against the applicant including probations, limitations or special requirements, or disciplinary actions; and any negative reports of the applicant due to behavior.

(8) pay a non-refundable fee pursuant to G.S. 90-13.1(a).

(9) upon request, supply any additional information the Board deems necessary to evaluate the applicant's qualifications.

(c) A resident training licensee applying to convert to a full license must satisfy all of the following from the time of submitting an application for a resident’s training license:

(1) no professional liability insurance claim(s) or payments(s);

(2) no regulatory board complaints, investigations, or actions, including the applicant's withdrawal of a license application;

(3) no adverse actions by a health care institution as described in G.S. 90-14.13(a);

(4) no adverse actions taken by a federal agency, the U.S. military, or medical societies;

If the applicant fails to satisfy all of the above, they may submit an application for a physician license under 21 NCAC 32B .1303.

(d) The Board must receive all of the following directly from the primary originating source before it begins processing an application:

(1) Proof of graduation medical education from the graduate medical education program director;
(2) Transcripts of examinations scores from the examining authority;
(3) Proof of board certification from the certifying body, if applicable;
(4) Physician profile from the AMA, and if applicable, the AOA;
(5) National Practitioner Data Bank report from the U.S. Department of Health and Human Services; and
(6) Practitioner profile from the Federation of State Medical Boards.

History Note: *Authority G.S. 90-5.1(a)(3); 90-8.1; 90-9.1; 90-9.2; 90-13.1.*
Eff. _____