MEDICINE BOARD[653]

[Prior to 5/4/88, see Health Department[470], Chs 135 and 136, renamed Medical Examiners Board[653] under the "umbrella" of Public Health Department[641] by 1986 Iowa Acts, ch 1245]
[Prior to 7/4/07, see Medical Examiners Board[653]; renamed by 2007 Iowa Acts, Senate File 74]

CHAPTER 1
ADMINISTRATIVE AND REGULATORY AUTHORITY

CHAPTERS 2 to 7
Reserved

CHAPTER 8
FEES

CHAPTER 9
PERMANENT AND ADMINISTRATIVE MEDICINE PHYSICIAN LICENSURE

CHAPTER 10
RESIDENT, SPECIAL AND TEMPORARY PHYSICIAN LICENSURE

CHAPTER 11
CONTINUING EDUCATION AND TRAINING REQUIREMENTS

CHAPTER 12
Reserved

CHAPTER 13
STANDARDS OF PRACTICE AND PRINCIPLES OF MEDICAL ETHICS

CHAPTERS 14 to 16
Reserved

CHAPTER 17
LICENSURE OF ACUPUNCTURISTS

CHAPTER 26
REINSTATEMENT AFTER DISCIPLINARY ACTION

CHAPTER 1
ADMINISTRATIVE AND REGULATORY AUTHORITY

[Prior to 5/4/88, see 470—135.1 to 135.10]

Chapter rescission date pursuant to Iowa Code section 17A.7: 5/21/30

653—1.1(17A,147) Definitions. The following definitions are applicable to the rules of the board of medicine:

"Acupuncture" means a form of health care developed from traditional and modern oriental medical concepts that employs oriental medical diagnosis and treatment, and adjunctive therapies and diagnostic techniques, for the promotion, maintenance, and restoration of health and the prevention of disease.

"Acupuncturist" means a person licensed to practice acupuncture in this state.

"Alternate member" means a person who is qualified under Iowa Code section 148.2A to substitute for a board member who is disqualified or becomes unavailable for a contested case hearing. An alternate board member is deemed a member of the board only for the hearing panel(s) for which the alternate board member serves.

"Board" means the board of medicine of the state of Iowa.

"Department" means the Iowa department of inspections, appeals, and licensing.

"Director" means the director of the department.

"Disciplinary proceeding" means any proceeding under the authority of the board pursuant to which licensee discipline may be imposed.

"License" means a certificate issued to a person licensed to practice medicine and surgery, osteopathic medicine and surgery, or acupuncture under the laws of the state of Iowa.

"Licensee" means a person licensed to practice medicine and surgery, osteopathic medicine and surgery, or acupuncture under the laws of the state of Iowa.

"Licensee discipline" or *"discipline"* means any sanction the board may impose upon its licensees for conduct that threatens or denies citizens of this state a high standard of professional care.

"Malpractice" means any error or omission, unreasonable lack of skill, or failure to maintain a reasonable standard of care by a physician in the practice of the physician's profession.

"Medical practice Acts" refers to Iowa Code chapters 147 and 148.

"Order" means a requirement, procedure or standard of specific or limited application adopted by the board relating to any matter the board is authorized to act upon, including the professional conduct of licensees and the examination for licensure and licensure of any person under the laws of this state.

"Peer review" means evaluation of professional services rendered by a professional practitioner.

"Peer reviewer(s)" means one or more persons acting in a peer review capacity who have been appointed by the board for such purpose.

"Physician" means a person licensed to practice medicine and surgery or osteopathic medicine and surgery under the laws of this state.

"Practice of acupuncture" means the insertion of acupuncture needles and the application of moxibustion to specific areas of the human body based upon oriental medical diagnosis as a primary mode of therapy. Adjunctive therapies within the scope of acupuncture may include manual, mechanical, thermal, electrical, and electromagnetic treatment, and the recommendation of dietary guidelines and therapeutic exercise based on traditional oriental medical concepts.

"The practice of medicine and surgery" means holding one's self out as being able to diagnose, treat, operate or prescribe for any human disease, pain, injury, deformity or physical or mental condition and who shall either offer or undertake, by any means or methods, to diagnose, treat, operate or prescribe for any human disease, pain, injury, deformity or physical or mental condition. This rule shall not apply to licensed podiatrists, chiropractors, physical therapists, nurses, dentists, optometrists, acupuncturists, pharmacists, and other licensed health professionals who are exclusively engaged in the practice of their respective professions.

"Prescription drugs" means drugs, medicine and controlled substances that by law can only be prescribed for human use by persons authorized by law.

"Profession" means medicine and surgery, osteopathic medicine and surgery, or acupuncture.

"Respondent" means a licensee charged by the board in a complaint and statement of charges with violations of statutes or rules relating to the practice of medicine and surgery, osteopathic medicine and surgery, or acupuncture.

"Rule" means a regulation, requirement, procedure, or standard of general application prescribed by the board relating to either the administration or enforcement of Iowa Code chapters 147, 148, and 148E.

[**ARC 9109C**, IAB 4/16/25, effective 5/21/25]

653—1.2(17A) Purpose of board. The purpose of the board is to administer and enforce the provisions of Iowa Code chapters 147, 148, 148E, and 272C with regard to the practice of medicine and surgery, osteopathic medicine and surgery, and acupuncture.

[**ARC 9109C**, IAB 4/16/25, effective 5/21/25]

653—1.3(17A) Organization of board.

1.3(1) The board:

a. Makes policy relative to matters involving medical and acupuncture education, licensure, practice, and discipline.

b. Conducts business according to board-approved policy.

c. Elects a chairperson, vice chairperson and a secretary from its membership at the last regular board meeting prior to May 1 or at another date in April scheduled by the board.

d. Has the authority and powers conferred in Iowa Code chapters 17A, 147, 148 and 272C and may establish committees of the board, the members of which, except for the executive committee, shall be appointed by the board chairperson and shall not constitute a quorum of the board. The board chairperson shall appoint committee chairpersons. Committees of the board may include:

(1) Executive committee. The membership is composed of the elected officers of the board and two at-large members appointed by the chairperson. At least one public member is appointed to the executive committee. The executive committee duties may include but are not limited to:

1. Guidance and supervision of the executive director.
2. Budgetary review and recommendations to the board.
3. Review and recommendations to the board on rules and legislative proposals.
4. Study and recommendations to the board on practice issues and policy.

(2) Screening committee. The committee reviews complaints and makes recommendations to the board on appropriate action including further investigation or referral to the board for closure.

(3) Licensure committee. Its duties may include:

1. Recommending appropriate action on completed applications for licensure.
2. Conducting interviews with applicants when appropriate.
3. Reviewing licensure examination matters.
4. Reviewing and recommending to the board appropriate changes in licensure application forms.
5. Reviewing and making recommendations to the board regarding volunteer physician applicants who wish to participate in the state-indemnified volunteer physician program and who are under investigation or who have or have had disciplinary action against a license in the present or in the past.
6. Making recommendations on licensure policy issues.

(4) Monitoring committee. The committee oversees the monitoring of licensees under board orders and makes recommendations to the board on these matters.

e. Establishes, in accordance with Iowa Code section 148.2A, a pool of alternate board members.

1.3(2) A majority of the members of the board shall constitute a quorum. Official action, including filing of formal charges or imposition of discipline, requires a majority vote of members present.

[**ARC 9109C**, IAB 4/16/25, effective 5/21/25]

653—1.4(17A) Official communications. All official communications, including submissions and requests, should be addressed to the Executive Director, Iowa Board of Medicine, 6200 Park Avenue, Suite 100, Des Moines, Iowa 50321.

[**ARC 9109C**, IAB 4/16/25, effective 5/21/25]

653—1.5(17A) Office hours. The office of the board is open for public business from 8 a.m. to 4:30 p.m., Monday through Friday of each week, except holidays.
[**ARC 9109C**, IAB 4/16/25, effective 5/21/25]

653—1.6(17A) Meetings. The board shall meet at least six times per year. Dates and location of board meetings may be obtained from the board's office or on the board's website at dial.iowa.gov. Except as otherwise provided by statute, all board meetings are open, and the public is permitted to attend the meetings.
[**ARC 9109C**, IAB 4/16/25, effective 5/21/25]

653—1.7(17A,272C) Adoption of uniform and model rules. The board hereby adopts by reference the following:

1. Uniform Rules on Agency Procedure, 481—Chapter 2, 481—Chapter 3, 481—Chapter 4, 481—Chapter 5, and 481—Chapter 6.
2. Military Service, Veteran Reciprocity, and Spouses of Active-Duty Service Members, 481—Chapter 7.
3. Licensing and Child Support Noncompliance, Student Loan Repayment Noncompliance, and Nonpayment of State Debt, 481—Chapter 8.
4. Model Rules for Use of Criminal Convictions in Eligibility Determinations and Initial Licensing Decisions, 481—Chapter 502.
5. Model Rules for Licensee Review Committee, 481—Chapter 505.
6. Model Rules for Contested Cases Before Licensing Boards, 481—Chapter 506.

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CHAPTER 2
PUBLIC RECORDS AND FAIR INFORMATION PRACTICES
Rescinded **ARC 9110C**, IAB 4/16/25, effective 5/21/25

CHAPTER 3
WAIVERS
Rescinded **ARC 9110C**, IAB 4/16/25, effective 5/21/25

CHAPTERS 4 to 7
Reserved

CHAPTER 8
FEES
[Prior to 5/30/01, see 653—Chapter 11]

Chapter rescission date pursuant to Iowa Code section 17A.7: 5/21/30

653—8.1(147,148,272C) Definitions.

"Board" means the Iowa board of medicine.

"Online transaction fee" means a fee of $7 assessed by the board for completing an online purchase. The online transaction fee is in addition to the actual service provided.

[**ARC 9111C**, IAB 4/16/25, effective 5/21/25]

653—8.2(147,148,272C) Application and licensure fees for acupuncturists.

8.2(1) The fees are as follows:

a. Initial application fee for licensure as an acupuncturist, $300.

b. Reactivation of application for licensure, $100.

c. Renewal fee for licensure as an acupuncturist, $300.

d. Fee for the evaluation of the fingerprint packet and the division of criminal investigation (DCI) and Federal Bureau of Investigation (FBI) criminal history background checks, $45.

e. Fee for reapplication of an acupuncture license, $400.

f. Penalty for failure to renew before expiration, $50.

8.2(2) Upon written request and payment of the designated fee, the board shall provide the following information about the status of an acupuncturist's license or acupuncturist's past registration:

a. Certified statement that verifies the status of licensure or past registration in Iowa that requires the board seal or a letter of good standing, $25.

b. Verification of the status of licensure or past registration in Iowa that does not require a certified statement or letter, $20.

[**ARC 9111C**, IAB 4/16/25, effective 5/21/25]

653—8.3(147,148,272C) Interstate medical licensure compact (IMLC) fees.

8.3(1) *Service fee for an application for an IMLC letter of qualification.* The service fee is paid directly to the interstate medical licensure compact commission. The interstate commission retains a portion of this service fee and remits a portion of this service fee to the board. The service fee paid to the interstate commission includes the $45 fee for the evaluation of the fingerprint packet and the criminal history background checks by the DCI and the FBI.

8.3(2) *Licensure fee for an Iowa license issued through the IMLC.* The licensure fee is paid directly to the interstate medical licensure compact commission. An applicant shall pay a licensure fee of $450 plus a service fee retained by the interstate commission.

8.3(3) *Licensure fee for renewal of active Iowa license issued through the IMLC.* The licensure fee is paid directly to the interstate medical licensure compact commission. The licensee shall pay the licensure fee described in subparagraph 8.4(1)*"c"*(1) plus a service fee retained by the interstate commission. If the license is not renewed prior to expiration, the licensee will incur a penalty as described in paragraph 8.4(1)*"d."*

[**ARC 9111C**, IAB 4/16/25, effective 5/21/25]

653—8.4(147,148,272C) Application and licensure fees to practice medicine and surgery or osteopathic medicine and surgery or administrative medicine.

8.4(1) Fees for permanent licensure.

a. Initial licensure, $450 plus the $45 fee for evaluation of the fingerprint packet and the criminal history background checks by the DCI and FBI.

b. Reactivation of application for licensure, $150.

c. Renewal of an active license to practice.

(1) $550 if renewal is made via paper application, or $450 if renewal is made via online application, per biennial period or a prorated portion thereof if the current license was issued for a period of less than 24 months.

(2) No renewal fee if a physician was on active duty in the U.S. armed forces, reserves or national guard during the renewal period. "Active duty" means full-time training or active service in the U.S. armed forces, reserves or national guard.

d. Penalty for failure to renew before expiration, $100 per calendar month after the expiration date of the license up to $200.

e. Placing a license on inactive status or allowing a license to become inactive, no fee.

f. Reactivation of a license to practice one year or more after becoming inactive, $500 plus the $45 fee for the evaluation of the fingerprint packet and the DCI and FBI criminal history background checks.

g. Reactivation of a license within one year of becoming inactive, $550 except when the license in the most recent license period had been granted for less than 24 months. In that case, the reinstatement fee is prorated according to the date of issuance and the physician's month and year of birth.

8.4(2) Fees for resident physician licensure.

a. Application for a resident physician license, $100 plus the $45 fee for the evaluation of the fingerprint packet and the DCI and FBI criminal history background checks.

b. Extension of a resident physician license, $25.

c. Late fee for extension of a resident physician license, $50, to be paid in addition to the extension fee.

8.4(3) Fees for special physician licensure.

a. Application for a special physician license, $300 plus the $45 fee for the evaluation of the fingerprint packet and the DCI and FBI criminal history background checks.

b. Renewal of a special physician license, $200.

8.4(4) Fees for temporary physician licensure.

a. Application for a temporary physician license, $100 plus the $45 fee for the evaluation of the fingerprint packet and the DCI and FBI criminal history background checks.

b. Renewal of a temporary physician license, $50.

8.4(5) Fee for photocopy of a licensure application, $20.

8.4(6) Fee for the evaluation of the fingerprint packet and the DCI and FBI criminal history background checks, $45.

[**ARC 9111C**, IAB 4/16/25, effective 5/21/25]

653—8.5(147,148,272C) Fees for verification of physician licensure and certification of examination scores.

8.5(1) *Verification fees.*

a. Physicians shall use VeriDoc to secure a certified statement that verifies Iowa licensure status for any state medical board that accepts VeriDoc. VeriDoc is accessible at www.veridoc.org. The fee for this service is $30.

b. A physician who needs a certified statement that verifies Iowa licensure status for a state medical board that does not accept verification from VeriDoc shall make a written request for a certified statement with payment of a $30 verification fee to the board of medicine. The board shall provide a certified statement that verifies Iowa licensure status to the nonaccepting state medical board.

c. The fee for verification of Iowa licensure status that does not require a certified statement or letter is $15.

d. The board provides an electronic verification service whereby users can input the licensee's license number to learn the licensee's current licensure status. There is no fee for this service. The board shall provide a license number for an individual caller to use in the automated telephone or electronic verification service. Businesses that utilize verifications will be required to utilize the automated telephone or electronic verification service or the alternative outlined in paragraph 8.5(1)*"c."*

8.5(2) *Fees for certification of physician examination scores.* Upon request and payment of the designated fee, the board may provide certification of scores of an examination given by the board in Iowa

as permitted under Iowa Code section 147.21 and 653—paragraph 2.13(2)*"f."* The scores available from the board are those from examinees who took the state-constructed examination.

a. Certified statement of grades attained by examination, $45.

b. Certified statement of grades attained by examination including examination history or additional documentation, $55.

[**ARC 9111C**, IAB 4/16/25, effective 5/21/25]

653—8.6(147,148,272C) Public records.

8.6(1) *Public records available at no cost.* The following records are available at no cost to the public:

a. Public action taken by the board against a licensee may be found under the licensee's name on the board's website under "Find A Physician." Public actions are posted on the board's website within approximately one week after the board has taken action.

b. Electronic files of press releases, statements of charges, final orders and consent agreements from each board meeting are available on the board's website.

8.6(2) *Purchase of public records.* Public records are available according to 481—Chapter 5.

[**ARC 9111C**, IAB 4/16/25, effective 5/21/25]

653—8.7(147,148,272C) Licensee data list. A data list of all physicians and acupuncturists includes the following information about each licensee: full name, year of birth, work address and telephone number (or other contact information on file if licensee's work address and telephone number are not available), Iowa county (if applicable), medical school (if applicable), year of graduation from medical school (if applicable), two medical specialties (if available), license issue date, license expiration date, license number, license type, license status, and an indicator of whether the board has taken any public action on the license. There is no fee for an electronic file of this list. A printed copy of the data list is available for a fee.

[**ARC 9111C**, IAB 4/16/25, effective 5/21/25]

653—8.8(147,148,272C) Returned checks. The board will charge a fee of $25 for a check returned for any reason. If a license had been issued by the board office based on a check that is later returned by the bank, the board shall request payment by certified check or money order. If the fees are not paid within two weeks of notification of the returned check by certified mail, the licensee shall be subject to disciplinary action for noncompliance with board rules.

[**ARC 9111C**, IAB 4/16/25, effective 5/21/25]

653—8.9(147,148,272C) Copies of the laws and rules. Electronic copies of laws and rules pertaining to the practice of medicine or acupuncture are available at www.legis.iowa.gov at no cost. Printed copies of these laws and rules are available for a fee.

[**ARC 9111C**, IAB 4/16/25, effective 5/21/25]

653—8.10(147,148,272C) Refunds. Application and licensure fees will be collected by the board and are not refundable except by board action in unusual instances.

[**ARC 9111C**, IAB 4/16/25, effective 5/21/25]

653—8.11(17A,147,148,272C) Waiver prohibited. Licensure and examination fees in this chapter are not subject to waiver.

[**ARC 9111C**, IAB 4/16/25, effective 5/21/25]

653—8.12(8,147,148,272C) Monitoring fee. The board may require payment of up to $300 per quarter to cover the board's expenses to monitor a licensee's compliance with a settlement agreement or final decision and order.

[**ARC 9111C**, IAB 4/16/25, effective 5/21/25]

653—8.13(147,148,272C) Application and licensure fees for genetic counselors.

8.13(1) The fees are as follows:

a. Initial application fee for licensure, $200.

b. Reactivation of application for licensure, $100.

c. Renewal of an active license, $200.

d. Penalty for failure to renew before expiration, $50.

e. Fee for the evaluation of the fingerprint packet and the DCI and FBI criminal history background checks, $45.

f. Fee for reactivation of a license, $300.

8.13(2) Upon written request and payment of the designated fee, the board shall provide the following information about the status of a genetic counselor's license:

a. Certified statement that verifies the status of licensure in Iowa that requires the board seal or a letter of good standing, $25.

b. Verification of the status of licensure in Iowa that does not require a certified statement or letter, $20.

[**ARC 9111C**, IAB 4/16/25, effective 5/21/25]

These rules are intended to implement Iowa Code sections 147.11, 147.80, 148.3, 148.5, 148.10, and 148.11.

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CHAPTER 9
PERMANENT AND ADMINISTRATIVE MEDICINE PHYSICIAN LICENSURE

[Prior to 5/30/01, see 653—Chapter 11]

Chapter rescission date pursuant to Iowa Code section 17A.7: 5/21/30

653—9.1(147,148) Definitions.

"ABMS" means the American Board of Medical Specialties.

"ACGME" means the Accreditation Council for Graduate Medical Education.

"AMA" means the American Medical Association.

"Any jurisdiction" means any state, the District of Columbia or territory of the United States of America or any other nation.

"Any United States jurisdiction" means any state, the District of Columbia or territory of the United States of America.

"AOA" means the American Osteopathic Association.

"Applicant" means a person who seeks authorization to practice medicine and surgery, osteopathic medicine and surgery, or administrative medicine in this state by making application to the board, or a physician who seeks licensure through the IMLC.

"Approved abuse education training program" means a training program using a curriculum approved by the abuse education review panel of the department of health and human services or a training program offered by a hospital, a professional organization for physicians, the department of education, an area education agency, a school district, the Iowa law enforcement academy, an Iowa college or university, or a similar state agency.

"Board" means the board of medicine.

"Board-approved resident training program" means a hospital-affiliated graduate medical education program accredited by ACGME, AOA, RCPSC, or CFPC at the time the applicant is enrolled in the program.

"Candidate" means a person who applies to sit for an examination administered by the board or its designated testing service.

"Category 1 credit" means any formal education program that is sponsored or jointly sponsored by an organization accredited for continuing medical education by the Accreditation Council for Continuing Medical Education, the Iowa Medical Society, or the Council on Continuing Medical Education of AOA. Credits designated as formal cognates by the American College of Obstetricians and Gynecologists or as prescribed credits by the American Academy of Family Physicians are accepted as equivalent to category 1 credits.

"CFPC" means the College of Family Physicians of Canada.

"COCA" means the Commission on Osteopathic College Accreditation.

"COMLEX" means the Comprehensive Osteopathic Medical Licensing Examination.

"Committee" means the licensure committee of the board.

"COMVEX-USA" means the Comprehensive Osteopathic Medical Variable-Purpose Examination for the United States of America.

"Core credentials" means those documents that demonstrate the applicant's identity, medical training and practice history.

"Current, active status" means a license that is in effect and grants the privilege of practicing administrative medicine, medicine and surgery or osteopathic medicine and surgery, as applicable.

"ECFMG" means the Educational Commission for Foreign Medical Graduates.

"Expedited license" means a full and unrestricted medical license granted by a member state to an eligible physician through the process set forth in the IMLC.

"FCVS" means the Federation Credentials Verification Service.

"FLEX" means the Federation Licensing Examination.

"Foreign medical school," also known as an "international medical school," means a medical school that is located outside of any United States jurisdiction or Canada.

"FSMB" means the Federation of State Medical Boards.

"IMLC" means the Interstate Medical Licensure Compact enacted in Iowa Code chapter 147B.

"Inactive license" means any license that is not in current, active status.

"Incidentally called into this state in consultation with a physician and surgeon licensed in this state" as set forth in Iowa Code section 148.2(5) means all of the following shall be true:

1. The consulting physician shall be involved in the care of patients in Iowa only at the request of an Iowa-licensed physician.
2. The consulting physician has a license in good standing in another United States jurisdiction.
3. The consulting physician provides expertise and acts in an advisory capacity to an Iowa-licensed physician. The consulting physician may examine the patient and advise an Iowa-licensed physician as to the care that should be provided, but the consulting physician may not personally perform procedures, write orders, or prescribe for the patient.
4. The consulting physician practices in Iowa for a period not greater than 10 consecutive days and not more than 20 total days in any calendar year. Any portion of a day counts as one day.
5. The Iowa-licensed physician requesting the consultation retains the primary responsibility for the management of the patient's care.

"Initial license" means the first permanent or administrative medicine license granted to a qualified individual.

"International medical school," also known as a "foreign medical school," means a medical school that is located outside of any United States jurisdiction or Canada.

"Interstate commission" means the interstate commission created pursuant to Iowa Code chapter 147B.

"LCME" means Liaison Committee on Medical Education.

"LMCC" means enrollment in the Canadian Medical Register as Licentiate of Medical Council of Canada with a certificate of registration as proof.

"MCCEE" means the Medical Council of Canada Evaluating Examination.

"Medical degree" means a degree of doctor of medicine and surgery or osteopathic medicine and surgery or comparable education from a foreign medical school.

"National Practitioner Data Bank" is a national data bank of disciplinary actions taken against health professionals, including physicians.

"NBME" means the National Board of Medical Examiners.

"NBOME" means the National Board of Osteopathic Medical Examiners.

"Observer" means a person who is not enrolled in an LCME- or COCA-accredited medical school or osteopathic medical school, who observes care to patients in Iowa for a defined period of time and for a noncredit experience, and who is supervised and accompanied by an Iowa-licensed physician as defined in subrule 9.2(3). An observer shall not provide or direct hands-on patient care, regardless of the observer's level of training or supervision. The supervising physician may authorize an observer to read a chart, observe a patient interview or examination, or witness procedures, including surgery. An observer shall not chart; touch a patient as part of an examination; conduct an interview; order, prescribe or administer medications; make decisions that affect patient care; direct others in providing patient care; or conduct procedures, including surgery. Any of these activities requires licensure to practice in Iowa. An unlicensed physician observer or a medical student observer who is not enrolled in an LCME- or COCA-accredited medical school may touch a patient to verify a physical finding in the immediate presence of a physician but shall not conduct a more inclusive physical examination.

An unlicensed physician observer may:

1. Participate in discussions regarding the care of individual patients, including offering suggestions about diagnosis or treatment, provided the unlicensed physician observer does not direct the care; and
2. Elicit information from a patient provided the unlicensed physician observer does not actually perform a physical examination or otherwise touch the patient.

"Permanent licensure" means licensure granted after review of the application and core credentials to determine that the individual is qualified to enter into clinical practice.

"Practice" means the practice of medicine and surgery or osteopathic medicine and surgery.

"Primary source verification" means:

1. Verification of the authenticity of documents with the original source that issued the document.

2. Original source verification by another jurisdiction's physician licensing organization.
3. Original source verification by the FSMB's Federation Credentials Verification Service.

"RCPSC" means the Royal College of Physicians and Surgeons of Canada.

"Reactivation" means the process for returning an inactive license to current, active status.

"Relinquishment" means that a person's permanent license to practice medicine and surgery, osteopathic medicine and surgery, or administrative medicine is deemed abandoned if the person fails to renew or reactivate the license within five years after its expiration. A license that has been relinquished is no longer valid or renewable. Relinquishment is not disciplinary in nature.

"Resident physician" means a physician enrolled in an internship, residency or fellowship.

"Resident training program" means a hospital-affiliated graduate medical education program that enrolls interns, residents or fellows and may be referred to as a postgraduate training program for purposes of licensure.

"Service charge" means the amount charged for making a service available online and is in addition to the actual fee for a service itself.

"SPEX" means Special Licensure Examination prepared by the Federation of State Medical Boards and administered by a licensing authority in any jurisdiction.

"Terminated license" means a nondisciplinary process by which an Iowa license issued through the Interstate Medical Licensure Compact is no longer eligible for renewal. A compact license is terminated when a licensee no longer meets the IMLC qualifications. A terminated IMLC license may not be reinstated.

"Uniform application for physician state licensure" means a web-based application that is intended to standardize and simplify the licensure application process for state medical licensure.

"USMLE" means the United States Medical Licensing Examination.

[**ARC 9112C**, IAB 4/16/25, effective 5/21/25]

653—9.2(147,148) General licensure provisions.

9.2(1) *Licensure required.* Licensure is required for practice in Iowa as identified in Iowa Code section 148.1; the exceptions are identified in subrule 9.2(2).

9.2(2) *Licensure not required.* The following persons are not required to obtain a license to practice in Iowa:

a. Those persons described in Iowa Code section 148.2(1) through 148.2(5). A medical student or osteopathic medical student in an international medical school may not take on the role of a medical student in the patient care setting unless the student is enrolled in the University of Iowa's Carver College of Medicine or in Des Moines University's College of Osteopathic Medicine; however, an international medical student or graduate of an international medical school not enrolled at either of these institutions may be an observer as defined in rule 653—9.1(147,148).

b. Those persons who are incidentally called into this state in consultation with a physician or surgeon licensed in this state as described in Iowa Code section 148.2(5) and as defined in rule 653—9.1(147,148).

c. Physicians and surgeons who hold a current, active license in good standing in another United States jurisdiction and who come into Iowa on a temporary basis to aid disaster victims at the time of a disaster in accordance with Iowa Code section 29C.6.

d. Physicians and surgeons who hold a current, active license in good standing in another United States jurisdiction and who come to Iowa to participate in further medical education may participate in patient care under the request and supervision of the patient's Iowa-licensed physician in charge of the education. The Iowa-licensed physician shall retain the primary responsibility for management of the patient's care.

e. Physicians and surgeons who hold a current, active license in good standing in another United States jurisdiction and who come into Iowa to serve as expert witnesses as long as they do not provide treatment.

f. Physicians and surgeons from out of state who hold a current, active license in good standing in another United States jurisdiction and who accompany one or more individuals into Iowa for the purpose of

providing medical care to these individuals on a short-term basis; e.g., a team physician for an out-of-state college football team that comes into Iowa for a game.

g. Physicians and surgeons who come to Iowa to observe patient care and who do not provide or direct hands-on patient care.

h. Visiting resident physicians who come to Iowa to practice as part of their resident training program if under the supervision of an Iowa-licensed physician. An Iowa physician license is not required of a physician in training if the physician has a resident or permanent license in good standing in the home state of the resident training program. An Iowa temporary license is required of a physician in training if the physician does not hold a resident or permanent physician license in good standing in the home state of the resident training program (more information can be found in rule 653—10.5(147,148)).

9.2(3) *Supervision of an observer.* An Iowa-licensed physician who supervises an observer shall accompany the observer and solicit consent from each patient, where feasible, for the observation. The physician shall inform the patient of the observer's background; e.g., a high school student considering a medical career or a medical graduate who is working on licensure. The supervising physician ensures that the observer remains within the scope of an observer as defined in rule 653—9.1(147,148).

[**ARC 9112C**, IAB 4/16/25, effective 5/21/25]

653—9.3(147,148) Eligibility for licensure.

9.3(1) *Requirements.* To be eligible for permanent or administrative medicine licensure, an applicant shall:

a. Fulfill the application requirements specified in rule 653—9.4(147,148).

b. Hold a medical degree from an educational institution approved by the board at the time the applicant graduated and was awarded the degree.

(1) Educational institutions approved by the board shall be fully accredited by an accrediting agency recognized by the board as schools of instruction in medicine and surgery or osteopathic medicine and surgery and empowered to grant academic degrees in medicine.

(2) The accrediting bodies currently recognized by the board are:

1. LCME for the educational institutions granting degrees in medicine and surgery; and
2. AOA for educational institutions granting degrees in osteopathic medicine and surgery.

(3) If the applicant holds a medical degree from an educational institution not approved by the board at the time the applicant graduated and was awarded the degree, the applicant shall meet one of the following requirements:

1. Hold a valid certificate issued by ECFMG;
2. Pass the MCCEE;
3. Have successfully completed a fifth pathway program established in accordance with AMA criteria;
4. Have successfully passed either a basic science examination administered by a United States or Canadian medical licensing authority or SPEX; and have successfully completed three years of resident training in a program approved by the board; and have submitted evidence of five years of active practice without restriction as a licensee of any United States or Canadian jurisdiction; or
5. Have successfully passed either a basic science examination administered by a United States or Canadian medical licensing authority or SPEX; and hold board certification by a specialty board approved by ABMS or AOA; and submit evidence of five years of active practice without restriction as a licensee of any United States or Canadian jurisdiction.

c. Have successfully completed one year of resident training in a hospital-affiliated program approved by the board at the time the applicant was enrolled in the program. An applicant who is a graduate of an international medical school must have successfully completed 24 months of such training.

(1) For those required to have 12 months of training, the program shall have been 12 months of progressive training in not more than two specialties and in not more than two programs approved for resident training by the board. For those required to have 24 months of training, the program shall have been 24 continuous months of progressive training in not more than two specialties and in not more than two programs approved for resident training by the board.

(2) Resident training approved by the board must be accredited by an accrediting agency recognized by the board for the purpose of accrediting resident training programs.

(3) The board approves resident training programs accredited by:

1. ACGME;
2. AOA;
3. RCPSC; and
4. CFPC.

(4) The board may accept resident training that is not accredited as specified in subparagraph 9.3(1)*"c"*(3) on a case-by-case basis. In making this determination, the board may consider any relevant factors, including but not limited to the following:

1. The length of time the program has been in existence;
2. The location of the program;
3. The institution or organization that administers the program;
4. The reason that the program is not accredited; and
5. Whether the program is accredited or recognized by any agency other than those listed in subparagraph 9.3(1)*"c"*(3).

(5) The board may accept each 12 months of practice as a special licensee as equivalent to one year of resident training in a hospital-affiliated program approved by the board.

(6) The board may accept a current, active ABMS or AOA board certification obtained through an alternate pathway as equivalent to resident training in a hospital-affiliated program approved by the board. The alternate pathway must be a minimum of 24 months completed at an institution with a program approved by the board as specified in subparagraph 9.3(1)*"c"*(3).

d. Pass one of the licensure examinations or combinations as prescribed in rule 653—9.7(147,148).

9.3(2) *Exceptions to the eligibility requirements.*

a. A military service applicant or a veteran may apply for credit for verified military education, training, or service toward any experience or educational requirement for permanent licensure under this subrule or may be eligible for permanent licensure through reciprocity as specified in 653—Chapter 18.

b. A physician who holds a valid Letter of Qualification asserting eligibility for licensure through the IMLC is eligible for a permanent Iowa medical license.

[**ARC 9112C**, IAB 4/16/25, effective 5/21/25]

653—9.4(147,148) Licensure application.

9.4(1) *Requirements.* To apply for licensure, an applicant shall:

a. Pay a nonrefundable initial application fee and fee for the evaluation of the fingerprint packet and the criminal history background checks by the division of criminal investigation (DCI) and the Federal Bureau of Investigation (FBI) as specified in 653—paragraph 8.4(1)*"a"*; and

b. Complete and submit the application and forms provided by the board, including required core credentials, documents, a completed fingerprint packet, and a sworn statement by the applicant attesting to the truth of all information provided by the applicant that has been signed by the applicant in the physical presence of a notary public.

c. Pass one of the examinations as prescribed in rule 653—9.7(147,148) and authorize the testing authority to verify scores.

9.4(2) *Application.* The application shall require the following information:

a. Full legal name, date and place of birth, home address, mailing address, principal business address, and personal email address regularly used by the applicant or licensee for correspondence with the board.

b. A statement listing every jurisdiction in which the applicant is or has been authorized to practice, including license numbers and dates of issuance.

c. A chronology accounting for all time periods from the date the applicant entered medical school to the date of the application.

d. A certified statement of scores on any licensure examination required in rule 653—9.7(147,148) that the applicant has taken in any jurisdiction. An official FCVS Physician Information Profile that supplies this information for the applicant is a suitable alternative.

e. A photocopy of the applicant's medical degree issued by an educational institution.

(1) A complete translation of any diploma not written in English shall be submitted. An official transcript, written in English and received directly from the school, showing graduation from medical school is a suitable alternative.

(2) An official FCVS Physician Information Profile that supplies this information for the applicant is a suitable alternative.

(3) If a copy of the medical degree cannot be provided because of extraordinary circumstances, the board may accept other reliable evidence that the applicant obtained a medical degree from a specific educational institution.

f. A sworn statement from an official of the educational institution certifying the date the applicant received the medical degree and acknowledging what, if any, derogatory comments exist in the institution's record about the applicant. If a sworn statement from an official of the educational institution cannot be provided because of extraordinary circumstances, the board may accept other reliable evidence that the applicant obtained a medical degree from a specific educational institution.

g. An official transcript, or its equivalent, received directly from the school for every medical school attended if requested by the board. A complete translation of any transcript not written in English shall be submitted if requested by the board. An official FCVS Physician Information Profile that supplies this information for the applicant is a suitable alternative.

h. If the educational institution awarding the applicant the degree has not been approved by the board, a current ECFMG status report or evidence of successful completion of a fifth pathway program in accordance with criteria established by AMA. An official FCVS Physician Information Profile that supplies this information for the applicant is a suitable alternative.

i. Documentation of successful completion of resident training approved by the board as specified in paragraph 9.3(1)*"c."* An official FCVS Physician Information Profile that supplies this information for the applicant is a suitable alternative.

j. Verification of an applicant's hospital and clinical staff privileges and other professional experience for the past five years if requested by the board.

k. A statement disclosing and explaining any informal or nonpublic actions, warnings issued, investigations conducted, or disciplinary actions taken, whether by voluntary agreement or formal action, by a medical or professional regulatory authority, an educational institution, a training or research program, or a health facility in any jurisdiction.

l. A statement disclosing and explaining the applicant's involvement in civil litigation related to practice in any jurisdiction. Copies of the legal documents may be requested if needed during the review process.

m. A statement disclosing and explaining any charge of a misdemeanor or felony involving the applicant filed in any jurisdiction, whether or not any appeal or other proceeding to have the conviction or plea set aside is pending. Copies of the legal documents may be requested if needed during the review process.

n. A completed fingerprint packet to facilitate a national criminal history background check. The fee for the evaluation of the fingerprint packet and the DCI and FBI criminal history background checks will be assessed to the applicant.

[**ARC 9112C**, IAB 4/16/25, effective 5/21/25]

653—9.5(272C) Licensure by verification. Licensure by verification is available in accordance with the following:

9.5(1) *Eligibility.* A person may seek licensure by verification if the person is currently licensed as a physician in at least one other jurisdiction that has a scope of practice substantially similar to that of Iowa.

9.5(2) *Board application.* The applicant must submit the following:

a. A completed application for licensure by verification.

b. A nonrefundable initial application fee and fee for the evaluation of the fingerprint packet and the criminal history background checks by the DCI and the FBI as specified in 653—paragraph 8.4(1)*"a."*

c. A completed fingerprint packet to facilitate a criminal history background check by the DCI and FBI.

d. A verification form, completed by the licensing authority in the jurisdiction that issued the applicant's license, verifying that the applicant's license in that jurisdiction complies with the requirements of Iowa Code section 272C.12. The completed verification form must be sent directly from the licensing authority to the board.

e. Proof of passing an examination as required by rule 653—9.7(147,148).

f. A copy of the complete criminal record, if the applicant has a criminal history.

g. A copy of the relevant disciplinary documents, if another jurisdiction has taken disciplinary action against the applicant.

h. A written statement from the applicant detailing the scope of practice in the other state.

i. Copies of relevant laws setting forth the scope of practice in the other state.

9.5(3) *Applicants with prior discipline.* If another jurisdiction has taken disciplinary action against an applicant, the board will determine whether the cause for the disciplinary action has been corrected and the matter has been resolved. If the board determines the disciplinary matter has not been resolved, the board will neither issue a license nor deny the application for licensure until the matter is resolved. A person who has had a license revoked, or who has voluntarily surrendered a license, in another jurisdiction is ineligible for licensure by verification.

9.5(4) *Applicants with pending licensing complaints or investigations.* If an applicant is currently the subject of a complaint, allegation, or investigation relating to unprofessional conduct pending before any regulating entity in another jurisdiction, the board will neither issue a license nor deny the application for licensure until the complaint, allegation, or investigation is resolved.

9.5(5) *Temporary licenses.* Applicants who satisfy all requirements for a license under this section except for passing a required examination specific to the laws of this state may be issued a temporary license that is valid for a period of three months and may be renewed once for an additional period of three months. The applicant must submit proof of passing the required examination before the temporary license expires.

[**ARC 9112C**, IAB 4/16/25, effective 5/21/25]

653—9.6(147,148) Licensure examinations.

9.6(1) *USMLE.*

a. The USMLE is a multipart examination consisting of Step 1, Step 2, and Step 3. Steps 1 and 2 are administered by NBME and ECFMG. The board contracts with FSMB for the administration of Step 3.

b. Applications are available at Department of Examination Services, FSMB, 400 Fuller Wiser Road, Suite 300, Euless, Texas 76039, or www.fsmb.org.

c. Candidates who meet the following requirements are eligible to take USMLE Step 3:

(1) Submit a completed application form and pay the required examination fee as specified in rule 653—8.3(147,148,272C).

(2) Document successful completion of USMLE Steps 1 and 2 in accordance with the requirements of NBME. Graduates of a foreign medical school shall meet the requirements of ECFMG.

(3) Document holding a medical degree from a board-approved educational institution. If a candidate holds a medical degree from an educational institution not approved by the board at the time the applicant graduated and was awarded the degree, the candidate shall meet the requirements specified in subparagraph 9.3(1)*"b"*(3).

(4) Document successful completion of a minimum of seven calendar months of resident training in a program approved by the board at the time of the application for Step 3 or enrollment in a resident training program approved by the board at the time of the application for Step 3.

d. The following conditions apply to applicants for licensure in Iowa who utilize USMLE as the licensure examination:

(1) Passing Steps 1, 2, and 3 is required within a ten-year period beginning with the date of passing either Step 1 or Step 2, whichever occurred first. If the applicant did not pass Steps 1, 2, and 3 within the required time frame, then the requirement will be satisfied by either proof of active board certification by the ABMS or AOA or proof the delay was caused by participation in a joint M.D./Ph.D. or D.O./Ph.D. program.

(2) Step 3 may be taken and passed only after Steps 1 and 2 are passed.

(3) A score of 75 or better on each step shall constitute a passing score on that step.

(4) Successful completion of a continuous, progressive three-year resident training program is required if the applicant passes the examination after more than six attempts on Step 1 or six attempts on Step 2 CK and Step 2 CS combined or three attempts on Step 3.

9.6(2) *NBME.* Successful completion of NBME Parts I, II and III with a passing score of 75 or better on each part is required for NBME certification.

9.6(3) *FLEX.*

a. (Old) FLEX is a three-day examination administered from 1968 to 1985. Applicants who took (Old) FLEX shall provide evidence of successful achievement of at least two of the following:

(1) Certification under seal that the applicant passed FLEX with a FLEX-weighted average of 75 percent or better, as determined by the state medical licensing authority, in no more than two sittings.

(2) Verification under seal of medical licensure in the state that administered the examination.

(3) Evidence of current certification by an American specialty board approved or recognized by the Council of Medical Education of AMA, ABMS, or AOA.

b. (New) FLEX is a three-day nationally standardized examination administered from 1985 to 1994. To be eligible for licensure, the candidate must have passed both components with a FLEX score of 75 or better within a seven-year period beginning with the date of initial examination.

9.6(4) *Combination examination sequences.* The board approved the following licensing combinations of examinations for licensure only if completed prior to January 1, 2000. These combinations are now only acceptable from an applicant who already holds a license from any United States jurisdiction.

a. FLEX Component I plus USMLE Step 3 with a passing score of 75 or better on each examination;

b. NBME Part I or USMLE Step 1 plus NBME Part II or USMLE Step 2 plus FLEX Component II with a passing score of 75 or better on each examination; or

c. NBME Part I or USMLE Step 1 plus NBME Part II or USMLE Step 2 plus NBME Part III or USMLE Step 3 with a passing score of 75 or better on each examination.

9.6(5) *COMLEX.* COMLEX is a three-level examination that replaced the three-part NBOME examination. All three examinations must be successfully completed in sequential order within ten years of the successful completion of COMLEX Level 1. If the applicant did not pass Levels 1, 2, and 3 within the required time frame, then the requirement will be satisfied by either proof of active board certification by the ABMS or AOA or proof the delay was caused by participation in a joint D.O./Ph.D. or M.D./Ph.D. program.

a. A standard score of 400 on Level 1 or Level 2 is required to pass the examination. A standard score of 350 on Level 3 is required to pass the examination.

b. A candidate shall have successfully completed a minimum of seven calendar months of resident training in a program approved by the board at the time of the application for Level 3 or enrollment in a resident training program approved by the board at the time of the application for Level 3.

c. Successful completion of a continuous, progressive three-year resident training program is required if the applicant passes the examination after more than six attempts on Level 1 or six attempts on Level 2 CE and Level 2 PF combined or three attempts on Level 3.

d. Each COMLEX level must be passed individually, and individual level scores shall not be averaged to compute an overall score.

e. Level 3 may be taken and passed only after Levels 1 and 2 are passed.

f. A failure of any COMLEX level, regardless of the jurisdiction for which it was taken, shall be considered a failure of that level for the purposes of Iowa licensure.

9.6(6) *NBOME.*

a. NBOME was a three-part examination. All three parts must have been successfully completed in sequential order within seven years of the successful completion of NBOME Part 1.

b. A passing score is required on each part of the examination.

c. A candidate shall have successfully completed a minimum of seven calendar months of resident training in a program approved by the board at the time of the application for NBOME Part 3. Candidates shall have completed their resident training by the last day of the month in which the examination was taken.

d. Successful completion of a three-year resident training program is required if the applicant passes the examination after more than six attempts on Part 1 or six attempts on Part 2 or three attempts on Part 3.

e. Each NBOME part must have been passed individually, and individual part scores shall not be averaged to compute an overall score.

f. Part 3 must have been taken and passed only after Parts 1 and 2 were passed.

g. A failure of any NBOME part, regardless of the jurisdiction for which it was taken, shall be considered a failure of that part for the purposes of Iowa licensure.

9.6(7) *LMCC.* The board accepts toward Iowa licensure a verification of a licensee's registration with the Medical Council of Canada, based on passing both parts of the Medical Council of Canada Qualifying Examination.

9.6(8) *State licensing examinations.* Licensing examinations administered by the board of medicine or another U.S. jurisdiction prior to 1974 are accepted if the examination was passed according to criteria established by that state at the time and led to licensure in that state.

[**ARC 9112C**, IAB 4/16/25, effective 5/21/25]

653—9.7(147,148) Permanent licensure application review process. The process below is utilized to review each application. Priority is be given to processing a licensure application when a written request is received in the board office from an applicant whose practice will primarily involve provision of services to underserved populations, including but not limited to persons who are minorities or low-income or who live in rural areas.

9.7(1) An application for initial licensure will be considered open from the date the application form is received in the board office with the nonrefundable initial licensure fee.

9.7(2) After reviewing each application, board staff will notify the applicant about how to resolve any problems. An applicant shall provide additional information when requested by staff or the board.

9.7(3) If the final review indicates no questions or concerns regarding the applicant's qualifications for licensure, staff may administratively grant the license. The staff may grant the license without having received a report on the applicant from the FBI.

9.7(4) If the final review indicates questions or concerns that cannot be remedied by continued communication with the physician, the executive director, director of licensure and director of legal affairs will determine if the questions or concerns indicate any uncertainty about the applicant's current qualifications for licensure.

a. If there is no current concern, staff will administratively grant the license.

b. If any concern exists, the application will be referred to the committee.

9.7(5) Staff will refer to the committee for review matters that include but are not limited to falsification of information on the application, criminal record, malpractice, substance abuse, competency, physical or mental illness, or professional disciplinary history.

9.7(6) If the committee is able to eliminate questions or concerns without dissension from staff or a committee member, the committee may direct staff to grant the license administratively.

9.7(7) If the committee is not able to eliminate questions or concerns without dissension from staff or a committee member, the committee will recommend that the board:

a. Request an investigation;

b. Request that the applicant appear for an interview;

c. If the physician has not engaged in active clinical practice or board-approved training in the past three years in any jurisdiction of the United States or Canada, require an applicant to:

(1) Successfully pass a competency evaluation approved by the board;

(2) Successfully pass SPEX, COMVEX-USA, or another examination approved by the board;

(3) Successfully complete a retraining program arranged by the physician and approved in advance by the board; or

(4) Successfully complete a reentry to practice program or monitoring program approved by the board.

d. Grant a license;

e. Grant a license under certain terms and conditions or with certain restrictions;

f. Request that the applicant withdraw the licensure application; or

g. Deny a license.

9.7(8) The board will consider applications and recommendations from the committee and will:

a. Request further investigation;

b. Require that the applicant appear for an interview;

c. If the physician has not engaged in active clinical practice or board-approved training in the past three years in any jurisdiction of the United States or Canada, require an applicant to:

(1) Successfully pass a competency evaluation approved by the board;

(2) Successfully pass SPEX, COMVEX-USA, or another examination approved by the board;

(3) Successfully complete a retraining program arranged by the physician and approved in advance by the board; or

(4) Successfully complete a reentry to practice program or monitoring program approved by the board.

d. Grant a license;

e. Grant a license under certain terms and conditions or with certain restrictions;

f. Request that the applicant withdraw the licensure application; or

g. Deny a license. The board may deny a license for any grounds on which the board may discipline a license. The procedure for appealing a license denial is set forth in rule 653—9.17(147,148).

[**ARC 9112C**, IAB 4/16/25, effective 5/21/25]

653—9.8(147,148) Licensure application cycle.

9.8(1) *Failure to submit application materials.* If the applicant does not submit all materials, including a completed fingerprint packet, within 90 days of the board's initial request for further information, the application will be considered inactive.

9.8(2) *Reactivation of the application.* To reactivate the application, an applicant shall submit a nonrefundable fee for reactivation of the application as specified in 653—paragraph 8.4(1)*"b"* within 30 days. If the application is not reactivated within 30 days, the application for licensure is withdrawn and the applicant must reapply and submit a new nonrefundable application fee and a new application, documents and core credentials.

9.8(3) *Period of reactivation.* The period for reactivation of application shall extend 90 days from the date the request and fee are received in the board office. During this period, the applicant shall update core credentials and submit the remaining requested materials. If the applicant does not update core credentials or submit all materials during the 90-day period of reactivation, the application for licensure is withdrawn and the applicant must reapply and submit a new nonrefundable application fee and a new application, documents and core credentials.

[**ARC 9112C**, IAB 4/16/25, effective 5/21/25]

653—9.9(147,148) Discretionary board actions on licensure applications. As circumstances warrant, the board may determine that any applicant for licensure is subject to the following:

9.9(1) The board may impose limits or restrictions on the practice of any applicant in this state that are equal in force to the limits or restrictions imposed on the applicant by any jurisdiction.

9.9(2) The board may defer final action on an application for licensure if there is an investigation or disciplinary action pending against an applicant in any jurisdiction until such time as the board is satisfied that licensure of the applicant poses no risk to the health and safety of Iowans.

9.9(3) The board is not precluded from taking disciplinary action after licensure is granted related to issues that arose in the licensure application process.

[**ARC 9112C**, IAB 4/16/25, effective 5/21/25]

653—9.10(147,148) Issuance of a license.

9.10(1) *Issuance.* Upon the granting of permanent or administrative medicine licensure, staff will issue a license to practice that will expire on the first day of the licensee's birth month.

a. Licenses of persons born in even-numbered years shall expire in an even-numbered year, and licenses of persons born in odd-numbered years shall expire in an odd-numbered year.

b. The license shall not be issued for a period less than two months or greater than two years and two months, in accordance with the licensee's month and year of birth.

c. When a resident physician receives a permanent Iowa license, the resident physician license will immediately become inactive.

d. When a physician with a special license receives a permanent Iowa license, the special license will immediately become inactive.

e. When a physician with a permanent Iowa license receives an Iowa administrative medicine license, the permanent Iowa license will immediately become inactive.

f. A physician with an active permanent Iowa license is ineligible for an Iowa resident license.

9.10(2) *Display of license certificate.* The license certificate shall be displayed in the licensee's primary location of practice.

[**ARC 9112C**, IAB 4/16/25, effective 5/21/25]

653—9.11(147,148) Notification required to change the board's data system.

9.11(1) *Change of contact information.* A licensee shall notify the board of any change in the home address, the address of the place of practice, home or practice telephone number, or personal email address regularly used by the applicant or licensee for correspondence with the board within one month of the change.

9.11(2) *Change of name.* A licensee shall notify the board of any change in name within one month of making the name change. Notification requires a notarized copy of a marriage license or a notarized copy of court documents.

9.11(3) *Deceased.* A licensee file shall be closed and labeled "deceased" when the board receives a copy of the physician's death certificate or other reliable information of the licensee's death.

9.11(4) *Practice name.* A licensee shall practice under the licensee's full legal name.

[**ARC 9112C**, IAB 4/16/25, effective 5/21/25]

653—9.12(147,148) Renewal of a permanent or administrative medicine license.

9.12(1) *Licensee obligation.* The licensee is responsible for renewing the license prior to its expiration. Failure of the licensee to receive notice does not relieve the licensee of responsibility for renewing that license.

9.12(2) *Renewal application requirements.* A licensee seeking renewal shall submit a completed renewal application; information on continuing education, training on chronic pain management, training on end-of-life care, and training on identifying and reporting abuse; and the required fee prior to the expiration date on the current license.

a. Renewal fee.

(1) The fees for renewal are specified in 653—subparagraph 8.4(1)*"c"*(1).

(2) There is no renewal fee due for a physician who was on active duty in the U.S. armed forces, reserves or national guard during the renewal period.

(3) A physician who fails to renew before the expiration of the license is charged a penalty fee as set forth in 653—paragraph 8.4(1)*"d."*

b. The requirements for continuing education and training on identifying and reporting abuse are found in 653—Chapter 11.

9.12(3) *Issuance of a renewal.* Upon receipt of the completed renewal application, staff will administratively issue a two-year license that expires on the first day of the licensee's birth month. In the event the board receives adverse information on the renewal application, the board will issue the renewal license but may refer the adverse information for further consideration.

9.12(4) *Failure to renew.* The license will become inactive and invalid if the licensee fails to renew a license within two months following its expiration date. A licensee whose license is invalid or inactive is prohibited from practice until the license is reactivated in accordance with rule 653—9.15(147,148).

9.12(5) *Display of license.* Renewal licenses shall be displayed along with the license certificate in the primary location of practice.

[**ARC 9112C**, IAB 4/16/25, effective 5/21/25]

653—9.13(147,148) Inactive status of a license.

9.13(1) *Definition of inactive status.* An inactive license is any license that is not a current, active license.

a. "Inactive status" may include licenses formerly known as delinquent, lapsed, or retired.

b. A physician whose license is inactive continues to hold the privilege of licensure in Iowa but may not practice medicine under an Iowa license until the license is reactivated to current, active status. A licensee who practices under an Iowa license when the license is inactive may be subject to disciplinary action by the board, injunctive action pursuant to Iowa Code section 147.83, criminal sanctions pursuant to Iowa Code section 147.86, or other available legal remedies.

9.13(2) *Mechanisms for becoming inactive.* A licensee seeking to become inactive may submit a written request to the board office, or a license may become inactive by failing to renew a license by the first day of the third month after the expiration date.

[**ARC 9112C**, IAB 4/16/25, effective 5/21/25]

653—9.14(147,148) Reactivation of an unrestricted Iowa license.

9.14(1) *Reactivation within one year of the license's becoming inactive.* An individual whose license is in inactive status for up to one year and who wishes to reinstate the license shall submit a completed renewal application; the reinstatement fee; documentation of continuing education; and, if applicable, documentation on training on chronic pain management, end-of-life care, and identifying and reporting abuse. All of the information shall be received in the board office within one year of the license's becoming inactive for the applicant to reinstate under this subrule.

a. Fee for reactivation of an unrestricted Iowa license within one year of the license's becoming inactive. The reactivation fee is specified in 653—paragraph 8.4(1)*"g."*

b. Continuing education and training requirements. Applicants for reactivation shall provide documentation of having completed:

(1) The number of hours of category 1 credit needed for renewal in the most recent license period. None of the credits obtained in the inactive period may be carried over to a future license period; and

(2) Training on chronic pain management, end-of-life care, and identifying and reporting abuse, if applicable, within the previous five years.

c. Issuance of a reactivated license. Upon receiving the completed application, staff will administratively issue a license that expires on the renewal date that would have been in effect if the licensee had renewed the license before the license expired.

d. Reinstatement application process. The applicant who fails to submit all reinstatement information required within 365 days of the license's becoming inactive shall be required to meet the reinstatement requirements of subrule 9.15(2). For example, if a physician's license expires on January 1, the completed reinstatement application is due in the board office by December 31, in order to meet the requirements of this subrule.

9.14(2) *Reactivation of an unrestricted Iowa license that has been inactive for one year or longer.* An individual whose license is in inactive status and who has not submitted a reactivation application that was received by the board within one year of the license's becoming inactive shall follow the application cycle specified in this rule and shall satisfy the following requirements for reactivation:

a. Submit an application for reactivation to the board. The application shall require the following information:

(1) Full legal name, date and place of birth, license number, home address, mailing address, principal business address, and personal email address regularly used by the applicant or licensee for correspondence with the board;

(2) A chronology accounting for all time periods from the date of initial licensure;

(3) Every jurisdiction in which the applicant is or has been authorized to practice including license numbers and dates of issuance;

(4) Documentation of successful completion of resident training approved by the board as specified in paragraph 9.3(1)*"c"* that was completed since the time of initial licensure. An official FCVS Physician Information Profile that supplies this information for the applicant is a suitable alternative;

(5) Verification of the applicant's hospital and clinical staff privileges, and other professional experience for the past five years if requested by the board;

(6) A statement disclosing and explaining any warnings issued, investigations conducted or disciplinary actions taken, whether by voluntary agreement or formal action, by a medical or professional regulatory authority, an educational institution, training or research program, or health facility in any jurisdiction;

(7) A statement disclosing and explaining the applicant's involvement in civil litigation related to practice in any jurisdiction. Copies of the legal documents may be requested if needed during the review process;

(8) A statement disclosing and explaining any charge of a misdemeanor or felony involving the applicant filed in any jurisdiction, whether or not any appeal or other proceeding is pending to have the conviction or plea set aside. Copies of the legal documents may be requested if needed during the review process; and

(9) A completed fingerprint packet to facilitate a national criminal history background check. The fee for the evaluation of the fingerprint packet and the DCI and FBI criminal history background checks will be assessed to the applicant.

b. Pay the reactivation fee plus the fee for the evaluation of the fingerprint packet and the DCI and FBI criminal history background checks specified in 653—paragraph 8.4(1)*"f."*

c. Provide documentation of completion of 40 hours of category 1 credit within the previous two years and documentation of training on chronic pain management, end-of-life care, and identifying and reporting abuse as specified in 653—Chapter 11.

d. If the physician has not engaged in active clinical practice or board-approved training in the past three years in any jurisdiction of the United States or Canada:

(1) Successfully pass a competency evaluation approved by the board;

(2) Successfully pass SPEX, COMVEX-USA, or another examination approved by the board;

(3) Successfully complete a retraining program arranged by the physician and approved in advance by the board; or

(4) Successfully complete a reentry to practice program or monitoring program approved by the board.

e. An individual who is able to submit a letter from the board with different reactivation criteria is eligible for reactivation based on those criteria.

[**ARC 9112C**, IAB 4/16/25, effective 5/21/25]

653—9.15(147,148) Reinstatement of a restricted Iowa license. A physician whose license has been suspended or revoked following a disciplinary proceeding is required to seek reinstatement pursuant to 653—Chapter 26.

[**ARC 9112C**, IAB 4/16/25, effective 5/21/25]

653—9.16(147,148) Relinquishment of license to practice. A person's permanent license to practice medicine and surgery, osteopathic medicine and surgery, or administrative medicine shall be deemed relinquished if the person fails to apply for renewal or reactivation of the license within five years after its expiration.

9.16(1) A license will not be reinstated, reissued, or restored once it is relinquished. The person may apply for a new license pursuant to Iowa Code sections 148.3 and 148.11 and 653—Chapters 9 and 10.

9.16(2) The relinquishment of license may be stayed if, at the date of relinquishment, there is an active:

a. Evaluation order pursuant to Iowa Code section 272C.9(1) and rule 653—24.4(272);

b. Combined statement of charges and settlement agreement pursuant to Iowa Code sections 17A.10(2) and 272C.3(4) and rule 653—25.3(17A);

c. Statement of charges pursuant to Iowa Code section 17A.12(2) and rule 653—25.4(17A);

d. Settlement agreement pursuant to Iowa Code sections 17A.10(2) and 272C.3(4) and rule 653—25.17(272C);

e. Final decision pursuant to Iowa Code sections 17A.12 and 272C.6 and rule 653—25.24(17A); or

f. Application for reactivation of the license pursuant to rule 653—9.15(147,148) or 653—9.16(147,148).

[**ARC 9112C**, IAB 4/16/25, effective 5/21/25]

653—9.17(147,148) Administrative medicine licensure.

9.17(1) *Application.* An application for an administrative medicine license shall be made to the board of medicine pursuant to the requirements established in Iowa Code section 148.3 and this chapter. An applicant for an administrative medicine license shall be subject to all of the permanent licensure requirements established in Iowa Code section 148.3 and this chapter, except that the applicant will not be required to demonstrate that the applicant has engaged in active clinical practice in the past three years as outlined in paragraphs 9.8(7)*"c"* and 9.15(2)*"d."*

The board may issue an administrative medicine license authorizing the licensee to practice administrative medicine only, as defined by this rule. The license shall be designated "administrative medicine license."

9.17(2) *Fees.* All license and renewal fees shall be paid to the board in accordance with 653—Chapters 8 and 9.

9.17(3) *Demonstration of competence.*

a. If an applicant for initial licensure or reactivation of an administrative medicine license has not actively practiced administrative or clinical medicine in a jurisdiction of the United States or Canada in the past three years, the board may require the applicant to demonstrate competence in a method prescribed by the board in accordance with paragraphs 9.8(7)*"c"* and 9.15(2)*"d."*

b. A physician who holds an administrative medicine license and has not engaged in active clinical practice in a jurisdiction of the United States or Canada for more than three years may be required to demonstrate competence to practice clinical medicine in a method prescribed by the board.

9.17(4) *No exemptions to laws and rules.* A physician with an administrative medicine license is subject to the same laws and rules governing the practice of medicine as a person holding a permanent Iowa medical license.

9.17(5) *Interstate medical licensure compact.* A physician who holds only an administrative medicine license may not be eligible for licensure under the interstate medical licensure compact.

[**ARC 9112C**, IAB 4/16/25, effective 5/21/25]

653—9.18(147,147B,148) Licensure through IMLC.

9.18(1) *Requirements for seeking a Letter of Qualification from the board of medicine.* An applicant shall meet all of the following requirements:

a. Designate Iowa as state of principal license. To designate Iowa as state of principal license, the physician must possess a full, unrestricted, permanent Iowa medical license and meet one of the following requirements at the time the application for a Letter of Qualification is reviewed by board staff:

(1) Iowa is the physician's primary residence, or

(2) At least 25 percent of the physician's medical practice occurs in Iowa, or

(3) The physician's employer is located in Iowa, or

(4) If the applicant does not meet any of the requirements under subparagraph 9.18(1)*"a"*(1), (2), or (3), the applicant can designate Iowa as the state of principal license if Iowa is the applicant's state of residence for the purposes of federal income tax.

b. Provide evidence of the following qualifications:

(1) Graduation from a medical school accredited by the LCME, COCA, or a medical school listed in the International Medical Education Directory or its equivalent.

(2) Passage of each component of the USMLE or the COMLEX within three attempts, or any of its predecessor examinations accepted by the board as an equivalent examination for licensure purposes as prescribed in rule 653—9.7(147,148).

(3) Successful completion of graduate medical education approved by the ACGME or the AOA. "Successful completion" means participation in an ACGME or AOA postgraduate training program that achieves ABMS or AOA board eligibility status.

(4) At the time of application, hold specialty certification or a time-unlimited specialty certificate recognized by the ABMS or the AOA. The specialty certification or a time-unlimited specialty certificate does not have to be maintained once a physician is determined to be eligible for licensure through the IMLC.

(5) Has never been convicted of or received adjudication, deferred adjudication, community supervision, or deferred disposition for any criminal offense by a court of appropriate jurisdiction.

(6) Has never held a license authorizing the practice of medicine subjected to discipline by a licensing agency in any state, federal, or foreign jurisdiction, excluding any action related to nonpayment of fees related to a license.

(7) Has never had a controlled substance license or permit suspended or revoked by a state or the U.S. Drug Enforcement Administration (DEA).

(8) Is not under active investigation by a licensing agency or law enforcement authority in any state, federal, or foreign jurisdiction.

9.18(2) *Application.* A physician seeking licensure through the IMLC who is qualified to designate Iowa as state of principal license shall file an application for a Letter of Qualification with the interstate commission at www.imlcc.org and pay the nonrefundable service fee. The application shall require the following:

9.18(3) *Letter of Qualification.*

a. After evaluation of the applicant's eligibility for licensure, the board will issue a Letter of Qualification to the applicant verifying or denying the applicant's eligibility. The applicant may appeal a determination of eligibility to the board of medicine within 30 days of issuance of the Letter of Qualification according to the processes outlined in rule 653—9.19(147,148).

b. The Letter of Qualification is valid for 365 days from its date of issuance to request licensure in a member state. The physician must maintain eligibility to claim Iowa as the state of principal license or designate a new state of principal license.

9.18(4) *Expedited licensure.* Physicians who have a valid Letter of Qualification may obtain licensure in Iowa through the IMLC. To obtain a permanent Iowa license through the IMLC, a qualified physician shall:

a. Complete the application process at the IMLC's website, www.imlcc.org.

b. Pay the licensure fee specified in 653—subrule 8.3(2) and any service fees that are required by the IMLC.

c. Comply with the continuing medical education requirements of the board, including mandatory trainings specified in 653—Chapter 11.

9.18(5) *Validity of a license issued through the IMLC.* A license issued through the IMLC is valid for a period consistent with other permanent licenses issued by the board. An Iowa license issued through the IMLC shall be deemed terminated if the licensee fails to maintain a state of principal license.

9.18(6) *Disciplinary actions against licenses issued through the IMLC.*

a. Physicians holding an Iowa license issued through the IMLC are subject to the laws and rules governing the practice of medicine in Iowa.

b. Any disciplinary action taken by another member board of the IMLC against a physician licensed through IMLC shall be deemed unprofessional conduct that may be subject to discipline by the board in addition to any other violation of the board's rules deemed appropriate by the board.

c. If a license issued through the IMLC to a physician is revoked, surrendered, or relinquished in lieu of discipline, or suspended by a member board of the IMLC, then the physician's Iowa expedited license is automatically and immediately suspended, without further action needed, for a period of 90 days upon entry of an order by the board. The 90-day suspension may be terminated early by the board.

d. Disciplinary actions by out-of-state boards can be considered conclusive regarding legal and factual matters. The home board may impose similar or lesser sanctions, as long as the sanctions comply with the board's laws, or pursue separate disciplinary action.

e. If the Iowa board, as the physician's state of principal license, revokes or suspends the physician's license, or accepts a license surrender in lieu of discipline, then all licenses issued to the physician through the IMLC shall automatically be placed, without further action necessary by any member board, on the

same status. If the Iowa board subsequently reinstates the physician's license, the licenses issued by the other member boards shall remain encumbered until the member boards take action to reinstate the licenses.

9.18(7) *Renewal of license issued through the IMLC.* To be eligible for renewal of a license issued through the IMLC, a licensee shall:

a. Complete an online renewal application on a form provided by the IMLC at www.imlcc.org.

b. Complete an attestation that the licensee:

(1) Maintains eligibility to designate a state as the state of principal license, pursuant to paragraph 9.21(1)*"a"*;

(2) Maintains a full and unrestricted license in the designated state of principal license;

(3) Has not been convicted of or received adjudication, deferred adjudication, community supervision, or deferred disposition for any offense by a court of appropriate jurisdiction;

(4) Has not had a license authorizing the practice of medicine subject to discipline by a licensing agency in any state, federal or foreign jurisdiction, excluding any action related to nonpayment of fees related to a license;

(5) Has not had a controlled substance license or permit suspended or revoked by a state or the U.S. DEA.

c. Pay licensure fee for the renewal of a license issued through the IMLC and pay any service fee assessed by the IMLC.

d. If audited, submit verification of completion of continuing medical education requirements set forth in 653—Chapter 11.

9.18(8) *Waivers.* The laws and rules relating to the IMLC cannot be waived.

9.18(9) *Advisory opinions.* The board will recognize advisory opinions issued by the interstate commission on the meaning or interpretation of the IMLC, its bylaws, rules and actions when determining an applicant's eligibility for licensure through the IMLC.

[**ARC 9112C**, IAB 4/16/25, effective 5/21/25]

653—9.19(147,148) Denial of licensure, determination of ineligibility for licensure through the IMLC, or termination of a license issued through the IMLC.

9.19(1) *Preliminary notice of denial.* Prior to the denial of licensure to an applicant, the board shall issue a preliminary notice of denial that shall be sent to the applicant by regular, first-class mail at the address provided by the applicant. The preliminary notice of denial is a public record and shall cite the factual and legal basis for denying the application, notify the applicant of the appeal process, and specify the date upon which the denial will become final if it is not appealed.

9.19(2) *Appeal procedure.* An applicant who has received a preliminary notice of licensure denial or a Letter of Qualification that asserts the board has determined that the applicant is ineligible for licensure through the IMLC, or a notice that a medical license is ineligible for renewal through the IMLC, may appeal and request a hearing on the issues related to the preliminary notice of licensure denial or ineligibility for licensure or licensure renewal through the IMLC by serving a request for hearing upon the executive director not more than 30 calendar days following the date when the notice was mailed. The applicant's current address shall be provided in the request for hearing. The request is deemed filed on the date it is received in the board office. If the request is received with a USPS nonmetered postmark, the board shall consider the postmark date as the date the request is filed. The request shall specify the factual or legal errors and that the applicant desires an evidentiary hearing, and may provide additional written information or documents in support of licensure, or a Letter of Qualification that asserts the applicant is eligible for licensure through the IMLC, or the applicant is eligible for licensure renewal through the IMLC.

9.19(3) *Hearing.* If an applicant appeals the preliminary notice of licensure denial or a determination of ineligibility for licensure or licensure renewal through the IMLC and requests a hearing, the hearing shall be a contested case and subsequent proceedings shall be conducted in accordance with rule 653—25.30(17A).

a. Hearings for applicants denied licensure, or determined to be ineligible for licensure or licensure renewal through the IMLC are contested cases open to the public.

b. Either party may request issuance of a protective order in the event privileged or confidential information is submitted into evidence.

c. Evidence supporting the denial of the license or the determination of ineligibility for licensure or licensure renewal through the IMLC may be presented by an assistant attorney general.

d. While each party shall have the burden of establishing the affirmative of matters asserted, the applicant shall have the ultimate burden of persuasion as to the applicant's qualification for licensure or licensure eligibility or licensure renewal through IMLC.

e. The board, after a hearing on license denial, may grant or deny the application for licensure. The board shall state the reasons for its decision and may grant the license, grant the license with restrictions or deny the license. The final decision is a public record. After a hearing on ineligibility for licensure renewal through the IMLC, the board may uphold the termination of the license or allow the licensee to renew. The board shall state the reasons for its decision, which is a public record. After a hearing on a Letter of Qualification determination, the board may uphold the ineligible determination or issue a Letter of Qualification asserting the applicant is eligible for licensure through the IMLC. The board shall state the reasons for its decision, which is a public record.

f. Judicial review of a final order of the board denying licensure, issuing a license with restrictions, terminating a license not eligible for renewal through the IMLC, or upholding a Letter of Qualification asserting that an applicant is ineligible for licensure through the IMLC may be sought in accordance with the provisions of Iowa Code section 17A.19, which are applicable to judicial review of any agency's final decision in a contested case.

9.19(4) *Finality.* If an applicant does not appeal a preliminary notice of denial in accordance with subrule 9.17(2), the preliminary notice of denial automatically becomes final. A final denial of an application for licensure is a public record.

9.19(5) *Failure to pursue appeal.* If an applicant appeals a preliminary notice of licensure denial or a notice of ineligibility for licensure or licensure renewal through the IMLC, in accordance with subrule 9.17(2), but the applicant fails to pursue that appeal to a final decision within one year from the date of the preliminary notice of licensure denial or a notice of ineligibility for licensure or licensure renewal through the IMLC, the board may dismiss the appeal. The appeal may be dismissed only after the board sends a written notice by first-class mail to the applicant at the applicant's last-known address. The notice shall state that the appeal will be dismissed and that the preliminary notice of licensure denial or a notice of ineligibility for licensure or licensure renewal through the IMLC will become final if the applicant does not contact the board to schedule the appeal hearing within 30 days of the date the letter is mailed from the board office. Upon dismissal of an appeal, the preliminary notice of licensure denial or a notice of ineligibility for licensure or licensure renewal through the IMLC becomes final. A final decision under this rule is a public record.

[**ARC 9112C**, IAB 4/16/25, effective 5/21/25]

These rules are intended to implement Iowa Code chapters 17A, 147, 147B, 148, and 272C.

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◊ Two or more ARCs

CHAPTER 10
RESIDENT, SPECIAL AND TEMPORARY PHYSICIAN LICENSURE

[Prior to 5/30/01, see 653—Chapter 11]

Chapter rescission date pursuant to Iowa Code section 17A.7: 5/21/30

653—10.1(147,148) Definitions.

"ABMS" means the American Board of Medical Specialties.

"ACGME" means the Accreditation Council for Graduate Medical Education.

"AMA" means the American Medical Association.

"Any jurisdiction" means any state, the District of Columbia or territory of the United States of America or any other nation.

"Any United States jurisdiction" means any state, the District of Columbia or territory of the United States of America.

"AOA" means the American Osteopathic Association.

"Applicant" means a person who seeks authorization to practice medicine and surgery or osteopathic medicine and surgery in this state by making application to the board.

"Approved abuse education training program" means a training program using a curriculum approved by the abuse education review panel of the department of health and human services or a training program offered by a hospital, a professional organization for physicians, the department of health and human services, the department of education, an area education agency, a school district, the Iowa law enforcement academy, an Iowa college or university, or a similar state agency.

"Board" means board of medicine.

"Board-approved activity" means one of the following activities:

1. Covering for an Iowa-licensed physician who unexpectedly is unavailable to provide medical care to the physician's patients;
2. Demonstrating or proctoring that involves providing hands-on patient care to patients in Iowa;
3. Conducting a procedure on a patient in Iowa when the consultant's expertise in the procedure is greater than that of the Iowa-licensed physician who requested the procedure;
4. Providing medical care to patients in Iowa, if the physician is enrolled in an out-of-state resident training program and does not hold a resident or permanent license in the home state of the resident training program;
5. Serving as a camp physician;
6. Participating as a learner in a program of further medical education that allows hands-on patient care when the physician does not currently hold a license in good standing in any United States jurisdiction; or
7. Any other activity approved by the board.

"Board-approved resident training program" means a hospital-affiliated graduate medical education program accredited by the ACGME, AOA, RCPSC, or CFPC at the time the applicant is enrolled in the program.

"Category 1 credit" means any formal education program that is sponsored or jointly sponsored by an organization accredited for continuing medical education by the Accreditation Council for Continuing Medical Education, the Iowa Medical Society, or the Council on Continuing Medical Education of AOA that is of sufficient scope and depth of coverage of a subject area or theme to form an educational unit and is planned, administered and evaluated in terms of educational objectives that define a level of knowledge or a specific performance skill to be attained by the physician completing the program. Credits designated as formal cognates by the American College of Obstetricians and Gynecologists or as prescribed credits by the American Academy of Family Physicians are accepted as equivalent to category 1 credits.

"CFPC" means the College of Family Physicians of Canada.

"Committee" means the licensure committee of the board.

"ECFMG" means the Educational Commission for Foreign Medical Graduates.

"FCVS" means the Federation Credentials Verification Service.

"FSMB" means the Federation of State Medical Boards.

"Incidentally called into this state in consultation with a physician and surgeon licensed in this state" as set forth in Iowa Code section 148.2(5) means all of the following shall be true:

1. The consulting physician shall be involved in the care of patients in Iowa only at the request of an Iowa-licensed physician.
2. The consulting physician has a license in good standing in another United States jurisdiction.
3. The consulting physician provides expertise and acts in an advisory capacity to an Iowa-licensed physician. The consulting physician may examine the patient and advise an Iowa-licensed physician as to the care that should be provided, but the consulting physician will not personally perform procedures, write orders, or prescribe for the patient.
4. The consulting physician practices in Iowa for a period not greater than 10 consecutive days and not more than 20 total days in any calendar year. Any portion of a day counts as one day.
5. The Iowa-licensed physician requesting the consultation retains the primary responsibility for the management of the patient's care.

"LCME" means Liaison Committee on Medical Education.

"Medical degree" means a degree of doctor of medicine and surgery or osteopathic medicine and surgery or comparable education from an international medical school.

"Permanent licensure" means licensure granted after review of the application and credentials to determine that the individual is qualified to enter into practice.

"Postgraduate training" means graduate medical education, e.g., an internship, residency or fellowship, in a hospital-affiliated training program approved by the board at the time the applicant was enrolled in the program.

"Practice" means the practice of medicine and surgery or osteopathic medicine and surgery.

"RCPSC" means the Royal College of Physicians and Surgeons of Canada.

"Resident physician" means a physician enrolled in an internship, residency or fellowship.

"Resident training program" means a hospital-affiliated graduate medical education program that enrolls interns, residents or fellows and may be referred to as a postgraduate training program for purposes of licensure.

"Service charge" means the amount charged for making a service available online and is in addition to the actual fee for a service itself. For example, one who renews a license online will pay the license renewal fee and a service charge.

"Training for chronic pain management" means required training on chronic pain management identified in 653—Chapter 11.

"Training for end-of-life care" means required training on end-of-life care identified in 653—Chapter 11.

"Training for identifying and reporting abuse" means training on identifying and reporting child abuse or dependent adult abuse required of physicians who regularly provide primary health care to children or adults, respectively.

"Uniform application for physician state licensure" means a web-based application that is intended to standardize and simplify the licensure application process for state medical licensure.

[**ARC 9113C**, IAB 4/16/25, effective 5/21/25]

653—10.2(148) Licensure required. Licensure is required for practice in Iowa as identified in Iowa Code section 148.1; the exceptions are identified in 653—subrule 9.2(2).

[**ARC 9113C**, IAB 4/16/25, effective 5/21/25]

653—10.3(147,148) Resident physician licensure.

10.3(1) *General provisions.*

a. The resident physician license authorizes the licensee to practice as an intern, resident or fellow while under the supervision of a licensed practitioner of medicine and surgery or osteopathic medicine and surgery in a board-approved resident training program in Iowa. When the ACGME, AOA, RCPSC, or CFPC fails to offer accreditation for a fellowship or the fellowship fails to seek accreditation, the board will approve the program if the parent program is accredited by one of the aforementioned accrediting bodies.

Completion of one or more years of a program that itself lacks such accreditation does not fulfill the one-year resident training requirement for permanent licensure.

b. An Iowa resident physician license or an Iowa permanent physician license is required of any resident physician enrolled in an Iowa resident training program and practicing in Iowa.

c. A resident physician license will expire on the expected date of completion of the resident training program as indicated on the licensure application.

d. A resident physician license is valid only for practice in the program designated in the application. When the physician leaves that program, the license will immediately become inactive. The director of the resident training program must notify the board within 30 days of the licensee's terminating from the program.

e. A resident physician licensee who changes resident training programs must apply for a new resident physician license as described in subrule 10.3(3). Such changes include a transfer to a different program in the same institution, a move to a program in another institution, or becoming a fellow after completing a residency in the same core program. An individual who contracts with an institution to be in two programs from the time of application for the resident license shall not be required to apply for another resident license for the second program.

f. A visiting resident physician may come to Iowa to practice as a part of the physician's resident training program if the physician is under the supervision of an Iowa-licensed physician. An Iowa physician license is not required of a physician in training if the physician has a resident or permanent license in good standing in the home state of the resident training program. An Iowa temporary physician license is required of a physician in training if the physician does not hold a resident or permanent physician license in good standing in the home state of the resident training program (more information can be found in rule 653—10.5(147,148)).

g. An Iowa license is not required for residents when they are training in a federal facility in Iowa. An Iowa license is not required for faculty who are teaching in and employed by a federal facility in Iowa and who are licensed in another state.

h. The director of a resident training program that enrolls a resident with an Iowa resident physician license shall report annually on October 1 on the resident's progress and whether any warnings have been issued, investigations conducted, or disciplinary actions taken, whether by voluntary agreement or formal action.

i. A resident physician licensee must notify the board of any change in name within one month of making the name change. Notification requires a notarized copy of a marriage license or a notarized copy of court documents.

j. A resident physician licensee's file shall be closed and labeled "deceased" when the board receives a copy of the physician's death certificate.

10.3(2) *Resident license eligibility.* To be eligible for a resident license, an applicant must meet all of the following requirements:

a. Fulfill the application requirements specified in subrule 10.3(3).

b. Be at least 20 years of age.

c. Hold a medical degree from an educational institution approved by the board at the time the applicant graduated and was awarded the degree.

(1) Educational institutions approved by the board must be fully accredited by an accrediting agency recognized by the board as schools of instruction in medicine and surgery or osteopathic medicine and surgery and empowered to grant academic degrees in medicine.

(2) The accrediting bodies currently recognized by the board are:

1. LCME for educational institutions granting degrees in medicine and surgery; and
2. AOA for educational institutions granting degrees in osteopathic medicine and surgery.

(3) If the applicant holds a medical degree from an educational institution not approved by the board at the time the applicant graduated and was awarded the degree, the applicant must:

1. Hold a valid certificate issued by ECFMG, or
2. Have successfully completed a fifth pathway program established in accordance with AMA criteria.

d. The applicant's license is not denied by the board due to the commission of a disqualifying offense, as provided in 653—subrule 9.3(3).

10.3(3) *Resident physician licensure application.*

a. Requirements. To apply for resident physician licensure, an applicant shall:

(1) Pay a nonrefundable initial application fee and fee for the evaluation of the fingerprint packet and the criminal history background checks by the division of criminal investigation (DCI) and the Federal Bureau of Investigation (FBI) as specified in 653—paragraph 8.4(2)*"a"*; and

(2) Complete and submit forms provided by the board, including required credentials, documents, a completed fingerprint packet, and a sworn statement by the applicant attesting to the truth of all information provided by the applicant.

b. Application. The application shall require the following information:

(1) Full legal name, date and place of birth, home address, and mailing address;

(2) A statement listing every jurisdiction in which the applicant is or has been authorized to practice, including license numbers and dates of issuance;

(3) A chronology accounting for all time periods from the date the applicant entered medical school to the date of the application;

(4) A photocopy of the applicant's medical degree issued by an educational institution.

1. A complete translation shall be submitted for any diploma not written in English. An official transcript, written in English and received directly from the school, verifying graduation from medical school is a suitable alternative. An official FCVS Physician Information Profile is a suitable alternative.

2. If a copy of the medical degree cannot be provided because of extraordinary circumstances, the board may accept other reliable evidence that the applicant obtained a medical degree from a specific educational institution;

(5) If the educational institution awarding the applicant the degree has not been approved by the board, the applicant shall provide a valid ECFMG certificate or evidence of successful completion of a fifth pathway program in accordance with criteria established by the AMA. An official FCVS Physician Information Profile is a suitable alternative;

(6) A statement disclosing and explaining any warnings issued, investigations conducted, or disciplinary actions taken, whether by voluntary agreement or formal action, by a medical or professional regulatory authority, an educational institution, training or research program, or health care facility in any jurisdiction;

(7) A statement disclosing and explaining the applicant's involvement in civil litigation related to practice in any jurisdiction. Copies of the legal documents may be requested if needed during the review process;

(8) A statement disclosing and explaining any charge of a misdemeanor or felony involving the applicant filed in any jurisdiction, whether or not any appeal or other proceeding is pending to have the conviction or plea set aside; and

(9) A completed fingerprint packet to facilitate a national criminal history background check. The fee for the evaluation of the fingerprint packet and the DCI and FBI criminal history background checks will be assessed to the applicant.

10.3(4) *Resident license application review process.* The process below shall be utilized to review each application for a resident license.

a. An application shall be considered open from the date the application form is received in the board office with the nonrefundable resident licensure fee.

b. After reviewing each application, staff shall notify the applicant or designee about how to resolve any problems identified by the reviewer.

c. If the final review indicates no questions or concerns regarding the applicant's qualifications for licensure, staff may grant administratively a resident license.

d. If the final review indicates questions or concerns that cannot be remedied by continued communication with the applicant, the executive director, director of licensure and administration, and director of legal affairs shall determine if the questions or concerns indicate any uncertainty about the applicant's current qualifications for licensure.

(1) If there is no current concern, staff shall grant administratively a resident license.

(2) If any concern exists, the application shall be referred to the committee.

e. Staff shall refer to the committee for review matters that include but are not limited to falsification of information on the application, criminal record, substance abuse, competency, physical or mental illness, or educational disciplinary history.

f. If the committee is able to eliminate questions or concerns without dissension from staff or a committee member, the committee may direct staff to grant administratively a resident license.

g. If the committee is not able to eliminate questions or concerns without dissension from staff or a committee member, the committee shall recommend that the board:

(1) Request an investigation;

(2) Request that the applicant appear for an interview;

(3) Grant a resident physician license for a particular residency program;

(4) Grant a license under certain terms and conditions or with certain restrictions;

(5) Request that the applicant withdraw the licensure application; or

(6) Deny a license.

h. The board shall consider applications and recommendations from the committee and shall:

(1) Request an investigation;

(2) Request that the applicant appear for an interview;

(3) Grant a resident physician license for a particular residency program;

(4) Grant a license under certain terms and conditions or with certain restrictions;

(5) Request that the applicant withdraw the licensure application; or

(6) Deny a license. The board may deny a license for any grounds on which the board may discipline a license. The procedure for appealing a license denial is set forth in rule 653—9.15(147,148).

10.3(5) *Resident license application cycle.* If the applicant does not submit all materials within 90 days of the board's initial request for further information, the application shall be considered inactive. An applicant must reapply and submit a new nonrefundable application fee and a new application, documents and credentials.

10.3(6) *Extension of a resident physician license.*

a. If the licensee fails to complete the program by the expiration date on the license, the licensee has a one-month grace period in which to complete the program or secure an extension from the board.

b. The resident physician licensee must apply for an extension if the licensee has not been granted permanent physician licensure and the licensee will not complete the program within the grace period. The following extension application materials are due in the board office prior to the expiration of the license:

(1) A letter requesting an extension and providing an explanation of the need for an extension;

(2) The extension fee as specified in 653—paragraph 8.4(2)*"b"*; and

(3) A statement from the director of the resident training program attesting to the new expected date of completion of the program and the individual's progress in the program and whether any warnings have been issued, investigations conducted, or disciplinary actions taken, whether by voluntary agreement or formal action.

c. Failure of the licensee to extend a license within one month following the expiration date will cause the license to become inactive and invalid.

d. To extend an inactive resident license within one year of becoming inactive, an applicant shall submit the following:

(1) A letter requesting an extension and providing an explanation of the need for an extension;

(2) The extension fee as specified in 653—paragraph 8.4(2)*"b"*; and

(3) A late fee as specified in 653—paragraph 8.4(2)*"c"*; and

(4) A statement from the director of the resident training program attesting to the new expected date of completion of the program and the individual's progress in the program and whether any warnings have been issued, investigations conducted, or disciplinary actions taken, whether by voluntary agreement or formal action.

e. If more than one year has passed since the resident license became inactive, the applicant shall apply for a new resident license as described in subrule 10.3(3).

10.3(7) *Review process for extending a resident license.* The process below shall be utilized to review each request for an extension of a resident license.

a. An extension request shall be considered open from the date the required letters and nonrefundable extension fee are received in the board office.

b. After reviewing each request for extension, staff shall notify the licensee or designee about how to resolve any problems identified by the reviewer. The applicant for license extension shall provide additional information when requested by staff or the board.

c. If the final review indicates no questions or concerns regarding the applicant's qualifications for continued licensure, staff may grant administratively an extension to a resident license.

d. If the final review indicates questions or concerns that cannot be remedied by continued communication with the applicant, the executive director, the director of licensure and administration, and the director of legal affairs shall determine if the questions or concerns indicate any uncertainty about the applicant's current qualifications for licensure.

(1) If there is no current concern, staff shall grant administratively an extension to a resident license.

(2) If any concern exists, the application shall be referred to the committee.

e. Staff shall refer to the committee for review matters that include but are not limited to falsification of information in the request, criminal record, substance abuse, competency, physical or mental illness, or educational disciplinary history.

f. If the committee is able to eliminate questions or concerns without dissension from staff or a committee member, the committee may direct staff to grant administratively an extension to a resident license.

g. If the committee is not able to eliminate questions or concerns without dissension from staff or a committee member, the committee shall recommend that the board:

(1) Request an investigation;

(2) Request that the licensee appear for an interview;

(3) Grant a license under certain terms and conditions or with certain restrictions;

(4) Request that the licensee withdraw the request for an extension; or

(5) Deny a request for an extension of the license.

h. The board shall consider applications and recommendations from the committee and shall:

(1) Request an investigation;

(2) Request that the licensee appear for an interview;

(3) Grant an extension to the resident physician license;

(4) Grant an extension to the resident physician license under certain terms and conditions or with certain restrictions;

(5) Request that the licensee withdraw the request for an extension; or

(6) Deny a request for an extension of the license. The board may deny an extension of a license for any grounds on which the board may discipline a license. The procedure for appealing a license denial of an extension is set forth in rule 653—9.15(147,148).

10.3(8) *Discipline of a resident license.* The board may discipline a license for any of the grounds for which licensure may be revoked or suspended as specified in Iowa Code section 147.55 or 148.6, Iowa Code chapter 272C, and 653—Chapter 23.

10.3(9) *Transition from a resident license to a permanent license.* When a resident physician receives a permanent Iowa license, the resident physician license shall immediately become inactive.

[**ARC 9113C**, IAB 4/16/25, effective 5/21/25]

653—10.4(147,148) Special licensure.

10.4(1) *General provisions.*

a. The board may grant a special license to a physician who is an academic staff member of a college of medicine or osteopathic medicine if that physician does not meet the qualifications for permanent licensure but is held in high esteem for unique contributions the individual has made to medicine and will make by practicing in Iowa. The license is not designed for physicians in regular faculty positions that could be filled by a physician qualified for permanent licensure in Iowa or for the purpose of training the

physician who receives the license. The board will consider granting and renewing a special license on a case-by-case basis.

b. A special license may be issued for a period of not more than one year and may be renewed annually prior to expiration.

c. A special license will specifically limit the licensee to practice at the medical college and at any health care facility affiliated with the medical college.

d. A special license will automatically be placed on inactive status when the licensee discontinues service on the academic medical staff for which the special license was granted.

e. The board may cancel a special license if the licensee has practiced outside the scope of this license or for any of the grounds for which licensure may be revoked or suspended as specified in Iowa Code sections 147.55, 148.6, and 272C.10 and 653—Chapter 23. When cancellation of such a license is proposed, the board shall promptly notify the licensee by sending a statement of charges and notice of hearing by certified mail to the last-known address of the licensee. This contested case proceeding shall be governed by the provisions of 653—Chapter 25.

f. A special physician licensee must notify the board of any change in home address or the address of the place of practice within one month of making an address change.

g. A special physician licensee must notify the board of any change in name within one month of making the name change. Notification requires a notarized copy of a marriage license or a notarized copy of court documents.

h. A special physician licensee file will be closed and labeled "deceased" when the board receives a copy of the physician's death certificate.

i. The board may accept each 12 months of practice as a special licensee as equivalent to one year of postgraduate training in a hospital-affiliated program approved by the board for the purposes of permanent licensure.

10.4(2) *Special license eligibility.* To be eligible for a special license, an applicant shall meet all of the following requirements:

a. Fulfill the application requirements specified in subrule 10.4(3);

b. Be at least 21 years of age;

c. Be a physician in a medical specialty;

d. Present evidence of holding a medical degree from an educational institution that is located in a jurisdiction outside the United States or Canada and that is listed in the Directory of Medical Schools published by the International Medical Education Directory;

e. Have completed at least two years of postgraduate education in any jurisdiction;

f. Have practiced for five years after postgraduate education;

g. Demonstrate proficiency in English by providing a valid ECFMG certificate or verification of a passing score on the Test of Spoken English (TSE) or the Test of English as a Foreign Language (TOEFL) examination administered by the Educational Testing Service;

h. Be licensed in a jurisdiction outside the United States or Canada and present evidence that any licenses held in any jurisdiction are unrestricted; and

i. The applicant's license is not denied by the board due to the commission of a disqualifying offense, as provided in 653—subrule 9.3(3).

10.4(3) *Special license application.*

a. Requirements. To apply for a special license, an applicant must:

(1) Pay a nonrefundable special license fee and a fee for the evaluation of the fingerprint packet and the criminal history background checks by the DCI and the FBI as specified in 653—paragraph 8.4(3)*"a"*;

(2) Complete and submit forms provided by the board, including required credentials, documents, a completed fingerprint packet, and a sworn statement by the applicant attesting to the truth of all information provided by the applicant;

(3) Provide verification of successful completion of a medical degree;

(4) Provide a valid ECFMG certificate or verification of a passing score on the TSE or TOEFL examination administered by the Educational Testing Service;

(5) Present a letter from the dean of the medical college in which the applicant will be practicing that indicates all of the following:

1. The applicant has been invited to serve on the academic staff of the medical school and in what capacity;

2. The applicant's qualifications and the unique contributions the applicant has made to the practice of medicine;

3. The unique contributions the applicant is expected to make by practicing in Iowa and how these contributions will serve the public interest of Iowans; and

(6) Present at least two letters of recommendation from universities, other educational institutions, or research facilities that indicate the applicant's noteworthy professional attainment.

b. Application. The application shall request the following information:

(1) Name, date and place of birth, home address, and mailing address;

(2) A statement listing every jurisdiction in which the applicant is or has been authorized to practice, including license numbers and dates of issuance;

(3) A chronology accounting for all time periods from the date the applicant entered medical school to the date of the application;

(4) A photocopy of the applicant's medical degree issued by an educational institution and a sworn statement from an official of the educational institution certifying the date the applicant received the medical degree and acknowledging what, if any, derogatory comments exist in the institution's record about the applicant. A complete translation of any diploma not written in English shall be submitted;

(5) A statement disclosing and explaining any warnings issued, investigations conducted, or disciplinary actions taken, whether by voluntary agreement or formal action, by a medical or professional regulatory authority, an educational institution, training or research program, or health facility in any jurisdiction;

(6) A statement disclosing and explaining the applicant's involvement in civil litigation related to practice in any jurisdiction. Copies of the legal documents may be requested if needed during the review process;

(7) A statement disclosing and explaining any charge of a misdemeanor or felony involving the applicant filed in any jurisdiction, whether or not any appeal or other proceeding is pending to have the conviction or plea set aside; and

(8) A completed fingerprint packet to facilitate a national criminal history background check. The fee for the evaluation of the fingerprint packet and the DCI and FBI criminal history background checks will be assessed to the applicant.

10.4(4) *Special license application review process.* The process below shall be utilized to review each application for a special license.

a. An application shall be considered open from the date the application form is received in the board office with the nonrefundable special licensure fee.

b. After reviewing each application, staff shall notify the applicant or the applicant's academic institution about how to resolve any problems identified by the reviewer. The applicant shall provide additional information when requested by staff or the board.

c. If the final review indicates no questions or concerns regarding the applicant's qualifications for licensure, staff may administratively grant a special license.

d. If the final review indicates questions or concerns that cannot be remedied by continued communication with the applicant, the executive director, director of licensure and administration, and director of legal affairs shall determine if the questions or concerns indicate any uncertainty about the applicant's current qualifications for licensure.

(1) If there is no current concern, staff shall administratively grant a special license.

(2) If any concern exists, the application shall be referred to the committee.

e. Staff shall refer to the committee for review matters that include but are not limited to falsification of information on the application, criminal record, substance abuse, questionable competency, physical or mental illness, or educational disciplinary history.

f. If the committee is able to eliminate questions or concerns without dissension from staff or a committee member, the committee may direct staff to grant administratively a special license.

g. If the committee is not able to eliminate questions or concerns without dissension from staff or a committee member, the committee shall recommend that the board:

(1) Request that the applicant appear for an interview;

(2) Grant a special license for practice at the medical college designated in the application;

(3) Grant a license under certain terms and conditions or with certain restrictions;

(4) Request that the applicant withdraw the licensure application; or

(5) Deny a license.

h. The board shall consider applications and recommendations from the committee and shall:

(1) Request that the applicant appear for an interview;

(2) Grant a special license for practice at the medical college designated in the application;

(3) Grant a license under certain terms and conditions or with certain restrictions;

(4) Request that the applicant withdraw the licensure application; or

(5) Deny a license. The board may deny a license for any grounds on which the board may discipline a license. The procedure for appealing a license denial is set forth in rule 653—9.15(147,148).

10.4(5) *Special license application cycle.* If the applicant does not submit all materials within 90 days of the board's initial request for further information, the application will be considered inactive. An applicant must reapply and submit a new nonrefundable application fee and a new application, documents and credentials.

10.4(6) *Renewal of a special license.*

a. If the special physician licensee has not qualified for and received a permanent license, the licensee must renew prior to expiration.

b. A special physician licensee may apply for a one-year renewal by submitting the following:

(1) A completed renewal application;

(2) The renewal fee as specified in 653—paragraph 8.4(3)*"b"*;

(3) Evidence of continuing education and training on chronic pain management, end-of-life care, and identifying and reporting abuse as specified in 653—Chapter 11; and

(4) A letter from the dean of the medical college that addresses the individual's unique contribution to the practice of medicine in Iowa, how the anticipated contribution will serve the public interest of Iowans, and the need for renewal of this license. For a licensee who received the initial special license prior to July 1, 2001, the only statement needed from the dean is verification of the academic appointment the licensee continues to hold.

c. Failure of the licensee to renew a license within one month of the expiration date will cause the license to become inactive. A licensee whose license is inactive is prohibited from practice until a new special license is granted according to subrules 10.4(3) and 10.4(4).

[**ARC 9113C**, IAB 4/16/25, effective 5/21/25]

653—10.5(147,148) Temporary licensure. The board may issue a temporary license authorizing a physician to participate in a board-approved activity in Iowa. Temporary licensure is granted on a case-by-case basis and depends upon the applicant's education and training, experience and licensure status elsewhere and upon the intended use of the temporary license.

10.5(1) *General provisions.*

a. The temporary license to practice is intended for a physician to participate in a board-approved activity, as defined in rule 653—10.1(147,148), in Iowa that is short-term. Temporary licensure is not intended for locum tenens.

b. The license may be restricted to the board-approved activity, location(s) or time period of up to one year.

(1) A physician who is granted a temporary license for a board-approved activity may qualify for renewal of that license if the physician needs an extension of the license for the original purpose or to pursue more than one board-approved activity within a year.

(2) A physician who wishes to continue in a board-approved activity in Iowa for short intervals beyond one year is eligible for a temporary license each year after reapplying and qualifying on an annual basis.

c. A physician incidentally called into this state in consultation with a physician and surgeon licensed in this state, as defined in rule 653—10.1(147,148), is not required to obtain a temporary license in Iowa.

d. The board may take disciplinary action on a temporary license if the licensee has practiced outside the scope of the temporary license or for any of the grounds for which licensure may be revoked or suspended as specified in Iowa Code sections 147.55, 148.6, and 272C.10 and 653—Chapter 23. Contested case proceedings shall be governed by the provisions of 653—Chapter 25.

e. A physician who holds a temporary license must notify the board of any change in address within three days of making an address change.

f. A physician who holds a temporary license must notify the board of any change in name within one month of making the name change. Notification requires a notarized copy of a marriage license or a notarized copy of court documents.

g. The file of a physician who holds a temporary license will be closed and labeled "deceased" when the board receives a copy of the physician's death certificate.

10.5(2) *Temporary license eligibility.* To be eligible for a temporary license, an applicant must meet all of the following requirements:

a. Fulfill the requirements specified in subrules 10.5(3) and 10.5(4);

b. Be at least 21 years of age;

c. Hold a medical degree from an educational institution approved by the board (if the applicant is an international medical graduate, the educational institution must be listed in the International Medical Education Directory);

d. Hold a current active, unrestricted license to practice medicine issued by any jurisdiction;

e. Be fluent in the English language;

f. Present a letter justifying the need for temporary licensure from the organization or individual seeking the applicant's participation in a board-approved activity;

g. The applicant's license is not denied by the board due to the commission of a disqualifying offense, as provided in 653—subrule 9.3(3).

10.5(3) *Requirements for a temporary license.* To apply for a temporary license, an applicant must:

a. Pay a nonrefundable initial application fee and fee for the evaluation of the fingerprint packet and the criminal history background checks by the DCI and the FBI as specified in 653—paragraph 8.4(4)*"a."* A physician who is serving as a camp physician and who is not receiving payment other than expenses shall be exempt from the license application fee and the fee for the criminal history background check.

b. Complete and submit forms provided by the board, including required credentials, documents, a completed fingerprint packet and a sworn statement by the applicant attesting to the truth of all information provided by the applicant.

10.5(4) *Application.* The application shall require the following information:

a. The applicant's full legal name, date and place of birth, home address, mailing address and principal business address;

b. A statement listing every jurisdiction in which the applicant is or has been authorized to practice, including the applicant's license number and date of issuance of the license;

c. A chronology accounting for all time periods from the date the applicant entered medical school to the date of the application;

d. A statement by the applicant that discloses and explains any warnings issued, investigations conducted, or disciplinary actions taken, whether by voluntary agreement or formal action, by a medical or professional regulatory authority, an educational institution, training or research program, or health facility in any jurisdiction;

e. A statement disclosing and explaining the applicant's involvement in civil litigation related to practice in any jurisdiction. Copies of the legal documents may be requested if needed during the review process;

f. A statement disclosing and explaining any charge of a misdemeanor or felony involving the applicant, filed in any jurisdiction, whether or not any appeal or other proceeding is pending to have the conviction or plea set aside;

g. A statement from the applicant that justifies the need for a temporary license, including where the applicant intends to practice and the type of practice involved;

h. A letter from the Iowa organization or individual seeking the applicant's services that explains the need for the applicant's participation in the board-approved activity in Iowa, the time period involved, the scope of practice, and the exact location and facilities where the board-approved activity will occur;

i. For an international medical graduate who does not hold a license in good standing in any United States jurisdiction, a statement, which shall be submitted by the Iowa organization or individual offering the board-approved activity, identifying who the applicant's immediate supervisor will be;

j. For an international medical graduate who does not hold a license in good standing in any United States jurisdiction:

(1) Verification, which shall be submitted from the licensing authority of the country in which the physician is licensed, that the physician has a license in good standing;

(2) Evidence of fluency in the English language;

k. For a resident physician who does not hold a current, active resident or permanent license in the home state of the resident training program, a statement, which shall be submitted by the resident director or individual offering the board-approved activity, identifying who the applicant's immediate supervisor will be; and

l. A completed fingerprint packet to facilitate a national criminal history background check. The fee for the evaluation of the fingerprint packet and the DCI and FBI criminal history background checks will be assessed to the applicant.

10.5(5) *Standard application review process for a temporary license.* The standard review process shall be utilized to review each application for a temporary license, except that the process identified in subrule 10.5(6) shall be used for any international medical graduate who does not currently hold a license in good standing in any United States jurisdiction or for any physician who seeks temporary licensure for an activity not listed in paragraphs "1" through "6" of the definition of "board-approved activity" in rule 653—10.1(147,148). The standard application review process is as follows:

a. An application shall be considered open from the date the application form and the nonrefundable fees are received in the board office.

b. After reviewing each application, staff shall notify the applicant or designee about how to resolve any problems identified by the reviewer.

c. If the final review indicates no questions or concerns regarding the applicant's qualifications for temporary licensure or the need for a temporary licensee, staff may administratively grant a temporary license to the applicant for a specific activity, location(s) or specified duration based on the nature of the board-approved activity. The license shall not be granted for a period longer than one year.

d. If the final review indicates questions or concerns that cannot be remedied by continued communication with the applicant, then the executive director, the director of licensure and administration, and the director of legal affairs shall determine if the questions or concerns indicate any uncertainty about the applicant's current qualifications for temporary licensure or the organization's or requesting individual's need for a licensee with a temporary license.

(1) If there is no current concern, staff shall administratively grant a temporary license.

(2) If any concern exists, the application shall be referred to the committee.

e. Staff shall refer to the committee for review matters that include but are not limited to falsification of information on the application, criminal record, malpractice, substance abuse, competency, physical or mental illness, educational disciplinary history, or questionable need on the part of the organization.

f. If the committee is able to eliminate questions or concerns without dissension from staff or a committee member, the committee may direct staff to administratively grant a temporary license for a specific activity, location(s) or specified duration based on the nature of the board-approved activity.

g. If the committee is not able to eliminate questions or concerns without dissension from staff or a committee member, the committee shall recommend that the board:

(1) Grant a temporary license for a specific activity, location(s) or specified duration based on the nature of the board-approved activity;

(2) Grant a temporary license under certain terms and conditions or with certain restrictions;

(3) Deny a temporary license; or

(4) Request that the applicant withdraw the temporary licensure application.

h. The board shall consider applications and recommendations from the committee and shall:

(1) Grant a temporary license for a specific activity, location(s) or specified duration based on the nature of the board-approved activity;

(2) Grant a temporary license under certain terms and conditions or with certain restrictions;

(3) Request that the applicant withdraw the temporary licensure application. The request shall not imply that the applicant is ineligible for permanent licensure if that application process is pursued; or

(4) Deny a temporary license. The board may deny a temporary license for any grounds on which the board may discipline a license or for lack of need for a physician's services by the organization or individual. The procedure for appealing a license denial is set forth in rule 653—9.17(147,148).

10.5(6) *Application review process for applicants with certain exceptions.* This application process shall be used to review applications submitted by an international medical graduate who does not currently hold a license in good standing in any United States jurisdiction or by a physician seeking temporary licensure for an activity not listed in paragraphs "1" through "6" of the definition of "board-approved activity" in rule 653—10.1(147,148). Following is the application review process for applicants with exceptions:

a. An application shall be considered open from the date the application form and the nonrefundable fees are received in the board office.

b. After reviewing each application, staff shall notify the applicant or designee about how to resolve any problems identified by the reviewer.

c. If the final review indicates no questions or concerns regarding the applicant's qualifications for temporary licensure or the need for a temporary license, staff shall submit the application to the committee for review and recommendation to the board about whether to grant a temporary license to the physician and whether the license should be granted for a specific activity, location(s) or specified duration based on the nature of the board-approved activity.

d. The board shall consider applications and recommendations from the committee and shall:

(1) Grant a temporary license for a specific activity, location(s) or specified duration based on the nature of the board-approved activity;

(2) Grant a temporary license under certain terms and conditions or with certain restrictions;

(3) Request that the applicant withdraw the temporary licensure application. The request shall not imply that the applicant is ineligible for permanent licensure if that application process is pursued; or

(4) Deny a temporary license. The board may deny a temporary license for any grounds on which the board may discipline a license or for lack of need for a physician's services by the organization or individual. The procedure for appealing a license denial is set forth in rule 653—9.17(147,148).

10.5(7) *Temporary license application cycle.* If the applicant does not submit all materials within 90 days of the board's initial request for further information, the application will be considered inactive. An applicant whose application is inactive must reapply and submit new nonrefundable fees and a new application, documents and credentials if the applicant wishes to pursue temporary licensure.

10.5(8) *Renewal of a temporary license.*

a. To apply for renewal of a temporary license, the licensee shall submit the following:

(1) A request for renewal;

(2) The renewal fee as specified in 653—paragraph 8.4(4)*"b"*; and

(3) Written justification for the renewal from the organization or individual seeking the applicant.

b. Failure of the licensee to renew a license by the expiration date will cause the license to become inactive. The individual shall not practice in Iowa until securing a permanent medical license or until becoming eligible for a second temporary license.

[**ARC 9113C**, IAB 4/16/25, effective 5/21/25]

653—10.6(147,148,148J) Provisional licensure for foreign medical graduates.

10.6(1) *General provisions.*

a. The board may grant a provisional license to a foreign medical graduate who meets the qualifications provided in Iowa Code chapter 148J and these rules.

b. A provisional license may be issued for a period of not more than one year and may be renewed annually prior to expiration.

c. A provisional license will specifically limit the licensee to practice at the health care facility that provided the foreign medical graduate with the offer of employment as required by Iowa Code chapter 148J to qualify for this license.

d. The board may cancel a provisional license if the licensee has practiced outside the scope of this license, the licensee's employment is terminated with the health care facility who offered the licensee employment to qualify for the provisional license, or the licensee ceases to have an eligible immigration status for employment in the United States of America or for any of the grounds for which licensure may be revoked or suspended as specified in Iowa Code sections 147.55, 148.6, and 272C.10 and 653—Chapter 23. When cancellation of such license is proposed, the board will promptly notify the licensee by serving a statement of charges and notice of hearing upon the licensee pursuant to 481—Chapter 506. This contested case proceeding shall be governed by the provisions of 481—Chapter 506.

e. A provisional licensee must notify the board of any change in the licensee's home address or the address of the place of practice within one month of making an address change.

f. A provisional licensee must notify the board of any change in name within one month of making the name change. Notification requires a notarized copy of a marriage license or a notarized copy of court documents.

g. A provisional licensee file will be closed and labeled "deceased" when the board receives a copy of the physician's death certificate.

10.6(2) *Provisional license eligibility.* To be eligible for a provisional license, an applicant shall meet all of the following requirements:

a. Fulfill the application requirements specified in subrule 10.6(3);

b. Be at least 21 years of age;

c. Present evidence of holding a medical degree from an international medical program in good standing. This can be achieved in the following two ways:

(1) The international medical program the licensee successfully completed is approved by the ECFMG; or

(2) By presenting sufficient evidence to the board that the international medical program the applicant completed is substantially similar to the requirements of the LCME;

d. Be in good standing with and have no pending discipline before the licensing or regulatory institution in the foreign country;

e. Have practice in medicine and surgery or osteopathic medicine and surgery as a licensed physician for five years following the completion of a residency or substantially similar postgraduate medical training. The applicant can demonstrate the postgraduate medical training is substantially similar to a residency in the following two ways:

(1) The residency or postgraduate training is approved by the ACGME, AOA, RCPSC, or CFPC; or

(2) By presenting sufficient evidence to the board that the residency or postgraduate training is substantially similar to the requirements of one of the four agencies listed in subparagraph 10.6(2)*"e"*(1);

f. Demonstrate proficiency in English by providing a valid ECFMG certificate or verification of a passing score on the TSE or TOEFL examination administered by the Educational Testing Service;

g. Be licensed in a jurisdiction outside the United States or Canada and present evidence that any licenses held in any jurisdiction are unrestricted;

h. The applicant's license is not denied by the board due to the commission of a disqualifying offense, as provided in 655—subrule 9.3(3); and

i. Have a passing score in all steps of the USMLE.

10.6(3) *Provisional license application.*

a. Requirements. To apply for a provisional license, an applicant must:

(1) Pay a nonrefundable special license fee and a fee for the evaluation of the fingerprint packet and the criminal history background checks by the DCI and the FBI as specified in 653—paragraph 8.4(3)*"a"*;

(2) Complete and submit forms provided by the board, including required credentials, documents, a completed fingerprint packet, and a sworn statement by the applicant attesting to the truth of all the information provided by the applicant;

(3) Provide a sworn statement from the director or the director's designee of the medical licensing or regulatory institution in the individual's resident country that the applicant's license is in good standing and is not subject to any pending discipline;

(4) Provide a certified record from the national policy agency in the individual's resident country of a complete criminal history of the applicant;

(5) Provide verification of successful completion of a medical degree;

(6) Provide a valid ECFMG certificate or verification of a passing score on the TSE or TOEFL examination administered by the Educational Testing Service; and

(7) Provide a sworn statement and supporting documents from the health care facility offering employment to the provisional licensee applicant that the facility has had the applicant's immigration status reviewed by a licensed attorney of this jurisdiction and a determination was made that the applicant has proper immigration status for employment in the United States of America.

b. Application. The application shall request the following information:

(1) Name, date and place of birth, home address, and mailing address;

(2) A statement listing every jurisdiction in which the applicant is or has been authorized to practice, including license numbers and dates of issuance;

(3) A chronology accounting for all time periods from the date the applicant entered medical school to the date of the application;

(4) A photocopy of the applicant's medical degree issued by an educational institution and a sworn statement from an official of the educational institution certifying the date the applicant received the medical degree and acknowledging what, if any, derogatory comments exist in the institution's record about the applicant. A complete translation of any diploma not written in English shall be submitted;

(5) A statement disclosing and explaining any warnings issued, investigations conducted, or disciplinary actions taken, whether by voluntary agreement or formal action, by a medical or professional regulatory authority, educational institution, training or research program, or health facility in any jurisdiction;

(6) A statement disclosing and explaining the applicant's involvement in civil litigation related to practice in any jurisdiction. Copies of the legal documents may be requested if needed during the review process;

(7) A statement disclosing and explaining any charge of a misdemeanor or felony involving the applicant filed in any jurisdiction, whether or not any appeal or other proceeding is pending to have the conviction or plea set aside; and

(8) A completed fingerprint packet to facilitate a national criminal history background check. The fee for the evaluation of the fingerprint packet and the DCI and FBI criminal history background checks will be assessed to the applicant.

10.6(4) *Provisional license application review process.* The process below shall be utilized to review each application for a provisional license.

a. An application is considered open from the date the application form is received in the board office with the nonrefundable provisional licensure fee.

b. After reviewing each application, staff will notify the applicant or the health care facility offering the applicant employment about how to resolve any problems identified by the reviewer. The applicant shall provide additional information when requested by staff or the board.

c. If the final review indicates no questions or concerns regarding the applicant's qualifications for licensure, staff may administratively grant a provisional license.

d. If the final review indicates questions or concerns that cannot be remedied by continued communication with the applicant, the executive director, director of licensure and administration, and

director of legal affairs will determine whether the questions or concerns indicate any uncertainty about the applicant's current qualifications for licensure.

(1) If there is no current concern, staff will administratively grant a provisional license.

(2) If any concern exists, the application will be referred to the committee.

e. Staff will refer to the committee for review matters that include but are not limited to falsification of information on the application, criminal record, substance abuse, questionable competency, physical or mental illness, or educational disciplinary history.

f. If the committee is able to eliminate questions or concerns without dissension from staff or a committee member, the committee may direct staff to administratively grant a provisional license.

g. If the committee is not able to eliminate questions or concerns without dissension from staff or a committee member, the committee will recommend that the board:

(1) Request that the applicant appear for an interview;

(2) Grant a provisional license;

(3) Grant a license under certain terms and conditions or with certain restrictions;

(4) Request that the applicant withdraw the licensure application; or

(5) Deny a license.

h. The board will consider applications and recommendations from the committee and:

(1) Request that the applicant appear for an interview;

(2) Grant a provisional license for practice at the medical college designated in the application;

(3) Grant a license under certain terms and conditions or with certain restrictions;

(4) Request that the applicant withdraw the licensure application; or

(5) Deny a license. The board may deny a license for any grounds on which the board may discipline a license. The procedure for appealing a license denial is set forth in rule 653—9.15(147,148).

10.6(5) *Provisional license application cycle.* If the applicant does not submit all materials within 90 days of the board's initial request for further information, the application will be considered inactive. An applicant must reapply and submit a new nonrefundable application fee and a new application, new documents and new credentials.

10.6(6) *Renewal of a provisional license.*

a. If the provisional licensee has not qualified for and received a permanent license, the licensee must renew prior to expiration.

b. A provisional licensee may apply for a one-year renewal by submitting the following:

(1) A completed renewal application;

(2) The renewal fee as specified in 653—paragraph 8.4(3)*"b"*;

(3) Evidence of continuing education and training on chronic pain management, end-of-life care, and identifying and reporting abuse as specified in 653—Chapter 11; and

(4) A letter from the chief medical officer for the health care facility employing the licensee that addresses the individual's fitness to the practice of medicine in Iowa, how the anticipated contribution will serve the public interest of Iowans, and the need for renewal of this license.

c. Failure of the licensee to renew a license within one month of the expiration date will cause the license to become inactive. A licensee whose license is inactive is prohibited from practice until a new provisional license is granted according to subrules 10.4(3) and 10.4(4).

10.6(7) *Conversion of a provisional license to a full license.*

a. After three consecutive years of holding a provisional license in good standing, the provisional licensee may apply to have the licensee's license converted to a full license to practice medicine and surgery or osteopathic medicine and surgery, provided the license has not been revoked pursuant to Iowa Code section 148J.2. The provisional licensee may alternatively elect to continue to renew the licensee's provisional license on a yearly basis.

b. The provisional licensee shall make application to the board for conversion of the licensee's provisional license using the application form provided by the board. The application shall include the following:

(1) A completed application;

(2) The renewal fee as specified in 653—paragraph 8.4(3)*"b"*;

(3) Evidence of continuing education and training on chronic pain management, end-of-life care, and identifying and reporting abuse as specified in 653—Chapter 11.

(4) A letter, submitted by the chief medical officer for the health care facility employing the licensee, that addresses the individual's fitness to practice medicine in Iowa, how the anticipated contribution will serve the public interest of Iowans, and the need for renewal of this license.

(5) An updated criminal background check as described in subrule 10.6(3).

(6) A statement disclosing and explaining any informal or nonpublic actions, warnings issued, investigations conducted, or disciplinary actions taken, whether by voluntary agreement or formal action, by a medical or professional regulatory authority, an educational institution, a training or research program, or a health facility in any jurisdiction.

(7) A statement disclosing and explaining the applicant's involvement in civil litigation related to the practice in any jurisdiction. Copies of the legal documents may be requested if needed during the review process.

(8) A statement disclosing and explaining any charge of a misdemeanor or felony involving the applicant filed in any jurisdiction, whether or not any appeal or other proceeding to have the conviction or plea set aside is pending. Copies of the legal documents may be requested if needed during the review process.

(9) The full legal name, date and place of birth, home address, mailing address, principal business address, and personal email address regularly used by the applicant or licensee for correspondence with the board.

(10) A statement listing every jurisdiction in which the applicant is or has been authorized to practice, including license numbers and dates of issuance.

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These rules are intended to implement Iowa Code chapters 17A, 147, 148, 148J, and 272C.

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◊ Two or more ARCs

CHAPTER 11
CONTINUING EDUCATION AND TRAINING REQUIREMENTS

[Prior to 5/4/88, see 470—135.101 to 470—135.110 and 135.501 to 135.512]

Chapter rescission date pursuant to Iowa Code section 17A.7: 5/21/30

653—11.1(272C) Definitions.

"ABMS" means the American Board of Medical Specialties. The board recognizes specialty board certification by ABMS.

"Accredited provider" means an organization approved as a provider of category 1 credit by one of the following board-approved accrediting bodies: Accreditation Council for Continuing Medical Education, Iowa Medical Society, or the Council on Continuing Medical Education of the AOA.

"Active duty" means full-time training or active service in the U.S. armed forces, reserves or national guard.

"Active licensee" means any person licensed to practice medicine and surgery or osteopathic medicine and surgery in Iowa who has met all conditions of licensure and maintains a current license to practice in Iowa.

"AMA" means the American Medical Association.

"AOA" means the American Osteopathic Association.

"Approved abuse education training program" means a training program using a curriculum approved by the abuse education review panel of the department of health and human services or a training program offered by a hospital, a professional organization for physicians, the department of education, an area education agency, a school district, the Iowa law enforcement academy, an Iowa college or university, or a similar state agency.

"Approved program or credit" means any category 1 credit offered by an accredited provider or any other program or credit meeting the standards set forth in these rules.

"Board" means the board of medicine.

"Carryover" means hours of category 1 credit earned in excess of the required hours in a license period that may be applied to the continuing education requirement in the subsequent license period; carryover may not exceed 20 hours of category 1 credit per renewal cycle.

"Category 1 credit" means any formal education program that is sponsored by an accredited provider. Credits designated as formal cognates by the American College of Obstetricians and Gynecologists or as prescribed credits by the American Academy of Family Physicians are accepted as equivalent to category 1 credits.

"Committee" means the licensure committee of the board.

"COMVEX-USA" means the Comprehensive Osteopathic Medical Variable-Purpose Examination for the United States of America.

"Continuing education" means education that is acquired by a licensee in order to maintain or enhance skills and knowledge present at initial licensure or to develop relevant skills and knowledge.

"Hour of continuing education" means a clock hour spent by a licensee in actual attendance at or completion of an approved category 1 credit.

"Inactive license" means any license that is not a current, active license.

"Licensee" means any person licensed to practice medicine and surgery or osteopathic medicine and surgery in the state of Iowa.

"Opioid" means any FDA-approved product or active pharmaceutical ingredient classified as a controlled substance that produces an agonist effect on opioid receptors and is indicated or used for the treatment of pain.

"Service charge" means the amount charged for making a service available on line and is in addition to the actual fee for a service itself.

"SPEX" means Special Licensure Examination prepared by the Federation of State Medical Boards and administered by a licensing authority in any jurisdiction. The passing score on SPEX is 75.

"Training for identifying and reporting abuse" means training as described in Iowa Code section 232.69; the full requirements for reporting of dependent adult abuse and the training requirements are in Iowa Code section 235B.16.

[**ARC 9114C**, IAB 4/16/25, effective 5/21/25]

653—11.2(272C) Continuing education credit and alternatives.

11.2(1) Continuing education credit may be obtained by attending category 1 credits as defined in this chapter.

11.2(2) The board accepts the following as equivalent to 50 hours of category 1 credit: participation in an approved resident training program or board certification or recertification by an ABMS or AOA specialty board within the licensing period.

11.2(3) Each year, the board acknowledges up to ten hours of category 1 credits for physicians who served on the board or Iowa professional health committee, are actively serving alternate members, or performed peer reviews in the previous year. Recipients are notified by the board's executive director via mail in January.

[**ARC 9114C**, IAB 4/16/25, effective 5/21/25]

653—11.3(272C) Continuing education and training requirements for renewal or reactivation. A licensee shall meet the requirements in this rule to qualify for renewal of a permanent license, an administrative medicine license, or special license or to qualify for reactivation of a permanent license or an administrative medicine license.

11.3(1) *Continuing education and training requirements.*

a. Continuing education for permanent license or administrative medicine license renewal. Except as provided in these rules, a total of 40 hours of category 1 credit or board-approved equivalent is required for biennial renewal of a permanent license or an administrative medicine license. This may include up to 20 hours of carryover credit.

(1) To facilitate license renewal according to birth month, a licensee's first license may be issued for less than 24 months. The number of hours of category 1 credit required of a licensee whose license has been issued for less than 24 months shall be reduced on a pro-rata basis.

(2) A licensee desiring to obtain credit for carryover hours reports the carryover, not to exceed 20 hours of category 1 credit, on the renewal application.

b. Continuing education for special license renewal. A total of 20 hours of category 1 credit shall be required for annual renewal of a special license. No carryover hours are allowed.

c. Training for identifying and reporting child and dependent adult abuse for permanent or special license renewal. A licensee shall complete the training for identifying and reporting child and dependent adult abuse as part of a category 1 credit or an approved training program. The licensee may utilize category 1 credit received for this training during the license period in which the training occurred to meet continuing education requirements in paragraph 11.3(1)*"a."*

(1) Training to identify child abuse. A licensee who regularly provides primary health care to children in Iowa must complete at least two hours of training provided by the department of health and human services pursuant to Iowa Code section 232.69(3)*"c"* in child abuse identification and reporting every three years. "A licensee who regularly provides primary health care to children" means all emergency physicians, family physicians, general practice physicians, pediatricians, and psychiatrists, and any other physician who regularly provides primary health care to children.

(2) Training to identify dependent adult abuse. A licensee who regularly provides primary health care to adults in Iowa must complete at least two hours of training provided by the department of health and human services pursuant to Iowa Code section 235B.16(5)*"c"* in dependent adult abuse identification and reporting every three years. "A licensee who regularly provides primary health care to adults" means all emergency physicians, family physicians, general practice physicians, internists, obstetricians, gynecologists, and psychiatrists and any other physician who regularly provides primary health care to adults.

d. Training for chronic pain management for permanent or special license renewal. The licensee shall complete the training for chronic pain management as part of a category 1 credit. The licensee may

utilize category 1 credit received for this training during the license period in which the training occurred to meet continuing education requirements in paragraph 11.3(1)*"a."*

(1) Licensees who prescribed opioids in the prior license period must complete two hours of category 1 credit on U.S. Centers for Disease Control and Prevention (CDC) guidelines for opioid prescribing every five years. The licensee may opt out of this requirement during license renewal if the licensee did not prescribe opioids in the previous cycle.

(2) A licensee who had a permanent or special license on January 1, 2019, has until January 1, 2024, to complete the chronic pain management training and shall then complete the training once every five years thereafter.

e. Training for end-of-life care for permanent or special license renewal. The licensee shall complete the training for end-of-life care as part of a category 1 credit. The licensee may utilize category 1 credit received for this training during the license period in which the training occurred to meet continuing education requirements in paragraph 11.3(1)*"a."*

(1) A licensee who regularly provides direct patient care to actively dying patients in Iowa must complete at least two hours of category 1 credit for end-of-life care every five years.

(2) A licensee who had a permanent or special license on January 1, 2019, has until January 1, 2024, to complete the end-of-life care training and shall then complete the training once every five years thereafter.

11.3(2) *Exemptions from renewal requirements.*

a. A licensee shall be exempt from the continuing education requirements in subrule 11.3(1) when, upon license renewal, the licensee provides evidence for:

(1) Periods that the licensee served honorably on active duty in the U.S. armed forces, reserves or national guard;

(2) Periods that the licensee practiced in another state or district and did not provide medical care, including telemedicine services, to patients located in Iowa if the other state or district had continuing education requirements for the profession and the licensee met all requirements of that state or district for practice therein;

(3) Periods that the licensee was a government employee working in the licensee's specialty and assigned to duty outside the United States; or

(4) Other periods of active practice and absence from the state approved by the board.

b. The requirements for training on chronic pain management and end-of-life care for license renewal shall be suspended for a licensee who provides evidence for:

(1) Periods described in subparagraph 11.3(2)*"a"*(1), (2), (3), or (4); or

(2) Periods that the licensee resided outside of Iowa and did not practice in Iowa.

11.3(3) *Extension for completion of or exemption from renewal requirements.* The board may grant an extension of time for or an exemption from completion of the renewal requirements in subrule 11.3(1) in cases of physical disability or illness.

a. A licensee requesting an extension or exemption shall complete and submit a request to the board that sets forth the reasons for the request and has been signed by the licensee and attending physician.

b. The board may grant an extension of time to fulfill the requirements in subrule 11.3(1).

c. The board may grant an exemption from the educational requirements for any period of time not to exceed one calendar year.

d. If the physical disability or illness for which an extension or exemption was granted continues beyond the period of waiver, the licensee must reapply for a continuance of the extension or exemption.

e. The board may, as a condition of any extension or exemption granted, require the applicant to make up a portion of the continuing education requirement by methods it prescribes.

11.3(4) *Reactivation requirement.* An applicant for license reactivation whose license has been inactive for one year or more shall provide proof of successful completion of 40 hours of category 1 credit completed within 24 months prior to submission of the application for reactivation or proof of successful completion of SPEX or COMVEX-USA within one year immediately prior to the submission of the application for reinstatement.

11.3(5) *Cost of continuing education and training for renewal or reinstatement.* Each licensee is responsible for all costs of continuing education and training required in 653—Chapter 11.

11.3(6) *Documentation.* A licensee shall maintain documentation of the continuing education and training, including dates, subjects, duration of programs, and proof of participation.

11.3(7) *Audits.* The board may audit continuing education and training documentation at any time. A licensee shall respond to a board audit and provide all materials requested within 30 days of a request made by board staff.

11.3(8) *Grounds for discipline.* A licensee may be subject to disciplinary action for failure to comply with continuing education and training requirements in 653—Chapter 11.

[**ARC 9114C**, IAB 4/16/25, effective 5/21/25]

653—11.4(272C) Failure to fulfill requirements for continuing education and training for identifying and reporting abuse.

11.4(1) Disagreement over whether material submitted fulfills the requirements specified in rule 653—11.3(272C).

a. Staff will work with a licensee or applicant to resolve any discrepancy concerning credit for renewal or reinstatement.

b. When resolution is not possible, staff will refer the matter to the committee.

(1) In the matter of a licensee seeking license renewal, staff will renew the license if all other matters are in order and inform the licensee that the matter is being referred to the committee.

(2) In the matter of an applicant seeking reactivation, staff will reactivate the license if all other matters are in order and inform the applicant that the matter is being referred to the committee.

c. The committee considers the staff's recommendation for denial of credit for continuing education or training for identifying and reporting abuse, chronic pain management, and end-of-life care.

(1) If the committee approves the credit, it will authorize the staff to inform the licensee or applicant that the matter is resolved.

(2) If the committee disapproves the credit, it will refer the matter to the board with a recommendation for resolution.

d. The board will consider the committee's recommendations.

(1) If the board approves the credit, it will authorize the staff to notify the licensee or applicant for reinstatement if all other matters are in order.

(2) If the board denies the credit, it will:

1. Close the case;
2. Send the licensee or applicant an informal, nonpublic letter of warning or education; or
3. File a statement of charges for noncompliance with the board's rules on continuing education or training and for any other violations that may exist.

11.4(2) Informal appearance for failure to complete requirements for continuing education or training.

a. The licensee or applicant may, within ten days after the date that the notification of the denial was sent by certified mail, request an informal appearance before the board.

b. At the informal appearance, the licensee or applicant will have the opportunity to present information, and the board will issue a written decision.

[**ARC 9114C**, IAB 4/16/25, effective 5/21/25]

These rules are intended to implement Iowa Code chapters 147 and 272C and sections 232.69 and 235B.16.

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1 Paragraph 11.4(1)“d” rescinded by 2018 Iowa Acts, House File 2377, section 23, effective 7/1/18.

CHAPTER 12
NONPAYMENT OF STATE DEBT
Rescinded **ARC 9110C**, IAB 4/16/25, effective 5/21/25

CHAPTER 13
STANDARDS OF PRACTICE AND PRINCIPLES OF MEDICAL ETHICS

[Prior to 5/4/88, see 470—135.251 to 470—135.402]

Chapter rescission date pursuant to Iowa Code section 17A.7: 5/21/30

653—13.1(148,272C) Standards of practice—packaging, labeling and records of prescription drugs dispensed by a physician.

13.1(1) A physician shall dispense a prescription drug only in a container that meets the requirements of the Poison Prevention Packaging Act of 1970, 15 U.S.C. Sections 1471-1476 (2001), unless otherwise requested by the patient, and of Section 502G of the Federal Food, Drug and Cosmetic Act, 21 U.S.C. Section 301 et seq. (2001).

13.1(2) A label affixed to a container in which a prescription drug is dispensed by a physician shall include:

a. The name and address of the physician.

b. The name of the patient.

c. The date dispensed.

d. The directions for administering the prescription drug and any cautionary statement deemed appropriate by the physician.

e. The name and strength of the prescription drug in the container.

13.1(3) The provisions of subrules 13.1(1) and 13.1(2) shall not apply to packaged drug samples.

13.1(4) Physicians must document all prescription drugs dispensed to patients, including required label information. Noting such information on the patient's chart or record maintained by the physician is sufficient.

[**ARC 9115C**, IAB 4/16/25, effective 5/21/25]

653—13.2(124,148,272C) Standards of practice—appropriate pain management.

13.2(1) *Standards.* This rule establishes standards of practice for the management of acute and chronic pain. The board encourages the use of nonopioid pharmacologic therapy and nonpharmacologic therapy.

a. This rule is intended to encourage appropriate pain management, including the use of opioids for the treatment of pain, while stressing the need to establish safeguards to minimize the potential for substance abuse and drug diversion.

b. The goal of pain management is to treat each patient's pain in relation to the patient's overall health. At the end of life, the goals may shift to palliative care.

c. Pain management is an important part of medical practice. Unmanaged or inappropriately treated pain impacts patients' quality of life, reduces patients' ability to be productive members of society, and increases patients' use of health care services.

d. Physicians treating pain with opioids in a manner consistent with appropriate pain management practices should not fear board action. Dosage is not the sole measure of determining whether a physician has complied with appropriate pain management practices. The board recognizes the complexity of treating patients with chronic pain or a substance abuse history. Generally, the board is concerned about a pattern of improper pain management or a single occurrence of willful or gross overtreatment or undertreatment of pain.

e. Inappropriate pain management is a departure from the acceptable standard of practice in Iowa and may be grounds for disciplinary action.

13.2(2) *Definitions.* For the purposes of this rule, the following terms are defined as follows:

"Acute pain" means the normal, predicted physiological response to a noxious chemical, thermal or mechanical stimulus and typically is associated with invasive procedures, trauma and disease. Generally, acute pain is self-limited, lasting no more than a few weeks following the initial stimulus.

"Addiction" means a primary, chronic, neurobiologic disease, with genetic, psychosocial, and environmental factors influencing its development and manifestations. It is characterized by behaviors that include the following: impaired control over drug use, craving, compulsive use, and continued use despite

harm. Physical dependence and tolerance are normal physiological consequences of extended opioid therapy for pain and are not the same as addiction.

"Chronic pain" means pain that lasts longer than three months or past the time of normal tissue healing.

"Pain" means an unpleasant sensory and emotional experience associated with actual or potential tissue damage or described in terms of such damage. Pain is an individual, multifactorial experience influenced by culture, previous pain events, beliefs, mood and ability to cope.

"Physical dependence" means a state of adaptation that is manifested by drug class-specific signs and symptoms that can be produced by abrupt cessation, rapid dose reduction, decreasing blood level of the drug, or administration of an antagonist. Physical dependence, by itself, does not equate with addiction.

"Pseudoaddiction" means an iatrogenic syndrome resulting from the misinterpretation of relief-seeking behaviors as though they are drug-seeking behaviors that are commonly seen with addiction. The relief-seeking behaviors resolve upon institution of effective analgesic therapy.

"Substance abuse" means the use of a drug, including alcohol, by the patient in an inappropriate manner that may cause harm to the patient or others, or the use of a drug for an indication other than that intended by the prescribing clinician. An abuser may or may not be physically dependent on or addicted to the drug.

"Tolerance" means a physiological state resulting from regular use of a drug in which an increased dosage is needed to produce a specific effect, or a reduced effect is observed with a constant dose over time. Tolerance may or may not be evident during opioid treatment and does not equate with addiction.

"Undertreatment of pain" means the failure to properly assess, treat and manage pain or the failure to appropriately document a sound rationale for not treating pain.

13.2(3) *Laws and regulations.* Nothing in this rule relieves a physician from fully complying with applicable federal and state laws and regulations.

13.2(4) *Undertreatment of pain.* The undertreatment of pain is a departure from the acceptable standard of practice in Iowa. Undertreatment may include a failure to recognize symptoms and signs of pain, a failure to treat pain within a reasonable amount of time, a failure to allow interventions, e.g., analgesia, to become effective before invasive steps are taken, a failure to address pain needs in patients with reduced cognitive status, a failure to use opioids for terminal pain due to the physician's concern with addicting the patient, or a failure to use an adequate level of pain management.

13.2(5) *Assessment and treatment of acute and chronic pain.* Appropriate assessment of the etiology of the pain is essential to the appropriate treatment of acute and chronic pain.

a. Prescribing opioids for the treatment of acute and chronic pain should only be accomplished within an established physician-patient relationship and should be based on clearly diagnosed and documented pain. Appropriate management of acute and chronic pain should include an assessment of the mechanism, type and intensity of pain. The patient's medical record should clearly document a medical history, a pain history, a clinical examination, a medical diagnosis and a treatment plan.

b. A physician who prescribes, dispenses or administers opioids to patients for the treatment of chronic pain should become familiar with the U.S. Centers for Disease Control and Prevention (CDC) Guideline for Prescribing Opioids for Chronic Pain published on March 15, 2016.

13.2(6) *Effective management of chronic pain.* To ensure that chronic pain is properly assessed and treated, a physician who prescribes, dispenses or administers opioids to a patient for the treatment of chronic pain shall exercise sound clinical judgment and establish an effective pain management plan in accordance with the following:

a. Patient evaluation. Prior to the patient starting treatment, a patient evaluation must be conducted that includes a physical examination, a comprehensive medical history, pain assessment, and examination of physical and psychological function. This evaluation should also cover diagnostic studies, past interventions, medication and substance abuse history, and any underlying conditions. Depending on the complexity of the case and the physician's expertise, consultation or referral to specialists in pain medicine, addiction medicine, or areas associated with the patient's pain may be necessary. Interdisciplinary evaluation is recommended.

b. Treatment plan. The physician must create a tailored treatment plan addressing the patient's individual needs, outlining treatment objectives such as pain relief or improved functioning, and indicating any planned diagnostic evaluations or treatments. The plan should include other treatment modalities and rehabilitation programs used. Short- and long-term pain relief needs should be considered, along with the patient's ability to request pain relief and the patient's setting. Whenever possible, opioids should be prescribed by one physician and filled at one pharmacy.

c. Informed consent. A discussion of the risks and benefits of opioids with the patient or person representing the patient must be documented.

d. Periodic review. The physician must regularly review the patient's drug treatment course and pain source. Drug therapy should be adjusted to meet individual patient needs, based on progress toward treatment plan objectives. If reviews show treatment plan objectives are not being met or indicate diversion or substance abuse patterns, the physician should reconsider drug therapy and explore other treatment options. Long-term opioid use may lead to tolerance and abnormal pain sensitivity, meaning increasing doses may not improve pain control or function.

e. Consultation/referral. A specialty consultation, including with a physician with expertise in addiction medicine or substance abuse counseling, may be considered if there is evidence of significant adverse effects, lack of response to the medication, diversion, or a pattern of substance abuse. The board encourages a multidisciplinary approach to chronic pain management.

f. Documentation. The physician shall keep accurate, timely, and complete records that detail compliance with this subrule, including patient evaluation, diagnostic studies, treatment modalities, treatment plan, informed consent, periodic review, consultation, and any other relevant information about the patient's condition and treatment.

g. Pain management agreements. Physicians treating chronic pain with opioids should consider implementing a pain management agreement with each patient outlining medication use rules and consequences for misuse. The decision to use such an agreement should be based on individual patient evaluation, weighing risks and benefits of long-term opioid treatment. If opioid treatment exceeds 90 days for chronic pain, and there is a concern for drug abuse or diversion, a pain management agreement should be used. If a physician opts not to use a pain management agreement, reasons should be documented in the patient's medical records. Pain management agreements are not required for hospice or nursing home patients.

h. Substance abuse history or comorbid psychiatric disorder. A patient's prior history of substance abuse does not necessarily contraindicate appropriate pain management. However, treatment of patients with a history of substance abuse or with a comorbid psychiatric disorder may require extra care and communication with the patient, monitoring, documentation, and consultation with or referral to an expert in the management of such patients. The board strongly encourages a multidisciplinary approach for pain management of such patients that incorporates the expertise of other health care professionals.

i. Drug testing. A physician who prescribes opioids to a patient for more than 90 days for the treatment of chronic pain should consider utilizing drug testing to ensure that the patient is receiving appropriate therapeutic levels of prescribed medications or if the physician has reason to believe that the patient is at risk of drug abuse or diversion.

j. Termination of care. The physician should consider termination of patient care if there is evidence of noncompliance with the rules for medication use, drug diversion, or a repeated pattern of substance abuse.

13.2(7) *Pain management for terminal illness.* The provisions of this subrule apply to patients who are at the stage in the progression of cancer or other terminal illness when the goal of pain management is comfort care. When the goal of treatment shifts to comfort care rather than cure of the underlying condition, the board recognizes that the dosage level of opioids to control pain may exceed dosages recommended for chronic pain and may come at the expense of patient function. The determination of such pain management should involve the patient, if possible, and others the patient has designated for assisting in end-of-life care.

13.2(8) *Prescription monitoring program.* The board of pharmacy established a prescription monitoring program pursuant to Iowa Code sections 124.551 through 124.558 to help prescribers and

pharmacists track controlled substance prescriptions. Physicians must register for this program when applying for or renewing their controlled substance prescribing registration. Before prescribing opioids, physicians or their agents must use the program to guide treatment decisions and enhance patient care quality. However, utilization is not required for patients in inpatient hospice care or long-term residential facilities. Orders in hospital settings are not considered prescriptions under these rules, as patient safety is managed within these settings.

13.2(9) *Electronic prescriptions.* Beginning January 1, 2020, all prescriptions (controlled and noncontrolled substances) are to be transmitted electronically as electronic prescriptions pursuant to Iowa Code section 124.308. A prescription shall be transmitted to a pharmacy by the physician or the physician's authorized agent in compliance with federal law and regulation for electronic prescriptions of controlled substances.

13.2(10) *Pain management resources.* The board strongly recommends that physicians consult the following resources regarding the proper treatment of chronic pain. This list is provided for the convenience of licensees, and the publications included are not intended to be incorporated in the rule by reference.

a. American Academy of Hospice and Palliative Medicine or AAHPM is the American Medical Association-recognized specialty society of physicians who practice in hospice and palliative medicine in the United States. The mission of the AAHPM is to enhance the treatment of pain at the end of life.

b. American Academy of Pain Medicine or AAPM is the American Medical Association-recognized specialty society of physicians who practice pain medicine in the United States. The mission of the AAPM is to enhance pain medicine practice by promoting a climate conducive to the effective and efficient practice of pain medicine.

c. American Pain Society or APS is the national chapter of the International Association for the Study of Pain, an organization composed of physicians, nurses, psychologists, scientists and other professionals who have an interest in the study and treatment of pain. The mission of the APS is to serve people in pain by advancing research, education, treatment and professional practice.

d. DEA Policy Statement: Dispensing Controlled Substances for the Treatment of Pain. On August 28, 2006, the Drug Enforcement Agency (DEA) issued a policy statement establishing guidelines for practitioners who dispense controlled substances for the treatment of pain. This policy statement may be helpful to practitioners who treat pain with controlled substances.

e. Interagency Guideline on Prescribing Opioids for Pain. Developed by the Washington State Agency Medical Directors' Group in collaboration with an expert advisory panel, actively practicing providers and public stakeholders, the guideline focuses on evidence-based treatment for chronic-pain patients. The guideline was published in 2007 and updated in 2015.

f. Responsible Opioid Prescribing: A Physician's Guide. In 2007, in collaboration with author Scott Fishman, M.D., the Federation of State Medical Boards' (FSMB's) Research and Education Foundation published a book on responsible opioid prescribing based on the FSMB Model Policy for the Use of Controlled Substances for the Treatment of Pain.

g. World Health Organization: Pain Relief Ladder. Cancer pain relief and palliative care. Technical report series 804. Geneva: World Health Organization.

h. CDC Guideline for Prescribing Opioids for Chronic Pain as referenced in paragraph 13.2(4)*"b."*

13.2(11) *Grounds for discipline.* A physician may be subject to disciplinary action for violation of these rules, the rules found in 653—Chapter 23, or any of the following:

a. A physician who prescribes opioids in dosage amounts exceeding what would be prescribed by a reasonably prudent physician in the state of Iowa acting in the same or similar circumstances.

b. A physician who knowingly fails to comply with the confidentiality requirements of Iowa Code section 124.553 or who delegates program information access to another individual except as provided in Iowa Code section 124.553.

c. A physician who knowingly fails to comply with other requirements of Iowa Code chapter 124.

13.2(12) *Unlawful access, disclosure, or use of information.* A person who intentionally or knowingly accesses, uses, or discloses information from the prescription monitoring program in violation of Iowa Code section 124.553, unless otherwise authorized by law, is guilty of a class "D" felony. This subrule shall

not preclude a physician who requests and receives information from the prescription monitoring program consistent with the requirements of Iowa Code section 124.553 from otherwise lawfully providing that information to any other person for medical care purposes.
[**ARC 9115C**, IAB 4/16/25, effective 5/21/25]

653—13.3(147,148) Standards of practice—chelation therapy. Chelation therapy or disodium ethylene diamine tetra acetic acid (EDTA) may only be used for the treatment of heavy metal poisoning or in the clinical setting when a licensee experienced in clinical investigations conducts a carefully controlled clinical investigation of its effectiveness in treating other diseases or medical conditions under a research protocol that has been approved by an institutional review board of the University of Iowa or Des Moines University—Osteopathic Medical Center.
[**ARC 9115C**, IAB 4/16/25, effective 5/21/25]

653—13.4(79GA,HF726) Standards of practice—automated dispensing systems. A physician who dispenses prescription drugs via an automated dispensing system or a dispensing system that employs technology may delegate nonjudgmental dispensing functions to staff assistants in the absence of a pharmacist or physician provided that the physician utilizes an internal quality control assurance plan that ensures that the medication dispensed is the medication that was prescribed. The physician must be physically present to determine the accuracy and completeness of any medication that is reconstituted prior to dispensing.

13.4(1) An internal quality control assurance plan shall include the following elements:

a. The name of the physician responsible for the plan and testing;

b. Methods that the dispensing system employs to ensure the accuracy of the patient's name and medication, dosage, directions and amount of medication prescribed;

c. Standards that the physician expects to be met to ensure the accuracy of the dispensing system and the training and qualifications of staff members assigned to dispense via the dispensing system;

d. The procedures utilized to ensure that the physician(s) dispensing via the automated system provide(s) patients counseling regarding the prescription drugs being dispensed;

e. Staff training and qualifications for dispensing via the dispensing system;

f. A list of staff members who meet the qualifications and who are assigned to dispense via the dispensing system;

g. A plan for testing the dispensing system and each staff member assigned to dispense via the dispensing system;

h. The results of testing that show compliance with the standards prior to implementation of the dispensing system and prior to approval of each staff member to dispense via the dispensing system;

i. A plan for interval testing of the accuracy of dispensing, at least annually; and

j. A plan for addressing inaccuracies, including discontinuing dispensing until the accuracy level can be reattained.

13.4(2) Those dispensing systems already in place shall show evidence of a plan and testing within two months of August 31, 2001.

13.4(3) The internal quality control assurance plan shall be submitted to the board of medicine upon request.
[**ARC 9115C**, IAB 4/16/25, effective 5/21/25]

653—13.5(147,148,272C) Standards of practice—office practices.

13.5(1) *Termination of the physician-patient relationship.* A physician may choose whom to serve. Having undertaken the care of a patient, the physician may not neglect the patient. A physician must provide a patient written notice of the termination of the physician-patient relationship. A physician shall ensure that emergency medical care is available to the patient during the 30-day period following notice of the termination of the physician-patient relationship.

13.5(2) *Patient referrals.* A physician shall not pay or receive compensation for patient referrals.

13.5(3) *Confidentiality.* A physician shall maintain the confidentiality of all patient information obtained in the practice of medicine. Information shall be divulged by the physician when authorized by law or the patient or when required for patient care.

13.5(4) *Sexual conduct.* It is unprofessional and unethical conduct, and is grounds for disciplinary action, for a physician to engage in conduct that violates the following prohibitions:

a. In the course of providing medical care, a physician shall not engage in contact, touching, or comments of a sexual nature with a patient, or with the patient's parent or guardian if the patient is a minor or under a guardianship.

b. A physician shall not engage in any sexual conduct with a patient when that conduct occurs concurrent with the physician-patient relationship, regardless of whether the patient consents to that conduct.

c. A physician shall not engage in any sexual conduct with a former patient unless the physician-patient relationship was completely terminated before the sexual conduct occurred. In considering whether that relationship was completely terminated, the board will consider the duration of the physician-patient relationship, the nature of the medical services provided, the lapse of time since the physician-patient relationship ended, the degree of dependence in the physician-patient relationship, and the extent to which the physician used or exploited the trust, knowledge, emotions, or influence derived from the physician-patient relationship.

d. A psychiatrist, or a physician who provides mental health counseling to a patient, shall never engage in any sexual conduct with a current or former patient, or with that patient's parent or guardian if the patient was a minor or under guardianship, regardless of whether the patient consents to that conduct.

13.5(5) *Disruptive behavior.* A physician shall not engage in disruptive behavior. Disruptive behavior is defined as a pattern of contentious, threatening, or intractable behavior that interferes with, or has the potential to interfere with, patient care or the effective functioning of health care staff.

13.5(6) *Sexual harassment.* A physician shall not engage in sexual harassment. Sexual harassment is defined as verbal or physical conduct of a sexual nature that interferes with another health care worker's performance or creates an intimidating, hostile or offensive work environment.

13.5(7) *Transfer of medical records.* A physician must provide a copy of all medical records generated by the physician in a timely manner to the patient or another physician designated by the patient, upon written request when legally requested to do so by the subject patient or by a legally designated representative of the subject patient, except as otherwise required or permitted by law.

13.5(8) *Retention of medical records.*

a. A physician shall retain all medical records, not appropriately transferred to another physician or entity, for at least seven years from the last date of service for each patient, except as otherwise required by law.

b. A physician must retain all medical records of minor patients, not appropriately transferred to another physician or entity, for a period consistent with that established by Iowa Code section 614.8.

c. Beginning July 1, 2023, a physician must appoint another Iowa-licensed physician, or other representative or entity that is held to the same standards of confidentiality as the physician, to ensure that all requirements of this subrule are met in the event of the physician's death or incapacitation. Upon request by the board, the physician must be able to establish by sufficient proof the appointment of a representative pursuant to this paragraph.

d. Upon a physician's death or retirement, the sale of a medical practice, or a physician's departure from the physician's medical practice:

(1) The physician or the physician's representative must ensure that all medical records are transferred to another physician or entity that is held to the same standards of confidentiality and agrees to act as custodian of the records.

(2) The physician or the physician's representative shall notify all active patients that their records will be transferred to another physician or entity that will retain custody of their records and that, at their written request, the records will be sent to the physician or entity of the patient's choice.

[**ARC 9115C**, IAB 4/16/25, effective 5/21/25]

653—13.6(148,272C) Standards of practice—medical directors at medical spas—delegation and supervision of medical aesthetic services performed by qualified licensed or certified nonphysician persons or qualified laser technicians. This rule establishes standards of practice for a physician or surgeon or osteopathic physician or surgeon who serves as a medical director at a medical spa. This rule does not apply to the standards of practice for a nonphysician licensed health professional who serves as a medical director at a medical spa pursuant to the rules of the professional's licensing authority.

13.6(1) *Definitions.* As used in this rule:

"Alter" means to change the cellular structure of living tissue.

"Capable of" means any means, method, device or instrument that, if used as intended or otherwise to its greatest strength, has the potential to alter or damage living tissue below the superficial epidermal cells.

"Damage" means to cause a harmful change in the cellular structure of living tissue.

"Delegate" means to entrust or transfer the performance of a medical aesthetic service to qualified licensed or certified nonphysician persons or qualified laser technicians.

"Medical aesthetic service" means the diagnosis, treatment, or correction of human conditions, ailments, diseases, injuries, or infirmities of the skin, hair, nails and mucous membranes by any means, methods, devices, or instruments including the use of a biological or synthetic material, chemical application, mechanical device, or displaced energy form of any kind if it alters or damages or is capable of altering or damaging living tissue below the superficial epidermal cells, with the exception of hair removal. Medical aesthetic service includes, but is not limited to, the following services: ablative laser therapy; vaporizing laser therapy; nonsuperficial light device therapy; injectables; tissue alteration services; nonsuperficial light-emitting diode therapy; nonsuperficial intense pulse light therapy; nonsuperficial radiofrequency therapy; nonsuperficial ultrasonic therapy; nonsuperficial exfoliation; nonsuperficial microdermabrasion; nonsuperficial dermaplane exfoliation; nonsuperficial lymphatic drainage; collagen induction therapy (microneedling); fat-freezing treatment (cool sculpting); botox injections; collagen injections; and tattoo removal.

"Medical director" means a physician who assumes the role of, or holds oneself out as, medical director at a medical spa. The medical director is responsible for implementing policies and procedures to ensure quality patient care and for the delegation and supervision of medical aesthetic services performed by qualified licensed or certified nonphysician persons or qualified laser technicians at a medical spa. The medical director is ultimately responsible for all medical aesthetic services performed by qualified licensed or certified nonphysician persons or qualified laser technicians at a medical spa.

"Medical spa" means any entity, however organized, that is advertised, announced, established, or maintained for the purpose of providing medical aesthetic services. Medical spa shall not include a dermatology practice that is wholly owned and controlled by one or more Iowa-licensed physicians if at least one of the owners is actively practicing at each location.

"Nonsuperficial" means that the therapy alters or damages or is capable of altering or damaging living tissue below the superficial epidermal cells.

"Qualified laser technician" means any person, licensed or unlicensed, who has successfully completed a minimum of 120 hours of training, including a minimum of 40 hours of didactic study and 80 hours of clinical training, in the safe and effective use of lasers in the performance of medical aesthetic services at an accredited laser training program. For the purposes of this rule, a qualified laser technician may only use lasers in the performance of delegated medical aesthetic services under the supervision of a qualified supervising physician at a medical spa. An unlicensed qualified laser technician may not perform any other medical aesthetic services defined in this rule.

"Qualified licensed or certified nonphysician person" means any person who is not licensed to practice medicine and surgery or osteopathic medicine and surgery but who is licensed or certified by another health- or skin care-related licensing board in Iowa and is qualified to perform delegated medical aesthetic services under the supervision of a qualified supervising physician at a medical spa.

"Supervision" means the oversight of qualified licensed or certified nonphysician persons or qualified laser technicians who perform medical aesthetic services delegated by a medical director.

13.6(2) *Delegation by a medical director.* A medical aesthetic service shall only be performed by qualified licensed or certified nonphysician persons or qualified laser technicians if the service has been

delegated by a medical director who is responsible for supervision of the services performed at a medical spa in Iowa. Nothing in this rule shall be interpreted to prevent a qualified nonphysician licensed health professional from serving as a medical director at a medical spa or from appropriately delegating medical aesthetic services pursuant to the rules of the professional's licensing authority.

13.6(3) *Medical director.* A medical director at a medical spa shall:

a. Hold an active unrestricted Iowa medical license to supervise each delegated medical aesthetic service;

b. Possess the appropriate education, training, experience and competence to safely supervise each delegated medical aesthetic service;

c. Retain responsibility for the supervision of each medical aesthetic service performed by qualified licensed or certified nonphysician persons or qualified laser technicians;

d. Ensure that advertising activities do not include false, misleading, or deceptive representations; and

e. Be clearly identified as the medical director in all advertising activities, Internet websites and signage related to the medical spa.

13.6(4) *Delegated medical aesthetic service.* When a medical director delegates a medical aesthetic service to qualified licensed or certified nonphysician persons or qualified laser technicians, the service shall be:

a. Within the medical director's scope of practice and medical competence to supervise;

b. Of the type that a reasonable and prudent physician would conclude is within the scope of sound medical judgment to delegate; and

c. A routine and technical service, the performance of which does not require the skill of a licensed physician.

13.6(5) *Supervision.* A medical director who delegates performance of a medical aesthetic service to qualified licensed or certified nonphysician persons or qualified laser technicians is responsible for providing appropriate supervision. The medical director shall:

a. Ensure that all licensed or certified nonphysician persons or qualified laser technicians are qualified and competent to safely perform each delegated medical aesthetic service by personally assessing the person's education, training, experience and ability;

b. Ensure that a qualified licensed or certified nonphysician person does not perform any medical aesthetic services that are beyond the scope of that person's license or certification unless the person is supervised by a qualified supervising physician or other qualified supervising nonphysician licensed health professional;

c. Ensure that all qualified licensed or certified nonphysician persons or qualified laser technicians receive direct, in-person, on-site supervision from the medical director or other qualified licensed physician or other qualified supervising nonphysician licensed health professional at least four hours each week and that the regular supervision is documented;

d. Provide on-site review of medical aesthetic services performed by qualified licensed or certified nonphysician persons or qualified laser technicians each week and review at least 10 percent of patient charts for medical aesthetic services performed by qualified licensed or certified nonphysician persons or qualified laser technicians;

e. Be physically located, at all times, within 60 miles of the location where delegated medical aesthetic services are performed;

f. Be available, in person or electronically, at all times, to consult with qualified licensed or certified nonphysician persons or qualified laser technicians who perform delegated medical aesthetic services, particularly in case of injury or an emergency;

g. Assess the legitimacy and safety of all equipment or other technologies being used by qualified licensed or certified nonphysician persons or qualified laser technicians who perform delegated medical aesthetic services;

h. Develop and implement protocols for responding to emergencies or other injuries suffered by persons receiving delegated medical aesthetic services performed by qualified licensed or certified nonphysician persons or qualified laser technicians;

i. Ensure that all qualified licensed or certified nonphysician persons or qualified laser technicians maintain accurate and timely medical records for the delegated medical aesthetic services they perform;

j. Ensure that each patient provides appropriate informed consent for medical aesthetic services performed by the medical director or other qualified licensed physician and all qualified licensed or certified nonphysician persons or qualified laser technicians and that such informed consent is timely documented in the patient's medical record;

k. Ensure that the identity and licensure and certification of the medical director, other qualified licensed physicians, and all qualified licensed or certified nonphysician persons or qualified laser technicians are visibly displayed at each medical spa where they perform medical aesthetic services and provided in writing to each patient receiving medical aesthetic services at a medical spa; and

l. Ensure that the board receives written verification of the education and training of all qualified licensed or certified nonphysician persons or qualified laser technicians who perform delegated medical aesthetic services at a medical spa, within 14 days of a request by the board.

13.6(6) *Continuing medical education.* A medical director shall complete and shall ensure that all other physicians, qualified licensed or certified nonphysician persons, and qualified laser technicians who practice at the medical spa complete a minimum of 20 hours of continuing medical education in the safe and effective performance of medical aesthetic services each year.

13.6(7) *Exceptions.* This rule is not intended to apply to physicians who serve as medical directors of licensed medical facilities, clinics or practices that provide medical aesthetic services as part of or incident to their other medical services.

13.6(8) *Other qualified nonphysician licensed health professionals.* Nothing in this rule shall be interpreted to contradict or supersede the rules established in 481—Chapters 780 and 781 and 655—Chapter 7.

[**ARC 9115C**, IAB 4/16/25, effective 5/21/25]

653—13.7(147,148,272C) Standards of practice—interventional chronic pain management. This rule establishes standards of practice for the practice of interventional chronic pain management. The purpose of this rule is to assist physicians who consider interventional techniques to treat patients with chronic pain.

13.7(1) *Definition.* As used in this rule:

"Interventional chronic pain management" means diagnosing and treating pain-related disorders using interventional techniques for subacute, chronic, persistent, and intractable pain. These techniques include percutaneous needle placement for drug injection, nerve ablation, and certain surgeries. Common procedures involve injecting steroids, analgesic, and anesthetics into targeted areas such as the spine, joints, or nerves. This may include lumbar, thoracic, and cervical spine injections; nerve blocks; and processes like vertebroplasty. Fluoroscopy is used to assess chronic pain causes or aid in identifying anatomical landmarks during these techniques. Specific procedures include joint injections, nerve blocks, epidural injections, and nerve destruction.

13.7(2) *Interventional chronic pain management.* The practice of interventional chronic pain management shall include the following:

a. Comprehensive assessment of the patient;

b. Diagnosis of the cause of the patient's pain;

c. Evaluation of alternative treatment options;

d. Selection of appropriate treatment options;

e. Termination of prescribed treatment options when appropriate;

f. Follow-up care; and

g. Collaboration with other health care providers.

13.7(3) *Practice of medicine.* Interventional chronic pain management is the practice of medicine.

[**ARC 9115C**, IAB 4/16/25, effective 5/21/25]

653—13.8(147,148,272C) Standards of practice—physicians who prescribe or administer abortion-inducing drugs.

13.8(1) *Definition.* As used in this rule:

"Abortion-inducing drug" means a drug, medicine, mixture, or preparation, when it is prescribed or administered with the intent to terminate the pregnancy of a woman known to be pregnant.

13.8(2) *Review of patient record.* A physician shall not induce an abortion by providing an abortion-inducing drug unless the physician has first reviewed the lab results, ultrasound images, and medical history provided by the patient to determine, and document in the woman's medical record, the gestational age and intrauterine location of the pregnancy. A physician may utilize telemedicine pursuant to rule 653—13.9(147,148,272C).

13.8(3) *Follow-up appointment required.* If an abortion is induced by an abortion-inducing drug, the physician or designee shall use all reasonable efforts to ensure a follow-up appointment is scheduled with the patient at the same facility within 12 to 18 days after the patient's use of an abortion-inducing drug to confirm the termination of the pregnancy and evaluate the woman's medical condition.

13.8(4) *Parental notification regarding pregnant minors.* A physician shall not induce an abortion by providing an abortion-inducing drug to a pregnant minor prior to compliance with the requirements of Iowa Code chapter 135L and rules 641—89.12(135L) and 641—89.21(135L).

[**ARC 9115C**, IAB 4/16/25, effective 5/21/25]

653—13.9(147,148,272C) Standards of practice—telemedicine. This rule establishes standards of practice for the practice of medicine using telemedicine.

13.9(1) *Definitions.* As used in this rule:

"Asynchronous store-and-forward transmission" means the collection of a patient's relevant health information and the subsequent transmission of the data from an originating site to a health care provider at a distant site without the presence of the patient.

"Board" means the Iowa board of medicine.

"In-person encounter" means that the physician and the patient are in the physical presence of each other and are in the same physical location during the physician-patient encounter.

"Licensee" means a medical physician or osteopathic physician licensed by the board.

"Telemedicine" means the practice of medicine using electronic audio-visual communications and information technologies or other means, including interactive audio with asynchronous store-and-forward transmission, between a licensee in one location and a patient in another location with or without an intervening health care provider. Telemedicine includes asynchronous store-and-forward technologies, remote monitoring, and real-time interactive services, including teleradiology and telepathology. Telemedicine shall not include the provision of medical services only through an audio-only telephone, email messages, facsimile transmissions, or U.S. mail or other parcel service, or any combination thereof.

"Telemedicine technologies" means technologies and devices enabling secure electronic communications and information exchanges between a licensee in one location and a patient in another location with or without an intervening health care provider.

13.9(2) *Practice guidelines.* A licensee who uses telemedicine shall utilize evidence-based telemedicine practice guidelines and standards of practice, to the degree they are available, to ensure patient safety, quality of care, and positive outcomes. The board acknowledges that some nationally recognized medical specialty organizations have established comprehensive telemedicine practice guidelines that address the clinical and technological aspects of telemedicine for many medical specialties.

13.9(3) *Iowa medical license required.* A physician who uses telemedicine in the diagnosis and treatment of a patient located in Iowa shall hold an active Iowa medical license consistent with state and federal laws. Nothing in this rule shall be construed to supersede the exceptions to licensure contained in 653—subrule 9.2(2).

13.9(4) *Standards of care and professional ethics.* A licensee who uses telemedicine is held to the same standards of care and professional ethics as a licensee using traditional in-person encounters with patients. Failure to conform to the appropriate standards of care or professional ethics while using telemedicine may be a violation of the laws and rules governing the practice of medicine and may subject the licensee to potential discipline by the board.

13.9(5) *Scope of practice.* A licensee who uses telemedicine shall ensure that the services provided are consistent with the licensee's scope of practice, including the licensee's education, training, experience, ability, licensure, and certification.

13.9(6) *Identification of patient and physician.* A licensee who uses telemedicine shall verify the identity of the patient and ensure that the patient has the ability to verify the identity, licensure status, certification, and credentials of all health care providers who provide telemedicine services prior to the provision of care.

13.9(7) *Physician-patient relationship.*

a. A licensee who uses telemedicine shall establish a valid physician-patient relationship with the person who receives telemedicine services. The physician-patient relationship begins when:

(1) The person with a health-related matter seeks assistance from a licensee;

(2) The licensee agrees to undertake diagnosis and treatment of the person; and

(3) The person agrees to be treated by the licensee whether or not there has been an in-person encounter between the physician and the person.

b. A valid physician-patient relationship may be established by:

(1) In-person encounter. Through an in-person medical interview and physical examination where the standard of care would require an in-person encounter;

(2) Consultation with another licensee. Through consultation with another licensee (or other health care provider) who has an established relationship with the patient and who agrees to participate in, or supervise, the patient's care; or

(3) Telemedicine encounter. Through telemedicine, if the standard of care does not require an in-person encounter, and in accordance with evidence-based standards of practice and telemedicine practice guidelines that address the clinical and technological aspects of telemedicine.

13.9(8) *Medical history and physical examination.* Generally, a licensee shall perform an in-person medical interview and physical examination for each patient. However, the medical interview and physical examination may not be in-person if the technology utilized in a telemedicine encounter is sufficient to establish an informed diagnosis as though the medical interview and physical examination had been performed in-person. Prior to providing treatment, including issuing prescriptions, electronically or otherwise, a licensee who uses telemedicine shall interview the patient to collect the relevant medical history and perform a physical examination, when medically necessary, sufficient for the diagnosis and treatment of the patient. An Internet questionnaire that is a static set of questions provided to the patient, to which the patient responds with a static set of answers, in contrast to an adaptive, interactive and responsive online interview, does not constitute an acceptable medical interview and physical examination for the provision of treatment, including issuance of prescriptions, electronically or otherwise, by a licensee.

13.9(9) *Nonphysician health care providers.* If a licensee who uses telemedicine relies upon or delegates the provision of telemedicine services to a nonphysician health care provider, the licensee shall:

a. Ensure that systems are in place to ensure that the nonphysician health care provider is qualified and trained to provide that service within the scope of the nonphysician health care provider's practice;

b. Ensure that the licensee is available in person or electronically to consult with the nonphysician health care provider, particularly in the case of injury or an emergency.

13.9(10) *Informed consent.* A licensee who uses telemedicine shall ensure that the patient provides appropriate informed consent for the medical services provided, including consent for the use of telemedicine to diagnose and treat the patient, and that such informed consent is timely documented in the patient's medical record.

13.9(11) *Coordination of care.* A licensee who uses telemedicine shall, when medically appropriate, identify the medical home or treating physician(s) for the patient, when available, where in-person services can be delivered in coordination with the telemedicine services. The licensee shall provide a copy of the medical record to the patient's medical home or treating physician(s).

13.9(12) *Follow-up care.* A licensee who uses telemedicine shall have access to, or adequate knowledge of, the nature and availability of local medical resources to provide appropriate follow-up care to the patient following a telemedicine encounter.

13.9(13) *Emergency services.* A licensee who uses telemedicine shall refer a patient to an acute care facility or an emergency department when referral is necessary for the safety of the patient or in the case of an emergency.

13.9(14) *Medical records.* A licensee who uses telemedicine shall ensure that complete, accurate and timely medical records are maintained for the patient when appropriate, including all patient-related electronic communications, records of past care, physician-patient communications, laboratory and test results, evaluations and consultations, prescriptions, and instructions obtained or produced in connection with the use of telemedicine technologies. The licensee shall note in the patient's record when telemedicine is used to provide diagnosis and treatment. The licensee shall ensure that the patient or another licensee designated by the patient has timely access to all information obtained during the telemedicine encounter. The licensee shall ensure that the patient receives, upon request, a summary of each telemedicine encounter in a timely manner.

13.9(15) *Privacy and security.* A licensee who uses telemedicine shall ensure that all telemedicine encounters comply with the privacy and security measures of the Health Insurance Portability and Accountability Act of 1996, PL 104-191, August 21, 1996, 110 Stat. 1936, and any amendments as of October 16, 2024, to ensure that all patient communications and records are secure and remain confidential.

a. Written protocols shall be established that address the following:

(1) Privacy;

(2) Health care personnel who will process messages;

(3) Hours of operation;

(4) Types of transactions that will be permitted electronically;

(5) Required patient information to be included in the communication, including patient name, identification number and type of transaction;

(6) Archiving and retrieval; and

(7) Quality oversight mechanisms.

b. The written protocols should be periodically evaluated for currency and should be maintained in an accessible and readily available manner for review. The written protocols shall include sufficient privacy and security measures to ensure the confidentiality and integrity of patient-identifiable information, including password protection, encryption or other reliable authentication techniques.

13.9(16) *Technology and equipment.* The board recognizes that three broad categories of telemedicine technologies currently exist, including asynchronous store-and-forward technologies, remote monitoring, and real-time interactive services. While some telemedicine programs are multispecialty in nature, others are tailored to specific diseases and medical specialties. The technology and equipment utilized for telemedicine shall comply with the following requirements:

a. Comply with relevant safety laws, rules, regulations, and codes for technology and technical safety for devices that interact with patients or are integral to diagnostic capabilities;

b. Be of sufficient quality, size, resolution and clarity such that the licensee can safely and effectively provide the telemedicine services; and

c. Be compliant with the Health Insurance Portability and Accountability Act of 1996, PL 104-191, August 21, 1996, 110 Stat. 1936, and any amendments as of October 16, 2024.

13.9(17) *Disclosure and functionality of telemedicine services.* A licensee who uses telemedicine shall ensure that the following information is clearly disclosed to the patient:

a. Types of services provided;

b. Contact information for the licensee;

c. Identity, licensure, certification, credentials, and qualifications of all health care providers who are providing the telemedicine services;

d. Limitations in the drugs and services that can be provided via telemedicine;

e. Fees for services, cost-sharing responsibilities, and how payment is to be made, if these differ from an in-person encounter;

f. Financial interests, other than fees charged, in any information, products, or services provided by the licensee(s);

g. Appropriate uses and limitations of the technologies, including in emergency situations;

h. Uses of and response times for emails, electronic messages and other communications transmitted via telemedicine technologies;

i. To whom patient health information may be disclosed and for what purpose;

j. Rights of patients with respect to patient health information; and

k. Information collected and passive tracking mechanisms utilized.

13.9(18) *Patient access and feedback.* A licensee who uses telemedicine shall ensure that the patient has easy access to a mechanism for the following purposes:

a. To access, supplement and amend patient-provided personal health information;

b. To provide feedback regarding the quality of the telemedicine services provided; and

c. To register complaints. The mechanism shall include information regarding the filing of complaints with the board.

13.9(19) *Financial interests.* Advertising or promotion of goods or products from which the licensee(s) receives direct remuneration, benefit or incentives (other than the fees for the medical services) is prohibited to the extent that such activities are prohibited by state or federal law. Notwithstanding such prohibition, Internet services may provide links to general health information sites to enhance education; however, the licensee(s) should not benefit financially from providing such links or from the services or products marketed by such links. When providing links to other sites, licensees should be aware of the implied endorsement of the information, services or products offered from such sites. The maintenance of a preferred relationship with any pharmacy is prohibited. Licensees shall not transmit prescriptions to a specific pharmacy, or recommend a pharmacy, in exchange for any type of consideration or benefit from the pharmacy.

13.9(20) *Circumstances where the standard of care may not require a licensee to personally interview or examine a patient.* Under the following circumstances, whether or not such circumstances involve the use of telemedicine, a licensee may treat a patient who has not been personally interviewed, examined and diagnosed by the licensee:

a. Situations in which the licensee prescribes medications on a short-term basis for a new patient and has scheduled or is in the process of scheduling an appointment to personally examine the patient;

b. For institutional settings, including writing initial admission orders for a newly hospitalized patient;

c. Call situations in which a licensee is taking call for another licensee who has an established physician-patient relationship with the patient;

d. Cross-coverage situations in which a licensee is taking call for another licensee who has an established physician-patient relationship with the patient;

e. Situations in which the patient has been examined in person by an advanced registered nurse practitioner or a physician assistant or other licensed practitioner with whom the licensee has a supervisory or collaborative relationship;

f. Emergency situations in which the life or health of the patient is in imminent danger;

g. Emergency situations that constitute an immediate threat to the public health including but not limited to empiric treatment or prophylaxis to prevent or control an infectious disease outbreak;

h. Situations in which the licensee has diagnosed a sexually transmitted disease in a patient and the licensee prescribes or dispenses antibiotics to the patient's named sexual partner(s) for the treatment of the sexually transmitted disease as recommended by the U.S. Centers for Disease Control and Prevention; and

i. For licensed or certified nursing facilities, residential care facilities, intermediate care facilities, assisted living facilities and hospice settings.

13.9(21) *Prescribing based solely on an Internet request, Internet questionnaire or a telephonic evaluation—prohibited.* Prescribing to a patient based solely on an Internet request or Internet questionnaire (i.e., a static questionnaire provided to a patient, to which the patient responds with a static set of answers, in contrast to an adaptive, interactive and responsive online interview) is prohibited. Absent a valid physician-patient relationship, a licensee's prescribing to a patient based solely on a telephonic evaluation is prohibited, with the exception of the circumstances described in subrule 13.9(20).

[**ARC 9115C**, IAB 4/16/25, effective 5/21/25]

653—13.10(135,147,148,272C,280) Standards of practice—prescribing epinephrine auto-injectors, bronchodilator canisters, bronchodilator canisters and spacers, or opioid antagonists in the name of an authorized facility.

13.10(1) Definition. For purposes of this rule:

"Authorized facility" means a facility as defined in Iowa Code section 135.185(1), a school district, or an accredited nonpublic school.

13.10(2) Notwithstanding any other provision of law to the contrary, a physician may prescribe epinephrine auto-injectors, bronchodilator canisters, bronchodilator canisters and spacers, or opioid antagonists in the name of an authorized facility to be maintained for use pursuant to Iowa Code sections 135.185, 135.190, 280.16 and 280.16A.

13.10(3) A physician who prescribes epinephrine auto-injectors, bronchodilator canisters, bronchodilator canisters and spacers, or opioid antagonists in the name of an authorized facility to be maintained for use pursuant to Iowa Code sections 135.185, 135.190, 280.16 and 280.16A, provided the physician has acted reasonably and in good faith, is not liable for any injury arising from the provision, administration, or assistance in the administration of an epinephrine auto-injector, bronchodilator canisters, bronchodilator canisters and spacers, or opioid antagonists.

[**ARC 9115C**, IAB 4/16/25, effective 5/21/25]

653—13.11(144E,147,148,272C) Standards of practice—experimental treatments for patients with a terminal illness.

13.11(1) *Exemption from discipline.* To the extent consistent with state law, the board will not revoke, fail to renew, suspend, or take any action against a physician's license based solely on the physician's recommendations to an eligible patient regarding access to or treatment with an investigational drug, biological product, or device.

13.11(2) *Eligible patient.* A physician shall ensure that a patient meets all of the following conditions prior to the use of an investigational drug, biological product, or device pursuant to this rule:

a. The patient has a terminal illness, attested to by the patient's treating physician.

b. The patient has considered and rejected or has tried and failed to respond to all other treatment options approved by the U.S. Food and Drug Administration (FDA).

c. The patient has received a recommendation from the patient's physician for an investigational drug, biological product, or device.

d. The patient has given written informed consent for the use of the investigational drug, biological product, or device.

e. The patient has documentation from the patient's physician that the patient meets the requirements of this rule.

13.11(3) *Investigational drug, biological product, or device.* A physician may recommend access to or treatment with an investigational drug, biological product, or device that has successfully completed phase 1 of an FDA-approved clinical trial but has not yet been approved for general use by the FDA and remains under investigation in an FDA-approved clinical trial.

13.11(4) *Terminal illness.* A physician shall ensure that a patient has a terminal illness prior to the use of an investigational drug, biological product, or device pursuant to this rule. A terminal illness is a progressive disease or medical or surgical condition that entails significant functional impairment and that is not considered by a treating physician to be reversible even with administration of treatments approved by the FDA and that, without life-sustaining procedures, will result in death.

13.11(5) *Written informed consent.* A physician shall obtain written informed consent prior to the use of an investigational drug, biological product, or device pursuant to this rule. Written informed consent is a written document that is signed by a patient, a parent of a minor patient, or a legal guardian or other legal representative of the patient and attested to by the patient's treating physician and a witness and that includes all of the following:

a. An explanation of the products and treatments approved by the FDA for the disease or condition from which the patient suffers.

b. An attestation that the patient concurs with the patient's treating physician in believing that all products and treatments approved by the FDA are unlikely to prolong the patient's life.

c. Clear identification of the specific proposed investigational drug, biological product, or device that the patient is seeking to use.

d. A description of the best and worst potential outcomes of using the investigational drug, biological product, or device and a realistic description of the most likely outcome. The description to include the

possibility that new, unanticipated, different, or worse symptoms might result and that death could be hastened by use of the proposed investigational drug, biological product, or device. The description is based on the treating physician's knowledge of the proposed investigational drug, biological product, or device in conjunction with an awareness of the patient's condition.

e. A statement that the patient's health plan or third-party administrator and provider are not obligated to pay for any care or treatments consequent to the use of the investigational drug, biological product, or device, unless the patient's health plan or third-party administrator and provider are specifically required to do so by law or contract.

f. A statement that the patient's eligibility for hospice care may be withdrawn if the patient begins curative treatment with the investigational drug, biological product, or device and that hospice care may be reinstated if treatment ends and the patient meets hospice eligibility requirements.

g. A statement that the patient understands that the patient is liable for all expenses consequent to the use of the investigational drug, biological product, or device and that this liability extends to the patient's estate unless a contract between the patient and the manufacturer of the investigational drug, biological product, or device states otherwise.

13.11(6) *Assisting suicide.* This rule is not to be construed to allow a patient's treating physician to assist the patient in committing or attempting to commit suicide as prohibited in Iowa Code section 707A.2.

13.11(7) *Grounds for discipline.* A physician may be subject to disciplinary action for violation of this rule or 653—Chapter 23. Grounds for discipline include but are not limited to the following:

a. The physician recommends access to or treatment with an investigational drug, biological product, or device to an individual who is not an eligible patient pursuant to this rule.

b. The physician fails to obtain appropriate written informed consent prior to recommending access to or treatment with an investigational drug, biological product, or device pursuant to this rule.

c. The physician assists the patient in committing or attempting to commit suicide as prohibited in Iowa Code section 707A.2.

[**ARC 9115C**, IAB 4/16/25, effective 5/21/25]

653—13.12(147,148,272C) Standards of practice—tick-borne disease diagnosis and treatment.

13.12(1) *Exemption from discipline.* A person licensed by the board under Iowa Code chapter 148 shall not be subject to discipline under this chapter or the board's enabling statute based solely on the physician's recommendation or provision of a treatment method for Lyme disease or other tick-borne disease if the recommendation or provision of such treatment meets all the following criteria:

a. The treatment is provided after an examination is performed and informed consent is received from the patient.

b. The physician identifies a medical reason for recommending or providing the treatment.

c. The treatment is provided after the physician informs the patient about other recognized treatment options and describes to the patient the physician's education, experience, and credentials regarding the treatment of Lyme disease or other tick-borne disease.

d. The physician uses the physician's own medical judgment based on a thorough review of all available clinical information and Lyme disease or other tick-borne disease literature to determine the best course of treatment for the individual patient.

e. The treatment will not, in the opinion of the physician, result in the direct and proximate death of or serious bodily injury to the patient.

13.12(2) *Lyme disease treatment.* Most cases of Lyme disease can be treated successfully with a few weeks of antibiotics. Over the past several years, the International Lyme and Associated Diseases Society (ILADS) has supported longer courses of antibiotics for some patients, versus the prescribed treatment durations identified by the Infectious Diseases Society of America (IDSA) and referenced by the CDC. While IDSA has expressed concern about overtreatment, ILADS points out that treatment decisions should be based on a risk-benefit analysis. Both groups have published evidence-based guidelines.

13.12(3) *Tick-borne diseases.* According to the CDC, tick-borne diseases include:

a. Anaplasmosis is transmitted to humans by tick bites primarily from the blacklegged tick (*Ixodes scapularis*) in the northeastern and upper midwestern regions of the United States (U.S.) and the western blacklegged tick (*Ixodes pacificus*) along the Pacific coast.

b. *Babesiosis* is caused by microscopic parasites that infect red blood cells. Most human cases of babesiosis in the U.S. are caused by *Babesia microti*. *Babesia microti* is transmitted by the blacklegged tick (*Ixodes scapularis*) and is found primarily in the northeastern and upper midwestern regions of the U.S.

c. *Borrelia mayonii* infection has recently been described as a cause of illness in the upper midwestern region of the U.S. This infection has been found in blacklegged ticks (*Ixodes scapularis*) in Minnesota and Wisconsin. *Borrelia mayonii* is a new species and is the only species besides *B. burgdorferi* known to cause Lyme disease in North America.

d. *Borrelia miyamotoi* infection has recently been described as a cause of illness in the U.S. This infection is transmitted by the blacklegged tick (*Ixodes scapularis*) and has a geographic range similar to that of Lyme disease.

e. *Bourbon virus* infection has been identified in a limited number of patients in the midwestern and southern regions of the U.S. At this time, it is not known if the virus might be found in other areas of the U.S.

f. *Colorado tick fever* is caused by a virus transmitted by the Rocky Mountain wood tick (*Dermacentor andersoni*). Colorado tick fever occurs in the Rocky Mountain states at elevations of 4,000 to 10,500 feet.

g. *Ehrlichiosis* is transmitted to humans by the lone star tick (*Amblyomma americanum*), found primarily in the south central and eastern regions of the U.S.

h. *Heartland virus* cases have been identified in the midwestern and southern regions of the U.S. Studies suggest that lone star ticks (*Amblyomma americanum*) can transmit the virus. It is unknown if the virus may be found in other areas of the U.S.

i. *Lyme disease* is transmitted by the blacklegged tick (*Ixodes scapularis*) in the northeastern and upper midwestern regions of the U.S. and by the western blacklegged tick (*Ixodes pacificus*) along the Pacific coast.

j. *Powassan disease* is transmitted by the blacklegged tick (*Ixodes scapularis*) and the groundhog tick (*Ixodes cookei*). Cases have been reported primarily from northeastern states and the Great Lakes region.

k. *Rickettsia parkeri rickettsiosis* is transmitted to humans by the Gulf Coast tick (*Amblyomma maculatum*).

l. *Rocky Mountain spotted fever* is transmitted by the American dog tick (*Dermacentor variabilis*), Rocky Mountain wood tick (*Dermacentor andersoni*), and the brown dog tick (*Rhipicephalus sanguineus*) in the U.S. The brown dog tick and other tick species are associated with Rocky Mountain spotted fever in Central America and South America.

m. *Southern tick-associated rash illness* is transmitted via bites from the lone star tick (*Amblyomma americanum*) found in the southeastern and eastern regions of the U.S.

n. *Tick-borne relapsing fever* is transmitted to humans through the bite of infected soft ticks. Tick-borne relapsing fever has been reported in 15 states: Arizona, California, Colorado, Idaho, Kansas, Montana, Nevada, New Mexico, Ohio, Oklahoma, Oregon, Texas, Utah, Washington, and Wyoming and is associated with sleeping in rustic cabins and vacation homes.

o. *Tularemia* is transmitted to humans by the dog tick (*Dermacentor variabilis*), the wood tick (*Dermacentor andersoni*), and the lone star tick (*Amblyomma americanum*). Tularemia occurs throughout the U.S.

p. *364D rickettsiosis* (*Rickettsia phillipi*) is transmitted to humans by the Pacific Coast tick (*Dermacentor occidentalis*). This is a new disease that has been found in California.

13.12(4) *Grounds for discipline.* A physician may be subject to disciplinary action for violation of these rules or the rules found in 653—Chapter 23. Grounds for discipline include but are not limited to the following:

a. The physician fails to perform and document an appropriate examination or fails to obtain and document appropriate informed consent from the patient.

b. The physician fails to identify and document a medical reason for recommending or providing the treatment.

c. The physician fails to inform the patient about other recognized treatment options or fails to describe to the patient the physician's education, experience, and credentials regarding the treatment of Lyme disease or other tick-borne diseases.

d. The physician fails to use the physician's own medical judgment based on a thorough review of all available clinical information and Lyme disease or other tick-borne disease literature to determine the best course of treatment for the individual patient.

e. The treatment provided, in the opinion of the physician, will likely result in the direct and proximate death of or serious bodily injury to the patient.

[**ARC 9115C**, IAB 4/16/25, effective 5/21/25]

653—13.13(124E,147,148,272C) Standards of practice—medical cannabidiol.

13.13(1) *Definitions.* For purposes of this rule:

"Bordering state" means the same as defined in Iowa Code section 331.910.

"Debilitating medical condition" means any of the following:

1. Cancer, if the underlying condition or treatment produces one or more of the following:
- Severe or chronic pain.
- Nausea or severe vomiting.
- Cachexia or severe wasting.
2. Multiple sclerosis with severe and persistent muscle spasms.
3. Seizures, including those characteristic of epilepsy.
4. AIDS or HIV as defined in Iowa Code section 141A.1.
5. Crohn's disease.
6. Amyotrophic lateral sclerosis.
7. Any terminal illness, with a probable life expectancy of under one year, if the illness or its treatment produces one or more of the following:
- Severe or chronic pain.
- Nausea or severe vomiting.
- Cachexia or severe wasting.
8. Parkinson's disease.
9. Chronic pain.
10. Ulcerative colitis.
11. Severe, intractable autism with self-injurious or aggressive behaviors.
12. Corticobasal degeneration.
13. Post-traumatic stress disorder.

"Department" means the Iowa department of public health.

"Form and quantity" means the types and amounts of medical cannabidiol allowed to be dispensed to a patient or primary caregiver as approved by the department subject to recommendation by the medical cannabidiol board and approval by the board of medicine.

"Medical cannabidiol" means any pharmaceutical grade cannabinoid found in the plant *Cannabis sativa* L. or *Cannabis indica* or any other preparation thereof that is delivered in a form recommended by the medical cannabidiol board, approved by the board of medicine, and adopted by the department pursuant to rule.

"Medical cannabidiol board" means the board established pursuant to Iowa Code section 124E.5.

"Primary caregiver" means a person who is a resident of this state or a bordering state, including but not limited to a parent or legal guardian, at least 18 years of age, who has been designated by a patient's health care practitioner as a necessary caretaker taking responsibility for managing the well-being of the patient with respect to the use of medical cannabidiol pursuant to the provisions of this chapter.

"Untreatable pain" means any pain whose cause cannot be removed and, according to generally accepted medical practice, the full range of pain management modalities appropriate for the patient has been used without adequate result or with intolerable side effects.

"Written certification" means a document signed by a physician licensed pursuant to Iowa Code chapter 148 with whom the patient has established a patient-physician relationship and who is the patient's

primary care provider that states that the patient has a debilitating medical condition and identifies that condition and provides any other relevant information.

13.13(2) *Written certification.* A physician who is a patient's primary care provider may provide the patient a written certification of diagnosis if, after examining and treating the patient, the physician determines, in the physician's medical judgment, that the patient suffers from a debilitating medical condition that qualifies for the use of medical cannabidiol pursuant to Iowa Code chapter 124E.

a. The physician shall provide explanatory information as provided by the department to the patient about the therapeutic use of medical cannabidiol and the possible risks, benefits, and side effects of the proposed treatment.

b. Subsequently, the physician shall do the following:

(1) Determine, on an annual basis, if the patient continues to suffer from a debilitating medical condition and, if so, may issue the patient a new written certification of that diagnosis.

(2) Otherwise comply with all requirements established by the department pursuant to rule.

c. A physician may provide, but has no duty to provide, a written certification pursuant to this rule.

13.13(3) *Adding or removing debilitating medical conditions and amending form and quantity of medical cannabidiol.* Recommendations made by the medical cannabidiol board pursuant to Iowa Code section 124E.5 relating to the addition or removal of allowable debilitating medical conditions for which the medical use of cannabidiol would be medically beneficial or to the amendment of the form and quantity of allowable medical uses of cannabidiol shall be made to the board of medicine for consideration. The medical cannabidiol board shall submit a written recommendation, a copy of the petition and all other information received during consideration of the petition. The board of medicine shall consider the information received from the medical cannabidiol board and may seek information from other sources if it is deemed relevant by the board of medicine. The decision regarding a recommendation by the medical cannabidiol board is at the sole discretion of the board of medicine. The board of medicine shall make its decision within 180 days of receipt of the recommendation from the medical cannabidiol board. If the recommendation is approved by the board of medicine, it shall be adopted by rule.

13.13(4) *Financial interests.* A physician shall not share office space with, accept referrals from, or have any financial relationship with a medical cannabidiol manufacturer or dispensary.

13.13(5) *Criminal prosecution.* A physician, including any authorized agent or employee thereof, shall not be subject to prosecution for the unlawful certification, possession, or administration of marijuana under the laws of this state for activities arising directly out of or directly related to the certification or use of medical cannabidiol in the treatment of a patient diagnosed with a debilitating medical condition as authorized by Iowa Code chapter 124E.

13.13(6) *Civil or disciplinary penalties.* A physician, including any authorized agent or employee thereof, shall not be subject to any civil or disciplinary penalties by the board of medicine or any business, occupational, or professional licensing board or entity, solely for activities conducted relating to a patient's possession or use of medical cannabidiol as authorized by Iowa Code chapter 124E. Nothing in this rule prevents the board of medicine from taking action in response to violations of any other sections of law or rule.

13.13(7) *Grounds for discipline.* A physician may be subject to disciplinary action for violation of these rules or the rules found in 653—Chapter 23. Grounds for discipline include but are not limited to the following:

a. The physician provides an individual a written certification without establishing a patient-physician relationship, including examining and treating the individual, or without being the individual's primary care provider.

b. The physician provides a patient a written certification without determining, in the physician's medical judgment, that the patient suffers from a debilitating medical condition that qualifies for the use of medical cannabidiol pursuant to Iowa Code chapter 124E.

c. The physician provides a patient a written certification without providing explanatory information as provided by the department to the patient about the therapeutic use of medical cannabidiol and the possible risks, benefits, and side effects of the proposed treatment.

d. The physician provides an individual a new written certification without determining, on an annual basis, that the patient continues to suffer from a debilitating medical condition.

e. The physician shares office space with, accepts referrals from, or has a financial relationship with a medical cannabidiol manufacturer or dispensary.

[**ARC 9115C**, IAB 4/16/25, effective 5/21/25]

653—13.14(146A) Abortion prerequisites.

13.14(1) *Written certification.* At least 24 hours prior to performing an abortion, a physician shall obtain written certification from the pregnant woman of each prerequisite as required in Iowa Code sections 146A.1(1)*"a"* through 146A.1(1)*"d"*(1). The written certification shall list each required prerequisite separately and shall include a line for date and signature of the pregnant woman. The physician shall maintain a copy of the certification as part of the pregnant woman's medical records.

13.14(2) *Exceptions.* This rule shall not apply to abortions performed in a medical emergency, as provided in Iowa Code section 146A.1(2).

13.14(3) *Discipline.* Failure to comply with this rule or the requirements of Iowa Code section 146A.1 may constitute grounds for discipline.

[**ARC 9115C**, IAB 4/16/25, effective 5/21/25]

653—13.15(135L,146A,146E,147,148,272C) Standards of practice for physicians who perform or induce abortions—definitions—detection of fetal heartbeat—fetal heartbeat exceptions—discipline.

13.15(1) *Standards of practice.* This rule sets forth the standards of practice for physicians who perform or induce abortions. More information is contained in Iowa Code section 146E.2(5).

13.15(2) *Definitions.* As used in this rule or in Iowa Code chapter 146E:

"Private health agency" means any establishment, facility, organization, or other entity that is not owned by a federal, state, or local government that either is a health care provider or employs or provides the services of a health care provider. Establishments, facilities, organizations, or other entities that are health care providers include the following:

1. A hospital as defined in Iowa Code section 135B.1;
2. A health care facility as defined in Iowa Code section 135C.1;
3. A health facility as defined in Iowa Code section 135P.1; or
4. A similar entity that either is a health care provider or employs or provides the services of a health care provider.

"Public health agency" means any establishment; facility; organization; administrative division; or entity that is owned by a federal, state, or local government that either is a health care provider or employs or provides the services of a health care provider. Establishments, facilities, organizations, administrative divisions, or other entities that are health care providers include the following:

1. A hospital as defined in Iowa Code section 135B.1;
2. A health care facility as defined in Iowa Code section 135C.1;
3. A health facility as defined in Iowa Code section 135P.1; or
4. A similar entity that either is a health care provider or employs or provides the services of a health care provider.

"Standard medical practice" means the degree of skill, care, and diligence that a physician of the same medical specialty would employ in like circumstances. As applied to the method used to determine the presence of a fetal heartbeat for purposes of Iowa Code chapter 146E and this rule, "standard medical practice" includes employing the appropriate means of detection depending on the estimated gestational age of the unborn child and the condition of the woman and her pregnancy.

"The pregnancy is the result of a rape" means a circumstance in which the pregnancy is the result of conduct that would constitute an offense under Iowa Code section 709.2, 709.3, 709.4, or 709.4A when perpetrated against a female, regardless of where the conduct occurred.

"The pregnancy is the result of incest" means a circumstance in which a sex act occurs between closely related persons that involves a vaginal penetration that causes a pregnancy. The closely related persons must be related, either legitimately or illegitimately, as an ancestor, descendant, brother or sister of the

whole or half blood, aunt, uncle, niece, or nephew. For purposes of this rule, a closely related person includes a stepparent, stepchild, or stepsibling, including siblings through adoption.

"Unborn child" means an individual organism of the species *Homo sapiens* from fertilization to live birth—that is, at all stages of development, including embryo and fetus.

"Woman" means a female individual regardless of her age.

13.15(3) *Detection of fetal heartbeat.* A physician who intends to perform or induce an abortion must determine via ultrasound whether the woman is carrying an unborn child with a detectable fetal heartbeat.

a. Obligation. The obligation under this rule requires a bona fide effort to detect a fetal heartbeat in the unborn child. This effort must be made in good faith and according to standard medical practice and reasonable medical judgment.

b. Method. The physician shall perform a transabdominal pelvic ultrasound on the woman to determine whether the unborn child has a detectable fetal heartbeat. This shall be performed in a manner consistent with standard medical practice, with real-time ultrasound equipment with a transducer of appropriate frequency. The equipment must be properly maintained and in proper functioning order.

13.15(4) *Fetal heartbeat exceptions.* The following applies to a physician who intends to perform or induce an abortion under a fetal heartbeat exception as defined in Iowa Code chapter 146E and this rule:

a. Incest or rape. For purposes of this rule, a pregnancy resulting from incest or rape may be reported within the appropriate time frame to a licensed physician whose services are retained for an abortion procedure.

(1) To determine whether the pregnancy is the result of incest, a physician who intends to perform or induce an abortion must use the following information:

1. Whether the sex act occurred between the woman and a closely related person, meaning, either legitimately or illegitimately, an ancestor, descendant, brother or sister of the whole or half blood, aunt, uncle, niece, or nephew, including a stepparent, stepchild, or stepsibling to include an adopted sibling.
2. The date the act occurred.
3. If initial reporting was to someone other than the physician who intends to perform or induce an abortion, the date the act was reported to a law enforcement agency, public health agency, private health agency, or family physician.

The physician who intends to perform or induce an abortion shall use this information to determine whether the fetal heartbeat exception for incest applies. This information does not prescribe the manner in which the physician is to obtain this information. This information and its source shall be documented in the woman's medical records.

The physician who intends to perform or induce an abortion may rely on the information received upon a good-faith assessment that the information is true. The physician who intends to perform or induce an abortion may require the person providing the information to sign a certification form attesting that the information is true.

(2) To determine whether the pregnancy is the result of a rape, a physician who intends to perform or induce an abortion must use the following information:

1. The date the sex act that caused the pregnancy occurred.
2. The age of the woman seeking an abortion at the time of that sex act.
3. Whether the sex act constituted a rape.
4. Whether the rape was perpetrated against the woman seeking an abortion.
5. If initial reporting was to someone other than the physician who intends to perform or induce an abortion, the date the rape was reported to a law enforcement agency, public health agency, private health agency, or family physician.

The physician who intends to perform or induce an abortion shall use this information to determine whether the fetal heartbeat exception for rape applies. This rule does not prescribe the manner in which the physician is to obtain this information. This information and its source shall be documented in the woman's medical records.

The physician who intends to perform or induce an abortion may rely on the information received upon a good-faith assessment that the information is true. The physician who intends to perform or induce an

abortion may require the person providing the information to sign a certification form attesting that the information is true.

b. Fetal abnormality. A certification from an attending physician that a fetus has a fetal abnormality that in the attending physician's reasonable medical judgment is incompatible with life must contain the following information:

(1) The diagnosis of the abnormality;

(2) The basis for the diagnosis, including the tests and procedures performed, the results of those tests and procedures, and why those results support the diagnosis; and

(3) A description of why the abnormality is incompatible with life.

The diagnosis and the attending physician's conclusion must be reached in good faith following a bona fide effort, consistent with standard medical practice and reasonable medical judgment, to determine the health of the fetus. The certification must be signed by the attending physician. A physician who intends to perform or induce an abortion may rely in good faith on a certification from an attending physician if the physician who intends to perform or induce an abortion has a copy of the certification. The certification must be included in the woman's medical records by the physician who intends to perform or induce an abortion.

13.15(5) *Discipline.* Failure to comply with this rule or the requirements of Iowa Code chapter 146E may constitute grounds for discipline.

[**ARC 9115C**, IAB 4/16/25, effective 5/21/25]

653—13.16(147,148) Principles of medical ethics. The Code of Medical Ethics (2002-2003) prepared and approved by the American Medical Association and the Code of Ethics (2002-2003) prepared and approved by the American Osteopathic Association is utilized by the board as guiding principles in the practice of medicine and surgery and osteopathic medicine and surgery in this state.

13.16(1) *Conflict of interest.* A physician should not provide medical services under terms or conditions that tend to interfere with or impair the free and complete exercise of the physician's medical judgment and skill or tend to cause a deterioration of the quality of medical care.

13.16(2) *Fees.* Any fee charged by a physician shall be reasonable.

[**ARC 9115C**, IAB 4/16/25, effective 5/21/25]

653—13.17(147A) Emergency medical care provider. A physician with a license in good standing may be staffed on an authorized emergency medical services (EMS) program provided the physician can document equivalency through education and additional skills training essential in the delivery of out-of-hospital emergency care. The equivalency shall be accepted when documentation has been reviewed and approved at the local level by the medical director of the authorized EMS service program and the department of health and human services bureau of emergency medical and trauma services in accordance with the form adopted by the department of health and human services.

[**ARC 9115C**, IAB 4/16/25, effective 5/21/25]

These rules are intended to implement Iowa Code chapters 124, 124E, 144E, 146E, 148 and 272C and sections 147.55, 148.6, 147.107, 272C.3 and 272C.4.

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[1] Effective date of 13.2(148,272C) delayed 70 days by the Administrative Rules Review Committee at its meeting held May 14, 1996.

CHAPTER 14
IOWA PHYSICIAN HEALTH COMMITTEE—IOWA PHYSICIAN HEALTH PROGRAM
Rescinded **ARC 9110C**, IAB 4/16/25, effective 5/21/25

CHAPTER 15
CHILD SUPPORT NONCOMPLIANCE
Rescinded **ARC 9110C**, IAB 4/16/25, effective 5/21/25

CHAPTER 16
STUDENT LOAN DEFAULT OR NONCOMPLIANCE
Rescinded **ARC 4979C**, IAB 3/11/20, effective 4/15/20

CHAPTER 17
LICENSURE OF ACUPUNCTURISTS

Chapter rescission date pursuant to Iowa Code section 17A.7: 5/21/30

653—17.1(148E) Scope of chapter. The rules in this chapter only apply to individuals licensed under Iowa Code chapter 148E. In accordance with Iowa Code section 148E.3, the rules in this chapter do not apply to the following:

1. A person otherwise licensed by the state to practice medicine and surgery, osteopathic medicine and surgery, chiropractic, podiatry, or dentistry who is exclusively engaged in the practice of the person's profession.
2. A student practicing acupuncture under the direct supervision of a licensed acupuncturist as part of a course of study approved by the board.

[**ARC 9116C**, IAB 4/16/25, effective 5/21/25]

653—17.2(148E) Definitions. The definitions stated in Iowa Code section 148E.1 apply to this chapter, in addition to those listed below.

"Accreditation Commission for Acupuncture and Oriental Medicine" or *"ACAOM"* means the United States-based accreditation commission that certifies acupuncture and oriental medicine training programs and colleges.

"Acupuncture needle" means a solid-core instrument including but not limited to acupuncture needles, dermal needles, intradermal needles, press tacks, plum blossom needles, prismatic needles, and disposable lancets.

"Acupuncture point" means a specific anatomical location on the human body that serves as the treatment site for the use of acupuncture.

"Applicant" means a person not otherwise authorized to practice acupuncture under Iowa Code section 148E.3 who applies to the board for a license.

"Ashi acupuncture point" means an acupuncture point that is located according to tenderness upon palpation. An ashi acupuncture point is also known as a trigger point.

"Committee" means the licensure committee of the board with oversight responsibility for administration of the licensure of acupuncturists.

"Department" means the department of inspections, appeals, and licensing.

"Disclosure sheet" means the written information licensed acupuncturists must provide to patients on initial contact.

"Disposable needles" means presterilized needles that are discarded after initial use pursuant to Iowa Code section 148E.5.

"License" means a license issued by the board pursuant to Iowa Code section 148E.2.

"Licensee" means a person holding a license to practice acupuncture issued by the board pursuant to Iowa Code chapter 148E.

"National Certification Commission for Acupuncture and Oriental Medicine" or *"NCCAOM"* means the United States-based commission that validates entry-level competency in the practice of acupuncture and oriental medicine through professional certification.

[**ARC 9116C**, IAB 4/16/25, effective 5/21/25]

653—17.3(147,148E) Eligibility for licensure.

17.3(1) *Eligibility requirements.* To be licensed to practice acupuncture by the board, a person shall meet all of the following requirements:

a. Fulfill all the application requirements as specified in rule 653—17.4(147,148E).

b. Hold current active status as a diplomate in NCCAOM or, after June 1, 2004, hold current active status as a diplomate in acupuncture or oriental medicine from NCCAOM.

c. Demonstrate sufficient knowledge of the English language to understand and be understood by patients and board and committee members.

(1) An applicant who passed the NCCAOM written and practical examination components in English may be presumed to have sufficient proficiency in English.

(2) An applicant who passed NCCAOM written or practical examination components in a language other than English shall pass the Test of Spoken English (TSE) or the Test of English as a Foreign Language (TOEFL) examinations administered by the Educational Testing Service.

d. Successfully complete a three-year postsecondary training program or acupuncture college program that is accredited by, in candidacy for accreditation by, or that meets the standards of the Accreditation Commission for Acupuncture and Oriental Medicine.

e. Successfully complete a course in clean needle technique approved by the NCCAOM.

f. The applicant's license is not denied by the board due to the commission of a disqualifying offense, as provided in 653—subrule 9.3(3).

17.3(2) *Waiver prohibited.* Provisions of this rule are not subject to waiver pursuant to 653—Chapter 3 or any other provision of law.

[**ARC 9116C**, IAB 4/16/25, effective 5/21/25]

653—17.4(147,148E) Application requirements.

17.4(1) *Application for licensure.* To apply for a license to practice acupuncture, an applicant shall:

a. Submit the completed application form provided by the board, including required credentials and documents, a completed fingerprint packet and a sworn statement by the applicant attesting to the truth of all information provided by the applicant;

b. Pay the nonrefundable initial application fee identified in 653—subrule 8.2(1); and

c. Pay the fee identified in 653—subrule 8.2(5) for the evaluation of the fingerprint packet and the national criminal history background checks by the division of criminal investigation (DCI) and the Federal Bureau of Investigation (FBI).

17.4(2) *Contents of the application form.* Each applicant shall submit the following information on the application form provided by the board:

a. The applicant's full legal name, date and place of birth, home address, mailing address, principal business address, and personal email address regularly used by the applicant or licensee for correspondence with the board;

b. A chronology accounting for all time periods from the date the applicant entered an acupuncture and oriental medicine training program or college to the date of the application;

c. The other jurisdictions in the United States or other nations or territories in which the applicant is authorized to practice acupuncture, including license, certificate of registration or certification numbers, and date of issuance;

d. Full disclosure of the applicant's involvement in civil litigation related to the practice of acupuncture in any jurisdiction of the United States, other nations or territories. Copies of the legal documents may be requested if needed during the review process;

e. A statement disclosing and explaining any informal or nonpublic actions, warnings issued, investigations conducted, or disciplinary actions taken, whether by voluntary agreement or formal action, by a medical, acupuncture or professional regulatory authority, an educational institution, a training or research program, or a health facility in any jurisdiction;

f. A statement disclosing and explaining any charge of a misdemeanor or felony involving the applicant filed in any jurisdiction, whether or not any appeal or other proceeding is pending to have the conviction or plea set aside;

g. The NCCAOM score report verification form submitted directly to the board by the NCCAOM;

h. An NCCAOM certificate that demonstrates that the applicant holds current active status as a diplomate in acupuncture or oriental medicine from the NCCAOM;

i. Proof of successful completion of a course in clean needle technique approved by the NCCAOM;

j. A description of the applicant's clinical acupuncture training, work experience and, where applicable, supporting documentation;

k. A copy of the applicant's acupuncture degree issued by an educational institution. If a copy of the acupuncture degree cannot be provided because of extraordinary circumstances, the board may accept other reliable evidence that the applicant obtained an acupuncture degree from a specific educational institution;

l. A complete translation of any diploma not written in English. An official transcript, written in English and received directly from the educational institution, showing graduation from an acupuncture training program or an educational institution is a suitable alternative;

m. A sworn statement from an official of the educational institution certifying the date the applicant received the acupuncture degree and acknowledging what, if any, derogatory comments exist in the institution's record about the applicant. If a sworn statement from an official of the educational institution cannot be provided because of extraordinary circumstances, the board may accept other reliable evidence that the applicant obtained an acupuncture degree from a specific educational institution;

n. An official transcript sent directly from an acupuncture training program or an educational institution attended by the applicant and, if requested by the board, an English translation of the official transcript;

o. Proof of the applicant's proficiency in the English language, when the applicant has not passed the English version of the NCCAOM written and practical examinations;

p. Verification of an applicant's hospital and clinical staff privileges and other professional experience for the past five years if requested by the board; and

q. A completed fingerprint packet to facilitate a national criminal history background check. The fee for evaluation of the fingerprint packet and the DCI and FBI criminal history background checks will be assessed to the applicant.

17.4(3) *Application cycle.* If the applicant does not submit all materials, including a completed fingerprint packet, within 90 days of the board's initial request for further information, the application is inactive.

a. To reactivate the application, an applicant shall submit a nonrefundable reactivation of application fee identified in 653—subrule 8.2(2) and shall update application materials if requested by the board. The period for requesting reactivation is limited to 30 days from the date the applicant is notified that the application is inactive, unless the applicant is granted an extension in writing by the committee or the board.

b. Once the application reactivation period is expired, applicants must reapply and submit a new, nonrefundable initial application fee and a new application, including required documents and credentials.

17.4(4) *Applicant responsibilities.* An applicant for licensure to practice acupuncture bears full responsibility for each of the following:

a. Paying all fees charged by regulatory authorities, national testing or credentialing organizations, health facilities, and educational institutions providing the information specified in subrule 17.4(2);

b. Providing accurate, up-to-date, and truthful information on the application form, including but not limited to that specified under subrule 17.4(2) related to prior professional experience, education, training, examination scores, diplomate status, licensure or registration, and disciplinary history; and

c. Submitting English translations of documents in foreign languages bearing the affidavit of the translator certifying that the translation is a true and complete translation of the foreign language original. The applicant shall bear the expense of the translation.

17.4(5) *Licensure application review process.* The process below is utilized to review each application. Priority is given to processing a licensure application when a written request is received in the board office from an applicant whose practice will primarily involve provision of services to underserved populations, including but not limited to persons who are minorities or low-income or who live in rural areas.

a. An application for initial licensure is considered open from the date the application form is received in the board office with the nonrefundable initial application fee.

b. After reviewing each application, staff will notify the applicant about how to resolve any problems identified by the reviewer. An applicant shall provide additional information when requested by staff or the board.

c. If the final review indicates no questions or concerns regarding the applicant's qualifications for licensure, staff may administratively grant the license. The staff may grant the license without having received a report on the applicant from the FBI.

d. If the final review indicates questions or concerns that cannot be remedied by continued communication with the applicant, the executive director, the director of licensure and the director of legal affairs will determine if the questions or concerns indicate any uncertainty about the applicant's current qualifications for licensure.

(1) If there is no current concern, staff will administratively grant the license.

(2) If any concern exists, the application will be referred to the committee.

e. Staff will refer to the committee for review matters that include but are not limited to: falsification of information on the application, criminal record, malpractice, substance abuse, competency, physical or mental illness, or professional disciplinary history.

f. If the committee is able to eliminate questions or concerns without dissension from staff or a committee member, the committee may direct staff to issue the license administratively.

g. If the committee is not able to eliminate questions or concerns without dissension from staff or a committee member, the committee will recommend that the board:

(1) Request an investigation;

(2) Request that the applicant appear for an interview;

(3) If an applicant has not engaged in active practice in the past three years in any jurisdiction of the United States, require an applicant to:

1. Successfully complete continuing education or retraining programs in areas directly related to the safe and healthful practice of acupuncture deemed appropriate by the board or committee;

2. Successfully pass a competency evaluation approved by the board;

3. Successfully pass an examination approved by the board; or

4. Successfully complete a reentry to practice program or monitoring program approved by the board;

(4) Issue a license;

(5) Issue a license under certain terms and conditions or with certain restrictions;

(6) Request that the applicant withdraw the licensure application; or

(7) Deny a license.

h. The board will consider applications and recommendations from the committee and will:

(1) Request an investigation;

(2) Request that the applicant appear for an interview;

(3) If an applicant has not engaged in active practice in the past three years in any jurisdiction of the United States, require an applicant to:

1. Successfully complete continuing education or retraining programs in areas directly related to the safe and healthful practice of acupuncture deemed appropriate by the board or committee;

2. Successfully pass a competency evaluation approved by the board;

3. Successfully pass an examination approved by the board; or

4. Successfully complete a reentry to practice program or monitoring program approved by the board;

(4) Issue a license;

(5) Issue a license under certain terms and conditions or with certain restrictions;

(6) Request that the applicant withdraw the licensure application; or

(7) Deny a license. The board may deny a license for any grounds on which the board may discipline a license.

17.4(6) *Grounds for denial of licensure.* The board, on the recommendation of the committee, may deny an application for licensure for any of the following reasons:

a. Failure to meet the requirements for licensure specified in rule 653—17.3(147,148E) as authorized by Iowa Code section 148E.2 or of this chapter.

b. Pursuant to Iowa Code section 147.4, upon any of the grounds for which licensure may be revoked or suspended as specified in Iowa Code sections 147.55 and 148E.8 or in 481—Chapter 8.

17.4(7) *Preliminary notice of denial.* Prior to the denial of licensure to an applicant, the board will issue a preliminary notice of denial that will be sent to the applicant by regular, first-class mail at the address provided by the applicant. The preliminary notice of denial is a public record and cites the factual

and legal basis for denying the application, notifies the applicant of the appeal process, and specifies the date upon which the denial will become final if it is not appealed.

17.4(8) *Appeal procedure.* An applicant who has received a preliminary notice of denial may appeal the denial and request a hearing on the issues related to the preliminary notice of denial by serving a request for hearing upon the executive director not more than 30 calendar days following the date when the preliminary notice of denial was mailed. The applicant's current address shall be provided in the request for hearing. The request is deemed filed on the date it is received in the board office. If the request is received with a USPS nonmetered postmark, the board will consider the postmark date as the date the request is filed. The request shall specify the factual or legal errors and that the applicant desires an evidentiary hearing and may provide additional written information or documents in support of licensure.

17.4(9) *Hearing.* If an applicant appeals the preliminary notice of denial and requests a hearing, the hearing will be a contested case open to the public and conducted in accordance with 481—Chapter 506.

17.4(10) *Finality.* If an applicant does not appeal a preliminary notice of denial in accordance with subrule 17.4(8), the preliminary notice of denial automatically becomes final. A final denial of an application for licensure is a public record.

17.4(11) *Failure to pursue appeal.* If an applicant appeals a preliminary notice of denial in accordance with subrule 17.4(8) but the applicant fails to pursue that appeal to a final decision within one year from the date of the preliminary notice of denial, the board may dismiss the appeal. The appeal may be dismissed only after the board sends a written notice by first-class mail to the applicant at the applicant's last-known address. The notice will state that the appeal will be dismissed and the preliminary notice of denial will become final if the applicant does not contact the board to schedule the appeal hearing within 30 days of the date the letter is mailed from the board office. Upon dismissal of an appeal, the preliminary notice of denial becomes final. A final denial of an application for licensure under this rule is a public record.

17.4(12) *Waiver prohibited.* Provisions of this rule are not subject to waiver pursuant to 481—Chapter 6 or any other provision of law.

[**ARC 9116C**, IAB 4/16/25, effective 5/21/25]

653—17.5(147,148E,272C) Biennial renewal of license required. Pursuant to Iowa Code section 148E.2, a license expires on October 31 of even-numbered years and can be renewed for the fee identified in 653—paragraph 8.2(2)*"c."* The applicant for renewal shall provide an NCCAOM certificate that demonstrates that the applicant holds current active status as a diplomate in acupuncture or oriental medicine from the NCCAOM.

17.5(1) *Expiration date.* Certificates of licensure to practice acupuncture expire on October 31 in even years.

17.5(2) *Prorated fees.* The first renewal fee for a license will be prorated on a monthly basis according to the date of issue.

17.5(3) *Renewal requirements and penalties for late renewal.* The licensee is responsible for renewing the license prior to its expiration. Failure of the licensee to receive notice does not relieve the licensee of responsibility for renewing that license.

a. Upon receipt of the completed renewal application, staff will administratively issue a license that expires on October 31 of even-numbered years. In the event the board receives adverse information on the renewal application, the board will issue the renewal license but may refer the adverse information for further consideration.

b. Every renewal shall be displayed in connection with the original certificate of licensure.

c. If the licensee fails to submit the renewal application and renewal fee prior to the expiration date on the current license, a penalty stated in 657—paragraph 8.2(2)*"g"* will be assessed for renewal in the grace period, a period up until January 1.

17.5(4) *Inactive license.* Failure of a licensee to renew by January 1 will result in inactivation of the license, and the license will be invalid.

a. Licensees are prohibited from engaging in the practice of acupuncture with an inactive or lapsed license.

b. Having an acupuncturist license in lapsed status does not preclude the board from taking disciplinary actions authorized in Iowa Code section 147.55 or 148E.8.

[**ARC 9116C**, IAB 4/16/25, effective 5/21/25]

653—17.6(147,272C) Reactivation of an inactive license.

17.6(1) *Reactivation requirements.* Licensees who allow their licenses to go inactive by failing to renew may apply for reactivation of a license. Pursuant to Iowa Code section 147.11, applicants for reactivation shall:

a. Submit completed application for reactivation of a license to practice acupuncture. The application shall include the following information:

(1) The applicant's full legal name, date and place of birth, home address, mailing address, principal business address, and personal email address regularly used by the applicant or licensee for correspondence with the board.

(2) Every jurisdiction in which the applicant is or has been authorized to practice, including license numbers and dates of issuance.

(3) Full disclosure of the applicant's involvement in civil litigation related to the practice of acupuncture in any jurisdiction of the United States, other nations or territories. Copies of the legal documents may be requested if needed during the review process.

(4) A statement disclosing and explaining any warnings issued, investigations conducted or disciplinary actions taken, whether by voluntary agreement or formal action, by a medical, acupuncture or professional regulatory authority, an educational institution, a training or research program, or a health facility in any jurisdiction.

(5) Verification of an applicant's hospital and clinical staff privileges and other professional experience for the past five years if requested by the board.

(6) A chronology accounting for all time periods from the date of initial licensure.

(7) A statement disclosing and explaining any charge of a misdemeanor or felony involving the applicant filed in any jurisdiction, whether or not any appeal or other proceeding is pending to have the conviction or plea set aside.

b. Submit a completed fingerprint packet to facilitate a national criminal history background check. The fee identified in 653—subrule 8.2(5) for the evaluation of the fingerprint packet and the DCI and FBI criminal history background checks will be assessed to the applicant.

c. Pay the reactivation fee identified in rule 653—8.2(147,148,272C) plus the fee identified in 653—subrule 8.2(5) for the evaluation of the fingerprint packet and the DCI and FBI criminal history background checks.

d. Provide an NCCAOM certificate which demonstrates that the applicant holds current active status as a diplomate in acupuncture or oriental medicine from the NCCAOM.

e. Meet any new requirements instituted since the license lapsed.

17.6(2) *Reactivation restrictions.* Pursuant to Iowa Code section 272C.3(2)*"d,"* the committee may require an applicant who has not engaged in active practice in the past three years in any jurisdiction of the United States to meet any or all of the following requirements prior to reactivation of a license:

a. Successfully complete continuing education or retraining programs in areas directly related to the safe and healthful practice of acupuncture deemed appropriate by the board or committee;

b. Successfully pass a competency evaluation approved by the board;

c. Successfully pass an examination approved by the board; or

d. Successfully complete a reentry to practice program or monitoring program approved by the board.

[**ARC 9116C**, IAB 4/16/25, effective 5/21/25]

653—17.7(272C) Continuing education requirements. Licensees shall demonstrate that they hold current active status as a diplomate from the NCCAOM. The NCCAOM requires 60 points of professional development activity every four years. Active NCCAOM certification satisfies the continuing education requirements established in Iowa Code section 272C.2.

[**ARC 9116C**, IAB 4/16/25, effective 5/21/25]

653—17.8(147,148E,272C) General provisions.

17.8(1) *Diagnostic and treatment modalities.* Diagnostic and treatment modalities used by licensees under this chapter may include one or more of the following acupunctural services:

a. The stimulation or piercing of the skin with an acupuncture needle for any of the following purposes:

(1) To evoke a therapeutic physiological response, either locally or distally to the area of insertion or stimulation.

(2) To relieve pain or treat the neuromusculoskeletal system.

(3) To stimulate ashi acupuncture points to relieve pain and dysfunction.

(4) To promote, maintain, and restore health and to prevent disease.

(5) To stimulate the body according to auricular, hand, nose, face, foot or scalp acupuncture therapy.

(6) To use acupuncture needles with or without the use of herbs, electric current, or application of heat.

b. The use of oriental medical diagnosis and treatment, including:

(1) Moxibustion, cupping, thermal methods, magnets, gua sha scraping techniques, acupatches, herbal poultices, hot and cold packs, electromagnetic wave therapy, light and color therapy, sound therapy, or therapy lasers.

(2) Massage, acupressure, reflexology, shiatsu and tui na massage, or manual stimulation, including stimulation by an instrument or mechanical device that does not pierce the skin.

(3) Herbal medicine and dietary supplements, including those of plant, mineral, animal, and nutraceutical origin.

c. Any other adjunctive service or procedure that is clinically appropriate based on the licensee's training as approved by NCCAOM or ACAOM.

17.8(2) *Use and disposal of needles.* A licensee shall use only presterilized, disposable needles and shall provide for the disposal of used needles in accordance with the requirements of the department.

17.8(3) *Standard of care.* A licensee shall be held to the same standard of care as persons licensed to practice medicine and surgery or osteopathic medicine and surgery. Pursuant to Iowa Code section 272C.3, any error or omission, unreasonable lack of skill, or failure to maintain a reasonable standard of care in the practice of acupuncture constitutes malpractice and is grounds for the revocation or suspension of a license to practice acupuncture in this state.

17.8(4) *Title.* An acupuncturist licensed under this title may use the words "licensed acupuncturist" or "L.Ac." to connote professional standing after the licensee's name in accordance with Iowa Code section 147.74(18).

17.8(5) *Change of contact information.* Licensees shall notify the board of changes in home address, address of the place of practice, home or practice telephone number, or personal email address regularly used by the applicant or licensee for correspondence with the board within one month of the change.

17.8(6) *Delegation of responsibilities.* A licensee shall perform all aspects of acupuncture treatment that involve penetration of the skin of a patient. The licensee may delegate other aspects of treatment to staff and patients who are properly trained by the licensee. It is permissible for appropriately trained staff and patients to remove acupuncture needles from the patient's body. The licensee is responsible for establishing and maintaining written training standards for staff.

17.8(7) *Change of full legal name.* A licensee shall notify the board of any change in the licensee's full legal name within one month of making the name change. Notification requires a notarized copy of a marriage license or a notarized copy of court documents.

17.8(8) *Deceased.* A licensee's file will be closed and labeled "deceased" when the board receives a copy of the licensee's death certificate or other reliable information of the licensee's death.

[**ARC 9116C**, IAB 4/16/25, effective 5/21/25]

These rules are intended to implement Iowa Code chapter 148E and sections 17A.10 through 17A.20, 147.55, 272C.3 through 272C.6, 272C.8 and 272C.9.

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◊ Two or more ARCs

CHAPTER 18
MILITARY SERVICE AND VETERAN RECIPROCITY
Rescinded **ARC 9110C**, IAB 4/16/25, effective 5/21/25

CHAPTER 19
PRESCRIBING PSYCHOLOGISTS

Chapter rescission date pursuant to Iowa Code section 17A.7: 5/21/30

653—19.1(148,154B) Joint rules adopted. The board of medicine adopts and incorporates the following rules as its own: 481—883.1(148,154B), 481—883.3(148,154B), 481—883.4(148,154B), 481—883.6(148,154B) through 481—883.8(148,154B), and 481—883.11(148,154B) through 481—883.13(148,154B).

[**ARC 9117C**, IAB 4/16/25, effective 5/21/25]

653—19.2(17A,124,147,148,154B,272C) Standards of practice—supervision of a conditional prescribing psychologist. A supervising physician shall be a person who is licensed to practice medicine and surgery or osteopathic medicine in Iowa who regularly prescribes psychotropic medications for the treatment of mental disorders as part of the physician's normal course of practice and who supervises a conditional prescribing psychologist. A supervising physician shall be board-certified in family medicine, internal medicine, neurology, pediatrics, or psychiatry. A supervising physician shall fully comply with the following standards of practice:

19.2(1) *Supervision.* During supervised practice, a supervising physician oversees a conditional prescribing psychologist to ensure patient safety and optimal outcomes. This includes ensuring proper clinical examinations, necessary testing, and appropriate psychopharmacology services for the patient's condition. Supervision can occur in person or electronically according to these rules.

19.2(2) *Primary supervising physician.* A supervising physician shall determine whether the supervising physician has been designated as a conditional prescribing psychologist's primary supervising physician and fulfills the responsibilities of the primary supervising physician in accordance with these rules. A conditional prescribing psychologist may have more than one supervising physician.

19.2(3) *Maximum number of conditional prescribing psychologists.* A supervising physician cannot supervise more than two conditional prescribing psychologists at one time.

19.2(4) *Minimum period of supervision.* The primary supervising physician shall ensure that a conditional prescribing psychologist completes a minimum of two years of supervised practice prescribing psychotropic medications to patients with mental disorders in accordance with these rules in order for the conditional prescribing psychologist to be eligible to apply for a prescription certificate.

19.2(5) *Minimum number of patients.* The primary supervising physician shall ensure that a conditional prescribing psychologist has seen a minimum of 300 patients who had a diagnosed mental disorder for whom pharmacological intervention was considered as a treatment option, even if a decision was made not to prescribe a psychotropic medication to the patient. The primary supervising physician shall ensure that a conditional prescribing psychologist has treated a minimum of 100 patients with psychotropic medication throughout the supervised practice period.

19.2(6) *Initial assessment.* Prior to supervising a conditional prescribing psychologist, each supervising physician shall assess the conditional prescribing psychologist's relevant education, training, experience, and competence.

19.2(7) *Scope of practice.* Each supervising physician shall ensure that all psychopharmacology services provided by a conditional prescribing psychologist are within the competence and scope of practice of the supervising physician and the conditional prescribing psychologist.

19.2(8) *Prescriptive authority.* Each supervising physician shall ensure that a conditional prescribing psychologist only prescribes psychotropic medications for the treatment of mental disorders.

19.2(9) *Prescriptions.* A supervising physician shall ensure that each prescription issued by a conditional prescribing psychologist identifies the prescriber as a "psychologist certified to prescribe" and includes the Iowa license number of the conditional prescribing psychologist and the name of the supervising physician.

19.2(10) *Active DEA and CSA registration.* A supervising physician shall ensure that a conditional prescribing psychologist has an active DEA registration and CSA registration at all times during the period of supervision.

19.2(11) *Patient populations.* A supervising physician shall ensure that a conditional prescribing psychologist only provides psychopharmacology services to patient populations within the conditional prescribing psychologist's education, training, experience, and competence. A supervising physician may establish limitations on the types of populations to whom a conditional prescribing psychologist may provide psychopharmacology services based on the conditional prescribing psychologist's education, training, experience, and competence.

19.2(12) *Psychotropic medications.* A supervising physician shall ensure that a conditional prescribing psychologist only prescribes psychotropic medications that are within the conditional prescribing psychologist's education, training, experience, and competence. A supervising physician may establish limitations on the types of psychotropic medications that a conditional prescribing psychologist may prescribe based on the conditional prescribing psychologist's education, training, experience, and competence.

19.2(13) *Specialization.* A supervising physician shall ensure that a conditional prescribing psychologist has completed the following training during the supervised practice period to be eligible to prescribe psychotropic medications to the respective population as a prescribing psychologist:

a. Children. To prescribe to patients who are less than 17 years of age, a conditional prescribing psychologist shall complete at least one year of the required two years of supervised practice in either:

(1) A pediatric practice,

(2) A child and adolescent practice, or

(3) A general practice provided the conditional prescribing psychologist treats a minimum of 50 patients who are less than 17 years of age.

b. Elderly patients. To prescribe to patients who are over 65 years of age, a conditional prescribing psychologist shall complete at least one year of the required two years of supervised practice in either:

(1) A geriatric practice, or

(2) A general practice with patients across the lifespan including patients who are over 65 years of age.

c. Serious medical conditions. To prescribe to patients with serious medical conditions, including but not limited to heart disease, cancer, stroke, seizures, or comorbid psychological conditions, or patients with developmental disabilities and intellectual disabilities, a supervising physician shall ensure that a conditional prescribing psychologist has completed at least one year prescribing psychotropic medications to patients with serious medical conditions if the conditional prescribing psychologist intends to treat patients with serious medical conditions after the supervised practice period.

19.2(14) *Informed consent.* A supervising physician shall ensure that a conditional prescribing psychologist obtains appropriate informed consent before the conditional prescribing psychologist provides psychopharmacology services to a patient.

19.2(15) *Release of information.* A supervising physician shall ensure that a conditional prescribing psychologist obtains a release of information authorizing the conditional prescribing psychologist to share information with the supervising physician before the conditional prescribing psychologist provides psychopharmacology services to a patient.

19.2(16) *Primary care physician.* A supervising physician shall ensure that each patient has a designated primary care physician before a conditional prescribing psychologist provides psychopharmacology services to a patient. A supervising physician shall ensure that a conditional prescribing psychologist maintains a cooperative relationship with the primary care physician who oversees a patient's general medical care to ensure that necessary medical examinations are conducted, the psychotropic medication is appropriate for the patient's medical condition, and significant changes in the patient's medical or psychological condition are discussed. A supervising physician shall ensure that a conditional prescribing psychologist engages in appropriate consultation with a patient's designated primary care physician while the conditional prescribing psychologist is providing psychopharmacology services to a patient.

19.2(17) *Chart reviews.* A supervising physician shall personally review a representative sample of the conditional prescribing psychologist's patient charts.

19.2(18) *Performance evaluations.* A supervising physician shall regularly evaluate the clinical judgment, skills and performance of a conditional prescribing psychologist to safely provide psychopharmacology services to patients and provide appropriate feedback to the conditional prescribing psychologist.

19.2(19) *Supervision plan.* Before supervising a conditional prescribing psychologist, a supervising physician must ensure there is an approved written supervision plan. This plan should outline the supervisory relationship, including review parameters, and consider both parties' education, training, and experience and the psychopharmacology services involved. A template is available from the boards of medicine and psychology. Both the supervising physician and the psychologist must keep a copy of the plan and provide it to the boards if requested. The supervision plan shall include the following:

a. Conditional prescribing psychologist's information. The name, license number, address, telephone number, and email address of the conditional prescribing psychologist.

b. Supervising physician's information. The name, license number, DEA registration number, CSA registration number, address, telephone number, email address, and practice locations of the supervising physician.

c. Designation of the primary supervising physician. Designation of the conditional prescribing psychologist's primary supervising physician.

d. Period of supervision. The beginning date of the supervision plan and estimated date of completion.

e. Locations and settings. A description of the locations and settings where and with whom supervision will occur.

f. Scope of practice. A description of the scope of practice of the supervising physician and the conditional prescribing psychologist.

g. Methods of communication. A description of how the supervising physician and conditional psychologist may communicate for appropriate supervision.

h. Initial assessment. A description of the steps the supervising physician has taken to assess a conditional prescribing psychologist's relevant education, training, experience, and competence prior to supervising the conditional prescribing psychologist.

i. Limitations on psychotropic medications. A description of any limitations on the types of psychotropic medications the conditional prescribing psychologist may prescribe consistent with the supervising physician's and prescribing psychologist's relevant education, training, experience, and competence.

j. Limitations on patient populations. A description of any limitations on the types of populations the conditional prescribing psychologist may treat with psychotropic medications consistent with the supervising physician's and prescribing psychologist's relevant education, training, experience, and competence.

k. Expectations and responsibilities. A description of the expectations and responsibilities of the supervisory relationship.

l. Specialization. A description of the specialized training to be completed by the conditional prescribing psychologist in order to provide psychopharmacology services to children (less than 17 years of age), elderly persons (over 65 years of age), or patients with serious medical conditions, including but not limited to heart disease, cancer, stroke, seizures, or comorbid psychological conditions, or patients with developmental disabilities and intellectual disabilities in accordance with rule 481—883.4(148,154B).

m. Chart reviews. A description of the steps the supervising physician has taken to personally review a representative sample of the conditional prescribing psychologist's patient charts.

n. Consultation between the supervising physician and the primary care physician. A requirement that the supervising physician consult with the patient's primary care physician on a regular basis regarding the patient's psychotropic treatment plan and any potential complications.

o. Performance evaluations. A description of the steps the supervising physician has taken to regularly evaluate the clinical judgment, skills and performance of a conditional prescribing psychologist to safely provide psychopharmacology services to patients and provide appropriate feedback to the conditional prescribing psychologist.

p. Termination of the supervision plan. A description of how the supervision plan may be terminated and the process for notifying affected patients.

q. Signatures. Signatures of the conditional prescribing psychologist and all supervising physicians.

r. Amendment to the supervision plan. A requirement that a conditional prescribing psychologist shall inform the board of psychology of any amendments to the supervision plan, including the addition of any supervising physicians, within 30 days of the change and that any amendment to a supervisory plan be subject to approval of the board of psychology.

s. Request for extension. If the primary supervising physician determines that a conditional prescribing psychologist is unable to successfully complete the supervised practice prior to the expiration of the conditional prescription certificate, the conditional prescribing psychologist may request an extension of the conditional prescription certificate provided that the conditional prescribing psychologist and the primary supervising physician can demonstrate that the conditional prescribing psychologist is likely to successfully complete the supervised practice within the extended time requested.

19.2(20) *Certification of completion.* At the conclusion of the supervised practice period, the primary supervising physician shall certify the following:

a. Supervision. That each supervising physician has provided supervision to the conditional prescribing psychologist in accordance with these rules.

b. Minimum period of supervised practice. That the conditional prescribing psychologist has successfully completed a minimum of two years of supervised practice.

c. Minimum number of patients. That the conditional prescribing psychologist has seen a minimum of 300 patients who had a diagnosed mental disorder with whom pharmacological intervention was considered as a treatment option, even if a decision was made not to prescribe a psychotropic medication to the patient, and that the conditional prescribing psychologist has treated a minimum of 100 patients with psychotropic medication throughout the supervised practice period.

d. Specialization. That a conditional prescribing psychologist who intends to provide psychopharmacology services to children (less than 17 years of age), elderly persons (over 65 years of age), or patients with serious medical conditions, including but not limited to heart disease, cancer, stroke, seizures, or comorbid psychological conditions, or patients with developmental disabilities and intellectual disabilities, has successfully completed a minimum of one year of supervised practice with the respective populations during the supervised practice period.

e. Demonstrated competence. That a conditional prescribing psychologist has successfully completed the supervised practice period and demonstrated competence in psychopharmacology by demonstrating competency in the milestones sufficient to obtain a prescription certificate in accordance with 481—subrule 883.3(2).

[**ARC 9117C**, IAB 4/16/25, effective 5/21/25]

653—19.3(17A,124,147,148,154B,272C) Standards of practice—collaboration with a prescribing psychologist. A collaborating physician shall be a person who is licensed to practice medicine and surgery or osteopathic medicine in Iowa, who regularly prescribes psychotropic medications for the treatment of mental disorders as part of the physician's normal course of practice, and who serves as a resource for a prescribing psychologist pursuant to a collaborative practice agreement. A collaborating physician shall be board-certified in family medicine, internal medicine, neurology, pediatrics, or psychiatry. A collaborating physician shall fully comply with the following standards of practice:

19.3(1) *Collaboration.* A collaborating physician shall provide appropriate collaboration with a prescribing psychologist to achieve patient safety and optimal clinical outcomes. A collaborating physician shall ensure that appropriate clinical examinations and necessary testing are performed and that all psychopharmacology services provided are appropriate for the patient's condition. Collaboration may be in person or via electronic communications in accordance with these rules. A prescribing psychologist may have more than one collaborating physician.

19.3(2) *Maximum number of prescribing psychologists.* A physician shall not serve as a collaborating physician for more than two prescribing psychologists at one time.

19.3(3) *Initial assessment.* Prior to serving as a collaborating physician, a physician shall assess a prescribing psychologist's relevant education, training, experience, and competence.

19.3(4) *Scope of practice.* A collaborating physician shall ensure that all psychopharmacology services provided by a prescribing psychologist are within the competence and scope of practice of the collaborating physician and the prescribing psychologist.

19.3(5) *Prescriptive authority.* A collaborating physician shall ensure that a prescribing psychologist only prescribes psychotropic medications for the treatment of mental disorders.

19.3(6) *Delegation.* A collaborating physician shall ensure that a prescribing psychologist does not delegate prescriptive authority to any other person.

19.3(7) *Narcotics.* A collaborating physician shall ensure that a prescribing psychologist does not prescribe narcotics.

19.3(8) *Active DEA and CSA registration.* A collaborating physician shall ensure that a prescribing psychologist has an active DEA registration and CSA registration at all times during the period of collaboration.

19.3(9) *Patient populations.* A collaborating physician shall ensure that a prescribing psychologist only provides psychopharmacology services to patient populations within the prescribing psychologist's education, training, experience, and competence. A collaborating physician may establish limitations on the types of populations to whom a prescribing psychologist may provide psychopharmacology services based on the prescribing psychologist's education, training, experience, and competence.

19.3(10) *Psychotropic medications.* A collaborating physician shall ensure that a prescribing psychologist only prescribes psychotropic medications that are within the prescribing psychologist's education, training, experience, and competence. A collaborating physician may establish limitations on the types of psychotropic medications that a prescribing psychologist may prescribe based on the prescribing psychologist's education, training, experience, and competence.

19.3(11) *Specialization.* A collaborating physician shall ensure that a prescribing psychologist has completed at least one year of the required two years of supervised practice with the respective population in accordance with rule 481—883.4(148,154B) before the prescribing psychologist provides psychopharmacology services to children (less than 17 years of age), elderly persons (over 65 years of age), or patients with serious medical conditions, including but not limited to, heart disease, cancer, stroke, seizures, or comorbid psychological conditions, or patients with developmental disabilities and intellectual disabilities.

19.3(12) *Informed consent.* A collaborating physician shall ensure that a prescribing psychologist obtains appropriate informed consent before a prescribing psychologist provides psychopharmacology services to a patient.

19.3(13) *Release of information.* A collaborating physician shall ensure that a prescribing psychologist obtains a release of information authorizing the prescribing psychologist to share information with the collaborating physician before the prescribing psychologist provides psychopharmacology services to a patient.

19.3(14) *Primary care physician.* A collaborating physician shall ensure that each patient has a designated primary care physician before a prescribing psychologist provides psychopharmacology services to a patient. A collaborating physician shall ensure that a prescribing psychologist maintains a cooperative relationship with the primary care physician who oversees a patient's general medical care to ensure that necessary medical examinations are conducted, the psychotropic medication is appropriate for the patient's medical condition, and significant changes in the patient's medical or psychological condition are discussed. A collaborating physician shall ensure that a prescribing psychologist engages in appropriate consultation with a patient's designated primary care physician while the prescribing psychologist is providing psychopharmacology services to a patient.

19.3(15) *Chart reviews.* A collaborating physician shall personally review a representative sample of the prescribing psychologist's patient charts.

19.3(16) *Performance evaluations.* A collaborating physician shall regularly evaluate the clinical judgment, skills and performance of a prescribing psychologist to safely provide psychopharmacology services to patients and provide appropriate feedback to the prescribing psychologist.

19.3(17) *Collaborative practice agreement.* Prior to serving as a collaborating physician for a prescribing psychologist, the collaborating physician shall ensure that the prescribing psychologist has a

written collaborative practice agreement in place. A template may be obtained from the boards of medicine and psychology. The collaborative practice agreement shall define the nature and extent of the collaborative relationship and outline specific parameters for review of the collaborative relationship. The collaborative practice agreement shall take into account the collaborating physician's and prescribing psychologist's relevant education, training, experience, and competence and the nature and scope of the psychopharmacology services to be provided. The collaborating physician shall review the terms of the collaborative practice agreement with the prescribing psychologist at least once each year. The collaborating physician and prescribing psychologist shall each maintain a copy of the collaborative practice agreement and provide a copy of the agreement to the boards of medicine and psychology upon request. The collaborative practice agreement shall include the following:

a. Prescribing psychologist's information. The name, license number, DEA registration number, CSA registration number, address, telephone number, email address, and practice locations of the prescribing psychologist.

b. Collaborating physician's information. The name, license number, DEA registration number, CSA registration number, address, telephone number, email address, and practice locations of the collaborating physician.

c. Period of collaboration. The time period covered by the collaborative practice agreement.

d. Locations and settings. A description of the locations and settings where and with whom collaborative practice will occur.

e. Scope of practice. A description of the scope of practice of the collaborating physician and the prescribing psychologist.

f. Methods of communication. A description of how the collaborating physician and prescribing psychologist may communicate for appropriate collaboration.

g. Initial assessment. A description of the steps the collaborating physician has taken to assess a prescribing psychologist's relevant education, training, experience, and competence prior to collaborating with a prescribing psychologist.

h. Limitations on psychotropic medications. A description of any limitations on the types of psychotropic medications the prescribing psychologist may prescribe consistent with the collaborating physician's and prescribing psychologist's relevant education, training, experience, and competence.

i. Limitations on patient populations. A description of any limitations on the types of populations the prescribing psychologist may treat with psychotropic medications consistent with the collaborating physician's and prescribing psychologist's relevant education, training, experience, and competence.

j. Expectations and responsibilities. A description of the expectations and responsibilities of the collaborative relationship.

k. Specialization. A description of the specialized training the prescribing psychologist has completed in order to provide psychopharmacology services to children (less than 17 years of age), elderly persons (over 65 years of age), or patients with serious medical conditions, including but not limited to, heart disease, cancer, stroke, seizures, or comorbid psychological conditions, or patients with developmental disabilities and intellectual disabilities in accordance with rule 481—883.4(148,154B).

l. Chart reviews. A description of the steps the collaborating physician has taken to personally review a representative sample of the prescribing psychologist's patient charts.

m. Consultation between the collaborating physician and the primary care provider. A requirement that the collaborating physician consult with the patient's primary care physician on a regular basis regarding the patient's psychotropic treatment plan and any potential complications.

n. Performance evaluations. A description of the steps the collaborating physician has taken to regularly evaluate the clinical judgment, skills and performance of the prescribing psychologist to safely provide psychopharmacology services to patients and provide appropriate feedback to the prescribing psychologist.

o. Termination of the collaborative practice agreement. A provision describing how the collaborative practice agreement may be terminated and the process for notifying affected patients.

p. Signatures. Signatures of the collaborating physician and the prescribing psychologist.

[**ARC 9117C**, IAB 4/16/25, effective 5/21/25]

653—19.4(17A,124,147,148,272C) Grounds for discipline. A physician who fails to comply with these rules may be subject to disciplinary action by the board of medicine.

[**ARC 9117C**, IAB 4/16/25, effective 5/21/25]

These rules are intended to implement Iowa Code chapters 148 and 154B.

[Filed ARC 4249C (Notice ARC 3905C, IAB 8/1/18), IAB 1/16/19, effective 2/20/19]
[Filed ARC 4835C (Notice ARC 4663C, IAB 9/25/19), IAB 12/18/19, effective 1/22/20]
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[Filed ARC 9117C (Notice ARC 8693C, IAB 12/25/24), IAB 4/16/25, effective 5/21/25]

CHAPTER 20
LICENSURE OF GENETIC COUNSELORS

Chapter rescission date pursuant to Iowa Code section 17A.7: 5/21/30

653—20.1(148H) Scope of chapter. This chapter does not apply to any of the following:

1. A physician or surgeon or an osteopathic physician or surgeon licensed under Iowa Code chapter 148, a registered nurse or an advanced registered nurse practitioner licensed under Iowa Code chapter 152, a physician assistant licensed under Iowa Code chapter 148C, or other persons licensed under Iowa Code chapter 147 when acting within the scope of the person's profession and doing work of a nature consistent with the person's education and training.
2. A person who is certified by the American Board of Medical Genetics and Genomics as a doctor of philosophy and is not a genetic counselor licensed pursuant to Iowa Code chapter 148H.
3. A person employed as a genetic counselor by the federal government or an agency thereof if the person provides genetic counseling services solely under the direction and control of the entity by which the person is employed.
4. A genetic counseling intern.

[**ARC 9118C**, IAB 4/16/25, effective 5/21/25]

653—20.2(148H) Definitions. The definitions stated in Iowa Code chapter 148H, in addition to those listed below, apply to this chapter.

"American Board of Genetic Counseling" or *"ABGC"* means the United States-based commission, or its equivalent or successor organization, that validates entry-level competency in the practice of genetic counseling through professional certification.

"American Board of Medical Genetics and Genomics" or *"ABMGG"* means the United States-based commission, or its equivalent or successor organization, that validates entry-level competency in the practice of genetic counseling through professional certification.

[**ARC 9118C**, IAB 4/16/25, effective 5/21/25]

653—20.3(148H) Titles used. A genetic counselor licensed under Iowa Code chapter 148H may use the words "genetic counselor" or "licensed genetic counselor" or the corresponding abbreviation "LGC" after the person's name. Persons who possess a provisional license shall add the designation "provisional licensed genetic counselor."

[**ARC 9118C**, IAB 4/16/25, effective 5/21/25]

653—20.4(148H) Qualifications for licensure.

20.4(1) Each applicant for licensure under Iowa Code chapter 148H shall:

a. Submit an application form and supporting documentation.

b. Hold active certification as a genetic counselor by the American Board of Genetic Counseling, as a genetic counselor by the American Board of Medical Genetics and Genomics, or as a medical geneticist by the American Board of Medical Genetics and Genomics, or the successor to any of the aforementioned organizations.

20.4(2) A licensee shall maintain active certification as a genetic counselor by the American Board of Genetic Counseling, as a genetic counselor by the American Board of Medical Genetics and Genomics, or as a medical geneticist by the American Board of Medical Genetics and Genomics, or the successor to any of the aforementioned organizations.

[**ARC 9118C**, IAB 4/16/25, effective 5/21/25]

653—20.5(148H) Qualifications for provisional licensure. The board may issue a provisional license to an applicant who meets all of the requirements for licensure except for the certification component and who has been granted active candidate status by the American Board of Genetic Counseling or the American Board of Medical Genetics and Genomics.

20.5(1) The applicant shall submit a provisional license application form, proof of active candidate status, and supporting documentation prescribed by the board.

20.5(2) A provisional license expires and becomes inactive upon the earliest of the following:

a. Issuance of a license as a genetic counselor by the board.

b. Loss of active candidate status.

(1) A person holding a provisional license that is inactive due to loss of active candidate status may submit an application for reactivation of the provisional license upon demonstrating that active candidate status has been reestablished.

(2) An application for extension of a provisional license shall be signed by a qualified supervisor.

c. The date printed on the provisional license.

20.5(3) A person with a provisional license shall work at all times under the supervision of a qualified supervisor.

[**ARC 9118C**, IAB 4/16/25, effective 5/21/25]

653—20.6(147,148H) Application requirements.

20.6(1) *Application for licensure.* To apply for a license to practice genetic counseling, an applicant shall:

a. Submit the completed application, including required credentials and documents, a completed fingerprint packet, and a sworn statement by the applicant attesting to the truth of all information provided by the applicant;

b. Pay the nonrefundable initial application fee identified in 653—subrule 8.13(1) and pay the fee identified in 653—subrule 8.13(6) for the evaluation of the fingerprint packet and the national criminal history background checks by the division of criminal investigation (DCI) and the Federal Bureau of Investigation (FBI).

20.6(2) *Contents of the application form.* Each applicant shall submit the following information on the application form provided by the board:

a. The applicant's full legal name, date and place of birth, home address, mailing address, principal business address, and personal email address regularly used by the applicant or licensee for correspondence with the board;

b. A chronology accounting for all time periods from the date the applicant entered a genetic counseling training program or educational institution to the date of the application;

c. The other jurisdictions in the United States or other nations or territories in which the applicant is authorized to practice genetic counseling, including license, certificate of registration or certification number and date of issuance;

d. Full disclosure of the applicant's involvement in civil litigation related to the practice of genetic counseling in any jurisdiction of the United States or other nations or territories. Copies of the legal documents may be requested if needed during the review process;

e. A statement disclosing and explaining any informal or nonpublic actions, such as letters of warning, letters of education, any confidential retraining, or any kind of confidential action taken toward a genetic counselor's certification or license that is not public discipline; warnings issued, investigations conducted, or disciplinary actions taken, whether by voluntary agreement or formal action, by a medical, genetic counseling or professional regulatory authority, an educational institution, a training or research program, or a health facility in any jurisdiction;

f. A statement disclosing and explaining any charge of a misdemeanor or felony involving the applicant filed in any jurisdiction, whether or not any appeal or other proceeding is pending to have the conviction or plea set aside;

g. A letter sent directly from the ABGC or ABMGG to the board verifying the applicant holds active certification in genetic counseling by the ABGC or ABMGG for genetic counselor licensure or a letter sent directly from ABGC or ABMGG to the board verifying the applicant has been granted active candidate status for provisional licensure;

h. A completed fingerprint packet to facilitate a national criminal history background check. The fee for evaluation of the fingerprint packet and the DCI and FBI criminal history background checks will be assessed to the applicant.

20.6(3) *Application cycle.* If the applicant does not submit all materials within 90 days of the board's initial request for further information, the application is inactive.

a. To reactivate the application, an applicant shall submit a nonrefundable reactivation of application fee identified in 653—subrule 8.13(2) and shall update application materials if requested by the board. The period for requesting reactivation is limited to 30 days from the date the applicant is notified that the application is inactive, unless the applicant is granted an extension in writing by the committee or the board.

b. Once the application reactivation period is expired, an applicant must reapply and submit a new, nonrefundable initial application fee and a new application, including required documents and credentials.

20.6(4) *Applicant responsibilities.* An applicant for licensure to practice genetic counseling bears full responsibility for each of the following:

a. Paying all fees charged by regulatory authorities, national certifying organizations, health facilities, and educational institutions providing the information specified in subrule 20.6(2);

b. Providing accurate, up-to-date, and truthful information on the application form including but not limited to that specified under subrule 20.6(2) related to prior professional experience, education, training, active certification, licensure, and disciplinary history.

20.6(5) *Licensure application review process.* Licensure applications will be reviewed pursuant to the process outlined in rule 653—9.7(147,148).

20.6(6) *Grounds for denial of licensure.* The board, on the recommendation of the committee, and after consultation with an Iowa-licensed genetic counselor, may deny an application for licensure for any of the following reasons:

a. Failure to meet the requirements for licensure specified in this chapter pursuant to Iowa Code section 148H.3.

b. Pursuant to Iowa Code section 147.4, upon any of the grounds for which licensure may be revoked or suspended as specified in Iowa Code sections 147.55 and 148H.7 or in rule 653—20.20(147,148H,272C).

20.6(7) *Preliminary notice of denial.* Prior to the denial of licensure to an applicant, the board issues a preliminary notice of denial that is sent to the applicant by regular, first-class mail at the address provided by the applicant. The preliminary notice of denial is a public record and cites the factual and legal basis for denying the application, notifies the applicant of the appeal process, and specifies the date upon which the denial will become final if it is not appealed.

20.6(8) *Appeal procedure.* An applicant who has received a preliminary notice of denial may appeal the denial and request a hearing on the issues related to the preliminary notice of denial by serving a request for hearing upon the executive director not more than 30 calendar days following the date when the preliminary notice of denial was mailed. The applicant's current address shall be provided in the request for hearing. The request is deemed filed on the date it is received in the board office. If the request is received with a USPS nonmetered postmark, the board considers the postmark date as the date the request is filed. The request shall specify the factual or legal errors and that the applicant desires an evidentiary hearing and may provide additional written information or documents in support of licensure.

20.6(9) *Hearing.* If an applicant appeals the preliminary notice of denial and requests a hearing, the hearing will be a contested case open to the public and conducted in accordance with 481—Chapter 506.

20.6(10) *Finality.* If an applicant does not appeal a preliminary notice of denial in accordance with subrule 20.6(8), the preliminary notice of denial automatically becomes final. A final denial of an application for licensure is a public record.

20.6(11) *Failure to pursue appeal.* If an applicant appeals a preliminary notice of denial in accordance with subrule 20.6(8) but the applicant fails to pursue that appeal to a final decision within one year from the date of the preliminary notice of denial, the board may dismiss the appeal. The appeal may be dismissed only after the board sends a written notice by first-class mail to the applicant at the applicant's last-known address. The notice will state that the appeal will be dismissed and the preliminary notice of denial will become final if the applicant does not contact the board to schedule the appeal hearing within 30 days of the date the letter is mailed from the board office. Upon dismissal of an appeal, the preliminary notice of denial becomes final. A final denial of an application for licensure under this rule is a public record.

20.6(12) *Waiver prohibited.* Provisions of this rule are not subject to waiver pursuant to 653—Chapter 3 or any other provision of law.
[**ARC 9118C**, IAB 4/16/25, effective 5/21/25]

653—20.7(147,148H) Display of license and notification required to change the board's data system.

20.7(1) *Display of license.* Licensed genetic counselors shall display the license issued by the board in a conspicuous place in their primary place of business.

20.7(2) *Change of contact information.* Licensees shall notify the board within one month of a change in home address, address of the place of practice, home or practice telephone number, or personal email address regularly used by the applicant or licensee for correspondence with the board.

20.7(3) *Change of full legal name.* A licensee shall notify the board of any change in the licensee's full legal name within one month of making the name change. Notification requires a notarized copy of a marriage license or a notarized copy of court documents.

20.7(4) *Deceased.* A licensee's file will be closed and labeled "deceased" when the board receives a copy of the licensee's death certificate or other reliable information of the licensee's death.
[**ARC 9118C**, IAB 4/16/25, effective 5/21/25]

653—20.8(147,148H,272C) Biennial renewal of license required. Pursuant to Iowa Code section 148H.3, a license expires on October 31 of odd-numbered years and can be renewed for the fee identified in 653—paragraph 8.14(2)*"c."*

20.8(1) *Application.* The applicant for renewal shall provide:

a. A renewal application.

b. A letter sent directly from the ABGC or ABMGG to the board verifying that the applicant holds active certification in genetic counseling by the ABGC or ABMGG for genetic counselor licensure or a letter sent directly from ABGC or ABMGG to the board verifying the applicant has been granted active candidate status for provisional licensure.

c. Satisfactory evidence to the board that in the period since the license was issued or last renewed, the applicant has completed 30 hours of National Society of Genetic Counselors or ABMGG continuing education units as approved by the board.

20.8(2) *Expiration date.* Certificates of licensure to practice genetic counseling expire on October 31 in odd years.

20.8(3) *Prorated fees.* The first renewal fee for a license will be prorated on a monthly basis according to the date of issue.

20.8(4) *Renewal requirements and penalties for late renewal.* The licensee is responsible for renewing the license prior to its expiration. Failure of the licensee to receive notice does not relieve the licensee of responsibility for renewing that license.

a. Upon receipt of the completed renewal application, staff will administratively issue a license that expires on October 31 of odd-numbered years. In the event the board receives adverse information on the renewal application, the board will issue the renewal license but may refer the adverse information for further consideration.

b. Every renewal shall be displayed in connection with the original certificate of licensure.

c. If the licensee fails to submit the renewal application and renewal fee prior to the expiration date on the current license, a penalty fee identified in 653—subrule 8.13(4) will be assessed for renewal in the grace period, a period up until January 1.

20.8(5) *Inactive license.* Failure of a licensee to renew by January 1 will result in inactivation of the license, and the license will become invalid.

a. Licensees are prohibited from engaging in the practice of genetic counseling with an inactive or lapsed license.

b. Having a genetic counselor license in inactive or lapsed status does not preclude the board from taking disciplinary actions authorized in Iowa Code section 147.55 or 148H.7.
[**ARC 9118C**, IAB 4/16/25, effective 5/21/25]

653—20.9(147,272C) Reactivation of an inactive license.

20.9(1) *Reactivation requirements.* Licensees who allow their licenses to go inactive by failing to renew may apply for reactivation of a license. Pursuant to Iowa Code section 147.11, applicants for reactivation shall:

a. Submit a completed application for reactivation of a license to practice genetic counseling. The application shall include the following information:

(1) The applicant's full legal name, date and place of birth, home address, mailing address, principal business address, and personal email address regularly used by the applicant or licensee for correspondence with the board.

(2) Every jurisdiction in which the applicant is or has been authorized to practice, including license numbers and dates of issuance.

(3) Full disclosure of the applicant's involvement in civil litigation related to the practice of genetic counseling in any jurisdiction of the United States or other nations or territories. Copies of the legal documents may be requested if needed during the review process.

(4) A statement disclosing and explaining any warnings issued, investigations conducted or disciplinary actions taken, whether by voluntary agreement or formal action, by a medical, genetic counseling or professional regulatory authority; an educational institution; a training or research program; or a health facility in any jurisdiction.

(5) Verification of an applicant's hospital and clinical staff privileges and other professional experience for the past five years if requested by the board.

(6) A chronology accounting for all time periods from the date of initial licensure.

(7) A statement disclosing and explaining any charge of a misdemeanor or felony involving the applicant filed in any jurisdiction, whether or not any appeal or other proceeding is pending to have the conviction or plea set aside.

b. Submit a completed fingerprint packet to facilitate a national criminal history background check. The fee identified in 653—subrule 8.13(6) for the evaluation of the fingerprint packet and the DCI and FBI criminal history background checks will be assessed to the applicant.

c. Pay the reactivation fee identified in 653—subrule 8.13(7) plus the fee identified in 653—subrule 8.13(6) for the evaluation of the fingerprint packet and the DCI and FBI criminal history background checks.

d. A letter sent directly from the ABGC or ABMGG to the board verifying the applicant holds active certification in genetic counseling by the ABGC or ABMGG for genetic counselor licensure or a letter sent directly from the ABGC or ABMGG to the board verifying the applicant has been granted active candidate status for provisional licensure.

e. Meet any new requirements instituted since the license lapsed.

20.9(2) *Reactivation for an applicant who has been out of practice for three years.* If an applicant for reactivation has not engaged in the field of genetic counseling or precision medicine in the past three years in any jurisdiction of the United States, the board may, after consultation with an Iowa-licensed genetic counselor, require an applicant to:

a. Successfully complete board-approved continuing education or remediation.

b. Successfully complete a board-approved employment-based monitoring program developed by the genetic counselor's employer, an Iowa-licensed genetic counselor and the board.

c. Successfully complete any other pathway as agreed upon by the board.

[**ARC 9118C**, IAB 4/16/25, effective 5/21/25]

653—20.10(272C) Code of ethics. The NSGC Code of Ethics prepared and approved by the National Society of Genetic Counselors shall be utilized by the board as guiding principles in the practice of genetic counseling in this state.

[**ARC 9118C**, IAB 4/16/25, effective 5/21/25]

653—20.11(148H,272C) Surrender of license to the board.

20.11(1) A genetic counselor whose ABGC certification has lapsed or whose certification has been revoked by the ABGC shall surrender the genetic counselor's license to the board.

20.11(2) A provisional licensee who loses active candidate status with the ABGC must immediately cease the practice of genetic counseling until the provisional licensee obtains an extension of the provisional license or obtains a new provisional license.

[**ARC 9118C**, IAB 4/16/25, effective 5/21/25]

These rules are intended to implement Iowa Code chapters 147, 148, 148H, and 272C.

[Filed ARC 4339C (Notice ARC 4095C, IAB 10/24/18), IAB 3/13/19, effective 4/17/19][1]
[Filed Emergency ARC 4468C, IAB 6/5/19, effective 5/15/19]
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[Filed ARC 9118C (Notice ARC 8703C, IAB 12/25/24), IAB 4/16/25, effective 5/21/25]

[1] April 17, 2019, effective date of Chapter 20 [ARC 4339C] delayed 70 days by the Administrative Rules Review Committee at its meeting held April 5, 2019; delay lifted at the meeting held May 14, 2019.

CHAPTER 21
PHYSICIAN SUPERVISION OF A PHYSICIAN ASSISTANT

Chapter rescission date pursuant to Iowa Code section 17A.7: 1/1/28

653—21.1(148,272C) Ineligibility determinants. A physician with an active permanent, special, or temporary Iowa license who is actively engaged in the practice of medicine in Iowa may supervise a physician assistant. A physician is ineligible to supervise a physician assistant for any of the following reasons:

21.1(1) The physician does not hold an active, permanent, special or temporary Iowa medical license.

21.1(2) The physician is subject to a disciplinary order of the board that restricts or rescinds the physician's authority to supervise a physician assistant. The physician may supervise a physician assistant to the extent that the order allows.

21.1(3) The physician does not have a written supervisory agreement in place with each physician assistant supervised by the physician.

21.1(4) The physician is already supervising five physician assistants.

[**ARC 3264C**, IAB 8/16/17, effective 9/20/17; **ARC 5252C**, IAB 11/4/20, effective 12/9/20]

653—21.2(148,272C) Exemptions from this chapter. This chapter shall not apply to the following:

21.2(1) A physician working in a federal facility or under federal authority when the provisions of this chapter conflict with federal regulations.

21.2(2) A physician who supervises a physician assistant providing medical care created by an emergency or a state or local disaster pursuant to Iowa Code section 148C.4.

653—21.3(148) Board notification. A physician who supervises a physician assistant shall notify the board of the supervisory relationship within 60 days of the provision of initial supervision and at the time of the physician's license renewal.

[**ARC 3264C**, IAB 8/16/17, effective 9/20/17]

653—21.4(148,272C) Supervisory agreements.

21.4(1) A physician who supervises a physician assistant shall establish a written supervisory agreement prior to supervising a physician assistant. A sample supervisory agreement form is available from the board. The purpose of the supervisory agreement is to define the nature and extent of the supervisory relationship and the expectations of each party. The supervisory agreement shall take into account the physician assistant's demonstrated skills, training and experience, proximity of the supervising physician to the physician assistant, and the nature and scope of the medical practice. The supervising physician shall maintain a copy of the supervisory agreement and provide a copy of the agreement to the board upon request. The supervisory agreement shall, at a minimum, address the following provisions.

a. Review of requirements. The supervising physician and the physician assistant shall review all of the requirements of physician assistant licensure, practice, supervision, and delegation of medical services as set forth in Iowa Code section 148.13 and chapter 148C, these rules, and 645—Chapters 326 to 329.

b. Assessment of education, training, skills, and experience. Each supervising physician shall assess the education, training, skills, and relevant experience of the physician assistant prior to providing supervision. Each supervising physician and physician assistant shall ensure that the other party has the appropriate education, training, skills, and relevant experience necessary to successfully collaborate on patient care delivered by the team. The method for assessing and providing feedback regarding the physician assistant's education, training, skills, and experience shall be reflected in the supervisory agreement.

21.4(2) The supervisory agreement between the physician assistant and the physician shall address all of the following:

a. The medical services the supervising physician delegates to the physician assistant. The medical services and medical tasks delegated to and provided by the physician assistant shall be in compliance with

645—subrule 327.1(1). All delegated medical services shall be within the scope of practice of the supervising physician and the physician assistant.

b. Methods for communication between the physician assistant and the physician and whether the physician assistant practices at the same site or a remote site. Each supervising physician and physician assistant shall conduct ongoing discussions and evaluation of the supervisory agreement, including supervision; expectations for both parties; assessment of education, training, skills, and relevant experience; review of delegated services; review of the medical services provided by the physician assistant; and the types of cases and situations when the supervising physician expects to be consulted.

(1) The plan for completing and documenting chart reviews. A licensed physician within the same facility or health care system as the physician assistant shall conduct an ongoing review of a representative sample of the physician assistant's patient charts encompassing the scope of the physician assistant's practice. The finding of the review shall be discussed with the physician assistant in a manner determined by the practice in consultation with the physician assistant's primary supervising physician.

(2) Remote medical site. "Remote medical site" means a medical clinic for ambulatory patients which is more than 30 miles away from the main practice location of the supervising physician and in which the supervising physician is present less than 50 percent of the time when the remote medical site is open. "Remote medical site" will not apply to nursing homes, patient homes, hospital outpatient departments, outreach clinics, or any location at which medical care is incidentally provided (e.g., diet center, free clinic, site for athletic physicals, jail facility). The supervisory agreement shall include a provision which ensures that the supervising physician visits the remote medical site, or communicates with a physician assistant at the remote medical site via electronic communications, at least every two weeks to provide additional medical direction, medical services and consultation specific to the medical services provided at the remote medical site. For purposes of this subparagraph, communication may consist of, but shall not be limited to, in-person meetings or two-way, interactive communication directly between the supervising physician and the physician assistant via the telephone, secure messaging, electronic mail, or chart review. The board shall only grant a waiver of this provision if substantially equal protection of public health, safety, and welfare will be afforded by a means other than that prescribed in this subparagraph.

(3) The expectations and plan for alternate supervision. The supervising physician will ensure that the alternate supervising physician is available for a timely consultation and will ensure that the physician assistant is notified of the means by which to reach the alternate supervising physician.

[**ARC 3264C**, IAB 8/16/17, effective 9/20/17; **ARC 4213C**, IAB 1/2/19, effective 2/6/19; **ARC 5252C**, IAB 11/4/20, effective 12/9/20]

653—21.5(148,272C) Grounds for discipline. A physician may be subject to disciplinary action for supervising a physician assistant in violation of these rules or the rules found in 653—Chapter 23 or 645—Chapters 326 and 327, which relate to duties and responsibilities for physician supervision of physician assistants. Grounds for discipline also include:

21.5(1) The physician supervises a physician assistant when the physician does not have sufficient training or experience to supervise a physician assistant in the area of medical practice in which a physician assistant is to be utilized.

21.5(2) A physician supervises more than five physician assistants at the same time.

21.5(3) The physician fails to ensure that the physician assistant is adequately supervised, including being available in person or by telecommunication to respond to the physician assistant.

21.5(4) The physician fails to adequately direct and supervise a physician assistant or fails to comply with the minimum standards of supervision in accordance with this chapter, Iowa Code section 148.13 and chapter 148C, and 645—Chapters 326 to 329.

[**ARC 0870C**, IAB 7/24/13, effective 8/28/13; **ARC 2532C**, IAB 5/11/16, effective 6/15/16; see Rescission note at end of chapter; **ARC 3264C**, IAB 8/16/17, effective 9/20/17]

653—21.6(148,272C) Disciplinary sanction. The board may restrict or rescind a physician's authority to supervise a physician assistant as part of a disciplinary sanction following a contested case proceeding, if the reason for the disciplinary action impacts the ability of the physician to supervise a physician assistant.

The board shall notify the board of physician assistants when it takes a disciplinary action against a physician's license that affects the physician's authority to supervise a physician assistant.
[**ARC 2532C**, IAB 5/11/16, effective 6/15/16; see Rescission note at end of chapter; **ARC 3264C**, IAB 8/16/17, effective 9/20/17]

653—21.7(148,272C) Communication with physician assistant supervisees. The physician shall notify all physician assistant supervisees within one workday upon receiving disciplinary action from the board or any other change in status that affects the physician's eligibility to supervise a physician assistant.
[**ARC 2532C**, IAB 5/11/16, effective 6/15/16; see Rescission note at end of chapter; **ARC 3264C**, IAB 8/16/17, effective 9/20/17]

653—21.8(17A,147,148,272C) Waiver requests. Waiver requests shall be submitted in conformance with 653—Chapter 3.
[**ARC 2532C**, IAB 5/11/16, effective 6/15/16; see Rescission note at end of chapter; **ARC 3264C**, IAB 8/16/17, effective 9/20/17; **ARC 5600C**, IAB 5/5/21, effective 6/9/21]

These rules are intended to implement Iowa Code sections 148.13 and 272C.3.

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1 Effective date of 3/1/89 delayed 70 days by Administrative Rules Review Committee at its February 13, 1989, meeting.

2 Effective date of 3/1/89 delayed until adjournment of the 1990 Session of the General Assembly at its May 9, 1989, meeting.

3 Delay until adjournment of the 1990 G.A. lifted by the Administrative Rules Review Committee at its August 3, 1989, meeting which allowed the rules to become effective August 4, 1989.

4 Effective date of 4/17/96 delayed 70 days by the Administrative Rules Review Committee at its meeting held April 16, 1996. Effective date delayed until adjournment of the 1997 General Assembly by the Administrative Rules Review Committee at its meeting held June 11, 1996.

5 Effective date of 1/28/04 delayed 70 days by the Administrative Rules Review Committee at its January 6, 2004, meeting; at its meeting held March 8, 2004, the Committee lifted the delay, effective March 9, 2004.

6 Amendments to ch 21 in ARC 2532C, which included the renumbering of 21.4 to 21.7 as 21.5 to 21.8 (Item 1), the adoption of new 21.4 (Item 2), and the amendment to the implementation sentence (Item 3), rescinded by 2017 Iowa Acts, House File 591, section 2, paragraph *"a,"* on 4/12/17 and, pursuant to paragraph *"b,"* prior language restored IAC Supplement 5/10/17.

CHAPTER 22
MANDATORY REPORTING

[Prior to 7/19/06, see 653—Chapter 12]

Chapter rescission date pursuant to Iowa Code section 17A.7: 5/21/30

653—22.1(272C) Mandatory reporting—judgments or settlements. Each licensee, including inactive licensees, will report to the board and provide a copy of every adverse judgment and settlement of a claim against the licensee in a malpractice action within 30 days from the date of said judgment or settlement. Failure to report judgments or settlements within the 30-day period is a basis for disciplinary action.

[**ARC 9119C**, IAB 4/16/25, effective 5/21/25]

653—22.2(272C) Mandatory reporting—wrongful acts or omissions.

22.2(1) *Definitions.* For the purposes of this rule, the following definitions apply:

"Knowledge" means any information or evidence of reportable conduct acquired by personal observation, from a reliable or authoritative source, or under circumstances causing the licensee to believe that wrongful acts or omissions may have occurred.

"Reportable conduct" means wrongful acts or omissions that are grounds for license revocation or suspension under these rules or that otherwise constitute negligence, careless acts or omissions that demonstrate a licensee's inability to practice medicine competently, safely, or within the bounds of medical ethics, pursuant to Iowa Code sections 272C.3(2) and 272C.4(6) and 653—Chapter 23.

22.2(2) *Reporting requirement.* A report shall be filed with the board, within 30 days from the date the licensee acquires knowledge, when a licensee has knowledge that another person licensed by the board may have engaged in reportable conduct. Failure to report is a basis for disciplinary action.

a. The report must contain the name and address of the licensee who may have engaged in the reportable conduct; the date, time, place, and circumstances in which the conduct occurred; and a statement explaining how knowledge of the reportable conduct was acquired.

b. The board makes the final determination of whether or not wrongful acts or omissions have occurred.

c. A physician is not required to report confidential communication obtained from a physician in the course of and as a result of a physician-patient relationship or when a state or federal statute prohibits such disclosure.

d. A licensee will not be civilly liable for filing a report with the board so long as such report is not made with malice.

[**ARC 9119C**, IAB 4/16/25, effective 5/21/25]

653—22.3(272C) Mandatory reporting—disciplinary action in another jurisdiction. Each licensee, including inactive licensees, will report to the board, within 30 days of the action, every license revocation, suspension or other disciplinary action taken against the licensee by a professional licensing authority of another state; an agency of the United States government; or any country, territory or other jurisdiction. Failure to report in accordance with this rule is a basis for disciplinary action.

[**ARC 9119C**, IAB 4/16/25, effective 5/21/25]

653—22.4(272C) Mandatory reporting—child abuse and dependent adult abuse. Each licensee will report child abuse and dependent adult abuse as required by state and federal law. Knowingly and willfully failing to report child abuse and dependent adult abuse is a basis for disciplinary action.

[**ARC 9119C**, IAB 4/16/25, effective 5/21/25]

653—22.5(272C) Mandatory reporting—hospital disciplinary action. Each licensee, including inactive licensees, will file with the board a copy of the disciplinary action or voluntary action and a written report describing any disciplinary action taken by a hospital for reasons relating to the physician's professional competence or conduct that results in a limitation, restriction, suspension, revocation, relinquishment or nonrenewal of the licensee's hospital privileges or any voluntary limitation, restriction, suspension, revocation, relinquishment or nonrenewal of the licensee's hospital privileges to avoid an investigation or

other hospital disciplinary action. A licensee is not required to report a limitation, restriction, suspension, revocation, relinquishment or nonrenewal of the licensee's privileges of fewer than ten days. A licensee is not required to report a voluntary, nondisciplinary limitation or relinquishment of hospital privileges made at the election of the licensee to narrow or change the nature of the licensee's medical practice for reasons not related to competency or conduct. The written report must be filed with the board within 30 days of the date of the action. Failure to file the written report and a copy of the action is a basis for disciplinary action. Reports shall be maintained by the board in accordance with Iowa Code section 272C.6(4).

[**ARC 9119C**, IAB 4/16/25, effective 5/21/25]

These rules are intended to implement Iowa Code chapters 17A, 147, 148, and 272C.

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[2] Effective date of rules 135.206, 135.207 and 135.208 [renumbered 12.6, 12.7 and 12.8, IAC 5/4/88] delayed by the Administrative Rules Review Committee 70 days from December 12, 1984. Delay lifted by committee on January 9, 1985.

CHAPTER 23
GROUNDS FOR DISCIPLINE

[Prior to 7/19/06, see 653—Chapter 12]

Chapter rescission date pursuant to Iowa Code section 17A.7: 5/21/30

653—23.1(272C) Grounds for discipline. The board has the authority to impose discipline for any violation of Iowa Code chapter 147, 148, 148E, 148H, 252J, 272C or 272D or the rules promulgated thereunder. The grounds for discipline apply to physicians, acupuncturists and genetic counselors. The board may impose any of the disciplinary sanctions set forth in 481—Chapter 506, including civil penalties in an amount not to exceed $10,000, when the board determines that the licensee is guilty of any of the following acts or offenses:

23.1(1) Violating any of the grounds for the revocation or suspension of a license as listed in Iowa Code section 147.55, 148.6, 148E.8, 148H.7, 272C.10, or 272C.15.

23.1(2) Professional incompetency. Professional incompetency includes but is not limited to any of the following:

a. Willful or repeated gross malpractice;

b. Willful or gross negligence;

c. A substantial lack of knowledge or ability to discharge professional obligations within the scope of the licensee's practice;

d. A substantial deviation by the licensee from the standards of learning or skill ordinarily possessed and applied by other physicians, acupuncturists or genetic counselors in the state of Iowa acting in the same or similar circumstances;

e. A failure by a physician, acupuncturist or genetic counselor to exercise in a substantial respect that degree of care that is ordinarily exercised by the average physician, acupuncturist or genetic counselor in the state of Iowa acting in the same or similar circumstances;

f. A willful or repeated departure from or the failure to conform to the minimal standard of acceptable and prevailing practice in the state of Iowa;

g. Failure to meet the acceptable and prevailing standard of care when delegating or supervising services provided by another physician, health care practitioner or individual who is collaborating with or acting as an agent, associate, or employee of the physician, acupuncturist or genetic counselor responsible for the patient's care, whether or not injury results.

23.1(3) Practice harmful or detrimental to the public. Practice harmful or detrimental to the public includes but is not limited to:

a. Failure to possess and exercise that degree of skill, learning and care expected of a reasonable, prudent physician, acupuncturist or genetic counselor acting in the same or similar circumstances.

b. Practicing without reasonable skill and safety as a result of a mental or physical impairment, chemical abuse or chemical dependency.

c. For acupuncturists only: prescribing, dispensing or administering any controlled substance or prescription medication for human use or performing any treatment or healing procedure not authorized in Iowa Code chapter 148E or 653—Chapter 17.

23.1(4) Unprofessional conduct. Engaging in unethical or unprofessional conduct includes but is not limited to the committing by a licensee of an act contrary to honesty, justice or good morals, whether the same is committed in the course of the licensee's practice or otherwise, and whether committed within this state or elsewhere; or a violation of the standards and principles of medical ethics or rule 653—13.7(147,148,272C), 653—13.20(147,148), 653—17.10(147,148E,272C) or 653—20.4(148H) as interpreted by the board.

23.1(5) Sexual misconduct. Engaging in sexual misconduct includes but is not limited to engaging in conduct set out at 653—subrule 13.7(4) or 13.7(6) as interpreted by the board.

23.1(6) Substance abuse. Substance abuse includes but is not limited to excessive use of alcohol, drugs, narcotics, chemicals or other substances in a manner that may impair a licensee's ability to practice the profession with reasonable skill and safety.

23.1(7) Indiscriminately or promiscuously prescribing, administering or dispensing any drug for other than lawful purpose includes but is not limited to:

a. Self-prescribing or self-dispensing controlled substances.

b. Prescribing or dispensing controlled substances to members of the licensee's immediate family.

(1) Prescribing or dispensing controlled substances to members of the licensee's immediate family is allowable for an acute condition or on an emergency basis when the licensee conducts an examination, establishes a medical record, and maintains proper documentation.

(2) Immediate family includes the physician's spouse or domestic partner and either of the physician's, spouse's, or domestic partner's parents, stepparents or grandparents; the physician's natural or adopted children or stepchildren and any child's spouse, domestic partner or children; the siblings of the physician or the physician's spouse or domestic partner and the sibling's spouse or domestic partner; or anyone else living with the physician.

23.1(8) Physical or mental impairment. Physical or mental impairment includes but is not limited to any physical, neurological or mental condition that may impair a licensee's ability to practice the profession with reasonable skill and safety. Being adjudged mentally incompetent by a court of competent jurisdiction automatically suspends a license for the duration of the license unless the board orders otherwise.

23.1(9) Felony criminal conviction. Being convicted of a felony in the courts of this state, another state, the United States, or any country, territory or other jurisdiction, as defined in Iowa Code section 148.6(2)*"b."* A copy of the record of conviction or plea of guilty or nolo contendere is conclusive evidence of the felony conviction.

23.1(10) Violation of the laws or rules governing the practice of medicine, acupuncture or genetic counseling of this state; another state; the United States; or any country, territory or other jurisdiction. Violation of the laws or rules governing the practice of medicine, acupuncture or genetic counseling includes but is not limited to willful or repeated violation of the provisions of these rules or the provisions of Iowa Code chapter 147, 148, 148E, 148H or 272C or other state or federal laws or rules governing the practice of medicine.

23.1(11) Violation of a lawful order of the board, previously entered by the board in a disciplinary or licensure hearing, or violation of the terms and provisions of a consent agreement or settlement agreement entered into between a licensee and the board.

23.1(12) Violation of an initial agreement or health contract entered into with the Iowa professional health programs (IPHP).

23.1(13) Failure to comply with an evaluation order. Failure to comply with an order of the board requiring a licensee to submit to evaluation under Iowa Code section 148.6(2)*"h"* or 272C.9(1).

23.1(14) Knowingly making misleading, deceptive, untrue or fraudulent representations in the practice of a profession. Knowingly making misleading, deceptive, untrue or fraudulent representations in the practice of a profession includes but is not limited to an intentional perversion of the truth, either orally or in writing, by a physician in the practice of medicine and surgery or osteopathic medicine and surgery, by an acupuncturist, or by a genetic counselor.

23.1(15) Fraud in procuring a license. Fraud in procuring a license includes but is not limited to an intentional perversion of the truth in making application for a license to practice acupuncture, medicine and surgery, osteopathic medicine and surgery, or genetic counseling in this state and includes false representations of material fact, whether by word or by conduct, by false or misleading allegations, or by concealment of that which should have been disclosed when making application for a license in this state, or attempting to file or filing with the board any false or forged document submitted with an application for a license in this state.

23.1(16) Fraud in representations as to skill or ability. Fraud in representations as to skill or ability includes but is not limited to a licensee's having made misleading, deceptive or untrue representations as to the acupuncturist's, physician's or genetic counselor's competency to perform professional services for which the licensee is not qualified to perform by education, training or experience.

23.1(17) Use of untruthful or improbable statements in advertisements. Use of untruthful or improbable statements in advertisements includes but is not limited to an action by a licensee in making

known to the public information or intention that is false, deceptive, misleading or promoted through fraud or misrepresentation and includes statements that may consist of but are not limited to:

a. Inflated or unjustified claims that lead to expectations of favorable results;

b. Self-laudatory claims that imply that the licensee is skilled in a field or specialty of practice for which the licensee is not qualified;

c. Representations that are likely to cause the average person to misunderstand; or

d. Extravagant claims or claims of extraordinary skills not recognized by the profession.

23.1(18) Obtaining any fee by fraud or misrepresentation.

23.1(19) Acceptance of remuneration for referral of a patient to other health professionals in violation of the law or medical ethics.

23.1(20) Knowingly submitting a false report of continuing education or failure to submit the required reports of continuing education.

23.1(21) Knowingly aiding, assisting, procuring, or advising a person in the unlawful practice of acupuncture, medicine and surgery, or osteopathic medicine and surgery.

23.1(22) Failure to report disciplinary action. Failure to report a license revocation, suspension or other disciplinary action taken against the licensee by a professional licensing authority of another state; an agency of the United States government; or any country, territory or other jurisdiction within 30 days of the final action by such licensing authority. A stay by an appellate court does not negate this requirement; however, if such disciplinary action is overturned or reversed by a court of last resort, such report will be expunged from the records of the board.

23.1(23) Failure to report voluntary agreements. Failure to report any voluntary agreement to restrict the practice of acupuncture, medicine and surgery, osteopathic medicine and surgery, or genetic counseling entered into with this state; another state; the United States; an agency of the federal government; or any country, territory or other jurisdiction.

23.1(24) Failure to notify the board within 30 days after occurrence of any settlement or adverse judgment of a malpractice claim or action.

23.1(25) Failure to file the reports required by rule 653—22.2(272C) within 30 days concerning wrongful acts or omissions committed by another licensee.

23.1(26) Failure to comply with a valid subpoena issued by the board pursuant to Iowa Code sections 17A.13 and 272C.6, 653—subrule 24.2(6), and 481—Chapter 506.

23.1(27) Failure to submit to a board-ordered mental, physical, clinical competency, or substance abuse evaluation or drug or alcohol screening.

23.1(28) The inappropriate use of a rubber stamp to affix a signature to a prescription. A person who is unable, due to a disability, to make a written signature or mark, however, may substitute in lieu of a signature a rubber stamp that is adopted by the disabled person for all purposes requiring a signature and that is affixed by the disabled person or affixed by another person upon the request of the disabled person and in the presence of the disabled person.

23.1(29) Maintaining any presigned prescription that is intended to be completed and issued at a later time.

23.1(30) Failure to comply with the recommendations issued by the Centers for Disease Control and Prevention of the United States Department of Health and Human Services for preventing transmission of human immunodeficiency virus and hepatitis B virus to patients during exposure-prone invasive procedures, or with the protocols established pursuant to Iowa Code chapter 139A.

23.1(31) Failure by a physician with HIV or HBV who practices in a hospital setting, and who performs exposure-prone procedures, to report the physician's HIV or HBV status to an expert review panel established by a hospital under Iowa Code section 139A.22(1) or to an expert review panel established by the department of health and human services under Iowa Code section 139A.22(3).

23.1(32) Failure by a physician with HIV or HBV who practices outside a hospital setting, and who performs exposure-prone procedures, to report the physician's HIV or HBV status to an expert review panel established by the department of health and human services under Iowa Code section 139A.22(3).

23.1(33) Failure by a physician subject to the reporting requirements of subrules 23.1(31) and 23.1(32) to comply with the recommendations of an expert review panel established by the department of

health and human services pursuant to Iowa Code section 139A.22(3), with hospital protocols established pursuant to Iowa Code section 139A.22(1), or with health care facility procedures established pursuant to Iowa Code section 139A.22(2).

23.1(34) Noncompliance with a support order or with a written agreement for payment of support as evidenced by a certificate of noncompliance issued pursuant to Iowa Code chapter 252J. Disciplinary proceedings initiated under this rule shall follow the procedures set forth in Iowa Code chapter 252J and 653—Chapter 15.

23.1(35) Fraud in the practice. Fraud in the practice includes but is not limited to any misleading, deceptive, untrue or fraudulent representation in the practice of acupuncture, medicine or surgery, or genetic counseling, made orally or in writing, that is contrary to the licensee's legal or equitable duty, trust, or confidence and is deemed by the board to be contrary to good conscience, prejudicial to the public welfare, and potentially injurious to another. Proof of actual injury need not be established.

23.1(36) Improper management of medical records. Improper management of medical records includes but is not limited to failure to maintain timely, accurate, and complete medical records.

23.1(37) Failure to transfer medical records to another physician in a timely fashion when legally requested to do so by the subject patient or by a legally designated representative of the subject patient.

23.1(38) Failure to respond to or comply with a board investigation initiated pursuant to Iowa Code section 272C.3 and rule 653—24.2(17A,147,148,272C).

23.1(39) Failure to comply with the direct billing requirements for anatomic pathology services established in Iowa Code section 147.106.

23.1(40) Failure to submit an additional completed fingerprint card and applicable fee, within 30 days of a request made by board staff, when a previous fingerprint submission has been determined to be unacceptable.

23.1(41) Failure to respond to the board or submit continuing education materials during a board audit, within 30 days of a request made by board staff or within the extension of time if one had been granted.

23.1(42) Failure to respond to the board or submit requested mandatory training for identifying and reporting abuse materials during a board audit, within 30 days of a request made by board staff or within the extension of time if one had been granted.

23.1(43) Nonpayment of state debt as evidenced by a certificate of noncompliance issued pursuant to Iowa Code chapter 272D and 653—Chapter 12.

23.1(44) Voluntary agreements. The board may take disciplinary action against a physician if that physician has entered into a voluntary agreement to restrict the practice of medicine in another state, district, territory, or country.

a. The board will use the following criteria to determine if a physician has entered into a voluntary agreement within the meaning of Iowa Code section 148.12 and this rule.

(1) The voluntary agreement was signed during or at the conclusion of a disciplinary investigation, or to prevent a matter from proceeding to a disciplinary investigation.

(2) The agreement includes any or all of the following:

1. Education or testing that is beyond the jurisdiction's usual requirement for a license or license renewal.
2. An assignment beyond what is required for license renewal or regular practice (e.g., adoption of a protocol, use of a chaperone, completion of specified continuing education, or completion of a writing assignment).
3. A prohibition or limitation on practice privileges (e.g., a restriction on prescribing or administering controlled substances).
4. Compliance with an educational plan.
5. A requirement that surveys or reviews of patients or patient records be conducted.
6. A practice monitoring requirement.
7. A special notification requirement for a change of address.
8. Payment that is not routinely required of all physicians in that jurisdiction, such as a civil penalty, fine, or reimbursement of any expenses.

9. Any other activity or requirements imposed by the board that are beyond the usual licensure requirements for obtaining, renewing, or reinstating a license in that jurisdiction.

b. A certified copy of the voluntary agreement shall be considered prima facie evidence.

23.1(45) Performing or attempting to perform any surgical or invasive procedure on the wrong patient or at the wrong anatomical site or performing the wrong surgical procedure on a patient.

23.1(46) Violation of the standards of practice for medical directors who delegate and supervise medical aesthetic services performed by nonphysician persons at a medical spa as set out in rule 653—13.8(148,272C).

23.1(47) Failure to provide the board, within 14 days of a request by the board as set out in 653—paragraph 13.8(5)*"l,"* written verification of the education and training of all nonphysician persons who perform medical aesthetic services at a medical spa.

23.1(48) Failure to file with the board a written report and a copy of the hospital disciplinary action within 30 days of any hospital disciplinary action or the licensee's voluntary action to avoid a hospital investigation or hospital disciplinary action as required by rule 653—22.5(272C).

23.1(49) Unethical conduct of acupuncturist. The Code of Ethics (2016) prepared and approved by the National Certification Commission for Acupuncture and Oriental Medicine (NCCAOM) is utilized by the board as guiding principles in the practice of acupuncture in this state. Unethical conduct in the practice of acupuncture includes but is not limited to:

a. Failing to provide patients with the information required in Iowa Code section 148E.6 or providing false information to patients;

b. Disclosing confidential information about a patient without proper authorization; or

c. Abrogating the boundaries of acceptable conduct in the practice of acupuncture established by the profession that the board deems appropriate for ensuring that acupuncturists provide Iowans with safe and healthful care.

This rule is intended to implement Iowa Code chapters 17A, 147, 148, 148E, 148H, 272C and 272D.

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CHAPTER 24
COMPLAINTS AND INVESTIGATIONS

[Prior to 7/19/06, see 653—Chapter 12]

Chapter rescission date pursuant to Iowa Code section 17A.7: 5/21/30

653—24.1(17A,147,148,272C) Complaints.

24.1(1) *Form and content of the complaint.* A complaint will be made in the form deemed acceptable by the board. The complaint will contain the following information:

a. The full name, address and telephone number of the complainant, except in instances in which the identity of the complainant is unknown.

b. The full name, address and telephone number, if known, of the licensee.

c. A clear and accurate statement of the facts that apprises the board of the allegations against the licensee.

24.1(2) *Place and time of filing of the complaint.* A written complaint may be delivered in person, by mail or electronically to the board office. The office address is Iowa Board of Medicine, 6200 Park Avenue, Suite 100, Des Moines, Iowa 50321.

24.1(3) *Immunity.* A person is not civilly liable as a result of filing a report or complaint with the board or peer review committee, or for the disclosure to the board or its agents or employees, whether or not pursuant to a subpoena of records, documents, testimony or other forms of information that constitute privileged matter concerning a recipient of health care services or some other person, in connection with proceedings of a peer review committee, or in connection with duties of the board. However, such immunity from civil liability is not applicable if such act is done with malice.

[**ARC 9121C**, IAB 4/16/25, effective 5/21/25]

653—24.2(17A,147,148,272C) Processing complaints and investigations.

24.2(1) *Complaint and investigative files.* Board staff shall open a complaint file upon receiving a complaint or other appropriate information or upon a motion of the board. A complaint file becomes an investigative file once an investigation is ordered.

a. If the board does not have legal jurisdiction over a matter or the complaint does not allege a violation of rule or law, staff may close the complaint file administratively without investigation or review by the board. All other complaints will be sent to the complaint review committee.

b. A complaint file will be labeled as such and is not a public record. A complaint file will become part of the licensee's history with the board.

c. Any time an investigation is ordered, a complaint file will be relabeled as an investigative file. An investigative file is not a public record. The investigative file will become part of the licensee's history with the board and may be shared with another licensing authority upon request.

24.2(2) *Complaint review committee.*

a. The complaint review committee includes the medical advisor, executive director, general counsel for the board, and chief investigator.

b. The complaint review committee reviews each complaint the board has received and takes one of the following four actions:

(1) Close a complaint file administratively for any of these reasons:

1. The board does not have legal jurisdiction over the matter;
2. The case involves a matter that the board is already addressing; or
3. The case is appropriate for referral to the board's Iowa physician health program, and investigation is not warranted.

(2) Recommend to the board's screening committee that the board close the complaint file without investigation.

(3) Request a letter of explanation from the physician, medical records, or both.

(4) Request a full investigation.

c. The complaint review committee uses the following to guide its decision making:

(1) Serious public safety issues include but are not limited to the following:

1. A clear violation of the laws and rules governing the practice of medicine, genetic counseling, or acupuncture, as applicable;

2. Significant investigative history that raises serious concerns about the licensee's ability to practice in a competent and safe manner;

3. Significant investigative history that raises serious concerns that the licensee has engaged in a pattern of unprofessional conduct or disruptive behavior that interferes with, or has the potential to interfere with, patient care or the effective functioning of health care staff;

4. Serious quality of care cases that include severe patient harm, a pattern of inappropriate treatment, or serious medical errors;

5. Serious criminal conduct;

6. Substance abuse or other impairment that significantly impacts the licensee's ability to practice the licensee's respective practice in a competent and safe manner;

7. Sexual misconduct;

8. Severe unprofessional conduct or disruptive behavior;

9. Disciplinary action by another regulatory authority; or

10. Unlicensed practice of medicine, genetic counseling, or acupuncture.

(2) Less serious public safety issues include but are not limited to the following:

1. Less serious quality of care cases that do not involve serious patient harm and are isolated occurrences rather than a part of a pattern of inappropriate treatment or serious medical errors;

2. A single incident involving a billing dispute;

3. A single incident involving rude behavior or personality conflicts;

4. A single incident of communication problems; or

5. Poor recordkeeping practices that are not repeated or ongoing in nature and do not significantly affect patient care.

d. The board may at any time reopen for review and reconsideration any complaint or investigative file that has been closed administratively.

e. The complaint review committee will indicate high-priority cases when they are assigned for investigation. The committee may provide recommendations to investigators regarding the nature of investigation to be completed. The medical advisor will provide medical advice to the investigators as part of the investigative process.

24.2(3) *Screening committee.* The screening committee will review the recommendations of the complaint review committee and take one of the following actions:

a. Recommend to the board that the complaint file be closed without investigation.

b. Request a letter of explanation from the physician, medical records, or both.

c. Review the materials acquired pursuant to paragraph 24.2(3)*"b"* and recommend to the board that the investigative file be closed, with or without issuing an informal letter.

d. Request an investigation for board review.

24.2(4) *Board action.*

a. The board will review the screening committee's recommendations and take one of the following actions:

(1) Close the complaint file without investigation. The board will notify the complainant.

(2) Close the investigative file that has been partially or fully investigated, with or without issuing an informal letter. The board will notify the complainant and the licensee of the decision.

(3) Request further investigation.

b. The board may reconsider and reopen a closed complaint or investigative file at a later date should it be deemed appropriate.

24.2(5) *Investigations.*

a. Complainants. At the time an investigation is opened, the complainant will be sent a letter with the name of the investigator assigned to the case and the investigator's contact information and a statement encouraging the complainant to submit any further information that would assist the investigator with the case.

(1) The complainant may request a meeting with the investigator prior to the completion of the investigation.

(2) The complainant will be informed of the confidentiality of the investigative information as provided in subrule 24.2(8).

(3) The complainant may contact the chief investigator with questions or concerns about the investigation.

b. Investigative subpoenas.

(1) Issuance of an investigative subpoena. The executive director or a designee may, upon the written request of a board investigator or upon the executive director's own initiative, subpoena books, papers, records, and other real evidence necessary for a board investigation.

(2) Request for subpoena. A written request for a subpoena will contain the following:

1. The name and address of the person to whom the subpoena will be directed;
2. A specific description of the books, papers, records or other real evidence requested;
3. An explanation of why the evidence sought to be subpoenaed is necessary for the board to determine whether it should institute a contested case proceeding; and
4. In the case of a subpoena request for mental health records, confirmation that the conditions described in subparagraph 24.2(5)*"b"*(4) have been satisfied.

(3) Contents of subpoena. Each subpoena will contain the following:

1. The name and address of the person to whom the subpoena is directed;
2. A description of the books, papers, records or other real evidence requested;
3. The date, time and location for production or inspection and copying;
4. The time within which a motion to quash or modify the subpoena must be filed;
5. The signature, address and telephone number of the executive director or designee;
6. The date of issuance; and
7. A return of service attached to the subpoena.

(4) Subpoena for mental health records. A subpoena for mental health records shall meet the requirements of subparagraph 24.2(5)*"b"*(3). The board shall document the following prior to the issuance of a subpoena for mental health records:

1. The nature of the complaint reasonably justifies the issuance of a subpoena;
2. Adequate safeguards have been established to prevent unauthorized disclosure;
3. An express statutory mandate, articulated public policy, or other recognizable public interest favors access; and
4. An attempt was made to notify the patient and to secure an authorization from the patient for release of the records at issue.

(5) Motion to quash or modify subpoena.

1. Any person who is adversely affected by compliance with the subpoena and desires to challenge the subpoena must file with the board a motion to quash or modify the subpoena within 14 days of service, or before if the time specified is less than 14 days. The motion shall describe the legal reasons why the subpoena should be quashed or modified and may be accompanied by legal briefs or factual affidavits.
2. Hearing on motion. Upon receipt of a timely motion to quash or modify a subpoena, the board may request an administrative law judge to hold a hearing and issue a decision, or the board may conduct a hearing and issue a decision. Oral argument may be scheduled at the discretion of the administrative law judge or the board. The administrative law judge or the board may quash or modify the subpoena, deny the motion, or issue an appropriate protective order.
3. Appeal of decision on motion. A person who is aggrieved by a ruling of an administrative law judge and who desires to challenge that ruling must appeal the ruling to the board by serving on the board's executive director, either in person or by certified mail, a notice of appeal within ten days after service of the decision of the administrative law judge.
4. Final agency action. If the person contesting the subpoena is not the person under investigation, the board's decision is final for purposes of judicial review. If the person contesting the subpoena is the person under investigation, the board's decision is not final for purposes of judicial review until either the

person is notified that the investigation has been concluded with no formal action or there is a final decision in the contested case.

c. Licensee response. Before a contested case begins, the investigator will attempt to reach the licensee at the licensee's listed address to allow the licensee to respond to the allegations. If the licensee cannot be found there, reasonable efforts to locate the licensee will be made. If the licensee cannot be located, the investigation will proceed without the licensee's response, and the findings will be sent to the board. Contact and response from the licensee can be in writing or through a personal interview.

d. Investigative report. Upon completion of an investigation, the investigator will prepare a report for the board's consideration. The report will set forth the information obtained in the course of the investigation and the response, if any, of the licensee.

e. Board review. The board will review the investigative record, discuss the case, and take one of the following actions:

(1) Close the investigative file without action. The board will notify the complainant and the licensee of the decision. The board may reconsider and reopen a closed complaint or investigative file at a later date should it be deemed appropriate.

(2) Request further investigation, including peer review.

(3) Meet with the licensee. The board or the licensee may request that the licensee appear before the board to discuss a pending investigation. The board has discretion on whether to grant a licensee's request for an appearance. By electing to participate in the appearance, the licensee waives any objection to a board member's both participating in the appearance and later participating as a decision maker in a contested case proceeding on the grounds that:

1. Board members have personally investigated the case, and
2. Board members have combined investigative and adjudicative functions.

If the executive director or director of legal affairs participates in the appearance, the licensee further waives any objection to having the executive director or director of legal affairs assist the board in the contested case proceeding.

(4) Issue an informal letter of warning or education. If the board concludes that there is not probable cause to file disciplinary charges, the board may issue the licensee an informal letter of warning or education. A letter of warning or education is an informal communication between the board and the licensee and is not formal disciplinary action or a public document.

(5) File a statement of charges. If the board determines that there is probable cause for taking formal disciplinary action against a licensee, the board shall file a statement of charges, thereby commencing a contested case proceeding.

Prior to the initiation of formal disciplinary charges in a case involving the supervision of a physician assistant, the board shall forward a copy of the investigative report to the board of physician assistants for its advice and recommendation. The board of physician assistants shall respond within six weeks or sooner if requested by the board of medicine. The board of medicine shall consider the advice and recommendation of the board of physician assistants.

(6) Request a combined statement of charges and settlement agreement. At the board's discretion, the board and the licensee may enter into a combined statement of charges and settlement agreement to resolve a contested case proceeding.

24.2(6) *Licensee-patient privileged communications.* The privilege of confidential communication between the recipient and the provider of health care services do not extend to afford confidentiality to medical records maintained by or on behalf of the subject of an investigation by the board, or records maintained by any public or private agency or organization, which relate to a matter under investigation by the board. No provision of Iowa Code section 622.10, except as it relates to an attorney of the licensee, or the stenographer or confidential clerk of the licensee's attorney, shall be interpreted to restrict access by the board or its staff or agents to information sought in an investigation being conducted by the board.

24.2(7) *Investigation of malpractice lawsuits, judgments and settlements.* The board will review reports received from insurance carriers and licensees involving malpractice lawsuits, adverse judgments, and settlements. The board may choose to investigate such reports in the same manner as is prescribed in

these rules for the review and investigation of other complaints to determine whether there is probable cause under applicable statutes or administrative rules for licensee discipline.

24.2(8) *Confidentiality of investigative information.* All investigative information gathered by the board or its employees or agents, including peer reviewers, is confidential and privileged. The information cannot be obtained through discovery, subpoena, or other legal means except by the licensee and the board. This information is not admissible in any judicial or administrative proceeding, except in cases involving licensee discipline. However, the board's statement of charges, settlement agreements, or decisions in disciplinary proceedings are public records.

[**ARC 9121C**, IAB 4/16/25, effective 5/21/25]

653—24.3(272C) Peer review. The board may assign any case to peer review for evaluation of the professional services rendered by the licensee and report to the board.

24.3(1) *Registration of peer reviewers.* The board may register peer reviewers by maintaining a list of peer reviewers in the board office. The board will enter into a contract with peer reviewers to provide peer review services.

24.3(2) *Case referral for peer review.* The board or board staff will determine which peer reviewer(s) will review a case and what investigative information is referred to a peer reviewer.

24.3(3) *Board assistance to peer reviewers.* The board may provide investigatory and related services to assist the peer reviewer(s).

24.3(4) *Confidentiality.* Peer reviewers shall observe the confidentiality requirements imposed by Iowa Code section 272C.6(4).

24.3(5) *Liability, defense and indemnity.* Peer reviewers are not liable for acts, omissions or decisions made in connection with service on the peer review committee. However, such immunity from civil liability does not apply if such act is done with malice. Peer reviewers are to be provided a defense by the state for civil lawsuits related to board peer review and will be indemnified for all such judgments or settlements as provided by applicable law and administrative rules.

24.3(6) *Written peer review report.* Peer reviewers will review the information provided by the board and provide a written report to the board.

a. The written report will contain a statement of facts, an opinion of the peer reviewers whether the licensee violated the standard of care, and the rationale supporting the opinion.

b. The written report shall be signed by all peer reviewers concurring in the report.

c. If the peer reviewers find that they are unable to review the case, the investigative information shall be returned to the board.

[**ARC 9121C**, IAB 4/16/25, effective 5/21/25]

653—24.4(272C) Order for physical, mental, or clinical competency evaluation. All licensees will undergo a physical, mental, or clinical evaluation as directed by the board. This evaluation may be ordered if there is probable cause of a mental, physical, or behavioral condition, including professional misconduct, disruptive behavior, or substance abuse. The evaluation may include various assessments for disruptive behavior or neuropsychological, psychiatric, sexual misconduct, or substance abuse evaluations. Clinical competency evaluations can be ordered if there is probable cause of professional incompetence. All evaluation orders and related information are confidential according to Iowa Code section 272C.6(4). The licensee will bear the cost, and orders will be delivered via personal service or certified mail, return receipt requested.

24.4(1) *Content of order.* A board order shall include the following items:

a. Probable cause. A showing by the board that there is probable cause to order the licensee to complete an evaluation.

b. Nature of evaluation or screening. A description of the type of evaluation or screening that the licensee needs to complete.

c. Evaluation facility. The name and address of the examiner or evaluation or treatment or screening facility that the board has identified to perform the evaluation.

d. Scheduling the evaluation. The amount of time in which the licensee must schedule the required evaluation.

e. Completion of the evaluation. The amount of time in which the licensee must complete the evaluation.

f. Board release. A requirement that the licensee sign all necessary releases for the board to communicate with the evaluator or the evaluation or treatment program and to obtain any reports generated by the program.

24.4(2) *Alternatives.* Following issuance of the evaluation order, the licensee may request additional time to schedule or complete the evaluation or to request the board to approve an alternative evaluator or treatment facility. The board will determine whether to grant such a request.

24.4(3) *Objection to order.* A licensee who is the subject of a board evaluation order and who objects to the order may file a request for hearing. The request shall be filed within 14 days of issuance of the evaluation order. A licensee who fails to timely file a request for hearing to object to an evaluation order waives any future objection to the evaluation order in the event formal disciplinary charges are filed for failure to comply with the evaluation order or on any other grounds. The request for hearing shall specifically identify the factual and legal issues upon which the licensee bases the objection. The hearing will be considered a contested case proceeding and will be governed by the provisions of 653—Chapter 25.

24.4(4) *Closed hearing.* Any hearing on an objection to the board order will be closed pursuant to Iowa Code section 272C.6(1).

24.4(5) *Order and reports confidential.* An evaluation order and any subsequent evaluation reports issued in the course of a board investigation are confidential investigative information pursuant to Iowa Code section 272C.6(4). However, all investigative information related to an evaluation order will be provided to the licensee in the event the licensee files an objection under subrule 24.4(3), in order to allow the licensee an opportunity to prepare for hearing.

24.4(6) *Admissibility.* In the event the licensee submits to evaluation and subsequent proceedings are held before the board, all objections will be waived as to the admissibility of the licensee's testimony or evaluation reports on the grounds that they constitute privileged communication. The medical testimony or examination reports will not be used against the licensee in any proceeding other than one relating to licensee discipline by the board.

24.4(7) *Failure to submit.* Failure of a licensee to submit to a board-ordered mental, physical, clinical competency or substance abuse evaluation or alcohol or drug screening constitutes a violation of the rules of the board and is grounds for disciplinary action.

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CHAPTER 25
CONTESTED CASE PROCEEDINGS

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CHAPTER 26
REINSTATEMENT AFTER DISCIPLINARY ACTION

[Prior to 7/19/06, see 653—Chapter 12]

Chapter rescission date pursuant to Iowa Code section 17A.7: 5/21/30

653—26.1(17A) Reinstatement. Any person whose license has not been permanently suspended or revoked by the board may apply to the board for reinstatement in accordance with the terms and conditions of the order of revocation or suspension.

26.1(1) If the order of revocation or suspension did not establish terms and conditions upon which reinstatement might occur, or if the license was voluntarily surrendered, an initial application for reinstatement may not be made until one year has elapsed from the date of the board order or the date of voluntary surrender.

26.1(2) All proceedings for reinstatement shall be initiated by the respondent, who shall file with the board an application for the reinstatement of the respondent's license. Such application will be docketed in the original case in which the license was revoked, suspended, or relinquished. All proceedings upon the petition for reinstatement are subject to the same rules of procedure as other cases before the board.

26.1(3) An application for reinstatement shall allege facts that, if established, will be sufficient to enable the board to determine that the basis for the revocation or suspension of the respondent's license no longer exists and that it will be in the public interest for the license to be reinstated. The burden of proof to establish such facts is on the respondent.

26.1(4) At the board's discretion, the board and the licensee may agree to enter into a reinstatement order by agreement, in lieu of a formal reinstatement hearing before the board.

26.1(5) A reinstatement order must be based upon the affirmative vote of a quorum of the board. The reinstatement order is public information pursuant to 481—Chapter 506.

26.1(6) A physician seeking reinstatement under this rule whose license became inactive during the period of suspension or revocation is also required to complete the reactivation process set forth in rule 653—9.13(147,148) or 653—9.14(147,148).

This rule is intended to implement Iowa Code chapters 17A, 147, 148, and 272C.

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[2] Effective date of rules 135.206, 135.207 and 135.208 [renumbered 12.6, 12.7 and 12.8, IAC 5/4/88] delayed by the Administrative Rules Review Committee 70 days from December 12, 1984. Delay lifted by committee on January 9, 1985.