Board of Licensure in Medicine/Board of Osteopathic Licensure Workgroup
161 Capitol Street
Augusta, Maine 04333-0137
October 22, 2025
5:30 pm

The October 22, 2025 meeting of the workgroup is being held with workgroup members participating virtually on Zoom. There will be an opportunity for the public to view the meeting at the Board's offices in Augusta. A link for the public to access the meeting virtually is included below and posted on the Board's website. **The Board encourages members of the public to attend the meeting virtually.**

Join Zoom meeting: https://mainestate.zoom.us/j/84678747985

Meeting ID: 846 7874 7985 Passcode: 55407552 or by phone (312) 626-6799 or 1 (646) 876-9923

I. Role Call of Board Members
II. Review of the FAQ Document
III. Review of Possible Advantages/Disadvantages Document
IV. Review of the draft budget numbers for the Board of Osteopathic Licensure
V. Review of Licensing Trends
VI. Review of Proposed Statute – BOLIM Staff side by side review edits
VII. Next Steps
VIII. Public Comment
A. Written Comments Received
IX. Adjourn

Board of Licensure in Medicine & Board of Osteopathic Licensure
Question & Answer

Are MD's and DO's currently licensed by separate boards?
➢ Yes, The Board of Osteopathic Licensure (BOL) licenses osteopathic physicians and physician assistants. The Board of Licensure in Medicine (BOLIM) licenses allopathic physicians and physician assistants. Maine is one of twelve (12) states that has separate boards.
Why are there two licensing boards?
➢ BOLIM began licensing allopathic physicians in 1895. When osteopathic physicians requested licensure from the state, they were given a separate board, BOL, in recognition of their focus on osteopathic medicine, including osteopathic manipulation.
What are other states doing?
➢ Boards have changed over time with a high of 30 states having separate boards in 1939. Today only 12 states have separate medical and osteopathic boards. Three states have consolidated medical and osteopathic boards since 2021. (Data provided by the Federation of State Medical Boards)
What has changed?
➢ MDs, DOs and PAs work side by side in a collaborative manner every day. The post graduate training for MDs and DOs are accredited by the same organization, and DOs and MDs can be found in every specialty. With the exception that DOs have additional training in osteopathic ideals, the education, training and examination requirements are similar.
What are the missions of the boards?
➢ The mission of both boards is the same: Protect the health, safety and welfare of Maine citizens.

Do the boards currently collaborate?
➢ Yes, the boards currently have 5 joint rules and share one staff person.
Why are the boards considering merging?
➢ There are several reasons for a proposed merger of the two boards. BOL has one (1) full-time employee that is responsible for all aspects of board functions, including administrative, legislative, licensing and investigative. BOLIM has ten (10) full-time employees. BOLIM currently reviews approximately 30 complaints and investigations each month. BOL sees a quarter to a third of that number each month. Merging would allow the work to be distributed among more members and may also allow for more efficient processing of licensing, complaints, investigations and hearings. There is a growing recognition in the profession that health care is delivered in a collaborative team setting. Merging would reflect the current realities of practice by placing three members of the collaborative health care team under one board. Although not yet determined, the boards are also looking to see what financial impact a merger would have.
Can MDs judge complaints against DOs and vice versa?
➢ Currently, DOs, PAs and public members evaluate and adjudicate complaints against DOs. Likewise, MDs, PAs and public members evaluate and adjudicate complaints against MDs. When there is a question of practice that is outside of the specialty of board members, the case is referred to an outside expert in the field for review, which board members then use to make a determination on the outcome of the case.
What would representation look like on a merged board?
➢ Although the boards have not settled on firm numbers, they are still studying the feasibility, they have agreed in principle that equal representation for DOs and MDs is required and that consistent proportional representation for PAs and public members is also required.
How can I find more information?
➢ More information and updates can be found on the boards' websites, www.maine.gov/osteo and www.maine.gov/md.

How can I provide input?
➢ The boards have created a workgroup that meets once a month. There will be time for public comment at those meetings. In addition, you can email questions and comments to board staff at tim.e.terranova@maine.gov and rachel.macarthur@maine.gov. Please copy both on any correspondence.

Board of Licensure in Medicine & Board of Osteopathic Licensure

This is a general list created for discussion purposes only. The workgroup will need to discuss how the information provided might impact public safety.

Possible Advantages	Possible Disadvantages
• As drafted the proposed statute recognizes that the three healthcare professions have their own education and values. It ensures that the individual education and values are preserved.	• Perception of a loss of identity for all three health care professions
Administrative	Administrative

• Shared resources
  ○ Staff
  ○ Financial
  ○ Board work
• Streamlining of functions
  ○ Invoices
  ○ Contracts, supplies
  ○ Payroll
  ○ Budget
  ○ Rulemaking
• One contact point for licenses, public, and other entities (hospitals, etc.)
• Avoid office closure for time off/vacation
• PAs licensed by only one board
	• Current work brought from each Board – as of 10/10/25
	  ○ BOLIM Adjudicatory Hearings - 2 (1 in progress and 1 ordered)
	  ○ BOLIM Open Complaints - 126
	  ○ BOLIM Open Investigations (ADs) - 27
	  ○ BOL Adjudicatory Hearings - 4 pending
	  ○ BOL Open Complaints - 46
	  ○ BOL Open Investigations - 6
	• Larger board could be seen as more bureaucratic
	• Possible confusion from licensees during the transition

Financial	Financial
• Costs are distributed to a larger pool of licensees • Streamlining of functions should see some savings over time	• Initial increase in cost to fund transition (funds can be taken from savings if approved/appropriated) • Fees are currently different and there would need to be some type of standardization
Standard Practices	Standard Practices
• Licensees will have consistent administrative standards and practices	• Licensees may need to adapt to standards/rules currently in place with only 1 board

Terranova, Tim E

From: Xiaomei Pei <xpei@fsmb.org>
Sent: Monday, October 6, 2025 3:35 PM
To: Terranova, Tim E; Aaron Young
Cc: Xiaomei Pei
Subject: Re: data request
Attachments: Maine_MD_DO_Licenses_Trends2020_2024.xlsx

Hi Tim,

Per your request, the attached file shows the results for all licensees and first-time license issued from 2020 to 2024 for Maine, as well as New Mexico, Illinois, Utah and all states, using 2024 FSMB census data. Please take a close look and let us know if you have any questions.

Below is a brief summary of my observations:

- All licensees
  - Across all states, the average annual increase rate for DO licenses issued was 7%, outpacing MD licenses at a 4% annual growth rate.
  - In Maine, both DO and MD licenses saw a significant decline from 2020 to 2021 (DO: -21% vs MD: -26%), possibly due to pandemic impact. DO licenses increased again through 2024.
  - Over the past five years, DO licenses in Maine grew at an average annual rate of 5%, with a steady upward trend since 2021. In contrast, New Mexico DO licenses showed a slight decline since 2022.
- First-time licenses
  - The national average annual increase in first-time licenses was 12% for DOs and 8% for MDs. Smaller volume states saw more year-to-year fluctuations.
  - First-time DO licenses in Maine remained stable over the period, averaging 3% annual growth. Illinois, by comparison, saw the first-time DO licenses decline since 2022.

Note:

- The number of first-time licenses excludes training, temporary, limited and resident licenses whenever they can be identified.
- For all states, the count of all issued licenses includes only one entry per MD or DO per year, even if an individual may have received multiple licenses in that year.

Thanks,

All Licenses Issued by Year										
	Maine		New Mexico		Illinois		Utah		**All US states**	
Year	DO	MD	DO	MD	DO	MD	DO	MD	**DO**	**MD**
2020	312	1,580	262	1,218	836	4,914	178	1,102	**17,023**	**89,991**
2021	245	1,174	266	1,170	916	4,977	262	1,172	**18,340**	**93,972**
2022	318	1,192	348	1,374	969	5,271	290	1,416	**20,319**	**102,117**
2023	335	1,258	284	1,629	1,117	5,799	307	1,360	**21,642**	**105,068**
2024	355	1,206	279	1,755	1,087	6,050	204	978	**22,139**	**106,099**
Total	1,565	6,410	1,439	7,146	4,925	27,011	1,241	6,028	**99,463**	**497,247**
Annual Increase % of all licenses by year										
2020 to 2021	-21%	-26%	2%	-4%	10%	1%	47%	6%	8%	4%
2021 to 2022	30%	2%	31%	17%	6%	6%	11%	21%	11%	9%
2022 to 2023	5%	6%	-18%	19%	15%	10%	6%	-4%	7%	3%
2023 to 2024	6%	-4%	-2%	8%	-3%	4%	-34%	-28%	2%	1%
Average annual increase (%)	5%	-6%	3%	10%	7%	5%	8%	-1%	7%	4%

Data source: 2024 FSMB Census Data

First-time licenses issued by Year

	Maine		New Mexico		Illinois		Utah		**All US States**	
Year	DO	MD	DO	MD	DO	MD	DO	MD	**DO**	**MD**
2020	35	68	14	119	198	1,039	28	249	**4,337**	**19,814**
2021	36	71	19	107	237	1,034	37	261	**5,124**	**22,351**
2022	29	60	18	117	265	1,074	42	282	**6,134**	**26,913**
2023	43	85	26	141	251	1,054	35	281	**7,026**	**28,841**
2024	35	74	28	111	173	627	31	266	**6,722**	**26,651**
Total	178	358	105	595	1,124	4,828	173	1,339	**29,343**	**124,570**
Annual Increase % of First-time licenses by year										
2020 to 2021	3%	4%	36%	-10%	20%	0%	32%	5%	18%	13%
2021 to 2022	-19%	-15%	-5%	9%	12%	4%	14%	8%	20%	20%
2022 to 2023	48%	42%	44%	21%	-5%	-2%	-17%	0%	15%	7%
2023 to 2024	-19%	-13%	8%	-21%	-31%	-41%	-11%	-5%	-4%	-8%
Average annual increase (%)	3%	4%	21%	0%	-1%	-10%	4%	2%	12%	8%

Terranova, Tim E

From: Amanda Mahan <amahan@mainedo.org>
Sent: Tuesday, September 30, 2025 3:44 PM
To: Terranova, Tim E
Cc: MacArthur, Rachel; Kathryn Brandt; Wilson, Lisa A; Willis, Jennifer; Charles Soltan
Subject: Re: BOL/BOLIM Feasibility Workgroup 9/24 Meeting

Tim,

Given the fact that there are no official channels to share such feedback with board leadership or this task force directly, coupled with the recent confusion over deliverance of official correspondence, I thought I would ensure our comments were shared directly. As you will notice, they were also shared with you as staff.

Many Thanks,
Amanda

Amanda Mahan
Executive Director
Maine Osteopathic Association
Phone: 207-623-1101
Website: www.mainedo.org

On Tue, Sep 30, 2025 at 2:28 PM Terranova, Tim E <Tim.E.Terranova@maine.gov> wrote:

> Good Afternoon,
>
> Thank you for your email. As you are aware, communications with board members needs to go through the appropriate Board office. Contacting individual Board Members directly is not appropriate.
>
> Please send all future communication to the appropriate Board office.
>
> Thank you

Timothy Terranova

Executive Director

Maine Board of Licensure In Medicine

(207) 287-6930

From: Amanda Mahan <amahan@mainedo.org>
Sent: Tuesday, September 30, 2025 1:26 PM
To: Dr. Christine Munroe <cmunroe@yorkhospital.com>; RFay-LeBlanc@greaterportlandhealth.org
Cc: Terranova, Tim E <Tim.E.Terranova@maine.gov>; MacArthur, Rachel <Rachel.MacArthur@maine.gov>; Kathryn Brandt <kbrandt@une.edu>
Subject: RE: BOL/BOLIM Feasibility Workgroup 9/24 Meeting

Good Afternoon,

Please see attached for comments from Kat Brandt, DO MOA President following the 9/24 Workgroup meeting.

Dr. Brandt is cced here should you want to reach out for further discussion.

Many Thanks,

Amanda

Amanda Mahan

Executive Director

Maine Osteopathic Association

Phone: 207-623-1101

Website: www.mainedo.org

September 29th, 2025

Maine Board of Osteopathic Licensure
Attn: Christine Munroe, D.O. Chair
142 State House Station
Augusta, ME 04333-0142

Maine Board of Licensure in Medicine
Attn: Renee Fay-LeBlanc, MD, Chair
137 State House Station
161 Capitol Street
Augusta, Maine 04333-0137

Dear BOL/BOLIM Feasibility Workgroup Members,

I am writing in response to the meeting Wednesday 9/24 as I was traveling and unable to raise my hand in time during the public comments. I was very heartened by much of the meeting, especially around seeking a budget estimate for an independent osteopathic board more in line with what the BOL staff expressed was needed.

However, towards the end of the meeting it came up that reasoning for merging included that the public did not consider there to be a difference between MDs and DOs and that the "standards of care are the same." While well intended, especially in the context of cooperating around handling issues of pandemic response, this is the crux of why the osteopathic community has been adamant about identity and independence. The standards of care are not the same. There is a difference between MDs and DOs and as Dr Diefenderfer eloquently said, many people seek that difference. Yes, we all strive to practice evidence-based medicine and agree on many things and can and should cooperate. But there is an entire domain of standard of care in osteopathic medicine that does not exist in allopathic medicine. It is within living memory that the allopathic community in Maine did not consider osteopathic physicians to meet the standard of care writ large. It is within recent memory we were shut out of training opportunities, our hospitals usurped and closed.

While the current draft vision of a merged board seeks to respect osteopathic identity, it does not do so in a way that structurally ensures that respect continues in perpetuity. I have observed during these meetings a genuine respect for osteopathic medicine. However, my concern is what happens when and if that sentiment changes?

Thank you for the opportunity to continue the dialogue on this important topic.

Sincerely,
Kathryn Brandt

Kathryn Brandt, DO, MS.MEdL, President, Maine Osteopathic Association, President@mainedo.org

Terranova, Tim E

From: Murray, Douglas <DMurray@nbome.org>
Sent: Thursday, September 25, 2025 8:26 PM
To: Terranova, Tim E; MacArthur, Rachel
Cc: Gimpel, John; Kathleen Creason
Subject: Follow-Up to Maine Workgroup
Attachments: Letter to Maine Board Workgroup 092525.pdf; NBOME Letter to Maine Board Workgroup Sept 2025.pdf

Mr. Terranova and Ms. MacArthur,

Enclosed please find a letter addressing an issue raised during last night's Workgroup meeting. We are hopeful that the Workgroup will continue to have an open dialogue about the issues raised in both our September 9 letter and the recent letter from the AOA and we look forward to being a part of that discussion. If you have any questions, please let me know.

Best Regards,

Douglas Murray, Esq.
General Counsel
(610) 825-1712

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Suite 200, Chicago, IL 60631

September 25, 2025

Timothy Terranova
Maine Board of Licensure in Medicine

Rachel MacArthur
Maine Board of Osteopathic Licensure

RE: Letter to Maine Workgroup

Dear Mr. Terranova and Ms. MacArthur:

I am writing to follow up on a matter discussed at the Maine Workgroup during its meeting last evening, which I attended virtually. As you both are likely aware, the NBOME sent a letter to the Workgroup recently providing support for the continuation of separate and independent medical boards in Maine. While we were pleased that the Workgroup included the letter in its meeting materials, we were disappointed that there was no discussion of the content of either NBOME or the AOA's letters during the meeting.

Additionally, Mr. Terranova made a statement that the NBOME was confused about which Board it was communicating to and sent its letter to the wrong board. This is incorrect, the letter which we have attached again was addressed to the Workgroup but as there is no dedicated email or other contact information for the Workgroup, it was sent to you both as the staff leads for each organization, as instructed in the FAQ document found on the on the Workgroup page on the BOLIM website. The language from the Workgroup FAQ document is below:

> ***The boards have created a workgroup that meets once a month. There will be time for public comment at those meetings. In addition, you can email questions and comments to board staff at tim.e.terranova@maine.gov and rachel.macarthur@maine.gov. Please copy both on any correspondence.***

We appreciate the efforts of the Workgroup to find a solution that will best serve the citizens and patients in Maine and we remain open and available to discuss the issues raised in our letter.

Sincerely,

Douglas Murray

Douglas Murray, Esq,
General Counsel

cc: John R. Gimpel, DO, MEd
Kathleen Creason

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TO: Maine BOLIM/BOL Workgroup

FROM: National Board of Osteopathic Medical Examiners

DATE: September 9, 2025

SUBJECT: Proposed Merger of BOLIM and BOL and Support for Separate Boards

The National Board of Osteopathic Medical Examiners (NBOME) **writes to express our support for enhancing the resources for the separate and distinct Maine Board of Osteopathic Licensure (BOL) to serve a key role in professional self-regulation for the practice of osteopathic medicine in support of the care of patients in the state of Maine.** We believe the patients and the profession are best served by a separate and distinct osteopathic medical board in Maine, as well as a separate and district Maine Board of Licensure in Medicine (BOLIM), without merging the two together as a single Board.

The NBOME, a 501(c)(3) nonprofit organization founded in 1934, has a mission to protect the public by providing the means to assess competencies for osteopathic medicine and related health care professions. The NBOME's COMLEX-USA examination is recognized and accepted for licensure purposes by all U.S. medical and osteopathic medical licensing boards and in other countries around the world. We appreciate your recognition that COMLEX-USA evaluates the competencies required for delivering safe and high quality osteopathic medical care to patients. We stand along with the American Osteopathic Association (AOA), the AOA-Commission on Osteopathic College Accreditation (AOA-COCA), the American Society of Osteopathic Medical Regulators (ASOMR), and now the Accreditation Council for Graduate Medical Education (ACGME) in working with the nation's state licensing boards in stewarding professional self-regulation for the osteopathic medical profession and continuing to earn the trust of the patients we serve. We stand alongside the stellar University of New England College of Osteopathic Medicine (UNECOM) in Maine (where I served as Dean and Vice President for Health Services 2007-2009), the only osteopathic medical school in New England and the only DO or MD-granting school in Maine, in credentialing DOs who serve throughout the state since 1978. The osteopathic model continues to expand in the United States in part due to this trust and the current system that generates compassionate, committed and competent physicians who disproportionately care for patients in many of our nation's rural and underserved communities and specialties of need, including in Maine. With now about 200,000 total practicing DOs, residents and students, of the top six states in number of practicing DOs, four of these are states that entrust separate and distinct osteopathic medical licensing boards with the important responsibility in professional self-regulation, licensure and discipline in these states. Now over 25% of all medical students in the United States are choosing to attend a DO-granting school.

Thank you again for allowing us to listen in to deliberation of the "Board of Licensure in Medicine/Board of Osteopathic Licensure Workgroup" virtual meeting on August 27, 2025, led by

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BOLIM Executive Director, Timothy Terranova. In listening to the deliberations of the workgroup and reviewing the meeting materials provided, it became even more clear that having a separate and distinct BOLIM and BOL remains critical in protecting the public and positioning the state for responsiveness to projections for further physician shortages particularly in rural and other underserved areas in Maine. Maintaining two distinct boards would further protect the public by allowing the BOLIM to focus on likely challenges that may emerge in the near future, including the extensive work cited by Mr. Terranova that is required each year by BOLIM staff related to the licensure of international medical graduates (i.e., for IMGs-MDs) who complete postgraduate training accredited by "the Canadian Medical Association, the Royal College of Physicians of Canada or the Royal Colleges of England, Ireland or Scotland". This was described by Mr. Terranova as "time-intensive work we have done for decades." Now with the 2025 change of the Liaison Committee on Medical Education (LCME) no longer accrediting Canadian MD-granting schools and should the Maine legislature approve pending Maine House Bill 105 which would create a temporary license for IMGs, it is likely that the work of the Maine BOLIM will escalate significantly due to these changes in the upcoming years. As outlined by the authoritative "Advisory Commission on Additional Licensing Models (August 2025)" (see link below), recommended requirements and responsibilities of state medical boards for internationally trained physicians (ITPs) include extensive needs for assessment, supervision, communication, reporting, and verification to help the board in protecting the public. For osteopathic medicine and DOs and the BOL, there is only one osteopathic medical school accreditation authority (AOA-COCA), and one licensing examination (COMLEX-USA) and one GME accreditor (ACGME). It would make sense to an observer that it is unwise to encumber the BOL and osteopathic physicians with the escalating challenges faced by the BOLIM, including those that are unique to the BOLIM and not relevant to the BOL. This would seem to be another very good reason to support two separate and distinct boards at this time, and why the public of Maine and the legislature should support a solution that ensures that both boards are well resourced to fulfill their respective professional self-regulation responsibilities.

Finally, as the BOL appears to be financially self-sustaining from physician licensure fees and also appears to have funding for additional staff that has not yet been resourced for that purpose, there would be no benefit to the state or taxpayers from merging the two separate and distinct boards into a single board with divergent responsibilities. On the contrary, eliminating the BOL and the BOLIM and creating a new board would necessarily involve new administrative and training costs, as already discussed in the proposals, and will likely disrupt the efficient service that the BOL currently provides to Maine DOs, for the benefit of patients. Additional costs incurred due to the complexities of monitoring of IMGs and ITPs in the future will be more efficiently managed by a separate BOLIM, not complicating professional self-regulation or DOs. While the BOL may be currently understaffed, adding some additional staff to the BOL and contracting between boards for select services (as done in numerous states) appears to be a more economically efficient approach rather than consolidating the boards. From the financial models presented during the meeting, it was not clear that there would be any cost efficiencies to creating a single board, and that is what numerous other states who have evaluated such mergers have determined in their deliberations, determining that the best

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course of action for the patients in their states was two strong, separate and distinct boards focused on what they each need to do for patients in their states.

For these reasons, the NBOME supports your collective and sincere efforts focused on protecting the public and considering what is best for them and for access to care throughout your great state. We believe that a strong, separate and distinct board for DOs, working collaboratively with a strong, separate, distinct board for MDs (MBBS, MCh and other international designations for MDs) is the solution that is in the best interests of the patients in Maine. We hope that the workgroup comes to this conclusion as does the BOLIM and the BOL and that the two boards and the workgroup provide the Maine legislature with a unified vision and recommendation for two strong boards, the BOM and the BOLIM. This, in our view, would be a victory for defensible and just professional self-regulation for both professions and related health care professions and the patients we have the privilege to serve.

Sincerely,

John R. Gimpel, DO, MEd
President & CEO

References:

Advisory Commission on Additional Licensing Models (August 2025)

Cc: Kathryn Brandt, DO, MS, MEdL, MOA, President
Jane E. Carreiro, DO, UNECOM, Dean & VP, Health Affairs
Kathleen S. Creason, MBA, AOA, Chief Executive Officer
Amanda Mahan, MOA, Executive Director
Raine Richards, JD, ASOMR VP, State & International Affairs

Terranova, Tim E

From: Terranova, Tim E
Sent: Friday, September 26, 2025 7:15 AM
To: 'Murray, Douglas'; MacArthur, Rachel
Cc: Gimpel, John; Kathleen Creason
Subject: RE: Follow-Up to Maine Workgroup
Attachments: NBOME for Dennis.pdf

Good Morning,
Thank you for your email.
I would like to take a moment to clarify my comments. I was not referring to the letter addressed to the workgroup, which was submitted appropriately. I was referring to the attached letter dated August 19th, 2025, (received 9/9/25) and signed by you.
As you can see, the address on the letter is :
Dennis E. Smith, Esq
Maine Board of Licensure in Medicine
137 State House Station
Augusta Maine, 04333
The first sentence reads, "On behalf of the National Board of Osteopathic Examiner's (NBOME), we want to congratulate you on your appointment to the Maine Board of Osteopathic Licensure."
I hope this information is helpful.
Tim

Timothy Terranova
Executive Director
Maine Board of Licensure In Medicine
(207) 287-6930

From: Murray, Douglas <DMurray@nbome.org>
Sent: Thursday, September 25, 2025 8:26 PM
To: Terranova, Tim E <Tim.E.Terranova@maine.gov>; MacArthur, Rachel <Rachel.MacArthur@maine.gov>
Cc: Gimpel, John <JGimpel@nbome.org>; Kathleen Creason <kcreason@osteopathic.org>
Subject: Follow-Up to Maine Workgroup

Mr. Terranova and Ms. MacArthur,

Enclosed please find a letter addressing an issue raised during last night's Workgroup meeting. We are hopeful that the Workgroup will continue to have an open dialogue about the issues raised in both our September 9 letter and the recent letter from the AOA and we look forward to being a part of that discussion. If you have any questions, please let me know.

Best Regards,

Douglas Murray, Esq.

General Counsel
(610) 825-1712

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August 19, 2025

Dennis E. Smith, Esq
Maine Board of Licensure in Medicine
137 State House Station
Augusta, ME 04333

Dear Mr. Smith,

On behalf of the National Board of Osteopathic Medical Examiners (NBOME), we want to congratulate you on your appointment to the Maine Board of Osteopathic Licensure. NBOME engages with the Federation of State Medical Boards along with the state licensing boards directly. We regularly provide updates about the COMLEX-USA program and our other assessment products, and we report news about our services in support of the vitally important work of the licensing community.

Founded in 1934, the NBOME is the leading assessment organization for the osteopathic medical profession. Our mission is to protect the public by providing the means to assess competencies for osteopathic medicine and related health care professions. The NBOME has developed and administers the Comprehensive Osteopathic Medical Licensing Examination (COMLEX-USA) series (Level 1, 2-CE, and 3) for osteopathic physicians, which is universally accepted and recognized for physician licensure in all 50 states. Passing scores on COMLEX- USA examinations indicate that the candidate's osteopathic medical knowledge and clinical skills have met an acceptable national standard for entry into osteopathic medical practice. Osteopathic medical students are also required to pass Levels 1 and 2-CE of the COMLEX-USA in order to graduate from an osteopathic medical school, in accordance with the Commission on Osteopathic College Accreditation (COCA) requirements.

For osteopathic physicians who may have been out of active practice or who otherwise require an assessment of their current knowledge and skills, the NBOME offers the Comprehensive Osteopathic Medical Variable-Purpose Examination (COMVEX), which provides licensing boards with an evaluation of a physician's knowledge of current osteopathic medical practice.

The NBOME also for the last several years has been exploring and piloting the development of an osteopathic clinical skills assessment program, the Core Competency Capstone (C3DO) in conjunction with various colleges of osteopathic medicine. The NBOME recently announced its intention to launch the C3DO program and incorporate this assessment into its COMLEX-USA program as an option for the verification of osteopathic clinical skills competencies as part of the eligibility requirements for COMLEX-USA Level 3 starting in 2028. More information on the C3DO program can be found on NBOME's website at: https://www.nbome.org/assessments/clinical-skills/c3do/

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Suite 200, Chicago, IL 60631

The NBOME also welcomes any state board members who are interested in participating in NBOME activities; currently we have state board members serving on the NBOME Board of Directors as well as participating in NBOME test development, standard-setting, or other committee work as part of NBOME's 900+ member National Faculty. More information on the NBOME National Faculty can be found at:

- NBOME National Faculty - https://www.nbome.org/who-we-are/national-faculty/

Additionally, below are links to several of other of our resources that may be of interest to you:

- Licensure Board Information on NBOME's website - https://www.nbome.org/resources-for/state-licensing-boards/
- The Osteopathic Examiner, a quarterly newsletter for licensure boards and other stakeholder groups. - https://www.nbome.org/publications-reports/#osteopathic-examiner
- NBOME Annual Report - https://www.nbome.org/app/uploads/2025/03/NBOME-2024-Annual-Report.pdf

We hope you find this information helpful. Please feel free to reach out to us whenever you have questions or if we can be of assistance to you.

Best regards,

Douglas Murray

Douglas Murray, Esq.
General Counsel
National Board of Osteopathic Medical Examiners
dmurray@nbome.org

cc: John R. Gimpel, DO, MEd, President and CEO, NBOME
Raine Richards, VP State and International Affairs, AOA

Terranova, Tim E

From: Murray, Douglas <DMurray@nbome.org>
Sent: Friday, September 26, 2025 10:56 AM
To: Terranova, Tim E; MacArthur, Rachel
Cc: Gimpel, John; Kathleen Creason
Subject: RE: Follow-Up to Maine Workgroup

Tim,

Thanks for clarifying as it wasn't clear from your comment what you were referring to. This is a welcome letter we send out to all new members of medical boards in the US, and our administrative assistant must have used the wrong address for this particular letter we apologize. You can be assured there is no confusion at NBOME regarding the roles and responsibilities of each Board in Maine and as noted in our Sept. 9 letter, we feel both Boards are servicing their respective communities well under the existing structure.

Thanks,
Doug

From: Terranova, Tim E <Tim.E.Terranova@maine.gov>
Sent: Friday, September 26, 2025 7:15 AM
To: Murray, Douglas <DMurray@nbome.org>; MacArthur, Rachel <Rachel.MacArthur@maine.gov>
Cc: Gimpel, John <JGimpel@nbome.org>; Kathleen Creason <kcreason@osteopathic.org>
Subject: RE: Follow-Up to Maine Workgroup

Good Morning,
Thank you for your email.
I would like to take a moment to clarify my comments. I was not referring to the letter addressed to the workgroup, which was submitted appropriately. I was referring to the attached letter dated August 19th, 2025, (received 9/9/25) and signed by you.
As you can see, the address on the letter is :
Dennis E. Smith, Esq
Maine Board of Licensure in Medicine
137 State House Station
Augusta Maine, 04333
The first sentence reads, "On behalf of the National Board of Osteopathic Examiner's (NBOME), we want to congratulate you on your appointment to the Maine Board of Osteopathic Licensure."
I hope this information is helpful.
Tim

Timothy Terranova
Executive Director
Maine Board of Licensure In Medicine

(207) 287-6930

From: Murray, Douglas <DMurray@nbome.org>
Sent: Thursday, September 25, 2025 8:26 PM
To: Terranova, Tim E <Tim.E.Terranova@maine.gov>; MacArthur, Rachel <Rachel.MacArthur@maine.gov>
Cc: Gimpel, John <JGimpel@nbome.org>; Kathleen Creason <kcreason@osteopathic.org>
Subject: Follow-Up to Maine Workgroup

Mr. Terranova and Ms. MacArthur,

Enclosed please find a letter addressing an issue raised during last night's Workgroup meeting. We are hopeful that the Workgroup will continue to have an open dialogue about the issues raised in both our September 9 letter and the recent letter from the AOA and we look forward to being a part of that discussion. If you have any questions, please let me know.

Best Regards,

Douglas Murray, Esq.
General Counsel
(610) 825-1712

DRAFT STATUTE FOR COMBINED MEDICAL BOARD PREPARED BY DENNIS SMITH, ESQ

CHAPTER XXX

PART A

MAINE MEDICAL BOARD

SUBCHAPTER 1

GENERAL PROVISIONS

§XXXX. Short title

This chapter may be known and cited as "the Maine Board of Medicine Medical Practice Act."

~~**§XXXX. Purpose**~~

~~The Maine Board of Medicine is the state regulatory agency charged with protecting the public through the licensing and regulation of physicians and physician assistants in Maine.~~

§XXXX. Definitions

As used in this chapter, unless the context otherwise indicates, the following terms have the following meanings.

1. Allopathic Physician. "Allopathic Physician" means a physician who graduated from medical school with an MD degree.

1. Board. "Board" means the Maine Board of Medicine established in Title 5, section 12004-A, subsection X.

~~**2. Commissioner.** "Commissioner" means the Commissioner of Professional and Financial Regulation.~~

3. License. "License" means a license, certificate, certification, registration, permit, approval or other similar document issued by the Board to qualified individuals granting authority to engage in the practice of medicine.

4. Osteopathic Physician. "Osteopathic Physician" means a physician who graduated from medical school with a DO degree.

4. Physician. "Physician" means an allopathic or osteopathic physician or surgeon licensed by the Board.

5. Physician ~~Assistant~~Associate. "Physician ~~Assistant~~Associate" means a physician ~~assistant~~associate licensed by the Board.

6. Practice of Medicine. "Practice of Medicine" means diagnosing, relieving in any degree or curing, or professing or attempting to diagnose, relieve or cure a human disease, ailment, defect or complaint, whether physical or mental, or of physical and mental origin, by attendance, by surgery, or by advice, or by prescribing or furnishing a drug, medicine, appliance, manipulation, method or a therapeutic agent and includes:

A. Advertising, holding out to the public, or representing in any manner that one is authorized to practice medicine in Maine;

B. Offering or undertaking to prescribe, order, give, or administer any drug or medicine for use by any other person;

Commented [TT1]: At least three different Commissioners are mentioned throughout the statute

Commented [TT2]: Is this an appropriate definition

Commented [TT3]: This is slightly different than 3270 Unless licensed by the board, an individual may not practice medicine or surgery or a branch of medicine or surgery or claim to be legally licensed to practice medicine or surgery or a branch of medicine or surgery within the State by diagnosing, relieving in any degree or curing, or professing or attempting to diagnose, relieve or cure a human disease, ailment, defect or complaint, whether physical or mental, or of physical and mental origin, by attendance or by advice, or by prescribing or furnishing a drug, medicine, appliance, manipulation, method or a therapeutic agent whatsoever or in any other manner unless otherwise provided by statutes of this State.

C. Offering or undertaking to prevent or to diagnose, correct, and/or treat in any manner or by any means, methods, or devices any disease, illness, pain, wound, fracture, infirmity, defect, or abnormal physical or mental condition of any person;

D. Offering or undertaking to perform any surgical operation upon any person;

E. Rendering a written or otherwise documented medical opinion concerning the diagnosis or treatment of a patient or the actual rendering of treatment to a patient within a state by a physician located outside the state as a result of transmission of individual patient data by electronic or other means from within a state to such physician or the physician's agent;

F. Rendering a determination of medical necessity or a decision affecting the diagnosis and/or treatment of a patient; and

G. Using the designation Doctor, Doctor of Medicine, Doctor of Osteopathic Medicine/Doctor of Osteopathy, Physician, Surgeon, Physician and Surgeon, Dr., M.D., D.O., or any combination thereof in the conduct of any occupation or profession pertaining to the prevention, diagnosis, or treatment of human disease or condition unless such a designation additionally contains the description of another branch of the healing arts for which one holds a valid license in the jurisdiction where the patient is located.

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H. Maintaining adequate medical records pursuant to the standard of care.

I. The rendering of medical services by physician associates

J. "Collaborative agreement" means a document agreed to by a physician assistant and a physician that describes the scope of practice for the physician assistant as determined by practice setting and describes the decision-making process for a health care team, including communication and consultation among health care team members.

K. "Consultation" means engagement in a process in which members of a health care team use their complementary training, skill, knowledge and experience to provide the best care for a patient.

L. "Health care team" means 2 or more health care professionals working in a coordinated, complementary and agreed-upon manner to provide quality, cost-effective, evidence-based care to a patient and may include a physician, physician assistant, advanced practice nurse, nurse, physical therapist, occupational therapist, speech therapist, social worker, nutritionist, psychotherapist, counselor or other licensed professional.

M. "Physician" means a person licensed as a physician under this chapter or chapter 36. [PL 2019, c. 627, Pt. B, §17 (NEW).]

N. "Physician assistant" means a person licensed under section 2594-E or 3270-E.

O. "Practice agreement" means a document agreed to by a physician assistant who is the principal clinical provider in a practice and a physician that states the physician will be available to the physician assistant for collaboration or consultation.

P. "Prescription or legend drug" has the same meaning as "prescription drug" in section 13702-A, subsection 30 and includes schedule II to schedule V drugs or other substances under the federal Controlled Substances Act, 21 United States Code, Section 812.

§XXXX. Individual license

Only an individual may be licensed under this chapter and only a licensed individual may provide services for which a license is required under this chapter.

§XXXX. License required

1. Unlicensed practice. A person may not engage in the practice of medicine without a license or during any period when that person's license has expired or has been suspended, surrendered, or revoked.

2. Penalties. A person who violates this section commits a Class E crime. Violation of this section is a strict liability crime as defined in Title 17-A, section 34, subsection 4-A.

Commented [TT4]: This appears to be inconsistent with Title 10 8003-C. There is no reference to Title 17-A in existing law and it is inadvisable to do so here.

§XXXX. Exemption for licensed or privileged person accompanying visiting athletic team

1. Licensed or privileged person accompanying visiting athletic team. This chapter does not apply to a person who holds a current unrestricted license to practice medicine and surgery in another state when the person, pursuant to a written agreement with an athletic team located in the state in which the person holds the license, provides medical services to any of the following while the team is traveling to or from or participating in a sporting event in this State:

A. A member of the athletic team;

B. A member of the athletic team's coaching, communications, equipment or sports medicine staff;

C. A member of a band or cheerleading squad accompanying the team;

D. The team's mascot.

2. Restrictions. A person authorized to provide medical services in this State pursuant to subsection 1 may not provide medical services at a health care facility, including a hospital, ambulatory surgical facility or any other facility where medical care, diagnosis or treatment is provided on an inpatient or outpatient basis.

SUBCHAPTER 2

MAINE BOARD OF MEDICINE

§XXXX. Board creation; declaration of policy; compensation

1. Board creation; declaration of policy. The Maine Board of Medicine, as established in Title 5, section 12004-A, subsection X, is created within this subchapter~~, its sole purpose being to protect the public health and welfare. The board carries out this purpose by ensuring that the public is served by competent and honest practitioners and by establishing minimum standards of proficiency in the professions regulated by the board by testing, licensing, regulating and disciplining practitioners of those regulated professions~~.

§XXXX. Board membership

1. Membership; terms; removal. The board consists of 17 members appointed by the Governor as follows:

A. Five allopathic physicians. Each physician member must hold a valid license under this chapter and must have been in the ~~actual~~ clinical practice of medicine in this State for a continuous period of five (5) years immediately preceding appointment.

B. Five osteopathic physicians. Each physician member must hold a valid license under this chapter and must have been in the ~~actual~~ clinical practice of medicine in this State for a continuous period of five (5) years immediately preceding appointment.

C. Four physician ~~assistant~~associates. Each physician ~~assistant~~associate must hold a valid license under this chapter and must have been in the ~~actual practice of medicine~~clinical rendering of medical services in this State for a continuous period of five (5) years immediately preceding appointment.

D. Three public members. The public members must be residents of this State and must have no financial interest in the medical profession and have never been licensed, certified or given a permit in this or any other state to practice medicine.

The Governor may accept nominations from professional associations and from other organizations and individuals. A member of the board must be a legal resident of the State. A person who has been disciplined by a medical regulatory body in any jurisdiction or who has been convicted of a crime that is related to the practice of medicine or which is punishable by more than one year's imprisonment, is not eligible for appointment to the board. Appointment of members must comply with Title 10, section 8009.

2. Terms. Terms of the members of the board are for 5 years. A person who has served 10 years or more on the board is not eligible for re-appointment to the board. A board member may be removed by the Governor for cause.

Commented [TT5]: Discussion for boards - Do you want term limits?

3. Quorum.

A. General business, rule making, policies, guidelines, legislation. A majority of the members of the board constitutes a quorum for the transaction of official general business, rulemaking, policy making, guidelines, and legislation.

B. Adjudicatory hearings. Five members of the board constitute a quorum for the conduct of adjudicatory hearings pursuant to this chapter. Adjudicatory hearing panels shall to the extent possible be composed of three members of the same license type as the respondent licensee and at least one public member.

Commented [TT6]: There was discussion about the size and composition panel but nothing definitive was determined.

4. Meetings. The board shall hold ~~regular monthly meetings~~a minimum of three regular meetings a year and any additional special meetings at a time and place the chair may designate.

5. Board Officers. The board shall elect the following officers, whose duties shall be enumerated by rule, to serve two-year terms: chair; vice-Chair, secretary. The secretary of the board shall perform such duties as delegated by the board through rule~~, including but not limited to license application review functions~~.

[3266] The members of the board shall meet on the 2nd Tuesday of July of the uneven-numbered years at the time and place the board may determine and shall elect a chair, vice-chair and a secretary who shall hold their respective offices for the term of 2 years. The secretary of the board shall perform such duties as delegated by the board, including license application review functions. The board through its executive director shall receive all fees, charges and assessments payable to the board and account for and pay over the same according to law. The board shall hold regular meetings at times and places as it may determine. The board shall cause a seal to be engraved and shall keep a record of all their proceedings.

6. Compensation. Members of the board shall be compensated according to the provisions of Title 5, chapter 379. If the fees to be collected under any of the provisions of this chapter are insufficient to pay the salaries and expenses provided by this section, the members of the board shall be entitled to only a pro rata payment for salary in any years in which such fees are insufficient.

Commented [TT7]: That section will need to be updated

7. Oath. Each member of the board shall, before entering upon the duties of the member's office, take the constitutional oath of office.

§XXXX. Powers and duties of the board

The board has the following powers and duties in addition to all other powers and duties imposed by this chapter:

1. Set standards. The power to set standards of eligibility for examination for candidates desiring admission to medical practice in Maine;

2. Adopt criteria. The power to design or adopt an examination and other suitable criteria for establishing a candidate's knowledge in medicine and its related skills;

3. Licensing and standards. The power to license and to set standards of practice for physicians and surgeons practicing medicine in Maine;

4. Hearings and procedure. The power to conduct adjudicatory hearings, the authority to administer oaths, compel the testimony of witnesses and compel the production of books, records and documents relevant to inquiry pursuant to a subpoena and take evidence in all matters relating to the exercise and performance of the powers and duties vested in the board;

5. Subpoena authority. The power to issue subpoenas in accordance with the terms of Title 5, section 9060, for the production of documents, records and the testimony of witnesses except that the authority applies to any stage of an investigation and is not limited to an adjudicatory proceeding, and during investigation this power is delegated to the Executive Director, or in the Executive Director's absence by the Assistant Executive Director;~~;~~

6. Legal representation. The power to engage legal counsel, to be approved by the Attorney General, and investigative assistants of its own choosing to advise the board generally and specifically, to represent the board in hearings before it and in appeals taken from a decision of the board;

7. Salary and duties. Except as provided in subsections 15 and 16, the power to employ and prescribe the duties of other personnel as the board determines necessary. Except as prescribed in subsection 15, the appointment and compensation of that staff is subject to the Civil Service Law;

Commented [TT8]: Will need to update

8. Rules. The power to adopt rules as the board determines necessary and proper to carry out this chapter. Rules adopted pursuant to this section are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A;

9. Complaints. The duty to investigate complaints in a timely fashion on its own motion and those filed with the board regarding the potential violation of a section of this chapter and the violation of rules adopted by the board pursuant to its authority;

10. Investigations. The duty to open investigations following receipt of ~~mandated~~ reports required by law to be filed with the board or other information and reports made to the board regarding a licensee or applicant for licensure.

11. Report. By March 1st of each year, the board shall submit to the Legislature a report consisting of statistics on the following for the preceding year:

A. The number of complaints against licensees received from the public or filed on the board's own motion;

B. The number of complaints dismissed for lack of merit or insufficient evidence of grounds for discipline;

C. The number of cases in process of investigation or hearing carried over at year end; and

D. The number of disciplinary actions finalized during the report ~~year as tabulated and categorized by the annual statistical summary of the Physician Data Base of the Federation of State Medical Boards of the United States, Inc~~.

12. Open financial records. The duty to keep a record of the names and residences of all individuals licensed under this chapter and a record of all money received and disbursed by the board, and records or duplicates must always be open to inspection in the office of the secretary during regular office hours. The board shall annually make a report to the Commissioner of Professional and Financial

Regulation and to the Legislature containing a full and complete account of all its official acts during the preceding year, and a statement of its receipts and disbursements and comments or suggestions as the board determines essential;

13. ~~Financial~~ Medical Education Contract Powers. The power to mandate, conduct and operate or contract with other agencies, individuals, firms or associations for the conduct and operation of programs of medical education, including statewide programs of health education for the general public and to disburse funds accumulated through the receipt of licensure fees for this purpose, provided that funds may not be disbursed for this purpose for out-of-state travel, meals or lodging for a physician being educated under this program. The power to conduct and operate or contract with other agencies or nonprofit organizations for the conduct and operation of a program of financial assistance to medical students indicating an intent to engage in family practice in rural Maine, under which program the students may be provided with interest-free grants or interest-bearing loans in an amount not to exceed $5,000 per student per year on terms and conditions as the board may determine.

Notwithstanding any other provision of this subsection, if the board contracts with the Commissioner of Education to provide funds for the costs of positions for which the State has contracted at the University of Vermont College of Medicine, or the Tufts University School of Medicine, the terms of the contract between the board and the commissioner must be in accordance with the requirements of Title 20-A, chapter 421;

14. Conduct Examinations. The power to conduct examinations relevant to licensure.

14. Other services and functions. The power to provide services and carry out functions necessary to fulfill the board's statutory responsibilities. The board may set reasonable fees for services such as providing license certification and verifications, providing copies of board law and rules, and providing copies of documents. The board may also set reasonable fees to defray its cost in administering examinations for special purposes that it may from time to time require and for admitting courtesy candidates from other states to its examinations;

15. Budget. The duty to submit to the Commissioner of Professional and Financial Regulation its budgetary requirements in the same manner as is provided in Title 5, section 1665, and the commissioner shall in turn transmit these requirements to the Bureau of the Budget without revision, alteration or change, unless alterations are mutually agreed upon by the department and the board or the board's designee;

16. Adequacy of budget, fees and staffing. The duty to ensure that the budget submitted by the board to the Commissioner of Professional and Financial Regulation is sufficient, if approved, to provide for adequate legal and investigative personnel on the board's staff and that of the Attorney General to ensure that professional liability complaints described in Title 24, section 2607 and complaints regarding a section of this chapter can be resolved in a timely fashion. The board's staff must include one position staffed by an individual who is primarily a consumer assistant. Within the limit set by this chapter, the board shall charge sufficient licensure fees to finance this budget provision. The board shall submit legislation to request an increase in these fees should they prove inadequate to the provisions of this subsection.

Within the limit of funds provided to it by the board, the Department of the Attorney General shall make available to the board sufficient legal and investigative staff to enable all consumer complaints mentioned in this subsection to be resolved in a timely fashion;

17. Executive director. The power to appoint an executive director who serves at the pleasure of the board and who shall assist the board in carrying out its administrative duties and responsibilities under this chapter. The salary range for the executive director must be set by the board within the range established by Title 2, section 6-C;

Commented [TT9]: Legal counsels will see if this is still needed.

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18. Approval of licenses. The power to direct staff to review and approve applications for licensure or renewal in accordance with criteria established in law or in rules adopted by the board. Licensing decisions made by staff may be appealed to the full board;

19. Protocols for professional review committee. The authority to establish protocols for the operation of a professional review committee as defined in Title 24, section 2502, subsection 4-A. The protocols must include the committee reporting information the board considers appropriate regarding reports received, contracts or investigations made and the disposition of each report, as long as the committee is not required to disclose any personally identifiable information. The protocols may not prohibit an impaired licensee under this chapter from seeking alternative forms of treatment;

20. Authority to order a mental or physical examination. The board or one of its investigative committees has the power to direct that a licensee or applicant for licensure or re-licensure undergo a mental and/or physical examination by a physician or other person. An individual examined pursuant to the direction of the committee may not prevent the testimony of the examining individual or prevent the acceptance into evidence of the report of an examining individual in any proceeding before the committee or board. ~~Failure to comply with a direction of the committee to submit to a mental or physical examination results in the immediate suspension of the license of the individual until the individual submits to the examination.~~

21. Assessment of costs. When there is a finding of a violation, the power to assess the licensee for all or part of the actual expenses incurred by the board or its agents for investigations and enforcement duties performed. For the purposes of this subsection, "actual expenses" includes, but is not limited to, travel expenses and the proportionate part of the salaries and other expenses of investigators or inspectors, hourly costs of hearing officers, costs associated with record retrieval and the costs of transcribing or reproducing the administrative record.

~~The Commissioner of Professional and Financial Regulation acts as a liaison between the board and the Governor.~~

~~The Commissioner of Professional and Financial Regulation does not have the authority to exercise or interfere with the exercise of discretionary, regulatory or licensing authority granted by statute to the board. The commissioner may require the board to be accessible to the public for complaints and questions during regular business hours and to provide any information the commissioner requires in order to ensure that the board is operating administratively within the requirements of this chapter.~~ 22. **Special license categories.** The board may issue a license limited to the practice of administrative medicine, or any other special license, as defined by routine technical rule of the board adopted pursuant to Title 5, chapter 375, subchapter 2-A.

§XXXX Role of the Commissioner

The Commissioner of Professional and Financial Regulation acts as a liaison between the board and the Governor.

The Commissioner of Professional and Financial Regulation does not have the authority to exercise or interfere with the exercise of discretionary, regulatory or licensing authority granted by statute to the board. The commissioner may require the board to be accessible to the public for complaints and questions during regular business hours and to provide any information the commissioner requires in order to ensure that the board is operating administratively within the requirements of this chapter.

§XXXX. Inspection or copying of record; procedure

1. Request for record; redaction. When the board receives a request to inspect or copy all or part of the record of an applicant or licensee, the board shall redact information that is not public before making the record available for inspection or copying.

Commented [TT10]: Already in law 10 MRS 8003-D, with additional timeframes permitted for assessment of costs: §8003-D. Investigations; enforcement duties; assessments When there is a finding of a violation, a board affiliated with the department identified in section 8001-A may assess the licensed person or entity for all or part of the actual expenses incurred by the board or its agents for investigations and enforcement duties performed. [PL 2011, c. 286, Pt. B, §4 (AMD).]
"Actual expenses" include, but are not limited to, travel expenses and the proportionate part of the salaries and other expenses of investigators or inspectors, hourly costs of hearing officers, costs associated with record retrieval and the costs of transcribing or reproducing the administrative record. [PL 1999, c. 687, Pt. C, §12 (NEW).]
The board, as soon as feasible after finding a violation, shall give the licensee notice of the assessment. The licensee shall pay the assessment in the time specified by the board, which may not be less than 30 days.

Commented [TT11]: This was moved from individual sections to cover all licensees

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2. Notice and opportunity to review. When the board acknowledges a request to inspect or copy an applicant's or a licensee's record as required by Title 1, section 408-A, subsection 3, the board shall send a notice to the applicant or licensee at the applicant's or licensee's last address on file with the board explaining that the request has been made and that the applicant or licensee may review the redacted record before it is made available for inspection or copying. The acknowledgment to the requester must include a description of the review process provided to the applicant or licensee pursuant to this section, including the fact that all or part of the record may be withheld if the board finds that disclosure of all or part of the redacted record creates a potential risk to the applicant's or licensee's Generated 01.07.2025 Chapter 48. BOARD OF LICENSURE IN MEDICINE | 31MRS Title 32, Chapter 48. BOARD OF LICENSURE IN MEDICINE personal safety or the personal safety of any 3rd party. The applicant or licensee has 10 business days from the date the board sends the notice to request the opportunity to review the redacted record. If the applicant or licensee so requests, the board shall send a copy of the redacted record to the applicant or licensee for review. The board shall make the redacted record available to the requester for inspection or copying 10 business days after sending the redacted record to the applicant or licensee for review unless the board receives a petition from the applicant or licensee under subsection 4. [PL 2019, c. 499, §3 (NEW).]

3. Reasonable costs. Reasonable costs related to the review of a record by the applicant or licensee are considered part of the board's costs to make the redacted record available for inspection or copying under subsection 2 and may be charged to the requester. [PL 2019, c. 499, §3 (NEW).]

4. Action based on personal safety or disclosure of confidential information. An applicant or licensee may petition the board to withhold the release of all or part of a record under subsection 2 based on the potential risk to the applicant's or licensee's personal safety or the personal safety of any 3rd party if the record is disclosed to the public. The applicant or licensee must petition the board to withhold all or part of the record within 10 business days after the board sends the applicant or licensee the redacted record. The petition must include an explanation of the potential safety risks and a list of items requested to be withheld. Within 60 days of receiving the petition, the board shall notify the applicant or licensee of its decision on the petition. If the applicant or licensee disagrees with the board's decision, the applicant or licensee may file a petition in Superior Court to enjoin the release of the record under subsection 5. [PL 2019, c. 499, §3 (NEW).]

5. Injunction based on personal safety. An applicant or licensee may bring an action in Superior Court to enjoin the board from releasing all or part of a record under subsection 2 based on the potential risk to the applicant's or licensee's personal safety or the personal safety of any 3rd party if the record is disclosed to the public. The applicant or licensee must file the action within 10 business days after the board notifies the applicant or licensee under subsection 4 that the board will release all or part of the redacted record to the requester. The applicant or licensee shall immediately provide written notice to the board that the action has been filed, and the board may not make the record available for inspection or copying until the action is resolved. [PL 2019, c. 499, §3 (NEW).]

6. Hearing. The hearing on an action filed under subsection 5 may be advanced on the docket and receive priority over other cases when the court determines that the interests of justice so require. [PL 2019, c. 499, §3 (NEW).]

7. Application. This section does not apply to requests for records from other governmental licensing or disciplinary authorities or from any health care providers located within or outside this State that are concerned with granting, limiting or denying an applicant's or licensee's employment or privileges.

Commented [TT12]: This section is a discussion point

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SUBCHAPTER 3

LICENSURE

§XXXX. Individual license

Only an individual may be licensed under this chapter and only a licensed individual may provide services for which a license is required under this chapter.

§XXXX. Licensure or privilege required

1. Unlicensed practice.

a. Unless licensed or privileged by the board, an individual may not practice medicine or render medical services to any patient located in Maine. A person shall not engage in the practice of medicine or render medical services without a license or during any period when that person's license is in inactive status, has expired, or has been suspended, surrendered, or revoked.

b. Any individual who practices medicine, renders medical services, or holds themselves out as doing so, when they hold no valid, active license or privilege to do so, may be subject to disciplinary action by the board, or legal action by the Department of the Attorney General under 10 M.R.S. § 8003-C.

2. Penalties. A person who violates this section commits a Class E crime. Violation of this section is a strict liability crime as defined in Title 17-A, section 34, subsection 4-A.

§XXXX. Exemption for licensed person accompanying visiting athletic team

1. Licensed person accompanying visiting athletic team. This chapter does not apply to a person who holds a current unrestricted license to practice medicine and surgery in another state when the person, pursuant to a written agreement with an athletic team located in the state in which the person holds the license, provides medical services to any of the following while the team is traveling to or from or participating in a sporting event in this State:

A. A member of the athletic team;

B. A member of the athletic team's coaching, communications, equipment or sports medicine staff;

C. A member of a band or cheerleading squad accompanying the team;

D. The team's mascot.

2. Restrictions. A person authorized to provide medical services in this State pursuant to subsection 1 may not provide medical services at a health care facility, including a hospital, ambulatory surgical facility or any other facility where medical care, diagnosis or treatment is provided on an inpatient or outpatient basis.

§XXXX. Application; fees; general requirements

~~1.~~ **Application.** An applicant seeking a license from the board must submit an administratively complete application, ~~with~~licensure or application

1. ~~the~~ fee(s) established by rule adopted by the board and any other materials required by the board.

2. Fees. All fees set in this chapter are nonrefundable application fees or administrative processing fees payable to the board at the time of application or at the time board action is requested. The board shall establish by rule the fees for each license issued by the board. The maximum fees for each license issued by the board are enumerated within this subchapter.

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3. Confidentiality of personal contact and health information. A personal residence address, personal telephone number or personal e-mail address submitted to the board as part of any application under this chapter is confidential and may not be disclosed except as permitted under this section or as otherwise required by law unless the applicant who submitted the information has indicated that the applicant is willing to have the applicant's personal residence address, personal telephone number or personal e-mail address treated as a public record. Personal health information submitted to the board as part of any application under this chapter is confidential and may not be disclosed except as otherwise permitted under this section or otherwise required by law.

Commented [TT13]: Should this apply to info provided in a complaint?

The board and its staff may disclose personal health information about and the personal residence address and personal email or telephone number of a licensee or an applicant for a license under this chapter to a government licensing or disciplinary authority or to a health care provider located within or outside this State that are concerned with granting, limiting or denying a license or employment or privileges to the applicant or licensee.

4. Public contact information required. An applicant or licensee shall provide the board with a current professional address and telephone number, which will be their public contact address. An applicant or licensee who does not have a public contact address and phone number must use their personal address and phone number as the public contact information.

5. Consent to physical or mental examination; objections to admissibility of examiner's testimony waived. For the purposes of this section, every physician and physician ~~assistant~~associate licensed or privileged by the board who accepts the privilege of ~~providing~~ practicing medicine or rendering medical services in this State by the filing of an application and of biannual registration renewal:

A. Is deemed to have consented to a mental or physical examination by a physician or other person selected or approved by the board when directed in writing by the board or investigative committee; and

B. Is deemed to have waived all objections to the admissibility of the examining physician's or other person's testimony or reports on the ground that these constitute a privileged communication.

Failure to comply with a direction of the board or committee to submit to a mental or physical examination results in the immediate suspension of the license of the individual until the individual submits to the examination or if the individual is an applicant for licensure the denial of licensure.

Commented [TT14]: This is different than 3286, which is recommended

Pursuant to Title 4, section 184, subsection 6, the District Court shall immediately suspend the license of a physician or physician ~~assistant~~associate who can be shown, through the results of the medical or physical examination conducted under this section or through other competent evidence, to be unable to render medical services with reasonable skill and safety to patients by reason of mental illness, alcohol intemperance, excessive use of drugs or narcotics or as a result of a mental or physical condition interfering with the competent provision of medical services.

6. Licenses must be displayed. Each physician or physician ~~assistant~~associate licensed under this chapter

is entitled to receive a license under the seal of the board and signed by the chair and the secretary, which must be publicly displayed at the individual's principal place of practice, as long as this individual continues the practice of medicine.

§XXXX-A. Licensure of physician ~~assistant~~associates

1. Qualification for licensure. The board may issue to an individual a license to practice as a physician ~~assistant~~associate under the following conditions:

A. A license may be issued to an individual who:

(1) Graduated from a physician assistant/associate program approved by the board;

(2) Passed a physician assistant/associate national certifying examination administered by the National Commission on Certification of Physician Assistants or its successor organization;

(3) Demonstrates current clinical competency either by having engaged in the clinical rendering of medical services during the preceding 24 months, or by providing a plan to practically demonstrate to the Board's satisfaction their clinical competency, the requirements of which may be set by rulemaking;

(4) Does not have a license or certificate of registration that is the subject of disciplinary action such as probation, restriction, suspension, revocation or surrender;

(5) Completes an application approved by the board;

(6) Pays an application fee of up to $300; and

(7) Passes an examination approved by the board; and

B. No grounds exist as set forth in section XXXX (Grounds for Discipline) to deny the application.

2. Rules. The board is authorized to adopt rules regarding the licensure and practice of physician ~~assistant~~associates. These rules may pertain to, but are not limited to, the following matters:

A. Information to be contained in the application for a license;

B. Education requirements for the physician ~~assistant~~associate;

C. Requirements for collaborative agreements and practice agreements, including uniform standards and forms;

D. Requirements for a physician ~~assistant~~associate to notify the board regarding certain circumstances, including but not limited to any change in address, the permanent departure of the physician ~~assistant~~associate from the State, any criminal convictions of the physician ~~assistant~~associate and any discipline by other jurisdictions of the physician ~~assistant~~associate;

E. Issuance of temporary physician ~~assistant~~associate licenses;

F. ~~Appointment of an advisory committee for continuing review of the physician assistant rules. The physician assistant members of the board must be members of the advisory committee~~;

G. Continuing education requirements as a precondition to continued licensure or licensure renewal;

H. Fees for the application for an initial physician ~~assistant~~associate license, which may not exceed $300; and

I. Fees for the biennial renewal of a physician ~~assistant~~associate license in an amount not to exceed $250.

3. Privileging of Physician Associates

A. The board will issue a privilege to a physician associate as permitted under Title 32 chapter XX (PA Compact statute).

B. The application fee to obtain a privilege through the P.A. Compact shall be no higher than the application fee for a physician associate license.

C. Fees for the renewal of a physician associate Compact privilege shall not to exceed $350.

§XXXX-B. Physician ~~assistant~~associate criminal history record information; fees

§3270-H. Criminal history record information; fees

Commented [TT15]: Need a discussion on raising the cap on all fees. They don't need to be raised now, but to plan for the future.

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DRAFT STATUTE FOR COMBINED MEDICAL BOARD

1. Background check. The board shall request a background check for each person who submits an application for initial licensure or licensure by endorsement as a physician associates under this chapter. The board shall request a background check for each licensed physician assistant who applies for an initial compact privilege and designates this State as the applicant's participating state in accordance with chapter 145-A. The background check must include criminal history record information obtained from the Maine Criminal Justice Information System, established in Title 16, section 631, and the Federal Bureau of Investigation.

A. The criminal history record information obtained from the Maine Criminal Justice Information System must include public criminal history record information as defined in Title 16, section 703, subsection 8.

B. The criminal history record information obtained from the Federal Bureau of Investigation must include other state and national criminal history record information.

C. An applicant or licensee shall submit to having fingerprints taken. The Department of Public Safety, Bureau of State Police, upon payment by the applicant or licensee of a fee established by the board, shall take or cause to be taken the applicant's or licensee's fingerprints and shall forward the fingerprints to the Department of Public Safety, Bureau of State Police, State Bureau of Identification so that the State Bureau of Identification can conduct state and national criminal history record checks. Except for the portion of the payment, if any, that constitutes the processing fee charged by the Federal Bureau of Investigation, all money received by the Bureau of State Police for purposes of this paragraph must be paid to the Treasurer of State. The money must be applied to the expenses of administration incurred by the Department of Public Safety. Any person who fails to transmit criminal fingerprint records to the State Bureau of Identification pursuant to this paragraph is subject to the provisions of Title 25, section 1550.

D. The subject of a Federal Bureau of Investigation criminal history record check may obtain a copy of the criminal history record check by following the procedures outlined in 28 Code of Federal Regulations, Sections 16.32 and 16.33. The subject of a state criminal history record check may inspect and review the criminal history record information pursuant to Title 16, section 709.

E. State and federal criminal history record information of an applicant for a physician assistant license may be used by the board for the purpose of screening the applicant. State and federal criminal history record information of a licensed physician assistant seeking an initial compact privilege may be used by the board for the purpose of taking disciplinary action against the licensee. A board action against an applicant for licensure or a licensee under this subsection is subject to the provisions of Title 5, chapter 341.

F. Information obtained pursuant to this subsection is confidential. The results of background checks received by the board are for official use only and may not be disseminated to the Physician Assistants Licensure Compact Commission established under section 18537 or to any other person. G. An individual whose license has expired and who has not applied for renewal may request in writing that the Department of Public Safety, Bureau of State Police, State Bureau of Identification remove the individual's fingerprints from the bureau's fingerprint file. In response to a written request, the bureau shall remove the individual's fingerprints from the fingerprint file and provide written confirmation of that removal. 2. Rules. The board, following consultation with the Department of Public Safety, Bureau of State Police, State Bureau of Identification, may adopt rules to implement this section. Rules adopted pursuant to this subsection are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A ~~**1. Background check.** The board shall request a background check for each person who submits an application for initial licensure or licensure by endorsement as a physician assistant under this chapter. The board shall request a background check for each licensed physician assistant who applies for an initial compact privilege and designates this State as the applicant's participating state from which the licensee is applying. The background check must include criminal history record information obtained from the Maine Criminal Justice Information System, established in Title 16, section 631, and the Federal Bureau of Investigation.~~

~~The criminal history record information obtained from the Maine Criminal Justice Information System must include public criminal history record information as defined in Title 16, section 703, subsection 8.~~

~~The criminal history record information obtained from the Federal Bureau of Investigation must include other state and national criminal history record information.~~

~~An applicant or licensee shall submit to having fingerprints taken. The Department of Public Safety, Bureau of State Police, upon payment by the applicant or licensee of a fee established by the board, shall take or cause to be taken the applicant's or licensee's fingerprints and shall forward the fingerprints to the Department of Public Safety, Bureau of State Police, State Bureau of Identification so that the State Bureau of Identification can conduct state and national criminal history record checks. Except for the portion of the payment, if any, that constitutes the processing fee charged by the Federal Bureau of Investigation, all money received by the Bureau of State Police for purposes of this paragraph must be paid to the Treasurer of State. The money must be applied to the expenses of administration incurred by the Department of Public Safety. Any person who fails to transmit criminal fingerprint records to the State Bureau of Identification pursuant to this paragraph is subject to the provisions of Title 25, section 1550.~~

~~The subject of a Federal Bureau of Investigation criminal history record check may obtain a copy of the criminal history record check by following the procedures outlined in 28 Code of Federal Regulations, Sections 16.32 and 16.33. The subject of a state criminal history record check may inspect and review the criminal history record information pursuant to Title 16, section 709.~~

~~State and federal criminal history record information of an applicant for a physician assistant license may be used by the board for the purpose of screening the applicant. State and federal criminal history record information of a licensed physician assistant seeking an initial compact privilege may be used by the board for the purpose of taking disciplinary action against the licensee. A board action against an applicant for licensure or a licensee under this subsection is subject to the provisions of Title 5, chapter 341.~~

~~Information obtained pursuant to this subsection is confidential. The results of background checks received by the board are for official use only and may not be disseminated to the Physician Assistants Licensure Compact Commission established under section 18537 or to any other person.~~

~~G. An individual whose license has expired and who has not applied for renewal may request in writing that the Department of Public Safety, Bureau of State Police, State Bureau of Identification remove the individual's fingerprints from the bureau's fingerprint file. In response to a written request, the bureau shall remove the individual's fingerprints from the fingerprint file and provide written confirmation of that removal.~~

~~**2. Rules.** The board, following consultation with the Department of Public Safety, Bureau of State Police, State Bureau of Identification, may adopt rules to implement this section. Rules adopted pursuant to this subsection are routine technical rules as defined in Title 5, chapter 375, subchapter 2A.~~

§XXXX. ~~Full~~ Qualification for licensure ~~of~~ as allopathic physicians

DRAFT STATUTE FOR COMBINED MEDICAL BOARD

Except where otherwise specified by this chapter, all applicants for licensure as an allopathic physician or surgeon in the State must satisfy the following requirements.

1. Medical education. Each applicant must:

A. Graduate from a medical school designated as accredited by the Liaison Committee on Medical Education;

B. Graduate from an unaccredited medical school, be evaluated by the Educational Commission for Foreign Medical Graduates and ~~receive~~ hold a ~~permanent~~ current certificate from the Educational Commission for Foreign Graduates; or

C. Graduate from an unaccredited medical school and achieve a passing score on ~~the Visa Qualifying Examination or another~~a comprehensive examination determined by the board to be substantially equivalent to the United States Medical Licensing Examination (USMLE) or other examinations designated by the board as the qualifying examination or examinations for licensure~~Visa Qualifying Examination~~.

2. Postgraduate training. Each applicant who has graduated from an accredited medical school on or after January 1, 1970 but before July 1, 2004 must have satisfactorily completed at least 24 months in a graduate educational program accredited by the Accreditation Council on Graduate Medical Education, the Canadian Medical Association or the Royal College of Physicians and Surgeons of Canada. Notwithstanding other requirements of postgraduate training, an applicant is eligible for licensure when the candidate has satisfactorily graduated from a combined postgraduate training program in which each of the contributing programs is accredited by the Accreditation Council on Graduate Medical Education and the applicant is eligible for accreditation by the American Board of Medical Specialties in both specialties. Each applicant who has graduated from an accredited medical school prior to January 1, 1970 must have satisfactorily completed at least 12 months in a graduate educational program accredited by the Accreditation Council on Graduate Medical Education, the Canadian Medical Association or the Royal College of Physicians and Surgeons of Canada. Each applicant who has graduated from an accredited medical school on or after July 1, 2004 or an unaccredited medical school must have satisfactorily completed at least 36 months in a graduate educational program accredited by the Accreditation Council on Graduate Medical Education, the Canadian Medical Association, the Royal College of Physicians and Surgeons of Canada or the Royal Colleges of England, Ireland or Scotland. An applicant who has completed 24 months of postgraduate training and has received an unrestricted endorsement from the director of an accredited graduate education program in the State is considered to have satisfied the postgraduate training requirements of this subsection if the applicant continues in that program and completes 36 months of postgraduate training. Notwithstanding this subsection, an applicant who is board certified by the American Board of Medical Specialties is deemed to meet the postgraduate training requirements of this subsection. Notwithstanding this subsection, in the case of subspecialty or clinical fellowship programs, the board may accept in fulfillment of the requirements of this subsection postgraduate training at a hospital in which the subspecialty clinical program, such as a training program accredited by the American Dental Association Commission on Dental Accreditation or its successor organization, is not accredited but the parent specialty program is accredited by the Accreditation Council on Graduate Medical Education, including training that occurs following graduation from a dental school accredited by the American Dental Association Commission on Dental Accreditation or its successor organization, but before graduation from a medical school accredited by the Liaison Committee on Medical Education or its successor organization.

3. Current clinical competency. The physician has engaged in active clinical practice in the previous 24 months, or has provided a plan to practically demonstrate to the Board's satisfaction their clinical competency, the requirements of which may be set by rulemaking.

Commented [TT16]: THE LCME stopped accrediting Canadian schools on 6/301/25. We need to discuss how to proceed with Canadian students.

Commented [TT17]: Obtaining this information is often a confusing and time consuming process. Is there a better way? Such as, Applicants who have graduated, trained and are licensed and registered in either England Scotland, Ireland or Canada are deemed to have meet the Medical Education, Postgraduate training and Examination requirements.

3. National board certification not required. The board may not require an applicant for initial licensure or license renewal as a physician under this chapter to obtain certification from a specialty medical board or to obtain a maintenance of certification as a condition of licensure. For the purposes of this subsection, "maintenance of certification" means a program that requires a physician to engage in periodic examination, self-assessment, peer evaluation or other activities to maintain certification from a specialty medical board.

4. Examination. Each applicant must achieve a passing score on each component of the uniform examination of the Federation of State Medical Boards or other examinations designated by the board as the qualifying examination or examinations for licensure. Each applicant must additionally achieve a passing score on a State of Maine examination administered by the board.

5. Fees. Each applicant shall pay a fee up to $600 plus the cost of the qualifying examination or examinations.

6. Board action. An applicant may not be licensed unless the board finds that the applicant is qualified and no cause exists, as set forth in section 3282-A, that may be considered grounds for disciplinary action against a licensed physician or surgeon.

7. Waiver for exceptional circumstances. The board may waive the requirements of subsection 2 for a physician who does not meet the postgraduate training requirements but who meets the requirements of this subsection.

A. To be considered for a waiver under this subsection, the physician must:

(1) Be a graduate of a foreign medical school, not including a medical school in Canada or Great Britain;

(2) Be licensed in another state; and

(3) Have at least 3 years of clinical experience in the area of expertise.

B. If the physician meets the requirements of paragraph A, the board shall use the following qualifications of the physician to determine whether to grant a waiver:

(1) Completion of a 3-year clinical fellowship in the United States in the area of expertise. The burden of proof as to the quality and content of the fellowship is placed on the applicant;

(2) Appointment to a clinical academic position at a licensed medical school in the United States;

(3) Publication in peer-reviewed clinical medical journals recognized by the board;

(4) The number of years in clinical practice; and

(5) Other criteria demonstrating expertise, such as awards or other recognition.

C. The costs associated with the board's determination of licensing eligibility in regard to paragraph B ~~must~~ may be ~~paid~~ assessed for payment by the applicant upon completion of the determination under paragraph A. The application cost must reflect and not exceed the actual cost of the final determination.

~~**8. Special license categories.** The board may issue a license limited to the practice of administrative medicine, or any other special license, as defined by routine technical rule of the board adopted pursuant to Title 5, chapter 375, subchapter 2-A.~~

§XXXX. ~~Full~~ Qualification for licensure ~~of~~ as an osteopathic physicians

Except where otherwise specified by this chapter, all applicants for licensure as an osteopathic physician or surgeon in the State must satisfy the following requirements.

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1. Osteopathic education. An applicant must graduate from an osteopathic medical school designated as accredited by the American Osteopathic Association's Commission on Osteopathic College Accreditation.

2. Postgraduate training. An applicant who has graduated from an accredited osteopathic medical school prior to January 1, 2026 must have satisfactorily completed at least 12 months in a medical graduate educational program accredited by the Accreditation Council on Graduate Medical Education or the American Osteopathic Association. An applicant who has graduated from an accredited osteopathic medical school on or after January 1, 2026 must have satisfactorily completed at least 36 months in a graduate educational program accredited by the Accreditation Council on Graduate Medical Education or the American Osteopathic Association.

The board may not require an applicant for initial licensure or license renewal as an osteopathic physician under this chapter to obtain certification from a specialty medical board or to complete maintenance of certification as a condition of licensure. For the purposes of this subsection, "maintenance of certification" means a program that requires a physician to engage in periodic examination, self-assessment, peer evaluation or other activities to maintain certification from a specialty medical board.

3. Current clinical competency. The physician has engaged in active clinical practice in the previous 24 months, or has provided a plan to practically demonstrate to the Board's satisfaction their clinical competency, the requirements of which may be set by rulemaking.

3. Examination. An applicant must achieve a passing score on each component of the National Board of Osteopathic Medical Examiners' Comprehensive Osteopathic Medical Licensing Examination of the United States, known as the COMLEX-USA examination, or other examinations designated by the board as the qualifying examination or examinations for licensure.

4. Fees. An applicant must pay a fee up to $600 plus the cost of the qualifying examination or examinations. Fees set in this chapter are nonrefundable application fees or administrative processing fees payable to the board at the time of application or at the time board action is requested.

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5. No cause for disciplinary action. An applicant may not be licensed unless the board finds that the applicant is qualified and no cause exists, as set forth in section 2591-A, that may be considered grounds for disciplinary action against a licensed physician.

~~**6. Special license categories.** The board may issue a license limited to the practice of administrative medicine, or any other special license, as set forth by routine technical rule of the board adopted pursuant to Title 5, chapter 375, subchapter 2-A.~~

§XXXX. Background check for expedited physician licensure through the Interstate Medical Licensure Compact

1. Background check. The board shall request a background check for an individual licensed under this chapter who applies for an expedited license under section 18506. The background check must include criminal history record information obtained from the Maine Criminal Justice Information System and the Federal Bureau of Investigation.

A. The criminal history record information obtained from the Maine Criminal Justice Information System must include a record of public criminal history record information as defined in Title 16, section 703, subsection 8.

B. The criminal history record information obtained from the Federal Bureau of Investigation must include other state and national criminal history record information.

C. An applicant shall submit to having fingerprints taken. The State Police, upon payment by the applicant, shall take or cause to be taken the applicant's fingerprints and shall forward the fingerprints to the State Bureau of Identification so that the bureau can conduct state and national

criminal history record checks. Except for the portion of the payment, if any, that constitutes the processing fee charged by the Federal Bureau of Investigation, all money received by the State Police for purposes of this paragraph must be paid over to the Treasurer of State. The money must be applied to the expenses of administration incurred by the Department of Public Safety.

D. The subject of a Federal Bureau of Investigation criminal history record check may obtain a copy of the criminal history record check by following the procedures outlined in 28 Code of Federal Regulations, Sections 16.32 and 16.33. The subject of a state criminal history record check may inspect and review the criminal history record information pursuant to Title 16, section 709.

E. State and federal criminal history record information of an applicant may be used by the board for the purpose of screening that applicant

F. Information obtained pursuant to this subsection is confidential. The results of background checks received by the board are for official use only and may not be disseminated to the Interstate Medical Licensure Compact Commission, established in section 18512, or to any other person or entity.

G. An individual whose expedited licensure through the Interstate Medical Licensure Compact under chapter 145 has expired and who has not applied for renewal may request in writing that the State Bureau of Identification remove the individual's fingerprints from the bureau's fingerprint file. In response to a written request, the bureau shall remove the individual's fingerprints from the fingerprint file and provide written confirmation of that removal.

2. Rules. The board, following consultation with the State Bureau of Identification, shall adopt rules to implement this section. Rules adopted pursuant to this subsection are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A.

§XXXX. Other physician license types.

1. Temporary licensure

A physician who is qualified under section XXXX may, without examination, be granted a temporary license for a period not to exceed one year when the board determines that this action is necessary in order to provide relief for local or national emergencies or for situations in which the number of physicians is insufficient to supply adequate medical services or for the purpose of permitting the physician to serve as locum tenens for another physician who is licensed to practice medicine in this State. The fee for this temporary license may not be more than $400.

2. Youth camp physicians

A physician who is qualified under section XXXX may, at the discretion of the board, be temporarily licensed as a youth camp physician so that the physician may care for the campers in that particular youth camp licensed under Title 22, section 2495 for which the physician was hired and retained as a youth camp physician. That physician is entitled to practice only on patients in the youth camp. The temporary license must be obtained each year. Application for this temporary license must be made in the same form and manner as for regular licensure. An examination may not be exacted from applicants for these temporary licenses. The fee for temporary licensure may not be more than $400 annually.

3. Emergency 100-day license

A physician who presents a current active unconditioned license from another United States licensing jurisdiction and who can provide reasonable proof of meeting qualifications for licensure in this State must be issued a license to serve temporarily for declared emergencies in the State or for other appropriate reasons as determined by the board. The license is effective for not more than 100 days. The fee for this license may be not more than $400.

5. ~~4.~~ Temporary Educational Certificate

a. **Residents.** An applicant who is qualified under section XXXX may receive a temporary educational certificate from the board to act as a hospital resident. A certificate to a hospital resident may be renewed every 3 years at the discretion of the board for not more than 8 years. ~~An applicant for a temporary educational certificate may not be certified unless the board finds that the applicant is qualified and that there exists no cause, as set forth in section XXXX, that would be considered grounds for disciplinary action against a licensed physician or surgeon. The board, in its discretion, may require an examination for applicants for temporary educational certificates. Recipients of these certificates are entitled to all the rights granted to physicians who are licensed to practice medicine and surgery, except that their practice is limited to the training programs in which they are enrolled. A temporary educational certificate may be suspended or revoked, or the board may refuse to renew the certificate, for the reasons stated in section XXXX, or if the resident has violated the limitations placed upon the temporary educational certificate. The fee for this license may be not more than $300.~~

~~5~~b. **Joint-program resident.** An applicant who is enrolled in a program of medical and graduate medical training conducted jointly by a medical school accredited by the Liaison Committee on Medical Education and a graduate medical education program approved by the Accreditation Council on Graduate Medical Education may receive a temporary educational certificate from the board to act as a hospital resident as part of that graduate medical education program if the applicant is concurrently enrolled in the final year of medical training and the initial year of graduate medical education. The board may not issue a certificate pursuant to this subsection for a period longer than that required to obtain the M.D. degree. The period during which the certificate is in force may not be considered in determining satisfaction of the requirement for postgraduate medical education under section XXXX. ~~The fee for this license may be not more than $300.~~

C. **Conditions for Temporary Educational Certificate**. An applicant for a temporary educational certificate may not be certified unless the board finds that the applicant is qualified and that there exists no cause, as set forth in section XXXX, that would be considered grounds for disciplinary action against a licensed physician or surgeon. The board, in its discretion, may require an examination for applicants for temporary educational certificates. Recipients of these certificates are entitled to all the rights granted to physicians who are licensed to practice medicine and surgery, except that their practice is limited to the training programs in which they are enrolled. A temporary educational certificate may be suspended or revoked, or the board may refuse to renew the certificate, for the reasons stated in section XXXX, or if the resident has violated the limitations placed upon the temporary educational certificate. The fee for this license may be not more than $300.

6. Visiting instructors. A physician who has an unrestricted license to practice medicine or surgery in another state may practice medicine or surgery in this State when the physician is performing medical procedures as part of a course of instruction in graduate medical education in a hospital located in this State. The right of a visiting medical instructor to practice medicine in this State may be suspended or revoked for the reasons stated in section XXXX, or if the visiting medical instructor has performed medical procedures that are not a part of a course of instruction. The fee for this license may be not more than $300.

7. Contract students. An applicant who is qualified under section XXXX who received a medical education as a contract student as provided in Title 20-A, chapter 421, and who agrees to practice in a primary care or other specialized area as defined in Title 20-A, section 11803, subsection 2, or an underserved area as defined in Title 20-A, section 11802, is considered to have completed the

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postgraduate training requirements of section XXXX, subsection XXXX, upon satisfactory completion of at least 12 months in a graduate educational program approved as specified in section XXXX. The board may make the relicensure of an individual for 4 years after the individual's licensure under this subsection contingent on the individual's continuing to practice in an underserved area. This subsection applies only to individuals entering into a contract under Title 20-A, chapter 421, on or before December 31, 1984. The fee for this license may be not more than $300.

§XXXX. Biennial renewal of ~~full~~ physician and physician ~~assistant~~associate licenses; qualification; fees; reinstatement after lapse

1. Renewal of ~~full~~ licenses. Except as otherwise provided in this chapter, a~~A~~ physician of physician ~~assistant~~associate with a ~~full~~ license issued by the board, including IMLC licenses, shall apply to the board for relicensure using application forms and submitting supporting documents required by the board. Except as provided in paragraph A for initial proration of expiration dates, the board shall provide to every licensee whose renewal application is approved and accepted ~~-~~proof of ~~full~~ license renewal that is valid for no longer than 2 years.

A. ~~Beginning with licenses expiring after July 1, 1994, r~~Regardless of the date of initial licensure or last license renewal, the license of every physician and physician ~~assistant~~associate born in an odd-numbered year expires at midnight ~~in 1995~~ on the last day of the month of the individual's birth in every odd-numbered year. The license of every physician and physician ~~assistant~~associate born in an even-numbered year expires at midnight ~~in 1996~~ on the last day of the month of the individual's birth in every even numbered year. ~~Upon~~ Prior to expiration, a physician or physician ~~assistant~~associate must renew the license issued pursuant to this section ~~and this license must be renewed every 2 years by the last day of the month of birth of the individual seeking license renewal~~ by means of application to the board, on forms prescribed and supplied by the board.

B. At least 60 days prior to expiration of a current ~~full~~ license, the board shall notify each licensee of the requirement to renew the license. If an administratively complete license renewal application, as determined pursuant to subsection X, paragraph X, has not been submitted prior to the expiration date of the existing license, the license immediately and automatically expires. A ~~full~~ license may be reinstated within 90 days after the date of expiration upon submission of an administratively complete application, and payment of the renewal fee and late fee. If an administratively complete renewal application is not submitted within 90 days of the date of the expiration of the ~~full~~ license, the license immediately and automatically lapses. The board may reinstate a ~~full~~ license that has lapsed pursuant to subsection 4.

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2. Criteria for full license renewal. Prior to renewing a license:

A. The board may pose any question to the licensee or other sources that the board determines appropriate related to qualification for relicensure. These matters may include, but are not limited to, confirmation of health status, professional standing and conduct, professional liability claims history and license status in other jurisdictions. The board shall, after affording the licensee due process, deny license renewal if the board finds cause that may be considered grounds for refusal to renew the license pursuant to section XXXX, including, but not limited to, a determination that an outstanding financial obligation to the board exists; and

B. Every licensee seeking renewal of a ~~full~~ license with the intent of conducting active clinical medical practice or rendering medical services in this State shall submit evidence, satisfactory to the board, of successful completion of a course of continuing medical education within the preceding 24 months, as prescribed by rule. A licensee may not engage in the clinical practice of medicine or render medical services in this State in any degree~~, including advising or prescribing medication for self, friends or family with or without charge~~, unless the board has found the licensee

qualified by continuing medical education and has marked the current license with the designation "active

3. Fees. The following fees apply to licensure.

A. The board may charge a license renewal application fee of not more than $500 to all applicants for full license renewal.

B. In addition to the application processing fee, the board may require payment of a late application fee of not more than $100 from all licensees, regardless of age, from whom the board has not received an administratively complete license renewal application prior to the license expiration date. An application is not administratively complete if it is not signed and dated by the licensee or does not provide full information and responses of sufficient detail to permit board review, evaluation and decision on renewal qualification. An application received without the required license renewal application fee is considered incomplete and the applicant is subject to a late fee.

C. The board may prorate the fee for biennial relicensure for individuals who have been issued a full license within the past 12 months. The manner of proration, if done, must be explained in the board's published schedule of fees. The board may waive all or a portion of the established license renewal application fee upon receipt of a request for waiver based on hardship or other special circumstance. Any waiver request granted and the basis for the waiver must be recorded in the minutes of the board's proceedings.

D. Unless received and deposited to the board's account in error and in violation of this section or the board's rules, a license renewal application fee or late fee paid to the board is not refundable if the board or the board's staff has commenced processing the application, regardless of the board's action on the application.

4. Reinstatement after lapse. A ~~full~~ license may be reinstated after the lapse of a license under the following conditions.

A. A license that has lapsed pursuant to subsection X, paragraph X may be reinstated upon application by the individual on forms provided by the board. An individual whose ~~full~~ license has lapsed for more than 5 years shall apply for a new license.

B. When applying for reinstatement, the licensee must state the reason why the ~~full~~ license lapsed and pay all fees in arrears at the time of lapse plus the current license renewal application fee and a nonrefundable reinstatement application processing fee of $100

C. The board may not reinstate a lapsed full license if the board finds any cause that may be considered a ground for discipline pursuant to section XXX if the license had been in force. Prior to concluding that no cause exists, the board shall conduct the inquiries required by subsection X, paragraph X for applications for renewal. In addition, the board may not reinstate the license of any individual who has not provided evidence satisfactory to the board of having actively engaged in the clinical practice of medicine or rendering of medical services ~~continuously for at least~~during the past ~~12~~ 24 months under the license of another jurisdiction of the United States or Canada unless the applicant has first satisfied the board of the applicant's current clinical competency by providing a plan to practically demonstrate to the Board's satisfaction their clinical competency, the requirements of which may be set through rulemaking~~by passage of written examinations or practical demonstrations as the board may from time to time prescribe for this purpose through rulemaking~~.

§XXXX. Withdrawal of license

A licensee who notifies the board in writing of the withdrawal of the individual's license is not required to pay licensure fees or penalties beyond those due at the time of the holder's withdrawal, but after a holder gives this notice, the holder's license to practice is not valid until reinstated by the board.

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An applicant for reinstatement is entitled to be reinstated upon paying a reinstatement fee of $50 and satisfying the board that the applicant has paid all fees and penalties due at the time of the applicant's withdrawal, and no cause exists for revoking or suspending the applicant's license, and the applicant has applied within 5 years after the applicant's withdrawal, and was in active practice outside this State within one year prior to the filing of application for reinstatement.

§XXXX. Inactive license status

A licensee who wants to retain licensure while not practicing or rendering medical services may apply for an inactive status license. During inactive status, the licensee must renew the license and pay the renewal fee set by rule. . Inactive status licensees shall not engage in the clinical practice of medicine or shall not engage in the clinical rendering of medical services. Continuing medical education hours and the jurisprudence examination are not required for inactive status licensees unless they seek reinstatement or conversion to active status.

SUBCHAPTER 4
COMPLAINTS AND INVESTIGATIONS

§XXXX. Investigative Committee. Separate investigative committees are established within the board with the power and authority to conduct and act upon investigations in accordance with this subchapter.

1. Composition. The composition of investigative committees are subject to the following. An investigation committee must contain, if possible:

A. If the investigation involves allegations against an allopathic physician: Two allopathic physicians, one osteopathic physician, one physician ~~assistant~~associate, and one public member.

B. If the investigation involves allegations against an osteopathic physician: Two osteopathic physicians, one allopathic physician, one physician ~~assistant~~associate, and one public member.

C. If the investigation involves allegations against a physician ~~assistant~~associate: Three physician ~~assistant~~associates, one physician, and one public member.

2. Powers and duties of an investigative committee. An investigative committee of the board has the following powers and duties:

A. The duty to investigate complaints, mandated reports, other reports and licensing matters in a timely fashion regarding potential violation of a section of this chapter and the violation of rules adopted by the board pursuant to its authority.

B. The power to issue subpoenas for the productions of documents and records;

C. The power to direct that a licensee or applicant for licensure or re-licensure undergo a mental and/or physical examination by a physician or other person. An individual examined pursuant to the direction of the committee may not prevent the testimony of the examining individual or prevent the acceptance into evidence of the report of an examining individual in any proceeding before the committee or board. ~~Failure to comply with a direction of the committee to submit to a mental or physical examination results in the immediate suspension of the license of the individual until the individual submits to the examination~~.

D. The power to dismiss complaints.

E. The power to dismiss complaints and issue letters of guidance or concern. A letter of guidance or concern may be used to educate, reinforce knowledge regarding legal or professional obligations and express concern over action or inaction by the licensee or registrant that does not rise to the level of misconduct sufficient to merit disciplinary action. The issuance of a letter of guidance or concern is not a formal proceeding and does not constitute an adverse disciplinary action of any form. Notwithstanding any provision of law to the contrary, a letter of guidance or concern is not confidential. The board may place a letter of guidance or concern, together with any underlying

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complaint, report and investigation materials, in a licensee's or registrant's file for a specified amount of time, not to exceed 10 years. Any letters, complaints and materials placed on file may be accessed and considered by the board in any subsequent action commenced against the licensee or registrant within the specified time frame. Complaints, reports and investigation materials placed on file are only confidential to the extent that confidentiality is required pursuant to Title 24, chapter 21.

F. The power to hold an informal conference with a licensee or applicant for licensure or re-licensure. The committee shall provide the licensee with adequate notice of the informal conference and the issues to be discussed. The complainant may attend and may be accompanied by up to 2 individuals, including legal counsel. The conference must be conducted in executive session of the committee, pursuant to Title 1, section 405, unless otherwise requested by the licensee. Before the committee decides what action to take at the conference or as a result of the conference, the committee shall give the complainant a reasonable opportunity to speak. Statements made at the conference may not be introduced at a subsequent formal hearing unless all parties consent. The complainant, the licensee or either of their representatives shall maintain the confidentiality of the informal conference.

G. The power, with the consent of the licensee, to enter into a consent agreement that resolves an investigation. Consent agreements may be entered into only with the consent of the applicant or licensee, the committee and the Department of the Attorney General. Any remedy, penalty or fine or cost recovery that is otherwise available by law, even if only in the jurisdiction of the District Court, may be achieved by consent agreement, including long-term suspension and permanent revocation of a professional license. A consent agreement is not subject to review or appeal and may be modified only by a writing executed by all parties to the original consent agreement. A consent agreement is enforceable by the board and by an action in Superior Court

H. The power to refer the investigation to an adjudicatory hearing before the board or to the Office of Attorney General to file a complaint in the District Court in accordance with Title 4, chapter 5.

3. Adjudicatory hearings.

A. Adjudicatory hearings will be conducted by an adjudicatory hearing panel comprised solely of a subset of board members, with a minimum quorum of five members serving as an adjudicatory hearing panel. A board member cannot serve on an adjudicatory hearing if they participated in the review and investigation of the licensee or applicant for licensure being adjudicated.

B. Adjudicatory hearings held by adjudicatory hearing panels shall be conducted consistent with MAPA.

C. Presiding officer. There shall be a presiding officer who shall conduct each board hearing, as determined by the adjudicatory hearing panel or by board rule.

D. Rulemaking regarding adjudicatory hearings. The board may promulgate rules governing its adjudicatory hearings, which shall be routine technical rulemaking.

§XXXX. Complaints; reports; investigations

1. Procedure. The board, acting through the investigation committee, shall investigate a complaint, on its own motion or upon receipt of a written complaint filed with the board, regarding alleged noncompliance with or violation of this chapter or any rules adopted by the board. The board shall notify the licensee of the content of a complaint filed against the licensee as soon as possible, but not later than 60 days after receipt of this information. The licensee shall respond within 30 days. The board shall share the licensee's response with the complainant, unless the board determines that it would be detrimental to the health of the complainant to obtain the response or that the complainant is not

legally entitled to the confidential medical information contained in the response. Board staff shall ensure that the complaint is referred to the appropriate investigative committee for review. When a complaint has been filed against a licensee and the licensee moves or has moved to another state, the board may report to the appropriate licensing board in that state the complaint that has been filed, other complaints in the physician's record on which action was taken and disciplinary actions of the board with respect to that physician.

When an individual applies for a license under this chapter, the board, acting through the investigation committee, may investigate the professional record of that individual, including professional records that the individual may have as a licensee in other states. The board may deny a license or authorize a restricted license based on the record of the applicant in other states or for any reason enumerated in this chapter that constitutes grounds for discipline.

When the board receives a report pursuant to Title 24, Section 2505 or 2506, regarding a licensee, board staff shall ensure that the report is referred to the appropriate investigative committee for review. Following review, the investigation committee may close the matter without action, further investigate or open a complaint.

§XXXX. Emergency action Upon its own motion or upon complaint, the board, or an investigative committee of the board, in the interests of public health, safety and welfare, shall treat as an emergency a complaint or allegation that an individual licensed under this chapter is or may be unable to practice medicine with reasonable skill and safety to patients by reason of mental illness, alcohol intemperance, excessive use of drugs, narcotics or as a result of a mental or physical condition interfering with the competent practice of medicine. In enforcing this paragraph, the board, or an investigative committee of the board, may compel a physician to submit to a mental or physical examination by a physician or another person designated by the board. Failure of a physician to submit to this examination when directed constitutes an admission of the allegations against the physician, unless the failure was due to circumstances beyond the physician's control, upon which a final order of disciplinary action may be entered without the taking of testimony or presentation of evidence. A physician affected under this paragraph must, at reasonable intervals, be afforded an opportunity to demonstrate that the physician can resume the competent practice of medicine with reasonable skill and safety to patients.

For the purpose of this chapter, by practicing or by making and filing a biennial license to practice medicine in this State, every physician licensed under this chapter who accepts the privilege to practice medicine in this State is deemed to have given consent to a mental or physical examination when directed in writing by the board and to have waived all objections to the admissibility of the examiner's testimony or examination reports on the grounds that the testimony or reports constitute a privileged communication.

Injunctions must issue immediately to enjoin the practice of medicine by an individual licensed to practice under this chapter when that individual's continued practice will or may cause irreparable damage to the public health or safety prior to the time proceedings under this chapter could be instituted and completed. In a petition for injunction pursuant to this section, there must be set forth with particularity the facts that make it appear that irreparable damage to the public health or safety will or may occur prior to the time proceedings under this chapter could be instituted and completed. The petition must be filed in the name of the board on behalf of the State.

§XXXX. Disciplinary action; judicial review

1. Disciplinary action. In addition to the powers under Title 10, section 8003, subsection 5-A, the board may suspend, revoke or refuse to issue or renew a license or privilege pursuant to Title 5, section 10004. The following are grounds for an action to refuse to issue, modify, suspend, revoke or refuse to renew the license of a person licensed under this chapter:

A. The practice of fraud, deceit or misrepresentation in obtaining a license or authority from the board or in connection with services within the scope of the license or authority;

B. Misuse of alcohol, drugs or other substances that has resulted or may result in the licensee performing services in a manner that endangers the health or safety of patients;

C. A professional diagnosis of a mental or physical condition that has resulted or may result in the licensee performing services in a manner that endangers the health or safety of patients;

D. Aiding or abetting the practice of medicine or rendering of medical servicesby an individual who is not licensed under this chapter and who has not been properly delegated the task ~~and who claims to be legally licensed~~;

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E. Incompetence in the practice for which the licensee is licensed or authorized by the board. A licensee is considered incompetent in the practice if the licensee has:

(1) Engaged in conduct that evidences a lack of ability or fitness to perform the duties owed by the licensee to a client or patient or the general public; or

(2) Engaged in conduct that evidences a lack of knowledge or inability to apply principles or skills to carry out the practice for which the licensee is licensed;

F. Unprofessional conduct. A licensee is considered to have engaged in unprofessional conduct if the licensee violates a standard of professional behavior, including engaging in disruptive behavior, that has been established in the practice for which the licensee is licensed. For purposes of this paragraph, "disruptive behavior" means aberrant behavior that interferes with or is likely to interfere with the delivery of care~~Unprofessional conduct. A licensee is considered to have engaged in unprofessional conduct if the licensee violates a standard of professional behavior that has been established in the practice for which the licensee is licensed or authorized by the board~~;

G. Subject to the limitations of Title 5, chapter 341, conviction of a crime that involves dishonesty or false statement or that relates directly to the practice for which the licensee is licensed or authorized by the board, or conviction of a crime for which incarceration for one year or more may be imposed;

H. A violation of this chapter or a rule adopted by the board;

I. Engaging in false, misleading or deceptive advertising;;

J. Prescribing ~~narcotic or hypnotic or other~~ drugs listed as controlled substances by the United States Drug Enforcement Administration for other than accepted therapeutic purposes;

K. Failure to report to the board a physician or physician associate licensed under this chapter or a physician associate privileged under the PA Comapct, ~~for addiction to alcohol or drugs or for mental illness~~ in accordance with Title 24, section 2505~~, except when the impaired physician is or has been a patient of the licensee or the physician has been referred to the Medical Professionals Health Program~~;

L. Failure to comply with the requirements of Title 24, section 2905-A;

M. Revocation, suspension or restriction of a license to practice medicine or other disciplinary action; denial of an application for a license; or surrender of a license to practice medicine following the institution of disciplinary action by another state or a territory of the United States or a foreign country if the conduct resulting in the disciplinary or other action involving the license would, if committed in this State, constitute grounds for discipline under the laws or rules of this State;

N. Engaging in any activity requiring a license under the governing law of the board that is beyond the scope of acts authorized by the license held

N. Continuing to act in a capacity requiring a license or authority under this chapter or a rule adopted by the board after expiration, suspension or revocation of that license or authority;

O. Noncompliance with an order of or consent agreement executed by the board;

P. Failure to produce any requested documents in the licensee's possession or under the licensee's control relevant to a pending complaint, proceeding or matter under investigation by the board;

Q. Failure to timely respond to a complaint notification sent by the board;

R. Failure to comply with the requirements of Title 22, section 7253;

S. Advertising, offering or administering conversion therapy to a minor.

2. Judicial review. Notwithstanding any provision of Title 10, section 8003, subsection 5~~-A~~ to the contrary, any nonconsensual revocation pursuant to Title 10, section 8003, subsection 5~~-A~~ of a license or authority issued by the board may be imposed only after a hearing conforming to the requirements of Title 5, chapter 375, subchapter 4 and is subject to judicial review exclusively in the Superior Court in accordance with Title 5, chapter 375, subchapter 7.

3. Letters of guidance. In addition to the authority conferred under Title 10, section 8003, subsection 5~~-A~~, the board may issue a letter of guidance or concern to a licensee or registrant. A letter of guidance or concern may be used to educate, reinforce knowledge regarding legal or professional obligations and express concern over action or inaction by the licensee or registrant that does not rise to the level of misconduct sufficient to merit disciplinary action. The issuance of a letter of guidance or concern is not a formal proceeding and does not constitute an adverse disciplinary action of any form. Notwithstanding any provision of law to the contrary, a letter of guidance or concern is not confidential. The board may place a letter of guidance or concern, together with any underlying complaint, report and investigation materials, in a licensee's or registrant's file for a specified amount of time, not to exceed 10 years. Any letters, complaints and materials placed on file may be accessed and considered by the board in any subsequent action commenced against the licensee or registrant within the specified time frame. Complaints, reports and investigation materials placed on file are only confidential to the extent that confidentiality is required pursuant to Title 24, chapter 21.

SUBCHAPTER 5

DELEGATION; SCOPE OF PRACTICE; REQUIREMENTS; STANDARDS

§XXXX. Delegation by physicians and physician ~~assistant~~associates

A physician or physician ~~assistant~~associate may delegate to the physician's or physician ~~assistant~~associate's employees or support staff or members of a health care team, including medical assistants, certain activities relating to medical care and treatment carried out by custom and usage when the activities are under the control of the physician or physician ~~assistant~~associate; the activities being delegated do not, unless otherwise provided by law, require a license, privilege, registration or certification to perform; the physician or physician ~~assistant~~associate ensures that the employees or support staff or members of a health care team have the appropriate training, education and experience to perform these delegated activities; and the physician or physician ~~assistant~~associate ensures that the employees or support staff perform these delegated activities competently and safely. The physician or physician ~~assistant~~associate who delegates an activity permitted under this subsection to employees or support staff, to program graduates or to participants in an approved training program is legally liable for the activity performed by these individuals, and any individual in this relationship is considered the physician's or physician ~~assistant~~associate's agent. This section may not be construed to apply to

registered nurses acting pursuant to Chapter 31 or physician ~~assistant~~associate acting pursuant to this chapter.

When the delegated activities are part of the practice of optometry as defined in chapter 151, then the individual to whom these activities are delegated must possess a valid license to practice optometry in Maine, or otherwise may perform only as a technician within the established office of a physician, and otherwise acting solely on the order of and under the responsibility of a physician skilled in the treatment of eyes as designated by the proper professional board, and without assuming evaluation or interpretation of examination findings by prescribing corrective procedures to preserve, restore or improve vision.

§XXXX Physician ~~assistant~~associates; scope of practice and agreement requirements

~~**1. Definitions.** As used in this section, unless the context otherwise indicates, the following terms have the following meanings.~~

~~A. "Collaborative agreement" means a document agreed to by a physician assistant and a physician that describes the scope of practice for the physician assistant as determined by practice setting and describes the decision-making process for a health care team, including communication and consultation among health care team members.~~

~~B. "Consultation" means engagement in a process in which members of a health care team use their complementary training, skill, knowledge and experience to provide the best care for a patient.~~

~~C. "Health care team" means 2 or more health care professionals working in a coordinated, complementary and agreed-upon manner to provide quality, cost-effective, evidence-based care to a patient and may include a physician, physician assistant, advanced practice nurse, nurse, physical therapist, occupational therapist, speech therapist, social worker, nutritionist, psychotherapist, counselor or other licensed professional.~~

~~D. "Physician" means a person licensed by the board.~~

~~E. "Physician assistant" means a person licensed by the board. .~~

~~F. "Practice agreement" means a document agreed to by a physician assistant who is the principal clinical provider in a practice and a physician that states the physician will be available to the physician assistant for collaboration or consultation.~~

~~G. "Prescription or legend drug" has the same meaning as "prescription drug" in section 13702-A, subsection 30 and includes schedule II to schedule V drugs or other substances under the federal Controlled Substances Act, 21 United States Code, Section 812.~~

2. Scope of practice. A physician ~~assistant~~associate may ~~provide~~ render any medical service for which the physician ~~assistant~~associate has been prepared by education, training and experience and is competent to perform. The scope of practice of a physician ~~assistant~~associate is determined by practice setting, including, but not limited to, a physician employer setting, physician group practice setting or independent private practice setting, or, in a health care facility setting, by a system of credentialing and granting of privileges.

3. Dispensing drugs. Except for distributing a professional sample of a prescription or legend drug, a physician ~~assistant~~associate who dispenses a prescription or legend drug:

A. Shall comply with all relevant federal and state laws and federal regulations and state rules; and

B. May dispense the prescription or legend drug only when:

(1) A pharmacy service is not reasonably available;

(2) Dispensing the drug is in the best interests of the patient; or

(3) An emergency exists.

4. Consultation. A physician ~~assistant~~associate shall, as indicated by a patient's condition, the education, competencies and experience of the physician ~~assistant~~associate and the standards of care, consult with, collaborate with or refer the patient to an appropriate physician or other health care professional. The level of consultation required under this subsection is determined by the practice setting, including a physician employer, physician group practice, or private practice, or by the system of credentialing and granting of privileges of a health care facility. A physician must be accessible to the physician ~~assistant~~associate at all times for consultation. Consultation may occur electronically or through telecommunication and includes communication, task sharing and education among all members of a health care team.

5. Collaborative agreement requirements. A physician ~~assistant~~associate with less than 4,000 hours of clinical practice documented to the board shall work in accordance with a collaborative agreement with an active physician that describes the physician ~~assistant~~associate's scope of practice, except that a physician ~~assistant~~associate working in a physician group practice setting or a health care facility setting under a system of credentialing and granting of privileges and scope of practice agreement may use that system of credentialing and granting of privileges and scope of practice agreement in lieu of a collaborative agreement. A physician ~~assistant~~associate is legally responsible and assumes legal liability for any medical service provided by the physician ~~assistant~~associate in accordance with the physician ~~assistant~~associate's scope of practice under subsection 2 and a collaborative agreement under this subsection. Under a collaborative agreement, collaboration may occur through electronic means and does not require the physical presence of the physician at the time or place that the medical services are provided. A physician ~~assistant~~associate shall submit the collaborative agreement, or, if appropriate, the scope of practice agreement, to the board for approval and the agreement must be kept on file at the main location of the place of practice and be made available to the board or the board's representative upon request. Upon submission to the board of documentation of 4,000 hours of clinical practice, a physician ~~assistant~~associate is no longer subject to the requirements of this subsection.

6. Practice agreement requirements. A physician ~~assistant~~associate who has more than 4,000 hours of clinical practice may be the principal clinical provider in a practice that does not include a physician partner as long as the physician ~~assistant~~associate has a practice agreement with an active physician, and other health care professionals as necessary, that describes the physician ~~assistant~~associate's scope of practice. A physician ~~assistant~~associate is legally responsible and assumes legal liability for any medical service provided by the physician ~~assistant~~associate in accordance with the physician ~~assistant~~associate's scope of practice under subsection 2 and a practice agreement under this subsection. A physician ~~assistant~~associate shall submit the practice agreement to the board for approval and the agreement must be kept on file at the main location of the physician ~~assistant~~associate's practice and be made available to the board or the board's representative upon request. Upon any change in the parties to the practice agreement or other substantive change in the practice agreement, the physician ~~assistant~~associate shall submit the revised practice agreement to the board for approval. Under a practice agreement, consultation may occur through electronic means and does not require the physical presence of the physician or other health care providers who are parties to the agreement at the time or place that the medical services are provided.

7. Construction. To address the need for affordable, high-quality health care services throughout the State and to expand, in a safe and responsible manner, access to health care providers such as physician ~~assistant~~associates, this section must be liberally construed to authorize physician ~~assistant~~associates to provide health care services to the full extent of their education, training and experience in accordance with their scopes of practice as determined by their practice settings.

§XXXX. Review committee immunity

A physician or physician ~~assistant~~associate licensed under this chapter who is a member of a utilization review committee, medical review committee, surgical review committee, peer review committee or disciplinary committee that is a requirement of accreditation by the Joint Commission on Accreditation of Hospitals or is established and operated under the auspices of the physician's or physician ~~assistant~~associate's respective state or county professional society or the Maine Board of Medicine is immune from civil liability for undertaking or failing to undertake an act within the scope of the function of the committee.

§XXXX. Records of proceedings of medical staff review committees confidential

All proceedings and records of proceedings concerning medical staff reviews, hospital reviews and other reviews of medical care conducted by committees of physicians and other health care personnel on behalf of hospitals located within the State or on behalf of individual physicians, when the reviews are required by state or federal law, rule or as a condition of accreditation by the Joint Commission on Accreditation of Hospitals or the American Osteopathic Association Committee on Hospital Accreditation or are conducted under the auspices of the state or county professional society to which the physician belongs, are confidential and are exempt from discovery.

Provision of information protected by this section to the board pursuant to Title 24, section 2506 does not waive or otherwise affect the confidentiality of the records or the exemption from discovery provided by this section for any other purpose.

§XXXX. Lyme disease treatment

1. Definitions. As used in this section, unless the context otherwise indicates, the following terms have the following meanings.

A. "Long-term antibiotic therapy" means the administration of oral, intramuscular or intravenous antibiotics, singly or in combination, for a period of time in excess of 4 weeks.

B. "Lyme disease" means:

(1) The presence of signs or symptoms compatible with acute infection with Borrelia burgdorferi;

(2) Late stage, persistent or chronic infection with Borrelia burgdorferi;

(3) Complications related to an infection under subparagraph (1) or (2); or

(4) The presence of signs or symptoms compatible with acute infection or late stage, persistent or chronic infection with other strains of Borrelia that are identified or recognized by the United States Department of Health and Human Services, Centers for Disease Control and Prevention as a cause of disease.

"Lyme disease" includes an infection that meets the surveillance criteria for Lyme disease established by the federal Centers for Disease Control and Prevention or a clinical diagnosis of Lyme disease that does not meet the surveillance criteria for Lyme disease set by the federal Centers for Disease Control and Prevention but presents other acute and chronic signs or symptoms of Lyme disease as determined by a patient's treating physician

2. Lyme disease treatment. A physician licensed under this chapter may prescribe, administer or dispense long-term antibiotic therapy for a therapeutic purpose to eliminate infection or to control a patient's symptoms upon making a clinical diagnosis that the patient has Lyme disease or displays symptoms consistent with a clinical diagnosis of Lyme disease. The physician shall document the clinical diagnosis and treatment in the patient's medical record. The clinical diagnosis must be based on knowledge obtained through medical history and physical examination only or in conjunction with testing that provides supportive data for the clinical diagnosis.

§XXXX. Treatment of minors

An individual licensed under this chapter who renders medical care to a minor for the prevention or treatment of a sexually transmitted infection or treatment of substance use or for the collection of sexual assault evidence through a sexual assault forensic examination is under no obligation to obtain the consent of the minor's parent or guardian or to inform the parent or guardian of the prevention or treatment or collection. This section may not be construed to prohibit the licensed individual rendering the prevention services or treatment or collection from informing the parent or guardian. For purposes of this section, "substance use" means the use of drugs or alcohol solely for their stimulant, depressant or hallucinogenic effect upon the higher functions of the central nervous system and not as a therapeutic agent recommended by a practitioner in the course of medical treatment.

§XXXX. . Posting of policy regarding acceptance of Medicare assignment

person licensed to practice medicine or render medical services under this chapter, or privileged under the PA Compact~~An allopathic physician licensed pursuant to chapter 48, an osteopathic physician licensed pursuant to chapter 36~~, a chiropractor licensed pursuant to chapter 9 and a podiatrist licensed pursuant to chapter 51 who treats Medicare-eligible individuals shall post in a conspicuous place that professional's policy regarding the acceptance of Medicare assignment. This posting must state the policy on accepting assignment and name the individual with whom the patient should communicate regarding the policy.

The Board of Licensure in Medicine, the Board of Osteopathic Licensure, the Board of Licensure of Podiatric Medicine and the Board of Chiropractic Licensure shall enforce the provisions of this section and inform each licensee of the licensee's obligation under this law. Each board may discipline a licensee under its jurisdiction for failing to comply with this section and impose a monetary penalty of not less than $100 and not more than $1,000 for each violation.

§XXXX. Release of contact lens prescription

After contact lenses have been adequately fitted and the patient released from immediate follow-up care by the physician, the patient may request a copy of the contact lens specifications from the physician. The physician shall provide a copy of the prescription, at no cost, which must contain the information necessary to properly duplicate the current prescription. The contact lens prescription must contain an expiration date not to exceed 24 months from the date of issue. The prescription may contain fitting guidelines and may also contain specific instructions for use by the patient.

The prescribing physician is not liable for an injury to or a condition of a patient that results from negligence in packaging, manufacturing or dispensing lenses by anyone other than the prescribing physician.

The dispensing party may dispense contact lenses only upon receipt of a written prescription, except that a physician may fill a prescription of an optometrist or another physician without a copy of the prescription. Mail order contact lens suppliers must be licensed by and register with the Board of ~~Commissioners of the Profession of~~ Pharmacy pursuant to section 13751, subsection 3-A and are subject to discipline by that board for violations of that board's rules and the laws governing the board. An individual who fills a contact lens prescription shall maintain a file of that prescription for a period of 5 years. An individual, a corporation or any other entity, other than a mail order contact lens supplier, that improperly fills a contact lens prescription or fills an expired prescription commits a civil violation for which a forfeiture of not less than $250 nor more than $1,000 may be adjudged. An individual may file a complaint with the board seeking disciplinary action concerning violations of this section.

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§XXXX. Expedited partner therapy

An individual licensed under this chapter may not be disciplined for providing expedited partner therapy in accordance with the provisions of Title 22, chapter 251, subchapter 3, article 5.

§XXXX. Issuance of prescription for ophthalmic lenses

A physician licensed by the board may not issue a prescription for ophthalmic lenses, as defined in section 19101, subsection 18, solely in reliance on a measurement of the eye by a kiosk, as defined in section 19101, subsection 13, without conducting an eye examination, as defined in section 19101, subsection 11.

§XXXX. Requirements regarding prescription of opioid medication

1. Limits on opioid medication prescribing. Except as provided in subsection 2, an individual licensed under this chapter and whose scope of practice includes prescribing opioid medication may not prescribe:

A. To a patient any combination of opioid medication in an aggregate amount in excess of 100 morphine milligram equivalents of opioid medication per day;

B. To a patient who, on the effective date of this section, has an active prescription for opioid medication in excess of 100 morphine milligram equivalents of an opioid medication per day, an opioid medication in an amount that would cause that patient's total amount of opioid medication to exceed 300 morphine milligram equivalents of opioid medication per day; except that, on or after July 1, 2017, the aggregate amount of opioid medication prescribed may not be in excess of 100 morphine milligram equivalents of opioid medication per day;

C. ~~On or after January 1, 2017, w~~Within a 30-day period, more than a 30-day supply of an opioid medication to a patient under treatment for chronic pain. "Chronic pain" has the same meaning as in Title 22, section 7246, subsection 1-C; or

D. ~~On or after January 1, 2017, w~~Within a 7-day period, more than a 7-day supply of an opioid medication to a patient under treatment for acute pain unless the opioid product is labeled by the federal Food and Drug Administration to be dispensed only in a stock bottle that exceeds a 7-day supply as prescribed, in which case the amount dispensed may not exceed a 14-day supply. "Acute pain" has the same meaning as in Title 22, section 7246, subsection 1-A.

2. Exceptions. An individual licensed under this chapter whose scope of practice includes prescribing opioid medication is exempt from the limits on opioid medication prescribing established in subsection 1 only:

A. When prescribing opioid medication to a patient for:

(1) Pain associated with active and aftercare cancer treatment;

(2) Palliative care, as defined in Title 22, section 1726, subsection 1, paragraph A, in conjunction with a serious illness, as defined in Title 22, section 1726, subsection 1, paragraph B;

(3) End-of-life and hospice care;

(4) Medication-assisted treatment for substance use disorder; or

(5) Other circumstances determined in rule by the Department of Health and Human Services pursuant to Title 22, section 7254, subsection 2; and

B. When directly ordering or administering a benzodiazepine or opioid medication to a person in an emergency room setting, an inpatient hospital setting, a long-term care facility or a residential care facility or in connection with a surgical procedure.

As used in this paragraph, "administer" has the same meaning as in Title 22, section 7246, subsection 1-B.

3. Electronic prescribing. An individual licensed under this chapter and whose scope of practice includes prescribing opioid medication with the capability to electronically prescribe shall prescribe all opioid medication electronically by July 1, 2017. An individual who does not have the capability to

electronically prescribe must request a waiver from this requirement from the Commissioner of Health and Human Services stating the reasons for the lack of capability, the availability of broadband infrastructure, and a plan for developing the ability to electronically prescribe opioid medication. The commissioner may grant a waiver including circumstances in which exceptions are appropriate, including prescribing outside of the individual's usual place of business and technological failures.

4. Continuing education. By December 31, 2017, an individual licensed under this chapter must successfully complete 3 hours of continuing education every 2 years on the prescription of opioid medication ~~as a condition of prescribing opioid medication~~. The board shall adopt rules to implement this subsection. Rules adopted pursuant to this subsection are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A.

5. Penalties. An individual who violates this section commits a civil violation for which a fine of $250 per violation, not to exceed $5,000 per calendar year, may be adjudged. The Department of Health and Human Services is responsible for the enforcement of this section.

6. Opioid medication policy. No later than January 1, 2018, a health care entity that includes an individual licensed under this chapter whose scope of practice includes prescribing opioid medication must have in place an opioid medication prescribing policy that applies to all prescribers of opioid medications employed by the entity. The policy must include, but is not limited to, procedures and practices related to risk assessment, informed consent and counseling on the risk of opioid use. For the purposes of this subsection, "health care entity" has the same meaning as in Title 22, section 1718-B, subsection 1, paragraph B.

§XXXX. Prohibition on providing conversion therapy to minors

An individual licensed, registered or certified under this chapter may not advertise, offer or administer conversion therapy to a minor.

§XXXX. Duty to warn and protect

1. Duty. A licensee of the board has a duty to warn of or to take reasonable precautions to provide protection from a patient's violent behavior if the physician has a reasonable belief based on communications with the patient that the patient is likely to engage in physical violence that poses a serious risk of harm to self or others. The duty imposed under this subsection may not be interpreted to require the licensee to take any action that in the reasonable professional judgment of the licensee would endanger the licensee or increase the threat of danger to a potential victim.

2. Discharge of duty. A licensee subject to a duty to warn or provide protection under subsection 1 may discharge that duty if the licensee makes reasonable efforts to communicate the threat to a potential victim, notifies a law enforcement agency or seeks involuntary hospitalization of the patient under Title 34-B, chapter 3, subchapter 4, article 3.

3. Immunity. No monetary liability and no cause of action may arise concerning patient privacy or confidentiality against a licensee for information disclosed to 3rd parties in an effort to discharge a duty under subsection 2.

SUBCHAPTER 6

TELEHEALTH SERVICES

§XXXX. Definitions

As used in this subchapter, unless the context otherwise indicates, the following terms have the following meanings.

1. Asynchronous encounter. "Asynchronous encounter" means an interaction between a patient and a person licensed under this chapter through a system that has the ability to store digital information, including, but not limited to, still images, video files, audio files, text files and other relevant data, and to transmit such information without requiring the simultaneous presence of the patient and the person licensed under this chapter.

2. Store and forward transfer. "Store and forward transfer" means the transmission of a patient's records through a secure electronic system to a person licensed under this chapter.

3. Synchronous encounter. "Synchronous encounter" means a real-time interaction conducted with an interactive audio or video connection between a patient and a person licensed under this chapter or between a person licensed under this chapter and another health care provider.

4. Telehealth services. "Telehealth services" means health care services delivered through the use of information technology and includes synchronous encounters, asynchronous encounters, store and forward transfers and telemonitoring.

5. Telemonitoring. "Telemonitoring" means the use of information technology to remotely monitor a patient's health status via electronic means, allowing the person licensed under this chapter to track the patient's health data over time. Telemonitoring may be synchronous or asynchronous.

§XXXX. Telehealth services permitted

A person licensed under this chapter may provide telehealth services as long as the licensee acts within the scope of practice of the licensee's license, in accordance with any requirements and restrictions imposed by this subchapter and in accordance with standards of practice.

§XXXX. Confidentiality

When providing telehealth services, a person licensed under this chapter shall comply with all state and federal confidentiality and privacy laws.

§XXXX. Professional responsibility

All laws and rules governing professional responsibility, unprofessional conduct and generally accepted standards of practice that apply to a person licensed under this chapter also apply to that licensee while providing telehealth services.

§XXXX. Rulemaking

The board shall adopt rules governing telehealth services by persons licensed under this chapter. These rules must establish standards of practice and appropriate restrictions for the various types and forms of telehealth services. Rules adopted pursuant to this section are routine technical rules as defined by Title 5, chapter 375, subchapter 2-A.

PART B

§XXXX. Transition. Notwithstanding the Maine Revised Statutes, Title 32, Chapters 36 and 48, the following provisions apply to the reassignment of the duties and responsibilities related to the licensing and regulation of allopathic physicians, osteopathic physicians and physician ~~assistant~~associates in Maine:

1. Timeline for immplementation

1. The Maine Board of Medicine is created and established by law. All other statutory references to, responsibilities of and authority conferred upon the Maine Board of Licensure in Medicine and the Maine Board of Osteopathic Licensure are deemed to refer to and vest in the Maine Board of Medicine created by this Act. The Maine Board of Medicine is the successor in every way to the powers, duties and functions related to the licensure and regulation of physicians and physician ~~assistant~~associates in Maine.

Commented [TT24]: §3300-D. Interstate practice of telehealth 1. Definition. For the purposes of this section, "telehealth" has the same meaning as in Title 24-A, section 4316, subsection 1. 2. Requirements. A physician not licensed to practice medicine in this State may provide consultative services through interstate telehealth to a patient located in this State if the physician is registered in accordance with subsection 3. A physician intending to provide consultative services in this State through interstate telehealth shall provide any information requested by the board and complete information on: A. All states and jurisdictions in which the physician is currently licensed; B. All states and jurisdictions in which the physician was previously licensed; and 28 | Chapter 48. BOARD OF LICENSURE IN MEDICINE Generated 01.07.2025MRS Title 32, Chapter 48. BOARD OF LICENSURE IN MEDICINE C. All negative licensing actions taken previously against the physician in any state or jurisdiction. 3. Registration. The board may register a physician to practice medicine in this State through interstate telehealth if the following conditions are met: A. The physician is fully licensed without restriction to practice medicine in the state from which the physician provides telehealth services; B. The physician has not had a license to practice medicine revoked or restricted in any state or jurisdiction; C. The physician does not open an office in this State, does not meet with patients in this State, does not receive calls in this State from patients and agrees to provide only consultative services as requested by a physician, advanced practice registered nurse or physician assistant licensed in this State and the physician, advanced practice registered nurse or physician assistant licensed in this State retains ultimate authority over the diagnosis, care and treatment of the patient; D. The physician registers with the board every 2 years, on a form provided by the board; and E. The physician pays a registration fee not to exceed $500. 4. Notification of restrictions. A physician registered to provide interstate telehealth services under this section shall immediately notify the board of restrictions placed on the physician's license to practice medicine in any state or jurisdiction. 5. Jurisdiction. In registering to provide interstate telehealth services to residents of this State under this section, a physician agrees to be subject to the laws and judicial system of this State and board rules with respect to providing medical services to residents of this State. 6. Notification to other states. The board shall obtain confirmation of licensure from all states and jurisdictions in which a physician applying for registration has ever been licensed prior to registering the physician pursuant to subsection 3. The board shall request notification from a state or jurisdiction if future adverse action is taken against the physician's license in that state or jurisdiction.

2. Notwithstanding the provisions of Title 5, all accrued expenditures, assets, liabilities, balances of appropriations, allocations, transfers, revenues or other available funds in an account or subdivision of an account of the Board of Licensure in Medicine and the Board of Osteopathic Licensure must be transferred to the proper accounts of the Maine Board of Medicine by the State Controller or by financial order upon the request of the State Budget Officer and with the approval of the Governor.

3. All rules of the Board of Licensure in Medicine and the Board of Osteopathic Licensure that are in effect on the effective date of this Act remain in effect until rescinded, revised or amended.

4. All contracts, agreements and compacts of the Board of Licensure in Medicine and the Board of Osteopathic Licensure as they pertain to the duties set forth in this Act that are in effect on the effective date of this Act remain in effect until they expire or are altered by the parties involved in the contracts or agreements. The Maine Board of Medicine is the successor agency for all contracts, agreements and compacts of the Board of Licensure in Medicine and the Board of Osteopathic Licensure.

5. All records of the Board of Licensure in Medicine and the Board of Osteopathic Licensure as they pertain to the duties set forth in this Act must be transferred to the Maine Board of Medicine as necessary to implement this Act.

6. All property and equipment of the Board of Licensure in Medicine and the Board of Osteopathic Licensure pertaining to the duties set forth in this Act are transferred to the Maine Board of Medicine as necessary to implement this Act.

7. Employees of the Board of Licensure in Medicine and the Board of Osteopathic Licensure who were employees of those respective boards immediately prior to the effective date of this Act retain all their employee rights, privileges and benefits, including sick leave, vacation and seniority, provided under the Civil Service Law or collective bargaining agreements. The Department of Administrative and Financial Services, Bureau of Human Resources shall provide assistance to the affected employees and the Maine Board of Medicine and shall assist with the orderly implementation of this subsection.

8. By January 31, 2027, the Maine Board of Medicine shall submit a report, including recommendations for any proposed legislation, to the Governor and the joint standing committee of the Legislature having jurisdiction over professional licensing boards.

9. The Department of Administrative and Financial Services, Bureau of the Budget shall work with employees of the Maine Board of Medicine with regard to the duties transferred to ~~it as~~it as set forth in this Act to develop the budget for the Maine Board of Medicine.