FIRST REPORT FROM THE HEALTH CARE PRACTICE TASKFORCE TO THE STATE ALLIANCE FOR E-HEALTH

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LETTER FROM CO-CHAIRS OF THE HEALTH CARE PRACTICE TASKFORCE

Dear Members of the State Alliance,

In response to our charge to identify and address issues pertaining to the regulatory, legal, and professional standards that have an impact on the practice of medicine, the Health Care Practice Taskforce has spent the last several months deliberating licensure and liability issues that create barriers to an interoperable electronic health information exchange (eHIE). From testimony and discussions at the Taskforce meetings, licensure quickly became the top priority issue for this Taskforce.

Recognizing the barriers created by the lack of uniformity in the licensure process for nurses, physicians and pharmacists, the Taskforce puts forth the following recommendations for your consideration:

> **Recommendation 1.1**: The State Alliance for e-Health should recommend that state medical, nursing, and pharmacy boards work to implement online licensure applications.
>
> **Recommendation 1.2:** The State Alliance for e-Health should recommend that all state nursing and pharmacy boards develop common core licensure application forms, and state medical boards adopt the FSMB's Common Licensure Application Form (CLAF). Individual states may include state specific requirements.

We present the following report for you consideration and look forward to speaking with you at the meeting of the State Alliance on e-Health.

Sincerely,

Dr. Darleen Bartz

and

Thelma McClosky Armstrong

Health Care Practice Taskforce Co-Chairs

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REPORT FROM THE HEALTH CARE PRACTICE TASKFORCE TO THE STATE ALLIANCE FOR E-HEALTH

I. Introduction

The Health Care Practice Taskforce is charged by the State Alliance for e-Health with identifying and addressing issues pertaining to "the regulatory, legal, and professional standards that have an impact on the practice of medicine and create barriers to interoperable, electronic health information exchange (eHIE)."[1] In addition to supporting the State Alliance on these issues, the charge specifically requires that the Practice Taskforce:

> "Develop and advance actionable policy statements, resolutions, and recommendations for referral to the State Alliance to inform their decision-making process in addressing state-level issues related to best practices and the harmonization of regulatory, legal, technical, and professional standards that have an impact on the practice of medicine in interoperable, eHIE."[2]

In response to the charge, the Health Care Practice Taskforce held their first meeting in February 2007 to examine licensure and liability issues in relation to eHIE. By March, the Taskforce developed a list of priority issues and corresponding questions to address in the coming months. These include:

- Licensure: What are the benefits and challenges surrounding various compact models and licensure schemes and how can they be applied to e-health activities? What are states' credential requirements for physicians, pharmacists, and nursing professionals, and should there be a nationwide set of core credentials for these professions?
- CLIA: How do the Clinical Laboratory Improvement Amendments (CLIA) hinder eHIE and what are some possible solutions?
- Liability: What do we know regarding physician's liability in eHIE, and how should that information be relayed to health care providers?

From testimony and discussions at the Taskforce meetings, licensure quickly became the top priority issue for the Taskforce. A problem that resonated throughout each meeting was how the licensure process is often a barrier to health care professionals who want to practice e-health across state lines in ways that would be classified as remote delivery of healthcare services, such as those defined as telehealth.[3] As such, the primary focus of this report is state licensure requirements.

II. Current State of Licensure for Medical Boards, Boards of Pharmacy and State Nursing Boards

The way medicine is practiced is constantly evolving. Currently, a collaboration of state and local health departments are moving toward integration of health information and an interconnected electronic system.[4] There is a great desire to improve quality of care while protecting patient safety, all of which can be facilitated by the use of health information technology.

Patients are now receiving more cross-state consultation with healthcare providers. As technology and procedures advance, consumers are pursuing specialty experts who reside in other states to provide direct consultation for a patient residing in another state. A more technology savvy healthcare consumer market is increasing the demand for internet and e-mail consultative services. In addition, disastrous events, such as Hurricane Katrina, focused attention on the Nation's need to permit healthcare providers to practice medicine in different states or across bordering state lines at a moment's notice.

In order to maintain consumer protections in this evolving e-health environment, it is necessary promote a system that ensures qualified, licensed providers are able to satisfy the demand for cross-state consultation. As the healthcare industry moves toward a more interconnected environment, with provider to provider exchanges of information across state lines, the necessity of streamlining the licensure process for physicians, nurses, and pharmacists will become increasingly vital to both licensed professionals and consumers.

Role of State Boards

"Historically, states have had the authority to regulate activities affecting the health, safety and welfare of their citizens. The state defines the process and procedures for granting a health professional license, renewing a license, and regulating medical practice within the state."[5] The structure and authority of healthcare licensing boards varies from state to state. Some boards are independent and maintain all licensing and disciplinary powers, while others are part of a larger umbrella agency, such as a state department of health, and share legal and investigative resources with other regulatory boards.[6]

State boards serve as the front line of protection for the millions of people who receive medical care by determining whether or not a physician, nurse or pharmacist meets the minimum necessary qualifications to practice in the given profession. The boards enforce practice acts and regulations in order to identify and take action against those who are responsible for poor quality care, unprofessional behavior, and other violations of these acts. The boards' capacity to be effective is often hampered by lack of resources and state funding. Many raise money through licensure and registration fees. In many states large proportions of these funds go into general revenues rather than the boards' own budgets.

The Taskforce has chosen to focus its initial recommendations on physician, nursing and pharmacy boards, recognizing the vital role that these professions play in the frontlines of the provision of health services for most Americans.

A. Physician Licensure

There are currently 70 boards of medicine in the United States and its territories that license and regulate allopathic and osteopathic physicians.[7] Some jurisdictions have separate allopathic and osteopathic boards, while other jurisdictions have composite boards, which license and regulate both allopathic and osteopathic physicians. The various boards can also be distinguished by their regulatory processes, funding and resources, but all 70 boards share the common charge of the protection of the public. In accordance with this charge, the licensure process ensures that only qualified, competent physicians are granted a license to practice in the jurisdiction. Over time, the various licensing boards have developed their own distinctive laws and regulations to accomplish their purposes. In short, there is a lack of uniformity in how boards achieve their

common goal, for example, the licensure of qualified, competent practitioners. As the boards differ in processes and resources, there also exist differences in the length of time from the submission of an application to the issuance of a license. Should a physician wish to obtain licenses in more than one jurisdiction, the physician must abide by the processes of the respective boards, which may require efforts that are viewed as duplicative and time-consuming.

According to the presenters at the February and April meetings of the Health Care Practice Taskforce, even though many state medical boards have similar basic licensure requirements, such as information on medical training and certification, a closer examination of individual state licensure rules reveals wide variation across the states with respect to the requirements for obtaining a license. For example, in the area of continuing medical education (CME), "fifty-one boards require anywhere from 12 hours (Alabama) to 50 hours (several states) of continuing medical education (CME) per year for license registration. Some states also mandate CME content, such as HIV/AIDS, risk management, or medical ethics. In addition, many states also require that a certain percentage of CME be category 1, as measured, for example, through the American Medical Association Physician's Recognition Award." [8]

Medical licensing authorities in the United States require each applicant for licensure to pass an examination to ensure the physician is competent to practice medicine safely. The Federation of State Medical Board (FSMB) and the National Board of Medical Examiners administer the United States Medical Licensing Examination (USMLE), a three-step examination designed to be taken at different points during medical education and training. [9] Another obstacle for a physician wishing to obtain multiple licenses is the fact that many states require a current licensing exam to be taken by applicants if it has been more than 7 years since the physician passed the initial examination.

After physicians are licensed, they must re-register periodically to continue their active status. During this re-registration process, physicians must demonstrate that they have maintained acceptable standards of professional conduct and medical practice. In a majority of states, physicians must also show that they have participated in a program of continuing medical education. [10]

B. Nurse Licensure

There are 59 nursing boards located in the 50 states, the District of Columbia, and four United States territories that license and regulate Advanced Practice Nurses, Registered Nurses (RNs), or as a Licensed Practical/Vocational Nurses (LPN/LVNs). Four states (California, Georgia, Louisiana and West Virginia) have two boards of nursing, one for registered nurses and one for licensed practical/vocational nurses.[11] Individuals who serve on a board of nursing are appointed to their positions. State law dictates the membership of the board of nursing, which usually includes a mix of registered nurses, licensed practical/vocational nurses, advanced practice registered nurses, and consumers.

Once a nurse completes education and training, a nurse must apply for a license in the state where he or she intends to work. As with physicians and pharmacists the requirements to obtain and keep a nursing license vary from state to state. However, all states use the licensure examination of the National Council of State Boards of Nursing, known as the NCLEX-RN or NCLEX-PN license examination for RNs and LPN/LVNs respectively which nurses must take in order to obtain a license. Applicants are eligible for examination for licensure as a RN if they hold a

degree, diploma, or certificate from an accredited nursing program that is approved by the State Board.

There are also variations in state law with respect to nurse licensure requirements for both RNs and LPN/LVNs. For example, continuing education is not mandated in some states, such as Connecticut, however all nurses are expected to keep current with nursing practice and advance as health professionals after graduation.

For the 22 states participating in the National Council of State Boards of Nursing (NCSBN) Nurse Licensure Compact (see discussion below for details), each state still sets its own licensure requirements, which may be similar but contain some variation in the details. This Compact is not applicable to advanced practice nurses such as nurse-practitioners. Nurses regulated under the Compact, must be licensed in their state of residence, while accepting the authority of each remote state's practice and discipline laws in which the nurse practices. The Compact enables remote states to take disciplinary actions allowed by law, with the exception of licensure actions. Only the state of residence can revoke a nurse's license.[12]

C. Pharmacist Licensure

State boards of pharmacy have many roles, some of which include:

- licensing pharmacists by examination or by reciprocity
- licensing pharmacies
- renewing pharmacists' licenses annually
- maintaining a register of pharmacists;
- approving degree programs for colleges of pharmacy; and
- investigating complaints of alleged violations of laws relating to the practice of pharmacy and disciplining pharmacists.

Pharmacist licensure requirements, like those of physicians and nurses, vary from state to state. Some states, such as Arkansas, require the successful completion of a criminal background check within the last four years, while others only require the applicant to be of "good moral character."[13] Some states also have minimum age requirements. To be licensed as a pharmacist in New York State, an applicant must be at least 21 years of age.[14] However, in many other states, the applicant need only be 18 years old.

There is some uniformity with regard to the testing mechanism used by states for applicants. Since 2004, when California was added, all 50 states utilize the National Association of Boards of Pharmacy (NABP) North American Pharmacist Licensure Examination (NAPLEX) as the professional practice examination required for initial licensure as a pharmacist. In addition, 44 of the 50 states use a state-specific version of the Multistate Pharmacy Jurisprudence Examination (MPJE), while the other states use a jurisprudence examination of their own. Both the NAPLEX and the MPJE examinations are computer-adaptive tests that are accessible from anywhere in the country to qualified candidates almost every day of the year.

III. Approaches that states are taking for streamlining licensure

The lack of uniformity in the licensure process and the methods which state boards accept licensure applications pose significant challenges to e-HIE. At the February and April meetings of the Health Care Practice Taskforce, Taskforce members received presentations from a

representative of a telehealth network and representatives from state medical boards each indicating the need for more streamlined licensure processes to support e-health activities across state lines.

States have identified some approaches for streamlining the licensure process including: a) common licensure; b) online licensure applications; c) licensure compacts; and d) reciprocity.

A. Common Licensure

The objectives of a uniform application are to:

- facilitate health care practice across state lines,
- reduce burden faced by applicants in seeking licensure in multiple states,
- reduce administrative redundancies and encourage uniformity,
- facilitate the mobilization of physicians to disaster-affected areas,
- maintain the same level of public protection as the current regulatory system, and
- assure state medical board revenues are sufficient to fulfill regulatory responsibility to protect the public.[15]

One well recognized example of a common licensure application form is the Common License Application Form (CLAF) developed by the Federation of State Medical Board (FSMB). The CLAF is designed to streamline the process for applying for licensure in multiple states with the technical platform (trusted agent platform) that allows for the common information to be immediately primary source verified and provided to the receiving medical board.[16] The States may add their individual requirements by allowing for the attachment of application addendums; thus achieving the objectives of the common licensure form while maintaining the integrity of the individualized state requirements.

In an effort to help streamline the licensure process for physicians in Ohio, the State Medical Board of Ohio is part of a nationwide pilot program testing a common licensure application for physicians. Through a pilot program of the FSMB, the State Medical Board of Ohio supports an online Common Licensure Application Form (CLAF). The CLAF is a uniform licensure application form developed by the FSMB in an attempt to:

- Reduce the number of incomplete applications received by state medical boards,
- Allow for the collection of uniform information, and
- Add convenience for physicians applying for licensure in multiple states.

The CLAF includes a common set of components that are found on most licensure applications, such as name, address, basic identification information, post graduate education, and examination history. The State medical boards can incorporate an addendum to the CLAF, which includes information that is specific to the Board's needs, such as information pertaining to preliminary education, proficiency in English, and board certifications.

Also utilizing the CLAF are Kentucky and New Hampshire. The State Medical Board of Ohio intends for the CLAF to be an added convenience for physicians that seek to practice in both Ohio and Kentucky. FSMB is currently working with additional medical boards to convert their applications to the CLAF.

B. Online Licensure Applications

The use of common tools, such as an online application, by multiple states is a crucial element in supporting the evolving practice of medicine in the electronic health exchange context. In some cases, the state-based application structure has failed to keep pace with advancements in technology.

At the February and April meetings Taskforce members learned that some medical boards are attempting to address these challenges by implementing online licensure applications ***and*** common licensure applications. For example, the North Carolina Medical Board recently implemented online licensure applications for Medical Doctors (MDs) and Doctors of Osteopathic Medicine (DOs). According to the North Carolina Medical Board, online licensure applications have not only reduced the timeframes for obtaining a license, but have also reduced administrative errors. Since the Board's implementation of online licensure applications, timeframes for obtaining a MD and DO license reduced approximately 25%, from four months to three months. Staff has also indicated that since information is entered electronically and drop down menus are incorporated for some fields, handwriting is no longer a factor for administrative errors.

As with the North Carolina Medical Board's online licensure applications, components of an online licensure application can include:

- a secure web portal to access the application,
- 24-7 access to a licensure application,
- drop down menus to select appropriate information for a field,
- links to the websites of medical schools and health care entities to obtain contact information for validating credentials,
- credit card payment capabilities, and
- instant updates on status of licensure application.

The North Carolina experience is an example of how the online application process can break down key barrier for physicians, as well as nurses and pharmacist, in their pursuit of multiple licenses.

Based upon the Health Care Practice Taskforce's request for more information regarding the number of state medical, nursing, and pharmacy boards that currently utilize online license applications, the National Governors Association Center for Best Practices conducted research to assess these figures. The websites of these boards were searched for online applications and members of the Federation of State Medical Board, the National Association of Boards of Pharmacy, and the National Council of State Boards of Nursing were contacted via e-mail requesting statistical information regarding this topic.

According to the e-mail reply of Kristin Hellquist, with the National Council of State Boards of Nursing, approximately 80% of nursing boards use online licensure applications.

Prior to conducting a search of the state boards of pharmacy websites**,** the NGA Center contacted Moira Gibbons**,** Legal Affairs Senior Manager for the National Association of Boards of Pharmacy (NAPB), requesting information regarding the number of states currently using an online application process. Although NAPB utilizes an online application to register licensure candidates for their examinations, it does not track the total number of sates with online applications used to obtain a pharmacist license. In her e-mail message to NGA, Ms. Gibbons

stated that because “the boards already collect a number of paper documents related to licensure (diplomas and other proof of graduation, documentation of completing requisite undergraduate and internship hours, affidavits, et al), some states may not have an immediate need to make an online licensure application available to applicants.” [17]

Lisa Robin, the Federation of State Medical Boards’ Vice President of Government Relations, responded to this inquiry informing NGA that only North Carolina, Ohio, New Hampshire and Kentucky utilize online applications. She also confirmed that while many states have “electronic applications” these are in fact PDF downloads that must be printed and mailed in.

C. Licensure Compacts

The major barriers presented by licensing, credentialing, and practice standards variations to the implementation of telehealth practice caused the Board of Nurse Examiners and the National Council of State Boards of Nursing (NCSBN) to work together to develop a Nurse Multi-state Licensure Mutual Recognition Model, herein the Nurse Licensure Compact (NLC). The compact allows practice, whether physical or electronic, across state lines when the nurse is licensed in a state that has adopted the interstate model.[18] Each nurse practicing in "remote" states and participating in the NLC has only one licensing record.

Since 1998, Nurse Licensure Compact has included registered nurses (RNs) and licensed practical or vocational nurses (LPN/VNs), but does not include advanced practice nurses, such as nurse-practitioners. "An interstate compact is an agreement between two or more states established for the purpose of remedying a particular problem of multi-state concern."[19] The Compact cannot be changed or amended without the consent of all party states.

The Compact allows for "mutual recognition" of nursing licensure among party states that agree to the compact. The mutual recognition model of nurse licensure allows a nurse to possess one license in the state of residency and to practice in other states, subject to each state's practice law and regulation. Under mutual recognition, a nurse may practice across state lines, in a physical or electronic capacity, unless otherwise restricted.

The American Nurses Association (ANA) has expressed concerns that the Compact may limit a nurse’s right to due process and raise significant liability questions. [20] Two keys to the success of the nursing community have been the ability to reach broad community consensus on the need for interstate licensure and the development of a widely accepted model based on mutual recognition. Since 1998 the nurses have successfully promoted the introduction of legislation and the adoption of state laws that may allow them to practice across the boarders of those states that adopt the compact. However, currently only 22 states have implemented the NLC, with Rhode Island planning implementation it the upcoming year.[21]

D. Reciprocity

Although there is no current mutual recognition model or uniform application for pharmacy boards, the National Association of Boards of Pharmacy’s (NABP) Electronic License Transfer Program (ELTP) enables licensed pharmacists to reciprocate an existing pharmacist license from one state or jurisdiction to another utilizing the uniform licensure requirements recognized by all states, the District of Columbia, Puerto Rico, and the Virgin Islands.[22] The program serves as a clearinghouse that screens the applicant's licenses for current license status and disciplinary

actions. It also verifies background information such as examination grades, internship hours, other state licenses, and legal issues.

The NABP utilizes a single on-line Preliminary Application in the ELTP as a means to obtain information about the various credentials that are needed to make a decision about a pharmacist's request for reciprocity. However, it is still up to each state board of pharmacy to determine eligibility for reciprocity in accordance with the laws of that state.[23] Many states and other jurisdictions also require applicants for reciprocity to successfully complete the Multistate Pharmacy Jurisprudence Examination (MPJE), since individual state laws and rules relating to drugs can vary significantly from state to state.[24]

IV. Recommendations

Recognizing the efficiency provided by online licensure applications and the promise that it holds for common licensure applications, the Taskforce recommended that:

> **Recommendation 1.1**: The State Alliance for e-Health should recommend that state medical, nursing, and pharmacy boards work to implement online licensure applications.
>
> **Recommendation 1.2:** The State Alliance for e-Health should recommend that all state nursing and pharmacy boards develop common core licensure application forms, and state medical boards adopt the FSMB's Common Licensure Application Form (CLAF). Individual states may include state specific requirements.

In support of the above recommendations, the Taskforce obtained the following position statements on licensure issues from various national member organizations. Concerning the issues of online licensure applications and common licensure applications, position statements are as follows:

- Federation of State Medical Boards (FSMB): The FSMB supports the work of online licensure applications and common licensure applications through the facilitation of the CLAF pilot project.
- American Osteopathic Association (AOA): The AOA supports the development of online licensure applications.
- American Medical Association (AMA): The AMA supports the FSMB's CLAF.

In an ideal world, states should implement both recommendations in concert, moving toward both the uniformity of the application and establishing an online approach. This combined recommendation advances an interconnected electronic health information infrastructure by promoting the adoption of an application system that is both uniform in its content and form as well as available online.

The Alliance may consider advancing theses recommendations to the states as one. However, the Taskforce did not want to condition one recommendation upon the other at the risk of alienating states that are willing to adopt a common application form, but are not prepared to implement this application online. It should be noted that in addition to the economic benefits to the states in using a common application, the administrative burdens of processing paper applications and lengthy timeframes for obtaining a license would be greatly reduced by an online application process.

For healthcare professionals, obtaining multiple licenses may facilitate the practice of telemedicine. The Taskforce recognizes that the need for cross-state licensure for telemedicine practice has the potential to create a backlash by state governments that may view common applications as the first step towards preempting their jurisdiction over professional licensure. [25] The Taskforce also recognizes that cross-state licensure encompasses broader issues than those relating to telemedicine alone. The need for multi-state licensure to practice telemedicine has focused a spotlight on the larger and more difficult question of professional licensure on a state-by-state basis versus licensure on a multi-state, regional or national basis.[26]

V. Taskforce Next Steps

In response to its charge by the State Alliance, the Taskforce plans to continue its examination of the regulatory, legal and professional standards impacting the practice of medicine. The Taskforce plans to further examine issues that create barriers to eHIE, and discuss possible solutions with respect to streamlining the licensure process.

A. The Licensure Process

The Taskforce will continue an examination general licensure models which may aid in reducing the barriers to interstate practice. Such models may include but are not limited to:

- Endorsement: State boards can grant licenses to health professionals in other states that have equivalent standards. This model allows states to retain their traditional power to set and enforce standards. Since providers must apply for a license in each state that they wish to practice, complying with diverse state requirements can be time consuming.
- Reciprocity: "Many states allow out-of-state licensed [providers] to receive an in-state license through abbreviated licensing processes such as endorsement, registration, or reciprocity. This does not necessarily eliminate the administrative and costly burden of obtaining licenses in multiple states, but it may reduce it However, the physician would be subject to multiple state medical board's statutes and regulations upon abbreviated application approval." [27]
- Mutual recognition: A system in which the licensing authorities voluntarily enter into an agreement to legally accept the licensure policies and processes of the licensee's home state.
- Registration: A model that permits a health professional who wishes to practice part-time in another state to inform the board of the other state and agree to operate under the legal authority and jurisdiction of that state.
- Limited licensure system: A licensure model that limits the scope of practice by allowing for the delivery of specific health services under a defined set of circumstances.
- Certain licensure exceptions such as the consulting exception whereby a physician who is unlicensed in a particular state can practice medicine in that state at the request of, and in consultation with, a referring physician.

The Center for Telehealth & E-Health Law (CTeL) will examine federal and state licensure laws, rules and procedures in order to identify common requirements and major areas of difference. CTeL will describe how such laws, rules and procedures permit or hinder the exchange of electronic health information including telehealth and e-mail exchanges. As part of its analysis, CTeL will explore potential labiality issues that may arise as a result of current licensure

requirements and identify states' definition of practice of medicine. CTeL will suggest solutions to permit the interstate transaction of electronic health information to support the delivery of health care. The Taskforce is due to receive this work product at the end of August 2007.

B. Addressing Liability

The Taskforce will examine liability issues that may arise in the eHIE context. One issue that maybe considered is the fact that several states have mandatory professional liability coverage minimums. The Taskforce may examine the extent to which multi-state licensure should include professional liability coverage.

As part of its support for the Health Care Practice Task Force, The National Association of Attorneys General (NAAG) is reviewing liability issues arising from the exchange of electronic health information. The review includes case law from the state and federal courts and information available about cases that did not proceed to trial but were reported in the media. The purpose of the review is to identify and analyze situations where electronic transfer of personal health information, faulty technology, or misuse and failure to use health information technology could change the dynamics of risk to individuals, health care providers, and other actors in the health care arena. The review will identify several areas that may deserve heightened attention because of the potential for liability. The Taskforce is due to receive this work product at the end of August 2007.

C. The Exchange of State Lab Results

The Taskforce will identify and discuss issues with respect to the exchange of state laboratory results and develop recommendations. The Taskforce will examine: patient access to information, the variation in state laws pertaining to the statutory definition of an "authorized person" to receive lab results, state law conflicts in relation to the Clinical Laboratory Improvement Amendments (CLIA), as well as regional health information organizations (RHIOs) issues and other third party matters.

The Taskforce anticipates developing additional recommendations and/or policy statements on the issues discussed above and intends to provide the State Alliance with a report on additional recommendations at the next scheduled meeting.

ENDNOTES

[1] Health Care Practice Taskforce official charge.
[2] Health Care Practice Taskforce official charge.
[3] Remote delivery differs from remote consultation, which is generally supported by current licensure models.
[4] U.S. Department of Health & Human Services, Office of the National Coordinator for Health Information Technology, available at http://www.hhs.gov/healthit/foundation.html, accessed on August 9, 2007.
[5] Joanne Kumekawa**, "**Center for Telemedicine Law, Quarterly Telemedicine Licensure Update" March 1999, available at http://www.hrsa.gov/telehealth/pubs/licens.htm, accessed on August 6, 2007.
[6] Ibid.
[7] Federation of State Medical Boards, "State of the States: Physician Regulation 2007," available at http://www.fsmb.org/pdf/FSMB%202007%20State%20of%20States%20Report.pdf , accessed on August 6, 2007.
[8] For more information on individual state licensure requirements and variations for with respect to physician licensure please consult the American Medical Association's "State Medical Licensure Requirements and Statistics 2007."
[9] United States Medical Licensing Examination, "2004 USMLE bulletin," available at http://www.usmle.org/bulletin/2004/Overview.htm, accessed on August 7, 2007.
[10] A majority of state boards of medicine utilize online applications for the licensure renewal process.
[11] National Council of State Boards of Nursing, available at https://www.ncsbn.org/126.htm, accessed on August 7, 2007.
[12] Ibid.
[13] Ark. Code Ann. § 17-95-409.
[14] New York State Education Department, "License Requirements, Physician," available at, http://www.op.nysed.gov/medlic.htm, accessed on August 3, 2007.
[15] Federation of State Medical Boards' Common License Application Form, available at https://s1.fsmb.org/claf/.
[16] Ibid.
[17] Email correspondence with Moira Gibbons, Legal Affairs Senior Manager, National Association of Boards of Pharmacy, July 27, 2007.
[18]Georgia A. Martin, "Telehealth: Are you at risk?" *Nursing Risk Management 2002*, available at: http://www.afip.org/Departments/legalmed/jnrm2002/georgia.htm, accessed on August 9, 2007.
[19] For a legal definition of "mutual recognition" please consult: Bryan A. Garner, *Black's Law Dictionary 8th ed.* West Publications, 2005.
[20] Rose Gonzalez Director and Janet Haebler Associate Director Government Affairs, American Nurses Association, Testimony before the Health Care Practice Taskforce, May 30, 2007.
[21] National Council of State Boards of Nursing. available at https://www.ncsbn.org/1058.htm, accessed on August 7, 2007.
[22] National Association of Boards of Pharmacy, available at http://www.nabp.net/index.html?target=/lictransfer/intro.asp&, accessed on August 9, 2007.
[23] Ibid.
[24] National Association of Boards of Pharmacy, available at http://www.nabp.net/competency/intro.asp#m, accessed on August 7, 2007.
[25] Laura Keidan Martin, "Not so fast, it's regulated: Some warnings for the e-health biz," *Business Law Today*, September/October 2000, available at http://www.abanet.org/buslaw/blt/blt9-martin.html, accessed on August 6, 2007.
[26] Joanne Kumekawa**, "**Center for Telemedicine Law, Quarterly Telemedicine Licensure Update" Vol.1 No.2, March 1999, available at http://www.hrsa.gov/telehealth/pubs/licens.htm, accessed on August 6, 2007.
[27] Thomas Wm. Mayo and Tara E. Kepler, *Telemedicine: Survey and Analysis of Federal and State Laws*, American Health Lawyers Association 2007: 16.