Minutes  
Alabama Board of Athletic Trainers  
Alabama State Board of Medical Examiners  
Advisory Council  
July 27, 2021

**ABAT Members Present**  
R. T. Floyd  
Chris King  
Kyle Southall

**Members Absent**

**ABME Members Present**  
Beverly Jordan, M.D. (virtual/TEAMS)  
Eric Law, M.D.  
James Robinson, M.D.

**Others Present**  
Matt Hart (ABME)  
Leah Taylor (ABAT)  
Amy Dorminey (ABME-Virtual/TEAMS)  
Amanda Hargrove (ABME-Virtual/TEAMS)  
Carla Kruger (ABME-Virtual/TEAMS)

Chris King, Advisory Council President, declared a quorum present and called the meeting to order at 5:04 p.m. He welcomed everyone and thanked them for their attendance.

Mr. King called for a review of the minutes of the July 1, 2021, meeting. *Dr. James Robinson made a motion that the minutes of the July 1, 2021, meeting of the ABAT-ABME Advisory Council be accepted as written and presented. Dr. Eric Law provided the second to the motion, and it passed unanimously with favorable votes from Dr. James Robinson, Dr. Eric Law, Mr. Chris King, Mr. Kyle Southall, and Dr. R. T. Floyd.* (Dr. Beverly Jordan joined the meeting virtually a short time following this vote.) These minutes are attached hereto and made a part hereof. (Attachment 1) Mr. Hart reported that the ABME approved during their regular Board Meeting the prior week the newly developed General Protocol contained in the minutes and as recommended by the Advisory Council. Mr. King reported that the members of the Alabama Board of Athletic Trainers will be reviewing them and voting at their meeting which follows this meeting.

Chris King reported that Matt Hart had continued to work on draft rules on Physician Supervision of Athletic Trainers (Attachment 2) and requested that he lead the Council through the them. Mr. Hart explained that he was presenting an updated draft of rules which would create stronger relationships between supervisory physicians and athletic trainers for future expansion as well as establish a set of standard and expanded protocols for various areas of practice. He invited the members to ask questions and make comments as he went through the document because feedback is very important in the development process. Discussion followed with many thoughts and ideas exchanged on the topics of standard practice protocols for various
areas of practice, supervisory physician registration and minimum requirements, the ratio of athletic trainers to physician requirements, qualifications of the supervising physician, physician presence, and reporting requirements. Mr. Hart will update the draft document based upon the feedback and guidance given during the discussions for presentation at the next meeting.

Mr. King then provided a verbal report regarding the current ratio of athletic trainers registered to supervisory physicians. He stated there are 167 different physicians supervising 910 athletic trainers statewide. The vast majority of the physicians supervise fewer than 10 athletic trainers, 18 supervise between 10-20 athletic trainers, and 9 supervise between 20-64. Discussion followed and it was agreed that 10-15 athletic trainers per physician was a very reasonable and manageable number. A popular idea was discussed whereby supervisory physicians whose situation would justify supervising more than the maximum number established could request a waiver. These discussions will continue during the development process.

Chairman Chris King tabled until the next meeting the discussion to establish a procedure to address the construction of each specific setting of practice and then presented questions from two sources regarding scope of practice. (Attachment 3) Discussion followed and it was determined that the new general protocol does not include the procedures in question and, therefore, fall outside the scope of practice of an athletic trainer. Through further discussion it was agreed that, if the on-site physician wants to use an athletic trainer in the additional role of a Medical Assistant and provides the necessary training to perform the various procedures, provides the necessary supervision, and is willing to assume responsibility for that person in that role, the procedures would then be allowable in the role of a Medical Assistant to perform. It is the desire of the Advisory Council to have secondary protocols developed at a later date that will address questions such as those presented.

Mr. King called for any other business. There being none, the next meeting date was discussed. It was decided to delay setting the date and location until later. Further meeting information will be announced at a later date.

Dr. Eric Law moved and Dr. James Robinson seconded that the meeting be adjourned. The motion carried unanimously. The meeting adjourned at 6:40 p.m.

Respectfully submitted,

Chris King, Chairman
# Alabama Athletic Training Advisory Council

**AGENDA**  
Date: July 27th Time: 5pm

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<tr>
<th>Athletic Trainer 1</th>
<th>Kyle Southall</th>
<th>Physician 1</th>
<th>Beverly Jordan</th>
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## Order and Procedures

1.0 **Call to Order**  
Time:

2.0 **Roll Call**

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<td>MD 1</td>
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<td>Chris King</td>
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<td>MD 2</td>
<td>James Robinson</td>
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<td>AT 3</td>
<td>RT Floyd</td>
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<td>MD 3</td>
<td>Eric Law</td>
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**Invited Guests:**

- Board of Medical Examiners
- Counsel
- Matt Hart
- Board of Athletic Trainers
- Executive Secretary
- Leah Taylor

**Other Guests:**

Quorum Established (3 full votes):  
Voting Reporting – Yay – Nay – Abstention - Absences

### 3.0 Approval of the Minutes & Review of Previous Discussions

3.1 **Consent Agenda**

### 4.0 Old Business

4.1 **Update Report from Matt Hart on Draft Rules**

### 5.0 New Business

5.1 **Discussion of the number of ATs licensed by a physician**

- There are 167 licensing physicians supervising 910 ATs in Alabama.
- There are 9 MDs with >20 ATs (ranging from 64-20)
- There are 18 MDs with >10 but <20 ATs.
### 5.2 Propose a procedure to address the construction of each specific setting protocol.

- Clinical (Physician office, Hospital, Physical Therapy Clinic etc)
- Secondary Schools
- Collegiate/Professional League
- Occupational

Do we need to add settings or to address more appropriate naming of settings? What is included in these protocols? What specific skills might be added to specific settings? What requirements will be necessary for these specific skills?

### 5.3 Questions of outside scope from two employers of ATs in the physician office setting.

Ms. Kelly Williamson @ UAB Ed. & Development
Ms. Jenny Degnan @ Andrews SM

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**6.0 Next meeting date and logistics.**

**7.0 Adjournment**

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**Notes:**

**Action Items:**
Attachment 1
Minutes
Alabama Board of Athletic Trainers
Alabama State Board of Medical Examiners
Advisory Council
July 1, 2021
Microsoft Teams Virtual Meeting

**ABAT Members Present**
R. T. Floyd
Chris King
Kyle Southall

**ABME Members Present**
Beverly Jordan, M.D.
Eric Law, M.D.
James Robinson, M.D.

**Members Absent**

**Others Present**
William Perkins (ABME)
Matt Hart (ABME)
Leah Taylor (ABAT)

Chris King, acting as the meeting’s facilitator, declared a quorum present and called the meeting to order at 5:32 p.m. He welcomed everyone and thanked them for their attendance at this inaugural meeting of the newly formed Advisory Council of the Alabama Board of Medical Examiners and Alabama Board of Athletic Trainers. Following his remarks, William Perkins gave welcoming remarks on behalf of the ABME.

Mr. King then addressed the need to elect a chairperson for the group and called for nominations.  *A motion was made by R.T. Floyd to nominate Chris King as Chairman of the Advisory Council. Dr. Beverly Jordan provided the second to the motion and moved to close the nominations. The motion passed with a roll-call vote of five in favor and one abstention by Chris King.*

Chris King reported that Matt Hart had been working on draft rules (Attachment 1) and requested that he lead the Council through the them. Mr. Hart explained that he was presenting a broad draft of rules which would create stronger relationships between supervisory physicians and athletic trainers for future expansion as well as establish a set of standard and expanded protocols for various areas of practice. Discussion followed with many thoughts and ideas exchanged on the topics of supervisory physician registration and minimum requirements, minimum physician presence, and quality assurance. A great deal of emphasis was placed on having an emergency action plan in place as soon as possible but within 30 days of a new collaborative agreement between a supervisory physician and athletic trainer. Other topics
discussed included the concept of a “covering” physician, the ratio of athletic trainers to supervisory physician, the need to change a supervisory physician, the need of more than one supervisory physician based upon AT’s different areas of practice, and having the same physician across different venues. Mr. Hart will update the draft document based upon the feedback and guidance given during the discussions.

Mr. King then presented the “2021 Licensed Athletic Trainer Protocol” (Attachment 2) for discussion. He stated that it was prepared based upon the latest practice analysis prepared by the BOC, which is updated about every 5 years. This general protocol would replace the one which has been in place since being approved by ABME on May 4, 1994. Discussion followed. Kyle Southall made a motion that the Advisory Committee accept the 2021 Licensed Athletic Trainer Protocol document as written and presented for recommendation to each Board for approval. Dr. James Robinson seconded the motion, and it passed unanimously.

The discussions then moved to the various protocols which will be needed now that new practice settings are recognized by the updates to the law. The new practice settings will include clinical areas, secondary schools, collegiate/professional leagues, and industrial/occupational areas.

Chairman King called for any other business. There being none, the next meeting date was discussed. It was decided to delay setting the date and location until later. Further meeting information will be announced once more information is available regarding the completion of updates to the draft rules.

Dr. Robinson moved and Dr. Law seconded that the meeting be adjourned. The motion carried unanimously. The meeting adjourned at 7:15 p.m.

Respectfully submitted,

____________________________
Chris King, Chairman
DRAFT RULES ON PHYSICIAN SUPERVISION OF ATHLETIC TRAINERS
V. 1

540-x-_.01 Definitions

The following definitions will apply to these rules:

(1) ADVISORY COUNCIL. The Advisory Council of the State Board of Medical Examiners and the Alabama Board of Athletic Trainers, established pursuant to Code of Alabama 1975, as amended, § 34-40-3.2.

(2) ATHLETIC TRAINER. A person who is licensed by the State Board of Athletic Trainers as an athletic trainer in Alabama.

(3) BOARD OF ATHLETIC TRainers. The Alabama Board of Athletic Trainers established pursuant to Code of Alabama 1975, as amended, § 34-40-3.

(4) BOARD OF MEDICAL EXAMINERS. The State Board of Medical Examiners established pursuant to Code of Alabama 1975, as amended, § 34-24-53.

(5) PHYSICIAN SUPERVISION. A formal relationship between an athletic trainer and a licensed physician under which the athletic trainer is authorized to practice as evidenced by a written protocol approved by the State Board of Medical Examiners. Physician supervision requires that there shall at all times be a direct, continuing, and close supervisory relationship between the athletic trainer and the physician to whom that athletic trainer is registered. The term does not require direct on-site supervision of the athletic trainer; however, supervision does include the professional oversight and direction required by these rules and by the written guidelines established by the Board of Athletic Trainers and the Board of Medical Examiners.

(6) QUALITY ASSURANCE. Documented evaluation of the practice of the athletic trainer against defined quality outcome measures, using a selected, meaningful sample of patient records which will identify areas needing improvement, set performance goals, and assess progress towards meeting established goals, with a summary of findings, conclusions, and, if indicated, recommendations for change. The supervising physician's signature on the patient record does not constitute quality improvement monitoring. (I do not know how we can do this in most AT settings.)

(7) PROTOCOL. A document approved by the Board of Athletic Trainers and the Board of Medical Examiners establishing the permissible functions and activities that an athletic trainer may perform under the supervision of a physician.

(8) SUPERVISING PHYSICIAN. A physician licensed by the Medical Licensure Commission of Alabama who agrees in writing to supervise one or more athletic trainers.
pursuant to the rules, regulations, and protocols established by the Board of Medical Examiners and Board of Athletic Trainers.

540-X-__,.02 Advisory Council

(1) The purpose of the Advisory Council is for enabling a mechanism for the exchange of information between the Board of Medical Examiners and Board of Athletic Trainers on matters related to the physician supervision of athletic trainers.

(2) The Advisory Council shall consist of the following:

(a) Three (3) physicians appointed by the Board of Medical Examiners. For the initial term, one member shall be appointed to a term concluding on July 1, 2022, one member shall be appointed to a term concluding on July 1, 2023, and one member shall be appointed to a term concluding on July 1, 2024. Thereafter, each appointee shall serve a term of three (3) years.

(b) Three (3) athletic trainers appointed by the Board of Athletic Trainers. For the initial term, one member shall be appointed to a term concluding on July 1, 2022, one member shall be appointed to a term concluding on July 1, 2023, and one member shall be appointed to a term concluding on July 1, 2024. Thereafter, each appointee shall serve a term of three (3) years.

(3) Members of the Advisory Council shall be eligible for reappointment. Should a vacancy occur on the Advisory Council, a successor shall be appointed by the original appointing authority to serve the unexpired term.

(4) The Advisory Council shall select one of its members to serve as chairperson for a term of one year. The office of chair shall alternate between a physician member and an athletic trainer member of the council. (duties of the chair?)

(5) Meetings of the Advisory Council shall be considered official functions of the Board of Athletic Trainers and Board of Medical Examiners. Any member of the Board of Athletic Trainers or Board Medical Examiners attending or participating in a meeting of the Advisory Council shall be entitled to their regular compensation as board members, pursuant to 34-40-3 and 34-24-54, respectively. Any member of the Advisory Council who is not a member of the Board of Athletic Trainers or Board of Medical Examiners shall receive per diem at a rate of one hundred dollars ($100) per day or any portion thereof that the Advisory Council member is attending an official meeting or function of the Advisory Council. All members of the Advisory Council shall receive reimbursement for subsistence and travel in accordance with state law as provided for state employees. Compensation of the members of the Advisory Council shall be paid by the appointing authority.

(6) The Advisory Council may exercise the following functions and responsibilities:
(a) Recommend model practice protocols to be used by athletic trainers;
(b) Review and/or recommend additions, deletions, or amendments to existing model practice protocols;
(c) Recommend rules establishing the ratio of physicians to athletic trainers;
(d) Recommend rules governing the ability to designate an alternate supervising physician when the supervising physician is temporarily unavailable;
(e) Review and/or recommend changes to the current rules and regulations governing the physician-athletic trainer relationship; and
(f) Serve in an advisory role regarding issues related to required education, renewal, and other matters concerning the physician-athletic trainer relationship.

(7) Notwithstanding any other provision of this Chapter, the Advisory Council shall serve in an advisory capacity only and any recommendation made by the Council shall be subject to approval by both the Board of Athletic Trainers and the Board of Medical Examiners.

540-X-03.03 Protocols

(1) There shall be a model practice protocol for each of the following areas of practice for athletic trainers:
   (a) Hospital/Physician Clinic Athletic Trainers;
   (b) Secondary Education Schools Athletic Trainers;
   (c) Post-Secondary Collegiate/Professional League Athletic Trainers; and
   (d) Industrial/Ainstitutional Athletic Trainers.

(2) In developing and evaluating model practice protocols, the Advisory Council shall consider the level of education, training, and experience required to safely perform the duties/procedures, the risks associated with the duties/procedures, the effectiveness and necessity of the duties/procedures, and the likelihood of positive patient outcomes.

(3) A physician and an athletic trainer may submit to the Advisory Council requests to deviate from their approved model practice protocol(s). The Advisory Council may review and evaluate these requests and make a recommendation to the Board of Athletic Trainers and Board of Medical Examiners. The Advisory Council may not grant deviations from protocols, but may only make a non-binding recommendation to the Board of Athletic Trainers and Board of Medical Examiners. Both the Board of Athletic Trainers and the Board of Medical Examiners must approve any request to deviate from the model practice protocol.

(4) Protocols deviating from the standard protocols shall be submitted to the Advisory Council for review and recommendation for approval or denial. When evaluating
whether to recommend the approval or denial of a non-standard protocol, the Advisory Council shall consider certain factors, including, but not limited to:

(a) The supervising physician's and athletic trainer(s)'s education, training, experience, and specialty;

(b) The supervising physician's and athletic trainer(s)'s disciplinary history and any licensure restrictions;

(c) FDA approved usages and recommendations;

(d) Whether a proposed protocol is within the current standard of care for treatment of the disease or condition specified in the protocol, including usages known as "off-label," and whether the use is supported by evidence-based research;

(e) Whether the proposed protocol creates an undue risk of harm to patients; and

(f) The routine scope of practice and services provided by the collaborating physician and the athletic trainer(s).

After consideration of the factors listed herein, the Advisory Council may make a non-binding recommendation of approval or denial of a non-standard protocol in whole or in part.

540-Y-.04 Limitations on the Physician Supervision of Athletic Trainers

1. A physician shall not supervise athletic trainers exceeding four full time equivalent positions (one hundred sixty (160) hours) per week. "One full time equivalent" (FTE) is herein described as an athletic trainer collectively working forty hours a week, excluding time on call.

2. A physician shall maintain independent medical judgment related to the practice of medicine at all times, irrespective of employment structure or business model.

3. A physician shall complete quarterly quality assurance with each athletic trainer. Documentation of any quality assurance review required by this chapter shall be maintained by the supervising physician for ______.

ADDITIONAL QUESTIONS/TBD

-Any specific advanced training, qualifications, or CMEs required of ATs to be able to work in physician registration?
- Requirements of physicians to work with ATs (years of experience, Board certified, specialty limitations, specific CMEs)?
- Minimum physician presence requirements?
- Voluntary and involuntary termination procedures?
ATTACHMENT 2
I. Injury and Illness Prevention and Wellness Promotion

Promoting healthy lifestyle behaviors with effective education and communication to enhance wellness and minimize the risk of injury and illness.

A. Identify risk factors by administering assessment, pre-participation examination and other screening instruments, and reviewing individual and group history and injury surveillance data.
B. Implement plans to aid in risk reduction using currently accepted and applicable guidelines.
C. Educate individuals and stakeholders about the appropriate use of personal equipment.
D. Minimize the risk of injury and illness by monitoring and implementing plans to comply with regulatory requirements and standard-operating procedures for physical environments and equipment.
E. Facilitate individual and group safety by monitoring and responding to environmental conditions (e.g., weather, surfaces and client work setting).
F. Optimize wellness (e.g., social, emotional, spiritual, environmental, occupational, intellectual, physical) for individuals and groups.

II. Examination, Assessment and Diagnosis

Following an evidence-based model, the AT conducts examinations and assessments of injuries and illnesses to form relevant related diagnoses. Evidence-based clinical decision-making relies on clinical expertise that integrates athletic training knowledge and skills, clinical experience, current best evidence, clinical circumstances and patient and societal values. As part of the examination, assessment and diagnosis process, the AT utilizes clinical acumen to obtain a thorough patient history, problem-solve through confounding data, exclude and confirm varied presentations of injury and illness, and prioritize relevant examination, assessment and diagnostic techniques.

A. Obtain an individual's history through observation, interview and review of relevant records to assess injuries and illnesses and to identify comorbidities.
B. Perform a physical examination that includes diagnostic testing to formulate differential diagnoses.
C. Formulate a clinical diagnosis by interpreting history and the physical examination to determine the appropriate course of action.
D. Interpret signs and symptoms of injuries, illnesses or other conditions that require referral, utilizing medical history and physical examination to ensure appropriate care.
E. Educate patients and appropriate stakeholders about clinical findings, prognosis and plan of care to optimize outcomes and encourage compliance.

III. Immediate and Emergency Care

Integrating best practices in immediate and emergency care for optimal outcomes.

A. Establish Emergency Action Plans to guide appropriate and unified response to events and optimize outcomes.
B. Triage to determine if conditions, injuries or illnesses are life-threatening.
C. Implement appropriate emergency and immediate care procedures to reduce the risk of morbidity and mortality.
D. Implement referral strategies to facilitate the timely transfer of care.
IV. Therapeutic Intervention

Rehabilitating and reconditioning injuries, illnesses and general medical conditions with the goal of achieving optimal activity level based on core concepts (i.e., knowledge and skillsets fundamental to all aspects of therapeutic interventions) using the applications of therapeutic exercise, modality devices and manual techniques.

A. Optimize patient outcomes by developing, evaluating and updating the plan of care.
B. Educate patients and appropriate stakeholders using pertinent information to optimize treatment and rehabilitation outcomes.
C. Administer therapeutic exercises to patients using appropriate techniques and procedures to aid recovery to optimal function.
D. Administer therapeutic devices to patients using appropriate techniques and procedures to aid recovery to optimal function.
E. Administer manual techniques to patients using appropriate methods and procedures to aid recovery to optimal function.
F. Administer therapeutic interventions for general medical conditions to aid recovery to optimal function.
G. Determine patients' functional status using appropriate techniques and standards to return to optimal activity level.

V. Healthcare Administration and Professional Responsibility

Integrating best practices in policy construction and implementation, documentation and basic business practices to promote optimal patient care and employee well-being.

A. Evaluate organizational, personal and stakeholder outcomes.
B. Develop policies, procedures and strategies to address risks and organizational needs.
C. Practice within local, state and national regulations, guidelines, recommendations and professional standards.
D. Use established documentation procedures to ensure best practice.

REFERENCE

Attachment 2
540-x-28-.01 Definitions.

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(4) BOARD OF MEDICAL EXAMINERS. The State Board of Medical Examiners established pursuant to Code of Alabama 1975, as amended, § 34-24-53.

(5) EMERGENCY ACTION PLAN.

(6) PHYSICIAN SUPERVISION. A formal relationship between an athletic trainer and a licensed physician under which the athletic trainer is authorized to practice as evidenced by a written protocol approved by the State Board of Medical Examiners. Physician supervision requires that there shall at all times be a direct, continuing, and close supervisory relationship between the athletic trainer and the physician to whom that athletic trainer is registered. The term does not require direct on-site supervision of the athletic trainer; however, supervision does include the professional oversight and direction required by these rules and by the written guidelines established by the Board of Athletic Trainers and the Board of Medical Examiners.

(7) PROTOCOL. A document approved by the Board of Athletic Trainers and the Board of Medical Examiners establishing the permissible functions and activities that an athletic trainer may perform under the supervision of a physician.

(8) SUPERVISING PHYSICIAN. A physician licensed by the Medical Licensure Commission of Alabama to whom an athletic trainer is registered and who agrees in writing to supervise one or more athletic trainers pursuant to the rules, regulations, and protocols established by the Board of Medical Examiners and Board of Athletic Trainers.

540-X-28-.02 Advisory Council
(1) The Advisory Council’s primary purpose is to provide a forum for the exchange of information between the Board of Medical Examiners and the Board of Athletic Trainers and for the formulation of recommendations on matters relating to the supervision of athletic trainers by physicians.

(2) The Advisory Council shall consist of the following:

(a) Three (3) physicians appointed by the Board of Medical Examiners. For the initial term, one member shall be appointed to a term concluding on June 30, 2022, one member shall be appointed to a term concluding on June 30, 2023, and one member shall be appointed to a term concluding on June 30, 2024. Thereafter, each appointee shall serve a term of three (3) years.

(b) Three (3) athletic trainers appointed by the Board of Athletic Trainers. For the initial term, one member shall be appointed to a term concluding on June 30, 2022, one member shall be appointed to a term concluding on June 30, 2023, and one member shall be appointed to a term concluding on June 30, 2024. Thereafter, each appointee shall serve a term of three (3) years.

(3) Members of the Advisory Council shall be eligible for reappointment. Should a vacancy occur on the Advisory Council, a successor shall be appointed by the original appointing authority to serve the unexpired term.

(4) The Advisory Council shall select one of its members to serve as chairperson for a term of one year. The office of chair shall alternate between a physician member and an athletic trainer member of the council. The chairperson shall preside over all meetings of the Advisory Council.

(5) Meetings of the Advisory Council shall be considered official functions of the Board of Athletic Trainers and Board of Medical Examiners. Any member of the Board of Athletic Trainers or Board Medical Examiners attending or participating in a meeting of the Advisory Council shall be entitled to their regular compensation as board members, pursuant to 34-40-3 and 34-24-54, respectively. Any member of the Advisory Council who is not a member of the Board of Athletic Trainers or Board of Medical Examiners shall receive per diem at a rate of one hundred dollars ($100) per day or any portion thereof that the Advisory Council member is attending an official meeting or function of the Advisory Council. All members of the Advisory Council shall receive reimbursement for subsistence and travel in accordance with state law as provided for state employees. Compensation of the members of the Advisory Council shall be paid by the appointing authority.

(6) The Advisory Council may exercise the following functions and responsibilities:

(a) Recommend model practice protocols to be used by athletic trainers;
(b) Review and/or recommend additions, deletions, or amendments to existing model practice protocols;

(c) Recommend rules establishing the ratio of physicians to athletic trainers;

(d) Review and/or recommend changes to the current rules and regulations governing the physician-athletic trainer relationship; and

(e) Serve in an advisory role regarding issues related to required education, registration, and other matters concerning the physician-athletic trainer relationship.

(7) Notwithstanding any other provision of this Chapter, the Advisory Council shall serve in an advisory capacity only and any recommendation made by the Council shall be subject to approval by both the Board of Athletic Trainers and the Board of Medical Examiners.

540-X-28-.03 Protocols

(1) There shall be a standard practice protocol for each of the following areas of practice for athletic trainers:

(a) Clinical Athletic Trainers;

(b) Secondary Schools Athletic Trainers;

(c) Collegiate/Professional League Athletic Trainers; and

(d) Occupational Setting Athletic Trainers.

(2) In developing and evaluating standard practice protocols, the Advisory Council shall consider the level of education, training, and experience required of an athletic trainer or physician to safely perform the duties/procedures, the risks associated with the duties/procedures, the effectiveness and necessity of the duties/procedures, and the likelihood of positive patient outcomes.

(3) A physician and an athletic trainer may submit to the Advisory Council requests to deviate from their approved standard practice protocol(s). The Advisory Council may review and evaluate these requests and make a recommendation to the Board of Athletic Trainers and Board of Medical Examiners. The Advisory Council may not grant deviations from protocols, but may only make a non-binding recommendation to the Board of Athletic Trainers and Board of Medical Examiners. Both the Board of Athletic Trainers and the Board of Medical Examiners must approve any request to deviate from the model practice protocol.

(4) Protocols deviating from the standard protocols shall be submitted to the Advisory Council for review and recommendation for approval or denial. When evaluating whether to recommend the approval or denial of a non-standard protocol, the Advisory Council shall consider certain factors, including, but not limited to:
(a) The supervising physician’s and athletic trainer(s)’s education, training, experience, and specialty;

(b) The supervising physician’s and athletic trainer(s)’s disciplinary history and any licensure restrictions;

(c) Whether a proposed protocol is within the current standard of care for treatment of the disease or condition specified in the protocol, including usages known as “off-label,” and whether the use is supported by evidence-based research;

(d) Whether the proposed protocol creates an undue risk of harm to patients; and

(e) The routine scope of practice and services provided by the collaborating physician and the athletic trainer(s).

After consideration of the factors listed herein, the Advisory Council may make a non-binding recommendation of approval or denial of a non-standard protocol in whole or in part.

540-X-28-.04 Registration

Each athletic trainer shall register prior to engaging in athletic training practice as defined by Ala. Code § 34-40-2(4). Registration of an athletic trainer, by the Board of Athletic Trainers, to practice athletic training under the supervision of a physician, approved by the Board of Medical Examiners, shall be accomplished in the following manner:

(1) A completed application for registration in the form specified in Appendix A to Chapter 28 shall be submitted to the Board of Athletic Trainers; and

(2) A detailed protocol in the form specified in Appendix B which sets forth the anticipated functions and activities of the athletic trainer and is signed by the supervising physician and the athletic trainer shall accompany the application.

(3) The athletic trainer and the supervising physician may be personally interviewed at the discretion of the Board of Athletic Trainers, Board of Medical Examiners, or the Advisory Council.

540-X-28-.05 Limitations on the Physician Supervision of Athletic Trainers

(1) A supervising physician shall not have registered to him or her more than ___ (___) athletic trainers.

(2) A supervising physician shall maintain independent medical judgment related to the practice of medicine at all times, irrespective of employment structure or business model.
540-X-28-.06 Qualifications of the Supervising Physician – Athletic Trainers

The physician to whom an athletic trainer is registered shall:

(1) Possess a current, unrestricted license to practice medicine in the State of Alabama;

(2) On the date of the application, have practiced medicine for at least one year or be certified by one or more of the specialty boards recognized by the American Board of Medical Specialties or the American Osteopathic Association;

(3) Have and maintain competency of the practice of athletic training in order to effectively and safely supervise and provide medical oversight of an athletic trainer; and

(4) Be willing to accept responsibility for the athletic trainer’s practice.

540-X-28-.07 Requirements for Supervised Practice – Athletic Trainers

(1) Physician supervision requires, at all times, a direct, continuing and close supervisory relationship between an athletic trainer and the supervising physician.

(2) There shall be no independent, unsupervised, or unregistered practice by an athletic trainer.

(3) The supervising physician shall be readily available for communication either direct or by telephone or telecommunication.

(4) The supervising physician shall be available for consultation or referrals of patients from the athletic trainer.

(5) An athletic trainer and their supervising physician shall practice at the same location for a minimum of ___ hours each year.

(6) An athletic trainer and their supervising physician shall meet at least once each calendar year to review their emergency action plan.

(7) In the event of an unanticipated, permanent absence of a supervising physician, another licensed physician who satisfies the requirements set forth in Rule 540-X-28-.05, may be designated as an athletic trainer’s temporary supervising physician for a period of up to sixty (60) days. During the sixty (60) day time period, a new protocol designating a new supervising physician should be submitted for approval.
(8) A supervising physician shall maintain independent medical judgment related to the practice of medicine at all times, irrespective of employment structure or business model.

540-X-28-.08 Exemption from Registration Requirements

(1) An athletic trainer may request in writing an exemption from the requirement of being registered under the limited circumstances designated in this rule.

(2) Requirements necessary to request and obtain an exemption from registration are the following:
   
   (a) The athletic trainer holds a current Alabama license.
   
   (b) The athletic trainer is employed as an instructor at a university or college.
   
   (c) The athletic trainer will not be engaging in active athletic training practice as defined by Ala. Code § 34-40-2(4).

(3) Upon review of information provided, the Board of Athletic Trainers may grant an exemption from registration when it determines that the requirements for exemption have been met.

540-X-28-.09 Grounds for Denial of Registration – Athletic Trainer and Supervising Physician

(1) The commission or any act by an athletic trainer which would constitute a violation of Ala. Code § 34-40-10 or any rule of the Board of Athletic Trainers.

(2) The commission or any act by a supervising physician which would constitute a violation of Ala. Code § 34-24-360 or any rule of the Board of Medical Examiners or the Medical Licensure Commission of Alabama.

(3) The physician to whom the athletic trainer is registered has permitted or required the athletic trainer to perform or to attempt to perform tasks which are beyond the athletic trainer’s competence or which are not authorized in the protocol(s) approved by the Board of Athletic Trainers and the Board of Medical Examiners.

(4) Refusal by the athletic trainer or the supervising physician to appear before the Board of Athletic Trainers, the Board of Medical Examiners, or the Advisory Council, after having been formally requested to do so in writing.

(5) The supervising physician’s license to practice medicine has been revoked, suspended, restricted, or disciplined in any manner.
(6) The athletic trainer’s license has been revoked, suspended, restricted, or disciplined in any manner.

(7) Failure of a supervising physician to maintain or produce for inspection upon request by the Board of Medical Examiners any documentation required to be maintained by the supervising physician.

(8) Failure of an athletic trainer to maintain or produce for inspection upon request by the Board of Athletic Trainers any documentation required to be maintained by the athletic trainer.

540-X-28-.10 Denial of Registration - Hearing

540-X-28-.11 Termination of Registration - Voluntary

(1) The athletic trainer shall immediately inform the Board of Athletic Trainers in writing of the effective date of the termination of any physician supervision and the reasons for such termination.

(2) Failure to timely notify the Board of Athletic Trainers of termination may be considered a violation of these rules and regulations for the purpose of approval of future applications for registration.

540-X-28-.12 Termination of Registration - Involuntary

The commission by an athletic trainer or a supervising physician of any act, offense, or condition set forth in Rule 540-X-28-.09 shall be grounds, within the discretion of the Board of Athletic Trainers or the Board of Medical Examiners, to terminate the registration of an athletic trainer to engage in athletic training practice under the supervision of a physician.

540-X-28-.13 Interim Approval – Athletic Trainer

An athletic trainer may obtain interim approval of a supervised practice protocol with an interim supervising physician after confirmed receipt by the Board of Athletic Trainers of a registration application and may continue in interim practice until such time as the pending application for registration is approved or denied, provided the interim supervising physician meets the qualifications established in these rules.
540-X-28-.14 Report to the Board of Medical Examiners

The Board of Athletic Trainers shall, not less than monthly, prepare and submit a report to the Board of Medical Examiners detailing any applications for registration, protocols, amendments thereto, or terminations received under this Chapter, along with a report of any actions taken by the Board of Athletic Trainers on these items.
Attachment 3
I work in Education and Development at UAB Medicine, in the ambulatory department. It is a passion of mine to assist all clinical staff to work at the top of their scope.

We have Athletic Trainers, who are Masters prepared, certified and Licensed in the State of Alabama. I know that these employees are educated on pharmacology during their training, however I do not see anything that specifically permits or prevents the Athletic Trainer from preparing medications for injections, drawing/spinning blood, or medication administration. (Although I know this is common practice in other institutions, possibly other states.) The lack of specific wording in the Alabama Athletic Trainers Licensure Act Code of Alabama has our leaders in a disagreement about what these staff members are allowed to do, per their state board.

Could you be of any assistance in this matter? Are there decisions/rulings that I am not aware of?

Kelly Williamson, BSN, RN-BC
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hsftraining@uabmc.edu
Hello,

Can a Licensed Athletic Trainer working in a clinical environment perform the following duties:

1. **Draw up medication for joint injection(s).**
   a. Under sterile technique prepare joint injections for M.D. or Advanced Practice Provider (APP).

2. **Draw blood from a patient to then use for a PRP procedure.**
   a. Under sterile technique, obtain 1-2 tubes of patient's own blood which will then be run through a centrifuge and PRP extracted to then inject back into patient's body by M.D. or APP.

3. **Dictate clinical note into electronic record.**
   a. Will be co-signed by supervising provider.

4. **Simple wound care including suture and staple removal from surgical wounds.**

5. **Assist with diagnostic ultrasound and joint injections.**
   a. Prepare the ultrasound probe, assist with sterile technique and documentation of the procedure.

Thank you,

Jenny Degnan

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