2015 SENATE HUMAN SERVICES

SB 2295

2015 SENATE STANDING COMMITTEE MINUTES

Human Services Committee
Red River Room, State Capitol

SB 2295
2/4/2015
23214

☐ Subcommittee
☐ Conference Committee

Committee Clerk Signature

Explanation or reason for introduction of bill/resolution:

A bill relating to the regulation of athletic trainers, and to provide a penalty.

Minutes:

Attach #1: Testimony by Steven Westereng
Attach #2: Testimony by Brandy Currie
Attach #3: Testimony by Damian Schlinger
Attach #4: Testimony by Jack McDonald
Attach #5: Testimony by Kevin Axtman
Attach #6: Testimony by Kathleen Day
Attach #7: Testimony by Tony Hollar
Attach #8: Testimony by Carol Olson
Attach #9: Email from Richard Zaruba
Attach #10: Email from Janet Eloyce Rasmussen
Attach #11: Email from Bud Wessman
Attach #12: Testimony by Sarah Ashley
Attach #13: Testimony by Cassie Beseman

Senator Dever introduced SB 2295 to the Senate Human Services Committee. He provided an example that when he fell down one step, he could have gone to therapist but not to athletic trainer. Either one is qualified to treat it. This recognizes those qualifications and who they are able to treat. If on the sports field they can treat, and if not, they can't. (2:34)

Represenative Karen Rohr (District 31), testified. She supports SB 2295.

Shane Goettle, Lobbyist, testified IN FAVOR of SB 2295. He represents North Dakota Athletic Trainers. 2 principles - to update the act. The education and training for this profession has expanded but the act has not. 2nd principle is to move beyond just athletes. Today, athletic trainers have to ask "Were you an athlete when the injury occurred". 177 today, they have expanded their availability. They still cover sports, but also working within the providers. Public is more familiar, and confident, and demand for services even for non-athletes. The practice act has not kept up with the times. Is the public protected? Is the individual performing the service adequately trained? Athletic trainers are educated, integrity of license. There is overlap. Competition gives patients choice, options. Should foster collaborative delivery. Mr. Goettle walked through the bill. (end 11:00)

Chairman Judy Lee where you have physicians listed in the bill, what about the areas where the primary care providers are nurse practitioners, are you amenable to having provider neutral language?

Mr. Goettl would be amendable to that. Wanted to limit to the 2 principles and remove qualifier of athlete.

Senator Howard Anderson, Jr. understands the intent to add "an illnesses to prevent" - that's a broad term. In back page working under supervision of physician, since someone may not have seen physician, you couldn't treat him since they hadn't seen the physician. Is that correct?

Mr. Goettle the term "direction" does not mean the physician is in the immediate vicinity. Most of the services performed by athletic trainers are at sporting events, where there isn't a doctor in the room. They are assessing the injury, doing some taping and so forth. It isn't that physician isn't immediately there, but orders coming from physicians that allows them to practice in those environments. Even in the clinical setting, it isn't necessarily the physicians in the room, but they are always available for consult.

Chairman Judy Lee asked if they considered the possibility of using the term general supervision versus direct supervision.

Mr. Goettle stated they are quite open to proper term to get settled on this. We settled on "direct", thought about other terminology; want to work with the doctors, open for dialog for other terms.

Chairman Judy Lee stated the term direct supervision usually means "in the room".

Senator Warner asked if Mr. Goettle could elaborate on growing concern about concussion injuries. What is the firewall between coaches, autonomy of decisions within scope of those injuries?

Mr. Goettle deferred to further testimony. It is part of their ethics to make independent evaluations, and make sure that they are adequately addressed. There has been a tremendous amount of training to coaches and awareness about return-to-play. Athletic trainer can make the decision without dealing with repercussions. They are governed by their licensing board.

Senator Warner assume that third party providers for insurance and to bill for the services provided. Will they be billed through the primary provider?

Mr. Goettle deferred to further testimony. The bill is not motivated for billing for athletic services. They usually are contracted through public entities.

Steve Westereng, Director for the University of North Dakota, Division of Sports Medicine, testified IN FAVOR of SB 2295 (attach #1) (18:02-23:02). Mr. Westereng's testimony included Athletic Trainer sheets, included in attachment #1.

Brandy Currie, Vice President of the North Dakota Athletic Trainers' Association, as well the Curriculum Coordinator and Instructor at the University of Mary, testified IN FAVOR of SB 2295 (attach #2). Ms. Currie's testimony includes numerous letters of support IN FAVOR of SB 2295, included in Attachment #2. (23:05-28:02)

Senator Warner asked if Ms. Currie could address question of billing.

Ms. Currie this is not our intent. There are already codes to use by athletic trainers. If insurance companies want to provide for reimbursement, that is an insurance concern and not here for this bill.

Senator Warner asked what about liability and immunity to prosecution in your practice, what do you do different from good Samaritan on the sidelines. Are you picking up some liability or is there some immunity.

Ms. Currie does provide standard first aide. Education is beyond that, recognizing and treating. Work under guidelines of physicians. We act accordingly. Ms. Currie indicated they are picking up liability, but our education dictates what we do.

Senator Howard Anderson, Jr. if you were a physician and took care of patient who fell down steps, they would not be immune. If pharmacist, I am immune because I'm a good Samaritan.

Ms. Currie indicated they are not looking to fall back on good Samaritan law.

Senator Howard Anderson, Jr. are you looking to expand beyond the sports facility and work in local clinic.

Ms. Currie not necessarily move off, but open up the option to work in offices.

Senator Howard Anderson, Jr. are you asking us to confirm what you already doing.

Ms. Currie because of the way this is written, physicians do not want to open the door.

Senator Howard Anderson, Jr. talked about Westereng testimony regarding certification, where national certification stated you work with physicians. Does that mean Chairman Judy Lee discussion regarding nurse practitioners would not fit with the national certification because it doesn't state that.

Ms. Currie indicated that if the language was changed to provider neutral language, that may be an issue.

Chairman Judy Lee stated that in many areas in the state, the primary physician is the nurse practitioner.

Ms. Currie concurred.

Chairman Judy Lee the University of Mary has both Athletic Training and Physical Training curriculums. Why would you go into the athletic training program instead of the physical therapy program?
Ms. Currie you need an undergraduate degree if going into physical therapy prorgram, so a lot of times they get pushed into athletic training program.

Ms. Currie also referred to her other written testimony that was provided in her packet (information included in attach #2). Ms. Currie identified the letters of support from Jill Wilson, Sara Bjerke, Robyn Gust, Terry Eckmann, Cassandra Heald, Tim Juelson, Jeremiah Penn, Nick Walker, and Alyssa Sorensen.

Dr. Dawn Mattern, sports medicine doctor, testified IN FAVOR of SB 2295. She is responsible for 12 athletic trainers and 3 graduate assistants. Together, they cover schools in the Minot area. She state she could not do this without competent people she can trust. They are in contact with her, and she is contact with them. She knows exactly how the athletic trainers will provide service. The liability part keeps her awake at night. She is responsible for being there, answering questions, and training. Agrees with the testimony already provided that education has expanded greatly. In 7 ½ years, our training is irrelevant old training, so educated athletic trainers reflect current and future training. The athletic trainers and physical therapist get along well, respect what everyone brings to the table. She is family physician and received extra year in athletic training. Reflecting what these professionals have in training, she passionately supports this bill. (39:40)

Dr. Bill Mann, in practice of 50 years, testified IN FAVOR of SB 2295. When he came to North Dakota in 1977, the medical profession was determined that there wouldn't be Nurse Practitioners or Physician Assistants. Fortunately the legislature helped that situation, and this is deja vu. The young incoming skills a glaring gap in assessment, where these physicians would learn the skills. Developed a relationship at the university. The involvement with athletic trainers was rewarding and rich. Support everything about their training. Always concerns about practice, but concern is to wrong spot. Do you recognize your scope of practice. Do you recognize a problem when it falls outside of scope. Do you recognize emergent conditions and behave appropriately. He has confidence that the athletic trainers he works with has this. He stressed importance of rural areas and being looked after by an athletic trainer. In rural state, this is very important. The athletic trainer is the first person in the morning and last out at night, and these hours are unsustainable in the long run. The only way the young people will continue entering athletic trainer, there is some alternative that prevents them from being the first person in and first person out. That is the organized health systems. Suggest that this would remove any doubt in the health systems.

Damian Schlinger testified on behalf of the North Dakota Board of Athletic Trainers IN FAVOR of SB 2295 (attach #3) (45:47-49:00)

Chairman Judy Lee how does the curriculum compare between athletic trainer and physical trainer at undergraduate level?

Mr. Schlinger can't speak to bounds of physical therapists, but growth of competencies has significantly increased for the athletic trainers.

Sarah Ashley, senior at high school, testified IN FAVOR of SB 2295. (attach #12, provided copy of written testimony after hearing) (50:00-51:33)

Cassie Beseman, a student at the University of Mary, testified in FAVOR of SB 2295 (attach #13, provided copy of written testimony after hearing). She provided a personal story about likely leaving North Dakota to practice and moving to Minnesota, where the athletic trainer practice is more broad. (51:45-53:35).

Senator Howard Anderson, Jr. seems to be some disagreement with practice acts in Minnesota and South Dakota versus North Dakota. Can you provide the information that provides that information.

Ms. Beseman indicated that Minnesota stated that you can help anyone that is active versus sports in North Dakota.

OPPOSTION TO SB 2295

Jack McDonald, appearing on behalf of the North Dakota Physical Therapy Association (NDPTA) and North Dakota Board of Physical Therapy, testified OPPOSED to SB 2295 (attach #4). (Oral testimony ends 1:01:33)

Senator Dever you are concerned with the education. Looking at act, it spells out what they are allowed to do. If this bill spelled out what their education is and what they could do within that, would that alleviate your concern?

Mr. McDonald indicated scope of practice is spelled out in state law. As written now, it gets rid of the scope of practice.

Senator Dever same thing with physical therapy, but it is spelled out.

Mr. McDonald yes, but tied into their training - scope of practice.

Senator Howard Anderson, Jr. is it true that physical therapists can practice without the physician where athletic trainers would not be allowed to do that.

Mr. McDonald responded, correct.

Chairman Judy Lee regarding provisions in neighboring states, in Minnesota, an athletic trainer can, and she read from the Minnesota bill. Is that they are limited to educating and counseling or that they are only limited to athletes?

Mr. McDonald thinks the intent is athlete.

V. Chairman Oley Larsen asked if an athletic trainer went to John Deere and tried to reduce injury, is that out of practice?

Mr. McDonald under the act, yes it would be out of their scope of practice. It goes back to outlining what is in their scope of practice.

Dr. Kevin Axtman, a licensed physical therapist and athletic trainer at Bismarck's Bone and Joint Center, testified in OPPOSITION to SB 2295. (attach #5) (1:07:00-1:10:15)

Senator Warner could someone provide curriculum in column for comparison between the physical therapists and athletic trainers?

Mr. Axtman sees these students, that this is somewhat uncomfortable. He's not bashing the athletic trainer field, but the bill allows them to do any and everything.

Chairman Judy Lee looked at Minnesota statute and their many definitions. There is no definition like that in North Dakota. Perhaps we should find definitions that are more limiting, such as defining illness and not be doing anything inappropriate.

Mr. Axtman answered yes that would be an option.

Tony Hollar, the reimbursement chair for the North Dakota Physical Therapy Association, testified OPPOSED to SB 2295 (attach #7)(1:13:00- 1:15:30)

Senator Dever his understanding of health care providers that are associated with clinics and hospitals, their scope of practice is defined by the institution that they work for. Athletic trainers work under the supervision of a physician. Then isn't their scope of practice defined by that physician?

Mr. Hollar indicated technically no. If an athletic trainer in a different facility is performing under physician and that physician is billing codes that unable to be performed by an athletic trainer, you are getting into a much higher liability issue. A physician takes the liability for what that athletic trainer is performing or medical facility.

Senator Dever - in accordance with their education. So how are you suggesting this limits them?

Mr. Hollar it takes out the limitation entirely from what they are able to do from their scope of practice. It takes a huge broadness of the category.

Chairman Judy Lee when talking about professional liability, she advised the students and others in the room to have personal liability. Hospital is liable but not responsible for an individual lawsuit. Professional liability policy is critical. Based on what Senator Dever question was, do you think that working around and refining the definitions - we don't have many definitions for athletic trainers, there are others that have provided longer list of definitions in neighboring states.

Mr. Hollar definitely. Getting together with NDATA and finding the definitions within the scope of practice could occur.

Chairman Judy Lee if we could ask the two organizations to get together, that would be helpful and provide the committee some guidance.

Carol Olson, PhD, OTR/L, FAOTA, testified OPPOSED to SB 2295 (attach #8) (1:22:12-1:26:15)

Chairman Judy Lee asked if she thought that occupation therapists should be included in amendment. Do all occupational therapists require a master's degree?

Ms. Olson said master's level, and considering doctorate.

Chairman Judy Lee asked if University of Mary why go into athletic trainer instead of physical therapists?

Mr. McDonald indicated 4 year program versus 6 year program. The University of Mary physical therapist students and instructors are at a conference and not available. He will provide a comparison list of the different curriculums.

Kathleen Day, President of the North Dakota Physical Therapy Association, testified IN OPPOSITION of SB 2295. (attach #6)

Senator Howard Anderson, Jr. we received letter from Doctor Zaruba. It has suggested language that may solve the issues. If the people who testified wants to look at that language, it may help.

No Neutral

<u>Closed Public Hearing</u>

The following electronic transmissions were sent in regards to SB 2295:
- **Mr. Richard Zaruba**, PT, DPT, PhD (attach #9)
- **Ms. Janet Eloyce Rasmussen** (attach #10)
- **Mr. Bud Wessman** (attach #11)

2015 SENATE STANDING COMMITTEE MINUTES

Human Services Committee
Red River Room, State Capitol

SB 2295
2/11/2015
23672

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Committee Clerk Signature

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A bill relating to the regulation of athletic trainers, and to provide a penalty.

Minutes:

Attach #1: Email from Robin Gust Attach #2: Testimony & Related Documentation from Shane Goettle

Chairman Judy Lee distributed an email from **Robyn Gust** (attach #1)

Mr. Shane Goettle, representing the North Dakota Athletic Trainers Association, distributed further testimony and documentation as requested from the initial hearing (Attach #2)

Senator Howard Anderson, Jr. has received many emails about this bill. Everyone gives an excellent case about why athletic trainers should be on the field treating athletic injuries. But those in favor of the bill state they need the bill so they could do what we are already doing. Why the additional things if they are already doing the things they do?

Mr. Goettle stated the grave difficulties they have now is the threshold question of "were you an athlete" is the screen to performing services. Some of the medical institutions are getting creative by giving them different titles, calling them physician extenders or ergonomic specialists. It requires some continued education so they get those titles.

Senator Howard Anderson, Jr. maybe we should change the name to ergonomic specialists.

Mr. Goettle indicated that is some discussion. The term athletic trainer has a long history. They have expanded beyond the term. State by state they are taking up the issue of the limits that their profession is experiencing.

Senator Warner a lot of our discussion is after an injury. The very term athletic trainer would indicate a preemptive role, and we haven't heard anything about that. There are issues with preemptive role as well; including extensive treatment after. Are there any issues relative to their practice act that we should be aware of?

Mr. Ray Hall, Governmental Affairs Chair for the North Dakota Athletic Trainers Association, spoke. Mr. Hall read from their current practice act, naming the areas that they assess and treat, relating to athletes only. As time has evolved, they are getting questions from the general public and would like to get rid of the term athlete. In proposed amendments we still have prevent of the injuries and illnesses. We aren't trying to change the scope, but re-word it.

Senator Warner is there a distinction between personal trainer and athletic trainer? Is there a responsibility or prudence, liability of personal trainer based on their advice.

Mr. Hall stated there is a difference. An Athletic Trainer goes through school and graduates from accredited school and is licensed. There are no provisions for personal trainers. They can take a certification test, but that isn't even required.

Chairman Judy Lee asked if the personal trainer be an individual who is more able to say these kind of activities will provide this kind of appropriate conditioning for certain areas of muscle or endurance or aerobics or whatever, focused on physical activity.

Senator Warner the term athletic trainer or athletic medicine indicates there is a preemptive role in what you are doing.

Mr. Hall stated the term athletic trainer it has come up at least twice on the national level. It is sometimes compared to Occupational Therapy; they don't deal with just workers. The athletic trainer profession has evolved. It is better to keep the name and educate what we are trained to do rather than try to reinvent a new name. If we had athletic therapist, there would be opposition from the all of the different therapists. They haven't found one new name for their profession.

Senator Howard Anderson, Jr. stated that one of the terms that scares people when they read the bill is comprehensive management of injuries and illnesses. That sounds familiar to a Nurse Practitioner or physician. It is too broad. Is there some language that you could agree on that would limit that specifically, would say if related to injuries, exercise, say what you want to do versus illness, which is very broad. It appears there are no limitations.

Mr. Hall the reason we put in the first section under the athletic training, part of the packet provided today are the competencies that all athletic trainers have to learn. After the neighboring states practice act, there is a sampling of illnesses that are in their competencies, it is within their education, so we aren't trying to treat outside of education.

Senator Howard Anderson, Jr. suggested if you have a list and you can make others comfortable with, then make it specific enough so there is no question.

V. Chairman Oley Larsen asked if 43-39-05 is. Isn't that their scope of practice in statute?

Chairman Judy Lee agrees with Senator Howard Anderson, Jr. on not having specific language and being too broad. The word illness is very broad. Chairman Judy Lee agreed with Senator Howard Anderson, Jr. to suggest language to where you can do what you are permitted to do, but help people reading the statute to be clear and specific.

Senator Howard Anderson, Jr. stated that V. Chairman Oley Larsen reference to the practice act, he is comfortable with the practice act but apparently you (Hall) are not comfortable with the practice act.

Mr. Hall the two changes that we have and the main change is that we want the individuals education, which ties into the certification and competencies. The other objective is to remove the word "athlete", because if a person has a muscular skeletal issue, the word athlete is causing the issue.

Senator Howard Anderson, Jr. you still aren't addressing what V. Chairman Oley Larsen is saying. If the definition of your practice act needs changes, then change that.

Senator Warner would you be comfortable if you added muscular skeletal issues? Are there other issues?

Mr. Hall in the athletic realm, we have athletes who come into a facility and are sick. They may have strep throat, something else. The athletic trainer will have early recognition of those, so if it is only muscular skeletal issue, then it prohibits that. We do more than that.

Senator Warner if skull fracture, then they would tell me to go to physician. It is still a referral authority. You aren't diagnosing the issue, but referring.

Mr. Hall stated it includes cuts and abrasions, that fall out of muscular skeletal that we deal with on a regular basis.

Senator Warner those would fall within the realm of first aid.

Mr. Hall if you have a staph infection, we are the first to see that many times. We may not treat that but we are recognizing that and referring it on.

Senator Howard Anderson, Jr. again, your description of the person who might come in who is sick and you make an assessment that they need referral, and it states here you have comprehensive management of injuries and illnesses, that is a big difference from recognizing that they are sick and referring to someone.

Chairman Judy Lee stated this won't be fix this afternoon, but is the discussion helpful to you?

Mr. Hall and **Mr. Goettle** confirmed yes. **Chairman Judy Lee** instructed don't be overly specific, but Senator Howard Anderson, Jr. is a good reference point of what things should be included and what you want to have and then where the committee goes from there. Make sure the documents asking for change reflect the adequate limitations. How do we make people comfortable that you are part of the chain for potential treatment options for someone but there is a point to refer at the appropriate level. The committee confirmed Chairman Judy Lee statement.

Mr. Hall then went through the attachment. After Mr. Goettle's written testimony, there is neighboring states practice acts, samples of definitions of states around us, the practice

acts in neighboring states, sample of illnesses pulled out of their scope of competencies, some curriculum for athletic trainers, occupational therapists, and physical therapists for comparison.

Chairman Judy Lee how many universities in North Dakota offer athletic training curriculum?

Mr. Hall answered four: University of North Dakota, University of Mary, Minot State University, Valley City State University in the process of getting one, and North Dakota State University has an entry level masters program.

V. Chairman Oley Larsen on these practice acts, is it a board or administrative rule. Can't this be administratively ruled rather than coming to legislature?

Mr. Hall the main thing is in current practice act, it states athletic injuries, so it is in statute. We have hospitals who said they will not hire athletic trainers because it says athlete injuries, and our practice act has to be wholly athletic related.

Senator Howard Anderson, Jr. reviewed quickly the documentation that Mr. Goettle and Mr. Hall had provided. He stated that there is some language that might actually work. Certainly the physical therapists and occupational therapists might agree that it might be okay regarding definitions and practice acts.

Mr. Hall indicated they did go through a lot of practice acts when they tried to come up with the language when they presented. We came up with what was believed to be the best. Michigan and Wisconsin have more updated versions of the practice acts, while Minnesota, Montana, and South Dakota there are parts that are modern but for the most part are still tied into the athlete area.

Chairman Judy Lee assigned the intern, Femi, to spend some time looking at definitions, so committee can compare and what we could discuss.

2015 SENATE STANDING COMMITTEE MINUTES

Human Services Committee
Red River Room, State Capitol

SB 2295
2/17/2015
23992

☐ Subcommittee
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Committee Clerk Signature *Donald Mueller*

Explanation or reason for introduction of bill/resolution:

A bill relating to the regulation of athletic trainers, and to provide a penalty.

Minutes:

Attach #1: SB 2295 Draft Bill with Amendment by Goettle

Shane Goettle distributed a draft SB 2295 with amendments (attach #1) that athletic trainers are interested in moving forward with. The Physical Therapists have not agreed with the proposed amendments - Jack McDonald needs his group to review. It is a conversation that was done with physical therapists and occupational therapists. The amendments reflect more definitions for athletic training in letters a through g. Each of those are tied to "physical activity," which then demands the definition of "physical activity." This is largely based on Wisconsin model but not identical to Wisconsin. They arrived at an agreement on the definition of physical activity with the occupational therapists. There is no agreement yet with the physical therapists. Mr. Goettle read through #3 - physical activity. The athletic trainer group had a discussion today and agreed this is the version they want to move forward with.

Chairman Judy Lee indicated she would like the occupational therapists and physical therapists consent or comment by tomorrow morning.

Senator Dever asked for clarification. Is this only when they are practicing athletic training or did they remove that restriction.

Chairman Judy Lee answered that it still says who is providing athletic training. But that is there name.

Mr. Goettle everything now comes under what is definition of athletic training. Athletic training is under the guidance of a physician, and listed athletic training is listed in letters "a" through "g".

V. Chairman Oley Larsen indicated that letter "a" discusses this, up to the more broad area and not just on the field.

Mr. Goettle stated this accomplishes the two goals that were communicated. (1) to come out of that strict definition of "are you an athlete when you received this injury; (2) that they are able to do everything they are trained and educated to do.

2015 SENATE STANDING COMMITTEE MINUTES

Human Services Committee
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SB 2295
2/18/2015
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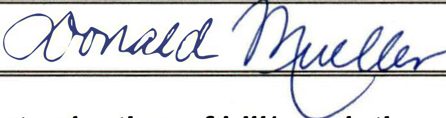
Committee Clerk Signature 

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Minutes:

Attach #1: Draft SB 2295 with proposed amendments

These are minutes from the Senate Human Services Committee on February 18, 2015, morning session.

Cory Fong representing the ND Athletic Trainer Association, distributed a draft SB 2295 with proposed amendments after collaboration with the occupational therapists, physical therapists, and athletic trainers (attach #1).

Mr. Fong reemphasized that the proposed amendments are aimed to modernize the act by doing two things: (1) decoupling from the limitation that Athletic Trainers can only treat athletic injuries, while providing more clarity and specificity than the original bill did for what services the Athletic Trainer can provide, and (2) aligning the services with their educational training. The amendments were modeled from the Wisconsin version. Mr. Fong continued to walk the committee through the draft bill, as proposed amended. Highlights include:

- Reaffirm the scope of practice and the services offered by Athletic Trainers is under the guidance of a physician. This was previously in the penalty section but now is stated in the definition.
- Decouple from narrow limitation of treating athletic injuries to align with educational and training background, have listed the specific duties, letters "a" through "f". They have key phrases such as "while participating in physical activity."
- Included letter "g", which is a referral to the appropriate health care provider as needed.

The term definition "physical activity" is now defined in Sub-Section 3. The last clause in this sub-section, "including participating in exercise, sports, games, recreation, wellness or fitness" is not to be exclusive of some of the other activities that athletic trainers are performing, for example in a work setting.

Jack McDonald, representing the North Dakota Physical Therapy Association, responded that the physical therapists still oppose SB 2295 along with the proposed amendments.

They recognize that the bill has been changed and describe some of the things they are doing, but basically they are still doing everything. The physical therapists remain concerned that the profession and the curriculum, named athletic trainer, are practicing outside of their scope. As an athletic trainer, they would be permitted to do rehabilitation work that they could find, ergonomics, injuries that they can. The training is still primarily athletic training when looking at their curriculum. Our objection is that they are moving out of the field of athletics. They are doing this now, and now they are trying to get scope of practice to catch up to what they are doing, but they shouldn't be. They state they are moving to a master's degree program but not there yet. It's a better bill with collaborative work, in better shape, but the basic premise that is until they have a master's degree and more training, they are opposed.

Chairman Judy Lee emphasized her support for the physical therapist profession overall. She assumes the scope of practice that is in rule would have been approved through the administrative rules process, and is appropriate for the educational accomplishments of athletic trainers as would be the rules for physical therapists.

Mr. McDonald confirmed that to be true. The physical therapy rules are not that elaborate, but they do follow the scope of practice. These are set out in statute and are flushed out more in the rules. Mr. McDonald is unaware of the administrative rules that the athletic trainers have.

Chairman Judy Lee talking about physical therapy, those criteria that are part of the licensing for physical therapists, some of the structure is in statute, but more in administrative rule. In addition to what the legislator may have passed, it has also gone through the process with the administrative rules committee where the rules would have been presented, opportunity for public comment, opportunity for changes and objections, and then adopted. The same process has taken place for other professions, including athletic trainers. Their scope of practice detail would be in their rules and regulations as a result of having gone through the administrative rules process. She understands the functions and education and training requirements are different between the physical therapist and the athletic trainers, but within their scope, their rules have gone through the same process. Why does someone else have any say as long as they are practicing within the scope.

Mr. McDonald responded that the athletic trainers and physical therapists work together in a lot of settings, but the rules have to be based on the scope of practice. The statute is being proposed to be changed, so rules will probably have to be revised to match the statute. There will be an opportunity if they change the rules to object to certain provisions in their rules, but the rules will be based on the statute.

Chairman Judy Lee indicated that the athletic trainer will not be working independently; they will be under the supervision of a physician. Physical Therapists can practice independently, so that is a huge difference. If working in a health care facility, they would have to meet the credentialing process of that facility, where the supervising medical professional will determine what the athletic trainer will be able to do, even if it is less than what the scope would permit.

Mr. McDonald agreed. The physician will tell them what to do, although there could be some broad grants.

Chairman Judy Lee indicated there would be some limitations by what the supervising physician or physical therapist directs.

Mr. McDonald provided another example where he is not sure what the relationship is with athletic trainer and physician if they provide demonstration at MDU for example. Ergonomics, wellness program.

Chairman Judy Lee explained that under the new draft, under the guidance of the physician, so they are still not working independently.

Senator Dever indicated that several years ago, the physical therapists rewrote their act and that was painful. There was one point they disagreed with chiropractor on level 5 manipulation. They did not work out their differences. Two years ago, the athletic trainers asked to rewrite the bill and there was no agreement with physical therapists. Should we just do this?

Mr. McDonald understands the concern. They would have preferred starting the negotiations earlier.

Ray Hall, an Governmental Affairs Chair for the North Dakota Athletic Trainers Association, was called to the podium to answer questions from the Senate Human Services Committee.

Senator Howard Anderson, Jr. asked now that you have moved the definition specific under the authority of a physician, how would you go to MDU for ergonomics.

Mr. Hall stated that in the employment realm, OcHealth is a big umbrella - they employ athletic trainers, physical therapists, doctors, and a director who is like a physician and the direction would come from them. It would likely come from that overseeing physician. It is a collaborative effort; it isn't just an athletic trainer going out and doing this service. It is the whole scope of occupational health that is included in this.

Senator Dever would you be able to direct bill for that or doctor do that.

Mr. Hall responded that athletic trainers do not bill for their services; their services are not recognized as reimbursable through insurance or Medicaid. It is not the intent of the bill to seek reimbursement. Athletic training services are usually paid through a fee-for-service. In an employment setting, a company will pay a work-evaluation fee and the athletic trainers will come in and provide suggestions on how to decrease injuries in the workforce. The codes are in place to do billing, but that is not the intent of the bill.

V. Chairman Oley Larsen responded that in reviewing testimony, athletic trainers were going into the John Deere facility and providing training. V. Chairman Oley Larsen questioned whether the occupational therapists felt the athletic trainer was practicing out of their scope.

Mr. Hall responded that this was discussed with occupational therapists and physical therapists. The concern is that persons with an athletic trainer background currently work under a different name. Occupational Therapists have indicated they do not have an objection to what occurred.

Recess

2015 SENATE STANDING COMMITTEE MINUTES

Human Services Committee
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2/18/2015
24085

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Committee Clerk Signature *Donald Mueller*

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Minutes:

No attachments

These are minutes from the Senate Human Services Committee on February 18, 2015 afternoon session.

V. Chairman Oley Larsen recapped the committee discussion with Mr. Ray Hall from this morning committee work.

Senator Axness gave full disclosure that he has a friend who is a physical therapist. His friend's concern was with the words "guidance of physician" rather than supervision or order of physician.

Mr. Cory Fong, representing the North Dakota Athletic Trainers Association, responded that there was much discussion about this with the group of athletic trainers, occupational therapists and physical therapists. They believed "guidance" was the right term. An "order" is such a narrow word and description of what happens. Mr. Fong stated that the one thing that is made much clearer in the amendments is the fact that they are putting this right in the definition of the athletic trainer, and not just in the penalty provisions at the end.

V. Chairman Oley Larsen moved to ADOPT AMENDMENT on SB 2295. The motion was seconded by **Senator Warner**. No discussion.

Roll Call Vote to Amend
6 Yes, 0 No, 0 Absent. Motion passes.

V. Chairman Oley Larsen moved the Senate Human Services Committee recommend a DO PASS SB 2295 AS AMENDED. The motion was seconded by **Senator Warner**. No discussion.

Roll Call Vote to DO PASS AS AMENDED
6 Yes, 0 No, 0 Absent. Motion passes.

V. Chairman Oley Larsen will carry SB 2295 to the floor.

15.0488.03001
Title.04000

Adopted by the Human Services Committee

February 19, 2015

TD 2/19/15

PROPOSED AMENDMENTS TO SENATE BILL NO. 2295

Page 1, line 11, after "means" insert "doing any of"

Page 1, line 15, remove "comprehensive management of injuries"

Page 1, replace lines 16 and 17 with "following under the guidance of a physician:

a. Preventing, recognizing, and evaluating injuries and illnesses sustained while participating in physical activity;

b. Managing and administering the initial treatment of injuries or illnesses sustained while participating in physical activity;

c. Giving emergency care or first aid for an injury or illness sustained while participating in physical activity;

d. Rehabilitating injuries or illnesses sustained while participating in physical activity;

e. Rehabilitating and physically reconditioning injuries or illnesses that impede or prevent an individual from returning to participating in physical activity, if the individual recently participated in, and intends to return to participation in, physical activity;

f. Establishing or administering risk management, conditioning, and injury prevention programs; or

g. Referring a patient to an appropriate health care provider as needed."

Page 1, line 20, after "4." insert: ""Physical Activity" means activity that requires physical strength, agility, range of motion, repetitive motion, speed, or stamina, including participation in exercise, sports, games, recreation, wellness, or fitness.

5."

Renumber accordingly

Date: 02/18 2015
Roll Call Vote #: 1

2015 SENATE STANDING COMMITTEE
ROLL CALL VOTES
BILL/RESOLUTION NO. SB2295

Senate Human Services Committee

☐ Subcommittee

Amendment LC# or Description: 15.0488.03001 Title.04000

Recommendation: ☒ Adopt Amendment
☐ Do Pass ☐ Do Not Pass ☐ Without Committee Recommendation
☐ As Amended ☐ Rerefer to Appropriations
☐ Place on Consent Calendar

Other Actions: ☐ Reconsider ☐ ______

Motion Made By Larsen Seconded By Warner

Senators	Yes	No	Senators	Yes	No
Senator Judy Lee (Chairman)	✓		Senator Tyler Axness	✓	
Senator Oley Larson (V-Chair)	✓		Senator John M. Warner	✓	
Senator Howard C. Anderson, Jr.	✓				
Senator Dick Dever	✓				

Total (Yes) 6 No 0

Absent 0

Floor Assignment ______

If the vote is on an amendment, briefly indicate intent:

Date: 02/18 2015
Roll Call Vote #: 2

2015 SENATE STANDING COMMITTEE
ROLL CALL VOTES
BILL/RESOLUTION NO. SB2295

Senate Human Services Committee

☐ Subcommittee

Amendment LC# or Description: 15.0488.03001 Title .04000

Recommendation:
☐ Adopt Amendment
☒ Do Pass ☐ Do Not Pass ☐ Without Committee Recommendation
☒ As Amended ☐ Rerefer to Appropriations
☐ Place on Consent Calendar

Other Actions: ☐ Reconsider ☐ ____

Motion Made By Larsen Seconded By Warner

Senators	Yes	No	Senators	Yes	No
Senator Judy Lee (Chairman)	✓		Senator Tyler Axness	✓	
Senator Oley Larsen (V-Chair)	✓		Senator John M. Warner	✓	
Senator Howard C. Anderson, Jr.	✓				
Senator Dick Dever	✓				

Total (Yes) 6 No 0

Absent 0

Floor Assignment Larsen

If the vote is on an amendment, briefly indicate intent:

REPORT OF STANDING COMMITTEE

SB 2295: Human Services Committee (Sen. J. Lee, Chairman) recommends **AMENDMENTS AS FOLLOWS** and when so amended, recommends **DO PASS** (6 YEAS, 0 NAYS, 0 ABSENT AND NOT VOTING). SB 2295 was placed on the Sixth order on the calendar.

Page 1, line 11, after "means" insert "doing any of"

Page 1, line 15, remove "comprehensive management of injuries"

Page 1, replace lines 16 and 17 with "following under the guidance of a physician:

a. Preventing, recognizing, and evaluating injuries and illnesses sustained while participating in physical activity;

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d. Rehabilitating injuries or illnesses sustained while participating in physical activity;

e. Rehabilitating and physically reconditioning injuries or illnesses that impede or prevent an individual from returning to participating in physical activity, if the individual recently participated in, and intends to return to participation in, physical activity;

f. Establishing or administering risk management, conditioning, and injury prevention programs; or

g. Referring a patient to an appropriate health care provider as needed."

Page 1, line 20, after "4." insert: ""Physical Activity" means activity that requires physical strength, agility, range of motion, repetitive motion, speed, or stamina, including participation in exercise, sports, games, recreation, wellness, or fitness.

5."

Renumber accordingly

2015 HOUSE HUMAN SERVICES

SB 2295

2015 HOUSE STANDING COMMITTEE MINUTES

Human Services Committee
Fort Union Room, State Capitol

SB 2295
3/25/2015
25437

☐ Subcommittee
☐ Conference Committee

Committee Clerk Signature	Donna Whetham

Explanation or reason for introduction of bill/resolution:

Relating to regulation of athletic trainers and to provide a penalty.

Minutes: | Attachment # 1-17.

Chairman Weisz: opened the hearing on SB 2295.

Sen. Dick Dever: District 32: Introduced and supported the bill. The bill involves athletic trainers. There is no question on football field if a football player is injured in a play whether or not the athletic trainer has the ability with their education to treat any injuries that fit that education. If however that play takes that player off the field and they collide with and if a spectator has the same injury our current law does not provide for the athletic trainers to treat a spectator, even though they have the education to deal with it. SB 2295 was introduced to allow athletic trainers to work within the bounds of their education. You have the 4000 version and the bill was introduced as a 3000 version and the differences are basically, Section 1 where it says training in accordance with the individual's education, it doesn't spell out what those qualifications were. The physical therapist, occupational therapist didn't have any comfort level with that broad language so they got together and they put together the rest of the language that adds more specificity to that. The came back to the committee and even though they agreed with what the language would be, they still oppose the bill. I would submit that it is not about what they can treat, but who they can treat. Over the years I have supported all three of those professions, athletic trainers brought a bill and struggled with trying to find the language that would work that would allow them to do what they are able to do. They do not just work on the field of play they work with Doctors and at clinics. They are part of a medical team. The physical therapists and the chiropractors a few years ago, the physical therapist were rewriting their chapter in the Century Code and the Chiropractors had an objection to one provision in that bill, the ability of physical therapists to do a level 5 manipulation. We went back and forth on that one point. So I think there comes a time when we decide what they should be allowed to do. I don't think there is any reason athletic trainers should be kept from doing what they are capable of doing. We received in the Senate a lot of emails on this bill but there was some exaggeration. If they state in the email that this bill will allow athletic trainers to treat Parkinson's disease, Alzheimer's disease, strokes, and heart attacks that is an

exaggeration, when people do that they concede that the arguments that are legitimate don't support their position.

Rep. Scott Louser: District 5: in Minot testified in support of the bill. I personally know many of the people here today and two testifying are Dr. Don Mattern, a former basketball player at NDSU and Steve Westereng, President of the Athletic Trainers Association, they are outstanding in their fields and they have the capacity and the trust of those that they serve. I am here as a parent and a board member of a hockey board in Minot, when there is an injury at a sporting event the professional that is there that we rely upon I have the expectation that they have the qualifications to be able to handle the issue. I would not question their credentials. I have a reasonable expectation that they should have the qualifications to handle the injuries.

Rep. Mooney: Is a co-sponsor of the bill and testified in support of SB 2295. Primarily because living in a rural area of North Dakota and gone through the 2013 session as well as the interim session, we have had a lot of discussion about the needs across our state, both in regular and behavioral and the whole spectrum of our health care needs across the state. After speaking with members of the athletic trainers who were discussing this proposed bill, I felt this is one piece that moves forward in that continuum of care going into the 21st century with our medical needs across the state. It also speaks to modernization, times change and our needs change.

Shane Goettle: Representing the ND Athletic Trainers Association testified in support of SB 2295. (See Testimony #1 & 2).

24:40

Rep. Porter: As we hear all of the different boards and professions that come through here, inside of the practice act why is it limited strictly to the orders of a physician when a family nurse practitioner is running a stand-alone type clinic that may want to refer to a athletic trainer a specific injury a patient had and how does that fit into this when you limit it to physician only?

Goettle: We had that discussion and there were members of other health care professionals and said, what about this? We simply said it is not our fight we are currently under physicians when it comes to rehabilitation and that is a larger issue we did not want to take on a complicate what we are trying to do here today.

26:25

Steve Westereng: Director of the University of ND Division of Sports Medicine: testified in support of SB 2295. (See Testimony #3).

29:49

Rep. Rich Becker: Two things, number one is the question of billing, I am understanding that athletic trainers could not set up a private practice somewhere and bill further services?

Westereng: Currently we are not asking for that, the codes are already to do that but that is not what we are looking for? Basically most of us are working under the direction of a physician right now and we don't bill for services in the state of North Dakota.

Rep. Rich Becker: The other question is there a life expectancy for athletic trainers, is there profession because of the seriousness of injuries, is the length of the time they are able to provide us services less than if they were other health professionals?

Westereng: Athletic training profession is a lot harder than people think, we are there a lot more hours. As example I have taken care of UND football for the last 15 years and I don't a day off from the day they start to the day they are done. The lifestyle is something to think about and everybody has to make their own choice for that.

Rep. Rich Becker: I have been approached by a couple of people that say what athletic trainers are looking for is an extension to their career path, when they get to a certain age and abilities to keep up with such as age and the ability to keep up to provide the services.

Westereng: We are talking more about allowing people who come to see a physician to work with an athletic trainer in that realm.

Brandy Currie: **Vice-President of the ND Athletic Trainers' Association**: testified in support of SB 2295. (See Testimony #4).

38:30

Rep. Mooney: How much education is required?

Currie: Athletic training is a 4 year bachelor's degree program. There is the clinical and educational component. Our educational component consists of competencies and there are 280 some competencies that must be taught. In the clinical piece, students from the 2nd year of the program they are involved in clinical in a variety of places such as hospitals and different professionals. So they learn a lot of things outside of the athletic environment. I want to point out along with my testimony I submitted testimony from Dr. Jeulson, Orthopaedic surgeon at Bone and Joint, Dr. Penn, trained in primary sports medicine Nick Walker, head girls basketball coach at Legacy High School, who were unable to be present but are in support of SB 2295.

40:45

Heather Golly: Associate Professor at Minot State University: testified in support of the bill. (See Testimony #5).

46:29

Rep. Mooney: We talked about you can't bill and you are not looking for billing privileges so how do you get paid?

Golly: We usually contract through Universities or schools in some state and in North Dakota most of the athletic trainers are hired through clinics.

Damian Schlinger: Vice-Chairman of ND Board of Athletic Trainers: testified in support of the SB 2295. (See Testimony # 6).

50:56

Rep. Hofstad: Draw a parallel for me between the education and the scope of practice and how that education has evolved over a number of years?

Schlinger: As when Mr. Westereng had pointed out that initially when any profession is started the beginnings can be humble and there are changes that go along. They went from on an educational basis of requiring now a 4 year degree and they have to pass a certification exam as well to demonstrate competency or knowledge of those competencies and be able to perform them with patients. In accordance with that the goal that we see with this bill is to have an act that is timeless. So we don't have to come back here every two years. We have something that is matched to the education and as that education changes an individual become educated on those changes. The board is responsible to insure they stay within those bounds.

52:27

Steve Churhill: Physical Therapist and Athletic Trainer: testified in support of the bill. I am in support of this bill because I am a business owner and an athletic trainer for 23 years and physical therapist for 18 years. I have worked in collaboration with many other medical professionals and treated many patients that weren't athletes, with collaborative effort I felt comfortable in treating that person. I think the language is fair and changing it to physical activity updates it significantly. I know athletic trainers have a fair amount of clinical experience with treating non-athletes because they come into my facility and work and see people there that are non- athletes. I feel an update is necessary.

54:34

Rep. Mooney: It is interesting you have both the athletic trainer and physical therapist qualifications, some of the emails I have received goes back to the scope of practice. Given your knowledge of both does this actually go beyond the scope of practice for athletic trainers?

Churchill: As a practitioner clinically it doesn't take long until you find something in front of you that don't feel comfortable treating as a physical therapist or an athletic trainer. I think our code of ethics governs everything that we do and makes us feel comfortable in treating things that we are skilled and have knowledge of. If we don't we are required by that code of ethics to refer on. The code of ethics in anything medical is first do no harm. There is nothing that concerns me based upon the language in the bill and I understand it has been collaborative efforts with other disciplines and other health care practitioners. I am comfortable and I don't have any concern in my mind.

Rep. Mooney: It has been my experience from some of the games I have attended, it seems like some of the focus of that work is to treat right there on the spot but then get them to the right individual, would that be a correct assessment, it is a facilitation process?

Churchill: It can be. Athletic trainers are the expert in acute management of the injury. Personal example of and athletic trainer. (57:00-57:37)

Robyn Gust: An athletic trainer testified in support of the bill. (See Testimony #7)

1:04:29

Rep. Oversen: As I am looking back at the original language in the Practice Act and what we are changing, there is a lot of conversation about now changing it to under the guidance of a physician. Previously as noted only the rehabilitation of injuries was under the direction or order of a physician, are there currently any AT's practicing not under the direct supervision of a physician and will this change their practice?

Gust: Nationwide we can't without being under the supervision of a physician and any questions about that are answered in the rules and regs side.

Rep. Oversen: What other settings might and athletic trainer be working where they are not working with a team?

Gust: I work for the hospital in Minot and we have all the schools in the area and as well as a physician extender. Our physician Dr. Mattern is on the rodeo and there are also some other areas. I work with the deaf. When defining rigorous physical activity, I work with the US deaf bowling team, they are athletes on that team, are they really athlete's, I don't know? They are physically active individuals and they are athletes on the team.

1:06:36

Dr. Dawn Mattern: Doctor at Trinity Health in Minot, ND testified in support of SB 2295. (See Testimony # 8).

1:11

Rep. Mooney: I've heard a lot about guidance, order or direction, can you tell us between those three words, what are the impacts of these words to you in the context of these bills?

Dr. Mattern: Guidiance may mean I am in the office and they are on the football field, I may be able to guide them from above or the little voice in their heads that say I think I should send this one. Direction means I am right there on their shoulder and I am telling them exactly what to do on the premises and an order is something I put in the computer.

Rep. Mooney: Each one has very specific meanings?

Dr. Mattern: Yes, very specific.

Dr. Bill Mann: Physician from Grand Forks: testified in support of SB 2295. For the past 30 years I have been involved in UND athletics and the athletic training program. I have no qualms of the capability of the athletic trainers but I do understand the things the committee is wrestling with. We are talking about presentations of symptoms and the diagnosis has not been made yet. I make no distinction between the resident in training and the athletic training student because the thing that concerns people is the fund of knowledge really doesn't concern me very much. The thing that goes through my mind is can this young person think, reason, is this person reliable. Personal example of athletic training situation and athletic trainers. (1:15-1:18). I support the amendment and I am glad for the attention you have given it. I will be happy to answer any questions you may have.

Chairman Weisz: Any other support of SB 2295? Seeing none. Any opposition to SB 2295?

1:18

Jack McDonald: **in behalf of the North Dakota Physical Therapy Association and the North Dakota Board of Physical Therapy**: Testified in opposition of the bill. (See Testimony #9).

1:29

Rep. Mooney: I'm looking at the proposed settlement language and it looks more restrictive than it was before?

McDonald: No, I don't believe so, basically what our settlement language was trying to do was to reinstate the term "vigorous" in there. The key for our settlement proposal was on page 2 line 10. That is where we inserted the word "vigorous".

Rep. Mooney: On page 1 line 19, I see "on the field of play" and on page 1 line 23 I see " with a written order from a physician". In that context and I imagine an athletic trainer is at a game situation and there isn't a physician at hand for a written order doesn't that provide more restrictions not less restrictions than even before this bill was introduced?

McDonald: The rehabilitation is already required under the law to be with a referral from a physician, we are just saying it is a written order.

Rep. Mooney: Isn't the written order more restrictive?

McDonald: I don't believe so.

Rep. Mooney: On page 3 on bullet point 2 it starts out with "An athletic trainer may purchase, store, and administer topical..." it goes on with a lengthy description, is this intended to specifically to tell athletic trainers what they may have on hand as far a product is concerned or what exactly is that?

McDonald: That is the language that is required by the board of Pharmacy and Pharmacists to use some of the products and we have some similar language that is in the Physical Therapy act right now and we just think that should be in the act as well. It is not meant to be any kind of restriction.

Rep. Kiefert: On page 1 of your testimony in paragraph 5 the bill also allows athletic trainers to practice their expanded services virtually free of any supervision from a physician. Aren't these people trained to work with a doctor, to seek a reference, to seek treatment, to seek advice and all of a sudden they don't have to do that?

McDonald: They are going to do the supervision by a physician on some of the rehabilitation products but they don't practice under the direct supervision of a physician right now. For instance if they are out on the football field at U of Mary, there is not necessarily a physician there, so they are practicing without a physician's supervision. What we are maintaining is that while the training is extensive everything that is geared toward them including a lot of the clinical work, is work with teams, with physicians and athletic teams. They have to serve a certain amount of time and work with an athletic team. Their emphasis has always been on athletic injuries now they are moving into treating any illnesses. It is a much larger and broader field.

1:36

Rep. Vicky Steiner: My son Luke Steiner, DPT Sports Medicine and Outpatient Therapy: is a sports physical therapist in Dickinson and he asked me to submit his testimony because he is unable to appear here today, in opposition to SB 2295. (See Testimony #10).

1:37:10

Kevin Axtman: Bone and Joint physical therapist: testified in opposition of SB 2295. (See Testimony #11).

1:44:15

Rep. D. Anderson: What is the definition of illness, I think the definition in the bill is pretty broad?

Axtman: It is broad I don't know where to start to define this, it would just be a very broad definition.

Rep. Mooney: I see you are a licensed physical therapist and an athletic trainer, can you tell me how long it has been since you practiced as an athletic trainer?

Axtman: I have been a physical therapist for 33 years and an athletic trainer for about 18 years. I became an athletic trainer after I was a physical therapist so I am kind of the odd one. I wanted to work better with my athletic patients.

Rep. Mooney: So are you currently practicing as an athletic trainer?

Axtman: Out in the field, no. I currently practice in the clinic as a physical therapist.

Rep. Mooney: You mentioned physical therapists like athletic trainers have had to update educational curriculum, as these updates took place has your board regulations or statutory requirements had to change along with that through your practice?

Axtman: Yes as we updated our practice act , I graduated 33 years ago and physical therapy was a bachelor's program and in the interim it went to a master's program and we didn't make any changes then, but we went up to a doctorate program and we were able to make those changes then.

Rep. Mooney: So your board in your profession has had to go through a progression of changes through the years as well.

Axtman: Yes.

Rep. Oversen: If a referral from a physician required for a PT to treat a patient or is that just typically how it happened?

Axtman: Typically it is how it happens. Certainly insurances like Blue Cross Blue Shield we can treat without referral. Medicare we cannot, they require a written referral.

Rep. Oversen: I would assume there are times when a patient comes in and you are not comfortable with what you are seeing and they haven't seen a physician and you would then refer them to a physician?

Axtman: Correct.

Rep. Oversen: Is there a legitimate concern that an athletic trainer would treat something without referring to a physician just as a PT would?

Axtman : Right, that is the concern with the language, we are basically asking for the same things, in a clinic we would want a written referral, all my patients are typically screened by a physician. Most of this language is compromised language in regards to this is what we have to go through and this is what we would expect you to have to go through.

Rep. Oversen: We had a conversation with the support about the difference between direction and guidance. What would be your definition and how that might change someone's scope of practice?

Axtman: A lot of it for the athletic trainers you cannot have direct supervision, especially in a field or covering special events. However what we were looking at we were looking at that clinical and rehab setting, especially out-patient settings.

Jeanine DeKrey: Vice-President of Physical Therapist Board: testified in opposition of SB 2295. (See Testimony #12).

1:53

Rep. Mooney: In your testimony you reference the UND website description of the athletic training programming and I realized that it is included here in your packet, is also the requirements for Physical and Occupational therapists included as well for what would be the program directive for those?

DeKrey: I don't have them but I can certainly get those to you if you want.

Axtman: I would like that.

1:55

Mary Dockter: **Chair of the University of Mary's Physical Therapy Program:** testified in opposition of SB 2295. (See Testimony #13).

2:03:53

Rep. Mooney: With regards to the education, the athletic trainer is a 4 year training and Physical Therapist is 3 additional years, the 4 original years are those all in regards to physical therapy or are the general studies?

Dockter: Our students have to come in with an undergraduate degree, it can be in anything. The most common degrees are exercise, science or athletic training.

Rep. Mooney: While athletic trainers are directly tied to clinics and doctors, they can't operate without direct supervision from a doctor that physical therapists do not have that same requirement unless they want to reimbursed.

Dockter: Correct, we have had full direct access since 1989 or so in the state of North Dakota.

Rep. Mooney: When you asked for that was that fairly controversial?

Dockter: In all 50 states it has been, we have been at fortyish for a while and now the last few states have matriculated through that, but where we have been restricted is the reimbursement. We just got BCBS within the last few years. In Medicare that comes up every year for direct access and it is denied.

2:06:25

Missy Taylor: U of Mary's Physical Therapy faculty member: testified in opposition to the bill. (See Testimony # 14).

2:11

Rep. Mooney: After you completed your education for athletic training did you serve as an athletic trainer?

Missy Taylor: Yes.

Rep. Mooney: So you found after your training you didn't feel qualified for referrals and that type of thing to the actual physician or place that would be more appropriate?

Taylor: I felt qualified on the field of play with athletes, I felt qualified with that with my education from the University of Mary. I recognized the patients I wanted to help I couldn't with the education I had and I wanted to continue with my doctorate in physical therapy because of that.

Rep. Oversen: With the story you shared with us and I am really trying to understand the concern behind this. In the situation where we are going to find an athletic trainer under the direction of a physician working with a clinic, working with a team, in your experience how do you think a person like your mother would present to an athletic trainer, or what other situations do you see where someone with such complex conditions would have been presenting to an athletic trainer? I can imagine someone with so many different conditions wouldn't even consider going to an athletic trainer knowing that is beyond their scope?

Taylor: My concern is the vague wording, where we are taking out "sport", "athletes", "athletic" and it says "physical activity". That seems really broad to me. So my mom, at her YMCA exercise class that she goes to every day, what if she injured her knee. There is a lot of puzzle pieces to her. You are right there are athletic trainers in Universities, colleges and schools but then it could also be an athletic trainer in the clinic and I think this is opening that up to that.

Rep. Oversen: Is it your concern if there is an athletic trainer working in the clinic that their wouldn't be the necessary oversight of the physician who would see that or who would catch that, or the athletic trainer, obviously would see the medical record of that patient, would say there is too many things at play here I can't take this one on.

Taylor: I would hope that would happen, it is the "what if" and I think that is what we are dealing with today. In an ideal situation they would recognize that it is outside the scope of practice for the athletic trainer where I think this act is broadening that scope of practice for them.

2:15

Carol Olson: North Dakota Occupational Therapy Association: testified in opposition of SB 2295. (See Testimony #15).

Rep. Mooney: Could you repeat the last part.

Carol Olson: There are the amendments proposed by the athletic trainers to add in the bill that they could provide services in accordance with the individual's education. We do agree that this should be taken out of there. That was part of the language that we agreed on and what they were supposed to be putting forward.

Rep. Mooney: I am trying to understand, why would we want that language out of the bill? Wouldn't we want them to be providing services in accordance with their education?

Olson: That really opens it up to, so this year what is in their education and these are the standards they need to meet and 5 years down the road they might change those standards and they might be totally different and say yes, we can treat strokes, we can treat all these different neuro-rehab type of conditions. We don't think that is what is in the scope of a 4 year degree.

Rep. Kiefert: If someone got hit in the head with a golf ball playing golf they can treat them but if a kid waiting for a school bus got hit in the head by a hail stone, what is the protocol? They can't help or what happens?

Olson: That is one of the things with the language that is negotiated. I think personally and with the ND Athletic Association, those kinds of things, that immediate treatment and care of an injury I think is very appropriate and then to refer on to the people that they should. If this child got hit with a hail stone and they have a traumatic head injury, I am sorry the Athletic Trainer needs to get that person to the hospital. Initially doing the first aid of that is very appropriate.

Written testimony from North Dakota resident who were unable to attend the hearing. (See Attachment # 16 & 17).

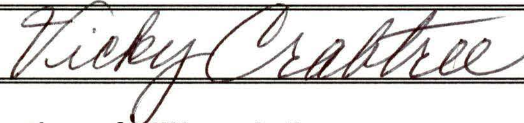
Chairman Weisz: Any other further testimony? Seeing none. Closed the hearing on SB 2295.

2015 HOUSE STANDING COMMITTEE MINUTES

Human Services Committee
Fort Union Room, State Capitol

SB 2295
4/6/2015
Job #25834

☐ Subcommittee
☐ Conference Committee

Committee Clerk Signature	

Explanation or reason for introduction of bill/resolution:

Minutes: | Attachment #1

Chairman Weisz called the meeting to order on HB 2295.

Rep. Porter: The proposed amendments (See Attachment #1).

Rep. Porter: We heard from the physical and occupational therapists in opposition or neutral to the athletic trainers. I went to Mr. Geto and went through the areas of concern and told them to work it out. The proposed amendments dated April 6 are what correlate back to the Christmas tree bill and the first amendment removes that broad language that says, "in accordance with the individual's education". Physical therapists were concerned with that if they start teaching brain surgery during their normal course of education that might mean they would start doing brain surgery. They came back and narrowed the scope. I will say the athletic trainers bent over backwards to accommodate the objections of the other two groups and they should be applauded for their efforts in updating their practices act and taking the consternation off the table. For the intern, on page 1 line 24 we should add a comma after the word "under" and flip flop "verbal and standing so we don't end up with the possibility of the word "understanding" On page 2, line 4, the same thing. (He went through the rest of the amendment.) I move the amendment.

Rep. Fehr: Second.

Rep. Muscha: On line 4, that looks like a period after "activity" and that shouldn't be there.

Rep. Porter: That should be a comma.

Rep. Rich Becker: Is this bill being watered down?

Rep. Porter: Yes. Both sides knew they needed to do some work. The presented their first pitch to us and what came out of it works for everybody. In the end they both got a bill they can be unhappy about.

VOICE VOTE: MOTION CARRIED

Rep. Porter: I move a Do Pass as Amended on SB 2295.

Rep. Fehr: Second.

ROLL CALL VOTE: 12 y 0 n 1 absent

Bill Carrier: Rep. Fehr

Adopted by the Human Services Committee

SB 4/6/15

April 6, 2015

PROPOSED AMENDMENTS TO ENGROSSED SENATE BILL NO. 2295

Page 1, line 9, remove "services in accordance with the"

Page 1, line 10, remove "individual's education"

Page 1, line 24, after "activity" insert ", under verbal, standing, or written orders, and in clinical settings written orders are required"

Page 2, line 4, after "activity" insert ", under verbal, standing, or written orders, and in clinical settings written orders are required"

Page 2, line 10, after "means" insert "any moderate or vigorous"

Page 2, line 11, replace ", including" with "during"

Page 2, line 12, after the second underscored comma insert "performance arts, stretching,"

Page 2, line 12, remove "or"

Page 2, line 12, after "fitness" insert ", or other settings set forth in subsection 5 of section 43-39-10"

Page 3, line 3, replace "direction" with "guidance or rehabilitation order"

Page 3, after line 5, insert:

"**SECTION 4.** Subsection 5 to section 43-39-10 of the North Dakota Century Code is created and enacted as follows:

5. Nothing in this chapter may be construed to prevent athletic trainers from providing: athletic training in hospital or clinical settings; injury screens; physician extender services; employee injury prevention, education or advice; or services to address injuries or illnesses, comparable to athletic injuries or illnesses, in military, industrial, or public safety settings."

Renumber accordingly

Date: 4-6-15
Roll Call Vote #: 1

2015 HOUSE STANDING COMMITTEE
ROLL CALL VOTES
BILL/RESOLUTION NO. 2295

House Human Services Committee

☐ Subcommittee

Amendment LC# or Description: See Attachment #1

Recommendation: ☒ Adopt Amendment
☐ Do Pass ☐ Do Not Pass ☐ Without Committee Recommendation
☐ As Amended ☐ Rerefer to Appropriations
☐ Place on Consent Calendar
Other Actions: ☐ Reconsider ☐ ______

Motion Made By Rep. Porter Seconded By Rep. Fehr

Representatives	Yes	No	Representatives	Yes	No
Chairman Weisz			Rep. Mooney		
Vice-Chair Hofstad			Rep. Muscha		
Rep. Bert Anderson			Rep. Oversen		
Rep. Dick Anderson					
Rep. Rich S. Becker					
Rep. Damschen					
Rep. Fehr					
Rep. Kiefert					
Rep. Porter					
Rep. Seibel					

Voice Vote
Motion Carried

Total (Yes) ______ No ______

Absent ______

Floor Assignment ______

If the vote is on an amendment, briefly indicate intent:

Date: 4-6-15
Roll Call Vote #: 2

2015 HOUSE STANDING COMMITTEE
ROLL CALL VOTES
BILL/RESOLUTION NO. 2295

House Human Services Committee

☐ Subcommittee

Amendment LC# or Description: ______

Recommendation: ☐ Adopt Amendment
☒ Do Pass ☐ Do Not Pass ☐ Without Committee Recommendation
☒ As Amended ☐ Rerefer to Appropriations
☐ Place on Consent Calendar

Other Actions: ☐ Reconsider ☐ ______

Motion Made By Rep. Porter Seconded By Rep. Fehr

Representatives	Yes	No	Representatives	Yes	No
Chairman Weisz	✓		Rep. Mooney	✓	
Vice-Chair Hofstad	✓		Rep. Muscha	✓	
Rep. Bert Anderson	✓		Rep. Oversen	✓	
Rep. Dick Anderson	✓				
Rep. Rich S. Becker	✓				
Rep. Damschen	✓				
Rep. Fehr	✓				
Rep. Kiefert	✓				
Rep. Porter	✓				
Rep. Seibel	✓				

Total (Yes) 12 No 0

Absent 1

Floor Assignment Rep. Fehr

If the vote is on an amendment, briefly indicate intent:

REPORT OF STANDING COMMITTEE

SB 2295, as engrossed: Human Services Committee (Rep. Weisz, Chairman) recommends **AMENDMENTS AS FOLLOWS** and when so amended, recommends **DO PASS** (12 YEAS, 0 NAYS, 1 ABSENT AND NOT VOTING). Engrossed SB 2295 was placed on the Sixth order on the calendar.

Page 1, line 9, remove "services in accordance with the"

Page 1, line 10, remove "individual's education"

Page 1, line 24, after "activity" insert ", under verbal, standing, or written orders, and in clinical settings written orders are required"

Page 2, line 4, after "activity" insert ", under verbal, standing, or written orders, and in clinical settings written orders are required"

Page 2, line 10, after "means" insert "any moderate or vigorous"

Page 2, line 11, replace ", including" with "during"

Page 2, line 12, after the second underscored comma insert "performance arts, stretching,"

Page 2, line 12, remove "or"

Page 2, line 12, after "fitness" insert ", or other settings set forth in subsection 5 of section 43-39-10"

Page 3, line 3, replace "direction" with "guidance or rehabilitation order"

Page 3, after line 5, insert:

"**SECTION 4.** Subsection 5 to section 43-39-10 of the North Dakota Century Code is created and enacted as follows:

5. Nothing in this chapter may be construed to prevent athletic trainers from providing: athletic training in hospital or clinical settings; injury screens; physician extender services; employee injury prevention, education or advice; or services to address injuries or illnesses, comparable to athletic injuries or illnesses, in military, industrial, or public safety settings."

Renumber accordingly

2015 CONFERENCE COMMITTEE

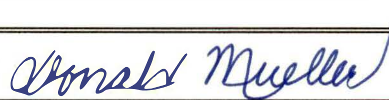
SB 2295

2015 SENATE STANDING COMMITTEE MINUTES

Human Services Committee
Red River Room, State Capitol

SB 2295
4/9/2015
25990

☐ Subcommittee
☒ Conference Committee

Committee Clerk Signature 

Explanation or reason for introduction of bill/resolution:

A bill relating to the regulation of athletic trainers, and to provide a penalty.

Minutes:

Attach #1: Proposed amendment

The following conference committee members were present for SB 2295 on April 9, 2015, 3:30 a.m.
Senator Larsen, Senator Anderson, Senator Axness
Representative Porter, Representative Seibel, Representative Muscha

Senator Larsen stated there were some amendments that were distributed earlier.

Representative Porter asked if there were any questions by the Senate conferees on the amendments made by the House, agreements by all of the other occupations. If not, he will walk into the next component. There were no questions.

Representative Porter passed out proposed amendment (attach #1). In the House version, there is both an amendment and draft bill. In the discussion that have ensued after the fact, the occupations got together and there was concern that was brought forth from the occupational therapists. All three groups, the physical therapists, athletic trainers, and the occupational therapists, further refined the bill. On page 2, under sub (f) of the draft bill markup, the new green language would be added. Then on page 3, they added inside of their scope to remove section 5 language on the next page. They just needed to add the small piece inside of their scope language to further define that they can in fact take care of someone who is injured to need athletic trainer skills where they may have hurt themselves while participating in a military type activity, industrial activity for repetitive motion kind of thing, or public safety activities. All of the groups have contacted us and approve of the amendments.

V. Chairman Oley Larsen commented when we talk about the industrial part, what comes to mind is the training and the involvement that they have with these companies, such as RDO. They are doing training that will lower workplace injuries. Is that what that is for?

Representative Porter answered some of that. For his business, they do our pre-employment screenings to make sure a person can do a dead-lift on the end of a stretcher of at least 150 pounds. They do that kind of stuff for us. So it is a combination of things that they do for the industrial or commercial work type setting.

The committee next discussed the proper motion.

Representative Porter moved the House recede from House amendments for SB 2295 and further amends, as per proposed amendment (referring to attachment #1). The motion was seconded by **Senator Howard Anderson, Jr**. No discussion.

Roll Call Vote
Senate: 3 Yes, 0 No, 0 Absent
Representatives: 3 Yes, 0 No, 0 Absent.
Motion carries 6-0-0.

Senator Larsen will carry SB 2295 to the Senate floor.
Representative Porter will carry SB 2295 to the House floor.

Adopted by the Conference Committee

April 10, 2015

4/10/15
[handwritten initials]

PROPOSED AMENDMENTS TO ENGROSSED SENATE BILL NO. 2295

That the House recede from its amendments as printed on pages 1175 and 1176 of the Senate Journal and pages 1408 and 1409 of the House Journal and that Engrossed Senate Bill No. 2295 be amended as follows:

Page 1, line 9, remove "services in accordance with the"

Page 1, line 10, remove "individual's education"

Page 1, line 23, replace "Rehabilitating" with "Under verbal, standing, or written orders, except in the case of providing services in a clinical setting which requires written orders, rehabilitating"

Page 2, line 1, replace "Rehabilitating" with "Under verbal, standing, or written orders, except in the case of providing services in a clinical setting which requires written orders, rehabilitating"

Page 2, line 6, remove "or"

Page 2, line 7, after "g." insert "Providing injury screening or physician extender services; or

h."

Page 2, line 10, after "means" insert "any moderate or vigorous"

Page 2, line 11, replace ", including" with "during"

Page 2, line 12, after the second underscored comma insert "performance arts, stretching,"

Page 2, line 12, remove "or"

Page 2, line 12, after "fitness" insert ", military, industrial, or public safety activities"

Page 3, line 3, replace "direction" with "guidance or rehabilitation order"

Renumber accordingly

Date: 4/9/2015
Roll Call Vote #: 1

2015 SENATE CONFERENCE COMMITTEE
ROLL CALL VOTES

BILL/RESOLUTION NO. SB 2295 as engrossed

Senate "Enter committee name" Committee

Action Taken
- ☐ **SENATE accede to House Amendments**
- ☐ **SENATE accede to House Amendments and further amend**
- ☐ **HOUSE recede from House amendments**
- ☒ **HOUSE recede from House amendments and amend as follows**

- ☐ **Unable to agree**, recommends that the committee be discharged and a new committee be appointed

Motion Made by: Rep. Porter Seconded by: Sen. Anderson

Senators	09			Yes	No		Representatives	09			Yes	No
Sen. Larsen	X			X			Rep. Porter	X			X	
Sen. Anderson	X			X			Rep. Seibel	X			X	
Sen. Axness	X			X			Rep. Muscha	X			x	
Total Senate Vote				3	0		Total Rep. Vote				3	0

Vote Count Yes: 6 No: 0 Absent: 0

Senate Carrier Sen. Larsen House Carrier Rep. Porter

LC Number 15.0488.04003 . Title .06000 of amendment

LC Number _____ . _____ of engrossment

Emergency clause added or deleted

Statement of purpose of amendment

REPORT OF CONFERENCE COMMITTEE

SB 2295, as engrossed: Your conference committee (Sens. Larsen, Anderson, Axness and Reps. Porter, Seibel, Muscha) recommends that the **HOUSE RECEDE** from the House amendments as printed on SJ pages 1175-1176, adopt amendments as follows, and place SB 2295 on the Seventh order:

That the House recede from its amendments as printed on pages 1175 and 1176 of the Senate Journal and pages 1408 and 1409 of the House Journal and that Engrossed Senate Bill No. 2295 be amended as follows:

Page 1, line 9, remove "services in accordance with the"

Page 1, line 10, remove "individual's education"

Page 1, line 23, replace "Rehabilitating" with "Under verbal, standing, or written orders, except in the case of providing services in a clinical setting which requires written orders, rehabilitating"

Page 2, line 1, replace "Rehabilitating" with "Under verbal, standing, or written orders, except in the case of providing services in a clinical setting which requires written orders, rehabilitating"

Page 2, line 6, remove "or"

Page 2, line 7, after "g." insert "Providing injury screening or physician extender services; or

h."

Page 2, line 10, after "means" insert "any moderate or vigorous"

Page 2, line 11, replace ", including" with "during"

Page 2, line 12, after the second underscored comma insert "performance arts, stretching,"

Page 2, line 12, remove "or"

Page 2, line 12, after "fitness" insert ", military, industrial, or public safety activities"

Page 3, line 3, replace "direction" with "guidance or rehabilitation order"

Renumber accordingly

Engrossed SB 2295 was placed on the Seventh order of business on the calendar.

2015 TESTIMONY

SB 2295

Attach #1
SB 2295
02/04/15
#23214

Madam Chairwoman and members of the Senate Human Services Committee,

My name is Steven Westereng and I am the Director for the University of North Dakota, Division of Sports Medicine. Today, I am speaking with you on behalf of the North Dakota Athletic Trainers Association as their President.

The members of the NDATA support the changes that are being proposed to the North Dakota law regulating athletic trainers in SB 2295.

Athletic trainers are health care professionals who are licensed by the State of North Dakota. By definition, Athletic Trainers (ATs) are healthcare professionals who collaborate with physicians. The services provided by ATs comprise prevention, emergency care, clinical diagnosis, therapeutic intervention and rehabilitation of injuries and medical conditions. (National Athletic Trainers Association)

North Dakota law regulating athletic trainers was first adopted in1983. In the last 32 years, the education and training for the profession has changed dramatically. Previously, a prospective candidate did not have to go through an accredited curriculum at a college or university to sit for the national board exam as one does now. Competencies are educational areas students are required to be taught by faculty of these curriculums. The number of competencies has gone up by 60% (175 to 290). These include areas in evidence based medicine, mental health, biostatistics, epidemiological data and others. In addition to education prior to becoming certified and licensed, an athletic trainer is required to have 50 continuing education units over a 2 year period including 10 hours in evidence based medicine by the Board of Certification, Inc. (BOC). The BOC also has a Standard of Professional Practice which must be upheld by the athletic trainer to continue to work in the profession.

Athletic Trainers are now more integrated into every major medical institution in this state. The public is now more familiar and confident with the services performed by athletic trainers. This familiarity has also increased demand for individual services, even from non-athletes who are, nevertheless, seeking services to restore and achieve physical activity goals after an injury. Because of the knowledge of athletic trainers, health care facilities in the state have employed us to work along with physicians in their daily practice.

The purpose of the Practice Act amendment is to ensure Athletic Trainers are properly educated and trained to deal with injuries and medical issues they encounter. It protects the integrity of the license to practice. This sets a standard and protects the public, who, when seeking services, has a right to a competent and professional standard of care. The Practice Act should **not** be used to constrain or limit the profession to boundaries that are tighter than warranted by education and training—rather, it should reflect current education and training. The Practice Act should **not** be used to constrain patient choice or to limit healthy competition within the field of health care services. The Practice Act should **not** be used to constrain where Athletic Trainers work. The Practice Act should not be something that needs to be "worked around" (i.e. practicing under other titles such as "ergonomic specialist" or "physician extenders", which require no additional education or training). Yet, this is the current state of affairs with regard to the present Practice Act.

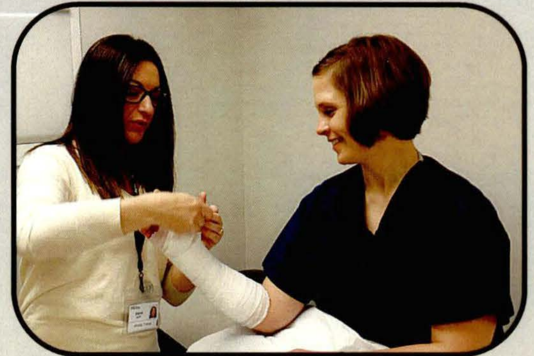
We believe SB 2295 is a good bill and the North Dakota Athletic Trainers Association asks this committee for a **"do pass"** recommendation.

In closing, I would like to say thank you to Madame Chairwomen and all the members of the Senate Human Services Committee for your time and consideration. Now, I would be happy to address any questions at this.

ATHLETIC TRAINERS

1.2

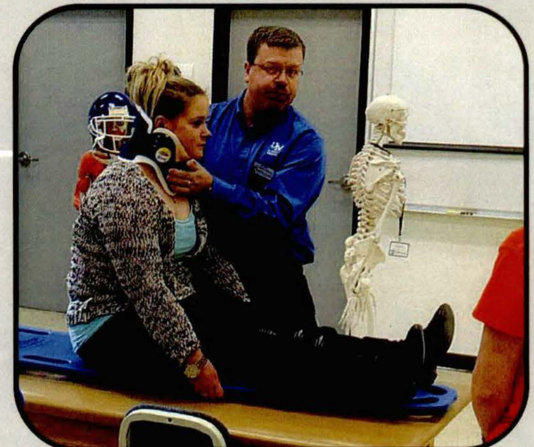
Athletic Trainers (ATs) are highly qualified, multi-skilled health care professionals. ATs are under the allied health professions category as defined by Health Resources Services Administration (HRSA) and Department of Health and Human Services (HHS). The services provided by ATs are comprised of prevention, emergency care, clinical diagnosis, therapeutic intervention, and rehabilitation of injuries and medical conditions. Athletic Trainers are an essential part of a health care team.



Professional practice and education

- Evidence-based practice and health promotion
- Prevention measures to ensure highest quality of care
- Clinical examination and diagnosis
- Immediate and acute care of injury and illness, especially in emergencies
- Treatment, rehabilitation and reconditioning
- Therapeutic intervention
- Psychosocial strategies and referral
- Health care administration
- Ethical and legal practice, cultural competence
- Professionalism and patient-centered approach

There are **177** Athletic Trainers working in a variety of settings in North Dakota including secondary schools, college/universities, and professional sports; occupational health departments; clinics with specialties in sports medicine, medical fitness and wellness; and physician offices working as physican extenders.



NDATA

NORTH DAKOTA ATHLETIC TRAINERS' ASSOCIATION

GOAL: To accurately reflect who we are and what we do as a profession

2009 Joint Statement on Cooperation: National Athletic Trainers' Association and the American Physical Therapy Association

- Agree that legal scope of practice is determined by legislature and regulatory bodies
- Neither organization will make false or misleading statements referring to the other as "not qualified"
- Members of both organizations should respect the rights, knowledge and skills of the other profession and compete honestly and ethically in the health care marketplace

OCCUPATIONAL THERAPY

PHYSICAL THERAPY

There is overlap in the services provided by 3 different professions. We believe this overlap serves the public, in a good way, by giving patients health care options and empowering patient choice.

Attach #2
SB2295
02/04/15
J#23214

Madam Chair and members of the Senate Human Services Committee, my name is Brandy Currie. I am Vice President of the North Dakota Athletic Trainers' Association as well the Curriculum Coordinator and Instructor at the University of Mary in Bismarck North Dakota. Additionally, I am employed by Sanford Health in Bismarck as an athletic trainer working in a local high school. I am here today on behalf of the North Dakota Athletic Trainers' Association and as an athletic training educator within the state.

We support the changes that are being proposed to the Century Code regulating athletic trainers in SB2295.

The code provisions regulating athletic trainers was first adopted in 1983. At that time, athletic trainers were mostly thought of as professionals who attended the sidelines of athletic events. But our profession, along with our education and training, has changed dramatically in the past 32 years, as has our role in delivering quality health care.

Athletic trainers are educated and trained in injury and illness prevention strategies that focus on optimizing health to improve an individual's quality of life. Athletic trainers are the only health care professionals whose expertise in prevention ranges from minor sprains to catastrophic head injuries, and from minor illnesses to exertional heat syndrome. Nutrition and wellness also play an integral role in athletic trainers' work in preventing injury and illness. Athletic trainers recognize when consultation with other health care providers is necessary and refer accordingly.

An accredited curriculum, established by the Commission on Accreditation of Athletic Training Education or CAATE, has since been adopted and educational competencies are used to guide teaching practices and student learning. These competencies are used as a standard measure of what students must be educated in upon completion of an entry-level Athletic Training education program. Knowledge, understanding and proficiency of the content of these competencies are essential for successful completion of our national board exam.

Professional, or entry-level Athletic Training education, uses a competency-based approach in both classroom and clinical settings. Using a medical-based education model, Athletic Training students are educated to provide comprehensive client/patient care in five domains of clinical practice:

1. prevention;

2.2

2. clinical evaluation and diagnosis;
3. immediate and emergency care:
4. treatment and rehabilitation; and
5. organization and professional health and well-being.

The educational requirements for CAATE-accredited Athletic Training education programs include acquisition of knowledge, skills, and clinical abilities along with a broad scope of foundational behaviors of professional practice. Students complete an extensive clinical learning requirement that is embodied in the clinical integration proficiencies (professional, practice-oriented outcomes) as identified in the Athletic Training Education Competencies put forth by CAATE.

Students are required to participate in a minimum of two years of academic clinical education. Throughout these experiences, students must gain clinical experiences with a variety of patient populations who vary by age and types of activities, and who are at risk for both musculoskeletal and general medical conditions. This clinical experience prepares future athletic trainers to provide care to a diverse population of patients who sustain injuries in a number of ways outside the traditional "athletic" realm.

This formal education allows athletic trainers to work in a variety of patient settings such as colleges and Universities, hospital and clinical, occupational health, military, performing arts, physician extender, professional sports, public safety and secondary schools. The roles of the athletic trainers in these settings vary slightly, but generally include: prevention; early recognition of injuries; triage; immediate care of injuries, proper referral as needed; and general patient education.

While these roles are dictated by the educational standards presented, many of them are not available to professionals in the state of North Dakota. In short, what my students are learning in the classroom cannot legally be translated into professional services in this state. The language of our current practice act creates confusion as to how athletic trainers can fill these roles in our state and has therefore limited the use of athletic trainers in these environments. This is obviously frustrating to future professionals as well as current professionals in our state. Some states have already amended their practice acts and numerous others are currently reviewing their practice acts to address this confusion and allow athletic trainers to work in the ways outlined by their education. In light of that, many students are actively pursuing work in other states besides North Dakota. We are forcing our highly qualified allied healthcare professionals to leave our state in order to work in their area of interest.

We believe this bill is a good bill and the North Dakota Athletic Trainers' Association asks this committee for a "do pass" recommendation.

Thank you for your time and consideration. I would be happy to address any questions.

2.4

Madam Chairwoman and members of the Senate Human Services Committee,

As the Administrative Director of Orthopedics and Sports Medicine at Altru Health System, we employ many Certified Athletic Trainers. These licensed individuals are the front line of our support to young high school and collegiate athletes. They are the point of first contact for a spectrum of problems that may range from overuse and training injuries to concussion. Beyond that, they are a vital component in ensuring supervision and compliance with the advice given by other health care providers.

The scope of practice of these important individuals was outlined in the Century Code of North Dakota in 1983. Since then, important, progressive, changes have occurred in their education and training.

Consequently, we support the changes that are being proposed to the Century Code, Bill 2295, which we regard as neither radical nor over-reaching but simply recognizing the capabilities gained in the current education and training. We support the proposed changes so that we may use these individuals to bring the highest level of care to this young population, comfortable that we are doing so under the meaning and intent of the Century Code of North Dakota.

Respectfully submitted,

Jill Wilson, OTR/L, CLT
Administrative Director of Orthopedics and Sports Medicine
Altru Health System
jawilson@altru.org

2.5

Madame Chairwomen and members of the Senate Human Services Committee, my name is Sara Bjerke and I am Executive Director of the North Dakota Athletic Trainers' Assocation. Since becoming an athletic trainer 20 years ago, I have been privileged to work in a variety of settings including youth, middle school, high school; Division II and Division I; amateur and semi-professional; and medical fitness.

I am here as an executive board member of the NDATA and as an athletic trainer in the state of North Dakota, to support the changes that are being proposed to North Dakota law regulating athletic trainers in SB2295.

I would like to start off by providing the committee with more information regarding Athletic Trainers (ATs). We are health care professionals who collaborate with physicians. Athletic training is recognized by the American Medical Association (AMA) as a health care profession. ATs are under the allied health professions category as defined by Heath Resources Services Administration (HRSA) and Department of Health and Human Services (HHS). We also have NPI (National Provider Identifier) numbers.

The statutory title of "athletic trainer" is a misnomer. Athletic trainers provide medical services to all types of people – not just athletes participating in sports – and do not train people as personal or fitness trainers do. However, the profession continues to embrace its proud culture and history by retaining the title. In other countries, athletic therapist and physiotherapist are similar titles. The AT profession was founded on providing medical services to athletes. The National Athletic Trainers' Assocation, the parent organization to the NDATA, represents more than 35,000 members in the U.S. and internationally. There are approximately 42,000 ATs practicing in the U.S. There are students in 325 accredited collegiate academic programs.

There are four accredited collegiate academic programs in North Dakota that students can enroll in to become an Athletic Trainer: Minot State, North Dakota State; University of Mary, and University of North Dakota. Valley City State is also in the process of becoming an accredited athletic training educational program. Students in these programs engage in rigorous classroom study and clinical education in a variety of practice settings such as high schools, colleges/universities, hospitals, physician offices and healthcare clinics over the course of the degree program.

There are 177 licensed Athletic Trainers in the state of North Dakota working in a variety of settings. All colleges/universities in the state have athletic trainers providing health care to students/athletes. Some ATs are employed by health systems/hospitals and provide medical coverage of events at secondary schools. Altru, Sanford and Trinity Health Systems have athletic trainers working in their orthopedic/sports medicine clinics as physican extenders. There are a few working in industrial settings providing prevention and wellness care for workers. Those are just a few examples of where Athletic Trainers are working across the state.

Thank you for your time and consideration. We believe SB 2295 is a good bill and ask this committee for a "do pass" recommendation. Now I would be happy to address any questions at this time.

2-6

2/3/15

Members of the Senate Human Services Committee:

Senator Judy Lee, Chairwoman	*Senator Tyler Axness*
Senator Oley Larson, Vice Chairman	*Senator Dick Dever*
Senator Howard C. Anderson, Jr	*Senator John M. Warner*

Dear Members of the Senate Human Services Committee:

My name is Robyn Gust and I am a certified athletic trainer currently working in Minot, North Dakota. Due to being unable to attend today's session, I have written this letter in regard to supporting SB 2295.

I have been a certified athletic trainer since 1994 and have worked in the state of North Dakota for the past fifteen years. In the 20 years of practicing my profession, I have witnessed many changes in the way we have treated patients and the way athletic trainers have been educated. Some changes have been very subtle, some very drastic. A prime example would be the major difference in how we treat a concussion now compared to even six years ago. Now, we are better educated on the cause, the recognition and how a concussion should be managed. Changes in the medical field are constant and necessary to ensure that those providing care are most up to date for the best outcomes of the patient.

One thing that has not changed in my entire career as an athletic trainer is the language in the practice act of this state. It does not use the current terminology that is utilized on the national level of the Board of Certification for athletic trainers or the National Athletic Trainers Association; and also does not reflect the education of athletic trainers. The language change recommendations for SB 2295 are vital to protect the public of North Dakota, ensuring those using the title of "Athletic Trainer" have the appropriate education, licensure and that an athletic trainer practices under the direction of a licensed physician. The language also speaks directly to the education of an athletic trainer, reflecting on curriculum content that athletic trainers must complete.

Two sessions ago, athletic trainers were in this same spot, at the state capital, lobbying for a concussion bill to protect the youth of the state. Shortly after, we were back again to support changes to make the bill better. At that time, I believe more people became aware of the scope of an athletic trainer and also the importance of the role an athletic trainer plays in the healthcare of our rural based state. We have returned to the capitol to urge the recommended changes that better state what an athletic trainer does in the most current language in SB2295.

In closing, I would like to say that I am very passionate about my profession. I am working in an ever changing field of the medical world and I make it a priority to have the most up to date information available to provide the best care. I am also just as passionate about protecting the patients that we care for as well as the athletic trainers of this state. That is why I support SB 2295, so that the practice act for the athletic trainers of North Dakota may also reflect the advancements and changes of the profession of athletic training. Thank you.

Sincerely,

Robyn Gust, MS/ATC
Trinity Health Sports Medicine Manager

2.7

Minot State UNIVERSITY

Department of Teacher Education and Human Performance

February 3, 2015

Dear Senator,

Please support SB 2295. The intent of the bill is to provide clarity regarding the education of athletic trainers, to protect the citizens of North Dakota, and to protect the Athletic Trainers.

I worked for twelve years as a director of a hospital-based wellness center and I am currently a Professor at Minot State University. I teach exercise physiology to our athletic training students. In my experience in working with those students and the athletic training faculty I have been impressed with the depth of the athletic training curriculum and the knowledge, skill and ability of the faculty delivering it. The athletic training students are well prepared to provide services that keep athletes/patients safe.

I believe it is essential that we allow athletic trainers to offer services within their scope of practice. In order for health care reform to be affordable we have to avoid "territorial boundaries" and allow professionals to provide the services they are trained and qualified to perform.

Thank you for your time and your support of SB 2295. I believe this bill is a responsible way to provide athletes and patients with services they need without unnecessary referrals.

Sincerely,

Terry Eckmann, PhD
Professor
Minot State University

500 University Ave W, Minot, ND 58707 701-858-3028 1-800-777-0750 FAX 701-858-3591

2,8

February 3, 2015

Human Services Committee:

My name is Cassandra Heald and I am currently a licensed certified athletic trainer in the state of North Dakota. I graduated from the University of North Dakota in 2011 with my Bachelors degree in Athletic Training. I then went to Minot State University to work as a graduate assistant while working on my Masters degree in Management. Currently I am working in the athletic training room at Minot State University and cover Bishop Ryan Catholic School and Glenburn covering all home events for both schools and providing regular school checks. I have been practicing in North Dakota since 2011.

I am contacting you in regards to SB2295. This bill is the practice act for the athletic trainers of North Dakota. This bill was initially drafted over 30 years ago, meaning the wording on this bill is older than I am. In the last 30 years the profession of athletic training has changed and grown significantly. Even since I became certified in 2011, the profession has changed.

An athletic trainer acts as a first responder in many situations. Typically we are the first medical professionals to see an injury. We are trained to evaluate, assess, and prevent injuries, we are trained to provide immediate care to injuries, we are trained to treat and rehabilitate injuries.
All certified athletic trainers have passed a national examination test (Board of Certification Exam) and most states require registration or licensure in within the state to practice. In North Dakota, we are licensed and are required to renew our license on an annual basis. In order to practice, all athletic trainers must work under the direction of a physician.

The main focus we are trying to update is the definition of an athletic trainer. We are looking to include the wording "services in accordance with the individual's education" into lines 9 and 10. This will ensure that individuals who are not trained cannot act as an athletic trainer and that athletic trainers are working within their educational knowledge.

I am asking your support of the North Dakota Scope of Practice Act, SB2295, for the profession that I have grown to love. I have gone about the requirements for my education to ensure that I stay up to date on changes that may be occurring in the profession. I am asking your support for SB2295 to help keep individuals who have not acquired the minimum requirements to practice from practicing in the state I have chosen to stay after graduation.

If you have any further questions or would like to speak more, please feel free to email me or call me with any additional concerns. Thank you for your time and consideration.

Cassandra Heald, MS, ATC
Trinity Sports Medicine, Bishop Ryan Catholic School, Glenburn High School
healdcassieATC@gmail.com
(701) 857-5286

2.9

TO: North Dakota Senate Human Service Committee

FROM: Tim Jeulson, MD

DATE: February 3, 2015

SUBJECT: Senate Bill No. 2295

Madame Chairwoman and members of the senate, thank you for taking the time to review SB 2295. I wish that I could be present with you, but I was already committed to my patients who had scheduled on the day that this bill will be discussed. My name is Tim Juelson and I am an orthopaedic surgeon practicing in Bismarck, ND, at the Bone & Joint Center. I am certified by the American Board of Orthopaedic Surgery and also completed an orthopaedic sports surgery fellowship with Dr. Andrews where we worked directly with many athletic trainers. I am privileged to have earned the first certificate of added qualification in orthopaedic sports surgery in North Dakota. My specialty focuses mostly on prevention, management, and treatment of sports related injuries. During my fellowship in Florida athletic trainers were directly involved in all aspects of patient care.

You have heard from some of the athletic trainers today, so I will be brief with my testimony in support of SB2295. Over the past years I have had the privilege of working with some of the certified athletic trainers whom you have heard from today. We have had many patients in common, particularly with my responsibilities to various high schools and the University of Mary athletes. Athletic trainers provide a valuable service, predominantly with management of injuries both simple and complex. Their role is both valuable and certainly has room for expansion into the future.

The bill before you today is representative of current athletic trainer's capability and scope of practice. Physicians are still involved in their supervision and it recognizes their current abilities. In discussion with the North Dakota Medical Association, there are no objections to SB2295.

Thank you for your time, and please let me know if there are any questions I can answer. My email is tjuelson@bone-joint.com and work number is 701-530-8800.

2.10

TO: North Dakota Senate Human Service Committee

FROM: Jeremiah Penn, MD

DATE: February 3, 2015

SUBJECT: Senate Bill No. 2295

My name is Dr. Jeremiah Penn. I am a family medicine physician with specialized training in primary care sports medicine. I am writing this letter in support of Senate Bill No. 2295, which amends the North Dakota Century Code as it pertains to the profession of athletic training.

I currently work at MidDakota Clinic in Bismarck, ND. I received my family medicine training through the University of North Dakota Center for Family Medicine in Bismarck and my sports medicine training through the Kaiser Permanente Primary Care Sports Medicine Fellowship in Fontana, CA. I currently volunteer as team physician with the University of Mary and have worked closely with most of the high school athletic trainers in the Bismarck area. I feel my close contact with the athletic training educational program at the University of Mary and frequent interactions with numerous athletic trainers qualifies me to comment on this bill.

I am in support of this bill because I feel it updates our Century Code with a more accurate description of how athletic trainers in our state actually practice. With the large number of high school and college athletes training and competing every day in our state, there is no possible way physicians can deal with every one of their issues. Having well qualified athletic trainers as the point of entry into the health system is an excellent way to initiate care for these athletes. After athletes have been evaluated, protocols to return them to optimal performance must be initiated and for many of them, the most practical way to return to optimal health is through daily visits with their athletic trainer.

One of the concerns I have heard about this bill is that it may provide athletic trainers the ability to function without medical oversight. While I think the education athletic trainers receive has broadened significantly, I do not think their training comes close to the breadth and depth of that of a physician. That is why I think it is important to note that although it is not explicitly stated in our Century Code, all athletic trainers are expected to work under a physician. Athletic trainers are regulated under the Board of Certification for Athletic Training. This board has seven standards of practice. The first of these seven standards is the following: <u>Direction – The Athletic Trainer renders service or treatment under the direction of a physician.</u>

I feel that this bill clarifies the relationship of an athletic trainer with a physician and allows them to feel comfortable providing the services they have been trained for. I know the athletic trainers I work with value our relationship as a part of a health care team. I would encourage the committee of offer this bill a "do pass" recommendation. If I can answer any questions or offer clarification, please contact me on my cell phone at (701)-527-3358. Thank you for your consideration.

#1
2.11

February 4, 2015
Senate Human Services Committee, Senator Judy Lee, Chairman
Testimony on SB 2295 from Nick Walker

Good morning, Chairman Lee and Members of the Senate Human Services Committee. My name is Nick Walker and I am the head girls' basketball coach at Legacy High School and head girls track coach at Century High School. I am here in favor of SB 2295.

I have been in the district now for 7 years and I fully understand the importance of having an athletic trainer in our building, at practice, and at sporting events. I believe that our kids in our schools are put in a great position by having the athletic trainers in our building. They care for injuries when needed and help prevent injuries by doing rehab or preventative measures to help our athletes be safe. I believe as a coach that it would be beneficial to all of our students and staff if the term "athletic injury" was changed to "Injury". This way, our athletic trainers would be able to help our kids that are injured in a non-sporting endeavor in or outside of the school day. This would also help to ensure that they are seen by a medical professional when we all know that some of our kids would not be afforded that opportunity if it wasn't for the medical professional in our school. Once again, I cannot express the respect I have for the athletic trainers in the school. They are key component of the safety and well-being of our kids in school.

Thank you for your time. I urge you give SB 2295 a do pass recommendation. I am glad to answer your questions,

Nick Walker
Bismarck Public Schools

2.12

Madam Chairperson and members of the Senate Human Services Committee, my name is Alyssa Sorensen and I am the Secretary/Treasurer for the North Dakota Athletic Trainers' Association and also the Assistant Athletic Trainer at Valley City State University. I am here today on behalf of the North Dakota Athletic Trainers' Association.

Occupational and industrial workers are at risk of acute and overuse on - the - job injuries. Their work environment requires special skills often including heavy lifting, carrying, movement and physical stress. Athletic trainers (ATs) can assist both employers and employees with services, including ergonomics assistance, injury prevention, stretching programs, early recognition program, onsite physical rehabilitation, working with aging workforce, wellness and safety. (NATA)

At the industrial level, providing care for the employees is very important. Often, the athletic trainer acts as an integral part of the overall health and safety team, providing proper referral, early intervention and expediting the care of the worker. They often work in conjunction with safety personnel, facility management, union representatives, ergonomists, physicians and other health care providers. The athletic trainer works with the employees to show proper stretching and exercise routines to prevent and treat injuries and medical conditions. ATs are often the "on -site" contact for physicians and other therapists, and are the first line of defense in injury prevention. With overall production being the key part to an industry surviving, often times the company loses sight of the actual employee working the production line. The athletic trainer is an advocate for the employees to ensure their overall health and wellness is kept a top priority.

Industry is maximizing production and income, while reducing costs and boosting worker productivity. Athletic trainers improve these outcomes. With the athletic trainer initially assessing an injury and providing proper referral, it saves overall cost to the company.

One great example right in North Dakota can be seen at John Deere in Valley City, North Dakota; where there was a 70% OSHA reduction of injuries once they hired an athletic trainer (Erin Welken, John Deere, Valley City). 100% of the companies who had hired an athletic trainer, reported that the athletic trainer provides a favorable return-on-investment (ROI) (NATA), further 68% of the companies indicated that the athletic trainer helped to decrease restricted workdays and worker's compensation claims for musculoskeletal disorders (MSDs) by more than 25%.

2.13

Large industrial plants have multiple shifts and one athletic trainer cannot be there all 24 hours of the day. However, the athletic trainer can train employees to act as part of an emergency response team. They can treat minor injuries, are CPR/AED certified. They understand concussions. This is also a huge asset to the community as there are now more individuals trained in emergency response.

North Dakota has a growing industrial economy. Farm machine and equipment production, the Bakken oil fields, the Falkirk mine, etc. make up a vast portion of North Dakota employment opportunities. These settings can only improve production and efficiency with the addition of an athletic trainer. Even though these athletic trainers are not working with "athletic" injuries their knowledge and education, specifically in ergonomics and injury management, make them an integral part of the health care team.

Thank you for your time and consideration. I would be happy to address any questions.

Attach #3
SB 2295
02/04/15
J# 23214

Damian Schlinger
Vice Chairman
North Dakota Board of Athletic Trainers
(701) 202-9078

February 4, 2015

This statement is on behalf of the North Dakota Board of Athletic Trainers in regard to Senate Bill 2295 (SB 2295) and its amendments to North Dakota Century Code 43-39, Athletic Trainer Practice Act.

The North Dakota Board of Athletic Trainers was established in 1983 to regulate the practice of Athletic Training in the State of North Dakota and protect the health and safety of the citizens of North Dakota. The members of this Board are appointed by the Office of the Governor.

We have reached out to members of the community, healthcare organizations, and healthcare professionals in researching our stance on this bill. The North Dakota Board of Athletic Trainers supports the amendments offered in this bill and respectfully requests a do-pass recommendation by this committee to protect and serve the healthcare needs of North Dakota citizens.

In order for our Board or any other regulatory board to perform well it must make determinations based on statute. What has occurred since the statute came into existence in 1983 is that it has aged significantly to the point where it no longer allows us to properly regulate the practice of an Athletic Trainer. This bill seeks to rectify this issue by matching the statute language to the current educational base of Athletic Trainers.

The current practice act lacks congruence between the educational base of the Athletic Trainer and the language in the statute creating uncertainty for the Board in the execution of its duties in that we can find Athletic Trainers practicing within the bounds of their professional education yet outside the bounds of the current statute.

The current statute creates uncertainty for the Athletic Trainer much the same way. Do they practice within the scope of their education or within the scope of the statute? In this situation does the patient end up receiving care, delaying care, or not receive care at all?

The current statute creates uncertainty for the business of healthcare in our state. Can hospitals, clinics, schools, etc. hire the Athletic Trainer for the job or not? The current statute hurts businesses in that they can't hire qualified professionals already within the state. We can retain the verbiage in the current statute which may push Athletic Trainers to seek employment in other states where the statutes reflect their educational base or we can update the statute and put their skills to work increasing the health and vitality of the citizens of North Dakota.

The practice act serves as a piece of communication from the state to its people and we hope to see it updated to assist the health and safety of the public, healthcare businesses, and Athletic Trainers.

Attach #4
SB 2295
02/04/15
JH 23214

February 4, 2015

SENATE HUMAN SERVICES COMMITTEE
SB 2295

SEN. LEE AND MEMBERS OF THE COMMITTEE:

My name is Jack McDonald. I'm appearing today on behalf of the North Dakota Physical Therapy Association (NDPTA) and the North Dakota Board of Physical Therapy to oppose SB 2295.

This bill makes a major, major change in the scope of practice of a medical profession with no accompanying proof that it is warranted or that it will result in greater public safety.

The Athletic Trainers Act was enacted in 1983 to set out the scope of practice of this profession and provide a method of regulation in order to protect public safety. The law at that time was carefully designed to match the training and work of athletic trainers. As you can see from some of the attachments to my testimony, our neighboring states of Minnesota, South Dakota and Montana have very similar statutes.

The legislation before you this morning turns the scope of practice upside down. It not only removes the term "athletic" from the law – a bit of irony for a profession that calls itself athletic trainers – but also now says they can treat any illness or injury whatsoever. In other words you name, we treat it. Kind of a one stop shopping center for anything that ails mankind.

You heard testimony earlier this week from pediatric therapists about their specialized training and practice in the area of acute pediatric therapy issues. Their training and experience allows them to do this. Under this legislation, of course, your neighborhood athletic trainer would also be able to provide these services.

We adamantly oppose this bill and ask that you give this bill a DO NOT PASS. At the very least, there is a proposed amendment attached at the end of my testimony that you should consider as an alternative.

If you have any questions, I will be happy to try to answer them. THANK YOU FOR YOUR TIME AND CONSIDERATION.

I've also distributed a letter opposing this bill from Kathleen Day of Fargo, the NDPTA president. Unfortunately, the major national meeting for physical therapists convenes today in Indianapolis and she was unable to attend the hearing today.

4.2

Home » Statutes » Codified_Laws »

South Dakota

Printer Friendly

36-29-1. Definitions. Terms used in this chapter, unless the context otherwise requires, mean:

(1) "Athletic trainer," a person with specific qualifications as set forth in § 36-29-3, whose responsibility is the prevention, evaluation, emergency care, treatment, and reconditioning of athletic injuries under the direction of the team or treating physician. The athletic trainer may use cryotherapy, which includes cold packs, ice packs, cold water immersion, and spray coolants; thermotherapy, which includes topical analgesics, moist hot packs, heating pads, infrared lamp, and paraffin bath; hydrotherapy, which includes whirlpool; and therapeutic exercise common to athletic training which includes stretching and those exercises needed to maintain condition; in accordance with a physician's written protocol. Any rehabilitative procedures recommended by a physician for the rehabilitation of athletic injuries which have been referred and all other physical modalities may be administered only following the prescription of the team or referring physician;

(2) "Board," the Board of Medical and Osteopathic Examiners as created by chapter 36-4.

Source: SL 1984, ch 255, § 1.

^ Back to Top

4.3

Montana Code Annotated 2014

37-36-101. Definitions. As used in this chapter, the following definitions apply:

(1) "Athlete" means a person who participates in an athletic activity that involves exercises, sports, or games requiring physical strength, agility, flexibility, range of motion, speed, or stamina and the exercises, sports, or games are of the type conducted in association with an educational institution or a professional, amateur, or recreational sports club or organization.

(2) "Athletic injury" means a physical injury received by an athlete.

(3) "Athletic trainer" means an individual who is licensed to practice athletic training.

(4) "Athletic training" means the practice of prevention, recognition, assessment, management, treatment, disposition, and reconditioning of athletic injuries. The term includes the following:

(a) the use of heat, light, sound, cold, electricity, exercise, reconditioning, or mechanical devices related to the care and conditioning of athletes; and

(b) the education and counseling of the public on matters related to athletic training.

(5) "Board" means the board of athletic trainers provided for in 2-15-1771.

(6) "Department" means the department of labor and industry provided for in 2-15-1701.

(7) "Licensee" means an individual licensed under this chapter.

History: En. Sec. 2, Ch. 388, L. 2007.

Provided by Montana Legislative Services

4.4

2014 Minnesota Statutes

Authenticate

148.7806 ATHLETIC TRAINING.
Athletic training by a registered athletic trainer under section 148.7808 includes the activities described in paragraphs (a) to (e).

(a) An athletic trainer shall:

(1) prevent, recognize, and evaluate athletic injuries;

(2) give emergency care and first aid;

(3) manage and treat athletic injuries; and

(4) rehabilitate and physically recondition athletic injuries.

The athletic trainer may use modalities such as cold, heat, light, sound, electricity, exercise, and mechanical devices for treatment and rehabilitation of athletic injuries to athletes in the primary employment site.

(b) The primary physician shall establish evaluation and treatment protocols to be used by the athletic trainer. The primary physician shall record the protocols on a form prescribed by the board. The protocol form must be updated yearly at the athletic trainer's registration renewal time and kept on file by the athletic trainer.

(c) At the primary employment site, except in a corporate setting, an athletic trainer may evaluate and treat an athlete for an athletic injury not previously diagnosed for not more than 30 days, or a period of time as designated by the primary physician on the protocol form, from the date of the initial evaluation and treatment. Preventative care after resolution of the injury is not considered treatment. This paragraph does not apply to a person who is referred for treatment by a person licensed in this state to practice medicine as defined in section 147.081, to practice chiropractic as defined in section 148.01, to practice podiatry as defined in section 153.01, or to practice dentistry as defined in section 150A.05 and whose license is in good standing.

(d) An athletic trainer may:

(1) organize and administer an athletic training program including, but not limited to, educating and counseling athletes;

(2) monitor the signs, symptoms, general behavior, and general physical response of an athlete to treatment and rehabilitation including, but not limited to, whether the signs, symptoms, reactions, behavior, or general response show abnormal characteristics; and

(3) make suggestions to the primary physician or other treating provider for a modification in the treatment and rehabilitation of an injured athlete based on the indicators in clause (2).

(e) In a clinical, corporate, and physical therapy setting, when the service provided is, or is represented as being, physical therapy, an athletic trainer may work only under the direct supervision of a physical therapist as defined in section 148.65.

History: *1993 c 232 s 7*

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4.5

Authenticate

2014 Minnesota Statutes

148.7802 DEFINITIONS.

Subdivision 1. **Applicability.** The definitions in this section apply to this chapter.

Subd. 2. **Approved continuing education program.** "Approved continuing education program" means a continuing education program that meets the continuing education requirements in section 148.7812 and is approved by the board.

Subd. 3. **Approved education program.** "Approved education program" means a university, college, or other postsecondary education program of athletic training that, at the time the student completes the program, is approved or accredited by a nationally recognized accreditation agency for athletic training education programs approved by the board.

* Subd. 4. **Athlete.** "Athlete" means a person participating in exercises, sports, games, or recreation requiring physical strength, agility, flexibility, range of motion, speed, or stamina.

* Subd. 5. **Athletic injury.** "Athletic injury" means an injury sustained by a person as a result of the person's participation in exercises, sports, games, or recreation requiring physical strength, agility, flexibility, range of motion, speed, or stamina.

* Subd. 6. **Athletic trainer.** "Athletic trainer" means a person who engages in athletic training under section 148.7806 and is registered under section 148.7808.

Subd. 7. **Board.** "Board" means the Board of Medical Practice.

Subd. 8. **Credential.** "Credential" means a license, permit, certification, registration, or other evidence of qualification or authorization to practice as an athletic trainer in this state or any other state.

Subd. 9. **Credentialing examination.** "Credentialing examination" means an examination administered by the Board of Certification, or the board's recognized successor, for credentialing as an athletic trainer, or an examination for credentialing offered by a national testing service that is approved by the board.

Subd. 10. **Primary employment site.** "Primary employment site" means the institution, organization, corporation, or sports team where the athletic trainer is employed for the practice of athletic training.

Subd. 11. **Primary physician.** "Primary physician" means a licensed medical physician who serves as a medical consultant to an athletic trainer.

History: *1993 c 232 s 3; 2014 c 291 art 4 s 14,15*

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"Athletic training" means the management of athletic injuries and illnesses to prevent, evaluate, assess, provide immediate care on the field of play, treat, and recondition. ~~practice of prevention, recognition, evaluation, management, treatment, and disposition of athletic injuries.~~ The term also means rehabilitation of athletic injuries, if under the ~~order~~ supervision of a licensed physician. ~~The term includes organization and administration of education programs, athletic facilities, and the education and counseling of the public.~~

"Illness" means those illnesses sustained as a result of participation in athletic activities.

attach #5
SB 2295
02/04/15
J# 23214

Wednesday, February 04, 2015

SB 2295 – Athletic Trainers Practice Act Changes

Good Morning Senate Human Services Committee members. My name is Kevin Axtman. I am a licensed physical therapist and athletic trainer at Bismarck's Bone and Joint Center. I served on the North Dakota Board of Physical Therapy for 10 years, from 1999-2009, and currently sit on the Board as an *ex officio* member representing the North Dakota Physical Therapy Association (NDPTA).

I was brought into this issue two years ago when similar practice act revisions were proposed by the North Dakota Board of Athletic Trainers. That legislation was defeated, but at the time this Committee strongly urged the athletic trainers to work with the physical therapists to come up with some agreeable language. Unfortunately, the athletic trainers apparently decided to forgo that suggestion and to instead just come back with this legislation, which even goes beyond the 2013 legislation.

The NDPTA strongly opposes SB 2295, specifically the change in the definition of "Athletic Training". The current language is very specific to treatment of "athletic" injuries. The proposed language is extremely broad and over reaching. It takes out references to athletic injuries and instead says instead that athletic trainers will now deal with the "comprehensive management of injuries and illnesses to prevent, clinically evaluate, assess, provide immediate care, treat, rehabilitate, and recondition." That's not even a complete sentence.

SB 2295 allows an athletic trainer to treat any "injuries and illnesses" regardless of the individual's health status or age. Even though the intent of the law is to supposedly modernize the language, the implications are that an athletic trainer would be able to treat and rehabilitate stroke victims, spinal cord injuries, cardiac patients, etc. This language would allow an athletic trainer to act as an EMT, paramedic, occupational therapist, physical therapist, nurse, and nurse practitioner, but without the training.

(OVER)

5.2

SB 2295 expand the athletic trainer's scope of practice far beyond that of nearly every other state. The athletic training practice acts of our neighbors Montana, Minnesota, and South Dakota all define athletic training much like North Dakota.

I became an athletic trainer after I was a physical therapist because it made me a better physical therapist when working with athletes and physically active patients. I oppose this bill because the proposed language goes well beyond the definition and training of athletic trainers.

Thank you for your time and consideration. If you have any questions, I would be glad to try to answer them.

attach #6
SB2295
02/04/15
J# 23214

February 4, 2015
SENATE HUMAN SERVICES COMMITTEE

SEN. LEE AND MEMBERS OF THE COMMITTEE:

My name is Kathleen Day. I am president of the North Dakota Physical Therapy Association (NDPTA). We oppose SB2295 as an unwarranted and unwise expansion of the athletic trainers' scope of practice.

Athletic trainers, as the name indicates, are trained and educated to treat physically active persons, primarily athletes. SB2295 removes the context of athletics from the Athletic Trainer Practice Act and would allow an athletic trainer to treat any individual for virtually any illness or injury, regardless of the individual's health status. For example, it would allow an athletic trainer to treat an acute stroke patient or cardiac patient. Athletic trainer education is not focused on evaluation and treatment of individuals with disease and disability, yet SB2295 would allow athletic trainers to treat such individuals.

The athletic training practice acts in most states, including Montana, Minnesota, and South Dakota, also define athletic training much like the current North Dakota practice act does, specifying that athletic trainers provide services to "athletes" with "athletic injures".

The NDPTA welcomes an opportunity to work collaboratively with the NDATA to modify their practice act, specifically with the definition of athletic trainer, but unfortunately, no such opportunity has been presented prior to the initiation of this legislative session. Since our notification of the bill's introduction, the NDPTA has attempted to get clarification from the NDATA on their definition of "illness" but have not received a clear response, and they not been cooperative with us on this endeavor. Two years ago changes were proposed to the legislature by the NDATA to change this definition, and this attempt failed. It was recommended by the legislature that the NDATA work in collaboration with the occupational and physical therapists of the state on any proposed changes, but, regrettably, this did not happen.

We ask for **a DO NOT PASS** on this bill. A change in scope of practice this broad would impact the public health and safety of North Dakotans. Please contact me if you have any additional questions or concerns.

Thank you for your attention to this matter.

Attach #7
SB2295
02/04/15
J# 23214

February 4, 2015

Senate Human Services Committee

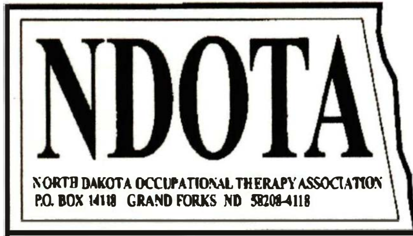
Senator Lee and Members of the Committee:

My name is Tony Hollar. I am the reimbursement chair for the North Dakota Physical Therapy Association. I oppose SB2295, the expansion of the athletic trainer scope of practice.

As an outpatient practitioner, I treat a wide variety of cases from pediatric to geriatric and from acute to chronic conditions. As a physical therapist, we are educated in the evaluation and treatment along the entire life span. The current definition of "athletic training" by the NDATA defines it as,"*the practice of prevention, recognition, evaluation, management, treatment, and disposition of athletic injuries".* Current curriculum for athletic training students is focused on treating athletes with athletic injuries. The expansion of the athletic trainer's scope of practice would allow evaluation and treatment of conditions that are not included in their education.

This expansion would put the safety of North Dakota citizens at risk. I ask for a **DO NOT PASS** on SB2295. Please contact me if you have any questions, comments or concerns. Thank you.

Attach #8
SB 2295
02/04/15
J#23214



February 4, 2015

Dear Chairman Lee,

On behalf of the North Dakota Occupational Therapy Association, I am writing this letter regarding Senate Bill 2295. The North Dakota Occupational Therapy Association has concerns regarding this bill in its current form.

As you are aware, a very similar bill was introduced by the athletic trainers in North Dakota last legislative session. The bill did not move forward and the committee strongly recommended athletic trainers work with other professions before the next legislative session so that the bill could be worked on without significant time constraints. The North Dakota Occupational Therapy Association was not contacted outside the legislative session as the committee advised.

Licensure laws exist to protect consumers and bill 2295 in its current form presents the same concerns for consumers as it did last session. Deleting the term athletic injuries and adding "comprehensive management of illness or injury" leaves room for broad interpretation of whom athletic trainers can treat and what those services may involve. It may be interpreted as treating someone who has suffered a variety of cardiovascular incidents, neurological impairments, or more severe musculoskeletal traumas. Treatment stages (immediate acute, acute, progressive, rehabilitation, chronic) in which athletic trainers are skilled are also unclear.

For example, patient A was in a motor vehicle accident and has suffered a brain injury. According to athletic training educational accreditation standards, athletic trainers would have the skills to explain the etiology of a brain injury and to assess immediate acute neurological impairments. They would not, however, have the skills to comprehensively manage the injury across treatment phases as stated in the bill. In comparison, occupational therapists are trained to assess motor, sensory, and cognitive deficits resulting from the injury followed by evidenced-based remediation or compensation for those deficits.

Patient B suffered a severe wrist injury. Athletic training standards indicate trainers in the field would have the ability to describe principles related to fabricating and applying splints and acute management of the injury on the field. In comparison, occupational therapists are trained in both

acute and progressive treatment of such an injury. This includes the ability to design, fabricate, apply, and fit dynamic splints key to the recovery of this injury. In addition, occupational therapists are trained to remediate and modify for deficits related to sensory and physical loss from such an injury. Again this illustrates a potential consumer safety issue with the current language of broad comprehensive management of illness and injury.

Patient C is a child with cerebral palsy, a neurological condition present at birth or within the first year of life. According to the athletic training standards, the athletic trainer can identify precautions and risk factors, participation restrictions and activity limitations to determine impact of the condition on the person's life, perform neurological assessments, and provide therapeutic interventions for persons with injury, illness or disability. Occupational therapists have extensive background in anatomy, physiology, neuroscience, assessment, and habilitative and rehabilitative treatment of this disorder across the lifespan. Again, the broad language of comprehensive illness or injury leave room for inappropriate interpretation of the skill set of the athletic trainer.

Additionally, while current National Athletic Training Association educational standards are referenced in the proposed bill, the standards are broad in nature also leaving room for interpretation and the degree level continues to be at a bachelors level neither of which support "comprehensive management of illness or injury". A review of the standards suggest that athletic trainers are able to manage the immediate acute stage of an injury on the field, but are not trained to progress treatment of acute phases within a clinic. Finally, the language presented in this bill is inconsistent with athletic training licensure laws in Minnesota, Montana, and South Dakota which all clearly utilize the term athletic injury instead of broadly stating "illness or injury". In addition, these licensure laws clearly define athlete.

The NDOTA opposes the bill as it is currently drafted. I am glad to answer any questions the committee might have.

Carol Olson, PhD, OTR/L, FAOTA
North Dakota Occupational Therapy Association

SB 2295

Richard Zaruba

Attach #9
SB2295
02/04/15
J# 23214

From: Zaruba, Richard [mailto:RZaruba@uj.edu]
Sent: Saturday, January 31, 2015 1:52 PM
To: Lee, Judy E.
Subject: RE: Please OPPOSE SB 2295

Hello Senator Lee,

I would be fine with the change with a couple simple revisions so it read:

2. "Athletic training" means the comprehensive management of musculoskeletal injuries and illnesses to prevent, evaluate, assess, provide immediate care, treat, rehabilitate and recondition, under the supervision of a licensed physician.

Instead of the ambiguous and actually all inclusive:

2. "Athletic training" means the comprehensive management of injuries and illnesses to prevent, evaluate, assess, provide immediate care, treat, rehabilitate and recondition.

For description of scope of practice. I don't think I would go to an athletic trainer for pneumonia. I understand that this proceeds the above statement:

1. "Athletic trainer" means an individual with specific qualifications set forth in section 43-39-05, who is providing athletic training services in accordance with the individual's education.

But it is interesting what people believe they have been educated to do versus what they are actually competent to do. Thank you for responding to my concerns.

Sincerely,
Richard Zaruba

Richard Zaruba, PT, DPT, PhD
Board Certified Orthopaedic Clinical Specialist Fellowship Trained in Orthopaedic Manual Physical Therapy Fellow of the American Academy of Orthopaedic Manual Physical Therapists Certified Strength and Conditioning Specialist Assistant Professor Physical Therapy Program University of Jamestown
4190 26th Avenue South
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SB2295
Zaruba
9.2

CHAPTER 43-39
ATHLETIC TRAINERS

43-39-01. Definitions.

1. "Athletic trainer" means an individual with specific qualifications set forth in section 43-39-05, who is providing athletic training services in accordance with the individual's education.
2. "Athletic training" means the comprehensive management of musculoskeletal injuries and illnesses to prevent, evaluate, assess, provide immediate care, treat, rehabilitate and recondition, under the supervision of a physician.
3. "Board" means the North Dakota board of athletic trainers established in section 43-39-02.
4. "Physician" means an individual licensed as a physician under chapter 43-17.

43-39-02. Board of athletic trainers.

1. The North Dakota board of athletic trainers shall consist of five members, comprising one licensed physician, one layperson, and three athletic trainers. Each member must be appointed by the governor. The members, other than the layperson, must be appointed from lists submitted to the governor by the North Dakota athletic trainers association for those members who are athletic trainers and from the North Dakota medical association for the member who is a physician, for terms as provided in this section. Each member of the board, except for the layperson, must be licensed in the member's profession in this state and a resident of this state, must have not less than two years' experience as a physician or athletic trainer immediately preceding appointment, and must be actively employed in the member's profession during the member's tenure on the board. The layperson may not be licensed in any health care field.
2. Members must be appointed to serve four-year staggered terms to commence on July first in the respective years of appointment and shall continue to serve until their successors are appointed. If a vacancy occurs during a term, the governor shall appoint a successor for the remainder of the unexpired term. No member may serve for more than two successive four-year terms. On the initial board, one physician and one athletic trainer must be appointed for a one-year term; the laymember and one athletic trainer must be appointed for a two-year term; and one athletic trainer must be appointed for a three-year term. Thereafter, their successors must be appointed for four-year terms.
3. The board each year shall elect one of its members as chairman and one as secretary-treasurer to the board. The board may make rules, in accordance with chapter 28-32 and not inconsistent with law, which may be necessary for the performance of its duties. The board may prescribe reasonable fees for application and examinations and for certificates of licensure. License fees must be used for the purpose of paying the costs of per diem compensation and travel reimbursement to the board. In addition, fees and other moneys collected and received by the board must be used for the purpose of implementing this chapter and may be used for continuing education purposes. The financial records of the board must be audited once every two years. The audit is to be paid for out of the funds of the board.
4. The board shall meet at least once each year. Additional meetings may be held on the call of the chairman or at the written request of any three members of the board. Three members constitute a quorum of the board. No action by the board or its members has any effect unless a quorum of the board is present.
5. The athletic trainer members of the initial board are not required to be licensed for the first one hundred eighty days of their membership on the board.

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43-39-03. Records.

The board shall keep a record of its proceedings under this chapter and a record of all persons licensed by the board. The record must show the name of every living licensee and the licensee's last-known place of employment and last-known place of residence and the date and number of the licensee's license certificate. Any interested person in the state is entitled to a printed copy of that record on application to the board and payment of such reasonable charge as may be fixed by the board based on the cost involved.

43-39-04. Unlawful practice.

1. A person may not practice athletic training or hold that person out as being an athletic trainer in this state unless that person is an individual licensed in accordance with this chapter.
2. A person may not consult, teach, or supervise or hold that person out as being able to consult, teach, or supervise athletic training curricular courses in this state unless that person is licensed in accordance with this chapter or chapter 43-17, or possesses a degree in a health-related field.
3. A person may not represent that person as being a licensed athletic trainer or use in connection with that person's name any letters, words, or insignia indicating or implying that the person is a licensed athletic trainer unless that person is an individual licensed in accordance with this chapter.

43-39-05. Qualifications.

To be eligible for an athletic trainer license, an applicant must meet all the requirements of certification established by the board of certification, incorporated.

43-39-06. Issuance of licenses.

1. An applicant for an athletic trainer license must submit an application to the board on forms prescribed by the board and submit the application fee required.
2. An applicant is entitled to an athletic trainer license if the applicant possesses the qualifications set forth in this chapter, satisfactorily meets approval by the board of athletic trainers, pays the license fee, and has not committed an act which constitutes grounds for denial of a license.

43-39-07. Initial license.

Repealed by S.L. 2013, ch. 332, § 6.

43-39-08. Examination required.

All license applicants must have previously passed the board of certification, incorporated, examination.

43-39-09. License renewal.

1. A license issued pursuant to this chapter expires one year from the date of issuance.
2. Licenses must be renewed according to the procedures established by the board.
3. A previously licensed person who has requested license renewal must have active status from the board of certification, incorporated.

43-39-10. Grounds for denial, suspension, or revocation of license - Application of chapter.

1. The board may refuse to issue a license to an applicant or may suspend or revoke the license of a licensee if the applicant or licensee:

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a. Has been convicted of a felony or misdemeanor involving moral turpitude, the record of a conviction being conclusive evidence of conviction.

b. Uses alcohol or narcotic drugs to the extent that the use affects the person's professional competency.

c. Has obtained or attempted to obtain a license by fraud, deceit, or material misrepresentation.

d. Is guilty of treating or undertaking to treat an individual's injury or illness, except as authorized pursuant to this chapter, or undertaking to practice independent of the order of a licensed physician, or is guilty of any act derogatory to the dignity and morals of the profession of athletic training.

2. Nothing in this chapter shall be construed to authorize the practice of medicine by any person. The provisions of this chapter do not apply to physicians licensed by the North Dakota state board of medical examiners; to dentists, duly qualified and registered under the laws of this state who confine their practice strictly to dentistry; to licensed optometrists who confine their practice strictly to optometry as defined by law; to licensed chiropractors who confine their practice strictly to chiropractic as defined by law; to occupational therapists who confine their practice to occupational therapy; to nurses who practice nursing only; to duly licensed chiropodists or podiatrists who confine their practice strictly to chiropody or podiatry as defined by law; to registered physical therapists; to massage therapists in their particular sphere of labor; nor to commissioned or contract physicians or physical therapists or physical therapists' assistants in the United States army, navy, air force, marine corps, and public health and marine health service.

3. The provisions of this chapter shall not apply to persons coming into this state for a specific athletic event or series of athletic events with an individual or group not based in this state.

4. Nothing in this chapter shall be construed to prevent schools, YMCA organizations, athletic clubs, and similar organizations from furnishing athletic training services to their students, players, or members.

43-39-11. Penalty.

Any person practicing as an athletic trainer without a license as required by this chapter is guilty of a class B misdemeanor.

SB 2295
Attach #10
02/04/15
J# 23214

From: janet.rasmussen@sanfordhealth.org [mailto:janet.rasmussen@sanfordhealth.org]
Sent: Monday, January 26, 2015 3:52 PM
To: Lee, Judy E.
Subject: Please OPPOSE SB 2295

Ms Janet Eloyce Rasmussen
1807 Queensbury St
West Fargo, ND 58078-4350

1/26/2015

Dear Senator Lee:

As your constituent and a member of the physical therapy profession in North Dakota, I want to share my concerns about SB 2295, which would inappropriately expand the scope of practice for athletic trainers in this state.

Athletic trainers, as the name indicates, are trained and educated to treat physically active persons, primarily athletes. The current North Dakota practice act reflects this by defining athletic training in the context of addressing "athletic injuries". Athletic trainer education is focused on injuries that occur in otherwise physically active persons participating in organized, individual or team sports, athletic games or recreational sports activities. It is not focused on evaluation and treatment of individuals with disease and disability, but SB 2295 would allow an athletic trainer to provide athletic training services to such individuals. For example, it would arguably allow an athletic trainer to treat an acute stroke patient or cardiac patient.

The athletic training practice acts in most states - including Montana, Minnesota, and South Dakota - also define athletic training much like the current North Dakota practice act does, specifying that athletic trainers provide services to "athletes" with "athletic injuries". Recent attempts in some states to implement language similar to SB 2295 have failed.

I respectfully ask you to vote NO on SB 2295. Thank you for your consideration of this issue.

Sincerely,

Ms Janet Eloyce Rasmussen

SB 2295
Attach #11
02/04/15
J# 23214

From: Bud & Lorraine Wessman [mailto:wessmanbl@cableone.net]
Sent: Monday, January 26, 2015 9:37 AM
To: Bowman, Bill L.; Carlisle, Ron; Dotzenrod, Jim A.; Holmberg, Ray E.; Kilzer, Ralph L.; Laffen, Lonnie J.; Lee, Judy E.; Mathern, Tim; O'Connell, David P.; Robinson, Larry J.; Sinner, George B.; ctriplette@nd.gov; tmwanzak@nd.gov; Wardner, Rich P.
Subject: SB 2295

Greetings to former Colleagues:
Now that I am retired, I have determined to not bother those of you in elected office who carry on the work that I hold dear - whether our prior connections were in Grand forks, at UND, in the legislature, or when I was Head of Human Services, I have come to respect and admire each of you for your dedication to public service in our great state of North Dakota.
BUT SB 2265 IS SO FAR "OUT OF BOUNDS" OF QUALITY HEALTH CARE THAT I FEEL COMPELLED TO ASK THAT YOU VOTE "NO" ON THIS BILL.
Athletic Trainers certainly have their place in the delivery of health care - as their name implies, they are "on the field, on the court, on the ice" as first responders and care givers for athletic injuries. But 2295 goes way beyond the acknowledged scope of practice for Athletic Trainers:
The current North Dakota athletic training practice act defines athletic training as the "prevention, recognition, evaluation, management, treatment, and disposition of athletic injuries" and requires that rehabilitation of athletic injuries be done under the order of a licensed physician. SB 2295 would redefine athletic training as the "comprehensive management of injuries and illnesses to prevent, clinically evaluate, assess, provide immediate care, treat, rehabilitate, and recondition." It also removes the physician order requirement for the rehabilitation of athletic injuries, thus further diminishing the all-important "physician oversight" that results in quality and focused health care.
Athletic Training has it's rightful place in health care - they do a great job on the field and in the training room - but I suspect the intent of SB 2295 is to shift "shift emphasis" to some type of non-descript "physician extender", opening new revenue streams for both the physician who 'manages" this new care provider, and the Athletic Trainer herself/himself - again, in my humble opinion, not a solid way to insure quality health care, and certainly beyond the scope of the Athletic Trainers education and expertise.
Thanks for your attention to this rather lengthy e-mail - - -be thankful I only think good thoughts about you and our past interactions, and don't bug you incessantly!!
Best regards and highest respect,
Bud Wessman

Lorraine & Bud Wessman

1594 Sundance Drive South
Fargo, ND 58104

Home Phone: (701)451-0123
Cell Phone: (701)388-9991

Attach #12
SB2295
02/04/15
JH 23214

TO: North Dakota Senate Human Service Committee

FROM: Sarah Ashley – Student CHS

DATE: February 3, 2015

SUBJECT: Senate Bill No. 2295

Madame Chair and members of the Senate Human Services Committee, my name is Sarah Ashley. I am a senior at a local high school who experienced a traumatic injury and has benefitted greatly from the athletic training program.

Having athletic trainers available to work with me along my road to recovery has proven to be the most beneficial element in my healing process. I suffered a double ankle injury earlier this year and with the help of these qualified allied health professionals I have been able to return to the high impact sport of gymnastics. My athletic trainer was able to determine my injury the first day I met with her. She then created a plan for my recovery that included hands on exercises that I would not have been able to do alone, as well as strengthening activities for me to do at home. The recovery plan changed as I healed, allowing for a quicker, better recovery. She truly administered quality care, as the healing process was not a smooth one. There were days that I was not able to complete typical exercises, but with her education she was able to create unique exercises to target specific problems. I would not have recovered as quickly as I did if not for the accessibility of my highly qualified athletic trainer. The simplicity of attaining treatment from a highly qualified professional made my rehabilitation much more effective as I received it daily. My athletic trainer truly was an invaluable part of my recovery.

I believe this bill is a good bill and I ask this committee for a "do pass" recommendation.

Thank you for your time and consideration. I would be happy to address any questions.

Attach#13
SB 2295
02/04/15
J#23214

February 4, 2015
Senate Human Services Committee, Senator Judy Lee, Chairman
Testimony for SB 2295 from Cassie Beseman

Good morning Chairman Lee and Members of the Senate Human Services Committee. My name is Cassie Beseman and I am here today to support SB 2295.

I have loved spending my college years here in North Dakota studying athletic training at the University of Mary. Unfortunately, due to the limitations imposed by North Dakota law that relate to athletic trainers, it is unlikely that I will be able to stay here in North Dakota after I graduate. Instead, I will likely to go back to Minnesota and work at a high school as both a teacher and an athletic trainer because once I have a family I would like to work in a clinic as the hours are more standard. In Minnesota, over half of the athletic trainers work in a clinic or a physical therapy setting.

With the way the North Dakota practice act is written, my work in a clinic is very limited. Also, in North Dakota I can help a high school basketball player who sprains his ankle, but I can't help a recreational basketball player who does the same thing. By removing the word "athletic" from the North Dakota practice act, athletic trainers similar to me will be able to apply their knowledge they have learned in the classroom to anyone physically active. This would allow the growing number of students we have here in North Dakota graduating with an athletic training degree to stay here in North Dakota

While I mentioned I want to begin my career through working in a high school, many of my colleagues want to go straight to a clinic. Until North Dakota removes the word "athlete" from the practice act, my colleagues and I are put in the position of leaving the state to find work elsewhere that matches our career and lifestyle goals.

Thank you for your time this morning. I hope you will give SB 2295 favorable consideration. I am glad to answer your questions.

Cassie Beseman

SB2295
02/11/2015
Attach#1
J# 23672

From: Robyn M. Gust [mailto:Robyn.Gust@trinityhealth.org]
Sent: Tuesday, February 10, 2015 2:21 PM
To: Lee, Judy E.
Subject: Response to hearing regarding SB 2295

Dear Senator Lee:

I am writing this letter in regard to supporting the changes of the North Dakota Athletic Training practice act in SB 2295 as well as addressing some items that were brought up during the hearing regarding SB 2295 last week. I was unable to attend the hearing due to prior commitments but did send a letter of support as well as have several co-workers and colleagues that could attend. Once they arrived back in Minot, we had multiple conversations regarding points of the hearing and I would like to address a few of them with this email.

One of the major points of the opposition to the bill was about the scope of an athletic trainer and how an athletic trainer was not educated or qualified to "treat" illnesses. I find this very interesting considering that I manage and treat illnesses on a daily basis within my scope of practice. Please allow me to explain. I have worked in athletic training for 20 years, most in the collegiate and high school settings. In those 20 years, I have had patients that have had a multitude of injuries and illnesses that I was responsible for managing. Every year I work football, I treat and manage patients for heat illness, an illness that kills young men in football every fall. Every winter I work wrestling, I treat and manage wrestlers with skin conditions and almost every spring, I treat and manage patients with eating disorders or iron deficiency which is common in young female runners. It is my job, my duty, and well within my scope to **recognize** that my patient has one of these illnesses and ensure that the appropriate steps are taken in order for that patient to receive the best care. These illnesses are listed in our competencies of education that our national organizations state that we MUST learn and be competent in managing before we can register and sit for our national certification examination.

Also in my 20 years of practice, I have had the responsibility to recognize other dangerous injuries and illnesses and make the appropriate referral to get the patient the best outcomes. Some of those I have managed include mononucleosis, bruised and/or ruptured spleen, bruised kidneys, influenza, anemia, hypokalemia, concussion, spinal cord trauma, anaphylactic shock, heart conditions, hernias, appendicitis, suicidal thoughts and attempts and testicular cancer. Did I treat testicular cancer? No, I did not; but I understood the signs and symptoms that a 20 year old hockey player presented with and immediately referred him to a physician because that is my job. Athletes see athletic trainers every day before practices and games or even just to stop into athletic training rooms around the country because something "Just doesn't feel right". It is the job of the athletic trainer to take a history, perform an examination and makes a determination on the best medical course of action. We do not seek these injuries and illnesses out, they are a part of the demographic that we serve and it is ensured by the National Board of Certification, the National Athletic Trainers Association, the Commission on Accreditation of Athletic Training Education and the North Dakota Licensure Board in this state that those practicing as athletic training have the appropriate education to perform the necessary duties of a Certified Athletic Trainer.
Currently, I have athletes on the teams I serve right now that have asthma, diabetes, sickle cell trait, anemia and depression conditions to name a few. I have had athletes in the past that have been pregnant, had hemophilia and a couple of athletes with cerebral palsy. I do not "treat" these illnesses, but I do assist them in managing them because I am on the sideline with them, I am on the bench with them and I am at their school every day. It is in my education, that is ever changing, that ensures that I am able to assist these athletes with proper management of medical conditions that they may have.

I understand that it was stated in the hearing that our scope should be "listed". To list every injury and illness an athlete trainer will see is next to impossible. If I have a patient at one of my schools that presents with an injury or illness that is not listed, does that mean I cannot treat or manage that person's problem and help him get the appropriate medical care? However, if we rely on staying within the athletic training practice act that an athletic trainer will practice within the scope of the education that is mandated, we are allowing the athletic trainer to

treat the patient as a whole according to the most up to date medical information. We also would not be confined to what those conditions may be or how they are treated in 2015 compared to 2025. Will we need to revisit this practice act as the medical field changes?

A colleague of mine informed me that the question was raised during the hearing as to why a person would want to go into athletic training as opposed to physical therapy. As the manager of a Sports Medicine department for the past 15 years and clinical instructor for an accredited athletic training program, I have interviewed hundreds of athletic trainers and potential athletic trainers and have asked that very question. The responses have been varied with the most common one being that either no one was there for them when they were an athlete to help them or that an athletic trainer **was** there when they were severely injured and helped them from the time they were injured to the time that they returned to playing their sport. No other profession can say that. We help our patients the moment that they are injured since most of the time we are there with them when it happens. We help them get the appropriate medical care and help them return, not to a "normal" life, but return to a state of athletic competition again if it is possible. We also ensure that the care they receive at the time of injury is appropriate so they are not injured further and the families know what direction the medical care should take at the time. Athletic Trainers want to work with a physically active, motivated population, and it doesn't hurt that we get to watch sports for a living either.

Athletic Trainers must be ready for anything. We don't have the luxury of accepting or not accepting a patient that is on a team we work with, depending on the injury or illness that person may have. We must be prepared to assist our patients with a vast array of medical conditions and injuries. I do not think that is appropriate for a medical profession that does not do our job, such as physical therapy or occupational therapy, dictate what is "in our scope" of practice since athletic trainers are the ones that are providing the care. That is why we have national organizations and educational standards. That is why it is imperative that the language of the North Dakota Athletic Training practice act be updated to what is current in the profession of athletic training. I am asking for your support on SB 2295 to ensure that it does.

I greatly appreciate the time you have taken in regard to this important legislation. If you would like further feedback from me or have questions, please feel free to contact me at this email address or call me at (701) 857-3486 for a phone conversation or to arrange a time to meet in person. Thank you for your time
Thank you very much!

Sincerely,

Robyn Gust MS/ATC

Sports Medicine Manager

Trinity Hospital
Minot, ND

(701) 857-3486

SB2295
02/11/15
Attach#2
J# 23672

Testimony to the Senate Human Services Committee
Chair Judy Lee
Shane Goettle
For North Dakota Athletic Trainers Association
Sgoettle@odney.com

Madam Chair and members of the Human Services Committee, my name is Shane Goettle and I represent the North Dakota Athletic Trainers Association. Members of the profession will discuss the history, as well as their education and training. I just want to briefly set the stage and walk you through the bill.

The availability of Athletic Trainers has tremendously expanded their availability to cover sports and athletic events across the state. The public is now far more familiar and confident with the services performed by athletic trainers. This familiarity has also increased demand for individual services, even from non-athletes who are, nevertheless, seeking services to restore and achieve physical activity goals after an injury.

The Practice Act, however, has not kept up with the times. As you carry out your role as policy-makers, I would suggest that your primary task is NOT to spend your time preserving or building fences between the various health professions, but rather to ask: "Is the public protected?" Put another way: "Is the individual performing this particular health related service adequately educated and trained to deliver quality care to the patient?" Again, that's the purpose of the Practice Act: to ensure, in this case, that Athletic Trainers are properly educated and trained to deal with the injuries and medical issues that they encounter–in short, to protect the integrity of the license to practice and protect the public.

We recognize there is overlap and some level of healthy competition among the health professions. We submit this is a good thing. Competition, first and foremost, gives patients options and choices. A dynamic health care system should foster healthy competition and choice, provided only that the individual performing the service is adequately educated and trained to address the injury or illness.

The changes we seek are simple:

- [Walk through Act]
- NOTE THAT CHIROPRACTORS, 43-06-01, while listing the specific services they can perform, also have a broad provision consistent with their education and training:

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1. "The practice of chiropractic" includes:
    a. All other procedures taught by chiropractic colleges accredited by the council on chiropractic education or its successor

Athletic trainers have NO intent to request, seek or insist that their services expand into billing– this is NOT their goal. Rather, they seek some definitional changes in NDCC § 43-39-01 that will accurately reflect who they are and what they do as a profession. Let me introduce Steve Westereng, President of the NDATA and Brandy Currie, who teaches at the University of Mary and serves Century High School athletic functions.

Table of Contents

Neighboring States and Their Practice Acts...

* *A summary of the current practice acts from Michigan, Wisconsin, Minnesota, South Dakota and Montana. This grid depicts the terminology used to define the various terms used in the athletic training practice acts in each of these states.*

Sampling of Illnesses Addressed in Educational Competencies.......

* *A sampling of a few competencies that highlight the fact that athletic trainers are educated to recognize and provide immediate treatment for a variety of illnesses. More are listed throughout the competency packet.*

Athletic Training Education Competencies..,

* *The 5th Edition of the Educational Competencies. These are the competencies published by CAATE, the accrediting body for athletic training education. These competencies are used by ever athletic training education program as the standards to be taught to all students.*

University of Mary Athletic Training Curriculum...............................

University of North Dakota Athletic Training Curriculum................

* *Course catalog descriptions of the athletic training courses being taught at the University of North Dakota*

University of North Dakota Physical Therapy Curriculum ....

* *Course catalog descriptions of the Physical Therapy courses being taught at the University of North Dakota*

University of North Dakota Occupational Therapy Curriculum.....

* *Course catalog descriptions of the Occupational Therapy courses being taught at the University North Dakota*

Neighboring States and their Practice Acts

STATE	DEFINITION OF ATHLETE	DEFINITION OF ATHLETIC TRAINER	DEFINTION OF ATHLETIC TRAINING	DEFINITION OF ATHLETIC INJURY	OTHER DEFINITIONS
M[illegible]n		"Athletic trainer" means an individual engaged in the practice of athletic training.	"Practice of athletic training" means the treatment of an individual for risk management and injury prevention, the clinical evaluation and assessment of an individual for an injury or illness, or both, the immediate care and treatment of an individual for an injury or illness, or both, and the rehabilitation and reconditioning of an individual's injury or illness, or both, as long as those activities are within the rules promulgated under section 17904 and performed under the direction and supervision of an individual licensed under part 170 or 175. The practice of athletic training does not include the practice of physical therapy, the practice of medicine, the practice of osteopathic medicine and surgery, the practice of chiropractic, or medical diagnosis or treatment		

STATE	DEFINITION OF ATHLETE	DEFINITION OF ATHLETIC TRAINER	DEFINTION OF ATHLETIC TRAINING	DEFINITION OF ATHLETIC INJURY	OTHER DEFINITIONS
W[illegible]n		"Athletic trainer" means an individual who engages in athletic training.	"Athletic training" means doing any of the following: **(a)** Preventing, recognizing and evaluating injuries or illnesses sustained while participating in physical activity. **(b)** Managing and administering the initial treatment of injuries or illnesses sustained while participating in physical activity. **(c)** Giving emergency care or first aid for an injury or illness sustained while participating in physical activity. **(d)** Rehabilitating and physically reconditioning injuries or illnesses sustained while participating in physical activity. **(e)** Rehabilitating and physically reconditioning injuries or illnesses that impede or prevent an individual from returning to participation in physical activity, if the individual recently participated in, and intends to return to participation in, physical activity. **(f)** Establishing or administering risk management, conditioning, and injury prevention programs.		"Physical activity" means vigorous participation in exercise, sports, games, recreation, wellness, fitness, or employment activities.

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STATE	DEFINITION OF ATHLETE	DEFINITION OF ATHLETIC TRAINER	DEFINTION OF ATHLETIC TRAINING	DEFINITION OF ATHLETIC INJURY	OTHER DEFINITIONS
Minnesota	"Athlete" means a person participating in exercises, sports, games, or recreation requiring physical strength, agility, flexibility, range of motion, speed, or stamina.	Athletic trainer" means a person who engages in athletic training under section 148.7806 and is registered under section 148.7808.	Athletic training by a registered athletic trainer under section 148.7808 includes the activities described in paragraphs (a) to (e). (a) An athletic trainer shall: (1) prevent, recognize, and evaluate athletic injuries; (2) give emergency care and first aid; (3) manage and treat athletic injuries; and (4) rehabilitate and physically recondition athletic injuries. The athletic trainer may use modalities such as cold, heat, light, sound, electricity, exercise, and mechanical devices for treatment and rehabilitation of athletic injuries to athletes in the primary employment site. (b) The primary physician shall establish evaluation and treatment protocols to be used by the athletic trainer. The primary physician shall record the protocols on a form prescribed by the board. The protocol form must be updated yearly at the athletic trainer's registration renewal time and kept on file by the athletic trainer. (c) At the primary employment site, except in a corporate setting, an athletic trainer may evaluate and treat an athlete for an athletic injury not previously diagnosed for not more than 30 days, or a period of time as designated by the primary physician on the protocol form, from the date of the initial evaluation and treatment. Preventative care after resolution of the injury is not considered treatment. This paragraph does not apply to a person who is referred for treatment by a person licensed in this state to practice medicine as defined in section 147.081, to practice chiropractic as defined in section 148.01, to practice podiatry as defined in section 153.01, or to practice dentistry as defined in section 150A.05 and whose license is in good standing. (d) An athletic trainer may: (1) organize and administer an athletic training program including, but not limited to, educating and counseling athletes; (2) monitor the signs, symptoms, general behavior, and general physical response of an athlete to treatment and rehabilitation including, but not limited to, whether the signs, symptoms, reactions, behavior, or general response show abnormal characteristics; and (3) make suggestions to the primary physician or other treating provider for a modification in the treatment and rehabilitation of an injured athlete based on the indicators in clause (2). (e) In a clinical, corporate, and physical therapy setting, when the service provided is, or is represented as being, physical therapy, an athletic trainer may work only under the direct supervision of a physical therapist as defined in section 148.65.	"Athletic injury" means an injury sustained by a person as a result of the person's participation in exercises, sports, games, or recreation requiring physical strength, agility, flexibility, range of motion, speed, or stamina.	

STATE	DEFINITION OF ATHLETE	DEFINITION OF ATHLETIC TRAINER	DEFINTION OF ATHLETIC TRAINING	DEFINITION OF ATHLETIC INJURY	OTHER DEFINITIONS
So[illegible] D[illegible]		"Athletic trainer," a person with specific qualifications as set forth in § 36-29-3, whose responsibility is the prevention, evaluation, emergency care, treatment, and reconditioning of athletic injuries under the direction of the team or treating physician. The athletic trainer may use cryotherapy, which includes cold packs, ice packs, cold water immersion, and spray coolants; thermotherapy, which includes topical analgesics, moist hot packs, heating pads, infrared lamp, and paraffin bath; hydrotherapy, which includes whirlpool; and therapeutic exercise common to athletic training which includes stretching and those exercises needed to maintain condition; in accordance with a physician's written protocol. Any rehabilitative procedures recommended by a physician for the rehabilitation of athletic injuries which have been referred and all other physical modalities may be administered only following the prescription of the team or referring physician;			
Montana	"Athlete" means a person who participates in an athletic activity that involves exercises, sports, or games requiring physical strength, agility, flexibility, range of motion, speed, or stamina and the exercises, sports, or games are of the type conducted in association with an educational institution or a professional, amateur, or recreational sports club or organization.	"Athletic trainer" means an individual who is licensed to practice athletic training.	"Athletic training" means the practice of prevention, recognition, assessment, management, treatment, disposition, and reconditioning of athletic injuries. The term includes the following: (a) the use of heat, light, sound, cold, electricity, exercise, reconditioning, or mechanical devices related to the care and conditioning of athletes; and (b) the education and counseling of the public on matters related to athletic training.	"Athletic injury" means a physical injury received by an athlete.	

A Sampling of Illnesses Addressed in Educational Competencies

PHP-14. Assess weight loss and hydration status using weight charts, urine color charts, or specific gravity measurements to determine an individual's ability to participate in physical activity in a hot, humid environment.
PHP-15. Use a glucometer to monitor blood glucose levels, determine participation status, and make referral decisions.
PHP-16. Use a peak-flow meter to monitor a patient's asthma symptoms, determine participation status, and make referral decisions.
AC-36. Identify the signs, symptoms, interventions and, when appropriate, the return-to-participation criteria for:
AC-36a. sudden cardiac arrest
AC-36b. brain injury including concussion, subdural and epidural hematomas, second impact syndrome and skull fracture
AC-36c. cervical, thoracic, and lumbar spine trauma
AC-36d. heat illness including heat cramps, heat exhaustion, exertional and hyponatremia
AC-36e. exertional sickling associated with sickle cell trait
AC-36f. rhabdomyolysis
AC-36g. internal hemorrhage
AC-36h. diabetic emergencies including hypoglycemia and ketoacidosis
AC-36i. asthma attacks
AC-36j. systemic allergic reaction, including anaphylactic shock
AC-36k. epileptic and non-epileptic seizures
AC-36l. shock
AC-36m. hypothermia, frostbite
AC-36n. toxic drug overdoses
AC-36o. local allergic reaction.

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Athletic Training Education Competencies

5th Edition

2.9

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Preface

The 5th edition of the Athletic Training Education Competencies (Competencies) provides educational program personnel and others with the knowledge, skills, and clinical abilities to be mastered by students enrolled in professional athletic training education programs. Mastery of these Competencies provides the entry–level athletic trainer with the capacity to provide athletic training services to clients and patients of varying ages, lifestyles, and needs.

The Commission on Accreditation of Athletic Training Education (CAATE) requires that the Competencies be instructed and evaluated in each accredited professional athletic training education program. The Competencies serve as a companion document to the accreditation standards, which identify the requirements to acquire and maintain accreditation, published by CAATE.

The Professional Education Council (PEC) of the NATA was charged with creating the 5th edition of the Competencies. The PEC developed and executed a systematic plan to draft the Competencies and to solicit and integrate feedback from multiple sources as the draft was revised. First, the PEC orchestrated an initial open call for feedback on the 4th edition of the Competencies. Next, groups of subject-matter experts, including practicing athletic trainers, educators, and administrators, were identified. In addition to the feedback on the 4th edition, these subject-matter experts considered today's healthcare system, current best practice in athletic training, and their own expertise in creating an initial draft of the 5th edition. Many conversations ensued and subsequent drafts were submitted. Following revision for form and consistency of language, a draft of the Competencies was again posted for open feedback. This valuable feedback was considered in its entirety by the PEC, and final revisions were made.

We thank the members of the PEC for their untiring efforts in revising this document to reflect the changing needs of athletic training education. The advice, cooperation, and feedback from the Board of Certification and the CAATE have also been instrumental in this process. Finally, the diligent and perceptive feedback that was received from stakeholders during the public comment periods was instrumental in creating a document that ensures that entry-level athletic trainers are prepared to work in a changing healthcare system. Together we are improving healthcare by improving the education of athletic trainers.

— NATA Executive Committee for Education, December 2010

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Introduction

This document is to be used as a guide by administrative, academic, and clinical program personnel when structuring all facets of the education experience for students. Educational program personnel should recognize that the Competencies are the ***minimum requirements*** for a student's professional education. Athletic training education programs are encouraged to exceed these minimums to provide their students with the highest quality education possible. In addition, programs should employ innovative, student-centered teaching and learning methodologies to connect the classroom, laboratory and clinical settings whenever possible to further enhance professional preparation.

The acquisition and clinical application of knowledge and skills in an education program must represent a defined yet flexible program of study. Defined in that knowledge and skills must be accounted for in the more formal classroom and laboratory educational experience. Flexible in that learning opportunities are everywhere. Behaviors are identified, discussed, and practiced throughout the educational program. Whatever the sequence of learning, patient safety is of prime importance; students must demonstrate competency in a particular task before using it on a patient. This begins a cycle of learning, feedback, refinement, and more advanced learning. Practice with concepts by gaining clinical experience with real life applications readies the student for opportunities to demonstrate decision-making and skill integration ability, Clinical Integrated Proficiencies (CIP). CIPs are designed to measure of real life application. Students should be assessed in their performance of CIPs on actual patients. If this is not possible, standardized/simulated patients or scenarios should be used to measure student proficiency.

Also, inherent in this document is the understanding that a comprehensive basic and applied science background is needed for students to develop appropriate levels of professional competence in the discipline-specific knowledge and skills described in this document.

All facets of the educational programs must incorporate current knowledge and skills that represent best practice. Programs must select such content following careful review of the research literature and consideration of the needs for today's entry-level practitioner. Because the knowledge within a profession is dynamic, information regarding current best practice is fluid and requires on-going examination and reflection.

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Summary of Major Changes included in 5th Edition

- The 12 content areas of the previous edition have been reorganized into 8 to eliminate redundancies and better reflect current practice.
  - — The pathology content area was eliminated, and these competencies are addressed throughout other content areas.
  - — The risk management/prevention and nutritional considerations content areas were combined to form the new **Prevention and Health Promotion (PHP)** content area. This change was made to reflect the current emphasis on prevention and wellness across health care and the lifespan.
  - — The orthopedic clinical exam/diagnosis and medical conditions/disabilities content areas were combined to form the **Clinical Examination and Diagnosis (CE)** content area. This change was made to emphasize that athletic trainers use one standard clinical examination model that changes based on the findings and needs of the patient.
  - — The therapeutic modalities, conditioning and rehabilitative exercise and pharmacology content areas were combined to form one content area that incorporates all aspects of **Therapeutic Interventions (TI).**
  - — A new content area was added to provide students with the basic knowledge and skills related to **Evidence-Based Practice (EBP).** The importance of using EBP concepts and principles to improve patient outcomes is being emphasized throughout the health care system and is reflected within this new content area.
- The **Acute Care (AC)** content area has been substantially revised to reflect contemporary practice.
  - — The addition of skill in assessing rectal temperature, oxygen saturation, blood glucose levels, and use of a nebulizer and oropharyngeal and nasopharyngeal airways reflects recommendations of NATA position statements that are published or in development.
- The content areas now integrate knowledge and skills, instead of separate sections for cognitive and psychomotor competencies. The action verb used in each competency statement identifies the expected outcome. In some places, knowledge is the expectation and not skill acquisition. For example, acute care competency #9 (AC-9) requires that athletic training students be knowledgeable about the various types of airway adjuncts including oropharyngeal airways (OPA), nasopharyngeal airways (NPO) and supraglottic airways. However, the accompanying skill competency AC-10 does not require skill acquisition in the use of the supraglottic airways.
- The **Clinical Integration Proficiencies (CIP)**, which are ideally assessed in the context of real patient care, have been removed from the individual content areas and reorganized into a separate section. This reorganization reflects clinical practice and demonstrates the global nature of the Proficiencies. For example, rather than just assessing students' ability to examine a real patient in a real clinical setting, the new CIPs require that students demonstrate the ability to examine and diagnose a patient, provide appropriate acute/emergent care, plan and implement appropriate therapeutic interventions, and make decisions pertaining to safe return to participation. This approach to student assessment better reflects the comprehensive nature of real patient care.

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Comparison of the Role Delineation Study/Practice Analysis, 6th Ed and the Competencies

The Role Delineation Study/Practice Analysis, 6th ed (RDS/PA) of the Board of Certification serves as the blue print for the certification examination. As such, the Competencies must include all tasks (and related knowledge and skills) included in the RDS/PA. Working with the BOC, we compared the RDS/PA with this version of the Competencies and can confidently state that the content of the RDS /PA is incorporated in this version.

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Foundational Behaviors of Professional Practice

These basic behaviors permeate professional practice and should be incorporated into instruction and assessed throughout the educational program.

Primacy of the Patient

- Recognize sources of conflict of interest that can impact the client's/patient's health.
- Know and apply the commonly accepted standards for patient confidentiality.
- Provide the best healthcare available for the client/patient.
- Advocate for the needs of the client/patient.

Team Approach to Practice

- Recognize the unique skills and abilities of other healthcare professionals.
- Understand the scope of practice of other healthcare professionals.
- Execute duties within the identified scope of practice for athletic trainers.
- Include the patient (and family, where appropriate) in the decision-making process.
- Work with others in effecting positive patient outcomes.

Legal Practice

- Practice athletic training in a legally competent manner.
- Identify and conform to the laws that govern athletic training.
- Understand the consequences of violating the laws that govern athletic training.

Ethical Practice

- Comply with the NATA's *Code of Ethics* and the BOC's *Standards of Professional Practice.*
- Understand the consequences of violating the NATA's *Code of Ethics* and BOC's *Standards of Professional Practice.*
- Comply with other codes of ethics, as applicable.

Advancing Knowledge

- Critically examine the body of knowledge in athletic training and related fields.
- Use evidence-based practice as a foundation for the delivery of care.
- Appreciate the connection between continuing education and the improvement of athletic training practice.
- Promote the value of research and scholarship in athletic training.
- Disseminate new knowledge in athletic training to fellow athletic trainers, clients/patients, other healthcare professionals, and others as necessary.

Cultural Competence

- Demonstrate awareness of the impact that clients'/patients' cultural differences have on their attitudes and behaviors toward healthcare.
- Demonstrate knowledge, attitudes, behaviors, and skills necessary to achieve optimal health outcomes for diverse patient populations.
- Work respectfully and effectively with diverse populations and in a diverse work environment.

Professionalism

- Advocate for the profession.
- Demonstrate honesty and integrity.
- Exhibit compassion and empathy.
- Demonstrate effective interpersonal communication skills.

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Evidence-Based Practice (EBP)

Evidence-based practitioners incorporate the best available evidence, their clinical skills, and the needs of the patient to maximize patient outcomes. An understanding of evidence-based practice concepts and their application is essential to sound clinical decision-making and the critical examination of athletic training practice.

Practicing in an evidence-based manner should not be confused with conducting research. While conducting research is important to the profession of athletic training, developing the ability to conduct a research project is not an expectation of professional education. This section focuses on the knowledge and skills necessary for entry-level athletic trainers to use a systematic approach to ask and answer clinically relevant questions that affect patient care by using review and application of existing research evidence. One strategy, among others, is to use a five-step approach: 1) creating a clinically relevant question; 2) searching for the best evidence; 3) critically analyzing the evidence; 4) integrating the appraisal with personal clinical expertise and patients' preferences; and 5) evaluating the performance or outcomes of the actions. Each competency listed below is related to such a systematic approach and provides the building blocks for employing evidence-based practice. Other specific evidence-based practice competencies have also been included in appropriate content areas.

All items listed in parentheses (eg) are intended to serve as examples and are not all encompassing or the only way to satisfy the competency.

Knowledge and Skills

EBP-1. Define evidence-based practice as it relates to athletic training clinical practice.

EBP-2. Explain the role of evidence in the clinical decision making process.

EBP-3. Describe and differentiate the types of quantitative and qualitative research, research components, and levels of research evidence.

EBP-4. Describe a systematic approach (eg, five step approach) to create and answer a clinical question through review and application of existing research.

EBP-5. Develop a relevant clinical question using a pre-defined question format (eg, PICO= Patients, Intervention, Comparison, Outcomes; PIO = Patients, Intervention, Outcomes).

EBP-6. Describe and contrast research and literature resources including databases and online critical appraisal libraries that can be used for conducting clinically-relevant searches.

EBP-7. Conduct a literature search using a clinical question relevant to athletic training practice using search techniques (eg, Boolean search, Medical Subject Headings) and resources appropriate for a specific clinical question.

EBP-8. Describe the differences between narrative reviews, systematic reviews, and meta-analyses.

EBP-9. Use standard criteria or developed scales (eg, Physiotherapy Evidence Database Scale [PEDro], Oxford Centre for Evidence Based Medicine Scale) to critically appraise the structure, rigor, and overall quality of research studies.

EBP-10. Determine the effectiveness and efficacy of an athletic training intervention utilizing evidence-based practice concepts.

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EBP-11. Explain the theoretical foundation of clinical outcomes assessment (eg, disablement, health-related quality of life) and describe common methods of outcomes assessment in athletic training clinical practice (generic, disease-specific, region-specific, and dimension-specific outcomes instruments).

EBP-12. Describe the types of outcomes measures for clinical practice (patient-based and clinician-based) as well as types of evidence that are gathered through outcomes assessment (patient-oriented evidence versus disease-oriented evidence).

EBP-13. Understand the methods of assessing patient status and progress (eg, global rating of change, minimal clinically important difference, minimal detectable difference) with clinical outcomes assessments.

EBP-14. Apply and interpret clinical outcomes to assess patient status, progress, and change using psychometrically sound outcome instruments.

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Prevention and Health Promotion (PHP)

Athletic trainers develop and implement strategies and programs to prevent the incidence and/or severity of injuries and illnesses and optimize their clients'/patients' overall health and quality of life. These strategies and programs also incorporate the importance of nutrition and physical activity in maintaining a healthy lifestyle and in preventing chronic disease (eg, diabetes, obesity, cardiovascular disease).

Knowledge and Skills

General Prevention Principles

PHP-1. Describe the concepts (eg, case definitions, incidence versus prevalence, exposure assessment, rates) and uses of injury and illness surveillance relevant to athletic training.

PHP-2. Identify and describe measures used to monitor injury prevention strategies (eg, injury rates and risks, relative risks, odds ratios, risk differences, numbers needed to treat/harm).

PHP-3. Identify modifiable/non-modifiable risk factors and mechanisms for injury and illness.

PHP-4. Explain how the effectiveness of a prevention strategy can be assessed using clinical outcomes, surveillance, or evaluation data.

PHP-5. Explain the precautions and risk factors associated with physical activity in persons with common congenital and acquired abnormalities, disabilities, and diseases.

PHP-6. Summarize the epidemiology data related to the risk of injury and illness associated with participation in physical activity.

Prevention Strategies and Procedures

PHP-7. Implement disinfectant procedures to prevent the spread of infectious diseases and to comply with Occupational Safety and Health Administration (OSHA) and other federal regulations.

PHP-8. Identify the necessary components to include in a preparticipation physical examination as recommended by contemporary guidelines (eg, American Heart Association, American Academy of Pediatrics Council on Sports Medicine & Fitness).

PHP-9. Explain the role of the preparticipation physical exam in identifying conditions that might predispose the athlete to injury or illness.

PHP-10. Explain the principles of the body's thermoregulatory mechanisms as they relate to heat gain and heat loss.

PHP-11. Explain the principles of environmental illness prevention programs to include acclimation and conditioning, fluid and electrolyte replacement requirements, proper practice and competition attire, hydration status, and environmental assessment (eg, sling psychrometer, wet bulb globe temperatures [WBGT], heat index guidelines).

PHP-12. Summarize current practice guidelines related to physical activity during extreme weather conditions (eg, heat, cold, lightning, wind).

PHP-13. Obtain and interpret environmental data (web bulb globe temperature [WBGT], sling psychrometer, lightning detection devices) to make clinical decisions regarding the scheduling, type, and duration of physical activity.

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PHP-14. Assess weight loss and hydration status using weight charts, urine color charts, or specific gravity measurements to determine an individual's ability to participate in physical activity in a hot, humid environment.

PHP-15. Use a glucometer to monitor blood glucose levels, determine participation status, and make referral decisions.

PHP-16. Use a peak-flow meter to monitor a patient's asthma symptoms, determine participation status, and make referral decisions.

PHP-17. Explain the etiology and prevention guidelines associated with the leading causes of sudden death during physical activity, including but not limited to:

- **PHP-17a.** Cardiac arrhythmia or arrest
- **PHP-17b.** Asthma
- **PHP-17c.** Traumatic brain injury
- **PHP-17d.** Exertional heat stroke
- **PHP-17e.** Hyponatremia
- **PHP-17f.** Exertional sickling
- **PHP-17g.** Anaphylactic shock
- **PHP-17h.** Cervical spine injury
- **PHP-17i.** Lightning strike

PHP-18. Explain strategies for communicating with coaches, athletes, parents, administrators, and other relevant personnel regarding potentially dangerous conditions related to the environment, field, or playing surfaces.

PHP-19. Instruct clients/patients in the basic principles of ergodynamics and their relationship to the prevention of illness and injury.

Protective Equipment and Prophylactic Procedures

PHP-20. Summarize the basic principles associated with the design, construction, fit, maintenance, and reconditioning of protective equipment, including the rules and regulations established by the associations that govern its use.

PHP-21. Summarize the principles and concepts related to the fabrication, modification, and appropriate application or use of orthotics and other dynamic and static splints.

PHP-22. Fit standard protective equipment following manufacturers' guidelines.

PHP-23. Apply preventive taping and wrapping procedures, splints, braces, and other special protective devices.

Fitness/Wellness

PHP-24. Summarize the general principles of health maintenance and personal hygiene, including skin care, dental hygiene, sanitation, immunizations, avoidance of infectious and contagious diseases, diet, rest, exercise, and weight control.

PHP-25. Describe the role of exercise in maintaining a healthy lifestyle and preventing chronic disease.

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PHP-26. Identify and describe the standard tests, test equipment, and testing protocols that are used for measuring fitness, body composition, posture, flexibility, muscular strength, power, speed, agility, and endurance.

PHP-27. Compare and contrast the various types of flexibility, strength training, and cardiovascular conditioning programs to include expected outcomes, safety precautions, hazards, and contraindications.

PHP-28. Administer and interpret fitness tests to assess a client's/patient's physical status and readiness for physical activity.

PHP-29. Explain the basic concepts and practice of fitness and wellness screening.

PHP-30. Design a fitness program to meet the individual needs of a client/patient based on the results of standard fitness assessments and wellness screening.

PHP-31. Instruct a client/patient regarding fitness exercises and the use of muscle strengthening equipment to include correction or modification of inappropriate, unsafe, or dangerous lifting techniques.

General Nutrition Concepts

PHP-32. Describe the role of nutrition in enhancing performance, preventing injury or illness, and maintaining a healthy lifestyle.

PHP-33. Educate clients/patients on the importance of healthy eating, regular exercise, and general preventative strategies for improving or maintaining health and quality of life.

PHP-34. Describe contemporary nutritional intake recommendations and explain how these recommendations can be used in performing a basic dietary analysis and providing appropriate general dietary recommendations.

PHP-35. Describe the proper intake, sources of, and effects of micro- and macronutrients on performance, health, and disease.

PHP-36. Describe current guidelines for proper hydration and explain the consequences of improper fluid/electrolyte replacement.

PHP-37. Identify, analyze, and utilize the essential components of food labels to determine the content, quality, and appropriateness of food products.

PHP-38. Describe nutritional principles that apply to tissue growth and repair.

PHP-39. Describe changes in dietary requirements that occur as a result of changes in an individual's health, age, and activity level.

PHP-40. Explain the physiologic principles and time factors associated with the design and planning of pre-activity and recovery meals/snacks and hydration practices.

PHP-41. Identify the foods and fluids that are most appropriate for pre-activity, activity, and recovery meals/snacks.

Weight Management and Body Composition

PHP-42. Explain how changes in the type and intensity of physical activity influence the energy and nutritional demands placed on the client/patient.

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PHP-43. Describe the principles and methods of body composition assessment to assess a client's/patient's health status and to monitor changes related to weight management, strength training, injury, disordered eating, menstrual status, and/or bone density status.

PHP-44. Assess body composition by validated techniques.

PHP-45. Describe contemporary weight management methods and strategies needed to support activities of daily life and physical activity.

Disordered Eating and Eating Disorders

PHP-46. Identify and describe the signs, symptoms, physiological, and psychological responses of clients/patients with disordered eating or eating disorders.

PHP-47. Describe the method of appropriate management and referral for clients/patients with disordered eating or eating disorders in a manner consistent with current practice guidelines.

Performance Enhancing and Recreational Supplements and Drugs

PHP-48. Explain the known usage patterns, general effects, and short- and long-term adverse effects for the commonly used dietary supplements, performance enhancing drugs, and recreational drugs.

PHP-49. Identify which therapeutic drugs, supplements, and performance-enhancing substances are banned by sport and/or workplace organizations in order to properly advise clients/patients about possible disqualification and other consequences.

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Clinical Examination and Diagnosis (CE)

Athletic trainers must possess strong clinical examination skills in order to accurately diagnosis and effectively treat their patients. The clinical examination is an on-going process, repeated to some extent each time the patient is treated. The development of these skills requires a thorough understanding of anatomy, physiology, and biomechanics. Athletic trainers must also apply clinical-reasoning skills throughout the physical examination process in order to assimilate data, select the appropriate assessment tests, and formulate a differential diagnosis.

The competencies identified in this section should be considered in the context of the competencies identified in other domains. For example, the knowledge and skills associated with acute care and therapeutic interventions, while applicable for this domain, are not repeated here.

The clinical examination process is comprehensive and may include a review of the systems and regions identified below based on the patient's relevant history and examination findings. Consideration must also be given to the patient's behavioral and cognitive status and history; competencies addressing this content area are included elsewhere.

Systems and Regions

a. Musculoskeletal
b. Integumentary
c. Neurological
d. Cardiovascular
e. Endocrine
f. Pulmonary
g. Gastrointestinal
h. Hepatobiliary
i. Immune
j. Renal and urogenital
k. The face, including maxillofacial region and mouth
l. Eye, ear, nose, and throat

Knowledge and Skills

CE-1. Describe the normal structures and interrelated functions of the body systems.

CE-2. Describe the normal anatomical, systemic, and physiological changes associated with the lifespan.

CE-3. Identify the common congenital and acquired risk factors and causes of musculoskeletal injuries and common illnesses that may influence physical activity in pediatric, adolescent, adult, and aging populations.

CE-4. Describe the principles and concepts of body movement, including normal osteokinematics and arthrokinematics.

CE-5. Describe the influence of pathomechanics on function.

CE-6. Describe the basic principles of diagnostic imaging and testing and their role in the diagnostic process.

CE-7. Identify the patient's participation restrictions (disabilities) and activity limitations (functional limitations) to determine the impact of the condition on the patient's life.

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CE-8. Explain the role and importance of functional outcome measures in clinical practice and patient health-related quality of life.

CE-9. Identify functional and patient-centered quality of life outcome measures appropriate for use in athletic training practice.

CE-10. Explain diagnostic accuracy concepts including reliability, sensitivity, specificity, likelihood ratios, prediction values, and pre-test and post-test probabilities in the selection and interpretation of physical examination and diagnostic procedures.

CE-11. Explain the creation of clinical prediction rules in the diagnosis and prognosis of various clinical conditions.

CE-12. Apply clinical prediction rules (eg, Ottawa Ankle Rules) during clinical examination procedures.

CE-13. Obtain a thorough medical history that includes the pertinent past medical history, underlying systemic disease, use of medications, the patient's perceived pain, and the history and course of the present condition.

CE-14. Differentiate between an initial injury evaluation and follow-up/reassessment as a means to evaluate the efficacy of the patient's treatment/rehabilitation program, and make modifications to the patient's program as needed.

CE-15. Demonstrate the ability to modify the diagnostic examination process according to the demands of the situation and patient responses.

CE-16. Recognize the signs and symptoms of catastrophic and emergent conditions and demonstrate appropriate referral decisions.

CE-17. Use clinical reasoning skills to formulate an appropriate clinical diagnosis for common illness/disease and orthopedic injuries/conditions.

CE-18. Incorporate the concept of differential diagnosis into the examination process.

CE-19. Determine criteria and make decisions regarding return to activity and/or sports participation based on the patient's current status.

CE-20. Use standard techniques and procedures for the clinical examination of common injuries, conditions, illnesses, and diseases including, but not limited to:
- **CE-20a.** history taking
- **CE-20b.** inspection/observation
- **CE-20c.** palpation
- **CE-20d.** functional assessment
- **CE-20e.** selective tissue testing techniques / special tests
- **CE-20f.** neurological assessments (sensory, motor, reflexes, balance, cognitive function)
- **CE-20g.** respiratory assessments (auscultation, percussion, respirations, peak-flow)
- **CE-20h.** circulatory assessments (pulse, blood pressure, auscultation)
- **CE-20i.** abdominal assessments (percussion, palpation, auscultation)
- **CE-20j.** other clinical assessments (otoscope, urinalysis, glucometer, temperature, opthalmoscope)

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CE-21. Assess and interpret findings from a physical examination that is based on the patient's clinical presentation. This exam can include:

- **CE-21a.** Assessment of posture, gait, and movement patterns
- **CE-21b.** Palpation
- **CE-21c.** Muscle function assessment
- **CE-21d.** Assessment of quantity and quality of osteokinematic joint motion
- **CE-21e.** Capsular and ligamentous stress testing
- **CE-21f.** Joint play (arthrokinematics)
- **CE-21g.** Selective tissue examination techniques / special tests
- **CE-21h.** Neurologic function (sensory, motor, reflexes, balance, cognition)
- **CE-21i.** Cardiovascular function (including differentiation between normal and abnormal heart sounds, blood pressure, and heart rate)
- **CE-21j.** Pulmonary function (including differentiation between normal breath sounds, percussion sounds, number and characteristics of respirations, peak expiratory flow)
- **CE-21k.** Gastrointestinal function (including differentiation between normal and abnormal bowel sounds)
- **CE-21l.** Genitourinary function (urinalysis)
- **CE-21m.** Ocular function (vision, ophthalmoscope)
- **CE-21n.** Function of the ear, nose, and throat (including otoscopic evaluation)
- **CE-21o.** Dermatological assessment
- **CE-21p.** Other assessments (glucometer, temperature)

CE-22. Determine when the findings of an examination warrant referral of the patient.

CE-23. Describe current setting-specific (eg, high school, college) and activity-specific rules and guidelines for managing injuries and illnesses.

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Acute Care of Injuries and Illnesses (AC)

Athletic trainers are often present when injuries or other acute conditions occur or are the first healthcare professionals to evaluate a patient. For this reason, athletic trainers must be knowledgeable and skilled in the evaluation and immediate management of acute injuries and illnesses.

The competencies identified in this section should be considered in the context of the competencies identified in other domains. For example, the knowledge and skills associated with the process of examination and documentation, while applicable for this domain, are not repeated here. Likewise, the knowledge and skills associated with the administrative and risk management aspects of planning for an emergency injury/illness situation are not repeated here.

Knowledge and Skills

Planning

- **AC-1.** Explain the legal, moral, and ethical parameters that define the athletic trainer's scope of acute and emergency care.
- **AC-2.** Differentiate the roles and responsibilities of the athletic trainer from other pre-hospital care and hospital-based providers, including emergency medical technicians/paramedics, nurses, physician assistants, and physicians.
- **AC-3.** Describe the hospital trauma level system and its role in the transportation decision-making process.

Examination

- **AC-4.** Demonstrate the ability to perform scene, primary, and secondary surveys.
- **AC-5.** Obtain a medical history appropriate for the patient's ability to respond.
- **AC-6.** When appropriate, obtain and monitor signs of basic body functions including pulse, blood pressure, respiration, pulse oximetry, pain, and core temperature. Relate changes in vital signs to the patient's status.
- **AC-7.** Differentiate between normal and abnormal physical findings (eg, pulse, blood pressure, heart and lung sounds, oxygen saturation, pain, core temperature) and the associated pathophysiology.

Immediate Emergent Management

- **AC-8.** Explain the indications, guidelines, proper techniques, and necessary supplies for removing equipment and clothing in order to access the airway, evaluate and/or stabilize an athlete's injured body part.
- **AC-9.** Differentiate the types of airway adjuncts (oropharygneal airways [OPA], nasopharyngeal airways [NPA] and supraglottic airways [King LT-D or Combitube]) and their use in maintaining a patent airway in adult respiratory and/or cardiac arrest.
- **AC-10.** Establish and maintain an airway, including the use of oro- and nasopharygneal airways, and neutral spine alignment in an athlete with a suspected spine injury who may be wearing shoulder pads, a helmet with and without a face guard, or other protective equipment.

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AC-11. Determine when suction for airway maintenance is indicated and use according to accepted practice protocols.

AC-12. Identify cases when rescue breathing, CPR, and/or AED use is indicated according to current accepted practice protocols.

AC-13. Utilize an automated external defibrillator (AED) according to current accepted practice protocols.

AC-14. Perform one- and two- person CPR on an infant, child and adult.

AC-15. Utilize a bag valve and pocket mask on a child and adult using supplemental oxygen.

AC-16. Explain the indications, application, and treatment parameters for supplemental oxygen administration for emergency situations.

AC-17. Administer supplemental oxygen with adjuncts (eg, non-rebreather mask, nasal cannula).

AC-18. Assess oxygen saturation using a pulse oximeter and interpret the results to guide decision making.

AC-19. Explain the proper procedures for managing external hemorrhage (eg, direct pressure, pressure points, tourniquets) and the rationale for use of each.

AC-20. Select and use the appropriate procedure for managing external hemorrhage.

AC-21. Explain aseptic or sterile techniques, approved sanitation methods, and universal precautions used in the cleaning, closure, and dressing of wounds.

AC-22. Select and use appropriate procedures for the cleaning, closure, and dressing of wounds, identifying when referral is necessary.

AC-23. Use cervical stabilization devices and techniques that are appropriate to the circumstances of an injury.

AC-24. Demonstrate proper positioning and immobilization of a patient with a suspected spinal cord injury.

AC-25. Perform patient transfer techniques for suspected head and spine injuries utilizing supine log roll, prone log roll with push, prone log roll with pull, and lift-and-slide techniques.

AC-26. Select the appropriate spine board, including long board or short board, and use appropriate immobilization techniques based on the circumstance of the patient's injury.

AC-27. Explain the role of core body temperature in differentiating between exertional heat stroke, hyponatremia, and head injury.

AC-28. Differentiate the different methods for assessing core body temperature.

AC-29. Assess core body temperature using a rectal probe.

AC-30. Explain the role of rapid full body cooling in the emergency management of exertional heat stroke.

AC-31. Assist the patient in the use of a nebulizer treatment for an asthmatic attack.

AC-32. Determine when use of a metered-dose inhaler is warranted based on a patient's condition.

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AC-33. Instruct a patient in the use of a meter-dosed inhaler in the presence of asthma-related bronchospasm.

AC-34. Explain the importance of monitoring a patient following a head injury, including the role of obtaining clearance from a physician before further patient participation.

AC-35. Demonstrate the use of an auto-injectable epinephrine in the management of allergic anaphylaxis. Decide when auto-injectable epinephrine use is warranted based on a patient's condition.

AC-36. Identify the signs, symptoms, interventions and, when appropriate, the return-to-participation criteria for:

- AC-36a. sudden cardiac arrest
- AC-36b. brain injury including concussion, subdural and epidural hematomas, second impact syndrome and skull fracture
- AC-36c. cervical, thoracic, and lumbar spine trauma
- AC-36d. heat illness including heat cramps, heat exhaustion, exertional heat stroke, and hyponatremia
- AC-36e. exertional sickling associated with sickle cell trait
- AC-36f. rhabdomyolysis
- AC-36g. internal hemorrhage
- AC-36h. diabetic emergencies including hypoglycemia and ketoacidosis
- AC-36i. asthma attacks
- AC-36j. systemic allergic reaction, including anaphylactic shock
- AC-36k. epileptic and non-epileptic seizures
- AC-36l. shock
- AC-36m. hypothermia, frostbite
- AC-36n. toxic drug overdoses
- AC-36o. local allergic reaction

Immediate Musculoskeletal Management

AC-37. Select and apply appropriate splinting material to stabilize an injured body area.

AC-38. Apply appropriate immediate treatment to protect the injured area and minimize the effects of hypoxic and enzymatic injury.

AC-39. Select and implement the appropriate ambulatory aid based on the patient's injury and activity and participation restrictions.

Transportation

AC-40. Determine the proper transportation technique based on the patient's condition and findings of the immediate examination.

AC-41. Identify the criteria used in the decision-making process to transport the injured patient for further medical examination.

AC-42. Select and use the appropriate short-distance transportation methods, such as the log roll or lift and slide, for an injured patient in different situations.

Education

AC-36. Instruct the patient in home care and self-treatment plans for acute conditions.

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Therapeutic Interventions (TI)

Athletic trainers assess the patient's status using clinician- and patient-oriented outcome measures. Based on this assessment and with consideration of the stage of healing and goals, a therapeutic intervention is designed to maximize the patient's participation and health-related quality of life.

A broad range of interventions, methods, techniques, equipment, activities using body movement, and medications are incorporated into this domain. These interventions are designed to enhance function by identifying, remediating, and preventing impairments and activity restrictions (functional limitations) to maximize participation. Rehabilitation is conducted in a wide variety of settings (eg, aquatic, clinic) with basic and contemporary equipment/modalities and on a wide range of patients with respect to age, overall health, and desired level of activity. Therapeutic interventions also include the use of prescription and nonprescription medications. For this reason, the athletic trainer needs to be knowledgeable about common prescription and nonprescription drug indications, adverse reactions, and interactions.

The competencies identified in this section should be considered in the context of the competencies identified in other content areas. For example, the knowledge and skills associated with the process of examination and documentation, while applicable for this content area, are not included here.

Therapeutic interventions include:

- Techniques to reduce pain
- Techniques to limit edema
- Techniques to restore joint mobility
- Techniques to restore muscle extensibility
- Techniques to restore neuromuscular function
- Exercises to improve strength, endurance, speed, and power
- Activities to improve balance, neuromuscular control, coordination, and agility
- Exercises to improve gait, posture, and body mechanics
- Exercises to improve cardiorespiratory fitness
- Functional exercises (eg, sports- or activity-specific)
- Exercises which comprise a home-based program
- Aquatic therapy
- Therapeutic modalities
  - superficial thermal agents (eg, hot pack, ice)
  - electrical stimulation
  - therapeutic ultrasound
  - diathermy
  - therapeutic low-level laser and light therapy
  - mechanical modalities
    - traction
    - intermittent compression
    - continuous passive motion
    - massage
    - biofeedback
- Therapeutic medications (as guided by applicable state and federal law)

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Knowledge and Skills

Physical Rehabilitation and Therapeutic Modalities

TI-1. Describe and differentiate the physiological and pathophysiological responses to inflammatory and non-inflammatory conditions and the influence of these responses on the design, implementation, and progression of a therapeutic intervention.

TI-2. Compare and contrast contemporary theories of pain perception and pain modulation.

TI-3. Differentiate between palliative and primary pain-control interventions.

TI-4. Analyze the impact of immobilization, inactivity, and mobilization on the body systems (eg, cardiovascular, pulmonary, musculoskeletal) and injury response.

TI-5. Compare and contrast the variations in the physiological response to injury and healing across the lifespan.

TI-6. Describe common surgical techniques, including interpretation of operative reports, and any resulting precautions, contraindications, and comorbidities that impact the selection and progression of a therapeutic intervention program.

TI-7. Identify patient- and clinician-oriented outcomes measures commonly used to recommend activity level, make return to play decisions, and maximize patient outcomes and progress in the treatment plan.

TI-8. Explain the theory and principles relating to expected physiological response(s) during and following therapeutic interventions.

TI-9. Describe the laws of physics that (1) underlay the application of thermal, mechanical, electromagnetic, and acoustic energy to the body and (2) form the foundation for the development of therapeutic interventions (eg, stress-strain, leverage, thermodynamics, energy transmission and attenuation, electricity).

TI-10. Integrate self-treatment into the intervention when appropriate, including instructing the patient regarding self-treatment plans.

TI-11. Design therapeutic interventions to meet specified treatment goals.
- **TI-11a.** Assess the patient to identify indications, contraindications, and precautions applicable to the intended intervention.
- **TI-11b.** Position and prepare the patient for various therapeutic interventions.
- **TI-11c.** Describe the expected effects and potential adverse reactions to the patient.
- **TI-11d.** Instruct the patient how to correctly perform rehabilitative exercises.
- **TI-11e.** Apply the intervention, using parameters appropriate to the intended outcome.
- **TI-11f.** Reassess the patient to determine the immediate impact of the intervention.

TI-12. Use the results of on-going clinical examinations to determine when a therapeutic intervention should be progressed, regressed or discontinued.

TI-13. Describe the relationship between the application of therapeutic modalities and the incorporation of active and passive exercise and/or manual therapies, including therapeutic massage, myofascial techniques, and muscle energy techniques.

TI-14. Describe the use of joint mobilization in pain reduction and restoration of joint mobility.

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TI-15. Perform joint mobilization techniques as indicated by examination findings.

TI-16. Fabricate and apply taping, wrapping, supportive, and protective devices to facilitate return to function.

TI-17. Analyze gait and select appropriate instruction and correction strategies to facilitate safe progression to functional gait pattern.

TI-18. Explain the relationship between posture, biomechanics, and ergodynamics and the need to address these components in a therapeutic intervention.

TI-19. Identify manufacturer, institutional, state, and/or federal standards that influence approval, operation, inspection, maintenance and safe application of therapeutic modalities and rehabilitation equipment.

TI-20. Inspect therapeutic equipment and the treatment environment for potential safety hazards.

Therapeutic Medications

TI-21. Explain the federal, state, and local laws, regulations and procedures for the proper storage, disposal, transportation, dispensing (administering where appropriate), and documentation associated with commonly used prescription and nonprescription medications.

TI-22. Identify and use appropriate pharmaceutical terminology for management of medications, inventory control, and reporting of pharmacological agents commonly used in an athletic training facility.

TI-23. Use an electronic drug resource to locate and identify indications, contraindications, precautions, and adverse reactions for common prescription and nonprescription medications.

TI-24. Explain the major concepts of pharmacokinetics and the influence that exercise might have on these processes.

TI-25. Explain the concepts related to bioavailability, half-life, and bioequivalence (including the relationship between generic and brand name drugs) and their relevance to the patient, the choice of medication, and the dosing schedule.

TI-26. Explain the pharmacodynamic principles of receptor theory, dose-response relationship, placebo effect, potency, and drug interactions as they relate to the mechanism of drug action and therapeutic effectiveness.

TI-27. Describe the common routes used to administer medications and their advantages and disadvantages.

TI-28. Properly assist and/or instruct the patient in the proper use, cleaning, and storage of drugs commonly delivered by metered dose inhalers, nebulizers, insulin pumps, or other parenteral routes as prescribed by the physician.

TI-29. Describe how common pharmacological agents influence pain and healing and their influence on various therapeutic interventions.

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TI-30. Explain the general therapeutic strategy, including drug categories used for treatment, desired treatment outcomes, and typical duration of treatment, for the following common diseases and conditions: asthma, diabetes, hypertension, infections, depression, GERD, allergies, pain, inflammation, and the common cold.

TI-31. Optimize therapeutic outcomes by communicating with patients and/or appropriate healthcare professionals regarding compliance issues, drug interactions, adverse drug reactions, and sub-optimal therapy.

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Psychosocial Strategies and Referral (PS)

Athletic trainers must be able to recognize clients/patients exhibiting abnormal social, emotional, and mental behaviors. Coupled with recognition is the ability to intervene and refer these individuals as necessary. Additionally, athletic trainers appreciate the role of mental health in injury and recovery and use interventions to optimize the connection between mental health and restoration of participation.

Knowledge and Skills

Theoretical Background

PS-1. Describe the basic principles of personality traits, trait anxiety, locus of control, intrinsic and extrinsic motivation, and patient and social environment interactions as they affect patient interactions.

PS-2. Explain the theoretical background of psychological and emotional responses to injury and forced inactivity (eg, cognitive appraisal model, stress response model).

PS-3. Describe how psychosocial considerations affect clinical decision-making related to return to activity or participation (eg, motivation, confidence).

PS-4. Summarize and demonstrate the basic processes of effective interpersonal and cross-cultural communication as it relates to interactions with patients and others involved in the healthcare of the patient.

PS-5. Summarize contemporary theory regarding educating patients of all ages and cultural backgrounds to effect behavioral change.

Psychosocial Strategies

PS-6. Explain the importance of educating patients, parents/guardians, and others regarding the condition in order to enhance the psychological and emotional well-being of the patient.

PS-7. Describe the psychological techniques (eg, goal setting, imagery, positive self-talk, relaxation/anxiety reduction) that the athletic trainer can use to motivate the patient during injury rehabilitation and return to activity processes.

PS-8. Describe psychological interventions (eg, goal setting, motivational techniques) that are used to facilitate a patient's physical, psychological, and return to activity needs.

PS-9. Describe the psychosocial factors that affect persistent pain sensation and perception (eg, emotional state, locus of control, psychodynamic issues, sociocultural factors, personal values and beliefs) and identify multidisciplinary approaches for assisting patients with persistent pain.

PS-10. Explain the impact of sociocultural issues that influence the nature and quality of healthcare received (eg, cultural competence, access to appropriate healthcare providers, uninsured/underinsured patients, insurance) and formulate and implement strategies to maximize client/patient outcomes.

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Mental Health and Referral

PS-11. Describe the role of various mental healthcare providers (eg, psychiatrists, psychologists, counselors, social workers) that may comprise a mental health referral network.

PS-12. Identify and refer clients/patients in need of mental healthcare.

PS-13. Identify and describe the basic signs and symptoms of mental health disorders (eg, psychosis, neurosis; sub-clinical mood disturbances (eg, depression, anxiety); and personal/social conflict (eg, adjustment to injury, family problems, academic or emotional stress, personal assault or abuse, sexual assault or harassment) that may indicate the need for referral to a mental healthcare professional.

PS-14. Describe the psychological and sociocultural factors associated with common eating disorders.

PS-15. Identify the symptoms and clinical signs of substance misuse/abuse, the psychological and sociocultural factors associated with such misuse/abuse, its impact on an individual's health and physical performance, and the need for proper referral to a healthcare professional.

PS-16. Formulate a referral for an individual with a suspected mental health or substance abuse problem.

PS-17. Describe the psychological and emotional responses to a catastrophic event, the potential need for a psychological intervention and a referral plan for all parties affected by the event.

PS-18. Provide appropriate education regarding the condition and plan of care to the patient and appropriately discuss with others as needed and as appropriate to protect patient privacy.

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Healthcare Administration (HA)

Athletic trainers function within the context of a complex healthcare system. Integral to this function is an understanding of risk management, healthcare delivery mechanisms, insurance, reimbursement, documentation, patient privacy, and facility management.

Knowledge and Skills

HA-1. Describe the role of the athletic trainer and the delivery of athletic training services within the context of the broader healthcare system.

HA-2. Describe the impact of organizational structure on the daily operations of a healthcare facility.

HA-3. Describe the role of strategic planning as a means to assess and promote organizational improvement.

HA-4. Describe the conceptual components of developing and implementing a basic business plan.

HA-5. Describe basic healthcare facility design for a safe and efficient clinical practice setting.

HA-6. Explain components of the budgeting process including: purchasing, requisition, bidding, request for proposal, inventory, profit and loss ratios, budget balancing, and return on investments.

HA-7. Assess the value of the services provided by an athletic trainer (eg, return on investment).

HA-8. Develop operational and capital budgets based on a supply inventory and needs assessment; including capital equipment, salaries and benefits, trending analysis, facility cost, and common expenses.

HA-9. Identify the components that comprise a comprehensive medical record.

HA-10. Identify and explain the statutes that regulate the privacy and security of medical records.

HA-11. Use contemporary documentation strategies to effectively communicate with patients, physicians, insurers, colleagues, administrators, and parents or family members.

HA-12. Use a comprehensive patient-file management system for appropriate chart documentation, risk management, outcomes, and billing.

HA-13. Define state and federal statutes that regulate employment practices.

HA-14. Describe principles of recruiting, selecting, hiring, and evaluating employees.

HA-15. Identify principles of recruiting, selecting, employing, and contracting with physicians and other medical and healthcare personnel in the deployment of healthcare services.

HA-16. Describe federal and state infection control regulations and guidelines, including universal precautions as mandated by the Occupational Safety and Health Administration (OSHA), for the prevention, exposure, and control of infectious diseases, and discuss how they apply to the practicing of athletic training.

HA-17. Identify key regulatory agencies that impact healthcare facilities, and describe their function in the regulation and overall delivery of healthcare.

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HA-18. Describe the basic legal principles that apply to an athletic trainer's responsibilities.

HA-19. Identify components of a risk management plan to include security, fire, electrical and equipment safety, emergency preparedness, and hazardous chemicals.

HA-20. Create a risk management plan and develop associated policies and procedures to guide the operation of athletic training services within a healthcare facility to include issues related to security, fire, electrical and equipment safety, emergency preparedness, and hazardous chemicals.

HA-21. Develop comprehensive, venue-specific emergency action plans for the care of acutely injured or ill individuals.

HA-22. Develop specific plans of care for common potential emergent conditions (eg, asthma attack, diabetic emergency).

HA-23. Identify and explain the recommended or required components of a pre-participation examination based on appropriate authorities' rules, guidelines, and/or recommendations.

HA-24. Describe a plan to access appropriate medical assistance on disease control, notify medical authorities, and prevent disease epidemics.

HA-25. Describe common health insurance models, insurance contract negotiation, and the common benefits and exclusions identified within these models.

HA-26. Describe the criteria for selection, common features, specifications, and required documentation needed for secondary, excess accident, and catastrophic health insurance.

HA-27. Describe the concepts and procedures for revenue generation and reimbursement.

HA-28. Understand the role of and use diagnostic and procedural codes when documenting patient care.

HA-29. Explain typical administrative policies and procedures that govern first aid and emergency care.

HA-30. Describe the role and functions of various healthcare providers and protocols that govern the referral of patients to these professionals.

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Professional Development and Responsibility (PD)

The provision of high quality patient care requires that the athletic trainer maintain current competence in the constantly changing world of healthcare. Athletic trainers must also embrace the need to practice within the limits of state and national regulation using moral and ethical judgment. As members of a broader healthcare community, athletic trainers work collaboratively with other healthcare providers and refer clients/patients when such referral is warranted.

Knowledge and Skills

PD-1. Summarize the athletic training profession's history and development and how current athletic training practice has been influenced by its past.

PD-2. Describe the role and function of the National Athletic Trainers' Association and its influence on the profession.

PD-3. Describe the role and function of the Board of Certification, the Commission on Accreditation of Athletic Training Education, and state regulatory boards.

PD-4. Explain the role and function of state athletic training practice acts and registration, licensure, and certification agencies including (1) basic legislative processes for the implementation of practice acts, (2) rationale for state regulations that govern the practice of athletic training, and (3) consequences of violating federal and state regulatory acts.

PD-5. Access, analyze, and differentiate between the essential documents of the national governing, credentialing and regulatory bodies, including, but not limited to, the NATA *Athletic Training Educational Competencies*, the BOC *Standards of Professional Practice*, the NATA *Code of Ethics*, and the BOC *Role Delineation Study/Practice Analysis*.

PD-6. Explain the process of obtaining and maintaining necessary local, state, and national credentials for the practice of athletic training.

PD-7. Perform a self-assessment of professional competence and create a professional development plan to maintain necessary credentials and promote life-long learning strategies.

PD-8. Differentiate among the preparation, scopes of practice, and roles and responsibilities of healthcare providers and other professionals with whom athletic trainers interact.

PD-9. Specify when referral of a client/patient to another healthcare provider is warranted and formulate and implement strategies to facilitate that referral.

PD-10. Develop healthcare educational programming specific to the target audience (eg, clients/patients, healthcare personnel, administrators, parents, general public).

PD-11. Identify strategies to educate colleagues, students, patients, the public, and other healthcare professionals about the roles, responsibilities, academic preparation, and scope of practice of athletic trainers.

PD-12. Identify mechanisms by which athletic trainers influence state and federal healthcare regulation.

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Clinical Integration Proficiencies (CIP)

The clinical integration proficiencies (CIPs) represent the synthesis and integration of knowledge, skills, and clinical decision-making into actual client/patient care. The CIPs have been reorganized into this section (rather than at the end of each content area) to reflect their global nature. For example, therapeutic interventions do not occur in isolation from physical assessment.

In most cases, assessment of the CIPs should occur when the student is engaged in real client/patient care and may be necessarily assessed over multiple interactions with the same client/patient. In a few instances, assessment may require simulated scenarios, as certain circumstances may occur rarely but are nevertheless important to the well-prepared practitioner.

The incorporation of evidence-based practice principles into care provided by athletic trainers is central to optimizing outcomes. Assessment of student competence in the CIPs should reflect the extent to which these principles are integrated. Assessment of students in the use of Foundational Behaviors in the context of real patient care should also occur.

Prevention & Health Promotion

CIP-1. Administer testing procedures to obtain baseline data regarding a client's/patient's level of general health (including nutritional habits, physical activity status, and body composition). Use this data to design, implement, evaluate, and modify a program specific to the performance and health goals of the patient. This will include instructing the patient in the proper performance of the activities, recognizing the warning signs and symptoms of potential injuries and illnesses that may occur, and explaining the role of exercise in maintaining overall health and the prevention of diseases. Incorporate contemporary behavioral change theory when educating clients/patients and associated individuals to effect health-related change. Refer to other medical and health professionals when appropriate.

CIP-2. Select, apply, evaluate, and modify appropriate standard protective equipment, taping, wrapping, bracing, padding, and other custom devices for the client/patient in order to prevent and/or minimize the risk of injury to the head, torso, spine, and extremities for safe participation in sport or other physical activity.

CIP-3. Develop, implement, and monitor prevention strategies for at-risk individuals (eg, persons with asthma or diabetes, persons with a previous history of heat illness, persons with sickle cell trait) and large groups to allow safe physical activity in a variety of conditions. This includes obtaining and interpreting data related to potentially hazardous environmental conditions, monitoring body functions (eg, blood glucose, peak expiratory flow, hydration status), and making the appropriate recommendations for individual safety and activity status.

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Clinical Assessment & Diagnosis / Acute Care / Therapeutic Intervention

CIP-4. Perform a comprehensive clinical examination of a patient with an upper extremity, lower extremity, head, neck, thorax, and/or spine injury or condition. This exam should incorporate clinical reasoning in the selection of assessment procedures and interpretation of findings in order to formulate a differential diagnosis and/or diagnosis, determine underlying impairments, and identify activity limitations and participation restrictions. Based on the assessment data and consideration of the patient's goals, provide the appropriate initial care and establish overall treatment goals. Create and implement a therapeutic intervention that targets these treatment goals to include, as appropriate, therapeutic modalities, medications (with physician involvement as necessary), and rehabilitative techniques and procedures. Integrate and interpret various forms of standardized documentation including both patient-oriented and clinician-oriented outcomes measures to recommend activity level, make return to play decisions, and maximize patient outcomes and progress in the treatment plan.

CIP-5. Perform a comprehensive clinical examination of a patient with a common illness/condition that includes appropriate clinical reasoning in the selection of assessment procedures and interpretation of history and physical examination findings in order to formulate a differential diagnosis and/or diagnosis. Based on the history, physical examination, and patient goals, implement the appropriate treatment strategy to include medications (with physician involvement as necessary). Determine whether patient referral is needed, and identify potential restrictions in activities and participa-tion. Formulate and communicate the appropriate return to activity protocol.

CIP-6. Clinically evaluate and manage a patient with an emergency injury or condition to include the assessment of vital signs and level of consciousness, activation of emergency action plan, secondary assessment, diagnosis, and provision of the appropriate emergency care (eg, CPR, AED, supplemental oxygen, airway adjunct, splinting, spinal stabilization, control of bleeding).

Psychosocial Strategies and Referral

CIP-7. Select and integrate appropriate psychosocial techniques into a patient's treatment or rehabilitation program to enhance rehabilitation adherence, return to play, and overall outcomes. This includes, but is not limited to, verbal motivation, goal setting, imagery, pain management, self-talk, and/or relaxation.

CIP-8. Demonstrate the ability to recognize and refer at-risk individuals and individuals with psychosocial disorders and/or mental health emergencies. As a member of the management team, develop an appropriate management plan (including recom-mendations for patient safety and activity status) that establishes a professional helping relationship with the patient, ensures interactive support and education, and encourages the athletic trainer's role of informed patient advocate in a manner consistent with current practice guidelines.

Healthcare Administration

CIP-9. Utilize documentation strategies to effectively communicate with patients, physicians, insurers, colleagues, administrators, and parents or family members while using appropriate terminology and complying with statues that regulate privacy of medical records. This includes using a comprehensive patient-file management system (including diagnostic and procedural codes) for appropriate chart documentation, risk management, outcomes, and billing.

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Athletic Training Major 4 yr. Degree Plan

*Athletic Training Pre-Admission Courses are in **BOLD** print, Sophomore year needs to be completed in correct sequence for the student to be able to be admitted into the program*

Freshman:	***Fall***	
ALU/HSL 122	Freshman Leadership Seminar/HSL (1 or 2 credits)	1
ART ---	Art Core (ART 108, 115, 116, MUS 196, ENG 130)	3
BIO 103	**General Biology** (Math-Science)	**4**
ENG 121/COM 110	College Comp II/Oral Communcations	3
PED 157	**First Aid (1/2 of sememster)**	**1**
PED 159	**Personal and Community Health (1/2 of sememster)**	**3**
POL 101/ANT 171	Responsible Citzenship (Core)/Culture Anthropology (Core)	3
		18
	Spring	
ANT 171/POL 101	Culture Anthropology (Core)/Responsible Citzenship (Core)	3
ATH 121	Intro to Athletic Training	1
ATH 151	**Intro to Athletic Training Taping Tech**	**1**
ATH 238	**Prevention & Care of Athletic Injuries**	**2**
ENG 121/COM 110	College Comp II/Oral Communcations	3
HPS 206	**Medical Terminology**	**2**
THE	Theology (Core 104, 108, 110)	3
	Spring Credits	***15***
	Total Freshman Credits	***33***

Sophomore:	***Fall***	
ATH 243	**Intro to Clinical Education in Athletic Training I**	**2**
BIO 207	**Human Anatomy and Physiology I** (Math-Science)	**4**
CIS 101	Intro to Computers	3
PHI 108	Search for truth	3
PSY 201	Introduction to Psychology (Social and Behavioral Science)	3
	Fall Credits	***15***
	Spring	
THE/PHI	Required core (THE wellness)	3
ATH 200	Intro to Clinical Experience	1
ATH 244	**Intro to Clinical Education in Athletic Training II**	**3**
ATH 314	**Advanced Techniques in Athletic Training**	**3**
BIO 208	**Human Anatomy and Physiology II (Math-Science)**	**4**
PED 360	**Biomechanical and Kinesiological Studies**	**4**
	Spring Credits	***18***
	Total Sophomore Credits	***33***

Junior:	***Fall***	
ATH 300	Clinical Experience I	1
ATH 327	Evaluative Procedures in Athletic Training I	4
ATH 329	Therapeutic Modalities in Athletic Training	3
ATH 353	General Medical Conditions in Athletic Training	3
MAT 180	Elementary Statistics/Applied Statistics (Liberal Arts)	4
	Fall Credits	***15***
	Spring	
ATH 305	Clinical Experience II	1
ATH 316	Basic Pharmacology for Human Performance Sciences	3
ATH 319	Therapeutic Exercise in Athletic Training	3
ATH 328	Evaluative Procedures in Athletic Training II	2

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PSY 207	Life Span Development (Social Science)	3
	Spring Credits	***12***
	Total Junior Credits	***27***
Senior:	***Fall***	
ATH 400	Clinical Experience III	1
ATH 441	Practicum in Athletic Training (or spring)	1
ATH 453	Athletic Training Senior Capstone I	3
ATH 354	Healthcare Administration	3
EXS 336	Exercise Physiology	4
	Fall Credits	***12***
	Spring	
ALU 499	Senior Outcomes Assessment: HPS	0
ATH 317	Sports Nutrition for Health and Performance	3
ATH 405	Clinical Experience IV	1
PHY 3xx	Psychology of Injury	3
ATH 454	Athletic Training Senior Capstone II	3
PHI/TH	Core	3
	Spring Credits	***13***
	Total Senior Credits	***25***
	Total Credits	***118***

The prospective student must have successfully completed the following courses with a grade of B or better to be admitted into the professional program: ATH 151, 238, 243; and PED 157; successfully completed the following courses with a grade of C- or better: BIO 103, 207; HPS 206; PED 159; have a minimum cumulative GPA of 2.5 on a 4.0 scale for Required course work (including transfer courses); and maintain First Aid and Emergency Cardiac Care Certification.

Athletic Training Education Program Professional Course Requirements:

ATH 200,244,300,305,314,316,317,319,327,328,329,353,354,400,405,441,453,454
EXS 336; PSY 201,207; MAT 180

Wellness Minor Requirements: HPS 310, PSY 207, ATH 317 or SCI 224, THE 302, 320, 363

Electives (8 Credits chosen among the following courses: ATH 238, BUS 215, 362, 371, 381; EXS 302; PSY 307, 308, 406; PED 159, 267, 326; THE 215 or 315).

Application and Admission to the U-Mary Physical Therapy Program Core Requirements:

BIO 207,208, 209; PSY 207,406; CHE 109 or 111, 110 or 112, PHY 204, 304
GPA above 3.5 recommended in these courses

CURRICULUM SUBJECT TO CHANGE

UND AT

2.42

B.S. in Athletic Training

[Req]uired 127 credits (36 of which must be numbered 300 or above, and 60 of which must be from a 4-year institution) [in]cluding:

I. Essential Studies Requirements (see University ES listing).

II. The following curriculum:

Pre-Admission Courses

The student must earn a letter grade of C or better in the following courses to be admitted in the program.

BIOL 150 & 150L	General Biology I and General Biology I Laboratory	4

The student must earn a letter grade of B or better in the following courses to be admitted in the program.

FMED 101	Orientation to Athletic Training	1
FMED 207	Prevention and Care of Athletic Injuries	2
FMED 207L	Laboratory Prevention and Care of Athletic Injuries	1

At the time of application to the Athletic Training Program, the student must have completed or be enrolled in all of the above courses. In addition, the student must show proof of First Aid and CPR certifications or enrollment in:

KIN 110	First Aid and CPR	1

Core Courses

The following core courses are required for the B.S. in Athletic Training:

[CH]EM 121 & 121L	General Chemistry I and General Chemistry I Laboratory **	4
COMM 110	Fundamentals of Public Speaking **	3
ENGL 110	College Composition I **	3
ENGL 130	Composition II: Writing for Public Audiences	3
MED 205	Medical Terminology	1
PHYS 161	Introductory College Physics I (includes lab) **	4
PHYS 162	Introductory College Physics II (includes lab) **	4
PSYC 111	Introduction to Psychology **	3
PSYC 241	Introduction to Statistics **	4
PSYC 250	Developmental Psychology	4
SOC 110	Introduction to Sociology **	3
Arts & Humanities Requirement **		9
Electives		16
Total Credits		**61**

Professional Courses

The following are essential professional courses to become an entry-level athletic trainer:

ANAT 204	Anatomy for Paramedical Personnel	3
FMED 205	Anatomy for Athletic Trainers	2
FMED 208	Procedures in Athletic Training	1
FMED 208L	Laboratory Procedures in Athletic Training	1
FMED 200	Understanding Medicine	3
FMED 211	Beginning Clinical Practicum I in Athletic Training	1
FMED 213	Beginning Clinical Practicum in Athletic Training	1
FMED 311	Intermediate Clinical Practicum I in Athletic Training	2
FMED 312	Medical Aspects of Sports	2
FMED 313	Intermediate Clinical Practicum II in Athletic Training	2
FMED 320	Athletic Training Modalities	2
FMED 320L	Laboratory Athletic Training Modalities	1
FMED 321	Athletic Training Rehabilitation Techniques	2
FMED 321L	Laboratory Athletic Injury Rehabilitation Techniques	1
FMED 343	Organizational Administration of Athletic Training	3
FMED 411	Advanced Clinical Practicum I in Athletic Training	2
FMED 413	Advanced Clinical Practicum II in Athletic Training	2
FMED 481	Athletic Injury Assessment	4
FMED 491	Seminar in Athletic Training	2
FMED 497	Internship in Athletic Training	3
NUTR 240	Fundamentals of Nutrition	3
KIN 332	Biomechanics	3
KIN 402	Exercise Physiology	3
PPT 301	Human Physiology	4
PPT 320	Pharmacology in Sport	2

Courses

FMED 101. Orientation to Athletic Training. 1 Credit.
Overview of the field of athletic training. Survey of the role of the athletic trainer. Films, lectures, and observation in nical settings. F,S.

MED 200. Understanding Medicine. 3 Credits.
n overview of the broad parameters of family medicine. Guest speakers are brought in to discuss various facets of medicine. S.

FMED 205. Anatomy for Athletic Trainers. 2 Credits.
A course to learn and palpate human anatomy structures and their functions. Prerequisite: Deparment consent. F.

FMED 207. Prevention and Care of Athletic Injuries. 2 Credits.
An introductory course into the care and treatment of athletic injuries. Corequisite: FMED 207L. F,S.

FMED 207L. Laboratory Prevention and Care of Athletic Injuries. 1 Credit.
A practical laboratory to develop athletic taping skills taught in FMED 207. Corequisite: FMED 207. F,S.

FMED 208. Procedures in Athletic Training. 1 Credit.
This course serves as an orientation class for incoming sports health majors. Policies and procedures as well as record keeping are covered. Prerequisites: FMED 207 and FMED 207L. Corequisite: FMED 205 and FMED 208L. F.

FMED 208L. Laboratory Procedures in Athletic Training. 1 Credit.
A course designed to allow students to get practical experiences in injury management, modality usage and record keeping skills taught in FMED 208. Prerequisites: FMED 207 and FMED 207L. Corequisite: FMED 205 and FMED 208. F.

FMED 211. Beginning Clinical Practicum I in Athletic Training. 1 Credit.
A clinical course designed to allow the student to develop specified clinical competencies in a directed, progressive manner. Prerequisites: FMED 101, FMED 207 and FMED 207L. Corequisite: FMED 208 and FMED 208L. F.

FMED 213. Beginning Clinical Practicum in Athletic Training. 1 Credit.
A clinical course designed to allow the student to develop specified clinical competencies in a directed, progressive manner. Prerequisites: FMED 208 and FMED 208L. S.

ED 311. Intermediate Clinical Practicum I in Athletic Training. 2 Credits.
linical course designed to allow the student to develop specified clinical competencies in a directed progressive anner. Prerequisite: FMED 213. F.

FMED 312. Medical Aspects of Sports. 2 Credits.
A course designed to introduce students to various medical specialities and medical problems and their effects on athletic participation. Prerequisite: Permission of instructor. F.

FMED 313. Intermediate Clinical Practicum II in Athletic Training. 2 Credits.
A clinical course designed to allow students to develop specified clinical competencies in a directed progressive manner. Prerequisite: FMED 481. Corequisite: FMED 320, FMED 321 and FMED 321L. S.

FMED 320. Athletic Training Modalities. 2 Credits.
A course designed to present the theoretical and applied principles and techniques for the application of modalities in sports injury care. Prerequisite: FMED 481. S.

FMED 320L. Laboratory Athletic Training Modalities. 1 Credit.
A course designed to practice the theoretical and applied principles and techniques for the application of modalities in sports injury care. Prerequisite: FMED 481. Corequisite: FMED 320. S.

FMED 321. Athletic Training Rehabilitation Techniques. 2 Credits.
A course designed to explain the principles and techniques of rehabilitation as they apply to athletic injuries. Prerequisite: FMED 481. Corequisite: FMED 321L. S.

FMED 321L. Laboratory Athletic Injury Rehabilitation Techniques. 1 Credit.
A course designed to allow students practical skill development of rehabilitation techniques utilized in athletic injury care as taught in FMED 321. Prerequisite: FMED 481. Corequisite: FMED 321. S.

FMED 343. Organizational Administration of Athletic Training. 3 Credits.
ourse designed to acquaint students with the theories and principles of administration. Administrative functions as relate to the athletic trainer will be explained. Prerequisite: Senior standing or consent of instructor. S.

FMED 411. Advanced Clinical Practicum I in Athletic Training. 2 Credits.
A clinical course designed to allow the student to develop specified clinical competencies in a directed progressive manner. Prerequisite: FMED 313. F.

FMED 413. Advanced Clinical Practicum II in Athletic Training. 2 Credits.
A clinical course designed to allow the student to develop specified clinical competencies in a directed progressive manner. Prerequisite: FMED 313. S.

FMED 481. Athletic Injury Assessment. 4 Credits.
A course designed to instruct the student in the theories and skills of injury evaluation. Prerequisite: FMED 213. F.

FMED 491. Seminar in Athletic Training. 2 Credits.
Advanced work in athletic training to include surgical and conservative injury management, rehabilitation and injury. Repeatable to 4 credits. Prerequisite: Permission of instructor. F,S.

FMED 494. Directed Studies in Athletic Training. 1-4 Credits.
An in-depth study in a subject area selected by the student under tutorial supervision. Repeatable to 6 credits. Prerequisite: Instructor approval. F,S.

FMED 497. Internship in Athletic Training. 3 Credits.
Off campus athletic training experience designed to expose the student to alternate concepts of care. Repeatable up to 6 credits with instructor permission. Prerequisite: FMED 313. F,S,SS.

UND PT

Doctor of Physical Therapy (D.P.T.)

Admission Requirements

Pre-Physical Therapy

Prior to admission, a minimum of 90 semester hours of credit from an approved college or university is required. Students should be broadly educated in the sciences and humanities. The Department of Physical Therapy recognizes that, since physical therapy deals with people, an understanding of literature, art, history, ethics, and philosophy is an adjunct to a physical therapist. Science and humanities are both viewed as necessary for the practice of physical therapy.

The following list of courses and credits indicates the core prerequisites all applicants must complete prior to admission to the physical therapy program. It is strongly recommended that students be computer literate prior to entering the professional program. Students may take additional electives from any field of study; however, the depth of the pre-physical therapy education should demonstrate that students have progressed from simple to complex studies in at least one content area. This requirement might typically be demonstrated by a discipline major, but in any case should demonstrate a basic comprehensiveness and integrity of study within a particular content area. This does not suggest that a separate undergraduate degree must be awarded; however, the breadth and depth in a discipline should be demonstrated. Course credits equivalent to a minor, i.e., approximately 20 credits at UND, in a particular discipline could accomplish this requirement. The prospective student should include eight (8) credits from upper level courses, i.e., 300 and/or 400 numbers.

- Two semesters of General Biology (8 cr.)
- Two semesters of General Chemistry (8 cr.)
- Two semesters of General Physics (8 cr.)
- One semester of Human Anatomy (3 cr.)
- One semester of Human Physiology (3 to 4 cr.)
- One semester of Introductory Psychology (3 cr.)
- One semester of Developmental Psychology (3 to 4 cr.)
- One semester of Abnormal Psychology (3 cr.)
- One semester of a Public Speaking course (3 cr.)
- One semester of an undergraduate statistics course (3 cr.)
- Essential Studies requirements

All of the prerequisite coursework must be completed before entering the professional program; however, the prospective student may be enrolled in pre-professional coursework at the time of application. Students must apply for the professional program through the PTCAS system. WICHE-eligible students should apply through the WICHE certification process. Please refer to the UND-PT website at: www.med.und.edu/physical-therapy for application details.

Admission Requirements

Acceptance is on a competitive basis, with the major determinant being the basic science grade point average. The basic science GPA is defined as: biology (eight semester credits), chemistry (eight semester credits), physics (eight semester credits), anatomy (three semester credits), physiology (four semester credits), and psychology (seven semester credits). In addition to the science GPA, GRE score, and cumulative GPA, an interview and letters of reference will be considered in the admission process. Prospective students are expected to complete at least 60 hours of physical therapy observation prior to application.

The applicant must meet the School of Graduate Studies's current minimum general admission rquirements as published in the graduate catalog.

1. Completion of the application for admission to the professional program and UND School of Graduate Studies application form.
2. Submission of score from the Graduate Record Examination General Test.
3. Satisfy the School of Graduate Studies' English Language Proficiency requirements as published in the graduate catalog.
4. Applicants who have received their bachelors or masters degree in the United States or English-speaking Canada are not required to submit the TOEFL or IELTS.

Degree Requirements

1. Students must be formally accepted into the professional education component of the DPT and endorsed by the Chair of Physical Therapy. NOTE: Acceptance by the UND Office of Admissions or the School of Graduate Studies does not constitute acceptance into the professional program in Physical Therapy.
2. The professional education component of the DPT will require three academic years and two summer sessions following completion of the pre-physical therapy entrance requirements.
3. No student will be allowed to remain in the program or complete the full-time clinical experiences unless he/she attains a letter grade of at least "C" in the major courses.
4. To advance to candidacy, the student must successfully complete the first year comprehensive examination, and maintain a cumulative School of Graduate Studies GPA of > 3.00 AND/OR a summer session GPA of > 3.00. Students who fail to advance to candidacy during the first year will be dismissed from the professional program.
5. After advancement to candidacy, the student is expected to maintain a cumulative GPA of > 3.00. The School of Graduate Studies will monitor the cumulative GPA, which must be > 3.00. If the cumulative GPA is not > 3.00, the School of Graduate Studies policies for probation and dismissal for GPA will govern the student's status.
6. Students in the professional program should be aware that there are special requirements for clinical uniforms, professional liability insurance, medical insurance, immunizations, CPR certification, and completion of a criminal background check. These requirements must be met prior to any clinical contact with patients. The student will also be responsible for travel, housing, and food costs, in addition to the payment of tuition and fees, during the full-time clinical experience semesters. The majority of these experiences will be completed at geographical locations other than the City of Grand Forks.
7. Prospective students should be aware that a felony conviction may affect a graduate's ability to obtain a professional license to practice physical therapy.
8. The faculty reserves the right to place on professional probation or to cancel the registration of any student in Physical Therapy whose performance in the classroom or the clinic is unsatisfactory.

Pre-Physical Therapy

Course	Title	Credits
ENGL 110	College Composition I	3
ENGL 120 or ENGL 125		3
COMM 110	Fundamentals of Public Speaking	3
Fine Arts and Humanities *		9
BIOL 150 & BIOL 151	General Biology I and General Biology II	8
CHEM 121 & CHEM 122	General Chemistry I and General Chemistry II	8
Social Science		3
PSYC 111	Introduction to Psychology	3
PHYS 161 & PHYS 162	Introductory College Physics I and Introductory College Physics II	8
ANAT 204	Anatomy for Paramedical Personnel	3
PPT 301	Human Physiology	4
PSYC 250	Developmental Psychology	4
PSYC 270	Abnormal Psychology	3
Statistics		3
Cognate/Minor (required)		
Electives (required, minimum of 20 with emphasis in a single discipline)		

Bachelor of General Studies Degree with Health Studies Option

This degree will be available to Physical Therapy students who:

1. do not already have a baccalaureate degree,
2. have completed at least 30 of the 90 pre-Physical Therapy credits at UND before beginning Professional Year One,
3. have successfully completed fall and spring semesters of Professional Year One.

The BGS degree would normally then be awarded at the end of the spring semester of Professional Year One if the student has completed all general UND graduation requirements:

1. 125 total credits,
2. 60 credits from 4-year schools, including at least 30 from UND,
3. 36 upper-level credits,
4. all essential studies requirements.

2.49

Professional Program - Physical Therapy

Professional Year 1		
Fall		**Credits**
PT 401	Intervention Techniques I	2
PT 402	Professional Communication and Behavior	2
PT 422	Anatomy for Physical Therapy	5
PT 423	Neuroscience for Physical Therapy	4
PT 510	Integrated Clinical Experience	0-1
PT 513	Intervention Techniques II	3
Spring		
PT 409	Clinical Pathology I	4
PT 412	Biomechanics and Kinesiology	4
PT 413	Exercise in Health and Disease	3
PT 415	Motor Control	3
PT 417	Clinical Exam and Evaluation I	4
PT 426	Manual Therapy I	2
PT 510	Integrated Clinical Experience	0-1
Summer		
PT 410	Clinical Pathology II	3
PT 512	Therapeutic Agents	3
PT 514	Case Management I	2
PT 510	Integrated Clinical Experience	0-1
PT 519	Electrotherapy and Electrodiagnosis	2
Professional Year 2		
Fall		
PT 521	Critical Inquiry I	1
PT 528	Clinical Education I	9
PT 529	Clinical Education II	9
Spring		
PT 522	Administration in Physical Therapy	3
PT 523	Lifespan I	3
PT 524	Psychological Aspects of Disability	2
PT 525	Clinical Examination and Evaluation II	3
PT 527	Critical Inquiry II	2
PT 540	Cardiopulmonary Physical Therapy	2
PT 584	Evidence in Practice	2
Electives		0-2

3.50

Summer		
PT 535	Lifespan II	2
PT 562	Readings:Physical Therapy	2
PT 591	Research in Physical Therapy	2
PT 592	Case Management II	2
Electives		1-2
Professional Year 3		
Fall		
PT 511	Applied Movement Science and Rehabilitation Procedures	4
PT 526	Manual Therapy II	2
PT 539	Prevention and Wellness	2
PT 541	Clinical Examination and Evaluation III	3
Electives		1-3
Spring		
PT 552	Clinical Education III	9
PT 553	Clinical Education IV	9
PT 995	Scholarly Project	1
	Total Credits:	**122-130**

2.51

Courses

PT 510. Integrated Clinical Experience. 1 Credit.
Short-term clinical experience to provide hands-on experience for students to apply knowledge learned during the first year of the professional program. Experiences will be set up in acute care, sub-acute care, long-term care, out-patient orthopedic, or a rural site. Registered in Professional Physical Therapy Curriculum is the prerequisite. F,S,SS.

PT 511. Applied Movement Science and Rehabilitation Procedures. 4 Credits.
Integration of clinical evaluation, functional goals, and treatment planning for individuals with neurological and multiple musculoskeletal dysfunction. The primary focus is on rehabilitation skills including assessment, exercise, handling techniques, functional activities, equipment prescription, patient education, and ADLs, as well as community mobility and governmental services. Laboratory. Prerequisite: Registered in Professional Physical Therapy Curriculum.

PT 512. Therapeutic Agents. 3 Credits.
Theory and application of various hydrotherapy, phototherapy, and thermotherapy modalities in Physical Therapy, including heat, light, sound, and water. Laboratory. Prerequisite: Registered in Professional Physical Therapy Curriculum.

PT 513. Intervention Techniques II. 3 Credits.
Theory and practical application of introductory patient care techniques in physical therapy. Laboratory. Prerequisite: Registered in Professional Physical Therapy Curriculum.

PT 514. Case Management I. 2 Credits.
Theory and practical application of introductory patient care techniques in physical therapy. Laboratory. Prerequisite: Registered in Professional Physical Therapy Curriculum.

PT 519. Electrotherapy and Electrodiagnosis. 2 Credits.
Theory and application of therapeutic electrical currents, biofeedback, electromyography, and nerve conduction velocity in physical therapy. Laboratory Prerequisite: Registered in Professional Physical Therapy Curriculum.

PT 521. Critical Inquiry I. 1 Credit.
Introduction to the collection of clinical data leading to a case study report. Prerequisite: Registered in Professional Physical Therapy Curriculum.

PT 522. Administration in Physical Therapy. 3 Credits.
Lectures/discussion and seminar formats used to explore concepts of administration procedures as applied to Physical Therapy and the health care delivery system. Prerequisite: Registered in Professional Physical Therapy Curriculum.

PT 523. Lifespan I. 3 Credits.
Course focus is on rehabilitation issues related to pediatrics including the characteristics of disabling conditions, developmental evaluation and intervention, the use of adaptive equipment, legal issues, and strategies to promote collaborative service provision to children and families. Laboratory. Prerequisite: Registered in Professional Physical Therapy Curriculum.

PT 524. Psychological Aspects of Disability. 2 Credits.
Readings and discussion course. Study of psychological coping mechanisms, reactions, and motivational factors pertinent to people with disabilities. Review of adjustment problems unique to specific disabilities and/or disease processes, including terminal illness. Prerequisite: Registered in Professional Physical Therapy Curriculum.

PT 525. Clinical Examination and Evaluation II. 3 Credits.
Emphasis is given to physical therapy examination, evaluation, and diagnoses as related to an advanced dynamic biomechanical evaluation. Also included will be the integration of NMS and support systems; clinical reasoning resulting in referral and/or modified physical therapy interventions; and the communication of findings and recommendations. Lecture & Laboratory. Prerequisite: Registered in Professional Physical Therapy Curriculum. F,S.

PT 526. Manual Therapy II. 2 Credits.
Theory and application of manual therapy skills for examination and intervention techniques, including thrust and nonthrust manipulations of the spine, pelvis, and associated areas. Laboratory. Prerequisite: Registered in Professional Physical Therapy Curriculum.

PT 527. Critical Inquiry II. 2 Credits.
Application, analysis, and evaluation of clinical decisionmaking components, strategies, and skills. Preparation of a clinical case study to be presented in oral and written forms. Prerequisite: Registered in Professional Physical Therapy Curriculum.

PT 528. Clinical Education I. 9 Credits.
The first in a sequence of four full-time clinical experiences in selected physical therapy provider centers throughout the United States. Prerequisite: Registered in Professional Physical Therapy Curriculum.

PT 529. Clinical Education II. 9 Credits.
The second in a sequence of four full-time clinical experiences in selected physical therapy provider centers throughout the United States. Prerequisite: Registered in Professional Physical Therapy Curriculum.

PT 535. Lifespan II. 2 Credits.
Examine the factors and forces that affect life quality in later years. The physiological, psychological, and sociological aspects of aging will be considered, including those influences in the cultural context that enhance and impede continued growth of the person. Laboratory. Prerequisite: Registered in Professional Physical Therapy Curriculum.

PT 537. Strategies Early Intervention. 2 Credits.
This course is designed to review current practices in early intervention. Course materials will focus on characteristics of disabling conditions that influence growth and development of motor skills, cognition, and educational development. Emphasis will be on collaborative service provision with an interdisciplinary approach. Topics also covered include: current issues, assessment of the child/family unit, and legislative guidelines for service provision. Prerequisite: Registered in Professional Physical Therapy Curriculum.

PT 538. Advanced Topics in Pediatric Physical Therapy. 3 Credits.
This course is designed to present current and advanced topics relating to pediatric physical therapy clients and their families. Prerequisite: Registered in Professional Physical Therapy Curriculum.

PT 539. Prevention and Wellness. 2 Credits.
The theory and practice of prevention of injury, maintenance and improvement of wellness, and promotion of health and healthy behaviors across the lifespan. Concepts are applied to the general, athletic, and industrial populations, with a view to interdisciplinary involvement in wellness optimization. Prerequisite: Registered in Professional Physical Therapy Curriculum.

PT 540. Cardiopulmonary Physical Therapy. 2 Credits.
This course is designed to expand the theoretical understanding and clinical application of cardiopulmonary physical therapy examination, evaluation, diagnosis, prognosis, intervention and outcomes. Laboratory. Prerequisite: Registered in Professional Physical Therapy Curriculum.

PT 541. Clinical Examination and Evaluation Ill. 3 Credits.
Emphasizes patient/client management elements of examination and evaluation. Emphasis is given to systems screening, physical therapy diagnoses, and clinical reasoning resulting in referral and /or modified physical therapy interventions. Emphasis is also given to the communication of findings. Laboratory. Registered in Professional Physical Therapy Curriculum is the prerequisite. F.

PT 549. Advanced Applied Anatomy/Clinical Kinesiology. 2 Credits.
Study of applied anatomy and its importance to research and clinical application, particularly as related to Physical Therapy. Prerequisite: Registered in Professional Physical Therapy Curriculum.

PT 552. Clinical Education III. 9 Credits.
The third in a sequence of four full-time clinical experiences in selected physical therapy provider centers throughout the United States. Prerequisite: Registered in Professional Physical Therapy Curriculum.

PT 553. Clinical Education IV. 9 Credits.
The fourth in a sequence of four full-time clinical experiences in selected physical therapy provider centers throughout the United States. Prerequisite: Registered in Professional Physical Therapy Curriculum.

PT 561. Seminar:Physical Therapy. 1-4 Credits.
This course serves to focus student attention toward graduate study in Physical Therapy. Explore and discuss areas of interest for students and faculty. May repeat to 4 credits maximum. Prerequisite: Registered in Professional Physical Therapy Curriculum.

PT 562. Readings:Physical Therapy. 1-4 Credits.
Review of current literature pertinent to Physical Therapy; critical examination of design, content, and validity of conclusions. Prerequisite: Registered in Professional Physical Therapy Curriculum.

PT 572. Teaching Experience in Physical Therapy. 1-4 Credits.
Supervised experience in University teaching in Physical Therapy. Projects in curriculum development, formulation of teaching/learning objectives, teaching materials, evaluation tools, and experience in competency-based learning environment. Prerequisite: Registered in Professional Physical Therapy Curriculum.

PT 583. Critical Inquiry III. 1 Credit.
Introduction to research instruments including surveys, electrical and mechanical instrumentation critical to research methods. Includes discussion of validation, calibration, and reliability of instruments used in physical therapy research. Students develop a proposal for their scholarly projects and complete IRB use of human subject forms. Prerequisite: Registered in Professional Physical Therapy Curriculum.

PT 584. Evidence in Practice. 2 Credits.
Application of qualitative and quantitative research designs. Interpretation of statistical tests used in evidence-based medicine. Critical review of current articles related to diagnosis, prognosis, therapy, harm, cost, systematic reviews, meta-analysis, and clinical practice guidelines. Application of evidence to physical therapy practice. Prerequisite: Registered in Professional Physical Therapy Curriculum. S.

PT 590. Directed Studies:Clinical Concepts in Physical Therapy. 1-12 Credits.
Individualized study of a particular area of interest for the student approved by his/her major advisor and supervised by preceptors with specialty and/or recognized expertise in the area of interest. Study may include library research, clinical research, discussion/seminars, projects, and directed clinical experience. Prerequisite: Registered in Professional Physical Therapy Curriculum.

PT 591. Research in Physical Therapy. 2 Credits.
Students develop the ability to effectively and accurately interpret and communicate results/clinical outcomes as a component of the written Scholarly Project. Frequent group and/or individual meetings with the advisor incorporate peer review discussion to facilitate student development of professional written and oral communication skills. Prerequisite: Registered in Professional Physical Therapy Curriculum. SS.

PT 592. Case Management II. 2 Credits.
Case management, with emphasis on the teaching and learning process and techniques targeted to promote and optimize physical therapy services, including advocacy. Strategies appropriate for conflict resolution are introduced. Professional development as a practitioner of physical therapy is emphasized through introduction and preliminary development of a portfolio. Prerequisite: Registered in Professional Physical Therapy Curriculum.

PT 995. Scholarly Project. 1 Credit.
Students provide a final written and oral report to the faculty on the results of their collaborative Scholarly Project. Prerequisite: Registered in Professional Physical Therapy Curriculum.

PT 996. Continuing Enrollment. 1-12 Credits.

PT 997. Research III:Independent Study. 2 Credits.

UND OT

Master of Occupational Therapy (M.O.T.)

Admission Requirements

Pre-Occupational Therapy

A pre-OT student typically spends the first two years as a pre-major at the University of North Dakota to complete the program prerequisites. In the beginning of the sophomore year when the student is completing the required courses as listed below, he/she must make written application for admission to the professional occupational therapy program. The CLEP in natural sciences will not meet the Biology and Chemistry requirements in Occupational Therapy. Students should *carefully* check all CLEP exams for potential acceptance at UND. A student must have at least a C in all prerequisite courses. The student must also obtain a minimum of a C in all professional level courses.

The following courses are required to be taken prior to professional program:

Course	Title	Credits
ENGL 110	College Composition I	3
ENGL 120 or ENGL 125		3
COMM 110	Fundamentals of Public Speaking	3
BIOL 150 & 150L or BIOL 151 & 151L	General Biology I and General Biology I Laboratory General Biology II and General Biology II Laboratory	4
CHEM 115 & 115L or CHEM 121 & 121L	Introductory Chemistry and Introductory Chemistry Laboratory General Chemistry I and General Chemistry I Laboratory	4
MATH 103	College Algebra	3
PSYC 111	Introduction to Psychology	3
PSYC 241 or SOC 326	Introduction to Statistics * Sociological Statistics	4-3
PSYC 250	Developmental Psychology	4
PSYC 270	Abnormal Psychology	3
ANAT 204	Anatomy for Paramedical Personnel	3
ANAT 204L	Anatomy for Paramedical Personnel Laboratory	2
SOC 110	Introduction to Sociology	3
PPT 301	Human Physiology	4
OT 200	Introduction to Occupational Therapy	2
Arts and Humanities Electives **		9
Total Credits		**57-56**

2.55

* As a prerequisite for PSYC 241 Introduction to Statistics, student needs to take MATH 103 College Algebra .

** When completing Arts and Humanities courses, it is required that the nine credit hours be in two departments and you must have a minimum of three credits in fine arts as part of the requirements of the Essential Studies program at the University of North Dakota. You also want to ensure that you have fulfilled the global diversity requirement. More information on Essential Studies graduation requirements can be found at: http://www.und.edu/dept/registrar/EssentialStudies/esindex.html.

Admission Requirements

Professional Program

Admission to the professional program in occupational therapy is on a competitive basis with consideration given to pre-professional performance in the sciences, general graduation requirements, leadership potential, volunteer work and personal qualifications. Each application is thoroughly reviewed. This review includes the applicant's academic record (must have minimum overall GPA of 2.75 based on a 4 point scale), pattern of withdrawals, incompletes, etc., elective coursework, volunteer and/or work experience, references, essay and a personal interview.

A prerequisite for admission to the UND Professional Program at the Year I level will be 60 hours of observation with a professional occupational therapy supervisor and should be distributed over the three required areas (Psychosocial, Physical Dysfunction, Pediatric).

Year III Professional Program

The applicant must meet the School of Graduate Studies' current minimum general admission requirements as published in the graduate catalog. Admission to the School of Graduate Studies requires:

1. Acceptance into the Professional Occupational Therapy program.
2. Successful completion of OT Professional Year I and II.
3. Completion of the School of Graduate Studies application forms.
4. Overall GPA of 2.75 or a 3.0 in both junior and senior years.
5. Satisfy the School of Graduate Studies' English Language Proficiency requirements as published in the graduate catalog.
6. Letter of endorsement from the Chair or Graduate Director of the Department that assures automatic advancement in status from the undergraduate program to the graduate program. The letter of endorsement will be written for students in good academic and professional standing in the program

It is important to be aware that a felony conviction may affect a graduate's ability to sit for the National Board for Certification in Occupational Therapy (NBCOT) certification examination or to attain state licensure as an Occupational Therapist. You will be asked to respond to the following questions when registering for the NBCOT exam:

- Have you ever been charged with or convicted of a felony?
- Have you ever had any professional license, registration or certification revoked, suspended or subject to probationary conditions by a regulatory authority or certification board?
- Have you ever been found by any court, administrative or disciplinary proceeding to have committed negligence, malpractice, recklessness, or willful or intentional misconduct, which resulted in harm to another?

Information regarding NBCOT's process of screening applicants for Character Review may be found at: www.nbcot.org. If you have any questions, the department will assist you in this process.

Many fieldwork facilities are requiring proof of immunizations, drug testing, fingerprints, and/or criminal background checks. It is the responsibility of the student to check the fieldwork information and to pay the cost for each process.

Degree Requirements

Bachelor of General Studies Degree with Health Studies Option

The BGS Health Studies degree is available to OT students who:

1. have completed their pre-OT work either at UND or at another institution.
2. have successfully completed the first two years of the OT professional sequence.

The BGS degree would normally then be awarded at the end of the Professional Year Two, prior to beginning the Graduate School career, if the student has completed all general UND graduation requirements, including:

1. 125 total credits,
2. 60 credits from 4-year schools, including at least 30 from UND,
3. 36 upper-level credits,
4. all essential studies requirements.

Students seeking the Master of Occupational Therapy degree at the University of North Dakota must satisfy all general requirements set forth by the School of Graduate Studies as well as particular requirements set forth by the Occupational Therapy Department.

To maintain graduate student status, the professional level Year III student is required to maintain a GPA of at least 3.0 for all work completed in Year III. Students who were previously on academic or professional probation will be dismissed from the School of Graduate Studies if placed on one additional probation within the professional program.

M.O.T Curriculum Sequence

School of Graduate Studies - Schedule A

Professional Year 1		
Fall		**Credits**
OT 423	Fundamentals of Neuroscience for Occupational Therapy	3
OT 425	Occupational Therapy with Infants and Pre-School Children	4
OT 427	Orientation to Occupational Therapy Theory	3
OT 428	Quantitative Rsrch Methods-O T	3
OT 431	Medical Science I	2
Spring		
OT 424	Muscle Function	4
OT 429	Occupational Therapy with School Age Children and Young Adults	4
OT 430	Psychosocial Aspects of Occupational Therapy for Children, Adolescents and Young Adults	4
OT 432	Medical Science II	3
OT 433	Group Leadership Skills in Occupational Therapy	2
OT 438	Practicum:Children/Adolescents	1
Summer		
OT 422	Anatomy Occupational Therapy	5
OT 426	Personal/Professional Developmnt	1

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Professional Year 2		
Fall		
OT 454	Gerontic Occupational Therapy	2
OT 456	Psychosocial Aspects of OT with the Maturing Adult	4
OT 458	Qualitative Research Methods for Occupational Therapy	3
OT 460	Introduction to Management and Leadership	2
OT 463	Psychosocial Dysfunction Seminar and Practicum Integration	3
OT 469	Interprofessional Health Care	1
Fall and Spring Semester Electives:		
OT 489	Independent Projects	1-3
OT 490	Occupational Therapy Seminar	1
OT 493	Workshop	1-6
OT 494	Directed Study in Occupational Therapy	1
OT 496	Community Experience	1-4
OT 497	Cooperative Education	1-6
OT 593	Teaching Experience in Occupational Therapy	1-3
Spring		
OT 451	Multicultural Competency in Occupational Therapy	3
OT 452	Assistive Technology I	3
OT 453	Physical Aspects of OT with the Maturing Adult	5
OT 461	Management in the U.S. Healthcare System	2
OT 462	Physical Dysfunction Seminar and Practicum Integration	3
OT 480	Introduction to Scholarly Writing in Occupational Therapy	1
Summer		
Elective Only Semester:		
OT 488	Elective Field Work in Occupational Therapy	3-9
OT 497	Cooperative Education	1-6
OT 593	Teaching Experience in Occupational Therapy	1-3

Professional Year 3		
Fall		
Required Core Courses:		
OT 504	Occupation and Vocation	3
OT 507	Innovative Management and Leadership	3
OT 509	Principles of Education in Occupational Therapy	3
OT 515	Integration of Occupational Therapy Theory	3

Fall Electives:		
OT 493	Workshop	1-12
OT 508	Therapeutic Procedures and Modalities in Occupational Therapy	2
OT 582	Graduate Practicum	1-3
OT 589	Readings in Occupational Therapy	1-2
OT 593	Teaching Experience in Occupational Therapy	1-3
OT 599	Special Topics in Occupational Therapy	1-2
Spring		
OT 585 or OT 587	Fieldwork in Psychosocial Dysfunction or Fieldwork in Physical Dysfunction	9
OT 995 or OT 997	Scholarly Project in Occupational Therapy or Independent Study	2
OT 589	Readings in Occupational Therapy	1-2
Summer		
OT 585 or OT 587	Fieldwork in Psychosocial Dysfunction or Fieldwork in Physical Dysfunction	9
	Total Credits:	**123-171**

School of Graduate Studies - Schedule B

Professional Year 1		
Fall		**Credits**
OT 423	Fundamentals of Neuroscience for Occupational Therapy	3
OT 425	Occupational Therapy with Infants and Pre-School Children	4
OT 427	Orientation to Occupational Therapy Theory	3
OT 428	Quantitative Rsrch Methods-O T	3
OT 431	Medical Science I	2
Spring		
OT 424	Muscle Function	4
OT 429	Occupational Therapy with School Age Children and Young Adults	4
OT 430	Psychosocial Aspects of Occupational Therapy for Children, Adolescents and Young Adults	4
OT 432	Medical Science II	3
OT 433	Group Leadership Skills in Occupational Therapy	2
OT 438	Practicum:Children/Adolescents	1
Summer		
OT 422	Anatomy Occupational Therapy	5
OT 426	Personal/Professional Developmnt	1

2.59

Professional Year 2		
Fall		
OT 452	Assistive Technology I	3
OT 453	Physical Aspects of OT with the Maturing Adult	5
OT 458	Qualitative Research Methods for Occupational Therapy	3
OT 460	Introduction to Management and Leadership	2
OT 462	Physical Dysfunction Seminar and Practicum Integration	3
Fall and Spring Semester Electives:		
OT 489	Independent Projects	1-3
OT 490	Occupational Therapy Seminar	1
OT 493	Workshop	1-6
OT 494	Directed Study in Occupational Therapy	1
OT 496	Community Experience	1-4
OT 497	Cooperative Education	1-6
OT 593	Teaching Experience in Occupational Therapy	1-3
Spring		
OT 451	Multicultural Competency in Occupational Therapy	3
OT 454	Gerontic Occupational Therapy	2
OT 456	Psychosocial Aspects of OT with the Maturing Adult	4
OT 461	Management in the U.S. Healthcare System	2
OT 463	Psychosocial Dysfunction Seminar and Practicum Integration	3
OT 469	Interprofessional Health Care	1
OT 480	Introduction to Scholarly Writing in Occupational Therapy	1
Summer		
Elective Only Semester:		
OT 488	Elective Field Work in Occupational Therapy	3-9
OT 497	Cooperative Education	1-6
OT 593	Teaching Experience in Occupational Therapy	1-3

Professional Year 3		
Fall		
OT 585 or OT 587	Fieldwork in Psychosocial Dysfunction or Fieldwork in Physical Dysfunction	9
OT 995 or OT 997	Scholarly Project in Occupational Therapy or Independent Study	2
OT 589	Readings in Occupational Therapy	1-2

Required Core Courses:		
OT 504	Occupation and Vocation	3
OT 507	Innovative Management and Leadership	3
OT 509	Principles of Education in Occupational Therapy	3
OT 515	Integration of Occupational Therapy Theory	3
Spring		
Spring Semester Electives:		
OT 493	Workshop	1-12
OT 508	Therapeutic Procedures and Modalities in Occupational Therapy	2
OT 582	Graduate Practicum	1-3
OT 589	Readings in Occupational Therapy	1-2
OT 593	Teaching Experience in Occupational Therapy	1-3
OT 599	Special Topics in Occupational Therapy	1-2
Summer		
OT 585 or OT 587	Fieldwork in Psychosocial Dysfunction or Fieldwork in Physical Dysfunction	9
	Total Credits:	**123-171**

OT 200. Introduction to Occupational Therapy. 2 Credits.
History, scope, objectives, and functions of Occupational Therapy. F,S.

OT 422. Anatomy Occupational Therapy. 5 Credits.
Detailed study of human anatomy, with an emphasis on skeletal muscle, its vasculature, and the peripheral nervous system. The laboratory portion of the course allows for a direct study of the human form through dissection of human cadavers. Prerequisite: Occupational Therapy majors only. SS.

OT 423. Fundamentals of Neuroscience for Occupational Therapy. 3 Credits.
Survey of the major theories of behavior, cognition, and neurological disorders based on experimental findings in neuroanatomy, neurophysiology, and neurobiology. Laboratory included. Prerequisite: Occupational Therapy majors only. F.

OT 424. Muscle Function. 4 Credits.
The study of musculature acting on the extremities and trunk. Theory and techniques of musculoskeletal evaluation with analysis of normal and pathological human motion. Laboratory included. Prerequisite: Occupational Therapy majors only. S.

OT 425. Occupational Therapy with Infants and Pre-School Children. 4 Credits.
Emphasis on reflexes, sensory systems, neurodevelopmental systems, illness and trauma, assessment procedures, treatment techniques, families and intervention teams, and treatment outcomes. Laboratory included. Prerequisite: Occupational Therapy majors only. F.

OT 426. Personal/Professional Developmnt. 1 Credit.
Promote self-awareness and interpersonal communication skills including basic listening skills, ability to provide meaningful feedback and appropriate group membership skills. Prerequisite: Occupational Therapy majors only. SS.

OT 427. Orientation to Occupational Therapy Theory. 3 Credits.
Orientation to human occupation, occupational performance assessment, theoretical practice models, and core processes in occupational therapy. Prerequisite: Occupational Therapy majors only. F.

OT 428. Quantitative Rsrch Methods-O T. 3 Credits.
Design and implementation of quantitative research, the evaluation of quantitative research studies, the interpretation of statistics as applied to occupational therapy, and the process of presentation and publication of quantitative research projects. Laboratory included. Prerequisite: Occupational Therapy majors only. F.

OT 429. Occupational Therapy with School Age Children and Young Adults. 4 Credits.
Normal and abnormal human development, disease and disability, school age through young adulthood. Emphasis on assessment, intervention planning and program outcomes for individuals with disabilities in a variety of practice settings including school, community, and medicine. Laboratory included. Prerequisite: Occupational Therapy majors only. S.

OT 430. Psychosocial Aspects of Occupational Therapy for Children, Adolescents and Young Adults. 4 Credits.
Psychosocial development and interruptions to development in children, adolescents, and young adults, with emphasis on OT evaluation, treatment planning and implementation, and treatment outcomes. Laboratory included. Prerequisite: Occupational Therapy majors only. S.

OT 431. Medical Science I. 2 Credits.
First in a two-semester sequence of courses, which covers human body, systems and disease and disability groups discussed from all aspects of comprehensive rehabilitation. Included are chronic illness, neurological and orthopedic conditions, general medicine and surgery, and sensory disabilities across the lifespan. Prerequisite: Occupational Therapy majors only. F.

OT 432. Medical Science II. 3 Credits.
Second in a two-semester sequence of courses, which covers human body, systems and disease and disability groups discussed from all aspects of comprehensive rehabilitation. Included are chronic illness, neurological and orthopedic conditions, general medicine and surgery, and sensory disabilities across the lifespan. Integration included. Prerequisite: Occupational Therapy majors only. S.

OT 433. Group Leadership Skills in Occupational Therapy. 2 Credits.
Didactic and experiential learning in a small group setting. Provides students with opportunities to function as group facilitators in a variety of practice settings. Prerequisite: Occupational Therapy majors only. S.

OT 438. Practicum:Children/Adolescents. 1 Credit.
Observation and experience in a university-approved pediatric and/or adolescent facility; supervised by occupational therapists, educators, and allied health professionals. Prerequisite: Occupational Therapy majors only. S.

OT 451. Multicultural Competency in Occupational Therapy. 3 Credits.
Develop an understanding of and an appreciation for social-cultural and ethnic diversity and use that understanding to address issues, solve problems, and shape civic, personal, and professional behavior. To recognize that diversity is intimately tied to the concepts of culture, race, language, identity and inter-group dynamics, as well as its applications to complex situations. These concepts are presented within the context of providing OT services. Prerequisite: Occupational Therapy majors only. S.

OT 452. Assistive Technology I. 3 Credits.
Introductory study of assistive technology devices and products, assessment, and application methods focuses on adaptations, modifications, and technology systems and services that assist individuals with disabilities in greater independence and accessibility across the lifespan. Laboratory included. Prerequisite: Occupational Therapy majors only. F,S.

OT 453. Physical Aspects of OT with the Maturing Adult. 5 Credits.
Study of the OT process as applied to physical dysfunction of the maturing adult. Emphasis is on OT evaluation, planning, implementation of treatment, and treatment outcomes. Laboratory included. Prerequisite: Occupational Therapy majors only. F,S.

OT 454. Gerontic Occupational Therapy. 2 Credits.
Occupational perspectives of the elderly, including age-related changes, assessment and intervention strategies and the role of occupational therapy in prevention and wellness programs. Laboratory included. Prerequisite: Occupational Therapy majors only. F,S.

OT 456. Psychosocial Aspects of OT with the Maturing Adult. 4 Credits.
Psychosocial development and interruptions to development in the maturing adult with emphasis on OT evaluation, treatment planning and implementation, and treatment outcomes. Laboratory included. Prerequisite: Occupational Therapy majors only. F,S.

OT 458. Qualitative Research Methods for Occupational Therapy. 3 Credits.
Design and implementation of qualitative research, evaluation of qualitative research studies, analysis and interpretation of qualitative data, and the process of publication and presentation of qualitative research projects. Laboratory included. Prerequisite: Occupational Therapy majors only. F.

OT 460. Introduction to Management and Leadership. 2 Credits.
Introduction to the management practices necessary to direct a quality health service and provide the knowledge and skills needed for entry-level leadership positions in OT practice. Focus is on clinical reasoning and critical analysis in administrative and management functions. Laboratory included. Prerequisite: Occupational Therapy majors only. F.

OT 461. Management in the U.S. Healthcare System. 2 Credits.
Provide an overview of health services system in the US and current trends and issues facing OT within this system. Content includes: federal and state roles, reimbursement of health care services, regulation, community services, health service providers, consultative, non-traditional areas of practice, service delivery models, legalities, and health policy advocacy. Prerequisite: Occupational Therapy majors only. S.

OT 462. Physical Dysfunction Seminar and Practicum Integration. 3 Credits.
The student begins to integrate and synthesize the theoretical knowledge of physical function/ dysfunction with clinical practice. It requires the application of foundational knowledge, tools and the theory of practice inherent in the role of an OT. Occupational therapy experiences in facilities, supervised by registered occupational therapists, qualified health professionals and university faculty. Prerequisites: OT 422, OT 423, OT 424, OT 425, OT 426, OT 427, OT 428, OT 429, OT 430, OT 431, OT 432, OT 433 and OT 438. F,S.

OT 463. Psychosocial Dysfunction Seminar and Practicum Integration. 3 Credits.
Integration and synthesizing of theoretical knowledge with clinical experience toward the application of therapeutic use of self, self-evaluation, and communication skills in professional development. Occupational therapy experiences in mental health field facilities, supervised by registered occupational therapists, qualified health professionals and university faculty. Prerequisites: OT 422, OT 423, OT 424, OT 425, OT 426, OT 427, OT 428, OT 429, OT 430, OT 431, OT 432, OT 433 and OT 438. F,S.

OT 469. Interprofessional Health Care. 1 Credit.
A process-learning course intended to provide experience in building a team of health professionals from different professions. The focus is on learning to work effectively with an interprofessional health care team. Emphasis is placed on effective teamwork, the unique contributions of different professions, patient or family centered approach in health care delivery, and awareness of potential medical errors. F,S.

OT 480. Introduction to Scholarly Writing in Occupational Therapy. 1 Credit.
This course is designed to provide students with an understanding of the expectations and mechanics of scholarly writing. It is the first step for the development of a scholarly paper that is a requirement of the MOT program. The course outcome is the development of a proposal in an area of interest to the student(s) which has been approved and supervised by a faculty advisor to meet the first requirement of OT 995 Scholarly Project in OT or OT 997 Independent Study. Course content includes the mechanics of writing, development, content and format of the scholarly paper; the use of appropriate resources; and a review of how to use the Publication Manual of the American Pscyhological Association and the OT department's graduate student manuals. S.

OT 488. Elective Field Work in Occupational Therapy. 3-18 Credits.
Application of occupational therapy in evaluation and treatment in optional areas of student special interest in selected fieldwork facilities. Variable credits, repeatable, with maximal total of 18 credits. Prerequisite: Occupational Therapy majors only. F,S,SS.

OT 489. Independent Projects. 1-3 Credits.
Individual study and/or research in a particular area of interest for the students with approval of a supervising faculty member. Elective for OT majors. Prerequisite: Occupational Therapy majors only.

OT 490. Occupational Therapy Seminar. 1 Credit.
Foundational knowledge relevant to the preparation of an independent study proposal. Serves as the basis for OT 494: Directed Study in Occupational Therapy. Prerequisite: Occupational Therapy majors only. F.

OT 493. Workshop. 1-12 Credits.
A workshop course with topics dictated by faculty and student interests primarily for but not confined to continuing education. Prerequisite: Occupational Therapy majors only. On demand.

OT 494. Directed Study in Occupational Therapy. 1 Credit.
Development of the proposal in an area of interest to the student approved and supervised by faculty. Serves as the basis for OT 997: Independent Study or OT 995: Scholarly Project in OT. Prerequisite: Occupational Therapy majors only. S.

OT 496. Community Experience. 1-4 Credits.
Student initiates and participates in off-campus professional learning activities related to OT under joint faculty and on-site professional supervision. Prerequisite: Permission of Department. F,S,SS.

OT 497. Cooperative Education. 1-6 Credits.
Qualified students are employed by selected facilities to further understanding of occupational therapy and health-related service provision. Prerequisite: Occupational Therapy majors only. F,S,SS.

OT 504. Occupation and Vocation. 3 Credits.
Application of assessment and problem-solving skills necessary for remediation/rehabilitation of occupational performance deficits in the work realm. Laboratory included. Prerequisite: Occupational Therapy majors only. F,S.

OT 507. Innovative Management and Leadership. 3 Credits.
Develop and demonstrate an understanding of the skills necessary to plan, implement and evaluate programs and material for educational, consultation and private practice. Prerequisite: Occupational Therapy majors only. F,S.

OT 508. Therapeutic Procedures and Modalities in Occupational Therapy. 2 Credits.
Occupational therapy theory and application of specific neuromuscular techniques and modalities to promote musculoskeletal function. Laboratory included. Prerequisite: Occupational Therapy majors only. F,S.

OT 509. Principles of Education in Occupational Therapy. 3 Credits.
Explores the methods and strategies used to develop, implement and evaluate education programs for students in academia and clinical settings, for patients/clients, businesses and professional staff. Information and discussion focus on the theory and research relevant to education in a variety of settings. Prerequisite: Occupational Therapy majors only. F,S.

OT 515. Integration of Occupational Therapy Theory. 3 Credits.
Analysis and applications of theoretical perspectives to occupational therapy process with individuals, groups, and service delivery systems. Prerequisite: Occupational Therapy majors only. F,S.

OT 582. Graduate Practicum. 1-3 Credits.
Supervised experience in a variety of OT practice settings. Students are afforded the opportunity to gain practical, on-the-job experience working in an area that matches the focus of their graduate study. Students will be supervised by on-site personnel. Prerequisite: Occupational Therapy majors only. F,S,SS.

OT 585. Fieldwork in Psychosocial Dysfunction. 9 Credits.
Application of occupational therapy in evaluation andtUniversity of North Dakota treatment in psychosocial dysfunction fieldwork facilities. Three months full-time. Prerequisite: Occupational Therapy majors only.

OT 587. Fieldwork in Physical Dysfunction. 9 Credits.
Application of occupational therapy in evaluation and treatment in physical dysfunction fieldwork facilities. Three months full-time. Prerequisite: Occupational Therapy majors only.

OT 589. Readings in Occupational Therapy. 1-2 Credits.
Selected readings in the student's area of interest with oral and/or written reports. Prerequisite: Occupational Therapy majors only. F,S,SS.

OT 593. Teaching Experience in Occupational Therapy. 1-3 Credits.
Supervised experience in higher education teaching in OT. Projects in course/curriculum development, writing course objectives, writing and delivering lectures and learning activities, and developing assessment tools for the classroom. Prerequisite: Occupational Therapy majors only. F,S,SS.

OT 599. Special Topics in Occupational Therapy. 1-2 Credits.
A series of lectures, discussions, and/or laboratory experiences developed around one or more specific topics in occupational therapy. Prerequisite: Occupational Therapy majors only. F,S,SS.

OT 995. Scholarly Project in Occupational Therapy. 2 Credits.
A collaborative investigation of relevant professional topic and production of a scholarly report with approval ofthe major faculty. Prerequisite: Occupational Therapy majors only.

OT 996. Continuing Enrollment. 1-12 Credits.

OT 997. Independent Study. 2 Credits.
Prerequisite: Occupational Therapy majors only.

OT 998. Thesis. 1-15 Credits.

15.0488.03000

Attach #1
SB2295
02/17/15
J#23992

Sixty-fourth
Legislative Assembly
of North Dakota

SENATE BILL NO. 2295

Introduced by

Senators Dever, Warner

Representatives Hofstad, Mooney, Rohr

from Shane Goettle

A BILL for an Act to amend and reenact sections 43-39-01 and 43-39-04 and subdivision d of subsection 1 of section 43-39-10 of the North Dakota Century Code, relating to the regulation of athletic trainers; and to provide a penalty.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. AMENDMENT. Section 43-39-01 of the North Dakota Century Code is amended and reenacted as follows:

43-39-01. Definitions.

1. "Athletic trainer" means ~~a person~~an individual with specific qualifications set forth in section 43-39-05, who is providing athletic training ~~services in accordance with the individual's education.~~
2. "Athletic training" means doing any of the ~~practice of prevention, recognition, evaluation, management, treatment, and disposition of athletic injuries. The term also means rehabilitation of athletic injuries, if under the order of a licensed physician. The term includes organization and administration of educational programs, athletic facilities, and the education and counseling of the public~~~~comprehensive management of injuries and illnesses to prevent, clinically evaluate, assess, provide immediate care, treat, rehabilitate, and recondition.~~following under the guidance of a physician:
   a. preventing, recognizing and evaluating injuries and illnesses sustained while participating in physical activity;
   b. managing and administering the initial treatment of injuries or illnesses sustained while participating in physical activity;
   c. giving emergency care or first aid for an injury or illness sustained while participating in physical activity;
   d. rehabilitating injuries or illnesses sustained while participating in physical activity;
   e. rehabilitating and physically reconditioning injuries or illnesses that impede or prevent an individual from returning to participation in physical activity, if the

1.2

individual recently participated in, and intends to return to participation in, physical activity;

f. establishing or administering risk management, conditioning, and injury prevention programs; or

g. referring a patient or client to an appropriate health care provider as needed.

3. "Physical activity" means activity that requires physical strength, agility, range of motion, repetitive motion, speed, or stamina, including participation in exercise, sports, games, recreation, wellness, or fitness.

34. "Board" means the North Dakota board of athletic trainers established in section 43-39-02.

45. "Physician" means adoctorofmedicinean individual licensed topracticeas a physician under chapter 43-17.

SECTION 2. AMENDMENT. Section 43-39-04 of the North Dakota Century Code is amended and reenacted as follows:

43-39-04. Unlawful practice

1. NoA person may not practice athletic training or hold that person out as being an athletic trainer in this state unless that person is an individual licensed in accordance with this chapter.
2. NoA person may not consult, teach, or supervise or hold that person out as being able to consult, teach, or supervise athletic training curricular courses in this state unless that person is an individual licensed in accordance with this chapter or chapter 43-17, or possesses a degree in a health-related field.
3. NoA person may not represent that person as being a licensed athletic trainer or use in connection with that person's name any letters, words, or insignia indicating or implying that the person is a licensed athletic trainer unless that person is an individual licensed in accordance with this chapter.

SECTION 3. AMENDMENT. Subdivision d of subsection 1 of section 43-39-10 of the North Dakota Century Code is amended and reenacted as follows:

d. Is guilty of treating or undertaking to treat ailmentsofhumanbeingsan individual's injury or illness, except as authorized pursuant to this chapter, or undertaking to practice independent of the orderdirectionguidance of a licensed physician, or is guilty of any act derogatory to the dignity and morals of the profession of athletic training.

15.0488.03000

Sixty-fourth
Legislative Assembly
of North Dakota

SENATE BILL NO. 2295

attach #1
SB2295
02/18/15
J# 24070

Introduced by

Senators Dever, Warner

Representatives Hofstad, Mooney, Rohr

A BILL for an Act to amend and reenact sections 43-39-01 and 43-39-04 and subdivision d of subsection 1 of section 43-39-10 of the North Dakota Century Code, relating to the regulation of athletic trainers; and to provide a penalty.

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   a. preventing, recognizing and evaluating injuries and illnesses sustained while participating in physical activity;
   b. managing and administering the initial treatment of injuries or illnesses sustained while participating in physical activity;
   c. giving emergency care or first aid for an injury or illness sustained while participating in physical activity;
   d. rehabilitating injuries or illnesses sustained while participating in physical activity;
   e. rehabilitating and physically reconditioning injuries or illnesses that impede or prevent an individual from returning to participation in physical activity, if the

1.2

individual recently participated in, and intends to return to participation in, physical activity;

f. establishing or administering risk management, conditioning, and injury prevention programs; or

g. referring a patient or client to an appropriate health care provider as needed.

3. "Physical activity" means activity that requires physical strength, agility, range of motion, repetitive motion, speed, or stamina, including participation in exercise, sports, games, recreation, wellness, or fitness.

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2. NoA person may not consult, teach, or supervise or hold that person out as being able to consult, teach, or supervise athletic training curricular courses in this state unless that person is an individual licensed in accordance with this chapter or chapter 43-17, or possesses a degree in a health-related field.
3. NoA person may not represent that person as being a licensed athletic trainer or use in connection with that person's name any letters, words, or insignia indicating or implying that the person is a licensed athletic trainer unless that person is an individual licensed in accordance with this chapter.

SECTION 3. AMENDMENT. Subdivision d of subsection 1 of section 43-39-10 of the North Dakota Century Code is amended and reenacted as follows:

d. Is guilty of treating or undertaking to treat ailmentsofhumanbeingsan individual's injury or illness, except as authorized pursuant to this chapter, or undertaking to practice independent of the orderdirectionguidance of a licensed physician, or is guilty of any act derogatory to the dignity and morals of the profession of athletic training.

SB 2295
3-25-15

#1

Testimony to the House Human Services Committee
Chairman Robin Weisz
Shane Goettle
For North Dakota Athletic Trainers Association
sgoettle@odney.com
701-426-0576

Chairman Weisz and members of the Human Services Committee, my name is Shane Goettle and I represent the North Dakota Athletic Trainers Association.

We have provided a handout for our witness line-up today. Members of the athletic trainers profession will discuss their history in this state, as well as their education and training. I just want to briefly set the stage and walk you through the bill.

In the last three decades since the Athletic Trainers Practice Act was first established by the legislature, the number of athletic trainers in North Dakota has slowly increased, and they have become more visible and familiar to the public. There are now around 177 Athletic Trainers in the State of North Dakota. They are certainly more visible, and the public is now far more familiar with and confident in the services performed by athletic trainers. This familiarity has also increased demand for individual services, even from non-athletes who are, nevertheless, seeking services to restore and achieve physical activity goals after an injury. The current Practice Act, however, has not kept up with the times.

As you carry out your role as policy-makers, I would suggest that your primary task is NOT to spend your time preserving or building fences to between the various health professions, but rather to ask: “Is the public protected? Put another way: “Is the individual performing this particular health related service adequately educated and trained to deliver quality care to the patient?”

Again, that's the purpose of the Practice Act: to ensure, in this case, that Athletic Trainers are properly educated and trained to deal with the injuries and medical issues that they encounter–in short, to protect the integrity of the license to practice and protect the public

We recognize there is overlap and some level of healthy competition among the health professions. We submit this is a good thing. Competition, first and foremost, gives patients options and choices. A dynamic health care system should foster healthy competition and choice, provided only that the individual performing the service is adequately educated and trained to address the injuries or illnesses that present themselves within the scope of their field.

Athletic trainers have NO intent to request, seek or insist that their services expand into billing–this is NOT their goal. Rather, they seek some definitional changes in NDCC § 43-39-01 that will accurately reflect who they are and what they do as a profession in today's modern health system.

The bill you have before has changed considerably since we first introduced it. That is a result of extensive conversations and input from physicians, occupational therapists, and physical therapists. You will hear from physicians today who are supporting the bill. We are offering amendments as well, attached to my testimony, that were requested by both the occupational therapists and physical therapists, but did not make it into the Senate version of the bill. We understand these amendments will address the remaining concerns of the occupational therapists, while admittedly not all of the physical therapists concerns. We urge you to adopt those amendments. Finally, you will hear from the physical therapists, who still have concerns about the bill. We

believe those concerns can be addressed through the regulatory process and a member of the licensure board will speak to that today as well.

Accompanying my testimony is a matrix that shows what states in this region of the country have in place for athletic trainers. Our immediate neighboring states of Montana, South Dakota and Minnesota have not yet modernized their acts. Wisconsin and Michigan have, however, and in looking at both of these modernization efforts, we zeroed in on the Wisconsin model for the definition of "athletic training" that you see proposed to you today.

Let me now walk through the act:

The first thing to understand about the structure of the bill before you is that it is anchored around two concepts:

1) Everything that Athletic Trainers would be permitted to do would be under the "guidance" of a physician. This is different than present, which technically only puts rehabilitation under the "direction" of a physician. We struggled to find the right word to describe this working relationship between physicians and athletic trainers that has evolved over the years. Once we agreed to put everything under this term "guidance," the physicians, who work with athletic trainers on a daily basis, agreed to support the bill you see before you today.

2) You will note that nearly all the activity the proposed bill would allow to be done as "athletic training" in this state is tied to a definition of "physical" activity", which is defined in the bill. I will get to that in a moment.

Let me walk through the bill with you:

Page 1, line 8 - "an individual" - recommended by legislative council

Page 1, lines 9-10 - the amendment we have offered removes the underlined words "services in accordance with the individual's education." We are deleting this phrase at the request of both OTs and PTs.

Page 1, line 11, Start using the Wisconsin model so the "Athletic training" means "doing any of" those things itemized in Section 2, a-f.

Page 1, lines 11-16, as I mentioned earlier, it's important to keep in mind as we go through the rest of the bill that one of the anchors is that everything the athletic trainers do under this proposal would be "under the guidance of a physician" If you look carefully under the struck language, you will note that presently only the "rehabilitation of athletic injuries" is under the "order" of a physician. Currently other activities that athletic trainers perform in the health care service industry are not under a physician. However, in practice, athletic trainers work day in and day out with physicians. So we struggled to capture just the right term to describe their relationship. Working with the physicians, we arrived at "guidance". We believe this term encompasses the relationship when athletic trainers are deployed in the field covering athletic events, charity softball tournaments, special olympics events, etc, while also respecting the close working relationship athletic trainers have with physicians in the clinical setting where they work directly with physicians to rehabilitate those persons with physical activity goals.

Page 1-2, a-e, the other anchor you can note is that in a-e, found on page 1, lines 17, through page 2 line 4, is the term "physical activity" (which is defined on page 2, line 10). A-F follow the Wisconsin statute word-for-word, which also anchors A-E under the definition of "physical activity." Let me just quickly walk through each

(walk through a-f). EXAMPLES, twin athletes, non-athletic injuries with athletic goals, screenings, etc.

Page 2, lines 7, g, is an addition to the Wisconsin model. We inserted this referral provision as a result of our meetings and discussion with OT and PT. The captures the very important point that ATs routinely refer treatment to other health care professionals as part of their day-to-day activity.

Page 2, lines 4-12, we define the anchor term "physical activity" This is where we part just a bit from the Wisconsin model. The Wisconsin model states that "physical activity" is "vigorous" participation, in exercise, sports, etc. We noted an immediate question and problem that arises with the term "vigorous". What does THAT mean? Is an athlete who sprains an ankle in the locker room engaged in "vigorous" activity? Is a bowler engaged in "vigorous" activity? Must the athletic trainer questions the "vigorousness" of the activity goals in order to treat? That seemed to trade one problem for another. So, after thorough discussion with both OTs and PTs, the OTs at least offered that if we replace "vigorous " with what you see now, that: "Physical activity means activity that" (instead of "vigorous") , is activity "that requires physical strength, agility, range of motion, repetitive motion, speed, or stamina". We felt that was an acceptable compromise, and fits well with what the athletic trainers wanted to accomplish in terms of their goals. You will hear later from the athletic trainers themselves how this proposed definition gets to the heart of what they do, without having to ask first, "are you an athlete?" in order to treat that person as a client.

Page 2, lines 13-27, these are all changes recommended by legislative council.

Page 3, lines 1-3, legislative council recommended deleting “ailments” and replacing with the language you see here. We also changed “order” . To be consistent , we have offered amendments that would replace “order” or “direction” with “guidance”. Again, this is in accord with our discussion with physicians, OTs and PTs.

That completes my testimony, Mr. Chairman. Before I introduce the rest of the presenters, I would stand for any questions, but you might want to hold some of your questions for the experts who you will hear from shortly, who will address the topics you see on our agenda.

PROPOSED AMENDMENTS TO SENATE BILL NO. 2295

Page 1, line 9, remove " services in accordance with the"

Page 1, line 10, remove "individual's education"

Page 3, line 3, replace "direction" with "guidance"

Renumber accordingly

#2

SB 2295

Shane Goettle

3-25-15

SB 2295

NORTH DAKOTA ATHLETIC TRAINERS PRESENTATION OUTLINE

Legislative Sponsors

Shane Goettle, NDTA Lobbyist:

- Overview of issues
- Explanation of bill

Steve Westereng NDATA president:

- Background
- Licensing
- Role in Health Systems
- Need for Changing Scope of Practice

Brandy Currie, NDATA Vice President and Educator:

- History and education of certified athletic trainers
- CAATE guidelines
- Educational competencies
- Domains of clinical practice.
- Role of athletic trainers and lack of availability

Heather Golly, Licensure board and Educator:

- Licensure board/Regulation
- Specific Education competencies, especially in regard to "illnesses"
- Comparison of education background

Damian Schlinger, Athletic Trainers Licensure Board:

- Licensure board's role: updating rules and regulations

Additional speakers in support of the bill:

Steve Churchill - Physical Therapist and Athletic Trainer
Robyn Gust - Athletic Trainer (Maybe presenting)
Dr. Mattern - Trinity Health, Minot, ND
Dr. Mann – UND Medical School

STATE	DEFINITION OF ATHLETE	DEFINITION OF ATHLETIC TRAINER	DEFINTION OF ATHLETIC TRAINING	DEFINITION OF ATHLETIC INJURY	OTHER DEFINITIONS
Michigan		"Athletic trainer" means an individual engaged in the practice of athletic training.	"Practice of athletic training" means the treatment of an individual for risk management and injury prevention, the clinical evaluation and assessment of an individual for an injury or illness, or both, the immediate care and treatment of an individual for an injury or illness, or both, and the rehabilitation and reconditioning of an individual's injury or illness, or both, as long as those activities are within the rules promulgated under section 17904 and performed under the direction and supervision of an individual licensed under part 170 or 175. The practice of athletic training does not include the practice of physical therapy, the practice of medicine, the practice of osteopathic medicine and surgery, the practice of chiropractic, or medical diagnosis or treatment		
STATE	DEFINITION OF ATHLETE	DEFINITION OF ATHLETIC TRAINER	DEFINTION OF ATHLETIC TRAINING	DEFINITION OF ATHLETIC INJURY	OTHER DEFINITIONS
Wisconsin		"Athletic trainer" means an individual who engages in athletic training.	"Athletic training" means doing any of the following: **(a)** Preventing, recognizing and evaluating injuries or illnesses sustained while participating in physical activity. **(b)** Managing and administering the initial treatment of injuries or illnesses sustained while participating in physical activity. **(c)** Giving emergency care or first aid for an injury or illness sustained while participating in physical activity. **(d)** Rehabilitating and physically reconditioning injuries or illnesses sustained while participating in physical activity. **(e)** Rehabilitating and physically reconditioning injuries or illnesses that impede or prevent an individual from returning to participation in physical activity, if the individual recently participated in, and intends to return to participation in, physical activity. **(f)** Establishing or administering risk management, conditioning, and injury prevention programs.		"Physical activity" means vigorous participation in exercise, sports, games, recreation, wellness, fitness, or employment activities.

STATE	DEFINITION OF ATHLETE	DEFINITION OF ATHLETIC TRAINER	DEFINTION OF ATHLETIC TRAINING	DEFINITION OF ATHLETIC INJURY	OTHER DEFINITIONS
Minnesota	"Athlete" means a person participating in exercises, sports, games, or recreation requiring physical strength, agility, flexibility, range of motion, speed, or stamina.	Athletic trainer" means a person who engages in athletic training under section 148.7806 and is registered under section 148.7808.	Athletic training by a registered athletic trainer under section 148.7808 includes the activities described in paragraphs (a) to (e). (a) An athletic trainer shall: (1) prevent, recognize, and evaluate athletic injuries; (2) give emergency care and first aid; (3) manage and treat athletic injuries; and (4) rehabilitate and physically recondition athletic injuries. The athletic trainer may use modalities such as cold, heat, light, sound, electricity, exercise, and mechanical devices for treatment and rehabilitation of athletic injuries to athletes in the primary employment site. (b) The primary physician shall establish evaluation and treatment protocols to be used by the athletic trainer. The primary physician shall record the protocols on a form prescribed by the board. The protocol form must be updated yearly at the athletic trainer's registration renewal time and kept on file by the athletic trainer. (c) At the primary employment site, except in a corporate setting, an athletic trainer may evaluate and treat an athlete for an athletic injury not previously diagnosed for not more than 30 days, or a period of time as designated by the primary physician on the protocol form, from the date of the initial evaluation and treatment. Preventative care after resolution of the injury is not considered treatment. This paragraph does not apply to a person who is referred for treatment by a person licensed in this state to practice medicine as defined in section 147.081, to practice chiropractic as defined in section 148.01, to practice podiatry as defined in section 153.01, or to practice dentistry as defined in section 150A.05 and whose license is in good standing. (d) An athletic trainer may: (1) organize and administer an athletic training program including, but not limited to, educating and counseling athletes; (2) monitor the signs, symptoms, general behavior, and general physical response of an athlete to treatment and rehabilitation including, but not limited to, whether the signs, symptoms, reactions, behavior, or general response show abnormal characteristics; and (3) make suggestions to the primary physician or other treating provider for a modification in the treatment and rehabilitation of an injured athlete based on the indicators in clause (2). (e) In a clinical, corporate, and physical therapy setting, when the service provided is, or is represented as being, physical therapy, an athletic trainer may work only under the direct supervision of a physical therapist as defined in section 148.65.	"Athletic injury" means an injury sustained by a person as a result of the person's participation in exercises, sports, games, or recreation requiring physical strength, agility, flexibility, range of motion, speed, or stamina.	

STATE	DEFINITION OF ATHLETE	DEFINITION OF ATHLETIC TRAINER	DEFINTION OF ATHLETIC TRAINING	DEFINITION OF ATHLETIC INJURY	OTHER DEFINITIONS
South Dakota		"Athletic trainer," a person with specific qualifications as set forth in § 36-29-3, whose responsibility is the prevention, evaluation, emergency care, treatment, and reconditioning of athletic injuries under the direction of the team or treating physician. The athletic trainer may use cryotherapy, which includes cold packs, ice packs, cold water immersion, and spray coolants; thermotherapy, which includes topical analgesics, moist hot packs, heating pads, infrared lamp, and paraffin bath; hydrotherapy, which includes whirlpool; and therapeutic exercise common to athletic training which includes stretching and those exercises needed to maintain condition; in accordance with a physician's written protocol. Any rehabilitative procedures recommended by a physician for the rehabilitation of athletic injuries which have been referred and all other physical modalities may be administered only following the prescription of the team or referring physician;			
STATE	DEFINITION OF ATHLETE	DEFINITION OF ATHLETIC TRAINER	DEFINTION OF ATHLETIC TRAINING	DEFINITION OF ATHLETIC INJURY	OTHER DEFINITIONS
Montana	"Athlete" means a person who participates in an athletic activity that involves exercises, sports, or games requiring physical strength, agility, flexibility, range of motion, speed, or stamina and the exercises, sports, or games are of the type conducted in association with an educational institution or a professional, amateur, or recreational sports club or organization.	"Athletic trainer" means an individual who is licensed to practice athletic training.	"Athletic training" means the practice of prevention, recognition, assessment, management, treatment, disposition, and reconditioning of athletic injuries. The term includes the following: (a) the use of heat, light, sound, cold, electricity, exercise, reconditioning, or mechanical devices related to the care and conditioning of athletes; and (b) the education and counseling of the public on matters related to athletic training.	"Athletic injury" means a physical injury received by an athlete.	

SB 2295
3-25-15

#3

Mr. Chairman and members of the House Human Services Committee,

My name is Steven Westereng and I am the Director of the University of North Dakota Division of Sports Medicine. Today, I am speaking with you on behalf of the North Dakota Athletic Trainers Association as their President.

The members of the NDATA support the changes that are being proposed to the North Dakota law regulating athletic trainers in SB 2295.

Athletic trainers are health care professionals who are licensed by the State of North Dakota. By definition, Athletic Trainers (ATs) are healthcare professionals who collaborate with physicians. The services provided by ATs comprise prevention, emergency care, clinical diagnosis, therapeutic intervention and rehabilitation of injuries and medical conditions. (National Athletic Trainers Association)

North Dakota law regulating athletic trainers was first adopted in1983. In the last 32 years, the education and training for the profession has changed dramatically. Previously, a prospective candidate did not have to go through an accredited curriculum at a college or university to sit for the national board exam as one does now. Competencies are educational areas students are required to be taught by faculty of these curriculums. The number of competencies has gone up by 60% (175 to 290). These include areas in evidence based medicine, mental health, biostatistics, epidemiological data and others. In addition to education prior to becoming certified and licensed, an athletic trainer is required to have 50 continuing education units over a 2 year period including 10 hours in evidence based medicine by the Board of Certification, Inc (BOC). The BOC also has a Standard of Professional Practice which must be upheld by the athletic trainer to continue to work in the profession.

Athletic Trainers are now more integrated into every major medical institution in this state. The public is now more familiar and confident with the services performed by athletic trainers. This familiarity has also increased demand for individual services, even from non-athletes who are, nevertheless, seeking services to restore and achieve physical activity goals after an injury. Because of the knowledge of athletic trainers, health care facilities in the state have employed us to work along with physicians in their daily practice.

The purpose of the Practice Act amendment is to ensure Athletic Trainers are properly educated and trained to deal with injuries and medical issues they encounter. It protects the integrity of the license to practice. This sets a standard and protects the public, who, when seeking services, has a right to a competent and professional standard of care. The Practice Act should <u>not</u> be used to constrain or limit the profession to boundaries that are tighter than warranted by education and training—rather, it should reflect current education and training. The Practice Act should <u>not</u> be used to constrain patient choice or to limit healthy competition within the field of health care services. The Practice Act should <u>not</u> be used to constrain where Athletic Trainers work. The Practice Act should not be something that needs to be "worked around" (i.e. practicing under other titles such as "ergonomic specialist" or "physician extenders", which require no additional education or training). Yet, this is the current state of affairs with regard to the present Practice Act

We believe SB 2295 is a good bill and the North Dakota Athletic Trainers Association asks this committee for a "do pass" recommendation.

Thank you for your time and consideration. I would be happy to answer any of your questions.

ATHLETIC TRAINERS

Athletic Trainers (ATs) are highly qualified, multi-skilled health care professionals. ATs are under the allied health professions category as defined by Health Resources Services Administration (HRSA) and Department of Health and Human Services (HHS). The services provided by ATs are comprised of prevention, emergency care, clinical diagnosis, therapeutic intervention, and rehabilitation of injuries and medical conditions. Athletic Trainers are an essential part of a health care team.

Professional practice and education

- Evidence-based practice and health promotion
- Prevention measures to ensure highest quality of care
- Clinical examination and diagnosis
- Immediate and acute care of injury and illness, especially in emergencies
- Treatment, rehabilitation and reconditioning
- Therapeutic intervention
- Psychosocial strategies and referral
- Health care administration
- Ethical and legal practice, cultural competence
- Professionalism and patient-centered approach

There are **177** Athletic Trainers working in a variety of settings in North Dakota including secondary schools, college/universities, and professional sports; occupational health departments; clinics with specialties in sports medicine, medical fitness and wellness; and physician offices working as physican extenders.

NDATA
NORTH DAKOTA ATHLETIC TRAINERS' ASSOCIATION

GOAL: To accurately reflect who we are and what we do as a profession

2009 Joint Statement on Cooperation: National Athletic Trainers' Association and the American Physical Therapy Association

- Agree that legal scope of practice is determined by legislature and regulatory bodies
- Neither organization will make false or misleading statements referring to the other as "not qualified"
- Members of both organizations should respect the rights, knowledge and skills of the other profession and compete honestly and ethically in the health care marketplace

OCCUPATIONAL THERAPY

PHYSICAL THERAPY

There is overlap in the services provided by 3 different professions. We believe this overlap serves the public, in a good way, by giving patients health care options and empowering patient choice.

NDATA
NORTH DAKOTA ATHLETIC TRAINERS' ASSOCIATION

Chairmen Weisz and members of the House Human Services Committee, my name is Sara Bjerke and I am Executive Director of the North Dakota Athletic Trainers' Assocation. Since becoming an athletic trainer 20 years ago, I have been privileged to work in a variety of settings including youth, middle school, high school; Division II and Division I; amateur and semi-professional; and medical fitness.

I am here as an executive board member of the NDATA and as an athletic trainer in the state of North Dakota, to support the changes that are being proposed to North Dakota law regulating athletic trainers in SB2295.

I would like to start off by providing the committee with more information regarding Athletic Trainers (ATs). We are health care professionals who collaborate with physicians. Athletic training is recognized by the American Medical Association (AMA) as a health care profession. ATs are under the allied health professions category as defined by Heath Resources Services Administration (HRSA) and Department of Health and Human Services (HHS). We also have NPI (National Provider Identifier) numbers.

The statutory title of "athletic trainer" is a misnomer. Athletic trainers provide medical services to all types of people – not just athletes participating in sports – and do not train people as personal or fitness trainers do. However, the profession continues to embrace its proud culture and history by retaining the title. In other countries, athletic therapist and physiotherapist are similar titles. The AT profession was founded on providing medical services to athletes. The National Athletic Trainers' Assocation, the parent organization to the NDATA, represents more than 35,000 members in the U.S. and internationally. There are approximately 42,000 ATs practicing in the U.S. There are students in 325 accredited collegiate academic programs.

There are four accredited collegiate academic programs in North Dakota that students can enroll in to become an Athletic Trainer: Minot State, North Dakota State; University of Mary, and University of North Dakota. Valley City State is also in the process of becoming an accredited athletic training educational program.

There are 177 licensed Athletic Trainers in the state of North Dakota working in a variety of settings. All colleges/universities in the state have athletic trainers providing health care to students/athletes. Some ATs are employed by health systems/hospitals and provide medical coverage of events at secondary schools. Altru, Sanford and Trinity Health Systems have athletic trainers working in their orthopedic/sports medicine clinics as physican extenders. There are a few working in industrial settings providing prevention and wellness care for workers. Those are just a few examples of where Athletic Trainers are working across the state.

Thank you for your time and consideration. We believe SB 2295 is a good bill and ask this committee for a "do pass" recommendation. Now I would be happy to address any questions at this time.

Chairman and members of the House Human Services Committee, my name is Alyssa Sorensen and I am the Secretary/Treasurer for the North Dakota Athletic Trainers' Association and also the Assistant Athletic Trainer at Valley City State University. I am here today on behalf of the North Dakota Athletic Trainers' Association.

Occupational and industrial workers are at risk of acute and overuse on - the - job injuries. Their work environment requires special skills often including heavy lifting, carrying, movement and physical stress. Athletic trainers (ATs) can assist both employers and employees with services, including ergonomics assistance, injury prevention, stretching programs, early recognition program, onsite physical rehabilitation, working with aging workforce, wellness and safety. (NATA)

At the industrial level, providing care for the employees is very important. Often, the athletic trainer acts as an integral part of the overall health and safety team, providing proper referral, early intervention and expediting the care of the worker. They often work in conjunction with safety personnel, facility management, union representatives, ergonomists, physicians and other health care providers. The athletic trainer works with the employees to show proper stretching and exercise routines to prevent and treat injuries and medical conditions. ATs are often the "on -site" contact for physicians and other therapists, and are the first line of defense in injury prevention. With overall production being the key part to an industry surviving, often times the company loses sight of the actual employee working the production line. The athletic trainer is an advocate for the employees to ensure their overall health and wellness is kept a top priority.

Industry is maximizing production and income, while reducing costs and boosting worker productivity. Athletic trainers improve these outcomes. With the athletic trainer initially assessing an injury and providing proper referral, it saves overall cost to the company.

One great example right in North Dakota can be seen at John Deere in Valley City, North Dakota; where there was a 70% OSHA reduction of injuries once they hired an athletic trainer (Erin Welken, John Deere, Valley City). 100% of the companies who had hired an athletic trainer, reported that the athletic trainer provides a favorable return-on-investment (ROI) (NATA), further 68% of the companies indicated that the athletic trainer helped to decrease restricted workdays and worker's compensation claims for musculoskeletal disorders (MSDs) by more than 25%.

Large industrial plants have multiple shifts and one athletic trainer cannot be there all 24 hours of the day. However, the athletic trainer can train employees to act as part of an emergency response team. They can treat minor injuries, are CPR/AED certified. They understand concussions. This is also a huge asset to the community as there are now more individuals trained in emergency response.

North Dakota has a growing industrial economy. Farm machine and equipment production, the Bakken oil fields, the Falkirk mine, etc. make up a vast portion of North Dakota employment opportunities. These settings can only improve production and efficiency with the addition of an athletic trainer. Even though these athletic trainers are not working with "athletic" injuries their knowledge and education, specifically in ergonomics and injury management, make them an integral part of the health care team.

Thank you for your time and consideration. I would be happy to address any questions.

March 21, 2015

Robin Tracy
3935 Dakota Drive
Grand Forks, ND 58201
701-746-5779

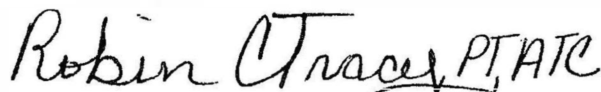
Dear ND House of Representatives Human Services Committee,

I am writing to ask you for your support of SB2295, to amend the Athletic Training Practice Act, currently before the Human Services Committee. As a dual credentialed/licensed physical therapist and athletic trainer, I am in favor of the amendment. The amendment more accurately describes the functions of a licensed athletic trainer and while it updates the practice act, it doesn't expand the scope of practice.

I am an assistant professor in the Athletic Training Program at UND and have held my position at UND for 20 years. The UND students, along with all athletic training students in accredited athletic training programs, are taught competencies in the comprehensive management of injuries and illnesses and then tested on competencies on the certification exam. This training includes recognizing, managing and being part of the treatment team for individuals with illnesses and injuries. My experience working with both athletic training and physical therapy students in the clinical setting has shown they have equivalent skills and knowledge in the evaluation, rehabilitation and testing of athletes and physically active patients. I feel that athletic trainers have gone through the training, testing and competencies to practice athletic training as stated in SB2295.

For the above reasons, I ask you to pass SB2295 and I thank you for your time and consideration in this matter. Feel free to contact me if you have any questions or concerns.

Respectfully submitted,



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robin.tracy@med.und.edu

#4
SB 2295
3/25/15

Mister Chairman and members of the House Human Services Committee, my name is Brandy Currie. I am Vice President of the North Dakota Athletic Trainers' Association as well the Curriculum Coordinator and Instructor at the University of Mary in Bismarck North Dakota. Additionally, I am employed by Sanford Health in Bismarck as an athletic trainer working in a local high school. I am here today on behalf of the North Dakota Athletic Trainers' Association and as an athletic training educator within the state.

We support the changes that are being proposed to the Century Code regulating athletic trainers in SB2295.

The code provisions regulating athletic trainers was first adopted in 1983. At that time, athletic trainers were mostly thought of as professionals who attended the sidelines of athletic events. But our profession, along with our education and training, has changed dramatically in the past 32 years, as has our role in delivering quality health care.

An accredited curriculum, established by the Commission on Accreditation of Athletic Training Education or CAATE, has since been adopted and educational competencies are used to guide teaching practices and student learning. These competencies are used as a standard measure of what students must be educated in upon completion of an entry-level Athletic Training education program. Knowledge, understanding and proficiency of the content of these competencies are essential for successful completion of our national board exam.

Professional, or entry-level Athletic Training education, uses a competency-based approach in both classroom and clinical settings. Using a medical-based education model, Athletic Training students are educated to provide comprehensive client/patient care in five domains of clinical practice:

1. prevention;
2. clinical evaluation and diagnosis;
3. immediate and emergency care:
4. treatment and rehabilitation; and
5. organization and professional health and well-being.

The educational requirements for CAATE-accredited Athletic Training education programs include

acquisition of knowledge, skills, and clinical abilities along with a broad scope of foundational behaviors of professional practice. Students complete an extensive clinical learning requirement that is embodied in the clinical integration proficiencies (professional, practice-oriented outcomes) as identified in the Athletic Training Education Competencies put forth by CAATE.

Students are required to participate in a minimum of two years of academic clinical education. Throughout these experiences, students must gain clinical experiences with a variety of patient populations who vary by age and types of activities, and who are at risk for both musculoskeletal and general medical conditions. This clinical experience prepares future athletic trainers to provide care to a diverse population of patients who sustain injuries in a number of ways outside the traditional "athletic" realm.

This formal education allows athletic trainers to work in a variety of patient settings such as colleges and Universities, hospital and clinical, occupational health, military, performing arts, physician extender, professional sports, public safety and secondary schools. The roles of the athletic trainers in these settings vary slightly, but generally include: prevention; early recognition of injuries; triage; immediate care of injuries, proper referral as needed; and general patient education.

While these roles are dictated by the educational standards presented, many of them are not always available to professionals in the state of North Dakota. In short, what my students are learning in the classroom cannot legally be translated into professional services in this state. The language of our current practice act creates confusion as to how athletic trainers can fill these roles in our state and has therefore limited the use of athletic trainers in these environments. In addition, it creates a level of uncertainty in terms of the legality in how they are practicing. This is obviously frustrating to future professionals as well as current professionals in our state. Some states have already amended their practice acts and numerous others are currently reviewing their practice acts to address this confusion and allow athletic trainers to work in the ways outlined by their education. In light of that, many students are actively pursuing work in other states besides North Dakota. We are forcing our highly qualified allied healthcare professionals to leave our state in order to work in their area of interest. Updating the language of the Century Code is simply that, it modernizes the code to more accurately reflect our education. It is not an expansion of services, it simply allows us to do what we are trained to do.

We believe this bill is a good bill and the North Dakota Athletic Trainers' Association asks this committee for a "do pass" recommendation.

Thank you for your time and consideration. I would be happy to address any questions.

Brandy Currie, M. Ed, ATC, LAT

TO: North Dakota Senate Human Service Committee

FROM: Jeremiah Penn, MD

DATE: March 23, 2015

SUBJECT: Senate Bill No. 2295

Mister Chairman and members of the House Human Services Committee, my name is Dr. Jeremiah Penn. I am a family medicine physician with specialized training in primary care sports medicine. I am writing this letter in support of Senate Bill No. 2295, which amends the North Dakota Century Code as it pertains to the profession of athletic training.

I currently work at MidDakota Clinic in Bismarck, ND. I received my family medicine training through the University of North Dakota Center for Family Medicine in Bismarck and my sports medicine training through the Kaiser Permanente Primary Care Sports Medicine Fellowship in Fontana, CA. I currently volunteer as team physician with the University of Mary and have worked closely with most of the high school athletic trainers in the Bismarck area. I feel my close contact with the athletic training educational program at the University of Mary and frequent interactions with numerous athletic trainers qualifies me to comment on this bill.

I am in support of this bill because I feel it updates our Century Code with a more accurate description of how athletic trainers in our state actually practice. With the large number of high school and college athletes training and competing every day in our state, there is no possible way physicians can deal with every one of their issues. Having well qualified athletic trainers as the point of entry into the health system is an excellent way to initiate care for these athletes. After athletes have been evaluated, protocols to return them to optimal performance must be initiated and for many of them, the most practical way to return to optimal health is through daily visits with their athletic trainer.

One of the concerns I have heard about this bill is that it may provide athletic trainers the ability to function without medical oversight. While I think the education athletic trainers receive has broadened significantly, I do not think their training comes close to the breadth and depth of that of a physician. That is why I think it is important to note that although it is not explicitly stated in our Century Code, all athletic trainers are expected to work under a physician. Athletic trainers are regulated under the Board of Certification for Athletic Training. This board has seven standards of practice. The first of these seven standards is the following: Direction – The Athletic Trainer renders service or treatment under the direction of a physician.

I feel that this bill clarifies the relationship of an athletic trainer with a physician and allows them to feel comfortable providing the services they have been trained for. I know the athletic trainers I work with value our relationship as a part of a health care team. I would encourage the committee of offer this bill a "do pass" recommendation. If I can answer any questions or offer clarification, please contact me on my cell phone at (701)-527-3358. Thank you for your consideration.

March 24, 2015
House Human Services Committee, Representative Robin Weisz, Chairman
Testimony on SB 2295 from Nick Walker

Good morning, Chairman Weisz and Members of the House Human Services Committee. My name is Nick Walker and I am the head girls' basketball coach at Legacy High School and head girls track coach at Century High School. I am here in favor of SB 2295.

I have been in the district now for 7 years and I fully understand the importance of having an athletic trainer in our building, at practice, and at sporting events. I believe that our kids in our schools are put in a great position by having the athletic trainers in our building. They care for injuries when needed and help prevent injuries by doing rehab or preventative measures to help our athletes be safe. I believe as a coach that it would be beneficial to all of our students and staff if the term "athletic injury" was changed to "Injury". This way, our athletic trainers would be able to help our kids that are injured in a non-sporting endeavor in or outside of the school day. This would also help to ensure that they are seen by a medical professional when we all know that some of our kids would not be afforded that opportunity if it wasn't for the medical professional in our school. Once again, I cannot express the respect I have for the athletic trainers in the school. They are key component of the safety and well-being of our kids in school.

Thank you for your time. I urge you give SB 2295 a do pass recommendation. I am glad to answer your questions,

Nick Walker
Bismarck Public Schools

TO: North Dakota Senate Human Service Committee

FROM: Tim Jeulson, MD

DATE: March 23, 2015

SUBJECT: Senate Bill No. 2295

Mister Chairman and members of the House Human Services Committee, thank you for taking the time to review SB 2295. I wish that I could be present with you, but I was already committed to my patients who had scheduled on the day that this bill will be discussed. My name is Tim Juelson and I am an orthopaedic surgeon practicing in Bismarck, ND, at the Bone & Joint Center. I am certified by the American Board of Orthopaedic Surgery and also completed an orthopaedic sports surgery fellowship with Dr. Andrews where we worked directly with many athletic trainers. I am privileged to have earned the first certificate of added qualification in orthopaedic sports surgery in North Dakota. My specialty focuses mostly on prevention, management, and treatment of sports related injuries. During my fellowship in Florida athletic trainers were directly involved in all aspects of patient care.

You have heard from some of the athletic trainers today, so I will be brief with my testimony in support of SB2295. Over the past years I have had the privilege of working with some of the certified athletic trainers whom you have heard from today. We have had many patients in common, particularly with my responsibilities to various high schools and the University of Mary athletes. Athletic trainers provide a valuable service, predominantly with management of injuries both simple and complex. Their role is both valuable and certainly has room for expansion into the future.

The bill before you today is representative of current athletic trainer's capability and scope of practice. Physicians are still involved in their supervision and it recognizes their current abilities. In discussion with the North Dakota Medical Association, there are no objections to SB2295.

Thank you for your time, and please let me know if there are any questions I can answer. My email is tjuelson@bone-joint.com and work number is 701-530-8800.

A Sampling of Illnesses Addressed in Educational Competencies

PHP-14. Assess weight loss and hydration status using weight charts, urine color charts, or specific gravity measurements to determine an individual's ability to participate in physical activity in a hot, humid environment.
PHP-15. Use a glucometer to monitor blood glucose levels, determine participation status, and make referral decisions.
PHP-16. Use a peak-flow meter to monitor a patient's asthma symptoms, determine participation status, and make referral decisions.
AC-36. Identify the signs, symptoms, interventions and, when appropriate, the return-to-participation criteria for:
AC-36a. sudden cardiac arrest
AC-36b. brain injury including concussion, subdural and epidural hematomas, second impact syndrome and skull fracture
AC-36c. cervical, thoracic, and lumbar spine trauma
AC-36d. heat illness including heat cramps, heat exhaustion, exertional and hyponatremia
AC-36e. exertional sickling associated with sickle cell trait
AC-36f. rhabdomyolysis
AC-36g. internal hemorrhage
AC-36h. diabetic emergencies including hypoglycemia and ketoacidosis
AC-36i. asthma attacks
AC-36j. systemic allergic reaction, including anaphylactic shock
AC-36k. epileptic and non-epileptic seizures
AC-36l. shock
AC-36m. hypothermia, frostbite
AC-36n. toxic drug overdoses
AC-36o. local allergic reaction.

Athletic Training Education Competencies

5th Edition

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Preface

The 5th edition of the Athletic Training Education Competencies (Competencies) provides educational program personnel and others with the knowledge, skills, and clinical abilities to be mastered by students enrolled in professional athletic training education programs. Mastery of these Competencies provides the entry-level athletic trainer with the capacity to provide athletic training services to clients and patients of varying ages, lifestyles, and needs.

The Commission on Accreditation of Athletic Training Education (CAATE) requires that the Competencies be instructed and evaluated in each accredited professional athletic training education program. The Competencies serve as a companion document to the accreditation standards, which identify the requirements to acquire and maintain accreditation, published by CAATE.

The Professional Education Council (PEC) of the NATA was charged with creating the 5th edition of the Competencies. The PEC developed and executed a systematic plan to draft the Competencies and to solicit and integrate feedback from multiple sources as the draft was revised. First, the PEC orchestrated an initial open call for feedback on the 4th edition of the Competencies. Next, groups of subject-matter experts, including practicing athletic trainers, educators, and administrators, were identified. In addition to the feedback on the 4th edition, these subject-matter experts considered today's healthcare system, current best practice in athletic training, and their own expertise in creating an initial draft of the 5th edition. Many conversations ensued and subsequent drafts were submitted. Following revision for form and consistency of language, a draft of the Competencies was again posted for open feedback. This valuable feedback was considered in its entirety by the PEC, and final revisions were made.

We thank the members of the PEC for their untiring efforts in revising this document to reflect the changing needs of athletic training education. The advice, cooperation, and feedback from the Board of Certification and the CAATE have also been instrumental in this process. Finally, the diligent and perceptive feedback that was received from stakeholders during the public comment periods was instrumental in creating a document that ensures that entry-level athletic trainers are prepared to work in a changing healthcare system. Together we are improving healthcare by improving the education of athletic trainers.

— NATA Executive Committee for Education, December 2010

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Introduction

This document is to be used as a guide by administrative, academic, and clinical program personnel when structuring all facets of the education experience for students. Educational program personnel should recognize that the Competencies are the ***minimum requirements*** for a student's professional education. Athletic training education programs are encouraged to exceed these minimums to provide their students with the highest quality education possible. In addition, programs should employ innovative, student-centered teaching and learning methodologies to connect the classroom, laboratory and clinical settings whenever possible to further enhance professional preparation.

The acquisition and clinical application of knowledge and skills in an education program must represent a defined yet flexible program of study. Defined in that knowledge and skills must be accounted for in the more formal classroom and laboratory educational experience. Flexible in that learning opportunities are everywhere. Behaviors are identified, discussed, and practiced throughout the educational program. Whatever the sequence of learning, patient safety is of prime importance; students must demonstrate competency in a particular task before using it on a patient. This begins a cycle of learning, feedback, refinement, and more advanced learning. Practice with concepts by gaining clinical experience with real life applications readies the student for opportunities to demonstrate decision-making and skill integration ability, Clinical Integrated Proficiencies (CIP). CIPs are designed to measure of real life application. Students should be assessed in their performance of CIPs on actual patients. If this is not possible, standardized/simulated patients or scenarios should be used to measure student proficiency.

Also, inherent in this document is the understanding that a comprehensive basic and applied science background is needed for students to develop appropriate levels of professional competence in the discipline-specific knowledge and skills described in this document.

All facets of the educational programs must incorporate current knowledge and skills that represent best practice. Programs must select such content following careful review of the research literature and consideration of the needs for today's entry-level practitioner. Because the knowledge within a profession is dynamic, information regarding current best practice is fluid and requires on-going examination and reflection.

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Summary of Major Changes included in 5th Edition

- The 12 content areas of the previous edition have been reorganized into 8 to eliminate redundancies and better reflect current practice.
  - — The pathology content area was eliminated, and these competencies are addressed throughout other content areas.
  - — The risk management/prevention and nutritional considerations content areas were combined to form the new **Prevention and Health Promotion (PHP)** content area. This change was made to reflect the current emphasis on prevention and wellness across health care and the lifespan.
  - — The orthopedic clinical exam/diagnosis and medical conditions/disabilities content areas were combined to form the **Clinical Examination and Diagnosis (CE)** content area. This change was made to emphasize that athletic trainers use one standard clinical examination model that changes based on the findings and needs of the patient.
  - — The therapeutic modalities, conditioning and rehabilitative exercise and pharmacology content areas were combined to form one content area that incorporates all aspects of **Therapeutic Interventions (TI).**
  - — A new content area was added to provide students with the basic knowledge and skills related to **Evidence-Based Practice (EBP).** The importance of using EBP concepts and principles to improve patient outcomes is being emphasized throughout the health care system and is reflected within this new content area.
- The **Acute Care (AC)** content area has been substantially revised to reflect contemporary practice.
  - — The addition of skill in assessing rectal temperature, oxygen saturation, blood glucose levels, and use of a nebulizer and oropharyngeal and nasopharyngeal airways reflects recommendations of NATA position statements that are published or in development.
- The content areas now integrate knowledge and skills, instead of separate sections for cognitive and psychomotor competencies. The action verb used in each competency statement identifies the expected outcome. In some places, knowledge is the expectation and not skill acquisition. For example, acute care competency #9 (AC-9) requires that athletic training students be knowledgeable about the various types of airway adjuncts including oropharyngeal airways (OPA), nasopharyngeal airways (NPO) and supraglottic airways. However, the accompanying skill competency AC-10 does not require skill acquisition in the use of the supraglottic airways.
- The **Clinical Integration Proficiencies (CIP)**, which are ideally assessed in the context of real patient care, have been removed from the individual content areas and reorganized into a separate section. This reorganization reflects clinical practice and demonstrates the global nature of the Proficiencies. For example, rather than just assessing students' ability to examine a real patient in a real clinical setting, the new CIPs require that students demonstrate the ability to examine and diagnose a patient, provide appropriate acute/emergent care, plan and implement appropriate therapeutic interventions, and make decisions pertaining to safe return to participation. This approach to student assessment better reflects the comprehensive nature of real patient care.

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Comparison of the Role Delineation Study/Practice Analysis, 6th Ed and the Competencies

The Role Delineation Study/Practice Analysis, 6th ed (RDS/PA) of the Board of Certification serves as the blue print for the certification examination. As such, the Competencies must include all tasks (and related knowledge and skills) included in the RDS/PA. Working with the BOC, we compared the RDS/PA with this version of the Competencies and can confidently state that the content of the RDS /PA is incorporated in this version.

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Foundational Behaviors of Professional Practice

These basic behaviors permeate professional practice and should be incorporated into instruction and assessed throughout the educational program.

Primacy of the Patient
- Recognize sources of conflict of interest that can impact the client's/patient's health.
- Know and apply the commonly accepted standards for patient confidentiality.
- Provide the best healthcare available for the client/patient.
- Advocate for the needs of the client/patient.

Team Approach to Practice
- Recognize the unique skills and abilities of other healthcare professionals.
- Understand the scope of practice of other healthcare professionals.
- Execute duties within the identified scope of practice for athletic trainers.
- Include the patient (and family, where appropriate) in the decision-making process.
- Work with others in effecting positive patient outcomes.

Legal Practice
- Practice athletic training in a legally competent manner.
- Identify and conform to the laws that govern athletic training.
- Understand the consequences of violating the laws that govern athletic training.

Ethical Practice
- Comply with the NATA's *Code of Ethics* and the BOC's *Standards of Professional Practice.*
- Understand the consequences of violating the NATA's *Code of Ethics* and BOC's *Standards of Professional Practice*.
- Comply with other codes of ethics, as applicable.

Advancing Knowledge
- Critically examine the body of knowledge in athletic training and related fields.
- Use evidence-based practice as a foundation for the delivery of care.
- Appreciate the connection between continuing education and the improvement of athletic training practice.
- Promote the value of research and scholarship in athletic training.
- Disseminate new knowledge in athletic training to fellow athletic trainers, clients/patients, other healthcare professionals, and others as necessary.

Cultural Competence
- Demonstrate awareness of the impact that clients'/patients' cultural differences have on their attitudes and behaviors toward healthcare.
- Demonstrate knowledge, attitudes, behaviors, and skills necessary to achieve optimal health outcomes for diverse patient populations.
- Work respectfully and effectively with diverse populations and in a diverse work environment.

Professionalism
- Advocate for the profession.
- Demonstrate honesty and integrity.
- Exhibit compassion and empathy.
- Demonstrate effective interpersonal communication skills.

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Evidence-Based Practice (EBP)

Evidence-based practitioners incorporate the best available evidence, their clinical skills, and the needs of the patient to maximize patient outcomes. An understanding of evidence-based practice concepts and their application is essential to sound clinical decision-making and the critical examination of athletic training practice.

Practicing in an evidence-based manner should not be confused with conducting research. While conducting research is important to the profession of athletic training, developing the ability to conduct a research project is not an expectation of professional education. This section focuses on the knowledge and skills necessary for entry-level athletic trainers to use a systematic approach to ask and answer clinically relevant questions that affect patient care by using review and application of existing research evidence. One strategy, among others, is to use a five-step approach: 1) creating a clinically relevant question; 2) searching for the best evidence; 3) critically analyzing the evidence; 4) integrating the appraisal with personal clinical expertise and patients' preferences; and 5) evaluating the performance or outcomes of the actions. Each competency listed below is related to such a systematic approach and provides the building blocks for employing evidence-based practice. Other specific evidence-based practice competencies have also been included in appropriate content areas.

All items listed in parentheses (eg) are intended to serve as examples and are not all encompassing or the only way to satisfy the competency.

Knowledge and Skills

EBP-1. Define evidence-based practice as it relates to athletic training clinical practice.

EBP-2. Explain the role of evidence in the clinical decision making process.

EBP-3. Describe and differentiate the types of quantitative and qualitative research, research components, and levels of research evidence.

EBP-4. Describe a systematic approach (eg, five step approach) to create and answer a clinical question through review and application of existing research.

EBP-5. Develop a relevant clinical question using a pre-defined question format (eg, PICO= Patients, Intervention, Comparison, Outcomes; PIO = Patients, Intervention, Outcomes).

EBP-6. Describe and contrast research and literature resources including databases and online critical appraisal libraries that can be used for conducting clinically-relevant searches.

EBP-7. Conduct a literature search using a clinical question relevant to athletic training practice using search techniques (eg, Boolean search, Medical Subject Headings) and resources appropriate for a specific clinical question.

EBP-8. Describe the differences between narrative reviews, systematic reviews, and meta-analyses.

EBP-9. Use standard criteria or developed scales (eg, Physiotherapy Evidence Database Scale [PEDro], Oxford Centre for Evidence Based Medicine Scale) to critically appraise the structure, rigor, and overall quality of research studies.

EBP-10. Determine the effectiveness and efficacy of an athletic training intervention utilizing evidence-based practice concepts.

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EBP-11. Explain the theoretical foundation of clinical outcomes assessment (eg, disablement, health-related quality of life) and describe common methods of outcomes assessment in athletic training clinical practice (generic, disease-specific, region-specific, and dimension-specific outcomes instruments).

EBP-12. Describe the types of outcomes measures for clinical practice (patient-based and clinician-based) as well as types of evidence that are gathered through outcomes assessment (patient-oriented evidence versus disease-oriented evidence).

EBP-13. Understand the methods of assessing patient status and progress (eg, global rating of change, minimal clinically important difference, minimal detectable difference) with clinical outcomes assessments.

EBP-14. Apply and interpret clinical outcomes to assess patient status, progress, and change using psychometrically sound outcome instruments.

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Prevention and Health Promotion (PHP)

Athletic trainers develop and implement strategies and programs to prevent the incidence and/or severity of injuries and illnesses and optimize their clients'/patients' overall health and quality of life. These strategies and programs also incorporate the importance of nutrition and physical activity in maintaining a healthy lifestyle and in preventing chronic disease (eg, diabetes, obesity, cardiovascular disease).

Knowledge and Skills

General Prevention Principles

PHP-1. Describe the concepts (eg, case definitions, incidence versus prevalence, exposure assessment, rates) and uses of injury and illness surveillance relevant to athletic training.

PHP-2. Identify and describe measures used to monitor injury prevention strategies (eg, injury rates and risks, relative risks, odds ratios, risk differences, numbers needed to treat/harm).

PHP-3. Identify modifiable/non-modifiable risk factors and mechanisms for injury and illness.

PHP-4. Explain how the effectiveness of a prevention strategy can be assessed using clinical outcomes, surveillance, or evaluation data.

PHP-5. Explain the precautions and risk factors associated with physical activity in persons with common congenital and acquired abnormalities, disabilities, and diseases.

PHP-6. Summarize the epidemiology data related to the risk of injury and illness associated with participation in physical activity.

Prevention Strategies and Procedures

PHP-7. Implement disinfectant procedures to prevent the spread of infectious diseases and to comply with Occupational Safety and Health Administration (OSHA) and other federal regulations.

PHP-8. Identify the necessary components to include in a preparticipation physical examination as recommended by contemporary guidelines (eg, American Heart Association, American Academy of Pediatrics Council on Sports Medicine & Fitness).

PHP-9. Explain the role of the preparticipation physical exam in identifying conditions that might predispose the athlete to injury or illness.

PHP-10. Explain the principles of the body's thermoregulatory mechanisms as they relate to heat gain and heat loss.

PHP-11. Explain the principles of environmental illness prevention programs to include acclimation and conditioning, fluid and electrolyte replacement requirements, proper practice and competition attire, hydration status, and environmental assessment (eg, sling psychrometer, wet bulb globe temperatures [WBGT], heat index guidelines).

PHP-12. Summarize current practice guidelines related to physical activity during extreme weather conditions (eg, heat, cold, lightning, wind).

PHP-13. Obtain and interpret environmental data (web bulb globe temperature [WBGT], sling psychrometer, lightning detection devices) to make clinical decisions regarding the scheduling, type, and duration of physical activity.

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PHP-14. Assess weight loss and hydration status using weight charts, urine color charts, or specific gravity measurements to determine an individual's ability to participate in physical activity in a hot, humid environment.

PHP-15. Use a glucometer to monitor blood glucose levels, determine participation status, and make referral decisions.

PHP-16. Use a peak-flow meter to monitor a patient's asthma symptoms, determine participation status, and make referral decisions.

PHP-17. Explain the etiology and prevention guidelines associated with the leading causes of sudden death during physical activity, including but not limited to:

- **PHP-17a.** Cardiac arrhythmia or arrest
- **PHP-17b.** Asthma
- **PHP-17c.** Traumatic brain injury
- **PHP-17d.** Exertional heat stroke
- **PHP-17e.** Hyponatremia
- **PHP-17f.** Exertional sickling
- **PHP-17g.** Anaphylactic shock
- **PHP-17h.** Cervical spine injury
- **PHP-17i.** Lightning strike

PHP-18. Explain strategies for communicating with coaches, athletes, parents, administrators, and other relevant personnel regarding potentially dangerous conditions related to the environment, field, or playing surfaces.

PHP-19. Instruct clients/patients in the basic principles of ergodynamics and their relationship to the prevention of illness and injury.

Protective Equipment and Prophylactic Procedures

PHP-20. Summarize the basic principles associated with the design, construction, fit, maintenance, and reconditioning of protective equipment, including the rules and regulations established by the associations that govern its use.

PHP-21. Summarize the principles and concepts related to the fabrication, modification, and appropriate application or use of orthotics and other dynamic and static splints.

PHP-22. Fit standard protective equipment following manufacturers' guidelines.

PHP-23. Apply preventive taping and wrapping procedures, splints, braces, and other special protective devices.

Fitness/Wellness

PHP-24. Summarize the general principles of health maintenance and personal hygiene, including skin care, dental hygiene, sanitation, immunizations, avoidance of infectious and contagious diseases, diet, rest, exercise, and weight control.

PHP-25. Describe the role of exercise in maintaining a healthy lifestyle and preventing chronic disease.

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PHP-26. Identify and describe the standard tests, test equipment, and testing protocols that are used for measuring fitness, body composition, posture, flexibility, muscular strength, power, speed, agility, and endurance.

PHP-27. Compare and contrast the various types of flexibility, strength training, and cardiovascular conditioning programs to include expected outcomes, safety precautions, hazards, and contraindications.

PHP-28. Administer and interpret fitness tests to assess a client's/patient's physical status and readiness for physical activity.

PHP-29. Explain the basic concepts and practice of fitness and wellness screening.

PHP-30. Design a fitness program to meet the individual needs of a client/patient based on the results of standard fitness assessments and wellness screening.

PHP-31. Instruct a client/patient regarding fitness exercises and the use of muscle strengthening equipment to include correction or modification of inappropriate, unsafe, or dangerous lifting techniques.

General Nutrition Concepts

PHP-32. Describe the role of nutrition in enhancing performance, preventing injury or illness, and maintaining a healthy lifestyle.

PHP-33. Educate clients/patients on the importance of healthy eating, regular exercise, and general preventative strategies for improving or maintaining health and quality of life.

PHP-34. Describe contemporary nutritional intake recommendations and explain how these recommendations can be used in performing a basic dietary analysis and providing appropriate general dietary recommendations.

PHP-35. Describe the proper intake, sources of, and effects of micro- and macronutrients on performance, health, and disease.

PHP-36. Describe current guidelines for proper hydration and explain the consequences of improper fluid/electrolyte replacement.

PHP-37. Identify, analyze, and utilize the essential components of food labels to determine the content, quality, and appropriateness of food products.

PHP-38. Describe nutritional principles that apply to tissue growth and repair.

PHP-39. Describe changes in dietary requirements that occur as a result of changes in an individual's health, age, and activity level.

PHP-40. Explain the physiologic principles and time factors associated with the design and planning of pre-activity and recovery meals/snacks and hydration practices.

PHP-41. Identify the foods and fluids that are most appropriate for pre-activity, activity, and recovery meals/snacks.

Weight Management and Body Composition

PHP-42. Explain how changes in the type and intensity of physical activity influence the energy and nutritional demands placed on the client/patient.

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PHP-43. Describe the principles and methods of body composition assessment to assess a client's/patient's health status and to monitor changes related to weight management, strength training, injury, disordered eating, menstrual status, and/or bone density status.

PHP-44. Assess body composition by validated techniques.

PHP-45. Describe contemporary weight management methods and strategies needed to support activities of daily life and physical activity.

Disordered Eating and Eating Disorders

PHP-46. Identify and describe the signs, symptoms, physiological, and psychological responses of clients/patients with disordered eating or eating disorders.

PHP-47. Describe the method of appropriate management and referral for clients/patients with disordered eating or eating disorders in a manner consistent with current practice guidelines.

Performance Enhancing and Recreational Supplements and Drugs

PHP-48. Explain the known usage patterns, general effects, and short- and long-term adverse effects for the commonly used dietary supplements, performance enhancing drugs, and recreational drugs.

PHP-49. Identify which therapeutic drugs, supplements, and performance-enhancing substances are banned by sport and/or workplace organizations in order to properly advise clients/patients about possible disqualification and other consequences.

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Clinical Examination and Diagnosis (CE)

Athletic trainers must possess strong clinical examination skills in order to accurately diagnosis and effectively treat their patients. The clinical examination is an on-going process, repeated to some extent each time the patient is treated. The development of these skills requires a thorough understanding of anatomy, physiology, and biomechanics. Athletic trainers must also apply clinical-reasoning skills throughout the physical examination process in order to assimilate data, select the appropriate assessment tests, and formulate a differential diagnosis.

The competencies identified in this section should be considered in the context of the competencies identified in other domains. For example, the knowledge and skills associated with acute care and therapeutic interventions, while applicable for this domain, are not repeated here.

The clinical examination process is comprehensive and may include a review of the systems and regions identified below based on the patient's relevant history and examination findings. Consideration must also be given to the patient's behavioral and cognitive status and history; competencies addressing this content area are included elsewhere.

Systems and Regions

a. Musculoskeletal
b. Integumentary
c. Neurological
d. Cardiovascular
e. Endocrine
f. Pulmonary
g. Gastrointestinal
h. Hepatobiliary
i. Immune
j. Renal and urogenital
k. The face, including maxillofacial region and mouth
l. Eye, ear, nose, and throat

Knowledge and Skills

CE-1. Describe the normal structures and interrelated functions of the body systems.

CE-2. Describe the normal anatomical, systemic, and physiological changes associated with the lifespan.

CE-3. Identify the common congenital and acquired risk factors and causes of musculoskeletal injuries and common illnesses that may influence physical activity in pediatric, adolescent, adult, and aging populations.

CE-4. Describe the principles and concepts of body movement, including normal osteokinematics and arthrokinematics.

CE-5. Describe the influence of pathomechanics on function.

CE-6. Describe the basic principles of diagnostic imaging and testing and their role in the diagnostic process.

CE-7. Identify the patient's participation restrictions (disabilities) and activity limitations (functional limitations) to determine the impact of the condition on the patient's life.

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CE-8. Explain the role and importance of functional outcome measures in clinical practice and patient health-related quality of life.

CE-9. Identify functional and patient-centered quality of life outcome measures appropriate for use in athletic training practice.

CE-10. Explain diagnostic accuracy concepts including reliability, sensitivity, specificity, likelihood ratios, prediction values, and pre-test and post-test probabilities in the selection and interpretation of physical examination and diagnostic procedures.

CE-11. Explain the creation of clinical prediction rules in the diagnosis and prognosis of various clinical conditions.

CE-12. Apply clinical prediction rules (eg, Ottawa Ankle Rules) during clinical examination procedures.

CE-13. Obtain a thorough medical history that includes the pertinent past medical history, underlying systemic disease, use of medications, the patient's perceived pain, and the history and course of the present condition.

CE-14. Differentiate between an initial injury evaluation and follow-up/reassessment as a means to evaluate the efficacy of the patient's treatment/rehabilitation program, and make modifications to the patient's program as needed.

CE-15. Demonstrate the ability to modify the diagnostic examination process according to the demands of the situation and patient responses.

CE-16. Recognize the signs and symptoms of catastrophic and emergent conditions and demonstrate appropriate referral decisions.

CE-17. Use clinical reasoning skills to formulate an appropriate clinical diagnosis for common illness/disease and orthopedic injuries/conditions.

CE-18. Incorporate the concept of differential diagnosis into the examination process.

CE-19. Determine criteria and make decisions regarding return to activity and/or sports participation based on the patient's current status.

CE-20. Use standard techniques and procedures for the clinical examination of common injuries, conditions, illnesses, and diseases including, but not limited to:

- CE-20a. history taking
- CE-20b. inspection/observation
- CE-20c. palpation
- CE-20d. functional assessment
- CE-20e. selective tissue testing techniques / special tests
- CE-20f. neurological assessments (sensory, motor, reflexes, balance, cognitive function)
- CE-20g. respiratory assessments (auscultation, percussion, respirations, peak-flow)
- CE-20h. circulatory assessments (pulse, blood pressure, auscultation)
- CE-20i. abdominal assessments (percussion, palpation, auscultation)
- CE-20j. other clinical assessments (otoscope, urinalysis, glucometer, temperature, opthalmoscope)

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CE-21. Assess and interpret findings from a physical examination that is based on the patient's clinical presentation. This exam can include:

- **CE-21a.** Assessment of posture, gait, and movement patterns
- **CE-21b.** Palpation
- **CE-21c.** Muscle function assessment
- **CE-21d.** Assessment of quantity and quality of osteokinematic joint motion
- **CE-21e.** Capsular and ligamentous stress testing
- **CE-21f.** Joint play (arthrokinematics)
- **CE-21g.** Selective tissue examination techniques / special tests
- **CE-21h.** Neurologic function (sensory, motor, reflexes, balance, cognition)
- **CE-21i.** Cardiovascular function (including differentiation between normal and abnormal heart sounds, blood pressure, and heart rate)
- **CE-21j.** Pulmonary function (including differentiation between normal breath sounds, percussion sounds, number and characteristics of respirations, peak expiratory flow)
- **CE-21k.** Gastrointestinal function (including differentiation between normal and abnormal bowel sounds)
- **CE-21l.** Genitourinary function (urinalysis)
- **CE-21m.** Ocular function (vision, ophthalmoscope)
- **CE-21n.** Function of the ear, nose, and throat (including otoscopic evaluation)
- **CE-21o.** Dermatological assessment
- **CE-21p.** Other assessments (glucometer, temperature)

CE-22. Determine when the findings of an examination warrant referral of the patient.

CE-23. Describe current setting-specific (eg, high school, college) and activity-specific rules and guidelines for managing injuries and illnesses.

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Acute Care of Injuries and Illnesses (AC)

Athletic trainers are often present when injuries or other acute conditions occur or are the first healthcare professionals to evaluate a patient. For this reason, athletic trainers must be knowledgeable and skilled in the evaluation and immediate management of acute injuries and illnesses.

The competencies identified in this section should be considered in the context of the competencies identified in other domains. For example, the knowledge and skills associated with the process of examination and documentation, while applicable for this domain, are not repeated here. Likewise, the knowledge and skills associated with the administrative and risk management aspects of planning for an emergency injury/illness situation are not repeated here.

Knowledge and Skills

Planning

AC-1. Explain the legal, moral, and ethical parameters that define the athletic trainer's scope of acute and emergency care.

AC-2. Differentiate the roles and responsibilities of the athletic trainer from other pre-hospital care and hospital-based providers, including emergency medical technicians/ paramedics, nurses, physician assistants, and physicians.

AC-3. Describe the hospital trauma level system and its role in the transportation decision-making process.

Examination

AC-4. Demonstrate the ability to perform scene, primary, and secondary surveys.

AC-5. Obtain a medical history appropriate for the patient's ability to respond.

AC-6. When appropriate, obtain and monitor signs of basic body functions including pulse, blood pressure, respiration, pulse oximetry, pain, and core temperature. Relate changes in vital signs to the patient's status.

AC-7. Differentiate between normal and abnormal physical findings (eg, pulse, blood pressure, heart and lung sounds, oxygen saturation, pain, core temperature) and the associated pathophysiology.

Immediate Emergent Management

AC-8. Explain the indications, guidelines, proper techniques, and necessary supplies for removing equipment and clothing in order to access the airway, evaluate and/or stabilize an athlete's injured body part.

AC-9. Differentiate the types of airway adjuncts (oropharygneal airways [OPA], nasopharyngeal airways [NPA] and supraglottic airways [King LT-D or Combitube]) and their use in maintaining a patent airway in adult respiratory and/or cardiac arrest.

AC-10. Establish and maintain an airway, including the use of oro- and nasopharygneal airways, and neutral spine alignment in an athlete with a suspected spine injury who may be wearing shoulder pads, a helmet with and without a face guard, or other protective equipment.

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AC-11. Determine when suction for airway maintenance is indicated and use according to accepted practice protocols.

AC-12. Identify cases when rescue breathing, CPR, and/or AED use is indicated according to current accepted practice protocols.

AC-13. Utilize an automated external defibrillator (AED) according to current accepted practice protocols.

AC-14. Perform one- and two- person CPR on an infant, child and adult.

AC-15. Utilize a bag valve and pocket mask on a child and adult using supplemental oxygen.

AC-16. Explain the indications, application, and treatment parameters for supplemental oxygen administration for emergency situations.

AC-17. Administer supplemental oxygen with adjuncts (eg, non-rebreather mask, nasal cannula).

AC-18. Assess oxygen saturation using a pulse oximeter and interpret the results to guide decision making.

AC-19. Explain the proper procedures for managing external hemorrhage (eg, direct pressure, pressure points, tourniquets) and the rationale for use of each.

AC-20. Select and use the appropriate procedure for managing external hemorrhage.

AC-21. Explain aseptic or sterile techniques, approved sanitation methods, and universal precautions used in the cleaning, closure, and dressing of wounds.

AC-22. Select and use appropriate procedures for the cleaning, closure, and dressing of wounds, identifying when referral is necessary.

AC-23. Use cervical stabilization devices and techniques that are appropriate to the circumstances of an injury.

AC-24. Demonstrate proper positioning and immobilization of a patient with a suspected spinal cord injury.

AC-25. Perform patient transfer techniques for suspected head and spine injuries utilizing supine log roll, prone log roll with push, prone log roll with pull, and lift-and-slide techniques.

AC-26. Select the appropriate spine board, including long board or short board, and use appropriate immobilization techniques based on the circumstance of the patient's injury.

AC-27. Explain the role of core body temperature in differentiating between exertional heat stroke, hyponatremia, and head injury.

AC-28. Differentiate the different methods for assessing core body temperature.

AC-29. Assess core body temperature using a rectal probe.

AC-30. Explain the role of rapid full body cooling in the emergency management of exertional heat stroke.

AC-31. Assist the patient in the use of a nebulizer treatment for an asthmatic attack.

AC-32. Determine when use of a metered-dose inhaler is warranted based on a patient's condition.

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AC-33. Instruct a patient in the use of a meter-dosed inhaler in the presence of asthma-related bronchospasm.

AC-34. Explain the importance of monitoring a patient following a head injury, including the role of obtaining clearance from a physician before further patient participation.

AC-35. Demonstrate the use of an auto-injectable epinephrine in the management of allergic anaphylaxis. Decide when auto-injectable epinephrine use is warranted based on a patient's condition.

AC-36. Identify the signs, symptoms, interventions and, when appropriate, the return-to-participation criteria for:
- AC-36a. sudden cardiac arrest
- AC-36b. brain injury including concussion, subdural and epidural hematomas, second impact syndrome and skull fracture
- AC-36c. cervical, thoracic, and lumbar spine trauma
- AC-36d. heat illness including heat cramps, heat exhaustion, exertional heat stroke, and hyponatremia
- AC-36e. exertional sickling associated with sickle cell trait
- AC-36f. rhabdomyolysis
- AC-36g. internal hemorrhage
- AC-36h. diabetic emergencies including hypoglycemia and ketoacidosis
- AC-36i. asthma attacks
- AC-36j. systemic allergic reaction, including anaphylactic shock
- AC-36k. epileptic and non-epileptic seizures
- AC-36l. shock
- AC-36m. hypothermia, frostbite
- AC-36n. toxic drug overdoses
- AC-36o. local allergic reaction

Immediate Musculoskeletal Management

AC-37. Select and apply appropriate splinting material to stabilize an injured body area.

AC-38. Apply appropriate immediate treatment to protect the injured area and minimize the effects of hypoxic and enzymatic injury.

AC-39. Select and implement the appropriate ambulatory aid based on the patient's injury and activity and participation restrictions.

Transportation

AC-40. Determine the proper transportation technique based on the patient's condition and findings of the immediate examination.

AC-41. Identify the criteria used in the decision-making process to transport the injured patient for further medical examination.

AC-42. Select and use the appropriate short-distance transportation methods, such as the log roll or lift and slide, for an injured patient in different situations.

Education

AC-36. Instruct the patient in home care and self-treatment plans for acute conditions.

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Therapeutic Interventions (TI)

Athletic trainers assess the patient's status using clinician- and patient-oriented outcome measures. Based on this assessment and with consideration of the stage of healing and goals, a therapeutic intervention is designed to maximize the patient's participation and health-related quality of life.

A broad range of interventions, methods, techniques, equipment, activities using body movement, and medications are incorporated into this domain. These interventions are designed to enhance function by identifying, remediating, and preventing impairments and activity restrictions (functional limitations) to maximize participation. Rehabilitation is conducted in a wide variety of settings (eg, aquatic, clinic) with basic and contemporary equipment/modalities and on a wide range of patients with respect to age, overall health, and desired level of activity. Therapeutic interventions also include the use of prescription and nonprescription medications. For this reason, the athletic trainer needs to be knowledgeable about common prescription and nonprescription drug indications, adverse reactions, and interactions.

The competencies identified in this section should be considered in the context of the competencies identified in other content areas. For example, the knowledge and skills associated with the process of examination and documentation, while applicable for this content area, are not included here.

Therapeutic interventions include:

- Techniques to reduce pain
- Techniques to limit edema
- Techniques to restore joint mobility
- Techniques to restore muscle extensibility
- Techniques to restore neuromuscular function
- Exercises to improve strength, endurance, speed, and power
- Activities to improve balance, neuromuscular control, coordination, and agility
- Exercises to improve gait, posture, and body mechanics
- Exercises to improve cardiorespiratory fitness
- Functional exercises (eg, sports- or activity-specific)
- Exercises which comprise a home-based program
- Aquatic therapy
- Therapeutic modalities
  - superficial thermal agents (eg, hot pack, ice)
  - electrical stimulation
  - therapeutic ultrasound
  - diathermy
  - therapeutic low-level laser and light therapy
  - mechanical modalities
    - traction
    - intermittent compression
    - continuous passive motion
    - massage
    - biofeedback
- Therapeutic medications (as guided by applicable state and federal law)

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Knowledge and Skills

Physical Rehabilitation and Therapeutic Modalities

TI-1. Describe and differentiate the physiological and pathophysiological responses to inflammatory and non-inflammatory conditions and the influence of these responses on the design, implementation, and progression of a therapeutic intervention.

TI-2. Compare and contrast contemporary theories of pain perception and pain modulation.

TI-3. Differentiate between palliative and primary pain-control interventions.

TI-4. Analyze the impact of immobilization, inactivity, and mobilization on the body systems (eg, cardiovascular, pulmonary, musculoskeletal) and injury response.

TI-5. Compare and contrast the variations in the physiological response to injury and healing across the lifespan.

TI-6. Describe common surgical techniques, including interpretation of operative reports, and any resulting precautions, contraindications, and comorbidities that impact the selection and progression of a therapeutic intervention program.

TI-7. Identify patient- and clinician-oriented outcomes measures commonly used to recommend activity level, make return to play decisions, and maximize patient outcomes and progress in the treatment plan.

TI-8. Explain the theory and principles relating to expected physiological response(s) during and following therapeutic interventions.

TI-9. Describe the laws of physics that (1) underlay the application of thermal, mechanical, electromagnetic, and acoustic energy to the body and (2) form the foundation for the development of therapeutic interventions (eg, stress-strain, leverage, thermodynamics, energy transmission and attenuation, electricity).

TI-10. Integrate self-treatment into the intervention when appropriate, including instructing the patient regarding self-treatment plans.

TI-11. Design therapeutic interventions to meet specified treatment goals.
- TI-11a. Assess the patient to identify indications, contraindications, and precautions applicable to the intended intervention.
- TI-11b. Position and prepare the patient for various therapeutic interventions.
- TI-11c. Describe the expected effects and potential adverse reactions to the patient.
- TI-11d. Instruct the patient how to correctly perform rehabilitative exercises.
- TI-11e. Apply the intervention, using parameters appropriate to the intended outcome.
- TI-11f. Reassess the patient to determine the immediate impact of the intervention.

TI-12. Use the results of on-going clinical examinations to determine when a therapeutic intervention should be progressed, regressed or discontinued.

TI-13. Describe the relationship between the application of therapeutic modalities and the incorporation of active and passive exercise and/or manual therapies, including therapeutic massage, myofascial techniques, and muscle energy techniques.

TI-14. Describe the use of joint mobilization in pain reduction and restoration of joint mobility.

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TI-15. Perform joint mobilization techniques as indicated by examination findings.

TI-16. Fabricate and apply taping, wrapping, supportive, and protective devices to facilitate return to function.

TI-17. Analyze gait and select appropriate instruction and correction strategies to facilitate safe progression to functional gait pattern.

TI-18. Explain the relationship between posture, biomechanics, and ergodynamics and the need to address these components in a therapeutic intervention.

TI-19. Identify manufacturer, institutional, state, and/or federal standards that influence approval, operation, inspection, maintenance and safe application of therapeutic modalities and rehabilitation equipment.

TI-20. Inspect therapeutic equipment and the treatment environment for potential safety hazards.

Therapeutic Medications

TI-21. Explain the federal, state, and local laws, regulations and procedures for the proper storage, disposal, transportation, dispensing (administering where appropriate), and documentation associated with commonly used prescription and nonprescription medications.

TI-22. Identify and use appropriate pharmaceutical terminology for management of medications, inventory control, and reporting of pharmacological agents commonly used in an athletic training facility.

TI-23. Use an electronic drug resource to locate and identify indications, contraindications, precautions, and adverse reactions for common prescription and nonprescription medications.

TI-24. Explain the major concepts of pharmacokinetics and the influence that exercise might have on these processes.

TI-25. Explain the concepts related to bioavailability, half-life, and bioequivalence (including the relationship between generic and brand name drugs) and their relevance to the patient, the choice of medication, and the dosing schedule.

TI-26. Explain the pharmacodynamic principles of receptor theory, dose-response relationship, placebo effect, potency, and drug interactions as they relate to the mechanism of drug action and therapeutic effectiveness.

TI-27. Describe the common routes used to administer medications and their advantages and disadvantages.

TI-28. Properly assist and/or instruct the patient in the proper use, cleaning, and storage of drugs commonly delivered by metered dose inhalers, nebulizers, insulin pumps, or other parenteral routes as prescribed by the physician.

TI-29. Describe how common pharmacological agents influence pain and healing and their influence on various therapeutic interventions.

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TI-30. Explain the general therapeutic strategy, including drug categories used for treatment, desired treatment outcomes, and typical duration of treatment, for the following common diseases and conditions: asthma, diabetes, hypertension, infections, depression, GERD, allergies, pain, inflammation, and the common cold.

TI-31. Optimize therapeutic outcomes by communicating with patients and/or appropriate healthcare professionals regarding compliance issues, drug interactions, adverse drug reactions, and sub-optimal therapy.

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Psychosocial Strategies and Referral (PS)

Athletic trainers must be able to recognize clients/patients exhibiting abnormal social, emotional, and mental behaviors. Coupled with recognition is the ability to intervene and refer these individuals as necessary. Additionally, athletic trainers appreciate the role of mental health in injury and recovery and use interventions to optimize the connection between mental health and restoration of participation.

Knowledge and Skills

Theoretical Background

PS-1. Describe the basic principles of personality traits, trait anxiety, locus of control, intrinsic and extrinsic motivation, and patient and social environment interactions as they affect patient interactions.

PS-2. Explain the theoretical background of psychological and emotional responses to injury and forced inactivity (eg, cognitive appraisal model, stress response model).

PS-3. Describe how psychosocial considerations affect clinical decision-making related to return to activity or participation (eg, motivation, confidence).

PS-4. Summarize and demonstrate the basic processes of effective interpersonal and cross-cultural communication as it relates to interactions with patients and others involved in the healthcare of the patient.

PS-5. Summarize contemporary theory regarding educating patients of all ages and cultural backgrounds to effect behavioral change.

Psychosocial Strategies

PS-6. Explain the importance of educating patients, parents/guardians, and others regarding the condition in order to enhance the psychological and emotional well-being of the patient.

PS-7. Describe the psychological techniques (eg, goal setting, imagery, positive self-talk, relaxation/anxiety reduction) that the athletic trainer can use to motivate the patient during injury rehabilitation and return to activity processes.

PS-8. Describe psychological interventions (eg, goal setting, motivational techniques) that are used to facilitate a patient's physical, psychological, and return to activity needs.

PS-9. Describe the psychosocial factors that affect persistent pain sensation and perception (eg, emotional state, locus of control, psychodynamic issues, sociocultural factors, personal values and beliefs) and identify multidisciplinary approaches for assisting patients with persistent pain.

PS-10. Explain the impact of sociocultural issues that influence the nature and quality of healthcare received (eg, cultural competence, access to appropriate healthcare providers, uninsured/underinsured patients, insurance) and formulate and implement strategies to maximize client/patient outcomes.

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Mental Health and Referral

PS-11. Describe the role of various mental healthcare providers (eg, psychiatrists, psychologists, counselors, social workers) that may comprise a mental health referral network.

PS-12. Identify and refer clients/patients in need of mental healthcare.

PS-13. Identify and describe the basic signs and symptoms of mental health disorders (eg, psychosis, neurosis; sub-clinical mood disturbances (eg, depression, anxiety); and personal/social conflict (eg, adjustment to injury, family problems, academic or emotional stress, personal assault or abuse, sexual assault or harassment) that may indicate the need for referral to a mental healthcare professional.

PS-14. Describe the psychological and sociocultural factors associated with common eating disorders.

PS-15. Identify the symptoms and clinical signs of substance misuse/abuse, the psychological and sociocultural factors associated with such misuse/abuse, its impact on an individual's health and physical performance, and the need for proper referral to a healthcare professional.

PS-16. Formulate a referral for an individual with a suspected mental health or substance abuse problem.

PS-17. Describe the psychological and emotional responses to a catastrophic event, the potential need for a psychological intervention and a referral plan for all parties affected by the event.

PS-18. Provide appropriate education regarding the condition and plan of care to the patient and appropriately discuss with others as needed and as appropriate to protect patient privacy.

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Healthcare Administration (HA)

Athletic trainers function within the context of a complex healthcare system. Integral to this function is an understanding of risk management, healthcare delivery mechanisms, insurance, reimbursement, documentation, patient privacy, and facility management.

Knowledge and Skills

HA-1. Describe the role of the athletic trainer and the delivery of athletic training services within the context of the broader healthcare system.

HA-2. Describe the impact of organizational structure on the daily operations of a healthcare facility.

HA-3. Describe the role of strategic planning as a means to assess and promote organizational improvement.

HA-4. Describe the conceptual components of developing and implementing a basic business plan.

HA-5. Describe basic healthcare facility design for a safe and efficient clinical practice setting.

HA-6. Explain components of the budgeting process including: purchasing, requisition, bidding, request for proposal, inventory, profit and loss ratios, budget balancing, and return on investments.

HA-7. Assess the value of the services provided by an athletic trainer (eg, return on investment).

HA-8. Develop operational and capital budgets based on a supply inventory and needs assessment; including capital equipment, salaries and benefits, trending analysis, facility cost, and common expenses.

HA-9. Identify the components that comprise a comprehensive medical record.

HA-10. Identify and explain the statutes that regulate the privacy and security of medical records.

HA-11. Use contemporary documentation strategies to effectively communicate with patients, physicians, insurers, colleagues, administrators, and parents or family members.

HA-12. Use a comprehensive patient-file management system for appropriate chart documentation, risk management, outcomes, and billing.

HA-13. Define state and federal statutes that regulate employment practices.

HA-14. Describe principles of recruiting, selecting, hiring, and evaluating employees.

HA-15. Identify principles of recruiting, selecting, employing, and contracting with physicians and other medical and healthcare personnel in the deployment of healthcare services.

HA-16. Describe federal and state infection control regulations and guidelines, including universal precautions as mandated by the Occupational Safety and Health Administration (OSHA), for the prevention, exposure, and control of infectious diseases, and discuss how they apply to the practicing of athletic training.

HA-17. Identify key regulatory agencies that impact healthcare facilities, and describe their function in the regulation and overall delivery of healthcare.

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HA-18. Describe the basic legal principles that apply to an athletic trainer's responsibilities.

HA-19. Identify components of a risk management plan to include security, fire, electrical and equipment safety, emergency preparedness, and hazardous chemicals.

HA-20. Create a risk management plan and develop associated policies and procedures to guide the operation of athletic training services within a healthcare facility to include issues related to security, fire, electrical and equipment safety, emergency preparedness, and hazardous chemicals.

HA-21. Develop comprehensive, venue-specific emergency action plans for the care of acutely injured or ill individuals.

HA-22. Develop specific plans of care for common potential emergent conditions (eg, asthma attack, diabetic emergency).

HA-23. Identify and explain the recommended or required components of a pre-participation examination based on appropriate authorities' rules, guidelines, and/or recommendations.

HA-24. Describe a plan to access appropriate medical assistance on disease control, notify medical authorities, and prevent disease epidemics.

HA-25. Describe common health insurance models, insurance contract negotiation, and the common benefits and exclusions identified within these models.

HA-26. Describe the criteria for selection, common features, specifications, and required documentation needed for secondary, excess accident, and catastrophic health insurance.

HA-27. Describe the concepts and procedures for revenue generation and reimbursement.

HA-28. Understand the role of and use diagnostic and procedural codes when documenting patient care.

HA-29. Explain typical administrative policies and procedures that govern first aid and emergency care.

HA-30. Describe the role and functions of various healthcare providers and protocols that govern the referral of patients to these professionals.

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Professional Development and Responsibility (PD)

The provision of high quality patient care requires that the athletic trainer maintain current competence in the constantly changing world of healthcare. Athletic trainers must also embrace the need to practice within the limits of state and national regulation using moral and ethical judgment. As members of a broader healthcare community, athletic trainers work collaboratively with other healthcare providers and refer clients/patients when such referral is warranted.

Knowledge and Skills

PD-1. Summarize the athletic training profession's history and development and how current athletic training practice has been influenced by its past.

PD-2. Describe the role and function of the National Athletic Trainers' Association and its influence on the profession.

PD-3. Describe the role and function of the Board of Certification, the Commission on Accreditation of Athletic Training Education, and state regulatory boards.

PD-4. Explain the role and function of state athletic training practice acts and registration, licensure, and certification agencies including (1) basic legislative processes for the implementation of practice acts, (2) rationale for state regulations that govern the practice of athletic training, and (3) consequences of violating federal and state regulatory acts.

PD-5. Access, analyze, and differentiate between the essential documents of the national governing, credentialing and regulatory bodies, including, but not limited to, the NATA *Athletic Training Educational Competencies*, the BOC *Standards of Professional Practice*, the NATA *Code of Ethics*, and the BOC *Role Delineation Study/Practice Analysis*.

PD-6. Explain the process of obtaining and maintaining necessary local, state, and national credentials for the practice of athletic training.

PD-7. Perform a self-assessment of professional competence and create a professional development plan to maintain necessary credentials and promote life-long learning strategies.

PD-8. Differentiate among the preparation, scopes of practice, and roles and responsibilities of healthcare providers and other professionals with whom athletic trainers interact.

PD-9. Specify when referral of a client/patient to another healthcare provider is warranted and formulate and implement strategies to facilitate that referral.

PD-10. Develop healthcare educational programming specific to the target audience (eg, clients/patients, healthcare personnel, administrators, parents, general public).

PD-11. Identify strategies to educate colleagues, students, patients, the public, and other healthcare professionals about the roles, responsibilities, academic preparation, and scope of practice of athletic trainers.

PD-12. Identify mechanisms by which athletic trainers influence state and federal healthcare regulation.

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Clinical Integration Proficiencies (CIP)

The clinical integration proficiencies (CIPs) represent the synthesis and integration of knowledge, skills, and clinical decision-making into actual client/patient care. The CIPs have been reorganized into this section (rather than at the end of each content area) to reflect their global nature. For example, therapeutic interventions do not occur in isolation from physical assessment.

In most cases, assessment of the CIPs should occur when the student is engaged in real client/patient care and may be necessarily assessed over multiple interactions with the same client/patient. In a few instances, assessment may require simulated scenarios, as certain circumstances may occur rarely but are nevertheless important to the well-prepared practitioner.

The incorporation of evidence-based practice principles into care provided by athletic trainers is central to optimizing outcomes. Assessment of student competence in the CIPs should reflect the extent to which these principles are integrated. Assessment of students in the use of Foundational Behaviors in the context of real patient care should also occur.

Prevention & Health Promotion

CIP-1. Administer testing procedures to obtain baseline data regarding a client's/patient's level of general health (including nutritional habits, physical activity status, and body composition). Use this data to design, implement, evaluate, and modify a program specific to the performance and health goals of the patient. This will include instructing the patient in the proper performance of the activities, recognizing the warning signs and symptoms of potential injuries and illnesses that may occur, and explaining the role of exercise in maintaining overall health and the prevention of diseases. Incorporate contemporary behavioral change theory when educating clients/patients and associated individuals to effect health-related change. Refer to other medical and health professionals when appropriate.

CIP-2. Select, apply, evaluate, and modify appropriate standard protective equipment, taping, wrapping, bracing, padding, and other custom devices for the client/patient in order to prevent and/or minimize the risk of injury to the head, torso, spine, and extremities for safe participation in sport or other physical activity.

CIP-3. Develop, implement, and monitor prevention strategies for at-risk individuals (eg, persons with asthma or diabetes, persons with a previous history of heat illness, persons with sickle cell trait) and large groups to allow safe physical activity in a variety of conditions. This includes obtaining and interpreting data related to potentially hazardous environmental conditions, monitoring body functions (eg, blood glucose, peak expiratory flow, hydration status), and making the appropriate recommendations for individual safety and activity status.

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Clinical Assessment & Diagnosis / Acute Care / Therapeutic Intervention

CIP-4. Perform a comprehensive clinical examination of a patient with an upper extremity, lower extremity, head, neck, thorax, and/or spine injury or condition. This exam should incorporate clinical reasoning in the selection of assessment procedures and interpretation of findings in order to formulate a differential diagnosis and/or diagnosis, determine underlying impairments, and identify activity limitations and participation restrictions. Based on the assessment data and consideration of the patient's goals, provide the appropriate initial care and establish overall treatment goals. Create and implement a therapeutic intervention that targets these treatment goals to include, as appropriate, therapeutic modalities, medications (with physician involvement as necessary), and rehabilitative techniques and procedures. Integrate and interpret various forms of standardized documentation including both patient-oriented and clinician-oriented outcomes measures to recommend activity level, make return to play decisions, and maximize patient outcomes and progress in the treatment plan.

CIP-5. Perform a comprehensive clinical examination of a patient with a common illness/condition that includes appropriate clinical reasoning in the selection of assessment procedures and interpretation of history and physical examination findings in order to formulate a differential diagnosis and/or diagnosis. Based on the history, physical examination, and patient goals, implement the appropriate treatment strategy to include medications (with physician involvement as necessary). Determine whether patient referral is needed, and identify potential restrictions in activities and participa-tion. Formulate and communicate the appropriate return to activity protocol.

CIP-6. Clinically evaluate and manage a patient with an emergency injury or condition to include the assessment of vital signs and level of consciousness, activation of emergency action plan, secondary assessment, diagnosis, and provision of the appropriate emergency care (eg, CPR, AED, supplemental oxygen, airway adjunct, splinting, spinal stabilization, control of bleeding).

Psychosocial Strategies and Referral

CIP-7. Select and integrate appropriate psychosocial techniques into a patient's treatment or rehabilitation program to enhance rehabilitation adherence, return to play, and overall outcomes. This includes, but is not limited to, verbal motivation, goal setting, imagery, pain management, self-talk, and/or relaxation.

CIP-8. Demonstrate the ability to recognize and refer at-risk individuals and individuals with psychosocial disorders and/or mental health emergencies. As a member of the management team, develop an appropriate management plan (including recom-mendations for patient safety and activity status) that establishes a professional helping relationship with the patient, ensures interactive support and education, and encourages the athletic trainer's role of informed patient advocate in a manner consistent with current practice guidelines.

Healthcare Administration

CIP-9. Utilize documentation strategies to effectively communicate with patients, physicians, insurers, colleagues, administrators, and parents or family members while using appropriate terminology and complying with statues that regulate privacy of medical records. This includes using a comprehensive patient-file management system (including diagnostic and procedural codes) for appropriate chart documentation, risk management, outcomes, and billing.

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3/22/15

SB 2295
3-25-15
HEATHER Golly

#5

Members of the House Human Services Committee:

Representative Robin Weisz, Chairman
Representative Curt Hofstad, Vice Chairman
Representative Bert Anderson
Representative Dick Anderson
Representative Rich Becker
Representative Chuck Damschen
Representative Alan Fehr
Representative Dwight Kiefert
Representative Gail Mooney
Representative Naomi Muscha
Representative Kylie Oversen
Representative Todd Porter
Representative Jay Seibel

Mister Chairman and members of the House Human Services Committee:
I would like to first take the time to thank you for hearing SB 2295 which is an important piece of legislation for the practice of Athletic Training in the State of North Dakota. I am an Associate Professor at Minot State University and I serve as the Program Director for the Athletic Training Program. I have practiced athletic training for almost 20 years with all but two of those years spent in North Dakota. In addition I have had the pleasure of being appointed to the North Dakota Licensure Board of Athletic Trainers. It is my passion to teach new athletic trainers how to work within the scope of practice and provide services that keep their athletes or patients safe. I am speaking to you today as an educator of athletic training students to urge you to support SB 2295. The intent of the bill is to provide updated language that reflects the education of athletic trainers, to protect the public of the state of North Dakota, and to protect the Athletic Trainer.

Opponents of the bill would like to see the language of the bill remain as it was constructed in the early 80's. I would like to address this point as a licensure issue from the position of Chair of the North Dakota Board of Athletic Trainers and as an educator. The inclusion of the current wording eases the job of deciding if an individual is practicing within their scope of practice. This wording in essence allows the Board of Athletic Trainers the ability to consult a document titled Athletic Training Educational Competencies to determine if a person is working within their scope of practice. This document is a continually updated document based on research conducted by the Professional Education Council (PEC) of the National Athletic Trainers Association that establishes the competencies that entry-level athletic trainers must possess. These competencies are used by the CAATE (the body that accredits athletic training education programs) to determine the curriculum for education, what must be taught, tested, and mastered by the students of athletic training programs before they can obtain eligibility for taking the Board of Certification, Inc. Exam. The first set of competencies was developed in 2004 and due to the rapid increase of knowledge; we are currently on the 5th edition. From a licensure standpoint, these competencies are easy to interpret and one can quickly determine if someone is practicing within the individual's education. Examples from the *Athletic Training Competencies* showing how it lends clarity from a licensure and education standpoint are following:

> **PHP-14.** Assess weight loss and hydration status using weight charts, urine color charts, or specific gravity measurements to determine an individual's ability to participate in physical activity in a hot, humid environment.

PHP-15. Use a glucometer to monitor blood glucose levels, determine participation status, and make referral decisions.
PHP-16. Use a peak-flow meter to monitor a patient's asthma symptoms, determine participation status, and make referral decisions.
...AC-36. Identify the signs, symptoms, interventions and, when appropriate, the return-to-participation criteria for:
AC-36a. Sudden cardiac arrest
AC-36b. Brain injury including concussion, subdural and epidural hematomas, second impact syndrome and skull fracture
AC-36c. Cervical, thoracic, and lumbar spine trauma **AC-36d.** Heat illness including heat cramps, heat exhaustion, exertional and hyponatremia **AC-36e.** Exertional sickling associated with sickle cell trait **AC-36f.** Rhabdomyolysis **AC-36g.** Internal hemorrhage **AC-36h.** Diabetic emergencies including hypoglycemia and ketoacidosis **AC-36i.** Asthma attacks **AC-36j.** Systemic allergic reaction, including anaphylactic shock **AC-36k.** Epileptic and non-epileptic seizures **AC-36l.** shock **AC-36m.** Hypothermia, frostbite **AC-36n.** Toxic drug overdoses **AC-36o.** Local allergic reaction. Page 13 and 19[1].

"In the US healthcare arena, the half-life of medical knowledge has been measured to be five years with the amount of information doubling every 18 months. Therefore, the BOC performs a role delineation study or practice analysis approximately every five years and requires that ATs report CE activities every two years to encourage and assure an AT's ongoing competence in the ever changing landscape of healthcare knowledge and skill."[2] Again, the updated wording in this bill would allow the Board of Athletic Trainers a document to consult for licensure purposes and this bill would produce a document that has an extended lifespan eliminating the necessity to draft new changes as frequently as every legislative session to keep up with the changes in medical knowledge.

Another point of discussion by the opposition is the use of the term illness in the proposed bill, as you can see from the previous paragraph there are a number of illnesses (more conditions are noted in the competencies document) that an athletic trainer must have an in-depth knowledge of in order to appropriately care for their patient. If during a practice, game, rehabilitation or training session a diabetic/asthmatic/sickle cell individual starts to have problems the athletic trainer must have the knowledge and the skills to manage care for this individual, prevent further damage, know when to refer to another medical professional or perform immediate care. An individual returning to activity after an illness requires special consideration regarding the amount, the intensity, and the type of activities a

[1] Retrieved on February 9th 2015 from http://www.nata.org/sites/default/files/5th_Edition_Competencies.pdf, Athletic Training Educational Competencies 5th Ed.
[2] Retrieved on February 9th 2015 from http://www.bocatc.org/images/stories/athletic_trainers/boc_certification_maintenance_requirements_1402df.pdf Certification Maintenance for Certified Athletic Trainers.

patient is performing in addition to monitoring how the patient is tolerating the return to activity. Examples of these situations would be a diabetic individual that has a newly fitted insulin pump and is now dealing with getting back into activity, or a newly diagnosed asthmatic learning how and when to utilize their inhaler during activity. Athletic training students must cover comprehensive classroom instruction on these topics as well as hands-on-clinical education experiences in settings that introduce students to a variety of general medical conditions. Our students are required to complete rotations in general medical areas that include the UND Center for Family Medicine with physicians seeing various illnesses and conditions, the Trinity Health/ Diabetes & Nutrition Counseling Center seeing patients with diabetic or other nutritional disorders, as well as receiving instruction from Dr. Verhey a Critical Care, Pulmonology, Internal Medicine Specialist on working with asthmatic patients as well as other conditions. Other physicians the students are in contact with include Dr. Messerly, a pediatrician; Dr. Krohn a Family Practice physician; and Dr. Mattern, who holds a Certificate of added qualifications in Sports Medicine and is a Family Medicine Physician, teaches the Medical Conditions course at Minot State University providing an in-depth view of illnesses our students my encounter in their careers.

The question regarding the education of athletic trainers versus physical therapists continues to be raised during the discussion of SB 2295. The doctorate of physical therapy program is a 3 + 3 program (3 years generals + 3 years content/clinical) Just to give you a comparison between the two professions 2008 15.7% of physical therapist APTA members reported having a Doctorate, 37.6% reported having a masters, and 11.6% were in transition-to DPT[3]. Contrast that to the same time frame, the NATA member profile revealed that 70% of Athletic Trainers reported having a master's or a doctorate at that time[4]. And, as important, by comparison to the DPT is a master's degree; the master's degree for athletic trainers is 6 years of education, (4 years of Bachelor's + 2 years of master's) same as a DPT.

In addition a portion of those Athletic Trainers reported having a Doctorate (4 years of Bachelor's + 2 years of master's + average PHD program length is 4 years), or 10 years. Our students are observing in the athletic training room their first semester in their introductory courses and once admitted to the program start practicing their skills under the supervision of a certified athletic trainer for the remainder of their four year degree. At Minot State University this equates to 10-20 hours per week, depending on their education level, for three years with actual patients.

As an educator of athletic training students I would like to ask for this committee to recommend a "Do Pass" on SB 2295.

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[3] Retried February 6, 2015 from http://www.moveforwardpt.com/asset.axd?id=9957519d-8110-4620-ab54-c1c972e9562e (2011, APTA, *Today's Physical Therapist: A comprehensive Review of a 21st-Century Health Care Profession*, Page. 29)

[4] Retrieved from http://www.nata.org/sites/default/files/AT_Facts.pdf on February 6, 2015 in the NATA Fact Sheet published in 2009.

Thank you for your time and I would be happy to answer any questions you may have regarding athletic training education.

Heather Golly, PhD, ATC, CSCS

UND AT

B.S. in Athletic Training

Required 127 credits (36 of which must be numbered 300 or above, and 60 of which must be from a 4-year institution) including:

I. Essential Studies Requirements (see University ES listing).

II. The following curriculum:

Pre-Admission Courses

The student must earn a letter grade of C or better in the following courses to be admitted in the program.

BIOL 150 & 150L	General Biology I and General Biology I Laboratory	4

The student must earn a letter grade of B or better in the following courses to be admitted in the program.

FMED 101	Orientation to Athletic Training	1
FMED 207	Prevention and Care of Athletic Injuries	2
FMED 207L	Laboratory Prevention and Care of Athletic Injuries	1

At the time of application to the Athletic Training Program, the student must have completed or be enrolled in all of the above courses. In addition, the student must show proof of First Aid and CPR certifications or enrollment in:

KIN 110	First Aid and CPR	1

Core Courses

The following core courses are required for the B.S. in Athletic Training:

CHEM 121 & 121L	General Chemistry I and General Chemistry I Laboratory **	4
COMM 110	Fundamentals of Public Speaking **	3
ENGL 110	College Composition I **	3
ENGL 130	Composition II: Writing for Public Audiences	3
MED 205	Medical Terminology	1
PHYS 161	Introductory College Physics I (includes lab) **	4
PHYS 162	Introductory College Physics II (includes lab) **	4
PSYC 111	Introduction to Psychology **	3
PSYC 241	Introduction to Statistics **	4
PSYC 250	Developmental Psychology	4
SOC 110	Introduction to Sociology **	3
Arts & Humanities Requirement **		9
Electives		16
Total Credits		**61**

Professional Courses

The following are essential professional courses to become an entry-level athletic trainer:

ANAT 204	Anatomy for Paramedical Personnel	3
FMED 205	Anatomy for Athletic Trainers	2
FMED 208	Procedures in Athletic Training	1
FMED 208L	Laboratory Procedures in Athletic Training	1
FMED 200	Understanding Medicine	3
FMED 211	Beginning Clinical Practicum I in Athletic Training	1
FMED 213	Beginning Clinical Practicum in Athletic Training	1
FMED 311	Intermediate Clinical Practicum I in Athletic Training	2
FMED 312	Medical Aspects of Sports	2
FMED 313	Intermediate Clinical Practicum II in Athletic Training	2
FMED 320	Athletic Training Modalities	2
FMED 320L	Laboratory Athletic Training Modalities	1
FMED 321	Athletic Training Rehabilitation Techniques	2
FMED 321L	Laboratory Athletic Injury Rehabilitation Techniques	1
FMED 343	Organizational Administration of Athletic Training	3
FMED 411	Advanced Clinical Practicum I in Athletic Training	2
FMED 413	Advanced Clinical Practicum II in Athletic Training	2
FMED 481	Athletic Injury Assessment	4
FMED 491	Seminar in Athletic Training	2
FMED 497	Internship in Athletic Training	3
NUTR 240	Fundamentals of Nutrition	3
KIN 332	Biomechanics	3
KIN 402	Exercise Physiology	3
PPT 301	Human Physiology	4
PPT 320	Pharmacology in Sport	2

Courses

FMED 101. Orientation to Athletic Training. 1 Credit.
Overview of the field of athletic training. Survey of the role of the athletic trainer. Films, lectures, and observation in clinical settings. F,S.

FMED 200. Understanding Medicine. 3 Credits.
An overview of the broad parameters of family medicine. Guest speakers are brought in to discuss various facets of medicine. S.

FMED 205. Anatomy for Athletic Trainers. 2 Credits.
A course to learn and palpate human anatomy structures and their functions. Prerequisite: Deparment consent. F.

FMED 207. Prevention and Care of Athletic Injuries. 2 Credits.
An introductory course into the care and treatment of athletic injuries. Corequisite: FMED 207L. F,S.

FMED 207L. Laboratory Prevention and Care of Athletic Injuries. 1 Credit.
A practical laboratory to develop athletic taping skills taught in FMED 207. Corequisite: FMED 207. F,S.

FMED 208. Procedures in Athletic Training. 1 Credit.
This course serves as an orientation class for incoming sports health majors. Policies and procedures as well as record keeping are covered. Prerequisites: FMED 207 and FMED 207L. Corequisite: FMED 205 and FMED 208L. F.

FMED 208L. Laboratory Procedures in Athletic Training. 1 Credit.
A course designed to allow students to get practical experiences in injury management, modality usage and record keeping skills taught in FMED 208. Prerequisites: FMED 207 and FMED 207L. Corequisite: FMED 205 and FMED 208. F.

FMED 211. Beginning Clinical Practicum I in Athletic Training. 1 Credit.
A clinical course designed to allow the student to develop specified clinical competencies in a directed, progressive manner. Prerequisites: FMED 101, FMED 207 and FMED 207L. Corequisite: FMED 208 and FMED 208L. F.

FMED 213. Beginning Clinical Practicum in Athletic Training. 1 Credit.
A clinical course designed to allow the student to develop specified clinical competencies in a directed, progressive manner. Prerequisites: FMED 208 and FMED 208L. S.

FMED 311. Intermediate Clinical Practicum I in Athletic Training. 2 Credits.
A clinical course designed to allow the student to develop specified clinical competencies in a directed progressive manner. Prerequisite: FMED 213. F.

FMED 312. Medical Aspects of Sports. 2 Credits.
A course designed to introduce students to various medical specialities and medical problems and their effects on athletic participation. Prerequisite: Permission of instructor. F.

FMED 313. Intermediate Clinical Practicum II in Athletic Training. 2 Credits.
A clinical course designed to allow students to develop specified clinical competencies in a directed progressive manner. Prerequisite: FMED 481. Corequisite: FMED 320, FMED 321 and FMED 321L. S.

FMED 320. Athletic Training Modalities. 2 Credits.
A course designed to present the theoretical and applied principles and techniques for the application of modalities in sports injury care. Prerequisite: FMED 481. S.

FMED 320L. Laboratory Athletic Training Modalities. 1 Credit.
A course designed to practice the theoretical and applied principles and techniques for the application of modalities in sports injury care. Prerequisite: FMED 481. Corequisite: FMED 320. S.

FMED 321. Athletic Training Rehabilitation Techniques. 2 Credits.
A course designed to explain the principles and techniques of rehabilitation as they apply to athletic injuries. Prerequisite: FMED 481. Corequisite: FMED 321L. S.

FMED 321L. Laboratory Athletic Injury Rehabilitation Techniques. 1 Credit.
A course designed to allow students practical skill development of rehabilitation techniques utilized in athletic injury care as taught in FMED 321. Prerequisite: FMED 481. Corequisite: FMED 321. S.

FMED 343. Organizational Administration of Athletic Training. 3 Credits.
A course designed to acquaint students with the theories and principles of administration. Administrative functions as they relate to the athletic trainer will be explained. Prerequisite: Senior standing or consent of instructor. S.

FMED 411. Advanced Clinical Practicum I in Athletic Training. 2 Credits.
A clinical course designed to allow the student to develop specified clinical competencies in a directed progressive manner. Prerequisite: FMED 313. F.

FMED 413. Advanced Clinical Practicum II in Athletic Training. 2 Credits.
A clinical course designed to allow the student to develop specified clinical competencies in a directed progressive manner. Prerequisite: FMED 313. S.

FMED 481. Athletic Injury Assessment. 4 Credits.
A course designed to instruct the student in the theories and skills of injury evaluation. Prerequisite: FMED 213. F.

FMED 491. Seminar in Athletic Training. 2 Credits.
Advanced work in athletic training to include surgical and conservative injury management, rehabilitation and injury. Repeatable to 4 credits. Prerequisite: Permission of instructor. F,S.

FMED 494. Directed Studies in Athletic Training. 1-4 Credits.
An in-depth study in a subject area selected by the student under tutorial supervision. Repeatable to 6 credits. Prerequisite: Instructor approval. F,S.

FMED 497. Internship in Athletic Training. 3 Credits.
Off campus athletic training experience designed to expose the student to alternate concepts of care. Repeatable up to 6 credits with instructor permission. Prerequisite: FMED 313. F,S,SS.

UND PT

Doctor of Physical Therapy (D.P.T.)

Admission Requirements

Pre-Physical Therapy

Prior to admission, a minimum of 90 semester hours of credit from an approved college or university is required. Students should be broadly educated in the sciences and humanities. The Department of Physical Therapy recognizes that, since physical therapy deals with people, an understanding of literature, art, history, ethics, and philosophy is an adjunct to a physical therapist. Science and humanities are both viewed as necessary for the practice of physical therapy.

The following list of courses and credits indicates the core prerequisites all applicants must complete prior to admission to the physical therapy program. It is strongly recommended that students be computer literate prior to entering the professional program. Students may take additional electives from any field of study; however, the depth of the pre-physical therapy education should demonstrate that students have progressed from simple to complex studies in at least one content area. This requirement might typically be demonstrated by a discipline major, but in any case should demonstrate a basic comprehensiveness and integrity of study within a particular content area. This does not suggest that a separate undergraduate degree must be awarded; however, the breadth and depth in a discipline should be demonstrated. Course credits equivalent to a minor, i.e., approximately 20 credits at UND, in a particular discipline could accomplish this requirement. The prospective student should include eight (8) credits from upper level courses, i.e., 300 and/or 400 numbers.

- Two semesters of General Biology (8 cr.)
- Two semesters of General Chemistry (8 cr.)
- Two semesters of General Physics (8 cr.)
- One semester of Human Anatomy (3 cr.)
- One semester of Human Physiology (3 to 4 cr.)
- One semester of Introductory Psychology (3 cr.)
- One semester of Developmental Psychology (3 to 4 cr.)
- One semester of Abnormal Psychology (3 cr.)
- One semester of a Public Speaking course (3 cr.)
- One semester of an undergraduate statistics course (3 cr.)
- Essential Studies requirements

All of the prerequisite coursework must be completed before entering the professional program; however, the prospective student may be enrolled in pre-professional coursework at the time of application. Students must apply for the professional program through the PTCAS system. WICHE-eligible students should apply through the WICHE certification process. Please refer to the UND-PT website at: www.med.und.edu/physical-therapy for application details.

Admission Requirements

Acceptance is on a competitive basis, with the major determinant being the basic science grade point average. The basic science GPA is defined as: biology (eight semester credits), chemistry (eight semester credits), physics (eight semester credits), anatomy (three semester credits), physiology (four semester credits), and psychology (seven semester credits). In addition to the science GPA, GRE score, and cumulative GPA, an interview and letters of reference will be considered in the admission process. Prospective students are expected to complete at least 60 hours of physical therapy observation prior to application.

The applicant must meet the School of Graduate Studies's current minimum general admission rquirements as published in the graduate catalog.

1. Completion of the application for admission to the professional program and UND School of Graduate Studies application form.
2. Submission of score from the Graduate Record Examination General Test.
3. Satisfy the School of Graduate Studies' English Language Proficiency requirements as published in the graduate catalog.
4. Applicants who have received their bachelors or masters degree in the United States or English-speaking Canada are not required to submit the TOEFL or IELTS.

Degree Requirements

1. Students must be formally accepted into the professional education component of the DPT and endorsed by the Chair of Physical Therapy. NOTE: Acceptance by the UND Office of Admissions or the School of Graduate Studies does not constitute acceptance into the professional program in Physical Therapy.
2. The professional education component of the DPT will require three academic years and two summer sessions following completion of the pre-physical therapy entrance requirements.
3. No student will be allowed to remain in the program or complete the full-time clinical experiences unless he/she attains a letter grade of at least "C" in the major courses.
4. To advance to candidacy, the student must successfully complete the first year comprehensive examination, and maintain a cumulative School of Graduate Studies GPA of > 3.00 AND/OR a summer session GPA of > 3.00. Students who fail to advance to candidacy during the first year will be dismissed from the professional program.
5. After advancement to candidacy, the student is expected to maintain a cumulative GPA of > 3.00. The School of Graduate Studies will monitor the cumulative GPA, which must be > 3.00. If the cumulative GPA is not > 3.00, the School of Graduate Studies policies for probation and dismissal for GPA will govern the student's status.
6. Students in the professional program should be aware that there are special requirements for clinical uniforms, professional liability insurance, medical insurance, immunizations, CPR certification, and completion of a criminal background check. These requirements must be met prior to any clinical contact with patients. The student will also be responsible for travel, housing, and food costs, in addition to the payment of tuition and fees, during the full-time clinical experience semesters. The majority of these experiences will be completed at geographical locations other than the City of Grand Forks.
7. Prospective students should be aware that a felony conviction may affect a graduate's ability to obtain a professional license to practice physical therapy.
8. The faculty reserves the right to place on professional probation or to cancel the registration of any student in Physical Therapy whose performance in the classroom or the clinic is unsatisfactory.

Pre-Physical Therapy

ENGL 110	College Composition I	3
ENGL 120 or ENGL 125		3
COMM 110	Fundamentals of Public Speaking	3
Fine Arts and Humanities *		9
BIOL 150 & BIOL 151	General Biology I and General Biology II	8
CHEM 121 & CHEM 122	General Chemistry I and General Chemistry II	8
Social Science		3
PSYC 111	Introduction to Psychology	3
PHYS 161 & PHYS 162	Introductory College Physics I and Introductory College Physics II	8
ANAT 204	Anatomy for Paramedical Personnel	3
PPT 301	Human Physiology	4
PSYC 250	Developmental Psychology	4
PSYC 270	Abnormal Psychology	3
Statistics		3
Cognate/Minor (required)		
Electives (required, minimum of 20 with emphasis in a single discipline)		

Bachelor of General Studies Degree with Health Studies Option

This degree will be available to Physical Therapy students who:

1. do not already have a baccalaureate degree,
2. have completed at least 30 of the 90 pre-Physical Therapy credits at UND before beginning Professional Year One,
3. have successfully completed fall and spring semesters of Professional Year One.

The BGS degree would normally then be awarded at the end of the spring semester of Professional Year One if the student has completed all general UND graduation requirements:

1. 125 total credits,
2. 60 credits from 4-year schools, including at least 30 from UND,
3. 36 upper-level credits,
4. all essential studies requirements.

Professional Program - Physical Therapy

Professional Year 1		
Fall		**Credits**
PT 401	Intervention Techniques I	2
PT 402	Professional Communication and Behavior	2
PT 422	Anatomy for Physical Therapy	5
PT 423	Neuroscience for Physical Therapy	4
PT 510	Integrated Clinical Experience	0-1
PT 513	Intervention Techniques II	3
Spring		
PT 409	Clinical Pathology I	4
PT 412	Biomechanics and Kinesiology	4
PT 413	Exercise in Health and Disease	3
PT 415	Motor Control	3
PT 417	Clinical Exam and Evaluation I	4
PT 426	Manual Therapy I	2
PT 510	Integrated Clinical Experience	0-1
Summer		
PT 410	Clinical Pathology II	3
PT 512	Therapeutic Agents	3
PT 514	Case Management I	2
PT 510	Integrated Clinical Experience	0-1
PT 519	Electrotherapy and Electrodiagnosis	2
Professional Year 2		
Fall		
PT 521	Critical Inquiry I	1
PT 528	Clinical Education I	9
PT 529	Clinical Education II	9
Spring		
PT 522	Administration in Physical Therapy	3
PT 523	Lifespan I	3
PT 524	Psychological Aspects of Disability	2
PT 525	Clinical Examination and Evaluation II	3
PT 527	Critical Inquiry II	2
PT 540	Cardiopulmonary Physical Therapy	2
PT 584	Evidence in Practice	2
Electives		0-2

Summer		
PT 535	Lifespan II	2
PT 562	Readings:Physical Therapy	2
PT 591	Research in Physical Therapy	2
PT 592	Case Management II	2
Electives		1-2
Professional Year 3		
Fall		
PT 511	Applied Movement Science and Rehabilitation Procedures	4
PT 526	Manual Therapy II	2
PT 539	Prevention and Wellness	2
PT 541	Clinical Examination and Evaluation III	3
Electives		1-3
Spring		
PT 552	Clinical Education III	9
PT 553	Clinical Education IV	9
PT 995	Scholarly Project	1
	Total Credits:	**122-130**

Courses

PT 510. Integrated Clinical Experience. 1 Credit.
Short-term clinical experience to provide hands-on experience for students to apply knowledge learned during the first year of the professional program. Experiences will be set up in acute care, sub-acute care, long-term care, out-patient orthopedic, or a rural site. Registered in Professional Physical Therapy Curriculum is the prerequisite. F,S,SS.

PT 511. Applied Movement Science and Rehabilitation Procedures. 4 Credits.
Integration of clinical evaluation, functional goals, and treatment planning for individuals with neurological and multiple musculoskeletal dysfunction. The primary focus is on rehabilitation skills including assessment, exercise, handling techniques, functional activities, equipment prescription, patient education, and ADLs, as well as community mobility and governmental services. Laboratory. Prerequisite: Registered in Professional Physical Therapy Curriculum.

PT 512. Therapeutic Agents. 3 Credits.
Theory and application of various hydrotherapy, phototherapy, and thermotherapy modalities in Physical Therapy, including heat, light, sound, and water. Laboratory. Prerequisite: Registered in Professional Physical Therapy Curriculum.

PT 513. Intervention Techniques II. 3 Credits.
Theory and practical application of introductory patient care techniques in physical therapy. Laboratory. Prerequisite: Registered in Professional Physical Therapy Curriculum.

PT 514. Case Management I. 2 Credits.
Theory and practical application of introductory patient care techniques in physical therapy. Laboratory. Prerequisite: Registered in Professional Physical Therapy Curriculum.

PT 519. Electrotherapy and Electrodiagnosis. 2 Credits.
Theory and application of therapeutic electrical currents, biofeedback, electromyography, and nerve conduction velocity in physical therapy. Laboratory Prerequisite: Registered in Professional Physical Therapy Curriculum.

PT 521. Critical Inquiry I. 1 Credit.
Introduction to the collection of clinical data leading to a case study report. Prerequisite: Registered in Professional Physical Therapy Curriculum.

PT 522. Administration in Physical Therapy. 3 Credits.
Lectures/discussion and seminar formats used to explore concepts of administration procedures as applied to Physical Therapy and the health care delivery system. Prerequisite: Registered in Professional Physical Therapy Curriculum.

PT 523. Lifespan I. 3 Credits.
Course focus is on rehabilitation issues related to pediatrics including the characteristics of disabling conditions, developmental evaluation and intervention, the use of adaptive equipment, legal issues, and strategies to promote collaborative service provision to children and families. Laboratory. Prerequisite: Registered in Professional Physical Therapy Curriculum.

PT 524. Psychological Aspects of Disability. 2 Credits.
Readings and discussion course. Study of psychological coping mechanisms, reactions, and motivational factors pertinent to people with disabilities. Review of adjustment problems unique to specific disabilities and/or disease processes, including terminal illness. Prerequisite: Registered in Professional Physical Therapy Curriculum.

PT 525. Clinical Examination and Evaluation II. 3 Credits.
Emphasis is given to physical therapy examination, evaluation, and diagnoses as related to an advanced dynamic biomechanical evaluation. Also included will be the integration of NMS and support systems; clinical reasoning resulting in referral and/or modified physical therapy interventions; and the communication of findings and recommendations. Lecture & Laboratory. Prerequisite: Registered in Professional Physical Therapy Curriculum. F,S.

PT 526. Manual Therapy II. 2 Credits.
Theory and application of manual therapy skills for examination and intervention techniques, including thrust and nonthrust manipulations of the spine, pelvis, and associated areas. Laboratory. Prerequisite: Registered in Professional Physical Therapy Curriculum.

PT 527. Critical Inquiry II. 2 Credits.
Application, analysis, and evaluation of clinical decisionmaking components, strategies, and skills. Preparation of a clinical case study to be presented in oral and written forms. Prerequisite: Registered in Professional Physical Therapy Curriculum.

PT 528. Clinical Education I. 9 Credits.
The first in a sequence of four full-time clinical experiences in selected physical therapy provider centers throughout the United States. Prerequisite: Registered in Professional Physical Therapy Curriculum.

PT 529. Clinical Education II. 9 Credits.
The second in a sequence of four full-time clinical experiences in selected physical therapy provider centers throughout the United States. Prerequisite: Registered in Professional Physical Therapy Curriculum.

PT 535. Lifespan II. 2 Credits.
Examine the factors and forces that affect life quality in later years. The physiological, psychological, and sociological aspects of aging will be considered, including those influences in the cultural context that enhance and impede continued growth of the person. Laboratory. Prerequisite: Registered in Professional Physical Therapy Curriculum.

PT 537. Strategies Early Intervention. 2 Credits.
This course is designed to review current practices in early intervention. Course materials will focus on characteristics of disabling conditions that influence growth and development of motor skills, cognition, and educational development. Emphasis will be on collaborative service provision with an interdisciplinary approach. Topics also covered include: current issues, assessment of the child/family unit, and legislative guidelines for service provision. Prerequisite: Registered in Professional Physical Therapy Curriculum.

PT 538. Advanced Topics in Pediatric Physical Therapy. 3 Credits.
This course is designed to present current and advanced topics relating to pediatric physical therapy clients and their families. Prerequisite: Registered in Professional Physical Therapy Curriculum.

PT 539. Prevention and Wellness. 2 Credits.
The theory and practice of prevention of injury, maintenance and improvement of wellness, and promotion of health and healthy behaviors across the lifespan. Concepts are applied to the general, athletic, and industrial populations, with a view to interdisciplinary involvement in wellness optimization. Prerequisite: Registered in Professional Physical Therapy Curriculum.

PT 540. Cardiopulmonary Physical Therapy. 2 Credits.
This course is designed to expand the theoretical understanding and clinical application of cardiopulmonary physical therapy examination, evaluation, diagnosis, prognosis, intervention and outcomes. Laboratory. Prerequisite: Registered in Professional Physical Therapy Curriculum.

PT 541. Clinical Examination and Evaluation III. 3 Credits.
Emphasizes patient/client management elements of examination and evaluation. Emphasis is given to systems screening, physical therapy diagnoses, and clinical reasoning resulting in referral and /or modified physical therapy interventions. Emphasis is also given to the communication of findings. Laboratory. Registered in Professional Physical Therapy Curriculum is the prerequisite. F.

PT 549. Advanced Applied Anatomy/Clinical Kinesiology. 2 Credits.
Study of applied anatomy and its importance to research and clinical application, particularly as related to Physical Therapy. Prerequisite: Registered in Professional Physical Therapy Curriculum.

PT 552. Clinical Education III. 9 Credits.
The third in a sequence of four full-time clinical experiences in selected physical therapy provider centers throughout the United States. Prerequisite: Registered in Professional Physical Therapy Curriculum.

PT 553. Clinical Education IV. 9 Credits.
The fourth in a sequence of four full-time clinical experiences in selected physical therapy provider centers throughout the United States. Prerequisite: Registered in Professional Physical Therapy Curriculum.

PT 561. Seminar:Physical Therapy. 1-4 Credits.
This course serves to focus student attention toward graduate study in Physical Therapy. Explore and discuss areas of interest for students and faculty. May repeat to 4 credits maximum. Prerequisite: Registered in Professional Physical Therapy Curriculum.

PT 562. Readings:Physical Therapy. 1-4 Credits.
Review of current literature pertinent to Physical Therapy; critical examination of design, content, and validity of conclusions. Prerequisite: Registered in Professional Physical Therapy Curriculum.

PT 572. Teaching Experience in Physical Therapy. 1-4 Credits.
Supervised experience in University teaching in Physical Therapy. Projects in curriculum development, formulation of teaching/learning objectives, teaching materials, evaluation tools, and experience in competency-based learning environment. Prerequisite: Registered in Professional Physical Therapy Curriculum.

PT 583. Critical Inquiry III. 1 Credit.
Introduction to research instruments including surveys, electrical and mechanical instrumentation critical to research methods. Includes discussion of validation, calibration, and reliability of instruments used in physical therapy research. Students develop a proposal for their scholarly projects and complete IRB use of human subject forms. Prerequisite: Registered in Professional Physical Therapy Curriculum.

PT 584. Evidence in Practice. 2 Credits.
Application of qualitative and quantitative research designs. Interpretation of statistical tests used in evidence-based medicine. Critical review of current articles related to diagnosis, prognosis, therapy, harm, cost, systematic reviews, meta-analysis, and clinical practice guidelines. Application of evidence to physical therapy practice. Prerequisite: Registered in Professional Physical Therapy Curriculum. S.

PT 590. Directed Studies:Clinical Concepts in Physical Therapy. 1-12 Credits.
Individualized study of a particular area of interest for the student approved by his/her major advisor and supervised by preceptors with specialty and/or recognized expertise in the area of interest. Study may include library research, clinical research, discussion/seminars, projects, and directed clinical experience. Prerequisite: Registered in Professional Physical Therapy Curriculum.

PT 591. Research in Physical Therapy. 2 Credits.
Students develop the ability to effectively and accurately interpret and communicate results/clinical outcomes as a component of the written Scholarly Project. Frequent group and/or individual meetings with the advisor incorporate peer review discussion to facilitate student development of professional written and oral communication skills. Prerequisite: Registered in Professional Physical Therapy Curriculum. SS.

PT 592. Case Management II. 2 Credits.
Case management, with emphasis on the teaching and learning process and techniques targeted to promote and optimize physical therapy services, including advocacy. Strategies appropriate for conflict resolution are introduced. Professional development as a practitioner of physical therapy is emphasized through introduction and preliminary development of a portfolio. Prerequisite: Registered in Professional Physical Therapy Curriculum.

PT 995. Scholarly Project. 1 Credit.
Students provide a final written and oral report to the faculty on the results of their collaborative Scholarly Project. Prerequisite: Registered in Professional Physical Therapy Curriculum.

PT 996. Continuing Enrollment. 1-12 Credits.

PT 997. Research III:Independent Study. 2 Credits.

UND OT

Master of Occupational Therapy (M.O.T.)

Admission Requirements

Pre-Occupational Therapy

A pre-OT student typically spends the first two years as a pre-major at the University of North Dakota to complete the program prerequisites. In the beginning of the sophomore year when the student is completing the required courses as listed below, he/she must make written application for admission to the professional occupational therapy program. The CLEP in natural sciences will not meet the Biology and Chemistry requirements in Occupational Therapy. Students should *carefully* check all CLEP exams for potential acceptance at UND. A student must have at least a C in all prerequisite courses. The student must also obtain a minimum of a C in all professional level courses.

The following courses are required to be taken prior to professional program:

Course	Title	Credits
ENGL 110	College Composition I	3
ENGL 120 or ENGL 125		3
COMM 110	Fundamentals of Public Speaking	3
BIOL 150 & 150L or BIOL 151 & 151L	General Biology I and General Biology I Laboratory General Biology II and General Biology II Laboratory	4
CHEM 115 & 115L or CHEM 121 & 121L	Introductory Chemistry and Introductory Chemistry Laboratory General Chemistry I and General Chemistry I Laboratory	4
MATH 103	College Algebra	3
PSYC 111	Introduction to Psychology	3
PSYC 241 or SOC 326	Introduction to Statistics * Sociological Statistics	4-3
PSYC 250	Developmental Psychology	4
PSYC 270	Abnormal Psychology	3
ANAT 204	Anatomy for Paramedical Personnel	3
ANAT 204L	Anatomy for Paramedical Personnel Laboratory	2
SOC 110	Introduction to Sociology	3
PPT 301	Human Physiology	4
OT 200	Introduction to Occupational Therapy	2
Arts and Humanities Electives **		9
Total Credits		**57-56**

* As a prerequisite for PSYC 241 Introduction to Statistics, student needs to take MATH 103 College Algebra .

** When completing Arts and Humanities courses, it is required that the nine credit hours be in two departments and you must have a minimum of three credits in fine arts as part of the requirements of the Essential Studies program at the University of North Dakota. You also want to ensure that you have fulfilled the global diversity requirement. More information on Essential Studies graduation requirements can be found at: http://www.und.edu/dept/registrar/EssentialStudies/esindex.html.

Admission Requirements

Professional Program

Admission to the professional program in occupational therapy is on a competitive basis with consideration given to pre-professional performance in the sciences, general graduation requirements, leadership potential, volunteer work and personal qualifications. Each application is thoroughly reviewed. This review includes the applicant's academic record (must have minimum overall GPA of 2.75 based on a 4 point scale), pattern of withdrawals, incompletes, etc., elective coursework, volunteer and/or work experience, references, essay and a personal interview.

A prerequisite for admission to the UND Professional Program at the Year I level will be 60 hours of observation with a professional occupational therapy supervisor and should be distributed over the three required areas (Psychosocial, Physical Dysfunction, Pediatric).

Year III Professional Program

The applicant must meet the School of Graduate Studies' current minimum general admission requirements as published in the graduate catalog. Admission to the School of Graduate Studies requires:

1. Acceptance into the Professional Occupational Therapy program.
2. Successful completion of OT Professional Year I and II.
3. Completion of the School of Graduate Studies application forms.
4. Overall GPA of 2.75 or a 3.0 in both junior and senior years.
5. Satisfy the School of Graduate Studies' English Language Proficiency requirements as published in the graduate catalog.
6. Letter of endorsement from the Chair or Graduate Director of the Department that assures automatic advancement in status from the undergraduate program to the graduate program. The letter of endorsement will be written for students in good academic and professional standing in the program

It is important to be aware that a felony conviction may affect a graduate's ability to sit for the National Board for Certification in Occupational Therapy (NBCOT) certification examination or to attain state licensure as an Occupational Therapist. You will be asked to respond to the following questions when registering for the NBCOT exam:

- Have you ever been charged with or convicted of a felony?
- Have you ever had any professional license, registration or certification revoked, suspended or subject to probationary conditions by a regulatory authority or certification board?
- Have you ever been found by any court, administrative or disciplinary proceeding to have committed negligence, malpractice, recklessness, or willful or intentional misconduct, which resulted in harm to another?

Information regarding NBCOT's process of screening applicants for Character Review may be found at: www.nbcot.org. If you have any questions, the department will assist you in this process.

Many fieldwork facilities are requiring proof of immunizations, drug testing, fingerprints, and/or criminal background checks. It is the responsibility of the student to check the fieldwork information and to pay the cost for each process.

Degree Requirements

Bachelor of General Studies Degree with Health Studies Option

The BGS Health Studies degree is available to OT students who:

1. have completed their pre-OT work either at UND or at another institution.
2. have successfully completed the first two years of the OT professional sequence.

The BGS degree would normally then be awarded at the end of the Professional Year Two, prior to beginning the Graduate School career, if the student has completed all general UND graduation requirements, including:

1. 125 total credits,
2. 60 credits from 4-year schools, including at least 30 from UND,
3. 36 upper-level credits,
4. all essential studies requirements.

Students seeking the Master of Occupational Therapy degree at the University of North Dakota must satisfy all general requirements set forth by the School of Graduate Studies as well as particular requirements set forth by the Occupational Therapy Department.

To maintain graduate student status, the professional level Year III student is required to maintain a GPA of at least 3.0 for all work completed in Year III. Students who were previously on academic or professional probation will be dismissed from the School of Graduate Studies if placed on one additional probation within the professional program.

M.O.T Curriculum Sequence

School of Graduate Studies - Schedule A

Professional Year 1		
Fall		**Credits**
OT 423	Fundamentals of Neuroscience for Occupational Therapy	3
OT 425	Occupational Therapy with Infants and Pre-School Children	4
OT 427	Orientation to Occupational Therapy Theory	3
OT 428	Quantitative Rsrch Methods-O T	3
OT 431	Medical Science I	2
Spring		
OT 424	Muscle Function	4
OT 429	Occupational Therapy with School Age Children and Young Adults	4
OT 430	Psychosocial Aspects of Occupational Therapy for Children, Adolescents and Young Adults	4
OT 432	Medical Science II	3
OT 433	Group Leadership Skills in Occupational Therapy	2
OT 438	Practicum:Children/Adolescents	1
Summer		
OT 422	Anatomy Occupational Therapy	5
OT 426	Personal/Professional Developmnt	1

Professional Year 2		
Fall		
OT 454	Gerontic Occupational Therapy	2
OT 456	Psychosocial Aspects of OT with the Maturing Adult	4
OT 458	Qualitative Research Methods for Occupational Therapy	3
OT 460	Introduction to Management and Leadership	2
OT 463	Psychosocial Dysfunction Seminar and Practicum Integration	3
OT 469	Interprofessional Health Care	1
Fall and Spring Semester Electives:		
OT 489	Independent Projects	1-3
OT 490	Occupational Therapy Seminar	1
OT 493	Workshop	1-6
OT 494	Directed Study in Occupational Therapy	1
OT 496	Community Experience	1-4
OT 497	Cooperative Education	1-6
OT 593	Teaching Experience in Occupational Therapy	1-3
Spring		
OT 451	Multicultural Competency in Occupational Therapy	3
OT 452	Assistive Technology I	3
OT 453	Physical Aspects of OT with the Maturing Adult	5
OT 461	Management in the U.S. Healthcare System	2
OT 462	Physical Dysfunction Seminar and Practicum Integration	3
OT 480	Introduction to Scholarly Writing in Occupational Therapy	1
Summer		
Elective Only Semester:		
OT 488	Elective Field Work in Occupational Therapy	3-9
OT 497	Cooperative Education	1-6
OT 593	Teaching Experience in Occupational Therapy	1-3

Professional Year 3		
Fall		
Required Core Courses:		
OT 504	Occupation and Vocation	3
OT 507	Innovative Management and Leadership	3
OT 509	Principles of Education in Occupational Therapy	3
OT 515	Integration of Occupational Therapy Theory	3

Fall Electives:		
OT 493	Workshop	1-12
OT 508	Therapeutic Procedures and Modalities in Occupational Therapy	2
OT 582	Graduate Practicum	1-3
OT 589	Readings in Occupational Therapy	1-2
OT 593	Teaching Experience in Occupational Therapy	1-3
OT 599	Special Topics in Occupational Therapy	1-2
Spring		
OT 585 or OT 587	Fieldwork in Psychosocial Dysfunction or Fieldwork in Physical Dysfunction	9
OT 995 or OT 997	Scholarly Project in Occupational Therapy or Independent Study	2
OT 589	Readings in Occupational Therapy	1-2
Summer		
OT 585 or OT 587	Fieldwork in Psychosocial Dysfunction or Fieldwork in Physical Dysfunction	9
	Total Credits:	**123-171**

School of Graduate Studies - Schedule B

Professional Year 1		
Fall		**Credits**
OT 423	Fundamentals of Neuroscience for Occupational Therapy	3
OT 425	Occupational Therapy with Infants and Pre-School Children	4
OT 427	Orientation to Occupational Therapy Theory	3
OT 428	Quantitative Rsrch Methods-O T	3
OT 431	Medical Science I	2
Spring		
OT 424	Muscle Function	4
OT 429	Occupational Therapy with School Age Children and Young Adults	4
OT 430	Psychosocial Aspects of Occupational Therapy for Children, Adolescents and Young Adults	4
OT 432	Medical Science II	3
OT 433	Group Leadership Skills in Occupational Therapy	2
OT 438	Practicum:Children/Adolescents	1
Summer		
OT 422	Anatomy Occupational Therapy	5
OT 426	Personal/Professional Developmnt	1

Professional Year 2

Fall		
OT 452	Assistive Technology I	3
OT 453	Physical Aspects of OT with the Maturing Adult	5
OT 458	Qualitative Research Methods for Occupational Therapy	3
OT 460	Introduction to Management and Leadership	2
OT 462	Physical Dysfunction Seminar and Practicum Integration	3
Fall and Spring Semester Electives:		
OT 489	Independent Projects	1-3
OT 490	Occupational Therapy Seminar	1
OT 493	Workshop	1-6
OT 494	Directed Study in Occupational Therapy	1
OT 496	Community Experience	1-4
OT 497	Cooperative Education	1-6
OT 593	Teaching Experience in Occupational Therapy	1-3
Spring		
OT 451	Multicultural Competency in Occupational Therapy	3
OT 454	Gerontic Occupational Therapy	2
OT 456	Psychosocial Aspects of OT with the Maturing Adult	4
OT 461	Management in the U.S. Healthcare System	2
OT 463	Psychosocial Dysfunction Seminar and Practicum Integration	3
OT 469	Interprofessional Health Care	1
OT 480	Introduction to Scholarly Writing in Occupational Therapy	1
Summer		
Elective Only Semester:		
OT 488	Elective Field Work in Occupational Therapy	3-9
OT 497	Cooperative Education	1-6
OT 593	Teaching Experience in Occupational Therapy	1-3

Professional Year 3

Fall		
OT 585 or OT 587	Fieldwork in Psychosocial Dysfunction or Fieldwork in Physical Dysfunction	9
OT 995 or OT 997	Scholarly Project in Occupational Therapy or Independent Study	2
OT 589	Readings in Occupational Therapy	1-2

Required Core Courses:		
OT 504	Occupation and Vocation	3
OT 507	Innovative Management and Leadership	3
OT 509	Principles of Education in Occupational Therapy	3
OT 515	Integration of Occupational Therapy Theory	3
Spring		
Spring Semester Electives:		
OT 493	Workshop	1-12
OT 508	Therapeutic Procedures and Modalities in Occupational Therapy	2
OT 582	Graduate Practicum	1-3
OT 589	Readings in Occupational Therapy	1-2
OT 593	Teaching Experience in Occupational Therapy	1-3
OT 599	Special Topics in Occupational Therapy	1-2
Summer		
OT 585 or OT 587	Fieldwork in Psychosocial Dysfunction or Fieldwork in Physical Dysfunction	9
	Total Credits:	**123-171**

OT 200. Introduction to Occupational Therapy. 2 Credits.
History, scope, objectives, and functions of Occupational Therapy. F,S.

OT 422. Anatomy Occupational Therapy. 5 Credits.
Detailed study of human anatomy, with an emphasis on skeletal muscle, its vasculature, and the peripheral nervous system. The laboratory portion of the course allows for a direct study of the human form through dissection of human cadavers. Prerequisite: Occupational Therapy majors only. SS.

OT 423. Fundamentals of Neuroscience for Occupational Therapy. 3 Credits.
Survey of the major theories of behavior, cognition, and neurological disorders based on experimental findings in neuroanatomy, neurophysiology, and neurobiology. Laboratory included. Prerequisite: Occupational Therapy majors only. F.

OT 424. Muscle Function. 4 Credits.
The study of musculature acting on the extremities and trunk. Theory and techniques of musculoskeletal evaluation with analysis of normal and pathological human motion. Laboratory included. Prerequisite: Occupational Therapy majors only. S.

OT 425. Occupational Therapy with Infants and Pre-School Children. 4 Credits.
Emphasis on reflexes, sensory systems, neurodevelopmental systems, illness and trauma, assessment procedures, treatment techniques, families and intervention teams, and treatment outcomes. Laboratory included. Prerequisite: Occupational Therapy majors only. F.

OT 426. Personal/Professional Developmnt. 1 Credit.
Promote self-awareness and interpersonal communication skills including basic listening skills, ability to provide meaningful feedback and appropriate group membership skills. Prerequisite: Occupational Therapy majors only. SS.

OT 427. Orientation to Occupational Therapy Theory. 3 Credits.
Orientation to human occupation, occupational performance assessment, theoretical practice models, and core processes in occupational therapy. Prerequisite: Occupational Therapy majors only. F.

OT 428. Quantitative Rsrch Methods-O T. 3 Credits.
Design and implementation of quantitative research, the evaluation of quantitative research studies, the interpretation of statistics as applied to occupational therapy, and the process of presentation and publication of quantitative research projects. Laboratory included. Prerequisite: Occupational Therapy majors only. F.

OT 429. Occupational Therapy with School Age Children and Young Adults. 4 Credits.
Normal and abnormal human development, disease and disability, school age through young adulthood. Emphasis on assessment, intervention planning and program outcomes for individuals with disabilities in a variety of practice settings including school, community, and medicine. Laboratory included. Prerequisite: Occupational Therapy majors only. S.

OT 430. Psychosocial Aspects of Occupational Therapy for Children, Adolescents and Young Adults. 4 Credits.
Psychosocial development and interruptions to development in children, adolescents, and young adults, with emphasis on OT evaluation, treatment planning and implementation, and treatment outcomes. Laboratory included. Prerequisite: Occupational Therapy majors only. S.

OT 431. Medical Science I. 2 Credits.
First in a two-semester sequence of courses, which covers human body, systems and disease and disability groups discussed from all aspects of comprehensive rehabilitation. Included are chronic illness, neurological and orthopedic conditions, general medicine and surgery, and sensory disabilities across the lifespan. Prerequisite: Occupational Therapy majors only. F.

OT 432. Medical Science II. 3 Credits.
Second in a two-semester sequence of courses, which covers human body, systems and disease and disability groups discussed from all aspects of comprehensive rehabilitation. Included are chronic illness, neurological and orthopedic conditions, general medicine and surgery, and sensory disabilities across the lifespan. Integration included. Prerequisite: Occupational Therapy majors only. S.

OT 433. Group Leadership Skills in Occupational Therapy. 2 Credits.
Didactic and experiential learning in a small group setting. Provides students with opportunities to function as group facilitators in a variety of practice settings. Prerequisite: Occupational Therapy majors only. S.

OT 438. Practicum:Children/Adolescents. 1 Credit.
Observation and experience in a university-approved pediatric and/or adolescent facility; supervised by occupational therapists, educators, and allied health professionals. Prerequisite: Occupational Therapy majors only. S.

OT 451. Multicultural Competency in Occupational Therapy. 3 Credits.
Develop an understanding of and an appreciation for social-cultural and ethnic diversity and use that understanding to address issues, solve problems, and shape civic, personal, and professional behavior. To recognize that diversity is intimately tied to the concepts of culture, race, language, identity and inter-group dynamics, as well as its applications to complex situations. These concepts are presented within the context of providing OT services. Prerequisite: Occupational Therapy majors only. S.

OT 452. Assistive Technology I. 3 Credits.
Introductory study of assistive technology devices and products, assessment, and application methods focuses on adaptations, modifications, and technology systems and services that assist individuals with disabilities in greater independence and accessibility across the lifespan. Laboratory included. Prerequisite: Occupational Therapy majors only. F,S.

OT 453. Physical Aspects of OT with the Maturing Adult. 5 Credits.
Study of the OT process as applied to physical dysfunction of the maturing adult. Emphasis is on OT evaluation, planning, implementation of treatment, and treatment outcomes. Laboratory included. Prerequisite: Occupational Therapy majors only. F,S.

OT 454. Gerontic Occupational Therapy. 2 Credits.
Occupational perspectives of the elderly, including age-related changes, assessment and intervention strategies and the role of occupational therapy in prevention and wellness programs. Laboratory included. Prerequisite: Occupational Therapy majors only. F,S.

OT 456. Psychosocial Aspects of OT with the Maturing Adult. 4 Credits.
Psychosocial development and interruptions to development in the maturing adult with emphasis on OT evaluation, treatment planning and implementation, and treatment outcomes. Laboratory included. Prerequisite: Occupational Therapy majors only. F,S.

OT 458. Qualitative Research Methods for Occupational Therapy. 3 Credits.
Design and implementation of qualitative research, evaluation of qualitative research studies, analysis and interpretation of qualitative data, and the process of publication and presentation of qualitative research projects. Laboratory included. Prerequisite: Occupational Therapy majors only. F.

OT 460. Introduction to Management and Leadership. 2 Credits.
Introduction to the management practices necessary to direct a quality health service and provide the knowledge and skills needed for entry-level leadership positions in OT practice. Focus is on clinical reasoning and critical analysis in administrative and management functions. Laboratory included. Prerequisite: Occupational Therapy majors only. F.

OT 461. Management in the U.S. Healthcare System. 2 Credits.
Provide an overview of health services system in the US and current trends and issues facing OT within this system. Content includes: federal and state roles, reimbursement of health care services, regulation, community services, health service providers, consultative, non-traditional areas of practice, service delivery models, legalities, and health policy advocacy. Prerequisite: Occupational Therapy majors only. S.

OT 462. Physical Dysfunction Seminar and Practicum Integration. 3 Credits.
The student begins to integrate and synthesize the theoretical knowledge of physical function/ dysfunction with clinical practice. It requires the application of foundational knowledge, tools and the theory of practice inherent in the role of an OT. Occupational therapy experiences in facilities, supervised by registered occupational therapists, qualified health professionals and university faculty. Prerequisites: OT 422, OT 423, OT 424, OT 425, OT 426, OT 427, OT 428, OT 429, OT 430, OT 431, OT 432, OT 433 and OT 438. F,S.

OT 463. Psychosocial Dysfunction Seminar and Practicum Integration. 3 Credits.
Integration and synthesizing of theoretical knowledge with clinical experience toward the application of therapeutic use of self, self-evaluation, and communication skills in professional development. Occupational therapy experiences in mental health field facilities, supervised by registered occupational therapists, qualified health professionals and university faculty. Prerequisites: OT 422, OT 423, OT 424, OT 425, OT 426, OT 427, OT 428, OT 429, OT 430, OT 431, OT 432, OT 433 and OT 438. F,S.

OT 469. Interprofessional Health Care. 1 Credit.
A process-learning course intended to provide experience in building a team of health professionals from different professions. The focus is on learning to work effectively with an interprofessional health care team. Emphasis is placed on effective teamwork, the unique contributions of different professions, patient or family centered approach in health care delivery, and awareness of potential medical errors. F,S.

OT 480. Introduction to Scholarly Writing in Occupational Therapy. 1 Credit.
This course is designed to provide students with an understanding of the expectations and mechanics of scholarly writing. It is the first step for the development of a scholarly paper that is a requirement of the MOT program. The course outcome is the development of a proposal in an area of interest to the student(s) which has been approved and supervised by a faculty advisor to meet the first requirement of OT 995 Scholarly Project in OT or OT 997 Independent Study. Course content includes the mechanics of writing, development, content and format of the scholarly paper; the use of appropriate resources; and a review of how to use the Publication Manual of the American Pscyhological Association and the OT department's graduate student manuals. S.

OT 488. Elective Field Work in Occupational Therapy. 3-18 Credits.
Application of occupational therapy in evaluation and treatment in optional areas of student special interest in selected fieldwork facilities. Variable credits, repeatable, with maximal total of 18 credits. Prerequisite: Occupational Therapy majors only. F,S,SS.

OT 489. Independent Projects. 1-3 Credits.
Individual study and/or research in a particular area of interest for the students with approval of a supervising faculty member. Elective for OT majors. Prerequisite: Occupational Therapy majors only.

OT 490. Occupational Therapy Seminar. 1 Credit.
Foundational knowledge relevant to the preparation of an independent study proposal. Serves as the basis for OT 494: Directed Study in Occupational Therapy. Prerequisite: Occupational Therapy majors only. F.

OT 493. Workshop. 1-12 Credits.
A workshop course with topics dictated by faculty and student interests primarily for but not confined to continuing education. Prerequisite: Occupational Therapy majors only. On demand.

OT 494. Directed Study in Occupational Therapy. 1 Credit.
Development of the proposal in an area of interest to the student approved and supervised by faculty. Serves as the basis for OT 997: Independent Study or OT 995: Scholarly Project in OT. Prerequisite: Occupational Therapy majors only. S.

OT 496. Community Experience. 1-4 Credits.
Student initiates and participates in off-campus professional learning activities related to OT under joint faculty and on-site professional supervision. Prerequisite: Permission of Department. F,S,SS.

OT 497. Cooperative Education. 1-6 Credits.
Qualified students are employed by selected facilities to further understanding of occupational therapy and health-related service provision. Prerequisite: Occupational Therapy majors only. F,S,SS.

OT 504. Occupation and Vocation. 3 Credits.
Application of assessment and problem-solving skills necessary for remediation/rehabilitation of occupational performance deficits in the work realm. Laboratory included. Prerequisite: Occupational Therapy majors only. F,S.

OT 507. Innovative Management and Leadership. 3 Credits.
Develop and demonstrate an understanding of the skills necessary to plan, implement and evaluate programs and material for educational, consultation and private practice. Prerequisite: Occupational Therapy majors only. F,S.

OT 508. Therapeutic Procedures and Modalities in Occupational Therapy. 2 Credits.
Occupational therapy theory and application of specific neuromuscular techniques and modalities to promote musculoskeletal function. Laboratory included. Prerequisite: Occupational Therapy majors only. F,S.

OT 509. Principles of Education in Occupational Therapy. 3 Credits.
Explores the methods and strategies used to develop, implement and evaluate education programs for students in academia and clinical settings, for patients/clients, businesses and professional staff. Information and discussion focus on the theory and research relevant to education in a variety of settings. Prerequisite: Occupational Therapy majors only. F,S.

OT 515. Integration of Occupational Therapy Theory. 3 Credits.
Analysis and applications of theoretical perspectives to occupational therapy process with individuals, groups, and service delivery systems. Prerequisite: Occupational Therapy majors only. F,S.

OT 582. Graduate Practicum. 1-3 Credits.
Supervised experience in a variety of OT practice settings. Students are afforded the opportunity to gain practical, on-the-job experience working in an area that matches the focus of their graduate study. Students will be supervised by on-site personnel. Prerequisite: Occupational Therapy majors only. F,S,SS.

OT 585. Fieldwork in Psychosocial Dysfunction. 9 Credits.
Application of occupational therapy in evaluation andtUniversity of North Dakota treatment in psychosocial dysfunction fieldwork facilities. Three months full-time. Prerequisite: Occupational Therapy majors only.

OT 587. Fieldwork in Physical Dysfunction. 9 Credits.
Application of occupational therapy in evaluation and treatment in physical dysfunction fieldwork facilities. Three months full-time. Prerequisite: Occupational Therapy majors only.

OT 589. Readings in Occupational Therapy. 1-2 Credits.
Selected readings in the student's area of interest with oral and/or written reports. Prerequisite: Occupational Therapy majors only. F,S,SS.

OT 593. Teaching Experience in Occupational Therapy. 1-3 Credits.
Supervised experience in higher education teaching in OT. Projects in course/curriculum development, writing course objectives, writing and delivering lectures and learning activities, and developing assessment tools for the classroom. Prerequisite: Occupational Therapy majors only. F,S,SS.

OT 599. Special Topics in Occupational Therapy. 1-2 Credits.
A series of lectures, discussions, and/or laboratory experiences developed around one or more specific topics in occupational therapy. Prerequisite: Occupational Therapy majors only. F,S,SS.

OT 995. Scholarly Project in Occupational Therapy. 2 Credits.
A collaborative investigation of relevant professional topic and production of a scholarly report with approval of the major faculty. Prerequisite: Occupational Therapy majors only.

OT 996. Continuing Enrollment. 1-12 Credits.

OT 997. Independent Study. 2 Credits.
Prerequisite: Occupational Therapy majors only.

OT 998. Thesis. 1-15 Credits.

UMary Advising Manual
Athletic Training Major 4 yr. Degree Plan

*Athletic Training Pre-Admission Courses are in **BOLD** print, Sophomore year needs to be completed in correct sequence for the student to be able to be admitted into the program*

Freshman:	***Fall***	
ALU/HSL 122	Freshman Leadership Seminar/HSL (1 or 2 credits)	1
ART ---	Art Core (ART 108, 115, 116, MUS 196, ENG 130)	3
BIO 103	**General Biology** (Math-Science)	**4**
ENG 121/COM 110	College Comp II/Oral Communcations	3
PED 157	**First Aid (1/2 of sememster)**	**1**
PED 159	**Personal and Community Health (1/2 of sememster)**	**3**
POL 101/ANT 171	Responsible Citizenship (Core)/Culture Anthropology (Core)	3
		18
	Spring	
ANT 171/POL 101	Culture Anthropology (Core)/Responsible Citzenship (Core)	3
ATH 121	Intro to Athletic Training	1
ATH 151	**Intro to Athletic Training Taping Tech**	**1**
ATH 238	**Prevention & Care of Athletic Injuries**	**2**
ENG 121/COM 110	College Comp II/Oral Communcations	3
HPS 206	**Medical Terminology**	**2**
THE	Theology (Core 104, 108, 110)	3
	Spring Credits	***15***
	Total Freshman Credits	***33***

Sophomore:	***Fall***	
ATH 243	**Intro to Clinical Education in Athletic Training I**	**2**
BIO 207	**Human Anatomy and Physiology I** (Math-Science)	**4**
CIS 101	Intro to Computers	3
PHI 108	Search for truth	3
PSY 201	Introduction to Psychology (Social and Behavioral Science)	3
	Fall Credits	***15***
	Spring	
THE/PHI	Required core (THE wellness)	3
ATH 200	Intro to Clinical Experience	1
ATH 244	**Intro to Clinical Education in Athletic Training II**	**3**
ATH 314	**Advanced Techniques in Athletic Training**	**3**
BIO 208	**Human Anatomy and Physiology II (Math-Science)**	**4**
PED 360	**Biomechanical and Kinesiological Studies**	**4**
	Spring Credits	***18***
	Total Sophomore Credits	***33***

Junior:	***Fall***	
ATH 300	Clinical Experience I	1
ATH 327	Evaluative Procedures in Athletic Training I	4
ATH 329	Therapeutic Modalities in Athletic Training	3
ATH 353	General Medical Conditions in Athletic Training	3
MAT 180	Elementary Statistics/Applied Statistics (Liberal Arts)	4
	Fall Credits	***15***
	Spring	
ATH 305	Clinical Experience II	1
ATH 316	Basic Pharmacology for Human Performance Sciences	3
ATH 319	Therapeutic Exercise in Athletic Training	3
ATH 328	Evaluative Procedures in Athletic Training II	2

PSY 207	Life Span Development (Social Science)	3
	Spring Credits	***12***
	Total Junior Credits	***27***
Senior:	***Fall***	
ATH 400	Clinical Experience III	1
ATH 441	Practicum in Athletic Training (or spring)	1
ATH 453	Athletic Training Senior Capstone I	3
ATH 354	Healthcare Administration	3
EXS 336	Exercise Physiology	4
	Fall Credits	***12***
	Spring	
ALU 499	Senior Outcomes Assessment: HPS	0
ATH 317	Sports Nutrition for Health and Performance	3
ATH 405	Clinical Experience IV	1
PHY 310	Psychology of Injury	3
ATH 454	Athletic Training Senior Capstone II	3
PHI/TH	Core	3
	Spring Credits	***13***
	Total Senior Credits	***25***
	Total Credits	***118***

Need 124 Credts to graduate

The prospective student must have successfully completed the following courses with a grade of B or better to be admitted into the professional program: ATH 151, 238, 243; and PED 157; successfully completed the following courses with a grade of C- or better: BIO 103, 207; HPS 206; PED 159; have a minimum cumulative GPA of 2.5 on a 4.0 scale for Required course work (including transfer courses); and maintain First Aid and Emergency Cardiac Care Certification.

Athletic Training Education Program Professional Course Requirements:
ATH 200,244,300,305,314,316,317,319,327,328,329,353,354,400,405,441,453,454
EXS 336; PSY 201,207; MAT 180

Wellness Minor Requirements: EXS 310, PSY 207, ATH 317 or SCI 224, THE 302, 320, 363
Electives (8 Credits chosen among the following courses: ATH 238, BUS 215, 362, 371, 381; EXS 302; PSY 307, 308, 406; PED 159, 267, 326; THE 215 or 315).
Application and Admission to the U-Mary Physical Therapy Program Core Requirements:
BIO 207,208, 209; PSY 207,406; CHE 109 or 111, 110 or 112, PHY 204, 304
GPA above 3.5 recommended in these courses

CURRICULUM SUBJECT TO CHANGE

SB 2295

#6
3/25/15

Damian Schlinger
Vice Chairman
North Dakota Board of Athletic Trainers
(701) 202-9078

March 25, 2015

This statement is on behalf of the North Dakota Board of Athletic Trainers in support of Senate Bill 2295 and its amendments to North Dakota Century Code 43-39, the Athletic Trainer Practice Act.

The North Dakota Board of Athletic Trainers was established to regulate the practice of Athletic Training in the State of North Dakota and protect the health and safety of the citizens of North Dakota. The members of this Board are appointed by the Office of the Governor.

In order for our Board or any other regulatory board to perform well it must make clear determinations based on the statute and rules of the Board. What has occurred since the statute came into existence is that it has aged significantly to the point where it no longer allows us to properly regulate the practice of an Athletic Trainer. This bill seeks to rectify this issue by matching the statute language to the current educational base of Athletic Trainers.

The lack of congruence between the educational base of the Athletic Trainer and the language in the statute creates uncertainty for the Board in the execution of its duties, and for the Athletic Trainer, in that we can find them practicing within the bounds of their professional education yet outside the bounds of the current statute. The current act also creates uncertainty for business looking to offer the services Athletic Trainers can provide. Can hospitals, clinics, schools, etc. hire the Athletic Trainer for the job or not? The current statute hurts businesses in that they can't hire qualified professionals already within the state. In this situation does the patient end up receiving care, delaying care, or not receive care at all?

The Board of Athletic Trainers will react in accordance with our duties and alter our rules and regulations to match that of the new statute with the passing of this bill. The Board will take on the responsibility for receiving input from others in the healthcare community to flesh out rules that further refine the interpretation of this statute, with the main concern of ensuring people are properly trained to serve the public.

The North Dakota Board of Athletic Trainers supports the amendments offered in this bill and respectfully requests a do-pass recommendation by this committee to protect and serve the healthcare needs of North Dakota citizens.

3-25-15

#7
SB 2295

House Human Services Committee
Support testimony SB 2295

Chairman Rep. Weisz	*Rep. Damschen*	*Rep. Muscha*
Vice Chair Rep. Hofstad	*Rep. Fehr*	*Rep. Oversen*
Rep. B. Anderson	*Rep. Keifert*	*Rep. Porter*
Rep D. Anderson	*Rep. Mooney*	*Rep. Seibel*
Rep. Becker		

My name is Robyn Gust and I am here today in support of SB 2295 in regard to updating the practice act for the athletic trainers of North Dakota. I have been a certified athletic trainer for 20 years, and very proud to have been licensed and working in my homes state of North Dakota for the past 15 years in Minot. I currently work with the physically active population in the secondary school, university and amateur setting and I am also on the Sports Medicine staff for the United Stated Deaf Olympic Team.

Today I would like to address the committee in regards to concerns and questions that have been raised on Section 1, 43-39-01, in defining "athletic training" and how an athletic trainer would, under the guidance of a physician, prevent, recognize, evaluate, manage or provide rehabilitation or physical reconditioning for an illness.

In the patient population I currently work with, our athletic trainers will "manage" illnesses on a regular basis, meaning we will <u>work in conjunction with</u> medical providers to ensure the well-being of patients with medical conditions. In the past year, I have personally worked with patients that have had asthma, iron deficiency anemia, sickle cell trait, heat illness, skin conditions, influenza, pneumonia and mononucleosis to name a few.

It is my responsibility as an athletic trainer, and within my education, to evaluate a person that may present with any of the conditions that I listed as well as an unlimited amount more and understand what the appropriate course of action may be which usually involves a referral to an appropriate medical provider. Once that medical provider has evaluated and made a medical diagnosis, a plan of care is developed in which our athletic trainers are included. It is the responsibility of the athletic trainer to help manage the plan and ensure that the medical provider's recommendations are followed. We do not have the luxury to choose what type of condition may present itself or what type of medical condition that our athletes may have with any of the teams we work with. That is why it is built into our education that athletic trainers must be competent in injury/illness prevention and wellness protection as well as clinical evaluation and diagnosis. Both of these areas are domains of athletic training education and are national standards.

Next I would like to speak to how an athletic trainer would be involved in rehabilitating an illness. In the past year, I had three college hockey players that were diagnosed with mononucleosis. The treatment plan from our medical director for that illness is at least 21 days of no activity and then a gradual progression back to activity if all signs and symptoms have cleared. They would not be allowed to jump back into playing hockey after 21 days of doing absolutely nothing but sleeping. It was my responsibility to follow the plan of care given to me by the treating physician. The days following the 21 days of rest, I reassessed the patients to determine if all signs and symptoms had cleared or if more rest was warranted. The next step is to develop a gradual exercise plan to safely return the patients to playing hockey. This was several check-ins with these patients over the course of several week before the

determination was made they were able to return to full contact hockey. The same can be said for other illness or medical condition, besides mono, where a gradual progression is needed while a patients works toward return to their competitive physical activity level. Other examples of rehabilitation of illnesses that I have been a part of are asthma, iron deficiency anemia, hernia surgeries, appendicitis surgery and heat illness recovery. These are not only conditions that were recognized by athletic trainers, the athletic trainers were involved in the rehabilitation as well.

This illness portion is included in SB 2295 and is well within the scope of practice and education of an athletic trainer. Athletic trainers do not diagnosis a person with a heart attack and then expect to do the surgery; that is not within our scope of practice and education. However, it is expected that an athletic trainer is able to evaluate a patient that presents with chest pain and make the appropriate medical referral and be involved in the management after that patient's plan has been developed by a physician or appropriate medical provider.

I would also like to point out that this is in no way expanding the scope of practice of an athletic trainer outside of caring for the physically active population. That is the demographic that our education is specific to, and is clearly defined in SB 2295.

In closing I would like to say that in 20 years of athletic training, I would like to stand up here and tell you that I am prepared for anything. I have completed the education, I continue to do more than the required amount of continued education on a yearly basis and continue to practice and hone my skills but I can honestly say that I am not always prepared for anything because we never know what may happen, that is the nature of the job of an athletic trainer. Our motto for my department, and most athletic trainers, is to "prepare for the worst and hope for the best". In my organization we try to accomplish that by working side by side with physicians, nurse practitioners, occupational therapist, physical therapist, exercise physiologist and chiropractors to name a few. And we do this because it is in the best interest of our patients, and that is our primary concern, and well within the scope of an athletic trainer.

I thank you for your time.

Robyn Gust, MS/ATC
Minot, ND

#8
SB 2295
3/25/17

Mr. Chairman;
Members of the House Human Services Committee;

My name is Dawn Mattern and I am a sports medicine and family physician in Minot. I am the Medical Director for our Physical Therapy, Occupational Therapy, and Athletic Training services. I urge your support for SB 2295.

I am responsible for 12 staff athletic trainers and 3 graduate assistant athletic trainers. I have set protocols and guidelines for injuries and illnesses that my athletic trainers follow in their care of active patients. These protocols and guidelines encompass common maladies such as ankle sprains, anterior knee pain, shoulder dislocations, colds, sore throats, and skin rashes. They will also touch on asthma, diabetes, sickle cell anemia, and concussion. Each direct the athletic trainer to refer the patient to a physician when the clinical course does not follow the expected treatment course. Athletic trainers are allowed to use their education to assess, evaluate, diagnose, treat, rehabilitate, and refer. With knowledge regarding exercise and the various injuries or illnesses, the athletic trainer is dually qualified for activity recommendations. They are not prescribing inhalers, but may give advice regarding activity participation for patients with asthma. They are not prescribing insulin, but may advise a diabetic athlete with a blood sugar over 400 to refrain from activity and follow their physician's recommendations.

Concussions have been re-defined and the knowledge regarding their side effects or long term effects expands with each passing week. A Practice Act that does not demand the incorporation of new treatments as well as information on new injuries or new illnesses will not ensure the safety of affected patients. A scope of practice defined by one's education allows for finite boundaries as well as professional freedom.

SB 2295 does not open the Athletic Trainers scope of practice, it restricts it to their education. It also ensures physician involvement and guidance. This bill does not make an athletic trainer into a physical therapist, their knowledge may overlap but each is fundamentally different and both have distinct and defined roles within the healthcare system.

I encourage your support for SB 2295.

Respectfully submitted,

Dawn Mattern MD

#9
SB 2295
3/25/15

March 25, 2015

HOUSE HUMAN SERVICES COMMITTEE SB 2295

REP. WEISZ AND MEMBERS OF THE COMMITTEE:

My name is Jack McDonald. I'm appearing today on behalf of the North Dakota Physical Therapy Association (NDPTA) and the North Dakota Board of Physical Therapy to oppose SB 2295.

This bill makes major, major changes in the scope of practice of a medical profession with no accompanying proof that it is warranted or that it will result in greater public safety.

The Athletic Trainers Act was enacted in 1983 to set out the scope of practice of this profession and provide a method of regulation in order to protect public safety. The law at that time was carefully designed to match the training and work of athletic trainers. As you can see from some of the attachments to my testimony, our neighboring states of Minnesota, South Dakota and Montana have very similar statutes.

The legislation before you this morning turns the scope of practice upside down. It not only removes the term "athletic" from the law – a bit of irony for a profession that calls itself athletic trainers – but also now says they can treat any illness or injury whatsoever. In other words you name, we treat it. Kind of a one stop shopping center for anything that ails mankind.

The bill also allows athletic trainers to practice their expanded services virtual free of any supervision from a physician, again a provision you'll see from the attachments is unlike any other state in the country.

We adamantly oppose this bill and ask that you give this bill a DO NOT PASS. At the very least, there is a proposed amendment attached in the packet that you should consider as an alternative.

Attached to my testimony are the definitions of athletic training from our neighboring states – South Dakota, Minnesota and Montana – that show the statutes and definitions all tie into the treatment of athletic injuries. Included in the packet are definitions from all the other states as well.

If you have any questions, I will be happy to try to answer them. THANK YOU FOR YOUR TIME AND CONSIDERATION.

 South Dakota

Printer Friendly

36-29-1. Definitions. Terms used in this chapter, unless the context otherwise requires, mean:

(1) "Athletic trainer," a person with specific qualifications as set forth in § 36-29-3, whose responsibility is the prevention, evaluation, emergency care, treatment, and reconditioning of athletic injuries under the direction of the team or treating physician. The athletic trainer may use cryotherapy, which includes cold packs, ice packs, cold water immersion, and spray coolants; thermotherapy, which includes topical analgesics, moist hot packs, heating pads, infrared lamp, and paraffin bath; hydrotherapy, which includes whirlpool; and therapeutic exercise common to athletic training which includes stretching and those exercises needed to maintain condition; in accordance with a physician's written protocol. Any rehabilitative procedures recommended by a physician for the rehabilitation of athletic injuries which have been referred and all other physical modalities may be administered only following the prescription of the team or referring physician;

(2) "Board," the Board of Medical and Osteopathic Examiners as created by chapter 36-4.

Source: SL 1984, ch 255, § 1.

^ Back to Top

37-36-101. Definitions. As used in this chapter, the following definitions apply:

(1) "Athlete" means a person who participates in an athletic activity that involves exercises, sports, or games requiring physical strength, agility, flexibility, range of motion, speed, or stamina and the exercises, sports, or games are of the type conducted in association with an educational institution or a professional, amateur, or recreational sports club or organization.

(2) "Athletic injury" means a physical injury received by an athlete.

(3) "Athletic trainer" means an individual who is licensed to practice athletic training.

(4) "Athletic training" means the practice of prevention, recognition, assessment, management, treatment, disposition, and reconditioning of athletic injuries. The term includes the following:

(a) the use of heat, light, sound, cold, electricity, exercise, reconditioning, or mechanical devices related to the care and conditioning of athletes; and

(b) the education and counseling of the public on matters related to athletic training.

(5) "Board" means the board of athletic trainers provided for in 2-15-1771.

(6) "Department" means the department of labor and industry provided for in 2-15-1701.

(7) "Licensee" means an individual licensed under this chapter.

History: En. Sec. 2, Ch. 388, L. 2007.

Provided by Montana Legislative Services

2014 Minnesota Statutes

Authenticate

148.7806 ATHLETIC TRAINING.

Athletic training by a registered athletic trainer under section 148.7808 includes the activities described in paragraphs (a) to (e).

(a) An athletic trainer shall:

(1) prevent, recognize, and evaluate athletic injuries;

(2) give emergency care and first aid;

(3) manage and treat athletic injuries; and

(4) rehabilitate and physically recondition athletic injuries.

The athletic trainer may use modalities such as cold, heat, light, sound, electricity, exercise, and mechanical devices for treatment and rehabilitation of athletic injuries to athletes in the primary employment site.

(b) The primary physician shall establish evaluation and treatment protocols to be used by the athletic trainer. The primary physician shall record the protocols on a form prescribed by the board. The protocol form must be updated yearly at the athletic trainer's registration renewal time and kept on file by the athletic trainer.

(c) At the primary employment site, except in a corporate setting, an athletic trainer may evaluate and treat an athlete for an athletic injury not previously diagnosed for not more than 30 days, or a period of time as designated by the primary physician on the protocol form, from the date of the initial evaluation and treatment. Preventative care after resolution of the injury is not considered treatment. This paragraph does not apply to a person who is referred for treatment by a person licensed in this state to practice medicine as defined in section 147.081, to practice chiropractic as defined in section 148.01, to practice podiatry as defined in section 153.01, or to practice dentistry as defined in section 150A.05 and whose license is in good standing.

(d) An athletic trainer may:

(1) organize and administer an athletic training program including, but not limited to, educating and counseling athletes;

(2) monitor the signs, symptoms, general behavior, and general physical response of an athlete to treatment and rehabilitation including, but not limited to, whether the signs, symptoms, reactions, behavior, or general response show abnormal characteristics; and

(3) make suggestions to the primary physician or other treating provider for a modification in the treatment and rehabilitation of an injured athlete based on the indicators in clause (2).

(e) In a clinical, corporate, and physical therapy setting, when the service provided is, or is represented as being, physical therapy, an athletic trainer may work only under the direct supervision of a physical therapist as defined in section 148.65.

History: *1993 c 232 s 7*

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2014 Minnesota Statutes

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148.7802 DEFINITIONS.

Subdivision 1. **Applicability.** The definitions in this section apply to this chapter.

Subd. 2. **Approved continuing education program.** "Approved continuing education program" means a continuing education program that meets the continuing education requirements in section 148.7812 and is approved by the board.

Subd. 3. **Approved education program.** "Approved education program" means a university, college, or other postsecondary education program of athletic training that, at the time the student completes the program, is approved or accredited by a nationally recognized accreditation agency for athletic training education programs approved by the board.

* Subd. 4. **Athlete.** "Athlete" means a person participating in exercises, sports, games, or recreation requiring physical strength, agility, flexibility, range of motion, speed, or stamina.

* Subd. 5. **Athletic injury.** "Athletic injury" means an injury sustained by a person as a result of the person's participation in exercises, sports, games, or recreation requiring physical strength, agility, flexibility, range of motion, speed, or stamina.

* Subd. 6. **Athletic trainer.** "Athletic trainer" means a person who engages in athletic training under section 148.7806 and is registered under section 148.7808.

Subd. 7. **Board.** "Board" means the Board of Medical Practice.

Subd. 8. **Credential.** "Credential" means a license, permit, certification, registration, or other evidence of qualification or authorization to practice as an athletic trainer in this state or any other state.

Subd. 9. **Credentialing examination.** "Credentialing examination" means an examination administered by the Board of Certification, or the board's recognized successor, for credentialing as an athletic trainer, or an examination for credentialing offered by a national testing service that is approved by the board.

Subd. 10. **Primary employment site.** "Primary employment site" means the institution, organization, corporation, or sports team where the athletic trainer is employed for the practice of athletic training.

Subd. 11. **Primary physician.** "Primary physician" means a licensed medical physician who serves as a medical consultant to an athletic trainer.

History: *1993 c 232 s 3; 2014 c 291 art 4 s 14,15*

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"Athletic training" means the management of athletic injuries and illnesses to prevent, evaluate, assess, provide immediate care on the field of play, treat, and recondition. ~~practice of prevention, recognition, evaluation, management, treatment, and disposition of athletic injuries.~~ The term also means rehabilitation of athletic injuries, if under the ~~order~~ supervision of a licensed physician. ~~The term includes organization and administration of education programs, athletic facilities, and the education and counseling of the public.~~

"Illness" means those illnesses sustained as a result of participation in athletic activities.

15.0488.04000

FIRST ENGROSSMENT

Sixty-fourth
Legislative Assembly
of North Dakota

ENGROSSED SENATE BILL NO. 2295

Introduced by

Senators Dever, Warner

Representatives Hofstad, Mooney, Rohr

PROPOSED settlement language

1 A BILL for an Act to amend and reenact sections 43-39-01 and 43-39-04 and subdivision d of
2 subsection 1 of section 43-39-10 of the North Dakota Century Code, relating to the regulation of
3 athletic trainers; and to provide a penalty.

4 **BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:**

5 **SECTION 1. AMENDMENT.** Section 43-39-01 of the North Dakota Century Code is
6 amended and reenacted as follows:

7 **43-39-01. Definitions.**

8 1. "Athletic trainer" means ~~a person~~an individual with specific qualifications set forth in
9 section 43-39-05, who is providing athletic training services in accordance with the
10 individual's education.

11 2. "Athletic training" means doing any of the ~~practice of prevention, recognition,~~
12 ~~evaluation, management, treatment, and disposition of athletic injuries. The term also~~
13 ~~means rehabilitation of athletic injuries, if under the order of a licensed physician. The~~
14 ~~term includes organization and administration of educational programs, athletic~~
15 ~~facilities, and the education and counseling of the public.~~following under the guidance
16 of a physician:

17 a. Preventing, recognizing, and evaluating injuries and illnesses sustained while
participating in physical activity;

18 b. Managing and administering the initial treatment of injuries or illnesses sustained
19 while participating in physical activity; on the field of play

20 c. Giving emergency care or first aid for an injury or illness sustained while
21 participating in physical activity;

22 d. Rehabilitating injuries or illnesses sustained while participating in physical
23 activity; with a written order from a physician.

1 e. Rehabilitating and physically reconditioning injuries or illnesses that impede or
2 prevent an individual from returning to participating in physical activity, if the
3 individual recently participated in, and intends to return to participation in,
physical activity;with a written order from a physician
4 f. Establishing or administering risk management, conditioning, and injury
5 prevention programs; or
6 g. Referring a patient to an appropriate health care provider as needed.
7 3. "Board" means the North Dakota board of athletic trainers established in section
9 43-39-02.
10 4. "Physical Activity" means vigorous activity that requires physical strength, agility, range of motion, repetitive motion, speed, and stamina, while participation in exercise, sports, games, recreation, wellness, or fitness.
11 5. "Physician" means ~~a doctor of medicine~~an individual licensed ~~to practice~~as a physician
12 under chapter 43-17.
13 **SECTION 2. AMENDMENT.** Section 43-39-04 of the North Dakota Century Code is
14 amended and reenacted as follows:
15 **43-39-04. Unlawful practice.**
16 1. ~~No~~A person may not practice athletic training or hold that person out as being an
17 athletic trainer in this state unless that person is an individual licensed in accordance
18 with this chapter.
19 2. ~~No~~A person may not consult, teach, or supervise or hold that person out as being able
20 to consult, teach, or supervise athletic training curricular courses in this state unless
21 that person is an individual licensed in accordance with this chapter or chapter 43-17~~,~~
22 or possesses a degree in a health-related field.
23 3. ~~No~~A person may not represent that person as being a licensed athletic trainer or use
24 in connection with that person's name any letters, words, or insignia indicating or
25 implying that the person is a licensed athletic trainer unless that person is an individual
26 licensed in accordance with this chapter.
27 **SECTION 3. AMENDMENT.** Subdivision d of subsection 1 of section 43-39-10 of the North
28 Dakota Century Code is amended and reenacted as follows:

1 d. Is guilty of treating or undertaking to treat ~~ailments of human beings~~an
2 individual's injury or illness, except as authorized pursuant to this chapter, or
3 undertaking to practice independent of the ~~order~~direction Guidance , of a licensed physician,
4 or is guilty of any act derogatory to the dignity and morals of the profession of
5 athletic training.

2. An athletic trainer may purchase, store, and administer topical medications, including aerosol medications as part of the practice of athletic training as defined herein, but shall not dispense or sell any of the medications to patients. An athletic trainer shall comply with any regulation adopted by the United States pharmacopoeia specifying protocols for storage of medications.

3-25-15

#10
SB 2295

Opposition to SB 2295

Chairman Weisz and Members of the Human Services Committee
My name is Vicky Steiner, District 37, City of Dickinson.

My son, Luke, is a sports physical therapist in Dickinson. He was unable to be here today and asked me to submit his information.

Dear Human Services Committee:

The bill SB 2295 has been introduced to **change** the athletic trainers' practice act. There are two main points that I contend with. Currently the North Dakota athletic training practice act defines athletic training as the "prevention, recognition, evaluation, management, treatment, and disposition of athletic injuries" AND requires that rehabilitation of athletic injuries be done under the order of a licensed physician.

SB 2295 would redefine athletic training as the "comprehensive management of injuries and illnesses to prevent, clinically evaluate, assess, provide immediate care, treat, rehabilitate, and recondition."

1st contention - It changes the physician order requirement to "guidance" from a physician for the rehabilitation of athletic injuries. "Guidance" is a broad term and for what cause is this part of the act even being changed?

2nd contention - Also, the bill does not specify that trainers manage injuries and illnesses of athletes only. Therefore, the general population would be fair game for trainers to evaluate, diagnose, rehab, etc. Athletic trainer's education and clinical experience does not include evaluating and treating the general population (non-athletic).

Those changes alone should send up red flags from both a safety and quality of care standpoint. It seems to me the way the act was written in the past was based on the amount and type of education/clinical experience an athletic trainer's program provides its students. Therefore the act contained the physician order requirement and the specific population (athletic) of whom they should manage care. So what has changed to allow an expanded scope of practice? I am unaware of any changes in athletic training programs which would warrant this expanded scope of practice. Also, if you compare the proposed changes to this act to all other state acts, it is the broadest language in the country regarding scope of practice for athletic trainers.

Please consider a Do Not Pass recommendation on SB 2295.

Luke Steiner, DPT
Sports Medicine and Outpatient Therapy
CHI – St. Joseph's Health

#11
SB 2295
3/25/15

March 25, 2015 – SB 2295

Chairman Weisz and members of the House Human Services Committee:

My name is Kevin Axtman and I am a licensed physical therapist and athletic trainer in Bismarck. I currently work at the Bone and Joint Center. I have served on the North Dakota Board of Physical Therapy 1999-2009, and am currently Member At Large over 30,000 with the North Dakota Physical Therapy Association. I OPPOSE SB 2295.

This same legislation was brought up and defeated during the 2013 legislative session, and at that time the Senate Human Services Committee strongly urged the athletic trainers and physical therapists work together on some agreeable practice act language.. Unfortunately, the athletic trainers apparently decided to forgo that suggestion and to instead just come back with this legislation. After having very little say during the initial Senate hearings, we have finally been able to have a meeting between the athletic trainers and physical therapists 3/17/2015.

The athletic trainers have insisted that their intent is not to expand their scope, but to define what they are doing presently including working with occupational health. The proposed language in the revised SB No. 2295 states otherwise. By deleting the "athletic" from "athletic injuries" throughout their practice act, an athletic trainer can work with any "injuries or illnesses while participating in physical activity". By deleting the word "athletic", it expands their scope of practice to the general public regardless of the patient's health status, or the type of work setting an athletic trainer can practice, even treating without a written referral from a physician. This would allow broad expansion of their scope of practice, far beyond that of any other state. **Please see the attachment in our packet listing the definitions of athletic training in all 50 states.**

Minnesota lawmakers were presented similar legislation in 2006 and voted "no" on the expansion of the athletic trainer's scope of practice. Minnesota lawmakers used findings from an independent scope of practice review team to help make this determination.

The ND physical therapists in their most recent meeting with the athletic trainers, have offered considerable compromising language which is similar to the Wisconsin athletic trainer's practice act. The physical

therapists have made concessions to the language that would allow the elimination of the terms "athlete" and "athletic injuries" from the athletic trainers practice act. Please note that in Wisconsin, the athletic trainers and physical therapists worked for many months on this compromised language.

A copy of our compromise bill offered to the athletic trainers is included in your packet.

Many of the suggested changes from the physical therapists are based on public safety. These include a "written order from a physician" (section 43-39-01), to ensure a medical doctor has seen the patient first, most importantly in a clinical setting. And "vigorous activity" (section 43-39-02), ensuring the patient is an active healthy individual and not complex with co-morbidities.

Physical therapists, just like athletic trainers, have had to update their education curriculums to meet the ever-changing healthcare landscape. Currently athletic training is an entry level bachelors program, with clinical rotations done in an athletic setting. Occupational therapists have an entry level Master's degree and physical therapists have an entry level Doctorate degree, all with clinical rotations done with the general public.

The athletic trainers have stated they are looking at an entry Master's degree, in the next 15 years. The physical therapists updated their scope of practice in 2005 only after their entry level Doctorate degree was well in place

Athletic trainers should upgrade their education to include non-athletic injuries and including clinical evaluations, and then update their practice act, instead of changing their scope now to include what they hope will be their training in the future.

Thank you for your time and consideration. If you have any questions, I would be glad to try to answer them.

#12
SB 2295
3/25/15

March 25, 2015 – House Human Services Committee – SB 2295

Chairman Weisz and Committee Members:

My name is Jeanne DeKrey. I have been licensed as a physical therapist in North Dakota for 32 years and currently serve as Vice President of the North Dakota Board of Physical Therapy. I am here today to express my concerns about Senate Bill 2295 and the proposed changes it seeks.

For much of this background, I am using "***Changes in Healthcare Professions' Scope of Practice: Legislative Concerns***" a collaboration document including Medicine, Nursing, PT, OT, Social Work, and Pharmacy. It is included in the packet you received. reference.

Changes in scope of practice are inherent and necessarily evolving. Practice acts need to evolve as capabilities change and inevitably lead to overlapping scopes of practice.

As a member of the PT licensing board, I recognize that the purpose of health care regulation must put public protection first, rather than professional self protection. At the same time, from a public protection viewpoint it is paramount that the public be assured the providers are prepared to practice safely, effectively and competently.

Practice acts should require licensees to demonstrate that they have the requisite training and competence to provide a service. As professions evolve, new techniques are developed, but not all practitioners are competent to perform these new techniques. While it is not realistic to require a skill or activity to be taught in an entry-level program before it becomes part of a profession's scope of practice; the entry-level training program and its accompanying accrediting standards should provide the framework, including the basic knowledge and skills needed, to acquire the new skill once out in the field. There should also be competence assessment tools that indicate whether the practitioner is competent to perform advanced skills safely.

My questions in regard to SB 2295 are:

1. Does current entry-level education prepare practitioners to safely, effectively and efficiently perform these skills with all individuals who are broadly classified as "physically active"? Would "vigorous physical activity" more closely align with the education, experience and scope of athletic training?

2. How has the education, training and assessment within the profession expanded to include the knowledge base, skill set and judgments required to perform the proposed change in scope of practice? You will hear additional testimony regarding educational preparation and would like to have you review how the UND website describes their program. It is included in the packet.

3. If the change in scope is an advanced skill that would not be tested on the entry-level licensure examination, how is competence in the new technique assured?

Minnesota has used a version of this Scope of Practice document and an independent review process for this specific issue and did not adopt the changes being proposed in SB 2295. The language offered by SB 2295 has been either defeated or significantly amended in every other jurisdiction that has considered it.

The potential compromise of addressing the areas of concern in rules rather than statute would seem to fall short. I would urge you to vote against this bill in its current form.

Thank you,

Respectfully submitted,
Jeanne DeKrey, PT, DPT, PRC

#13
SB 2295
3/25/15

March 25, 2015 – House Human Services Committee – SB 2295

CHASIRMAN WEISZ AND COMMITTEE MEMBERS

Good afternoon. My name is Mary Dockter and I am Chair of the University of Mary's Physical Therapy Program, a position I have held since 2010. I started my career in academia at the University of Mary in 1998, first as faculty member, and then as Director of Clinical Education. Prior to that, I worked clinically as a physical therapist (PT) in a variety of areas including acute, outpatient orthopedics, and home healthcare with patients across the lifespan and with a multitude of diagnoses. I am on several national committees that deal with entry-level and advanced practice education for PT and thus, have a good understanding of didactic and clinical PT education. I am here to voice my opposition to SB 2295.

I want to first state that I have great respect for athletic trainers. I have had the pleasure of working with a number of outstanding clinicians in the past, and currently work with a group of dedicated and skilled AT educators. Additionally, our PT program benefits from having outstanding students matriculate into our doctoral PT program from the undergrad AT program at UMary, as well as other programs across the nation. On a typical year, approximately 30% of our students enter our program with an AT degree and we often advise high school students to take this route for their required pre-admission undergraduate degree. Faculty note that students with AT degrees are confident with their patient interaction skills, musculoskeletal assessment, and prescribing and performing certain interventions for conditions affecting the extremities.

The PT education curriculum has two components: didactic and clinical. The didactic component includes classroom and laboratory experiences to assist the student in gaining the knowledge and skills required to manage patients across the lifespan, with a variety of complex diagnoses, and in a variety of settings. The didactic component is designed to provide students with the knowledge, skills, attitudes, and behaviors that are needed for entry into the practice of physical therapy (see document entitled Minimum Entry-Level Skills). However, the didactic

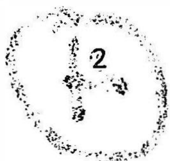
component cannot provide students with the opportunity to apply their knowledge, skills, attitudes, and behaviors in the "real world" of physical therapist practice.

Our clinical education program at the University of Mary is representative of most physical therapy programs which includes a clinical education component that typically involves experiences in clinical sites away from, and outside the direct control of, the academic institution (CAPTE, Evaluative Criteria PT Programs, pg 4). Our clinical education program includes contracts with approximately 300-350 clinical sites throughout the nation and students are required to complete experiences in outpatient orthopedics; acute care; and in neurorehabilitative settings. The students are introduced to medically complex and often times fragile patients with complex diagnoses and co-morbidities in multiple body systems.

During this time in the clinic, the students are directly mentored by licensed physical therapists with experience in performing examination, evaluation, and advanced screening prior to initiating rehabilitation through physical activities such as range of motion, strengthening, aerobic endurance/stamina, balance and/or agility training.

In general, the clinical education courses account for at least one third of the curriculum. Clinical internships are critical to the development of competent, professional (entry-level) practitioners and are designed to maximize student learning. Faculty rely heavily on practitioners to design, implement, and assess student learning experiences and student performances, and utilize mechanisms to ensure students are exposed to a variety of PT settings, to communicate with clinical education faculty, to monitor the quality of the students' experiences, and to assess student performance.

According to the 2012-2013 Biennial Accreditation Report, the average length of professional curriculum of DPT programs was 122.5 weeks (93.2 didactic weeks, 35.6 clinical education weeks). DPT programs on average required 230 credits (115 preprofessional, 116.3 professional). These are



substantial increases from when PT professional programs were at a Master's Level (CAPTE, Evaluative Criteria PT Programs, pg 5). PT programs first transitioned from a Master's degree to a Doctoral degree in the mid-1990's with all programs transitioned by 2015. The main differences between the master's and doctoral level degrees include:

- increased content in areas such as diagnostics, imaging, pharmacology, advanced practice skills (manual therapy, pediatrics, geriatrics), basic sciences (histology, pathology), business practices, and health promotion
- emphasis on evidence-based practice, case-based activities, and clinical decision-making
- changes in the clinical education component such as increased hours, longer rotations, and more roles
- and changes in expected student outcomes including increased practice autonomy, professionalism, clinical decision-making, and diagnostic skills.

The main reason for the evolution from a master's to a doctoral level was in response to changing expectations for graduates resulting from significant changes in practice. One significant change is the ability for PTs to practice without referral in some form in all 50 states. Clinicians must recognize and screen for conditions that require referral to another healthcare professional, as well as how crucial it is to understand co-morbid conditions that may require a change in the normal plan of care. For instance, a female patient may come in for examination and treatment of her knee. Further questioning reveals the patient has a history of falls, cancer with lymph node removal, osteoporosis, depression, and is on medication for high blood pressure. All of these conditions greatly affect how the PT will manage the knee injury. In fact, not taking into consideration the co-morbid conditions could cause the patient additional harm.

I am not an athletic trainer and have not completed an AT academic program. However, I can speak with confidence that students in our program, who have completed AT coursework, do not have the background

knowledge and skills in managing patients with complex medical conditions and multiple co-morbidities prior to completing the PT program.

Therefore, I am opposed to the proposed language in SB2295. I would support language that is present in other states that defines AT scope of practice consistent with their educational preparation.

Respectfully,

Mary Dockter, PT, PhD
Fellow of the APTA Education Leadership Institute
Professor and Chair, Department of Physical Therapy
University of Mary

#14
SB2295
3/25/15

March 25 – SB 2295 – House Human Services Committee

Chairman Weisz and Committee Members:

Good afternoon. My name is Missy Taylor and I am a full time faculty member in the University of Mary's Physical Therapy Program, a position I have held since 2010. I received my Bachelor's in Athletic Training from the Univ. of Mary in 2003 and then continued my education and received my Doctorate of Physical Therapy from the Univ. of Mary in 2006.

Prior to my current position in academia, I worked as a physical therapist (PT) as well as an athletic trainer (AT). I provided athletic training coverage for high school sporting events in the evenings and on weekends and worked in acute care and inpatient rehabilitation as a PT during the day. I am currently a licensed AT and PT. I received my board certification in neurology from the American Physical Therapy Association (APTA) in 2013. I have also served on several committees for the North Dakota Physical Therapy Association (NDPTA). I am here today to voice my opposition to SB 2295.

I have a great deal of respect for athletic trainers because I am one. I currently work with an outstanding group of AT educators at the University of Mary. Additionally, our PT program benefits from having AT students matriculate into our doctoral PT program, like I once did. Our PT students with AT degrees are well prepared and do very well building off of the knowledge they gained in their respective AT programs.

But having myself completed both AT and PT academic programs, I can confidently say that with only my AT degree I would not have possessed the necessary knowledge and skills or felt comfortable managing patients with complex medical conditions and co-morbidities. I gained the knowledge, skills, and confidence through the three-year PT doctorate curriculum that included 32 weeks of hands on clinical experience working with complex patients. My clinical experiences in North Dakota hospitals and clinics included intense learning and skill development in acute care, orthopedics, pediatrics, and inpatient rehabilitation.

Through these experiences, I not only developed a passion for acute care and neurorehabilitation, but also became competent in my ability to work with people who have co-morbidities as well as to screen for conditions outside my scope of practice.

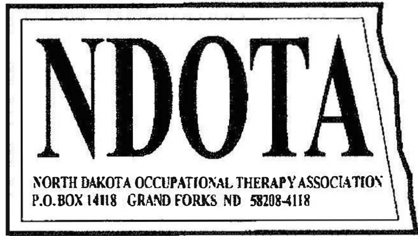
Lastly, I have a personal story to share. My mother is 58 years old and has multiple myeloma, which is an incurable cancer of the blood that can lead to lesions of the bones. Her symptoms previous to her diagnosis were back and hip pain that mimicked a musculoskeletal condition. A clinician must be able to recognize when a patient requires referral to another healthcare provider, which is what my mother needed. She currently, along with the cancer, has medication-induced diabetes, degenerative disc disease, arthritis of the tailbone, and has a history of back surgery as well as reoccurring episodes of vertigo. She continues to participate in regular physical activity. If she were to injure her knee now, I do not feel that an athletic trainer would have the background in pathophysiology to be able to effectively manage her condition along with her complex medical history.

Therefore, I am opposed to the proposed language in SB 2295. I would support language that is consistent with current AT education and that is present in other state's practice acts.

Respectfully,

Missy Taylor PT, DPT, ATC, NCS
Neurologic Certified Specialist
Assistant Professor
Department of Physical Therapy
University of Mary

#15
SB 2295
3/25/15



March 24, 2015

Dear Chairman Weisz & House Human Services Committee,

On behalf of the North Dakota Occupational Therapy Association, I am testifying regarding Senate Bill 2295. The North Dakota Occupational Therapy Association has concerns regarding this bill in its current form.

As you are aware, the athletic trainers in North Dakota proposed a bill during the 2013 legislative session which did not move forward. The Senate committee strongly recommended athletic trainers work with other professions outside the legislative session so that the bill could be worked on without significant time constraints. The North Dakota Occupational Therapy Association was not contacted outside the legislative session as the committee advised, but instead, we were approached at the beginning of this legislative session. We did work with the athletic trainers in the last several months and agreed upon language that we would not oppose. However, the bill that has been submitted to this committee does not include that language. Specifically, we agreed on the amendments proposed by the athletic trainers today, which are:

PROPOSED AMENDMENTS TO SENATE BILL NO. 2295

Page 1, line 9, remove " services in accordance with the"
Page 1, line 10, remove "individual's education"
Page 3, line 3, replace "direction" with "guidance"
Renumber accordingly

If these amendments are made to the bill, the North Dakota Occupational Therapy Association is neutral on this bill. If the amendments are NOT made, we oppose the bill.

Thank you for your time.

Carol Olson, PhD, OTR/L, FAOTA
North Dakota Occupational Therapy Association

#16
SB 2295
3/25/15

Sports Medicine

School of Medicine & Health Sciences

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(#)

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B.S. in Athletic Training

Introduction

The Department of Family Medicine offers the B.S. in Athletic Training degree under the auspices of the Division of Sports Medicine. This degree program was formally approved by the North Dakota Board of Higher Education in September, 1990. Athletic Training was recognized as an allied health field by the AMA June, 1990.

The degree program entails a four-year curriculum designed to prepare the student for an entry-level position in the field of athletic training. Upon completion of the curriculum, the student will be prepared to take the BOC Certification Examination.

Admission to the curriculum is competitive. Students are selected using the following criteria: academic performance (2.75 GPA minimum), departmental application, references, 100 hours of directed observation, and completion of FMed 101, 207, 207L, Biol 150 and 150L, and PXW 310. It is recommended that students applying for this program meet with the academic coordinator early in their freshman year.

Students pursuing the Athletic Training degree are encouraged to utilize the electives in this program to prepare for advanced study. Suggested areas of study include: post-graduate study in exercise science, physical therapy or medicine. The Athletic Training program offered is accredited by the Commission on Accreditation of Athletic Training Education (CAATE).

Requirements

Required 127 credits (36 of which must be numbered 300 or above, and 60 of which must be from a 4-year institution) including:

1. General Education Requirements (see University GER listing).
2. The following curriculum:

   Pre-Admission Courses
   The student must earn C or better in the following courses to be admitted in the program:

- Biol 150/150L. General Biology I and Laboratory. 4 credits.

The student must earn B or better in the following courses to be admitted in the program.

- FMed 101. Orientation to Athletic Training. 1 credit.
- FMed 207. Prevention and Care of Athletic Injuries. 2 credits.
- FMed 207L. Prevention and Care of Athletic Injuries Lab. 1 credit.

At the time of application to the Athletic Training Program, the student must have completed or be enrolled in all of the above courses. In addition, the student must show proof of the First Aid and CPR certifications or enrollment in:

- PXW 310. First Aid and CPR. 2 credits.

Core Courses

The following core courses are required for the B.S. in Athletic Training:

- Chem 121, 121L. General Chemistry I/Laboratory. 4 credits.*
- Comm 110. Fundamentals of Public Speaking. 3 credits.*
- Engl 110. College Composition I. 3 credits.*
- Engl 120. College Composition II. 3 credits.*
- Med 205. Medical Terminology. 1 credit.
- Phys 161, 161L. Introductory College Physics I/Laboratory. 4 credits.*
- Phys 162, 162L. Introductory College Physics II/Laboratory. 4 credits.*
- Psyc 111. Introduction to Psychology. 3 credits.*
- Psyc 241. Statistics for Behavioral Science. 4 credits.*
- Psyc 250. Developmental Psychology. 4 credits.
- Soc 110. Introduction to Sociology. 3 credits.*
- Arts & Humanities Requirement. 9 credits.*
- Electives. 13 credits.

*indicates course satisfies General Education Requirements.

Professional Courses

The following are essential professional courses to become an entry-level athletic trainer:

- Anat 204 & 204L. Anatomy for Paramedical Personnel and Lab. 5 credits.
- FMed 208. Procedures in Athletic Training. 1 credit.
- FMed 208L. Laboratory Procedures in Athletic Training. 1 credit.
- FMed 200. Understanding Medicine. 3 credits.
- FMed 211. Beginning Practicum I. 1 credit.
- FMed 213. Beginning Practicum II. 1 credit.
- FMed 311. Intermediate Practicum I. 2 credits.
- FMed 312. Medical Aspects of Sports. 2 credits.
- FMed 313. Intermediate Practicum II. 2 credits.
- FMed 320. Athletic Training Modalities. 2 credits.
- FMed 320L. Athletic Training Modalities Laboratory. 1 credit.
- FMed 321. Athletic Training Rehabilitation Techniques. 2 credits.
- FMed 321L. Athletic Training Rehabilitation Techniques Lab. 1 credit.
- FMed 343. Organizational Admin. in Athletic Training. 2 credits.
- FMed 411. Advanced Practicum I. 2 credits.
- FMed 413. Advanced Practicum II. 2 credits.
- FMed 481. Athletic Injury Assessment. 4 credits.
- FMed 491. Seminar in Athletic Training. 2 credits.
- FMed 497. Internship in Athletic Training. 3 credits.
- Nutr 240. Fundamentals of Nutrition. 3 credits.
- PXW 332. Biomechanics. 4 credits.
- PXW 402. Exercise Physiology. 4 credits.
- PXW 403. Health Education. 2 credits.
- PPT 315. Human Pharmacology. 3 credits.
- PPT 301. Human Physiology. 4 credits.

Courses

101. Orientation to Athletic Training. 1 credit. Overview of the field of athletic training. Survey of the role of the athletic trainer. Films, lectures, and observation in clinical settings. F,S

200. Understanding Medicine. 3 credits. An overview of the broad parameters of family medicine. Guest speakers are brought in to discuss various facets of medicine. S

207. Prevention and Care of Athletic Injuries. 2 credits. Corequisite: FMed 207L. An introductory course into the care and treatment of athletic injuries. F, S

207L. Laboratory Prevention and Care of Athletic Injuries. 1 credit. Corequisite: FMed 207. A practical laboratory to develop athletic taping skills taught in FMed 207. F, S

208. Procedures in Athletic Training. 1 credit. Prerequisites: FMed 207, 207L. Corequisites: FMed 208L, Anat 204 and 204L. This course serves as an orientation class for incoming sports health majors. Policies and procedures as well as record keeping are covered. F

208L. Laboratory Procedures in Athletic Training. 1 credit. Prerequisites: FMed 207 and 207L. Corequisite: FMed 208, Anat 204 and 204L. A course designed to allow students to get practical experiences in ıry management, modality usage and record keeping skills taught in FMed 208. F

211. Beginning Clinical Practicum I in Athletic Training. 1 credit. Prerequisites: FMed 207 and 207L, FMed 101. Corequisites: FMed 208 and 208L. A clinical course designed to allow the student to develop specified clinical competencies in a directed, progressive manner. F

213. Beginning Clinical Practicum II in Athletic Training. 1 credit. Prerequisites: FMed 208 and 208L. A clinical course designed to allow the student to develop specified clinical competencies in a directed, progressive manner. S

311. Intermediate Clinical Practicum I in Athletic Training. 2 credits. Prerequisite: FMed 213. A clinical course designed to allow students to develop specified clinical competencies in a directed, progressive manner. F

312. Medical Aspects of Sports. 2 credits. Prerequisite: Permission of instructor. A course designed to introduce students to various medical specialities and medical problems and their effects on athletic participation. F

313. Intermediate Clinical Practicum II in Athletic Training. 2 credits. Prerequisite: FMed 481. Corequisites: FMed 320, 321, 321L. A clinical course designed to allow the students to develop specified clinical competencies in a directed progressive manner. S

320. Athletic Training Modalities. 2 credits. Prerequisite: FMed 481. A course designed to present the theoretical and applied principles and techniques for the application of modalities in sports injury care. S

320L. Laboratory Modalities in Athletic Training. 1 credit. Prerequisite: FMed 481. Corequisite: FMed 320. A course designed to practice the theoretical and applied principles and techniques for the application of modalities in sports injury care. S

321. Athletic Training Rehabilitation Techniques. 2 credits. Prerequisite: FMed 481. Corequisite: FMed 321L. A course designed to explain the principles and techniques of rehabilitation as they apply to athletic injuries. S

321L. Laboratory Athletic Injury Rehabilitation Techniques. 1 credit. Prerequisite: FMed 481. Corequisite FMed 321. A course designed to allow students practical skill development of rehabilitation techniques utilized in athletic injury care as taught in FMed 321. S

343. Organizational Administration of Athletic Training. 2 credits. Prerequisite: Senior standing or consent of the instructor. A course designed to acquaint students with the theories and principles of administration. Administrative functions as they relate to the athletic trainer will be explained. S

411. Advanced Clinical Practicum I in Athletic Training. 2 credits. Prerequisite: FMed 313. A clinical course designed to allow students to develop specified clinical competencies in a directed, progressive manner. F

413. Advanced Clinical Practicum II in Athletic Training. 2 credits. Prerequisite: FMed 313. A clinical course designed to allow the students to develop specified clinical competencies in a directed progressive manner. S

481. Athletic Injury Assessment. 4 credits. Prerequisite: FMed 213. A course designed to instruct the students in the theories and skills of injury evaluation. F

491. Seminar in Athletic Training. 2 credits, repeatable to 4 credits. Permission of instructor. Advanced work in athletic training to include surgical and conservative injury management, rehabilitation and injury. F,S

494. Directed Studies in Athletic Training. 1-4 credits. (Repeatable to maximum of 6 credits.) Prerequisites: Upper level status in athletic training or other allied health field, PT students, fourth year medical students, or instructor permission. An in-depth study in a subject area selected by the student under tutorial supervision. F,S

497. Internship in Athletic Training. 3 credits. Prerequisite: FMed 313. Off campus athletic training experience designed to expose the student to alternate concepts of care. Repeatable up to 6 credits with instructor permission. F,S,SS

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under the direction or referral, or both, of a licensed physician after meeting the requirements of the act and rules and regulations. Licensed athletic trainers follow protocols approved jointly by the State Board of Medical Examiners and the Alabama Board of Athletic Trainers. **Alabama**

direction" means the physician authorizes a procedure by a verbal order if the physician is present or by written order, telecommunication, or athletic training treatment plans, protocols, or standing orders established by the physician if the physician is not present. **Alaska**

performed under the direction of a licensed physician: Does not include treating, assessing or evaluating a person who sustains an injury under any circumstance other than during participation in or preparation for competitive team or individual sports. **Arizona**

"DIRECTION OF A PHYSICIAN, DENTIST, OR HEALTH CARE PROFESSIONAL" MEANS THE PLANNING OF SERVICES WITH A PHYSICIAN, DENTIST, OR HEALTH CARE PROFESSIONAL; THE DEVELOPMENT AND APPROVAL BY THE PHYSICIAN, DENTIST, OR HEALTH CARE PROFESSIONAL OF PROCEDURES AND PROTOCOLS TO BE FOLLOWED IN THE EVENT OF AN INJURY OR ILLNESS; THE MUTUAL REVIEW OF THE PROTOCOLS ON A PERIODIC BASIS; AND THE APPROPRIATE CONSULTATION AND REFERRAL BETWEEN THE PHYSICIAN, DENTIST, OR HEALTH CARE PROFESSIONAL AND THE ATHLETIC TRAINER. **Colorado**

with the consent and under the direction of a health care provider (4) "Standing orders" means written protocols, recommendations and guidelines for treatment and care, furnished and signed by a health care provider specified under subdivision (1) of this section, to be followed in the practice of athletic training that may include, but not be limited to, (A) appropriate treatments for specific athletic injuries, (B) athletic injuries or other conditions requiring immediate referral to a licensed health care provider, and (C) appropriate conditions for the immediate referral to a licensed health care provider of injured athletes of a specified age or age group; **Connecticut**

All treatment of athletic injuries requires a physician's referral, except for minor sprains, strains, and contusions, first aid excluded. Treatment of musculoskeletal injuries that are not defined as an "athletic injury" will require direction from a physical therapist and direct supervision of every fifth treatment. An athletic trainer may not independently initiate, modify, or discontinue a physical therapy plan of care. Athletic training shall not include radiology, surgery, prescription drugs, or authorize the medical diagnosis of disease. **Delaware**

"Supervision" means the easy availability of the supervisor to the athletic trainer, which includes the ability to communicate by telecommunications. **Florida**

Nothing in this paragraph shall be construed to expand the scope of practice of an athletic trainer beyond the determination of the advising and consenting physician as provided for in paragraph **Georgia**

"Treating physician" means a physician or osteopathic physician licensed under chapter 453 who, within the licensee's scope of practice and individual competency, is responsible for the athletic training services provided by an athletic trainer and oversees the practice of athletic training by an athletic trainer. **Hawaii**

and carries out the practice of athletic training under the direction of a designated Idaho licensed physician, registered with the board or a designated Idaho licensed chiropractic physician. This direction will be provided by verbal order when the directing physician is present and by written order or by athletic training service plans or protocols, as established by board rule, when the directing physician is not present. **Idaho**

upon the direction of his or her team physician or consulting physician, carries out the practice of prevention/emergency care or physical, With a physician, determination of when an athlete may safely return to full participation post-injury; **Illinois**

under the direction of a licensed physician, osteopath, podiatrist, or chiropractor. However, in a clinic accessible to the general public, the term means practicing athletic training only upon the referral and order of a licensed physician, osteopath, podiatrist, or chiropractor. **Indiana**

who, upon the advice and consent of a team physician, carries out the practice of prevention or physical rehabilitation, or both, of injuries incurred by participating athletes at an educational institution, professional athletic organization, or other bona fide athletic organization. In carrying out these functions the athletic trainer is authorized to use whatever physical modalities as are deemed necessary by a team physician; **Kentucky**

under the general supervision of a physician carries out the practice of prevention, emergency management, and physical rehabilitation of injuries and sports-related conditions incurred by athletes. In carrying out these functions, the athletic trainer shall use whatever physical modalities are prescribed by a team physician or consulting physician, or both. General supervision" means the service is furnished and under a physician's overall direction control, but the physician's presence shall not be required during the provision of service. "Physical rehabilitation" means the care given to athletes following injury and recovery. These treatments and rehabilitation programs may consist of pre-established methods of physical modality use and exercise as prescribed by a team physician, consulting physician, or both. **Louisiana**

EVALUATION AND TREATMENT PROTOCOL" MEANS A DOCUMENT THAT IS EXECUTED BY A PHYSICIAN AND AN ATHLETIC TRAINER THAT MEETS THE REQUIREMENTS OF § 14–5D–11 OF THIS SUBTITLE.) "PRACTICE ATHLETIC TRAINING" MEANS APPLICATION OF THE FOLLOWING PRINCIPLES AND METHODS FOR MANAGING ATHLETIC INJURIES FOR ACTIVE INDIVIDUALS AND ATHLETES IN GOOD OVERALL HEALTH UNDER THE SUPERVISION OF A LICENSED PHYSICIAN: PRACTICE ATHLETIC TRAINING" DOES NOT INCLUDE:) EXCEPT FOR THE CONDITIONING OF AN ATHLETE UNDER THE SUPERVISION OF A TREATING PHYSICIAN, THE TREATMENT, REHABILITATION, OR RECONDITIONING OF NONATHLETIC INJURIES OR DISEASE. "SUPERVISION" MEANS THE RESPONSIBILITY OF A PHYSICIAN TO PROVIDE ONGOING AND

IMMEDIATELY AVAILABLE INSTRUCTION THAT IS ADEQUATE TO ENSURE THE SAFETY AND WELFARE OF A PATIENT AND IS APPROPRIATE TO THE SETTING. **Maryland**

performed under the direction and supervision of an individual licensed under direction" means either a written, electronic, or verbal order issued by a physician or authorized representative of a physician. Michigan

The primary physician shall establish evaluation and treatment protocols to be used by the athletic trainer. The primary physician shall record the protocols on a form prescribed by the board. The protocol form must be updated yearly at the athletic trainer's registration renewal time and kept on file by the athletic trainer. In a clinical, corporate, and **physical therapy** setting, when the service provided is, or is represented as being, **physical therapy**, an athletic trainer may work only under the direct supervision of a physical therapist as defined in section 148.65. At the primary employment site, except in a corporate setting, an athletic trainer may evaluate and treat an athlete for an athletic injury not previously diagnosed for not more than 30 days, or a period of time as designated by the primary physician on the protocol form, from the date of the initial evaluation and treatment. Preventative care after resolution of the injury is not considered treatment. **Minnesota**

as long as those activities are performed under the direction of a licensed physician, nurse practitioner or physician assistant. The practice of athletic training does not include the practice of physical therapy, the practice of medicine, the practice of osteopathic medicine and surgery, the practice of nursing or the practice of chiropractic. who, upon the advice, consent and oral or written prescriptions or referrals of a licensed physician, nurse practitioner or physician assistant, **Mississippi**

and who, upon the direction of the team physician and/or consulting physician, practices prevention, emergency care, first aid, treatment, or physical rehabilitation of injuries incurred by athletes **Missouri**

injuries under guidelines established with a licensed physician and who is licensed to perform the functions set out in section 71-1,240. When athletic training is provided in a hospital outpatient department or clinic or an outpatient-based medical facility, the athletic trainer will perform the functions described in section 71-1,240 with a referral from a licensed physician for athletic training; **Nebraska**

and under the direction of a physician licensed in any state or in Canada. **New Hampshire**

to athletes under a plan of care designed and overseen by a physician licensed in this State, f."Supervision" means that a physician licensed in this State is accessible to an athletic trainer, either on-site or through voice communication, during athletic training. **New Jersey**

athletic trainer" means a person who, with the advice and consent of a licensed physician, practices the treatment, prevention, care and rehabilitation of injuries incurred by athletes; **New Mexico**

to per rm athletic training under the supervision of a physician and limits his or her practice to secondary schools, institutions of postsecondary education, professional athletic organizations, or a person who, under the supervision of a physician, carries out comparable functions on orthopedic athletic injuries, excluding spinal cord injuries, in a health care organization. Supervision of an athletic trainer by a physician shall be continuous but shall not be construed as requiring the physical presence of the supervising physician at the time and place where such services are performed. The scope of work described herein shall not be construed as authorizing the reconditioning of neurologic injuries, conditions or disease. **New York**

Athletic trainer. - A person who, under a written protocol with a physician licensed under Article 1 of Chapter 90 of the General Statutes and filed with the North Carolina Medical Board, carries out the practice of care, prevention, and rehabilitation of injuries incurred by athletes **North Carolina**

The term also means rehabilitation of athletic injuries, if under the order of a licensed physician. **North Dakota**

acute athletic injuries upon the referral of an individual authorized under Chapter 4731. of the Revised Code to practice medicine and surgery, osteopathic medicine and surgery, or podiatry, a dentist licensed under Chapter 4715. of the Revised Code, a physical therapist licensed under this chapter, or a chiropractor licensed under Chapter 4734. of the Revised Code **Ohio**

under the direction of a physician, podiatrist or dentist, provide athletic training services to a physically active person under the care of a physician, dentist or podiatrist.

Direction—Supervision over the actions of a certified athletic trainer by means of referral by prescription to treat conditions for a physically active person from a licensed physician, dentist or podiatrist or written protocol approved by a supervising physician, except that the physical presence of the supervising physician, dentist or podiatrist is not required if the supervising physician,

dentist or podiatrist is readily available for consultation by direct communication, radio, telephone, facsimile, telecommunications or by other electronic means. *Physically active person*—An individual who participates in organized, individual or team sports, athletic games or recreational sports activities. **Pennsylvania**

the direction of his or her team physician and/or consulting physician, carries out the practice of athletic training to athletic injuries incurred by athletes. no athlete shall receive athletic training services if classified as geriatric by the consulting physician. No athlete shall receive athletic training services if non-athletic or age-related conditions exist or develop that render the individual debilitated or non-athletic. **Rhode Island**

upon the advice and consent of a licensed physician, carries out the practice of care, prevention, and physical rehabilitation of athletic injuries, **South Carolina**

evaluation, emergency care, treatment, and reconditioning of athletic injuries under the direction of the team or treating physician Any rehabilitative procedures recommended by a physician for the rehabilitation of athletic injuries which have been referred and all other physical modalities may be administered only following the prescription of the team or referring physician; **South Dakota**

upon the advice, consent and oral or written prescriptions or referrals of a physician licensed under this title, carries out the practice of prevention, recognition, evaluation, management, disposition, treatment, or rehabilitation of athletic injuries **Tennessee**

means the form of health care that includes the practice of preventing, recognizing, assessing, managing, treating, disposing of, and reconditioning athletic injuries under the direction of a physician **Texas**

an injury sustained by an athlete that affects the individual's participation or performance in sports, games, recreation, or exercise; or
(b) a condition that is within the scope of practice of an athletic trainer identified by a directing physician or physical therapist as benefitting from athletic training services A directing physician shall provide direction to an athletic trainer by a verbal order when in the presence of the athletic trainer and by written order or by athletic training service plans or protocols when a directing physician is not present. **Utah**

Athletic training may only be applied in the "traditional setting" and the "clinical setting":

(A) Without further referral, to athletes participating in organized sports or athletic teams at an interscholastic, intramural, instructional, intercollegiate, amateur, or professional level.

(B) With a referral from a physician, osteopathic physician, dentist, or chiropractor, to athletes or the physically active who have an athletic or orthopedic injury and have been determined, by a physician's examination, to be free of an underlying pathology that would affect treatment.

"Orthopedic injury" means a disruption of musculoskeletal tissue continuity that is sustained by a physically active individual. An individual with this type of injury may be treated by an athletic trainer as long as the individual does not have any underlying pathologies that would affect treatment.

(9) "Physically active individual" means an individual who is well conditioned, healthy, and free from underlying pathology, who participates in athletic or recreational activities which require physical skills and utilize strength, power, endurance, speed, flexibility, range of motion, or agility.

"Referral" means sending a patient for treatment.

(11) "Settings" means any areas in which an athletic trainer may practice athletic training. These areas include:

(A) "Traditional setting" means working with any organized sports or athletic teams at an interscholastic, intramural, instructional, intercollegiate, amateur, or professional level.

(B) "Clinical setting" means an outpatient orthopedic or sports medicine clinic that employs one of the following: physician, osteopathic physician, chiropractor, or physical therapist.

(12) "Underlying pathology" means any disease process, including but not limited to neuromuscular disease, diabetes, spinal cord injuries, and systemic diseases. **Vermont**

immediately upon the onset of such injury or condition; and subsequent treatment and rehabilitation of such injuries or conditions under the direction of the patient's physician **Virginia**

An athletic trainer can practice athletic training through the consultation, referral, or guidelines of a licensed health care provider working within their scope of practice. (b) "Athletic training" does not include: Any medical diagnosis; "Licensed health care provider" means a physician, physician assistant, osteopathic physician, osteopathic physician assistant, advanced registered nurse practitioner, naturopath, physical therapist, chiropractor, dentist, massage practitioner, acupuncturist, **Washington**

a licensee may provide athletic training to an individual without a referral, except that a licensee may not provide athletic training as described under s. 448.95 (5) (d) or (e) in an outpatient rehabilitation setting unless the licensee has obtained a written referral for the individual from a practitioner licensed

Wisconsin

An injury or athletic-related illness or both that affects the athlete's participation or performance in sports, games and exercise related to participation with an educational institution or professional, amateur or recreational sports club or organization; and

(B) A condition that is within the scope of practice of an athletic trainer identified by a directing physician as benefiting from athletic training services. **Wyoming**

Alabama DEFINITION OF A LICENSED ATHLETIC TRAINER

Any person licensed by the Alabama Board of Athletic Trainers as an athletic trainer and who practices athletic training on an athlete under the direction or referral, or both, of a licensed physician after meeting the requirements of the act and rules and regulations. Licensed athletic trainers follow protocols approved jointly by the State Board of Medical Examiners and the Alabama Board of Athletic Trainers.

DOMAINS OF ATHLETIC TRAINING These domains are categorized according to the major tacks comprising the role of the certified athletic trainer. There domains have been identified as those necessary to be effective in functioning as a certified athletic trainer.

- Prevention of athletic injuries/illnesses.
Evaluation and recognition of athletic injuries/illnesses and medical referral.
First Aid and emergency care.
Rehabilitation and reconditioning of athletic injuries.
Organization and administration.
Counseling
- Guidance and education of athletes.

Alaska **Sec. 08.07.030. Scope of practice of athletic trainers.** (a) An athletic trainer may practice athletic training only under the direction of a person licensed to practice medicine or osteopathy under AS 08.64. In this subsection, "direction" means the physician authorizes a procedure by a verbal order if the physician is present or by written order, telecommunication, or athletic training treatment plans, protocols, or standing orders established by the physician if the physician is not present.
(b) An athletic trainer shall immediately refer an athlete to an appropriate licensed health care professional if the athletic trainer determines that athletic training is contraindicated or the symptoms or conditions present require treatment outside the scope of practice of an athletic trainer.
(c) The practice of an athletic trainer includes
(1) the treatment of an athlete for an athletic injury or illness prevention;
(2) the clinical evaluation and assessment of an athlete for an athletic injury or illness sustained or exacerbated while participating in an athletic or sport-related exercise or activity;
(3) the immediate care and treatment of an athlete for an athletic injury or illness sustained or exacerbated while participating in an athletic or sport-related exercise or activity; and
(4) the rehabilitation and reconditioning of an athlete from an athletic injury or illness sustained or exacerbated while participating in an athletic or sport-related exercise or activity.

(d) In this section, "health care professional" has the meaning given to "health care provider" in AS 09.65.300.

Arizona (a) Includes the following activities performed under the direction of a licensed physician:

(i) Examining, evaluating and testing a person to determine the person's injury status and the person's progress in recovery from athletic injuries.

(ii) Using heat, cold, water, light, sound, electricity, passive or active exercise, massage or mechanical devices to treat, rehabilitate or recondition athletic injuries.

(iii) Administering athletic training programs and facilities at the athletic training facility or at the site of athletic practice or competition.

(iv) Education and counseling related to all aspects of the practice of athletic training.

(b) Does not include treating, assessing or evaluating a person who sustains an injury under any circumstance other than during participation in or preparation for competitive team or individual sports. This subdivision does not prevent the athletic trainer of a professional sports organization or an accredited educational institution from treating at the organization's or institution's athletic facility any injury of the type that occurs in sports regardless of the circumstances under which the injury was sustained.

Arkansas

17-93-401. Short title.

This subchapter shall be known and may be cited as the "Arkansas Athletic Trainers Act".

17-93-402. Definitions.

For purposes of this subchapter, unless the context otherwise requires: (1) "Athlete" means an individual who is participating in organized athletic or team activities at the interscholastic, intramural, intercollegiate, or professional level, or sanctioned recreational sports activities;

(2) "Athletic injury or illness" means an injury or illness sustained by the athlete as a result of participation in those organized athletic or team activities which require physical strength, agility, flexibility, range of motion, speed, or stamina, or any comparable injury or illness to an athlete which prevents the person from participating in activities described in subdivision (1) of this section;

(3) "Athletic trainer" means a person licensed by the state to engage in athletic training;

(4) "Athletic training" means the prevention, recognition, evaluation, treatment, and rehabilitation of an athletic injury or illness and the organization and administration of exercise, conditioning, and athletic training programs;

California No regulations found

Colorado

12-29.7-103. Definitions. AS USED IN THIS ARTICLE, UNLESS THE CONTEXT OTHERWISE REQUIRES:

(2) "ATHLETE" MEANS A PERSON WHO, IN ASSOCIATION WITH AN EDUCATIONAL INSTITUTION, AN ORGANIZED COMMUNITY SPORTS PROGRAM OR EVENT, OR A PROFESSIONAL, AMATEUR, OR RECREATIONAL ORGANIZATION OR SPORTS CLUB, PARTICIPATES IN GAMES, SPORTS, RECREATION, OR EXERCISE REQUIRING PHYSICAL STRENGTH, FLEXIBILITY, RANGE OF MOTION, SPEED, STAMINA, OR AGILITY.

(3) "ATHLETIC TRAINER" MEANS A PERSON REGISTERED TO PRACTICE ATHLETIC TRAINING UNDER THIS ARTICLE.

(4) (a) "ATHLETIC TRAINING" MEANS THE PERFORMANCE, PURSUANT TO THE DIRECTION OF A COLORADO LICENSED OR OTHERWISE LAWFULLY PRACTICING PHYSICIAN, DENTIST, OR HEALTH CARE PROFESSIONAL OF THOSE SERVICES

THAT REQUIRE THE EDUCATION, TRAINING, AND EXPERIENCE REQUIRED BY THIS ARTICLE FOR REGISTRATION AS AN ATHLETIC TRAINER PURSUANT TO SECTION 12-29.7-107. "ATHLETIC TRAINING" INCLUDES SERVICES APPROPRIATE FOR THE PREVENTION, RECOGNITION, ASSESSMENT, MANAGEMENT, TREATMENT, REHABILITATION, AND RECONDITIONING OF INJURIES AND ILLNESSES SUSTAINED BY AN ATHLETE:

(I) ENGAGED IN SPORTS, GAMES, RECREATION, OR EXERCISE REQUIRING PHYSICAL STRENGTH, FLEXIBILITY, RANGE OF MOTION, SPEED, STAMINA, OR AGILITY; OR

(II) THAT AFFECT AN ATHLETE'S PARTICIPATION OR PERFORMANCE IN SUCH SPORTS, GAMES, RECREATION, OR EXERCISE.

(b) "ATHLETIC TRAINING" INCLUDES:

(I) THE PLANNING, ADMINISTRATION, EVALUATION, AND MODIFICATION OF METHODS FOR PREVENTION AND RISK MANAGEMENT OF INJURIES AND ILLNESSES;

(II) THE IDENTIFICATION AND APPROPRIATE CARE AND REFERRAL OF MEDICAL CONDITIONS AND DISABILITIES ASSOCIATED WITH ATHLETES;

(III) THE RECOGNITION, ASSESSMENT, TREATMENT, MANAGEMENT, PREVENTION, REHABILITATION, RECONDITIONING, AND APPROPRIATE REFERRAL OF INJURIES AND ILLNESSES;

(IV) THE USE OF THERAPEUTIC MODALITIES FOR WHICH THE ATHLETIC TRAINER HAS RECEIVED APPROPRIATE TRAINING AND EDUCATION;

(V) THE USE OF CONDITIONING AND REHABILITATIVE EXERCISE;

(VI) THE USE OF TOPICAL PHARMACOLOGICAL AGENTS, IN CONJUNCTION WITH THE ADMINISTRATION OF THERAPEUTIC MODALITIES AND PURSUANT TO PRESCRIPTIONS ISSUED IN ACCORDANCE WITH THE LAWS OF THIS STATE, FOR WHICH THE ATHLETIC TRAINER HAS RECEIVED APPROPRIATE TRAINING AND EDUCATION;

(VII) THE EDUCATION AND COUNSELING OF ATHLETES CONCERNING THE PREVENTION AND CARE OF INJURIES AND ILLNESSES;

(VIII) THE EDUCATION AND COUNSELING OF THE GENERAL PUBLIC WITH RESPECT TO ATHLETIC TRAINING SERVICES;

(IX) THE REFERRAL OF AN ATHLETE RECEIVING ATHLETIC TRAINING SERVICES TO APPROPRIATE HEALTH CARE PERSONNEL AS NEEDED; AND

(X) THE PLANNING, ORGANIZATION, ADMINISTRATION, AND EVALUATION OF THE PRACTICE OF ATHLETIC TRAINING.

(c) AS USED IN THIS SUBSECTION (4), "INJURIES AND ILLNESSES" INCLUDES THOSE CONDITIONS IN AN ATHLETE FOR WHICH ATHLETIC TRAINERS, AS THE RESULT OF THEIR EDUCATION, TRAINING, AND COMPETENCY, ARE QUALIFIED TO PROVIDE CARE.

(5) "DIRECTION OF A PHYSICIAN, DENTIST, OR HEALTH CARE PROFESSIONAL" MEANS THE PLANNING OF SERVICES WITH A PHYSICIAN, DENTIST, OR HEALTH CARE PROFESSIONAL; THE DEVELOPMENT AND APPROVAL BY THE PHYSICIAN, DENTIST, OR HEALTH CARE PROFESSIONAL OF PROCEDURES AND PROTOCOLS TO BE FOLLOWED IN THE EVENT OF AN INJURY OR ILLNESS; THE MUTUAL REVIEW OF THE PROTOCOLS ON A PERIODIC BASIS; AND THE APPROPRIATE CONSULTATION AND REFERRAL BETWEEN THE PHYSICIAN, DENTIST, OR HEALTH CARE PROFESSIONAL AND THE ATHLETIC TRAINER.

Connecticut

Sec. 20-65f. Definitions. As used in this chapter:

(1) "Athletic training" means the application or provision, with the consent and under the direction of a health care provider, of (A) principles, methods and procedures of evaluation, prevention, treatment and rehabilitation of athletic injuries sustained by athletes, (B) appropriate preventative and supportive devices, temporary splinting and bracing, physical modalities of heat, cold, light massage, water, electric stimulation, sound, exercise and exercise equipment, (C) the organization and administration of athletic training programs, and (D) education and counseling to athletes, coaches, medical personnel and athletic communities in the area of the prevention and care of athletic injuries. For purposes of this subdivision, "health care provider" means a person licensed to practice medicine or surgery under chapter 370, chiropractic under chapter 372, podiatry under chapter 375 or natureopathy under chapter 373;

(2) "Athletic injury" means any injury sustained by an athlete as a result of such athlete's participation in exercises, sports, games or recreation requiring strength, agility, flexibility, range of motion, speed or stamina, or any comparable injury that prevents such athlete from participating in any such activities;

(3) "Athlete" means any person who is a member of any professional, amateur, school or other sports team, or is a regular participant in sports or recreational activities, including, but not limited to, training and practice activities, that require strength, agility, flexibility, range of motion, speed or stamina. For purposes of this subdivision, "regular" means not less than three times per week;

(4) "Standing orders" means written protocols, recommendations and guidelines for treatment and care, furnished and signed by a health care provider specified under subdivision (1) of this section, to be followed in the practice of athletic training that may include, but not be limited to, (A) appropriate treatments for specific athletic injuries, (B) athletic injuries or other conditions requiring immediate referral to a licensed health care provider, and (C) appropriate conditions for the immediate referral to a licensed health care provider of injured athletes of a specified age or age group;

Delaware

§ 2602. Definitions.

As used in this chapter, unless the content requires otherwise, the following words shall have the following meanings:

(1) "Athletic injury" is a musculoskeletal injury resulting from or limiting participation in or training for scholastic, recreational, professional or sanctioned amateur athletic activities.

(2) "Athletic trainer" means a person who is licensed by the State Examining Board of Physical Therapists and Athletic Trainers, to practice "athletic training," after meeting the requirements of this chapter and rules and regulations promulgated pursuant thereto.
(3) "Athletic training" means the prevention evaluation and treatment of athletic injuries by the utilization of therapeutic exercises and modalities such as heat, cold, light, air, water, sound, electricity, massage and non-thrust mobilizations. All treatment of athletic injuries requires a physician's referral, except for minor sprains, strains, and contusions, first aid excluded. Treatment of musculoskeletal injuries that are not defined as an "athletic injury" will require direction from a physical therapist and direct supervision of every fifth treatment. An athletic trainer may not independently initiate, modify, or discontinue a physical therapy plan of care. Athletic training shall not include radiology, surgery, prescription drugs, or authorize the medical diagnosis of disease.
(4) "Board" means the State Examining Board of Physical Therapists which shall administer and enforce this chapter.
(5) "First aid" is emergency care and treatment of an injured person before definitive medical and surgical management can be secured.

Florida

468.70 Legislative intent.--It is the intent of the Legislature that athletes be assisted by persons adequately trained to recognize, prevent, and treat physical injuries sustained during athletic activities. Therefore, it is the further intent of the Legislature to protect the public by licensing and fully regulating athletic trainers.

468.701 Definitions.--As used in this part, the term:

(1) "Athlete" means a person who participates in an athletic activity.
(2) "Athletic activity" means the participation in an activity, conducted by an educational institution, a professional athletic organization, or an amateur athletic organization, involving exercises, sports, games, or recreation requiring any of the physical attributes of strength, agility, flexibility, range of motion, speed, and stamina.
(3) "Athletic injury" means an injury sustained which affects the athlete's ability to participate or perform in athletic activity.
(4) "Athletic trainer" means a person licensed under this part.
(5) "Athletic training" means the recognition, prevention, and treatment of athletic injuries.
(6) "Board" means the Board of Athletic Training.
(7) "Department" means the Department of Health.
(8) "Direct supervision" means the physical presence of the supervisor on the premises so that the supervisor is immediately available to the trainee when needed.
(9) "Supervision" means the easy availability of the supervisor to the athletic trainer, which includes the ability to communicate by telecommunications.

Georgia "43-5-1. Effective 7/1/08

(1) 'Athletic injury' means any injury sustained by a person as a result of such person´s participation in exercises, sports, games, or recreational activities, or any
activities requiring physical strength, agility, flexibility, range of motion, speed, or stamina without respect to where or how the injury occurs. Nothing in this paragraph
shall be construed to expand the scope of practice of an athletic trainer beyond the

determination of the advising and consenting physician as provided for in
paragraph
(2) of this Code section.
(2) 'Athletic trainer' means a person with specific qualifications, as set forth in
Code
Sections 43-5-7 and 43-5-8 who, upon the advice and consent of a physician,
carries
out the practice of prevention, recognition, evaluation, management, disposition,
treatment, or rehabilitation of athletic injuries; and, in carrying out these functions,
the
athletic trainer is authorized to use physical modalities, such as heat, light,
sound,
cold, electricity, or mechanical devices related to prevention, recognition,
evaluation,
management, disposition, rehabilitation, and treatment. Nothing in this Code
section
shall be construed to require licensure of elementary or secondary school
teachers,
coaches, or authorized volunteers who do not hold themselves out to the public
as
athletic trainers.
(3) 'Board' means the Georgia Board of Athletic Trainers."

Hawaii

Definitions. As used in this chapter:
Athlete" means a person who prepares for or participates in organized sports or sports-related activities, amateur or recreational sports involving athletic competition, including interscholastic, intercollegiate, intramural, semiprofessional, or professional sports activities.

"Athletic injury" means an injury that affects the preparation for or participation in organized sports or sports-related activities, or amateur or recreational sports involving athletic competition, including interscholastic, intercollegiate, intramural, semiprofessional, or professional sports activities.

"Athletic trainer" means an individual, whether or not registered under this chapter, who engages in the practice of athletic training or represents oneself to be an athletic trainer.
"Department" means the department of commerce and consumer affairs.

"Director" means the director of commerce and consumer affairs.

"Practice of athletic training" refers to the application by an athletic trainer, whether or not registered under this chapter and without regard to certification by any certifying body, of principles and methods to:
(1) Prevent athletic injuries;
(2) Recognize, evaluate, and assess athletic injuries and conditions;
(3) Provide immediate care of athletic injuries, including common emergency medical care;
(4) Treat, rehabilitate, and recondition athletic injuries;
(5) Administer athletic training services and organization; and

(6) Educate athletes; provided that the practice of athletic training does not include provision of medical services as defined in section 453-1, occupational therapy services as defined in section 457G-1, or physical therapy or physical therapy services as defined in section 461J-1.

"Treating physician" means a physician or osteopathic physician licensed under chapter 453 who, within the licensee's scope of practice and individual competency, is responsible for the athletic training services provided by an athletic trainer and oversees the practice of athletic training by an athletic trainer.

Idaho

(1) "Athlete" means a person who participates in exercises, sports, or games requiring physical strength, agility, flexibility, range of motion, speed or stamina and which exercises, sports or games are of the type generally conducted in association with an educational institution or professional, amateur or recreational sports club or organization.

(2) "Athletic injury" means a physical injury, harm, hurt or common condition (such as heat disorders), incurred by an athlete, preventing or limiting participation in athletic activity, sports or recreation, which athletic trainers are educated to evaluate and treat or refer to the directing physician.
(3) "Athletic trainer" means a person who has met the qualifications for licensure as set forth in this chapter, is licensed under this chapter, and carries out the practice of athletic training under the direction of a designated Idaho licensed physician, registered with the board or a designated Idaho licensed chiropractic physician.
(4) "Athletic training" means the application by a licensed athletic trainer of principles and methods of:
(a) Prevention of athletic injuries;
(b) Recognition, evaluation and assessment of athletic injuries and conditions;
(c) Immediate care of athletic injuries including common emergency medical situations;
(d) Rehabilitation and reconditioning of athletic injuries;
(e) Athletic training services administration and organization; and
(f) Education of athletes.
(5) "Board" means the Idaho state board of medicine.
(6) "Board of athletic trainers" means the Idaho board of athletic trainers established in this chapter.
(7) "Directing physician" means a designated person duly licensed to practice medicine in Idaho, registered with the board or a designated Idaho licensed chiropractic physician, who is responsible

for the athletic training services provided by the athletic trainer and oversees the practice of athletic training of the athletic trainer, as established by board rule. This chapter does not authorize the practice of medicine or any of its branches by a person not so licensed by the board.
(a) This direction will be provided by verbal order when the directing physician is present and by written order or by athletic training service plans or protocols, as established by board rule, when the directing physician is not present.

Illinois

Sec. 3. Definitions. As used in this Act: (1) "Department" means the Department of Professional Regulation. (2) "Director" means the Director of Professional Regulation. (3) "Board" means the Illinois Board of Athletic Trainers appointed by the Director. (4) "Licensed athletic trainer" means a person licensed to practice athletic training as defined in this Act and with the specific qualifications set forth in Section 9 of this Act who, upon the direction of his or her team physician or consulting physician, carries out the practice of prevention/emergency care or physical reconditioning of injuries incurred by athletes participating in an athletic program conducted by an educational institution, professional athletic organization, or sanctioned amateur athletic organization employing the athletic trainer; or a person who, under the direction of a physician, carries out comparable functions for a health organization-based extramural program of athletic training services for athletes. Specific duties of the athletic trainer include but are not limited to: A. Supervision of the selection, fitting, and maintenance of protective equipment;
B. Provision of assistance to the coaching staff in the development and implementation of conditioning programs;
C. Counseling of athletes on nutrition and hygiene;
D. Supervision of athletic training facility and inspection of playing facilities;
E. Selection and maintenance of athletic training equipment and supplies;
F. Instruction and supervision of student trainer staff;

G. Coordination with a team physician to provide: (i) pre-competition physical exam and health history updates,
(ii) game coverage or phone access to a physician or paramedic,
(iii) follow-up injury care, (iv) reconditioning programs, and (v) assistance on all matters pertaining to the health and well-being of athletes.
H. Provision of on-site injury care and evaluation as well as appropriate transportation, follow-up treatment and rehabilitation as necessary for all injuries sustained by athletes in the program;
I. With a physician, determination of when an athlete may safely return to full participation post-injury; and
J. Maintenance of complete and accurate records of all athletic injuries and treatments rendered.
To carry out these functions the athletic trainer is authorized to utilize modalities, including, but not limited to, heat, light, sound, cold, electricity, exercise, or mechanical devices related to care and reconditioning. (5) "Referral" means the guidance and direction given by the physician, who shall maintain supervision of the athlete. (6) "Athletic trainer aide" means a person who has received on-the-job training specific to the facility in which he or she is employed, on either a paid or volunteer basis, but is not enrolled in an accredited athletic training curriculum.

Indiana

IC 25-5.1-1-3 Athletic trainer Sec. 3. "Athletic trainer" means an individual who is or may be employed by an educational institution, a professional or an amateur athletic organization, an athletic facility, or a health care facility to practice athletic training.

IC 25-5.1-1-4

Athletic training Sec. 4. "Athletic training" means the practice of prevention, recognition, assessment, management, treatment, disposition, and reconditioning of athletic injuries under the direction of a licensed physician, osteopath, podiatrist, or chiropractor. However, in a clinic accessible to the general public, the term means practicing athletic training only upon the referral and order of a licensed physician, osteopath, podiatrist, or chiropractor. The term includes the following: (1) Practice that may be conducted by an athletic trainer through the use of heat, light, sound, cold, electricity, exercise, rehabilitation, or mechanical devices related to the care and the conditioning of athletes. (2) The organization and administration of educational programs and athletic facilities. (3) The education and the counseling of the public on matters related to athletic training.

Iowa

152D.1 Definitions.

As used in this chapter, unless the context otherwise requires:

1. *"Board"* means the board of examiners for athletic training created under chapter 147.

2. *"Licensed athletic trainer"* means a person licensed under this chapter.

3. *"Practice of athletic training"* means the prevention, physical evaluation, emergency care, and physical reconditioning relating to injuries and illnesses incurred through sports-induced trauma, which occurs during the preparation for or participation in a sports competition or during a physical training program, either of which is sponsored by an educational institution, amateur or professional athletic group, or other recognized organization, by a person who uses the title of licensed athletic trainer.

Kansas

65-6902. Definitions. As used in this act:
(a) "Board" means the state board of healing arts.
(b) "Athletic training" means the practice of injury prevention, physical evaluation, emergency care and referral or physical reconditioning relating to athletic activity.
(c) "Athletic trainer" means a person licensed under this act.
History: L. 1995, ch. 146, § 2; L. 2004, ch. 24, § 2; July 1.

Kentucky

311.900 Definitions.
(1) "Athletic trainer" means a person with specific qualifications, as set forth in KRS 311.916, who, upon the advice and consent of a team physician, carries out the practice of prevention or physical rehabilitation, or both, of injuries incurred by participating athletes at an educational institution, professional athletic organization, or other bona fide athletic organization. In carrying out these functions the athletic trainer is authorized to use whatever physical modalities as are deemed necessary by a team physician; and (2) "Council" means the Kentucky Advisory Council on Athletic Trainers.

Louisiana

this Chapter, the following words and phrases have the meanings hereinafter ascribed to them:
(1) "Athlete" means an individual designated as such by the board, an educational institution, a professional athletic organization, or other board-approved organization who participates in an athletic activity sponsored by such institution or organization.
(2) "Athletic trainer" means an individual licensed by the board as an athletic trainer with the specific qualifications set forth in R.S. 37:3306.1 who, under the general supervision of a physician carries out the practice of prevention, emergency management, and physical rehabilitation of injuries and sports-related conditions incurred by athletes. In carrying out these functions, the athletic trainer shall use whatever physical modalities are prescribed by a team physician or consulting physician, or both.
(3) "Board" means the Louisiana State Board of Medical Examiners.
(4) "Board approved organization" means one of the following:
(a) Approved organization, including but not limited to the Amateur Athletic Union, the International Olympic Committee and its affiliates, the Pan American Sports Organization, the National Collegiate Athletic Association, the National Association of Intercollegiate Athletics, college and university intramural sports, and sports events of the National Federation of State High School Associations
(b) An organization, whose athletic activity meets one or more of the following:
(i) Has an officially-designated coach or individual who has the responsibility for athletic activities of the organization.
(ii) Has a regular schedule of practices or workouts that are supervised by an officially-designated coach or individual.
(iii) Is an activity generally recognized as having an established schedule of competitive events or exhibitions.
(iv) Has a policy that requires documentation of having a signed medical clearance by a licensed physician or other board authorized health care provider as a condition for participation for the athletic activities of the organization.
(5) "BOC" means the Board of Certification, Inc. or its successor.
(6) "CAATE" means the Commission on Accreditation of Athletic Training Education or its successor.

(7) "Educational institution" means a university, college, junior college, high school, junior high school, or grammar school, whether public or private.
(8) "Emergency management" means the care given to an injured athlete under the general supervision of the team or consulting physician.. To accomplish this care, an athletic trainer may use such methods as accepted first aid procedures approved by the American Red Cross, the American Heart Association or protocol previously established by the athletic trainer and the team or consulting physicians.
(9) "General supervision" means the service is furnished under a physician's overall direction and control, but the physician's presence shall not be required during the provision of service.
(10) "Physician" means a person licensed to practice medicine by the board in the state who is qualified by training and experience to supervise an athletic trainer.
(11) "Physical rehabilitation" means the care given to athletes following injury and recovery. These treatments and rehabilitation programs may consist of preestablished methods of physical modality use and exercise as prescribed by a team physician, consulting physician, or both. Physical rehabilitation also includes working cooperatively with and under the general supervision of a medical physician in respect to the following:
(a) Reconditioning procedures.
(b) Operation of therapeutic devices and equipment.
(c) Fitting of braces, guards, and other protective devices.
(d) Referrals to other physicians, auxiliary health services, and institutions. Referrals will be made with the agreement of the athlete or, in the case of a minor, with the agreement of a parent or guardian except when circumstances require emergency transfer and the parent or guardian is unavailable.
(12) "Practice of prevention" shall include but is not limited to the following:
(a) Working cooperatively with supervisors and coaches in establishing and implementing a program of physical conditioning for athletes.
(b) Applying protective or injury-preventive devices such as taping, padding, bandaging, strapping, wrapping, or bracing.
(c) Working cooperatively with supervisors, coaches, and a team physician or consulting physician in the selection and fitting of protective athletic equipment for each athlete and constantly monitoring that equipment for safety.
(d) Counseling and advising supervisors, coaches, and athletes on physical conditioning and training such as diet, flexibility, rest, and reconditioning.

Maine

1. Athlete. "Athlete" means a physically active individual training for or participating in an amateur, educational or professional athletic organization or any other association that sponsors athletic programs or events in the State. [1995, c. 275, §1 (new).]

2. Athletic injury. "Athletic injury" means a disruption of tissue continuity that is sustained by an athlete or recreational athlete when that injury: [1995, c. 275, §1 (new).]

A. Results from that individual's participation in or training for sports, fitness training or other athletic competition; or

[1995, c. 275, §1 (new).]

B. Restricts or prevents that individual from participation in those activities.

[1995, c. 275, §1 (new).]

3. Athletic trainer. "Athletic trainer" means a person licensed by the department to use that title after meeting the requirements of this chapter. [1995, c. 275, §1 (new).]

4. Athletic training. "Athletic training" means: [1995, c. 275, §1 (new).]

A. Prevention of athletic injuries; [1995, c. 275, §1 (new).]

B. Recognition and evaluation of athletic injuries; [1995, c. 275, §1 (new).]

C. Management, treatment and disposition of athletic injuries; [1995, c. 275, §1 (new).]

D. Rehabilitation of athletic injuries; [1995, c. 275, §1 (new).]

E. Organization and administration of an athletic training program; and [1995, c. 275, §1 (new).]

F. Education and counseling of athletes, recreational athletes, coaches, family members, medical personnel and communities in the area of care and prevention of athletic injuries.

Maryland

14–5D–01.

(A) IN THIS SUBTITLE THE FOLLOWING WORDS HAVE THE MEANINGS INDICATED.

(B) "ATHLETE" MEANS AN INDIVIDUAL WHO PARTICIPATES IN AN ATHLETIC ACTIVITY.

(C) "ATHLETIC ACTIVITY" MEANS EXERCISE, RECREATION, SPORT, COMPETITION, OR GAME THAT:

(1) REQUIRES PHYSICAL STRENGTH, RANGE OF MOTION, FLEXIBILITY, CONTROL, SPEED, STAMINA, OR AGILITY; AND

(2) IS ASSOCIATED WITH AN EDUCATIONAL INSTITUTION OR A PROFESSIONAL, AMATEUR, OR RECREATIONAL SPORTS CLUB OR ATHLETIC ORGANIZATION.

(D) "ATHLETIC INJURY" MEANS AN INJURY OR CONDITION SUSTAINED BY AN INDIVIDUAL THAT AFFECTS THE INDIVIDUAL'S AN ATHLETE'S PARTICIPATION OR PERFORMANCE IN SPORTS, GAMES, RECREATION, EXERCISE, OR OTHER ACTIVITIES AN ATHLETIC ACTIVITY.

(E) "BOARD" MEANS THE STATE BOARD OF PHYSICIANS.

(F) "COMMITTEE" MEANS THE ATHLETIC TRAINER ADVISORY COMMITTEE ESTABLISHED UNDER § 14–5D–04 OF THIS SUBTITLE.

(G) "EDUCATIONAL INSTITUTION" INCLUDES:

(1) THE SCHOOLS IN THE PUBLIC ELEMENTARY AND SECONDARY EDUCATION SYSTEM OF THE STATE;

(2) A NONCOLLEGIATE EDUCATIONAL INSTITUTION GOVERNED UNDER § 2–206 OF THE EDUCATION ARTICLE; AND

(3) AN INSTITUTION OF HIGHER EDUCATION AS DEFINED IN §10–101 OF THE EDUCATION ARTICLE.

(H) "EVALUATION AND TREATMENT PROTOCOL" MEANS A DOCUMENT THAT IS EXECUTED BY A PHYSICIAN AND AN ATHLETIC TRAINER THAT MEETS THE REQUIREMENTS OF § 14–5D–11 OF THIS SUBTITLE.

(I) "LICENSE" MEANS A LICENSE ISSUED BY THE BOARD TO PRACTICE ATHLETIC TRAINING.

(J) "LICENSED ATHLETIC TRAINER" MEANS AN INDIVIDUAL WHO IS LICENSED BY THE BOARD TO PRACTICE ATHLETIC TRAINING.

(K) "NATIONAL CERTIFYING BOARD" MEANS THE NATIONAL ATHLETIC TRAINERS' ASSOCIATION BOARD OF CERTIFICATION, INC., OR ITS SUCCESSOR ORGANIZATION.

(L) (1) "PRACTICE ATHLETIC TRAINING" MEANS APPLICATION OF THE FOLLOWING PRINCIPLES AND METHODS FOR MANAGING ATHLETIC INJURIES FOR ACTIVE INDIVIDUALS AND ATHLETES IN GOOD OVERALL HEALTH UNDER THE SUPERVISION OF A LICENSED PHYSICIAN:

(I) PREVENTION;
(II) CLINICAL EVALUATION AND ASSESSMENT;
(III) IMMEDIATE CARE; AND
(IV) TREATMENT, REHABILITATION, AND RECONDITIONING.
(2) "PRACTICE ATHLETIC TRAINING" INCLUDES:
(I) ORGANIZATION AND ADMINISTRATION OF AN ATHLETIC TRAINING PROGRAM; AND
(II) INSTRUCTION TO COACHES, ATHLETES, PARENTS, MEDICAL PERSONNEL, AND COMMUNITY MEMBERS REGARDING THE CARE AND PREVENTION OF ATHLETIC INJURIES.
(3) "PRACTICE ATHLETIC TRAINING" DOES NOT INCLUDE:
(I) THE PRACTICE OF:
1. CHIROPRACTIC, INCLUDING ADJUSTMENTS, MANIPULATION, OR HIGH VELOCITY MOBILIZATIONS OF THE SPINE OR EXTREMITIES;
2. MASSAGE THERAPY;
3. MEDICINE;
4. OCCUPATIONAL THERAPY; OR
5. PHYSICAL THERAPY;
(II) THE RECONDITIONING OF SYSTEMIC NEUROLOGIC INJURIES, CONDITIONS, OR DISEASE; OR
(III) EXCEPT FOR THE CONDITIONING OF AN ATHLETE UNDER THE SUPERVISION OF A TREATING PHYSICIAN, THE TREATMENT, REHABILITATION, OR RECONDITIONING OF NONATHLETIC INJURIES OR DISEASE.
"SUPERVISION" MEANS THE RESPONSIBILITY OF A PHYSICIAN TO PROVIDE ONGOING AND IMMEDIATELY AVAILABLE INSTRUCTION
THAT IS ADEQUATE TO ENSURE THE SAFETY AND WELFARE OF A PATIENT AND IS APPROPRIATE TO THE SETTING.

Massachusetts

"Athletic trainer', any person who is duly licensed in accordance with this section as an athletic trainer and who limits his practice to schools, teams or organizations with whom he is associated and who is under the direction of a physician or dentist duly registered in the commonwealth.
"Athletic training', the application of principles, methods and procedures of evaluation and treatment of athletic injuries, preconditioning, conditioning and reconditioning of the athlete through the use of appropriate preventative and supportive devices, temporary splinting and bracing, physical modalities of heat, cold, massage, water, electric stimulation, sound, exercise and exercise equipment under the discretion of a physician. Athletic training includes instruction to coaches, athletes, parents, medical personnel and communities in the area of care and prevention of athletic injuries.

Michigan

(a) "Athletic trainer" means an individual engaged in the practice of athletic training.

(b) "Practice of athletic training" means the treatment of an individual for risk management and injury prevention, the clinical evaluation and assessment of an individual for an injury or illness, or both, the immediate care and treatment of an individual for an injury or illness, or both, and the rehabilitation and reconditioning of an individual's injury or illness, or both, as long as those activities are within the rules promulgated under section 17904 and performed under the direction and supervision of an individual licensed under part 170 or 175. The practice of athletic training does not include the practice of physical therapy, the practice of medicine, the practice of osteopathic medicine and surgery, the practice of chiropractic, or medical diagnosis or treatment.

(2) In addition to the definitions in this part, article 1 contains general definitions and principles of construction applicable to all articles in this code and part 161 contains definitions applicable to this part.

Sec. 17902. (1) Beginning on the effective date of the rules promulgated under section 17904, an individual shall not engage in the practice of athletic training unless licensed under this part or otherwise authorized to engage in the practice of athletic training under subsection (2). An individual licensed under this part shall not provide, offer to provide, or represent that he or she is qualified to provide any services that he or she is not qualified to perform by his or her education, training, or experience or that he or she is otherwise prohibited by law from performing.

(2) Subsection (1) does not prohibit an individual licensed under any other part or any other act from performing activities that are considered the practice of athletic training so long as those activities are within the individual's scope of practice and the individual does not use the titles protected under subsection (3).

(3) Beginning on the effective date of the rules promulgated under section 17904, an individual shall not use the titles "athletic trainer", "licensed athletic trainer", "certified athletic trainer", "athletic trainer certified", "a.t.", "a.t.l.", "c.a.t.", "a.t.c.", or similar words that indicate that the person is an athletic trainer unless the individual is licensed under this article as an athletic trainer.
(2) The athletic training services specified in subrule (1) of this rule shall be performed under the direction and supervision of either an allopathic physician or an osteopathic physician and surgeon who shall be licensed under Part 170 or Part 175 of the code.
(3) As used in subrule (2) of this rule and section 17901 (1) (b) of the code, "direction" means either a written, electronic, or verbal order issued by a physician or authorized representative of a physician. The order shall comply with the requirements of the federal health insurance portability and accountability act of 1996.

Minnesota 148.7806 Athletic training.
Athletic training by a registered athletic trainer under section 148.7808 includes the activities described in paragraphs (a) to (e).
(a) An athletic trainer shall:
(1) prevent, recognize, and evaluate athletic injuries;
(2) give emergency care and first aid;
(3) manage and treat athletic injuries; and
(4) rehabilitate and physically recondition athletic injuries.
The athletic trainer may use modalities such as cold, heat, light, sound, electricity, exercise, and mechanical devices for treatment and rehabilitation of athletic injuries to athletes in the primary employment site.
(b) The primary physician shall establish evaluation and treatment protocols to be used by the athletic trainer. The primary physician shall record the protocols on a form prescribed by the board. The protocol form must be updated yearly at the athletic trainer's registration renewal time and kept on file by the athletic trainer.
(c) At the primary employment site, except in a corporate setting, an athletic trainer may evaluate and treat an athlete for an athletic injury not previously diagnosed for not more than 30 days, or a period of time as designated by the primary physician on the protocol form, from the date of the initial evaluation and treatment. Preventative care after resolution of the injury is not considered treatment. This paragraph does not apply to a person who is referred for treatment by a person licensed in this state to practice medicine as defined in
section 147.081, to practice chiropractic as defined in section 148.01, to practice podiatry as defined in section 153.01, or to practice dentistry as defined in section 150A.05 and whose license is in good standing.
(d) An athletic trainer may:
(1) organize and administer an athletic training program including, but not limited to, educating and counseling athletes;

(2) monitor the signs, symptoms, general behavior, and general physical response of an athlete to treatment and rehabilitation including, but not limited to, whether the signs, symptoms, reactions, behavior, or general response show abnormal characteristics; and
(3) make suggestions to the primary physician or other treating provider for a modification in the treatment and rehabilitation of an injured athlete based on the indicators in clause (2)

(e) In a clinical, corporate, and **physical therapy** setting, when the service provided is, or is represented as being, **physical therapy**, an athletic trainer may work only under the direct supervision of a physical therapist as defined in section 148.65.

Mississippi

(b) "Athletic training" means the treatment of an athlete for risk management and athletic injury prevention, the clinical evaluation and assessment of an athlete for an injury or illness, or both, the immediate care and treatment for an injury or illness, or both, and the rehabilitation and reconditioning of an athlete's injury or illness, or both, as long as those activities are performed under the direction of a licensed physician, nurse practitioner or physician assistant. The practice of athletic training does not include the practice of physical therapy, the practice of medicine, the practice of osteopathic medicine and surgery, the practice of nursing or the practice of chiropractic.
(c) "Athletic trainer" means a person licensed by the State Department of Health as an athletic trainer after meeting the requirements of this chapter and rules and regulations promulgated pursuant to this chapter, who, upon the advice, consent and oral or written prescriptions or referrals of a licensed physician, nurse practitioner or physician assistant, carries out the practice of athletic training, and in carrying out these functions the athletic trainer is authorized to use physical modalities, such as heat, light, sound, cold, electricity or mechanical devices related to prevention, recognition, evaluation, management, disposition, rehabilitation and treatment. An athletic trainer shall practice only in those areas in which the athletic trainer is competent by reason of training or experience that can be substantiated by records or other evidence found acceptable by the board in the exercise of the board's considered discretion.
(d) "Athletic injury" means any injury sustained by a person as a result of the person's participation in sports, games or recreational activities requiring physical strength, flexibility, range of motion, speed or stamina, or comparable injury.
(e) "Athlete" means an individual who participates in exercises, sports, or games requiring physical strength, agility, flexibility, range of motion, speed or stamina; or an individual with an athletic injury that a licensed physician, nurse practitioner or physician assistant deems would benefit from athletic training services.
(f)

Missouri

334.702. As used in sections 334.700 to 334.725, unless the context clearly requires otherwise, the
following terms mean:
(1) "Athlete", a person who participates in a sanctioned amateur or professional sport or recreational
sport activity;
(2) "Athletic trainer", a person who meets the qualifications of section 334.708 and who, upon the
direction of the team physician and/or consulting physician, practices prevention, emergency care, first

aid, treatment, or physical rehabilitation of injuries incurred by athletes in the manner, means, and
methods deemed necessary to effect care or rehabilitation, or both;
(3) "Board", the Missouri board for the healing arts;
(4) "Committee", the athletic trainers advisory committee;
(5) "Division", the division of professional registration of the department of economic development;
(6) "Student athletic trainer", a person who assists in the duties usually performed by a licensed athletic
trainer and who works under the direct supervision of a licensed athletic trainer.

Montana

(1) "Athlete" means a person who participates in an athletic activity that involves exercises, sports, or games requiring physical strength, agility, flexibility, range of motion, speed, or stamina and the exercises, sports, or games are of the type conducted in association with an educational institution or a professional, amateur, or recreational sports club or organization.
(2) "Athletic injury" means a physical injury received by an athlete.
(3) "Athletic trainer" means an individual who is licensed to practice athletic training.

Nebraska

For purposes of sections 71-1,238 to 71-1,242, unless the context otherwise requires:
(1) Athletic trainer means a person who is responsible for the prevention, emergency care, first aid, treatment, and rehabilitation of athletic injuries under guidelines established with a licensed physician and who is licensed to perform the functions set out in section 71-1,240. When athletic training is provided in a hospital outpatient department or clinic or an outpatient-based medical facility, the athletic trainer will perform the functions described in section 71-1,240 with a referral from a licensed physician for athletic training;
(2) Athletic training means the prevention, evaluation, emergency care, first aid, treatment, and rehabilitation of athletic injuries utilizing the treatments set out in section 71-1,240;
(3) Athletic injuries means the types of musculoskeletal injury or common illness and conditions which athletic trainers are educated to treat or refer, incurred by athletes, which prevent or limit participation in sports or recreation;

Nevada

NRS 640B.015 "Athlete" defined. "Athlete" means a natural person who:
1. Participates in an athletic activity conducted by:
(a) An intercollegiate athletic association or interscholastic athletic association; or
(b) A professional athletic organization; or
(c) An amateur athletic organization; or
2. Participates in a recreational sport activity that:
(a) Has officially designated coaches;
(b) Conducts regularly scheduled practices or workouts that are supervised by coaches; and
(c) Has established schedules for competitive events or exhibitions.
(Added to NRS by 2003, 894)
NRS 640B.021 "Athletic injury" defined. "Athletic injury" means an injury or athletic-related illness, or both, that a person sustains as a result of:

1. His participation in an athletic activity conducted by:
(a) An intercollegiate athletic association or interscholastic athletic association; or
(b) A professional athletic organization; or
(c) An amateur athletic organization; or
2. His participation in a recreational sport activity that:
(a) Has officially designated coaches;
(b) Conducts regularly scheduled practices or workouts that are supervised by coaches; and
(c) Has established schedules for competitive events or exhibitions.

New Hampshire

I. "Board" means the governing board of athletic trainers established in RSA 328-F. II. "Athletic trainer" means a person licensed under this chapter to practice athletic training. III. "Athletic training" means the practice, with respect to injuries or conditions incurred by participants in organized or recreational sports, of: (a) Prevention; (b) Assessment and evaluation; (c) Acute care, management, treatment and disposition; (d) Rehabilitation and reconditioning; and (e) Education, counseling and program administration, Provided such care is within the professional preparation and education of athletic trainers and under the direction of a physician licensed in any state or in Canada.

New Jersey

45:9-37.36 **Definitions.** 2.As used in this act: a."Advisory committee" means the Athletic Training Advisory Committee established in section 5 of P.L.1984, c.203 (C.45:9-37.39); b."Athlete" means an individual who participates in strenuous physical exercise, physical conditioning, or a sport; c."Athletic trainer" means a person who practices athletic training; d."Athletic training" means and includes the practice of physical conditioning and reconditioning of athletes and the prevention of injuries incurred by athletes. Athletic training shall also include the application of physical treatment modalities to athletes under a plan of care designed and overseen by a physician licensed in this State, as recommended by the advisory committee and defined in regulation by the board; e."Board" means the State Board of Medical Examiners; f."Supervision" means that a physician licensed in this State is accessible to an athletic trainer, either on-site or through voice communication, during athletic training.

New Mexico

As used in the Athletic Trainer Practice Act [Chapter 61, Article 14D NMSA 1978]:
A. "athlete" means a person trained to participate in exercise requiring physical agility and stamina;
B. "athletic trainer" means a person who, with the advice and consent of a licensed physician, practices the treatment, prevention, care and rehabilitation of injuries incurred by athletes;
C. "board" means the athletic trainer practice board;
D. "department" means the regulation and licensing department;
E. "district" means an area having the same boundaries as a congressional district in the state; and
F. "licensed physician" means a chiropractor, osteopath or physician licensed pursuant to Articles 4, 6 or 10 of Chapter 61 NMSA 1978.

New York

§ 8351. Definition. As used in this article "athletic trainer" means any person who is duly certified in accordance with this article to perform athletic training under the supervision of a physician and limits his or her practice to secondary schools, institutions of postsecondary education, professional athletic organizations, or a person who, under the supervision of a physician, carries out comparable functions on orthopedic athletic injuries, excluding spinal cord injuries, in a health care organization. Supervision of an athletic trainer by a physician shall be continuous but shall not be construed as

requiring the physical presence of the supervising physician at the time and place where such services are performed.

The scope of work described herein shall not be construed as authorizing the reconditioning of neurologic injuries, conditions or disease.

§ 8352. Definition of practice of athletic training. The practice of the profession of athletic training is defined as the application of principles, methods and procedures for managing athletic injuries, which shall include the preconditioning, conditioning and reconditioning of an individual who has suffered an athletic injury through the use of appropriate preventative and supportive devices, under the supervision of a physician and recognizing illness and referring to the appropriate medical professional with implementation of treatment pursuant to physician's orders. Athletic training includes instruction to coaches, athletes, parents, medical personnel and communities in the area of care and prevention of athletic injuries.

The scope of work described herein shall not be construed as authorizing the reconditioning of neurologic injuries, conditions or disease.

North Carolina

§ 90-523. Definitions.

The following definitions apply in this Article:

(1) Athletes.- Members of sports teams, including professional, amateur, and school teams; or participants in sports or recreational activities, including training and practice activities, that require strength, agility, flexibility, range of motion, speed, or stamina.

(2) Athletic trainer. - A person who, under a written protocol with a physician licensed under Article 1 of Chapter 90 of the General Statutes and filed with the North Carolina Medical Board, carries out the practice of care, prevention, and rehabilitation of injuries incurred by athletes, and who, in carrying out these functions, may use physical modalities, including heat, light, sound, cold, electricity, or mechanical devices related to rehabilitation and treatment. A committee composed of two members of the North Carolina Medical Board and two members of the North Carolina Board of Athletic Trainer Examiners shall jointly define by rule the content, format, and minimum requirements for the written protocol required by this subdivision. The members shall be selected by their respective boards. The decision of this committee shall be binding on both Boards unless changed by mutual agreement of both Boards.

North Dakota

CHAPTER 43-39

ATHLETIC TRAINERS

43-39-01. Definitions.

1. "Athletic trainer" means a person with specific qualifications set forth in section 43-39-05, who is providing athletic training.
2. "Athletic training" means the practice of prevention, recognition, evaluation, management, treatment, and disposition of athletic injuries. The term also means rehabilitation of athletic injuries, if under the order of a licensed physician. The term includes organization and administration of educational programs, athletic facilities, and the education and counseling of the public.
3. "Board" means the North Dakota board of athletic trainers established in section 43-39-02.
4. "Physician" means a doctor of medicine licensed to practice under chapter 43-17.

Ohio

As used in sections 4755.60 to 4755.65 and 4755.99 of the Revised Code:

(A) "Athletic training" means the practice of prevention, recognition, and assessment of an athletic injury and the complete management, treatment, disposition, and reconditioning of acute athletic injuries upon the referral of an individual authorized under Chapter 4731. of the Revised Code to practice medicine and surgery, osteopathic medicine

and surgery, or podiatry, a dentist licensed under Chapter 4715. of the Revised Code, a physical therapist licensed under
this chapter, or a chiropractor licensed under Chapter 4734. of the Revised Code. Athletic training includes the administration of topical drugs that have been prescribed by a licensed health care professional authorized to prescribe
drugs, as defined in section 4729.01 of the Revised Code. Athletic training also includes the organization and administration of educational programs and athletic facilities, and the education of and consulting with the public as it
pertains to athletic training.
(B) "Athletic trainer" means a person who meets the qualifications of this chapter for licensure and who is employed by an educational institution, professional or amateur organization, athletic facility, or health care facility to
practice athletic training.
(C) "The national athletic trainers association, inc." means the national professional organization of athletic trainers that provides direction and leadership for quality athletic training practice, education, and research.
(D) "Athletic injury" means any injury sustained by an individual that affects the individual's participation or performance in sports, games, recreation, exercise, or other activity that requires physical strength, agility, flexibility,
speed, stamina, or range of motion.

Oklahoma

§59-526. Definitions.

As used in the Oklahoma Athletic Trainers Act:

1. "Athletic trainer" means a person with the qualifications specified in Section 530 of this title, whose major responsibility is the rendering of professional services for the prevention, emergency care, first aid and treatment of injuries incurred by an athlete by whatever methods are available, upon written protocol from the team physician or consulting physician to effect care, or rehabilitation;
2. "Apprentice athletic trainer" means a person who assists in the duties usually performed by an athletic trainer under the direct supervision of a licensed athletic trainer;
3. "Board" means the State Board of Medical Licensure and Supervision; and
4. "Committee" means the Athletic Trainers Advisory Committee.

Oregon

(1) "Athlete" means any individual participating in fitness training and conditioning, sports or other competitions, practices or activities requiring physical strength, agility, flexibility, range of motion, speed or stamina, generally conducted in association with an educational institution, or professional or amateur sports activity.
(2) "Athletic injury" means an injury occurring as the result of participating as an athlete.
(3) "Board" means the Board of Athletic Trainers.
(4) "Practice athletic training" means the application by a registered athletic trainer of principles and methods of:

(a) Prevention of athletic injuries;
(b) Recognition, evaluation and immediate care of athletic injuries;

(c) Rehabilitation and reconditioning of athletic injuries;
(d) Health care administration; and
(e) Education and counseling.

(5) "Registered athletic trainer" means

Pennsylvania

Section 51.1. Athletic trainers.

(a) General rule.--An athletic trainer certified by the board may, under the direction of a physician, podiatrist or dentist, provide athletic training services to a physically active person under the care of a physician, dentist or podiatrist. An athletic trainer certified under this section shall refer a physically active person with conditions outside the scope of athletic training services to a physician, dentist or podiatrist.

This subchapter implements section 51.1 of the act (63 P. S. § 422.51a) to provide for the certification and practice standards of athletic trainers.

§ 18.502. Definitions.

The following words and terms, when used in this subchapter, have the following meanings, unless the context clearly indicates otherwise:

Approved athletic training education programs—An athletic training education program that is accredited by a Board-approved Nationally recognized accrediting agency.

Athletic training services—The management and provision of care of injuries to a physically active person, with the direction of a licensed physician.

(i) The term includes the rendering of emergency care, development of injury prevention programs and providing appropriate preventative and supportive devices for the physically active person.

(ii) The term also includes the assessment, management, treatment, rehabilitation and reconditioning of the physically active person whose conditions are within the professional preparation and education of a certified athletic trainer.

(iii) The term also includes the use of modalities such as: mechanical stimulation, heat, cold, light, air, water, electricity, sound, massage and the use of therapeutic exercise, reconditioning exercise and fitness programs.

(iv) The term does not include surgery, invasive procedures or prescription of any medication or controlled substance.

BOC—The Board of Certification, Inc., a National credentialing organization for athletic trainers.

Certified athletic trainer—A person who is certified to perform athletic training services by the Board or by the State Board of Osteopathic Medicine.

Direction—Supervision over the actions of a certified athletic trainer by means of referral by prescription to treat conditions for a physically active person from a licensed physician, dentist or podiatrist or written protocol approved by a supervising physician, except that the physical presence of the supervising physician, dentist or podiatrist is not required if the supervising physician, dentist or podiatrist is readily available for consultation by direct communication, radio, telephone, facsimile, telecommunications or by other electronic means.

Physically active person—An individual who participates in organized, individual or team sports, athletic games or recreational sports activities.

Rhode Island

(1) "Athletic trainer" means a person with the specific qualifications established in § 5-60-10 who, upon the direction of his or her team physician and/or consulting physician, carries out the practice of athletic training to athletic injuries incurred by athletes in preparation of or participation in an athletic program being conducted by an educational institution under the jurisdiction of an interscholastic or intercollegiate governing body, a professional athletic organization, or a board sanctioned amateur athletic organization; provided, that no athlete shall receive athletic training services if classified as geriatric by the consulting physician. No athlete shall receive athletic training services if non-athletic or age-related conditions exist or develop that render the individual debilitated or non-athletic. To carry out these functions, the athletic trainer is authorized to utilize modalities such as heat, light, sound, cold, electricity, exercise, or mechanical devices related to care and reconditioning. The athletic trainer, as defined in this chapter, shall not represent himself or herself or allow an employer to represent him or her to be, any other classification of healthcare professional governed by a separate and distinct practice act. This includes billing for services outside of the athletic trainer's scope of practice, including, but not limited to services labeled as physical therapy.

South Carolina

(a) "**Athletic trainer**" means a person with specific qualifications as set forth in Section 44-75-50 who, upon the advice and consent of a licensed physician, carries out the practice of care, prevention, and physical rehabilitation of athletic injuries, and who, in carrying out these functions, may use physical modalities, including, but not limited to, heat, light, sound, cold, electricity, or mechanical devices related to rehabilitation and treatment. (b) "Certificate" means official acknowledgment by the department that an individual has successfully completed educational and other requirements referred to in this act which entitle that individual to perform the functions and duties of an **athletic trainer**. (c) "Department" means the Department of Health and Environmental Control. (d) "Board" means the Board of Health and Environmental Control.

South Dakota

36-29-1. Definitions. Terms used in this chapter, unless the context otherwise requires, mean:
(1) "Athletic trainer," a person with specific qualifications as set forth in § 36-29-3, whose responsibility is the prevention, evaluation, emergency care, treatment, and reconditioning of athletic injuries under the direction of the team or treating physician. The athletic trainer may use cryotherapy, which includes cold packs, ice packs, cold water immersion, and spray coolants; thermotherapy, which includes topical analgesics, moist hot packs, heating pads, infrared lamp, and paraffin bath; hydrotherapy, which includes whirlpool; and therapeutic exercise common to athletic training which includes stretching and those exercises needed to maintain condition; in accordance with a physician's written protocol. Any rehabilitative procedures recommended by a physician for the rehabilitation of athletic injuries which have been referred and all other physical modalities may be administered only following the prescription of the team or referring physician;

Tennessee

63-24-101. Chapter definitions.
As used in this chapter, unless the context otherwise requires:
(1) "Athletic injury" means any injury sustained by a person as a result of such person's participation in exercises, sports, games, or recreation requiring physical strength, agility, flexibility, range of motion, speed, or stamina, or comparable athletic injury that prevents such person from participating in such activities;
(2) "Athletic trainer" means a person with specific qualifications as set forth in this chapter, who, upon the advice, consent and oral or written prescriptions or referrals of a physician licensed under this title, carries out the practice of prevention, recognition, evaluation, management, disposition, treatment, or rehabilitation of athletic injuries, and, in carrying out these functions the athletic trainer is authorized to use physical modalities, such as heat, light, sound, cold, electricity, or mechanical

devices related to prevention, recognition, evaluation, management, disposition, rehabilitation, and treatment; an athletic trainer shall practice only in those areas in which such athletic trainer is competent by reason of training or experience that can be substantiated by records or other evidence found acceptable by the board in the exercise of the board's considered discretion; and
(3) "Board" means the board of ~~medical examiners~~. athletic trainers.

Texas

§ 451.001. DEFINITIONS. In this chapter:
(1) "Athletic injury" means an injury sustained by a person as a result of the person's participation in an organized sport or sport-related exercise or activity, including interscholastic, intercollegiate, intramural, semiprofessional, and professional sports activities.
(2) "Athletic trainer" means a person who practices athletic training, is licensed by the board, and may use the initials "LAT," "LATC," and "AT" to designate the person as an athletic trainer. The terms "sports trainer" and "licensed athletic trainer" are equivalent to "athletic trainer."
(3) "Athletic training" means the form of health care that includes the practice of preventing, recognizing, assessing, managing, treating, disposing of, and reconditioning athletic injuries under the direction of a physician licensed in this state or another qualified, licensed health professional who is authorized to refer for health care services within the scope of the person's license.

Utah

(2) "Athlete" means an individual, referee, coach, or athletic staff member who participates in
exercises, sports, or games requiring physical strength, agility, flexibility, range of motion,
speed, or stamina, and the exercises, sports, or games are of a type generally conducted in association with an educational institution or professional, amateur, or recreational
sports club or organization.
(3) "Athletic injury" means:
(a) an injury sustained by an athlete that affects the individual's participation or performance in sports, games, recreation, or exercise; or
(b) a condition that is within the scope of practice of an athletic trainer identified by a directing physician or physical therapist as benefitting from athletic training services.
(4) "Athletic trainer" means an individual who is licensed under this chapter and carries out the
practice of athletic training.
(5) "Board" means the Athletic Trainers Licensing Board created in Section 58-40a-201
.
(6) "Directing physician" means a physician and surgeon licensed under Section 58-67-301 , an
osteopathic physician and surgeon licensed under Section 58-68-301 , a chiropractic physician
licensed under Chapter 73, Chiropractic Physician Practice Act, a naturopathic physician
licensed under Chapter 71, Naturopathic Physician Practice Act, or dentist licensed under

Section 58-69-301 who, within the licensee's scope of practice and individual competency, is
responsible for the athletic training services provided by the athletic trainer and oversees the
practice of athletic training by the athletic trainer, as established by board rule.
(7) The "practice of athletic training" means the application by a licensed and certified athletic
trainer of principles and methods of:
(a) prevention of athletic injuries;
(b) recognition, evaluation, and assessment of athletic injuries and conditions;
(c) immediate care of athletic injuries, including common emergency medical situations;
(d) rehabilitation and reconditioning of athletic injuries;
(e) athletic training services administration and organization; and
(f) education of athletes.

***58-40a-103.* Duties of directing physician.**

A directing physician shall provide direction to an athletic trainer by a verbal order when in the
presence of the athletic trainer and by written order or by athletic training service plans or
protocols when a directing physician is not present.

Vermont

As used in this chapter:

(1) "Athlete" means any individual participating in fitness training and conditioning, sports or other athletic competition, practices or events requiring physical strength, agility, flexibility, range of motion, speed or stamina.

(2) "Athletic injury" means a disruption of tissue continuity, physiological function, or neurological function that is sustained by an athlete when that injury:

(A) results from that individual's participation in or training for sports, fitness training, or other athletic competition; or

(B) restricts or prevents that individual from participation in those activities.

(3) "Athletic training" means the application of principles and methods of conditioning, the prevention, immediate care, recognition, evaluation, assessment, and treatment of athletic and orthopedic injuries within the scope of education and training, the organization and administration of an athletic training program and the education and counseling of athletes, coaches, family members, medical personnel, and communities in the area of care and prevention of athletic and orthopedic injuries. Athletic training may only be applied in the "traditional setting" and the "clinical setting":

(A) Without further referral, to athletes participating in organized sports or athletic teams at an interscholastic, intramural, instructional, intercollegiate, amateur, or professional level.

(B) With a referral from a physician, osteopathic physician, dentist, or chiropractor, to athletes or the physically active who have an athletic or orthopedic injury and have been determined, by a physician's examination, to be free of an underlying pathology that would affect treatment.

(4)

"Licensed athletic trainer" means a person licensed in accordance with the provisions of this chapter.

(5) "Conditioning" means programs designed to enhance the following physiological areas: flexibility, muscle strength, muscle endurance, neuromuscular coordination and cardio-respiratory endurance that will assist in improved athletic performance specific to the sport in which the athlete participates. Conditioning includes programs used before the season, and programs to reestablish performance during the season.

(6) "Director" means the director of the office of professional regulation.

(7) "Disciplinary action" or "disciplinary cases" includes any action taken by the administrative law officer established in section 129 of Title 3 against a licensed athletic trainer or applicant premised upon a finding of wrongdoing or unprofessional conduct. It includes all sanctions of any kind, denying, suspending or revoking licenses, issuing warnings, and other sanctions.

(7) "Disciplinary action" or "disciplinary cases" includes any action taken by the administrative law officer established in section 129 of Title 3 against a licensed athletic trainer or applicant premised upon a finding of wrongdoing or unprofessional conduct. It includes all sanctions of any kind, denying, suspending or revoking licenses, issuing warnings, and other sanctions.

(8) "Orthopaedic injury" means a disruption of musculoskeletal tissue continuity that is sustained by a physically active individual. An individual with this type of injury may be treated by an athletic trainer as long as the individual does not have any underlying pathologies that would affect treatment.

(9) "Physically active individual" means an individual who is well conditioned, healthy, and free from underlying pathology, who participates in athletic or recreational activities which require physical skills and utilize strength, power, endurance, speed, flexibility, range of motion, or agility.

(10) "Referral" means sending a patient for treatment.

(11) "Settings" means any areas in which an athletic trainer may practice athletic training. These areas include:

> (A) "Traditional setting" means working with any organized sports or athletic teams at an interscholastic, intramural, instructional, intercollegiate, amateur, or professional level.
>
> (B) "Clinical setting" means an outpatient orthopaedic or sports medicine clinic that employs one of the following: physician, osteopathic physician, chiropractor, or physical therapist.

(12) "Underlying pathology" means any disease process, including but not limited to neuromuscular disease, diabetes, spinal cord injuries, and systemic diseases. (Added 1997, No. 108 (Adj. Sess.), § 1, eff. Jan. 1, 1999; amended 1999, No. 133 (Adj. Sess.), § 31; 2003, No. 60, § 23.)

§ 4152.

Virginia

"Practice of athletic training" means the prevention, recognition, evaluation, and treatment of injuries or conditions related to athletic or recreational activity that requires physical skill and utilizes

strength, power, endurance, speed, flexibility, range of motion or agility or a substantially similar injury or condition resulting from occupational activity immediately upon the onset of such injury or condition; and subsequent treatment and rehabilitation of such injuries or conditions under the direction of the patient's physician or under the direction of any doctor of medicine, osteopathy, chiropractic, podiatry, or dentistry, while using heat, light, sound, cold, electricity, exercise or mechanical or other devices.

Washington

"Athlete" means a person who participates in exercise, recreation, sport, or games requiring physical strength, range-of-motion, flexibility, body awareness and control, speed, stamina, or agility, and the exercise, recreation, sports, or games are of a type conducted in association with an educational institution or professional, amateur, or recreational sports club or organization.

(2) "Athletic injury" means an injury or condition sustained by an athlete that affects the person's participation or performance in exercise, recreation, sport, or games and the injury or condition is within the professional preparation and education of an athletic trainer.

(3) "Athletic trainer" means a person who is licensed under this chapter. An athletic trainer
can practice athletic training through the consultation, referral, or guidelines of a licensed
health care provider working within their scope of practice.

(4)(a) "Athletic training" means the application of the following principles and methods as
provided by a licensed athletic trainer:

(i) Risk management and prevention of athletic injuries through preactivity screening
Risk management and prevention of athletic injuries through preactivity screening
and evaluation, educational programs, physical conditioning and reconditioning programs, application of commercial products, use of protective equipment, promotion of healthy behaviors, and reduction of environmental risks;

(ii) Recognition, evaluation, and assessment of athletic injuries by obtaining a history of the athletic injury, inspection and palpation of the injured part and associated structures, and performance of specific testing techniques related to stability and function to determine the extent of an injury;

(iii) Immediate care of athletic injuries, including emergency medical situations through the application of first-aid and emergency procedures and techniques for nonlife-threatening or life-threatening athletic injuries;

(iv) Treatment, rehabilitation, and reconditioning of athletic injuries through the application of physical agents and modalities, therapeutic activities and exercise, standard reassessment techniques and procedures, commercial products, and educational programs, in accordance with guidelines established with a licensed health care provider as provided in section 8 of this act; and

(v) Referral of an athlete to an appropriately licensed health care provider if the athletic injury requires further definitive care or the injury or condition is outside an athletic trainer's scope of practice, in accordance with section 8 of this act.

(b) "Athletic training" does not include:

(i) The use of spinal adjustment or manipulative mobilization of the spine and its immediate articulations;

(ii) Orthotic or prosthetic services with the exception of evaluation, measurement, fitting, and adjustment of temporary, prefabricated or direct-formed orthosis as defined in chapter 18.200 RCW;
(iii) The practice of occupational therapy as defined in chapter 18.59 RCW;
(iv) The practice of acupuncture as defined in chapter 18.06 RCW;
(v) Any medical diagnosis; and
(vi) Prescribing legend drugs or controlled substances, or surgery.
(5) "Committee" means the athletic training advisory committee.
(6) "Department" means the department of health.
(7) "Licensed health care provider" means a physician, physician assistant, osteopathic physician, osteopathic physician assistant, advanced registered nurse practitioner, naturopath, physical therapist, chiropractor, dentist, massage practitioner, acupuncturist,
occupational therapist, or podiatric physician and surgeon.

West Virginia

(a) "Board" means the West Virginia Athletic Training Licensure Board.

(b) "Licensed athletic trainer" means a person licensed to practice the allied health care profession of athletic training under this article who practices or administers athletic training to any person.

(c) "Athletic training" means the practice assessment, of management, treatment, disposition and reconditioning of athletic injuries.

(d) "Athletic injury" means any injury sustained by an individual that affects the individual's participation or performance in sports, games, recreation, exercise or other activity that requires physical strength, agility, flexibility, speed, stamina or range of motion; or condition identified by a licensed physician as benefitting from athletic training services.

Wisconsin

448.95 Definitions. In this subchapter:
(1) "Affiliated credentialing board" means the athletic trainers affiliated credentialing board.
(4) "Athletic trainer" means an individual who engages in athletic training.
(5) "Athletic training" means doing any of the following:
(a) Preventing, recognizing and evaluating injuries or illnesses sustained while participating in physical activity.
(b) Managing and administering the initial treatment of injuries or illnesses sustained while participating in physical activity.
(c) Giving emergency care or first aid for an injury or illness sustained while participating in physical activity.
(d) Rehabilitating and physically reconditioning injuries or illnesses sustained while participating in physical activity.
(e) Rehabilitating and physically reconditioning injuries or illnesses that impede or prevent an individual from returning to participation in physical activity, if the individual recently participated in, and intends to return to participation in, physical activity.
(f) Establishing or administering risk management, conditioning, and injury prevention programs.

(5m) "Consulting physician" means a person licensed as a physician under subch. II who consults with an athletic trainer while the athletic trainer is engaging in athletic training.
(6) "Licensee" means a person who is licensed as an athletic trainer under this subchapter.
448.95(7)**(7)** "Physical activity" means vigorous participation in exercise, sports, games, recreation, wellness, fitness, or employment activities.
Subject to sub. (1) (a), a licensee may provide athletic training to an individual without a referral, except that a licensee may not provide athletic training as described under s. 448.95 (5) (d) or (e) in an outpatient rehabilitation setting unless the licensee has obtained a written referral for the individual from a practitioner licensed or certified under subch. II, III, IV, V, or VII of this chapter; under ch. 446; or under s.

Wyoming

(i) "Athlete" means individuals associated with an educational institution, or a professional, amateur or recreational sports club or athletic organization participating in exercises, sports or games that require physical strength, agility, flexibility, range of motion, speed or stamina;
(ii) "Athletic injury" means:
(A) An injury or athletic-related illness or both that affects the athlete's participation or performance in sports, games and exercise related to participation with an educational institution or professional, amateur or recreational sports club or organization; and
(B) A condition that is within the scope of practice of an athletic trainer identified by a directing physician as benefiting from athletic training services.
(iii) "Board" means the state board of athletic training created under this chapter;
(iv) "License" means a current document certifying the athletic trainer has met the qualifications required to perform the functions and duties of an athletic trainer in this state;
(v) "Licensed athletic trainer" means a person licensed under this chapter who meets the qualifications set by the board and practices athletic training;
(vi) "Practice of athletic training" means the application of the principles and methods of prevention, recognition, evaluation and assessment of athletic injuries and illnesses, immediate care of athletic injuries including common injuries, medical emergencies, psychosocial intervention and referral, conditioning and rehabilitative exercise, nutritional aspects of injuries and illnesses, the use of therapeutic modalities, proper healthcare administration, professional development and the understanding and education of applications, precautions, interactions, indications and contraindications of pharmacology for athletes. "Practice of athletic training" does not include the practice of physical therapy as defined in W.S. 33-25-101(a)(i).

"Changes in Healthcare Professions' Scope of Practice: Legislative Considerations"*

MN APTA supports the published document ***"Changes in Healthcare Professions' Scope of Practice: Legislative Concerns"***, a "collaborative effort in 2006 (revised 10/09), by representatives from six national healthcare regulatory organizations...to assist legislators and regulatory bodies with making decisions about changes to healthcare professions' scopes of practice."*

This document, based on reports from the **Institute of Medicine** and the **Pew Healthcare Commission**, proposed a process for addressing scope of practice which is focused on patient safety. This process gets to purpose of regulation which is to:

1. "Ensure that the public is protected from unscrupulous, incompetent and unethical practitioners";
2. "Offer some assurance to the public that the regulated individual is competent to provide certain services in a safe and effective manner"; and
3. "Provide a means by which individuals who fail to comply with the profession's standards can be disciplined, including the revocation of their licenses."*

This document* states the argument for scope of practice changes should have a foundational basis within four areas:

1. "An established history of the practice scope within the profession",
2. Relationship of the practitioners' "education and training" to scope of practice,
3. "Supporting evidence" related to how the new or revised scope of practice benefits the public, and
4. The capacity of the regulatory agency involved (an "appropriate regulatory environment") to effectively manage modifications to scope of practice.

MN APTA supports the premise stated in this document—"If a profession can provide support evidence in these areas, the proposed changes in scope of practice are likely to be in the public's best interest."*

MN APTA believes that overlapping scopes of practice are a reality in a rapidly changing healthcare environment. MN APTA supports the above stated criteria related to who is qualified to perform functions safely without risk of harm to the public are the only justifiable conditions for defining scopes of practice.

* *Changes in Healthcare Professions' Scope of Practice: Legislative Considerations*
Developed by:
Federation of State Medical Boards (FSMB)
National Council of State Boards of Nursing, Inc (NCSBN)
Federation of State Boards of Physical Therapy (FSBPT)
National Board for Certification in Occupational Therapy (NBCOT)
Association of Social Work Boards (ASWB)
National Association of Boards of Pharmacy (NABP)

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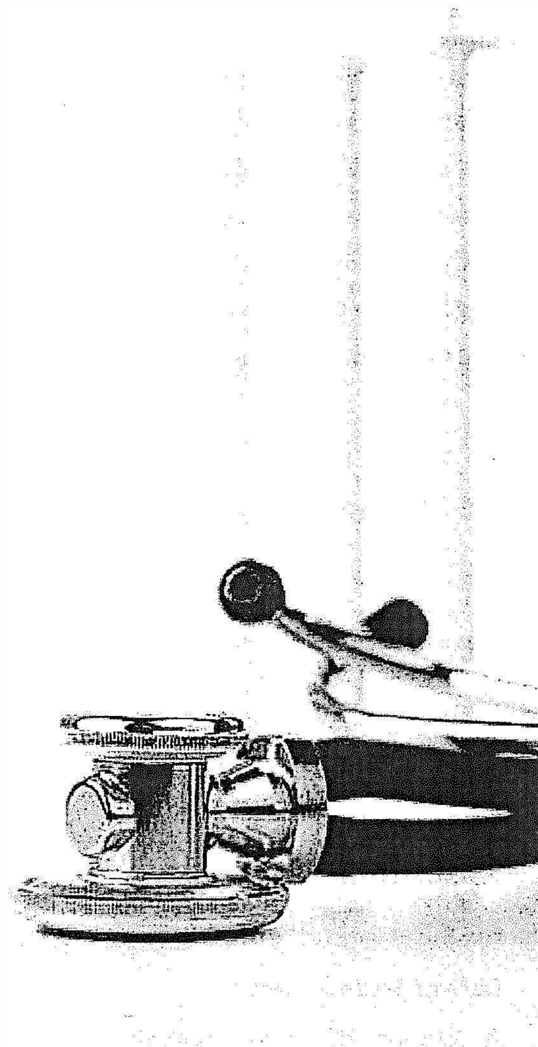

Changes in Healthcare Professions' Scope of Practice: Legislative Considerations

This document is the result of collaboration between the following organizations:

Association of Social Work Boards (ASWB)

Federation of State Boards of Physical Therapy (FSBPT)

Federation of State Medical Boards of the United States, Inc. (FSMB)

National Association of Boards of Pharmacy (NABP®)

National Board for Certification in Occupational Therapy, Inc. (NBCOT®)

National Council of State Boards of Nursing, Inc. (NCSBN®)

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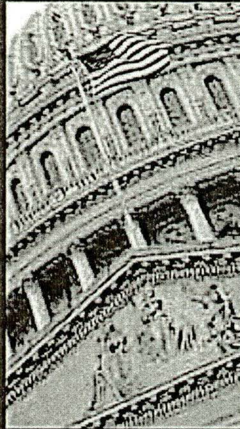
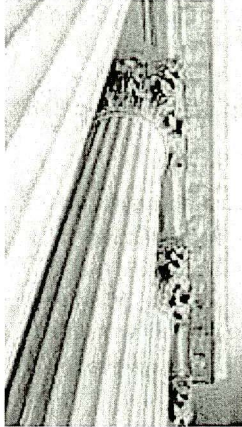


A new era of healthcare reform is sweeping state and federal government in the U.S. During these difficult economic times policymakers are faced with many challenges, not the least of which are legislative and regulatory debates on how to maximize the use of all healthcare practitioners and the debate among healthcare practitioners regarding the continuous evolution of scopes of practice. Law and rule makers charged with consumer protection will find this document helpful in guiding discussions on how the most effective and efficient care can be delivered to the American public in an era of continuous changes in healthcare.



Executive Summary

This document is a result of a collaborative effort in 2006 by representatives from six healthcare regulatory organizations. It has been developed to assist legislators and regulatory bodies with making decisions about changes to healthcare professions' scopes of practice.

Proposed changes to a healthcare professions' scope of practice often elicit strongly worded comments from several professional interest groups. Typically, these debates are perceived as turf battles between two or more professions, with the common refrain of "this is part of my practice so it can't be part of yours." Often lost among the competing arguments and assertions are the most important issues of whether this proposed change will better protect the public and enhance consumers' access to competent healthcare services.

Healthcare education and practice have developed in such a way that most professions today share some skills or procedures with other professions. It is no longer reasonable to expect each profession to have a completely unique scope of practice, exclusive of all others. We believe that scope of practice changes should reflect the evolution of abilities of each healthcare discipline, and we have therefore attempted to develop a rational and useful way to make decisions when considering practice act changes.

Based on reports from the Institute of Medicine[1] and the Pew Healthcare Commission[2] we propose a process for addressing scope of practice, which is focused on patient safety. The question that healthcare professionals must answer today is whether their profession can provide this proposed service in a safe and effective manner. If an issue does not address this question, it has no relevance to the discussion.

[1] *Crossing the Quality Chasm: A New Health System for the 21st Century,* The Institute of Medicine, National Academy Press, 2001.

[2] *Reforming Healthcare Workforce Regulation: Policy Considerations for the 21st Century,* Report of the Pew Health Professions Commission's Taskforce on Healthcare Workforce Regulation, December 1995, ix.

This process gets to the heart of regulation which, according to Schmitt and Shimberg[3], is intended to:

1. "Ensure that the public is protected from unscrupulous, incompetent and unethical practitioners";

2. "Offer some assurance to the public that the regulated individual is competent to provide certain services in a safe and effective manner"; and

3. "Provide a means by which individuals who fail to comply with the profession's standards can be disciplined, including the revocation of their licenses."

The argument for scope of practice changes should have a foundational basis within four areas: (1) an established history of the practice scope within the profession; (2) education and training; (3) supporting evidence; and (4) appropriate regulatory environment. If a profession can provide support evidence in these areas, the proposed changes in scope of practice are likely to be in the public's best interest.

[3] *Demystifying Occupational and Professional Regulation: Answers to Questions You May Have Been Afraid to Ask*, Schmitt, K. and Shimberg, B., Council on Licensure, Enforcement and Regulation, 1996.

Changes in Healthcare Professions' Scope of Practice: Legislative Considerations

A. Purpose

The purpose of this document is to provide information and guidance for legislative and regulatory agency decision making regarding changes in the scope of practice of healthcare professions. Specifically, the purpose is to:

- Promote better consumer care across professions and competent providers;
- Improve access to care; and
- Recognize the inevitability of overlapping scopes of practice.

We envision this document as an additional resource to be used by state legislatures, healthcare professions and regulatory boards in preparing proposed changes to practice acts and briefing legislators regarding those changes, just as various professions' model practice acts are used.

B. Background

This paper was a collaborative project developed by representatives of the regulatory boards of the following healthcare professions: medicine, nursing, occupational therapy, pharmacy, physical therapy and social work. It attempts to address scope of practice issues from a public protection viewpoint by determining whether a specific healthcare profession is capable of providing the proposed care in a safe and effective manner.

We believe that it is critical to review scope of practice issues broadly if our regulatory system is going to achieve the recommendations made by both the Institute of Medicine and the Pew Health Commission Taskforce on Healthcare Workforce Regulation. These reports urge regulators to allow for innovation in the use of all types of clinicians in meeting consumer needs in the most effective and efficient way, and to explore pathways to allow all professionals to provide services to the full extent of their current knowledge, training, experience and skills.

C. Historical Context

The history of professional licensure must be taken into account if one is to understand the current regulatory system governing scope of practice. Physicians were the first health professionals to obtain legislative recognition and protection of their practice authority. The practice of medicine was defined in broad and undifferentiated terms to include all aspects of an individual's care. Therefore, when other healthcare professions sought legislative recognition, they were seen as claiming the ability to do tasks which were already included in the universal and implicitly exclusive authority of medicine. This dynamic has fostered a view of scope of practice that is conceptually faulty and potentially damaging.

D. Introduction

The scope of practice of a licensed healthcare profession is statutorily defined in each state's laws in the form of a practice act. State legislatures have the authority to adopt or modify practice acts and therefore adopt or modify a particular scope of practice of a healthcare profession. Sometimes such modifications of practice acts are just the formalization of changes already occurring in education or practice within a profession due to the results of research, advances in technology, and changes in societal healthcare demands, among other things.

This process sometimes pits one profession against another before the state legislature. As an example, one profession may perceive another profession as "encroaching" into their area of practice. The profession may be economically or otherwise threatened and therefore opposes the other profession's legislative effort to change scope of practice. Proposed changes in scopes of practice that are supported by one profession but opposed by other professions may be perceived by legislators and the public as "turf battles." These turf battles are often costly and time consuming for the regulatory bodies, the professions and the legislators involved.[4] Aside from guidance on scope of practice issues, this document may assist in preventing costly legislative battles; promote better consumer care and collaboration among regulatory bodies, the professions and between competent providers; and improve access to care.

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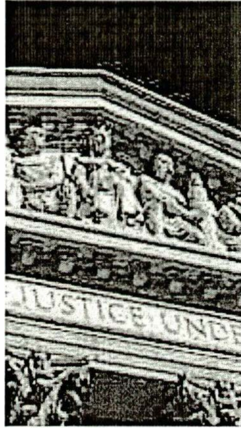
[4] *Strengthening Consumer Protection: Priorities for Healthcare Workforce Regulation*, Report from Pew Health Professions Commission, 1998.



The Purpose of Regulation

Before providing information regarding scope of practice decisions, we must ask the very basic question, "What is the purpose of regulation?" According to Schmitt and Shimberg,[5] regulation is intended to:

1. "Ensure that the public is protected from unscrupulous, incompetent and unethical practitioners";
2. "Offer some assurance to the public that the regulated individual is competent to provide certain services in a safe and effective manner"; and
3. "Provide a means by which individuals who fail to comply with the profession's standards can be disciplined, including the revocation of their licenses."

A. Defining Scope of Practice

A 2005 Federation of State Medical Boards report defined scope of practice as the "Definition of the rules, the regulations, and the boundaries within which a fully qualified practitioner with substantial and appropriate training, knowledge, and experience may practice in a field of medicine or surgery, or other specifically defined field. Such practice is also governed by requirements for continuing education and professional accountability."[6]

B. Assumptions Related to Scope of Practice

In attempting to provide a framework for scope of practice decisions, basic assumptions can be made:

1. **The purpose of regulation — public protection — should have top priority in scope of practice decisions, rather than professional self-interest.** This encompasses the belief that the public should have access to providers who practice safely and competently.

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[5] *Demystifying Occupational and Professional Regulation: Answers to Questions You May Have Been Afraid to Ask*, Schmitt, K. and Shimberg, B., Council on Licensure, Enforcement and Regulation, 1996.

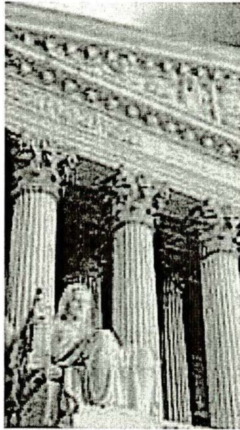
[6] *Assessing Scope of Practice in Health Care Delivery: Critical Questions in Assuring Public Access and Safety*, Federation of State Medical Boards, 2005.

2. **Changes in scope of practice are inherent in our current healthcare system.** Healthcare and its delivery are necessarily evolving. These changes relate to demographic changes (such as the aging of the "baby boomers"); advances in technology; decreasing healthcare dollars; advances in evidence-based healthcare procedures, practices and techniques; and many other societal and environmental factors. Healthcare practice acts also need to evolve as healthcare demands and capabilities change.

3. **Collaboration between healthcare providers should be the professional norm.** Inherent in this statement is the concept that competent providers will refer to other providers when faced with issues or situations beyond the original provider's own practice competency, or where greater competence or specialty care is determined as necessary or even helpful to the consumer's condition.

4. **Overlap among professions is necessary.** No one profession actually owns a skill or activity in and of itself. One activity does not define a profession, but it is the entire scope of activities within the practice that makes any particular profession unique. Simply because a skill or activity is within one profession's skill set does not mean another profession cannot and should not include it in its own scope of practice.

5. **Practice acts should require licensees to demonstrate that they have the requisite training and competence to provide a service.** No professional has enough skills or knowledge to perform all aspects of the profession's scope of practice. For instance, physicians' scope of practice is "medicine," but no physician has the skill and knowledge to perform every aspect of medical care. In addition, all healthcare providers' scopes of practice include advanced skills that are not learned in entry-level education programs and would not be appropriate for an entry-level practitioner to perform. As professions evolve, new techniques are developed, but not all practitioners are competent to perform these new techniques.



The Basis for Decisions Related to Changes in Scope of Practice

Arguments for scope of practice changes should have a foundational basis within four areas: (1) an established history of the practice scope within the profession; (2) education and training; (3) supportive evidence; and (4) appropriate regulatory environment. This foundation should provide the framework for analyzing and determining if a change in statutory scope of practice is warranted in a particular situation. If a profession can provide supporting evidence in these areas, the proposed changes in scope of practice should be adopted.

A. Historical Basis

The first of these relates to the history and evolution of the profession and its practice. This historical framework provides the basis for the essentials of the profession, including its theoretical basis, how it developed over the years and how it is presently defined. Changes in statutory scope of practice should fit within the historical, evolutionary and present practice context for the profession.

Questions to be considered in this area include:

1. Has there been an evolution of the profession towards the addition of the new skill or service?
2. What is the evidence of this evolution?
3. How does the new skill or service fit within or enhance a current area of expertise?

B. Education and Training

Tasks added to scopes of practice are often initially performed by professionals as advanced skills. Over time, as these new skills and techniques are utilized by a sufficient cohort of practitioners, they become entry-level skills and are taught as such in entry-level curricula. It is not realistic to require a skill or activity to be taught in an entry-level program before it becomes part of a profession's scope of practice. If this were the standard, there would be few, if any increases in scope of practice. However, the entry-level training program and its accompanying accrediting standards should provide the framework,

including the basic knowledge and skills needed, to acquire the new skill once out in the field. There should be appropriate accredited postprofessional training programs and competence assessment tools that indicate whether the practitioner is competent to perform the advanced skill safely.

Questions to be considered in this area include:

1. Does current entry-level education prepare practitioners to perform this skill as their experience increases?
2. If the change in scope is an advanced skill that would not be tested on the entry-level licensure examination, how is competence in the new technique assured?
3. What competence measures are available and what is the validity of these measures?
4. Are there training programs within the profession for obtaining the new skill or technique?
5. Are standards and criteria established for these programs?
6. Who develops these standards?
7. How and by whom are these programs evaluated against these standards?

C. Evidence

There should be evidence that the new skill or technique, as used by these practitioners, will promote access to quality healthcare. The base of evidence should include the best available clinical evidence, clinical expertise and research. Other forms of evidence include evolving concepts of disease/disability management, quality improvement and risk data, standards of care, infection control data, cost-effectiveness analysis and benchmarking data. Available evidence should be presented in an easy-to-understand format and in an objective and transparent manner.

Questions to be considered in this area include:

1. Is there evidence within the profession related to the particular procedures and skills involved in the changes in scope?
2. Is there evidence that the procedure or skill is beneficial to public health?

D. Regulatory Environment

A consideration in proposing changes in scope of practice is the regulatory environment. Often, it is the professional association that promotes and lobbies for scope of practice changes. The regulatory board should be involved in the process and be prepared to deal with the regulatory issues related to the proposed changes.

Questions to be considered in this area include:

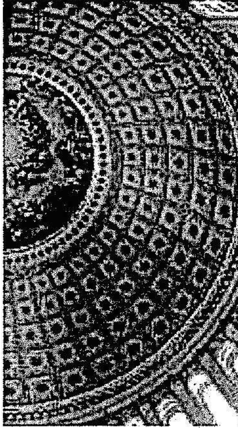
1. Is the regulatory board authorized to develop rules related to a changed or expanded scope?
2. Is the board able to determine the assessment mechanisms for determining if an individual professional is competent to perform the task?
3. Is the board able to determine the standards that training programs should be based on?
4. Does the board have sufficient authority to discipline any practitioner who performs the task or skill incorrectly or might likely harm a patient?
5. Have standards of practice been developed for the new task or skill?
6. How has the education, training and assessment within the profession expanded to include the knowledge base, skill set and judgments required to perform the tasks and skills?
7. What measures will be in place to assure competence?

Basis for Legislative Decision Making

Although the areas for decision making previously listed do not specifically mention public protection, supplying documentation in historical basis, education and training, evidence, and the regulatory environment is likely to ensure that the public will be protected when these changes are made.

Potential for harm to the consumer is difficult to prove or disprove relative to scope of practice. It is the very fact that there is potential for harm that necessitates regulation. If a strong basis for the redefined scope is demonstrated as described, this basis will be rooted in public protection.

This document rests on the premise that the only factors relevant to scope of practice decision making are those designed to ensure that all licensed practitioners be capable of providing competent care.



Conclusion

This document presents important issues for consideration by legislators and regulatory bodies when establishing or modifying a profession's scope of practice. The primary focus of this paper is public protection. When defining a profession's scope of practice, the goal of public protection can be realized when legislative and/or regulatory bodies include the following critical factors in their decision-making process:

- **Historical basis** for the profession, especially the evolution of the profession advocating a scope of practice change;
- Relationship of **education and training** of practitioners to scope of practice;
- **Evidence** related to how the new or revised scope of practice benefits the public; and
- The **capacity of the regulatory agency** involved to effectively manage modifications to scope of practice changes.

Overlapping scopes of practice are a reality in a rapidly changing healthcare environment. The criteria related to who is qualified to perform functions safely without risk of harm to the public are the only justifiable conditions for defining scopes of practice.

Appendix

Contact Information:

Association of Social Work Boards (ASWB)
400 South Ridge Parkway, Suite B
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540.829.6880 phone
www.aswb.org

Federation of State Boards of Physical Therapy (FSBPT)
124 West Street South, Third Floor
Alexandria, VA 22314
703.299.3100
www.fsbpt.org

Federation of State Medical Boards Inc. (FSMB)
400 Fuller Wiser Road
Suite 300
Euless, TX 76039
817.868.4000
www.fsmb.org

Related resource information:
www.fsmb.org/pdf/2005_grpol_scope_of_practice.pdf

National Association of Boards of Pharmacy (NABP®)
1600 Feehanville Drive
Mount Prospect, IL 60056
847.391.4406
www.nabp.net

National Board for Certification in Occupational Therapy, Inc. (NBCOT®)
12 South Summit Avenue
Suite 100
Gaithersburg, MD 20877
301.990.7979
www.nbcot.org

National Council of State Boards of Nursing, Inc. (NCSBN®)
111 East Wacker Drive
Suite 2900
Chicago, IL 60601
312.525.3600
www.ncsbn.org

Related resource information:
www.ncsbn.org/NursingRegandInterpretationofSoP.pdf

Developed by:
(In May 2006)

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Revised 1/12

General Physical Activities Defined by Level of Intensity

The following is in accordance with CDC and ACSM guidelines.

Moderate activity+ 3.0 to 6.0 METs* (3.5 to 7 kcal/min)	**Vigorous activity**+ Greater than 6.0 METs* (more than 7 kcal/min)
Walking at a moderate or brisk pace of 3 to 4.5 mph on a level surface inside or outside, such as • Walking to class, work, or the store; • Walking for pleasure; • Walking the dog; or • Walking as a break from work. Walking downstairs or down a hill Racewalking—less than 5 mph Using crutches Hiking Roller skating or in-line skating at a leisurely pace	Racewalking and aerobic walking—5 mph or faster Jogging or running Wheeling your wheelchair Walking and climbing briskly up a hill Backpacking Mountain climbing, rock climbing, rapelling Roller skating or in-line skating at a brisk pace
Bicycling 5 to 9 mph, level terrain, or with few hills Stationary bicycling—using moderate effort	Bicycling more than 10 mph or bicycling on steep uphill terrain Stationary bicycling—using vigorous effort
Aerobic dancing—high impact Water aerobics	Aerobic dancing—high impact Step aerobics Water jogging Teaching an aerobic dance class
Calisthenics—light Yoga Gymnastics General home exercises, light or moderate effort, getting up and down from the floor Jumping on a trampoline Using a stair climber machine at a light-to-moderate pace Using a rowing machine—with moderate effort	Calisthenics—push-ups, pull-ups, vigorous effort Karate, judo, tae kwon do, jujitsu Jumping rope Performing jumping jacks Using a stair climber machine at a fast pace Using a rowing machine—with vigorous effort Using an arm cycling machine—with vigorous effort
Weight training and bodybuilding using free weights, Nautilus- or Universal-type weights	Circuit weight training
Boxing—punching bag	Boxing—in the ring, sparring Wrestling—competitive
Ballroom dancing Line dancing Square dancing Folk dancing Modern dancing, disco Ballet	Professional ballroom dancing—energetically Square dancing—energetically Folk dancing—energetically Clogging
Table tennis—competitive Tennis—doubles	Tennis—singles Wheelchair tennis
Golf, wheeling or carrying clubs	----
Softball—fast pitch or slow pitch Basketball—shooting baskets Coaching children's or adults' sports	Most competitive sports Football game Basketball game Wheelchair basketball Soccer Rugby Kickball Field or rollerblade hockey Lacrosse

Volleyball—competitive	Beach volleyball—on sand court
Playing Frisbee Juggling Curling Cricket—batting and bowling Badminton Archery (nonhunting) Fencing	Handball—general or team Racquetball Squash
Downhill skiing—with light effort Ice skating at a leisurely pace (9 mph or less) Snowmobiling Ice sailing	Downhill skiing—racing or with vigorous effort Ice-skating—fast pace or speedskating Cross-country skiing Sledding Tobogganing Playing ice hockey
Swimming—recreational Treading water—slowly, moderate effort Diving—springboard or platform Aquatic aerobics Waterskiing Snorkeling Surfing, board or body	Swimming—steady paced laps Synchronized swimming Treading water—fast, vigorous effort Water jogging Water polo Water basketball Scuba diving
Canoeing or rowing a boat at less than 4 mph Rafting—whitewater Sailing—recreational or competition Paddle boating Kayaking—on a lake, calm water Washing or waxing a powerboat or the hull of a sailboat	Canoeing or rowing—4 or more mph Kayaking in whitewater rapids
Fishing while walking along a riverbank or while wading in a stream—wearing waders	----
Hunting deer, large or small game Pheasant and grouse hunting Hunting with a bow and arrow or crossbow—walking	----
Horseback riding—general Saddling or grooming a horse	Horsebackriding—trotting, galloping, jumping, or in competition Playing polo
Playing on school playground equipment, moving about, swinging, or climbing Playing hopscotch, 4-square, dodgeball, T-ball, or tetherball Skateboarding Roller-skating or in-line skating—leisurely pace	Running Skipping Jumping rope Performing jumping jacks Roller-skating or in-line skating—fast pace
Playing instruments while actively moving; playing in a marching band; playing guitar or drums in a rock band Twirling a baton in a marching band Singing while actively moving about—as on stage or in church	Playing a heavy musical instrument while actively running in a marching band
Gardening and yard work: raking the lawn, bagging grass or leaves, digging, hoeing, light shoveling (less than 10 lbs per minute), or weeding while standing or bending Planting trees, trimming shrubs and trees, hauling branches, stacking wood Pushing a power lawn mower or tiller	Gardening and yard work: heavy or rapid shoveling (more than 10 lbs per minute), digging ditches, or carrying heavy loads Felling trees, carrying large logs, swinging an ax, hand-splitting logs, or climbing and trimming trees Pushing a nonmotorized lawn mower
Shoveling light snow	Shoveling heavy snow
Moderate housework: scrubbing the floor or	Heavy housework: moving or pushing heavy

bathtub while on hands and knees, hanging laundry on a clothesline, sweeping an outdoor area, cleaning out the garage, washing windows, moving light furniture, packing or unpacking boxes, walking and putting household items away, carrying out heavy bags of trash or recyclables (e.g., glass, newspapers, and plastics), or carrying water or firewood General household tasks requiring considerable effort	furniture (75 lbs or more), carrying household items weighing 25 lbs or more up a flight or stairs, or shoveling coal into a stove Standing, walking, or walking down a flight of stairs while carrying objects weighing 50 lbs or more
Putting groceries away—walking and carrying especially large or heavy items less than 50 lbs.	Carrying several heavy bags (25 lbs or more) of groceries at one time up a flight of stairs Grocery shopping while carrying young children *and* pushing a full grocery cart, or pushing two full grocery carts at once
Actively playing with children—walking, running, or climbing while playing with children Walking while carrying a child weighing less than 50 lbs Walking while pushing or pulling a child in a stroller or an adult in a wheelchair Carrying a child weighing less than 25 lbs up a flight of stairs Child care: handling uncooperative young children (e.g., chasing, dressing, lifting into car seat), or handling several young children at one time Bathing and dressing an adult	Vigorously playing with children—running longer distances or playing strenuous games with children Racewalking or jogging while pushing a stroller designed for sport use Carrying an adult or a child weighing 25 lbs or more up a flight of stairs Standing or walking while carrying an adult or a child weighing 50 lbs or more
Animal care: shoveling grain, feeding farm animals, or grooming animals Playing with or training animals Manually milking cows or hooking cows up to milking machines	Animal care: forking bales of hay or straw, cleaning a barn or stables, or carrying animals weighing over 50 lbs Handling or carrying heavy animal-related equipment or tack
Home repair: cleaning gutters, caulking, refinishing furniture, sanding floors with a power sander, or laying or removing carpet or tiles General home construction work: roofing, painting inside or outside of the house, wall papering, scraping, plastering, or remodeling	Home repair or construction: very hard physical labor, standing or walking while carrying heavy loads of 50 lbs or more, taking loads of 25 lbs or more up a flight of stairs or ladder (e.g., carrying roofing materials onto the roof), or concrete or masonry work
Outdoor carpentry, sawing wood with a power saw	Hand-sawing hardwoods
Automobile bodywork Hand washing and waxing a car	Pushing a disabled car
~Occupations that require extended periods of walking, pushing or pulling objects weighing les than 75 lbs, standing while lifting objects weighing less than 50 lbs, or carrying objects of less than 25 lbs up a flight of stairs Tasks frequently requiring moderate effort and considerable use of arms, legs, or occasional total body movements. For example: • Briskly walking on a level surface while carrying a suitcase or load weighing up to 50 lbs • Maid service or cleaning services	~Occupations that require extensive periods of running, rapid movement, pushing or pulling objects weighing 75 lbs or more, standing while lifting heavy objects of 50 lbs or more, walking while carrying heavy objects of 25 lbs or more Tasks frequently requiring strenuous effort and extensive total body movements. For example: • Running up a flight of stairs while carrying a suitcase or load weighing 25 lbs or more • Teaching a class or skill requiring

• Waiting tables or institutional dishwashing • Driving or maneuvering heavy vehicles (e.g., semi-truck, school bus, tractor, or harvester)—not fully automated and requiring extensive use of arms and legs • Operating heavy power tools (e.g., drills and jackhammers) • Many homebuilding tasks (e.g. electrical work, plumbing, carpentry, dry wall, and painting) • Farming—feeding and grooming animals, milking cows, shoveling grain; picking fruit from trees, or picking vegetables • Packing boxes for shipping or moving • Assembly-line work—tasks requiring movement of the entire body, arms or legs with moderate effort • Mail carriers—walking while carrying a mailbag • Patient care—bathing, dressing, and moving patients or physical therapy	active and strenuous participation, such as aerobics or physical education instructor • Firefighting • Masonry and heavy construction work • Coal mining • Manually shoveling or digging ditches • Using heavy nonpowered tools • Most forestry work • Farming—forking straw, baling hay, cleaning barn, or poultry work • Moving items professionally • Loading and unloading a truck

Source: U.S. Department of Health and Human Services, Public Health Service, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Division of Nutrition and Physical Activity. *Promoting physical activity: a guide for community action*. Champaign, IL: Human Kinetics, 1999. (Table adapted from Ainsworth BE, Haskell WL, Leon AS, et al. Compendium of physical activities: classification of energy costs of human physical activities. *Medicine and Science in Sports and Exercise* 1993;25(1):71-80. Adapted with technical assistance from Dr. Barbara Ainsworth.)

* The ratio of exercise metabolic rate. One MET is defined as the energy expenditure for sitting quietly, which, for the average adult, approximates 3.5 ml of oxygen uptake per kilogram of body weight per minute (1.2 kcal/min for a 70-kg individual). For example, a 2-MET activity requires two times the metabolic energy expenditure of sitting quietly.
+ For an average person, defined here as 70 kilograms or 154 pounds. The activity intensity levels portrayed in this chart are most applicable to men aged 30 to 50 years and women aged 20 to 40 years. For older individuals, the classification of activity intensity might be higher. For example, what is moderate intensity to a 40-year-old man might be vigorous for a man in his 70s. Intensity is a subjective classification.

Data for this chart were available only for adults. Therefore, when children's games are listed, the estimated intensity level is for adults participating in children's activities.
To compute the amount of time needed to accumulate 150 kcal, do the following calculation: 150 kcal divided by the MET level of the activity equals the minutes needed to expend 150 kcal. For example:
150 ÷ 3 METS = 50 minutes of participation. Generally, activities in the moderate-intensity range require 25-50 minutes to expend a moderate amount of activity, and activities in the vigorous-intensity range would require less than 25 minutes to achieve a moderate amount of activity. Each activity listed is categorized as light, moderate, or vigorous on the basis of current knowledge of the overall level of intensity required for the average person to engage in it, taking into account brief periods when the level of intensity required for the activity might increase or decrease considerably.

Persons with disabilities, including motor function limitations (e.g., quadriplegia) may wish to consult with an exercise physiologist or physical therapist to properly classify the types of physical activities in which they might participate, including assisted exercise. Certain activities classified in this listing as moderate might be vigorous for persons who must overcome physical challenges or disabilities.

~Note: Almost every occupation requires some mix of light, moderate, or vigorous activities, depending on the task at hand. To categorize the activity level of your own position, ask yourself: How many minutes each working day do I spend doing the types of activities described as light, moderate, or vigorous? To arrive at a total workday caloric expenditure, multiply the minutes spent doing activities within each intensity level by the kilocalories corresponding to each level of intensity. Then, add together the total kilocalories spent doing light, moderate, and vigorous activities to arrive at your total energy expenditure in a typical day.

#17
SB 2295
3/25/15

March 25, 2015 – House Human Services Committee – SB 2295

Dear Human Services Committee:

My name is Bruce Wessman. I am executive director of the North Dakota Board of Physical Therapy. Please see the attachments that highlights terminology of the athletic trainers practice acts in 49 states (California not included). Please note that only 3 states have done what North Dakota proposes to do and that is to eliminate all references to athletes or athletic injuries from their practice act. The states that have done this are Wisconsin, Michigan and Pennsylvania. Please note that Pennsylvania makes it clear in their definition of a "physically active person" that athletic trainers treat individuals that are injured from participation in sports. Michigan requires that athletic trainers perform under the direction and supervision of a licensed provider and "direction" means either a written, electronic, of verbal order. Wisconsin requires a written referral to treat in the out-patient rehab setting. Please note that Wisconsin also further defines the clientele of the athletic trainer by inserting the term "Vigorous" in the definition of physical activity. Vigorous is defined in the following link. http://www.cdc.gov/nccdphp/dnpa/physical/pdf/PA_Intensity_table_2_1.pdf

The other document highlights the number of states that use the term "Under the Guidance" when referring to the supervision requirements of athletic trainers. Please note there are NO states that use the term "under the guidance". Two states use the term "guidelines" Nebraska and Washington, however they use modifiers to help define or limit the term guidance.

Nebraska states: When athletic training is provided in a hospital outpatient department or clinic or an outpatient-based medical facility, the athletic trainer will perform the functions described in section 71-1,240 with a referral from a licensed physician for athletic training; Washington prohibits athletic trainers from treating any "medical diagnosis"

These documents are provided to support the claim that if SB2295 passes, the athletic trainers in North Dakota will have the most liberal practice act in the country.

March 20, 2015

Dear Legislators:

My name is Brenda Miller and I am currently a Family Practice Physician serving the Bismarck-Mandan area. Prior to obtaining my medical degree, I worked as a physical therapist for 8 years. Additionally, I served as the physician liaison for the State Board of Physical Therapy for 10 years. Therefore, I feel I have a good sense of the role of the physical therapist, as well as other allied health professions, and the process of licensure, scope of practice, and state practice acts. I am writing this brief note expressing my opposition to the athletic trainer's bill (SB 2295).

The current bill set forth by the athletic trainers would significantly increase the autonomy of athletic trainers. They have chosen to remove the word "athletic/athletic injuries" and have replaced it with physical activity and illness. I believe that this change will overstep their educational background by allowing them to treat "unwell" people who have multiple co-morbidities as opposed to the healthy, athletic population who have been pre-screened by physicians. Treating patients with "illness" requires a strong background in medical conditions, pharmacology, and systems screening. An undergraduate AT degree does not currently include either the significant didactic or clinical training required for this level of patient care management.

Additionally, I would strongly recommend that the proposed bill ensure that athletic trainers work under the supervision and direction of a physician as opposed to "guidance" as suggested in their proposed language.

In summary, as a practicing physician, former NDBPT physician liaison, and former practicing physical therapist, I feel that the proposed changes are too broad and extend their care beyond that of the AT educational background. I understand there is representative language from the other state's practice acts which should be reviewed and represented in this language.

Respectfully yours,

March 3rd, 2015

Dear Legislators:

My name is Keith E Swanson and I serve as the physician liaison for the State Board of Physical Therapy for the great state of North Dakota. I am writing this brief note strongly expressing both my personal opposition and the State Board of Physical Therapy's opposition to the athletic trainer's bill (SB 2295) moving through the legislature at this time. I have been both a Physical Therapist and now a physician for the past 15 years. Additionally, I work very closely with physician extenders such as Nurse Practitioners and Physician Assistants on a daily basis. Thus, I feel I have particular insight into issues relating to scope of care and treatment boundaries, etc.

The current bill set forth by the athletic trainers would significantly increase the autonomy of athletic trainers to include basically any illness effecting anybody (not just athletes), whether related to an athletic injury or not. We feel strongly that affording athletic trainers the latitude to essentially treat any illness is overstepping their level of expertise and may, in fact, be dangerous for an athlete's (or a "weekend warrior's") overall health. The level of training in the myriad of possible medical conditions is simply not in the scope of a typical athletic trainer's education. That is why they call it the "practice" of medicine as I am humbly reminded of on a regular basis. Further, if one were to closely examine athletic trainers' specific scope of practice in surrounding states, it clearly stipulates that they should be caring for athletic injuries on the field of athletic play. In Minnesota, a similar bill was soundly rejected.

I have worked with a number of very talented athletic trainers over the years and have nothing but complete respect for what they do on the athletic field. However, as this bill stands right now, if you were to present to an urgent care clinic yourself or with a loved one, ask yourself if you would be comfortable with an athletic trainer functioning essentially on the level of a physician.

In summery, as a representative of North Dakota's Physical Therapy voice, we feel strongly that athletic trainers should remain focused at what their intense training has vetted them to be; experts in the immediate "on-field" care of athletic injuries.

If you would like to further discuss this issue with me, my contact information is as follows:

Office: 701 780 6225
Mobile: 701 330 5747
Email: kswanson1971@yahoo.com

Respectfully yours,

Keith E Swanson MD, FACP, FSVM, RPVI

March 25, 2015

SB 2295

CHAIRMAN WEISZ AND MEMBERS OF THE HOUSE HUMAN SERVICES COMMITTEE

My name is Bruce Wessman and I am the Executive Officer of the North Dakota Board of Physical Therapy. I am writing to voice my concerns with SB 2295.

First and most importantly I am not questioning the athletic trainer's ability to treat active healthy individuals. No one is questioning the value and expertise the trainer brings to the medical community. I am questioning the language of the bill. The fact that it is so broadly written makes regulation and patient safety a concern. Please take note of the following points.

- illness is added to the definition of what an AT can treat. Please note there are no modifiers or limitations placed on the term "illness" not even the addition of "sport". There is no question that athletic trainers are involved in the recognition and management of illnesses however the most significant illnesses that require emergency recognition and management take place on the field of play not in a clinic setting. The AT needs to have the ability to recognize and stabilize these illnesses. They do not have the depth of education to treat illnesses other than sport illnesses. Skin diseases such as fungal, viral and bacterial infections are common in athletics. The AT provides significant knowledge in the prevention of the spread of communicable diseases such as MRSA. However the treatment of infections usually requires a course of antibiotics which is not in the AT's scope of practice. My area of concern is that the language is much too broad. Why not say what they do? The athletic trainer "recognizes, educates and manages sport illnesses" on the field of play. The public will not be well served and well protected by having persons attempt to treat them for problems for which they are not trained

- SB2295 substitutes the word physical activity for athletic injuries. It then goes on to define physical activity in such a manner that there are no limitations placed on who the AT can treat. For example they leave out the word "vigorous" as is seen in the Wisconsin act. Without limitations, treatment by an athletic trainer could include treatment of non-healthy individuals which is not appropriate for their level of education. By substituting the term physical activity for athletic injury the athletic trainer will now be able to treat people with significant co-morbidities not just the healthy individual. The complexities involved with the treatment of these

individuals played a major role in the advancement of physical therapy from a baccalaureate degree to a doctoral degree. The educational preparedness of the AT will lag the advancement in their scope of practice. Students of athletic training are well aware that Athletic Training is an entry level degree into the medical field. The following is taken from the UND Athletic training home page.

"The degree program entails a four-year curriculum designed to prepare the student for an entry-level position in the field of athletic training. Upon completion of the curriculum, the student will be eligible to take the BOC Inc. Certification Examination. Students pursuing the Athletic Training degree are encouraged to utilize the electives in this program to prepare for advanced study. Suggested areas of study include: post-graduate study in kinesiology, physical therapy or medicine. The Athletic Training program offered is accredited by the Commission on Accreditation of Athletic Training Education (CAATE)."

- Under the guidance of a physician" is a term found but not defined in SB 2295. The PT practice act defines onsite and direct supervision and differentiates between the supervision requirements at different locations. SB2295 does not. How is "guidance" defined? Does the type or amount of guidance differ from the field of play to a clinic? What guidance is required to treat non-athletic injuries in the clinic? Is a written order required for an AT to treat in the clinic? I feel "Under the guidance of a physician" is too broad and needs to be defined.

As a regulator, when broad and undefined language is used to advance the scope of practice of a profession, I feel concern for public safety. I urge you to vote no on SB2295.

Thank you for your time and consideration.

March 25, 2015 – HOUSE HUMAN SERVICES COMMITTEE – SB 2295

Dear Chairman Weisz and Committee members:

My name is Kathleen Day and I am writing with concerns related to SB2295, the expansion of the scope of practice for Athletic Trainers in North Dakota. I am the President of the North Dakota Physical Therapy Association and a practicing Physical Therapist with over 37 years of experience with the VA Health Care System in Fargo. As the largest healthcare organization in the US, treating a multitude of complex individuals, the VA Health Care System does not employ athletic trainers.

The proposed language would arguably give the athletic trainers in North Dakota the most permissive and liberal scope of practice in the country. This broad scope contains no standards limiting the types of injuries and illnesses athletic trainers would be authorized to clinically evaluate and treat. Athletic trainers, as their title implies, have their education based in athletics with minimal clinical education with hands on learning of skills to competently assess and treat complex patients. As the bill reads, athletic trainers would be allowed to provide comprehensive management of injuries and illnesses without supervision or direct physician involvement. I have not heard an explanation as to why they wish to remove all references to athletics if their education provides them a degree in Athletic Training.

Minnesota lawmakers, when faced with a similar expansion of the AT scope of practice in 2006, utilized an independent scope of practice review team commissioned to determine an unbiased opinion of the bill. The basis of this document as a filter represented six healthcare regulatory organizations to assist legislators with making decisions in scopes of practice. The foundation of the document covered four basic areas: 1) established history of the practice scope within the profession, 2) relationship of education and training reflective of the scope of practice change, 3) supporting evidence related to how new scope of practice benefits the public, and 4) capacity of the regulatory agency involved to effectively manage modifications to scope of practice. Minnesota used the findings of this commission to deny the athletic trainers bill that would have expanded their scope of practice similar to the ND bill.

We were not informed of the upcoming legislation until a few days prior to the Senate committee hearing. We were not approached over the last two years to work on language that would be suitable for all concerned as was recommended in the previous legislative session. The Athletic Trainers have claimed to model the language after the Wisconsin scope of practice but this is not accurate since Wisconsin's statute has two significant points deliberately omitted from SB 2295 that make a very big difference.

Wisconsin has included “vigorous” in their language which supports the treatment of healthy individuals and they require a written referral from a physician. NDPTA has suggested changes to the proposed language to offer better clarification and define the role of the athletic trainer within the healthcare arena but no compromises were forthcoming. We feel we were reasonable in our requests and conceded to some language we had previously strongly opposed.

In the changing healthcare arena, different healthcare professions may share some of the same skills. However, education must support the skills that are performed to ensure the public is receiving appropriate care based on the level of training and clinical experience. The Physical Therapy profession has continued to enhance their education to reach a doctoral level with a change in the scope of practice to reflect this change. This seems to be a logical approach and not change a scope of practice with future expectations on advanced levels in education.

I would urge a no vote to this bill as presented with current language.

Thank you.

Respectfully,

Kathleen Day, PT, DPT

March 25, 2015 – House Human Services Committee – SB 2295

My name is Henry C. "Bud" Wessman, JD, PT, LNHA. I am a retired Federal Administrative Judge (former Member, Provider Reimbursement Review Board – Medicare – Baltimore) and former Executive Director of the North Dakota Department of Human Services under Gov. Ed Schafer. I also was honored to be the founder of the first Physical Therapy educational program in North Dakota in 1967 by starting the Department of Physical Therapy within the University of North Dakota's School of Medicine. I have had the pleasure of watching that program grow from its initial Baccalaureate entry level, to a Master's entry level, and now to the Doctoral entry level, as the demands and intricacies of the field have expanded. During our 26 years in Grand Forks, I was honored to be elected to the Grand Forks City Council, and elected twice to 4 year terms as Mayor. I also had the pleasure of representing District 43 in your House of Representatives during the 46th Legislative Session

Words have consequences. When you delete the words "ATHLETIC injury" from the definition of an "ATHLETIC Trainer" in NDCC§43-39-01.2, you have gutted the focus (ATHLETIC) of the Act and the practioner, and have created a non sequitur in North Dakota law where the Title of the Act does not define the "practice" ("athletic training means the practice of prevention, recognition, evaluation, management, treatment, and disposition of *athletic injuries*"); or, you have created an entirely new health care provider which broadly defines the practioner as capable of treating ANY "injury or illness" without the focus on the basis for the practice ("ATHLETIC Injury"), and a new health care field that will not, by absence of that focus, be responsive to the North Dakota Board of Athletic Trainers.

Please vote "NO" when SB 2295 comes before you.

SB 2295 purports to "modernize" the Scope of Practice for Athletic Trainers by removing the qualifying term "athletic injury" and substituting the very liberal catch-all of "injury and illness". Such a broad dilution of definition will allow Athletic Trainers (ATCs) to theoretically provide services to any illness or injury – acute stroke, cardiac problems, neurologic disorders, pulmonary disease, influenza, migraine, or a host of other complicated "illness or injury" significantly beyond the current training and education of Athletic Trainers, as long as the patient was involved in "physical activity", which can be as broadly defined as basic breathing to stay alive.

While the ATCs and their supporters may attempt to classify this as a "turf" issue between Physical Therapists and ATCs, rest assured that I find ATCs to be invaluable colleagues when they function within the scope of their practice and training – there is no professional I would rather have handling injuries on the playing field or in the training room than an ATC, that is what they are educated to do. But to remove the identifying term "athletic injury" from their Scope of Practice and broadly substitute "injury or illness" invites the opportunity for a lesser educated professional to expand their attempt at care-giving far beyond the level of their expertise and training, while at

the same time raising the cost of health care by allowing yet another practioner to access the health insurance pool of providers.

My points are simply this:

- Athletic Training is just that – athletic training. The whole premise of the profession revolves around its ability to treat and rehab athletic injuries. ATCs are good at this, but they are not educated, nor are they qualified, to treat more complicated and intense "injury or illness", such as acute stroke or cardiac patients. Yet SB 2295 would allow this to occur, without any advancement in the ATC educational program. It is interesting to note that in the University of North Dakota materials on the BS Degree for ATC it is rightly suggested that "Students pursuing the Athletic Training degree are encouraged to utilize the electives in this program to prepare for advanced study. Suggested areas of study include: post-graduate study in kinesiology, physical therapy, or medicine". Clearly, the educational programs in ATC anticipate that if the individual ATC wishes to broaden their scope to treat all "injury or illness", rather than the specific "athletic injury" for which they are trained, they should broaden their educational background and move into an appropriate field, not simply attempt to change the Scope of their Practice Act.

- You may have received a letter from an Athletic Trainer in which the individual suggested that some ATCs are already functioning as "physician extenders", and that somehow, if you vote to change the Scope of the Athletic Trainer's Scope of Practice, this current dubious practice will be legal. Passing SB 2295 and attempting to rationalize the profession into a "physician extender" status does exactly what I described above – it raises the cost of health care by "inventing" a new back-door avenue of access to health insurance dollars with a billing mechanism for ATCs, while at the same time assuring that professionals, like ATCs, would be allowed to practice beyond the educational qualifications and training they possess.

- SB 2295 goes well beyond any definition of Scope of Practice for Athletic Trainers of any State in our geographic region, and in my opinion, for the reasons stated above, will put North Dakota at a significant disadvantage for recruiting appropriately trained health care providers, while decreasing the quality of care by allowing lesser-trained personnel to provide health care for our State's valuable residents.

Thank you for your attention to this. If there is any further information I can provide, please contact me and I will follow up immediately.

Bud Wessman - (701)388-9991 – wessmanbl@cableone.net

#1

PROPOSED AMENDMENTS TO SENATE BILL NO. 2295
4-6-15

Page 1, line 9, remove " services in accordance with the"

Page 1, line 10, remove "individual's education"

Page 1, line 24, after "activity" insert ", under standing, verbal, or written orders, and in clinical settings written orders shall be required"

Page 2, line 4, after "activity" insert ", under standing, verbal, or written orders, and in clinical settings written orders shall be required"

Page 2, line 10, after "means" insert "any moderate or vigorous"

Page 2, line 11, replace ", including" with "during"

Page 2, line 12, after "recreation," insert "performing arts, stretching,"

Page 2. Line 12, remove "or"

Page 2, Line 12, after "fitness" insert "or other settings set forth in section 43-39-10(5)"

Page 3, line 3, replace "direction" with "guidance or rehabilitation order"

Page 3, after line 5, insert:

SECTION 5. AMENDMENT. Subsection 5 of section 43-39-10 of the North Dakota Century Code is created and enacted as follows:

5. Nothing in this chapter shall be construed to prevent athletic trainers from providing: athletic training in hospital or clinical settings; injury screens; physician extender services; employee injury prevention, education or advice; or services to address injuries or illnesses, comparable to athletic injuries or illnesses, in military, ~~employment~~ industrial, or public safety settings.

Renumber accordingly

Attach #1
SB 2295
04/09/15

PROPOSED AMENDMENTS TO
FIRST ENGOSSMENT
with House Amendments
ENGROSSED SENATE BILL NO. 2295
15.04488.05000
4-9-15

Page 2, line 7, after "programs" insert ", or providing injury screening or physician extender services"

Page 2, line 14, replace "other settings set forth in subsection 5 of section 43-39-10" with "military, industrial, or public safety activities"

Page 3, remove lines 8-14.

Renumber accordingly

1.2

15.0488.05000

Sixty-fourth
Legislative Assembly
of North Dakota

SENATE BILL NO. 2295

Introduced by

Senators Dever, Warner

Representatives Hofstad, Mooney, Rohr

A BILL for an Act to amend and reenact sections 43-39-01 and 43-39-04 and subdivision d of subsection 1 of section 43-39-10 of the North Dakota Century Code, relating to the regulation of athletic trainers; and to provide a penalty.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. AMENDMENT. Section 43-39-01 of the North Dakota Century Code is amended and reenacted as follows:

43-39-01. Definitions.

1. "Athletic trainer" means ~~a person~~an individual with specific qualifications set forth in section 43-39-05, who is providing athletic training.

2. "Athletic training" means doing any of the ~~practice of prevention, recognition, evaluation, management, treatment, and disposition of athletic injuries. The term also means rehabilitation of athletic injuries, if under the order of a licensed physician. The term includes organization and administration of educational programs, athletic facilities, and the education and counseling of the public~~~~comprehensive management of injuries and illnesses to prevent, clinically evaluate, assess, provide immediate care, treat, rehabilitate, and recondition.~~following under the guidance of a physician:

   a. preventing, recognizing and evaluating injuries and illnesses sustained while participating in physical activity;

   b. managing and administering the initial treatment of injuries or illnesses sustained while participating in physical activity;

   c. giving emergency care or first aid for an injury or illness sustained while participating in physical activity;

   d. rehabilitating injuries or illnesses sustained while participating in physical activity, under verbal, standing, or written orders, and in clinical settings written orders shall be required;

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e. rehabilitating and physically reconditioning injuries or illnesses that impede or prevent an individual from returning to participation in physical activity, if the individual recently participated in, and intends to return to participation in, physical activity. under verbal, standing, or written orders, and in clinical settings written orders shall be required;

f. establishing or administering risk management, conditioning, and injury prevention programs, or providing injury screening or physician extender services; or

g. referring a patient or client to an appropriate health care provider as needed.

3. "Physical activity" means any moderate or vigorous activity that requires physical strength, agility, range of motion, repetitive motion, speed, or stamina during participation in exercise, sports, games, recreation, performing arts, stretching, wellness, fitness, or ~~other settings set forth in section 43-39-10(5)~~military, industrial, or public safety activities.

~~3~~4. "Board" means the North Dakota board of athletic trainers established in section 43-39-02.

~~4~~5. "Physician" means ~~a doctor of medicine~~an individual licensed ~~to practice~~as a physician under chapter 43-17.

SECTION 2. AMENDMENT. Section 43-39-04 of the North Dakota Century Code is amended and reenacted as follows:

43-39-04. Unlawful practice

1. ~~No~~A person may not practice athletic training or hold that person out as being an athletic trainer in this state unless that person is an individual licensed in accordance with this chapter.

2. ~~No~~A person may not consult, teach, or supervise or hold that person out as being able to consult, teach, or supervise athletic training curricular courses in this state unless that person is an individual licensed in accordance with this chapter or chapter 43-17~~,~~ or possesses a degree in a health-related field.

3. ~~No~~A person may not represent that person as being a licensed athletic trainer or use in connection with that person's name any letters, words, or insignia indicating or implying that the person is a licensed athletic trainer unless that person is an individual licensed in accordance with this chapter.

SECTION 4. AMENDMENT. Subdivision d of subsection 1 of section 43-39-10 of the North Dakota Century Code is amended and reenacted as follows:

d. Is guilty of treating or undertaking to treat ~~ailments of human beings~~an individual's injury or illness, except as authorized pursuant to this chapter, or undertaking to

practice independent of the ~~order~~guidance or rehabilitation order of a licensed physician, or is guilty of any act derogatory to the dignity and morals of the profession of athletic training.

~~**SECTION 5. AMENDMENT.** Subsection 5 of section 43-39-10 of the North Dakota Century Code is created and enacted as follows:~~

~~5. Nothing in this chapter shall be construed to prevent athletic trainers from providing: athletic training in hospital or clinical settings; injury screens; physician extender services; employee injury prevention, education or advice; or services to address injuries or illnesses, comparable to athletic injuries or illnesses, in military, industrial, or public safety settings.~~