



OREGON MEDICAL BOARD
REGULAR QUARTERLY MEETING
October 2, 2025, 10:30^{AM}
Oregon Medical Board – Boardroom

Agenda items may be taken out of order and the agenda may be amended.

PUBLIC SESSION

1	Call to Order, Roll Call, and Announcements	SHAW
2	Swearing in New Board Members	SHAW
3	Nominating Committee	SHAW
4	Recusal Announcements	SHAW
5	Executive Session Announcement	SHAW

Pursuant to ORS 192.660(2)(f), (h), and (L), the Oregon Medical Board will convene in Executive Session to consult with counsel regarding the legal rights and duties of the Board regarding litigation likely to be filed, and to consider records that are exempt by law from public disclosure, including:

- written advice from counsel,
- information obtained as part of a Board investigation,
- information received in confidence by the Board,
- information of a personal nature, the disclosure of which would constitute an invasion of privacy,
- and records which are otherwise confidential under Oregon law.

Designated staff and members of the news media shall be allowed to attend the Executive Session. Other public officials may be permitted to attend at the Board's discretion. All others are excluded from Executive Session. Pursuant to ORS 192.660(4) and ORS 676.175(8), members of the news media and public officials are directed not to report on the specific information discussed during the Executive Session, disclose information obtained as part of an investigation to any other member of the public, or record the Executive Session by audio or video means. The Board will reconvene in Public Session prior to taking any final action.

EXECUTIVE SESSION

Board members discussed investigative cases in consideration of issuance of Notices of Proposed Disciplinary Action and Notices of Intent to Deny, approvals of signed agreements and orders, modifications of order terms, terminations of agreements and orders, Investigative Committee consent agendas, meeting minutes, applications for licensure, and case resolution options.

PUBLIC SESSION

39 Automatic Suspension Orders Issued:**SHAW**

- KNIGHT-KING, Zachary J., PA, July 25, 2025

40 Interim Stipulated Orders Issued:**SHAW**

- DOW, Joshua E., MD, July 11, 2025
- WACEK, Paul D., PA, August 4, 2025 PA Esquivel recused
- MERLO-GRIFANTINI, Heather, MD, September 24, 2025
-

41 Orders Terminating Interim Stipulated Orders Issued:**SHAW**

- KNIGHT-KING, Zachary J., PA, July 25, 2025

42 Board Actions in Matters Discussed During Executive Session**SHAW****43 Annual Performance Progress Report****BLASI****44 Project Sprout Quarterly Status Report****BLASI****45 2025-27 Agency Budget Update****BLASI****46 Agency Head Transactions Report****BLASI****47 Public Comment****SHAW**

20 minutes have been allocated for public comments today. To ensure all speakers have an opportunity to be heard, comments are limited to 2 minutes each. Members of the public who signed up to provide comments will be called in the order they registered. If time allows, those who did not sign up may raise their virtual hand and will be called upon to speak.

48 HB 2143: Five-Needle Protocol Implementation**SHAW**

- 1) OAR 847-005-0005: Licensure Fees and OAR 847, Division 71 Five-Needle Protocol – FIRST REVIEW
- 2) HB 2143: Five-Needle Protocol, Implementation Workgroup Meeting Minutes

49 Acupuncture Advisory Committee**SHAW**

- 1) OAR 847, Division 8, Rule 70, Division 10, Rule 73, and Division 70, Rules 5, 16,17, 19, 22, 33, 37, 45, 60, 70, 73 – FIRST REVIEW
- 2) Acupuncture Advisory Committee Meeting Minutes

50 EMS Advisory Committee**SHAW**

- 1) OAR 847-035-0030: Scope of Practice – FIRST REVIEW
- 2) Nomination of New EMS Advisory Committee Physician Member Position
- 3) EMS Advisory Committee Meeting Minutes

51	SB 476 (2025) Approved Medical School Definition OAR 847-010-0090 Clinical Clerkships and Preceptorships OAR 847-020-0100 Definitions OAR 847-020-0120 Basic Requirements for Licensure of an Approved Medical School Graduate	FIRST REVIEW	SHAW
52	SB 873: (2025) Repealing Unused Volunteer Emeritus License OAR 847-023-0000 Definitions OAR 847-023-0005 Qualifications OAR 847-023-0010 Documents and Forms to be Submitted for Licensure OAR 847-023-0015 Letters and Official Verifications to be Submitted for Licensure OAR 847-026-0000 Qualifications for License by Endorsement	FIRST REVIEW	DAOUD
53	HB 3043 (2025) Health Professional Services Updates OAR 847-065-0010 Purpose, Intent and Scope OAR 847-065-0015 Definitions OAR 847-065-0020 Participation in Health Professionals' Services Program OAR 847-065-0025 Eligibility for Participation in Health Professionals Services Program OAR 847-065-0030 Procedure for Board Referrals OAR 847-065-0035 Procedure for Self-Referred Licensees OAR 847-065-0040 Disqualification Criteria OAR 847-065-0045 Approval of Independent Third-Party Evaluators; OAR 847-065-0050 Approval of Treatment Providers OAR 847-065-0055 Licensee Responsibilities OAR 847-065-0065 Substantial Non-Compliance Criteria OAR 847-065-0070 Licensees with Primary Residence or Work Site Outside of Oregon	FIRST REVIEW	ESQUIVEL
54	Notices of Proposed Rulemaking		BLASI
55	OAR 847-001-0000 Notice of Proposed Rule	FINAL REVIEW	ESQUIVEL
56	OAR 847-008-0020 Locum Tenens Registration	FINAL REVIEW	BLASI
57	OAR 847-010-0300 Access to Mental Health Assessment, Treatment, or Services	FINAL REVIEW	DAOUD
58	OAR 847-020-0170 Examination for Licensure	FINAL REVIEW	SHAW
59	Statement of Philosophy Review: Mesotherapy and Injection Lipolysis		DAOUD
60	2026-27 Meeting Schedule		BLASI
61	2025 Succession Plan		ESQUIVEL
62	Governor's Expectations for State Agencies Quarterly Report	TENTATIVE	DAOUD
63	Secretary of State Audit Recommendations Update		SHAW

64	2025 Legislative Session Update and Implementation Plans	SHAW
65	2025 International Conference on Medical Regulation Meeting Highlights	SHAW
66	Vaccine Access	SHAW
67	New Licensure Count	BLASI
68	Nominating Committee Recommendations	SHAW
69	Closing Comments for the Good of the Board	SHAW

BEFORE THE
OREGON MEDICAL BOARD
STATE OF OREGON

In the Matter of)
ZACHARY JAMES KNIGHT-KING, PA) ORDER OF LICENSE SUSPENSION
LICENSE NO. PA150255)
)

1.

The Oregon Medical Board (Board) is the state agency responsible for licensing, regulating and disciplining certain health care providers, including physician associates, in the State of Oregon. Zachary James Knight-King, PA (Licensee) is a licensed physician associate in the State of Oregon.

2.

Facts

2.1 At all relevant times, Licensee was licensed to practice medicine under ORS chapter 677. Licensee is an adult.

2.2 On January 26, 2024, Licensee entered into an Interim Stipulated Order to voluntarily withdraw from practice and place his license in Inactive status pending the completion of the Board's investigation into his ability to safely and competently practice medicine.

2.3 Effective on or around June 16, 2025, Licensee was incarcerated at the Coffee Creek Correctional Facility and was placed in the custody of the Multnomah County Sheriff. The Coffee Creek Correctional Facility is a penal institution.

3.

Law

ORS 677.225(1)(b) provides that a license issued under ORS chapter 677 is suspended automatically if the Licensee is an adult in custody in a penal institution. ORS 677.205(1)(c) provides additional authority for such a suspension.

1 4.

2 4.1 Licensee's license to practice medicine is hereby suspended, in accordance with
3 ORS 677.225(1)(b) and under the additional authority of ORS 677.205(1)(c) and OAR 847-001-
4 0035. This suspension will remain in effect until Licensee presents satisfactory evidence to the
5 Board that Licensee is no longer incarcerated, and the Board is satisfied with due regard to the
6 public interest that Licensee's privilege to practice medicine may be restored.

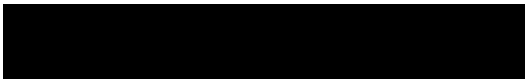
7 4.2 The January 26, 2024, Interim Stipulated Order terminates effective the date the
8 Executive Director signs this Order of License Suspension.

9 5.

10 This Order is a public record and is a disciplinary action that is reportable to the National
11 Practitioner Data Bank and the Federation of State Medical Boards. Pursuant to ORS 677.202,
12 Licensee is not entitled to a hearing on this automatic suspension.

13
14 IT IS SO ORDERED this 25th day of July, 2025.

15 OREGON MEDICAL BOARD
16 State of Oregon

17 
18 NICOLE KRISHNASWAMI, JD
19 EXECUTIVE DIRECTOR
20
21
22
23
24
25
26
27

STATE OF OREGON

JOSHUA EMPEDOCLES DOW, MD) INTERIM STIPULATED ORDER
LICENSE NO. MD27829)

1.

The Oregon Medical Board (Board) is the state agency responsible for licensing, regulating and disciplining certain healthcare providers, including physicians, in the State of Oregon. Joshua Empedocles Dow, MD (Licensee) is a licensed physician in the State of Oregon.

2.

The Board received credible information regarding Licensee that resulted in the Board initiating an investigation. In order to address the Board's concerns while this matter is under investigation, Licensee and the Board agree to the entry of this Interim Stipulated Order, which is not an admission of any wrongdoing on the part of the Licensee. Licensee understands the terms of this Order and signs freely, without fraud or duress.

3.

While this matter is under investigation, Licensee agrees to the following conditions:

3.1 Licensee voluntarily withdraws from the practice of medicine and his license is placed in Inactive status pending the completion of the Board's investigation into his ability to safely and competently practice medicine.

3.2 Licensee understands that violating any term of this Order will be grounds for disciplinary action under ORS 677.190(17).

3.3 Licensee must notify the Oregon Medical Board within 10 days as to how patients may access or obtain their medical records.

///

1 4.

2 At the conclusion of the Board's investigation, Licensee's status will be reviewed in an
3 expeditious manner. Following that review, if the Board determines that Licensee shall not be
4 permitted to return to the practice of medicine, Licensee may request a hearing to contest that
5 decision.

6 5.

7 This Order is issued by the Board pursuant to ORS 677.265(1) and (2) for the purpose
8 of protecting the public, and making a complete investigation in order to fully inform itself with
9 respect to the performance or conduct of the Licensee and Licensee's ability to safely and
10 competently practice medicine. Pursuant to ORS 677.425, Board investigative materials are
11 confidential and shall not be subject to public disclosure. However, as a stipulation this Order is
12 a public document and is reportable to the National Practitioner Data Bank and the Federation of
13 State Medical Boards. This Order becomes effective the date it is signed by the Board's
14 Executive Director or Medical Director in accordance with OAR 847-001-0030.

15
16 IT IS SO STIPULATED THIS 11th day of July, 2025.

17
18 
19 JOSHUA EMPEDOCLES DOW, MD

20 IT IS SO ORDERED THIS 11th day of July, 2025.

21 State of Oregon
22 OREGON MEDICAL BOARD

23 
24 NICOLE KRISHNASWAMI, JD
25 EXECUTIVE DIRECTOR
26
27

BEFORE THE
OREGON MEDICAL BOARD
STATE OF OREGON

In the Matter of)
)
PAUL DENNIS WACEK, PA) INTERIM STIPULATED ORDER
LICENSE NO. PA01087)
)

1.

The Oregon Medical Board (Board) is the state agency responsible for licensing, regulating and disciplining certain healthcare providers, including physicians, in the State of Oregon. Paul Dennis Wacek, PA (Licensee) is a licensed physician associate in the State of Oregon.

2.

The Board received credible information regarding Licensee that resulted in the Board initiating an investigation. In order to address the Board's concerns while this matter is under investigation, Licensee and the Board agree to the entry of this Interim Stipulated Order, which is not an admission of any wrongdoing on the part of the Licensee. Licensee understands the terms of this Order and signs freely, without fraud or duress.

3.

While this matter is under investigation, Licensee agrees to the following conditions:

3.1 Licensee voluntarily withdraws from the practice of medicine and his license is placed in Inactive status pending the completion of the Board's investigation into his ability to safely and competently practice medicine.

3.2 Licensee understands that violating any term of this Order will be grounds for disciplinary action under ORS 677.190(17).

///

///

1 4.

2 At the conclusion of the Board's investigation, Licensee's status will be reviewed in an
3 expeditious manner. Following that review, if the Board determines that Licensee shall not be
4 permitted to return to the practice of medicine, Licensee may request a hearing to contest that
5 decision.

6 5.

7 This Order is issued by the Board pursuant to ORS 677.265(1) and (2) for the purpose
8 of protecting the public, and making a complete investigation in order to fully inform itself with
9 respect to the performance or conduct of the Licensee and Licensee's ability to safely and
10 competently practice medicine. Pursuant to ORS 677.425, Board investigative materials are
11 confidential and shall not be subject to public disclosure. However, as a stipulation this Order is
12 a public document and is reportable to the National Practitioner Data Bank and the Federation of
13 State Medical Boards. This Order becomes effective the date it is signed by the Board's
14 Executive Director or Medical Director in accordance with OAR 847-001-0030.

15
16 IT IS SO STIPULATED THIS 30 day of July, 2025.

17 
18
19 PAUL DENNIS WACEK, PA

20 IT IS SO ORDERED THIS 4th day of August, 2025.

21 State of Oregon
22 OREGON MEDICAL BOARD

23 
24 JORDANA GAUMOND, MD
25 MEDICAL DIRECTOR
26
27

BEFORE THE
OREGON MEDICAL BOARD
STATE OF OREGON

In the Matter of)
)
HEATHER CALLEEN MERLO-) INTERIM STIPULATED ORDER
GRIFANTINI, MD)
LICENSE NO. MD153468)

1.

The Oregon Medical Board (Board) is the state agency responsible for licensing, regulating and disciplining certain healthcare providers, including physicians, in the State of Oregon. Heather Calleen Merlo-Grifantini, MD (Licensee) is a licensed physician in the State of Oregon.

2.

The Board received credible information regarding Licensee that resulted in the Board initiating an investigation. In order to address the Board's concerns while this matter is under investigation, Licensee and the Board agree to the entry of this Interim Stipulated Order, which is not an admission of any wrongdoing on the part of the Licensee. Licensee understands the terms of this Order and signs freely, without fraud or duress.

3.

While this matter is under investigation, Licensee agrees to the following conditions:

3.1 Licensee voluntarily withdraws from the practice of medicine and her license is placed in Inactive status pending the completion of the Board's investigation into her ability to safely and competently practice medicine.

3.2 Licensee understands that violating any term of this Order will be grounds for disciplinary action under ORS 677.190(17).

///

///

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27

4.

At the conclusion of the Board's investigation, Licensee's status will be reviewed in an expeditious manner. Following that review, if the Board determines that Licensee shall not be permitted to return to the practice of medicine, Licensee may request a hearing to contest that decision.

5.

This Order is issued by the Board pursuant to ORS 677.265(1) and (2) for the purpose of protecting the public, and making a complete investigation in order to fully inform itself with respect to the performance or conduct of the Licensee and Licensee's ability to safely and competently practice medicine. Pursuant to ORS 677.425, Board investigative materials are confidential and shall not be subject to public disclosure. However, as a stipulation this Order is a public document and is reportable to the National Practitioner Data Bank and the Federation of State Medical Boards. This Order becomes effective the date it is signed by the Board's Executive Director or Medical Director in accordance with OAR 847-001-0030.

IT IS SO STIPULATED THIS 24 day of Sept, 2025.


HEATHER CALLEEN MERLO-GRIFANTINI, MD

IT IS SO ORDERED THIS 24 day of September, 2025.

State of Oregon
OREGON MEDICAL BOARD


NICOLE KRISHNASWAMI, JD
EXECUTIVE DIRECTOR

BEFORE THE
OREGON MEDICAL BOARD
STATE OF OREGON

In the Matter of)
ZACHARY JAMES KNIGHT-KING, PA) ORDER OF LICENSE SUSPENSION
LICENSE NO. PA150255)
)

1.

The Oregon Medical Board (Board) is the state agency responsible for licensing, regulating and disciplining certain health care providers, including physician associates, in the State of Oregon. Zachary James Knight-King, PA (Licensee) is a licensed physician associate in the State of Oregon.

2.

Facts

2.1 At all relevant times, Licensee was licensed to practice medicine under ORS chapter 677. Licensee is an adult.

2.2 On January 26, 2024, Licensee entered into an Interim Stipulated Order to voluntarily withdraw from practice and place his license in Inactive status pending the completion of the Board's investigation into his ability to safely and competently practice medicine.

2.3 Effective on or around June 16, 2025, Licensee was incarcerated at the Coffee Creek Correctional Facility and was placed in the custody of the Multnomah County Sheriff. The Coffee Creek Correctional Facility is a penal institution.

3.

Law

ORS 677.225(1)(b) provides that a license issued under ORS chapter 677 is suspended automatically if the Licensee is an adult in custody in a penal institution. ORS 677.205(1)(c) provides additional authority for such a suspension.

1 4.

2 4.1 Licensee's license to practice medicine is hereby suspended, in accordance with
3 ORS 677.225(1)(b) and under the additional authority of ORS 677.205(1)(c) and OAR 847-001-
4 0035. This suspension will remain in effect until Licensee presents satisfactory evidence to the
5 Board that Licensee is no longer incarcerated, and the Board is satisfied with due regard to the
6 public interest that Licensee's privilege to practice medicine may be restored.

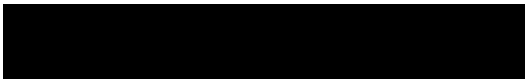
7 4.2 The January 26, 2024, Interim Stipulated Order terminates effective the date the
8 Executive Director signs this Order of License Suspension.

9 5.

10 This Order is a public record and is a disciplinary action that is reportable to the National
11 Practitioner Data Bank and the Federation of State Medical Boards. Pursuant to ORS 677.202,
12 Licensee is not entitled to a hearing on this automatic suspension.

13
14 IT IS SO ORDERED this 25th day of July, 2025.

15 OREGON MEDICAL BOARD
16 State of Oregon

17 
18 NICOLE KRISHNASWAMI, JD
19 EXECUTIVE DIRECTOR
20
21
22
23
24
25
26
27

**FULL BOARD
OCTOBER 2, 2025
VIDEOCONFERENCE**

Discussion Item

Member Assigned: Blasi

Subject: Annual Performance Progress Report

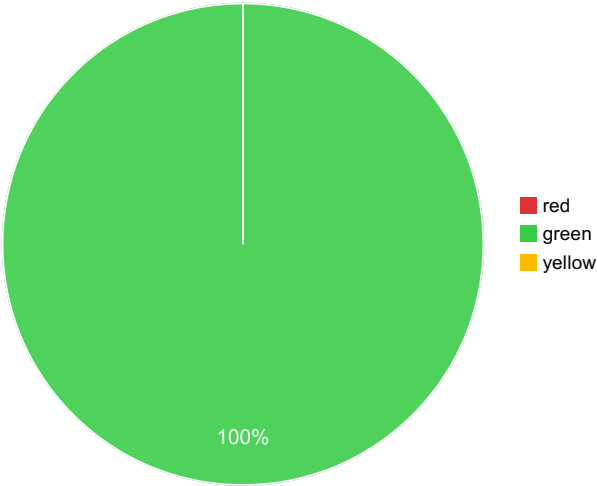
Oregon Medical Board

Annual Performance Progress Report

Reporting Year 2025

Published: 8/18/2025 11:26:26 AM

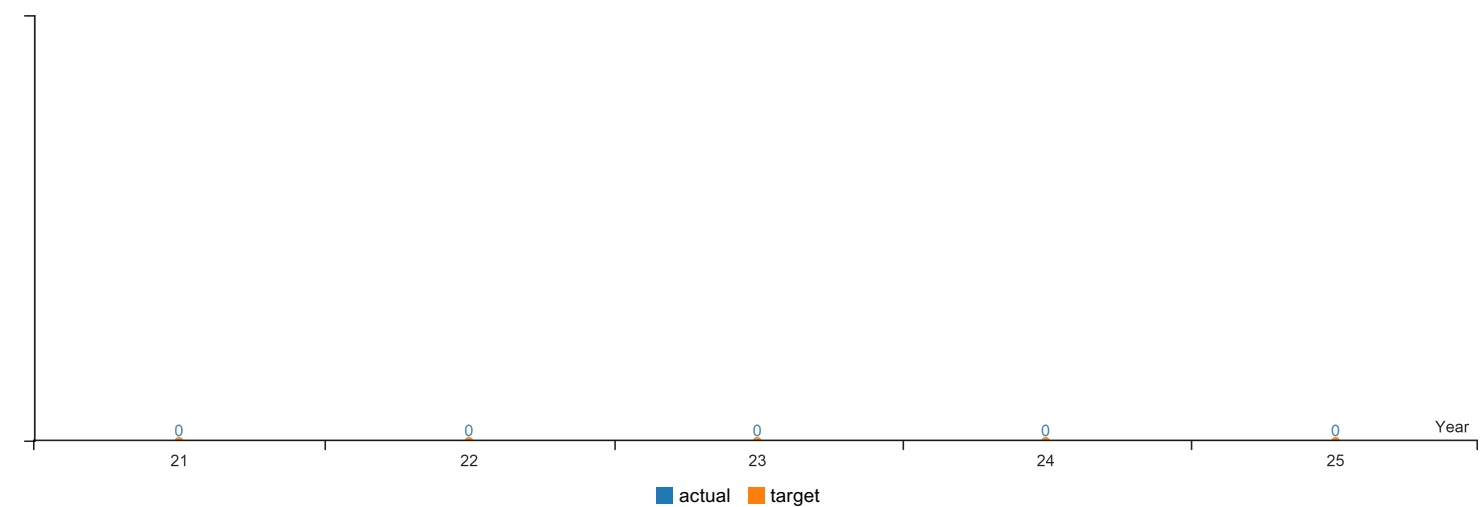
KPM #	Approved Key Performance Measures (KPMs)
1	LICENSE APPROPRIATELY - Number of Board-Issued license denials overturned upon appeal.
2	DISCIPLINE APPROPRIATELY - Number of disciplinary actions overturned on appeal.
4	MONITOR LICENSEES WITH BOARD ORDERS AND CORRECTIVE ACTION AGREEMENTS - Percentage of licensees with Board Orders or Corrective Action Agreements who have a new Notice of Proposed Disciplinary Action within 5 years.
6	RENEW LICENSES EFFICIENTLY - Average number of calendar days to process and mail a license renewal.
7	ASSESS CUSTOMER SATISFACTION WITH AGENCY SERVICES - Percent of customers rating satisfaction with the agency's customer service as "good" or "excellent" for: overall customer service, timeliness, accuracy, helpfulness, expertise, information availability.
8	BOARD BEST PRACTICES - Percent of total best practices met by the Board.
9	LICENSE EFFICIENTLY - Average number of calendar days from receipt of completed license application to issuance of license.



Performance Summary	Green	Yellow	Red
	= Target to -5%	= Target -5% to -15%	= Target > -15%
Summary Stats:	100%	0%	0%

KPM #1	LICENSE APPROPRIATELY - Number of Board-Issued license denials overturned upon appeal.
	Data Collection Period: Jul 01 - Jun 30

* Upward Trend = negative result



Report Year	2021	2022	2023	2024	2025
LICENSE APPROPRIATELY					
Actual	0	0	0	0	0
Target	0	0	0	0	0

How Are We Doing

This measure demonstrates that we are appropriately licensing. There have been no successful challenges to the Board's licensing decisions since the agency began collecting this data in 2002. For fiscal year 2025, the Board issued 2,635 full licenses. There were four Final Orders denying licensure during this fiscal year and no appeals.

Fiscal Year	2021	2022	2023	2024	2025
Licenses Issued	1,785	2,048	2,372	2,404	2,635
Final Orders Denying Licensure	0	0	1	1	4
Orders and Agreements Appealed	0	0	0	0	0
Orders and Agreements Upheld on appeal	1	0	0	0	0
Orders and Agreements Overturned on appeal	0	0	0	0	0
Appeals Pending at Close of Fiscal Year	0	0	0	0	0

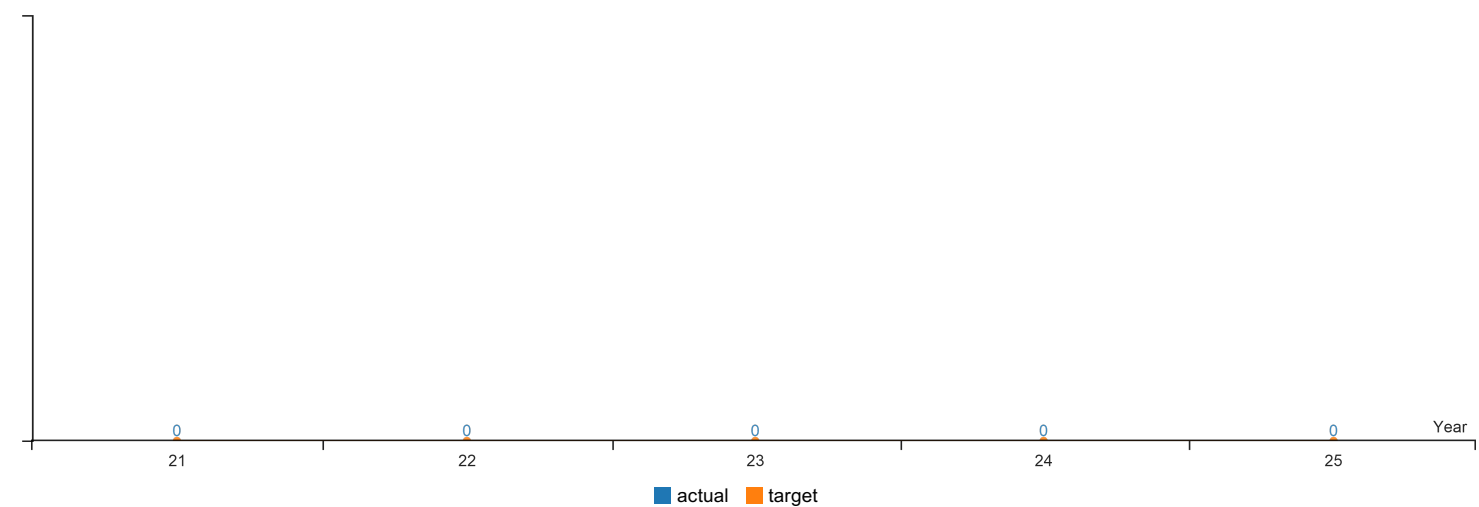
This measure is associated with our strategic plan goal of efficiently managing licensure.

Factors Affecting Results

The Board provides extensive due process to all applicants to ensure appropriate outcomes. The target is set at zero based on past history and the expectation that there will continue to be no successful appeals of our licensure decisions. The lower the results, the more successful we are at meeting this performance measure.

KPM #2	DISCIPLINE APPROPRIATELY - Number of disciplinary actions overturned on appeal.
	Data Collection Period: Jul 01 - Jun 30

* Upward Trend = negative result



Report Year	2021	2022	2023	2024	2025
DISCIPLINE APPROPRIATELY					
Actual	0	0	0	0	0
Target	0	0	0	0	0

How Are We Doing

This measure demonstrates the Board's disciplinary actions that are overturned on appeal, an indication of the appropriateness of the Board's decisions. Results for this measure include all public disciplinary orders that have been appealed. For fiscal year 2025, 53 orders and agreements were issued which were reportable to the National Practitioner Data Bank; none were appealed. The Board has no appeals pending at the end of fiscal year 2025, and the Board began this fiscal year with no pending appeals. The Board tailors disciplinary outcomes to the facts of each case.

Fiscal Year	2021	2022	2023	2024	2025
Investigations Closed	880	820	830	839	826
Orders and Agreements Issued	85	77	63	51	53
Orders and Agreements Appealed	1	2	0	0	0
Orders and Agreements Upheld on appeal	0	2	1	1	0
Orders and Agreements Overturned on appeal	0	0	0	0	0
Orders and Agreements Withdrawn or Closed without Opinion/Judgement	0	1	1	0	0
Appeals Pending at Close of Fiscal Year	4	3	1	0	0

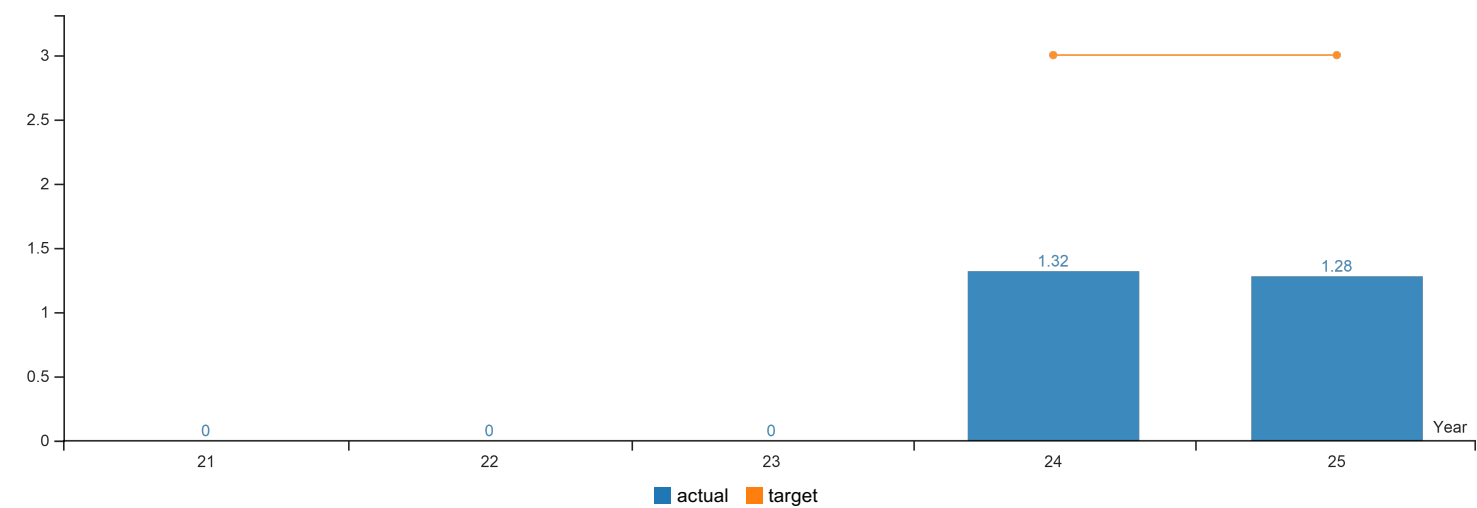
This measure is associated with our strategic plan goal of equitably reviewing complaints against licensees and applicants.

Factors Affecting Results

The Board provides extensive due process to all applicants and licensees to ensure appropriate outcomes. The target is set at zero based on past history and the expectation that there will continue to be no successful appeals of our disciplinary decisions. The lower the results, the more successful we are at meeting this performance measure.

KPM #4	MONITOR LICENSEES WITH BOARD ORDERS AND CORRECTIVE ACTION AGREEMENTS - Percentage of licensees with Board Orders or Corrective Action Agreements who have a new Notice of Proposed Disciplinary Action within 5 years.
	Data Collection Period: Jul 01 - Jun 30

* Upward Trend = negative result



Report Year	2021	2022	2023	2024	2025
MONITOR LICENSEES WITH BOARD ORDERS AND CORRECTIVE ACTION AGREEMENTS					
Actual				1.32%	1.28%
Target				3%	3%

How Are We Doing

This measure reflects how we are doing to ensure that our licensees are safe to practice medicine. Some licensees, due to the existence of an Order or Agreement issued by the Board, require some degree of monitoring by the Board's Compliance Officer. Monitoring is done through phone calls, emails, letters, meetings, and interviews by the agency Compliance Officer and Board members.

This measure is associated with our strategic plan goal of remediating licensees to safe and active practice.

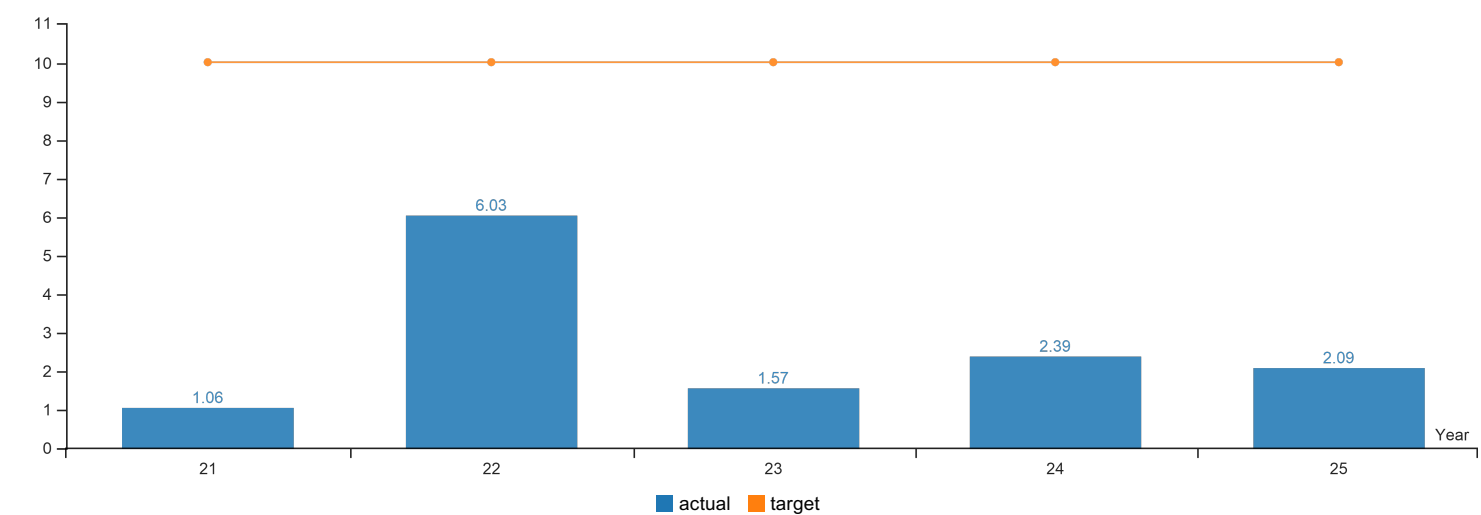
Factors Affecting Results

There are relatively few licensees with Board Orders or Corrective Action Agreements. Thus, results are significantly impacted by one or two cases. The lower the percentage, the more effective the Board is at remediating licensees and preventing recidivism.

For fiscal year 2023, this measure replaced a similar previous measure, changing the measurement period from three years to five years and changing the indicator from a mere complaint to a Notice of Proposed Disciplinary Action to better measure recidivism. A Notice of Proposed Disciplinary Action is a legal document issued by the Board after a complaint is investigated when the Board believes a violation of the Medical Practice Act has occurred. The need for this subsequent disciplinary action, even if unrelated to prior disciplinary action, is considered recidivism. Data is not available for fiscal years prior to 2024.

KPM #6	RENEW LICENSES EFFICIENTLY - Average number of calendar days to process and mail a license renewal.
	Data Collection Period: Jul 01 - Jun 30

* Upward Trend = negative result



Report Year	2021	2022	2023	2024	2025
Average number of calendar days to process and mail a license renewal					
Actual	1.06	6.03	1.57	2.39	2.09
Target	10	10	10	10	10

How Are We Doing

This measure demonstrates our efficiency in renewing health care professionals' licenses. We process renewal applications efficiently and consistently, while also ensuring public safety by thoroughly evaluating each application.

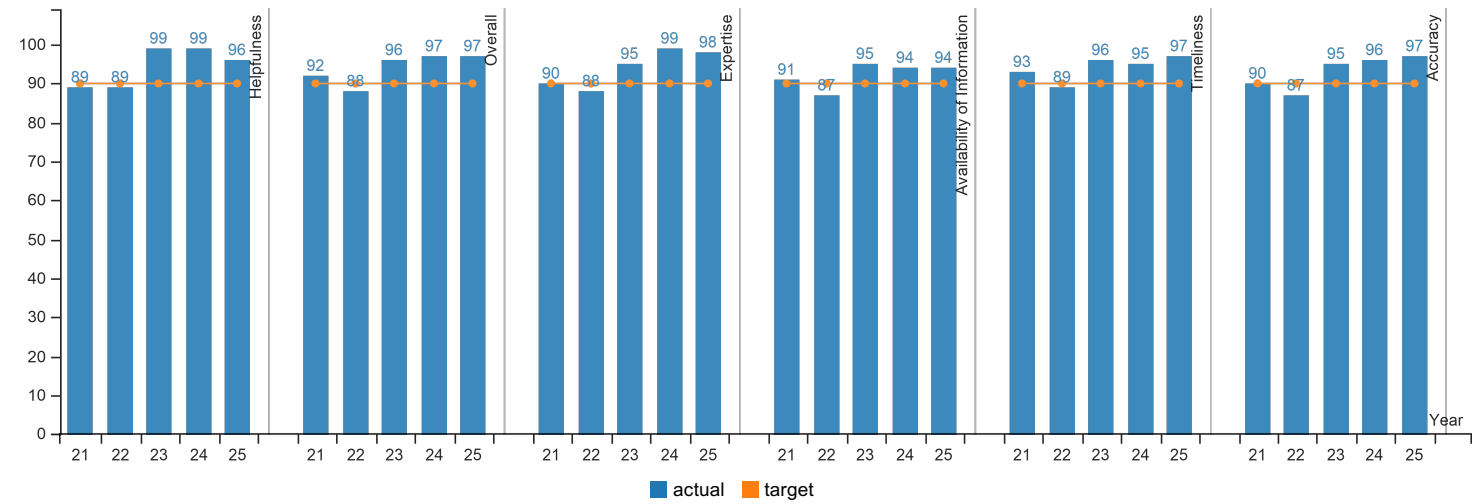
The data presented includes those renewals that are outliers, with problems or concerns that need to be reviewed by staff which can add significant time to the renewal process. The renewal of most physician, physician associate, podiatrist, and acupuncture licenses (approximately 966 individuals in fiscal year 2025) generally occurs biennially during even numbered fiscal years. This results in a 3-month period of high activity for all agency staff.

The Board has exceeded the target since 2008. This measure is associated with our strategic plan goal of efficiently managing licensure.

Factors Affecting Results

While operational efficiency is our goal, rushing licensure renewal--potentially compromising patient safety--is not. Preparing a thorough check of all information provided by renewing licensees is essential to ensuring the licensee meets state requirements and will continue to practice safely.

KPM #7	ASSESS CUSTOMER SATISFACTION WITH AGENCY SERVICES - Percent of customers rating satisfaction with the agency's customer service as "good" or "excellent" for: overall customer service, timeliness, accuracy, helpfulness, expertise, information availability.
	Data Collection Period: Jul 01 - Jun 30



Report Year	2021	2022	2023	2024	2025
Helpfulness					
Actual	89%	89%	99%	99%	96%
Target	90%	90%	90%	90%	90%
Overall					
Actual	92%	88%	96%	97%	97%
Target	90%	90%	90%	90%	90%
Expertise					
Actual	90%	88%	95%	99%	98%
Target	90%	90%	90%	90%	90%
Availability of Information					
Actual	91%	87%	95%	94%	94%
Target	90%	90%	90%	90%	90%
Timeliness					
Actual	93%	89%	96%	95%	97%
Target	90%	90%	90%	90%	90%
Accuracy					
Actual	90%	87%	95%	96%	97%
Target	90%	90%	90%	90%	90%

How Are We Doing

This measure demonstrates our applicants and licensees' level of satisfaction with the services we provide. We manage a continuous survey process that utilizes SurveyMonkey, an Internet survey tool. All survey data collected is 100% anonymous.

The agency's Management Council monitors the survey results on a continuous basis, and we use the feedback from our customers to improve our systems and processes. Our success is demonstrated by the consistently positive feedback received from our customers.

For fiscal year 2025 we had a population (surveys sent) of 5,097. We received 65 total responses, a 1% response rate.

Factors Affecting Results

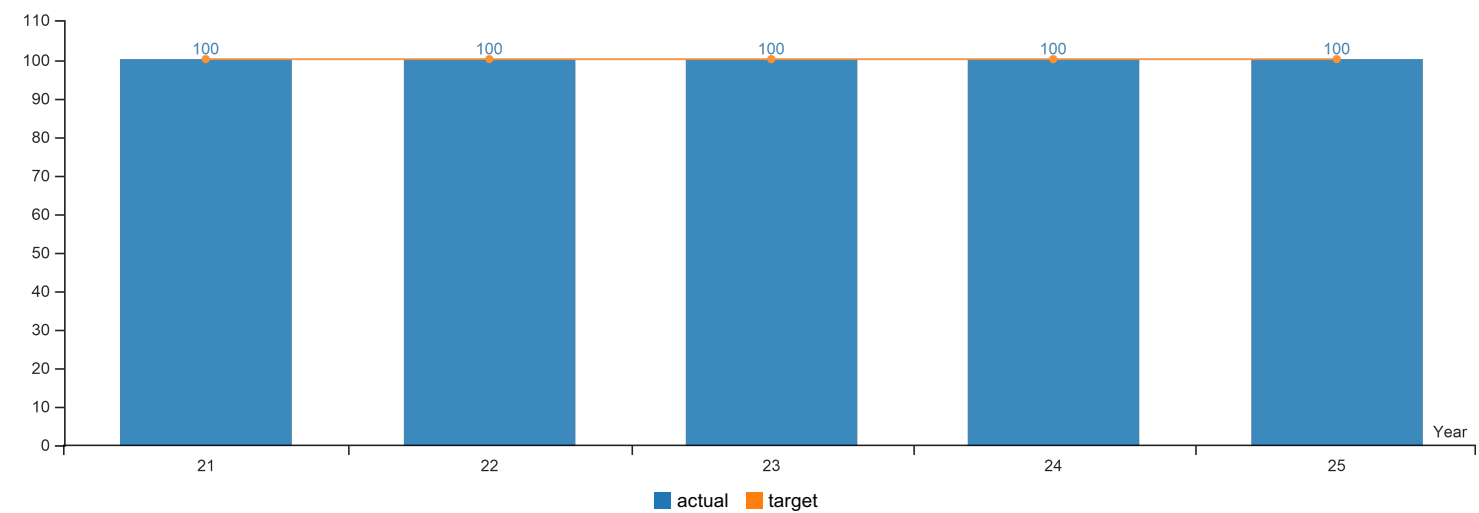
We provide a survey to each new licensee, each licensee who renewed their license and each licensee who reactivated their license. All other survey results are combined to reach an agency-wide result for reporting purposes. Equal weighting is given to each response. Results for each individual group are retained by the agency and used at a management and team level.

Based on legislative direction, the target was changed to 90% beginning in fiscal year 2020.

The higher the percentage, the higher our customers' satisfaction with our services.

KPM #8	BOARD BEST PRACTICES - Percent of total best practices met by the Board.
	Data Collection Period: Jul 01 - Jun 30

* Upward Trend = positive result



Report Year	2021	2022	2023	2024	2025
Percent of total best practices met by the Board					
Actual	100%	100%	100%	100%	100%
Target	100%	100%	100%	100%	100%

How Are We Doing

This measure demonstrates that we are meeting management best practices with respect to governance oversight by our Board. The criteria being evaluated includes Executive Director performance expectations and feedback, strategic management and policy development, and fiscal oversight and board management. The Oregon Medical Board engages in an ongoing strategic planning process that addresses several of the issues evaluated in this measure. Board members discuss oversight and governance activities at the Administrative Affairs Committee and Board meetings. The Board Chair is in constant communication with the agency Executive Director on management issues.

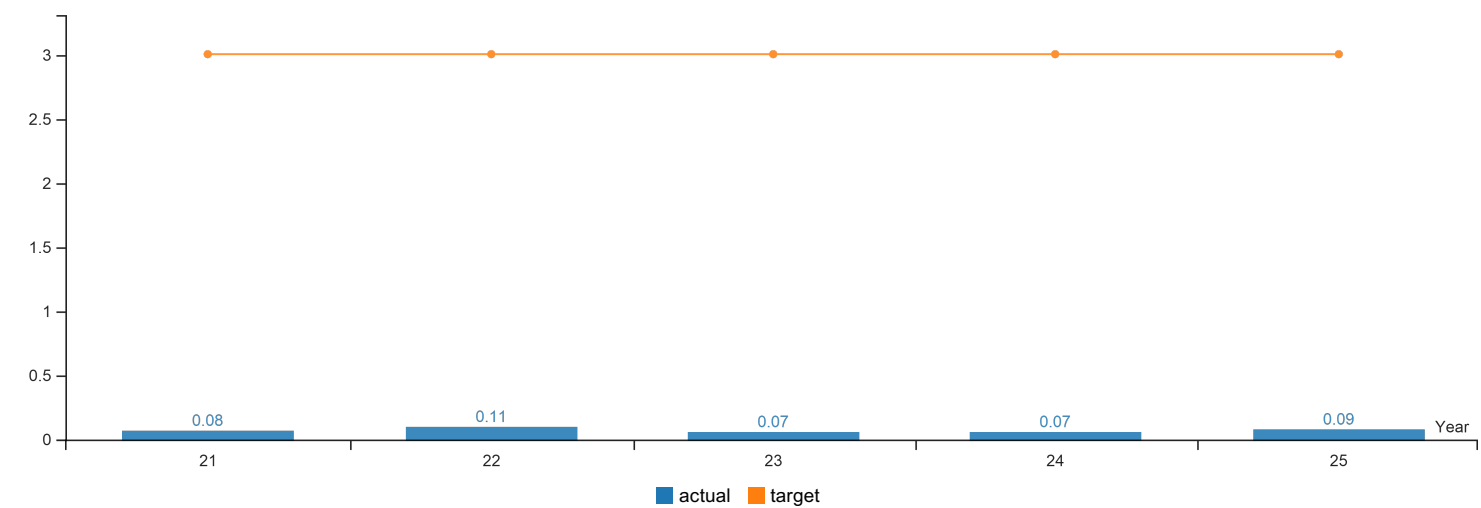
The Board has been able to meet the target since the measure was implemented in 2007.

Factors Affecting Results

For consistency with the other health regulatory boards, the target changed to 100% beginning in fiscal year 2018. However, it should be noted that if the Oregon Medical Board were to have a dissenting Board member, we would not meet this target. The higher the percentage, the better the Board is doing at fulfilling governance best practices.

KPM #9	LICENSE EFFICIENTLY - Average number of calendar days from receipt of completed license application to issuance of license.
	Data Collection Period: Jul 01 - Jun 30

* Upward Trend = negative result



Report Year	2021	2022	2023	2024	2025
Average number of days to process an application for medical licensure					
Actual	0.08	0.11	0.07	0.07	0.09
Target	3	3	3	3	3

How Are We Doing

This measure demonstrates our efficiency in licensing health care professionals and the customer service we provide to the citizens of Oregon. We process applications efficiently and consistently with public safety. We perform careful background checks on all applicants for licensure. The measure reflects the time to licensure within direct control of the agency - the number of days to license after the applicant has submitted all necessary documents. For fiscal year 2025 there were 2,635 full licenses granted.

The Board has been able to exceed the target since the measure was implemented in 2009. This measure is associated with our strategic plan goal of efficiently managing licensure and renewal of licensure.

Factors Affecting Results

While operating efficiency is our goal, rushing licensure for applicants, and possibly compromising patient safety, is not. Preparing a thorough check of all credentials provided by applicants is essential to making sure the applicant meets state requirements for providing medical care.

**FULL BOARD
OCTOBER 2, 2025
VIDEOCONFERENCE**

Discussion Item

Member Assigned: Blasi

Subject: Project Sprout Update



Oregon Medical Board

Core Business Suite Replacement Project

Project Sprout Status Report

As of August 18, 2025



Project High Level Status

In April, we engaged with EIS on the project restart and submitted our Business Case, Project Charter, and IT Investment form, Stage Gate 1 artifacts. These project initiation documents describe our high-level plan for an internally developed system. We expect to receive Stage Gate 1 endorsement by early September.

Statewide Quality Assurance (SWQA) has determined the project requires Independent Quality Management Services (IQMS), this will bring in an independent vendor to review and ensure risks are minimized for the project. We are working with SWQA, EIS, and the Department of Administrative Services Procurement Services (DASPS) division to contract for these services. We are expecting this to add significant costs to the project. We will have more information on the impacts once the RFQ is completed.

We requested the legislature grant additional 2025-27 budget limitation to fund Project Sprout. The legislature approved a limited duration Project Manager position to lead the project but provided no budget limitation given that the project has not yet received EIS Stage Gate approvals. Necessary project funding for 2025-27 will be requested during the February 2026 short legislative session.

Milestones & Accomplishments (May 12, 2025 through August 18, 2025):

- Submitted and refined Project Sprout Stage Gate 1 Artifacts in collaboration with EIS

Next Steps:

- Initiate Stage Gate 2 project planning activities
- Collaborate with SWQA, EIS, and DASPS on IQMS contract solicitation

Schedule Status:

- To be determined

Budget Status:

- To be determined

**FULL BOARD
OCTOBER 2, 2025
VIDEOCONFERENCE**

Discussion Item

Member Assigned: Blasi

Subject: 2025-27 Budget Update

Oregon Medical Board 2025-27 Legislatively Adopted Budget Expenditures Only

2023-25 Legislatively Approved Budget

Personal Services	\$11,739,429
Services, Supplies, and Capital Outlay	7,532,988
TOTAL 23-25 Legislatively Approved Budget	<u><u>\$19,272,417</u></u>

2025-27 Budget Process

23-25 Legislatively Approved Budget	\$19,272,417	
+ Personal Services Steps/COLA for 25-27	707,981	1
Subtotal: Base Budget	\$19,980,398	
+ Inflation/adjustments on Services & Supplies	105,012	2
SUBTOTAL: CURRENT SERVICE LEVEL	\$20,085,410	4.2% ³
+ Policy Option Packages		
Fee Adjustments	<i>Revenue Only</i>	
Budget Adjustments	\$0	
Business Efficiency and Succession Planning	\$342,741	
Health Professionals' Services Program	\$125,000	
Criminal Background Check Fees	\$110,000	
Merchant Services Fees	\$80,000	
SUBTOTAL: AGENCY REQUESTED BUDGET	\$20,743,151	7.6% ³
+/- Ways & Means Action: Project Sprout	\$0	4
+/- Legislation: SB 476, Internationally Trained Physicians	\$59,747	5
+/- Adjustments to DOJ and State Government charges	\$239,176	
2025-27 LEGISLATIVELY ADOPTED BUDGET	<u><u>\$20,967,892</u></u>	8.8% ³

1 DAS Prescribed adjustment for COLA and steps increases. This may or may not occur, depending on collective bargaining.

2 DAS Prescribed 4.2% increase on services and supplies and increases in State Government Service charges. Includes phase-out of 2023-25 CORE Project budget.

3 Percentage increase from 2023-25 LAB.

4 HB 5022, OMB Budget. Added 1 Limited Duration position without additional budget

5 SB 476 OMB budget increase

**FULL BOARD
OCTOBER 2, 2025
VIDEOCONFERENCE**

Discussion Item

Member Assigned: Blasi

Subject: Agency Head Transactions Report

MEMORANDUM

DATE: September 10, 2025

TO: Administrative Affairs Committee

FROM: Carol A. Brandt, Business Manager

SUBJECT: Review and Approval of Agency Head Transactions

Action Requested

I request that the Administrative Affairs Committee recommend Board approval of the attached financial transactions of the OMB Executive Director.

Background

In my role as the Board's chief financial officer, I routinely audit, review, and approve all appropriate financial and payroll transactions of the Board including those made by the Executive Director. I perform these duties with the purpose of ensuring that Board financial transactions conform to all applicable state statutes and guidelines. In addition to my review, state policy requires that agency head transactions be reviewed and approved annually by the agency's governing board, and that these post-transaction reviews and approvals be documented in the minutes of the board or commission meeting.

To conform to this policy, I am submitting the following summary level information for your review and approval regarding the Executive Director's transactions for Fiscal Year 2025 (July 1, 2024 through June 30, 2025):

Attachment #1: Leave Accrual Report for Executive Director

This report shows the Executive Director's accrual and usage of leave during Fiscal Year 2025. Prior to the transition to Workday Payroll, I reviewed the Director's timesheet monthly for compliance with all state and federal requirements. Since the transition to Workday Payroll in December 2022, this review is not available. The Workday Payroll system has been modified to route her use of leave to me for approval. Payroll transactions are reviewed by our payroll provider, DAS Shared Services. I recommend that you approve the end-of-year leave balance as shown in the last column of this report.

Attachment #2: Travel Expense Reimbursements and Bank (Credit) Card payments

This report summarizes all reimbursements made to the Executive Director and all credit card purchases made by the Director during Fiscal Year 2025. I reviewed and approved payment for these transactions after determining that sufficient documentation was submitted "to provide an audit trail" and that the purchases were made "in accordance with the prevailing state policies as listed." We maintain full documentation for these transactions according to the standards of the State Archives Division. I recommend that you review and approve these transactions.

Thank you for assisting me with this important task.

ANNUAL REPORT TO ADMINISTRATIVE AFFAIRS COMMITTEE

Leave Accrual/Use Report

Nicole Krishnaswami, Executive Director, Oregon Medical Board

July 1, 2024 – June 30, 2025

Accrual or Leave Type	Beginning Balance 7/01/24	Accrual Per Month	Earned/ Added	Used through 6/30/25	Ending Balance 6/30/25
Vacation	191.48	13.34	160.08	105.50	246.06
Sick Leave	690.13	8.00	96.00	27.25	758.88
Discretionary Leave	40.00		0.00	8.00	32.00
Personal Business	0.00		24.00	24.00	0.00
Special Day Leave	0.00		8.00	0.00	8.00

Note: Data for this report is taken from payroll transaction registers for the reporting period.

Travel Expense Reimbursements and Bank (Credit) Card Payments

For the period of July 1, 2024 to June 30, 2025

<i>Document</i>	<i>Paid To:</i>	<i>Date</i>	<i>Payment For:</i>	<i>Amount</i>
<i>VP019045</i>				
	Nicole Krishnaswami (Reimbursement)	8/7/2024	Travel Reimbursement-CMBLS Programs, \$795.47 reimbursed by AIM	\$1,114.93
<i>VP019075</i>				
	US Bank	9/25/2024	Travel Expense-Parking in Salem for Behavioral Health & Health Care Meeting	\$4.50
	US Bank	9/25/2024	Travel Expense-Parking in Salem for Agency Boards & Commissions Meeting	\$5.00
	US Bank	9/25/2024	Travel Expense-Power cord for Nicole's laptop	\$42.59
<i>VP019080</i>				
	Nicole Krishnaswami (Reimbursement)	10/1/2024	Travel Reimbursement-Various statewide meetings, Sept'24	\$124.62
<i>VP019103</i>				
	US Bank	10/25/2024	Professional Development-Annual Health Law Registration	\$100.00
<i>VP019125</i>				

<i>Document</i>	<i>Paid To:</i>	<i>Date</i>	<i>Payment For:</i>	<i>Amount</i>
	US Bank	11/25/2024	Travel Expense-Parking for meeting with Senator Bonham	\$4.00
<i>VP019147</i>				
	US Bank	12/26/2024	Professional Development-OSB Membership 2025	\$733.00
<i>VP019159</i>				
	Nicole Krishnaswami (Reimbursement)	1/16/2025	Travel Reimbursement-Alt. Licensing Models Mtg. \$1508.67 reimbursed by FSMB	\$1,005.54
<i>VP019165</i>				
	US Bank	1/27/2025	Professional Development-Airport parking f/ Alt. Models Licensing Conference	\$72.00
<i>VP019174</i>				
	Nicole Krishnaswami (Reimbursement)	2/11/2025	Travel Reimbursement-Various statewide meetings, Jan'25	\$65.10
<i>VP019182</i>				
	US Bank	2/25/2025	Travel Expense-Parking for HB 3060, SB 874 & SB 873 hearings	\$4.50
	US Bank	2/25/2025	Travel Expense-Parking for HB 3043 & HB 3060 hearings	\$6.35
	US Bank	2/25/2025	Travel Expense-Parking for senate confirmation hearing	\$4.00

<i>Document</i>	<i>Paid To:</i>	<i>Date</i>	<i>Payment For:</i>	<i>Amount</i>
	US Bank	2/25/2025	Travel Expense-Parking for meeting with legislators in Salem	\$10.00
<i>VP019190</i>				
	Nicole Krishnaswami (Reimbursement)	3/4/2025	Travel Reimbursement-Various statewide meetings, Feb'25	\$254.20
<i>VP019210</i>				
	US Bank	3/25/2025	Travel Expense-Parking for SB 476 public hearing	\$5.00
	US Bank	3/25/2025	Travel Expense-Parking for OMB budget hearing	\$4.00
<i>VP019216</i>				
	Nicole Krishnaswami (Reimbursement)	4/4/2025	Travel Expense-Parking for Agency Boards & Commissions Network Meeting	\$65.10
<i>VP019245</i>				
	US Bank	4/25/2025	Professional Develop.-Health Law Section Registration	\$25.00
	US Bank	4/25/2025	Board Expense-Printed materials for FSMB meeting in Seattle	\$29.33
	US Bank	4/25/2025	Board Expense-Oregon Medical 2025 FSMB poster printed	\$106.98
<i>VP019256</i>				

<i>Document</i>	<i>Paid To:</i>	<i>Date</i>	<i>Payment For:</i>	<i>Amount</i>
	Nicole Krishnaswami (Reimbursement)	5/14/2025	Travel Reimbursement-AIM & FSMB Meetings, \$1509.14 reimbursed by AIM & FSMB	\$1,610.19

VP019275

Nicole Krishnaswami (Reimbursement)	6/3/2025	Travel Reimbursement-HB 5022 work session	\$65.10

VP019277

US Bank	5/26/2025	Travel Expense-Parking for work session HB 5022	\$6.00
US Bank	5/26/2025	Professional Development-Seeking Solution to Oregon's Primary Care Webinar	\$15.00
US Bank	5/26/2025	Professional Development-IAMRA Internat'l Conference on Medical Regulation	\$1,631.53

VP019290

Nicole Krishnaswami (Reimbursement)	6/11/2025	Travel Reimbursement-World Federation for Medical Education Conferences	\$1,789.71

FULL BOARD
OCTOBER 2, 2025
VIDEOCONFERENCE

Public Session

Rule Review

First Review: Five-Needle Protocol

AC ACTION: The Committee moved to file a notice of proposed rulemaking.

OREGON ADMINISTRATIVE RULES

CHAPTER 847, DIVISION 071 – OREGON MEDICAL BOARD

First Review – October 2025

The Oregon Legislature passed House Bill 2143 (2025) and Governor Kotek signed the bill into law. This legislation allows individuals with specific training and registration to provide five-needle protocol (5NP) treatments beginning March 1, 2026, without additional licensure.

The law directs the Oregon Medical Board to establish rules for training qualifications and safety standards. The OMB's role is to implement the law that has already been enacted. The proposed rulemaking establishes the qualifications for registration of 5NP technicians and creates sanitation and best practice standards for 5NP treatments.

In August and September 2025, the OMB convened a Workgroup of acupuncturists, physicians, and community members to provide recommendations on the draft rules. The Board's Acupuncture Advisory Committee reviewed this draft during a special meeting held September 12, 2025. Their meeting minutes are attached along with public comments received during their review.

During the Workgroup and Acupuncture Advisory Committee meetings, there were discussions and comments provided related to requiring supervision of 5NP technicians, ranging from direct supervision to indirect supervision, and ranging from supervision by a physician or acupuncturist to supervision by other licensed health care providers. Workgroup and Committee members who supported a supervision requirement expressed patient safety concerns related to 5NP Technicians working in isolation. Workgroup and Committee members who opposed adding a supervision requirement highlighted the intent of HB 2143 to allow low-barrier access to 5NP treatments and the lack of evidence supporting public safety concerns. OMB Staff noted that under ORS 183.400 an agency can only write rules pursuant to constitutional authority or statutory authority granted through enabling legislation. Agencies cannot exceed the authority granted by the legislature. The absence of statutory language does not create implied authority for agencies to write rules in that area. HB 2143 does not impose supervision requirements or authorize the OMB to write rules requiring supervision.

[The following language is new. For readability, it is not bolded/underlined.]

Division 71: Five-Needle Protocol

847-071-0000

Purpose Statement

Five-needle protocol (5NP) represents a unique fusion of ancient Eastern healing practices with modern healing and social justice movements. In Oregon, 5NP is a standardized, supportive treatment for individuals experiencing substance use disorders, mental health conditions, and trauma. The five points are the shen men, sympathetic, liver, kidney and lung points on the human

outer ear. The Oregon Medical Board is responsible for establishing training and registration requirements and regulating the practice of 5NP technicians in order to expand access to safe, standardized, low-barrier treatment in a manner that protects individuals in Oregon accessing 5NP treatments.

847-071-0005

Definitions

As used in division 71 rules regulating five-needle protocol:

- (1) “Acupuncture” has the meaning given in ORS 677.757.
- (2) “Board” means the Oregon Medical Board.
- (3) “Five-needle protocol” or “5NP” has the meaning given in Oregon Laws 2025, chapter 296, section 2, the standardized five-needle treatment protocol in which five points on the human outer ear are stimulated with sterile, single-use disposable needles, ear seeds or ear beads for the purpose of achieving temporary relief from the symptoms of substance use disorder, mental health conditions or trauma. The five points are the shen men, sympathetic, liver, kidney and lung points.
- (4) “5NP technician” means an individual registered by the Oregon Medical Board to provide five-needle protocol treatments in Oregon.

Statutory/Other Authority: OL 2025, chapter 296, section 2 (HB 2143), ORS 677.265

Statutes/Other Implemented: OL 2025, chapter 296, section 2 (HB 2143)

847-071-0007

Five-Needle Protocol Registration Required

- (1) Except as provided in sections (2) and (3) of this rule, no person may provide five-needle protocol (5NP) treatment without first obtaining a registration from the Oregon Medical Board.
- (2) An acupuncturist licensed under ORS 677.757 to 677.770 may provide 5NP treatment without additional 5NP registration.
- (3) A physician licensed to practice medicine as a medical doctor or doctor of osteopathic medicine pursuant to ORS Chapter 677 may provide 5NP treatment without additional 5NP registration.

Statutory/Other Authority: OL 2025, chapter 296, section 2 (HB 2143), ORS 677.265

Statutes/Other Implemented: OL 2025, chapter 296, section 2 (HB 2143)

847-071-0020

Qualifications

(1) An applicant for registration as a five-needle protocol (5NP) technician must:

(a) Be at least 18 years of age;

(b) Have successfully completed a training program as described in OAR 847-071-0025. If the program was completed more than ten years before the date of application the applicant must demonstrate current competency through relevant courses or 5NP treatments; and

(c) Have good moral character as those traits would relate to the applicant's ability to provide 5NP treatments. Substance use disorder in remission, mental health conditions, or other lived experiences alone are not a reflection of current moral character.

(2) Criminal history is not an automatic disqualification for registration. The Board evaluates each applicant's background and experience and will consider additional information provided by the applicant.

(3) No applicant is entitled to registration who:

(a) Has had a registration, license, or certificate in a health-related field revoked or suspended unless the registration, license, or certificate has been restored or reinstated and the applicant is in good standing in the state which previously revoked the registration, license, or certificate;

(b) Has been refused a registration, license, or certificate in a health-related field on any grounds other than failure of a licensure examination; or

(c) Has been guilty of conduct similar to that which would be prohibited by or to which ORS 677.190 would apply.

Statutory/Other Authority: OL 2025, chapter 296, section 2 (HB 2143), ORS 677.265

Statutes/Other Implemented: OL 2025, chapter 296, section 2 (HB 2143)

847-071-0025

Five-Needle Protocol Training

(1) Before training five-needle protocol (5NP) technicians in Oregon, a 5NP trainer must:

(a) Request board approval by providing required documentation demonstrating qualifications under this section, and

(b) Meet one of the following requirements:

(A) Be an actively licensed Oregon acupuncturist or a physician licensed under ORS 677.100 to 677.133 who is in good standing with the Oregon Medical Board and has been practicing auricular acupuncture for a period of at least two years; or

(B) Hold active 5NP technician registration issued by the Oregon Medical Board for a minimum of two years and co-teach a minimum of two 5NP training programs described in section (2) of the rule. The 5NP trainer that co-taught must provide the Oregon Medical Board a letter of recommendation and evaluation of the individual seeking approval as a 5NP trainer; or

(C) Be an active National Acupuncture Detoxification Association (NADA) Registered Trainer or People's Organization of Community Acupuncture (POCA) Auricular Acu-Technician (AAT) Trainer.

(2) The 5NP training program must include at least 30 hours of didactic and 40 ears needled during supervised clinical training, mechanisms to monitor a participant's engagement, and contain the following elements:

(a) Sanitation and hygiene techniques,

(b) Infection control precaution procedures,

(c) Consent documentation and the individual's rights,

(d) Ear needling and point location,

(e) Plans to address potential risks, side effects, and complications,

(f) Collaboration with other 5NP technicians, health care providers, and community resources,

(g) Trauma informed care,

(h) Origins of 5NP,

(i) Maintaining professional boundaries, and

(j) Reporting requirements.

(3) Training programs completed prior to the first adoption of this rule may be substantially similar to the requirements described in section (2) of this rule.

(4) A “5NP student” is an individual enrolled in a 5NP training program described in section (2) of this rule. This chapter does not prohibit a 5NP student from providing 5NP treatments rendered in the course of the training program.

Statutory/Other Authority: OL 2025, chapter 296, section 2 (HB 2143), ORS 677.265

Statutes/Other Implemented: OL 2025, chapter 296, section 2 (HB 2143)

847-071-0030

Application

(1) An application for registration as a five-needle protocol (5NP) technician may be accessed on the Board’s website.

(2) When applying for registration, the applicant must submit to the Board:

(a) A complete application provided by the Board,

(b) Registration and criminal records check fees as outlined in OAR 847-005-0005,

(c) National fingerprint-based background check as provided in OAR 847-008-0068, and

(d) The following documentation:

(A) Legal Name and Age: A copy of a birth certificate, state issued identification card, or other documentation as approved by the Board,

(B) Five-Needle Protocol Training: A copy of a certificate showing completion of a training program as described in OAR 847-071-0025 and if applicable documentation to demonstrate current competency as described in OAR 847-071-0020(1)(b),

(C) Photograph: A close-up, passport-quality photograph, front view, head and shoulders (not profile), with features distinct, taken within 90 days preceding the filing of the application, and

(D) Verification of other Health-Related Registration, License, or Certificate: If requested by the Board, verification from all states or territories in which the applicant currently or previously held a health-related license, registration, or certification to practice and evidence that the applicant is in good standing and not subject to any disciplinary action or pending investigations in that state or territory.

(3) An applicant may submit additional information on their background and experience for consideration.

(4) Every applicant must complete an application and document evidence of qualifications listed in OAR 847-071-0020 to the satisfaction of the Board before an applicant may be considered eligible for registration.

(5) The Board may query the National Practitioner Data Bank (NPDB) system during the application process.

(6) Omissions or providing false, misleading, incomplete, or deceptive statements or information on any Board application is grounds for denial of registration or disciplinary action by the Board.

(7) An application submitted with fees to the Board that is not complete within 90 days from application submission will expire.

(8) 5NP fees are not refundable and may not be credited toward other Board fees.

(9) An applicant whose application has been expired, withdrawn, or denied must submit a new application, documentation, and fees. While a new application and documentation is required, the Board may still consider information provided in previous applications.

Statutory/Other Authority: OL 2025, chapter 296, section 2 (HB 2143), ORS 677.265

Statutes/Other Implemented: OL 2025, chapter 296, section 2 (HB 2143)

847-071-0035

Registration

(1) Upon Board approval of an application, the Board will issue a registration and post the five-needle protocol (5NP) technician's name, registration, and other applicable information on the Board's website.

(2) A 5NP technician must hold an active registration to provide 5NP treatments.

(3) Registration expires December 31 of odd-numbered years and may be renewed biennially by:

- (a) Submitting a Board-required renewal application;
 - (b) Paying the registration fee outlined in OAR 847-005-0005;
 - (c) Completing at least one hour of courses per registration period related to 5NP treatment or pain management; and
 - (d) Completing at least one hour per year of cultural competency courses or experiences that apply linguistic skills, use cultural information for therapeutic relationships, or elicit understanding and apply cultural and ethnic data in the process of clinical care, as provided in OAR 950-040-0020 or approved by the Oregon Health Authority under ORS 413.450.
- (4) Upon failure to renew under section (3) of this rule, the registration will lapse.
- (a) A 5NP technician may not provide treatments under a lapsed registration.
 - (b) Lapse of a registration is not discipline.
 - (c) A lapsed registration must be renewed within 90 days, or the registration will expire.
- (5) A 5NP technician must keep a current mailing address on file with the Board.
- (6) A 5NP technician who voluntarily chooses to not provide 5NP treatments in Oregon must be listed as expired.
- (7) A 5NP technician with an expired registration must reapply by submitting a new application, documentation, and fees as outlined in OAR 847-005-0005.
- (8) Failure to comply with laws and rules related to 5NP technicians may result in loss of registration.

Statutory/Other Authority: OL 2025, chapter 296, section 2 (HB 2143), ORS 677.265, ORS 676.850

Statutes/Other Implemented: OL 2025, chapter 296, section 2 (HB 2143), ORS 676.850, ORS 413.450

847-071-0040

Five-Needle Protocol Regulations

(1) Five-needle protocol (5NP) treatment must be practiced in accordance with Board rules and Oregon Laws 2025, chapter 296, section 2, including only:

(a) To provide temporary relief from the symptoms of substance use disorder, mental health conditions, or trauma; and

(b) Utilizing five ear points: shen men, sympathetic, liver, kidney, and lung points.

(2) A 5NP technician may not use the title “acupuncturist” or advertise or hold themselves out as being an acupuncturist or otherwise indicate they are authorized to practice acupuncture as defined in ORS 677.757.

(3) A 5NP technician must obtain written consent from the individual or the individual’s representative prior to providing treatment by:

(a) Clearly explaining the 5NP treatment, including needle placement, duration, and expected sensations;

(b) Discussing potential risks and realistic treatment outcomes;

(c) Respecting the individual’s right to decline treatment or withdraw consent at any time; and

(d) Having the individual self-identify the reason(s) for the 5NP treatment and date of treatment.

(4) Written consent for a 5NP treatment must be retained for at least three years from date of treatment and provided to the individual or the individual’s representative upon their request.

(5) For the individual and 5NP technician safety, a 5NP technician must:

(a) Use only sterile, single-use disposable needles, ear seeds, or ear beads;

(b) Adhere to sanitation and hygiene protocols;

(c) Meet community standards of care; and

(d) Establish clear procedures for handling complications or adverse reactions.

(6) A 5NP technician must set and maintain professional boundaries with all individuals receiving 5NP treatments and protect the individuals' privacy and dignity.

Statutory/Other Authority: OL 2025, chapter 296, section 2 (HB 2143), ORS 677.265,

Statutes/Other Implemented: OL 2025, chapter 296, section 2 (HB 2143), ORS 192.556

847-071-0050

Disciplinary Proceedings

(1) The Board may suspend or revoke the registration of a five-needle protocol (5NP) technician if the Board finds that the technician:

(a) Represented themselves or allowed another person to represent them as a physician, acupuncturist, or other health care provider, unless the 5NP technician holds the appropriate license.

(b) Performed any act other than 5NP which constitutes the practice of acupuncture in violation of ORS 677.759 or Oregon Laws 2025, chapter 296.

(c) Engaged in conduct constituting gross or repeated negligence in providing 5NP treatments.

(d) Is incompetent to provide 5NP treatments.

(e) Violated any of the provisions of ORS 677.190 or OAR 847-071-0040.

(2) Any Board investigation or disciplinary proceeding must be held in accordance with ORS Chapter 183, ORS 676.150 to 676.180, and ORS 677.184 to 677.228.

Statutory/Other Authority: OL 2025, chapter 296, section 2 (HB 2143), ORS 677.265

Statutes/Other Implemented: OL 2025, chapter 296, section 2 (HB 2143)

OREGON ADMINISTRATIVE RULES

CHAPTER 847, DIVISION 005 – OREGON MEDICAL BOARD

First Review – October 2025

[HB 2143 \(2025\)](#) authorizes the Oregon Medical Board to establish registration and renewal fees for five-needle protocol (5NP) technicians. The proposed rulemaking sets fees at \$100 for initial registration and \$50 annually (\$100 biennially) for renewal starting March 1, 2026. The Board determined and provided the fee amounts during the legislative process based on estimated costs to implement HB 2143.

Additionally, the Board will apply its existing Criminal Records Check Fee to 5NP technicians during the initial application process and as needed for renewals or investigations, as permitted under HB 2143.

847-005-0005 Licensure Fees

(1) Doctor of Medicine (MD) and Doctor of Osteopathic Medicine (DO) Licensing Fees:

(a) Initial License Application — \$375.

(b) Registration: Active, Administrative Medicine, Inactive, Locum Tenens, Military/Public Health, Telemedicine, Telemonitoring and Teleradiology — \$314/year. Per ORS 677.290(3), fee includes \$10/year for the Oregon Health and Science University Library.

(c) Registration: Emeritus — \$50/year.

(d) Limited License, SPEX/COMVEX, Visiting Professor, Fellow, Medical Faculty, Postgraduate Application and Registration — \$185.

(2) Acupuncture Licensing Fees:

(a) Initial License Application — \$245.

(b) Registration: Active, Inactive, Locum Tenens and Military/Public Health — \$201/year.

(c) Registration: Emeritus — \$50/year.

(d) Limited License, Visiting Professor, Pending Examination Application and Registration — \$75.

(3) Physician Associate Licensing Fees:

(a) Initial License Application — \$245.

(b) Registration: Active, Inactive, Locum Tenens, Military/Public Health, and Telemedicine — \$239/year.

(c) Registration: Emeritus — \$50/year.

(d) Limited License, Pending Examination Application and Registration — \$75.

(4) Doctor of Podiatric Medicine Licensing Fees:

(a) Initial Application — \$340.

(b) Registration: Active, Administrative Medicine, Inactive, Locum Tenens, Military/Public Health, Telemedicine and Telemonitoring — \$304/year.

(c) Registration: Emeritus — \$50/year.

(d) Limited License, Postgraduate Application and Registration — \$185.

(5) Other Application or Licensing Fees:

(a) Reactivation Application Fee — \$50.

(b) Electronic Prescription Drug Monitoring Program — \$35/year. Per ORS 431A.850-431A.895, fee is assessed to licensees authorized to prescribe or dispense controlled substances in Oregon for the purpose of creating and maintaining the Prescription Drug Monitoring Program administered by the Oregon Health Authority.

(c) Workforce Data Fee — \$2/year. Per ORS 676.410, fee is assessed for the purpose of creating and maintaining a healthcare workforce data base administered by the Oregon Health Authority.

(d) Criminal Records Check Fee — \$52. Per ORS 181A.195(9)(e), fee is the actual cost of acquiring and furnishing criminal offender information.

(e) Health Professionals' Services Program Fee — \$25/year. Fee is assessed to sustain the Health Professionals' Services Program.

(6) Delinquent Registration Renewals:

(a) Delinquent MD/DO Registration Renewal — \$195.

(b) Delinquent Acupuncture Registration Renewal — \$80.

(c) Delinquent Physician Associate Registration Renewal — \$80.

(d) Delinquent Doctor of Podiatric Medicine Registration Renewal — \$195.

(7) All Board fees and fines are non-refundable and non-transferable.

(8) Registration fees in this rule and other fees described in section (5)(b), (5)(c), and (5)(e) for Active, Administrative Medicine, Inactive, Locum Tenens, Military/Public Health, Telemedicine, Telemonitoring and Teleradiology statuses are collected biennially except where noted in OAR chapter 847.

(9) Five-needle protocol (SNP) Technician Fees:

(a) Application & Registration — \$100.

(b) Renewal Registration: Active — \$50/year.

(c) SNP applicants and technicians are exempt from fees outlined in other sections of this rule, except for the Criminal Records Check Fee in section (5)(d).

Statutory/Other Authority: ORS 677.265, 181A.195, 431A.880 & 676.410

Statutes/Other Implemented: ORS 677.265, 181A.195, 431A.880, 676.410 & 677.290, [Oregon Laws 2025, chapter 296, section 2](#)

Enrolled House Bill 2143

Sponsored by Representative NOSSE; Representative NELSON (Presession filed.)

CHAPTER

AN ACT

Relating to five-needle protocol; creating new provisions; amending ORS 677.761; and prescribing an effective date.

Be It Enacted by the People of the State of Oregon:

SECTION 1. Section 2 of this 2025 Act is added to and made a part of ORS chapter 677.

SECTION 2. (1) As used in this section, “five-needle protocol” means the standardized five-needle treatment protocol in which five points on the human outer ear are stimulated with sterile, single-use disposable needles, ear seeds or ear beads for the purpose of achieving temporary relief from the symptoms of substance use disorder, mental health conditions or trauma. The five points are the shen men, sympathetic, liver, kidney and lung points.

(2) The Oregon Medical Board may establish by rule a registry of individuals who are qualified to provide the five-needle protocol. The board may adopt rules to establish:

(a) Qualifications for registration, including but not limited to education and training requirements;

(b) An application and registration fee;

(c) The form and manner of application;

(d) Sanitation and best practice standards;

(e) A schedule of violations and disciplinary actions; and

(f) Any other requirements or standards the board determines necessary.

(3) The board may issue a five-needle protocol registration to an applicant who meets the requirements established by the board by rule under this section.

(4) The board shall adopt rules regarding the renewal of a registration issued under this section.

(5) The board may, for the purpose of requesting a state or nationwide criminal records check under ORS 181A.195, require the fingerprints of an individual who is applying for or renewing a registration under this section or an individual who is under investigation by the board for a reason related to registration under this section.

(6)(a) Except as provided in paragraph (b) of this subsection, only an individual registered under this section may provide the five-needle protocol and shall use only objectively safe practices and materials, as further described by the board by rule.

(b) An acupuncturist licensed under ORS 677.757 to 677.770 may provide the five-needle protocol without registration under this section.

(7) Subject to ORS 677.759, unless an individual is an acupuncturist licensed under ORS 677.757 to 677.770, the individual may not hold themselves out as being an acupuncturist or

otherwise indicate that the individual is authorized to practice acupuncture, as defined in ORS 677.757.

(8)(a) Subject to paragraph (b) of this subsection, a proceeding for disciplinary action of an individual registered under this section must be substantially in accord with the following procedure:

(A) An individual, including a member of the board, may file a complaint to the board and the board shall verify the complaint; and

(B) A hearing must be given to the individual accused in the complaint in accordance with ORS chapter 183 as a contested case.

(b) Paragraph (a)(B) of this subsection does not apply if the individual accused in the complaint admits to the facts of a complaint described in paragraph (a) of this subsection so long as the complaint alleges facts that establish the individual is in violation of one or more grounds for suspension or revocation of a registration, as determined by the board by rule.

SECTION 3. ORS 677.761 is amended to read:

677.761. Nothing in ORS 677.757 to 677.770 is intended to:

(1) Prevent, limit or interfere with an individual licensed or certified by the Oregon Medical Board from practicing health care other than acupuncture within the scope of the license or certification of the individual.

(2) Limit any other licensed or certified health care practitioner from practicing acupuncture or other therapy within the scope of the license or certification of the individual.

(3) Limit the activities of any person who engages in the business of providing Oriental massage, exercise and related therapeutic methods or who provides substances listed in an Oriental pharmacopoeia, or vitamins or minerals or dietary advice, so long as the activities of the person are not otherwise prohibited by law.

(4) Limit the ability of practitioners from outside Oregon to demonstrate the practice of acupuncture as part of a recognized and limited duration educational program, lecture or event within this state under rules adopted by the board.

(5) Prevent, limit or interfere with the provision of the five-needle protocol, as defined in section 2 of this 2025 Act, in compliance with the requirements of section 2 of this 2025 Act.

SECTION 4. (1) Section 2 of this 2025 Act and the amendments to ORS 677.761 by section 3 of this 2025 Act become operative on March 1, 2026.

(2) The Oregon Medical Board may take any action before the operative date specified in subsection (1) of this section that is necessary for the board to exercise, on and after the operative date specified in subsection (1) of this section, all of the duties, functions and powers conferred on the board by section 2 of this 2025 Act and the amendments to ORS 677.761 by section 3 of this 2025 Act.

SECTION 5. This 2025 Act takes effect on the 91st day after the date on which the 2025 regular session of the Eighty-third Legislative Assembly adjourns sine die.

What to Expect, 5NP Treatment Description

In Oregon, 5NP is a standardized, supportive treatment for individuals who self-identify as experiencing substance use disorders, mental health conditions, and trauma. Treatments are provided by state-registered 5NP technicians and contain:

1. **5NP Technician Preparation:** verifying an individual's consent form, washing hands with soap or sanitizer.
2. **Your Preparation:** sit comfortably, no extensive intake or discussion, ear(s) may be prepared by wiping with alcohol wipe.
3. **Needles/Seeds/Beads:** thin single-use disposable needles, ear seeds, or ear beads are placed on the five ear points: shen men, sympathetic, liver, kidney, and lung points. You may feel a mild pinch or tingling when the needles are inserted or beads and seeds placed, which usually fades quickly. Ear seeds and ear beads should be used with caution for individuals with diabetes.
4. **Relax:** sit quietly for 30-45 minutes, no talking or interaction required. It is normal to experience warmth, deep relaxation, or even fall asleep. Do not get up while needles are in place. If you need to move, alert the 5NP technician. If a needle falls out, let the 5NP technician know, do not pick it up. Never touch another person's fallen needle.
5. **Treatment Conclusion:** the 5NP technician may remove or direct you to remove the needles. Removed needles must be placed in a sharps container. If you remove your own needles, wash hands with soap or sanitizer. Ear beads or ear seeds are not worn for more than 3 days, and you will be given instructions on their care and duration of wear. If they cause discomfort, remove them immediately.
6. **Post-Treatment:** no extensive debriefing required, though brief check-ins may occur. Sharps container will be properly disposed of by 5NP technician.

Possible Side Effects/Healing Reaction

I understand that 5NP may result in certain side effects or healing reactions, including but not limited to local bruising, slight bleeding, fainting, temporary pain and discomfort, nausea or vomiting, and temporary aggravation of symptoms existing prior to treatment. Conventional medicine therapy also may be indicated, either in response to an emergency or as deemed necessary at the discretion of a licensed health care practitioner.

Infectious Disease/Clean Needle Procedures

I understand that there are infectious diseases which have the potential to be carried through the air, through physical contact, and through body fluids. 5NP technicians follow standard precautions to guard against the spread of infection and use only sterilized, prepackaged, single-use, disposable needles. The needles that are used for this treatment are single-use and applied according to national professional standards.

Five-Needle Protocol (5NP) Treatment & Informed Consent DRAFT

Medical Referral

I understand that 5NP is a complementary therapy, not a substitute for medical treatment, diagnosis, or prescribed medications. I understand that I should consult a licensed health care provider if there is a worsening of an ailment or condition or if a new ailment or condition arises. I also understand that if I am currently under the care of a healthcare provider, I should not alter my medications or treatment plans or discontinue my provider's care without first discussing such changes with my provider.

Voluntary Consent

I voluntarily consent to receive 5NP treatment from a 5NP technician. A 5NP technician is not a licensed acupuncturist. I understand that I may be treated with needles, ear seeds, or ear beads. I have not been guaranteed any specific outcomes concerning the uses and effects of 5NP. I understand that I am free to discontinue 5NP treatment at any time. I understand that 5NP is not a standalone cure for substance use disorders, mental health conditions, or trauma.

I am obtaining 5NP treatment for the purpose of achieving temporary relief from the symptoms of substance use disorder, mental health conditions, or trauma.

Individual Receiving 5NP Treatment Name (Printed):

Signature:

Date:

Representative of the Individual (if applicable):

Name (Printed):

Signature:

Date:

5NP Technician Name:

Treatment Date & Time:



HB 2143: Five-Needle Protocol (5NP)

Frequently Asked Questions



Responses are based on [HB 2143 \(2025\)](#) and OMB draft rules that are still being developed. FAQs will be revised and added to align with rules adopted by the Oregon Medical Board in early 2026. Additional questions may be submitted to elizabeth.ross@omb.oregon.gov for consideration.

Questions are organized in the following groups:

- 5NP Overview & Background
- Regulation & Rulemaking Process
- 5NP Technicians
- 5NP Treatments
- Informed Consent Form
- 5NP Continuing Education
- 5NP Training & Trainers

5NP Overview & Background

1. Why is the Oregon Medical Board (OMB) creating five-needle protocol (5NP) regulations?

In June 2025, the Oregon Legislature passed House Bill 2143 (2025), and Governor Kotek signed the bill into law. This legislation allows individuals with specific training and OMB registration to provide 5NP treatments beginning March 1, 2026. The law also directs the Oregon Medical Board to establish comprehensive rules for training qualifications and safety standards, see full text of legislation [here](#). The OMB's role is to implement the law that has already been enacted.

2. What is five-needle protocol (5NP)?

Under the new law in Oregon (HB 2143), 5NP is a standardized treatment protocol in which five points on the human outer ear are stimulated with sterile, single-use disposable needles, ear seeds, or ear beads for the purpose of achieving temporary relief from the symptoms of substance use disorder, mental health conditions or trauma. The five points are the shen men, sympathetic, liver, kidney and lung points on the human outer ear.

3. Where did 5NP originate from?

5NP emerged from an intersection of grassroots activism and community-driven healthcare innovation. In the 1970s, advocacy efforts demanded accessible drug detoxification services at Lincoln Hospital in South Bronx, NY. The protocol represents a unique fusion of ancient Eastern healing practices with modern healing social justice movements of the Black Panthers and Young Lords. These activists recognizing the failure of traditional medical systems to adequately serve marginalized populations struggling with addiction, collaborated with healthcare providers to develop what became known as acudetox which transformed a hospital detox program into a community-centered healing practice. This grassroots origin reflects the protocol's core values of accessibility, community empowerment, and culturally responsive care,



establishing it as more than just a medical intervention but as a tool for social healing that emerged from communities most affected by addiction and trauma. The protocol's evolution from this activist foundation to its current global application maintains its commitment to serving underserved populations and providing trauma-informed care that honors both individual healing and collective community wellness.

Regulation & Rulemaking Process

4. Who regulates 5NP in Oregon?

The Oregon Medical Board (OMB). Currently, Oregon-licensed acupuncturists and MD/DO physicians with appropriate training may provide 5NP treatments, and the OMB regulates both professions. HB 2143 will allow an individual with specific training and OMB registration to provide 5NP treatments without a license to practice acupuncture beginning March 1, 2026. OMB will also regulate these 5NP technicians by establishing and enforcing rules, including qualifications, registration, standards, and disciplinary actions.

5. What process is the OMB using to create the 5NP rules and regulations?

In August and September 2025, the OMB formed a Workgroup of acupuncturists and community members to gather input on draft rules and related materials. The Workgroup's input will be reviewed by the OMB's Acupuncture Advisory Committee on September 12, 2025, and the Oregon Medical Board on October 2, 2025.

5NP Rulemaking Timeline (tentative):

August-September 2025 – HB 2143 Workgroup meets

September 12, 2025 – Acupuncture Advisory Committee reviews the Workgroup's recommendations and makes recommendations to the Oregon Medical Board

October 2, 2025 – Oregon Medical Board reviews all recommendations

After October meeting – OMB files notice and public comment opens

November 24, 2025, 5PM – Public comment period ends

December 5, 2025 – Final review by the Acupuncture Advisory Committee

January 8, 2026 – Final review and possible adoption by the Board

January-March 2026 – OMB staff develop systems for program

March 1, 2026 – Rules become effective

6. How can I stay updated on 5NP implementation in Oregon?

Sign up for the OMB's acupuncture interested parties email list through [Subscriber Lists](#) to receive updates about the 5NP program development.

7. Can I participate in the rulemaking process?

Yes. All meetings listed above are open to the public and may have designated comment periods as noted on the agenda, see [OMB's Public Meeting Notices](#). Written comments may be emailed to Elizabeth Ross at elizabeth.ross@omb.oregon.gov. All public comments, drafts, or meeting



materials received during the designated comment periods will be posted on the [OMB's Public Meeting website](#) and/or [5NP website](#).

8. Who can I contact for more information?

For questions about 5NP implementation in Oregon, contact Elizabeth Ross at elizabeth.ross@omb.oregon.gov or visit the OMB's [5NP webpage](#).

5NP Technicians

9. Can anyone in Oregon provide a 5NP treatment?

Beginning March 1, 2026, individuals who complete required training, meet the qualifications, and register with the Oregon Medical Board (OMB) may provide 5NP treatments. Oregon-licensed acupuncturists and MD/DO physicians with appropriate training may already provide 5NP treatments and will not need to obtain a 5NP registration to continue providing this care within their practice.

10. What are the qualifications for a 5NP technician?

A 5NP technician must:

1. Be at least 18 years of age,
2. Successfully complete a 5NP training program as described in OMB rule, and
3. Have good moral character as those traits would relate to the applicant's ability to provide 5NP treatments. Substance use disorder in remission, mental health conditions, or other lived experiences alone are not a reflection of current moral character.

11. How does the OMB review good moral character to qualify as a 5NP technician?

All 5NP technician applicants must complete a national fingerprint-based background check. Criminal history is not an automatic disqualification for 5NP registration. The Board evaluates each applicant's background and experience and will consider additional information provided by the applicant. To be evidence of a lack of good moral character, the acts or conduct in question must be rationally connected to the applicant's ability to safely provide 5NP treatments. Substance use disorder in remission, mental health conditions, or other lived experiences alone are not a reflection of current moral character.

12. What training is required to become a 5NP technician?

5NP technicians will be required to successfully complete a 5NP training program consisting of at least 30 didactic hours and 40 ears needled under supervision. The OMB is still developing the rules for this program, and this may be updated. In general, 5NP training offered by the National Acupuncture Detoxification Association (NADA) or People's Organization of Community Acupuncture (POCA) will meet the requirement.

13. Do I need to be a licensed healthcare provider to apply for 5NP registration?

No. HB 2143 does not require a 5NP technician applicant to hold a related healthcare license.



14. Does a nurse or other licensed healthcare provider need to qualify and register as a 5NP technician to provide 5NP treatments?

Yes. Anyone who wants to provide 5NP treatments must first register with the OMB. The only exception is for Oregon-licensed acupuncturists and MD/DO physicians who have appropriate training; these individuals do not need to obtain 5NP registration.

15. Can a 5NP technician diagnose?

No. 5NP technicians will not diagnose. The individual receiving a 5NP treatment will self-identify that they are seeking treatment for temporary relief from the symptoms of substance use disorder, mental health conditions, or trauma.

16. What standards must 5NP technicians follow?

The OMB is developing rules for sanitation standards and professionalism requirements. These will include safety protocols, hygiene requirements, and ethical standards.

17. Is there a registry of qualified 5NP technicians?

Yes. The OMB will maintain a public registry of qualified 5NP technicians starting in March 2026 that will be available online.

18. Do 5NP technicians have any reporting requirements?

As a person registered with the Oregon Medical Board, each 5NP technician will be responsible for the reporting requirements in [ORS 676.150](#), including arrests and convictions and prohibited or unprofessional conduct by healthcare providers.

19. Can a 5NP technician use the title “acupuncturist” or offer “acupuncture”?

No. A 5NP technician may not use the title “acupuncturist” or advertise or hold themselves out as being an acupuncturist or otherwise indicate they are authorized to practice acupuncture as defined in [ORS 677.757](#).

20. Where can I report a 5NP technician for unprofessional or other conduct?

Complaints about treatment provided or unprofessional conduct by 5NP technicians should be reported to the OMB. Information about filing a complaint is [available online](#).

5NP Treatments

21. What is a 5NP treatment?

The protocol works by stimulating five specific points in the outer ear that are believed to help restore balance and calm the nervous system by helping to reduce cravings, anxiety, and withdrawal symptoms while promoting relaxation and mental clarity.



22. What is the 5NP protocol designed for?

Based on Oregon HB 2143, a 5NP technician may only provide 5NP treatments for the purpose of achieving temporary relief from the symptoms of substance use disorder, mental health conditions or trauma.

23. What points can a 5NP technician needle or apply ear beads or ear seeds?

The five points are the shen men, sympathetic, liver, kidney and lung points on the human outer ear. A 5NP technician cannot use any other points.

24. What are the minimum safety elements of a 5NP treatment?

A 5NP technician must:

- Use only sterile, single-use disposable needles, ear seeds, or ear beads;
- Adhere to sanitation and hygiene protocols, including proper disposal of needles in a sharps container;
- Meet community standards of care, including trauma informed care;
- Establish clear procedures for handling complications or adverse reactions; and
- Set and maintain professional boundaries with all individuals receiving 5NP treatments and protect the individual's privacy and dignity.

25. What are community standards of care?

The degree of care, skill, and diligence that is used by ordinarily careful 5NP technicians in the same or similar circumstances in 5NP technician's community or a similar community.

26. Does HIPAA apply?

HIPAA (Health Insurance Portability and Accountability Act) may apply to 5NP treatments, but the specific application depends. In general, HIPAA applies to covered entities and business associates who conduct certain healthcare transactions electronically. It may not apply if treatment is provided in certain community or volunteer settings that don't meet covered entity criteria or if no protected health information is created, transmitted, or stored electronically. The Oregon Medical Board cannot provide legal advice, and one may need to seek legal advice regarding application of HIPAA and other federal or state laws. Information is available on the [U.S. Department of Health and Human Services webpage](#).

27. Where should I report adverse events?

Complaints about treatment provided by a 5NP technician should be reported to the OMB. Information about filing a complaint is [available online](#). Any adverse events that occur through no wrongdoing by the 5NP technician may be reported to People's Organization of Community Acupuncture (<https://acupunctureconsumersafety.net/>).

28. Can a 5NP treatment include electrical stimulation or electro-stimulation?

No. 5NP technicians may only use single-use disposable needles, ear seeds, or ear beads.



Informed Consent Form

29. Does a 5NP technician need to obtain an Informed Consent form every time?

Yes. A 5NP technician must obtain a signed and dated informed consent form prior to each treatment. Simply signing a name on a clipboard would not meet Oregon's consent documentation requirements for 5NP treatments.

30. Is the OMB's Informed Consent form required?

No. OMB recommends use of its "5NP Informed Consent Form." However, 5NP technicians may create their own form, including electronically generated forms, containing the same information contained on the OMB Informed Consent form.

31. Why does a 5NP technician need to obtain written Informed Consent prior to every treatment?

Informed consent is a fundamental requirement in healthcare to ensure a person understands what they're agreeing to receive. It respects a person's right to make informed decisions about care they receive, even for standardized treatments. Informed consent must be in writing as it will be the only documentation of the 5NP treatment and may be used to resolve any concerns raised to the Oregon Medical Board.

32. How long does a 5NP technician need to retain Informed Consent forms?

A minimum of 3 years.

33. May an individual get a copy of their Informed Consent form?

Yes. A 5NP technician must provide a copy of an informed consent form to the individual who received treatment if requested.

5NP Continuing Education

34. Why do 5NP technicians need to take continuing education to renew their registration?

Continuing education provides an opportunity for 5NP technicians to refresh and strengthen their knowledge and competency, remain engaged with the educational standards, and promote a culture of continuous learning.

35. Why is the Oregon Health Authority pain education class relevant to 5NP technicians?

Pain is interconnected with the conditions 5NP treatment in Oregon may address (substance use disorder, mental health conditions, trauma). [OHA's pain education course](#) is free, accessible, and includes relevant content about acupuncture, cultural competency, and trauma-informed care.



5NP Training & Trainers

36. How do I know if a 5NP training program meets OMB requirements?

5NP training programs completed prior to 2026 may be substantially similar to meet the requirements described in the rule for a training program. In general, 5NP trainings completed with National Acupuncture Detoxification Association (NADA) or People's Organization of Community Acupuncture (POCA) will meet the OMB's requirements. In 2026 after rules are adopted, a person may contact the OMB's licensing staff by email at licensing@omb.oregon.gov to inquire if a 5NP training program meets the OMB's rules.

37. Are there requirements to be a 5NP trainer?

Yes. A 5NP trainer will need to meet the requirements in OMB rule:

- Be an actively licensed Oregon acupuncturist or a physician licensed under ORS 677.100 to 677.133 who is in good standing with the Oregon Medical Board and has been practicing auricular acupuncture for a period of at least two years, or
- Be an active National Acupuncture Detoxification Association (NADA) Registered Trainer or People's Organization of Community Acupuncture (POCA) Auricular Acu-Technician (AAT) Trainer.

After the 5NP program has been established in Oregon, there may be an additional pathway for 5NP technicians to become a 5NP trainer.

From: Lisa Rohleder <[REDACTED]>
Sent: Monday, September 15, 2025 10:19 AM
To: ROSS Elizabeth * OMB
Subject: okay to submit as public comment?

Hi Elizabeth,

would it be okay to submit this newsletter as public comment? I wanted to try to highlight some aspects of 5NP which aren't necessarily obvious in the rulemaking process.

Lisa Rohleder, L.Ac. she/her
[REDACTED]

<https://workingclassacu.substack.com/>

Begin forwarded message:

From: Lisa Rohleder from Acupuncture Can Change the World
<workingclassacu@substack.com>
Subject: On Making Relatives
Date: September 15, 2025 at 12:50:39 AM PDT
To: [REDACTED]
Reply-To: Lisa Rohleder from Acupuncture Can Change the World
<reply+2v876a&2iug66&&98e5b44d6b6584dfb8d0e0f32d01ed351ca75cfb28559d45e85aac944d997789@mg1.substack.com>

Forwarded this email? [Subscribe here](#) for more

On Making Relatives

5NP as decolonization: an interview with Dolores Jimerson, MSW

LISA ROHLEDER

SEP 15



READ IN APP ↗



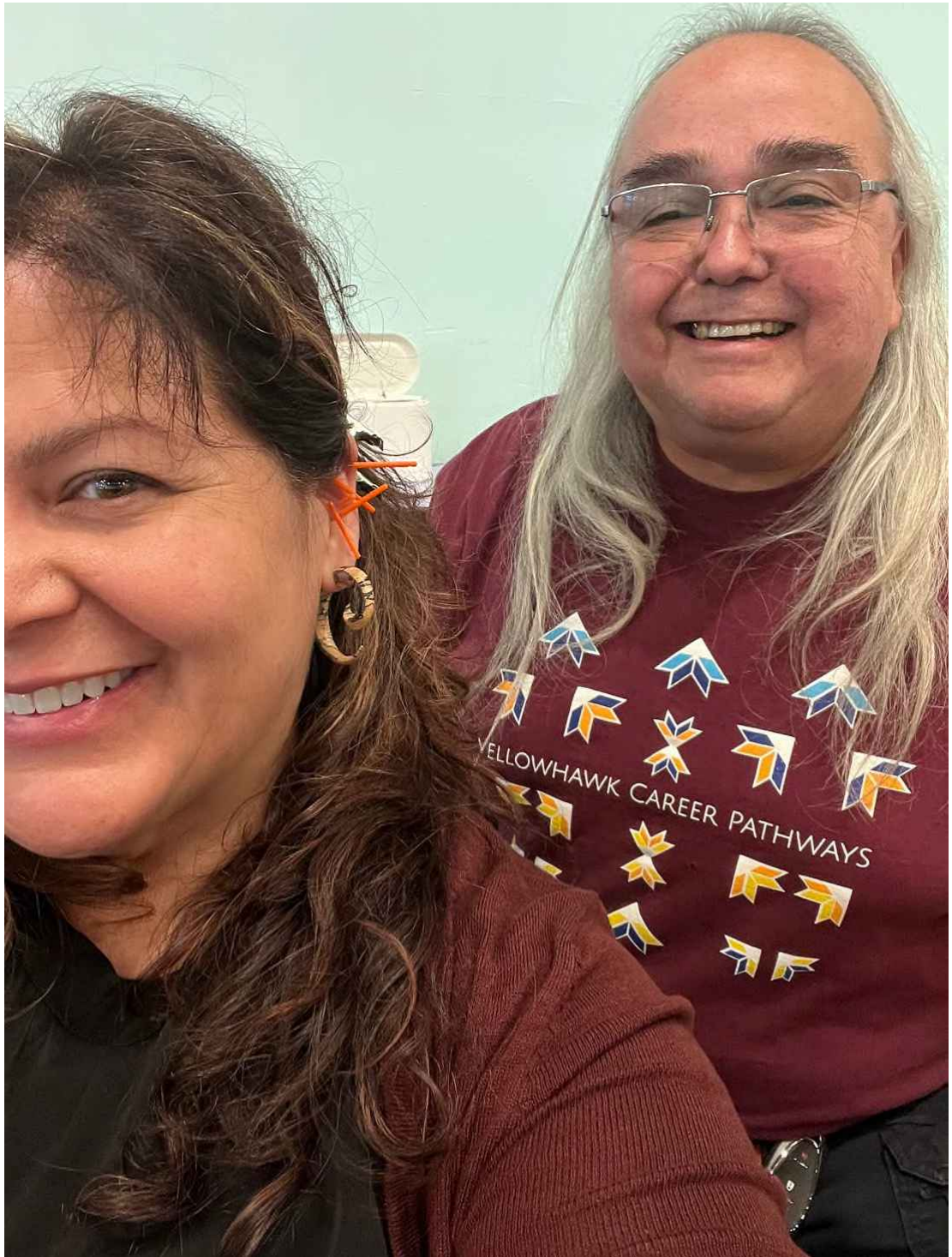
Dolores with 5NP trainees at POCA Tech last summer

Dolores Jimerson is the Behavioral Health Education Director for the Northwest Portland Area Indian Health Board. We were introduced by email a few years ago, and last summer we met in person when she led a 5NP training in POCA Tech's classroom for a cohort of tribal alcohol and drug counselors.

It's not a secret that I'm frustrated with some L.Acs' response to the rulemaking process for 5NP in Oregon. But I don't want to just yell at people, so I asked Dolores if she would be willing to help explain why community members providing 5NP is so important, and she graciously agreed (even though she was on vacation at the time!). This is an excerpt from a longer conversation.

Acupuncture Can Change the World is a reader-supported publication. To receive new posts and support my work, consider becoming a free or paid subscriber.





5NP self portrait by Dolores Jimerson

Me: First, do you mind recapping your own history with 5NP?

Dolores: Sure. In 2016 I went to a NADA training in Albuquerque and became an Acudetox Specialist (or 5NP Tech, to use the OMB's term). I was working

at the Yellowhawk Tribal Health Center, on the Confederated Tribes of the Umatilla Indian Reservation, doing integrated care in primary care and behavioral health.

At the time, Indian Health Services recognized 5NP as a best practice in addressing methamphetamine use and suicide prevention, and word quickly got out on the reservation. The tribe's sovereign status meant they could decide who could provide 5NP, so I began offering it to patients. It was something that they could use while they were on a wait list for other services, and people loved it. There was so much need that in 2017 I applied to become a registered trainer myself, and in 2018 we trained a cohort on the reservation.



5NP tribal cohort: photo credit Dolores Jimerson

Of course there were elders doing this on tribal country before I ever started. As one of them said to me, our people used to use porcupine quills as a needling practice.

Me: Can you talk about why 5NP is important to Native communities?

Dolores: It has been so hard to get access to care and access to culturally relevant services. It is still so difficult to find trauma informed services that resonate with our culture and that are appropriate for generational trauma, for indigenous trauma. 5NP isn't talk therapy. 5NP is meant to be used in conjunction with other things — and those things include tribal ceremonies. We are so relational, and 5NP is an opportunity for that relational worldview to be used. When you're sitting in a circle, receiving this from someone in your community — as opposed to some stranger who doesn't know you — it's very powerful. 5NP is something that we can do within our own culture.

As we're having this conversation, I'm seeing all these faces — all these people who have experienced connection and healing through receiving 5NP. I remember one person who was a hospice patient, and 5NP brought him so much peace. He said to me, *Because of this I was able to address some things on this side of the stars that I otherwise would have had to do on the other side*. He had such a peaceful passing, it was such a beautiful thing for him and his family.

In our trainings we talk about how just the act of someone asking for help and consenting to receive it is so significant. Even if you put only one needle in someone's ear and they change their mind and say *no, I don't actually want to do this* and you take it out — nonetheless you have activated the point and you've activated the healing.



On tribal lands it's all about community. We are there for each other. 5NP and the idea of acudetox resonate with so many tribal people because of our cultural values.

Me: Can you expand on that?

Dolores: Different tribes have different ways of saying this. My people are the Haudenosaunee and we say: When we were created, Creator blew breath into us and gave us our original instructions, which include things like: be grateful; do no harm; be generous. Remember that everything has life and is interconnected. Everyone was meant to have family. If you meet someone who doesn't have family, you make relatives with them, you make connection.

If you think of people who are living on the street, they're disconnected, they're dysregulated. If they can show up to that circle of 5NP — and that's all they have to do, just show up — it's a feeling of *I can be connected to community again*. It brings people back together.

5NP expresses our value of generosity: we give back, we share, we make connection.

Me: Will Miller also talked about this. Early on when I was working on 5NP for Oregon with him, it was very striking to me the way he kept inviting everybody into the process. Particularly people *I* didn't necessarily want to invite, who I didn't really want to work with, and who I wouldn't have invited, on my own. The way he kept extending generosity and grace and possibility to *everybody* — it was humbling, and at some point I said something like, working on this project with you is an amazing experience, I wouldn't have been capable of this kind of openness on my own. And he responded, very matter-of-factly, Well these are our cultural values and this is how we live them.

I think something's that's hard to explain to people who aren't familiar with 5NP is the way it creates benefits that sort of spill over to the whole community, beyond what you would think of as the result of an individual acupuncture treatment or even the group where it's happening.

Dolores: And that is also consistent with indigenous cultural values. For example, when we hold a sweat lodge ceremony, maybe not everyone can actually go into the sweat lodge — but we believe that you benefit just by being present, even if you can't go in yourself. Not everyone needs to be receiving the treatment — just being in the space, everyone benefits. I have witnessed this.

In 2022 there was a shooting at the casino in Pendleton. In the aftermath, I was asked to go and provide 5NP — they asked me because the community knew me. I said that I couldn't do it alone, and other NADA-trained people came forward to help me. We were there for two days — people were lined up, waiting to receive 5NP. One of the casino managers who hadn't been able to sleep for two days fell asleep in his chair, it was the first time he could calm down enough. Because people received 5NP they were able to be open to other things, like therapy. We were praying with them. I wish you could have felt that, what it felt like in that room.

Me: I think I know what you mean. Also, I suspected I was going to cry in this conversation, turns out I was right.

Dolores: For tribal people, what we love about 5NP is that it's decolonization at its best. If you think about what colonization was, it's imposing a worldview as a way of being. It's: *I am going to separate you from your resources, your homeland, all your family, all your food, all your medicine, put you in this unfamiliar place and let's see how you survive.*

Decolonization is about community, connection and love. And the gratitude and the remembering that we are all interdependent.



Photo credit: Dolores Jimerson

Me: What I most wish I could convey about 5NP in Oregon, from my own experience of working on the process, is how much it's an example of Native cultural values in action, of generosity and inclusion and making connections

— and how it's potentially so good for *everyone*, just for this expansion of 5NP to be *happening*, period.

It's similar to what it's been like for my clinic to be a small-business client of NAYA, the Native American Youth and Family Center, and their neighborhood economic development arm. To be invited into a vision of community prosperity, to be included and supported as a part of the Cully neighborhood. This experience of being a beneficiary and subsequently a participant in this exercise of Native cultural values —it's been deeply meaningful for me personally, and it's been so important for WCA as an organization and for POCA Tech as a school.

I wish acupuncturists could understand that being invited to participate in the process of expanding 5NP beyond tribal lands is an honor and a gift. It's a kind of healing, in its own right.



Photo credit: Dolores Jimerson

Dolores: Making relatives is also about responsibility. We're not acupuncturists, we're not trying to learn what acupuncturists learn.

For us, 5NP trainings are a form of indigenous pedagogy. Our tradition is oral and it's about hands on learning. Learning is what's given in the cellular memory. When I train tribal people to provide 5NP, I tell them: you have to be able to convey this in a way that makes sense to your own community.

It's a relational way of learning. We set intentions, say prayers, come together. We want people to feel safe in the training cohort. We share this relational way of being — not just with each other but also honoring our elders, including our 5NP elders.

And the purpose of the training is not for us to replace acupuncturists in their roles. The purpose of 5NP training is for us to take care of each other, to take care of our families, to take care of our communities. This is not about us opening up big fancy clinics.

One of our cultural values is, do no harm. We believe that if you're not in a good space, you shouldn't be cooking food, you shouldn't be doing anything for others until you tend to yourself. It's the same with providing 5NP.

It's a community responsibility and we take it seriously.

Recently, eight of the nine tribes in Oregon voted to allocate more funding for training 5NP providers. The only tribe that said no was Umatilla — and that's because they're fully staffed with 5NP providers in their public health and behavioral health services.

5NP in Oregon is not something new. It's *been* happening.

Me: Thank you. I'm so glad we had this conversation.

Acupuncture Can Change the World is a reader-supported publication. To receive new posts and support my work, consider becoming a free or paid subscriber.

From: K U <[REDACTED]>
Sent: Friday, September 12, 2025 2:11 AM
To: ROSS Elizabeth * OMB
Subject: 5NP Testimony

You don't often get email from [REDACTED]. [Learn why this is important](#)

Hi Elizabeth,

My name is Kiera Usagawa and I'm a community herbalist in Portland. I support 5NP and it's potential to support our community members in an accessible and safe way.

Thank you,
Kiera Usagawa
she/her/hers
Portland, 97211

From: [Margeaux Fraasa](#)

Sent: Friday, September 12, 2025 10:36:28 AM

To: [KINGHAM Gretchen * OMB](#)

Subject: 5NP Advocacy

Sensitivity: Normal

You don't often get email from [REDACTED]. [Learn why this is important](#)

Hello Gretchen,

My name is Margeaux and I work as a consultant with a nonprofit in the Willamette Valley, serving farmworker families.

We are very excited about 5NP in Oregon, and are showing up and staying tuned in for the rules and regulations process. 5NP in Oregon is important for our community members who often experience language barriers, lack of access to healthcare and insurance, and historical oppression to have access to an amazing community healthcare tool such as 5NP.

In your process, we hope that you all are able to make this certification process as accessible as possible for BIPOC communities such as the Indigenous farmworker communities we serve. Having 5NP available for our community will be very supportive for pain, trauma, stress and more that farmworker families experience on a daily basis.

We are very excited about the progress for 5NP training coming in 2026, and appreciate the OMB Acupuncture Advisory Committee work in making this possible, listening to the needs of the community as well.

Thank you,
Margeaux

Margeaux Fraasa

Consultant

The Anahuac Program

Ph: [REDACTED] | Email: [REDACTED]

<https://www.anahuacfarm.org>

instagram: [@the_anahuac_program](#)

facebook: [The Anahuac Program](#)

From: KINGHAM Gretchen * OMB
Sent: Thursday, September 11, 2025 10:30 AM
To: ROSS Elizabeth * OMB
Subject: FW: 5NP

From: Jenifer Kimiko Escobedo <[REDACTED]>
Sent: Thursday, September 11, 2025 8:57 AM
To: KINGHAM Gretchen * OMB <gretchen.kingham@omb.oregon.gov>
Subject: 5NP

You don't often get email from [REDACTED] [Learn why this is important](#)

Hello,

I'm just writing in support of 5NP. As part of the acupuncture community I have seen firsthand how effective 5NP acupuncture can be. Bringing that to the community in spaces that can't be reached otherwise would be a tremendous and beautiful thing! It is a trusted tool that can help so many!!

Thank you so much for your support and consideration.

Take care,
Kimiko E.

Sent from Samsung Galaxy smartphone.
Get [Outlook for Android](#)

From: Melissa Poulin <[REDACTED]>
Sent: Thursday, September 11, 2025 2:30 PM
To: ROSS Elizabeth * OMB
Subject: Support for 5NP

You don't often get email from [REDACTED]. [Learn why this is important](#)

I am writing to express my support of 5NP, and providing training for people who want to share this simple, effective, low-cost, and very safe addiction treatment with more people in desperate need of it. As a licensed acupuncturist, I can confidently say that I have witnessed the power of this protocol to change lives, time and time again. The negligible but vocal negative response to the passage of Oregon's 5NP law is unfortunately coming from people more concerned with keeping acupuncture private and expensive, than with widening access to medicine that can be life-saving for so many. I whole-heartedly support OMB's continued efforts to create safe training for folks who would like to practice this medicine with this specific, limited, safe, and effective protocol.

Thanks so much,
Melissa Poulin, L.Ac.

This email is confidential and may be legally protected. It is intended solely for the addressee. Access to this email by anyone else, unless expressly approved by the sender or an authorized addressee, is unauthorized. If you are not the intended recipient, any disclosure, copying, distribution or any action omitted or taken in reliance on it, is prohibited and may be unlawful. If you believe that you have received this email in error, please contact the sender and delete this e-mail and destroy all copies.

From: Erin Engelke <[REDACTED]>
Sent: Wednesday, September 10, 2025 10:06 PM
To: ROSS Elizabeth * OMB
Subject: Testimonial Support for 5NP in Oregon

You don't often get email from [REDACTED]. [Learn why this is important](#)

To the Acupuncture Advisory Committee,

It is with vehement passion that I urge you to remain fully open and supportive of the newly passed 5NP law in Oregon. The state needs this. The people of Oregon need this. Thank you to people who worked hard to pass the law and are making it happen!

There is underwhelming evidence suggestive in the claims that practicing 5NP without a full DOM is unsafe. The simplicity of the protocol eliminates the need for clinical judgement. The points used are specific, and never vary. That's a feature, not a bug. To assume that people will use this protocol in bad faith or unsafely is discriminatory and elitist, and frankly illogical.

It's an acceptable argument that people permitted to do anything in service of human and health care should have appropriate training and adept skill in their chosen field. Auricular therapy, the way it is being developed in Oregon, is very different from an acupuncture practice in a clinical, spa, or other health care setting. Just like an acupuncture clinic is dramatically different from an ER or an OR. We trust that these various practitioners have knowledge, skill, and can perform at a high level, or they wouldn't be licensed or certified to do so. This argument is above reproach. However, we can also safely argue that a person trained and licensed to administer auricular therapy with five specific and unchanging locations in the ear, is not performing acupuncture at the same level as a licensed acupuncturist in any given setting. Just like acupuncturists are not practicing under the delusion that we are conducting open-heart or brain surgery. Different skill-sets require different training. That is what the 5NP law aims to do- create another skill-set with a different type of training requirement that isn't akin to either acupuncture or western medical intervention.

Creating access to the auricular protocol will not jeopardize the Acupuncture Profession in the way that alarmist, anti-5NP practitioners fear it could. This claim reeks of territorial gatekeeping in a nation that is already damaged by the privatization of health care. Please let 5NP and auricular therapy be part of the solution.

Sincerely,
Erin Engelke
she/her
L.Ac

From: Leah Castaneda <[REDACTED]>
Sent: Wednesday, September 10, 2025 8:21 PM
To: ROSS Elizabeth * OMB
Subject: I support 5NP!

You don't often get email from [REDACTED]. [Learn why this is important](#)

Hello!

I am a mother, a student, a friend, a worker, an Oregonian, and above all - a human that cares about other humans. The passage of the 5NP law was a major milestone in increasing access to healthcare, particularly for marginalized and underserved communities. It is imperative that the law move through this current process without being walked back to limit access by the creation/addition of unnecessary restrictions. 5NP is safe, effective, and highly accessible. It does not threaten the livelihood of anyone, acupuncturist or other. It is not a diluted form of acupuncture, and it does not require a Master's level of education. It is a thoughtful and specific approach to caring for communities that centers relief from suffering rather than profit or gain.

I will be working Friday morning, and unable to attend the Acupuncture Advisory Committee's Public Session, but I am absolutely in support of 5NP and hope that the spirit in which the law was passed can be upheld for the benefit of all Oregonians. Thank you.

Warmly,

Leah Castaneda

From: Arabee Koch <[REDACTED]>
Sent: Wednesday, September 10, 2025 7:13 PM
To: ROSS Elizabeth * OMB
Subject: HB 2143 Support

You don't often get email from [REDACTED]. [Learn why this is important](#)

September 9, 2025

To the Oregon Medical Board and 5NP work group,

Thank you for the opportunity to comment on the house bill 2143 regarding the implementation of the 5NP.

I am currently a student of acupuncture and fully support the 5NP bill and feel it is crucial that it is implemented in a way that allows for optimum equitability and accessibility.

5NP is a safe simple protocol that involves minimal skill and very little training. 5NP is inherently low risk.

Personally I have witnessed it help people overcome addiction and manage cravings in addition to help regulate stress and trauma.

I fully support 5NP and hope that the OMB and 5NP work group continue to create an equitable accessible training protocol that does not over regulate the 5NP practice. This is an easy protocol that should be accessible to all communities in the interest of public health.

Thank you.

Arabee Koch

September 10, 2025 - Prepared by Susan Williams Regarding HB 2143

My name is Susan Williams. I am a four year resident of the State of Oregon, however, in 2021 I was an Arizona resident and Chair of the Arizona Acupuncture Board of Examiners.

As one of our top Board initiatives during my two term tenure as Chair, our Board worked closely with stakeholders, including licensed acupuncturists (LAc), addiction treatment professionals, a recently retired Federal Court Judge (the honorable Charles Pyle) and others.

Our Board developed and successfully pushed legislation through the Senate and House that both amended and clarified the role of acupuncture detoxification specialist (ADS) certification process as Senate Bill 1255, which was approved by the Governor of Arizona on May 4, 2021.

As such, I'm testifying and writing to you in support of Oregon House Bill 2143. Although not identical to the legislation passed in Arizona, Oregon House Bill 2143 is substantially similar and can only benefit the residents of the State of Oregon.

Since implementation, per David Geriminsky, the then, and current, Executive Director for the Arizona Acupuncture Board of Examiners, the number of ADSs has increased by 45.7% and in the 4-1/2 years since implementation, there have been no consumer, or other, complaints filed with the Board. This truly is a "do no harm" form of treatment, that is:

- Easily learned by lay individuals
- Broadly accessible
- Administered in a wide range of environments

This treatment can, and is, used for treating alcoholism, substance abuse, trauma & chemical dependency.

So how did I get so passionate about acupuncture detoxification or 5NP? Despite my privileged life, the opioid epidemic has touched me seven times with overdose deaths impacting people close to me, including a 3rd generation Army veteran, Staff Sergeant Craig Brennan, who was found in his vehicle, lifeless, next to his two war dogs, from an opioid overdose.

Through acupuncture training in Portland and researching Dr. Michael Smith and the National Acupuncture Detoxification Association, I became convinced that auricular acupuncture can be an important, even life-saving response to the opioid crisis. Ever since I have been committed to expanding community access to this very safe, inexpensive and humble treatment.

From: Haley Merritt <[REDACTED]>
Sent: Wednesday, September 10, 2025 12:44 PM
To: ROSS Elizabeth * OMB
Subject: In support of 5NP

You don't often get email from [REDACTED]. [Learn why this is important](#)

Hello my name is Haley Merritt. I have been a licensed acupuncturist for the past 12 years. I am strongly in support of 5NP. This is a simple, affordable and safe treatment for addiction and trauma. People can learn how to do it safely within a few days. There are very minimal adverse events. The needles are tiny and are not inserted very deeply and there are no major organs, arteries or nerves in the ear that can be potentially damaged.

5NP specifically impacted my life. My father died of liver failure due to alcoholism. He was given 4 months to live. He received 5NP regularly and was able to quit drinking which prolonged his life for an additional 2 years.

This treatment needs to be available to as many people who want it as possible. The only way to do that is through training people specifically in 5np. There are not enough acupuncturists and it is not profitable enough for the acupuncture profession to meet the high demand for this treatment. Please continue moving this law forward.

Thank you.
-Haley

This email is confidential and may be legally protected. It is intended solely for the addressee. Access to this email by anyone else, unless expressly approved by the sender or an authorized addressee, is unauthorized. If you are not the intended recipient, any disclosure, copying, distribution or any action omitted or taken in reliance on it, is prohibited and may be unlawful. If you believe that you have received this email in error, please contact the sender and delete this e-mail and destroy all copies.

From: Julia Neace <[REDACTED]>
Sent: Wednesday, September 10, 2025 11:46 AM
To: ROSS Elizabeth * OMB
Subject: Written Comment - HB 2143 Workgroup Five-Needle (5NP) Protocol

You don't often get email from [REDACTED]. [Learn why this is important](#)

Hello Elizabeth,

Here is my comment:

To the Oregon Medical Board and 5NP work group,

Thank you for the chance to comment on the house bill 2143 regarding the implementation of the 5NP protocol.

I am currently a student of acupuncture and fully support the 5NP bill. I feel it is crucial that it is implemented in a way that maximizes accessibility and minimizes barriers.

5NP is a safe, simple protocol that requires minimal skill and very little training. 5NP is inherently low risk.

I have witnessed 5NP help people overcome addiction, manage cravings, decrease stress and process trauma. 5NP is an essential tool that needs to be widely available in our communities especially in these incredibly stressful, uncertain times we are living in.

I fully support the 5NP bill and rollout, and hope that the OMB and 5NP work group continue to create an equitable, accessible training protocol that does not over regulate the 5NP practice, which would lock out the very people that need this tool the most. This is a simple, quick, minimally invasive, low risk protocol with nearly no needed overhead, that has the ability to save lives. It must be easily accessible to all communities in the interest of public health.

**Thank you,
Julia Neace**

This email is confidential and may be legally protected. It is intended solely for the addressee. Access to this email by anyone else, unless expressly approved by the sender or an authorized addressee, is unauthorized. If you are not the intended recipient, any disclosure, copying, distribution or any action omitted or taken in reliance on it, is prohibited and may be unlawful. If you believe that you have received this email in error, please contact the sender and delete this e-mail and destroy all copies.

From: Bex Groebner <[REDACTED]>
Sent: Tuesday, September 9, 2025 11:41 AM
To: ROSS Elizabeth * OMB
Subject: Re: Written Comment - HB 2143 Workgroup Five-Needle (5NP) Protocol

Hi Elizabeth!

I think my comment below may have gotten missed. Can you let me know you received it? Thank you!

On Sep 6, 2025, at 1:46 PM, Bex Groebner <[REDACTED]> wrote:

To the Oregon Medical Board and the 5NP Workgroup,

Thank you for the opportunity to provide input on the implementation of [HB 2143](#) and the development of rules regarding the [Five-Needle Protocol \(5NP\)](#).

I am a Doctor of Acupuncture and run a Portland-based acupuncture business called The Local Healer, where I have employed and mentored a number of acupuncturists in the last decade. I have taught medical ethics, biomedical physiology & pathology, nutrition, living anatomy, and pediatrics classes to acupuncture and naturopathic students at both [NUNM](#) and [OCOM](#) since 2015. I am a past board member of the Oregon Association of Acupuncturists.

I currently serve as the Clinical Training and Program Director and a clinical supervisor for the [Acupuncture Relief Project/Good Health Nepal](#), where we operate free, [rural primary care clinics](#). Since 2017, I have trained and supervised many international healthcare providers at our clinics in the Makwanpur Region of Nepal, including acupuncturists, physical therapists, chiropractors, massage therapists and naturopathic doctors. My work has consistently centered on safety, access, and education in integrative medicine.

From this perspective, I strongly support accessible and community-based training standards for 5NP. This protocol has a decades-long history of safe use in diverse and marginalized communities, including [Black](#), Native, veteran, recovery, and protest communities. It has [proven to be](#) a low-risk, effective tool for addressing trauma, addiction, pain and stress in contexts where barriers to licensed acupuncture or other health services are high.

Key features of 5NP include:

Safety and Simplicity: 5NP is a *standardized, non-diagnostic ear protocol* using only five points. It is inherently low-risk, requires minimal training, and has been delivered safely for decades in both clinical and community-based settings.

Equity and Access: *The purpose of HB 2143 is to expand access.* If training requirements are made unnecessarily burdensome, the very peer providers and community members who most need this tool will be excluded. Brief, focused training with clear safety guidelines is sufficient to prepare individuals to provide 5NP responsibly.

Public Health Impact: In both my professional practice and personal life, I have seen 5NP make a meaningful difference, from harm reduction work in Oregon, to addiction recovery

settings, to international primary care clinics. Its ability to promote nervous system regulation and vagal tone provides profound benefits in situations of trauma, stress, and addiction.

I recognize that some licensed acupuncturists have voiced too-late opposition, suggesting that 5NP is a “medical procedure” requiring advanced training in Chinese medicine theory and clinical judgment. With respect, this is a mischaracterization of both the protocol and its history.

5NP is a standardized, non-diagnostic procedure requiring very basic technical skill. There is no diagnosis involved, and the law itself makes clear that 5NP practitioners are not practicing acupuncture as defined under existing rules. Unlike body acupuncture, it does not require knowledge of meridians, syndrome differentiation, or broader Traditional Asian medical theory. The most important safety considerations are straightforward: clean needle technique, awareness of fainting response, and prevention of needle stick injuries. These can be fully taught in a short, focused training.

It is also important to clarify the history:

- Auricular point theory [was first mapped by Dr. Paul Nogier](#), a French physician in the 1950s, after observing folk cauterization practices in the Lyon region for sciatica.
- His model was reflexology-oriented and biomedical in its framing and the auricular homunculus (the ‘inverted fetus’ representation of the body on the ear) does not derive from classical TCM theory.
- Chinese medicine researchers later integrated and validated Nogier’s work within their own framework during the 50s and 60s.

In the 1970s, **Dr. Michael Smith** at Lincoln Hospital in the South Bronx adapted auricular acupuncture into the Five-Needle Protocol, specifically for addiction treatment in marginalized communities.

To insist that 5NP requires a foundation in Chinese medicine theory is historically inaccurate. The protocol was developed outside of traditional TCM frameworks and then adapted for community health and recovery settings, precisely because it could be taught quickly and delivered safely without years of specialized training.

For these reasons, I strongly encourage the Board to keep training requirements proportionate to the actual scope and risks of the procedure. We can support safe, accessible practice while honoring the intent of HB 2143. Over-regulation or gatekeeping risks undermining the very communities this law was designed to serve.

Thank you for centering community health in this important process.

Respectfully,

Dr. Rebecca Groebner, DAc, LAc

[Redacted Signature]

September 9th, 2025

Regarding: 5NP Ear Acupuncture Law - public support!

Attn: OMB Acupuncture Advisory Committee

My name is Moses Cooper and I have had the privilege of serving lower income patients with community acupuncture in the Portland area since 2005. As an acupuncturist employee of Working Class Acupuncture (WCA) for two decades, and as an acupuncture clinical supervisor for student interns in the only community acupuncture school (POCA Technical Institute), I have supported well over 60,000 patients, and counted. I have accompanied patients while they management forms of stress, pain, and addiction recovery.

WCA is the founding clinic of the larger community acupuncture movement. Community acupuncture prioritizes a preferential access to marginalized patient populations; accompaniment; trauma-informed communication; and, ease of access to services, including accessible pricing for services.

In my years of direct patient care, I observe a clear need from patients (and supporters of patients, such as family/friends/coworkers) for low barrier health services. I specifically notice a need for addiction recovery services for many kinds of substances. There is a clear need for ways to support ordinary and lower income people to manage acute and chronic forms of toxic stress. I observe a need for long term support in emotional regulation, that affects physical muscle tension and physical pain management.

I see 5NP ear acupuncture programs as a profoundly helpful and needed form of community healthcare. 5NP ear acupuncture is, for me, a realistic approach for supporting people managing high intensity mood regulation and addiction recovery from any type of addictive substance.

Ear acupuncture supports the body/mind to move into a calmer emotional state. This supports anyone managing intense stress levels and thus softens dramatic mood fluctuations that typically accompany deeply challenging loss of support, whether losing a coping substance or valued relationships. 5NP treatment is used to treat alcoholism, substance abuse, trauma, and chemical dependency.

5NP ear acupuncture is supportive in many ways:

- Impressively portable. It can be used in varied environments and locations (from health clinics to business offices, and from outdoor pop-up events to disaster recovery shelters)
- Relatively easy and timely to train and to learn, by lay individuals,
- Relatively low cost to offer training to staff and services to patients,

- Offered using trauma informed communication, which minimizes shame in relation to patients accessing addiction recovery services
- Safe to perform and to receive. Minimal-to-no side effects (rare, if any...)

5NP acupuncture treatment is used to manage many and varied mental health and mood challenges at the same time. It can be used to manage addiction to alcohol, nicotine, cannabis, alcohol, using harder drugs, managing prescribed medication side effects, or any other substance abuse experiences. It is non-toxic, can be used while taking any other substances, can be administered quickly, with minimal training, and minimal side effects. 5NP is clearly a supportive form of healthcare!

I fully support the Oregon 5NP ear acupuncture program creation, and thank you for supporting Oregon residents as you develop the rules for using this new community support tool.

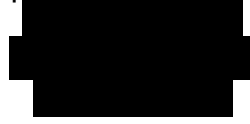
Thank you for your investment in community ;-)

Moses Cooper, L.Ac.

Punk & Supervisor
Working Class Acupuncture - Rockwood
www.workingclassacupuncture.org
2240 SE 182nd Ave
Portland, OR 97233




Beardall Acupuncture and Chiropractic Clinic, PC
Christopher Beardall, DC, L.Ac.



Oregon Medical Board
Acupuncture Advisory Committee
1500 SW 1st Avenue, Suite 620
Portland, OR 97201

**Re: Formal Commentary on the Proposed Administrative Rules for HB 2143
Recommendations for Upholding Patient Safety and Professional Standards for the Five-
Needle Protocol in Oregon**

Dear Members of the Oregon Medical Board and the Acupuncture Advisory Committee:

I respectfully submit the following formal commentary on the proposed administrative rules for House Bill 2143 (2025), specifically regarding the regulation of the Five-Needle Protocol (5NP) and the registration of 5NP technicians. My intent is to assist the Board in fulfilling its statutory mandate to protect the health, safety, and welfare of Oregonians while ensuring that access to care does not come at the expense of patient safety or professional accountability.

Introduction: Upholding Public Safety in Rulemaking for HB 2143

House Bill 2143 defines the 5NP and authorizes the creation of a new category of practitioner—the 5NP technician. The Oregon Medical Board has been granted explicit discretionary authority to establish training requirements, sanitation standards, and overall regulatory oversight for this new role. This is not a passive duty but a direct obligation to ensure that rules align with the Board’s mission of safeguarding public health.

While the legislative intent to expand access to supportive care for individuals facing substance use, trauma, and mental health challenges is commendable, it is imperative that administrative rules reflect rigorous standards of training, infection control, scope of practice, documentation, and program oversight. Anything less risks creating a two-tier system of care that exposes already vulnerable populations to preventable harm.

This commentary identifies five areas where the August 28, 2025, workgroup draft falls short and offers evidence-based recommendations:

1. Training and qualifications

2. Clinical supervision and scope of practice
 3. Infection control protocols
 4. Documentation standards
 5. Oversight of training programs
-

Section 1: Training and Qualifications

- **Problem:** The proposed 31-hour training standard is grossly inadequate compared to other ancillary health roles (e.g., phlebotomy and medical assisting) and inconsistent with the National Acupuncture Detoxification Association (NADA) protocol.
 - **Risk:** Allowing minimally trained technicians to perform invasive auricular acupuncture risks patient injury and misrepresents the standardized NADA protocol.
 - **Recommendation:** Require a minimum **70 hours of training**, including 30 hours of didactic instruction and **100 hours of supervised clinical practice**. Curriculum should include Clean Needle Technique (CNT), OSHA Bloodborne Pathogen training, auricular anatomy, adverse event management, ethics/scope, and trauma-informed care.
-

Section 2: Clinical Supervision and Scope of Practice

- **Problem:** Allowing unsupervised practice is inconsistent with Oregon’s standards for allied health professionals and contradicts integrated care models.
 - **Risk:** Vulnerable patients with substance use or mental health disorders may present with complex co-morbidities, creating risks far beyond the competence of minimally trained technicians.
 - **Recommendation:** Require **general supervision** by a licensed healthcare provider (MD, DO, NP, or L.Ac.), formal referral/collaboration agreements, and a **strictly limited scope**—restricted only to the insertion of five sterile needles into the five specified auricular points.
-

Section 3: Infection Control

- **Problem:** Draft language permitting patient self-removal of needles directly violates the **OSHA Bloodborne Pathogens Standard (29 CFR 1910.1030)** and CDC safe injection guidelines.
- **Risk:** Legal liability for the state, public exposure to bloodborne pathogens, and unsafe sharps handling.
- **Recommendation:** Explicitly incorporate OSHA standards, prohibit unsafe practices (e.g., patient removal of needles, recapping), and require practitioner-only removal with immediate sharps disposal.

Section 4: Documentation Standards

- **Problem:** Requiring only a signed consent form fails to establish continuity of care, professional accountability, or regulatory oversight.
- **Risk:** Lack of treatment records undermines patient safety, obstructs complaint investigations, and exposes patients to fragmented care.
- **Recommendation:** Require a **treatment record for every session**, including patient identifiers, date/time, practitioner signature, confirmation of needle insertion/removal, adverse events, and retention for at least 7 years.

Section 5: Oversight of Training Programs

- **Problem:** No mechanism currently exists for OMB oversight of training institutions, risking inconsistent or substandard education.
- **Risk:** Inadequate preparation of practitioners, proliferation of unregulated training entities, and erosion of public trust.
- **Recommendation:** Require **OMB approval of training programs**, submission of detailed curricula, instructor qualifications, supervised clinical plans, and periodic audits for compliance.

Conclusion: Prudent Regulation to Preserve Trust

The Oregon Medical Board has a critical opportunity—and responsibility—to ensure that the implementation of HB 2143 both increases access to care and upholds the highest standards of public safety. The draft rules, as currently written, fall short of these obligations. By adopting the recommendations outlined above, the Board can establish a framework that both honors legislative intent and protects the people of Oregon from preventable harm.

I urge the Board and the Acupuncture Advisory Committee to incorporate these recommendations before advancing the administrative rules for final approval. Thank you for your attention to these critical issues and for your continued commitment to safeguarding the health and safety of our communities.

Respectfully submitted,

Christopher Beardall, DC, L.Ac.

September 9, 2025

Oregon Medical Board
1500 SW 1st Avenue, Suite 620
Portland, OR 97201

Dear members of the Acupuncture Advisory Committee,

My name is Winona Vaitekunas and I am a graduate of POCA Technical Institute (POCA Tech) and a board member of POCA Cooperative (POCA). I'm writing to share my personal comment regarding rule making for House Bill 2143.

First, I would like to personally thank the members of OMB's Acupuncture Advisory Committee and the previous work by OMB's 5NP Workgroup for the time and effort toward implementing this bill. As a member of POCA Tech's 8th Cohort, I was one of the first people involved in the initial thought experiment and research project that blossomed into a relationship with NAYA Action Fund and their continued community of support that has accompanied this bill from the beginning.

HB2143 has always been a bipartisan and community-oriented collaborative effort to bring this simple and safe protocol to Oregonians. I began participating in the Oregon Association of Acupuncturists (OAA) Legislative Advocacy Committee meetings in January of 2024 to present the idea of a future bill to bring 5NP technicians to Oregon. NAYA Action Fund's 5NP Coalition continued to collaborate with the OAA at committee and board meetings throughout the legislative process of the bill. Thanks to their input, and the support of 87 public testimonies in favor of the bill, HB2143 passed unanimously through the Oregon House of Representatives and with an overwhelming majority in the Oregon Senate. Oregon legislators confidently voted in favor of HB2143 because of the demonstrated positive impact this auricular protocol brings.

Now, we stand at the precipice of a new piece of Oregon's history through this rulemaking process. Oregon follows after nearly half of the United States to allow non-acupuncturists to provide 5NP. Thanks to over four decades of research and tens of states legislation before us, we have the ability to learn from history as we move forward in making our own. In that regard, I'd like to share the following legislative data:

1. States requiring supervision of 5NP technicians are in the national minority.

14 states have a route to 5NP techs practicing without licensed supervision.

6 states require direct supervision.

4 states delegate the role exclusively to licensed healthcare providers such as nurses, PAs, and physicians.

Source:

Stuyt, Elizabeth B et al. "NADA Protocol for Behavioral Health. Putting Tools in the Hands of Behavioral Health Providers: The Case for Auricular Detoxification Specialists." *Medicines (Basel, Switzerland)* vol. 5,1 20. 7 Feb. 2018, doi:10.3390/medicines5010020

2. States with supervision requirements have gone through the legislative process to remove them.

There is active legislative work in other states continuously working to improve accessibility to this protocol. Even Texas amended their law in 2023 to remove the requirement of 5NP techs practicing "under the supervision of a licensed acupuncturist or physician."

Source:

Texas State Legislature. Texas Constitution and Statutes. Acts 2023, 88th Leg., R.S., Ch. 397 (H.B. 1106), Sec. 1, eff. September 1, 2023.

3. States with restrictive requirements have chosen to amend their legislation to remove them and expand access.

Colorado amended their law in 2021 to remove the a requirement for an auricular acudetox practitioner to be licensed, registered, or certified as a mental health professional. Their 5NP techs must simply "complete a training program in auricular acudetox... that meets or exceeds standards of training established by the National Acupuncture Detoxification Association."

Texas amended their law in 2023 to allow more people to qualify to become acudetox specialists and to update the rules adopted by their medical board to allow for "the treatment of addiction, trauma, or physical, emotional, or psychological stress" instead of the initial rules requiring the exclusive treatment of "alcoholism, substance abuse, or chemical dependency."

There are no location requirements in any bill that I'm aware of, and no state has felt the need to implement or amend rules restricting where 5NP can be practiced.

Source:

Colorado General Assembly, "Concerning the Practice of Auricular Acudetox by a Professional, and, in Connection Therewith, Clarifying That in Order to Perform Auricular Acudetox, a Person Does Not Need to Be Licensed, Certified, or Registered as a Mental Health Professional." (2021). Session Laws 2001-Present. 8824

Texas State Legislature. Texas Constitution and Statutes. Acts 2023, 88th Leg., R.S., Ch. 397 (H.B. 1106), Sec. 1, eff. September 1, 2023.

I strongly support keeping the spirit of 5NP forefront to this rulemaking process. This protocol was created by Black and Puerto Rican revolutionaries treating addiction in their communities. Now over four decades later, Oregonians and organizations like the Native American Youth and Family Center (NAYA), APANO, Pineros y Campesinos Unidos del Noroeste (PCUN) and Family Forward Oregon (FFO) are asking for effective community healing that can only happen through

your decision to prioritize accessibility and think critically about how your rulemaking process impacts people in our community. NADA and POCA have grown out of these communities and provided safe and effective auricular acudetox training for years that has been the national, and international, standard for safe trauma-informed care through 5NP. Like the 5 Needle Protocol, this law was designed to provide a safe and effective tool to the most marginalized people in the healthcare system, so I ask that you listen closely to them as you meet as a committee and move forward with OMB through the rest of this rulemaking process.

Thank you,

Winona Vaitekunas

From: Nancy Whitson <[REDACTED]>
Sent: Tuesday, September 9, 2025 4:18 PM
To: ROSS Elizabeth * OMB
Cc: Tony Whitson
Subject: A Few Additional Comments re:: 5NP Draft Regulations and FAQs

Hiello, Elizabeth

Here are just a few more thoughts I want to add.

The first are regarding language in the regulations that appears unclear or problematic in places, which were clarified so very effectively in the FAQs. My concern is that, since the FAQs do not become part of the law, the law itself will remain vague and subject to interpretations not in line with what the OMB intends in enacting these regulations. Some of these key issues need to be clearly stated in the regulation itself.

In Item#2. (and any other items that refer to the 5np treatment)—would it be helpful to replace “treatment” with “protocol, to alleviate confusion between the 5NP protocol and a possible illegal practice of medicine?

(Item 3 p 22 describes 5NP as a community-centered healing practice. Thinking of various forms of community healing practices: Are they also “practicing medicine” illegally?)

FAQ Items 9 & 14 state that in addition to registered 5NP Techs, “physicians with appropriate training” are also qualified to provide 5NP. This appropriate training stipulation does not appear in the actual regulation. I think it should be stated clearly in the regulation, so that it is clear that only persons who have had training in ear acupuncture will be practicing it on the public.

(FAQ)Items 10&11. “Good moral character as those traits relate to the candidate’s ability to perform the protocol”. The meaning of this sentence is not clear, as has been voiced by many participants.

The FAQs do make clear the Board's intention, but again, the language in the FAQs is not part of the law.

I did hear explained in the meeting that without that requirement, the board would have no basis for excluding anyone who met the requirements. But clarity is needed re: what kinds of person—who is a known member of the community, selected, trained, evaluated and passed in content and practice, by an approved 5NP training program, which then maintains a commitment to provide that person ongoing support— would need to be excluded? (Someone with real “bad moral character” would not get past all that vetting).

If that requirement stays in the reg, and if it must use the term “good moral character” then it needs to include language such as that in the FAQ: “ To be evidence of a lack of good moral character, the acts or conduct in question must be rationally connected to the applicant's ability to safely provide 5NP treatments.” and , **“as evidenced by:** (letters of

recommendation, the findings of the criminal background check, prior history, or whatever would be actual evidence of moral character).

Without stipulating what the criteria are for "good" or "bad" moral character, it remains a subjective value judgement, and open to changes in moral/cultural climate and interpretation.

Two other items where I'd like to support the proposed regulation as currently written:

(FAQ) Item 12. The length of training needed to safely and effectively provide this protocol . This has been well-established; there's no basis for changing it, and consistency of requirements is important for smooth implementation and coordination with established auricular acupuncture certification trainings.

(FAQ) Item 10. Those opposing the 18 min age kept repeating the worry that these regs allow "any 18 y/o" to practice 5np—ignoring the multiple additional qualifications, at each step of which the person's suitability and capability would continue to be assessed.

Thank you very much for reading through and considering all my concerns.

Nancy Whitson
former (retired, inactive) RN, PHN, NP, CNM, IBCLC

From: Matthew Jernstedt <[REDACTED]>
Sent: Tuesday, September 9, 2025 1:48 PM
To: ROSS Elizabeth * OMB
Subject: 5NP

You don't often get email from [REDACTED]. [Learn why this is important](#)

Hi there, I just want to give my support in favor of passing the 5NP bill to allow greater access to this helpful protocol. As a social worker, It would be extremely beneficial to have more tools, including 5NP, to better serve my community. I look forward to having access to 5NP Tech training starting next March!!

Sincerely,
Matthew Jernstedt

This email is confidential and may be legally protected. It is intended solely for the addressee. Access to this email by anyone else, unless expressly approved by the sender or an authorized addressee, is unauthorized. If you are not the intended recipient, any disclosure, copying, distribution or any action omitted or taken in reliance on it, is prohibited and may be unlawful. If you believe that you have received this email in error, please contact the sender and delete this e-mail and destroy all copies.

From: Jaxinn Kearns <[REDACTED]>
Sent: Tuesday, September 9, 2025 6:56 AM
To: ROSS Elizabeth * OMB
Subject: HB 2143

You don't often get email from [REDACTED]. [Learn why this is important](#)

Dear AAC and OMB,

I am writing to share my concerns regarding HB 2143, also known as the 5NP bill. I am not an acupuncturist or a licensed healthcare provider, but learned about this bill during a recent doctor's appointment. I feel compelled to add my perspective as an 18 year old member of the public with experience in peer mentorship and community health work through the Oregon Department of Human Services.

I have lived experience with PTSD, I have seen the devastating effects of addiction, and I deeply value affordable, accessible community healthcare. For those reasons, I find this bill both surprising and quite troubling. The idea that the OMB might allow any 18 year old with only a day or two of training to insert needles into vulnerable patients is alarming. The person who cuts my hair is required to complete far more training and oversight than what this bill proposes for someone performing a medical intervention.

This bill is framed as a way to increase access to care, but in reality, it risks lowering the quality of care for those who need it most. It is especially concerning that it targets marginalized populations, who already face inequities in healthcare, by offering them subpar treatment from undertrained providers. I understand that this is just one service out of what should be a comprehensive care plan, but it appears to be cutting corners. Rather than addressing disparities and systematic problems with our healthcare system, this approach seems to shortchange the very communities it claims to serve.

Oregon already has accessible acupuncture options, with coverage through Medicaid and other insurance programs. Licensed acupuncturists are well-trained professionals who provide safe, effective, and comprehensive care. If the true goal is to increase access, why not elevate and expand the role of these trained providers and increase the insurance acupuncture coverage mandate instead of carving off small fragments of their expertise and handing them to minimally trained individuals? At the very least, this treatment should remain within licensed medical offices and under the direct supervision of licensed acupuncturists. The relative safety of this treatment to date is due to being practiced with professional oversight and medical supervision. Stripping away those safeguards puts patients at unnecessary risk and I am offended that this is posing as a solution.

If we accept the logic of this bill, where does it stop? Could other medical procedures such as suturing or mole removal be reduced to "weekend certificates"? This path risks dismantling healthcare into fragments of superficial training, rather than preserving the integrity and safety of medicine as a whole. A barefoot doctor, a Traditional medical provider, a lay midwife doesn't gain a license in a weekend. This is a sloppy interpretation of grassroots medicine.

I urge the OMB to reject quick fixes and instead make decisions that support long-term, safe, and responsible healthcare for our communities. True access comes from empowering trained providers to practice at the top of their scope, not from lowering standards for the most vulnerable.

Thank you, J.P.

From: Jemila Hart [REDACTED] >
Sent: Tuesday, September 9, 2025 6:26 AM
To: ROSS Elizabeth * OMB
Subject: Written Comments for Acupuncture Advisory Committee Meeting on 9/12

You don't often get email from [REDACTED]. [Learn why this is important](#)

I support 5NP!

The 5NP protocol is a simple, safe and effective tool for treating addiction and trauma. 5NP becomes an especially powerful tool for healing when put in the hands of people working to address addiction and trauma in their own communities.

Jemila Hart, LAc

This email is confidential and may be legally protected. It is intended solely for the addressee. Access to this email by anyone else, unless expressly approved by the sender or an authorized addressee, is unauthorized. If you are not the intended recipient, any disclosure, copying, distribution or any action omitted or taken in reliance on it, is prohibited and may be unlawful. If you believe that you have received this email in error, please contact the sender and delete this e-mail and destroy all copies.

From: Sara <[REDACTED]>
Sent: Monday, September 8, 2025 2:41 PM
To: KINGHAM Gretchen * OMB; ROSS Elizabeth * OMB
Subject: For OMB AAC Meeting Packet Please

Dear AAC,

My name is Sara Biegelsen and I was a member of the community input based work group that just concluded on the 5NP Rules and Regulations. I wanted to reach out to this next phase of the Rules and Regs process to put voice to some of the sideline concerns that began to arise that were not actual draft material we were there to discuss.

If the topic of adding Supervision is actually addressed in your meetings, though it is not in the current draft of OMBs Rules and Regs, I would like to advocate against it.

Adding Supervision seems like a misuse of OMB time and money. If it seemed that adding Supervision as a requirement to 5NP Rules and Regs made Oregonians safer, I would not say this.

I do not believe that having a Supervisor actually increases safety. I believe it to be more of an obstructive bureaucratic layer to the process. I believe that the majority of 5NP practicing states function quite safely and well without Supervision as a component to their Rules and Regs.

Part of the information shared to 5NP Trainees (future 5NP Technicians) is that they are always able to reach out and check back in with their trainers if/when they need support or guidance. Additionally, there is typically a forum trainees are invited to upon completion of training so they have peer support available as well.

I did a little self-education and was looking at the OMBs 2 year process of **un**-supervising PAs between 2022 and 2024 seems like a lesson already learned.

Additionally, of the portion of states that have 5NP legislatures that include Supervision, I believe most are *general* as opposed to *direct*, and some are even beginning their process to remove the Supervision portion of their Rules and Regs.

5NP is a system created for and by communities to create access via trust. It seems having a supervisor's presence required not only makes access harder (finding someone willing to sit around while the 5NP clinic occurs) but also weakens the component of trust and community building that is central to 5NP and its generative second-hand benefits.

Thank you for your consideration.

And my apologies for taking up your time if this is not even something that you are discussing.

with gratitude,
Sara Biegelsen, LAc.

From: KINGHAM Gretchen * OMB
Sent: Monday, September 8, 2025 8:25 PM
To: ROSS Elizabeth * OMB
Subject: FW: In support.

From: Nikita Vincent <[REDACTED]>
Sent: Monday, September 8, 2025 4:50 PM
To: KINGHAM Gretchen * OMB <Gretchen.Kingham@omb.oregon.gov>
Subject: In support.

You don't often get email from [REDACTED] [Learn why this is important](#)

Nikita Vincent

[REDACTED]
[REDACTED]
[REDACTED]

September 8, 2025

Oregon Medical Board
Acupuncture Advisory Committee

Dear Members of the Oregon Medical Board,

I am writing in strong support of the continued approval and expansion of the 5 Needle Protocol (5NP) as a recognized and supported practice in Oregon.

As a person who has been clean for 24 years, I know firsthand the ongoing challenges of recovery. I had the opportunity to experience 5NP once, and I truly believe that if this practice were more widely available, it could provide meaningful support to others working to sustain their sobriety.

This tool is especially important for communities of color in rural areas, where access to culturally relevant and affordable recovery resources is often limited. By ensuring that 5NP remains a supported practice, the Oregon Medical Board can play a critical role in expanding access to care and giving people in recovery another pathway toward healing and stability.

I urge you to continue your support of 5NP as a needed and valuable practice for the health and well-being of our communities. Specifically rural communities where support is needed most.

Thank you for your leadership and commitment to expanding equitable health options in Oregon.

Sincerely,

Nikita Vincent

From: [REDACTED]
Sent: Monday, September 8, 2025 3:56 PM
To: ROSS Elizabeth * OMB
Subject: 5NP technicians

You don't often get email from [REDACTED] [Learn why this is important](#)

Attn: Acupuncture Advisory Committee of the Oregon Medical Board
Re: Rules for 5NP Technicians

**I am concerned about the safety of the practice of acupuncture in Oregon,
regarding the new practitioner, the 5NP technician.
I ask the Oregon Medical Board to take more time to write these rules.**

The 8-29-25 draft of the rules allows anyone age 18 or over to perform this medical treatment independently, with 31 hours of training. No medical experience required, no medical supervision or referral. No restriction on location- in the mall, on a bus, or anywhere.

This 8-29 draft lacks basic infection control items, even allowing patients to remove their own needles, exposing the public to bloodborne pathogens, a violation of OSHA & the CDC.

No documentation of the treatment is required. The patient's signature on a simple consent form suffices.

All of these items are inadequate by current medical standards.

One more- there is no oversight of the training institutions or entities by the OMB.

**I recommend that the Acupuncture Advisory Committee of the OMB
Continue the standard standards for 5NP technicians as your other practitioners.**

Jill Wyatt
Baker City, OR 97814

Dear Acupuncture Advisory Committee,

My name is Maddie Foley, DACM, LAc, and I practice in Lane County. I am the current Treasurer of the OAA, although I am not writing as a representative of the OAA. I am writing to urge for effective rulemaking recommendations regarding 5 NP, that are in line with established best practices from the 20+ states with similar laws. Most of the concerns we heard in the previous workgroup echoed similar conversations that were addressed and resolved within the OAA meetings, and incorporated both into bill language and rulemaking suggestions in good faith collaboration between OAA and 5 NP advocates. The completed and passed HB 2143 and rulemaking draft is the direct result of 2+ years of collaboration between 5 NP advocates and the OAA.

As acting Treasurer, I have been privy to much of the conversation that took place between 5 NP advocates (including myself), and the OAA board and Advocacy Committee over the past two years. Throughout this process, we have found that we have a lot of common ground regarding concern for patient safety, which has been a priority throughout the 5 NP conversations, and continues to be a priority. Fortunately, 5 NP is an extraordinarily safe, simple, and effective procedure when administered by individuals with proper training, and the training offered by POCA and NADA are both outstanding and appropriate for the level of care 5 NP techs will be performing.

There are a couple items of concern that came up in the workgroup which I would like to address directly, the first being proposed supervision of techs, which I strongly advocate against. For context, I am a volunteer at Serenity Lane in Coburg, where I provide weekly 5 NP treatments for a couple of hours for folks in both acute detox and residential programs. As an acupuncturist already working in this setting, I can attest from experience that it is completely unnecessary to have supervision of techs, and this would be a huge barrier to care and essentially invalidate the entire purpose of having the techs in the first place. Supervising techs would be a huge waste of my time, and I would be hesitant to sign onto that commitment if

asked because I know perfectly well that my role as a supervisor would be extremely minimal, and would not contribute to patient safety. Like most acupuncturists, I'm extremely busy, and don't have time in my schedule to sit around and watch other people perform the same protocol over and over again, nor is it professionally or intellectually stimulating for me to do 5 NP all day myself. If it's a job that I wouldn't want to do, then probably no one would want to do it, and given the already limited number of acupuncturists in our state, that would create a huge barrier to care that's completely unnecessary and not in line with well-established demonstrations of safety and best practice for 5 NP techs.

There are over 20 states that allow 5 NP to be performed by a non-acupuncturist technician, and of those states, 7 or so have supervision requirements of some kind. We have been advised repeatedly by 5 NP practitioners in other states to **avoid** any sort of supervision provisions in rulemaking, because of the unnecessary barriers that have predictably arisen from supervision requirements. **To be clear, supervision would nullify much of the purpose of having technicians in the first place, and make the existence of techs redundant in many ways**, which would be a terrible shame and ultimately pointless given the good that 5 NP could do for so many people, and its safety record. Safety training such as proper disposal of needles, clean needle technique, trauma-informed care, proper needling technique, adverse-effect mitigation and blood borne pathogens are already included in both POCA and NADA training. Additionally, it's a common practice for trainers of these programs to remain an ongoing point-of-contact for practicing technicians after they complete the program.

Additionally, I advocate against restricting the practice to any particular setting or practitioners holding other healthcare licenses. 5 NP, at its core, is a grassroots practice that is best served by meeting people where they are, whether that's in a church basement AA meeting or in the formal structure of a residential treatment facility. Recovery is dynamic, so any practice aimed at supporting recovery needs to meet the varied, dynamic needs of the people receiving care. I have personally delivered 5 NP in a number of non-healthcare settings,

including on the street, at health fairs, and in the Oregon State Capitol building, and the procedure was no more safe or effective because I'm a licensed acupuncturist—it was safe because I adhered to the same basic safety and sanitation protocols that are essential to the training of 5 NP technicians. You simply do not need a healthcare background to be able to understand and safely apply 5 NP, and the training is robust in comparison to the simplicity of the procedure.

So to the members of the AAC –please don't let the theoretically perfect get in the way of the pragmatically good. Some acupuncturists are just never going to like this no matter what, but please understand that we are doing this because people are dying and 5 NP can help. In Oregon we had almost 1,500 fatal overdoses in 2024 alone, and the impact of those numbers on our communities is staggering and devastating. **5 NP is not a threat to the sanctity of acupuncture, it is not a threat to the livelihoods of licensed acupuncturists, nor is it a threat to public safety or positive public perception of acupuncture.** This is our chance to make this practice widely available and to give acupuncture a deserved seat at the table to combat the severe challenges of public health in this day and age. I urge your support for a reasonable set of rules that are in line with the experience and advice of your fellow acupuncturists here in Oregon and in the 20+ states who have already taken on this work. Thank you for your considerations, and for volunteering your time to represent acupuncture in Oregon.

HB 2143- Rules Recommendations

9-8-25 Version/Arndt

Oregon Medical Board
Acupuncture Advisory Committee
1500 SW 1st Avenue, Suite 620
Portland, OR 97201

Re: Public Comment for AAC meeting regarding Division 71 Draft Rules Implementing HB 2143 (Five-Needle Protocol Technicians)

Dear Members of the Acupuncture Advisory Committee of the Oregon Medical Board, I come with years of experience in both western/conventional medicine and in acupuncture.

My career began as a nurse's aid in 1975, progressing to an LPN and then to an RN in 1980. My experience in Portland Adventist hospital included med-surg and ICU-CCU units. Then, it was quite the upheaval in 1982 when I announced I was leaving my successful RN career to study acupuncture! Back then we were the outliers. After working for decades to gain public trust, now it seems that many professionals want to jump on the wagon and add acupuncture to their scope, but they don't realize the complexity needed for practicing acupuncture and in some situations, for practicing medicine.

Below I suggest 3 models for the rules for the 5NP technicians,

depending on how much regulation is desired. The OMB could limit certain items for 4-6 years, reevaluate the rules then, and widen the application as decided. This is how LAc's evolved. In 1973 we could only practice in a MD/DO's office and we were "registered". Then we were required to obtain the patient's history or a referral in order to perform acupuncture. In 1991 we changed from "registered" status to "licensed" and gained independent practitioner status. In 1993 our scope of practice was broadened greatly.

I have serious concerns regarding the Division 71 draft rules for House Bill 2143, which involves a new category of "Five-Needle Protocol (5NP) Technicians." The law, HB 2143, begins with a contradictory definition of "5 Needle Protocol" (5NP), by describing it as: "the standardized five-needle treatment protocol in which five points on the human outer ear are stimulated with sterile, single-use disposable needles, ear seeds or ear beads..." then saying "the individual may not hold themselves out as being an acupuncturist or otherwise indicate that the individual is authorized to practice acupuncture, as defined in..." This can only be acupuncture but is not called acupuncture. This contradiction counters the typical statutory protections and sets a dangerous precedent for deregulation through reclassification. Thus, it creates a complicated situation for formulating the rules. This is compared to allowing an individual to drive without a license, as long as s/he reads up on driving and stays within 3 miles of their residence!

THE CURRENT REGULATORY STRUCTURE involves either:

- 1- obtaining extensive education/training and practice independently, OR
- 2- obtaining minimal education/training and practicing under the supervision of an extensively-trained practitioner and/or in an institution with extensive oversight.

Note: The lowest requirements for an individual to practice independently of extensively-trained practitioners, or outside of a standard institution in Oregon, are for LMTs who obtain 625 hours of training. It appears that lowest requirements in order for an independent practitioner in Oregon to perform an invasive treatment like insertion of needles are Licensed Acupuncturists.

The OMB has been regulating MDs for 136 years, Licensed Acupuncturists for 52 years, and Podiatrists & PAs for years. One would expect that suggestions for options B & C below would continue to be the standard for new practitioners like the 5NP technicians. It appears that only a minority of other states allowing 5NP allow it without supervision.

THREE POSSIBLE MODELS for RULES for 5NP Technicians

Model A- Techs are independent practitioners with minimal schooling

This is a huge departure from the current regulatory structure as above.

Note: Model A aligns with the situation in many other countries but is atypical for the OMB & the US.

Model B- Techs obtain minimal schooling with clinical supervision by trained practitioners

Model C- Techs are independent practitioners with substantial training but do not require clinical supervision

Note: Models B & C align the training and oversight of the current regulatory structure in Oregon, providing standard safety, quality of care and patients' rights to all populations of patients.

Note: HB 21243 does not define if 5NP Techs as independent practitioners, but left the regulation up to the OMB.

The 8-29-25 draft of the rules formulated by the workgroup seems to follow Model A. It contains many areas of hazards to patient safety and quality of care. Since the 5NP proponents desire easy access for their practitioners (as well as for patients), Model B seems most practical while promoting safety.

Sincerely,
Karina (Natalie) Arndt, Emeritus LAc, Retired RN

Recommendations for 5NP Rules- Modest Training w/Clinical supervision

Note:

Only the lines from the rules draft that require changes are included below.

Additions to the rules are in red. Deletions are in strike-out & in green.

Terminology

Since it appears that the 5NP technician/practitioner will be practicing medicine, omit "individual" and replace with "patient" throughout the rules, consistent with ORS 677.085. As needed, utilize the terms practitioner, treatment, etc.

Rule 00 Purpose Statement (847-071-0000)

~~Five-needle protocol (5NP) represents a unique fusion of ancient Eastern healing practices with modern social justice movements. In Oregon, 5NP is a standardized, supportive treatment for individuals experiencing substance use disorders, mental health conditions, and trauma. The five points are the shen men, sympathetic, liver, kidney and lung points.~~

Five-needle protocol (5NP) involves insertion of acupuncture needles at 5 acupuncture points on the human auricle. The five points are: shen men, sympathetic, liver, kidney and lung. 5NP is intended to provide temporary relief for individuals for symptoms of substance use disorder, mental health conditions, or trauma.

The Oregon Medical Board is responsible for establishing training and registration requirements and regulating the practice of 5NP technicians in order to expand access to safe, standardized, ~~low-barrier~~ easily accessible treatment and to do so in a manner that protects individuals in Oregon accessing 5NP treatments.

Rule 05 Definitions (847-071-0005)

(3) "Five-needle protocol" or "5NP" has the meaning given in Oregon Laws 2025, chapter 296, section 2, the standardized five-needle treatment protocol in which five points on the human outer ear are stimulated with sterile, single-use solid core, disposable needles, ear seeds or ear beads for the purpose of achieving temporary relief from the symptoms of substance use disorder, mental health conditions or trauma. The needles are not to exceed 0.5 inches in length.* The five points are the shen men, sympathetic, liver, kidney and lung points. The locations of the five points are as defined in common acupuncture texts.

**Note: One LAc stated that everyone had agreed, during the drafting of HB2143, that the needles were to be 0.5 inches or less. I endorse such limitation since it wards off applying needles to body points where organ damage can occur.*

Rule 07 Five-Needle Protocol Treatment (847-071-0007)

(2) An acupuncturist licensed under ORS 677.757 to 677.770 may provide 5NP treatment without ~~additional~~ obtaining 5NP registration.

(3) A physician licensed to practice medicine as a medical doctor or doctor of osteopathic medicine pursuant to ORS Chapter 677 may provide 5NP treatment without ~~additional~~ obtaining 5NP registration.

Rule 20 Qualifications (847-071-0020)

(1) An applicant for registration as a five-needle protocol (5NP) technician must:

- (a) ~~Be at least 18 years of age;~~ Be at least 21 years of age or direct supervision/onsite of tech ages 18-20;

Rule 25 Training Requirements (847-071-0025)

With a brief look, it looks acceptable, but we were not able to completely review this section.

847-071-0025 (2) The 5NP training program must include *

at least ~~30 hours~~ 60 hours* of didactic education

and ~~40 ears~~ 30 hours of supervised clinical training* and 40 ears needled during supervised clinical training,

Note: Licensed acupuncturists fulfill roughly 2500 hours of graduate-level education during a 3-4 year program.

**Note: Most phlebotomy programs require 40-80 hours of classroom training and 20-40 hours of clinical experience.* mechanisms to monitor a participant's engagement, and contain the following elements:

~~(a) Sanitation and hygiene techniques;~~

a) Full training in the items in the national standards for insertion of acupuncture needles,*

Note: this refers to the "Clean Needle Technique" from the NCCAOM, but likely is not available for this purpose.

**Note: 5NP technicians will complete the OSHA training as is required by the employer of the technician.*

- (b) Infection control precaution procedures,
 - (c) ~~Consent documentation and the individual's rights,~~
Standard medical documentation and protection of patients' rights, including but not limited to:
informed consent as defined by the Joint Commission, and as defined in Rule 40,
patient privacy and confidentiality,
documentation of patient's health condition, treatment given and any complications from the treatment.
 - (d) ~~Ear needling and point location,~~ points stimulated and which objects were utilized, including whether retained objects were placed in the ear,
 - (e) Plans to address potential risks, side effects, and complications,
 - (g) Trauma informed care and origins of 5NP,
 - (f) Collaboration with other 5NP technicians, health care providers, and community resources,
 - (h) Maintaining professional boundaries, and
 - (i) Reporting requirements.
- *Note: These requirements are based on the model of supervision of the 5NP technician by the appropriate independent practitioner, as defined in this document.*

(3) The OMB will approve and monitor any institutions or entities providing education, training and certification for 5NP technicians and 5NP trainers.

Rule 40 Five-Needle Protocol Regulations (847-071-0040)

- (3) A 5NP technician must obtain written informed consent from the ~~individual~~ patient or the ~~individual's~~ patient's representative prior to providing treatment ~~by~~ with inclusion of the follow items in the consent form:
- (a) Clearly explaining the 5NP treatment, including needle placement, duration, and expected sensations;
 - (b) Discussing potential risks, complications, side effects, and expected benefits of the 5NP treatment. ~~realistic treatment outcomes;~~
 - (c) providing a clear disclaimer that the patient understands that the 5NP treatment is limited by law to only provide temporary relief from the symptoms of substance use disorder, mental health conditions, or trauma.
 - ~~(d)~~ (d) Respecting the ~~individual's~~ patient's right to decline treatment or withdraw consent at any time;
 - ~~(e)~~ (e) Having the ~~individual~~ patient self-identify the reason(s) for the 5NP treatment and date of treatment.
 - (f) consent and agreement to care of retained objects
 - (1) retained objects (needles, seeds, beads) are to be removed and safely disposed of in 3 days or sooner,
 - (2) written and verbal instructions provided to patient including:
keep the ear dry when retained objects are in place,
remove retained objects sooner than 3 days if any irritation or discomfort occurs, and
seek medical treatment if signs of infection appearing.

Note: For more information on written consent, see <https://govfacts.org/explainer/your-medical-rights-healthcare-consent-privacy-and-refusal/>: "For consent to be legally and ethically valid, healthcare providers must cover five essential elements as required by [The Joint Commission](#) and medical ethics boards.

Note: Commenters stated that standards typical of medical clinics may be offensive for some patients, since they may not want to reveal their personal information and that the treatment is complete even if there is no dialogue with the patient. An omission of these typical medical standards appears to deprive such patients of their rights and discriminate against them.

- (5) For the ~~individual and~~ patient and the 5NP technician safety and identification, the 5NP technician must:
 - (a) Use only sterile, single-use disposable needles, no longer than 0.5 inches in length, ear seeds, or ear beads;
 - (b) Adhere to sanitation and hygiene protocols, including but not limited to protocols of the NCCAOM's Clean Needle Technique
 - (c) Meet community standards of care; ~~and~~
 - (d) Establish clear procedures for handling complications or adverse reactions.
- (6) For the patient and 5NP technician safety, a 5NP technician is prohibited from:
 - (a) placement with retention of objects cited in (3) (f) (1) into the external ears of patients with diabetes mellitus,
 - (b) stimulation of any locations on the ear by electrical, laser, or non-needle means,
 - (c) treatment of patients under the influence of alcohol or drugs,
 - (d) allowing patients and individuals without documented training in national standards for use of acupuncture needles, or OSHA's Bloodborne Pathogens Standard (29 CFR 1910.1030 from removing needles from patients, *
 - (e) Require nametags identifying practitioners as "5NP Technicians with a QR code for reporting incidents." **

**Note: OSHA standards are determined by the employer, although permitting practice without running water, relying solely on hand sanitizer, and allowing patients to remove their own needles violates CDC infection-control guidelines (CDC, 2019) and OSHA's Bloodborne Pathogens Standard (29 CFR 1910.1030). These provisions expose patients and communities to avoidable risks of infection, bloodborne pathogen transmission, and unsafe sharps disposal.*

***Note: Recommend this for all settings to clarify the public that the technician is not an LAc or physician.*

LACs were initially required to wear a nametag anywhere, now it is only required in multi-disciplinary clinics.

Place this subject of supervision of technicians in the appropriate Rule section.

Clinical Supervision: Refer to standards in the medical field.

Suggestions:

- phone contact with the supervisor is required at all times,
- onsite supervision is not required at all times, except for the 5NP technician who is:
 - under the age of 21, or
 - the 5NP technician who has accrued 160 hours of supervised clinical practice.
- supervisors are LAcS, MDs, DOs, RNs, PAs, Podiatrists, and NDs who are either licensed or qualified to practice acupuncture or are registered with the OMB as 5NP technicians.

Note: Onsite, direct supervision is not required of other medical practitioners like RNs and Emergency Responders.

Note: consider wording that the OMB will reevaluate these rules in 5 years.

Rule ?? Discipline (847-071-00__)

Implement biennial random audits of at least 2% of registrants.

Rule 42 Billing & Marketing:

Prohibit billing of Medicare/Medicaid.

Require clear public disclosure of technician status and Medicare/Medicaid non-coverage.

Require clear disclaimer that the 5NP is limited by law to only provide temporary relief from the symptoms of substance use disorder, mental health conditions, or trauma.

Note: There is no evidence that an agency like the OMB is able to "Require" or even recommend malpractice insurance.

Rule 45 Infection Control:

Require exposure control plans similar to OSHA requirements for a workplace with exposure to bloodborne pathogens, as well as standard sanitation and safety standards, including but not limited to Sharps disposal, HBV vaccination, PPE, and post-exposure protocols required.

**Note: OSHA standards are applicable only in workplace situations.*

Note: a patient can easily contaminate their hand w/their own blood, use the door knob, another person uses the door knob and then contacts the blood material.

Rule 47 Adverse Events:

Enforce facility standards for sanitation and emergency preparedness.

Mandatory reporting of adverse events within 10 days of the occurrence of the event.

Rule 47 Facility Standards

5NP treatments to be performed only by established medical or detoxification clinics, to be re-evaluated by the OMB after the rules have been in effect for 5 years.

This wording would make it available for a clinic to offer 5NP in public areas.

Treatment areas must be cleanable, adequately spaced, and equipped with handwashing or sanitizer facility.

Appropriate placement needed for this item:

Continuing Education

Require 2 hours every 2 years with renewal. Include a broad option of topics: community health issues, etc.

Misc Notes

Age Requirement:

Because of the education requirements to become **any type of independent practitioner in Oregon**, all such individuals are at least 21 years old. Requiring 5NP techs to be 21 seems reasonable, and defensible legally.

In Oregon, one must be 21 to:

drink alcohol, be employed at premises dispensing psilocybin or cannabis, or to play a Video Lottery game.

In most states, one must be 21 to:

obtain a credit card without a co-signer, adopt a pet, reserve travel accommodations, fly a plane, obtain a concealed weapons license, and gamble in casinos.

Standard education & training for professionals inserting needles

Body piercing: 750 hours of theory and practical education.

Tattoo artists: 360 hours of training.

Phlebotomists: 60-120 hours of classroom training & clinical experience, not independent practitioners.

Retained Objects: Ear Needles, Seeds or Beads

The ear is mainly cartilage, plus it gets poor circulation because of its location. If the ear becomes infected, then it does not heal quickly compared to other tissues, and can more easily result in the loss of part or all of the external ear.

There is no research showing that retained objects, tiny ear needles or ear seeds or beads cause redness or irritation of the ear, IF retention or embedded application is used, these safety parameters come to mind, and this topic to be included in the didactic hours and examination portion of the training.

- not used for patients with diabetes mellitus

- retention time not to exceed 3 days

- patient instructed to remove needles, seeds or beads if any irritation, swelling or redness appears on the ear.

- seek medical advice if signs of infection appear.

- only to be used in established medical clinics such that the patient can be monitored as needed

Note: no research was quickly found regarding irritation and infection from retained acupuncture objects in the auricle.

Much information is available on the internet regarding auricle infections and complications.

In my encounters with retained objects, a patient came to me who had not removed the bead in weeks, and it was halfway embedded into the ear. I have diabetes and I can develop redness and discomfort after only 3 days retention of ear tacs. I saw this occasionally with my patients as well. Other LAc's & a physician I spoke with recently has seen it from ear seeds and beads.

Location & Safety

Emergency Responders and RNs practice their medicine in compromised locations. They are trained extensively to accomplish this & practice in coordination with medical personnel off site. The tech may be in an entirely different situation- one may begin practicing medicine alone, in locations like a shopping mall, bus, etc., & after 30 hrs of education & 40 ears. Consider that the tech may be 18 years old with no previous job experience, no medical experience other than this small training, and not necessarily being a high school graduate. Drastically different than an EMT, emergency responder on the highway, or an RN in the patient's home.

"It only takes a few hours to learn to do the 5NP treatment"

Yes, it's easy. However, the 5NP Tech needs many additional hours to practice this medical treatment safely, especially if the tech would practice independently.

"5NP is not the practice of medicine"

Actually, it likely is. A legal decision may be required to confirm this. See notes below.

"There is no liability insurance for 5NP Techs"

I would predict that insurance companies would devise this if requested.

THE PRACTICE OF MEDICINE

Is an individual providing 5NP treatments “practicing medicine”?

Compare the definition of the practice of medicine with the wording implemented from HB 2143:

The Practice of Medicine: ORS 677.085

“What constitutes practice of medicine...”

“(4) Offer or undertake to diagnose, cure or **treat in any manner**, or by any means, methods, devices or instrumentalities, any disease, illness, pain, wound, fracture, infirmity, deformity, defect or (any) **abnormal physical or mental condition of any person.**”

Division 71: Five-Needle Protocol 847-071-0000:

The five-needle protocol (5NP) is a standardized, supportive **treatment** for **patients** experiencing substance use **disorders, mental health conditions, and trauma.**”

847-071-0000 Purpose Statement:

The five-needle protocol (5NP) is a standardized, supportive **treatment** for **patients** experiencing substance use disorders, mental health conditions, and trauma. The Oregon Medical Board is responsible for establishing training and registration requirements and regulating **the practice** of 5NP technicians in order to expand access to safe, standardized, low-barrier **treatment.**

Proponent say that this is intended to be in a “community-based” setting. However, it is still a medical treatment, and individuals are still patients. It has also been said that “5NP involves minimal record-keeping since it's a non-verbal intervention using standardized points without making a diagnosis”. 5NP techs will still be practicing medicine, and it'll be based on the diagnosis in the law.

Qualifying Diagnosis

The language in this law is difficult to apply. The tech has no medical training, yet is authorized to administer a medical treatment, and for 2 medical conditions and for a general condition of “trauma”. Yet, 5NP can only be accomplished by a diagnosing practitioner providing the diagnosis of the 3 conditions which qualify for the 5NP treatment.

What is the practice of patients reporting their own diagnosis, ie, “self-identifying”?

Note: LAc's are not authorized to diagnose their patients' conditions, but they allow patients to identify or report their western medicine diagnosis. This “self-identified” diagnosis is utilized for medical documentation of what the patient is reporting, and for the purposes of billing. LAc's are authorized to diagnose the patient according to TCM system.

Consider:

OMB either requires a diagnosis from a qualified practitioner, or investigates a solution for this conundrum.

From the Oregon Medical Board Report, Summer 2025:

The mission of the Oregon Medical Board is to protect the health, safety, and wellbeing of Oregon citizens by regulating the practice of medicine in a manner that promotes access to quality care.

From: Yarrow Geggus <[REDACTED]>
Sent: Monday, September 8, 2025 1:06 PM
To: ROSS Elizabeth * OMB
Subject: Written Comment - HB 2143 Workgroup Five-Needle (5NP) Protocol

You don't often get email from [REDACTED] [Learn why this is important](#)

To the Oregon Medical Board and the 5NP Workgroup,

I strongly support the 5 Needle Protocol (5NP) in Oregon. Please support the development this unique intervention by keeping the regulations simple and barriers to become a technician low, to ensure that 5NP becomes truly accessible and available across our state to those who may benefit.

As someone who uses 5NP to manage C-PTSD and stress, I know first hand how quickly it calms the nervous system without side effects. It's simple, gentle, and empowering. Unlike other treatments, 5NP doesn't require talking or reliving trauma—just a quiet space and a trained technician.

This safe and simple practice has already proven itself in addiction treatment centers, disaster zones, and prisons. Expanding access through non-acupuncturist technicians will help bring this valuable tool to more people who need it—especially when delivered by peers with lived experience. Oregon deserves a diverse, community-rooted 5NP provider network.

This is not just a healthcare issue—it's a matter of social justice. 5NP is safe, effective, and accessible, and has the potential to benefit everyone, especially communities most impacted by substance use, poverty, and systemic injustices like racism and ableism.

Thank you for centering the community-first spirit of HB2143 and your hard work on developing appropriate rules and regulations to ensure that 5NP becomes truly accessible and available across our state to those who may benefit.

Yarrow Geggus, M.S.

Southeast Portland, OR.

97215

This email is confidential and may be legally protected. It is intended solely for the addressee. Access to this email by anyone else, unless expressly approved by the sender or an authorized addressee, is unauthorized. If you are not the intended recipient, any disclosure, copying, distribution or any action omitted or taken in reliance on it, is prohibited and may be unlawful. If you believe that you have received this email in error, please contact the sender and delete this e-mail and destroy all copies.

September 8, 2025

Attention: Acupuncture Advisory Committee and Member of the Oregon Medical Board

My name is Jennifer Kehl. I worked for 20 years as a nurse in the ER, and now work as an acupuncturist in a community clinic. I also provide acupuncture for addiction/recovery in a harm reduction program. I am writing in support of House Bill 2143.

As a nurse working in an ER where a majority of the patient population consisted of those struggling with mental illness, homelessness, and substance abuse, I saw first hand what harm reduction means, and what it can do for those with limited resources.

You may hear many statistics today about the breadth of the addiction and mental health struggles in our country. Those statistics represent people I would see everyday. People like:

- The 32 year old woman struggling with alcoholism whose funeral we had in our chapel.
- The 27 year old young woman who almost needed her leg amputated due to damage to vessels in her leg from IV heroin use.
- The man who had so many abscesses from heroin use that my nurse friend told me through tears "I don't even know where to start".
- The young man who swallowed his meth stash while being arrested. He had a fever of 107 and a heart rate of 200 in the ER. He was pronounced dead later that day.
- The 20 year old college student with mental illness and a developing meth addiction whose desperate mother screamed at me through the phone "JUST DO SOMETHING!!!"

With these and countless other images in my mind, I can't see any reason why we shouldn't use every single tool we have in our toolbox. It's imperative that we care for our fellow human beings in whatever way we are able.

Although I am fairly new to the acupuncture profession, I have already seen how regular acupuncture can help with harm reduction. I think about a patient I saw in my internship. He was coming in for neuropathy and blurted out one day "I don't want to drink anymore, it's weird! My family doesn't even believe me, I've been drinking every day for 30 years!" I frequently add the 5 needle protocol to my treatments for those who mention wanting help with smoking cessation, or just wanting to drink less. Even though people may only come in every week or two, they all report at least "cutting down". I hear this a lot: "I just don't think about it as much".

As an acupuncturist, I also use 5 needle protocol every day for those struggling with mental illness and trauma. Besides the immediate calming effects, patients have reported after several treatments that they are still sad or stressed sometimes, but they don't feel the physical effects in their body as much, and they report recovering much quicker when they are struggling.

This medicine is cheap and effective. It is safe and can be taught easily to non-acupuncturists. This is not about the acupuncture profession or bureaucracy. This is about our responsibility as human beings to care for each other in any way we can.

Thank you for considering my support of House Bill 2143.

Jennifer Kehl, RN, LAc



From: letty chichitonyolotli <[REDACTED]>
Sent: Sunday, September 7, 2025 2:21 PM
To: KINGHAM Gretchen * OMB
Subject: 5np community commentary and testimony

You don't often get email from [REDACTED] [Learn why this is important](#)

My name is Letty Dogheart

I am writing as a member of the community. As a disabled veteran and community worker with a background in public health

I am writing specifically to advocate for the 5NP training requirements to be no more than 30 hr and 40 ears.

Asking for more than this is asking for a more specialized scope of practice outside of the 5 points that 5NP training traditionally train for.

I do not aspire to be or desire to be an acupuncturist tho this training may inspire others to pursue and education to become one

Asking for more than 30 hrs and 40 ears in training is creating an undo barrier for people who don't have the privilege of time or the financial access to pay for a longer training that are typically used as a compliment to current efforts people are engaged in in community care work.

Additionally it's ableist. I have PTSD, which has caused changes in how my brain operates. I joined the United States Navy because of plans to go to Med school after my time. Unfortunately, I was unable to pursue that dream. However, community herbalist courses, one off trainings on suicide prevention and other community/public health courses offered through local non profits and institutions that provide CEUs to licensed professionals have afforded me the opportunity to continue my education to better serve my community as a community member.

Additionally, requiring supervision for a community worker level of training creates another undo financial barrier to potential 5NP techs who often are getting this training as a way to provide care for the communities they are part of in a community setting. Many of whom belong to historically excluded populations. NOT as a way to make a career solely on 5NP.

Lastly, the proposed increase of minimum age to 21 to register to be a 5NP tech is not only ageist but cynical. Youth under 18 in Oregon who are candidates for attending a training to become a 5NP Tech are not randomly attending a course to help care for community just to do it. They are already connected to community and already in relationship with peers and adults who are in these community caretaking roles. The relationships to community are what makes 5NP as a modality of care to community uniquely the People's Medicine.

We have the opportunity to equip Oregonians with tools to develop skills to care for one another in places and setting Licensed acupuncturists are not typically at. Exposing individuals to the benefits of acupuncture and connecting them to further and more individualized care.

Acupuncturists who are in relationship with future 5NP techs will benefit from the potential referrals to ongoing care. And as a whole, Oregonians will benefit from the access to low barrier care resources and connection to community.

thank you for your time and consideration.

letty dogheart

Disabled United States Navy Veteran, Community Herbalist, Health Educator and Farmer

From: maria chernishoff <[REDACTED]>
Sent: Sunday, September 7, 2025 2:14 PM
To: KINGHAM Gretchen * OMB

You don't often get email from [REDACTED] [Learn why this is important](#)

Hi Gretchen im writing in regards to the 5NP .please pass this bill so more people can help others with passed trauma situations and addictions.people who do reflexology can boost mentalhealth benefits with adding the 5NP to the sessions. I

From: PJ Alexander <[REDACTED]>
Sent: Sunday, September 7, 2025 8:36 PM
To: ROSS Elizabeth * OMB
Subject: Written Comment - HB 2143 Workgroup Five-Needle (5NP) Protocol

You don't often get email from [REDACTED] [Learn why this is important](#)

Dear Oregon Medical Board and 5NP workgroup -

Thank you for taking the time to hear feedback from the community in regards to implementing 5NP throughout Oregon.

I have worked in direct service roles supporting my community for the past 5 years. From my experience, it is clear that there are many holes in our current social safety nets. 5NP in Oregon would help knit together part of this net, as it has the potential to ease the pain of thousands of Oregonians.

As outlined by Cicely Saunders's, [pain is not simply physical](#); it is composed of a person's physical, psychological, social, spiritual, and practical realities. Unlike other forms of care, 5NP has the potential to address pain's multiple facets. On top of physical pain relief, these 5 pins/seeds offer social, psychological, and spiritual relief because they can be administered by a peer in a community setting.

Additionally, it empowers community members - who may have limited time & money - the opportunity to gain a tangible healing skill they can use to directly support their community.

I currently attend an acupuncture program, and I have seen first hand the power and healing available in just these 5 needles! During a supervised intern shift, I needled someone's ears with the 5NP protocol; when they came back to my shift the next week they reported better sleep & improved mood during the days directly following the treatment. This is just one example of the hundreds of people I have used 5NP to treat. I wholeheartedly support 5NP's structured and timely arrival to Oregon, and thank you for taking the time and energy to bring this important medicine to our state!

Be well -
PJ Alexander

From: Nancy Whitson <[REDACTED]>
Sent: Sunday, September 7, 2025 10:20 AM
To: ROSS Elizabeth * OMB
Cc: Tony Whitson
Subject: Comments on 5NO meeting of September 3

Dear Ms. Ross and OMB Members

I want to thank the OMB and members of the Workgroup for all the hard work they've put towards moving this bill towards implementation. I've followed this closely from Salem in January through the work group sessions, because I see that what this bill does is so important..

I'm kind of an old person, and maybe one of the truest things I've learned in my career in health care, and in my life, is this: As a community, as a state, as a city or society, we are only as strong, only as secure as our weakest, and most vulnerable. It can seem possible or convenient to ignore their needs, but in reality their weakness weakens all of us. The rollout of 5NP in Oregon is important for the strength and well-being of our communities, through both greater access to a basic tool for health, and building community connection and empowerment.

I especially appreciate the effective, clarifying FAQs, and how well they elaborate the underlying goal of the 5NP project.

What I want to comment on in this letter is an item in the FAQs that is crucial to the development of all the regulations;

Item #3, on the origination of 5np, relates how the activists transformed a hospital detox program into a community-centered healing practice. "This grassroots origin reflects **the protocol's core values of accessibility, community empowerment, and culturally responsive care**, establishing it as **more than just a medical intervention but as a tool for social healing** that emerged from communities most affected by addiction and trauma. The protocol's evolution from this activist foundation to its current global application **maintains its commitment to serving underserved populations and providing trauma-informed care that honors both individual healing and collective community wellness.**"

My first job as a Nurse Practitioner was with a migrant farmworker program in Iowa. The training included attendance at the annual National Farmworkers Health conference in San Antonio. The thread that ran through everything, the core foundation at the focus, was the myriad kinds of barriers various populations experience to healthcare and known effective strategies for overcoming the barriers; and the stark

reality that no kind of health program, technology, or medicine can be effective if people don't access it.

The factor that most determined people receiving the care was, we went to them-- where they were (at their worksites), when it would work for them (at the end of their workday).

Other crucial factors were trust, (including across the power gap of class difference), affordability, familiarity (establishing consistent relationships with us), and respect for their autonomy and cultural ways of being. These were most strongly afforded by the health care team consisting of people who were like them--yes, protocol-trained community health promoters were part of the team-- and meeting them/providing care as a community experience. In every one of these aspects, the crucial factor was to find how best we could go to them, where they were.

I feel strongly that the regulations that will shape and define what 5NP becomes in Oregon, and what it will accomplish, depends on how closely it embodies the protocol's core values so beautifully written into item #3 of the FAQs: accessibility, community empowerment, and culturally responsive care.

I so appreciate the process the OMB and Workgroup committees have taken to carefully tease and hammer out to enact this 5NP Tech role with the best possible balance between ensuring the necessary safety and accessibility. (what a remarkable collaboration!)

The biggest issue that persists in the discussion that places the biggest barrier to the access this bill is aiming for, is that of requiring that 5NP Techs be supervised by some kind of licensed person. Glaringly apparent is the severe restriction this would place, and I don't see any benefit from it. Would it require the licensed person to be present with all the techs? Or would it be a matter of a licensed person merely signing off on the work of people they haven't been present for? (but would be assuming responsibility for)? It could only create a large amount of bureaucracy that would consume and strain the scant resources available, and would greatly restrict the possible provision of care.

And, it's unneeded. A person practicing under a protocol is very often a person with a solid training focused in a narrow, well-delineated procedure or set of actions; they develop the expertise required to provide the protocol at a high level of quality, within the less extensive amount of training, because the protocol is so defined and limited. I have worked in several situations utilising protocol-trained health workers, who are able to efficiently can deliver excellent quality to wider populations; these also offer the great advantage that the training is focused enough that it is possible to offer to less-resourced communities; so also, involving them, increasing their autonomy over their own care, and making possible that they own their own care.

And just one more time I want to say that we all, as an entire community, are likely affected in some way by addiction, and we are all, certainly, in the present time affected by trauma. We are not doing this “for” someone else, we are doing what it takes to make us all stronger and healthier together; we all need this kind of expansion of access, now more than ever.

Thank you for your consideration, dedication and commitment to listening to the community.

Nancy Whitson

From: Arielle a <[REDACTED]>
Sent: Saturday, September 6, 2025 10:55 AM
To: ROSS Elizabeth * OMB
Subject: In support of 5NP law

[You don't often get email from [REDACTED]. Learn why this is important at <https://aka.ms/LearnAboutSenderIdentification>]

To whole it may concern,

Overjoyed that this law of 5NP is becoming reality. Oregon needs it more than ever to support all kinds of populations of folks, from people recovering from drug addiction, to survivors of trauma and abuse, to people who are simply depressed and need a little extra support. It is amazing to make this available to the public and will absolutely make an enormous positive impact on the community.

Many licensed acupuncturists in Oregon are screaming that it is “dangerous” and that is just not the truth. They feel threatened and are using “public safety” and “danger” as buzzwords to get the attention of the OMB. However, anyone who takes any time to look into that will see that, that is just their opinion and there is no data to back up those claims. The facts are that ear acupuncture, with adequate training (which does not take long) is one of the safest and easiest interventions one can do for ptsd, addiction, trauma, stress, and more. It helps with so many things, in community, and facilitated in community. These people coming out in opposition are not going to be the same folks who would be in the street or in the AA recovery group etc offering 5NP anyhow, either. They feel threatened and angry because school takes such a long time for them but 5NP is simple and does not require any sort of foundations in Chinese medicine!! It has radical roots and has infinite more benefits than down sides. 5NP is generally not for profit beyond training folks how to do it and is an intervention by and for the people. I urge and encourage the OMB to continue to support 5NP law and the necessary training guidelines to make this reality. I am certain OMB has excellent judgement and will find a way to work with the acupuncture community to ensure public safety- the people screaming it will not be safe do not seem to have the same faith. Please stay grounded in the facts rather than let angry folks who are more concerned with making sure that other people do not use needles, than for public health.

Thank you
Arielle Avenia
L.Ac. Candidate, Masters Certificate in Acupuncture

From: Dolores Jimerson <[REDACTED]>
Sent: Wednesday, September 3, 2025 5:46 PM
To: ROSS Elizabeth * OMB
Subject: 5NP comments

Follow Up Flag: Follow up
Flag Status: Flagged

Hi Elizabeth,

I regret I needed to leave the 5NP meeting, but wish to share some comments regarding dubious moral character. In my experience many of my technicians come with a lived experience. The Spirit of NADA is about the absence of ego and removing barriers to increase access. I work with tribal communities and our worldview is a relational one, language needs to be clear and literal. That being said, why not use more specific language?

Technicians shall abide by the laws/rules that govern 5NP technicians and will be self-aware, practicing in a culturally safe and trauma informed manner.

Terms like self-awareness, cultural safety and trauma informed care can all be defined specifically.

Respectfully submitted,

Dolores

Dolores Jimerson, LCSW, ADS, RT
Behavioral Health Education Director
Northwest Portland Area Indian Health Board
Email: [REDACTED]

NPAIHB serves the 43 federally-recognized tribes of Oregon, Washington and Idaho and our office is located within the traditional and ancestral homelands of the Multnomah, Kathlamet, Clackamas, Tumwater, Watlala bands of the Chinook, the Tualatin, Kalapuya and many other indigenous nations of the Willamette and Columbia River regions.

EMAIL CONFIDENTIALITY:

This message is a confidential communication from Dolores Jimerson. The information contained in this communication, and any attachments thereto, is privileged and confidential and intended solely for use by the addressee(s). Any other use or dissemination, or copying of this communication is strictly prohibited. If this was erroneously sent to you, please notify Dolores Jimerson and permanently delete the original and any electronic or printed copies of this electronic communication. Thank you for your assistance.

From: Lisa Rohleder <[REDACTED]>
Sent: Tuesday, September 2, 2025 12:49 PM
To: ROSS Elizabeth * OMB
Subject: clarification ahead of the workgroup meeting

Follow Up Flag: Follow up
Flag Status: Flagged

Hi Elizabeth,

thanks for posting all the materials ahead of the meeting! I reviewed the comments and I wondered if it's necessary to clear up some misunderstandings (which a number of acupuncturists share). Please disregard if not helpful. If it's appropriate to add to public comment that's fine with me.

One of the training suggestions from Karina (Natalie) Arndt was:

NCCAOM Clean Needle Technique course (8 hrs)
OSHA Blood Bloodborne Pathogens training course & HIPPA protocols- if needed above CNT course

The NCCAOM does not offer the Clean Needle Technique course — it's offered by CCAHM, the Council of Colleges of Acupuncture and Herbal Medicine. We are in the process of signing our new students at POCA Tech up for it now. The course availability is very limited and registration is difficult and frustrating even for acupuncture students enrolled in an accredited acupuncture school. The material essentially duplicates what is offered in the POCA/NADA training under the heading of clean field, sanitation, and blood borne pathogens. To require it would be needlessly redundant and registering for CCAHM's course would create unnecessary barriers for 5NP Techs due to CCAHM's limited availability. As you know we discussed the need not to describe this part of the training as "Clean Needle Technique" because that term is proprietary to CCAHM. As a result, however, some acupuncturists may misunderstand that this material is not part of the required training when actually, it is.

Similarly, acupuncturists often misunderstand the role of OSHA. The OSHA blood borne pathogens training is targeted to EMPLOYERS, not practitioners. It is not appropriate for an individual 5NP Tech learning about blood borne pathogen safety (or even an individual acupuncturist). OSHA applies to employers, not individuals. Similarly -- I believe this was already noted -- HIPAA (not "HIPPA") applies to the electronic transmission of health information. Acupuncturists often use HIPAA as a sort of shorthand for patient confidentiality but it's significantly different.

There was more than one comment to the effect of "A patient who is inebriated or under influence of drugs will not be given the 5NP treatment." Historically, 5NP was administered to patients entering Central City Concern's Hooper Detox as part of the admissions process for detoxification. (I used to work there, and this was part of my job.) The reason that 5NP is also known as "acudetox" is that it was designed to be offered to patients who are seeking detoxification treatment. My understanding is that CODA hopes to use it for this purpose in their new detoxification center in Washington County.

thanks again,

Lisa Rohleder, L.Ac. she/her



<https://workingclassacu.substack.com/>

This email is confidential and may be legally protected. It is intended solely for the addressee. Access to this email by anyone else, unless expressly approved by the sender or an authorized addressee, is unauthorized. If you are not the intended recipient, any disclosure, copying, distribution or any action omitted or taken in reliance on it, is prohibited and may be unlawful. If you believe that you have received this email in error, please contact the sender and delete this e-mail and destroy all copies.

From: Shannon Conrad <[REDACTED]>
Sent: Monday, September 1, 2025 7:26 PM
To: ROSS Elizabeth * OMB
Subject: Concerns Regarding the Recently Passed OMB Law Allowing subpar 5np training

Hi Elizabeth and OMB board,

I understand that this unfortunate law has already passed, and it may be too late to reverse it. However, I strongly urge you to uphold your duty to protect the public and place safety first. Please do not allow unqualified, undertrained individuals to practice medicine under the guise of acupuncture.

Even if limited to the 5NP ear protocol, acupuncture is still a medical procedure requiring skill, clinical judgment, and a foundation in the theory of Chinese Medicine. Without rigorous training, Clean Needle Technique, and clinical supervision, this becomes a dangerous, diluted form of medicine that jeopardizes patient safety.

I must ask: is this legislation truly about patient care, or is it simply a money grab by organizations looking to profit from training programs for minimally qualified practitioners? Here in Portland, we are fortunate to have a highly respected acupuncture school with teachers who possess advanced training and decades of experience. Why are we undermining their expertise and the profession's integrity by lowering the bar and handing medicine over to those with insufficient preparation?

If this law is to remain in place, at minimum it must be implemented with safeguards equivalent to those for licensed acupuncturists, including:

- 150 supervised clinical hours and 60 didactic hours.
- Treatments to take place in a clinical setting, with proper sanitation and EHR charting ability
- A college degree and a minimum age of 21 for maturity and professionalism.
- Certification in Clean Needle Technique.
- Ongoing supervision by a licensed acupuncturist.
- Equal licensing fees, malpractice insurance, and continuing education requirements.

To allow anything less is to weaken medical standards and risk public harm. I am disappointed this law was passed without adequate representation of our profession, but I urge you now to exercise your authority to enforce the highest medical standards. The public deserves nothing less.

Sincerely,
Shannon Conrad, LAc

--

Shannon Conrad
[REDACTED]

Dear Workgroup Members,

I come with years of experience in both western/conventional medicine and in acupuncture.

My career began as a nurse's aid in 1975, progressing to an LPN and then to an RN in 1980. My experience in Portland Adventist hospital included med-surg and ICU-CCU units. Then, it was quite the upheaval in 1982 when I announced I was leaving my successful RN career to study acupuncture! Back then we were the outliers. After working for decades to gain public trust, now it seems that many professionals want to jump on the wagon and add acupuncture to their scope, but they don't realize the complexity needed for practicing acupuncture and in some situations, for practicing medicine.

Below I suggest 3 models for the rules for the 5NP technicians, depending on how much regulation is desired.

The OMB could limit certain items for 4-6 years, reevaluate the rules then, and widen the application as decided. This is how LACs evolved. In 1973 we could only practice in a MD/DOs office and we were "registered". Then we were required to obtain the patient's history or a referral in order to perform acupuncture. In 1991 we changed from "registered" status to "licensed" and gained independent practitioner status. In 1993 our scope of practice was broadened greatly.

Sincerely,

Karina (Natalie) Arndt: LAC since 1987, Emeritus LAC since 2020; Retired RN with 38 years in western medicine

THE CURRENT REGULATORY STRUCTURE involves either:

- 1- obtaining extensive education/training and practice independently, OR
- 2- obtaining minimal education/training and practicing under the supervision of an extensively-trained practitioner and/or in an institution with extensive oversight.

Note: The lowest requirements for an individual to practice independently of extensively-trained practitioners, or outside of a standard institution in Oregon, are for LMTs who obtain 625 hours of training. It appears that lowest requirements in order for an independent practitioner in Oregon to perform an invasive treatment like insertion of needles are Licensed Acupuncturists.

The OMB has been regulating MDs for 136 years, Licensed Acupuncturists for 52 years, and Podiatrists & Pas for years. One would expect that suggestions for options B & C below would continue to be the standard for new practitioners like the 5NP technicians. It appears that only a minority of other states allowing 5NP allow it without supervision.

THREE POSSIBLE MODELS for RULES for 5NP Technicians

Model A- Techs are independent practitioners with minimal schooling

This is a huge departure from the current regulatory structure as above.

Note: Model A aligns with the position taken by many Republican and Libertarian lawmakers in Oregon.

Model B- Techs obtain minimal schooling with clinical supervision by trained practitioners

Model C- Techs are independent practitioners with substantial training but do not require clinical supervision

Note: Models B & C align the training and oversight of the current regulatory structure in Oregon, providing standard safety, quality of care and patients' rights to all populations of patients.

Note: HB 21243 does not define if 5NP Techs as independent practitioners, but left the regulation up to the OMB.

General Rules Suggestions for all 3 models:

Rule 00 Purpose Statement (847-071-0000)

Replace "low-barrier treatment" with "easily accessible treatment", which is clearer terminology for the general population.

Rule 05 Definitions (847-071-0005)

(3) "Five-Needle Protocol" or "5NP" means the insertion of sterile, solid core, single-use needles ear seeds or ear beads at exactly five acupuncture points of the human auricle. The solid core needles are no to exceed 0.5" in length.

The five points are shen men, sympathetic, liver, kidney and lung.

The location of the five points is as defined in common acupuncture texts.

Note: One LAC stated that people had agreed, during the drafting of HB2143, that the needles were to be 0.5 inches or less. I endorse such limitation since it wards off applying needles to body points where organ damage can occur.

Rule 07 Five-Needle Protocol Treatment (847-071-0007)

(2) An acupuncturist licensed under ORS 677.757 to 677.770 may provide 5NP treatment without (remove: additional) add: obtaining 5NP registration.

Same word switch suggestion for (3)

Rules Suggestions According to the 3 models above:

Rule 20 Qualifications 847-071-0020

(1) An applicant for registration as a five-needle protocol (5NP) technician must:

(a) Be at least: **Option A: 18 years of age; Option B & C: 21 years**

Options B & C: Add: "Successful passage of written and practical competency exams."

No other changes for Rule 20 to the 8-20-25 draft.

Rule 25 Training Requirements (847-071-0025) (Trainer requirements same)

5NP Tech Requirements:

Option A- Same as 8-29 Draft

Option B- Same as 8-29 Draft plus:

50 hours didactic training, 40 5NP treatments of single ears under supervision

Training to include same as 8-20 Draft plus:

NCCAOM Clean Needle Technique course (8 hrs)

OSHA Blood Bloodborne Pathogens training course & HIPPA protocols- if needed above CNT course.

Option C- Same as Option B plus: 500 hours didactic training

Rules 25, 35, 40, 42, 45, 47-

Option A: same as 8-29 Draft

Option B & Option C, Add the following to the 8-29-25 draft:

Remove the word "individual, and replace with the word "patient" in all rules.

Rule 25 Training Requirements:

OMB to evaluate and monitor any institutions providing education, training and certification for NP Techs and Trainers.

Rule 35 Discipline:

Biennial random audits ($\geq 2\%$)

Rule 40 Five-Needle Protocol Regulations:

Add the item of **retained needles**, since such needles are commonly used.

Ear Needles, Seeds and Beads:

To be retained for a maximum of 3 days

Clear instructions provided to patient to remove ear needles, seeds or beads if any irritation or discomfort occurs, and seek medical treatment if signs of infection appearing.

Add to the consent form that the patient is consenting to retained objects, and is responsible for removal within 3 days.

No electrical or laser stimulation, or other non-needling stimulation to the ear needles or to any location on the ear.

Rule 42 Billing & Marketing:

5NP Technicians may not bill Medicare/Medicaid.

All marketing must disclose non-coverage and technician status.

Rule 45 Infection Control:

Require 5NP technicians to complete the NCCAOM Clean Needle Technique.

OSHA-compliant exposure control plan. Sharps disposal, HBV vaccination, PPE, and post-exposure protocols required.

Patients only remove their own needles if they are trained in exposure control & blood borne pathogens.

Note: a patient can easily contaminate their hand w/their own blood, use the door knob, another person uses the door knob and contacts the blood material.

Rule 47 Adverse Events:

Mandatory reporting within 10 days.

Require 5NP Techs to carry malpractice insurance unless covered under the facility where practicing.

Establish a grace period for this requirement until such insurance is available from insurance companies.

Rule 47 Facility Standards

Treatment areas must be cleanable, adequately spaced, and equipped with handwashing or sanitizer facility.

Where should these items go in the Rules?

5NP tech wears a nametag, identifying the practitioner as a 5NP technician, for clarity for the public.

LAcS were initially required to wear a nametag anywhere, now it only when in a multi-disciplinary clinic.

A patient who is inebriated or under influence of drugs will not be given the 5NP treatment.

Consent form: add that the patient is consenting to retained objects, and is responsible for removal within 3 days.

Clinical Supervision: Refer to standards in the medical field.

I suggest these items:

-onsite supervision is not needed at all times.

-supervisors to be LAcS (active licensees or Emeritus), MDs/DOs qualified to practice acupuncture,

RNs, PAs, Podiatrists, NDs, with 5NP technician training. Begin with these, broaden after 4-6 years as see fit.

Misc Notes

Age Requirement:

Because of the education requirements to become **any type of independent practitioner in Oregon**, all such individuals are at least 21 years old. Requiring 5NP techs to be 21 seems reasonable, and defensible legally.

In Oregon, one must be 21 to:

drink alcohol, be employed at premises dispensing psilocybin or cannabis, or to play a Video Lottery game.

In most states, one must be 21 to:

obtain a credit card without a co-signer, adopt a pet, reserve travel accommodations, fly a plane, obtain a concealed weapons license, and gamble in casinos.

Standard education & training for professionals inserting needles

Body piercing: 750 hours of theory and practical education.

Tattoo artists: 360 hours of training.

Phlebotomists: 60-120 hours of classroom training & clinical experience, not independent practitioners.

NCCAOM "Clean Needle Technique"

This 8-hour course is tailored for the insertion of acupuncture needles. CNT is required for Oregon LAc's for 30 years. It's administered by the NCCAOM, including a practical exam. NCCAOM has been the accrediting institution for acupuncture for 43 years & used in Oregon for over 35 years.

Ear Seeds or Beads:

The ear is mainly cartilage, plus it gets poor circulation because of its location. If the ear becomes infected, then it does not heal quickly compared to other tissues, and can more easily result in the loss of part or all of the external ear.

OMB may decide to initially forbid the retention of ear seeds & beads and reevaluate in 4-6 years.

Then OMB could require training, as in a continuing education class to update, techs.

If retention or embedded application is used, these safety parameters come to mind, and this topic to be included in the didactic hours and examination portion of the training.

- not used for patients with diabetes mellitus
- retention time not to exceed 3 days
- instruct patient to keep the ear dry when needles, seeds or beads are in place
- patient instructed to remove needles, seeds or beads if any irritation, swelling or redness appears on the ear.
- seek medical advice if signs of infection appear.
- only to be used in established medical clinics such that the patient can be monitored as needed
- 5NP tech carries liability insurance to compensate patient in case of infection & loss of ear cartilage

Location & Safety

Emergency Responders practice their medicine in compromised locations. They are trained extensively to accomplish this & practice in coordination with medical personnel off site. The tech may be in an entirely different situation- one may begin practicing medicine alone, in locations like a shopping mall, bus, etc., & after 30 hrs of education & 40 ears.

Adding in that the tech may be 18 years old with no previous job experience, no medical experience other than this small training, and not necessarily a high school graduate. Drastically different than an EMT, emergency responder.

Continuing Education

Require 2 hours every 2 years with renewal. Include a broad option of topics: community health issues, etc.

"It only takes a few hours to learn to do the 5NP treatment"

Yes, it's easy. However, the 5NP Tech needs many additional hours to practice this medical treatment safely.

"5NP is not the practice of medicine"

Actually, it likely is. A legal decision may be required to confirm this. See notes below.

"There is no liability insurance for 5NP Techs"

I would predict that insurance companies would devise this if requested.

THE PRACTICE OF MEDICINE

Is an individual providing 5NP treatments “practicing medicine”?

Compare the definition of the practice of medicine with the wording implemented from HB 2143:

The Practice of Medicine: ORS 677.085

“What constitutes practice of medicine...”

“(4) Offer or undertake to diagnose, cure or **treat in any manner**, or by any means, methods, devices or instrumentalities, any disease, illness, pain, wound, fracture, infirmity, deformity, defect or (any) **abnormal physical or mental condition of any person.**”

Division 71: Five-Needle Protocol 847-071-0000:

The five-needle protocol (5NP) is a standardized, supportive **treatment** for **patients** experiencing substance use **disorders, mental health conditions, and trauma.**”

847-071-0000 Purpose Statement:

The five-needle protocol (5NP) is a standardized, supportive **treatment** for **patients** experiencing substance use disorders, mental health conditions, and trauma. The Oregon Medical Board is responsible for establishing training and registration requirements and regulating **the practice** of 5NP technicians in order to expand access to safe, standardized, low-barrier **treatment.**

Proponent say that this is intended to be in a “community-based” setting. However, it is still a medical treatment, and individuals are still patients. It has also been said that “5NP involves minimal record-keeping since it's a non-verbal intervention using standardized points without making a diagnosis”. 5NP techs will still be practicing medicine, and it'll be based on the diagnosis in the law.

“Patient” or “Individual” & other terms

Recommend: use the standard medical words: patient, treatment, practitioner, provider, etc, since a medical treatment is being performed for relief of symptoms.

Clarify to techs that they are responsible for all aspects of healthcare: professional boundaries, informed consent, medical documentation, reporting requirements, proper identification of the patient etc.

Qualifying Diagnosis

The language in this law is difficult to apply. The tech has no medical training, yet is authorized to administer a medical treatment, and for 3 medical conditions. Yet, It can only be accomplished by a diagnosing practitioner providing the diagnosis of the 3 conditions which qualify for the 5NP treatment.

What is the practice of patients reporting their own diagnosis, ie, “self-identifying”?

Note: LAc's are not authorized to diagnose their patients' conditions, but they allow patients to identify or report their western medicine diagnosis. This “self-identified” diagnosis is utilized for medical documentation of what the patient is reporting, and for the purposes of billing. LAc's are authorized to diagnose the patient according to TCM system.

Recommendation:

OMB either requires a diagnosis from a qualified practitioner, or investigates a solution for this conundrum.

From the Oregon Medical Board Report, Summer 2025:

The mission of the Oregon Medical Board is to protect the health, safety, and wellbeing of Oregon citizens by regulating the practice of medicine in a manner that promotes access to quality care.



Beardall Acupuncture and Chiropractic Clinic, PC
Christopher Beardall, DC, L.Ac.



September 1, 2025

Oregon Medical Board
1500 SW 1st Avenue, Suite 620
Portland, OR 97201

Re: Public Comment on Division 71 Draft Rules Implementing HB 2143 (Five-Needle Protocol Technicians)

Dear Members of the Oregon Medical Board,

I am writing to express professional concern regarding the Division 71 draft rules implementing House Bill 2143, which would establish a new category of “Five-Needle Protocol (5NP) Technicians.” In my professional medical opinion, these rules raise important considerations regarding patient safety, professional standards, and the Oregon Medical Board’s responsibility to uphold public trust. Accordingly, I offer the following recommendations for your review and consideration.

Major Concerns

1. Inadequate Training Requirements

The proposed 70-hour training requirement is profoundly insufficient. Licensed acupuncturists undergo thousands of hours of graduate-level education, including anatomy, physiology, pathology, differential diagnosis, and supervised clinical practice (Council of Colleges of Acupuncture and Herbal Medicine, 2023). In contrast, the draft rules authorize independent 5NP practice after 30 didactic and 40 clinical hours—less than the >700 hours currently required for cosmetic body piercing in Oregon (Oregon Health Licensing Office).

2. Absence of Professional Supervision

Oregon’s proposal eliminates any requirement for professional supervision, diverging sharply from other states. New Mexico (NMAC 16.2.14), New Hampshire (RSA 328-G:11), and Michigan mandate licensed professional oversight. Even Texas and Colorado, with more flexible models, restrict practice to already-licensed professionals (e.g., nurses, counselors, physicians).

Oregon’s approach—no prior licensure, no supervision, no documentation, no insurance—is unprecedented and unsafe.

3. Infection Control and Sharps Safety

Permitting practice without running water, relying solely on hand sanitizer, and allowing patients to remove their own needles violates CDC infection-control guidelines (CDC, 2019) and OSHA’s Bloodborne Pathogens Standard (29 CFR 1910.1030). These provisions expose patients and communities to avoidable risks of infection, bloodborne pathogen transmission, and unsafe sharps disposal.

4. Lack of Accountability Mechanisms

Without malpractice insurance, medical documentation, or mandatory adverse-event reporting, patient harm will go unreported and uncompensated. The Federation of State Medical Boards (FSMB, 2021) identifies accountability and transparency as core responsibilities of licensure. Oregon’s draft rules abandon these principles.

5. Misclassification of Acupuncture

The rules redefine auricular acupuncture as “not acupuncture” to bypass Oregon’s Acupuncture Practice Act, despite explicitly permitting needle insertion at recognized acupuncture points (e.g., Shenmen, Sympathetic, Kidney, Liver, Lung). This legal fiction erodes statutory protections and sets a dangerous precedent for deregulation through reclassification.

Public Health Risks

- Increased risk of infection, vasovagal reactions, or psychological distress without trained oversight.
- Unsafe sharps handling and disposal in community settings.
- Absence of documentation and oversight eliminates investigation and patient recourse in cases of negligence.
- Devaluation of Oregon’s licensed acupuncturists, physicians, and allied professionals who undergo rigorous training and accountability.

Comparative State Models

- **New Mexico:** Requires NADA-equivalent training plus supervision by a Doctor of Oriental Medicine.
- **Texas:** Requires NADA training plus pre-existing licensure (RN, LCSW, MD, PA).
- **New Hampshire:** Requires supervision by a licensed acupuncturist with site visits.
- **New York:** Current proposals still require general supervision.

No state combines Oregon’s deficiencies—minimal training, no supervision, and no licensure requirement. Oregon would become a national outlier in regulatory permissiveness.

My Professional Recommendations

Terminology

- Replace “individual” with “patient” throughout the rules, consistent with ORS 677.085.

Rule 25 – Training Requirements

- OMB must evaluate, approve, and monitor training institutions.
- Require completion of the NCCAOM Clean Needle Technique (CNT) course.
- Minimum age: 21 years.

Rule 35 – Discipline

- Implement biennial random audits of at least 2% of registrants.

Rule 40 – Five-Needle Protocol Regulations

- Retained objects (needles, seeds, beads) limited to 3 days, with written removal instructions.
- Prohibit electrical, laser, or non-needle stimulation.
- Exclude patients under the influence of alcohol or drugs.

Rule 42 – Billing & Marketing

- Prohibit billing of Medicare/Medicaid.
- Require clear public disclosure of technician status and non-coverage.

Rule 45 – Infection Control

- Require OSHA-compliant exposure control plans.
- Prohibit patients from removing their own needles without documented training.
- Facilities must meet sanitation and safety standards.

Rule 47 – Adverse Events & Facility Standards

- Mandate adverse event reporting within 10 days.
- Require malpractice insurance.
- Enforce facility standards for sanitation and emergency preparedness.

Professional Identification

- Require nametags identifying practitioners as “5NP Technicians with a QR code for reporting incidents.”

Supervision

- Require supervision by a licensed healthcare professionals—such as Acupuncturists, MDs/DOs, Registered Nurses (RNs), Physician Assistants (PAs), or Naturopathic Physicians (NDs) who have completed appropriate 5NP training and/or already meet State of Oregon Acupuncture Licensure Act.
- Consider scope expansion only after safety data are available.

Continuing Education

- Require 6 hours every 2 years, including infection control and trauma-informed care.

The Practice of Medicine

Division 71 explicitly describes 5NP as treatment for substance use disorders, trauma, and mental health conditions. Under ORS 677.085, such activity constitutes the practice of medicine. Regardless of legislative framing as “supportive care,” these interventions remain medical treatments and must be regulated accordingly.

Conclusion and Recommendation

The Oregon Medical Board’s mission is to safeguard the health and safety of the public. As currently drafted, Division 71 rules expose vulnerable populations—those with addiction, trauma, and psychiatric illness—to foreseeable harm, while undermining professional licensure integrity.

I strongly urge the Board to:

1. Revise the draft rules to require ≥ 150 hours of training plus CNT certification.
2. Mandate malpractice insurance and adverse event reporting.
3. Align infection control standards with CDC and OSHA requirements.
4. Require licensed professional supervision.
5. Use accurate medical terminology to reflect the seriousness of this intervention.

Oregon has a unique opportunity to expand access to care while preserving safety and accountability. That goal requires rigorous regulation, not deregulation through expediency.

Respectfully submitted,

Christopher Beardall, DC, L.Ac.

References

- CDC. *Guidelines for Infection Control in Healthcare Personnel*. 2019.
- Council of Colleges of Acupuncture and Herbal Medicine. *Educational Standards for Acupuncture Programs*. 2023.
- FSMB. *Essentials of a State Medical and Osteopathic Practice Act*. 2021.
- New Mexico Administrative Code (NMAC 16.2.14).
- New Hampshire Revised Statutes (RSA 328-G:11).
- Oregon Health Licensing Office. *Body Piercing Training Requirements*.
- OSHA. *Bloodborne Pathogens Standard* (29 CFR 1910.1030).

Dear Members of the Oregon Medical Board,

I am writing as an acupuncturist with 20 years of experience practicing in various clinical settings, ranging from pop up trauma and pain treatment events for veterans, hospitals, private clinics and even Lincoln Recovery Center, where NADA treatment was first popularized. I request that the Oregon Medical Board consider specific regulatory measures regarding the training, supervision, and scope of practice for 5NP (Five Needle Protocol) technicians. Based on my understanding and concern for the safety and efficacy of this practice, I would like to propose that 5NP technicians undergo clinical supervision, comparable to most other states allowing this practice and greater than has been suggested thus far, as per the document provided by the OMB reading materials for this work group that describes the requirements for each state. I also request that technicians receive greater designated training hours and practice exclusively within medical clinic settings.

At this time, the required age of the technician is only 18 years. This 18 year old is not required to have any other job or education experience and is being given unrestricted access to independently provide this medical care to vulnerable populations. Coupled with the limited training recommended in this bill, this seems contrary to all other medical technicians, most of which require 9 months + of training, and thus seems unsafe and unethical.

Acupuncture, including the 5NP protocol, involves the insertion of needles into the skin and cartilage, which carries an inherent risk of infection. Performing these treatments in a medical clinic environment ideally ensures a calm and sterile setting, mitigating risks associated with infection and would allow for easy clean up. It is better to be provided while seated, in a clean clinic than on a city bus, better provided in a clinic where people wear shoes than in a yoga studio where people are barefoot, and better in a clinic than in a park where needles could get lost in the grass where children play. Medical clinics are subject to stringent health regulations, ensuring standards of care, sanitation, and safety measures for both patients and practitioners. Requiring 5NP technicians to practice in these regulated environments guarantees that the necessary protocols for patient confidentiality, infection control, and basic record keeping are adhered to. Whereas pop ups occur in times of traumatic events and disasters, they are generally run by licensed health care workers, not any 18 year old with a day certificate. A licensed health care worker is more inclined to follow protocols and ensure safety due to greater training and because they have a license at stake. There are several adverse event reports that suggest that most AEs are due to a poor sense of responsibility of the providers. Requiring clinical supervision and a clinical environment helps to mitigate risk. In addition, patients are protected because the provider has malpractice insurance. To have a bill allowing the insertion of needles intended for medical treatment with no boundaries around practice space, no protections for the patient in the event of an injury and such minimal provider training creates unnecessary risk, even for a safe procedure.

Emergency Preparedness and Immediate Response: Although rare, adverse effects can occur from acupuncture treatments. Bruising and bleeding are not the only AEs but also syncope, injuries secondary to syncope such as concussion, and mental health crises. A medical clinic setting ensures that appropriate emergency response personnel and measures are available to navigate all of these complexities, including access to life-saving equipment and BLS/first aid

trained personnel. The training suggested for this 5NP provider can cover the mechanics of 5 needles in the ear but not all of the potential clinical dynamics that warrant more experienced supervision.

Practicing acupuncture within a medical clinic allows for better integration with other treatments and healthcare providers, which is what this bill seeks to accomplish. This collaborative environment ensures that acupuncture is part of a comprehensive treatment plan, including mental health care and pain management. It also ensures that the treatment is appropriately based on the patient's needs and offers a comprehensive approach to patient care. If this medicine is meant to serve as many patients as possible, and one of the goals is to restore patient agency, then it seems imperative that the patient have more thorough health care be a choice. 5NP is acupuncture after all, it is just an acupuncture point combination. There are many others that could offer better assistance. Requiring that this 5NP treatment is offered in a clinical setting with some acupuncture supervision ensures that the patient has the opportunity for more thorough treatment, otherwise it is placing band-aids on bullet holes and patting oneself on the back in the name of access to care and the opioid crisis. It is a short cut.

Please remember that acupuncture availability has grown substantially since the 1970's. This progress has been achieved through years of advocacy, rigorous training, and legal efforts to ensure that acupuncture is practiced safely and effectively by licensed professionals. Many individuals and organizations have worked tirelessly to bring acupuncture to the forefront of modern healthcare, have it covered by most health insurance and ensure its accessibility to all populations. Medicaid and Medicare cover acupuncture now. Many, many LAc's offer additional low cost, sliding scale and community style treatments. Deregulating the practice undermines the quality of care and the integrity of the acupuncture profession, is unsafe to patients and potentially decreases access to care. Offering treatments in non-medical settings to individuals without appropriate clinical supervision and training is not equitable care but quite the opposite.

From the NADA website: "In the U.S.A. and Canada, many localities encourage the implementation of a NADA program through regulations that allow non-acupuncturist health providers to be trained in the NADA protocol, often under the supervision of a licensed acupuncturist or medical doctor." Most others that don't require supervision require that the provider have another working medical licensure. These statements were disputed in the previous workshop meeting but the information is written on a document provided by the OMB for our reading.

I propose the following measures for the 5NP technician role:

1. Supervision Requirements:

5NP technicians should practice under the clinical supervision of a licensed acupuncturist or MD/DO qualified to perform acupuncture. Supervision should not necessarily be required at all times, but a supervisor should be readily available in the event of complications or adverse reactions.

2. Training and Certification:

Technicians should complete a standardized training program that includes at least:

- 50 hours of didactic training
- 40 supervised clinical treatment hours
- Certification in the NCCAOM Clean Needle Technique (CNT) course (8 hours)
- OSHA-compliant Bloodborne Pathogens training, as well as HIPAA protocols, as required

3. Liability Insurance

- Some aspect of liability insurance is required for patient safety

By working within these frameworks, we can continue to expand access to acupuncture services while maintaining the highest standards of patient safety and professionalism.

Whereas I commend this group for wanting to help as many people as possible, I would also like to offer another viewpoint from a recent patient of mine who was treated with 5NP in a detox/trauma facility. He reported feeling like a factory farmed animal. He reported being rounded into a room like a sheep, where seemingly untrained people stabbed him repeatedly in the ears and then acted as if he was supposed to be better. He said it was incredibly painful, whereas regular acupuncture treatment, even in the ears, is not. He had to keep asking, “when are we actually going to talk about or work on the cause because the drinking is just the symptom?” Of course, different things work for different people and I think that NADA is a wonderful offering, when done well, but I also see that this reduction in regulation as being similar to the supersize me fast food culture.

Thank you for your consideration.

Submitted by: Dr. Jen Kearns, DACM, LAc on September 1, 2025

From: Sara <[REDACTED]>
Sent: Saturday, August 30, 2025 1:10 PM
To: ROSS Elizabeth * OMB
Subject: Re: B 2143/5NP Workgroup Meeting 9/3

Hope your long weekend was restful.

Here is some pre-edits, though i will mention in workgroup as well.

Suggested edits to the BEAUTIFUL FAQ page. (I really love it, it makes me feel like the workgroup discussions found a home to expand into beyond the edits to rules and regs section).

Regarding FAQ 21
5NP Treatments

possible edit, having TCM theory is not ideal maybe.....

21. What is a 5NP treatment?

The protocol works by stimulating five specific acupoints in the ear that are believed to help restore balance and calm the nervous system. It provides balance to emotional and adrenal flow which helps to reduce cravings, anxiety, and withdrawal symptoms while promoting relaxation and mental clarity.

Below is TMI, but i tried to summarize above while removing acu-lingo

Three major theories:

1)Ear/vagus nerve innervation

2)The ear is a microsystem for the body. the points used as Master Points, many correspond with organs of detoxification.

3)Ear and body acupuncture releases endorphins, balances serotonin and decreases cortisol – decreasing pain and improving mood.

Sympathetic - Helps shift the nervous system from a sympathetic (fight or flight) dominant state to a parasympathetic (rest or digest) state

Shen Men - Stress relief, relaxation, calms the brain, supports emotional processing, helps with anxiety, depression, insomnia

Kidney - Related to fear - this point supports the adrenal glands which are often over stimulated by chronic stress

Lung - Related to grief - this point regulates the skin which is also another primary organ of detox

Liver - Related to anger - this point supports emotional flow and helps relax muscle tension

On Sat, Aug 30, 2025 at 12:46 PM Sara <[REDACTED]> wrote:

Greeting Elizabeth

This is so exciting to see take shape!

A suggested edit of not too late:

3. Needles/Beads/Seeds: thin single-use disposable needles, ear seeds, or ear beads are placed on the five ear points: shen men, sympathetic, liver, kidney, and lung points. You may feel a mild pinch or tingling when the needles are inserted or beads and seeds placed, which usually fades quickly. **Ear seeds and ear beads should not be used for individuals with diabetes.**

As this is not a true contraindication or precaution, can it be edited to:

Ear seeds and ear beads are recommended to not be retained beyond the day of treatment for individuals with diabetes.

I believe some voiced concern about the seed retention was settled at 3 days and then removed to avoid negative side effects for diabetics.

But if people are more comfortable having the recommendation be retention no longer than day of, that seems fine. The exclusion of diabetics is inaccurate and therefore I believe this draft edit to have over compensated for the concern raised.

Thank you!!!!

Doing my homework on reading through the rest of the packet for Wednesday

Just saw this jump out instantly as a miscommunication point.

Pun intended

Thank you for all you are doing!

-sara-

From: Nancy Whitson
Sent: Friday, August 29, 2025 10:06 PM
To: ROSS Elizabeth * OMB
Subject: 5NP Workgroup

You don't often get email from . [Learn why this is important](#)

Dear Ms. Ross, and members of the OMB and Workgroup,

I am a retired RN, NP and CNM, who has worked in public health settings throughout my career, out of a strong desire to increase access to people who have all kinds of barriers to health and care.

I have worked with community health workers here in the US and internationally, as well as in their training programs, and have seen first-hand the power of health care designed for broad outreach and low-barrier access. So I'm enthusiastic about the 5NP bill, and so grateful for all your hard work and commitment to the best possible roll-out for implementing this important resource to our communities.

In attending the workgroup sessions and reading the draft, I'm wondering about a couple points.

First, under Qualifications, item 1(c), the requirement that the applicant have "good moral character," I'm wondering if this wording is something that always is added to any registration language.

As a regulatory requirement for licensure, this language is problematic, as it is entirely subjective and vague, requiring an applicant to fit whatever the current values of the OMB members hold as their personal standards of "good" and "moral".

This is particularly inappropriate in our current moment, as these terms are increasingly being politicized and weaponized to exclude various groups of people, and to serve particular ideologies.

Setting this possibility into regulatory law opens the door to this use by any future board members.

This is not a hypothetical risk, as we are seeing every day concrete examples of government agencies, policies, and officeholders being eliminated or coerced into positions that compromise the health and well-being of the population; in many arenas, but especially in the arena of health policy, what was previously considered "good" can now be deemed "immoral."

(Some examples: supporting or facilitating a woman's right to choice over her own pregnancy, or even providing her information; providing life-saving intervention to save a woman's life during some obstetrical emergencies; providing information, support or medical care for nonbinary people. Or just being a nonbinary person, or anyone other than heterosexual. There are people now in government advocating even broader interpretations of "bad moral character", such as: supporting stem-cell research, support for women in domestic violence situations. Supporting freedom of speech is being labelled as terrorism, in other words, immoral.)

A requirement for registration to practice a health protocol, if worded as a completely subjective sentiment, in these times only invites being wielded as a tool of exclusion, or an ideological control method.

If this requirement is meant to in some way overlap with the criminal background check requirement, then maybe they could the same requirement; if so, it should clearly specify the intention of the criminal background check: what specifically it is meant to protect against, ie, what kind of findings may arise from a background check that would be considered relevant to the practice of this protocol.

The concern has been voiced by the workgroup that the criminal check would intimidate from applying, some of the very people who would be ideal to provide 5NP. I believe the statement that was added is not sufficient: saying what the criminal check does not intend will not prevent the intimidation, unless the regulation is explicit about what it does intend (for example, "To further the assurance of safety within the community of recipients, providers, and the public, the Board will use a criminal background check so that applicants with histories of violent crime, or sexual predators, or _____, will have the opportunity to present further information to the Board to be considered for registration.").

These are the two areas of concern I felt the need to voice.

Thank you again for your consideration, and all your hard work on this bill,
Nancy Whitson

From: Shannon Conrad <[REDACTED]>
Sent: Wednesday, August 27, 2025 3:11 PM
To: ROSS Elizabeth * OMB
Subject: Opposition to Expanding 5NP Ear Needling to Non-Acupuncturists

You don't often get email from [REDACTED]. [Learn why this is important](#)

Dear Oregon Medical Board Members,

I am writing to strongly oppose the proposal to expand the scope of practice to allow non-acupuncturists to perform the 5 Needle Protocol (5NP) ear needling.

This proposed expansion undermines the standards of safety, training, and professional rigor that the field of acupuncture has worked diligently to uphold. Licensed acupuncturists complete extensive education, clinical training, and examination to ensure that patient care is safe, effective, and evidence-based. Even modalities such as “dry needling” are recognized as acupuncture and require the same level of expertise and licensure.

By contrast, professions such as tattooing and piercing—while not medical—still require significant schooling, licensing, and oversight to protect the public. It is inconceivable that a medical intervention involving the insertion of needles could be reduced to a short course for individuals without the necessary medical background. To do so risks patient safety and sends a message that medicine itself can be watered down into a commodity.

If this proposal moves forward, it will contribute to the erosion of professional standards in health care and open the door to “quick fix” training programs that mislead the public, such as the alarming online advertisements claiming one can “become an acupuncturist for \$19 and a 4-hour online course.” This is not only misleading but dangerous. I understand this is not the intended bill's purpose, but would serve as a step in that direction regardless.

I believe there has not been more vocal resistance against this measure as it is not widely known amongst our community of licensed acupuncturist Membership in our state association is not mandatory, licensing fees are high, and the state acupuncture society has been historically lackadaisical and ineffective.

I urge the Board to reject this measure and maintain the rigorous standards that protect Oregon patients and preserve the integrity of medicine. We cannot afford to “dumb down” medical practice at the expense of patient safety and professional accountability. We have more acupuncturists in Oregon per capita than any other state- there does not seem to be the need to train laypeople to practice medicine without proper training and stringent licensing, as all acupuncturists have to undergo.

I ask you to ensure the training standards and licensing requirements be equal to or exceeding those required for acupuncture licensing.

Thank you for your attention to this critical matter.

Sincerely,
Shannon Conrad, L.Ac

Licensed Acupuncturist and Small Business Owner

Shannon Conrad



On Thu, Aug 21, 2025 at 4:37 PM ROSS Elizabeth * OMB <elizabeth.ross@omb.oregon.gov> wrote:

Ms. Conrad,

Thank you for taking the time to share your concerns about 5NP in Oregon. 5NP is acupuncture and a legislative/statute change was required to allow a non-acupuncturist the ability to provide 5NP treatments.

I want to provide some context about where we are in this process. Earlier this year, the Oregon Legislature passed HB 2143 (2025), which Governor Kotek signed into law. This legislation allows qualified individuals to provide 5NP treatments without an acupuncture license, effective March 1, 2026. The law also directs the Oregon Medical Board to establish comprehensive rules for qualifications and training requirements. You can review the full text of the legislation here:

<https://olis.oregonlegislature.gov/liz/2025R1/Downloads/MeasureDocument/HB2143>.

The OMB's role is focused on implementing the law that has already been enacted. As we move forward with implementation, the OMB remains committed to our core mission of protecting patients. Our goal is to develop rules that carry out the mission through qualifications for individuals providing 5NP treatments, along with comprehensive sanitation and safety standards.

The OMB formed a Workgroup of acupuncturists and community members to assist with this process, the current draft rules the Workgroup will be reviewing next week are posted [online](#) (pages 13-21). Your perspective as a practicing acupuncturist is important to this process. We welcome comments on the draft rules regarding qualification requirements, training standards, safety protocols, or other aspects of implementation to protect Oregon patients. Written comments on the draft rules received by Monday, August 25 5PM will be shared with the Workgroup.

Thank you again for your engagement on this important issue and let me know if you have additional questions.

Warm regards,



Elizabeth Ross (she/her)

Legislative & Policy Analyst

Oregon Medical Board

1500 SW 1st Ave, Suite 620, Portland, OR 97201

Desk: 971-673-2667 | **OMB:** 971-673-2700

OUR MISSION: *To protect the health, safety, and wellbeing of Oregon citizens by regulating the practice of medicine in a manner that promotes access to quality care.*

Data Classification Level 2 - Limited

*****CONFIDENTIALITY NOTICE*****

This email may contain information that is privileged, confidential, or otherwise exempt from disclosure under applicable law. If you are not the addressee or it appears from the context or otherwise that you have received this email in error, please advise me immediately by reply email, keep the contents confidential, and immediately delete the message and any attachments from your system.

From: Shannon Conrad <[REDACTED]>
Sent: Thursday, August 21, 2025 2:36 PM
To: ROSS Elizabeth * OMB <elizabeth.ross@omb.oregon.gov>
Subject: Strong Opposition to Non-Licensed Practice of the 5 Needle Protocol (5NP)

You don't often get email from [REDACTED] [Learn why this is important](#)

Dear OMB

I am writing to state in the strongest possible terms my opposition to the idea of allowing non-licensed individuals to perform the 5 Needle Protocol (5NP). This is not just a minor policy issue—it is a profoundly dangerous and misguided concept that undermines public safety, professional integrity, and the very foundations of modern healthcare regulation.

Let us be clear: **the 5NP is acupuncture**. Acupuncture is a medical intervention involving the insertion of needles into the body. Licensed acupuncturists undergo thousands of hours of rigorous training in anatomy, physiology, pathology, Chinese medical theory, clean needle technique, and supervised clinical practice. This training exists for one reason—to **protect patients**. To suggest that individuals without this foundation should be allowed to needle patients is nothing short of reckless.

Authorizing non-acupuncturists to practice 5NP would set a disastrous precedent. It would effectively say that medicine can be practiced without a license if the procedure appears “simple” or “limited.” Would we ever allow an unlicensed person to prescribe a “basic” drug protocol? Perform a “simple” surgical procedure or stitches? Of course not. To even consider such a rollback is to drag us back to a time when people practiced medicine without adequate knowledge, training, or accountability—a time when patients routinely suffered harm from ignorance and unregulated care.

This is not modernization—it is regression. It is a step back into the stone age of medicine.

Acupuncture is a respected, powerful, and effective field of medicine precisely because it is held to professional standards. Diluting those standards by allowing unlicensed providers to needle patients does not expand access—it **erodes safety, public trust, and the integrity of the profession itself.**

I urge you in the strongest possible terms: reject this proposal outright. Protect patients. Uphold licensing laws. Do not open the door to untrained, unaccountable individuals practicing medicine without a license.

Respectfully,
Shannon Conrad, L.Ac.

--

Shannon Conrad

www.spiritpointmedicine.com



From: Dr. Annabelle Snow <[REDACTED]>
Sent: Monday, August 25, 2025 12:32 AM
To: ROSS Elizabeth * OMB
Subject: HB 2143: Concerns about the introduction of 5NP/ear acupuncture in Oregon

Dear Ms. Ross,

I've recently learned about 5NP/ear acupuncture treatments being expanded in Oregon, and although I applaud the move as it is an impactful treatment, I do have some concerns. I recognize that I'm coming late to this conversation and that the bill has already passed, even really the opportunity to voice much of an opinion is quickly passing. Nonetheless, I do feel strongly enough about this to make a comment by sending this email. I've been an acupuncturist in Oregon since 2004, and I can tell you that ear treatments are a powerful and impactful treatment. I utilize ear acupuncture treatments with most of my patients. Over the years our clinic has done many ear acupuncture treatments at outreach events, and I will tell you that it is a strong treatment and the administration of it should not be taken lightly or offered by just anyone.

My concern is that ear acupuncture is still acupuncture and in the characterization of 5NP as **not** acupuncture and **not** a treatment and that the patients are individuals, **not patients**, it's downplaying the seriousness of it as a treatment and downplaying the potential for adverse events if this treatment is not in the right hands. I've had seated patients nearly go into needle shock with just ear needles. 5NP is acupuncture, plain and simple. I've also had patients experience a huge emotional release, which for some patients is scary and their reaction to the trigger can vary widely. Are these registered providers with no medical or mental health training equipped to handle someone getting triggered into a response to trauma or PTSD? Yes, this treatment is limited to one part of the body, and limited (if the provider is trained well enough) to 5 very specific points, but it is acupuncture, nonetheless. Why is needling in the ear really that different than needling in the body? So why should we allow just anyone to practice acupuncture? Ear seeds and pressure points at the 5NP points are also impactful. Why not start there instead of allowing everyone to utilize acupuncture needles?

I would like to respectfully recommend that there be more oversight within this expansion. Is it really true that virtually anyone who is 18 years of age or older could start needling patients with very little training or oversight? Why not start the expansion with **setting some limits on WHO can be registered such as mental health providers, social workers, medical providers of any kind, LMTs**, etc? This list could be expanded to include anyone who would realistically be working within the populations that the law is intended to serve. To expand it out so suddenly to anyone who wants to do ear acupuncture in any setting and without any real medical training or oversight feels unnecessarily risky.

What happens if a registered provider or patient gets hurt, gets an infection, goes into needle shock? What if the patient has a clotting disorder and starts bleeding more heavily? What if they are diabetic or have cancer and more prone to infection? If I understand correctly, no medical history will be taken, and no chart notes will be written down. Acupuncture, even in the ears, isn't necessarily a suitable treatment for everyone, in any state of mind and/or in various levels of substance use. Acupuncture should not be administered to anyone who is using drugs or alcohol at the time of the treatment.

Shouldn't anyone using acupuncture needles (instead of ear seeds or balls) be required to have some sort of true medical training? Is 30 hours of training enough to equip these medical providers to go out into the community by themselves in a variety of settings and administer acupuncture? Do the registered providers have to carry any malpractice insurance? If not, why not? If a registered 5NP provider hurts someone it will negatively impact all of us practicing acupuncture.

My questions/comments include:

- Could the initial roll out of this bill include expansion to include only medical providers, mental health providers, social workers, and other individuals? Once the details are tested out, expansion could widen.
- Who does a registered 5NP provider turn to if they need help with a difficult patient or situation?
- Perhaps anyone who is not a medical provider could be required to have an acupuncturist or MD/acupuncturist as their "sponsor" who oversees the care they are providing in the community, essentially answering questions, mentoring them, and maybe takes responsibility for them? I see this as something akin to an acupuncturist who wants to work on animals must secure a veterinarian to work under. This would allow the 5NP providers to get additional support from the experts who regularly practice ear acupuncture and keep the oversight within the acupuncture community.
- Acupuncture (even ear acupuncture) should not be administered to anyone who is using drugs or alcohol at the time of the treatment, especially if the administrator is not a medical provider.
- Will they be required to take CPR? Why not the pain management seminar we have to take?
- What happens if a patient gets hurt? Do they have legal or financial recourse against a registered 5NP provider?
- What happens if a patient goes into an emotional trauma trigger? Are these providers trained and equipped to manage it?
- What is the process for patient complaints?
- I believe it should be a requirement to communicate clearly that they are not licensed acupuncturists, that they are trained only to administer ear acupuncture to the 5 points. I believe the bill states that they cannot say that they are licensed acupuncturists, but I'm suggesting that the rules state that they are required to publicize/communicate that they are NOT so as not to confuse patients.

I'm all for expanding the usage of ear acupuncture/5NP but I strongly believe it's a mistake to take it too lightly and allow just anyone in the state of Oregon to practice ear acupuncture. Let's slow this down and do it right by setting some reasonable restrictions. Let's make sure that anyone using acupuncture needles goes through the same requirements as the rest of us, and has the proper support, training and experience to manage anything that might arise from administering this treatment in the community. Ear acupuncture is still acupuncture and should be considered as such.

Thank you for your time and your willingness to consider some of my points as the OMB creates the rules around this new expansion of acupuncture in Oregon.

Sincerely,
Annabelle

Dr. Annabelle Snow (she/her), DAOM, LAc, Clinic Director
North Portland Wellness Center
Clinic: [REDACTED] **Web:** northportlandwellness.com

From: Danielle Reghi <[REDACTED]>
Sent: Monday, August 25, 2025 4:59 PM
To: ROSS Elizabeth * OMB
Subject: Public Testimony on 5NP

Hi Elizabeth,

I would like to attend these meetings, but unfortunately they fall at a time that I am at work. So I will give some input this way. I heard that some concerning remarks were made at the last 5NP meeting. I hear that people were commenting that they are excited to treat pain with 5NP, and that there was some discussion over this being acupuncture.

While 5NP, and ear needles are a component of acupuncture, 5NP as a stand alone is not acupuncture. When this bill was initially presented to groups that I was in, the understanding was that the proponents of this bill wanted people in rehab settings to be able to have access to 5NP for inpatients and outpatient drug rehab purposes. There is historical context of 5NP being used in this way in the 70's in the Bronx New York. I got on board with the bill with the understanding that this is how 5NP would be used. We were told there would be explicit rules around safety, that practitioners could only use those 5 points, and that this would help to increase access to this therapy for marginalized communities that have a hard time accessing care otherwise. I want to be sure that people aren't under the impression that they are practicing acupuncture without a license. And I want people to understand that 5NP is for a specific purpose and cannot treat health issues, and is not a substitute for medical care, or acupuncture. Also, I want to make sure that there is clear messaging around ethics, and that people adhere to clean needle technique protocols. I also want to make sure that 5NP practitioners do not call themselves acupuncturists. I tried to get this in earlier, but got a call from work, so I will cut this short to make sure I get this to you by 5PM. But please let me know if you would like more input or clarification, and I will try to make some of the meetings.

Thanks,

Dainelle Reghi LAc

--

Dr. Danielle Reghi
she / her
DACM, LAC.

www.zenspacepdx.com

Follow us on IG:
@zenspacepdx
@cuppingstudio
@holisticallydriven



Beardall Acupuncture and Chiropractic Clinic, PC
Christopher Beardall, DC, L.Ac.



August 25, 2025

Oregon Medical Board
1500 SW 1st Avenue, Suite 620
Portland, OR 97201

Subject: Testimony and Recommendations Regarding HB 2143 and Division 71 Draft Rules

Dear Members of the Oregon Medical Board,

Executive Summary: Safeguarding Public Safety in the Five-Needle Protocol

With the passage of HB 2143 (2025), Oregon has authorized a new practitioner category—the Five-Needle Protocol (5NP) Technician. While this legislation is intended to increase access to supportive care, it also places a clear obligation on the Oregon Medical Board (OMB) to implement rules that protect the public from potential harm. Unfortunately, the draft rules under OAR Chapter 847, Division 71, fall short of this duty. As currently written, the proposed training, vetting, and oversight requirements are inadequate for a practice that involves the invasive use of needles.

This testimony presents an integrated reform framework to strengthen Division 71, ensuring 5NP Technicians are held to a professional and safety standard commensurate with their responsibilities.

The Problem: Inadequate Safeguards in the Current Draft Rules

By carving out an exception to Oregon’s established licensing requirements for acupuncturists under ORS 677.759, HB 2143 demands the creation of a rigorous alternative system. The current draft rules, however, fail to provide sufficient safeguards.

- **Inadequate Training:** The proposed 70-hour minimum is dangerously low for an invasive procedure. This pales in comparison to training hours required for other health

professions—such as EMTs (OAR 333-264-0014) and Oregon phlebotomy programs, which often require 190 hours.

- **Insufficient Background Checks:** Although HB 2143 grants the OMB authority to conduct background checks under ORS 181A.195, the draft rules do not require FBI fingerprint-based national checks. This omission creates a dangerous inconsistency, as EMTs undergo this higher level of scrutiny.
 - **Minimal Professional Standards:** Allowing registration at age 18 is insufficient for a role that requires maturity, clinical judgment, and patient interaction skills. Additionally, the absence of standardized identification and a transparent disciplinary framework undermines accountability.
-

An Integrated Framework for Reform

To ensure patient safety, the following reforms must be adopted in full within OAR 847-071:

1. **Increase Training to 150 Hours, Competency-Based.**
Expand training requirements from 70 to 150 hours, covering infection control, sterile technique, adverse event management, HIPAA compliance, and mandatory abuse reporting.
 2. **Set a Minimum Registration Age of 21.**
Requiring registrants to be at least 21 provides an important safeguard for clinical maturity and professional accountability.
 3. **Mandate FBI Fingerprint-Based National Background Checks.**
This must be a baseline requirement to ensure individuals with disqualifying histories in other states cannot register in Oregon.
 4. **Require Standardized Identity Badges.**
Each technician should wear a verifiable badge including name, photo, title (“Registered 5NP Technician”), and a QR code linking to the OMB public registry.
-

Strengthening Oversight and Accountability

Even with stronger entry standards, effective regulation demands ongoing oversight.

- **Apply the OMB’s Full Disciplinary Authority.**
5NP Technicians must be subject to ORS 677.190, 677.205, and 677.320, with clear grounds for discipline, mandatory self-reporting, and transparent investigations.
- **Create a Public Registry.**
A searchable online database should display each technician’s registration status and disciplinary history, mirroring systems for other licensed providers.
- **Require Professional Liability Insurance.**
Mandatory liability coverage protects both patients and providers, aligning with best practices in other healthcare professions.

Recommended Revisions to Division 71 Rules

847-071-0000 Purpose Statement

The Five-Needle Protocol (5NP) is a standardized, supportive treatment for patients experiencing substance use disorders.

847-071-0005 Definitions

“Five-Needle Protocol (5NP)” means insertion of sterile, single-use needles at exactly five auricular points (including Sympathetic). “5NP Technician” means an individual registered by the Oregon Medical Board to provide 5NP treatments.

847-071-0007 Treatment Authorization

Only licensed acupuncturists, physicians, or registered 5NP Technicians may perform 5NP. Technicians may not use acupuncture outside of 5NP.

847-071-0020 Qualifications

Applicants must:

- Be at least 21 years old.
- Complete approved training.
- Pass written and practical competency exams.
- Be disqualified for specified criminal convictions.

847-071-0025 Training Requirements

Minimum 150 hours: 50 didactic (anatomy, OSHA, ethics, privacy) + 100 clinical (supervised insertions). Annual CE: 6 hours.

847-071-0030 Registration

Requires FBI fingerprint-based background check, training certificate, and OSHA/HIPAA compliance attestation.

847-071-0035 Discipline

OMB may impose warnings, fines, suspension, or revocation. Random audits (5% annually) will be conducted.

847-071-0042 Billing & Marketing

Technicians may not bill Medicare/Medicaid. All marketing must disclose non-coverage and technician status.

847-071-0045 Infection Control

Facilities must maintain OSHA-compliant Exposure Control Plans, sharps disposal, HBV vaccination, PPE, and post-exposure protocols.

847-071-0046 Adverse Events

Reportable within 10 days: prolonged bleeding, infection, syncope, or ED transfer.

847-071-0047 Facility Standards

Treatment areas must be cleanable, properly spaced, and free of food/beverages. Handwashing stations required.

847-071-0048 Privacy & Records

Covered entities must comply with HIPAA; others must implement written privacy safeguards and obtain informed consent.

Thank you for your consideration of these recommendations. Adopting these measures will ensure HB 2143 fulfills its intent to expand access while upholding the highest standards of patient safety.

Respectfully submitted,

Christopher Beardall, DC, L.Ac.

.



Beardall Acupuncture and Chiropractic Clinic, PC
Christopher Beardall, DC, L.Ac.



August 25, 2025

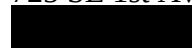
Oregon Medical Board
1500 SW 1st Avenue, Suite 620
Portland, OR 97201

Policy Brief

Ensuring Public Safety in the Regulation of the Five-Needle Protocol (5NP) under HB 2143 (2025)

Testimony Submitted by:

Christopher Beardall, DC, L.Ac.
Beardall Acupuncture and Chiropractic Clinic, PC
725 SE 1st Ave, Canby, OR 97013



Date: August 25, 2025

Submitted to: Oregon Medical Board

1. Background

The passage of **HB 2143 (2025)** authorized the creation of a new practitioner category, the **Five-Needle Protocol (5NP) Technician**, intended to expand access to supportive treatment for individuals experiencing substance use disorders.

Unlike licensed acupuncturists (regulated under ORS 677.759), this new category creates a carve-out with substantially reduced entry requirements. As a result, the **Oregon Medical Board (OMB)** has been tasked with drafting rules under OAR Chapter 847, Division 71, to govern this emerging profession.

Because the 5NP involves invasive procedures (needle insertion into auricular points), strong regulatory standards are necessary to safeguard public health. The **current draft rules**, however,

propose training, vetting, and oversight that fall significantly below established safety norms in Oregon healthcare regulation.

2. Problem Statement

The draft rules for Division 71 fail to establish adequate safeguards, creating substantial risks for patient safety.

- **Inadequate Training**
 - Draft requires only **70 hours** of training.
 - By contrast: EMTs (OAR 333-264-0014) undergo significantly more instruction; Oregon phlebotomy programs often exceed **190 hours**.
 - A 70-hour minimum is insufficient for competencies in infection control, sterile technique, and emergency response.
- **Weak Background Checks**
 - Draft allows state-level checks only.
 - No requirement for **FBI fingerprint-based national checks**, which EMTs must complete.
 - This creates a **dangerous double standard**, allowing individuals with out-of-state offenses to gain registration.
- **Minimal Professional Standards**
 - Minimum age of **18** is too low for a clinical role requiring mature judgment.
 - Lack of standardized identity verification and a **public disciplinary system** undermines accountability.

3. Policy Recommendations

To correct these deficiencies, an **integrated reform package** should be adopted in the Division 71 rules.

A. Training Standards

- **150 hours minimum** (replacing proposed 70 hours).
 - **50 hours didactic** (anatomy, OSHA, ethics, HIPAA, privacy).
 - **100 hours clinical** (supervised insertions, adverse event management).
- **Annual continuing education**: at least **6 hours**.

B. Registration Standards

- **Minimum age: 21 years**.
- **FBI fingerprint-based national background check** for all applicants, under ORS 181A.195.

- **Standardized identity badge:** must display photo, name, title (“Registered 5NP Technician”), and QR code linking to public OMB registry.

C. Oversight and Enforcement

- Apply the **full disciplinary authority of the OMB** under ORS 677.190, 677.205, and 677.320.
- Create a **public, searchable registry** displaying registration status and disciplinary history.
- Require **professional liability insurance** for all registered 5NP Technicians.
- Conduct **annual random audits** (minimum 5%).

D. Facility and Clinical Standards

- OSHA-compliant infection control: sharps disposal, HBV vaccine availability, PPE, and exposure protocols.
- Facilities must have **handwashing stations**, cleanable treatment spaces, and separation from food/beverages.
- **Adverse events** (infection, bleeding, syncope, ER transfer) must be reported within **10 days**.
- Records and privacy: HIPAA compliance or equivalent written safeguards; informed consent required.

4. Draft Rule Language (Proposed Revisions to OAR 847-071)

847-071-0000 Purpose Statement

The Five-Needle Protocol (5NP) is a standardized supportive treatment for patients experiencing substance use disorders.

847-071-0005 Definitions

“Five-Needle Protocol (5NP)” means insertion of sterile, single-use needles at exactly five auricular points. “5NP Technician” means an individual registered by the OMB to provide 5NP treatments.

847-071-0020 Qualifications

- Minimum age: 21.
- Completion of approved training (150 hours).
- Successful passage of written and practical competency exams.
- Disqualification for specified criminal convictions.

847-071-0025 Training Requirements

- 150 hours minimum (50 didactic, 100 clinical).
- 6 hours continuing education annually.

847-071-0030 Registration

- FBI fingerprint-based national background check.
- Training certificate and OSHA/HIPAA compliance attestation required.

847-071-0035 Discipline

- OMB may issue warnings, fines, suspensions, or revocations.
- Annual random audits ($\geq 5\%$).

847-071-0042 Billing & Marketing

- 5NP Technicians may not bill Medicare/Medicaid.
- All marketing must disclose non-coverage and technician status.

847-071-0045 Infection Control

- OSHA-compliant exposure control plan.
- Sharps disposal, HBV vaccination, PPE, and post-exposure protocols required.

847-071-0046 Adverse Events

- Mandatory reporting within 10 days.

847-071-0047 Facility Standards

- Treatment areas must be cleanable, adequately spaced, and equipped with handwashing stations.

847-071-0048 Privacy & Records

- HIPAA compliance where applicable.
- Written privacy safeguards and informed consent otherwise required.

5. Conclusion

The creation of the 5NP Technician category under HB 2143 introduces an important new avenue of care but also significant risks if not carefully regulated. The current draft rules under Division 71 are **insufficient to ensure public safety**.

Adopting the recommended reforms will:

- Align training and oversight with comparable invasive healthcare professions.
- Strengthen background checks and accountability systems.
- Protect patients through enforced facility standards and mandatory insurance.

In doing so, Oregon can expand access to supportive care while **preserving public trust and safety in healthcare regulation.**

Submitted respectfully,

Christopher Beardall, DC, L.Ac.

.

HB 2143- Suggestions to AAC/OMB

Aug. 25, 2025 Version by Arndt

Dear Workgroup Members,

Below are my points for the Rules for the 5NP Technician. They focus on patient safety and precedents set by regulation of other professions, especially by the OMB.

My points may be called “narrow”, or conservative:

Firstly, I suggest that the OMB try certain items for 4-6 years, and reevaluate the Rules then. The OMB can then widen the application as decided. This is how LAcS evolved. In 1973 we could only practice in a MD/DOs office. Then we needed the patient's history or a referral. In 1991 we gained independent practitioner status. In 1993 we defined our scope of practice more clearly, and broadened it.

The OMB has been regulating MDs for 136 years, Licensed Acupuncturists for 52 years, and Podiatrists, Physician Assistants & Emergency Medical Technicians for years. One would expect that suggestions below, like quality of the education and training with examination standards, standards of care, etc., will be included for these practitioners as well.

Note: Recommendations are in blue.

Sincerely,

Karina (Natalie) Arndt

Emeritus LAc, Retired RN

Qs for OMB

Q1- So we all know what is generally required for the tech's, what are the OMB's “best practice standards” and where are standards defined? (“best practice standards” are in HB 2143)

Q2- Will 5NP Techs be required to follow the “OMB's Licensee Handbook, following items like the “reporting requirements” & “professional boundaries”?

Q3- How does the OMB define: “trauma informed care”;

Q4- What is the minimum age requirement for LAcS and other healthcare practitioners in Oregon?

QUALIFICATIONS

Age

Recommendation:

Individuals must be at least 21 years of age. Oregon doesn't allow individuals under age 21 to: drink alcohol, be employed at premises dispensing psilocybin or cannabis, or to play a Video Lottery game.

In most states one must be 21 to: obtain a credit card without a co-signer, adopt a pet, reserve travel accommodations, fly a plane, obtain a concealed weapons license, and gamble in casinos.

5NP Technician Training Requirements

Recommendation:

35 hours of didactic training, including items already mentioned and:

5 hours of training of “best practice of care” standards

If the Rules authorize utilization of embedded beads/seeds, 1 hour of education on safety & application of such.

Written examination demonstrating understanding of the information presented.

Clinical Training: performance of administering the 5NP treatment to 40 ears, including:

final clinical exam of administration of a treatment, to be done by an LAc.

Completion of the NCCAOM “Clean Needle Technique”

This is an 8-hour course that has been required for LAcS for about 30 years. Why should a tech learn anything less?

It is done remotely with a practical exam.

Training Quality:

OMB to evaluate and monitor any institutions providing education, training and certification for NP Techs.

Technician Trainer Requirements

Recommendation:

OMB to evaluate and monitor any institutions providing education, training and certification for NP Tech Trainers.

SAFETY: THE TREATMENT, LOCATION, ETC

Ear Seeds or Beads:

HB 2143: "(a) Use only sterile, single-use disposable needles, ear seeds, or ear beads;"

Recommendation:

NO retention, or "embedded" application of the seeds or beads.

Reevaluate this after 4-6 years. Require training, as in a continuing education class to update techs.

IF retention or embedded application is used, these safety parameters come to mind, and this topic to be included in the didactic hours and examination portion of the training.

- not used for patients with diabetes mellitus
- retention time not to exceed 3 days
- instruct patient to keep the ear dry when seeds or beads are in place
- patient to report any irritation, swelling or redness at the site of the retained seed/s or bead/s
- only to be used in established medical clinics such that the patient can be monitored as needed
- 5NP tech carries liability insurance to compensate patient in case of infection & loss of ear cartilage

Note: 1- The ear is mainly cartilage, which has poor circulation. 2- the ear itself has poorer circulation compared to the rest of the body. Given these 2 factors, the ear is especially prone to the tissue not heal properly from infections, and result in the loss of part or all of the external ear.

Treatment Locations

Will this be available in public places like shopping malls, public parks, public buses, private lounges, fitness clubs?

Recommendation:

Restrict the practice of 5NP to established medical clinics, or only to detox and rehab clinics.

The OMB can take the authority to decide on an individual basis, whether other locations are approved or not.

Modification of this recommendation:

The OMB will review this restriction after 4-6 years of enactment.

Recommendation:

Restrict the practice of 5NP to established medical clinics, detox and rehab clinics, or as OMB decides.

The OMB can take the authority to decide on an individual basis, whether a location is appropriate or not.

Treatments are to be supervised (on-site or remotely) by LAc's, physicians authorized to perform acupuncture, RNs, or other healthcare providers as approved by the OMB.

Recommendation:

OMB to decide if the tech needs to wear a nametag, and how it should identify the practitioner.

NO Treatment Performed if Patient is Under the Influence

I'm told that in Hooper clinic in Portland, 5NP acupuncture was never administered to patients who were inebriated or under the influence of drugs. Also, it's a general rule to not give acupuncture to a patient who is in such a state. Lastly, the rules for body piercing in Oregon forbid this procedure if one is inebriated or under the influence of drugs.

Recommendation:

5NP treatment is not administered to a patient who is inebriated or under the influence of drugs.

Electrical and Other Types of Stimulation

Will electrical stimulation be added to the treatment? This is common for reducing cravings.

Recommendation:

Specifically forbid the application of electrical stimulation, laser treatment or other non-needling stimulation to the ear needles or the 5 authorized points on the ear.

Liability & Malpractice Insurance

Will techs maintain this insurance? Is it available?

THE PRACTICE OF MEDICINE

Is an individual providing 5NP treatments “practicing medicine”?

Compare the definition of the practice of medicine with the wording implemented from HB 2143:

The Practice of Medicine: ORS 677.085

“What constitutes practice of medicine...”

“(4) Offer or undertake to diagnose, cure or **treat in any manner**, or by any means, methods, devices or instrumentalities, any disease, illness, pain, wound, fracture, infirmity, deformity, defect or (any) **abnormal physical or mental condition of any person.**”

Division 71: Five-Needle Protocol 847-071-0000:

The five-needle protocol (5NP) is a standardized, supportive **treatment** for **patients** experiencing substance use **disorders, mental health conditions, and trauma.**”

847-071-0000 Purpose Statement:

The five-needle protocol (5NP) is a standardized, supportive **treatment** for **patients** experiencing substance use disorders, mental health conditions, and trauma. The Oregon Medical Board is responsible for establishing training and registration requirements and regulating **the practice** of 5NP technicians in order to expand access to safe, standardized, low-barrier **treatment.**

It was said that this is intended to be in a “community-based” setting. However, it is still a medical treatment, and individuals are still patients. It has also been said that “5NP involves minimal record-keeping since it's a non-verbal intervention using standardized points without making a diagnosis”. 5NP techs will still be practicing medicine, and it'll be based on the diagnosis in the law.

“Patient” or “Individual” & other terms

Recommend: use the standard medical words: patient, treatment, practitioner, provider, etc, since a medical treatment is being performed for relief of symptoms.

Clarify to techs that they are responsible for all aspects of healthcare: professional boundaries, informed consent, medical documentation, reporting requirements, proper identification of the patient etc.

Qualifying Diagnosis

The language in this law is difficult to apply. The tech has no medical training, yet is authorized to administer a medical treatment, and for 3 medical conditions. It can only be accomplished by a diagnosing practitioner providing the diagnosis of the 3 conditions which qualify for the 5NP treatment.

What is the practice of patients reporting their own diagnosis, ie, “self-identifying”?

Note: LAc's are not authorized to diagnose their patients conditions, but they allow patients to identify or report their western medicine diagnosis. This “self-identified” diagnosis is utilized for medical documentation of what the patient is reporting, and for the purposes of billing. LAc's are authorized to diagnose the patient according to TCM system.

Recommendation:

OMB either requires a diagnosis from a qualified practitioner, or investigates a solution for this conundrum.

From the Oregon Medical Board Report, Summer 2025:

The mission of the Oregon Medical Board is to protect the health, safety, and wellbeing of Oregon citizens by regulating the practice of medicine in a manner that promotes access to quality care.

From: Lisa Rohleder <[REDACTED]>
Sent: Friday, August 22, 2025 1:58 PM
To: ROSS Elizabeth * OMB
Subject: 5NP consent form

Follow Up Flag: Follow up
Flag Status: Flagged

It's fabulous!!! I love it, what a great tool! Just one suggested edit: based on the adverse events reporting, add "nausea and/or vomiting" to the list of possible side effects?

have a lovely weekend,

Lisa Rohleder, L.Ac. she/her

[REDACTED]
<https://workingclassacu.substack.com/>

This email is confidential and may be legally protected. It is intended solely for the addressee. Access to this email by anyone else, unless expressly approved by the sender or an authorized addressee, is unauthorized. If you are not the intended recipient, any disclosure, copying, distribution or any action omitted or taken in reliance on it, is prohibited and may be unlawful. If you believe that you have received this email in error, please contact the sender and delete this e-mail and destroy all copies.

My name is Karina (Natalie) Arndt. I've been an LAc in Oregon since 1987, and was an RN for 33 years. I have taken the 5NP course from "Acupuncturists Without Border", and have supported their activities financially for many years for over 12 years. I hope that the details of this bill will lead to a safe and effective delivery of this wonderful health care treatment to people in need.
Sincerely, Karina (Natalie) Arndt, LAc

Safety of Embedded Beads, Seeds

Aside from the ear lobe, the external ear, auricle, is mainly cartilage. Cartilage doesn't have much circulation. Also, the ears do not have vigorous circulation due to their location. Thus, infections in them do not heal as easily as the rest of the body. And, patients are prone to losing part or all of the ear if they get infected. This is especially important for patients with diabetes, especially if the a1C is significantly elevated. As we know, diabetics are prone to amputations, due to infection & poor circulation.

It was drilled into me in school, to take extra precautions when using an embedded seed, bead, or a miniature tac. Early in my career, I had a patient who came to me with a small metal bead on their ear. It had been there about 2 weeks. I was surprised to see that the metal ball was getting buried into the skin- it was about halfway below the surface of the skin. For this reason, I never used ear balls/seeds/beads, and stayed with tacs. And, I used the ear tacs frequently, many weeks putting 3- 20 tacs in per week. I never had any complications, with these precautions that I took:

I first cleansed the skin with 99% alcohol.

Aside from some anti-bacterial effect, it dried the skin out nicely so the tape adhered especially well. I instructed the patient to keep the ear dry. No swimming. When they shower, to fashion a little "shower cap" with a small plastic bag and a rubber band. Immediately remove it if it feels irritated or uncomfortable or gets red or swollen. Remove it in 1 week. Since I was giving them treatments regularly, returning in a week was no issue. If they didn't return in that time, I called them to be sure they had removed the tac. Some patients used them for months, and were very familiar with watching for any complications, and came in every week for a "tac change".

Will the training include the proper precautions of using embedded seeds/beads in the ear?

I noticed the rules/law for body piercings- that it is not to be done when a person is inebriated.

Also, in general, one does not administer acupuncture is inebriated, or under the influence of drugs, etc. Will that be addressed?

Practicing Medicine?

Division 71: Five-Needle Protocol 847-071-0000: "The five-needle protocol (5NP) is a standardized, supportive treatment for patients experiencing substance use disorders, mental health conditions, and trauma."

The tech will be administering a medical treatment. They will decide if the patient has one of the above 3 conditions.

Will it be interpreted that the tech is diagnosing &/or practicing medicine?

And will this require that the tech will decide that the person has one of these conditions?

How will the trained tech maintain responsibility to the patients?

That is, will they maintain malpractice liability insurance? Will it be available for this technique?

Will someone licensed to practice acupuncture supervise the procedure at all?

Will there be informed consent? HIPPA? Will there be proof of identification be required of the patients?

Will it be clear that no medical advice is given? No recommendation on meds, prescription, or OTC

Locations?

Will this be administered in locations like shopping malls, bars, public parks, etc?

Sorry, but this setting may predispose to problems...

Will a Licensed Acupuncturist supervise the treatments? At least for the 1st year of a tech doing it?

Misc

Will electrical stimulation be added to the treatment? This is common for reducing cravings.

Any age limit of the patients, and if so, need parental/guardian consent?

Any age limit of the people administering the treatment?



Approved by the Board on October XXX, 2025.

OREGON MEDICAL BOARD

Meeting of the HB 2143 Five-Needle (5NP) Protocol Workgroup

September 3, 2025 • Held via Video Conference

PUBLIC SESSION

Welcome

Dilip Babu, MD, Workgroup Chair, called the meeting to order at 4:03 PM and called the roll. A quorum was confirmed.

The following Workgroup Members were present:

Sara Biegelsen, LAc

Letty Dogheart

Maddie Foley, DACM, LAc

Whitsitt Goodson, LAc

Jen Kearns, DAOM, LAc

Eve Klein, MD

Adrianna Locke, MAc, LAc

Nicole Noceto, LAc

Jill Shaw, DO (left at 5:30pm)

Dilip Babu, MD, Chair

Moss Roberts was absent by prior notice.

Oregon Medical Board (OMB) Staff present:

Elizabeth Ross, JD, Legislative & Policy Analyst

Gretchen Kingham, Executive Assistant

Dr. Babu welcomed Workgroup members, discussed ground rules for the meeting, provided an agenda overview, and invited public participation during the comment period or through written submissions to Board staff.

Dr. Babu read an Emily Dickinson poem:

*“Hope is the thing with feathers
That perches in the soul,
And sings the tune without the words,
And never stops at all,
And sweetest in the gale is heard;
And sore must be the storm
That could abash the little bird
That kept so many warm.
I’ve heard it in the chilliest land,
And on the strangest sea;
Yet, never, in extremity,
It asked a crumb of me”*

Dr. Babu asked whether there was any discussion regarding the August 27, 2025, meeting minutes.

Staff noted there was a technological glitch that merged Rule 50 Disciplinary Proceedings and Rule 35 Registration. This has been corrected on the official draft minutes.

The Workgroup offered no comments.

Overview & Updates

Elizabeth Ross, OMB Legislative & Policy Analyst, provided updates on changes made since the previous meeting.

Staff clarified that after each meeting, OMB staff members reviewed meeting notes to identify areas where the workgroup had reached general consensus on additions or changes that would fit within the structure of the House Bill 2143 and align with Oregon Medical Board policies and mission to protect the health, safety, and wellbeing of Oregon citizens. Only changes meeting these criteria were implemented, though staff acknowledged that not every committee member might agree with every modification.

Specific Updates:

- **Five-Point Clarification:** Staff added the five specific acupuncture points (shenmen, sympathetic, liver, kidney, and lung points) directly into the purpose statement of the draft rules in order to address the frequent public inquiries about which five points are included in five-needle protocol.
- **Definition Addition:** Originally, the draft simply stated that "5-needle protocol has the meaning given in the Oregon law" and referenced House Bill 2143. However, due to confusion with how to access the definition in the statute or bill, staff added the exact definition directly in the rules, acknowledging this would require future updates if the legislature modified the statute.
- **Informed Consent Form Revisions:** Extensive changes were made to the form based on workgroup discussions from the previous meeting.
- **FAQ Development:** Staff created a FAQ document covering topics that emerged from the two previous meetings and questions they'd been fielding about what 5NP would look like in Oregon. The FAQ was based on current draft rules, HB 2143, and information publicly available about 5NP. Staff welcomed editing and feedback. Additionally, staff emphasized that FAQs are guidance documents, not enforceable law, and must be based on rule and statute.
- **Resource Integration:** The packet included additional resources provided by workgroup members, including the POCA Auricular Acu-Technician (AAT) Ethics Pledge and rules for Oregon Pharmacy Technicians and Traditional Health Workers.
- **Public Input Process:** Staff explained that all input received—whether oral, written, or from workgroup member statements during meetings—would be included in packets and given equal weight when presented to both the Acupuncture Advisory Committee and the Board for review.

Review of Draft Rules

The main discussion focused on the "good moral character" requirement for registration qualification.

Members reasoned that without defining what good moral character means specifically or establishing a clear assessment process, the requirement remained ambiguous. A member referenced reading about how segregationists used ethics violations to target NAACP lawyers after *Brown v. Board of Education* and contended that vague ethics and moral character requirements are avenues for people acting in bad faith to limit access in the future, even if current OMB members and staff were acting in good faith.

Additionally, members discussed expecting people with criminal justice system involvement to apply for and benefit from this registration, noting that a character requirement might exclude exactly the population the program was designed to serve.

Staff acknowledged that "good moral character" is challenging but explained that the requirement serves as a necessary third qualification criterion (beyond age and training completion) that allows the Board to deny registration in extreme cases involving criminal convictions that would be incompatible with providing 5NP treatments and the Board's mission to protect the public. Without such a provision, the Board would have no grounds to deny registration to applicants who meet the basic age and training requirements, regardless of any concerning criminal history, such as a recent conviction involving harm to children or hate crimes. Staff elaborated that the criminal background check rule requires applicants to submit a criminal background check, and the "good moral character" rule allows the OMB to consider information received from the criminal background check; the rules work together. Submitting a background check would be meaningless if there was not a rule providing the OMB with recourse for convictions that cause concern for public safety. Removing the "good moral character" requirement would eliminate the Board's ability to protect public safety in extreme cases.

Staff noted that the requirement includes language tying moral character assessments to the applicant's ability to provide 5NP treatments, and recent updates explicitly state that substance use disorders in remission, mental health conditions, or other lived experiences alone do not reflect current moral character. The provision exists in other OMB licensing rules, such as the acupuncture licensing qualifications.

Several members acknowledged understanding the structural need for some form of qualification criteria but remained concerned about the vagueness of "good moral character." One member conducted research during the meeting and found extensive literature critiquing good moral character requirements in professional licensing. Alternative language used by other jurisdictions includes concepts like "good judgment and trustworthiness" and "adhering to professional rules of conduct."

A workgroup member raised concerns about the first sentence of the purpose statement, which describes 5NP as "a unique fusion of ancient Eastern healing practices and modern social justice movements." The characterization potentially dismisses the community-based treatment traditions that have long existed in Chinese medicine. Other members noted that the sentence attempts to provide important historical context while maintaining professional regulatory language. The distinction was seen as important for understanding why 5NP technicians exist and for differentiating their practice from licensed acupuncturists. The historical development through the Black Panthers and Young Lords was viewed as genuinely unique, even while acknowledging broader traditions of community-based healing.

Additional suggestions included separating "Trauma-Informed Care" and "Origins of 5NP" into separate training requirement lines, as they represent different time periods and concepts; including healing justice movements alongside social justice movements in the description. It was also suggested throughout the rules clarifying that the five points referenced are specifically ear points to avoid confusion with other acupuncture points.

The discussion of good moral character requirements remained ongoing, with OMB staff open to exploring alternative language and appreciating suggestions from the workgroup.

Review of Supporting Materials

Review of Informed Consent Form

The discussion began with appreciation for changes that had removed previous requirements for treatment in a "quiet, clean, comfortable space."

Multiple workgroup members questioned whether the statement "ear seeds and ear beads should not be used for individuals with diabetes" represented a true medical contraindication. One member stated definitively that 5NP treatment is not actually contraindicated for diabetics, while another reported being unable to find supporting

research for this restriction. The group explored whether the concern related specifically to retained items like seeds and beads rather than the actual 5NP needle treatment itself. Members pointed out that 5NP treatment could actually benefit individuals managing diabetes, making the blanket contraindication potentially harmful by discouraging beneficial treatment. The workgroup also noted that the existing requirement limiting ear beads or seeds to no more than three days already addresses retention concerns for all individuals regardless of health status.

Questions arose about the language regarding needle disposal, particularly when an individual might remove their own needles. The group clarified that regardless of who removes needles, all needles must immediately go into sharps containers. They distinguished between immediate needle disposal (into sharps containers) and post-treatment disposal (the 5NP technician's responsibility for proper disposal of sharps containers). One member raised practical concerns about blood exposure when individuals self-remove needles, particularly regarding potential contamination if individuals don't properly manage any bleeding. The group addressed this by noting that 5NP technicians, being trained in sanitary practices, remain responsible for managing the treatment space and providing appropriate safety instructions. Additionally, the instructions direct individuals to wash or sanitize their hands after removing their needles.

Discussion arose about the language distinguishing between "washing" and "sanitizing" hands, with one member noting this seemed to imply different levels of cleanliness. The group clarified that this language stems from Clean Needle Technique guidelines accommodating settings without access to running water, and one member suggested clarifying that both "washing hands with soap and water" and "hand sanitizer" represent acceptable methods of hand hygiene rather than different categories of cleanliness.

OMB staff provided clarification about consent requirements, emphasizing that the informed consent form or substantially similar documentation containing the same information would be required for all treatments. They specifically noted that simply signing a sign-in sheet would not meet the informed consent requirement, as would be clarified in the FAQs. This led to broader discussion about practical considerations around identification and tracking of individuals receiving 5NP.

One member asked about translating the Informed Consent Form into languages other than English to serve diverse communities. OMB staff confirmed plans to translate the form into Oregon's top five languages initially, with additional translations available upon request. They noted this approach mirrors their current practice with other medical resources and leverages state translation resources.

The review concluded with identification of minor technical corrections, including a grammatical issue requiring the addition of "technician" to a sentence about needle removal directions. Overall, the workgroup expressed satisfaction with the informed consent form, with one member specifically appreciating the inclusion of "healing reaction" language that recognizes reactions are not necessarily negative outcomes. This language was seen as more appropriate than simply listing "side effects," as it acknowledges the complexity of healing responses.

Review of Frequently Asked Questions

The discussion opened with concerns about Question 21, which described 5NP treatment using traditional Chinese medicine diagnostic terminology. Members suggested removing the middle part and retaining the five points are believed to help restore balance and calm the nervous system and their effects on reducing cravings, anxiety, and withdrawal symptoms while promoting relaxation and mental clarity.

Another suggestion emerged to align the FAQs with earlier recommendations to clarify the five points are on the human outer ear.

The discussion shifted to training requirements in response to written public comments questioning the adequacy of current hour requirements. One member noted that Oregon's law necessarily builds on existing, well-established training courses and questioned how Oregon would modify requirements when working with established national programs that wouldn't change their curricula exclusively for one state.

This led to broader discussion about supervision requirements that exist in other states. One member advocated for supervision as a necessary safety measure given the bill's expansion beyond traditional controlled

environments. Other members disagreed and one member strongly opposed any supervision requirements. They contended that supervision would create unnecessary barriers without improving outcomes.

Technical suggestions included changing "whether" to "that" in Question 15 to clarify that individuals self-identify as seeking treatment for specific purposes rather than having to specify which particular purpose applies. Questions arose about minimum safety elements in Question 24, with suggestions to add proper needle disposal in sharps containers and trauma informed care within the community standards of care.

The workgroup addressed adverse event reporting procedures, clarifying the distinction between complaints to OMB about 5NP technician practice versus contributions to POCA's Adverse Event Reporting Database (AERD). Members learned that AERD serves as a voluntary, anonymous system for collecting safety data to build understanding of treatment outcomes over time, while OMB complaints focus on regulatory violations by 5NP technicians.

Discussion touched on reporting requirements, with OMB staff clarifying that 5NP technicians would not be mandatory child abuse or elder abuse reporters since those statutes list specific professions, but they would be subject to requirements for reporting criminal convictions and concerns about other licensed providers.

Questions arose about community standards of care, which members related back to disciplinary proceedings concepts. The standard was explained as accountability to the 5NP community—following training principles, ethics pledges, and practices that other 5NP practitioners would consider appropriate. Members acknowledged this creates similar vagueness to "good moral character" requirements but noted it empowers the community rather than solely the regulatory board to define standards.

The historical context discussion resurfaced around Question 1, with strong advocacy for specifically naming the Black Panther Party and Young Lords Party rather than using generic "modern social justice movements" language. One member emphasized these were revolutionary movements by people of color, not simply social justice activists, and argued for explicit recognition of their contributions. Another member suggested adding language about revolutionary grassroots activism and community-driven healthcare innovation emerging from communities of color in the 1970s.

Technical questions addressed registration fees, with OMB staff confirming a combined \$150 initial fee (including background check) followed by \$100 biennial renewals. Discussion covered the timing of renewal cycles and alignment with existing OMB practices.

Various smaller clarifications were proposed, including specifying that the five points are located on the ear to avoid confusion with other acupuncture points; excluding electro stimulation explicitly; and refining language about which healthcare providers need 5NP registration versus those whose existing licenses already permit the practice.

The workgroup expressed overall appreciation for the comprehensive FAQ document, recognizing it as valuable public education that addresses likely questions while maintaining regulatory appropriateness. Members noted the substantial work completed in developing these materials within a week's timeframe.

Public Comment

Karina (Natalie) Arndt, Emeritus Licensed Acupuncturist, speaking in an individual capacity and for Jen Kearns and others with alternative perspectives. Karina began by explaining use of nonviolent communication principles. In this framework, everyone shares the same basic needs, with the most fundamental being to enrich life and make the world a better place. Karina acknowledged that while some people focus on making the world better for themselves, everyone present was devoted to helping their community. Karina then outlined her understanding of the primary goals of those supporting the current draft and apologized for not being able to verify these assumptions beforehand. Karina suggested the supporters' major goals included: first, ease and accessibility for both technicians and individuals receiving 5NP treatment; second, trust from the acupuncture community and the

OMB that practitioners would work ethically and maintain safety standards; and third, overall safety. Karina expressed ongoing confusion and disagreement with how the current law is written, specifically noting the contradiction that people would be "putting in acupuncture needles, but they're not doing acupuncture." Noting the law is difficult and contradictory, making it harder for the OMB to write effective rules.

Karina then presented three models. Model A represented minimal training with independent practitioners, similar to the current draft approach. Model C involved higher training requirements, specifically suggesting 500 hours, which was the minimum required for Licensed Massage Therapists to become independent practitioners in Oregon, combined with autonomy and independent practice status. Karina acknowledged this would likely be controversial. Karina endorsed Model B, which would allow technicians to qualify relatively quickly with minimal training but require supervision from licensed acupuncturists, MDs, DOs, RNs, or PAs. These supervisors would need to be authorized to practice acupuncture or have completed 5NP protocol training. Karina noted that supervision could be conducted off-site, noting that location itself wasn't the determining factor since EMTs start IVs on highways and medical personnel practice on battlefields while still delivering quality care. Karina emphasized that supervision should be particularly important for individuals with less experience, a graduated system where more experienced practitioners could work in mobile units or other settings with only phone connection to their supervisors. Karina concluded by acknowledging that ultimately, the OMB would make these decisions since they would be responsible for addressing any problems that might occur with the public.

Sara Farahat, speaking in an individual capacity and not representing any organization, asked whether informed consent forms would be required each time an individual comes in for treatment, expressing concern about the potential for excessive paperwork given that many people receiving 5NP treatments are repeat clients.

OMB Staff clarified that this was not the appropriate time for the workgroup to answer questions, but provided an Informed Consent Form would be required for each treatment session. Staff explained the rationale was that this documentation would serve as the only record of treatment received.

Closing Discussion

Dr. Dilip Babu opened the final agenda item, inviting any additional closing thoughts from workgroup members.

Adrianna Locke, MAc, LAc, inquired about future meeting schedules, specifically asking how to find information about upcoming Acupuncture Advisory Committee and OMB meetings and whether the OMB would announce these meetings for public signup. OMB Staff explained that OMB meeting notices are posted monthly, with the September notice currently posted. Staff offered to email workgroup members with meeting information.

Staff also clarified that workgroup members would participate as members of the public in future Committee and Board meetings, with opportunities for public comment, except for Dr. Dilip Babu who serves on the Acupuncture Advisory Committee along with Dr. Jill Shaw.

EL Dogheart confirmed the dates listed on the FAQ sheet were accurate, and staff confirmed that September 12th would be the next Acupuncture Advisory Committee meeting, followed by the October 2nd Board meeting.

Jen Kearns, DAOM, LAc, thanked Elizabeth for her patience with questions throughout the process, particularly from those unfamiliar with regulatory procedures and for how her concerns were summarized in meeting documentation. Jen also shared her closing thoughts, acknowledging the goal of improving access to care while expressing concerns about regulatory standards. Jen noted her concern about the broad scope of people who would be authorized to provide these services. Also noting this could set a precedent for reduced healthcare regulation, suggesting a shift toward a "buyer beware" healthcare system with less scope regulation across all medical fields.

Whitsitt Goodson, LAc, expressed appreciation for how the workgroup responded to concerns raised during discussions, particularly regarding moral character requirements. Whitsitt noted feeling heard and seeing responsive adjustments to feedback. Whitsitt shared enthusiasm for the historical significance of the initiative, describing how the original practitioners were essentially teenagers without formal acupuncture knowledge who were helping their community through difficult times, predating acupuncture licensure in the United States.

Whitsitt characterized the work as "returning 5NP back to the people" and creating justice by making 5NP available in communities as it originally started. Whitsitt thanked all participants for their detailed discussions and contributions.

Maddie Foley, DACM, LAc, expressed gratitude to the OMB and all participants for their time commitment over recent weeks, months, and years devoted to the project. Maddie described the process as an interesting exercise in balancing perfectionism with practical outcomes, noting that good regulation requires balancing usefulness and pragmatism with optimism. Maddie appreciated the thoroughness of the group and the opportunity for public discourse. Maddie expressed hope that the Acupuncture Advisory Committee and Oregon Medical Board would have a good understanding of the workgroup's discussions and deliberations.

EL Dogheart expressed gratitude to the original cohort that initiated the current process. EL shared their background as a peer educator, HIV test counselor, and community health worker and expressed excitement about 5NP being available for community members to care for one another.

Adrianna Locke, MAC, LAc, noted the exceptional diversity of the workgroup professionally and socioeconomically. Adrianna expressed appreciation for Oregon's willingness to prioritize care, acknowledge when efforts miss the mark, but continue trying and iterating. Adrianna praised the expertise and community experience evident among participants and expressed hope about seeing everyone in person someday. Adrianna also thanked Dilip for the heart-centered opening remarks at each meeting, noting a meaningful synchronicity with a recent reading.

Sara Biegelsen, LAc, acknowledged the significant undertaking for the OMB and Dilip as facilitator, praising how extensive discussions were transformed into comprehensive documentation. Sara thanked Elizabeth for work in this process.

Dilip Babu, MD, thanked all workgroup members for their time commitment and noted how they made his facilitation role manageable. Dilip praised the workgroup design that did not require consensus, allowing his focus to remain on ensuring all viewpoints were presented and every voice was heard. Dilip expressed personal motivation stemming from his belief in the great need for 5NP services in Oregon and felt hopeful that the thorough discussions with diverse voices moved the state significantly closer to providing this important care to fellow Oregonians.

Dilip concluded by announcing that workgroup recommendations would be presented to the Acupuncture Advisory Committee on September 12th and to the Oregon Medical Board on October 2nd. Dilip invited all participants to attend these meetings, with information available on the board's website or through board staff contact. Dilip thanked everyone for their participation and directed any additional written comments or questions to Elizabeth Ross at the email address provided in meeting materials.

Dr. Babu adjourned the meeting at 6:18pm.



Oregon

Tina Kotek, Governor

Medical Board

1500 SW 1st Avenue, Suite 620

Portland, OR 97201-5847

(971) 673-2700

FAX (971) 673-2669

www.oregon.gov/omb

Approved by the Board on October XXX, 2025.

OREGON MEDICAL BOARD

Meeting of the HB 2143 Five-Needle (5NP) Protocol Workgroup

August 27, 2025 • Held via Video Conference

PUBLIC SESSION

Welcome

Dilip Babu, MD, Workgroup Chair, called the meeting to order at 4:03 PM and called the roll. A quorum was confirmed.

The following Workgroup Members were present:

Sara Biegelsen, LAc

Letty Dogheart

Maddie Foley, DACM, LAc

Whitsitt Goodson, LAc

Jen Kearns, DAOM, LAc

Eve Klein, MD

Adrianna Locke, MAc, LAc

Nicole Noceto, LAc

Jill Shaw, DO

Dilip Babu, MD, Chair

Moss Roberts was absent by prior notice.

Oregon Medical Board (OMB) Staff present:

Nicole Krishnaswami, JD, Executive Director

Elizabeth Ross, JD, Legislative & Policy Analyst

Netia N. Miles, Licensing Manager

Gretchen Kingham, Executive Assistant

Dr. Babu welcomed Workgroup members, discussed ground rules for the meeting, provided an agenda overview, and invited public participation during the comment period or through written submissions to Board staff.

Dr. Babu read a Maya Angelou poem:

*"A Last love,
proper in conclusion,
should snip the wings
forbidding further flight.
But I, now,
reft of that confusion,
am lifted up
and speeding toward the light."*

Dr. Babu asked whether there was any discussion regarding the August 13 meeting minutes. The Workgroup offered no comments.

HB 2143 Overview & Rule Development Process

Elizabeth Ross, OMB Legislative & Policy Analyst, reviewed HB 2143 (2025) in detail to outline what is in the bill setting the framework for the rules and the OMB's development of this new program. The bill allows an individual to provide 5NP treatments without a license to practice acupuncture beginning March 1, 2026. The law states:

- 5NP "means the standardized five-needle treatment protocol in which five points on the human outer ear are stimulated with sterile, single-use disposable needles, ear seeds or ear beads for the purpose of achieving temporary relief from the symptoms of substance use disorder, mental health conditions or trauma."
- OMB may establish a registry of individuals qualified to provide 5NP and adopt rules to establish:
 - Qualifications for registration
 - An application and registration fee
 - Sanitation and best practice standards
 - A schedule of violations and disciplinary actions
 - Any other requirements or standards the OMB determines necessary
- For requesting state or nationwide criminal records, OMB may require fingerprints of an individual who is applying for or renewing a 5NP registration.

In developing the rules, the requirements in HB 2143 are also aligned with the Board's mission to protect the health, safety, and wellbeing of Oregon citizens by regulating the practice of medicine in a manner that promotes access to quality care.

Additionally, Ms. Ross discussed the rulemaking process, highlighting that Oregon law encourages state agencies to seek public input before giving notice to adopt rules. That this Workgroup is a key component of OMB's public engagement.

The Workgroup offered no comments.

Review of Draft Rules

Workgroup members reviewed and discussed the draft rules section by section.

Rule 00 Purpose Statement

The Workgroup discussed the revision replacing "patients" with "individuals" in the purpose statement. A member expressed concern that this change diminishes the medical nature of acupuncture treatment. Several members supported the language change, noting that 5NP technicians will not hold medical licenses, so "individuals" is more appropriate than "patients."

Netia N. Miles, Licensing Manager, provided a historical account of how acupuncture became established in Oregon, beginning with the Oregon Medical Board's support in the 1970s. Legislation in 1973 established acupuncture regulations within the Oregon Medical Board. The first licensed acupuncturist was in Lincoln City. Through the mid-1980s, acupuncturists worked under physician supervision. The regulatory landscape evolved significantly in the late 1980s and early 1990s, when acupuncturists gained the authority to practice independently.

Rule 05 Definitions

The Workgroup discussed the definitions but had no suggested changes.

Rule 07 Five-Needle Protocol Treatment

The discussion focused on who can provide 5NP treatment without additional registration. Currently, acupuncturists and physicians can provide 5NP based on existing training, while physician associates cannot. Page 3 of 7 Updated August 28, 2025 practice acupuncture without separate certification. Members discussed whether all providers should be required to take specific 5NP training for cultural context reasons. Several members noted they did not want to increase barriers for providers already able to practice 5NP.

Rule 20 Qualifications

Discussion centered on criminal history provisions, age requirements, and practice location restrictions. Workgroup members praised the inclusion of language stating that criminal history would not automatically disqualify applicants from registration. However, members raised concerns about the "good moral character" requirement, with worry it could be misused. Members discussed refining the "good moral character" language, with suggestions to look at Community Health Worker and similar regulations and POCA ethics pledges as models. It was suggested to add a statement that lived experience with a history of substance use disorder in remission was not a reflection of current moral character.

The discussion shifted to safety concerns. A member noted concerns about the 18-year minimum age requirement, preferring 21 years old. Location concerns were also raised, noting that the program was originally presented as being for detox clinics, VA facilities, and community healthcare settings, but there were worries about practitioners working in other venues like malls or street corners.

OMB staff provided caution on regulating practice locations and age requirements. Any regulations must be focused exclusively on patient safety concerns and that regulatory agencies cannot restrict practice locations without direct patient safety concerns.

Rule 25 Five-Needle Protocol Training

Training requirements sparked discussion on whether the proposed 70 hours of training was adequate for safe practice. A member expressed concerns that these requirements were insufficient without medical supervision or licensed acupuncturist oversight while providing treatments. Other members noted that the 70-hour requirement aligned with established NADA and POCA training programs that had demonstrated good safety records for years.

Some members characterized additional supervision requirements as burdensome regulations that would increase barriers for providers. This discussion also covered the importance of balancing flexibility with appropriate safety boundaries for different practice contexts.

Participants agreed that 5NP providers should be exposed to the community-based origins and philosophy behind the practice, viewing this historical grounding as an important element of proper training.

Rule 30 Application

Members expressed appreciation for clarifying that applicants may submit additional background information and letters of recommendation for consideration, particularly relevant for populations with criminal history concerns.

Public Meetings Law Overview

Staff provided a brief overview of Oregon Public Meeting Law requirements, including notice requirements, public access, documentation, and prohibitions on private deliberations between meetings. Key points included that email discussions among all members could constitute illegal meetings, and all consensus-building must occur in a public meeting.

Rule 50 Disciplinary Proceedings

Members asked how the OMB defines "gross or repeated negligence" and "incompetence" in this context.

Staff explained that these standards are measured against other similarly situated practitioners in similar communities. When complaints about negligent care arise, the Board would ask another 5NP practitioner to review the care provided and assess its appropriateness. Gross negligence specifically refers to a willful disregard for patient well-being—a higher standard than simple negligence. The Board looks for patterns of negligence rather than single incidents, or cases of complete disregard for patient safety. For incompetence, the definition involves practitioners performing procedures far outside established standards, such as needling other body parts.

This led to concerns about how care could be reviewed without traditional medical documentation. OMB staff acknowledged this challenge but explained that trained investigators would use alternative methods, including interviewing witnesses, gathering patient statements, and obtaining corroborating medical records from other healthcare providers when relevant (such as medical records if the situation required medical care).

The discussion shifted to broader concerns about patient protection and safety. One participant worried that expanding 5NP practice to any 18-year-old without traditional medical safeguards could increase risks. They noted that unlike conventional medical procedures, 5NP practitioners typically do not carry malpractice insurance and patients lack traditional protections. In response, another member emphasized the importance of clear training standards and ensuring providers understand their responsibilities, including how to handle adverse events and respect participant rights.

Several Workgroup members highlighted that 5NP is inherently community-based, emphasizing that the community-based nature provides inherent safeguards, as communities self-regulate against unsafe practitioners. Members expressed appreciation that the disciplinary process would be grounded in community standards of care and involve people experienced with the 5NP practice. One member noted concern about potential bad faith complaints from those opposed to 5NP practice but felt reassured that the investigation process seemed robust and community-grounded enough to protect legitimate 5NP treatments.

Rule 35 Registration

The discussion centered on continuing education requirements for 5NP technicians. Staff reported that the Oregon Health Authority had confirmed 5NP technicians could participate in the existing pain management education course that acupuncturists and physicians currently take. Participants noted that pain is not listed as something 5NP treats but acknowledged that pain is interconnected with the conditions it does address (substance use disorder, mental health conditions, trauma). The pain management course was considered because it is free, accessible, and includes relevant content about acupuncture, cultural competency, and trauma-informed care. Other members emphasized that the pain education would be valuable for technicians working with populations heavily impacted by the opioid epidemic, many of whom ended up in that situation due to limited or outdated pain management options. Workgroup members discussed how 5NP technicians understanding pain treatment could help refer people to licensed acupuncturists.

Some participants expressed preference for eliminating continuing education requirements entirely in favor of simply requiring continued practice, which would align with POCA's maintenance requirements.

Rule 40 Five-Needle Protocol Regulations

The Workgroup discussion focused on documentation requirements and how to balance regulatory needs with practical implementation. Concerns emerged around the section (3)(d) requirement for individuals to self-identify their reasons for seeking 5NP treatment. Workgroup members preferred keeping this general rather than requiring people to specify exactly why they were seeking treatment, recognizing that 5NP is designed as a hands-off intervention where practitioners serve more as community health educators connecting people to resources and do not diagnose.

The conversation shifted to practical documentation methods, noting some use a single consent form with boilerplate language at the top and space for multiple signatures, functioning as both consent and sign-in sheet. This system simplifies record-keeping by eliminating the need to track whether someone is a new or returning patient, while still maintaining adequate documentation for regulatory purposes. The discussion revealed some concerns about HIPAA compliance and patient privacy. Participants acknowledged that certain settings serving vulnerable populations might need additional privacy protections.

The conversation also touched briefly on ear seeds and circulation concerns, with experienced practitioners noting that safety information is available through organizations like Acupuncturists Without Borders and is included with ear seed purchases.

The discussion concluded with the importance of clearly identifying that 5NP technicians are not acupuncturists. There was agreement that consent forms or other methods should explicitly state 5NP technicians are not licensed acupuncturists.

Review of Informed Consent Form

The Workgroup discussed a draft 5NP description and consent form, with the key question being whether this should be a required form or simply provided as an example. The consensus emerged that rather than mandating a specific form, certain required elements should be specified while allowing practitioners flexibility to create their own versions. This approach would accommodate needs like translation into other languages and adaptation to different practice settings and electronic formats.

The discussion revealed practical considerations about implementation. One concern was that since the consent form might be the only documentation retained for 5NP practice, standardization could be important for potential disciplinary proceedings. However, participants recognized that rigid requirements might not work in all settings—for example, guaranteeing a "quiet, clean, comfortable space" is not always feasible when practicing in community settings with limited resources.

A significant portion of the discussion focused on needle removal procedures. The draft form allowed either the technician or the patient to remove needles. Some workgroup members stated that only 5NP technicians should remove needles for safety and accountability reasons, while others noted that patient self-removal is common practice in many clinics, particularly busy ones where it helps with efficiency and can reduce needle stick injuries. The compromise suggested was clearer language about proper disposal in sharps containers regardless of who removes the needles.

Participants suggested adding specific timeframes for how long ear seeds could remain in place, clearer infection warnings especially for diabetic patients, and expanding the list of possible side effects to include nausea and vomiting. There was also discussion about making the side effects list more comprehensive by adding language like "but not limited to" since individual reactions can vary.

The group discussed hygiene protocols. The draft required hand washing and alcohol preparation of ears, but participants noted these are not always practical or necessary. In settings without running water, hand sanitizer is acceptable under clean needle technique standards. Similarly, alcohol wiping of ears is not universally practiced, particularly for ear seeds that do not break the skin. Some noted that alcohol can be triggering for people with medical trauma. The consensus moved toward making these practices optional rather than required.

The discussion also centered on how to describe the relationship between 5NP and acupuncture in the consent form. Participants acknowledged this is both a political and legal issue—while 5NP clearly derives from acupuncture and uses the same tools and points, legally it must be distinguished to avoid requiring acupuncture licensing. Various approaches were suggested, including describing it as a "standardized supportive treatment derived from acupuncture" or simply removing references to "acupuncture" when describing the needles. The group favored adding clear language that technicians are not licensed acupuncturists and directing patients to seek licensed acupuncturists for acupuncture treatment.

The final discussion was about whether to require a checkbox for patients to confirm they were seeking treatment within the allowance of the law (for substance use disorders, mental health conditions, or trauma) or allow the signature on the form to serve as the acknowledgment. Members worried the checkbox could create barriers. Some people receive 5NP for general wellness or as supportive companions to others receiving treatment. The group preferred removing the checkbox format and instead incorporating this as an "I understand" statement, recognizing that the purpose is already described elsewhere in the form.

Public Comment

Karina (Natalie) Arndt, a licensed acupuncturist, expressed frustration about not being aware of the earlier legislative process and discussions with the Oregon Acupuncture Association, explaining the questions and concerns are not because they are opposed to the idea of the program, but because this was new to them. Karina stated this is a confusing situation where people are performing acupuncture without being held to all the liability and requirements of an acupuncturist. She also shared that she doesn't want the acupuncture community divided over this issue.

Zachary Krebs, a licensed acupuncturist who owns a community clinic in Oregon City, offered enthusiastic support for the 5NP program and the Workgroup's efforts. Mr. Krebs expressed gratitude that people would finally have access to 5NP in Oregon, calling it an incredible achievement. Regarding training requirements, Zachary felt the proposed training hours were more than adequate, stating that in his opinion, someone could learn the protocol in a 4-hour workshop or less, though Zachary appreciated the broader scope of the training program. Zachary argued against supervision requirements as unnecessary obstacles to patient care, noting there is no evidence of harm or public safety issues with 5NP implementation in other states. Zachary compared the situation to other healthcare roles, pointing out that 18-year-olds can complete training to become phlebotomy technicians or certified nursing assistants. For the consent form, Zachary suggested language stating that "a 5-needle protocol practitioner is not a licensed acupuncturist" and is "trained to provide this specific ear protocol and are not licensed to practice acupuncture in general."

Lisa Rohleder, a licensed acupuncturist representing POCA Technical Institute (different from POCA cooperative), expressed appreciation for the Workgroup's efforts. As director of an accredited acupuncture school and manager of a voluntary adverse events reporting database for acupuncture, Lisa spoke about safety, emphasizing the importance of being specific about safety concerns. Lisa outlined the definite elements of 5NP safety: hygiene (including clean field and not leaving seeds or beads on too long), sterile single-use needles, needle management (immediate disposal in sharps containers), and management of adverse events including fainting, nausea, needle shock, and bleeding, plus social safety and de-escalation. Lisa emphasized that these safety elements do not change based on location and can be covered within the proposed training hours.

Winona (Noni) Vaitekunas, a licensed acupuncturist, provided historical context, noting that controlled clinical trials and outcome studies on the 5NP protocol have been appearing since the 1970s. Addressing supervision concerns, Noni cited National Institute of Health research showing that 8 states allow 5NP technicians to practice without supervision of licensed health professionals, 13 states require direct supervision, and 6 states delegate directly to licensed healthcare providers—putting supervision requirements in the minority. Noni noted that Colorado was removing their supervision requirement, indicating a trend away from such requirements. Noni described the advocacy during the legislative process for accessible community spaces like church basements, libraries, and shelters. Noni provided examples of successful 5NP delivery, including a recent collaboration with Portland Street Medicine that brought 5NP to a street corner at Southeast 82nd and Sandy, as well as treatments at churches, schools, nonprofit organizations, and the state capital.

Christopher Beardall, a chiropractic doctor and licensed acupuncturist, supports 5NP for behavioral problems and drug abuse, having practiced it on Portland streets and at a detox center. However, he expressed significant concerns about the proposed regulations. Christopher advocated for supervision requirements, especially for beginning practitioners, worrying about practitioners working alone without oversight. Christopher called for stronger background checks and vetting, arguing for a minimum age of 21 rather than 18, believing practitioners

need more professional and mental maturity when treating disadvantaged populations. Christopher suggested increased training requirements of at least 80 hours didactic plus 40 hours practical experience with supervision and emphasized the need for a formal adverse events reporting system. Christopher expressed concern that this would become "the largest unlicensed medical practice institution in Oregon" and stressed the need to avoid isolation of technicians, find regulatory blind spots, and provide legal and ethical processes to avoid vulnerabilities like HIPAA breaches.

Closing Remarks

Adrianna Locke, MAC, LAc, opened by reflecting on the historical presentation, describing Oregon's acupuncture history as a cautionary tale about allowing fear to override evidence and care. Adrianna expressed deep gratitude for the workgroup's focus on meeting diverse community needs during a time when healthcare access faces numerous challenges, emphasizing the importance of not repeating past gatekeeping mistakes.

Jen Kearns, DAOM, LAc, acknowledged the value of care while advocating for necessary legal protections and professional standards. Jen expressed concerns about relying solely on practitioner ethics, arguing that safeguards must be codified in law. While recognizing systemic problems in medical education and practice, Jen maintained that allowing unlicensed individuals to practice medicine could increase risks, even for generally safe practices like acupuncture.

Dilip Babu, MD, brought the discussion back to the central theme of community care. Drawing from his experience as a physician, Dilip highlighted what makes the 5NP approach special: its grassroots nature of community members caring for one another. Dilip expressed genuine excitement and emotional connection to the collective effort, viewing it as a meaningful step forward for community-driven healthcare.

Sara Biegelsen, LAc, concluded with appreciation for the collaborative process, noting how effectively previous meeting feedback had been incorporated into the workgroup's revisions. Sara's comments reflected optimism about the ongoing work and anticipation for the final meeting.

Dr. Babu closed the meeting, noting that staff will work on any areas identified before the workgroup's next meeting on Wednesday, September 3, 4-7PM, and will send updated materials and draft rules by the end of the week. Workgroup members and the public were encouraged to email any questions regarding the rules and any possible questions to include in the draft frequently asked questions document.

Dr. Babu adjourned the meeting at 6:42pm.



Approved by the Board on October XXX, 2025.

OREGON MEDICAL BOARD
Meeting of the HB 2143 Five-Needle (5NP) Protocol Workgroup
August 13, 2025 • Held via Video Conference

PUBLIC SESSION

Welcome

Dilip Babu, MD, Workgroup Chair, called the meeting to order at 4:00pm and called the roll. A quorum was confirmed.

The following Workgroup Members were present:

Sara Biegelsen, LAc

Letty Dogheart

Maddie Foley, DACM, LAc

Whitsitt Goodson, LAc

Jen Kearns, DAOM, LAc

Eve Klein, MD (arrived at 4:05)

Adrianna Locke, MAc, LAc

Moss Roberts

Jill Shaw, DO

Dilip Babu, MD

Nicole Noceto, LAc, was absent by prior notice.

OMB Staff present:

Nicole Krishnaswami, JD, Executive Director

Elizabeth Ross, JD, Legislative & Policy Analyst

Netia N. Miles, Licensing Manager

Gretchen Kingham, Executive Assistant

Dr. Babu welcomed Workgroup members, discussed ground rules for the meeting, provided an agenda overview, and invited public participation during the comment period or through written submissions to Board staff.

Dr. Babu read an Emily Dickinson poem:

"Pain has an element of blank;

It cannot recollect

When it began, or if there were

A time when it was not.

It has no future but itself,

Its infinite realms contain

Its past, enlightened to perceive

New periods of pain."

Dr. Babu explained that the Workgroup members have a shared desire to address and relieve the pain and suffering of fellow Oregonians. He asked the Workgroup members and those in attendance to remember this grounding purpose throughout the meeting to implement 5NP in Oregon.

Workgroup Member Introductions

Dr. Babu invited Workgroup members to introduce themselves:

- **Dilip Babu, MD:** Oncologist, OMB Acupuncture Advisory Committee, Workgroup Chair
- **Jill Shaw, DO:** OBGYN, Oregon Medical Board Chair
- **Eve Klein, MD:** Addiction Medicine, OMB Associate Medical Director
- **Maddie Foley, DACM, LAc:** Practicing Acupuncturist
- **Jen Kearns, DAOM, LAc:** Practicing Acupuncturist
- **Whitsitt Goodson, LAc:** Acupuncture Educator
- **Sara Biegelsen, LAc:** 5NP Trainer/Acupuncture Educator
- **Adrianna Locke, MAc, LAc:** Practicing Acupuncturist, Clinic Owner
- **Letty Dogheart:** Navy Veteran, trained in 5NP, performs 5NP on Tribal Lands in Puyallup Territory
- **Moss Roberts:** Community Member

Workgroup Charter

Workgroup members acknowledged the 5NP Protocol Workgroup Charter.

Background & HB 2143 Overview

Elizabeth Ross, OMB Legislative & Policy Analyst, discussed HB 2143 (2025), signed into law by Governor Kotek on June 11, 2025. The law allows individuals to provide five-needle protocol (5NP) treatments without a license to practice acupuncture beginning March 1, 2026.

The new law authorizes the Oregon Medical Board (OMB) to establish rules regarding:

- Qualifications for 5NP registration, including education and training
- A registry of individuals qualified to provide 5NP
- Sanitation and best practice standards
- A schedule of violations and disciplinary actions
- Any other requirements or standards the OMB determines necessary

To assist with drafting the rules, staff reviewed OMB's acupuncture rules, other states with 5NP regulations, and guidelines from the National Acupuncture Detoxification Association (NADA) and People's Organization of Community Acupuncture (POCA).

Review of Draft Rules

Workgroup members reviewed and discussed the draft rules section by section.

Rule 00 Purpose Statement

Discussion centered on the primary goal of expanding access to safe, standardized, and low-barrier treatment, with particular recognition that 5NP emerged from communities supporting and caring for themselves, especially communities of color.

One workgroup member raised concerns that the scope and boundaries were insufficient and could lead to commercialization of 5NP.

Most workgroup members noted that 5NP has traditionally not been limited to particular settings and should be flexible enough to encompass various applications, including AA meetings, mental health facilities, and community settings. Members noted that this modality serves as a gateway to accessing other health care and community resources, which can be particularly valuable for underserved populations like unhoused, veterans, and people without insurance.

The group discussed several proposed modifications to the draft purpose statement language.

- Replacing "patients" with "people" to better reflect the community-based nature of the treatment
- Adding "self-identified" before conditions to emphasize the non-diagnostic approach
- Including an acknowledgment of historical origins of 5NP in communities of color

The consensus was to emphasize this as "community medicine" rather than strictly medical treatment. Key principles of 5NP include:

- No diagnosis requirement
- Low-barrier access
- Community-based delivery
- Standardized training and safety protocols
- Connection to broader care networks

Rule 05 Definitions

Several Workgroup members noted their support of the draft language in OAR 847-071-0005, Definitions.

It was clarified that "5NP Technician" is used to describe individuals providing 5NP treatments, as agreed upon with the Oregon Association of Acupuncturists (OAA) during the legislative session.

A Workgroup member noted that in 5NP treatments, acupuncture needles are used, but 5NP treatments are not acupuncture.

Rule 07 Five-Needle Protocol Treatment

The Workgroup's discussion focused on clarifying training and registration requirements for medical doctors and acupuncturists who want to provide 5NP treatments, questioning whether medical doctors could perform 5NP without any training.

Staff provided context about physician oversight, explaining that while physicians have very broad scopes of practice and aren't restricted in what type of medicine they can practice, they are held to standards of care requiring proper training and experience in whatever treatment they provide. Using the example that a family medicine physician wouldn't be expected to perform orthopedic surgery without appropriate training, staff clarified that the same standard would apply to physicians wanting to provide 5NP—they would need to be trained and experienced in the protocol to include it as part of their practice, regardless of their broad scope of practice. However, they would not be required to receive the specific 5NP training as outlined in these rules or to register as a 5NP technician.

A suggestion was made to clarify that acupuncturists and physicians can offer 5NP "without additional 5NP registration."

Rule 20 Qualifications

Discussion focused on the Oregon Medical Board's "good moral character" requirement and background check processes for 5NP technicians.

Members expressed concern about how moral character standards might create barriers for people in recovery who have criminal histories but want to become 5NP technicians, questioning whether criminal history would be an automatic disqualifier. Workgroup members asked if there were "good moral character" definitions or rubrics.

Staff stated that the Oregon Medical Board has no automatic disqualifiers for criminal history. Instead, criminal history is only one component of an individualized review process that is focused on the applicant's ability to provide 5NP treatments. Applicants may provide additional information and circumstances as needed. To carry out its mission, the OMB has a duty to the public to ensure that 5NP practitioners are safe to practice.

Rule 25 Five-Needle Protocol Training

Discussion centered on the correct number of training hours with Workgroup members stating that the current trainings require 30 hours of didactic training and 40 ears during clinical training.

Participants emphasized the importance of maintaining accessibility through hybrid online/in-person training models while ensuring core competencies including:

- Ear anatomy
- Infection control
- Trauma-informed care
- The revolutionary history of 5NP

The Workgroup also discussed documentation practices, noting that 5NP involves minimal record-keeping since it's a non-verbal intervention using standardized points without making a diagnosis.

Members also discussed baseline standards that could accommodate both NADA and POCA training approaches.

Staff were asked to clarify the meaning and expectations of "collaboration with healthcare providers" and "reporting requirements." Staff clarified that training on collaboration would teach 5NP technicians how to seek resources or guidance from others and noted that reporting requirements remain undefined pending OMB's review of whether 5NP technicians would fall under mandatory reporting obligations that apply to other healthcare providers licensed or registered by the OMB.

Workgroup members asked about what the next steps are in the process, specifically how their comments would be included. OMB staff noted they are taking detailed notes to revise the draft rules, with the goal of creating requirements general enough to encompass existing training courses while ensuring safety and competency standards are met.

Rule 30 Application

The Workgroup's discussion centered on the necessity of criminal background checks, identity documents, and photographs. Staff acknowledged these concerns while explaining the proposed requirements represented the minimum information required to maintain the OMB's mission of patient safety and to create a public registry of verified qualified practitioners.

Staff explained the established procedures which allow for alternative documents and clarified several important points:

- Oregon explicitly does not consider citizenship status when granting licenses or registrations.
- The OMB already has processes for accepting alternative documentation to establish legal name and age.
- Criminal history is not automatically disqualifying, and the OMB already has processes for evaluating individual applicants.

Staff noted they regularly work with applicants who have criminal backgrounds and evaluate each case holistically, sometimes including personal impact statements and letters of support.

Workgroup members shared several ideas, including:

- A tiered system where 5NP trainers could vouch for individuals in their 5NP course
- Community recommendations from training facilities
- Explicit language clarifying that background checks are not automatic disqualifiers

There was consensus that public information about the process should clearly state that criminal history does not prevent registration, as many ideal 5NP technicians could be people in recovery who have lived experience with addiction and the criminal justice system.

Rule 35 Registration

The workgroup examined continuing education requirements for maintaining 5NP registration, with the draft proposing 3 hours of courses every 2 years. Participants questioned whether this was necessary given that no accrediting body exists for 5NP practice and continuing education classes specific to 5NP do not currently exist.

Several members suggested that active practice might suffice for maintaining registration instead of formal coursework, noting that POCA requires practitioners to perform at least one treatment annually to stay in good standing, which could be documented through consent forms.

OMB staff stated that the 3-hour requirement was modeled on Texas regulations; 5NP technicians will not be required to complete the Oregon Health Authority's pain management course that acupuncturists must complete but would fall under the broad cultural competency education requirement (1 hour annually) that applies to all OMB licensees. The cultural competency education requirement can be met through various educational activities and typically involves a simple attestation process, with only a small percentage of practitioners audited for documentation.

Members discussed the possibility of creating free continuing education options that could fulfill the 3-hour requirement. Participants appreciated that the draft specified that lapse of registration would not be considered disciplinary action.

Rule 40 Five-Needle Protocol Regulations

Discussion focused on consent forms, record-keeping requirements, and scope of practice limitations. OMB staff announced they would create a draft consent form for 5NP technicians based on the Workgroup's input. The group suggested extending the record retention periods from one year to three years to encompass a full two-year registration period.

A significant portion of the discussion centered on the draft language limiting 5NP practice to providing "temporary relief from symptoms of substance use disorders, mental health conditions, or trauma." Workgroup members expressed concern that this narrow scope didn't reflect the reality of 5NP use for general stress relief and everyday wellness, noting that requiring documentation of specific reasons conflicted with the non-diagnostic, non-verbal nature of the intervention. Members explored solutions including self-attestation by patients on consent forms or general language indicating treatment falls within legal scope without requiring specific condition identification. Staff clarified that HB 2143 clearly defines 5NP to be provided within the context of, "... temporary relief from the symptoms of substance use disorder, mental health conditions or trauma. conditions or trauma." A change to the law would be needed to expand for other uses.

The conversation also addressed adverse event procedures and "community standards of care." OMB staff described the OMB's complaint-driven regulatory model, explaining that the Board does not conduct proactive inspections but requires licensees to demonstrate their procedures and standards in response to a complaint about their practice. Common complications discussed included vasovagal reactions, ear bleeding, and needle shock, with reporting typically handled through training organizations' databases.

Rule 50 Disciplinary Proceedings

There was no discussion regarding Rule 50 Disciplinary Proceedings due to time restraints.

Public Comment

Winona (Noni) Vaitekunas, POCA Technical Institute, expressed appreciation for the diverse voices in the Workgroup. Noni suggested removing background checks and fingerprinting. If retained, the rules should explicitly state that criminal history is not a disqualifier from registration.

Natalie (Karina) Arndt, practicing acupuncturist, provided written comment prior to the meeting, which was added to the Workgroup's materials. Karina noted support for acupuncturists without borders and the idea of 5NP technicians but expressed concern with the level of clarity in the draft rules, stating 5NP seems like the practice of

medicine—treating diseases. Karina questioned whether HIPAA is involved, whether patients' identity is actually confirmed, and whether there is a way for patients to pursue malpractice if there is a problem. Karina shared concerns about diabetics having embedded seeds or beads and suffering serious complications due to infection. A Workgroup member responded that 5NP training involves what to do in adverse situations and another stated they would be sharing this information with people and that it should be something to know.

Sarah Farahat, 5NP provider, noted her gratitude that Oregon is establishing 5NP. She shared her experience as an Egyptian American providing 5NP to victims of torture in Palestine and other countries. Sarah stated that bridge training for re-entry would be helpful for people who were trained but haven't practiced 5NP recently. Sarah additionally shared that she is not worried about people exploiting this procedure and that it needs to be easily accessible to the community—the benefits outweigh any concerns previously expressed. Sarah also explained she uses a waiver for treatment that explains the scope of 5NP and requires the person's information.

Fletcher Watson, RN, chronic pain treatment provider, expressed appreciation for the work and excitement to learn 5NP is coming to Oregon. Fletcher noted his awareness of 5NP detox programs and experience seeing it practiced regularly with veterans in southern Oregon at a residential rehabilitation facility. Fletcher stated that seeds are used at his facility but are only retained for 3 days maximum. Additionally, Fletcher's role in the VA involved looking at the amount of care provided in the community—innovation included bringing in acupuncturists and implementing 5NP protocol. It was a valuable bridge for many veterans who had never considered acupuncture before. They were very receptive to trying acupuncture after experiencing 5NP within the VA.

Micaela Foley, POCA's legislative liaison and a POCA trainer, expressed support for the initiative. She noted that the most cumbersome portion is the hours and treatments required. She explained that NADA and POCA trainings are similar in structure, usually requiring about 30 didactic hours and 40 treatments, and encouraged aligning those requirements so that neither training is excluded. She recommended removing the 3 continuing education hours since those don't currently exist, noting there is a continuing education course that POCA Tech offers online for acupuncturists and trainers for about \$10, which would be a good option for people who haven't received the history and other aspects of training. Micaela encouraged reducing the requirements for background checks or plainly stating in the language that criminal history is not a disqualifier. She noted that while Acupuncturists Without Borders is doing great work, their reach is limited, whereas 5NP could reach tens of thousands more people to treat in their communities and respond to natural disasters. She emphasized that there is so much trauma in communities every day, and this could be an effective and accessible intervention. She described that the clinic where she trains sees huge numbers of people excited about acupuncture every time they conduct a training, and these experiences can serve as a bridge to get people into acupuncture clinics, observing that "acupuncture begets acupuncture."

Closing Remarks

Whitsitt Goodson, LAc, expressed being heartened by the developments in Oregon, noting that while the impact may seem small, it is lifesaving and reduces suffering. He offered heartfelt thanks to the group.

Maddie Foley, DACM, LAc, remarked on the interesting exercise in regulatory function, noting the challenge of balancing perfection with practicality. She acknowledged this as a difficult and courageous dialogue, appreciating how this simple, effective treatment touches on the essence of witnessing suffering and determining appropriate responses. She expressed appreciation for the time and engagement of all participants.

Moss Roberts thanked Dilip for excellent meeting facilitation and expressed gratitude to OMB staff for coordinating materials, preparing draft rules, and creating space for all questions and discussions.

Sara Biegelsen, LAc, expressed appreciation to the OMB for opening up this important conversation.

Letty Dogheart offered thanks to the ancestors who opened doors for today's work and shared a prayer for the descendants who will benefit from the group's efforts.

Jen Kearns, DAOM, LAc, thanked the group for considering her comments even if they did not share the same concerns.

Dr. Babu shared that he opened with an Emily Dickinson poem because all members share the mission to reduce pain and suffering, which serves as motivation to help Oregonians. He then closed the meeting, noting that staff will work on any areas identified before the workgroup's next meeting on Wednesday, August 27, 4-7PM, and will send updated materials and draft rules a week before the next meeting.

Dr. Babu adjourned the meeting at 6:52pm

From: Melissa <[REDACTED]>
Sent: Thursday, September 18, 2025 10:23 PM
To: ROSS Elizabeth * OMB
Subject: HB2143

You don't often get email from [REDACTED] [Learn why this is important](#)

Good evening,

I attended the virtual meeting about 5NP and was not able to speak as I was working.

I want to emphasize how valuable this could be for people and I believe it is safe and concerns from what we heard from places outside of our community support that and that having less barriers is helpful.

I am a nurse and have an independent practice and if I could offer this service in a world where people are unable to access care, therapy or even 5NP I could help them. It saddened me a few months ago when I was about to go to Arizona for a training that in Oregon I can't help people in this way because despite my skill and license I am not an acupuncturist.

I hope I can in a few months after being trained, thank you!

Melissa M. Ozmore RN, BSN PMH-BC, BCPA, HNB-BC (She/Her/Hers)

Board Certified in Holistic, Psychiatric-Mental Health Nursing & Patient Advocacy

Oregon Nurse Association Cabinet for Human Rights and Ethics

OFNHP - RN AFT - Local 5017 - Steward - **Social Justice Committee**

Parent and Educational Advocate (SEAT 2.0 – COPAA Candidate)

Need an advocate or nursing services?

Visit: [PIECESOFYOURLIFE.COM](https://www.piecesofyourlife.com)

From: Patti <[REDACTED]>
Sent: Friday, September 19, 2025 10:14 AM
To: ROSS Elizabeth * OMB
Subject: HB 2143 (2025) 5NP program in Oregon

You don't often get email from [REDACTED]. [Learn why this is important](#)

As an addiction treatment professional with over 15 years experience, I am looking forward to being able to provide the additional support and benefit that the 5NP protocol will offer my clients. Similar to the benefits of peer support, offering this accessible skill to the community can only improve client engagement in care. Having seen the benefit of acupuncture in an addiction treatment setting, I stronger support these rules be approved.

Patti Thompson, Professional Counseling Associate, QMHP, CADC III

--

Free clicks to support good causes :-)

<http://www.care2.com/>

<http://www.thehungersite.com/>

From: [REDACTED]
Sent: Saturday, September 20, 2025 5:29 PM
To: ROSS Elizabeth * OMB
Subject: 5NP

To: Acupuncture Advisory Committee and Oregon Medical Board
Subject: Draft Rules for 5NP Practitioners

Dear Oregon Medical Board,

My father was a doctor, in public health. He would be horrified at the current draft of the rules and associated details regarding the regulation of 5NP, ear acupuncture.

My acupuncturist has *never* asked me to remove my own needles, and according to my discretion, as included in the consent form suggested by the current draft of the rules. All of my medical practitioners, including my acupuncturist, always hold to the common standards of health care. I request that 5NP practitioners uphold the same standards.

I am told that the 5NP tech won't get a medical history of the patient. If the 5NP tech doesn't take a health history, how will they know if the patient has diabetes, a bleeding disorder, etc.?

Clinical training should be 40 hours, with 40 "ears", not the "40 ears" in the current draft, which could be done in an hour. I request that the OMB add provisions for oversight of the training, for infection control standards, and for direct supervision for techs under 21. In general, 5NP techs should only practice with the supervision of established medical clinics. Compared to 80 hours of training for 5NP practitioners, Oregon body piercers get 750 hours of training plus written and practical exams. They aren't even practicing medicine! LMTs need 625 hours, including an exam in order to practice independently. Phlebotomists take 60-120 hour, and phlebotomists are supervised in a structured facility.

I learned that the draft for the rules has not changed since my last public comment. Please do not enact rules with substandard regulations of these new practitioners.

I will see practitioners that are fully certified and licensed. I will not see practitioners that have received a few hours of training and do not follow common standards of health care. What you are proposing will endanger people's health.

Sincerely,

Jill Wyatt
Baker City, OR 97814

From: Hellen Odumbe <[REDACTED]>
Sent: Monday, September 22, 2025 10:50 AM
To: ROSS Elizabeth * OMB
Subject: Concerns Regarding HB 2143, 5NP Bill– Request for Critical Amendments

You don't often get email from [REDACTED]. [Learn why this is important](#)

I am writing to express serious concerns regarding House Bill 2143, which proposes to allow individuals aged 18 and older to administer a specific five-point auricular acupuncture treatment for trauma, mental health conditions, and substance use after completing a weekend training course.

While I fully support the bill's intent to expand access to care, especially for underserved and remote communities, I am deeply concerned that, in its current form, HB 2143 may do more harm than good. Without key safeguards, the bill risks undermining patient safety and the clinical integrity of care being offered to highly vulnerable populations.

The proposed training model, which involves minimal hours and no clinical experience requirement, is simply insufficient for a treatment aimed at addressing complex health issues. Although the five-point protocol can be safe when performed correctly, the bill's lack of a mandatory supervision requirement is a significant oversight.

A review of similar laws in 32 states shows that the majority (21) require supervision by a Licensed Acupuncturist (LAc) or a Medical Doctor (MD). This standard is not arbitrary, it exists to ensure that individuals administering care are doing so within a structured, professional framework that supports patient safety, ethical oversight, and continuity of care.

To strengthen HB 2143 and ensure it truly benefits those it aims to serve, I respectfully urge the inclusion of the following amendments:

1. Require Professional Supervision

Practitioners of the five-point protocol should be supervised by a Licensed Acupuncturist or Medical Doctor. This ensures clinical oversight, maintains a standard of care, and provides patients with a critical layer of protection.

2. Restrict Practice to Licensed Clinics

The treatment should be administered only in licensed clinics or similarly regulated healthcare settings. This promotes sanitation, confidentiality, and a professional therapeutic environment.

3. Increase Clinical Training Requirements

The training must be expanded to a minimum of 40 hours (not just "40 ears") to ensure practitioners have sufficient understanding of both the technique and the clinical context in which it is used.

While I understand and share the urgency behind this legislation, particularly in response to the opioid crisis and growing mental health needs, it's crucial that the solutions we implement are both effective and safe. As currently written, this bill resembles a "band-aid on a bullet hole": well-intentioned but inadequate to address the depth and seriousness of the issues at hand.

Thank you for your time and thoughtful consideration of these important concerns. I would welcome the opportunity to discuss this further with you or your staff.

Regards,

--

Hellen Odumbe, BCBA, M.Ed

Owner

Upendo Behavior Services, LLC

Phone:

Email:

From: Carol McIntyre <[REDACTED]>
Sent: Monday, September 22, 2025 8:09 PM
To: ROSS Elizabeth * OMB
Subject: House bill 2143

You don't often get email from [REDACTED]. [Learn why this is important](#)

To Whom It May Concern:

House bill 2143 has multiple gross oversites. First and foremost, safety needs to be addressed. Procedure, cleanliness of individual, the person performing 5NP, the surroundings and proper disposal of needles are all major concerns with lack of direction from this bill. Second, take into consideration the extremely minimal training people are undergoing who would be allowed to perform 5NP. There are multiple licensed acupuncturists who spent hours for training and testing, including practicum, not to mention the tuition costs, in order to properly administer acupuncture to individuals. Third, without the individual administering the 5NP being liable for how their actions may affect others is in absolute disregard for respecting the medical practice of acupuncture as well as the individuals targeted by this bill. This bill is a complete disgrace to the practice of acupuncture on multiple levels and should be retracted.

Sincerely,
Dr. Carol McIntyre
ND, LAc, MSOM

Be Well~

Carol McIntyre, ND, MSOM, LAc.

[REDACTED]

From: Mari <[REDACTED]>
Sent: Monday, September 22, 2025 8:35 PM
To: ROSS Elizabeth * OMB
Subject: 5NP concerns

Dear Dr Ross,

I would like to express concerns over the lack of required training and investment in the 5NP protocol bill.

As a licensed acupuncturist for over 20 years, I have spent numerous hours and time in training to be able to utilize acupuncture needles including bleeding techniques for the ear.

Further, for our licensure requirements, we spent many clinical (basically volunteer) hours providing 5NP protocols in addiction recovery programs and detox centers.

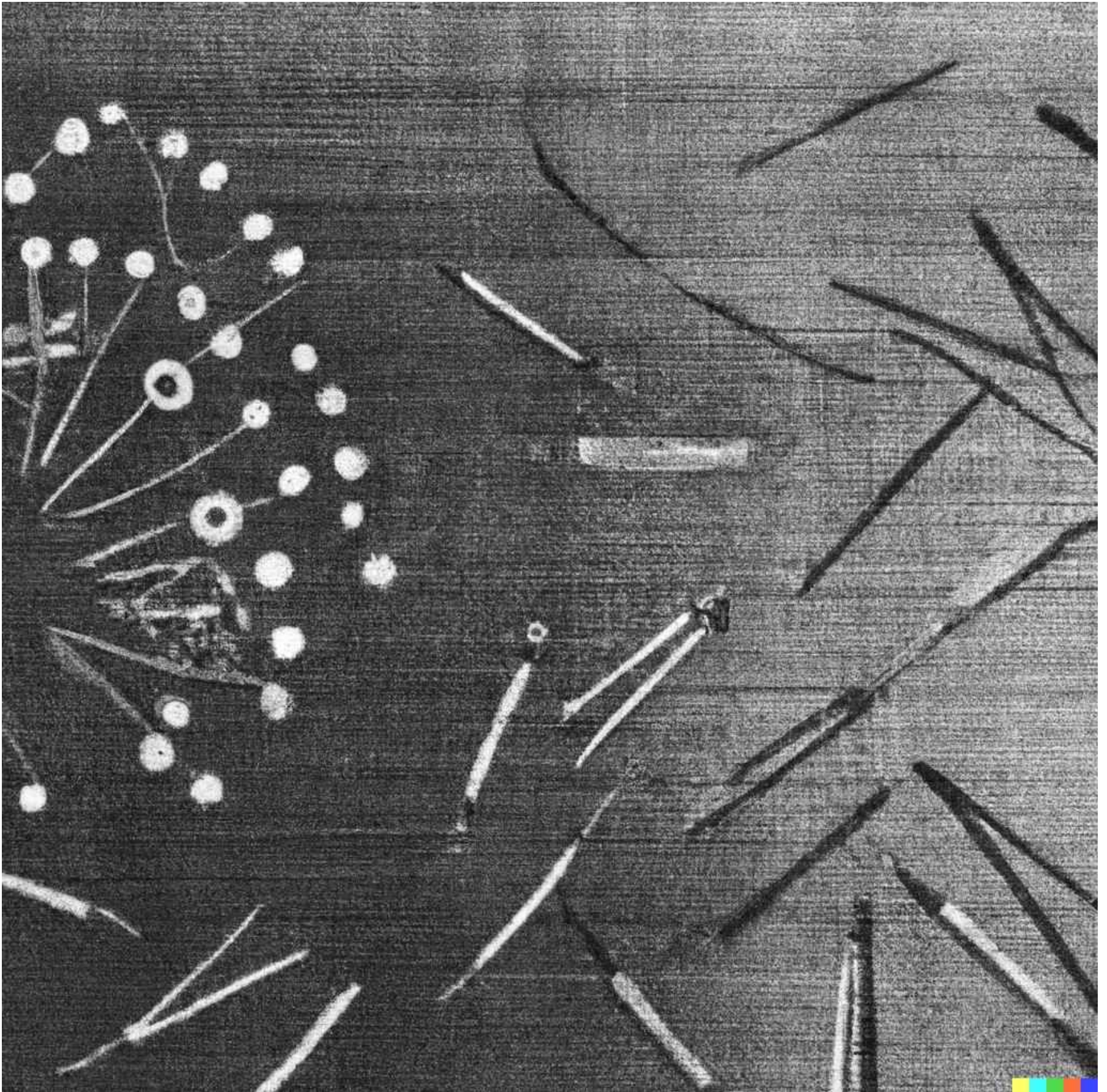
It is my belief that those wishing to provide 5NP protocol undergo at least 10 hours of training to understand the needle safety, disposal, clean needle technique, acupoint location and needle technique before allowing this bill to go through.

Currently Oregon has allowed Physical therapists to perform acupuncture with no training requirements and now this bill is up, which is cause for alarm.

While ear needling is safe and low risk, there are basic guidelines to be followed.

Please consider this in your review of the bill.

Regards,
Mari Greenly.
Mari Greenly LAc, MSOM
East Bridge Acupuncture
[REDACTED]
Portland, OR 97214



Responding to Adverse Events in Acupuncture

*An educational zine written by community acupuncturists
to promote safety in acupuncture. For practitioners,
students, clinic staff, and volunteers.*

September 2024

Index

INTRODUCTION.....	4
COMMON ADVERSE EVENTS SEEN IN COMMUNITY ACUPUNCTURE	5
THE ADVERSE EVENTS REPORTING DATABASE (AERD)	7
RED FLAGS OF MEDICAL EMERGENCIES UNRELATED TO ACUPUNCTURE	10
TRAUMA-INFORMED COMMUNICATION FOR RECEPTIONISTS	12
TRAUMA-INFORMED COMMUNICATION (TIC)	17
ADVERSE EVENT ANECDOTES	20
- Anecdote 1	20
- Anecdote 2	21
WHEN TO REFER OUT	22
ABOUT WORKING CLASS ACUPUNCTURE (WCA)	23
ABOUT POCA TECH (THE PEOPLE’S ORGANIZATION FOR COMMUNITY ACUPUNCTURE TECHNICAL INSTITUTE)	23
HOW TO GET MORE COPIES	24
CREDITS	25

INTRODUCTION

Acupuncture is generally considered very safe, but any intervention comes with its risks and occasional unintended effects. Information about adverse effects in acupuncture is very difficult to find, as not much of it exists in the first place. Most data that we found on the subject was collected 10 or more years ago, and much of it from Korea and China. The most reliable updated source for information and risk mitigation in regards to AE can be found in the Clean Needle Technique (CNT) handbook.

This manual aims to raise awareness about possible adverse acupuncture events and to help acupuncture clinics, especially community clinics, respond in a way that promotes safety. This zine is part of an effort to address the dearth of data and to open discussion about safety within the acupuncture profession (and the medical field in general).

An acupuncture adverse event is a negative consequence or injury to a patient because of treatment and not necessarily because of error. An acupuncture error is an incorrect action or plan that may or may not cause harm to a patient. ~Lisa Rohleder L.Ac and Jersey Rivers, L.Ac (no date), Punking Part 2: Praxis and Safety.

We recommend a framework for trauma-informed communication with patients who report negative effects, and introduce the Adverse Event Reporting Database. With the goal of increasing safety for patients and practitioners, the AERD disseminates data from voluntary, anonymous reports of safety incidents related to acupuncture treatment. We hope this zine will be a useful resource in building a culture of safety for the acupuncture community.

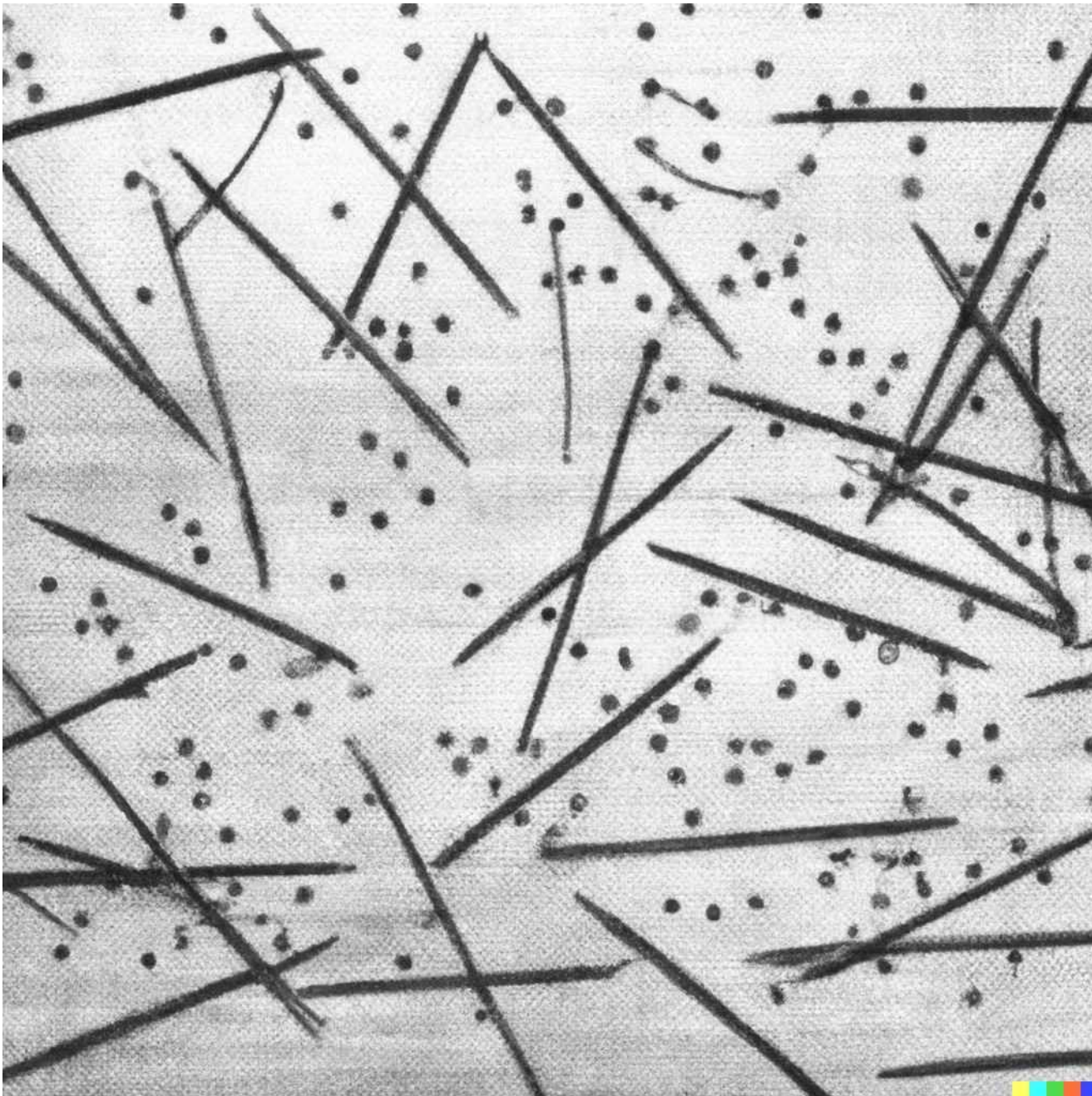
Perfect is the enemy of good. We did our best to gather the most up-to-date and accurate information, stories, advice, and sources. We welcome productive feedback, resources, and additional safety information to amend or add to a future edition.

Sources Cited

Lisa Rohleder and Jersey Rivers, n.d. *Punking Part 2: Praxis and Safety*.

Lisa Rohleder, 2021, January 1st. “Let Us Tell You About Our AERD! No, wait, come back...”, Acu Safety Nerd. <https://www.acusafetynerd.com/let-us-tell-you-about-our-aerd-no-wait-come-back>.

Lisa Rohleder, 2023, May 22nd. “Four Stages and Safety”, Acu Safety Nerd. <https://www.acusafetynerd.com/four-stages-and-safety>.



WHAT ARE ACUPUNCTURE ADVERSE EVENTS?

Adverse events, or “**AE**” are negative or undesired effects that arise during or after any process involved in an acupuncture treatment, including receiving acupuncture needles of any number, depth or placement.

The following are the most commonly encountered (and therefore, the most relevant) AE at community clinics and how an acupuncturist can respond to a patient who reports these events. It does not represent an exhaustive list.

For a more comprehensive list of potential adverse events and errors, refer to the Clean Needle Technique Manual (7th edition) Published by the Council of the Colleges of Acupuncture and Oriental Medicine (found here: https://www.ccahm.org/ccaom/CNT_Manual.asp)

COMMON ADVERSE EVENTS SEEN IN COMMUNITY ACUPUNCTURE

Many adverse events are minor and self-resolve. Pneumothorax (bottom of table) is an extremely rare, but potential event requiring emergency care.

Adverse Event	Description	How to respond
Bruising	Bruising can occur during acupuncture but should be minimized. If frequent, seek help to improve needling technique and avoid veins/arteries.	Bruises may be prevented by applying mild pressure with a cotton ball after needle removal.
Bleeding	Minimal bleeding is normal and beneficial; severe bleeding should be avoided by being aware of veins and arteries.	Minimize bleeding by applying mild pressure with a cotton ball after needle removal.
Headache	Acupuncture may trigger minor headaches, particularly with head/scalp points. Severe headaches with confusion or dizziness need medical attention.	Encourage water intake and a light snack if needed. Persistent or severe headaches should be evaluated by a medical professional. Avoid problematic points in future treatments. Update patient's chart.
Nicked Nerve	A nicked nerve can cause burning or electrical shock sensations. It might not be avoidable due to nerve variability.	Sensations often resolve in minutes but can persist up to 6 weeks. Patients should be informed and encouraged to seek medical help if there is loss of function.
Needle Shock, Dizziness, and/or Fainting	Involuntary responses to needle insertion, including faintness, clamminess, and nausea.	Remove needles immediately, elevate feet, and keep the patient seated until symptoms subside. For dizziness, guide the patient to sit or lie down appropriately. If fainting occurs, elevate feet, cover for warmth, and seek emergency help if consciousness is not regained within one minute.

Adverse Event	Description	How to respond
Reaction at Needle Site (redness, soreness)	Reactions can be due to histamine response, alcohol not drying, excessive needle manipulation, or patient movement.	Monitor the site and use alternating ice packs and warm compresses. Persistent symptoms may indicate infection; seek medical attention if necessary.
Symptoms Worse Following Treatment	Symptoms might worsen temporarily as part of the healing process or indicate an adverse event.	Communicate that worsening symptoms can be a common occurrence. If not expected, re-evaluate the diagnosis and treatment plan.
Psycho-emotional Triggers	Emotional responses like crying can occur as the body releases stored stress or endorphins.	Allow and support emotional release, provide tissues, and address any requests to remove needles. Offer support and inquire if further assistance is needed.
Pneumothorax : SERIOUS EMERGENCY EVENT!	A rare but serious condition where air enters the chest space, causing lung pressure and breathing difficulties.	Keep the patient calm and seated or lying down. Cover the needle site with a dressing to prevent air entry. Seek emergency medical attention immediately. Symptoms include bluish skin, chest tightness, lightheadedness, fatigue, abnormal breathing, rapid heart rate, shock, and collapse.

Sources Cited

Clean Needle Technique 7th Edition Manual English, revised February 2020
Published by the Council of Colleges of Acupuncture and Oriental Medicine©2015

WCA website: <https://www.workingclassacupuncture.org/>

Dupuis, Chad. May 20th. 2006. "Headache after Acupuncture Treatment". Yin Yang House. <https://yinyanghouse.com/forum/t-headache-after-acupuncture-treatment-1915/>

Working Class Acupuncture Handbook n.d. *Health Related Situations and Emergencies*. https://drive.google.com/file/d/1nVqRLDI07Rg4dtqRF7r2dNAvUYQ7SsWA/view?usp=drive_link

THE ADVERSE EVENTS REPORTING DATABASE (AERD)

The AERD is a platform where patients and practitioners can report adverse events that happen to them in the context of an acupuncture treatment. The AERD exists for several reasons, one of them is to understand and compile the adverse events and errors that happen in clinics and serve as an educational tool for practitioners to make acupuncture more safe. There is a long delay between any given adverse event and when it potentially could make it into the Clean Needle Technique Manual, so reporting helps bring awareness to possible adverse events that are not widely known.

The AERD represents an effort to normalize communicating about safety, and provides a space to transparently and freely communicate safety issues with more immediacy. When folks are met with neutrality and curiosity around adverse events, they are more likely to continue talking about them and learning. What is a huge surprise is that AERD is the *~only~* database for adverse events in the acupuncture profession. The only one! At best, such a gap in attention given to safety might bring up a false idea that no adverse events ever happen with acupuncture. At its worst, such a misunderstanding could confuse practitioners that adverse events only happen to “bad practitioners” who engage in “bad practices”, making them ashamed, guilty, and quiet about it. To counter this safety avoidance, AERD creates a structure for communicating about *safety work*.

“Safety work is gathering information, sharing information, having meetings, arguing, and making decisions; that’s how policies get developed. Safety work is drafting plans, revising plans, and managing uncertainty. Safety work is communicating. And it’s never done.” Lisa Rohleder, 2020

The AERD is accessed at: <https://acupunctureconsumersafety.net>

How does it work?

Filling out an adverse event or error report on the AERD website can be done anonymously or not. All reports are sent to the survey host- SurveyMonkey- who was chosen for having excellent cyber security practices. Do not identify anyone but yourself while reporting, in order to respect the privacy of the patient or any other parties involved.

What is reported to the AERD?

Anything that a patient complains about with regard to treatment, including but not limited to the list of events from the CNT manual. Anything that happens in your clinic, related to treatment, that you don’t want to happen again. See the table on the following page for data from 2023.

Adverse Events Reported to the AERD in 2023

Adverse Event	Count	Details
Bruising/hematoma	14	Including one bruise “the size of a softball”
Dizziness	5	
Symptoms getting worse after treatment	5	
Headache	5	
Migraine	1	
Patients feeling needle sensation in places without needles	2	
Psychoemotional trigger	2	
Pain after treatment	2	
Error that did not overlap with an adverse event	1	
Swelling and pain at the needle site feeling worse for 7 days	1	
Fainting	1	
Moxa burns	1	
Nausea	1	
Extreme fatigue after first treatment	1	
Needle left in	1	At Yin Tang
Nicked tendon on insertion	1	
Just plain weird	3	One case: tingling sensation from R shoulder to L shoulder, no needles in either; two cases: feeling needles where there weren’t any
Practitioner error	1	Involving how to respond to a patient reporting a needle feeling weird
Combined adverse events	1	Bruising, bleeding, redness, soreness at needle site combined with psychoemotional triggers
Electric shock	1	Due to a smart watch notification and PC6 needle
Professional concern	1	People paying too much for acupuncture, categorized under “an adverse event for the whole profession”

Why use the AERD?

From the AcuSafety Blog: *“Part of a culture of safety is the sense that we don’t have to hide our mistakes, and in fact we don’t want to; what we want to do is learn from them, together.”*

“Researchers who study adverse events reporting as a safety practice agree that it works best when the process of reporting is voluntary, anonymous, and can’t be linked to any kind of negative consequence. The prospect of being punished makes people clam up, about errors and events that aren’t errors but might be cast as such (<http://acusafetynerd.com/a-queer-perspective-on-safety>). You can’t build a culture of safety in an atmosphere of fear and condemnation, because nobody will want to talk, compare notes, collaborate, or do any work that requires any degree of trust. For an AERD to do its job, sharing information about safety should feel as neutral and routine as possible, no big deal. Just another pro-social behavior like, say, recycling.” (Rohleder, 2021. *Not a Weapon*, Acu Safety Nerd)

Another very important reason to use the AERD is to consider perceived adverse events and how practitioners can approach them, as clinicians and as business owners.

“Perceived adverse events will never make it into the medical literature. And “perceived adverse events” should not equal “patients are liars”. A perceived adverse event can be as big a deal for the patient and the acupuncturist as an objectively verified adverse event.” (Rohleder, 2021. *Let Us Tell You About our AERD No Wait Come Back*. Acu Safety Nerd)

Perhaps the most remarkable thing is how little we know about acupuncture safety and adverse events. It’s true that acupuncture is generally very safe and rarely causes serious or lasting undesired effects. **But sometimes it’s not safe for certain people or under certain circumstances.** We will keep exploring, documenting, and paying attention to continue understanding how to make acupuncture more and more accessible to any one who wants to use it.

Sources Cited

All by Lisa Rohleder, accessed October 2023:

“Homemade Swiss Cheese Making Imperfect Safety”. Acu Safety Nerd. December 31st 2020. (<https://acusafetynerd.com/homemade-swiss-cheese-making-imperfect-safety>)

“Let Us Tell You About Our AERD No Wait Come Back”, Acu Safety Nerd. Jan 1, 2021. (<https://acusafetynerd.com/let-us-tell-you-about-our-aerd-no-wait-come-back>)

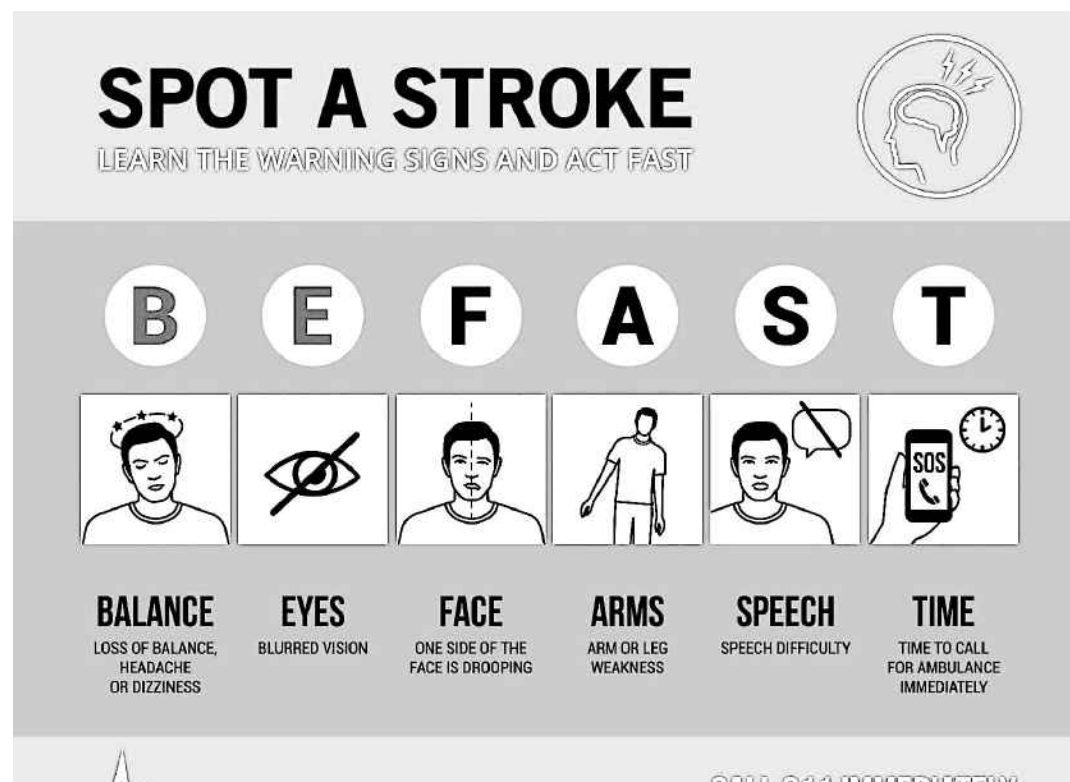
“Safety and Organization”, Acu Safety Nerd. January 4th, 2021 (<https://acusafetynerd.com/safety-and-organization>)

“Not a Weapon”, Acu Safety Nerd. January 10th, 2021. <https://acusafetynerd.com/not-a-weapon> “About Data”, Acupuncture Consumer Safety.net. <https://acupunctureconsumersafety.net/about.html#about-data>.

RED FLAGS OF MEDICAL EMERGENCIES UNRELATED TO ACUPUNCTURE

As health providers, it is important to be aware of symptoms of serious conditions that warrant emergency care. In the event that acupuncture patients at your clinic present any of the following signs, an immediate emergency room visit is advised. If the patient is unable to drive themselves or loses consciousness, call 911 for an ambulance. According to the American College of Emergency Physicians, the following are warning signs of a potentially life threatening medical emergency:

- Bleeding that will not stop
- Breathing problems (difficulty breathing, shortness of breath)
- Change in mental status (such as unusual behavior, confusion, difficulty arousing)
- Chest pain or discomfort lasting for two minutes or more
- Choking - Call 911 even if CPR resolves the issue
- Coughing up or vomiting blood
- Fainting or loss of consciousness
- Actively planning self harm
- Head or spine injury
- Severe or persistent vomiting
- Sudden, severe pain anywhere in the body
- Sudden dizziness, weakness, or change in vision
- Severe abdominal pain or pressure
- Unusual or severe headache
- New inability to speak
- Swelling of the face, eyes, or tongue
- Bluish skin color
- Strokes can be life threatening, symptoms below:



Common Emergency Medical Conditions (Unrelated to Acupuncture Adverse Events)

Condition	Symptoms
Arrhythmias	Extra heartbeats, palps, flip-flops, fluttering. Px may or may not report palpitations. Palps that reliably occur w/exercise and disappear with rest are a red flag for heart dz of some type.
Angina Pectoris	Chest pain caused by angina usually feels tight, dull or heavy. It may spread to arms, neck, jaw, or back. Triggered by physical exertion or stress.
Appendicitis	Inflammation of appendix with threat of rupture and infection. Middle-upper abdominal pain followed by vomiting, pain moves to right lower quadrant. Rebound tenderness. Loss of appetite. Pain can also manifest as back pain or present on the left side.
Aneurysm	Can have no symptoms until rupture. Visual disturbances, pain above or around the eye, numbness or weakness on one side of face, difficulty speaking, headaches, loss of balance, difficulty concentrating or short-term memory problems.
Concussion and TBI	From violent, sudden, or impactful blow/shaking. Symptoms include headache, confusion, memory loss, nausea, vomiting, excessive fatigue, ringing in ears, dizziness. Post head-injury can lead to bleeding in the brain. In seizure patients, can indicate impending seizure.
Deep Vein Thrombosis (DVT)	Blood clot deep in the calf with risk of traveling to lung (pulmonary embolism). Unilateral ankle/distal calf swelling, redness, heat. Homan's sign (dorsiflexion pain). Referral: with chest pain and SOB = PE complication, 911; otherwise urgent ER.
Hypoglycemia	Low blood sugar, especially from insulin overdose. Symptoms include anxiety, tremor, sweating, racing pulse. Manage by administering sugar then protein, or may progress to coma = ER.
Meningitis (Bacterial Infection)	Highly contagious. Fever, chills, fatigue, lethargy, loss of appetite, nausea, shivering. Inflammation of brain and spinal cord membranes. Headache, fever, stiff neck.
MRSA (Bacterial Infection)	Highly contagious, a type of staph resistant to medications. Swollen, painful red bumps with pus, and/or fever. High chance of becoming abscessed. Can be contracted in hospitals, person-to-person, or from unhygienic environments.
Myocardial Infarction (MI) - Heart Attack	New pain or discomfort in chest. Lightheadedness, nausea, vomiting. Pain in jaw, neck, or back. Discomfort or pain in arm or shoulder. Shortness of breath.
Pancreatitis	Severe and persistent abdominal pain in upper left or middle abdomen. Pain worsens when lying on back, improves when leaning forward. Nausea, vomiting. May be worse after fatty meal or alcohol.
Pre-Eclampsia	Hypertension (HTN/HBP). Persistent headache, proteinuria, vision symptoms (blurriness, flashing lights, seeing spots, sensitivity to light), UR abdominal pain, decreased urine output, shortness of breath, face/hand edema.
Pyelonephritis	Kidney infection. Pain with urination, frequent urination, high fever. Back and flank pain, malaise, higher fever.
Radiculopathies (Pinched Nerve)	Pain or numbness radiating down one (most common) or both legs. Due to impingement of sciatic nerve, usually at spine or glute. Emergent referral if sequela of traumatic injury with loss of bladder/bowel control, numbness, muscle weakness (R/O Cauda-equina syndrome).
Transient Ischemic Attack (TIA)	15-min episode of unilateral numbness or tingling that resolves completely. Higher risk of clotting in those using estrogen or progesterone.



TRAUMA-INFORMED COMMUNICATION FOR RECEPTIONISTS

Listed below are some common ways a person's trauma can be activated ("triggered") by interacting with reception, paperwork, scheduling, or getting oriented to the clinic as a new patient. These events are not things that we would not necessarily report to the AERD because they're not necessarily acupuncture related. Note: the following situations may produce dissociation or a range of emotional responses from minor to intense.

- Filling out forms can be a trauma trigger
- In too much pain to fill out forms
- Too unnerved/stressed out to focus on reading forms
- They have a disability that makes navigating the intake process very difficult
- They have trouble speaking and/or prefers not to speak
- Anxiety caused by being outside their home and/or around strangers
- Very scared in anticipation of needles

- Person had been strong armed/convinced to try acupuncture when they really don't want to
- The person is non-gender conforming or transgender and is referred to by the wrong pronouns
- A situation in where there is not enough time to fill out forms (such as a street-based pop up clinic)
- Doesn't have any money or enough money to pay for tx
- Feels guilty about not being able to pay more
- Arrives to the clinic without an appointment and is asked to wait a long time to be seen, or to come back later in the day/ another day
- Is asked to pay a late fee from a previously missed/canceled visit
- Became upset in person or on the phone due to something said by receptionist or someone else at the front desk
- The exact time that they want to come in isn't available on the calendar
- Exiting acupuncture treatment with an adverse event and is now upset in the lobby
- Arrived very late to their appointment and stressed out about it
- The receptionist was busy when they came in, so they were not greeted, or were greeted "too slowly"
- Doesn't speak/write/understand the language that the forms are written in
- If the person translating for the patient is unfamiliar and/or personally scared of acupuncture themselves, they may (initially) translate the acupuncture experience expectations in a way that is emotionally charged. This can lead to worry for the new patient. Note: this first emotional response is often soothed as the acupuncturist shares the current acupuncture info and expectations of treatment. it can be helpful for the acupuncturist to ask the new patient if they have any questions to clarify treatment expectations.
- Can't read or write (and doesn't let you know)
- Can't read or write (and lets you know)

The more you say, the more you can say wrong.

It is often unnecessary to tell someone to stop doing something - being admonished can be a trauma trigger. That being said, there are rare circumstances in which those situations arise, and in the meantime there are more elegant, graceful, positive, and encouraging ways to teach patients how to use the clinic. This only serves to ensure the safety and accessibility of the space remain preserved for all of the other patients. If it's not disturbing the peace or posing a safety hazard, there is a good chance it's not an issue.

It is best to stick to a neutral script, stay even-mannered, and play the part of customer service person. You can communicate with your face and ears! Listen, be welcoming. Be helpful and communicate concisely. In 9/10 cases, boundaries can be enforced simply through patient education. See examples in the following table.

AVOID ...	Instead Try...
For example, if someone is using a cellphone in the lobby... avoid saying something like, "You're not allowed to talk so loud in here"	"Excuse me, are you able to speak more quietly or take your phone call outside?" (If it persists) "Hey there I'm sorry, people are resting in the other room so we try to keep down the noise level out here.. thanks for understanding" In rare situations a patient is hard of hearing and technologically limited in skills with phone usage options. If you notice a person is hard-of-hearing, you could say: "If you need to talk louder, to hear your phone call, you are welcome to connect headphones to your phone, or use your phone outside". "Thanks for helping us keep the noise level down in the clinic".
Make lifestyle suggestions	Listen and nod if they offer info about why they are visiting. You could say "Well I am glad you
Making treatment suggestions	Listen and nod if they offer info about why they are visiting. You could say "Well I am glad you could make it in today! I hope it helps". You're not that patient's care provider, and it's not trauma informed to make tx suggestions. Receptionists support patients in developing a safe relationship with their acupuncturist. They can help this relationship along by gently directing any acupuncture related questions from patients directly to their acupuncturist.
Scolding a patient for being late to their appointment	"I'm glad you made it!" "Welcome back!" Note: One unusual but common enough situation: If the patient is really late, like 1 hour or more, they may disrupt the acupuncturist work flow with other patients if you just send them back for treatment right away. So, slow communication down briefly by gently remind the patient that new behavior may be needed today for them to continue with treatment. For example, you could say: "we are glad you were still able to make it today! I'll check in with the acupuncturist right now to find how soon they can treat you." Then, reception walks into the acupuncture tx room and checks reasonable treatment timing with the acupuncturist quietly to confirm how soon to send back the very late patient. Sometimes it is right away and other times the patient may need to wait in the lobby 10-20 minutes-ish before starting treatment.

AVOID ...	Instead Try...
Admonishing/scolding a patient for not giving advance notice for a same-day or last-minute cancellation ie “Why didn’t you call sooner?”	“Thanks for calling to let us know you won’t be making it! Just a reminder that we do have a \$20 same-day missed appointment fee, and if you have pre-paid treatment credits we can just subtract one from your account. Thanks so much for understanding. Do you want to reschedule for another day?” Depending on the acupuncture clinic policies/culture, you may be able to offer to waive the missed appointment fee if the patient is open to rescheduling a new appointment right now/during your same phone call.
“What happened to you/ Why are you here?”	Resist asking. The reason for a patient’s presence in the clinic is between them and their punk. Receptionists don’t need to know!
(Someone shows you, the receptionist, an injury or the pt has a part of their body in bandages/cast etc or tells you about a severe health/ life circumstance) “That looks painful/bad/awful” etc and any other judgement-based observation	Resist commenting. You can say something neutral, if nothing at all “Glad you could make it in”
Assuming someone’s level of ability based off of their use of a mobility device such as cane, walker, wheelchair, crutches, etc. Also: saying “Let me do that for you”	ASK: “Would you like help [with the door(s)]?” “Do you need any assistance with that]?”
Assuming a patients pronouns because of the way that they look	You can use gender neutral pronouns “they/them/theirs”, refer to the person by name, check the patients chart to see if pronouns are listed, or if you need to refer to that person and they are present you are welcome to directly ask their pronouns
“You NEED to fill out the rest of this form!” re: patient is having a hard time filling out intake forms due to stress, trauma, pain, or something else.	Ask if they are able to provide consent signatures. We are able to collect a minimum of: consent paperwork signatures and contact info from a new patient. They don’t need to fill out any of the health history if they are being triggered by it

AVOID ...	Instead Try...
(Patient told you that they paid online.) “Did you, actually though?”	Believe them if they told you that they made an online payment. Say something like “Ok, great!”. Then, check them in on the scheduler as “paid online” (called “self pay” at WCA)
Someone who is not a patient or on the schedule asks to “Take a peek” at the back room. You say sure and wave them through, unattended.	Someone who is not a pre-existing patient or on the schedule asks to “Take a peek” at the back room. Use your best judgement. Does this person just ask to see the back room or do they seem genuinely interested in getting acupuncture? If the latter and the shift is not busy, you can see if there is another person to watch the desk, while you quietly show them the treatment area for a moment. If it is busy or you don’t want to or your gut says so, you can just say, “Sorry, we can’t do that today but let me know if you have any other questions.”
“You NEED to fill out the rest of this form!” re: patient is having a hard time filling out intake forms due to stress, trauma, pain, or something else.	Ask if they are able to provide consent signatures. We are able to collect a minimum of: consent paperwork signatures and contact info from a new patient. They don’t need to fill out any of the health history if they are being triggered by it
Looking disappointed, angry, or put-out when a patient pays at the bottom of the sliding scale	It’s a sliding scale for a reason. Many people pay the bottom end, this is common. Say “Thank you!” If someone is complaining about cost, asking about “cheaper” tx “sales” or “deals”, you can tell them about our quarterly 5 acupuncture tx’s for \$85 sale, or tell them to consult with their punk anytime about a payment plan. Receptionists cannot offer a tx plan or any type of other discounts that are not already noted on the pts account
Asking why a patient can’t pay more	Please NEVER do this. You have no idea what someone's circumstances are and asking them to pay more can undermine the clinic’s reason for being
Joking about a patient being “rich” for paying the top of the sliding scale	Resist making comments about payments. Just say “Thank you” and/or “We appreciate your support”
“I know how you feel”	In fact, you don’t know how someone feels! You can say “That sounds really tough/hard” or just mm and nod with an empathic look on your face

TRAUMA-INFORMED COMMUNICATION (TIC) WITH PATIENTS REPORTING ADVERSE EVENTS

Existing outside the binaries of safe/unsafe and right/wrong, safety is not absolute or ever certain. Developing a culture of safety accepts that risk is inherent, and focuses on reducing harm given the circumstances. Intentional, trauma-informed communication is key to acupuncture safety. It provides some guiding principles to help reduce harm as we navigate this nebulous realm of safety.

On a busy day in a WCA clinic, 100+ people come through the doors for treatment. **Practitioner error** is a game of numbers. No matter how carefully and considerately an acupuncturist treats each of their patients, should they needle enough people, they will doubtlessly encounter an adverse event just because of the numbers. Adverse events are not errors, they are just things that happen regardless of whether a practitioner made a mistake -- so in TIC, that would be somebody getting triggered due to circumstances beyond your control. It is also inevitable that practitioners will make errors. Acupuncturists should expect to have to respond to both adverse events and errors as part of their jobs.

In often unavoidable and distressing situations, how we respond to a patient reporting an adverse experience is important to the healing process!! When a patient reaches out to you with a complaint or observation about something that happened to them during or as the effect of an acupuncture treatment, this framework provides an order of operations to address the issue:

1. **Attitude:** First you'll want to promote a collaborative and respectful interaction and avoid an adversarial or defensive one. Approach the conversation with neutrality, curiosity, and empathy; be as attentive and relaxed as you can, and prepare to take notes. Lead with empathy. Remember that the patient is making an effort and taking a risk by letting you know there's a problem.

"What helped me was an orientation toward openness, listening, empathy, and gathering information, as opposed to scrambling to figure out what went wrong and who to blame for it." - Lisa Rohleder L.Ac and Jersey Rivers, L.Ac in Punking Part 2: Praxis and Safety.

2. **Listen:** From your open, non-defensive mindset, now ensure the patient feels heard and gather as much information as you can. A good way to start off is to express empathy such as, "Oh, I'm sorry to hear that. Please tell me about what you're experiencing". Use active listening, encouraging the patient to keep sharing and ask clarifying questions to make sure you understand what they say. Believe what they share with you, and support their agency to offer or decline to give more information.

“It may be more useful to ask, “How can we move forward productively to make more safety for everyone?” than to try to nail down The Truth of The Matter. Mystery and safety can co-exist, as long as you stay focused on the praxis of safety” - Lisa Rohleder L.Ac and Jersey Rivers, L.Ac in Punking Part 2: Praxis and Safety.

3. **Discern:** You'll want to discern whether this negative response or adverse event is due to treatment, or if there's a chance it could be caused/complicated by something else. **An adverse acupuncture event or negative response entails a new type of symptom or a change in the pattern of symptoms.** With their consent, ask follow up questions to get a very detailed picture of what may be going on. (For instance, symptoms of depression, anxiety, and trauma often manifest somatically and interplay with pain and other physical conditions. Patients could attribute inherent flares or fluctuations to the acupuncture itself. And though these side effects are not likely for a large percentage of the population, doing our duty to listen and to affirm patients means to believe them. If their experience is having more anxiety after acupuncture, that may be an AE.) Always believe and uphold their experience of reality, and validate their feelings. Perceived effects or impacts are just as important as objectively verifiable ones. If a patient complains about something that happened related to treatment, or you are aware that an AE listed in the CNT manual occurred, report it to AERD (more info in following chapters). You can let your patient know that you'll be reporting their experience anonymously to a database intended to help promote acupuncture safety.
4. **Case Management:** *This is an example of a boundary between receptionists and acupunks. "Case Management" is not something that receptionists do, it's something that the acupuncturist is responsible for.* Determine if any other actions need to be taken. The discernment process may lead acupunks to follow up with conversations about whether the treatment is appropriate or effective for them, frequency of visits, and checking expectations. It may be an opportunity to help patients assess their journey and progress. If it seems acupuncture isn't working or they can't follow a sufficient course of treatment, it may require gently suggesting other modalities without making them feel discouraged or rejected. Always affirm the patient's agency by supporting their choice on whether and how they want to move forward.
5. **Wrap up the conversation:** At this point, you've ensured the patient has no further information to share or questions to ask, and you both are clear about your next action steps to take. Please thank the patient for sharing their experience, and get to those action steps!

Practicing clear, structured, intentional communication with patients helps maintain boundaries you set when you decide how you want to show up for them in the clinic, as opposed to reacting to how they show up with you ~paraphrased from Lisa Rohleder L.Ac and Jersey Rivers, L.Ac in Punking Part 2: Praxis and Safety.

Closing remarks on trauma informed communication:

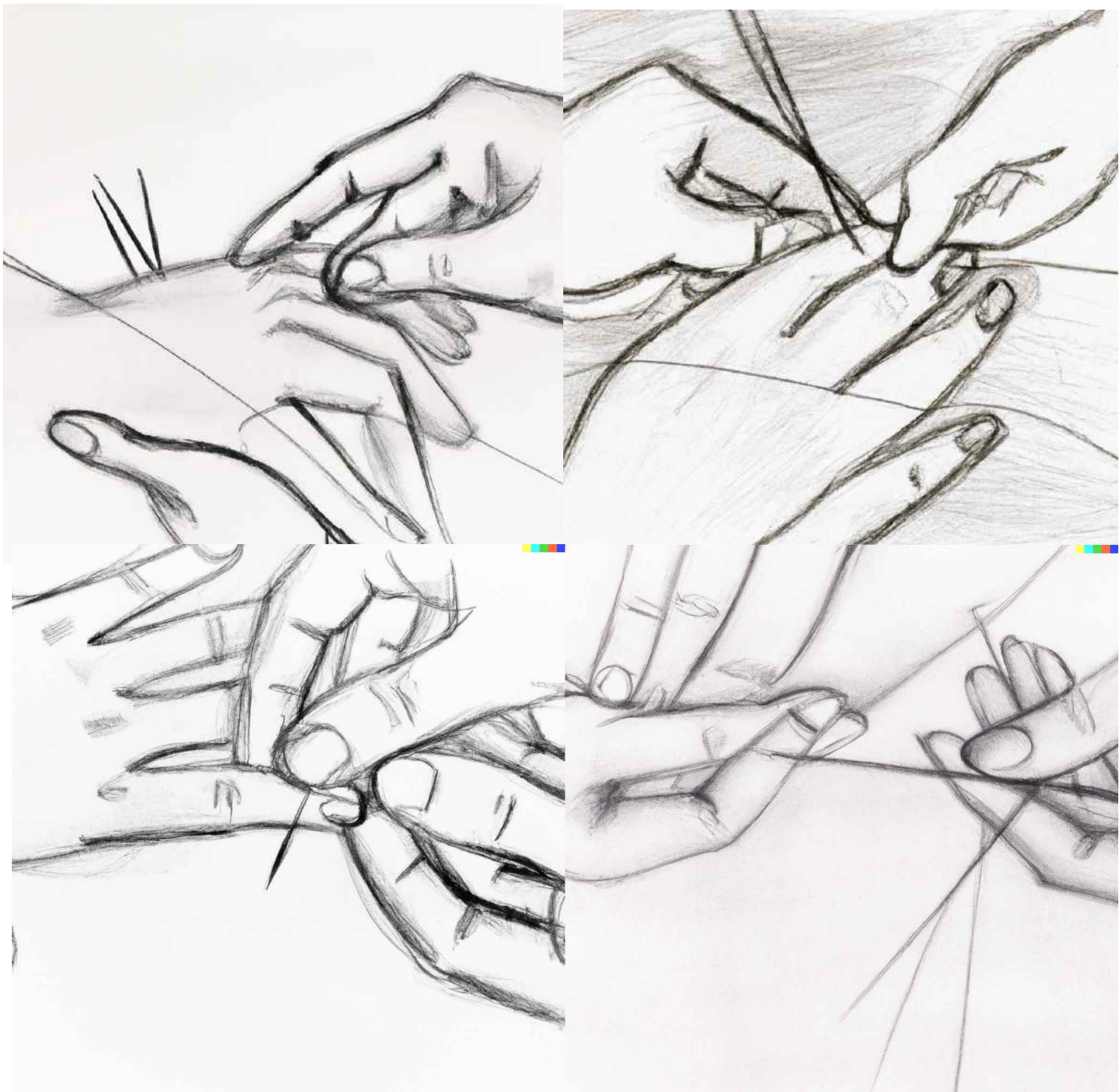
*“A core aspect of a community acupuncturist’s job is to **actively create safety** in their clinic, as opposed to just following safety guidelines.”- Lisa Rohleder L.Ac and Jersey Rivers, L.Ac in Punking Part 2: Praxis and Safety.*

Keep in mind that a culture of safety goes beyond a list of dos and don’ts, and entails a multilayered, adaptive approach to reducing risk. Safety work is an ongoing collective and personal process~ Thanks for your care and participation!

Sources Cited

Lisa Rohleder and Jersey Rivers, n.d. *Punking Part 2: Praxis and Safety*.

Acupuncture Consumer Safety, n.d. “About”, Adverse Events and Errors. <https://acupunctureconsumersafety.net/about.html>. Accessed October 2023.



ADVERSE EVENT ANECDOTES

Anecdote 1:

“When I was a student I gave my brother an acupuncture treatment. He was sitting upright in a regular chair, which I thought was okay. When I put the needles in, specifically only 1 needle which was the liver point in his ear, he had a seizure immediately. I removed the needle but during the seizure he got very stiff and rigid in the fetal position. We called 911 but as they were on their way there, he came-to and said that he didn’t want the paramedics to come, that he was fine - it has happened before. We had him lay flat on his back and stayed with him until he felt better.

After the tx he remained an acupuncture patient for many years and always requests the seizure treatment (narrator says this with a laugh). He said that he felt kind of reset after that, way more clear headed. The experience didn’t turn him off of acupuncture nor did it dissuade the student from continuing her education.”

“If a patient is dizzy or woozy... give food and water. A lot of the time it is because they haven’t eaten anything before coming to the clinic. I ask them when the last time they ate. Make sure they don’t have food allergies and give them something to eatr (this is benefit of having a clinic kitchen with lots of snacks). If it’s because of nausea I make sure they are sitting, give them a trash can and water or have them lay down.”

“Personally, I experienced a nerve nick at BL 62.. The feeling was electrical so I told the punk and they took out the needle. I didn’t know it would hurt for so long though. There was pain, burning, and I had shooting pain up the back of my leg when I walked or flexed my foot. It healed after 2 weeks. She apologized but that was all there was to do. I think I was the one who filed the report in the AERD.”

-Haley Merritt

Anecdote 2:

“I received an email from a patient that I have been treating weekly, for about the last 2 months. She came in for spine pain, stomach cramping and nausea (and had undergone an endoscopy/colonoscopy procedure 2 days prior for it). We heard from her 2 days after being treated.

With guidance and coaching from a supervisor, I was able to respond to her concerns quickly and openly— I gave the patient a call to hear more about the experience. I learned that she felt great during the treatment, that her stomach cramping had subsided. She reported that 20 seconds or so after needles were removed from her head, that a severe headache came on in her right temple. Following that was dizziness and “fogginess” that she described as confusion. She also mentioned that a needle was left behind on the right side of her head near her temple, and that she removed it herself. Because of the severity of her headache and confusion, she had already visited urgent care and then was referred to the ER, which checked her for signs of heart attack or stroke (and found none). The headache and foginess still remains. She will be seeing a GP soon, to follow up. In her initial email, she wondered if acupuncture is contraindicated for people that are her age, of which I let her know that there is no evidence or reporting that would indicate that it would not be safe. But it was obvious that the headache could have been an AE from the treatment and let her know that, too. I had not needled her right temple, but had put 3 needles in her left ear, and 5 needles down the center of her scalp. Since I charted everything, I was able to reassure her that the right temple pain was not from a needle in that area. I also let her know that we were grateful for all of the information and that should she decide to continue treatment, we could discontinue needles in the scalp moving forward. I filed a report in the AERD and told her not to hesitate in contacting us again should she have any questions or feedback. As this just happened, I don’t have an end to this story yet- I’m not sure if she will return to the clinic or what will happen in regards to her symptoms.”

-POCA TECH 2nd year student, 1st year student intern

WHEN TO REFER TO OUT (FOR ACUPUNCTURISTS)

Resources for students

When to refer out is something that all acupuncturist students are required to have classes in, thanks to ACAHM curriculum standards! Schools are also required to provide this information in student clinic manuals. If you are a current acu student and would like more info on how and when to refer out- ask your teachers.

Resources for licensed acupuncturists

L.Ac's and students can brush-up on red flag conditions Read this book "**An Acupuncturist's Guide to Medical Red Flags and Referrals Paperback – November 1, 2010**" available to order all over the internet, used or new.

We also found this amazing PDF made by "The Acupuncture Society (UK)", which is somewhat dated but still helpful! <https://acupuncture society.org.uk/pdf/BAC%20Red%20Flags.pdf>

Resources for receptionists

Receptionists *are not responsible* for referring patients out and *do not* make these recommendations- this is done by acupuncturists only.

ABOUT WORKING CLASS ACUPUNCTURE (WCA)

Working Class Acupuncture has been providing low-cost acupuncture for the Portland, Oregon community since 2002, through a cooperative, financially self-sustaining model. Our goal is to offer people as much acupuncture as they want, in support of whatever goals they have, so that they can use it in whatever way works best for them. We offer treatments on a sliding scale, currently \$25-\$45 with a \$10 intake fee for first appointments.

WCA creates access to acupuncture.

Working Class Acupuncture is a nonprofit acupuncture clinic with four locations in Portland, Oregon: Cully, Hillsdale, Rockwood and North (2023). The first location in the Cully neighborhood opened its doors in 2002. In the summer of 2024, a new student clinic opened in Northeast Portland (42nd and Wygant), on site of POCA Tech.

Working Class Acupuncture works to create a safer and comfortable environment for all members of our community. We welcome people of all genders, sexes, races, colors, incomes, national origins, ages, abilities or disabilities, marital statuses (legal or otherwise), familial situations, religions, sizes and shapes, sexual orientations, and political beliefs. Your level of care will never be based on any of these factors.

ABOUT POCA TECH (THE PEOPLE'S ORGANIZATION FOR COMMUNITY ACUPUNCTURE TECHNICAL INSTITUTE)

POCA Tech offers a three-year, master's-level, accredited program designed to educate the next generation of community acupuncturists. A POCA Tech Master's-level certificate qualifies graduates for acupuncture licensure in Oregon and most other US states. Our school is grassroots, independent, and small— admitting 10-20 students per year, who all pay out-of-pocket and without the aid of federal funding or support from traditional student loans. Being debt-free helps to encourage PTI graduates to offer affordable treatments, as they will not have the burden of repaying a mortgage's worth of student loan debt.

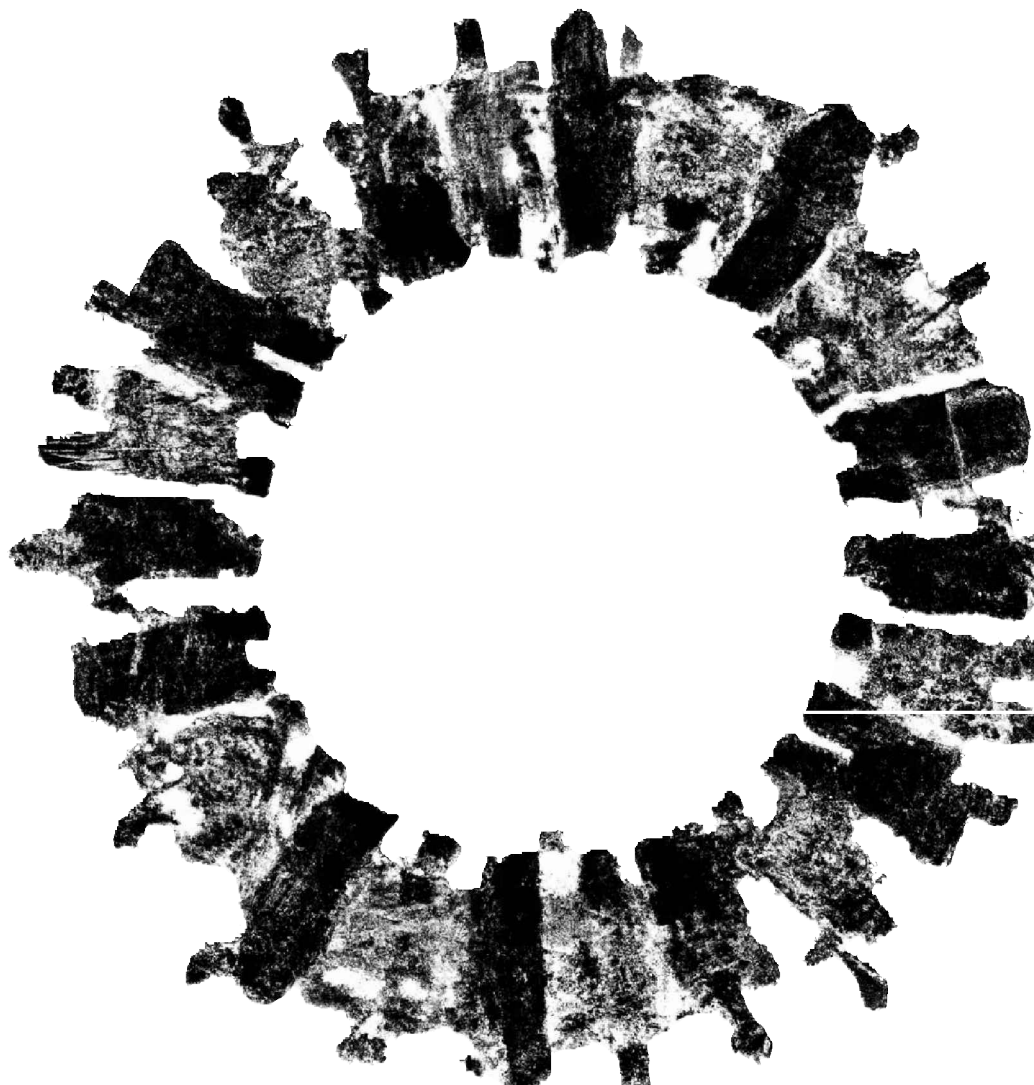
Attending the student clinic to receive acupuncture allows student interns to receive valuable, practical experience and meanwhile keeps the cost of your treatments incredibly low at \$10-\$20 per visit.

Read more about how to visit our student clinic here:

<https://www.workingclassacupuncture.org/poca-technical-institute/student-clinic/>

Want to help? Here is a link to the Sustainers website with opportunities to volunteer and donate.

<https://www.workingclassacupuncture.org/get-involved/>



HOW TO GET MORE COPIES

PDF (digital). Digital copies are free

Visit <https://www.workingclassacupuncture.org/poca-technical-institute/publications/>

Donations are encouraged and can be made online at the link below—
Proceeds from this document directly benefit the existence of POCA
Technical institute

[https://www.workingclassacupuncture.org/poca-technical-institute/the-school/
support-us/](https://www.workingclassacupuncture.org/poca-technical-institute/the-school/support-us/)

CREDITS

This manual was contributed to by POCA Tech students and faculty.

Arielle Avenia (C9) - project manager, cover art, graphics, layout, printing production, distribution coordinator, editor, interviewer

Yarrow Geggus (C10) - writer, researcher, and editor

Katia Bushanski (C10) - writer and researcher

Michelle Cavanaugh - writer and researcher

Haley Merritt, L.Ac at WCA Hillsdale - story contributor

Sonya Gregg, L.Ac at WCA Cully - story contributor

Moses Cooper, L.Ac at WCA Rockwood - editor

Lisa Rohleder - project instigator, fact checking, and editor

From: Amy Chitwood Burslem <[REDACTED]>
Sent: Tuesday, September 23, 2025 10:09 AM
To: ROSS Elizabeth * OMB
Subject: HB 2143 (2025): 5NP Protocol for Non-Acupuncturists

You don't often get email from [REDACTED]. [Learn why this is important](#)

The sender cannot be verified, use extreme caution!

This bill is dangerous, plain and simple. Non-acupuncturists practicing acupuncture consistently leads to outcomes that cause damage and harm. Providing acupuncture to the public something only a licensed acupuncture who has gone through school should be able to do.

Please do not move forward with this bill. It will cause more harm than good.

“[HB 2143 \(2025\)](#) establishes a regulatory structure allowing non-acupuncturists to apply for registration to administer five-needle protocol (5NP) under the jurisdiction of the Oregon Medical Board (OMB). The bill is designed to protect and inform the public by ensuring individuals obtain the appropriate education, training, and background checks prior to administering 5NP treatment. The bill also requires the OMB to set 5NP sanitation and best practice standards by rule.”

From: Beth Yohalem-Ilsley <[REDACTED]>
Sent: Tuesday, September 23, 2025 8:02 AM
To: ROSS Elizabeth * OMB
Subject: Vote no on HB2143 5NP

You don't often get email from [REDACTED]. [Learn why this is important](#)

To whom it may concern:

The bill HB2143 regarding 5NP is disturbing on many counts and I urge the OMB to vote against its passage in its current form and to mandate the following changes:

- Require **supervision by a LAc or MD**.
- Require **40 hours of supervised clinical training as per NADA** (not just 40 ears).
- Require **standard infection-control and OSHA compliance** (sharps disposal, PPE, exposure protocols).
- Prohibit **patients from removing their own needles**.
- Prohibit treatment of patients **under the influence of alcohol or drugs**.

These are basic safety protocols. The bill is currently flawed for the following reasons:

- **No professional standards:** Unlike most states, OR's proposed rules allow unsupervised practice with **no liability insurance, no supervision, and no restrictions** on where 5NP may be performed.
- **Risk to patient safety:** Training requirements are **719 hours less than for a cartilage ear piercer**. Providers are not required to follow standard infection-control practices, OSHA workplace protocols, or exposure-control plans.
- **Out of step with national norms:** Of the **29 state examples** provided by OMB, **25 require supervision by a Licensed Acupuncturist (L. Ac) or Medical Doctor (MD)**. In addition to supervision, many require the technician to already be a licensed healthcare provider and to practice only in licensed healthcare facilities.

I urge the OMB to consider the implications and possible consequences of passing the bill in its current form. All licensed healthcare providers are rigorously trained in health and safety protocols. Why would you pass it in its current form? Would the benefits really outweigh the risks?

Imagine needles all over the floor when people remove their own needles and infections where needle insertion have bled and not been tended to properly. These include opportunistic blood borne pathogens and localized infections. Imagine bare feet stepping on the needles on the floor because of improper disposal. These include children running around and stepping them.

Please vote no on this bill.

Beth Yohalem-Ilsley (she/they/hers)
Licensed Acupuncturist
www.mississippihealthcenter.com

Ph [REDACTED] f [REDACTED]

From: Dr. Annabelle Snow <[REDACTED]>
Sent: Tuesday, September 23, 2025 11:12 AM
To: ROSS Elizabeth * OMB
Subject: Re: HB 2143: Concerns about the introduction of 5NP/ear acupuncture in Oregon

Hello Ms. Ross,

Thank you for your follow up and for your thoughtful consideration of the many facets of this new acupuncture expansion.

I wanted to re-iterate some of my key concerns/suggestions, as they are echoed by many of my colleagues in the field.

- Require supervision by an LAc, MD or other healthcare provider who is regulated by the OMB. Alternately, in the initial roll out, consider limiting this expansion to those who are already licensed healthcare providers.
- Require record-keeping and periodic review by supervisors.
- Require 40 hours of supervised clinical training as per NADA (not just 40 ears).
- Require standard infection-control and OSHA compliance (sharps disposal, PPE, exposure protocols).
- Require treatment locations be vetted and/or approve vs allowing anyone to practice acupuncture anywhere. Perhaps even have a specific set up and/or tool kit required for acupuncture treatments in the field. For years we attempted to do ear treatments in public places and there are many challenges that go along with it including maintaining a sterile/clean field, having enough flat surfaces, carrying all the required materials and disposal, personal sanitation (without handwashing facilities), not to mention that you really don't know who will show up.
- Prohibit patients from removing their own needles.
- Prohibit treatment of patients that may be under the influence of alcohol or drugs.
- Require that the provider advertise and/or post that they are not a licensed healthcare provider and/or a licensed acupuncturist so that the patient is getting treatment at their own risk. If someone has a negative experience or gets hurt, it will impact all acupuncturists in the state of Oregon.

Thank you very much. Please reach out if I can further clarify any of my thoughts/concerns/suggestions.

Sincerely,
Annabelle

Dr. Annabelle Snow (she/her), DAOM, LAc, Clinic Director
North Portland Wellness Center
Clinic: [REDACTED] **Web:** northportlandwellness.com

From: Ryan Milley <[REDACTED]>
Sent: Tuesday, September 23, 2025 11:41 AM
To: ROSS Elizabeth * OMB
Subject: HB 2143 Bill

You don't often get email from [REDACTED] [Learn why this is important](#)

The sender cannot be verified, use extreme caution!

Dear OMB,
Please consider the following Suggested Improvements to HB 2143 Bill:

- Require **supervision by a LAc or MD.**
- Require **40 hours of supervised clinical training as per NADA** (not just 40 ears).
- Require **standard infection-control and OSHA compliance** (sharps disposal, PPE, exposure protocols).
- Prohibit **patients from removing their own needles.**
- Prohibit treatment of patients **under the influence of alcohol or drugs.**

In health,

Ryan

--

Ryan J Milley, MAcOM, LAc, Dipl. OM (NCCAOM)
Mill-e-Moto (inside Meridian Acupuncture and Wellness)

[REDACTED]
Tigard, OR 97223

p: [REDACTED]
f: [REDACTED]

Mill-e-Moto.com

[Facebook](#)

[LinkedIn](#)

Confidentiality Notice:

This email message, including any attachments, is for the sole use of the intended recipient(s) and may contain confidential and privileged information. Any unauthorized review, use, disclosure or distribution is prohibited and may be unlawful. If you are not the intended recipient, please delete this e-mail immediately.

Notice to Patients:

Patient advice via email, like advice via telephone, may be less accurate simply because the patient is not physically examined and interviewed in person. Internet email has inherent limitations as to privacy and security. By using email, and requesting that I do so, you agree to waive any claim you may have against me for unintended violation of confidentiality caused by any limitations of e-mail security and privacy.

From: Janene Mitchell, LAc <[REDACTED]>
Sent: Tuesday, September 23, 2025 12:42 PM
To: ROSS Elizabeth * OMB
Subject: HB 2143
Attachments: OMB HB 2143.docx

You don't often get email from [REDACTED]. [Learn why this is important](#)

Comments - file is attached below and here in case you can't open it. Thanks!

September 23, 2025

Re: HB 2143

To the Oregon Medical Board:

I am writing as a licensed acupuncturist who's been in practice for 24 years to express my concerns about HB 2143. I understand that while the goal is to expand access for marginalized communities, this bill as it currently stands may create risks for those very populations. Most other states balance this by requiring supervision, plus higher standards of training. Of the **29 state examples** provided, **25 require supervision by a Licensed Acupuncturist (LAc) or Medical Doctor (MD)**. In addition to supervision, **many require the technician be a licensed healthcare provider and practice only in licensed healthcare facilities**. All of these steps are taken to better protect public safety.

Your proposed rules would allow **unsupervised practice with no liability insurance, and no restrictions on where 5NP may be performed**. Providers are **not required to follow standard infection-control practices, OSHA workplace protocols, or exposure-control plans**. They would receive **no training on how to handle any patient issues that can arise**, such as a drop in blood pressure, dizziness and fainting, or mood changes in persons with poor mental health that could impact their treatment. For example, I have seen a patient manipulating their needles when I left them unattended for a short while. How would an untrained individual handle that situation? Sometimes people become confused or afraid to continue receiving the treatment. Do they know what to do when an individual starts to pass out to keep them from falling and injuring themselves? To begin with, how will they determine who should and who should not receive treatment?

Only **30 hours of training** and **needling 40 ears** are required before an individual is considered to be an "independent healthcare provider." These training requirements are **719 hours less than for a cartilage ear piercer!** How can this be considered best practices?

Proposed changes:

- Require **40 hours of supervised clinical training as per NADA** (not just 40 ears).

- Require **standard infection-control and OSHA compliance** (sharps disposal, PPE, exposure protocols).
- **Prohibit patients from removing their own needles.**
- **Prohibit treatment of patients under the influence of alcohol or drugs.** This is very important.

Please consider these recommendations based on valid concerns expressed by many in the healthcare community. Thank you for your work on HB 2143. We all want more people to be cared for, but not at the risk of putting some in harm's way.

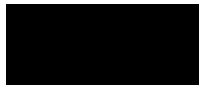
Janene Mitchell, LAc, FABORM

OR 178026 CA 7960

--

Janene Mitchell, LAc, FABORM (she/her/hers)
Licensed Acupuncturist & Herbalist

Specializing in fertility, pregnancy care, menopause & cosmetic acupuncture.



cell
A Woman's Time clinic

HealthProfs.com

[A Woman's Time clinic](#)

[Cosmetic acupuncture](#)

[ABORM - The Acupuncture & TCM Board of Reproductive Medicine](#)

Information contained in this email may be personal and sensitive and must be treated accordingly. If this correspondence contains healthcare information it is being provided to you after appropriate authorization from the patient or under circumstances that don't require patient authorization. You, the recipient, are obligated to maintain it in a safe, secure and confidential manner. Redisclosure without additional patient consent or as permitted by law is prohibited. Unauthorized redisclosure or failure to maintain confidentiality subjects you to application of appropriate sanction. If you have received this correspondence in error, please notify the sender at once and destroy any copies you have made.

September 23, 2025

Elizabeth Ross, Oregon Medical Board
P.O. Box 25244
Portland, OR 97298

Via email to: elizabeth.ross@omb.oregon.gov

RE: Opposition to HB 2143 and Proposed Rules for Five-Needle Protocol (5NP)

Dear Ms. Ross,

As a Doctor (DAOM) of Acupuncture and Oriental Medicine with 21 years of experience practicing in Oregon, I am writing to express my profound opposition to the current proposed rules for HB 2143 and the 5NP. While I support the goal of expanding access to care for marginalized communities, these rules, as drafted, pose a grave and unnecessary risk to public health and safety. The proposed regulations dangerously dilute professional standards, disregard fundamental public health principles, and undermine the integrity of the acupuncture profession.

Inadequate Training and Standards

The proposed 30 hours of training and needling 40 ears is grossly insufficient to qualify an individual as an "independent healthcare provider." This level of training is, as you know, significantly less than that required for a cartilage ear piercer, a fact that highlights the absurdly low bar being set for a medical procedure. The vast majority of states that allow for non-acupuncturists to administer 5NP require supervision by a **Licensed Acupuncturist (L.Ac.)** or **Medical Doctor (MD)**. Oregon's proposed unsupervised practice, without liability insurance or professional standards, is an outlier and a recipe for harm.

Patient Safety and Public Health Risks

Allowing unsupervised, untrained individuals to perform this protocol in unregulated settings like city buses, waiting rooms, or hair salons creates a significant public health hazard. Auricular needles can carry blood-borne pathogens, including Hepatitis A, B, and C. Hepatitis A and B are not curable. These needles are small and can easily fall out and be lost, especially in high-volume, non-clinical environments. This creates a biohazard risk for both the person who received the treatment and anyone who comes into contact with the needle. Unlike most L.Ac.s, these new providers are not required to be vaccinated or follow basic infection-control protocols, sharps disposal, or OSHA workplace safety standards. This not only endangers the public but also opens the door to potential outbreaks of serious, transmissible diseases.

Furthermore, allowing patients to remove their own needles is incredibly risky and goes against all established clinical best practices. It increases the chance of a dropped needle and subsequent public contamination. Providing this treatment to individuals who may be under the influence of alcohol or drugs, a core target population for this bill, adds another layer of risk, as they may be less aware of their surroundings and more likely to improperly handle needles.

Diluting Professionalism and Undermining the Licensed Acupuncture Profession

The bill's premise that there is a shortage of L.Ac.s in Oregon is factually incorrect. In the Portland metropolitan area alone, there are over 960 licensed acupuncturists, many of whom have master's or doctorate-level degrees and struggle to make ends meet, often working second jobs. These professionals are eager to provide safe, effective, and low-cost care to all Oregonians, including those in marginalized communities. The current law makes it a felony to practice acupuncture without a license for a good reason—it protects the public from harm. The proposed rules would carve out a dangerous exception to this felony law, implying that needling certain areas of the body is inherently safe, which is a false and dangerous assumption that could lead to further dismantling of the profession.

This move is an irresponsible attempt to fast-track a medical procedure without proper consideration of the existing workforce or the high risks involved. It "dumbs down" a legitimate, highly-trained profession, opening the door for individuals with minimal training to expand their scope of practice. This is how patient harm occurs, as we have seen in other instances, such as the cupping example where a patient was severely burned, resulting in a 12-hour skin graft surgery. While that was a supervised procedure, the example highlights the severe consequences that can arise from procedures that are seen as "simple" by untrained individuals.

Recommendations for Improvement

To protect the public and still achieve the worthy goals of HB 2143, I urge the Oregon Medical Board to adopt the following critical amendments:

- **Require supervision by a Licensed Acupuncturist or Medical Doctor:** This is the national norm for a reason. It ensures safety and accountability.
- **Require 40 hours of supervised clinical training:** The current requirement of "40 ears" is not a substitute for hands-on, supervised training.
- **Mandate standard infection-control and OSHA compliance:** This includes proper sharps disposal and the use of personal protective equipment (PPE).
- **Prohibit patients from removing their own needles:** This is a basic safety measure.
- **Prohibit treatment of patients under the influence of drugs or alcohol:** This minimizes risk in a vulnerable population.

Thank you for your consideration of these critical public safety issues.

Respectfully,

Tracy Andersen, DAOM, LAc

www.acupunctureoregon.com

Tina Vecera
Wild Rose Acupuncture & Eastern Herbs
[REDACTED] [REDACTED] Bandon, Oregon 97411

Comment Regarding House Bill 2143 (2025): Five-Needle Protocol and Oregon Medical Board Rule Making Process

Comment submitted to Oregon Medical Board on September 23, 2025

Oregon Medical Board
1500 SW 1st Avenue, Suite 620
Portland, Oregon 97201
September 23, 2025

Oregon Medical Board:

Access to medical care is of utmost importance. Acupuncture and Eastern Herbs promise effective and wholistic healing when offered safely. Within the challenges of these times, Oregon has an opportunity to provide this access to many people, and, ultimately, to most anyone if the health care delivery is well planned and implemented.

The draft bill as presented shows several omissions and deficiencies regarding regulating for patient safety and the credentialing, training and education of providers named as “technicians”. It is unclear from the way the bill is written and the minimal hours of education and training how the technicians could be adequately trained to rule out medical red flags for triage or referral, and numerous other issues regarding clinical management of patients.

Given the limitations described, the bill is inadequate in ensuring patient safety. The technicians need more credentialing, training and education, definition of the allowed kind of medical setting, and supervision in the medical setting by licensed acupuncturists.

I am currently in private practice with nearly 29 years of practice experience. There are many reasons, including patient safety, why the practice of acupuncture in Oregon have required pre-requisite college classwork and many hours, into years, of specialized education, student observation, student clinical supervision, student internship followed by granting of educational degrees and passing completion of national board examinations, followed by state licensing and then by continuing education and re-certifications on a regular, continuing basis.

My education at Oregon College of Oriental Medicine (OCOM) included a public health class taught by David Eisen, L.Ac., M.S.W., OMD(AM), at that time serving as director and clinical

Tina Vecera
Wild Rose Acupuncture & Eastern Herbs
780 2nd ST SE Ste 3, Bandon, Oregon 97411

services director of what was then named Portland Addictions Acupuncture Clinic (PAAC) by my best memory, under Central City Concern. He was a founding member and had served on the board of directors for the National Acupuncture Detoxification Association (NADA). Dr. Eisen taught NADA's Five-Needle Protocol in the public health class and it is important to note that he taught students that acupuncture treatment of drug and alcohol dependence and addiction (except nicotine) should not be treated in an acupuncture private practice setting, but only in a clinical setting including an interactive team with providers such as licensed physicians, licensed social workers and therapists offering private and group counseling and credentialed drug and alcohol counselors. Five-Needle Protocol was, to my understanding, designed especially for these integrated clinic settings. The draft bill omits requirements for what settings are acceptable for delivery of medical care by technicians.

Many of my OCOM student observation and student internship hours were in the clinical settings described in class by Dr. Eisen such as PAAC, Hooper Detoxification Center and Mental Health - West, all in Portland. Once I became licensed as an acupuncturist, I worked in these clinics for a couple of years or so and provided Five-Needle Protocol for most every patient, and sometimes a few distal points on scalp or extremities, depending on the constitution and needs of the patient.

When I provide Five-Needle Protocol in private practice, I treat additional acupuncture points at other body locations than the ear auricles to provide balance and address the person's constitution and presenting symptoms and my findings from Chinese tongue and pulse diagnosis. (I do not provide treatment for drug or alcohol dependence/addiction in private practice except in the case of rare requests for nicotine smoking cessation treatment.)

The bill draft fails to accurately define Five-Needle Protocol as a style of acupuncture. Acupuncture is currently defined in Oregon as "stimulation of specific points on the surface of the body by insertion of needles." Hence, Five-Needle Protocol is a style of acupuncture.

The draft bill, by failing to define Five-Needle Protocol as a style of acupuncture, pretends the practice of Five-Needle Protocol is something else, thus obscuring the knowledge, skill and perceptions acquired by licensed acupuncturists, and suggesting a small fragment of education, training and knowledge will be adequate and equivalent for safe and effective delivery of health care, apparently because the size of auricles of the ears and the number of acupuncture points involved represent a small portion of the whole body, mind and spirit of the person to receive treatment.

Regarding the draft bill defining Five-Needle Protocol as a *treatment*: Can a protocol, by definition, be a treatment? A medical protocol refers to a medical guideline *for* a treatment. The wonder of acupuncture is that in so many cases of addiction, dependency, trauma, stress and pain, the Five-Needle Protocol has been shown, most always in combination with other modalities offered by an integrative team, that people experience relief and recovery.

Tina Vecera
Wild Rose Acupuncture & Eastern Herbs
780 2nd ST SE Ste 3, Bandon, Oregon 97411

Given the limited training, credentialing, educational and professional standards for technicians found in the draft bill, the bill is inadequate in ensuring patient safety without requiring additional training, credentialing, education and professional standards, definition of the allowed type of medical setting, and supervision in the medical setting by licensed acupuncturists.

Respectfully,

Tina

Tina Vecera, L.Ac., M.Ac.O.M.
Wild Rose Acupuncture & Eastern Herbs
[REDACTED]
Bandon, Oregon 97411
[REDACTED] (mobile)
[REDACTED]

From: Yvonne Perez Emerson <[REDACTED]>
Sent: Tuesday, September 23, 2025 1:59 PM
To: ROSS Elizabeth * OMB
Subject: 5NP program in Oregon

You don't often get email from [REDACTED]. [Learn why this is important](#)

Hello there,

My name is Yvonne Pérez Emerson, I am a Curandera (traditional Mexican folk healer) here in Portland. I work with clients to weave various modalities through traditional practices that nurture the soul and the body. My practice has been passed down and learned through my maestros in Oaxaca. Part of our trainings is in the 5NP offerings as this practice is often offered to calm our patients suffering from trauma (sustos). I would like to offer this modality to the patients I see here in Portland, not just afar.

Recently I sat with two 16 year old boys who have been in a migrant half-way house downtown for almost 3 years. The director reached out to me because these two wanted Limpias (an energetic cleansing) I think they would have also benefited from the 5NP offering as well. I hope that Oregon can follow the lead of other states who let Curanderas like me serve our community with this practice for reducing stress and calming the soul. As a servant in the field of Curanderismo we often treat folks for free (like these two boys) and the cost to become an acupuncturist is out of reach for us. As a traditional service, 5NP (which is offered by many Curanderas throughout New Mexico, other parts of the country and Mexico) is another modality offering we can serve our community with.

Thank you for taking the time to read this.

Yvonne Pérez Emerson [Case de Ritual](#)

From: KE Edmisten <[REDACTED]>
Sent: Tuesday, September 23, 2025 2:06 PM
To: ROSS Elizabeth * OMB
Subject: from KE Edmisten, LAc

You don't often get email from [REDACTED]. [Learn why this is important](#)

I am opposed to this measure of allowing untrained people to use acupuncture as part of their treatment.... We went to school for years, were supervised & trained w experienced acupuncturists, teachers & mentors. I am hoping you will vote NO on this bill & encourage people to go to Acupuncture School if they want to become an Acupuncturist. Thank you soooooooooo much for your consideration !! Sincerely, KE Edmisten AC 187

Catherine M. Gurski, ND, MSOM, LAc.

Portland, OR 97209

Dear Oregon Medical Board and Elizabeth Ross,

As a licensed acupuncturist in Oregon practicing for more than twenty years, I have some questions about the licensing and training requirements for the new proposed 5NP Program in Oregon.

If the program is to allow ear needling of the public, what are the training requirements? Will there be training on clean needle techniques and safe disposal, OSHA, blood borne pathogens and safe use of PPE? Is needle insertion to be limited to the ears only and if so what type of needles and how many needles per treatment in one or both ears? Are the hours of training inclusive of other health care personal or is it on par with ear piercing or body piercing training? Will there be annual licensing and/or CE training and who will oversee this?

Is there a health intake form for patients before the treatment and any advice given for post treatment?

Additionally what is the setting for the needling to take place? Is there protection of patient confidentiality? Is someone going to oversee the 5NP practitioners or are they trained to work independently and if so, what does that training involve?

Will this protocol be covered under insurance and how if 5NP training does is not from an accredited four year program for acupuncture training?

These are just a few questions and concerns that I have as a licensed health care provider concerning House Bill 2143 (2025).

Sincerely,

Catherine M. Gurski, ND, MSOM, LAc.

Public Comment for OMB Rules for 5NP Practitioners (HB 2143)

Arndt 9-23-25

Oregon Medical Board
1500 SW 1st Avenue, Suite 620
Portland, OR 97201

Dear Members of the Oregon Medical Board,

*Also see my submissions dated 8-11, 8-25, 9-4 and 9-8 for more info, especially explanations of my recommendations.
I have attempted to not repeat my past information here, aside from complete list of recommendations on page 2.*

I come with years of experience in both western/conventional medicine and acupuncture.

My career began as a nurse's aide in 1975, progressing to an LPN and then to an RN in 1980. My experience in Portland Adventist hospital included med-surg and ICU-CCU units. Then, it was quite the upheaval in 1982 when I announced I was leaving my successful RN career to study acupuncture! Back then we were the outliers. After working for decades to gain public trust, now it seems that many professionals want to jump on the wagon and add acupuncture to their scope, but they don't realize the complexity needed for practicing acupuncture and in some situations, for practicing medicine. I hope these recommendations are clear and make sense to you. Feel free to contact me if you have questions.

Sincerely, Karina (Natalie) Arndt,

LAc since 1987, Emeritus LAc since 2020; Retired RN (38 years in western medicine)

First, Trust in Individuals Supporting HB 2143

I know some of the LAc's who promoted HB 2143 and operate POCA Institute who will train 5NP practitioners. I fully trust them to train quality 5NP practitioners. However, I do not know about trusting others who may offer trainings or perform 5NP. I raise these concerns here, and give these recommendations, to protect the public against individuals who may not have the best interests of patients in mind. Then 5NP will be safe, durable and have widespread use.

Regulation in the Healthcare World

In the broader field of medicine, tight regulation of practitioners evolves not only from statutory rules but also from these four overlapping systems: a) facility policies, b) medical standards, c) insurance requirements, d) malpractice policies. Additional regulation comes from extensive training for the practitioner, before and after licensure.

In Oregon, Licensed Acupuncturists are independent practitioners, performing an invasive procedure. They obtain a minimum of 2000 hours of training. This actually is the bare minimum, for any practitioner in Oregon, to practice independently and perform invasive procedure/s.

Current Rules' Draft: 5NP Practice *without* the 4 Systems and *without* Extensive Training

IF 5NP is practiced independently of these 4 structures, coupled with 30 hours of didactic training and "40 ears" (which can be done in 2 hours), then NO regulation beyond the general language in the rules will exist.

This constitutes a **major departure from the regulatory norms** governing similar procedures and health services.

Acupuncture involves sticking needles in people for health treatments. The OMB regulates acupuncture.

HB 2143 authorizes individuals to stick needles into the ear for health benefits. OMB must regulate 5NP as acupuncture.

Regulations may be in the form of detailed rules, or rules in combination with the 4 systems described above.

I maintain that the regulations for LAc's and all other practitioners exist for a reason- patient safety and well-being.

Any departure from regulations in these forms will create opportunities for unsafe situations for patients.

The Current Rules Draft

The current rules draft contains generalized language as found in rules for many health care practitioners.

But, 5NP practitioners will have no or little involvement with the 4 systems described above, and the training currently in the rules draft is roughly 5% of the needling-only training that LAc's obtain.

This essentially produces a practitioner without any regulation.

Oregon Patients in a Vulnerable Spot

This lack of regulation would place Oregon patients in a vulnerable situation:

- 1- 5NP is for patients with substance abuse and mental health disorders.
- 2- Proponents intend to focus on treating patients in disadvantaged living situations.
- 3- Citizens in these 2 groups, may not have the resources to recognize, deal with, and report abuses of a violation of their rights and safety in healthcare.

Recall the abuses eventually identified with Dr. Farley, MD, who lost his license in 2020. He practiced more than 25 years in the affluent suburb of West Linn. More than 170 women have now come forward to report the abuse. But it took decades until this abuse, in a privileged and educated city, was identified. How will houseless and poor individuals with mental health issues stand up for themselves in case of abuse?

Ease of Regulation for OMB

These recommendations will assist the Board in regulating these new practitioners with ease and efficiency.

Potential Ad for 5NP Training Program

Yes, this is absurd! However, is everything here legit according to the current rules' draft?

"Do you want a side hustle in healthcare? Practice out of your home, in the park, or where ever you like!

2 Weekend classes and you'll be making \$100+ per hour in your spare time.

Learn the cool protocol for giving temporary relief for symptoms of substance use, mental health conditions or trauma. Must be 18 years or older, but no high school diploma or GED required. No tests.

You put 'em in, they take 'em out.! They put their own needles in the sharps. You don't have to touch the dirty things.

Perfect add-on for: manicurists, a slow day at your booth at a local fair, or offer "Drive Thru" service- no need for customers to get out of the car. No supervisors. No medical experience- no need to learn those crazy medical words! No exams, we'll hand you a certificate in 2 weeks Then you apply and register."

COMPLETE LIST OF RECOMMENDATIONS FOR 5NP RULES

See my past submissions for explanations and more details.

AGE at least 21 years of age. Direct supervision required for practitioners 18-20 years of age.

CLINICAL SUPERVISION by qualified practitioners* associated with established Medical Clinics and Offsite/mobile clinics where the 5NP practitioner maintains real-time phone access to a qualified supervisor.

**Qualified practitioners: LACs, MD/DOs qualified to practice acupuncture.*

PAs, NPs & NDs who are registered with the OMB to practice 5NP. Consider including 5NP-RNs registered to practice 5NP.

TRAINING PROGRAM REQUIREMENTS

40 hours of didactic instruction. 40 hours of supervised clinical training* (NADA standards) with 40 ears needled.

Include teaching standard healthcare standards with ample clinical time for reinforcement. For hygiene and infection, include items from the "Clean Needle Technique", and standards of OSHA for bloodborne pathogens.

OVERSIGHT OF TRAINING PROGRAMS

OMB approves and monitors any training programs for 5NP technicians and 5NP trainers.

Training programs must include both a written exam and a practical skills assessment for granting certificates.

REQUIRE STANDARD MEDICAL STANDARDS

Infection Control

National standards items in Clean Needle Technique for acupuncture needling.

Patients prohibited from removing their own needles. (Also, they might take some needles with them!)

Exposure control plans as in OSHA requirements for a workplace: Sharps disposal, PPE, post-exposure protocols, etc.

Patient Rights

Safety Measures: Prohibit administration of 5NP to patients who are under the influence of alcohol or drugs.

Note: this was the absolute standard at Hooper, a major detox treatment center in Portland.

Retained objects (needles, seeds & beads): Diabetes screening, max retention of 3 days, clear instructions for removal.

Privacy standards as defined in HIPAA and informed consent details as defined by the Joint Commission.

Clear disclaimer: 5NP is limited by law to only provide temporary relief from... (include language of the law)

Name badges identifying practitioners as "5NP Technicians" with a QR code for reporting incidents.

Documentation

Include patient's qualifying condition & current health condition, treatment given, complications from treatment.

Include description and placement of any retained objects- tracking, care and location of retained needles, seeds.

Qualifying Diagnosis: With the patient, supervising practitioner affirms intention of the treatment at the initial treatment.

Mandatory reporting of adverse events to OMB within 10 days of the occurrence of the event.

Monitoring for Discipline: Biennial random audits of at least 2% of registrants.

Continuing Education: 2 hours every 2 years with renewal.

Needles only: No electrical, laser, or other non-needling stimulation to the ear needles or any location on the ear.

Retained Objects: These are needles, seeds or beads that are taped onto the ear.

No retained placement of needles, seeds or beads on the ears of patients with diabetes mellitus.

Written and verbal instructions given to the patient if retained objects (needles, seeds or beads) are placed:

- Keep the ear dry when retained objects are in place;
- Remove retained objects in 3 days;
- If irritation, redness, discomfort, etc. occurs at any time, remove them immediately and seek medical treatment

Purpose Statement and Definition

Five-needle protocol (5NP) involves insertion of acupuncture needles at 5 acupuncture points on the human auricle. The five points are: shen men, sympathetic, liver, kidney and lung. 5NP is intended to provide temporary relief for individuals for symptoms of substance use disorder, mental health conditions, or trauma.

Needles not to exceed 0.5 inches in length. Point locations per standard acupuncture texts to ensure proper placement.

From: Leela Longson <[REDACTED]>
Sent: Tuesday, September 23, 2025 4:58 PM
To: ROSS Elizabeth * OMB
Subject: HB 2143 and 5np Rule Making

You don't often get email from [REDACTED]. [Learn why this is important](#)

Hello,

I would like to express my concerns about allowing minimally trained lay-people to provide 5np acupuncture. Although the protocol itself is simple, one needs some training and professional standards. For example, one can easily put the needle right through the cartilage and into their own finger, thereby causing bloodborne exposure to both the provider and patient when the needle is then removed. Patients often experience pain with ear needling, and it's necessary to practice for some time before one can both be more delicate and guide patients to receive treatment with more relaxation.

Please require at least 40 HOURS of supervised training as per the NADA protocol, and require infection and exposure training.

I want to also express my dismay that the OMB holds acupuncture training in such low regard as to allow people with such minimal training to needle the public, not to mention dry needling.

Best wishes,
Leela Longson, LAc

--

Leela Longson
Quest Center for Integrative Health

www.quest-center.org

Gender pronouns: She, Her

IMPORTANT WARNING: This e-mail and any files transmitted with it contain CONFIDENTIAL information, including PRIVATE AND CONFIDENTIAL HEALTH INFORMATION which is intended for the use of the person to whom it is addressed. If the reader of this e-mail/attachment is not the intended recipient, employee, or agent responsible to deliver it to the intended recipient, you are hereby notified that any dissemination, distribution, reproduction, reading, or copying of this information is STRICTLY PROHIBITED. If you received this e-mail in error, please delete the related e-mail and all attachments and notify the sender immediately (reply e-mail).

If this email contains information related to the diagnosis, referral, and/or treatment of substance dependence or abuse: This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Dear Members of the Oregon Medical Board,

I am writing in response to various questions that came up in the AAC meeting pertaining to the 5NP bill, after public commentary had already ceased. I am an acupuncturist with 20 years of experience practicing in various clinical settings. I have treated in-patients in multiple hospital departments, have maintained a general private practice in both rural and urban environments, have held trauma and pain treatment events for veterans and have practiced at Lincoln Recovery Center, where NADA treatment was first popularized. I have also worked as a peer mentor at Riker's Island in NY and as a volunteer with a prison work release program in Hopewell, NJ. I am a proponent of improving community health and also maintaining health safety. I request that the Oregon Medical Board consider specific regulatory measures regarding the training, supervision, and scope of practice for 5NP technicians.

Based on my understanding and concern for the safety, longevity and efficacy of this practice, I propose that 5NP technicians have required supervision, comparable to most other states allowing this practice, as per the document provided by the OMB for the rule making work group. Please note that of the **25 regulated state examples** provided by OMB, **at least 22 require supervision by a Licensed Acupuncturist or MD**. In addition to supervision, **many require the technician to maintain a previous healthcare license** and to practice **only in licensed healthcare facilities**. The AAC work group did not appear to be familiar with this document and some erroneous statements were made. I request that we adhere to these safety standards.

From the NADA website: "In the U.S.A. and Canada, many localities encourage the implementation of a NADA program through regulations that allow non-acupuncturist health providers to be trained in the NADA protocol, often under the supervision of a licensed acupuncturist or medical doctor."

After several hours of workshopping over several weeks, it was stated at the end of the AAC/OMB meeting, that we may not be capable of adding supervision to the rules. I do not believe this to be true. The statute states that **the OMB may add any other requirements or standards they determine necessary**.

Please remember, that there is a great assumption of safety being discussed in these meetings because of the way that 5NP has been provided thus far, which has included medical and acupuncture supervision. **THIS BILL DOES NOT MAINTAIN THE CURRENT NOR PREVIOUS STANDARDS**. At this time, the required age of the technician is only 18 years. This 18 year old is not required to have any other job or education experience, is not vetted by lengthy training, teaching or testing, and is being given unrestricted access to independently provide medical care to vulnerable populations involving the insertion of needles. This is contrary to other medical technicians, most of which require 9 months + of training, some form of supervision, to work in a clinical setting, to have some form of liability insurance, and to have more skin in the game and licensure at stake. Furthermore, 5NP training creates an independent health care provider that inserts needles into cartilage, with **719 hours less training than those required for a cartilage ear piercer**, which is a cosmetic and not medical procedure.

Imagine these scenarios, which are entirely possible under this bill:

18 year old with no prior work experience starts an open clinic in the park. They gather on camping stools on cement. Patient A is under the influence but provider doesn't notice, as they have received zero training in health related observation. Patient receives needles, provider walks away and patient passes out. They hit their head on cement. Young provider did not understand how quickly this could happen, has never experienced it before and calls 911. EMTs show up to witness acupuncture in the park but there is no acupuncturist around. The patient had lost consciousness and so they ask the provider the patient's name. The provider doesn't know. They check through their consent forms. The patient reports a different name when asked. They had signed a fake name on the paper. The provider is asked about other known health conditions but of course they do not know. Other unaffiliated park goers witness all of this. Maybe it all turns out fine, although the patient has a concussion, but now several people that witnessed or had involvement distrust both acupuncturists and the OMB.

Imagine that a young technician unknowingly has Hep B. They took their didactic class online while they were performing other household tasks. There was no test required to determine competency. They are treating a large number of people, because these treatments can attract 50+ people at a time, and while rushing to freehand needle, they accidentally prick themselves with one. They brought limited supplies with them, have a larger number of attendees than expected and think it's ok because there was no visible blood and they have no known sicknesses so they proceed to use the needle.

Another provider is doing a yoga and acupuncture combo in the park. Patients are allowed to remove their own needles. One patient is in a hurry to meet their partner and they walk away with 2 needles in. Their sympathetic point is high up in a deep fold in their particular ear anatomy. They drop 2 needles walking by the playground and a child falls on one. Perhaps one of those points bled profusely, as ears can easily do, after the needle fell out. That blood smeared in all kinds of places.

There has been an assumption that all technicians will have the same discretion as all of the healthcare providers in the room talking about this, however that discretion is learned with experience and months to years of training.

In the workgroup, some had said that problems will be minimal because Poca has been "tracking," and has determined so, however one could speculate that a service with such minimal "tracking," ie no charting, minimal if any name use, and lacking consistency in providers, patients and location built into its performance is not going to have the most accurate statistical account of adverse events. It is also assumed that communities will hold each other accountable so that greater safety rules are unnecessary. Let's please remember that we are asking people to self regulate in the provision of a treatment where one of the primary afflictions being treated is due to the very fact that people cannot self regulate. It has been stated that medicine in the state of OR is already self regulatory, in that the OMB does not perform random inspections. However, in most scenarios it takes a long time to become a healthcare provider, requires many months or years of observation by peers and teachers, requires clinical experience and testing. None of that is self regulatory. Additionally, insurance companies do random audits all the time and large facilities are inspected by agencies such as the Joint Commission.

Please also remember that we cannot base rules on the safety of this treatment thus far because this bill expands the providers in quantity and context exponentially. Please also remember that the rule making workshop was made primarily of supporters of this bill and a large number of Poca or Poca Tech affiliates, both of which stand to profit from this bill being highly unregulated. Trainings are advertised at \$450 per person. This bill substantially expands the number of people that these organizations can offer trainings to.

I would also like to add that this bill specifically asks technicians not to pose as acupuncturists and yet across the country, this technique is being referred to as acuwellness, offered for an upcharge in out of pocket therapy offices and the like. It does appear to advertise acupuncture yet to not exactly be about treating the marginalized.

I propose the following measures for the 5NP technician role:

1. Supervision Requirements:

5NP technicians should practice under the clinical supervision of a licensed acupuncturist or MD/DO qualified to perform acupuncture. Supervision should not necessarily be required at all times, but a supervisor should be readily available in the event of complications or adverse reactions.

2. Training and Certification:

Technicians should complete a standardized training program that includes at least:

- 30 hours of didactic training
- 40 supervised clinical treatment hours
- Certification in the NCCAOM Clean Needle Technique (CNT)
- OSHA-compliant Blood Born Pathogens training, as well as HIPAA protocols, as required

By working within these frameworks, we can continue to expand access to acupuncture services while maintaining the highest standards of patient safety and professionalism.

Thank you for your time and consideration.

Submitted by: Dr. Jen Kearns, DACM, LAc on September 23, 2025

FULL BOARD
OCTOBER 2, 2025
VIDEOCONFERENCE

Public Session

Rule Review

First Review: Chapter 847, Division 070, 008, and 010

AC ACTION: The Committee moved to file a notice of proposed rulemaking.

OREGON ADMINISTRATIVE RULES

CHAPTER 847, DIVISION 070, 008, and 010 – OREGON MEDICAL BOARD

First Review – October 2025

The proposed rulemaking implements [SB 874\(2025\)](#) adding a definition for “Traditional Eastern medicine” to provide cohesion and clarify the OMB’s authority to regulate acupuncturists. The bill replaced the term “Oriental medicine” with “Traditional Eastern medicine” throughout ORS chapter 677. The bill also clarifies the definition of "acupuncture" and updates the Oregon Association of Acupuncturists name. SB 874 did not change the scope of practice for acupuncturists in Oregon.

Additionally, the National Certification Commission for Acupuncture and Oriental Medicine (NCCAOM) is changing their name to the National Certification Board for Acupuncture and Herbal Medicine (NCBAHM) in January 2026. The proposed rule also makes this update. Their exam titles, including Foundations of Oriental Medicine, will remain the same.

847-070-0005

Definitions

As used in the rules regulating the practice of acupuncture:

(1)(a) "Acupuncture" **has the meaning given in ORS 677.757,** ~~as means an Oriental health care practice used to promote health and to treat neurological, organic or functional disorders by the stimulation of specific points on the surface of the body by the insertion of needles.~~

~~"Acupuncture" includes the treatment method of moxibustion, as well as the use of electrical, thermal, mechanical or magnetic devices, with or without needles, to stimulate acupuncture points and acupuncture meridians and to induce acupuncture anesthesia or analgesia.~~

(a) Traditional Eastern medicine used to promote health and treat neurological, organic or functional disorders through the insertion of needles into specific points on the body at varying depths, including insertion into the skin, subcutaneous tissue, muscle layers and fascia, and into or near joint spaces based on anatomical location and the practitioner’s clinical assessment. The type of needle inserted, and the depth, angle and technique of insertion, are informed by specialized training in acupuncture theory, biomedical anatomy and diagnostic evaluation to safely stimulate biological and physiological responses and support the body’s healing process.

(b) The treatment method of moxibustion and the use of electrical, thermal, mechanical or magnetic devices, with or without needles, to stimulate acupuncture points and acupuncture meridians and to induce acupuncture anesthesia or analgesia.

~~(b)~~ The ~~practice of acupuncture also includes the following~~ modalities as authorized by the Oregon Medical Board:

(A) Traditional **Eastern medicine** and ~~modern Oriental Medical and~~ acupuncture techniques of diagnosis and evaluation;

(B) ~~Oriental massage~~ **Traditional Eastern medicine manual therapy**, exercise and related therapeutic methods; and

(C) The use of **Traditional Eastern medicine** ~~Oriental~~ pharmacopoeia, vitamins, minerals and dietary advice.

(2) "Board" means the Oregon Medical Board for the State of Oregon.

(3) "Clinical training" means supervised clinical training which consists of diagnosis and actual patient treatment which includes insertion of acupuncture needles.

(4) "Committee" means the Acupuncture Advisory Committee.

(5) "Licensed Acupuncturist" means an individual authorized by the Board to practice acupuncture pursuant to ORS Chapter 677.

(6)(a) "**Traditional Eastern medicine manual therapy** ~~Oriental massage~~" means methods of manual therapy, including manual mobilization, manual traction, compression, rubbing, kneading and percussion, with or without manual implements, for indications including limited range of motion, muscle spasm, pain, scar tissue, contracted tissue and soft tissue swelling, edema and inflammation, as described in instructional programs and materials of **Traditional Eastern medicine** ~~Oriental~~ or Asian health care.

(b)(A) **Traditional Eastern medicine manual therapy** ~~Oriental massage~~ as practiced in Oregon does not include high-velocity, short-amplitude, manipulative thrusting procedures to the articulations of the spine or extremities.

(B) **Traditional Eastern medicine manual therapy** ~~Oriental massage~~ as practiced in Oregon does not include internal pelvic massage (intravaginal, intra-anal, or intra-rectal) or genital massage.

(7) "Physician" means an individual licensed to practice medicine as a medical doctor or doctor of osteopathic medicine pursuant to ORS Chapter 677.

(8) "Traditional Eastern medicine" has the meaning given in ORS 677.010, as acupuncture and traditional Chinese medicine, regulated by ORS chapter 677 if the medicine is practiced within the context of a person's license to practice acupuncture issued under ORS 677.757 to 677.770.

Statutory/Other Authority: ORS 677.265 & 677.759

Statutes/Other Implemented: ORS 677.265, 677.757, 677.759 & 677.780

847-070-0016

Qualifications

(1) An applicant for licensure as an acupuncturist must have:

(a) Graduated from an acupuncture program that satisfies the standards of the Accreditation Commission for Acupuncture and Herbal Medicine (ACAHM), or its successor organization, or an equivalent accreditation body that are in effect at the time of the applicant's graduation. An acupuncture program may be established as having satisfied those standards by demonstration of one of the following:

(A) Accreditation, or candidacy for accreditation by ACAHM at the time of graduation from the acupuncture program; or

(B) Approval by a foreign government's Ministry of Education, or Ministry of Health, or equivalent foreign government agency at the time of graduation from the acupuncture program. Each applicant must submit their documents to a foreign credential equivalency service, which is approved by the National Certification ~~Commission Board~~ for Acupuncture and ~~Oriental Herbal~~ Medicine (~~NCCAOM~~ **NCBAHM**) for the purpose of establishing equivalency to the ACAHM accreditation standard. Acupuncture programs that wish to be considered equivalent to an ACAHM accredited program must also meet the curricular requirements of ACAHM in effect at the time of graduation.

(b) Current certification in acupuncture by the **NCBAHM** ~~NCCAOM~~. An applicant will be deemed certified by the **NCBAHM** ~~NCCAOM~~ in Acupuncture if the applicant has passed the **NCBAHM** ~~NCCAOM~~ Acupuncture Certification Examinations or has been certified through the **NCBAHM** ~~NCCAOM~~ Credentials Documentation Examination.

(A) The applicant must pass three (3) **NCBAHM** ~~NCCAOM~~ Certification exam components: Biomedicine, Foundations of Oriental Medicine, and Acupuncture with Point Location.

(B) The applicant has no more than four attempts to pass each component of the **NCBAHM** ~~NCCAOM~~ Certification Exam listed in subsection (A) of this section. If the applicant does not pass each component of the **NCBAHM** ~~NCCAOM~~ Certification Exam within four attempts, the applicant is not eligible for licensure.

(C) An applicant who has passed each component of the **NCBAHM** ~~NCCAOM~~ Certification Exam but not within the four attempts required by this rule may request a waiver of this requirement if the applicant passed each component of the exam within five attempts and:

(i) Has obtained a Doctor of Acupuncture and Oriental Medicine degree; or

(ii) Experienced extenuating circumstances that do not indicate an inability to safely practice acupuncture as determined by the Board.

(2) An applicant who does not meet the criteria in OAR 847-070-0016(1) must have the following qualifications:

(a) Five years of licensed clinical acupuncture practice in the United States. This practice must include a minimum of 500 acupuncture patient visits per year. Documentation must include:

(A) Two affidavits from office partners, clinic supervisors, accountants, or others approved by the Board, who have personal knowledge of the years of practice and number of patient visits per year; and

(B) Notarized copies of samples of appointment books, patient charts and financial records, or other documentation as required by the Board; and

(b) Practice as a licensed acupuncturist in the U.S. during five of the last seven years prior to application for Oregon licensure. Licensed practice includes clinical practice, clinical supervision, teaching, research, and other work as approved by the Board within the field of acupuncture and **Traditional Eastern** ~~oriental~~ medicine. Documentation of this practice will be required and is subject to Board approval; and

(c) Successful completion of the ACAHM western medicine requirements in effect at the time of graduation from the acupuncture program, unless the applicant graduated from a non-accredited acupuncture program prior to 1989; and

(d) Current certification in acupuncture by the **NCBAHM** ~~NCCAOM~~. An applicant will be deemed certified in Acupuncture by the **NCBAHM** ~~NCCAOM~~ if the applicant has passed the **NCBAHM** ~~NCCAOM~~ Acupuncture Certification Examinations or has been certified through the **NCBAHM** ~~NCCAOM~~ Credentials Documentation Examination.

(A) The applicant must pass three (3) **NCBAHM** ~~NCCAOM~~ Certification exam components: Biomedicine, Foundations of Oriental Medicine, and Acupuncture with Point Location.

(B) The applicant has no more than four attempts to pass each component of the **NCBAHM** ~~NCCAOM~~ Certification Exam listed in subsection (A) of this section. If the applicant does not pass each component of the **NCBAHM** ~~NCCAOM~~ Certification Exam within four attempts, the applicant is not eligible for licensure.

(C) An applicant who has passed each component of the **NCBAHM** ~~NCCAOM~~ Certification Exam but not within the four attempts required by this rule may request a waiver of this requirement if the applicant passed each component of the exam within five attempts and:

(i) Has obtained a Doctor of Acupuncture and Oriental Medicine degree; or

(ii) Experienced extenuating circumstances that do not indicate an inability to safely practice acupuncture as determined by the Board.

(3) An individual whose acupuncture training and diploma were obtained in a foreign country and who cannot document the requirements of subsections (1) or (2) of this rule because the required documentation is now unobtainable, may be considered eligible for licensure if it is

established to the satisfaction of the Board that the applicant has equivalent skills and training and can document one year of training or supervised practice under a licensed acupuncturist in the United States.

(4) In addition to meeting the requirements in (1), (2) or (3) of this rule, all applicants for licensure must have the following qualifications:

(a) Licensure in good standing from the state or states of all prior and current health related licensure; and

(b) Have good moral character as those traits would relate to the applicant's ability properly engage in the practice of acupuncture; and

(c) Have the ability to communicate in the English language well enough to be understood by patients and physicians. This requirement is met if the applicant passes the **NCBAHM**~~NCCAOM~~ written acupuncture examination in English, or if in a foreign language, must also have passed an English language proficiency examination:

(A) A Test of English as a Foreign Language (TOEFL) score of 500 or more for the written TOEFL exam, 173 or more for the computer based TOEFL exam, or 65 or more for the internet based TOEFL exam;

(B) A Test of Spoken English (TSE) score of 200 or more prior to July 1995, and a score of 50 or more after July 1995; or

(C) A Occupational English Test score of at least 350 for speaking and at least 300 for reading, writing, and listening on any OET health-related profession.

(d) An applicant who is certified through the **NCBAHM**~~NCCAOM~~ Credentials Documentation Examination must also have passed an English proficiency examination described in subsection (c).

Statutory/Other Authority: ORS 677.265 & ORS 677.759

Statutes/Other Implemented: ORS 677.265, ORS 677.759 & ORS 677.780

847-070-0017

Clinical Training

(1) A clinical supervisor must meet the following requirements:

(a) Be an actively licensed Oregon acupuncturist who has practiced as an acupuncturist for a period of at least five years, and is in good standing with the Board; or

(b) Be an actively licensed Oregon physician who is in good standing with the Board, who has been practicing acupuncture for a period of at least five years, and has passed the examination for acupuncture; or

(c) Be an acupuncturist or physician licensed, registered, or certified by another jurisdiction, who is in good standing with such jurisdiction, who has been practicing acupuncture for a period of a least five years and has passed a qualifying examination for acupuncture, or been certified in acupuncture by the National Certification ~~Commission~~ **Board** for Acupuncture and ~~Oriental~~ **Herbal** Medicine (~~NCBAHM~~ **NCCAOM**) through its Credentials Documentation Examination. If a portion of those five or more years was prior to licensing, registration, or certification, then prior practice must be documented to the Board's satisfaction. The ~~NCBAHM~~ **NCCAOM** Certification Standards for Documentation will be used. All clinical supervisors under this section are subject to Board approval.

(2) Board approved clinical supervisors, acupuncturists or physicians may supervise no more than two acupuncture students in an informal private clinical setting.

(3) An “acupuncture student” is an individual:

(a) Enrolled in a school approved to offer credit for post-secondary clinical education in Oregon; or

(b) A practitioner licensed to practice acupuncture in another state or foreign country who is enrolled in clinical training provided by a clinical supervisor approved by the Oregon Medical Board.

(4) An acupuncture student must comply with OAR 847-070-0005 to 847-070-0055.

(5) An acupuncture student may not perform any act that constitutes the practice of medicine or the practice of acupuncture, except under direct supervision of a person approved by the Board as a clinical supervisor to provide clinical training as described in this rule.

Statutory/Other Authority: ORS 677.265

Statutes/Other Implemented: ORS 677.060(3)

847-070-0019

Interview and Examination

(1) In addition to all other requirements for licensure, the Board may require an applicant to appear for a personal interview regarding information received in the application process. Unless excused in advance, failure to appear before a Committee of the Board for a personal interview violates ORS 677.190(17) and may subject the applicant to disciplinary action.

(2) If there is reasonable cause to question the qualifications of an applicant, the Board in its discretion may require the applicant to do one or more of the following:

(a) Obtain certification or re-certification in Acupuncture or Oriental Medicine by the National Certification ~~Commission~~ **Board** for Acupuncture and ~~Oriental~~ **Herbal** Medicine (~~NCBAHM~~ **NCCAOM**);

(b) Pass an evaluation which may be written, oral, practical, or any combination thereof;

(c) Provide documentation of current **NCBAHM**~~NCCAOM~~ Acupuncture certification;

(d) Complete 15 hours of continuing education acceptable to the Board for every year the applicant has ceased practice prior to application for Oregon licensure. Continuing education that meets **NCBAHM**~~NCCAOM~~'s recertification requirements would qualify as Board-approved continuing education;

(e) Complete a Board-approved mentorship tailored to the applicant's time out of practice under a Board-approved mentor who must individually supervise the applicant. The mentor must report the successful completion of the mentorship to the Board.

(3) An applicant must pass an open-book examination on the Medical Practice Act (ORS Chapter 677) and Oregon Administrative Rules (OAR chapter 847, division 70). If an applicant fails the examination three times, the applicant must attend an informal meeting with a Board member, the Executive Director, a Board investigator and/or the Medical Director of the Board to discuss the applicant's failure of the examination before being given a fourth and final attempt to pass the examination. If the applicant does not pass the examination on the fourth attempt, the applicant may be denied licensure.

Statutory/Other Authority: ORS 677.265 & 677.759

Statutes/Other Implemented: ORS 677.759

847-070-0022

Documents to be Submitted for Licensure

The documents submitted must be legible and no larger than 8 ½" x 11". All documents and photographs will be retained by the Board as a permanent part of the application file. If original documents are larger than 8 ½" x 11", the copies must be reduced to the correct size with all wording and signatures clearly shown. Official translations are required for documents issued in a foreign language. The following documents are required:

(1) Application: Completed formal application provided by the Board. Required dates must include month, day and year.

(2) Birth Certificate: A copy of birth certificate and a copy of Change of Name documentation, Marriage Certificate, or Divorce Decree if the applicant's name has been changed by court order, adoption, marriage, divorce, etc.

(3) Acupuncture School Diploma: A copy of a diploma showing graduation from an approved school of acupuncture for those applicants who qualify under OAR 847-070-0016(1).

(4) Photograph: A close-up, passport-quality photograph, front view, head and shoulders (not profile), with features distinct, taken within 90 days preceding the filing of the application.

(5) A letter from the Dean of the applicant's program of acupuncture for those applicants who qualify under OAR 847-070-0016(1).

(6) A letter from the National Certification ~~Commission~~ **Board** for Acupuncture and ~~Oriental Herbal~~ Medicine (~~NCBAHM~~ **NCCAOM**) verifying current certification in acupuncture by the ~~NCBAHM~~ **NCCAOM** for those applicants who qualify under OAR 847-070-0016(1) or (2).

(7) If requested by the Board, a letter verifying licensure in good standing from the state or states of all prior and current health-related licensure.

(8)(a) A letter from the Director or other official for practice and employment to include a statement regarding eligibility for rehire and specific beginning and ending dates of practice and employment, for the past five (5) years only.

(b) If the applicant has ceased practice for more than two (2) years, employment verifications will be required for the past ten (10) years or redacted patient logs from the past five (5) years.

(c) If such verification is unavailable or incomplete, and for acupuncturists who have been or are in solo practice, three reference letters from acupuncturists in the local treatment community who are familiar with the applicant's practice and who have known the applicant for more than six months.

Statutory/Other Authority: ORS 677.265 & 677.759

Statutes/Other Implemented: ORS 677.275 & 677.759

847-070-0033

Visiting Acupuncturist Requirements

(1) The Oregon Medical Board may grant approval for a visiting acupuncturist to demonstrate acupuncture needling as part of a seminar, conference, or workshop sponsored by an Oregon school or an Oregon school's program of acupuncture or **Traditional Eastern** ~~oriental~~ medicine, or professional organization of acupuncture, or any seminar, conference, or workshop approved by the National Certification ~~Commission~~ **Board** for Acupuncture and ~~Oriental Herbal~~ Medicine (~~NCBAHM~~ **NCCAOM**) to provide continuing education training for a period up to ten days no more than three times a year. The visiting acupuncturist who requests additional time beyond the ten days, or submits more than three requests in a year, must apply for and obtain a license to practice in the state of Oregon. An Oregon licensed acupuncturist must be in attendance at the seminar, conference or workshop.

(2) Prior to being granted approval, the following information must be submitted to the Oregon Medical Board:

(a) A letter from the school or program of acupuncture or **Traditional Eastern** ~~oriental~~ medicine, or organization which will have an out-of-state acupuncturist demonstrate needling as part of a seminar, conference, or workshop with the following information:

(A) Dates of the seminar, conference, or workshop in which the visiting acupuncturist will be demonstrating acupuncture needling;

(B) Description of the seminar, conference or workshop;

(C) Name of the responsible Oregon acupuncturist, licensed under ORS 677, actively registered and in good standing with the Board, who will be in attendance and responsible for the conduct of the visiting acupuncturist at the seminar, conference or workshop.

(D) A curriculum vitae for the visiting acupuncturist; and

(b) If the visiting acupuncturist is licensed, certified or registered to practice as an acupuncturist in the state in which the acupuncturist is practicing, the visiting acupuncturist must provide documentation that their license, certificate, or registration is active and in good standing.

(3) The request for approval to practice in the state of Oregon as a visiting acupuncturist must be received at least two weeks prior to the beginning date of such practice.

Statutory/Other Authority: ORS 677.265

Statutes/Other Implemented: ORS 677.265(1) & (2)

847-070-0037

Limited License, Pending Examination

(1) An acupuncturist who meets all requirements for Oregon acupuncture licensure but has not yet passed the acupuncture certification examination given by the National Certification ~~Commission~~ **Board** on Acupuncture and ~~Oriental~~ **Herbal** Medicine (~~NCBAHM~~ **NCCAOM**) may be issued a Limited License, Pending Examination for the purpose of obtaining clinical training in Oregon under the supervision of a Board approved clinical supervisor if the following criteria are met:

(a) The application file is complete to the satisfaction of the Board with the exception of pending certification by the ~~NCBAHM~~ **NCCAOM**;

(b) The applicant has not previously failed the ~~NCBAHM~~ **NCCAOM** examination;

(c) The clinical supervisor approved to supervise the applicant meets the qualifications in OAR 847-070-0017 and is on-site and available to supervise at all times when the applicant is training; and

(d) The applicant has submitted the appropriate form and fee prior to being issued a Limited License, Pending Examination.

(2) Any person obtaining clinical training under a Limited License, Pending Examination must identify themselves to patients as an acupuncture trainee and wear a name tag identifying themselves as a trainee.

(3) A Limited License, Pending Examination may be granted for a period of six months.

(4) Upon receipt of verification that the applicant has passed the acupuncture certification examination given by the **NCBAHM**~~NCCAOM~~, and if the applicant's application file is otherwise satisfactorily complete, the applicant shall be scheduled for approval of permanent licensure.

(5) The Limited License, Pending Examination will automatically expire if the applicant fails the acupuncture certification examination given by the **NCBAHM**~~NCCAOM~~.

Statutory/Other Authority: ORS 677.265

Statutes/Other Implemented: ORS 677.759

847-070-0045

Inactive Registration and Re-Entry to Practice

(1) Any acupuncturist licensed in this state who changes location to some other state or country shall be listed by the Board as inactive.

(2) If the acupuncturist wishes to resume active status, the acupuncturist must file an Affidavit of Reactivation and pay a processing fee, satisfactorily complete the reactivation process and be approved by the Board before beginning active practice in Oregon.

(3) The Board may deny active registration if it judges the conduct of the acupuncturist during the period of inactive registration to be such that the acupuncturist would have been denied a license if applying for an initial license.

(4) If an acupuncturist applicant has ceased practice for a period of 12 or more consecutive months immediately preceding the application for licensure or reactivation, the applicant may be required to do one or more of the following:

(a) Obtain certification or re-certification in Acupuncture or Oriental Medicine by the National Certification ~~Commission~~ **Board** for Acupuncture and ~~Oriental~~ **Herbal** Medicine (**NCBAHM**~~NCCAOM~~);

(b) Provide documentation of current **NCBAHM**~~NCCAOM~~ Acupuncture or Oriental Medicine certification;

(c) Complete 15 hours of continuing education acceptable to the Board for every year the applicant has ceased practice;

(d) Complete a Board-approved mentorship tailored to the applicant's time out of practice under a Board-approved mentor who must individually supervise the licensee. The mentor must report the successful completion of the mentorship to the Board; and

(e) Additional requirements as determined appropriate by the Board.

(5) The acupuncturist applicant who has ceased practice for a period of 24 or more consecutive months may be required to complete a re-entry plan to the satisfaction of the Board. The re-entry plan must be reviewed and approved through a Consent Agreement for Re-entry to Practice prior to the applicant beginning the re-entry plan. Depending on the amount of time out of practice, the re-entry plan may contain one or more of the requirements listed in section (4) of this rule and such additional requirements as determined appropriate by the Board.

Statutory/Other Authority: ORS 677.265 & ORS 677.759

Statutes/Other Implemented: ORS 677.759 & ORS 677.175

847-070-0060

License Application Withdrawals and Denials

(1) An applicant may withdraw an application for licensure prior to review by the Board's Administrative Affairs Committee or Acupuncture Advisory Committee. The Board will not report the withdrawal to the National Certification ~~Commission~~ **Board** for Acupuncture and ~~Oriental Herbal~~ Medicine (~~NCBAHM~~ **NCCAOM**). The applicant may submit a new application for licensure at any time.

(2) An applicant may withdraw an application for licensure up to 30 days after the Board has voted to deny the application on the basis that the applicant is not eligible for licensure for reason(s) other than the applicant's failure to demonstrate good moral character. The Board will not report the withdrawal to the ~~NCBAHM~~ **NCCAOM**. The applicant may submit a new application for licensure at any time.

(3) An applicant may request to withdraw an application for licensure after review by the Administrative Affairs Committee. If the Board grants the request, the withdrawal will be reported to the ~~NCBAHM~~ **NCCAOM**. The applicant may submit a new application for licensure no sooner than two years after the date of withdrawal.

(4) An applicant may request to withdraw an application for licensure after review by the Board's Investigative Committee. If the Board grants the request, the applicant may withdraw their application only through issuance of a Stipulated Order of suspended judgment of license denial. The suspension of judgment is based on the applicant's withdrawal of their application and agreement not to reapply for licensure for at least two years after issuance of the Stipulated Order. The order will be reported to the ~~NCBAHM~~ **NCCAOM** and the National Practitioner Databank.

(5) An applicant whose application has been denied may submit a new application for licensure as stated in the Board's Order, but no sooner than two years after the date of denial.

Statutory/Other Authority: ORS 677.265

Statutes/Other Implemented: ORS 677.265, ORS 677.100, ORS 677.190, ORS 677.220 & ORS 677.759

847-008-0070

Continuing Medical Competency (Education)

The Oregon Medical Board is committed to ensuring the continuing competence of its licensees for the protection, safety and well being of the public. All licensees must engage in a culture of continuous quality improvement and lifelong learning.

(1) Licensees renewing registration who had been registered with Active, Administrative Medicine Active, Locum Tenens, Military/Public Health Active, Telemedicine Active, Telemonitoring Active, or Teleradiology Active status for the previous registration period must demonstrate ongoing competency to practice medicine by:

(a) Ongoing participation in a program of recertification or maintenance of certification by an American Board of Medical Specialties (ABMS) board, the American Osteopathic Association's Bureau of Osteopathic Specialists (AOA-BOS), the American Board of Podiatric Medicine (ABPM), the American Board of Foot and Ankle Surgery (ABFAS), the National Commission on Certification of Physician Assistants (NCCPA), or the National Certification ~~Commission~~ **Board** for Acupuncture and ~~Oriental Herbal~~ Medicine (**NCBAHM**~~NCCAOM~~); or

(b) 60 hours of continuing medical education (CME) per two years relevant to the licensee's current medical practice, or 30 hours of CME if licensed during the second year of the biennium, as follows:

(A) American Medical Association (AMA) Category 1;

(B) American Osteopathic Association (AOA) Category 1-A or 2-A;

(C) American Podiatric Medical Association's (APMA) Council on Podiatric Medical Education approved sponsors of continuing education; or

(D) American Academy of Physician Associates (AAPA) Category 1 (pre-approved); or

(c) 30 hours of **NCBAHM**~~NCCAOM~~-approved courses per two years relevant to the licensee's current practice, or 15 hours if licensed during the second year of the biennium.

(2) Licensees renewing registration who had been registered with Emeritus status for the previous registration period must demonstrate ongoing competency by:

(a) Ongoing participation in re-certification by an ABMS board, the AOA-BOS, the ABPM, the ABFAS, the NCCPA, or the **NCBAHM**~~NCCAOM~~; or

(b) 15 hours of CME per year as follows:

(A) AMA Category 1 or 2;

(B) AOA Category 1-A, 1-B, 2-A or 2-B;

(C) APMA-approved continuing education; or

(D) AAPA Category 1 or 2; or

(c) 8 hours of **NCBAHM**~~NCCAOM~~-approved courses.

(3) Licensees who have lifetime certification without participation in a program of recertification or maintenance of certification with the ABMS, AOA-BOS, ABPM, ABFAS, or NCCPA must submit the required CME in section (1) (b) of this rule or section (2) (b) of this rule if renewing with Emeritus status.

(4) Licensees who have lifetime certification without participation in a program of recertification or maintenance of certification with the **NCBAHM**~~NCCAOM~~ must submit the required CME in section (1) (c) of this rule or section (2) (c) of this rule if renewing with Emeritus status.

(5) Licensees serving in the military may provide documentation of military training or experience that is substantially equivalent to the continuing education required by the Board to meet the requirements of this rule.

(6)(a) CME in cultural competency is considered relevant CME for the current practice of all licensees and may be used toward satisfying the required CME hours and the cultural competency continuing education hours required in OAR 847-008-0077.

(b) CME in suicide risk assessment, treatment and management is considered relevant CME for the current practice of all licensees and may be used toward satisfying the required CME hours.

(c) CME in the detection and early diagnosis of Alzheimer's disease and in the appropriate prescribing of antipsychotic drugs to treat patients with Alzheimer's disease is considered relevant CME for the current practice of all physician and physician associate licensees and may be used toward satisfying the required CME hours. Licensees practicing in primary care or geriatric care are encouraged to obtain the CME described here.

(7) Licensees who perform Level II office-based surgical procedures and who are not eligible or maintaining certification with an ABMS, AOA-BOS, ABPM, ABFAS, or NCCPA specialty board, must obtain 50 hours of CME each year. The CME hours must be relevant to the surgical procedures to be performed in the office-based facility and must be accredited as described in section (1)(b) of this rule. This requirement may not be satisfied with cultural competency CME or other CME that is only generally relevant to the licensee's practice.

(8) The Board may audit licensees for compliance with CME. Audited licensees have 60 days from the date of the audit to provide course certificates. Failure to comply or misrepresentation of compliance is grounds for disciplinary action.

(9) As the result of an audit, if licensee's CME is deficient or licensee does not provide adequate documentation, the licensee will be fined \$250 and must comply with CME requirements within 120 days from the date of the audit.

(a) If the licensee does not comply within 120 days of the date of the audit, the fine will increase to \$1000; and

(b) If the licensee does not comply within 180 days of the date of the audit, the licensee's license will be suspended for a minimum of 90 days.

(10) The following licensees are exempt from this rule:

(a) Licensees in residency training; and

(b) Volunteer Camp licensees.

Statutory/Other Authority: ORS 677.265, ORS 676.850 & ORS 676.860

Statutes/Other Implemented: ORS 677.265, ORS 677.512, ORS 677.759, ORS 677.837, ORS 676.850, ORS 676.860 & ORS 677.487

847-010-0073

Reporting Requirements

(1) Board licensees and health care facilities must report to the Board as required by ORS 676.150, 677.092, 677.190, and 677.415. These reports include, but are not limited to, the following:

(a) A licensee must self-report to the Board:

(A) Any conviction of a misdemeanor or felony or any arrest for a felony crime to the Board within 10 days after the conviction or arrest;

(B) Any adverse action taken by another licensing jurisdiction or any peer review body, health care institution, professional or medical society or association, governmental agency, law enforcement agency or court for acts or conduct similar to acts or conduct that would constitute grounds for disciplinary action as described in ORS chapter 677;

(C) Any official action taken against the licensee within 10 business days of the official action; or

(D) A voluntary withdrawal from practice, voluntary resignation from the staff of a health care facility or voluntary limitation of the licensee's staff privileges at a health care facility if the

licensee's voluntary action occurs while the licensee is under investigation by the health care facility or its committee for any reason related to possible medical incompetence, unprofessional conduct or physical incapacity or impairment within 30 calendar days.

(b) A licensee who has reasonable cause to believe that another state licensed health care professional has engaged in prohibited or unprofessional conduct must report the conduct within 10 working days to the board responsible for the other professional unless disclosure is prohibited by state or federal laws relating to confidentiality or protection of health information.

(c) A licensee must report within 10 business days to the Board any information that appears to show that a licensee is or may be medically incompetent or is or may be guilty of unprofessional or dishonorable conduct or is or may be a licensee with a physical incapacity.

(d) A health care facility must report to the Board:

(A) Any official action taken against a licensee within 10 business days of the date of the official action; or

(B) A licensee's voluntary withdrawal from practice, voluntary resignation from the staff of a health care facility or voluntary limitation of the licensee's staff privileges at a health care facility if the licensee's voluntary action occurs while the licensee is under investigation by the health care facility or its committee for any reason related to possible medical incompetence, unprofessional conduct or physical incapacity or impairment within 30 calendar days.

(2) For purposes of the statutes, reporting to the Board means making a report to the Board's Investigation Unit or the Board's Executive Director or the Board's Medical Director. Making a report to the Board's Health Professionals' Services Program (HPSP) or HPSP's Medical Director does not satisfy the duty to report to the Board.

(3) For the purposes of ORS chapters 676 and 677, the terms medical incompetence, unprofessional conduct, and impaired licensee have the following meanings:

(a) Medical Incompetence: A licensee who is medically incompetent is one who is unable to practice medicine with reasonable skill or safety due to lack of knowledge, lack of ability, or impairment. Evidence of medical incompetence shall include:

(A) Gross or repeated acts of negligence involving patient care.

(B) Failure to achieve a passing score or satisfactory rating on a competency examination or program of evaluation when the examination or evaluation is ordered or directed by the Board or a health care facility.

(C) Failure to complete a course or program of remedial education when ordered or directed to do so by the Board or a health care facility, or a medical education or training program.

(b) Unprofessional conduct: Unprofessional conduct includes the behavior described in ORS 677.188(4), defined as conduct which is unbecoming to a person licensed by the Board or detrimental to the best interest of the public, and which includes:

(A)(i) Any conduct or practice contrary to recognized standards of ethics of the medical, podiatric, or acupuncture professions, or

(ii) Any conduct which does or might constitute a danger to the health or safety of a patient or the public, to include a violation of patient boundaries, or

(iii) Any conduct or practice which does or might adversely affect a provider's ability to safely and skillfully practice medicine, podiatry, or acupuncture; or

(iv) Practicing with a condition that is adversely affecting a provider's ability to safely and skillfully practice medicine, podiatry, or acupuncture.

(B) Willful performance of any surgical or medical treatment which is contrary to acceptable medical standards.

(C)(i) Willful and repeated ordering or performance of unnecessary laboratory tests or radiologic studies; or

(ii) Administration of unnecessary treatment; or

(iii) Employment of outmoded, unproved, or unscientific treatments, except as allowed in ORS 677.190 (1)(b); or

(iv) Failing to obtain consultations when failing to do so is not consistent with the standard of care; or

(v) Otherwise utilizing medical service for diagnosis or treatment which is or may be considered inappropriate or unnecessary.

(D) Fraud in the performance of, or the billing for, medical procedures.

(E) Repeated instances of disruptive behavior in the health care setting that could adversely affect the delivery of health care to patients.

(F) Sexual misconduct: Licensee sexual misconduct is behavior that exploits the licensee-patient relationship in a sexual way. The behavior is non-diagnostic and non-therapeutic, may be verbal, physical or other behavior, and may include expressions of thoughts and feelings or gestures that are sexual or that reasonably may be construed by a patient as sexual. Sexual misconduct includes but is not limited to:

(i) Sexual violation: Licensee-patient sex, whether or not initiated by the patient, and engaging in any conduct with a patient or the patient's immediate family that is sexual or may be reasonably interpreted as sexual, including but not limited to:

(I) Sexual intercourse;

(II) Genital to genital contact;

(III) Oral to genital contact;

(IV) Oral to anal contact;

(V) Genital to anal contact;

(VI) Kissing in a romantic or sexual manner;

(VII) Touching breasts, genitals, or any sexualized body part for any purpose other than appropriate examination or treatment, or where the patient has refused or has withdrawn consent;

(VIII) Encouraging the patient to masturbate in the presence of the licensee or masturbation by the licensee while the patient is present; or

(IX) Offering to provide practice-related services, such as medications, in exchange for sexual favors.

(ii) Sexual impropriety: Behavior, gestures, or expressions that are seductive, sexually suggestive, or sexually demeaning to a patient or the patient's immediate family, to include:

(I) Sexually exploitative behavior, to include taking, transmitting, viewing, or in any way using photos or any other image of a patient, their family or associates for the prurient interest of others.

(II) Intentional viewing in the health care setting of any sexually explicit conduct for prurient interests.

(III) Having any involvement with child pornography, which is defined as any visual depiction of a minor (a child younger than 18) engaged in sexually explicit conduct.

(IV) Sexually explicit communication in person, by mail, by telephone, or by other electronic means, including but not limited to text message, e-mail, video or social media.

(G) Conduct not otherwise allowed by Oregon law which is contrary to or inconsistent with recognized standards of ethics of the medical, podiatric, or acupuncture professions, specifically conduct that is contrary to or inconsistent with:

(i) Any principle, opinion, or provision of the American Medical Association's 2016 Code of Ethics.

(ii) Ethical standards established by a specialty board as defined in OAR 847-020-0100:

(I) In which the licensee is certified, and

(II) Which were in place at the time the conduct occurred.

(iii) Ethical standards established by the medical college or specialty society:

(I) In which the licensee practices or practiced at the time of the conduct, and

(II) Which were in effect as of April 7, 2022.

(iv) Any provision of the American Osteopathic Association's 2016 Code of Ethics.

(v) Any provision of the American Podiatric Medical Association's 2017 Code of Ethics.

(vi) Any provision of the 2008 (reaffirmed in 2013) American Association of Physician Assistants' Guidelines for Ethical Conduct for the Physician Assistant Profession.

(vii) Any provision of the Oregon Association of Acupuncturists' ~~and Oriental Medicine's~~ 2008 Code of Ethics.

(viii) Any provision of the National Certification ~~Commission~~ Board for Acupuncture and ~~Oriental~~ Herbal Medicine's 2023 Code of Ethics.

(H) Intentionally contacting the known complainant or allowing any person authorized to act on behalf of the licensee to contact the known complainant in regard to the complaint or investigation unless and until the licensee has requested a contested case hearing and the Board has authorized the taking of the complainant's deposition pursuant to ORS 183.425.

(I) In the practice of acupuncture, the failure to meet the standard of care of a reasonably prudent, careful, and skillful practitioner of acupuncture under the same circumstances, in the same or similar community. In the practice of acupuncture, errors of such repetition or magnitude that a willful disregard of practice standards or patient safety may be inferred.

(J) Discrimination in the practice of medicine, podiatry, or acupuncture resulting in differences in the quality of healthcare delivered that is not due to access-related factors or clinical needs, preferences, and appropriateness of intervention.

(c) Licensee Impairment: A licensee who is impaired is a licensee who is unable to practice medicine with reasonable skill or safety due to factors which include, but are not limited to:

(A) The use of alcohol, drugs, prescribed medication, or other substances while on or off duty which causes impairment when on duty, including taking call or supervising other healthcare professionals, regardless of practice setting.

(B) Mental or emotional illness.

(C) Physical deterioration or long term illness or injury which adversely affects cognition, motor, or perceptive skills.

(4) For the purposes of the reporting requirements of this rule and ORS 677.415, licensees shall be considered to be impaired if they refuse to undergo an evaluation for mental or physical competence or chemical impairment, or if they resign their privileges to avoid such an evaluation, when the evaluation is ordered or directed by a health care facility or by this Board.

(5) For the purposes of the reporting requirements of this rule and ORS 677.415, official action does not include administrative suspensions of seven or fewer calendar days for failure to maintain or complete records. Administrative suspensions described in this section must be reported as an official action when the suspensions occur more than three times in any 12-month period.

(6) A report made by a board licensee or the Oregon Medical Association or other health professional association, to include the Osteopathic Physicians and Surgeons of Oregon, Inc, or the Oregon Podiatric Medical Association to the Board under ORS 677.415 shall include the following information:

(a) The name, title, address and telephone number of the person making the report;

(b) The information that appears to show that a licensee is or may be medically incompetent, is or may be guilty of unprofessional or dishonorable conduct or is or may be a licensee with an impairment.

(7) A report made by a health care facility to the Board under ORS 677.415 (5) and (6) shall include:

(a) The name, title, address and telephone number of the health care facility making the report;

(b) The date of an official action taken against the licensee or the licensee's voluntary action withdrawing from practice, voluntary resignation or voluntary limitation of licensee staff privileges; and

(c) A description of the official action or the licensee's voluntary action, as appropriate to the report, including:

(A) The specific restriction, limitation, suspension, loss or denial of the licensee's medical staff privileges and the effective date or term of the restriction, limitation, suspension, loss or denial; or

(B) The fact that the licensee has voluntarily withdrawn from the practice of medicine or podiatry, voluntarily resigned from the staff of a health care facility or voluntarily limited the licensee's privileges at a health care facility and the effective date of the withdrawal, resignation or limitation.

(8) A report made under ORS 677.415 Section 2 may not include any information that is privileged peer review data, see ORS 41.675.

(9) All required reports shall be made in writing.

(10) Any person who reports or provides information in good faith as required by the statutes is immune from civil liability for making the report.

Statutory/Other Authority: ORS 677.265 & 677.417

Statutes/Other Implemented: ORS 676.150, 677.092, 677.190, 677.205, 677.265 & 677.415

Enrolled Senate Bill 874

Printed pursuant to Senate Interim Rule 213.28 by order of the President of the Senate in conformance with pre-session filing rules, indicating neither advocacy nor opposition on the part of the President (at the request of Governor Tina Kotek for Oregon Medical Board)

CHAPTER

AN ACT

Relating to Oriental medicine; amending ORS 677.010, 677.275, 677.757, 677.759, 677.761 and 677.780.

Be It Enacted by the People of the State of Oregon:

SECTION 1. ORS 677.010 is amended to read:

677.010. As used in this chapter, subject to the exemptions in ORS 677.060 and unless the context requires otherwise:

(1) "Approved internship" means the first year of post-graduate training served in a hospital that is approved by the **Oregon Medical Board** or by the Accreditation Council [of] **for Graduate Medical Education or its successor organization**, the American Osteopathic Association **or its successor organization** or the Royal College of Physicians and Surgeons of Canada **or its successor organization**.

(2) "Approved school of medicine" means a school offering a full-time resident program of study in medicine or osteopathic medicine leading to a degree of Doctor of Medicine or Doctor of Osteopathic Medicine, such program having been fully accredited or conditionally approved by the Liaison Committee on Medical Education, or its successor agency, or the American Osteopathic Association, or its successor agency, or having been otherwise determined by the board to meet the association standards as specifically incorporated into board rules.

[(3) "Board" means the Oregon Medical Board.]

[(4)] (3) "Diagnose" means to examine another person in any manner to determine the source or nature of a disease or other physical or mental condition, or to hold oneself out or represent that a person is so examining another person. It is not necessary that the examination be made in the presence of such other person; [it] **the examination** may be made on information supplied either directly or indirectly by such other person.

[(5)] (4) "Dispense" means the preparation and delivery of a prescription drug, pursuant to a lawful order of a practitioner, in a suitable container appropriately labeled for subsequent administration to or use by a patient or other individual entitled to receive the prescription drug.

[(6)] (5) "Dispensing physician" means a physician or podiatric physician and surgeon who purchases prescription drugs for the purpose of dispensing them to patients or other individuals entitled to receive the prescription drug and who dispenses them accordingly.

[(7)] (6) "Drug" means all medicines and preparations for internal or external use of humans, intended to be used for the cure, mitigation or prevention of diseases or abnormalities of humans, which are recognized in any published United States Pharmacopoeia or National Formulary, or otherwise established as a drug.

[(8)] (7) “Fellow” means an individual who has not qualified under ORS 677.100 (1) and (2) and who is pursuing some special line of study as part of a supervised program of a school of medicine, a hospital approved for internship or residency training, or an institution for medical research or education that provides for a period of study under the supervision of a responsible member of that hospital or institution, such school, hospital or institution having been approved by the board.

[(9)] (8) “Intern” means an individual who has entered into a hospital or hospitals for the first year of post-graduate training.

[(10)] (9) “License” means permission to practice, whether by license, registration or certification.

[(11)] (10) “Licensee” means an individual holding a valid license issued by the board.

[(12)] (11) “Physical incapacity” means a condition that renders an individual licensed under this chapter unable to practice under that license with professional skill and safety by reason of physical illness or physical deterioration that adversely affects cognition, motor or perceptive skill.

[(13)] (12) “Physician” means a person who holds a degree of Doctor of Medicine or Doctor of Osteopathic Medicine, or a person who holds a degree of Doctor of Podiatric Medicine if the context in which the term “physician” is used does not authorize or require the person to practice outside the scope of a license issued under ORS 677.805 to 677.840.

[(14)] (13) “Podiatric physician and surgeon” means a physician licensed under ORS 677.805 to 677.840 to practice podiatry.

[(15)(a)] (14)(a) “Podiatry” means:

(A) The diagnosis or the medical, physical or surgical treatment of ailments of the human foot, ankle and tendons directly attached to and governing the function of the foot and ankle, and treatment involving the use of a general or spinal anesthetic if that treatment is performed in a hospital licensed under ORS 441.025 or in an ambulatory surgical center licensed by the Oregon Health Authority and is under the supervision of or in collaboration with a podiatric physician and surgeon;

(B) Assisting in the performance of surgery, as provided in ORS 677.814; and

(C) The treatment of skin, skin-related structures and subcutaneous masses, and wounds involving skin, skin-related structures and subcutaneous masses, on the human leg no further proximal than the tibial tubercle.

(b) “Podiatry” does not include administering general or spinal anesthetics or the amputation of the entire foot.

[(16)] (15) “Prescribe” means to direct, order or designate the use of or manner of using by spoken or written words or other means.

[(17)] (16) “Resident” means an individual who, after the first year of post-graduate training, in order to qualify for some particular specialty in the field of medicine, pursues a special line of study as part of a supervised program of a hospital approved by the board.

(17) “Traditional Eastern medicine” means the practice of medicine, specifically acupuncture and traditional Chinese medicine, regulated by this chapter if the medicine is practiced within the context of a person’s license to practice acupuncture issued under ORS 677.757 to 677.770.

SECTION 2. ORS 677.275 is amended to read:

677.275. Each administrative law judge conducting hearings on behalf of the **Oregon Medical Board** is vested with the full authority of the board to schedule and conduct hearings on behalf and in the name of the board on all matters referred by the board, including issuance of licenses, proceedings for placing licensees on probation and for suspension and revocation of licenses, and shall cause to be prepared and furnished to the board, for decision thereon by the board, the complete written transcript of the record of the hearing. This transcript shall contain all evidence introduced at the hearing and all pleas, motions and objections, and all rulings of the administrative law judge. Each administrative law judge may administer oaths and issue summonses, notices and subpoenas, but may not place any licensee on probation or issue, refuse, suspend or revoke a license.

SECTION 3. ORS 677.757 is amended to read:

677.757. As used in ORS 677.757 to 677.770:

[(1)(a) “Acupuncture” means an Oriental health care practice used to promote health and to treat neurological, organic or functional disorders by the stimulation of specific points on the surface of the body by the insertion of needles. “Acupuncture” includes the treatment method of moxibustion, as well as the use of electrical, thermal, mechanical or magnetic devices, with or without needles, to stimulate acupuncture points and acupuncture meridians and to induce acupuncture anesthesia or analgesia.]

[(b) The practice of acupuncture also includes the following modalities as authorized by the Oregon Medical Board:]

[(A) Traditional and modern techniques of diagnosis and evaluation;]

[(B) Oriental massage, exercise and related therapeutic methods; and]

[(C) The use of Oriental pharmacopoeia, vitamins, minerals and dietary advice.]

(1) “Acupuncture” means:

(a) Traditional Eastern medicine used to promote health and treat neurological, organic or functional disorders through the insertion of needles into specific points on the body at varying depths, including insertion into the skin, subcutaneous tissue, muscle layers and fascia, and into or near joint spaces based on anatomical location and the practitioner’s clinical assessment. The type of needle inserted, and the depth, angle and technique of insertion, are informed by specialized training in acupuncture theory, biomedical anatomy and diagnostic evaluation to safely stimulate biological and physiological responses and support the body’s healing process.

(b) The treatment method of moxibustion and the use of electrical, thermal, mechanical or magnetic devices, with or without needles, to stimulate acupuncture points and acupuncture meridians and to induce acupuncture anesthesia or analgesia.

(c) The following modalities, as authorized by the Oregon Medical Board:

(A) Traditional Eastern medicine and acupuncture techniques of diagnosis and evaluation;

(B) Traditional Eastern medicine manual therapy, exercise and related therapeutic methods; and

(C) The use of Traditional Eastern medicine pharmacopoeia, vitamins, minerals and dietary advice.

(2) [“Oriental pharmacopoeia”] “Traditional Eastern medicine pharmacopoeia” means a list of herbs described in [traditional Oriental] Traditional Eastern medicine texts commonly used in accredited schools of [Oriental] Traditional Eastern medicine if the texts are approved by the Oregon Medical Board.

SECTION 4. ORS 677.759 is amended to read:

677.759. (1) [No person shall] **A person may not** practice acupuncture without first obtaining a license to practice medicine and surgery or a license to practice acupuncture from the Oregon Medical Board except as provided in subsection (2) of this section.

(2) Notwithstanding subsection (1) of this section, the board may issue a license to practice acupuncture to an individual licensed to practice acupuncture in another state or territory of the United States if the individual is licensed to practice medicine and surgery or acupuncture in the other state or territory. The board [shall] **may** not issue such a license unless the requirements of the other state or territory are similar to the requirements of this state.

(3) The board shall examine the qualifications of an applicant and determine who shall be authorized to practice acupuncture.

(4) Using the term “acupuncture,” “acupuncturist,” [“Oriental medicine”] **“Traditional Eastern medicine”** or any other term, title, name or abbreviation indicating that an individual is qualified or licensed to practice acupuncture is prima facie evidence of practicing acupuncture.

(5) In addition to the powers and duties of the board described in this chapter, the board shall adopt rules consistent with ORS 677.757 to 677.770 governing the issuance of a license to practice acupuncture.

SECTION 5. ORS 677.761 is amended to read:

677.761. Nothing in ORS 677.757 to 677.770 is intended to:

(1) Prevent, limit or interfere with an individual licensed or certified by the Oregon Medical Board from practicing health care other than acupuncture within the scope of the license or certification of the individual.

(2) Limit any other licensed or certified health care practitioner from practicing acupressure or other therapy within the scope of the license or certification of the individual.

(3) Limit the activities of any person who engages in the business of providing [*Oriental massage*] **Traditional Eastern medicine manual therapy**, exercise and related therapeutic methods or who provides substances listed in [*an Oriental*] **Traditional Eastern medicine** pharmacopoeia, or vitamins or minerals or dietary advice, so long as the activities of the person are not otherwise prohibited by law.

(4) Limit the ability of practitioners from outside Oregon to demonstrate the practice of acupuncture as part of a recognized and limited duration educational program, lecture or event within this state under rules adopted by the board.

SECTION 6. ORS 677.780 is amended to read:

677.780. (1) There is established an Acupuncture Advisory Committee consisting of six members appointed by the Oregon Medical Board. Of the committee members appointed by the board:

(a) One shall be a person who is a current member of the board.

(b) Two shall be physicians licensed under ORS chapter 677.

(c) Three shall be acupuncturists licensed under ORS [677.759] **677.757 to 677.770**. In appointing the three acupuncturists, the board may receive nominations from the [*Oregon Association of Acupuncture and Oriental Medicine*] **Oregon Association of Acupuncturists, or its successor organization**, and other professional acupuncture organizations.

(2) The term of office of each committee member is three years, but a committee member serves at the pleasure of the board. A committee member may not serve more than two consecutive terms. A committee member serves until a successor is appointed and qualified. If there is a vacancy for any cause, the board shall make an appointment to become immediately effective for the unexpired term.

(3) A committee member is entitled to compensation and expenses as provided for board members in ORS 677.235.

(4) A majority of the members of the committee constitutes a quorum for the transaction of business.



NCCAOM Name Change to NCBAHM

Frequently Asked Questions (FAQ)

We are pleased to share with you the following Frequently Asked Questions (FAQ) to help clarify and support our plan for a name change from the **National Certification Commission for Acupuncture and Oriental Medicine (NCCAOM)** to the **National Certification Board for Acupuncture and Herbal Medicine (NCBAHM)**. We recognize that such a transition raises questions, and we are committed to providing clarity, transparency, and support throughout this process. This FAQ was developed to address the most common inquiries we've received and to offer guidance on what name change means for our Diplomates, candidates, Providers and the broader acupuncture and herbal medicine community.

Table of Contents

NCCAOM Name Change to NCBAHM.....	1
1. What is the new name of the organization and when will the name change go into effect?	2
Rationale for Name Change.....	2
2. Why was the name changed?	2
3. Does this change affect the organization's mission and does the name affect the NCCAOM's work as a credentialing organization?.....	2
4. Why is the NCCAOM using the term "Herbal Medicine" as opposed to Chinese medicine to replace Oriental medicine in its new name?.....	2
Feedback from Stakeholders.....	3
5. Was the public consulted before making this decision?.....	3
6. What were the main concerns from those who opposed the change?.....	3
Regulatory Impact of Name Change.....	3
7. How will NCBAHM address potential regulatory issue	3
How will the Name Change Affect Diplomates?	4
8. Does this affect certification or credentialing for current Diplomates?	4
9. Will the credential "Diplomate of Oriental Medicine" change?	4
10. Will I receive a new certificate when the name change goes into effect?.....	4
Name Change Impacting Profession.....	4
11. What does this change mean for the profession as a whole?	4
12. Who can I contact for more information or support during the transition?	5



1. What is the new name of the organization and when will the name change go into effect?

The National Certification Commission for Acupuncture and Oriental Medicine (NCCAOM) will be the National Certification Board for Acupuncture and Herbal Medicine (NCBAHM) effective January 2026. Until then, the NCCAOM will continue to use its current name, logo, digital badges and credentials. The NCCAOM will unveil its new logo and digital badges in January 2026. Until then, all Diplomates can continue to use the current digital badge. The future Professional Designations for active Diplomates to use starting in 2026:

John Smith, Dipl. Ac. (NCBAHM)TM

John Smith, Dipl. C.H. (NCBAHM)TM

John Smith, Dipl. ABT (NCBAHM)TM

John Smith, Dipl. A.H.M. (NCBAHM)TM

Rationale for Name Change

2. Why was the name changed?

The name change marks an important step in the continued evolution of our organization and the profession we serve. It reflects our commitment to more accurately represent the full scope of practice, while embracing inclusive, modern, and culturally respectful language. In addition, we are recognizing the name change of our national standards organization, Accreditation Commission for Acupuncture and Herbal Medicine (ACAHM) and Council of Colleges for Acupuncture and Herbal Medicine (CCAHM).

3. Does this change affect the organization's mission and does the name affect the NCCAOM's work as a credentialing organization?

No. Our mission remains unchanged: to assure the safety and well-being of the public and to advance and advocate for the professional practice of NCCAOM Board-Certified AcupuncturistsTM through national standards focused on competence and credentialing. NCCAOM will continue its work to fulfill its mission through its national certification programs, exam development and professional development activity programs.

4. Why is the NCCAOM using the term "Herbal Medicine" as opposed to Chinese medicine to replace Oriental medicine in its new name?

The NCCAOM will continue to certify practitioners specifically in Chinese herbal medicine as part of our mission, which has been the case since our inception. The updated name is intended to accurately represent the current certifications we offer —



which include acupuncture, Chinese herbal medicine, and related modalities — while aligning with national and international recognition standards for the profession.

While we recognize and respect the many rich traditions of herbal medicine practiced worldwide, NCCAOM certification is focused on the competencies and standards related to Chinese herbal medicine. Much of TCM is also used in other herbal medicine traditions (ie, Japanese/Kanoo & Korean traditions for example). The name change is meant to convey the depth and breadth of our existing credentials more clearly, not to imply certification in other traditions. In addition, the new name is in sync with recent name changes by national leadership organizations in AHM.

Feedback from Stakeholders

5. Was the public consulted before making this decision?

Yes. In May 2025, we invited public comments and received extensive feedback from Diplomates and stakeholders. The **majority supported the change**, highlighting its relevance, accuracy, and cultural sensitivity.

6. What were the main concerns from those who opposed the change?

Some stakeholders expressed concerns about potential regulatory and legislative impacts, such as the need to update state or federal language that references the former name. Please see Question 8.

Regulatory Impact of Name Change

7. How will NCBAHM address potential regulatory issue

We are actively working with **state associations and regulatory bodies** to support the transition. Our team is committed to helping stakeholders update language in laws and regulations to reflect the new organizational name. We understand the complexities and challenges involved with updating state legislation to reflect the new name, and we are well aware that this work will need to be done gradually, carefully and strategically. We are fully prepared to work with each state to address these changes gradually. Our approach will be collaborative and tailored to each state's circumstances, ensuring that we move forward in a way that protects the profession and minimizes vulnerability.

The intent behind the name change is to strengthen recognition of the full scope of the profession nationally and internationally, and we are committed to supporting states throughout the transition process.



How will the Name Change Affect Diplomates?

8. Does this affect certification or credentialing for current Diplomates?

No. Your certification remains valid and unchanged. While the organization's name has been updated, all current exams, policies and processes continue under the same accredited national standards.

9. Will the credential "Diplomate of Oriental Medicine" change?

The NCCAOM is planning to change "Diplomate of Oriental Medicine (OM)" to "Diplomate of Acupuncture and Herbal Medicine" in 2026. We will provide **guidance to Diplomates** of OM on how to reference their board certification appropriately during this transition. We will also be updating the "Diplomate of Oriental Medicine" designation. Until then, Diplomates of OM will continue to use this credential until the announcement in 2026.

10. Will I receive a new certificate when the name change goes into effect?

We anticipate beginning the rollout of the new branding — including Diplomate digital badges and certificates — in January 2026. At that time, certificates with the updated name and logo will be issued to **newly certified Diplomates and to those completing their recertification process. Diplomates recertified prior to 2026 will use their wall certificates and ID cards until their next recertification process, at which point they will receive their updated credentials with the new NCCAOM name and logo.** Digital badges will be uploaded to **all certified Diplomates** by the end of the first quarter in 2026.

Name Change Impacting Profession

11. What does this change mean for the profession as a whole?

This name change is a significant step in helping acupuncture and herbal medicine gain greater **visibility, integration, and respect** in mainstream U.S. healthcare. The name better represents the **full scope of practice** and helps unify our field nationally and internationally. The NCCAOM has been working actively with the American Society of Acupuncturists on advocating and promoting acupuncturists with federal and state policy makers.

The name change is just one part of a broader, long-term strategy to strengthen the identity of our profession, support licensure, and protect the public. Much of our work is focused on initiatives that directly benefit practitioners and patients, including:



- Collaborating with state and national associations to expand scope of practice and access to services.
- Advocating for Medicare recognition for licensed acupuncturists.
- Partnering with organizations and agencies, such as the Department of Veterans Affairs, to bring acupuncture care to veterans.
- Supporting research, education, and public outreach to increase awareness of the profession's benefits.

12. Who can I contact for more information or support during the transition?

Please reach out to NCCAOM via email publicrelations@thenccaom.org for any questions or assistance related to the name change.



Oregon

Tina Kotek, Governor

Oregon Medical Board
1500 SW 1st Ave. Ste 620
Portland, OR 97201-5847
Voice (971) 673-2700
FAX (971) 673-2670
www.oregon.gov/OMB

Approved by the Board on October XXX, 2025.

ACUPUNCTURE ADVISORY COMMITTEE
SEPTEMBER 12, 2025
VIDEOCONFERENCE MEETING AGENDA
NOON

The mission of the Oregon Medical Board is to protect the health, safety, and wellbeing of Oregon citizens by regulating the practice of medicine in a manner that promotes access to quality care.

PUBLIC SESSION

1	Call to Order	Behall

Dr. Behall, Chair, called the meeting to order at 12:02 p.m. and called the roll.

The following members were present:

Diane Behall, LAc, DAOM, Chair

Lisa Tongel, LAc

Dilip Babu, MD

Paul Yutan, MD (left around 1:00PM)

Carli Gaines, LAc, RN

Staff present:

Elizabeth Ross, Legislative & Policy Analyst

Netia N. Miles, Licensing Manager

Shayne Nylund, Committee Coordinator

Jordana Gaumond, MD, Medical Director

Nicole Krishnaswami, JD, Executive Director (arrived around 1:40PM)

Note: All vote tallies are shown as follows: Ayes – Nays – Abstentions – Absentees.

1	Public Comments	Behall

Dr. Behall opened the floor to public comments.

Letty Dogheart introduced themselves as a disabled veteran, community healthcare worker, health educator, and community herbalist originally from Coahuila who has been living in Multnomah Territory for 13 years. They were trained in 5NP through the Canoe Journey Herbalists in Puyallup territory and have provided 5NP care at Canoe Journey events and other tribal events in coastal Salish lands. Dogheart expressed strong support for the implementation of 5NP, emphasizing the critical need for community members to have access to care providers that look like them. Dogheart shared a recent example of working with migrant farm workers and described how these workers are under tremendous stress. While they were able to offer auricular seeds on the five points, they noted that these individuals really needed the full needling treatment and had to be referred to other resources. Dogheart emphasized that at that moment, they could have provided complete 5NP treatment in a safe community space. Dogheart concluded by stressing the importance of accessible training requirements that work with busy community schedules and expressed appreciation for all the work that had brought the legislation this far.

Karina Natalie Arndt, an emeritus acupuncturist licensed since 1987, acknowledged the painful reality of widespread suffering from substance abuse, mental health issues, and trauma, expressing that everyone present wanted to see improvement in these areas and recognizing 5NP as a useful tool. However, they raised significant legal concerns about HB 2143's language after consulting with Stephen Kafoury, who served as the acupuncturist lobbyist for over 20 years and has extensive experience in legislative law. Noting HB 2143 does not explicitly define or state that 5NP is not the practice of acupuncture, creating legal ambiguity as acupuncture is defined as "putting needles into people" and 5NP involves inserting needles into people. This uncertainty led Arndt to propose three implementation models in a written submission: Model A featuring minimal training with easy access and no supervision; Model B involving small amounts of training with clinical supervision; and Model C requiring moderate training for independent practitioners. They recommended Model B, believing it would allow practitioners to become certified quickly while providing better assurance for patient safety, patient rights, and quality of care. They suggested maximizing mobility for supervision, drawing from their nursing experience 40 years ago when they performed complex procedures in home settings, and proposed mobile units connected with acupuncture clinics to provide oversight for community-based technicians.

Jennie Brixey identified themselves as a program specialist for Native American and Alaska Native communities at the Multnomah County Health Department, though they emphasized they were speaking as an individual community member rather than representing their employer. They described their role as a longtime community health worker in the Portland Native community and a registered traditional health worker with the Oregon Health Authority. Brixey shared that they had personally benefited from acupuncture and ear seeds during their own healing process, making this support deeply personal. They expressed strong concerns about requiring acupuncturist supervision, viewing it as a significant barrier to access. Brixey explained that while many urban tribal community members can access these services on reservations, many people are far from their homelands and living in the city. They described community health workers ready to do this training and emphasized that these are highly skilled individuals who have completed their own training programs and are trusted members of their community. Brixey concluded by

Note: All vote tallies are shown as follows: Ayes – Nays – Abstentions – Absentees.

expressing gratitude for the time and energy being invested in this process while acknowledging it would be a contentious topic.

Susan Williams, an Oregon resident who served as chair of the Arizona Acupuncture Board of Examiners in 2021 described how Arizona's board worked closely with stakeholders including licensed acupuncturists, addiction treatment professionals, and others to successfully pass a bill to clarify the role of acupuncture detoxification specialists (ADSs). Williams reported impressive results from Arizona's implementation: the number of ADSs increased by 45.7% since implementation, and in the four-plus years since the law took effect, there have been zero consumer or other complaints filed with the board. They described 5NP as "a no-harm form of treatment that can easily be learned by lay individuals, broadly accessible in many types of environments, and administered in a wide range of environments." Their passion for the work stemmed from personal tragedy—despite their privileged life, the opioid epidemic touched them seven times with overdose deaths and motivated them to champion greater accessibility to auricular acupuncture treatment. Through their acupuncture training in Portland and researching the National Acupuncture Detoxification Association, they became convinced that auricular acupuncture could be lifesaving in responding to the opioid crisis.

Margeaux Fraasa, a consultant and contractor with the NAYA Program of CAPACES Leadership Institute in the Willamette Valley, spoke primarily from their work with migrant Indigenous communities. They explained that NAYA is a traditional education program where all staff and the community they serve are migrant Indigenous peoples, many working as farmworkers in the local area. Fraasa provided cultural context, explaining that while acupuncture has lineage from the Asian continent, many of their migrant Indigenous communities have similar ancestral practices involving needles from maguey (agave) or lime trees used on pressure points by traditional healers to promote movement and healing of physical pain or trapped emotional trauma. They highlighted significant access barriers, noting that acupuncture and natural health practices, like home births, are often more accessible to people of privilege rather than low-income or historically oppressed communities. Fraasa described multiple barriers facing community members, including language barriers and historical oppression within Western medical system spaces. They emphasized seeing tremendous need for this type of support and having community health workers on their team who are ready to show up and support their community. Fraasa viewed 5NP as having ancestral roots in supporting people through natural ways of aligning the body and its health. They agreed with other commenters that acupuncturist supervision would be very limiting to the certification process.

Whitsitt Goodson brought multiple professional perspectives as a licensed acupuncturist working at Working Class Acupuncture in Portland, faculty member at POCA Technical Institute, board member of the Oregon Association of Acupuncturists (OAA), and active participant in the 5NP Workgroup. Having been involved in 5NP efforts almost from the beginning in Oregon, Goodson endorsed the Workgroup's recommendations as substantially representing their viewpoints and described them as quite effective at promoting public safety and regulating 5NP technicians. They emphasized the critical importance of maintaining minimal barriers and ensuring patient access, explaining that 5NP targets people who already face far too many barriers to accessing any kind of medical care. Goodson characterized 5NP as non-diagnostic, very simple, and inherently very safe, creating a pathway to connect with hard-to-reach populations during what they described as a crisis of mental health and addiction. They concluded by encouraging the Committee to keep patient access and simplicity as primary considerations, viewing 5NP as a potentially life-saving tool for people in need.

Note: All vote tallies are shown as follows: Ayes – Nays – Abstentions – Absentees.

Dr. Jen Kearns brought 20 years of acupuncture experience, including work with Michael Smith at Lincoln Recovery Center, serving as a peer mentor at Rikers Island in New York, and running various pop-up veterans' clinics for PTSD and pain using 5NP. As the only Workgroup member bringing concerns to the rulemaking discussions, Kearns is a proponent of community health and understands communities are in need but expressed serious reservations about the current bill's structure as poorly written and unclear. Kearns emphasized that while everyone referenced positive contexts where 5NP treatment had been successful, the current bill does not contain those protective contexts. Their primary concern was that anyone 18 years or older could perform the procedure anywhere, in any setting, which they found unsafe. They argued that boundaries were necessary and recommended supervision by either an acupuncturist or medical doctor to provide malpractice coverage, clinical settings. While acknowledging Oregon's excellent Medicaid system and substantial acupuncture coverage, Kearns worried about offering what they termed a band-aid, sending someone into the community as a medical provider with minimal training could be as damaging as providing inadequate care to the most vulnerable populations. They expressed concern that this doesn't ensure access to other healthcare or guidance toward additional services, and worried about implementation expanding beyond its intended context into settings like yoga studios and coffee shops. Despite supporting the concept, they felt the bill didn't hit the mark and needed better structure.

Zachary Krebs spoke as both a brain surgery survivor and chronic pain patient, as well as the owner of a small acupuncture clinic in Oregon. After their surgery, Krebs spent months learning to walk again while dealing with double vision and daily chronic pain, crediting acupuncture with helping calm their nervous system and enabling them to keep moving forward. This experience fostered their strong belief in the 5NP and its potential usefulness in Oregon. Krebs emphasized that 5NP is already successfully used in many other states because it works and is safe, simple, non-pharmaceutical, and cost-free. They highlighted its accessibility through group settings to people who might never enter a traditional acupuncture clinic, often the people who need it most. They specifically identified people battling addiction, in recovery programs, trauma survivors, experiencing homelessness, and others in marginalized communities who are too often excluded from the healthcare system. They argued that Oregon's implementation must avoid artificial barriers, specifically opposing required acupuncturist supervision or unnecessary additional training hours that wouldn't make the protocol safer. Krebs pointed out that acupuncturists aren't available everywhere, especially in rural or underserved communities, making gatekeeping of this simple, safe, community-based treatment counterproductive. Speaking as both a healthcare professional and someone who had lived through pain, they described understanding how small acts of relief can feel like lifelines, viewing the 5NP as a potential lifeline for thousands of Oregonians, especially those that society too often leaves behind.

Sonya Gregg, co-director of POCA Technical Institute, spoke from experience attempting to address healthcare access gaps through acupuncturist training. Their school's mission focuses on recruiting and training students to provide acupuncture to underserved communities, but they acknowledged the harsh reality that they simply don't have the capacity to train enough licensed acupuncturists to address the opioid epidemic. Gregg characterized 5NP as a safe, low-barrier treatment that could support communities across Oregon, particularly in far-reaching areas where no other options exist. They emphasized that training community members such as recovery mentors and traditional health workers to provide 5NP would make treatment accessible to communities that licensed acupuncturists cannot

Note: All vote tallies are shown as follows: Ayes – Nays – Abstentions – Absentees.

reach. They specifically supported the POCA or NADA training model with their specified hourly requirements, urging the Committee not to create additional barriers like direct supervision or increased training hours. Gregg advocated for trained technicians to have complete autonomy to apply 5NP in any setting they deem appropriate without direct oversight, concluding with a sincere encouragement for the Committee to vote in favor of trained 5NP technician autonomy.

Lara Pacheco, an acupuncturist working for Working Class Acupuncture in partnership with CODA (a substance use support program), provided both 5NP and broader acupuncture services through this collaboration. Speaking as an Indigenous, Latinx person, they emphasized the critical importance of communities providing care for themselves through simple and effective methods like 5NP. Pacheco echoed many previous speakers about the importance of lowering barriers and removing supervision requirements, noting that multiple states have successfully implemented similar programs without safety issues. They shared that several of their patients who are struggling with addiction are "more than thrilled to learn this really simple and effective, safe protocol to keep on providing it for their communities." They assured the Committee that there would be no end to demand for acupuncture services in general, indicating no concern about professional competition. Their testimony emphasized the need to make this care accessible to the people who need it most by putting it directly in the hands of community members, concluding with strong advocacy for lowering barriers, removing clinical supervision requirements, and enabling community-based care delivery.

Maddie Foley brought multiple perspectives as treasurer of the Oregon Association of Acupuncturists (OAA), an integral participant in passing House Bill 2143, a member of the 5NP Workgroup, and a practicing acupuncturist in Lane County. They emphasized speaking as an individual rather than representing the organizations with which they're affiliated. Foley directly challenged arguments they had heard supporting supervision requirements, particularly claims about sufficient numbers of acupuncturists and robust Medicaid coverage, stating these arguments were not in line with reality. They reported that their clinic is one of the only clinics in Lane County that accepts Medicaid, and while there are plenty of acupuncturists in the area, very few work with Medicaid patients. This creates a significant gap between the theoretical availability of care and actual access, particularly given the severe addiction and mental health problems in Lane County. Drawing from their volunteer work providing 5NP in both hospital acute detox and inpatient residential settings, Foley offered practical insights into supervision requirements. While expressing love for 5NP, they noted that as a practicing doctor of acupuncture and Chinese medicine, supervising the simple 5NP day in and day out would not be professionally stimulating, and they wouldn't want to spend two hours weekly supervising capable technicians performing what amounts to 5 points in each ear. Foley emphasized that the law was developed in collaboration with the OAA and incorporated recommendations from other states with implementation experience, noting that other states were actively working to dismantle the types of regulations being considered for Oregon implementation.

Chris Monteiro, a licensed acupuncturist practicing in Rhode Island, brought the perspective of someone who had participated in similar legislative efforts in their state. They noted that while Oregon's proposed law was superior to Rhode Island's because it would allow more people to use 5NP, Rhode Island's law had been successfully operating for approximately four years. Monteiro reported that Rhode Island had trained several hundred people including social workers, mental health counselors, peer recovery counselors, and licensed drug and alcohol counselors, with no complaints or problems arising. They

Note: All vote tallies are shown as follows: Ayes – Nays – Abstentions – Absentees.

expressed a wish that more people could access this tool in Rhode Island and noted they had legislation pending to increase availability to other trained individuals. As a POCA trainer, Monteiro emphasized that their training, which includes practice sessions to hone skills, had proven adequate to provide safe and effective preparation. They described building a supportive community that supports one another as they continue developing this work. They expressed excitement about Oregon's thorough process to ensure rules would facilitate easy 5NP implementation.

Adriana Locke, a 5NP Workgroup member and licensed acupuncturist who owns and operates Zocalo Wellness (described as a majority OHP clinic), spoke to their experience providing culturally specific healthcare and their mission to diversify the acupuncture profession. Their clinic focuses on providing living wage jobs to diverse acupuncturists to keep them in Oregon, specifically targeting acupuncturists of color, trans and queer non-binary acupuncturists, and Native acupuncturists. Locke provided insight into the homogeneity of Oregon's acupuncture profession, noting there are very few acupuncturists of color and very few who can provide culturally specific care. They described the barriers to obtaining an acupuncture license as "incredible," sharing that they personally carry six figures of debt from their education. This context informed their argument that requiring acupuncturists to provide 5NP in culturally specific situations—such as on reservations, in Native communities, or in Indigenous migrant communities—is simply unreasonable because such practitioners don't exist in sufficient numbers. They characterized the 5NP opportunity as amazing for expanding access without expanding barriers, expressing personal investment in seeing culturally specific, linguistically specific providers delivering accessible medicine that acupuncturists in Oregon are not currently positioned to provide. While acknowledging Oregon's OHP system and acupuncture coverage, Locke emphasized that significant barriers remain, including authorization requirements and the challenge of building trust. They noted receiving referrals from white acupuncturists who had damaged relationships with communities of color through culturally inappropriate care, emphasizing that these same practitioners would not be suitable supervisors for community-based 5NP providers.

Michaela Foley spoke as POCA Cooperative's legislative liaison and trainer, working annually with thousands of auricular acupuncture technicians across the country and internationally. They emphasized 5NP's compatibility with culturally specific care paradigms and solidarity models needed in current times, arguing that acupuncturists simply lack the people power to meet existing needs. Having recently graduated from acupuncture school themselves and being in the midst of board examinations, Foley spoke personally about the financial and educational barriers to becoming an acupuncturist. They explained that the debt burden acupuncturists face, combined with the income requirements to pay off that debt, makes it unrealistic for professional acupuncturists to supervise 5NP treatments in the volume and manner needed. They noted that professional acupuncturists and medical professionals are already stretched too thin to provide the oversight that would be required. Drawing from their work with other states' legislation, Foley reported that states with the least restrictive rules and regulations experience the most success. As the person who personally handles all complaints received by POCA, they provided important safety data: they had never received a safety complaint, only minor interpersonal complaints occasionally. They emphasized that POCA maintains a rigorous training program that doesn't allow unqualified practitioners to practice, expressing excitement about bringing this proven model to Oregon communities that desperately need this therapy.

Note: All vote tallies are shown as follows: Ayes – Nays – Abstentions – Absentees.

Rebecca Davis, an acupuncturist who co-owns a small clinic and works as a mental health administrator, provided perspective from both the acupuncture and mental health fields. Davis reported that therapists in their area had expressed interest in becoming 5NP trained, particularly to treat young people experiencing significant mental health challenges. Davis attested to the substantial difficulties young people face accessing mental health appointments due to scheduling constraints and insurance limitations around acupuncture reimbursement for providers. Their testimony emphasized supporting accessibility from a mental health field perspective, viewing 5NP as an important tool for addressing gaps in youth mental health services.

There were other members of the public in attendance; however, they did not comment.

OREGON ADMINISTRATIVE RULES (OAR)

3	Chapter 847, Division 070, 008, and 010	FIRST REVIEW	Gaines
The proposed rulemaking implements SB 874(2025) adding a definition for “Traditional Eastern medicine” to provide cohesion and clarify the OMB’s authority to regulate acupuncturists. The bill replaced the term “Oriental medicine” with “Traditional Eastern medicine” throughout ORS chapter 677. The bill also clarifies the definition of "acupuncture" and updates the Oregon Association of Acupuncturists name. SB 874 did not change the scope of practice for acupuncturists in Oregon. Additionally, the National Certification Commission for Acupuncture and Oriental Medicine (NCCAOM) is changing their name to the National Certification Board for Acupuncture and Herbal Medicine (NCBAHM) in January 2026. The proposed rule also makes this update. Their exam titles, including Foundations of Oriental Medicine, will remain the same.			

The Committee reviewed Chapter 847, Division 070, 008, and 010. Ms. Gaines noted the changes were straightforward and praised the more specific acupuncture definition.

RECOMMENDATION: Ms. Gaines moved the Committee recommend filing a notice of proposed rulemaking on Chapter 847, Division 070, 008, and 010 as written. Dr. Babu seconded the motion. Dr. Behall, Dr. Yutan, Ms. Tongel, Ms. Gaines and Dr. Babu voted “aye”. The motion passed 5-0-0-0.

4	Five-Needle Protocol	FIRST REVIEW	Babu
The Oregon Legislature passed House Bill 2143 (2025) and Governor Kotek signed the bill into law. This legislation allows individuals with specific training and registration to provide five-needle protocol (5NP) treatments beginning March 1, 2026, without additional licensure. The law directs the Oregon Medical Board to establish rules for training qualifications and safety standards. The OMB's role is to implement the law that has already been enacted. The proposed rulemaking establishes the qualifications for registration of 5NP technicians and creates sanitation and best practice standards for 5NP treatments.			

Note: All vote tallies are shown as follows: Ayes – Nays – Abstentions – Absentees.

In August and September 2025, the OMB convened a Workgroup of acupuncturists, physicians, and community members to provide recommendations on the draft rules. Their meeting minutes are attached along with public comments received during their review.

Additionally, HB 2143 authorizes the OMB to establish registration and renewal fees 5NP technicians. The proposed fee rulemaking sets fees at \$100 for initial registration and \$50 annually (\$100 biennially) for renewal starting March 1, 2026. The Board determined and provided the fee amounts during the legislative process based on estimated costs to implement HB 2143. The Board will apply its existing Criminal Records Check Fee to 5NP technicians during the initial application process and as needed for renewals or investigations, as permitted under HB 2143.

The Committee discussed implementing House Bill 2143, which authorizes Five-Needle Protocol treatments beginning March 1, 2026. Dr. Dilip Babu presented the Workgroup's findings from extensive August-September 2025 meetings involving acupuncturists, physicians, and community members.

Dr. Babu outlined nine proposed rules covering the complete regulatory framework. The rules establish a purpose statement defining 5NP for treating substance use disorder, mental health conditions, and trauma. Key definitions include the 5NP protocol itself and 5NP technician qualifications. Licensed acupuncturists and physicians may practice 5NP without additional registration under this new system. The qualification requirements include a minimum age of 18, completion of 30 hours of didactic training plus 40 supervised treatment sessions, and good moral character standards. Criminal history does not automatically disqualify candidates. Registration fees were set at \$100 initially, with renewal costs of \$50 annually or \$100 biennially starting March 1, 2026.

Dr. Paul Yutan opened the discussion by stating this was a robust discussion and he felt honored to be a part of it. Dr. Yutan provided his experience with 5NP has mostly been with the VA, and it's been very effective. He noted all the points of the community are well heard, and he was okay with the rules as provided. *Dr. Yutan then left the meeting.*

Carli Gaines started by praising the Workgroup's efforts and the clear definition of 5NP, which she felt left no room for misinterpretation. However, she raised concerns about supervision, noting this was a major theme in public comments. Gaines argued that while she didn't believe supervision should be limited to acupuncturists, some form of clinical oversight was necessary. She drew parallels to other healthcare roles like phlebotomists and medical assistants, noting these positions require direct supervision despite similar entry-level requirements. Gaines also commented that many states allowing 5NP certifications require the person to already be a licensed provider.

Lisa Tongel presented a contrasting viewpoint, emphasizing the bill's intent to provide access to marginalized communities through culturally and linguistically specific care. She expressed concern that supervision requirements would create barriers contrary to the legislation's purpose and could be culturally insensitive. She highlighted the minimal incident reports from other states that had

Note: All vote tallies are shown as follows: Ayes – Nays – Abstentions – Absentees.

implemented similar programs and expressed trust in POCA and NADA organizations to address safety concerns adequately during the training.

Dr. Babu acknowledged the supervision debate as a central theme in Workgroup discussions. As a physician focused on patient safety, he had carefully examined safety concerns but remained unclear about specific risks associated with 5NP. He noted the treatment appeared safer than many procedures in his medical practice and cited successful implementation in other states without significant safety complaints. Dr. Babu emphasized his priority was removing barriers to increase access for Oregonians, particularly given the devastating effects of substance use disorders he witnesses in his practice.

Dr. Behall articulated specific safety scenarios that concerned her, including needle shock, fainting, and mental health crises. Drawing from her experience in chronic pain management with lower-income populations, she emphasized that complex cases always arise, requiring experienced medical judgment. While acknowledging 5NP's straightforward nature, she stressed the importance of having backup support for unexpected situations. She suggested supervision didn't necessarily require on-site presence but could involve accessible medical directors or clinical supervisors.

The discussion also reviewed the training structure outlined in the draft rules. The rules require the 40 treatment sessions occur during the training course under direct supervision of a 5NP trainer, not as independent community practice. The training curriculum also includes elements to address potential risks, side effects, and complications, as well as trauma-informed care components.

The Committee also discussed concerns regarding needle removal procedures. The draft consent form allowed either the technician or patient to remove needles, reflecting current practice in some 5NP settings. Ms. Gaines and Dr. Behall expressed concerns, noting this deviates from standard medical protocols and creates potential needle-stick injury risks. They would prefer technician-only needle removal.

OMB Executive Director, Nicole Krishnaswami, clarified that the legislation intended for 5NP technicians not to be supervised. During the legislative process, lawmakers considered models ranging from complete deregulation to supervised practice, ultimately choosing the independent model with registration and standards set by the OMB. She commented that adding supervision requirements would require new legislative action, as this would exceed the board's statutory authority. Ms. Gaines noted this legislative clarification resolved concerns about supervision, as it became clear such requirements were outside the Oregon Medical Board's rulemaking authority.

OMB staff explained that the Committee was making first review recommendations to the board for October consideration, with final Committee review scheduled for December, after public comment collection.

RECOMMENDATION: Dr. Babu moved the Committee recommend filing a notice of proposed rulemaking on Chapter 847, Division 71, Rules 0, 5, 7, 20, 25, 30, 35, 40, and 50, and Division 5, Rule 5. Ms. Gaines seconded the motion. Dr. Babu, Ms. Gaines and Ms. Tongel voted “aye”. Dr. Behall voted “nay”. Dr. Yutan was absent by prior notification. The motion passed 3-1-0-1.

Note: All vote tallies are shown as follows: Ayes – Nays – Abstentions – Absentees.

5	Review of 5NP Supporting Materials	Babu

Dr. Babu introduced the 5NP supporting materials. There was no discussion from the Committee.

ADJOURN @ 2:06 p.m.

DRAFT

OREGON ADMINISTRATIVE RULES

CHAPTER 847, DIVISION 035 – OREGON MEDICAL BOARD

First Review – October 2025

On May 16, 2025, the EMS Committee reviewed if an Emergency Medical Technician (EMT) may access medication vials, with a syringe and needle, and draw up a medication for an on-scene Paramedic. The EMS Committee concluded EMTs should not be pulling up medications from vials, unless preloaded, except epinephrine as provided in the current rule. The EMS Committee requested a draft a rule amendment to add “single dose” to the current rule.

The proposed amendment clarifies that an EMT may assist the on-scene Advanced EMT, EMT-Intermediate, or Paramedic by opening, assembling and uncapping preloaded single dose medication syringes and vials.

847-035-0030

Scope of Practice

- (1) The Oregon Medical Board has established a scope of practice for emergency and nonemergency care for emergency medical services providers. Emergency medical services providers may provide emergency and nonemergency care in the course of providing prehospital care as an incident of the operation of ambulance and as incidents of other public or private safety duties, but is not limited to "emergency care" as defined in OAR 847-035-0001.
- (2) The scope of practice for emergency medical services providers is the maximum functions which may be assigned to an emergency medical services provider by a Board-approved supervising physician. The scope of practice is not a set of statewide standing orders, protocols, or curriculum.
- (3) Supervising physicians may not assign functions exceeding the scope of practice; however, they may limit the functions within the scope at their discretion.
- (4) Standing orders for an individual emergency medical services provider may be requested by the Board or Authority and must be furnished upon request.
- (5) An emergency medical services provider, including an Emergency Medical Responder, may not function without assigned standing orders issued by a Board-approved supervising physician.
- (6) An emergency medical services provider, acting through standing orders, must respect the patient’s wishes including life-sustaining treatments. Physician-supervised emergency medical services providers must request and honor life-sustaining treatment orders executed pursuant to ORS 127.663 through 127.684 if available. A patient with life-sustaining treatment orders always requires respect, comfort and hygienic care.

(7) Whenever possible, medications should be prepared by the emergency medical services provider who will administer the medication to the patient.

(8) An **Emergency Medical Responder** may:

- (a) Conduct primary and secondary patient examinations;
- (b) Take and record vital signs;
- (c) Utilize noninvasive diagnostic devices in accordance with manufacturer's recommendation;
- (d) Open and maintain an airway by positioning the patient's head;
- (e) Provide external cardiopulmonary resuscitation and obstructed airway care for infants, children, and adults;
- (f) Provide care for musculoskeletal injuries;
- (g) Provide hemorrhage control;
- (h) Provide emergency moves for endangered patients;
- (i) Assist with prehospital childbirth;
- (j) Complete a clear and accurate prehospital emergency care report form on all patient contacts and provide a copy of that report to the senior emergency medical services provider with the transporting ambulance;
- (k) Administer medical oxygen;
- (L) Maintain an open airway through the use of:
 - (A) A nasopharyngeal airway device;
 - (B) An oropharyngeal airway device;
 - (C) A pharyngeal suctioning device;
- (m) Operate a bag mask ventilation device with reservoir;
- (n) Provide care for suspected medical emergencies, including administering liquid oral glucose for hypoglycemia;
- (o) Prepare and administer aspirin by mouth for suspected myocardial infarction (MI) in patients with no known history of allergy to aspirin or recent gastrointestinal bleed;
- (p) Prepare and administer epinephrine by automatic injection device for anaphylaxis;

(q) Administer and distribute short-acting opioid antagonist kit and distribute the necessary medical supplies to administer the short-acting opioid antagonist as provided in ORS 689.800;

(r) Perform cardiac defibrillation with an automated external defibrillator; and

(s) Perform other emergency tasks as requested if under the direct visual supervision of a physician and then only under the order of that physician.

(9) An **Emergency Medical Technician (EMT)** may:

(a) Perform all procedures that an Emergency Medical Responder may perform;

(b) Ventilate with a non-invasive manual or continuous positive pressure delivery device;

(c) Insert a supraglottic airway device to facilitate ventilation through the glottic opening by displacing tissue and sealing of the laryngeal area;

(d) Perform tracheobronchial tube suctioning;

(e) Provide care for suspected shock;

(f) Provide care for suspected medical emergencies, including:

(A) Obtain a capillary blood specimen for blood glucose monitoring;

(B) Prepare and administer epinephrine for anaphylaxis;

(C) Administer activated charcoal for poisonings; and

(D) Prepare and administer nebulized and metered dose albuterol or levalbuterol with or without ipratropium for known asthmatic and chronic obstructive pulmonary disease (COPD) patients suffering from suspected bronchospasm.

(g) Transport stable patients with saline locks, heparin locks, foley catheters, or in-dwelling vascular devices;

(h) Assist the on-scene Advanced EMT, EMT-Intermediate, or Paramedic by:

(A) Assembling and priming IV fluid administration sets; and

(B) Opening, assembling and uncapping preloaded **single dose** medication syringes and vials;

(i) Complete a clear and accurate prehospital emergency care report form on all patient contacts;

(j) Assist a patient with administration of sublingual nitroglycerine tablets or spray and with metered dose inhalers that have been previously prescribed by that patient's personal physician

and that are in the possession of the patient at the time the EMT is summoned to assist that patient;

(k) In the event of a release of organophosphate agents, the EMT who has completed Authority-approved training may prepare and administer atropine sulfate and pralidoxime chloride by autoinjector, using protocols approved by the Authority and adopted by the supervising physician;

(L) In the event of a declared Mass Casualty Incident (MCI) as defined in the local Mass Casualty Incident plan, monitor patients who have isotonic intravenous fluids flowing;

(m) Administer over-the-counter medications in unit dose packaging for immediate use under specific written protocols authorized by the supervising physician or direct orders from a licensed physician;

(n) Acquire and transmit cardiac monitoring and electrocardiogram (ECG);

(o) Prepare and administer immunizations in the event of an outbreak or epidemic as declared by the Governor of the state of Oregon, the State Public Health Officer or a county health officer, as part of an emergency immunization program, under the agency's supervising physician's standing order. Prior to vaccine administration, the EMT must be trained by the supervising physician or their designee. The EMT and the EMS agency or employer must maintain records of training; and

(p) Prepare and administer immunizations for seasonal and pandemic influenza vaccinations according to the CDC Advisory Committee on Immunization Practices (ACIP), and/or the Oregon State Public Health Officer's recommended immunization guidelines as directed by the agency's supervising physician's standing order. Prior to vaccine administration, the EMT must be trained by the supervising physician or their designee. The EMT and the EMS agency or employer must maintain records of training.

(10) An **Advanced Emergency Medical Technician (AEMT)** may:

(a) Perform all procedures that an EMT may perform;

(b) Initiate and maintain peripheral intravenous (I.V.) lines;

(c) Initiate saline or similar locks;

(d) Obtain peripheral venous blood specimens;

(e) Initiate and maintain an intraosseous infusion;

(f) Prepare and administer the following medications under specific written protocols authorized by the supervising physician or direct orders from a licensed physician:

(A) Analgesics for acute pain: nitrous oxide;

(B) Hypoglycemia reversal agents:

(i) Hypertonic dextrose;

(ii) Glucagon;

(C) Intraosseous infusion anesthetic: Lidocaine;

(D) Bronchodilators:

(i) Albuterol or levalbuterol;

(ii) Ipratropium bromide;

(E) Vasodilators for cardiac chest pain: Sublingual nitroglycerine; and

(F) Isotonic crystalloid solutions.

(g) Distribute medications at the direction of the Oregon State Public Health Officer as a component of a mass distribution effort. The AEMT must be trained by the supervising physician or their designee. The AEMT and the EMS agency or employer must maintain records of training; and

(h) Prepare and administer routine or emergency immunizations and tuberculosis skin testing, as part of an EMS Agency's occupational health program, to the AEMT's EMS agency personnel, under the supervising physician's standing order. Prior to administration, the AEMT must be trained by the supervising physician or their designee. The AEMT and the EMS agency or employer must maintain records of training.

(11) An **EMT-Intermediate** may:

(a) Perform all procedures that an Advanced EMT may perform;

(b) Prepare and administer the following medications under specific written protocols authorized by the supervising physician, or direct orders from a licensed physician:

(A) Vasoactive medications for cardiac arrest:

(i) Epinephrine;

(ii) Vasopressin;

(B) Antiarrhythmics:

(i) Atropine sulfate;

(ii) Lidocaine;

(iii) Amiodarone;

(C) Analgesics for acute pain:

(i) Morphine;

(ii) Ketorolac tromethamine;

(iii) Fentanyl;

(D) Antihistamine: Diphenhydramine;

(E) Diuretic: Furosemide;

(F) Anti-Emetic: Ondansetron;

(c) Insert an orogastric tube;

(d) Maintain during transport any intravenous medication infusions or other procedures which were initiated in a medical facility, if clear and understandable written and verbal instructions for such maintenance have been provided by the physician, nurse practitioner or physician associate at the sending medical facility;

(e) Perform electrocardiographic rhythm interpretation;

(f) Perform cardiac defibrillation with a manual defibrillator; and

(g) Administer benzodiazepines for seizures or agitation. Prior to administration of benzodiazepines, the EMT-I must be trained by the supervising physician or their designee. The EMT-I and the EMS agency or employer must maintain records of training.

(12) A **Paramedic** may:

(a) Perform all procedures that an EMT-Intermediate may perform;

(b) Initiate and maintain mechanical ventilation during transport if formally trained on the particular equipment and if acting under written protocols specific to the particular equipment;

(c) Initiate the following airway management techniques:

(A) Endotracheal intubation;

(B) Cricothyrotomy; and

- (C) Transtracheal jet insufflation which may be used when no other mechanism is available for establishing an airway;
- (d) Initiate a nasogastric tube;
- (e) Provide advanced life support in the resuscitation of patients in cardiac arrest;
- (f) Perform emergency cardioversion in the compromised patient;
- (g) Transcutaneous pacing of bradycardia that is causing hemodynamic compromise;
- (h) Initiate needle thoracostomy for tension pneumothorax;
- (i) Obtain peripheral arterial blood specimens under specific written protocols authorized by the supervising physician;
- (j) Access indwelling catheters and implanted central IV ports for fluid and medication administration;
- (k) Initiate and maintain urinary catheters under specific written protocols authorized by the supervising physician or under direct orders from a licensed physician;
- (L) Prepare and initiate or administer any medications or blood products under specific written protocols authorized by the supervising physician or under direct orders from a licensed physician; and
- (m) Interpret electrocardiogram (ECG).

Statutory/Other Authority: ORS 682.245

Statutes/Other Implemented: ORS 682.245, ORS 127.663 & ORS 127.666

FULL BOARD
OCTOBER 2, 2025
VIDEOCONFERENCE

Public Session

Subject: **Appointment of Luke Welle, MD, to the EMS Advisory
Committee**

EMS ACTION: The Committee moved to nominate Luke Welle, MD, for the physician
member position.

FULL BOARD
OCTOBER 2, 2025
VIDEOCONFERENCE

Public Session

**Subject: Emergency Medical Services Advisory Committee Meeting Minutes from
August 8, 2025**



Oregon

Tina Kotek, Governor

Oregon Medical Board

1500 SW 1st Ave. Ste 620

Portland, OR 97201-5847

Voice (971) 673-2700

FAX (971) 673-2670

www.oregon.gov/OMB

EMERGENCY MEDICAL SERVICES ADVISORY COMMITTEE

AUGUST 8, 2025

VIDEOCONFERENCE MEETING MINUTES

9 A.M.

The mission of the Oregon Medical Board is to protect the health, safety, and wellbeing of Oregon citizens by regulating the practice of medicine in a manner that promotes access to quality care.

PUBLIC SESSION

Call to Order

LEPIN

Michael Lepin, Chair, called the meeting to order at 9:02 a.m. and called the roll.

The following members were present:

Michael Lepin, Paramedic, Chair

Patti Louie, PhD, Public Member

Frank Ehrmantraut, Paramedic

Matthew Neth, MD

Jill Shaw, DO, Board Liaison

Absent: Rusty Riis, Paramedic

A quorum of the Committee was confirmed. There were no conflicts of interest or biases to declare.

Staff present:

Nicole Krishnaswami, JD, Executive Director

Elizabeth Ross, JD, Legislative and Policy Analyst

Shayne Nylund, Committee Coordinator

Jordana Gaumond, MD, Medical Director

Netia N. Miles, Licensing Manager

Guests present:

Sergio Camba, MD

Scott Cooper

Mohamud Daya, MD

Rebecca Long, Oregon Health Authority

David Lehrfeld, MD, Oregon Health Authority

Dave Lapof, Siletz Fire District

Adam Wagner, Oregon Health Authority

Luke Welle, MD

Time Certain: 9:05 a.m.

1	EMS Advisory Committee Open Physician Interview	LEPIN

The Committee interviewed Luke Welle, MD, for the open physician position.

DISCUSSION ITEMS

2	OAR 847-035-0030: Scope of Practice	FIRST REVIEW	LEPIN
Proposed Amendment #1 The Oregon Medical Board’s EMS Advisory Committee on February 21, 2025, reviewed a scope of practice change request to allow EMTs, AEMTs, EMT-Is, and Paramedics to perform nasopharyngeal swabs for the testing of infectious disease. The proposed change would increase access to nasopharyngeal swab testing beyond hospitals and healthcare facilities. EMS providers are trained in managing airways. Additionally, EMS providers were allowed to perform this task during the declared emergency in 2020. There were no complaints or adverse patient safety events recorded during the emergency scope of practice change for this task. Proposed Amendment #2 On May 16, 2025, the EMS Committee reviewed if an Emergency Medical Technician (EMT) may access medication vials, with a syringe and needle, and draw up a medication for an on-scene Paramedic. The EMS Committee concluded EMTs should not be pulling up medications from vials, unless preloaded, except epinephrine as provided in the current rule. The EMS Committee requested a draft a rule amendment to add “single dose” to the current rule. The proposed amendment clarifies that an EMT may assist the on-scene Advanced EMT, EMT-Intermediate, or Paramedic by opening, assembling and uncapping preloaded single dose medication syringes and vials.			

Proposed Amendment #1

The Committee reviewed proposed amendment #1. Mr. Ehrmantraut stated that the Oregon Medical Board (OMB) requested information on patient volumes, infectious diseases being tested, the processes regarding result sharing with health systems, as well as billing procedures and consent processes. He questioned whether this practice aligned with national scope standards. David Lehrfeld, MD, Oregon Health Authority (OHA), noted that hundreds of nasopharyngeal swabs were utilized during the COVID-19 pandemic under emergency scope of practice changes and clarified this practice has been permanently added to the national scope of practice for EMT level and above.

The Committee recommended tabling the discussion on Proposed Amendment #1 in order to review additional data regarding responses to the Board’s inquiries at their meeting on November 11, 2025.

Note: All vote tallies are shown as follows: Ayes – Nays – Abstentions – Absentees.

Proposed Amendment #2

The Committee reviewed proposed amendment #2. Board staff noted that the Committee had previously discussed allowing EMTs to draw from single-dose vials at their meeting in May 2025. Mr. Lepin clarified that the intent of the amendment was to permit drawing from single-dose vials while maintaining restrictions on multi-dose vials with an existing exception for epinephrine in anaphylaxis cases. Mr. Ehrmantraut noted the proposed amendment would allow an EMT to draw a complete 4-milligram dose from a single 4-milligram vial of Zofran.

RECOMMENDATION: Mr. Ehrmantraut moved the Committee recommend filing a notice of proposed rulemaking on OAR 847-035-0030(9)(h)(B) as written. Dr. Neth seconded the motion. Mr. Ehrmantraut, Dr. Louie, Dr. Neth, and Mr. Lepin voted “aye.” Mr. Riis was absent. The motion passed 4-0-0-1.

3	Administering Blood and Blood Products	EHRMANTRAUT

The Committee reviewed questions from Myrtle Point Ambulance regarding EMT-Intermediates administration of blood products during inter-facility transfers. They inquired if EMT-Is could administer blood during transfers, complete ongoing transfusions, start second units, or initiate transfusions that were sent but not started. Dr. Neth stated that EMT-Is could potentially complete already-started transfusions with proper physician guidance on monitoring transfusion reactions; however, initiating new blood products falls under paramedic scope of practice. Additionally, he emphasized the complexity of properly spiking blood bags and the importance of recognizing transfusion reactions.

The Committee confirmed EMT-Is could complete blood transfusions that were already initiated and hanging, provided the sending physician gives appropriate guidance on monitoring parameters. Additionally, the Committee confirmed that starting new units or initiating transfusions exceeded the EMT-I scope of practice.

4	Scope of Practice Change Request: Administering Intranasal Epinephrine for Anaphylaxis at the EMR Level	NETH

The Committee reviewed a scope of practice change request to allow intranasal epinephrine (NEFFY) administration for anaphylaxis at the EMR level and above. The proposal highlighted several advantages including painless administration, similarity to existing naloxone delivery methods, and reduced needle stick injury risk. Additionally, the proposal noted that training requirements would be minimal since the delivery method matched currently used intranasal naloxone procedures, and that the cost was anticipated to be similar to current epinephrine auto-injectors.

Mohamud Daya, MD, stated that intranasal drug formulations require specific safety and pharmacokinetic studies, noting that the intranasal epinephrine dose is two milligrams delivered in a two-dose package. He predicted increased availability of intranasal medications due to their safety and ease of administration. Rebecca Long, OHA, noted that her department is also updating rules to include NEFFY in their severe allergic reaction training protocols for laypersons, which are currently limited to auto-injectors.

Note: All vote tallies are shown as follows: Ayes – Nays – Abstentions – Absentees.

The Committee expressed support for the proposed change request and recommended OMB staff draft rule language for review at their next meeting on November 11, 2025.

5	Scope of Practice Change Request: Requiring EMS Agencies to Carry and Administer Long-Acting Neuromuscular Blocking Agents	LEPIN

The Committee reviewed a scope of practice change request from Metro West EMS, which would allow agencies that carry long-acting neuromuscular blocking agents to also carry sugammadex for emergency paralysis reversal. The proposal suggested mandatory carriage of reversal agents when agencies are authorized to use paralytic medications like rocuronium or vecuronium.

Mr. Lepin and Dr. Neth both agreed this request falls outside the Committee's scope and would be more appropriately addressed as a policy or ambulance requirement. Dr. Daya noted that sugammadex is not typically used to rescue failed airways after paralytic administration and further suggested that its use may interfere with subsequent paralytic medications that might be needed.

The Committee confirmed that the scope of practice request was not within their jurisdiction.

6	Meeting Minutes – Board-Approved Minutes from May 16, 2025	LOUIE

The Committee reviewed the May 16, 2025, meeting minutes. No action taken; informational only.

7	Confirm Next Meeting Date – November 21, 2025	LEPIN

The next meeting date was confirmed as November 21, 2025.

8	Public Comments	LEPIN

No members of the public provided comment.

9	Elect New Committee Member	RIIS

RECOMMENDATION: Mr. Lepin moved that the Committee nominate Luke Well, MD, for the physician member position. Dr. Louie seconded the motion. Mr. Ehrmantraut, Dr. Louie, Dr. Neth, and Mr. Lepin voted “aye.” Mr. Riis was absent. The motion passed 4-0-0-1.

ADJOURN @ 9:46 a.m.

Note: All vote tallies are shown as follows: Ayes – Nays – Abstentions – Absentees.

**FULL BOARD
OCTOBER 2, 2025
VIDEOCONFERENCE**

Public Session

Rule Review

Member Assigned: Shaw

First Review: 847-010-0090; 847-020-0100; 847-020-0120
Subject: Clinical Clerkships and Preceptorships; Definitions;
Basic Requirements for Licensure of an Approved Medical
School Graduate

OREGON ADMINISTRATIVE RULES

CHAPTER 847, DIVISION 010 – OREGON MEDICAL BOARD

First Review – October 2025

The proposed rulemaking implements [SB 476 \(2025\) section 7a](#) which updated the definition for “approved medical school” to include the Committee on Accreditation of Canadian Medical Schools, effective January 1, 2026.

As of July 1, 2025, Canadian medical schools were no longer accredited by the Liaison Committee on Medical Education (through U.S. Department of Education). Without the proposed amendment, Canadian medical school graduates would have to apply for Oregon licensure as an international medical graduate and meet additional requirements.

847-010-0090

Clinical Clerkships and Preceptorships

A medical student may participate in the diagnosis and treatment of Oregon patients under the following circumstances:

(1) The student is enrolled in a medical school accredited by the Liaison Committee on Medical Education, ~~or~~ the Commission on Osteopathic College Accreditation, **or the Committee on Accreditation of Canadian Medical Schools**;

(2) The student is supervised by an actively practicing, Oregon-licensed health care professional in good standing who is qualified and competent to supervise the student’s clinical experience; and

(3) Care is delivered within the scope and context of a course, clerkship, preceptorship or other clinical experience approved by an accredited medical school or affiliated teaching institution in Oregon.

Statutory/Other Authority: ORS 677.265

Statutes/Other Implemented: ORS 677.265 & ORS 677.010

847-020-0100

Definitions

For the purpose of OAR chapter 847, division 020, the following terms are defined:

(1) “Approved school of medicine” means a school offering a full-time resident program of study in medicine or osteopathic medicine leading to a degree of Doctor of Medicine or Doctor of Osteopathic Medicine, such program having been fully accredited or conditionally approved by the Liaison Committee on Medical Education, or its successor agency, or the American

Osteopathic Association, or its successor agency, **or the Committee on Accreditation of Canadian Medical Schools, or its successor agency,** or ~~having been~~ **has** otherwise **been** determined by the Board to meet the association standards.

(2) “School of medicine” means approved schools of medicine (as defined above) and international medical and osteopathic schools.

(3) “Specialty board” means a certification board recognized by the American Board of Medical Specialties (ABMS) or the American Osteopathic Association’s Bureau of Osteopathic Specialties (AOA-BOS).

Statutory/Other Authority: ORS 677.265

Statutes/Other Implemented: ORS 677.010 & ORS 677.265

847-020-0120

Basic Requirements for Licensure of an Approved Medical School Graduate

The following requirements for licensure must be met by graduates of an approved school of medicine:

(1) Must have graduated from an **an approved school of medicine as defined in OAR 847-020-0100** ~~school~~ offering a full-time resident program of study in medicine or osteopathic medicine leading to a degree of Doctor of Medicine or Doctor of Osteopathic Medicine, ~~such program having been fully accredited or conditionally approved by the Liaison Committee of Medical Education, or the American Osteopathic Association, or having been otherwise determined by the Board to meet the association standards;~~

(2) Must satisfactorily complete an approved internship, residency or fellowship in the United States or Canada of at least one year in not more than one training program accredited for internship, residency or fellowship training by the Accreditation Council for Graduate Medical Education, the American Osteopathic Association, the College of Family Physicians of Canada, or the Royal College of Physicians and Surgeons of Canada;

(3) Must pass a written licensing examination as provided in ORS 677.110 and OAR 847-020-0170; and

(4) Must satisfactorily meet the requirements of ORS 677.100.

Statutory/Other Authority: ORS 677.265

Statutes/Other Implemented: ORS 677.100 & ORS 677.110

83rd OREGON LEGISLATIVE ASSEMBLY--2025 Regular Session

Enrolled Senate Bill 476

Sponsored by Senators JAMA, FREDERICK, MANNING JR, NERON, PATTERSON, REYNOLDS;
Senator PHAM K, Representatives GRAYBER, NELSON, TRAN (Presession filed.)

SECTION 7a. If Senate Bill 874 becomes law, section 7 of this 2025 Act (amending ORS 677.010) is repealed and ORS 677.010, as amended by section 1, chapter 344, Oregon Laws 2025 (Enrolled Senate Bill 874), is amended to read:

677.010. As used in this chapter, subject to the exemptions in ORS 677.060 and unless the context requires otherwise:

(1) “Approved internship” means the first year of post-graduate training [*served in a hospital that is approved by the Oregon Medical Board or*] **that is accredited** by the Accreditation Council for Graduate Medical Education or its successor organization, the American Osteopathic Association or its successor organization or the Royal College of Physicians and Surgeons of Canada or its successor organization, **and approved by the Oregon Medical Board.**

(2) “Approved school of medicine” means a school offering a full-time resident program of study in medicine or osteopathic medicine leading to a degree of Doctor of Medicine or Doctor of Osteopathic Medicine, [*such program having been*] **if the program of study is** fully accredited or conditionally approved by the Liaison Committee on Medical Education, or its successor agency, or the American Osteopathic Association, or its successor agency, **or the Committee on Accreditation of Canadian Medical Schools, or its successor agency,** or [*having been otherwise*] **has otherwise been** determined by the board to meet the association standards as specifically incorporated into board rules.

(3) “Approved training program” means a residency program that is accredited by the Accreditation Council of Graduate Medical Education, or its successor organization, the American Osteopathic Association, or its successor organization, or the Royal College of Physicians and Surgeons of Canada, or its successor organization, and approved by the board.

[(3)] (4) “Diagnose” means to examine another person in any manner to determine the source or nature of a disease or other physical or mental condition, or to hold oneself out or represent that a person is so examining another person. It is not necessary that the examination be made in the presence of such other person; the examination may be made on information supplied either directly or indirectly by such other person.

[(4)] (5) “Dispense” means the preparation and delivery of a prescription drug, pursuant to a lawful order of a practitioner, in a suitable container appropriately labeled for subsequent administration to or use by a patient or other individual entitled to receive the prescription drug.

[(5)] (6) “Dispensing physician” means a physician or podiatric physician and surgeon who purchases prescription drugs for the purpose of dispensing them to patients or other individuals entitled to receive the prescription drug and who dispenses them accordingly.

[(6)] (7) “Drug” means all medicines and preparations for internal or external use of humans, intended to be used for the cure, mitigation or prevention of diseases or abnormalities of humans, which are recognized in any published United States Pharmacopoeia or National Formulary, or otherwise established as a drug.

[(7)] (8) “Fellow” means an individual who has not qualified under ORS 677.100 (1) and (2) and who is pursuing some special line of study as part of a supervised program of a school of medicine, a hospital approved for internship or residency training, or an institution for medical research or education that provides for a period of study under the supervision of a responsible member of that hospital or institution, such school, hospital or institution having been approved by the board.

[(8)] (9) “Intern” means an individual who has entered into a hospital or hospitals for the first year of post-graduate training.

[(10)] (10) “Internationally trained physician” means a physician who graduated from a medical school that is not an approved school of medicine and who completed a training program that is not an approved training program.

[(9)] (11) “License” means permission to practice, whether by license, registration or certification.

[(10)] (12) “Licensee” means an individual holding a valid license issued by the board.

[(11)] (13) “Physical incapacity” means a condition that renders an individual licensed under this chapter unable to practice under that license with professional skill and safety by reason of physical illness or physical deterioration that adversely affects cognition, motor or perceptive skill.

[(12)] (14) “Physician” means a person who holds a degree of Doctor of Medicine or Doctor of Osteopathic Medicine, or a person who holds a degree of Doctor of Podiatric Medicine if the context in which the term “physician” is used does not authorize or require the person to practice outside the scope of a license issued under ORS 677.805 to 677.840.

[(13)] (15) “Podiatric physician and surgeon” means a physician licensed under ORS 677.805 to 677.840 to practice podiatry.

[(14)(a)] (16)(a) “Podiatry” means:

(A) The diagnosis or the medical, physical or surgical treatment of ailments of the human foot, ankle and tendons directly attached to and governing the function of the foot and ankle, and treatment involving the use of a general or spinal anesthetic if that treatment is performed in a hospital licensed under ORS 441.025 or in an ambulatory surgical center licensed by the Oregon Health Authority and is under the supervision of or in collaboration with a podiatric physician and surgeon;

(B) Assisting in the performance of surgery, as provided in ORS 677.814; and

(C) The treatment of skin, skin-related structures and subcutaneous masses, and wounds involving skin, skin-related structures and subcutaneous masses, on the human leg no further proximal than the tibial tubercle.

(b) “Podiatry” does not include administering general or spinal anesthetics or the amputation of the entire foot.

[(15)] (17) “Prescribe” means to direct, order or designate the use of or manner of using by spoken or written words or other means.

[(16)] **(18)** “Resident” means an individual who, after the first year of post-graduate training, in order to qualify for some particular specialty in the field of medicine, pursues a special line of study as part of a supervised program of a hospital approved by the board.

[(17)] **(19)** “Traditional Eastern medicine” means the practice of medicine, specifically acupuncture and traditional Chinese medicine, regulated by this chapter if the medicine is practiced within the context of a person’s license to practice acupuncture issued under ORS 677.757 to 677.770.

**FULL BOARD
OCTOBER 2, 2025
VIDEOCONFERENCE**

Public Session

Rule Review

Member Assigned: Daoud

First Review: 847-023-0000; 847-023-0005; 847-023-0010; 847-023-0015;
847-026-0000

Subject: Definitions; Qualifications; Documents and Forms to be
Submitted for Licensure; Letters and Official Verification
to be Submitted for Licensure; Qualifications for License
by Endorsement

OREGON ADMINISTRATIVE RULES

CHAPTER 847, DIVISION 023 & 026 – OREGON MEDICAL BOARD

First Review – October 2025

SB 873 (2025) repeals ORS 677.120 to remove unneeded regulations, effective January 1, 2026. The proposed rulemaking implements the bill by repealing the related rules. No out-of-state physician currently holds a volunteer emeritus license.

The proposed rulemaking also updates the rule outlining the qualifications for licensure by expedited endorsement because it referenced qualifications established in the volunteer emeritus license rules. There are no substantive changes to the qualifications for expedited endorsement.

~~Division 23: Rules for Licensure of Volunteer Emeritus Physicians~~

~~847-023-0000~~

~~Definitions~~

~~(1) “Health clinic” means a public health clinic or a health clinic operated by a charitable corporation that mainly provides primary physical health, dental or mental health services to low-income patients without charge or using a sliding fee scale based on the income of the patient.~~

~~(2) “Emeritus registration” means a licensee who has retired from active practice, but does only volunteer, non-remunerative practice and receives no direct monetary compensation, may register and pay an annual emeritus registration fee.~~

~~Statutory/Other Authority: ORS 677.265~~

~~Statutes/Other Implemented: ORS 677.120 & 677.265~~

~~847-023-0005~~

~~Qualifications~~

~~(1) The Board may issue a volunteer emeritus license to a physician who volunteers at a health clinic provided that the physician:~~

~~(a) Has a current license to practice medicine in another state or territory of the United States or the District of Columbia; and~~

~~(b) Has successfully passed one of the examinations or combination of examinations per OAR 847-020-0170.~~

~~(2) A physician applying for a license to volunteer in health clinics who has not completed postgraduate training within the past 10 years or been certified or recertified by a specialty board within the past ten years may be required to demonstrate clinical competency by passing the Special Purpose Examination (SPEX) or Comprehensive Osteopathic Medical Variable Purpose Examination (COMVEX). This requirement may be waived if the applicant has done one or more of the following:~~

~~(a) Received a current appointment as Professor or Associate Professor at the Oregon Health and Science University or the Western University of Health Sciences College of Osteopathic Medicine of the Pacific Northwest;~~

~~(b) Completed at least 50 hours of Board approved continuing medical education each year for the past three years; or~~

~~(c) Can demonstrate ongoing participation in maintenance of certification with a specialty board as defined in OAR 847-020-0100.~~

~~(3) A physician applying for a license to volunteer in health clinics who has not practiced medicine for a period of 12 or more consecutive months may be required to demonstrate clinical competency by passing the SPEX or COMVEX. This requirement may be waived if the applicant has done one or more of the following:~~

~~(a) Within ten years of filing an application with the Board, completed an accredited one year residency, or an accredited or Board approved one year clinical fellowship;~~

~~(b) Within ten years of filing an application with the Board, been certified or recertified by a specialty board recognized by the American Board of Medical Specialties (ABMS) or the American Osteopathic Association (AOA-BOS);~~

~~(c) Obtained continuing medical education to the Board's satisfaction; or~~

~~(d) Can demonstrate ongoing participation in maintenance of certification with the ABMS or AOA-BOS.~~

~~(4) A physician applying for a license to volunteer in health clinics who has not practiced medicine for a period of 24 or more consecutive months may be required to complete a re-entry plan to the satisfaction of the Board. The re-entry plan must be reviewed and approved through a~~

~~Consent Agreement prior to the applicant beginning the re-entry plan. Depending on the amount of time out of practice, the applicant may be required to do one or more of the following:~~

~~(a) Pass the SPEX/COMVEX examination;~~

~~(b) Practice for a specified period of time under a mentor/supervising physician who will provide periodic reports to the Board;~~

~~(c) Obtain certification or re-certification, or participate in maintenance of certification, with a specialty board as defined in OAR 847-020-0100;~~

~~(d) Complete a re-entry program as determined appropriate by the Board;~~

~~(e) Complete one year of accredited postgraduate or clinical fellowship training, which must be pre-approved by the Board's Medical Director;~~

~~(f) Complete at least 50 hours of Board-approved continuing medical education each year for the past three years.~~

~~(5) The applicant may be granted a Limited License, SPEX/COMVEX according to OAR 847-010-0064.~~

~~Statutory/Other Authority: ORS 677.120 & 677.265~~

~~Statutes/Other Implemented: ORS 677.100, 677.120, 677.132, 677.265 & 677.420~~

~~847-023-0010~~

~~Documents and Forms to be Submitted for Licensure~~

~~The documents submitted must be legible and no larger than 8 1/2" x 11". All documents and photographs will be retained by the Board as a permanent part of the application file. If original documents are larger than 8 1/2" x 11", the copies must be reduced to the correct size with all wording and signatures clearly shown. Official translations are required for documents issued in a foreign language. The following documents are required:~~

~~(1) Application: Completed formal application provided by the Board. Required dates must include month, day and year. The application fee is waived for physicians applying for a volunteer emeritus license.~~

~~(2) Birth Certificate: A copy of birth certificate.~~

~~(3) Medical School Diploma: A copy of a diploma showing graduation from an approved school of medicine or an international school of medicine. International medical graduates must have graduated after meeting the attendance requirements specified in OAR 847-020-0130.~~

~~(4) American Specialty Board Certification or Recertification: A copy of the certification or recertification certificate issued by the American Specialty Board in the applicant's specialty, if applicable.~~

~~(5) Photograph: A close-up, color, passport-quality photograph, front view, head and shoulders (not profile), with features distinct, taken within 90 days preceding the filing of the application.~~

~~(6) The results of a Practitioner Self-Query from the National Practitioner Data Bank sent directly to the Board by the applicant.~~

~~(7) Legible fingerprints as described in 847-008-0068 for the purpose of a criminal records background check.~~

~~(8) An open book examination on the Medical Practice Act (ORS chapter 677) and Oregon Administrative Rules chapter 847. If an applicant fails the examination three times, the applicant must attend an informal meeting with a Board member, the Executive Director, a Board investigator and/or the Medical Director of the Board to discuss the applicant's failure of the examination before being given a fourth and final attempt to pass the examination. If the applicant does not pass the examination on the fourth attempt, the applicant may be denied licensure.~~

~~(9) Any other documentation or explanatory statements as required by the Board.~~

~~Statutory/Other Authority: ORS 181A.195 & 677.265~~

~~Statutes/Other Implemented: ORS 181A.195, 677.100, 677.120 & 677.265~~

847-023-0015

Letters and Official Verifications to be Submitted for Licensure

~~(1) The applicant must ensure that either official documents are sent directly to the Board from the source or a certified copy is sent directly to the Board from another state medical board where the applicant is licensed:~~

~~(a) The Verification of Medical Education form, which includes degree issued, date of degree, dates of attendance, dates and reason of any leaves of absence or repeated years, and dates, name and location of medical school if a transfer student. Graduates of medical schools in the United~~

~~States must have graduated from a school per OAR 847-020-0120(1) and graduates of international medical schools must have graduated from a school per 847-020-0130(2).~~

~~(b) A Dean's Letter of Recommendation, which includes a statement concerning the applicant's moral and ethical character and overall performance as a medical student. If the school attests that a Dean's Letter is unavailable or the Board determines that it is unacceptable, a copy of the transcripts may be acceptable.~~

~~(c) A letter from the Fifth Pathway Hospital, if such applies, which includes an evaluation of overall performance and specific beginning and ending dates of training.~~

~~(d) A letter from the Director of Medical Education, Chairman or other official of the internship, residency and fellowship hospitals in the United States and other countries in which the postgraduate training was served, which includes an evaluation of overall performance and specific beginning and ending dates of training.~~

~~(2) The applicant must ensure that official documents are sent directly to the Board from:~~

~~(a) The Director or other official for practice and employment in hospitals, clinics, etc. in the United States and other countries: A currently dated original letter (a copy is not acceptable), from the hospital/clinic, which must include an evaluation of overall performance and specific beginning and ending dates of practice and employment, for the past five (5) years only. If the applicant has not practiced for more than two years, employment verifications will be required for the past ten (10) years. If such verification is unavailable or incomplete, and for physicians who have been or are in solo practice without hospital privileges at the time of solo practice, provide three reference letters from physicians in the local medical community who are familiar with the applicant's practice and who have known the applicant for more than six months.~~

~~(b) The health licensing board in a state, district, territory or jurisdiction in the United States or Canada where the applicant has been licensed and is currently practicing or most recently practiced: Verification, which must show license number, date issued and status.~~

~~(c) Official Examination Certifications: An official examination certification showing the examination score is required from the National Board of Medical Examiners (NBME), the National Board of Osteopathic Medical Examiners (NBOME), the Federation Licensing Examination (FLEX), the Federation of State Medical Boards for the United States Medical Licensing Examination (USMLE), or the Medical Council of Canada.~~

~~(d) The Federation of State Medical Boards: A Board Action Databank Inquiry report.~~

~~(e) The Educational Commission for Foreign Medical Graduates Verification of Certification.~~

~~(f) Any other documentation as required by the Board, including but not limited to medical records and criminal or civil records.~~

~~Statutory/Other Authority: ORS 677.265~~

~~Statutes/Other Implemented: ORS 677.100, 677.120 & 677.265~~

Division 26: Rules for License by Expedited Endorsement and Servicemembers Civil Relief Act

847-026-0000

Qualifications for License by Endorsement

(1) The Oregon Medical Board may issue a license by endorsement to a physician who:

(a) Meets the requirements for licensure as stated in OAR 847-020-0120, 847-020-0130, 847-020-0170, **847-020-0182, 847-020-0183** and **847-023-0005**;

(b) Has a current license to practice medicine in another state or territory of the United States or the District of Columbia;

~~(bc)~~ Has not had privileges at a hospital, clinic, or surgical center denied, reduced, restricted, suspended, revoked, terminated and has not been subject to staff disciplinary action or non-renewal of an employment contract for reasons in the Board's judgment related to medical practice or unprofessional conduct, or been requested to voluntarily resign or had privileges suspended while under investigation;

~~(ed)~~ Is eligible for primary source verification of medical education, post-graduate training and examination scores through the state in which the applicant was originally licensed. The Board may use current certification by the American Board of Medical Specialties or the American Osteopathic Association's Bureau of Osteopathic Specialists as a proxy for verification of medical education, post-graduate training and examination scores from the initial state of licensure;

~~(de)~~ Is in good standing, with no restrictions or limitations upon, actions taken against, or investigation or disciplinary action pending against his/her license in any state, district, territory, or jurisdiction where applicant is or has been licensed;

~~(ef)~~ Has no significant malpractice claim patterns or patient care issues as determined by the Board;

(g) Has one (1) year of current, active, unrestricted, unlimited clinical practice in their medical specialty, if any, as an active, unrestricted, unlimited licensee of a state, district, territory, or jurisdiction in the United States or Canada in the year preceding the physician's submission to the Board of an application to practice in Oregon, or if retired must have been retired for no more than one (1) calendar year preceding the physician's submission to the Board of an application to practice in Oregon.

(A) Clinical patient practice will be documented by verification of staff privileges, or non-consulting medical employment.

(B) A year of accredited clinical fellowship in the applicant's medical specialty as an active, unrestricted, unlimited licensee of a state, district, territory or jurisdiction in the United States or Canada qualifies as a year of clinical practice.

(2) A physician is not eligible for licensure by endorsement if the Board finds that the applicant has engaged in conduct prohibited by ORS 677.190.

(3) An applicant ineligible for licensure by endorsement may make a full and complete application per the requirements of OAR 847, division 020, or OAR 847, division 023.

Statutory/Other Authority: ORS 677.133 & 677.265

Statutes/Other Implemented: ORS 677.133 & 677.265

Enrolled Senate Bill 873

Printed pursuant to Senate Interim Rule 213.28 by order of the President of the Senate in conformance with presession filing rules, indicating neither advocacy nor opposition on the part of the President (at the request of Governor Tina Kotek for Oregon Medical Board)

CHAPTER

AN ACT

Relating to physician qualifications for special licenses; amending ORS 677.100; repealing ORS 677.120; and prescribing an effective date.

Be It Enacted by the People of the State of Oregon:

SECTION 1. ORS 677.100 is amended to read:

677.100. (1) An applicant for a license to practice medicine in this state, except as otherwise provided in subsection (2) of this section, must possess the following qualifications:

(a) Have attended and graduated from a school of medicine.

(b) Have satisfactorily completed the following post-graduate requirement:

(A) Satisfactory completion of an approved rotating internship if a graduate of an approved school of medicine;

(B) One year of training in an approved program if a graduate of an approved school of medicine; or

(C) Three years of training in an approved program if a graduate of an unapproved school of medicine.

(c) Have complied with each rule of the Oregon Medical Board which applies to all similar applicants for a license to practice medicine in this state.

(d) Have provided evidence sufficient to prove to the satisfaction of the board that the applicant is of good moral character. For purposes of this section, the lack of good moral character may be established by reference to acts or conduct that reflect moral turpitude or to acts or conduct which would cause a reasonable person to have substantial doubts about the individual's honesty, fairness and respect for the rights of others and for the laws of the state and the nation. The acts or conduct in question must be rationally connected to the applicant's fitness to practice medicine.

(2) If an applicant establishes that the applicant is of good moral character and has qualifications which the board determines are the equivalent of the qualifications required by subsection (1)(a) to (c) of this section, the applicant satisfies the requirements of subsection (1) of this section.

(3) An applicant for a license to practice medicine must make written application to the board showing compliance with this section, ORS 677.110[, 677.120] and the rules of the board, and containing such further information as the rules of the board may require.

SECTION 2. ORS 677.120 is repealed.

SECTION 3. This 2025 Act takes effect on the 91st day after the date on which the 2025 regular session of the Eighty-third Legislative Assembly adjourns sine die.

Passed by Senate March 11, 2025

.....
Obadiah Rutledge, Secretary of Senate

.....
Rob Wagner, President of Senate

Passed by House May 19, 2025

.....
Julie Fahey, Speaker of House

Received by Governor:

.....M.,....., 2025

Approved:

.....M.,....., 2025

.....
Tina Kotek, Governor

Filed in Office of Secretary of State:

.....M.,....., 2025

.....
Tobias Read, Secretary of State

**FULL BOARD
OCTOBER 2, 2025
VIDEOCONFERENCE**

Public Session

Rule Review

Member Assigned: Esquivel

First Review: 847-065-0010; 847-065-0015; 847-065-0020;
847-065-0025; 847-065-0030; 847-065-0035; 847-065-0040;
847-065-0045; 847-065-0050; 847-065-0055;
847-065-0065; 847-065-0070

Subject: Purpose, Intent and Scope; Definitions; Participation in Health Professionals' Services Program; Eligibility for Participation in Health Professionals Services Program; Procedure for Board Referrals; Procedure for Self-Referred Licensees; Disqualification Criteria; Approval of Independent Third- Party Evaluators; Approval of Treatment Providers; Licensee Responsibilities; Substantial Non-Compliance Criteria; Licensees with Primary Residence or Work Site Outside of Oregon

OREGON ADMINISTRATIVE RULES

CHAPTER 847, DIVISION 065 – OREGON MEDICAL BOARD

First Review – October 2025

For the Health Professionals' Services Program (HPSP), [HB 3043 \(2025\)](#) adds criteria to the initial evaluation process, updates definitions for direct supervisor and diversion agreements, and authorizes boards to define substantial noncompliance with the program, effective January 1, 2026. The proposed rulemaking updates the HPSP rules to align with HB 3043.

Following the September 10, 2025 Administrative Affairs Committee review, Board staff recommend removing proposed language that would have required HPSP participants to maintain an active practice Oregon license. This removed language appears with strikethrough in the draft. Currently, four HPSP participants hold an inactive status license, and two of these had inactive status when entering the program due to prior Interim Stipulated Orders. The existing HPSP rules already define "licensee" as any physician, podiatric physician, physician associate, or acupuncturist licensed or certified by the Board.

Division 65: Health Professionals' Services Program

847-065-0010

Purpose, Intent and Scope

The Oregon Medical Board recognizes that substance use disorders and/or mental health disorders are potentially progressive, chronic ~~diseases~~ **conditions**. The Board believes that physicians, podiatric physicians, physician associates, and acupuncturists who develop these ~~diseases~~ **conditions** can, with appropriate treatment, be assisted with recovery and ~~return to the~~ **safely** practice ~~of~~ medicine, podiatry, or acupuncture. It is the intent of the Board that a licensee with a substance use disorder and/or mental health disorder may have the opportunity to enter the Health Professionals' Services Program (HPSP). Participation in the HPSP does not shield a licensee from possible disciplinary action.

Statutory/Other Authority: ORS 676.190, 677.265 & 677.200

Statutes/Other Implemented: ORS 676.185, [676.190](#), [676.194](#), 676.200, [OL 2025, chapter 499, section 2-3](#)

847-065-0015

Definitions

The following definitions apply to OAR chapter 847, division 065, except as otherwise stated in the definition:

(1) “Assessment or evaluation” means the process an independent ~~third-party~~ **clinical** evaluator uses to diagnose the licensee and to make treatment recommendations for the licensee.

(2) “Board” means the Oregon Medical Board.

(3) “Business day” means Monday through Friday, except legal holidays as defined in ORS 187.010 and ORS 187.020.

(4) “Contractor” means the entity that has contracted with the health profession licensing boards to ~~conduct~~ **administer** the HPSP.

(5) “Diagnosis” means the principal mental health or substance use diagnosis listed in the current Diagnostic Statistical Manual (DSM). The diagnosis is determined through the assessment and any examinations, tests or consultations suggested by the assessment.

(6) “DSM” means the Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association.

(7) “Federal regulations” means:

(a) As used in ORS 676.185(~~54~~)(d), a “positive toxicology test result as determined by federal regulations pertaining to drug testing” means a test result that meets or exceeds the cutoff concentrations shown in 49 CFR § 40.87 (2009); and

(b) As used in ~~ORS 676.190(6)(g)~~ **Oregon Laws 2025, chapter 499, section 3(1)(d)**, ~~requiring a~~ “~~licensee to submit to~~ random drug or alcohol testing in accordance with federal regulations” means ~~licensees are selected for~~ random **testing selection** by a scientifically valid method, such as a random number table or a computer-based random number generator that is matched with licensees’ unique identification numbers or other comparable identifying numbers. Under the selection process used, each covered licensee must have an equal chance of being tested each time selections are made, as described in 40 CFR § 199.105(c)(5) (2009). Random drug tests must be unannounced and the dates for administering random tests must be spread reasonably throughout the calendar year, as described in 40 CFR § 199.105(c)(7) (2009).

(8) “Fitness to practice evaluation” means the process a qualified, independent ~~third-party~~ **clinical** evaluator uses to determine if the licensee can safely perform the essential functions of the licensee’s health practice.

(9) “Independent ~~third-party~~ **clinical** evaluator” means an individual or center who is approved by the Board to evaluate, diagnose, and make treatment recommendations for substance use disorders and/or mental health disorders.

(10) “Licensee” means a licensed physician, podiatric physician, physician associate or acupuncturist who is licensed or certified by the Board.

(11) “Mental health disorder” means a clinically significant syndrome identified in the current DSM that is associated with disability or with significantly increased risk of disability.

(12) “Monitoring agreement” **has the meaning given in ORS 676.185**~~means an individualized agreement between a licensee and the contractor that meets the requirements for a diversion agreement set by ORS 676.190.~~

(13) “Positive toxicology test result” means a test result that meets or exceeds the cutoff concentrations shown in 49 CFR 40.87 (2009), a test result that shows other drugs or alcohol, or a test result that fails to show the appropriate presence of a currently prescribed drug that is part of a treatment program related to a condition being monitored by HPSP.

(14) “Provisional enrollment” means temporary enrollment, pending verification that a licensee meets all program eligibility criteria.

(15) “Self-referred licensee” means a licensee who seeks to participate in the program without a referral from the Board.

(16) “Substance use disorder” means a disorder related to the taking of a drug of abuse, including alcohol. This includes substance use disorders with modifiers of mild, moderate, or severe and substance-induced disorders, including but not limited to intoxication, withdrawal, and other substance/medication-induced mental health disorders (psychotic disorders, bipolar and related disorders, depressive disorders, anxiety disorders, obsessive-compulsive and related disorders, sleep disorders, sexual dysfunctions, delirium, and neurocognitive disorders), as defined in DSM-5 criteria.

(17) “Substantial non-compliance” **occurs when**~~means that~~ a licensee is in violation of the terms of their monitoring agreement in a way that gives rise to concerns about the licensee’s ability or willingness to participate in the HPSP. Substantial non-compliance ~~and non-compliance include, but are not limited to, the factors listed~~ **is further described** in ORS 676.185(5). Conduct that occurred before a licensee entered into **HPSP is not substantial non-compliance**~~a monitoring agreement does not violate the terms of that monitoring agreement.~~

(18) “Toxicology testing” means urine testing or alternative chemical monitoring including blood, saliva, breath, nail, or hair as conducted by a laboratory certified, accredited or licensed and approved for toxicology testing.

(19) “Treatment” means the planned, specific, individualized health and behavioral-health procedures, activities, services and supports that a treatment provider uses to remediate symptoms of a substance use disorder and/or mental health disorder.

(20) “Workplace monitor” has the meaning given in ORS 676.185.

Statutory/Other Authority: ORS 676.190, 677.265 & 676.200

Statutes/Other Implemented: ORS 676.185, 676.190, 676.194, 676.200, OL 2025m chapter 499, section 2-3

847-065-0020

Participation in Health Professionals' Services Program

Effective July 1, 2010, the Board must participate in the Health Professionals’ Services Program and may refer eligible licensees to the ~~contractor~~ **HPSP** in lieu of or in addition to discipline. Only licensees who meet the eligibility criteria may ~~be referred by the Board to the contractor~~ **enter into the HPSP**.

Statutory/Other Authority: ORS 676.190, 677.265 & 676.200

Statutes/Other Implemented: ORS 676.185, 676.190, 676.194, 676.200

847-065-0025

Eligibility for Participation in Health Professionals Services Program

To be eligible to participate in the Health Professionals’ Services Program, a licensee must:

(1) Hold an actively practicing license status in Oregon;

(1) ~~Licensee must be~~ evaluated by an independent ~~third-party~~ **clinical** evaluator;

(2) ~~The evaluation must include~~ **Have received** a diagnosis of a substance use disorder and/or mental health disorder with the appropriate diagnostic code from the DSM, and treatment recommendations;

(3) ~~Licensee must p~~Provide a written ~~statement agreeing~~**agreement** to enter the HPSP and ~~agreeing to abide by all rules established by the Board;~~ and

(4) ~~Licensee must e~~Enter into the a “HPSP Monitoring Agreement.” **as described in OAR 847-065-0055.**

~~(5) The Board will determine whether a Board-referred licensee’s practice has presented or presents a danger to the public. The contractor will determine whether a self-referred licensee’s practice has presented or presents a danger to the public.~~

Statutory/Other Authority: ORS 676.190, 677.265 & 676.200

Statutes/Other Implemented: ORS 676.185, 676.190, 676.194, 676.200, OL 2025, chapter 249, sections 2-3

847-065-0030

Procedure for ~~Board Referrals~~ **Board-Referred Licensees**

(1) When the Board receives information involving a licensee who may have a substance use and/or a mental health disorder, the Board staff will investigate and complete a report to be presented at a Board meeting.

(2) If the licensee meets eligibility criteria and the Board approves entry into the HPSP, the Board will provide a written referral. The referral must include:

(a) A copy of the report from the independent ~~third-party~~**clinical** evaluator who diagnosed the licensee;

(b) The treatment recommendations developed by the independent ~~third-party~~**clinical** evaluator;

(c) A statement that the Board has investigated the licensee’s professional practice and conduct;

(d) A description of any restrictions or requirements imposed by the Board or recommended by the Board on the licensee’s professional practice;

(e) ~~A~~**The licensee’s** written **agreement** ~~statement from the licensee agreeing~~ to enter the HPSP and ~~agreeing~~ to abide by all **rules established by the Board and all** terms and conditions established by the contractor; and

(f) A statement that the licensee has agreed to report:

(A) Any arrest for or conviction of a misdemeanor or felony crime to the Board within three business days after the licensee is arrested or convicted.

(B) Any citation for the use or possession of any DEA scheduled substances, including but not limited to citations for Class E violations, to the contractor within three business days of the citation.

(3) The Executive Director or Medical Director has the authority to approve a licensee's entry into the HPSP.

Statutory/Other Authority: ORS 676.190, 677.265 & 676.200

Statutes/Other Implemented: ORS 676.185, 676.190, 676.194, 676.200, OL 2025, chapter 499, sections 2-3

847-065-0035

Procedure for Self-Referred Licensees

Board licensees may self-refer to the HPSP.

(1) Provisional Enrollment: To be provisionally enrolled in the program, a self-referred licensee must:

(a) Sign a written consent allowing disclosure and exchange of information among the contractor, the contractor's investigator, the licensee's employer, independent ~~third-party~~ **clinical** evaluators and treatment providers;

(b) Sign a written consent allowing disclosure and exchange of information among the contractor, the Board, the licensee's employer, independent ~~third-party~~ **clinical** evaluators and treatment providers in the event the contractor determines the licensee to be in substantial non-compliance with their monitoring agreement as defined in OAR 847-065-0065;

(c) Attest that the licensee is not, to the best of the licensee's knowledge, under investigation by the Board; and

(d) Agree to and sign a provisional enrollment agreement, which includes a statement that the licensee agrees to report to the contractor:

(A) Any arrest for or conviction of a misdemeanor or felony crime to the Board within three business days after the licensee is arrested or convicted.

(B) Any citation for the use or possession of any DEA scheduled substances, including but not limited to citations for Class E violations, within three business days of the citation.

(2) Final Enrollment: To move from provisional enrollment to final enrollment in the program, a self-referred licensee must:

(a) Obtain at the licensee's own expense and provide to the contractor, an independent ~~third-party~~ **clinical** evaluator's written evaluation containing a DSM diagnosis and diagnostic code and treatment recommendations;

(b) Agree to cooperate with the contractor's investigation to determine whether the licensee's practice while impaired, as defined in OAR 847-010-0073, presents or has presented a danger to the public;

(c) Enter into a monitoring agreement; and

(d) ~~Has met~~ **Meet** all eligibility requirements to participate in the HPSP.

(3) Once a self-referred licensee seeks enrollment in the HPSP, failure to successfully complete final enrollment, as outlined in section (2) of this rule, may constitute substantial non-compliance and may be reported to the Board.

Statutory/Other Authority: ORS 676.190, 677.265 & 676.200

Statutes/Other Implemented: ORS 676.185, 676.190, 676.194, 676.200, OL 2025, chapter 499, sections 2-3

847-065-0040

Disqualification Criteria

Licensees, either Board-referred or self-referred, may be disqualified from entering or participating in the HPSP for factors including, but not limited to:

(1) Licensee's disciplinary history;

(2) Severity and duration of the licensee's impairment;

(3) ~~Extent to which~~ **IL** licensee's practice can **not reasonably** be limited or managed to eliminate danger to the public;

(4) If licensee's impairment cannot be **adequately** managed with treatment and monitoring;

- (5) Evidence of criminal history that involves injury or endangerment to others;
- (6) Evidence of sexual misconduct;
- (7) Evidence of non-compliance with a monitoring program from another state;
- (8) Pending investigations with the Board or boards from other states;
- (9) Previous Board investigations with findings of substantiated abuse or dependence; and
- (10) Prior enrollment in, but failure to successfully complete, the Oregon Medical Board Health Professionals Program or HPSP.

~~(11) Failure to hold an actively practicing license status in Oregon.~~

Statutory/Other Authority: ORS 676.190, 677.265 & 676.200

Statutes/Other Implemented: ORS 676.185, 676.190, 676.194, 676.200, & 676.200 OL 2025,
chapter 499, sections 2-3

847-065-0045

Approval of Independent ~~Third-Party~~ Clinical Evaluators

- (1) To be approved by the Board as an independent ~~third-party~~ clinical evaluator, an evaluator must be:
 - (a) Licensed as required by the jurisdiction in which the evaluator works;
 - (b) Able to provide a comprehensive assessment of and written report describing a licensee's diagnosis, degree of impairment, and treatment recommendations; and
 - (c) Able to facilitate toxicology testing of the licensee at intake.
- (2) The Board reserves the right to not approve an independent ~~third-party~~ clinical evaluator for any reason.
- (3) The Board or contractor will not accept an evaluator as independent in a particular case if, in the Board's or contractor's judgment, the evaluator's judgment is likely to be influenced by a personal or professional relationship with a licensee.

Statutory/Other Authority: ORS 676.190, 677.265 & 676.200

Statutes/Other Implemented: ORS 676.185, 676.190, 676.194, 676.200, OL 2025, chapter 499, sections 2-3

847-065-0050

Approval of Treatment Providers

(1) To be approved by the Board as a treatment provider, a provider must be:

(a) Licensed as required by the jurisdiction in which the provider works;

(b) Able to provide appropriate treatment considering the licensee's diagnosis, degree of impairment, and treatment recommendations proposed by the independent ~~third-party~~ **clinical** evaluator; and

(c) Able to facilitate toxicology testing of the licensee at intake.

(2) A treatment provider may not have a personal or professional relationship with a licensee.

(3) The Board will maintain a list of treatment providers available to licensees upon request.

Statutory/Other Authority: ORS 676.190, 677.265 & 676.200

Statutes/Other Implemented: ORS 676.185, 676.190, 676.194, 676.200, OL 2025, chapter 499, sections 2-3

847-065-0055

~~Licensee Responsibilities~~ **Monitoring Agreement**

~~All licensees must:~~ **To participate in the Health Professionals' Services Program, a licensee must enter into a written monitoring agreement with the HPSP which requires the licensee to:**

(1) Consent to disclosure and exchange of information between the HPSP, the board, and the licensee's employer, evaluators and treatment entities in compliance with ORS 179.505 and 42 C.F.R. part 2;

~~(1) Agree to report any arrest for or conviction of a misdemeanor or felony crime to the contractor within three business days after the licensee is arrested or convicted of the crime;~~

~~(2) Agree to report to the contractor any citation for the use or possession of any DEA scheduled substances, including but not limited to citations for Class E violations, within three business days of the citation;~~

~~(23)~~ Comply continuously with their ~~ir monitoring~~ agreement, including any restrictions on their practice, for two years or longer as described in OAR 847-065-0060, as specified in the monitoring agreement or addenda to the monitoring agreement;

(3) Participate in a treatment plan and all required activities in the treatment plan as approved by a clinical evaluator or treatment provider;

(4) Abstain from mind-altering or intoxicating substances or potentially addictive drugs, unless the drug is approved by the contractor and prescribed for a documented medical condition by a person authorized by law to prescribe the drug to the licensee;

(5) Report use of mind-altering or intoxicating substances or potentially addictive drugs within 24 hours to contractor;

(6) Submit to random drug or alcohol testing as outlined in the monitoring agreement;

~~(6) Participate in a treatment plan approved by a third-party evaluator or treatment provider;~~

(7) Limit practice as required by the contractor or the Board;

(8) ~~Cooperate with supervised monitoring of practice~~ **Designate a workplace monitor;**

(9) Participate in a follow-up evaluation, when necessary, of THE licensee's fitness to practice;

~~(10) Submit to random drug or alcohol testing as outlined in the monitoring agreement;~~

~~(11)~~ Report at least weekly to the contractor regarding the licensee's compliance with the monitoring agreement;

~~(12)~~ Report applications for licensure in other states, changes in employment and changes in practice setting to the contractor;

~~(13) Agree to be responsible for the cost of evaluations, toxicology testing, treatment, monitoring groups, and periodic monitoring consultations;~~

(12) Report any arrest for or conviction of a misdemeanor or felony crime to the contractor within three business days after the licensee is arrested or convicted of the crime;

(13) Report to the contractor any citation for the use or possession of any DEA scheduled substances, including but not limited to citations for Class E violations, within three business days of the citation;

(14) Report to the contractor any investigations or disciplinary action by any state, or state or federal agency, including Oregon;

~~(15) Participate in required activities according to the treatment plan; and~~

(15) Agree to be responsible for the cost of evaluations, toxicology testing, treatment, monitoring groups, and periodic monitoring consultations; and

(16) Maintain a license status and report any changes in license status.

Statutory/Other Authority: ORS 676.190, 677.265 & 676.200

Statutes/Other Implemented: ORS 676.185, 676.190, 676.194, 676.200, OL 2025, chapter 499, sections 2-3

847-065-0065

Substantial Non-Compliance Criteria

(1) The contractor will report substantial non-compliance with a monitoring agreement to the Board within one business day after the contractor learns of the substantial non-compliance, including but not limited to information that a licensee:

(a) Engaged in criminal behavior;

(b) Engaged in conduct that caused injury, death or harm to the public, including engaging in sexual impropriety with a patient;

(c) Was impaired in a health care setting in the course of the licensee's employment;

(d) Received a positive toxicology test result;

(e) Violated a restriction on the licensee's practice imposed by the contractor or the Board;

(f) Was civilly committed for mental illness;

- (g) Entered into a monitoring agreement, but failed to participate in the HPSP;
- (h) Was referred to the HPSP, but failed to enroll in the HPSP;
- (i) Forged, tampered with, or modified a prescription;
- (j) Violated any rules of prescriptive authority;
- (k) Violated any provisions of OAR 847-065-0055;
- (L) Violated any terms of the monitoring agreement; or
- (m) Failed to complete the monitored practice requirements as stated in OAR 847-065-0060.

(2) The Board will review reports from the program. The Board may request the contractor to provide the licensee's complete record, and the contractor must send these records to the Board as long as a valid release of information is in place.

(3) If the Board **conducts an investigation and** finds that a licensee ~~is~~ **has been** substantially non-compliant with a monitoring agreement, the Board may ~~investigate and determine the appropriate sanction~~ **pursue disciplinary action in accordance with ORS 677.200**.

Statutory/Other Authority: ORS 676.190, 677.265 & 676.200

Statutes/Other Implemented: ORS 676.185, 676.190, 676.194, 676.200, OL 2025, chapter 499, sections 2-3

847-065-0070

Licensees with Primary Residence or Work Site Outside of Oregon

If a licensee's primary residence or work site is located outside the State of Oregon, the licensee must enroll in the HPSP, in accordance with OAR 847-065-0025 and 847-065-0030 for Board-referred or 847-065-0035 for self-referred licensees, and may choose to be monitored by the out-of-state's health professional program if the following conditions are met:

- (1) The other state's health professional program is substantially similar ~~with to~~ the relevant Oregon statutes **and rules**. It is the duty of the contractor to verify this information and notify the Board of any discrepancies;

(2) The other state's health professional program sends quarterly reports on the licensee to the contractor; and

(3) The other state's health professional program will promptly report any substantial non-compliance with the licensee's monitoring agreement to the contractor.

Statutory/Other Authority: ORS 676.190, 677.265 & 676.200

Statutes/Other Implemented: ORS 676.185, 676.190, 676.194, 676.200, OL 2025, chapter 499, sections 2-3

Enrolled House Bill 3043

Introduced and printed pursuant to House Rule 12.00. Presession filed (at the request of Governor Tina Kotek for Oregon State Board of Nursing)

CHAPTER

AN ACT

Relating to the impaired health professional program; creating new provisions; amending ORS 675.583, 676.185, 676.190, 676.194, 676.200 and 678.112; and prescribing an effective date.

Be It Enacted by the People of the State of Oregon:

SECTION 1. Sections 2 and 3 of this 2025 Act are added to and made a part of ORS 676.185 to 676.200.

SECTION 2. A health professional licensing board may establish by rule a process through which a licensee enrolled in the impaired health professional program established under ORS 676.190 who has successfully completed the program may petition the licensee's health professional licensing board to remove from any records held by the health professional licensing board information relating to the licensee's participation in the program. A health professional licensing board that establishes a process described in this section may determine whether to grant a licensee's petition.

SECTION 3. (1) A monitoring agreement required under ORS 676.190 must require that the licensee who is party to the monitoring agreement:

(a) Subject to subsection (3) of this section, consent to disclosure and exchange of information between the impaired health professional program established under ORS 676.190, the licensee's health professional licensing board, employer, evaluators and treatment entities, in compliance with ORS 179.505 and 42 C.F.R. part 2;

(b) Comply continuously with the agreement for at least two years to successfully complete the program;

(c) Agree to participate in a recommended treatment plan;

(d) Subject to subsection (4) of this section, submit to random drug or alcohol testing in accordance with federal regulations; and

(e) Subject to subsection (4) of this section, abstain from the use of mind-altering or intoxicating substances or potentially addictive drugs unless the drugs are:

(A) Prescribed for a documented medical condition by a person authorized by law to prescribe the drug to the licensee; and

(B) Approved by the program if the licensee's health professional licensing board has granted the program that authority.

(2) The monitoring agreement described in subsection (1) of this section must also:

(a) Require the licensee to report at least the following information to the impaired health professional program:

(A) The licensee's use of mind-altering or intoxicating substances or potentially addictive drugs within 24 hours of the use, if the licensee's monitoring agreement requires the licensee to abstain from the use of those substances;

(B) In compliance with rules adopted under ORS 676.190, the licensee's compliance or noncompliance with the agreement;

(C) Regarding the licensee, any arrest for or conviction of a misdemeanor or felony crime within three business days after the licensee is arrested or convicted; and

(D) Any applications that the licensee submits for licensure in other states, changes in the licensee's employment and changes in the licensee's practice setting;

(b) Contain limits on the licensee's practice of the licensee's health profession; and

(c) Provide that the licensee is responsible for the cost of evaluations, toxicology testing and treatment.

(3) Notwithstanding subsection (1)(a) of this section, information related to a licensee who self-enrolls in the impaired health professional program may be disclosed to the licensee's health professional licensing board only if the licensee is noncompliant with the licensee's monitoring agreement.

(4) The requirements of subsection (1)(d) and (e) of this section do not apply to a monitoring agreement for a licensee who is diagnosed with solely a mental health disorder and whose health professional licensing board does not otherwise require the licensee to submit to random drug or alcohol testing.

SECTION 4. ORS 676.185 is amended to read:

676.185. As used in ORS 676.185 to 676.200:

[1] "*Direct supervisor*" means the individual who is responsible for:]

[a] Supervising a licensee enrolled in the impaired health professional program;]

[b] Monitoring the licensee's compliance with the requirements of the program; and]

[c] Periodically reporting to the program on the licensee's compliance with the requirements of the program.]

[2] (1) "Health [profession] **professional** licensing board" means:

(a) A health professional regulatory board as defined in ORS 676.160; or

(b) The Health Licensing Office for a board, council or program listed in ORS 676.565.

[3] "*Impaired professional*" means a licensee who is unable to practice with professional skill and safety by reason of habitual or excessive use or abuse of drugs, alcohol or other substances that impair ability or by reason of a mental health disorder.]

[4] (2) "Licensee" means a health professional licensed or certified by or registered with a health [profession] **professional** licensing board.

(3) "**Monitoring agreement**" means a written agreement entered into between the impaired health professional program established under ORS 676.190 and a licensee enrolled in the program that includes the provisions described in section 3 of this 2025 Act.

[5] (4) "Substantial noncompliance" includes the following:

(a) Criminal behavior;

(b) Conduct that causes injury, death or harm to the public, or a patient, including sexual impropriety with a patient;

(c) Impairment in a health care setting in the course of employment;

(d) A positive toxicology test result as determined by federal regulations pertaining to drug testing;

(e) Violation of a restriction on a licensee's practice imposed by the impaired health professional program established under ORS 676.190 or the licensee's health [profession] **professional** licensing board;

(f) Civil commitment for mental illness;

(g) Failure to participate in the program after entering into a [diversion] **monitoring** agreement under ORS 676.190; or

(h) Failure to enroll in the program after being referred to the program.

(5) “Workplace monitor” means an individual who is free of conflicts of interest, agrees to serve as a liaison between the impaired health professional program and a licensee enrolled in the program, and has responsibility for at least:

- (a) Monitoring the licensee’s safe practice in the workplace;
- (b) Completing a monthly safe practice report and submitting the report to the program;
- (c) Informing the program of any concerns regarding the licensee, including any unsafe practices in which the licensee engages in the workplace; and
- (d) Receiving noncompliance reports from the program that may require the licensee to cease practicing.

SECTION 5. ORS 676.190 is amended to read:

676.190. (1) The health [profession] **professional** licensing boards may establish or contract to establish an impaired health professional program **to assist licensees who are unable to practice with professional skill and safety by reason of habitual or excessive use or abuse of drugs, alcohol or other substances that impair ability or by reason of a mental health disorder.**

(2) A program established or contracted for under this section must:

(a) Enroll licensees of participating health [profession] **professional** licensing boards who have been diagnosed with alcohol or substance abuse or a mental health disorder;

(b) Require that a licensee sign a written consent prior to enrollment in the program allowing disclosure and exchange of information between the program, the licensee’s **health professional licensing** board, the licensee’s employer, evaluators and treatment entities in compliance with ORS 179.505 and 42 C.F.R. part 2;

(c) Enter into [diversion] **monitoring** agreements with enrolled licensees, **regardless of whether the licensee was referred by the licensee’s health professional licensing board or was self-referred;**

(d) If the enrolled licensee has a [direct supervisor] **workplace monitor**, assess the ability of the [direct supervisor] **workplace monitor** to supervise the licensee, including an assessment of any documentation of the [direct supervisor’s] **workplace monitor’s** completion of specialized training;

(e) Report substantial noncompliance with a [diversion] **monitoring** agreement to a noncompliant licensee’s **health professional licensing** board within one business day after the program learns of the substantial noncompliance; and

(f) At least weekly, submit to licensees’ **health professional licensing** boards:

(A) A list of licensees who were referred to the program by a health [profession] **professional** licensing board and who are enrolled in the program; and

(B) A list of licensees who were referred to the program by a health [profession] **professional** licensing board and who successfully complete the program.

(3) The lists submitted under subsection (2)(f) of this section are exempt from disclosure as a public record under ORS 192.311 to 192.478.

(4) When the program reports substantial noncompliance under subsection (2)(e) of this section to a licensee’s **health professional licensing** board, the report must include:

(a) A description of the substantial noncompliance;

(b) A copy of a report from the independent [third party] **clinical evaluator** who diagnosed the licensee under ORS 676.200 (2)(a) or subsection [(7)(a)] **(6)(c)** of this section stating the licensee’s diagnosis;

(c) A copy of the licensee’s [diversion] **monitoring** agreement; and

(d) The licensee’s employment status.

(5) The program may not diagnose or treat licensees enrolled in the program.

[(6) The diversion agreement required by subsection (2) of this section must:]

[(a) Require the licensee to consent to disclosure and exchange of information between the program, the licensee’s board, the licensee’s employer, evaluators and treatment programs or providers, in compliance with ORS 179.505 and 42 C.F.R. part 2;]

[(b) Require that the licensee comply continuously with the agreement for at least two years to successfully complete the program;]

[(c) Require that the licensee abstain from mind-altering or intoxicating substances or potentially addictive drugs, unless the drug is:]

[(A) Prescribed for a documented medical condition by a person authorized by law to prescribe the drug to the licensee; and]

[(B) Approved by the program if the licensee's board has granted the program that authority;]

[(d) Require the licensee to report use of mind-altering or intoxicating substances or potentially addictive drugs within 24 hours;]

[(e) Require the licensee to agree to participate in a recommended treatment plan;]

[(f) Contain limits on the licensee's practice of the licensee's health profession;]

[(g) Require the licensee to submit to random drug or alcohol testing in accordance with federal regulations, unless the licensee is diagnosed with solely a mental health disorder and the licensee's board does not otherwise require the licensee to submit to random drug or alcohol testing;]

[(h) Require the licensee to report to the program regarding the licensee's compliance with the agreement;]

[(i) Require the licensee to report any arrest for or conviction of a misdemeanor or felony crime to the program within three business days after the licensee is arrested or convicted;]

[(j) Require the licensee to report applications for licensure in other states, changes in employment and changes in practice setting; and]

[(k) Provide that the licensee is responsible for the cost of evaluations, toxicology testing and treatment.]

[(7)(a)] **(6)(a)** A health [profession] **professional** licensing board may establish by rule an option to permit licensees of the health [profession] **professional** licensing board to self-refer to the program.

(b) The program shall require a licensee who self-refers to the program to attest that the licensee is not, to the best of the licensee's knowledge, under investigation by the licensee's **health professional licensing** board. The program shall enroll the licensee on the date on which the licensee attests that the licensee, to the best of the licensee's knowledge, is not under investigation by the licensee's **health professional licensing** board.

(c) When a licensee self-refers to the program, the program shall:

(A) Require that an independent [third party] **clinical evaluator** approved by the licensee's board to evaluate alcohol or substance abuse or mental health disorders evaluate the licensee for alcohol or substance abuse or mental health disorders; and

(B) Investigate to determine whether the licensee's practice while impaired has presented or presents a danger to the public.

(d) When a licensee self-refers to the program, the program may not report the licensee's enrollment in or successful completion of the program to the licensee's **health professional licensing** board.

[(8)] **(7)** The health [profession] **professional** licensing boards shall arrange for an independent [third party] **clinical evaluator** to conduct an audit every four years of an impaired health professional program for the licensees of those health [profession] **professional** licensing boards to ensure compliance with program guidelines. The health [profession] **professional** licensing boards shall report the results of the audit to the Legislative Assembly in the manner provided by ORS 192.245 and to the Governor. The report may not contain individually identifiable information about licensees.

[(9)] **(8)** The health [profession] **professional** licensing boards, in consultation with one another, may adopt rules to carry out this section **and section 3 of this 2025 Act**.

(9) In addition to other fees that a health professional licensing board imposes on licensees, a health professional licensing board may adopt rules to impose a fee of \$25 per year on each person licensed by the health professional licensing board who is eligible to enroll in the program. A health professional licensing board that adopts rules described in this section shall collect the \$25 fee at the same time the health professional licensing board collects other fees imposed on licensees.

SECTION 6. ORS 676.194 is amended to read:

676.194. (1) The Impaired Health Professional Program Work Group is established.

(2) The work group consists of the designees of any health [profession] **professional** licensing boards that elect to establish or contract for an impaired health professional program as described in ORS 676.190.

(3) The work group shall facilitate the establishment and continuation of the impaired health professional program described in ORS 676.190.

(4) A majority of the members of the work group constitutes a quorum for the transaction of business.

(5) Official action by the work group requires the approval of a majority of the members of the work group.

(6) The work group shall elect one of its members to serve as chairperson.

(7) The work group shall meet at times and places specified by the call of the chairperson or of a majority of the members of the work group.

(8) The work group may adopt rules necessary for the operation of the work group.

(9) The Oregon Medical Board shall provide staff support to the work group.

(10) Members of the work group are not entitled to compensation, but may be reimbursed for actual and necessary travel and other expenses incurred by them in the performance of their official duties in the manner and amounts provided for in ORS 292.495. Claims for expenses shall be paid out of funds appropriated to the health professional licensing board that the member represents for purposes of the work group.

(11) All agencies of state government, as defined in ORS 174.111, are directed to assist the work group in the performance of duties of the work group and, to the extent permitted by laws relating to confidentiality, to furnish information and advice the members of the work group consider necessary to perform their duties.

SECTION 7. ORS 676.200 is amended to read:

676.200. (1)(a) A health [profession] **professional** licensing board that is authorized by law to take disciplinary action against licensees may adopt rules opting to participate in the impaired health professional program established under ORS 676.190 and may contract with or designate one or more programs to deliver therapeutic services to its licensees.

(b) A **health professional licensing** board may not establish the **health professional licensing** board's own impaired health professional program for the purpose of monitoring licensees of the **health professional licensing** board that have been referred **or that have been self-referred** to the program.

(c) A **health professional licensing** board may adopt rules establishing additional requirements for licensees referred to the impaired health professional program established under ORS 676.190 or a program with which the **health professional licensing** board has entered into a contract or designated to deliver therapeutic services under [subsection (1) of this section] **paragraph (a) of this subsection**.

(2) If a **health professional licensing** board participates in the impaired health professional program, the **health professional licensing** board shall establish by rule a procedure for referring licensees to the program. The procedure must provide that, before the **health professional licensing** board refers a licensee to the program, the **health professional licensing** board shall ensure that:

[(a) An independent third party approved by the board to evaluate alcohol or substance abuse or mental health disorders has diagnosed the licensee with alcohol or substance abuse or a mental health disorder and provided the diagnosis and treatment options to the licensee and the board;]

(a) An independent clinical evaluator, who is a licensed health care professional with demonstrated expertise in the areas of concern, and who is approved by the health professional licensing board:

(A) Provides a comprehensive clinical assessment of the licensee including both a mental health disorder assessment and an alcohol or substance use disorder assessment, according

to guidelines established by the Diagnostic and Statistical Manual of Mental Disorders (DSM-5-TR);

(B) Diagnoses the licensee with a mental health disorder or an alcohol or substance use disorder; and

(C) Suggests a monitoring care plan and recommended fitness level for the licensee's return to practice and, if applicable, recommends the criteria treatment plan of the American Society of Addiction Medicine, or its successor organization;

(b) The **health professional licensing** board has investigated to determine whether the licensee's professional practice while impaired has presented or presents a danger to the public; and

(c) The licensee has agreed to report any arrest for or conviction of a misdemeanor or felony crime to the **health professional licensing** board within three business days after the licensee is arrested or convicted.

(3) A **health professional licensing** board that participates in the impaired health professional program shall review reports received from the program. If the **health professional licensing** board finds that a licensee is substantially noncompliant with a *[diversion]* **monitoring** agreement entered into under ORS 676.190, the **health professional licensing** board may suspend, restrict, modify or revoke the licensee's license or end the licensee's participation in the impaired health professional program.

(4) A **health professional licensing** board may not discipline a licensee solely because the licensee:

(a) Self-refers to or participates in the impaired health professional program;

(b) Has been diagnosed with alcohol or substance abuse or a mental health disorder; or

(c) Used controlled substances or cannabis, **or used psilocybin pursuant to ORS 475A.210 to 475A.722**, before entry into the impaired health professional program, if the licensee did not practice while impaired.

SECTION 8. ORS 678.112 is amended to read:

678.112. Persons licensed *[to practice nursing]* **or certified by the Oregon State Board of Nursing** who elect not to participate in the impaired health professional program established under ORS 676.190 or who fail to comply with the terms of participation shall be reported **by the program** to the *[Oregon State Board of Nursing]* **board** for formal disciplinary action under ORS 678.111.

SECTION 9. ORS 675.583 is amended to read:

675.583. (1) **As used in this section:**

(a) **"Impaired professional" means a regulated social worker who is unable to practice with professional skill and safety by reason of habitual or excessive use or abuse of drugs, alcohol or other substances that impair ability or by reason of a mental health disorder.**

(b) **"Prohibited conduct" has the meaning given that term in ORS 676.150.**

[(1)] (2) Unless state or federal laws relating to confidentiality or the protection of health information prohibit disclosure, a regulated social worker shall report to the State Board of Licensed Social Workers any information the regulated social worker has that appears to show that a regulated social worker is or may be an impaired professional *[as defined in ORS 676.185]*, or may have engaged in unprofessional conduct according to the guidelines of the code of ethics, to the extent that disclosure does not conflict with the requirements of ORS 675.580.

[(2)] (3) A regulated social worker shall report any prohibited conduct *[as defined in ORS 676.150]* in the manner provided in ORS 676.150.

[(3)] (4) Notwithstanding ORS 676.175, any information that the board obtains pursuant to subsection *[(1)]* (2) of this section is confidential and may not be disclosed except as provided by the board by rule.

[(4)] (5) A person who reports or provides information to the board under subsection *[(1)]* (2) of this section in good faith is not subject to an action for civil damages as a result of reporting or providing information to the board.

SECTION 10. (1) Sections 2 and 3 of this 2025 Act and the amendments to ORS 675.583, 676.185, 676.190, 676.194, 676.200 and 678.112 by sections 4 to 9 of this 2025 Act become operative on January 1, 2026.

(2) A health professional licensing board, as defined in ORS 676.185, may take any action before the operative date specified in subsection (1) of this section that is necessary to enable the health professional licensing board to exercise, on and after the operative date specified in subsection (1) of this section, all of the duties, functions and powers conferred on the health professional licensing board by sections 2 and 3 of this 2025 Act and the amendments to ORS 675.583, 676.185, 676.190, 676.194, 676.200 and 678.112 by sections 4 to 9 of this 2025 Act.

SECTION 11. This 2025 Act takes effect on the 91st day after the date on which the 2025 regular session of the Eighty-third Legislative Assembly adjourns sine die.

Passed by House June 17, 2025

.....
Timothy G. Sekerak, Chief Clerk of House

.....
Julie Fahey, Speaker of House

Passed by Senate June 20, 2025

.....
Rob Wagner, President of Senate

Received by Governor:

.....M.,....., 2025

Approved:

.....M.,....., 2025

.....
Tina Kotek, Governor

Filed in Office of Secretary of State:

.....M.,....., 2025

.....
Tobias Read, Secretary of State

MEMORANDUM

TO: Oregon Medical Board
SUBJECT: HPSP Additional Information
DATE: September 18, 2025

At the Administrative Affairs Committee meeting on September 10, 2025, members questioned whether a Health Professionals' Services Program (HPSP) rule, OAR 847-065-0055(4), requiring participants to avoid "mind-altering or intoxicating substances" applied to substances like nicotine, caffeine, and melatonin.

The HPSP staff clarified they use a blacklist approach, meaning they specify what's prohibited rather than what's allowed. Their restrictions focus on scheduled controlled substances and alcohol, while common substances like coffee, nicotine, and melatonin are permitted since they're not specifically banned and aren't subject to the program's testing protocols. Provided below is the program's over-the-counter medication guidelines for reference.



HPSP MEDICATION GUIDE

REVISED 12/1/2011

Many medications may be problematic to persons in recovery from chemical dependence and/or on psychiatric medications. These include prescription and over-the-counter medications. The chemical ingredients in many OTC remedies have effects very similar to those of addictive drugs, and often the brain cannot distinguish one from another. The effect is that of a trigger with the emergence of powerful cravings. In addition, some drugs may cause false positives on urine drug screens, which should be avoided.

This guide is intended to help HPSP licensees understand what types of medications are generally safe to take without a doctor's guidance, and which need to be avoided all together (i.e. because they contain alcohol) or used only with a doctor's guidance. Please contact your agreement monitor and consult your primary care physician and pharmacist if you have further questions.

We are indebted to Talbott Recovery Center and Serenity Lane for their help in providing information used in this guide.

ALCOHOL CONTAINING MEDICATIONS:

This is a **partial** list of over-the-counter medications which contain alcohol. You must avoid these types of medications that contain alcohol. They can result in a positive urine screen and there is no way to differentiate between over-the-counter medication and alcohol for consumption. Please remember that you are responsible for ensuring that nothing you put in or on your body contains alcohol.

Consult your pharmacist or physician for alternatives that do not contain alcohol.

Cough Medicines:	
✓ Vicks 44	✓ Terpin Hydrate Elixir
✓ Nyquil	✓ Pertussin Plus
✓ Romilar	✓ MOST COUGH MEDICINES CONTAIN ALCOHOL
✓ Robitussin	
Mouthwashes:	
✓ Listerine	✓ Colgate
✓ Scope	✓ MOST MOUTHWASHES CONTAIN ALCOHOL

Also, please remember that non-alcoholic beer DOES CONTAIN ALCOHOL. If you drink one and test positive for alcohol, you will need to be assessed.

OVER-THE-COUNTER MEDICATIONS REQUIRING PHYSICIAN GUIDANCE:

This is a **partial** list of over-the-counter medications which should be used only under physician guidance.

Decongestants (Many are Combination Products):	
✓ Actifed (pseudoephedrine/triprolidine) OTC ✓ Mucinex D (pseudoephedrine/guaifenesin) OTC ✓ Alavert D (loratadine/pseudoephedrine) OTC ✓ Novafed (pseudoephedrine) OTC ✓ Allegra D (fexofenadine/pseudoephedrine) ✓ Profen (pseudoephedrine) OTC ✓ Bromfed DM (pseudoephedrine/chlorpheniramine/pyrilamine) ✓ Clarinex D (desloratadine/pseudoephedrine) ✓ Claritin D (loratadine/pseudoephedrine) OTC pyrilamine)	✓ Deconamine SR (pseudoephedrine/ Semprex-D (pseudoephedrine/acrivastine) chlorpheniramine) OTC ✓ Dimetapp (pseudoephedrine/brompheniramine)OTC ✓ Sudafed (pseudoephedrine) OTC ✓ Duratuss (pseudoephedrine/guaifenesin) ✓ Zyrtec D (cetirizine/pseudoephedrine) ✓ Entex PSE (pseudoephedrine/guaifenesin) ✓ Humibid DM (pseudoephedrine/dextromethorphan/ potassium guaiaacolsulfonate)
Decongestants should be used with caution because they are stimulating and can trigger relapse.	
Sleep Aids:	
✓ Excedrin PM (diphenhydramine) OTC ✓ Sominex (diphenhydramine) OTC ✓ Nytol (diphenhydramine) OTC ✓ Tylenol PM (diphenhydramine/acetaminophen) OTC	✓ Sleep-eze (diphenhydramine) OTC ✓ Unisom (diphenhydramine) OTC
Sleep aids act in the central nervous system and can alter judgment and cause sedation.	
Vertigo/Motion Sickness:	
✓ Dramamine (dimenhydrinate) OTC	
These medications affect the central nervous system and can cause dizziness, drowsiness or blurred vision.	
Antihistamines (Sedating):	
✓ Periactin (cyproheptadine) ✓ Atarax (hydroxyzine hydrochloride) ✓ Polarmine (dexchlorpheniramine) ✓ Benadryl (diphenhydramine) OTC ✓ Tavist (clemastine) OTC	✓ Chlor-Trimeton (chlorpheniramine) OTC ✓ Teldrin (chlorpheniramine) OTC ✓ Dimetane (brompheniramine) OTC ✓ Vistaril (hydroxyzine pamoate) ✓ Efidac (chlorpheniramine) OTC
Sedating antihistamines should be used with caution because they have the potential to alter judgment and cause fatigue or sedation.	

MEDICATION INFORMATION FOR THOSE IN RECOVERY:

The following is a list of OTC medications judged to be **safe** for people in recovery. Please note that this list is not inclusive of all safe medications and its listing here does not represent an endorsement of its effectiveness.

Cough Medications:	Nasal Sprays:	Sinus/Cold/Flu Medications:
✓ Halls Mentholyptus ✓ Ricola Cough Drops ✓ Robitussin-Guaifensin Syrup ✓ Tessalon Pearles Avoid: Any medication containing Pseudoephedrine or Dextromethorphan ("DM") No: Codeine, hydrocodone, Benadryl	✓ Saline Nasal Spray Avoid: Medicated nasal sprays No: NeoSynephrine, Sudafed, or products containing Pseudoephedrine	✓ Airborne ✓ Alavert ✓ Claritin ✓ Zycam Cold Remedy No: Benadryl, products containing Dextromethorphan ("DM"), antihistamine or Pseudoephedrine
Diarrhea/Gas Medications:	Nicotine Preparations:	Skin Preparations:
✓ Beano ✓ Citrucel ✓ Dulcolax ✓ Gas-X Strips, Chewable Tabs or Gel Caps ✓ Imodium ✓ Kaopectate ✓ Simethicone Suggestion: Dietary control, exercise, increased water consumption	✓ Comit ✓ NicoDerm ✓ Nicorette ✓ Nicotine Transdermal Systems Never: Smoke while using these products	✓ Caladryl ✓ Calamine Lotion ✓ Clotrimazole ✓ Cortain ✓ Cortizone-10 ✓ Cruex ✓ Desenex ✓ Hydrocortisone Ointment/Cream ✓ Lamisil ✓ Lotrimin ✓ Neosporin ✓ Tinactin (Tolnaftate) ✓ Triple Antibiotic Ointment

Mouthwash:	Supplements:	Stomach Acid Preparations:
✓ Crest Pro-Health Rinse ✓ Biotene Mouthwash ✓ Listerine Breath Strips ✓ Therabreath Oral Rinse ✓ Tom's Natural <i>Avoid: All alcohol-based products</i>	✓ Multivitamins <i>Avoid: Herbal "energy" supplements</i> <i>Note: Discuss with physician before taking specific vitamins or supplements</i>	✓ Alka-Seltzer ✓ Gaviscon ✓ Maalox ✓ Milk of Magnesia ✓ Mylanta ✓ Pepcid ✓ Pepto-Bismol ✓ Prilosec ✓ Roloids ✓ Tagamet HB ✓ Tums ✓ Zantac
Stool Softeners, Fiber, Laxatives:	Note:	
✓ Benefiber ✓ Colace Stool Softener ✓ Dulcolax Stool Softener ✓ FiberCon ✓ Fleets Enemas ✓ Metamucil ✓ Colace Laxative ✓ Doxidan Laxative ✓ Per-Colace Laxative <i>Suggestion: Dietary control, exercise, increased water consumption</i> <i>Note: May be habit forming causing dependence for normal functioning</i>	Brand names have been listed here; however, most pharmacies carry their own label of medication. Compare the label on the brand name with the store label to be sure that none of the "to be avoided" ingredients have been added.	

Please feel free to share this list with your Primary Care Physician. Discuss any new medications and over-the-counter medications you are considering with your PCP.

**FULL BOARD
OCTOBER 2, 2025
VIDEOCONFERENCE**

Public Session

Rule Review

Member Assigned: Esquivel

Final Review: 847-001-0000
Subject: Notice of Proposed Rule

OREGON ADMINISTRATIVE RULES

CHAPTER 847, DIVISION 001 – OREGON MEDICAL BOARD

Final Review – October 2025

ORS 183.341 requires all state agencies to adopt rules of procedure to provide a reasonable opportunity for interested persons to be notified of the agency's intention to adopt, amend or repeal a rule. To align with current practice and account for advances in technology, the rule amendments remove specific delivery methods and requirements to provide notice to specific media outlets.

For more than 15 years, the Oregon Medical Board has emailed rulemaking notices to persons on the OMB's interested parties list. Currently, there are over 1,100 emails on this list. There are links on the OMB's webpage to allow anyone to sign up.

OMB has been mailing the Capitol Press room in the State Capitol rulemaking notices. With construction and other changes, this room no longer exists, and mail was returned. To ensure the media still receive rulemaking notices, OMB staff added the Oregon Capitol press corps members to OMB's interested party list, which includes Associated Press reporters.

No public comments received for this rulemaking.

847-001-0000

Notice of Proposed Rule

Prior to adoption, amendment, or repeal of any permanent rule, the Oregon Medical Board must give notice of the intended action:

(1) In the Secretary of State's Bulletin referred to in ORS 183.360 at least 21 days before the effective date of the intended action;

(2) ~~Mail a copy of the notice to~~ To persons on the Oregon Medical Board's ~~mailing~~ list established pursuant to ORS 183.335-(8) at least 28 days before the effective date of the rule; ~~and~~

(3) ~~In regard to rules adopted on or after January 1, 2006, To persons specified in ORS 183.335(15)~~ at least 49 days before the effective date of the rule, ~~the Board must provide notice to the persons specified in ORS 183.335(15); and.~~

~~(4) Mail or furnish a copy of the notice to:~~

~~(a) The Associated Press; and~~

~~(b) The Capitol Press Room.~~

Statutory/Other Authority: ORS 677.265

Statutes/Other Implemented: ORS 183.335, 183.341 & 677.275

**FULL BOARD
OCTOBER 2, 2025
VIDEOCONFERENCE**

Public Session

Rule Review

Member Assigned: Blasi

Final Review: 847-008-0020
Subject: Locum Tenens Registration

OREGON ADMINISTRATIVE RULES

CHAPTER 847, DIVISION 008 – OREGON MEDICAL BOARD

Final Review – October 2025

The rulemaking clarifies the locum tenens status requirements, that the licensee must not qualify for active status under OAR 847-008-0015(2).

No public comments received for this rulemaking.

847-008-0020

Locum Tenens Registration

- (1) Any licensee ~~whose official state of residence is a state other than Oregon~~ who proposes to practice intermittently within ~~the State~~ **Oregon and who does not qualify under OAR 847-008-0015** shall register and pay the biennial locum tenens registration fee.
- (2) The licensee practicing in Oregon with a locum tenens registration status may practice for a period not longer than two hundred and forty consecutive days in the biennium, or a total of two hundred and forty days on an intermittent basis in the biennium. A licensee practicing in Oregon with a locum tenens registration status who wishes to reactivate to active registration status, may be granted an additional ninety days to complete the reactivation process.
- (3) A volunteer camp physician, who provides medical care at a non-profit camp, shall practice with locum tenens registration status. The volunteer camp physician with locum tenens status may practice in Oregon for a period not longer than fourteen days per year.
- (4) A licensee who registers as locum tenens and who does not practice in Oregon during the biennium, shall be registered as inactive at the time of registration renewal, and shall be required to reactivate to locum tenens registration status prior to practicing in Oregon.
- (5) Requirements, procedures, and fees for a Locum Tenens registration shall be the same as for active registration.
- (6) Any licensee registered as locum tenens shall provide the Board with timely notification of the location and duration of each Oregon practice prior to beginning of such practice.
- (7) The licensee with locum tenens status who wishes to practice under a different license status must submit the reactivation application and fee and satisfactorily complete the reactivation process.

Statutory/Other Authority: ORS 677.265

Statutes/Other Implemented: ORS 677.172 & 677.265

**FULL BOARD
OCTOBER 2, 2025
VIDEOCONFERENCE**

Public Session

Rule Review

Member Assigned: Daoud

Final Review: 847-010-0300
Subject: Access to Mental Health Assessment, Treatment, or Services

OREGON ADMINISTRATIVE RULES

CHAPTER 847, DIVISION 010 – OREGON MEDICAL BOARD

Final Review – October 2025

Each person is an individual with unique strengths and needs and must be met with developmentally, culturally and linguistically appropriate and individually responsive services that recognize the individual as a whole person.

SB 1557 (2024) and SB 729 (2025) direct the Oregon Medical Board, among other health licensing agencies that license or certify mental or behavioral health providers, to adopt rules that prohibit licensees from denying any individual to access mental health assessment, treatment or services on the basis that the individual also has an intellectual or developmental disability. The rulemaking implements this statutory requirement.

The Oregon Board of Psychology is going through the process to adopt a similar rule.

No public comments received for this rulemaking.

847-010-0300

Access to Mental Health Assessment, Treatment, or Services

Licensees may not deny any individual access to mental health assessment, treatment, or services on the basis that the individual also has an intellectual or developmental disability.

Statutory/Other Authority: ORS 677.265 and OL 2024, chapter 96, section 5 (SB 1557) as amended by OL 2025, chapter 313, section 1 (SB 729)

Statutes/Other Implemented: OL 2024, chapter 96, section 5 (SB 1557) amended by OL 2025, chapter 313, section 1 (SB 729)

Enrolled Senate Bill 729

Sponsored by Senator GELSER BLOUIN; Senators HAYDEN, PATTERSON, REYNOLDS, Representatives ANDERSEN, NELSON, PHAM H, TRAN (Presession filed.)

CHAPTER

AN ACT

Relating to mental health services for individuals with disabilities; amending section 5, chapter 96, Oregon Laws 2024; and prescribing an effective date.

Be It Enacted by the People of the State of Oregon:

SECTION 1. Section 5, chapter 96, Oregon Laws 2024, is amended to read:

Sec. 5. (1) *[The Oregon Health Authority]* **A public body, as defined in ORS 174.109,** a community mental health program, a licensed medical provider or other certified or licensed practitioner, an education provider or a coordinated care organization may not deny any individual *[under the age of 21 years]* access to mental health assessment, treatment or services on the basis that the individual also has an intellectual or developmental disability.

(2) The **Oregon Health** Authority, the Department of Human Services, the Department of Education, the Oregon Medical Board and other health licensing agencies that license or certify mental or behavioral health providers shall adopt rules to carry out the provisions of this section.

[(3)(a)] **(3)** As used in this section, “education provider” means:

[(A)] **(a)** A school district, as defined in ORS 332.002;

[(B)] **(b)** The Oregon School for the Deaf;

[(C)] **(c)** An educational program under the Youth Corrections Education Program;

[(D)] **(d)** A public charter school, as defined in ORS 338.005;

[(E)] **(e)** An education service district, as defined in ORS 334.003;

[(F)] **(f)** An approved recovery school, as defined in ORS 336.680; or

[(G)] **(g)** Any state-operated program that provides educational services to students.

[(b) “Education provider” does not include:]

[(A) The Oregon Youth Authority;]

[(B) The Department of Corrections; or]

[(C) The Department of Education, except when functioning as an education provider on behalf of the Oregon School for the Deaf.]

SECTION 2. This 2025 Act takes effect on the 91st day after the date on which the 2025 regular session of the Eighty-third Legislative Assembly adjourns sine die.

**FULL BOARD
OCTOBER 2, 2025
VIDEOCONFERENCE**

Public Session

Rule Review

Member Assigned: Shaw

Final Review: 847-020-0170
Subject: Examination for Licensure

OREGON ADMINISTRATIVE RULES

CHAPTER 847, DIVISION 020 – OREGON MEDICAL BOARD

Final Review – October 2025

In 2021, the Medical Council of Canada Qualifying Examination (MCCQE) part 2 was discontinued and no longer required to receive Licentiate of Medical Council of Canada (LMCC) certification. The examination requirement for LCMM only requires a physician to pass MCCQE part 1. Other states such as Washington, California, Maine, Minnesota, and Arizona that accept a Canadian examination require LMCC certification, rather than specifying MCCQE parts.

To align with the Oregon Medical Board's current practice of accepting LMCC certification for examination purposes, the rulemaking updates the requirement to LMCC certification.

No public comments received for this rulemaking.

847-020-0170

Examination for Licensure

(1) The applicant must have passed one of the following examinations or combinations of examinations:

(a) United States Medical Licensing Examination (USMLE) Steps 1, 2, and 3.

(b) National Board of Osteopathic Medical Examiners (NBOME) examination or the Comprehensive Osteopathic Medical Licensing Examination (COMLEX) or any combination of their parts.

(c) ~~Medical Council of Canada Qualifying Examination (MCCQE) Parts 1 and 2~~ **Licentiate of Medical Council of Canada (LMCC).**

(d) Federation Licensing Examination (FLEX) Components 1 and 2 or FLEX Days I, II, and III.

(e) National Board of Medical Examiners (NBME) Parts I, II, and III.

(f) State licensing examination administered by a state or territory of the United States, if approved by the Board.

(g)(A) NBME Part I or USMLE Step 1; and

(B) NBME Part II or USMLE Step 2; and

(C) NBME Part III or USMLE Step 3 or FLEX Component 2.

(h) FLEX Component 1 and USMLE Step 3.

(2) The score achieved on each Step, Part, Component or state examination must equal or exceed the figure established by the entity administering the examination as a passing score.

(3) All Steps, Parts or Components listed in subsections (1)(g)–(h) must be administered prior to January 2000, except for applicants who participated in and completed a combined MD/DO/PhD program.

(4) The applicant who bases an application on passing the USMLE or the NBOME examination or the COMLEX must have done so under the following conditions:

(a) All three Steps of USMLE, or all three Levels of the NBOME examination or COMLEX or any combination, must be passed within a seven-year period which begins when the first Step or Level, either Step 1 or Step 2 or Level 1 or Level 2, is passed. An applicant who has not passed all three Steps or Levels within the seven-year period may request an exception to the seven-year requirement if he/she:

(A) Has current certification by a specialty board as defined in 847-020-0100; or

(B) Suffered from a documented significant health condition which by its severity would necessarily cause a delay to the applicant's medical study; or

(C) Participated in a combined MD/DO/PhD program; or

(D) Completed continuous approved post-graduate training with the equivalent number of years to an MD/DO/PhD program; or

(E) Experienced other extenuating circumstances that do not indicate an inability to safely practice medicine as determined by the Board.

(b) The applicant must have passed USMLE Step 3 or NBOME's COMLEX Level 3 within four attempts whether for Oregon or any other state. After the third failed attempt, the applicant must have completed one additional year of postgraduate training in the United States or Canada prior to readmission to the examination. The Board must approve the additional year of training to determine whether the applicant is eligible for licensure. The applicant, after completion of the required year of training, must have passed USMLE Step 3 or COMLEX Level 3 on their fourth and final attempt. An applicant who has passed USMLE Step 3 or COMLEX Level 3, but not within the four attempts as required, may request a waiver of this requirement if he/she has current certification by a specialty board as defined in 847-020-0100.

(5) The applicant who bases an application upon passing the FLEX examination must have done so under the following conditions:

(a) The FLEX examination must have been passed within seven years of the first attempt. The applicant who has taken the FLEX examination (Day I, II, and III) administered between June

1968 and December 1984 must have taken the entire examination at one sitting. The applicant who has taken the FLEX examination (Components 1 and 2), in June 1985 or after, was not required to take both Components 1 and 2 at one sitting.

(b) The applicant may not have taken the FLEX examination more than a total of four times, whether in Oregon or other states, whether the components were taken together or separately. After the third failed attempt, the applicant must have satisfactorily completed one year of approved training in the United States or Canada prior to having taken the entire FLEX examination at one sitting on the fourth and final attempt. An applicant who has passed the FLEX examination but not within the four attempts may request a waiver of this requirement if he/she has current certification by a specialty board as defined in 847-020-0100.

(c) Only the applicant's scores on the most recently taken FLEX examination will be considered to determine eligibility.

Statutory/Other Authority: ORS 677.265

Statutes/Other Implemented: ORS 677.110, ORS 677.120 & ORS 677.265



The MCC ceases delivery of the MCCQE Part II

June 10, 2021

Following our [May 31](#) communication, the Medical Council of Canada (MCC) confirms that it is stepping away from the delivery of the Medical Council of Canada Qualifying Examination (MCCQE) Part II going forward.

Recognising the impact of the pandemic, and the unprecedented challenges associated with delivering a MCCQE Part II examination, the MCC Council, at a meeting on June 9, affirmed updated criteria informing policy on the granting of the **Licentiate of the Medical Council of Canada (LMCC)** to candidates meeting all the following requirements:

1. Are a graduate from:
 - a) a medical school accredited by the Committee on Accreditation of Canadian Medical Schools or the Liaison Committee on Medical Education;
or
 - b) a medical school listed in one or more directories of medical schools approved from time to time by resolution and be a medical school listed in the World Directory of Medical Schools which includes a sponsor note indicating it is an acceptable medical school in Canada;
or
 - c) a United States School of Osteopathic Medicine accredited by the American Osteopathic Association.
2. Have successfully completed the MCCQE Part I (PASS).
3. Have successfully completed:
 - a) at least 12 months of acceptable clinical post graduate medical training as determined by the Executive Director;
or
 - b) at least 12 months of acceptable osteopathic post graduate clinical training in a program accredited by the Accreditation Council for Graduate Medical Education (ACGME) as determined by the Executive Director.
4. Have the required medical credentials including verification of postgraduate training successfully source verified through MCC or, in exceptional circumstances, have



provided evidence of the required medical credentials acceptable to the Executive Director.

Where an individual otherwise meets all of the above criteria but is subject to a prohibition order barring him or her from writing the MCCQE Part II examination, the Executive Director may award that individual the LMCC only after the expiration of the barring order.

The LMCC is not a licence to practise medicine. The authority to issue licences is reserved to the provincial and territorial Medical Regulatory Authorities (MRAs).

Independent standardized assessments remain a key component of medical licensure and are critical in ensuring patient safety in Canada. We will continue to work with the Assessment Innovation Task Force (AITF), the medical community and partner organizations, to reflect on how clinical skills and emerging competencies required of physicians will be assessed in the future. Criteria for the award of the LMCC may be reviewed at a future date as standardised assessment requirements for physicians evolve.

We recognize that the exam fees are substantial and are expediting the refund of the MCCQE Part II exam fee within the next 30 days to the credit card that was used for payment. Processing and the award of the LMCC for candidates who were registered for the latest exam session is expected to take up to two months. For other eligible candidates, this process will require coordination with third parties and may take longer. A separate fee for processing the LMCC is expected to be applied following the meeting of the MCC Finance Committee in late June as this cost was previously included in the exam fee.

For questions about the MCCQE Part II, please contact the MCC [service desk](#).

Weblink: <https://mcc.ca/news/the-mcc-ceases-delivery-of-the-mccqe-part-ii/>

[Home](#)

Work to relaunch USMLE Step 2 CS discontinued

Posted January 26, 2021

The Federation of State Medical Boards (FSMB) and NBME, co-sponsors of the United States Medical Licensing Examination® (USMLE®), are today announcing the discontinuation of work to relaunch a modified Step 2 Clinical Skills examination (Step 2 CS).

Following the May 2020 suspension of Step 2 CS due to the COVID-19 pandemic, we announced our intention to take 12-18 months to bring back a modified Step 2 CS exam that was appreciably better than the prior assessment. After reviewing current and anticipated progress with the exam and in consideration of the rapidly evolving medical education, practice and technology landscapes, we have decided to discontinue Step 2 CS. We have no plans to bring back Step 2 CS, but we intend to take this opportunity to focus on working with our colleagues in medical education and at the state medical boards to determine innovative ways to assess clinical skills.

Independent standardized assessments of medical knowledge and clinical skills are important inputs for state medical licensure decisions. In the absence of Step 2 CS, elements of clinical reasoning and communication will continue to be assessed on other exams (Steps) in the USMLE sequence. Computer-based case simulations in Step 3 and communication content recently bolstered in Step 1 are examples of these efforts that will continue. While not a replacement for Step 2 CS, these formats continue to contribute positively, e.g., measuring critical knowledge of medical communication.

Our change in direction will allow us to take additional time to partner with the medical education and medical board community to better develop innovative ways to assess the breadth of clinical skills in medicine.

For questions about the Step 2 CS discontinuation and any other USMLE-related inquiries please contact the USMLE support team: <https://www.usmle.org/contact/>

"The FSMB is committed to supporting state medical boards in their principal mission to protect the public," said Humayun J. Chaudhry, DO, MACP, President and CEO of the FSMB. "As co-sponsors of the USMLE program, we will continue to seek innovative and sensible ways to assess medical licensing eligibility."

"NBME's commitment to performance-based assessment and clinical skills has accelerated. Our newest area of focus around competency -based assessment, and our exploration of novel assessments, will allow us to work with the medical education and regulatory communities to develop assessments of these essential skills and the optimal way to integrate these assessments into the education and licensure space," said Peter J. Katsufakis, MD, MBA, President and CEO, NBME.

ECFMG will continue to oversee requirements for its certification of International Medical Graduates (IMGs) and has [announced](#) an expansion of its pathways that will allow qualified IMGs to meet the requirements for ECFMG Certification and to continue to pursue U.S. graduate medical education.

EXAMS & EXAM DAY	SCORES & TRANSCRIPTS	RESOURCES	SPONSORS
Step 1	Exam Results & Scoring	Exam Resources	FSMB.org
Step 2 CK		Common Questions	NBME.org
Step 3	Score Rechecks	Bulletin of Information	
Exam Day Overview	Transcripts	Announcements	
Security and Fairness		Performance Data	
Test Accommodations			
Reschedule an Exam			

Washington Administrative Code (WAC)

WAC 246-919-360 Examinations accepted for licensure. (1) The commission may accept certain examinations as a basis for licensure. These examinations include USMLE, Federation Licensure Examination (FLEX), National Boards Examination (NBE), or those given by the other states, or territories of the United States. Those who have taken the Licentiate of the Medical Council of Canada (LMCC) and hold a valid LMCC certification obtained after 1969, may be granted a license without examination.

(2) Examination combination acceptable. Any applicant who has successfully completed Part I (NBE) or Step 1 (USMLE) plus Part II or Step 2 plus Part III or Step 3; or FLEX Component 1 plus Step 3; or Part I or Step 1, plus Part II or Step 2, plus FLEX Component 2 shall be deemed to have successfully completed a medical licensure examination as required by RCW 18.71.070. (For clarification, see Table 1.)

Table 1

Accepted Examinations taken in Sequence	Other Acceptable Combinations
NBME Part I <i>plus</i> NBME Part II <i>plus</i> NBME Part III	NBME Part I or USMLE Step 1 <i>plus</i> NBME Part II or USMLE Step 2 <i>plus</i> NBME Part III or USMLE Step 3
FLEX Component 1 <i>plus</i> FLEX Component 2	FLEX Component 1 <i>plus</i> USMLE Step 3 or NBME Part I or USMLE Step 1 <i>plus</i> NBME Part II or USMLE Step 2 <i>plus</i> FLEX Component 2
USMLE Step 1 <i>plus</i> USMLE Step 2 <i>plus</i> USMLE Step 3	

[Statutory Authority: RCW 18.71.017 and 18.130.050. WSR 20-22-003, § 246-919-360, filed 10/21/20, effective 11/21/20. Statutory Authority: RCW 18.71.017, 18.130.050, 18.71.090, and [18.71.]095. WSR 06-18-042, § 246-919-360, filed 8/30/06, effective 9/30/06. Statutory Authority: RCW 18.71.017. WSR 04-04-067, § 246-919-360, filed 2/2/04, effective 3/4/04. Statutory Authority: RCW 18.71.017 and 18.71A.020. WSR 96-03-073, § 246-919-360, filed 1/17/96, effective 2/17/96.]

**FULL BOARD
OCTOBER 2, 2025
VIDEOCONFERENCE**

Discussion Item

Member Assigned: Daoud

Subject: Statement of Philosophy Review Mesotherapy and Injection
Lipolysis Update

OREGON MEDICAL BOARD
Statement of Philosophy

Mesotherapy and Injection Lipolysis

Proposed Updated Statement of Philosophy:

[The following language is new. For readability, it is not bolded/underlined.]

Background

Mesotherapy is the practice of injecting chemical preparations such as enzymes, hormones, plant extracts, vitamins, and/or other substances into the dermal layer of the skin (intra dermal) or the deeper, subcutaneous tissue layer beneath the skin for cosmetic purposes.

Injection lipolysis is a type of mesotherapy using a nonsurgical procedure that involves administering a series of injections under the skin into the subcutaneous layer to break down fat cells in the areas around the injection sites. Preparations utilizing deoxycholic acid (DCA) and/or phosphatidylcholine (PPC) are known to be used for injection lipolysis. DCA and PPC are both emulsifiers and surfactants. PPC is the most abundant phospholipid component of cell membranes, a precursor to acetylcholine, and a constituent of lipoproteins. PPC works to disrupt the membrane of fat cells through the release of lipids. DCA is a bile salt that helps emulsify and break down fat as well as maintain PPC solubility for injection.

Currently, Kybella is the only FDA-approved fat-dissolving injectable drug. It's active ingredient is DCA and it is solely approved for reducing fat under the chin in adults. Physicians may order individualized prescriptions from a compounding pharmacy designed for a specific patient for the purpose of injection lipolysis. However, there is a risk of FDA investigation and sanctions involving compounded drugs that are not approved by the FDA.

Safety and Efficacy of Injection Lipolysis

Any clinical study involving subcutaneous injection of these drugs requires Food and Drug Administration (FDA) approval of an investigational new drug (IND) application plus approval by an institutional review board (IRB).

Reports of adverse events have been documented following the injection of compounded preparations for injection lipolysis. These adverse events include mycobacterium skin infections, inferior alveolar nerve injury, skin ulcers, panniculitis, alopecia, nausea, diarrhea, and dizziness. The depth of injection lipolysis is critical to prevent damage to the underlying fascia layer.

The U.S. Food and Drug Administration has specifically noted significant risks associated with unapproved fat-dissolving injections.

Patients should be advised that unapproved fat-dissolving injections have been associated with serious complications. These include permanent scarring, severe infections, skin deformities, cysts, and painful knots. Many of these adverse reactions have occurred when injections were

administered by improperly licensed personnel or when individuals attempted to inject themselves with products purchased online.

Recommendations Regarding Injection Lipolysis

Injection lipolysis is typically performed using FDA-approved products or with proprietary formulations provided by compounding pharmacies. The Board only supports injection of medications which are FDA-approved for injection lipolysis. While Board licensees are authorized to prescribe medications consistent with the established standards of care, regardless of approval by the FDA, they should avoid prescribing medications that have little scientific evidence. Licensees should be aware and inform patients of possible side effects before administering and prescribing any medication.

Healthcare providers should emphasize to patients that safe and effective use of these products depends on correct injection techniques, proper needle placement, and professional administration. Patients should never purchase ingredients for unapproved fat-dissolving injections or attempt to inject themselves.

-Adopted October 2007

-Amended October 2025 (DRAFT)

Resources:

U.S. Food & Drug Administration, [Using Fat-Dissolving Injections That Are Not FDA Approved Can Be Harmful, December 20, 2023](#)

Current Statement of Philosophy:

Background

~~Treatments most properly called “injection lipolysis” have been commonly associated with the term “mesotherapy” to reduce or eliminate unwanted local accumulations of fat. Various terms for treatments that purport to “dissolve” fat seem to be used interchangeably, although “mesotherapy” has gained prominence in the public vernacular.~~

~~Injection lipolysis is typically done with trade-named products such as Lipodissolve™ and Lipostabil™ or with proprietary formulations provided by compounding pharmacies. The one common ingredient in all injection lipolysis formulations is phosphatidylcholine (PPC).~~

~~In the United States, sodium deoxycholate (DC), a constituent of bile, is a second major ingredient used to keep the PPC soluble and in an injectable form without precipitating out of solution.~~

~~Phosphatidylcholine (PPC) and sodium deoxycholate (DC) are both phospholipids, emulsifiers, and surfactants. PPC is the most abundant phospholipid component of cell membranes, a precursor to acetylcholine, and a constituent of lipoproteins. DC is a constituent of bile. Both substances are naturally present in the human body.~~

~~In contrast to injections into the mesoderm, injection lipolysis treatments are delivered into the subcutaneous fat. In both cases, the depth of injection is critical to prevent damage to fascia. It~~

has been hypothesized that treatment with PPC and DC reduces subcutaneous fat by adipocyte necrosis due to direct toxic or surfactant effects.

Phosphatidylcholine (PPC) and sodium deoxycholate (DC) are both approved by the U.S. Food and Drug Administration (FDA) for use as surfactants and drug carriers, among other applications, but neither is approved for subcutaneous injection. Lipodissolve™ and Lipostabil™ are not approved by the FDA.

Proprietary formulations of PPC / DC and other drugs have been manufactured by compounding pharmacies, yet such formulations lack standardization in terms of good manufacturing practices and sterility.

The FDA is well aware that injections to reduce fat deposits are performed, but the agency thus far has not exercised its enforcement power to restrict the use of compounded PPC / DC.

Safety and Efficacy of Injection Lipolysis

To date, reports on the safety and efficacy of injection lipolysis have been anecdotal. Any clinical study involving subcutaneous injection of these drugs requires FDA approval of an investigational new drug (IND) application plus IRB approval.

Reports of adverse events, including mycobacterium skin infections have been reported following the injection of compounded preparations for injection lipolysis.

Recommendations Regarding Injection Lipolysis

Patients must be informed that this procedure uses compounded drugs that are not approved by the FDA for injection.

The use of a PPC/DC combination is permitted in the context of a clinical trial operating under a FDA-approved IND (investigational new drug) study protocol.

Physicians may order individualized prescriptions from a compounding pharmacy designed for a specific patient for the purpose of injection lipolysis. “Bulk” purchases of the compounded drugs will not be possible. There is the risk of FDA investigation and sanctions involving compounded drugs that are not approved by the FDA.

Lipodissolve™ and Lipostabil™ are not approved by the FDA. It is illegal to import or use them.

**FULL BOARD
OCTOBER 2, 2025
VIDEOCONFERENCE**

Informational Items

Member Assigned: Blasi

Subject: 2026-27 Board Committee Meeting Schedule Draft



DRAFT

Approved by the Board on XXX

2026 - 2027 BOARD AND COMMITTEE MEETING DATES

Meetings are held hybrid, virtual, or in person at
Crown Plaza, 1500 S.W. 1st Ave., Suite 620, Portland, 97201

BOARD

8:00 AM

1st Thursday of January, April, July, and October - in person
Friday after the October Board meeting - in person retreat

January 8, 2026	April 2-3, 2026	July 9, 2026	October 1-2, 2026
January 7, 2027	April 1, 2027	July 1 or 8, 2027	October 7-8, 2027

INVESTIGATIVE COMMITTEE

8:00 AM

1st Thursday of every month without Board a meeting – in person

Full Board Conference-Call Meeting, 5:00 PM

February 5, 2026	March 5, 2026	May 7, 2026	June 4, 2026
August 6, 2026	September 3, 2026	November 5, 2026	December 3, 2026

ADMINISTRATIVE ADVISORY COMMITTEE

5:00 PM

2nd Wednesday of March, June, September, and December - virtual

March 11, 2026	June 10, 2026	September 9, 2026	December 9, 2026
March 10, 2027	June 9, 2027	September 8, 2027	December 8, 2027

ACUPUNCTURE ADVISORY COMMITTEE

12:00 PM

1st Friday of June and December - virtual

Application Filing Deadline – 6 weeks in advance of meeting. File Completion Deadline – 3 weeks in advance of meeting.

June 5, 2026	December 4, 2026	June 4, 2027	December 3, 2027

EMERGENCY MEDICAL SERVICES(EMS) ADVISORY COMMITTEE

9:00 AM

3rd Friday of February, May, August, and November - virtual

February 20, 2026	May 15, 2026	August 21, 2026	November 20, 2026
February 19, 2027	May 21, 2027	August 20, 2027	November 19, 2027

LEGISLATIVE ADVISORY COMMITTEE

TBD

Meets at the call of the Chair - virtually

2026

JANUARY

- Board 8th 8:00 AM

FEBRUARY

- Investigative Committee 5th 8:00 AM
- EMS Advisory Committee 20th 9:00 AM

MARCH

- Investigative Committee 5th 8:00 AM
- Administrative Affairs Committee 11th 5:00 PM

APRIL

- Board/Board Training 2nd – 3rd 8:00 AM

MAY

- Investigative Committee 7th 8:00 AM
- EMS Advisory Committee 15th 9:00 AM

JUNE

- Investigative Committee 4th 8:00 AM
- Acupuncture Advisory Committee 5th 12:00 PM
- Administrative Affairs Committee 10th 5:00 PM

JULY

- Board 9th 8:00 AM

AUGUST

- Investigative Committee 6th 8:00 AM
- EMS Advisory Committee 21st 9:00 AM

SEPTEMBER

- Investigative Committee 3rd 8:00 AM
- Administrative Affairs Committee 9th 5:00 PM

OCTOBER

- Board/Board Retreat 1st – 2nd 8:00 AM

NOVEMBER

- Investigative Committee 5th 8:00 AM
- EMS Advisory Committee 20th 9:00 AM

DECEMBER

- Investigative Committee 3rd 8:00 AM
- Acupuncture Advisory Committee 4th 12:00 PM
- Administrative Affairs Committee 9th 5:00 PM

**FULL BOARD
OCTOBER 2, 2025
VIDEOCONFERENCE**

Informational Items

Member Assigned: Esquivel

Subject: 2025 Succession Plan



2025 Workforce and Succession Plan

Oregon Medical Board

971-673-2700

Email: Info@omb.oregon.gov

Agency webpage: www.Oregon.gov/OMB

TABLE OF CONTENTS

Assessment Mission, Vision, Values.....	1
Workforce Planning Overview and Challenges.....	3
Succession Planning Previous Plan Year to Current	4
Succession Planning Identification of Highly Critical and Critical Positions.....	5
Succession Planning Competency Development.....	7
Succession Planning Evaluation and Action Plan	9

Workforce and Succession Plan 2025

Assessment | Mission, Vision, and Values

Mission

The mission of the Oregon Medical Board is to protect the health, safety, and wellbeing of Oregon citizens by regulating the practice of medicine in a manner that promotes access to quality care.

Vision

To foster for every Oregonian a thriving, consistently excellent community of medical professionals.

Values

Integrity: a commitment to acting honestly, ethically, and fairly.

Accountability: a willingness to accept responsibility for actions in a transparent manner.

Excellence: an expectation of the highest quality work and innovation.

Customer Service: a dedication to provide equitable, caring service to all Oregonians with professionalism and respect.

Equity: a devotion to creating and fostering an environment where everyone has access and opportunity to thrive.



Changes

Over the course of the year since the previous Succession Plan, there have been no changes to the mission, vision, or values of the Oregon Medical Board.

Workforce Planning

Workforce planning is a strategic process that involves analyzing and planning an organization's workforce to ensure that it has the right people with the right skills in the right places at the right time with a focus on recruiting and maintaining a diverse workforce, addressing environmental changes, and preparing for upcoming changes (expansion, restructure, or reduction).

Workforce Planning | Overview

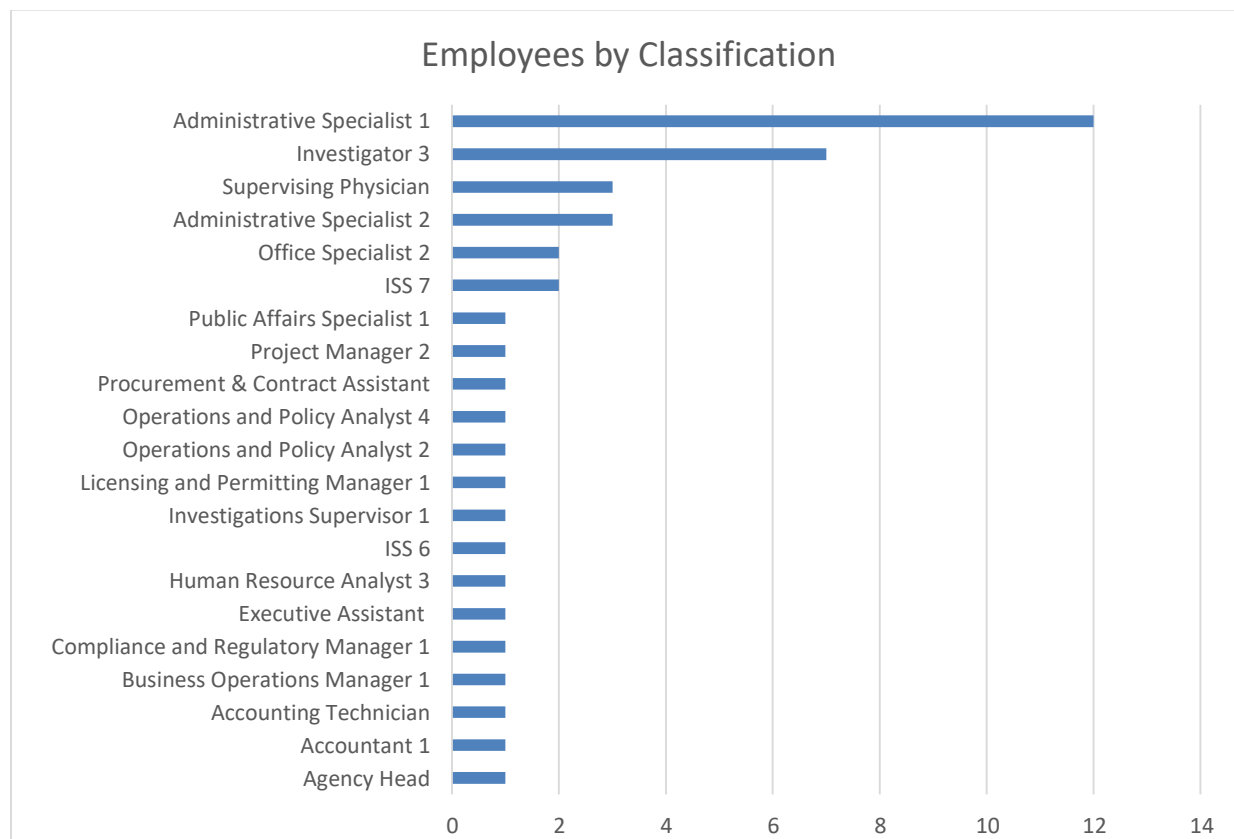
The Oregon Medical Board is a small state agency, with 43.75 budgeted positions. As a result, most positions have several functions, and many positions do not have a dedicated back-up, including the Investigations Manager and the Executive Director positions. This requires additional forethought for succession planning.

In the 2025-2027 budget, the agency successfully added a 0.5 FTE Supervising Physician position for an Associate Medical Director. This addresses the critical need identified in the 2023 and 2024 Succession Plans. The OMB also received a 1.0 FTE limited duration Project Manager 2 position to assist the agency with Project Sprout (see p.3 for information), as well as a .25 FTE permanent Administrative Specialist 1 position to support the provisional licensing of internationally trained physicians, per 2025 SB 476. Additionally, Currently 5 agency employees (approximately 12% of the staff) are eligible to retire.

Workforce and Succession Plan 2025

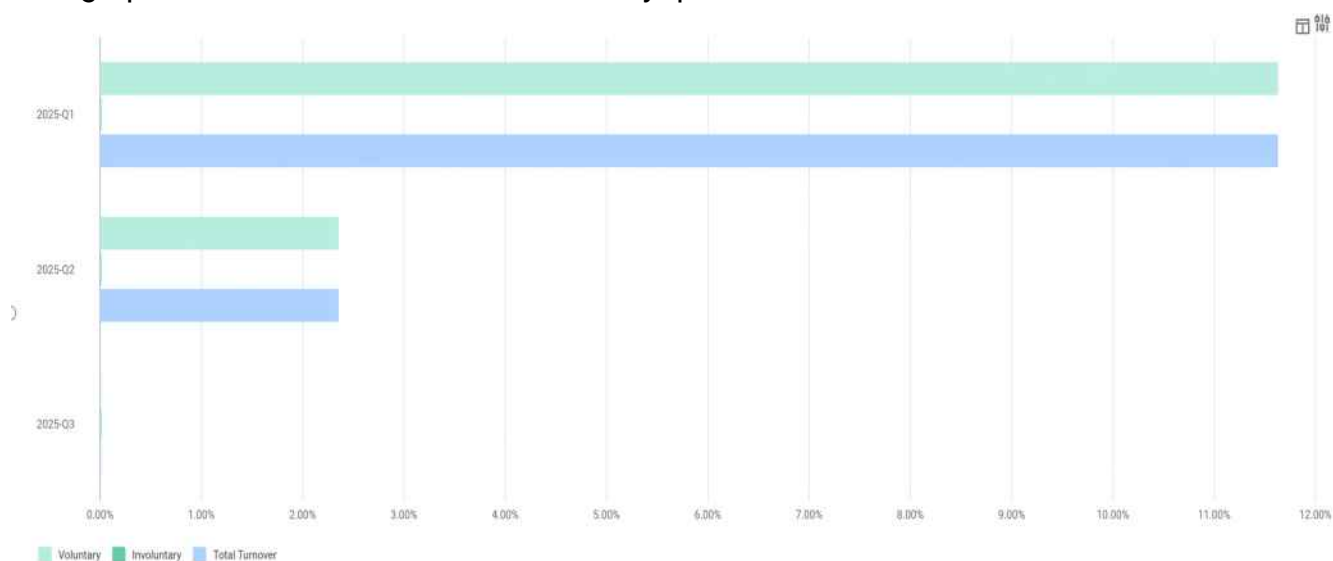
Current Workforce by Classification

This graph shows a breakdown of the various classifications occupied by OMB employees, demonstrating that many classifications are occupied by only one employee.



Turnover Rate

This graph shows a breakdown of turnover by quarter from 8/1/24 to 7/31/25.



Workforce and Succession Plan 2025

Current Staffing Needs | Vacancies

As of August 15, 2025, the agency has vacancies in Licensing, Investigations, and Business Services. Recruitments are underway in Investigations and Business Services, but the Licensing section expects to delay any recruitment until near the end of calendar year 2025 so as not to be training new employees during the biennial renewal period (October-December 2025) when approximately 25,000 physicians and physician associates are renewing their licenses.

Future Staffing Needs | Anticipated Needs

The Core Business Systems Replacement Project (“Project Sprout”) will require substantial IT and Business Analyst resources as it moves forward. The most experienced technical employees will focus on building, testing, and launching the new system. To maintain regular operations during this time, additional limited duration staff will be needed to fill the gaps left by senior team members working on the project.

Talent Gaps | Current and Future

Over the past several years, the agency has seen an increase in complaints from patients who have experienced trauma. Job requirements are now updated to include this safety-first expectation, prioritizing candidates with skills and experience in trauma-informed approaches.

2026 Retirement Eligibility | One-Year Forecast

Approximately 12% (5 out of 42.5) of the agency’s current workforce is eligible to retire within the next year. Of these positions, the Administrative Specialist 1 and Investigator 3 positions can be absorbed by remaining staff while recruiting and re-filling these positions. The Compliance and Regulatory Manager is the only position of its kind in the agency and would likely require a lengthy recruitment process.

Position	Eligible to Retire Now	Eligible to Retire $\leq$ 1 Year
Investigations Manager	1	
Admin Spec 1 (Licensing)	3	
Investigator 3	1	

Workforce Planning | Challenges

Challenge: Workload and resources for Project Sprout

- Goal: Secure additional funding and staff to complete the project.
- Additional Resources: potential budget request in short session.
- Potential Partners: DAS EIS to complete stage gates within target timeline.
- Target completion date: July 2029
- Contingencies: Potential staffing/funding shortages.

Workforce and Succession Plan 2025

Challenge: Workload and resources for legislative requirements, specifically 5NP and ITPs

- Goal: Meet legislative timelines and outcomes for 5NP (Five Needle Protocol) and ITP (Internationally Trained Physicians) legislative directives.
- Additional Resources: Hire additional staff to address these new workloads without overburdening existing staff.
- Potential Partners: International Association of Medical Regulatory Authorities (IAMRA), the Federation of State Medical Boards (FSMB), the Educational Commission for Foreign Medical Graduates (ECFMG), the World Federation for Medical Education (WFME), the Accreditation Commission for Graduate Medical Education (ACGME), the American Board of Medical Specialties (ABMS), the Oregon Medical Association (OMA), the Osteopathic Physicians and Surgeons of Oregon (OPSO), the Oregon Association of Acupuncturists (OAA), the People's Organization of Community Acupuncture (POCA), National Acupuncture Detoxification Association (NADA), and other interested parties.
- Target completion date: March 1, 2026, for 5NP implementation, and January 1, 2027, for ITP implementation.
- Contingencies: Potential staffing/funding shortages as well as the need to be responsive to the needs of the communities affected by this legislation.

Succession Planning

Succession Plan 2025 | Review Previous Plan Year to Current

Summary of gains made from previous succession plan.

Position(s) Identified in 2024	2024 Status (critical, highly critical)	2025 Status (non-critical, critical, highly critical)	Reason Provide brief narrative of why status changed or stayed the same
IT Positions	Highly Critical	Highly Critical	Existing IT positions are required for the multi-year core business suite replacement project
Medical Director	Critical	Non-Critical	A 0.5 FTE Associate Medical Director position as added in the 2025-27 budget
Investigations Manager	Critical	Critical	Current incumbent has not yet retired. Will need to recruit once vacant.
Executive Director	Not Identified	Critical	Agency's management team identified this role as not having sufficient back-up

Highly Critical

1. Position number one: IT Positions

- a. Competencies of position: The IT positions are critical to the OMB's ability to securely and efficiently utilize the vast amounts of sensitive data involved in effectively licensing and regulating the practice of medicine in Oregon. With the shift in the agency's database replacement project to focus potentially on in-house IT talent rather than an outside vendor, these competencies have become paramount to the agency's continued success. These competencies include database architecture, software development, quality assurance and testing, and data security.
- b. Why identified as highly critical (see factors): The risk of not successfully completing the database replacement project is that the agency becomes increasingly likely to have a significant issue with the ability to continue to provide licensing services as well as managing the investigations processes and effectively overseeing compliance cases. The current agency database was developed by a vendor that is no longer supporting it, which has necessitated the support moving internal to the agency, and prompted the need for a replacement solution. This puts additional pressure on the internal IT team of 3 FTE to support the current aging database while taking on the added work of building, testing and implementing the new database solution. Additionally, these positions are challenging to recruit if replacements were needed due to specialized knowledge required and the learning curve for new staff to understand agency processes and business needs.
- c. Was this position identified on your 2024 Succession Plan? Yes.

Critical

2. Position number two: Executive Director

- a. Competencies of position: The Executive Director position is critical to the OMB in that regulating the practice of medicine in a manner that protects Oregonians requires effective and efficient review of applications for licensure and investigations alleging that a licensee is an immediate danger to the health, safety, or wellbeing of Oregonians. The competencies for this critical position include leadership skills, the ability to manage the nexus of legal and medical challenges, an understanding of and ability to apply complex laws, as well as the capacity to work within a team.
- b. Why identified as critical (see factors): The Executive Director is the only position authorized to act on the Board's behalf and direct the agency staff in several scenarios. For example, only the OMB Executive Director may close the office, deploy the continuity of operations plan (COOP), oversee per diem and expense reimbursements, and oversee contracts.
- c. Was this position identified on your 2024 Succession Plan: No

Workforce and Succession Plan 2025

3. Position number three: Investigations Manager

- a. Competencies of position: The Investigations Manager position is critical to the OMB in that regulating the practice of medicine requires addressing complaints efficiently and effectively. The competencies for this critical position include leadership skills, the ability to manage the nexus of legal and medical challenges, understand and apply complex laws, as well as work within a team.
- b. Why identified as critical (see factors): The current Investigations Manager is eligible for retirement, and the risk of this position being unfilled for any significant amount of time would be that a section of the agency would be without direct leadership and guidance, directly impacting the ability to meet the agency's mission.
- c. Was this position identified on your 2024 Succession Plan: Yes

POSITION IDENTIFICATION REFERENCE CHART

NOT A CRITICAL POSITION	• Vacancy would cause limited impact • Limited specialized knowledge or skills required • Strong recruitment potential • Competitive compensation package • Limited direct promotional opportunities
CRITICAL POSITION	• Vacancy would cause an impact • Some specialized knowledge or skills required • Challenging recruitment • Moderately competitive compensation package • Skill set in demand • Promotional opportunities • Anticipate vacancy within the next 1 to 5 years
HIGHLY CRITICAL POSITIONS	• Vacancy would cause a significant impact • Specialized knowledge or skills required • Very challenging recruitment • No competitive compensation package/compression issues • Skill set in high demand • Promotional opportunities • Anticipate vacancy within the next year

Highly Critical

1. Position number one: IT Positions

- a. *How can competency be developed? How are you going to build the bench strength for this position?*

The intention for these positions is to focus on retention and to allow current staff to continue to develop their skillsets at the ISS 7 levels developing the new database solution. As the database development and implementation has moved in-house, we would look to hire additional IT limited duration positions to support the ongoing day-to-day needs of the rest of the agency. Once the project is completed successfully, we will need to re-assess the ongoing agency IT needs regarding permanent positions.

- b. *Gaps: what are potential recruitment or retention challenges for this position?*

These positions are challenging to recruit due to the specialized knowledge required and due to the ISS classification series itself. Recruiting to specific IT competencies is challenging, in addition to the learning curve for new staff to understand agency processes and business needs.

- c. *What are the skill development challenges in relation to the existing and future workforce (i.e., current employees need to develop new skills, specialized skills/degree/license are required, etc.), and how do you plan to overcome them?*

In the IT profession, it is not unusual for people to be hired on a project or contract basis, so the need to fill the positions as limited duration hires should not be exceptionally hard to overcome. However, training them to the agency's needs would challenge the existing IT staff while they are working on the database replacement project. To overcome this, the agency plans to continue the current LDs through the duration of the project to allow senior staff to focus on the critical project work.

Critical

2. Position number two: Executive Director

- a. *Development plan for competency development. How are you going to build the bench strength for this position?*

The OMB plans to continue to develop staff internally to build leadership skills, and recruit when appropriate to fill the position, as well as any additional vacancies that may be created in the event of an internal hire.

- b. *Gaps: what are potential recruitment or retention challenges for this position?*

The recruitment challenges are that this particular skill set (legal aspects of regulating medical care) are difficult to find, and so the need to recruit for leadership skills, the ability to manage the nexus of legal and medical challenges, team focus, political savvy, and equity mindedness can be challenging.

Workforce and Succession Plan 2025

- c. *What are the skill development challenges in relation to the existing and future workforce (i.e., current employees need to develop new skills, specialized skills/degree/license are required, etc.), and how do you plan to overcome them?*

Our plan is to continue to develop staff internally by providing opportunities to take on leadership tasks but also be prepared to widen our search outside the agency and the state if necessary to fill the role with the best possible candidate.

3. Position number three: Investigations Manager

- a. *Development plan for competency development. How are you going to build the bench strength for this position?*

The OMB plans to continue to develop staff internally to build leadership skills, and recruit when appropriate to fill the position, as well as any additional vacancies that may be created in the event of an internal hire.

- b. *Gaps: what are potential recruitment or retention challenges for this position?*

The recruitment challenges are that this particular skill set (investigations in medical care) are difficult to find, and so the need to recruit for leadership skills, investigations skills, team focus, and equity mindedness can be challenging. For the past several people in this position, they have been promoted internally from an investigator position or a supervisory role within the agency. That may not be an option with the next iteration of this role.

- c. *What are the skill development challenges in relation to the existing and future workforce (i.e., current employees need to develop new skills, specialized skills/degree/license are required, etc.), and how do you plan to overcome them?*

Several of the current investigative staff have supervisory or leadership experience from previous roles. The challenge for staffing this position is developing more of the soft skills, political tact, coaching, etc. to be successful in this role. We will continue to provide opportunities for staff to develop their skills in these areas.

Agency-wide plans for competency development

The OMB continues to be committed to developing staff for opportunities within the agency and within the enterprise of State government. Several investigations staff have attended training from the Council on Licensure, Enforcement and Regulation (CLEAR) for a national certification. In addition, two Licensing staff have attended a Licensing Specialist training through the Administrators in Medicine (AIM). On the management team, many members have completed Leadership Oregon, and the new Medical Director is currently enrolled in an MBA program with an educational subsidy from the OMB.

What are the agency's plans to evaluate and revisit this plan to ensure the agency is on track (i.e. "The agency's leadership team will evaluate this succession plan quarterly and make adjustments as necessary")? Further areas to refine your evaluation strategies are included below.

Workforce and Succession Plan 2025

Overall Plan Review

How will the agency review the plan in its entirety (i.e. quarterly/annually and by whom)?

The OMB's Executive Director, Human Resources Manager, and Public Affairs Specialist review the agency's succession plan annually.

Highly Critical/Critical Positions

Has the work changed and has how the work is done changed or new programs added?

The work involved in developing the new IT database takes contributions from subject matter experts across the agency, which has increased the workload, and will continue as program features are developed and tested. All the agency's work is also being done with consideration towards the increase in national and international collaboration regarding the medical workforce, as a shortage of qualified healthcare professionals is an ongoing issue everywhere.

As a small agency, many positions are one of a kind within the agency, which can be perceived as all positions being critical for the agency's ongoing success. In particular, the Agency Head, or Executive Director, could be seen as a critical position although there is no reason to think this position will become vacant in the foreseeable future. Given that the agency is small, and there is no Deputy Director position, this could be a vulnerability. In recognition of this, authority has been delegated for specific tasks and responsibilities in the absence of the Executive Director to the Business Manager, the Legislative and Policy Analyst, and the Medical Director. While there is no reason to believe these delegations will be needed, but a plan is in place should it be required.

Competency Adjustment

How will the agency evaluate and adjust competencies?

The agency continues to use the Performance and Accountability Feedback quarterly reviews to open conversations regarding goals and development opportunities with all staff. This is the primary tool for assessing staff competencies and providing growth options. Additionally, the agency has engaged experts to train staff in a trauma-informed approach to the complaints and investigations processes, which is a developing competency area for public-facing staff.

Employee Goals

How will the agency evaluate employee goals (i.e., PAF guidelines to discuss employee interest and cross-training/promotional opportunities)?

The OMB will evaluate employee goals through quarterly check-ins between managers and their supervised employees.

The OMB's Strategic Plan also sets targets for professional development opportunities for staff, and the management team is intentional in identifying opportunities and making those available for staff.

Workforce and Succession Plan 2025

Recruitment Strategies

What is the evaluation process to determine if the current and future recruitment and retention strategies are working and how will they be adjusted as needed?

The OMB continues to work toward the Governor's expectations of a 50-day recruitment and has been able to successfully recruit for most positions over the past year, with a couple of failed recruitments. As of August 15, 2025, the agency has opened 10 requisitions year to date, with more on the horizon.

Retention strategies include quarterly PAF meetings with employees, which provide an opportunity for feedback from staff, including goals for development and growth. Additionally, staff are encouraged to seek training opportunities and discuss them with their manager.

Adjustments to recruitment and retention strategies will be discussed and developed with Human Resources, the agency management team, and the Executive Director. As part of the Strategic Plan and DEI Plan, these strategies are reviewed quarterly for progress toward stated goals.

Action Plan

In 2024, the agency instituted an Annual in-service day for the entire staff, which was very successful and well-received. Another in-service day is planned for October 2025.

The goal of sending six staff members to attend training to develop their skills and expertise has been met or exceeded. Employee development will continue at the same rate.

Conclusion

The agency's Succession Plan works in conjunction with the Strategic Plan, Affirmative Action Plan and DEI Action Plan. The management team reviews the action items from these various plans periodically throughout the year to ensure the agency is on track to meet stated goals and objectives. The OMB remains committed to ensuring optimal staffing and providing quality resources to enable staff to do their best work in support of the agency's mission.

**FULL BOARD
OCTOBER 2, 2025
VIDEOCONFERENCE**

Informational Items

Member Assigned: Daoud

Subject: Governor's Expectations for State Agencies Quarterly Report

**FULL BOARD
OCTOBER 2, 2025
VIDEOCONFERENCE**

Informational Items

Member Assigned: Shaw

Subject: Secretary of State Audit Recommendations Update

MEMORANDUM

TO: Oregon Medical Board, Administrative Affairs Committee
SUBJECT: OMB Audit Recommendations Update
DATE: August 26, 2025

In January 2024, the Oregon Secretary of State published an audit of the Oregon Medical Board with four recommendations. Below is a summary of OMB's ongoing work.

Recommendation 1 Implement sanctioning guidelines and/or a sanction matrix to help reduce the risk of inconsistent and inequitable case decisions.		
Agree or Disagree with Recommendation	Target date to complete implementation activities	Name and phone number of specific point of contact for implementation
Agree	Implemented April 3, 2025	Nicole Krishnaswami 971-673-2700

OMB staff reviewed investigative guidance from fellow state boards and organizations. Additionally, the Board hired an intern studying for a masters in biostatistics to conduct a five-year retrospective review of the OMB's investigative case outcomes. Through these efforts, Board staff drafted an initial guidelines document.

In August 2024, the Board convened a workgroup of licensee-representing attorneys, advocates for patient safety, professional associations, members of the public, and OMB members. The workgroup held public meetings to refine the guidelines. The Workgroup's recommendations were reviewed by the OMB's Administrative Affairs Committee, as well as all members of the Board, throughout the process. The [OMB Disciplinary Guidelines](#) were adopted by the Board on April 3, 2025, and are posted online and provide below.

Recommendation 2 Add the ability to categorize cases by primary or most serious complaint type, or another effective categorization system, to the agency's forthcoming new data system.		
Agree or Disagree with Recommendation	Target date to complete implementation activities	Name and phone number of specific point of contact for implementation
Agree	Implemented July 1, 2025	Nicole Krishnaswami 971-673-2700

Update: Upon review, the OMB's current database captures "complaint category" when a complaint is *received*. This is not adequate for analyzing the equity and consistency of disciplinary *outcomes*. Staff reworked an existing statutory violation field to meet this need. The field will be populated by the Executive Director in consultation with the Assistant Attorney General and Investigations Manager during the order drafting process. The field will allow designation of a primary and secondary statutory violation for the order. OMB started collecting data for Board Actions taken at the July 10, 2025, Board meeting.

Recommendation 3 Use complaint data to conduct regular, systematic reviews of past cases to help monitor for and ensure equity and consistency.		
Agree or Disagree with Recommendation	Target date to complete implementation activities	Name and phone number of specific point of contact for implementation
Agree	July 1, 2026	Nicole Krishnaswami 971-673-2700

Update: A full year's data will be necessary for meaningful analysis. See plan summary below.

Recommendation 4 Develop and implement written policies and procedures for analyzing board disciplinary decisions for equity and consistency.		
Agree or Disagree with Recommendation	Target date to complete implementation activities	Name and phone number of specific point of contact for implementation
Agree	January 1, 2026	Nicole Krishnaswami 971-673-2700

Update: Following implementation of the OMB disciplinary guidelines on April 3, 2025, Board staff began collecting data on all disciplinary and corrective action decisions starting with those decisions made at the board meeting on July 10, 2025.

The plan is to compare disciplinary and corrective action decisions with similar statutory violations to see if outcomes are consistent and equitable, while accounting for unique circumstances and mitigating or aggravating factors. The analysis will also develop recommendations to ensure future disciplinary and corrective action decisions are equitable and consistent. As Board staff develop this process to collect and review data to carry out the analysis and review for Recommendation #3, written policies and procedures will be created and updated as needed.

**FULL BOARD
OCTOBER 2, 2025
VIDEOCONFERENCE**

Informational Items

Member Assigned: Shaw

Subject: 2025 Legislative Session Update & Implementation Plans

MEMORANDUM

TO: Oregon Medical Board, Administrative Affairs Committee
SUBJECT: 2025 Legislative Session Update & Implementation Plans
DATE: August 25, 2025

Below are bills impacting the Board. Each bill includes a link to the bill (click the bill number), a summary, and implementation plan with a progress status:  Work started or  Complete

SB 873: Repealing Unused Volunteer Emeritus License

Repeals ORS 677.120 to remove unneeded regulations because no out-of-state physicians held a Volunteer Emeritus license. Instead, HB 4096 (2022) created an authorization for out-of-state physicians to practice in Oregon for up to 30 days each calendar year. Effective January 1, 2026.

Implementation Plan

Division 23 Repeal Rulemaking AAC & Board meeting reviews	First Review Sept. 10 + Oct. 2, 2025 Final Review Dec. 10, 2025 + Jan. 8, 2026	
Update OMB website	January 2026	

SB 874: Defining Traditional Eastern medicine within the Medical Practice Act

Adds a definition for “Traditional Eastern medicine” to provide cohesion and clarify the OMB’s authority to regulate acupuncturists. Replaces the term “Oriental” with “Traditional Eastern medicine” throughout ORS chapter 677. The bill also clarifies the definition of "acupuncture" and updates the Oregon Association of Acupuncturists name. SB 874 does not change the scope of practice for acupuncturists in Oregon. Effective January 1, 2026.

Implementation Plan

Division 70 & 847-010-0073 rulemaking, Acupuncture Committee & Board meetings	First Review Sept. 12* + Oct. 2, 2025 Final Review Dec. 5, 2025 + Jan. 8, 2026 *Extra Acupuncture Committee meeting	
Communications to partner organizations	Fall 2025	
Update materials, forms, and website	January 2026	
Newsletter article	Winter 2026 Edition	

HB 5022: OMB Budget Bill

The OMB 2025-27 budget of \$20,743,151 Other Funds with 43 positions. The budget includes a 20% increase to license registration fees on July 1, 2026, and adds a \$25 per year passthrough fee to support the Health Professionals’ Services Program on July 1, 2025.

Implementation Plan

Modify IT systems for HPSP fee and train staff	May 2025-June 2025	
HPSP fee rulemaking Board meeting review	Final Review July 10, 2025	
HPSP fee effective	July 10, 2025	

OMB 25-27 Budget	starting July 1, 2025	✓
License registration fee rulemaking, AAC & Board review	First Review Dec.10, 2025 + Jan. 8, 2026 Final Review Mar. 11 + Apr. 2, 2026	
Request for additional Business Suite Replacement project funding	Utilize process for consideration during the 2026 Legislative Session	
Update fees OMB website	July 1, 2026	
New registration fees effective	July 1, 2026	

HB 2143: Creating five-needle protocol (5NP) for non-Acupuncturists

Creates a new regulated profession, under the jurisdiction of the OMB, allowing an individual with required training to provide 5NP treatment without a license to practice acupuncture starting March 1, 2026. Allows the Oregon Medical Board to establish by rule:

- Qualifications for 5NP registration, including education and training
- A registry of individuals qualified to provide 5NP
- Sanitation and best practice standards
- A schedule of violations and disciplinary actions
- Any other requirements or standards the board determines necessary

The OMB estimates about 200 technicians would register in the first year with an additional 60 per biennium. The OMB would need to charge a \$148 initial registration fee (including criminal background check) and \$100 renewal fee.

Implementation Plan

Create 5NP webpage	June 2025, omb.oregon.gov/5NP	✓
OMB staff research and create a draft structure for the program	July 2025	✓
OMB staff solicit/form workgroup	July 2025	✓
Newsletter article	Summer 2025 edition	✓
5NP workgroup reviews and develops recommendations	August 2025	✍
5NP rulemaking Acupuncture Committee & Board meeting reviews	First Review Sept. 12* + Oct. 2, 2025 Final Review Dec. 5, 2025 + Jan. 8, 2026 *Extra Acupuncture Committee meeting	✍
Fee adoption process	Through rulemaking and utilize DAS process	
Seek funding limitation increase	Utilize DAS process	
Create database/IT systems, develop internal procedures, materials/forms, and train staff	October 2025-February 2026	
Start accepting applications	March 3, 2026 (first business day of March)	
Add 5NP to Annual Report	Winter 2026	
Newsletter article	Spring 2026 edition, ongoing	
Collect data and report on 5NP	Ongoing, Annual Reports	

SB 476: Internationally Educated Limited License and Workforce Grant

Requires licensing board staff who interact with internationally educated individuals to receive culturally responsive training. By July 1, 2026, licensing boards must develop and post guidance regarding pathways to licensure for internationally educated individuals. The bill also makes updates for Canadian Medical School accreditation effective January 1, 2026. Lastly, the bill creates a provisional license for internationally educated physicians starting January 1, 2027, and every odd-numbered year the OMB must report to the Legislature on the program.

Implementation Plan for Staff Training & Website

Board staff receive culturally responsive training	Once trainings are approved by the Office of Immigrant and Refugee Advancement	
Update website on pathways to licensure for internationally educated individuals.	Prior to July 1, 2026	

Implementation Plan for Updates to Canadian Medical School Accreditation

847-020-0120 rulemaking	First Review Sept. 10 + Oct, 2, 2025	
AAC & Board meeting reviews	Final Review Dec. 10, 2025 + Jan. 8, 2026	
Update website and materials	January 8, 2027	

Implementation Plan for Internationally Trained Physicians Provisional Licensure

Create Internationally Trained Physicians Webpage	Summer 2025, updates ongoing, omb.oregon.gov/ITP	✓
Newsletter article	Fall 2025	
OMB staff research and create a draft structure for the program	Fall 2025	
OMB staff solicit and form ITP workgroup	December 2025	
ITP workgroup reviews and develops recommendations	January-May 2026	
ITP rulemaking	First Review March/June + April/July 2026	
AAC & Board reviews	Final Review September + October 2026	
Fee adoption process	Through rulemaking and utilize DAS process	
Create database/IT systems, develop internal procedures, materials/forms, train staff	August-December 2026	
Newsletter article	Fall 2026, and ongoing as needed	
Start accepting applications	January 1, 2027	
Report to Legislature on program	By February 1, 2027, and every odd year	

HB 3727: Out-of-State Telemedicine Practice

Specifies an Oregon-licensed physician or PA may use telemedicine to engage in the practice of medicine when a patient is temporarily located out of state if they have an established patient-provider relationship. The physician and PA would also be subject to the laws regulating the practice of medicine in the jurisdiction where the patient is located at the time the patient receives health care services. Effective January 1, 2026.

Implementation Plan

Update OMB website	January 2026	

HB 3211: Nonopioid Directive Form

Requires the Oregon Health Authority to develop and make available a nonopioid directive form effective January 1, 2026.

Implementation Plan

Update OMB website	January 2026	
Newsletter Article	Spring 2026	

HB 3043: Health Professional Services Updates

Adds criteria to the initial evaluation process, updates definitions for direct supervisor and diversion agreements, and authorizes boards to define substantial noncompliance with the program. The bill allows boards to impose an additional \$25/year fee on licensees as a passthrough-fee rather than a board paying for this program from registration fees. Effective January 1, 2026.

**As of June 26th, this bill was still waiting for the Governor's signature.*

Implementation Plan

HPSP updates Rulemaking AAC & Board meeting reviews	First Review Sept. 10 + Oct. 2, 2025 Final Review Dec. 10 + Jan. 8, 2026	
Update OMB website	January 2026	
Newsletter Article	Winter 2026	

HB 3127: Report of Death

Requires medical certifiers to submit reports of death through the state electronic reporting system (Oregon Vital Events Registration System) by January 1, 2026. Non-electronic submission would no longer be accepted.

Implementation Plan

Update OMB website	January 2026	
Newsletter Article	Winter 2026	

MEMORANDUM

TO: Oregon Medical Board

SUBJECT: IAMRA 16th International Conference on Medical Regulation - Dublin, Ireland

DATE: September 18, 2025

Conference Overview

The International Association of Medical Regulatory Authorities (IAMRA) held its 16th International Conference on Medical Regulation from September 3-6, 2025, in Dublin, Ireland. The Medical Council of Ireland hosted the conference, which drew more than 460 participants from 37 countries.

Oregon Medical Board Representation

The Oregon Medical Board was represented by:

- Jill Shaw, DO, Chair
- Sudeep Taksali, MD, Vice Chair
- Nicole Krishnaswami, JD, Executive Director



Conference Theme and Key Highlights

Under the theme "People-focused regulation for a safer global community," the conference emphasized placing patients and communities at the center of health practitioner regulation. Notable highlights included:

- **Opening Address:** WHO Director-General Dr. Tedros Adhanom Ghebreyesus addressed regulation's critical role in health systems, healthcare workforce development, and universal health care access.
- **Keynote Presentation:** Former Irish Prime Minister Dr. Leo Varadkar challenged attendees to modernize health systems and regulatory frameworks.
- **Workshop:** Dr. Taksali led – and Dr. Shaw and Ms. Krishnaswami supported – a workshop on physician wellness, sharing Oregon's area of excellence with the global regulatory community.
- **Plenary Session:** Ms. Krishnaswami facilitated a plenary session on compassionate regulation, which focused on supporting health care providers without sacrificing standards for public protection.

Key Learning Areas

The conference provided valuable insights through:

- Practical strategies to strengthen regulatory effectiveness and responsiveness
- Interactive workshops on AI integration, compassionate regulation, and workforce planning
- Discussions on inclusive regulation, health equity, and cultural safety
- Focus sessions on preparing tomorrow's doctors
- A pre-conference workshop supporting low- and middle-income countries (LMICs) and advancing the 2024 IAMRA-WHO Memorandum of Understanding

Historic Leadership Election

Ms. Krishnaswami was elected Chair of IAMRA at the Members General Assembly, marking the first time in IAMRA's history that a U.S. state medical board director has held this position. This milestone recognizes Oregon's leadership in innovative regulatory practices and provides an unprecedented opportunity to influence global medical regulation standards.

Initiatives for 2025-27

IAMRA committed to several key initiatives:

1. **Global Peer Learning Program:** Knowledge exchange among regulators with strong support for LMIC regulators
2. **WHO Guidance Implementation:** Joint initiatives, technical support, and education programs
3. **AI and Emerging Technologies Network:** Development of future-ready regulatory responses to healthcare's digital transformation
4. **Compassionate and Culturally Safe Regulation:** Advancing approaches that promote fairness and community responsiveness

The conference reinforced Oregon's position as a leader in innovative, compassionate medical regulation and provides valuable insights for our ongoing regulatory enhancement efforts.

IAMRA will reconvene as a global community in Hong Kong SAR in 2027.

For additional information about IAMRA initiatives, visit: <https://www.iamra.com/>



Press Release · September 17, 2025

Governor Kotek Makes Access to Safe, Effective Vaccines Possible in Oregon Ahead of Respiratory Virus Season

Five state agencies adopt latest scientific recommendations from the West Coast Health Alliance, making vaccines available in Oregon and mitigating disruption caused by Trump Administration



Governor Tina Kotek directed state agencies to develop a coordinated approach to reduce disruption to COVID-19 vaccine access caused by the Trump Administration. Today, five state agencies took various actions to implement the [West Coast Health Alliance \(WCHA\) respiratory vaccine recommendations](#) and restore access to vaccines at the pharmacy.

"If you want to get vaccinated before respiratory virus season, you can in Oregon," Governor Kotek said. "The confusion created by the Trump Administration for simple vaccine administration in states across the country

puts people at risk. Staying safe shouldn't be hard or expensive – these actions today mean Oregonians seeking a vaccine can do so easily and affordably.”

Following clear, evidence-based vaccine guidance, state agencies clear a path for health care providers to provide consistent plans of care so families have certainty about access and coverage surrounding vaccine care in Oregon.

Oregon Health Authority

In addition to issuing the West Coast Health Alliance recommendation earlier today, OHA has issued guidance for the Medicaid program requiring coverage of WCHA-recommended vaccines, as well as a consumer-facing FAQ. The Public Employees' Benefit Board has also issued a contract amendment to adopt WCHA recommendations and ensure continuity of coverage for these vaccines.

"As a physician, I swore an oath to do no harm—and we know vaccines are among the most powerful tools to prevent illness and save lives," said Dr. Sejal Hathi, MD, MBA, Director, Oregon Health Authority. "As a new mother, I want the same protection for my newborn that every Oregon family deserves. At a time when Washington D.C. is undermining our most basic public health safeguards, Oregon is charting a different course: affirming that public health is about protecting people, not playing politics, and ensuring every family who wants protection this respiratory virus season can get it—simply, safely, and affordably.”

For West Coast Health Alliance recommendations, click [WCHA 2025-2026 Respiratory Virus Season Immunization Recommendations](#).

For a general FAQ, click [West Coast Health Alliance Frequently Asked Questions for the Public](#).

Department of Consumer and Business Services

Through its Division of Financial Regulation, the department has issued a [bulletin on the coverage of COVID-19 vaccines](#). The bulletin reiterates the expectations that all health benefit plans in Oregon must provide coverage for FDA-approved COVID-19 vaccines without cost sharing (such as co-pay, co-insurance, or deductible). Plans provided by the Oregon Educators Benefit Board fall under DCBS regulation and will align with coverage requirements as

specified by the division.

“Consumers deserve certainty and continuity in vaccination coverage through these challenging times,” Acting Insurance Commissioner TK Keen said. “We appreciate the cooperation of insurance carriers in fulfilling this mandate.”

For more information on the insurance requirements, including where to submit a vaccine coverage complaint, visit the [West Coast Health Alliance and COVID-19 vaccine insurance coverage webpage](#).

Oregon Board of Pharmacy

The board took swift action to adopt recommendations from the West Coast Health Alliance (WCHA) to both expand and preserve access to lifesaving vaccines ahead of respiratory season. Oregon licensed pharmacists are permitted to prescribe and administer COVID-19, Influenza, and RSV vaccines in accordance with board-approved protocols, incorporating WCHA recommendations.

“We are concerned by delayed federal guidance that has caused confusion and created barriers to accessing updated vaccines,” said Gary Runyon, Pharm.D., R.Ph., Executive Director, Oregon Board of Pharmacy. “Though unfortunate, these recent circumstances have brought to light the pivotal role that pharmacists play in providing preventative healthcare on the frontlines as America’s most accessible healthcare providers. The Oregon Board of Pharmacy recognizes the unwavering dedication of its licensees to promoting public health and safety.”

For more information, visit the [Oregon Board of Pharmacy website](#).

Oregon Medical Board

Oregon physicians and physician associates may administer and prescribe vaccines in accordance with the WCHA Recommendations without fear of disciplinary action. The Oregon Medical Board recognizes the exceptional dedication and medical expertise that physicians and PAs bring to patient care.

“We have full confidence in our licensed physicians and PAs to review the WCHA Recommendations and apply their professional medical judgment in offering and prescribing vaccines to their patients,” said Nicole Krishnaswami,

Executive Director for the Oregon Medical Board. "Oregon's healthcare professionals consistently demonstrate a commitment to evidence-based medicine and patient safety. With the WCHA Recommendations in place, any patient who wants a vaccine should receive one so long as it's not contraindicated."

The [Oregon Medical Board's website](#) provides up-to-date information for physicians, PAs, and the public. OMB has also created a [Vaccine Administration FAQ](#).

Oregon State Board of Nursing

Oregon nurses may administer and prescribe vaccines in accordance with the WCHA Recommendations without fear of disciplinary action.

"The Oregon State Board of Nursing has ongoing confidence in our nursing professionals to operate in accordance with the WCHA recommendations," said Rachel Prusak, MSN, APRN, FNP-C, Executive Director of the Oregon State Board of Nursing. "All nurse practitioners should feel empowered to prescribe vaccines within their scope of practice and in accordance with WCHA recommendations, and all nurses in Oregon should feel confident in administering vaccines. This ensures that any patient who wants a vaccine can receive one, provided there are no contraindications."

All nurses are encouraged to review the WCHA recommendations and use their professional and clinical judgment when providing vaccines to patients. For up-to-date information, nurses, nurse practitioners, and the public can visit:

[Oregon State Board of Nursing : Vaccine Guidance : State of Oregon.](#)

Representatives from each state agency and licensing board will be available to answer questions later today at 5:00 p.m. during a media availability hosted by Oregon Health Authority – watch or attend here:

<https://youtube.com/live/2TydWPMLOVc>.

###



2025-2026 Respiratory Virus Vaccine Recommendations Frequently Asked Questions

September 17, 2025

The Oregon Medical Board (OMB) recognizes the ongoing questions regarding influenza, COVID-19, and RSV vaccine protocols for the 2025-2026 respiratory season. The following Frequently Asked Questions are provided to assist physicians and PAs with implementing new recommendations issued by Oregon, California, Hawaii, and Washington.

What is the issue?

On Aug. 27, 2025, the U.S. Food and Drug Administration (FDA) limited approval for updated COVID-19 vaccines to all people 65 years and older and people 6 months through under 64 years with underlying medical conditions. As of Sept. 17, 2025, the Centers for Disease Control and Prevention (CDC) Advisory Committee on Immunization Practices (ACIP) has not yet issued recommendations for the updated COVID-19 vaccine – while CDC already moved COVID-19 from the list of shots recommended for all healthy kids and pregnant women to a recommendation to have a discussion with your provider about benefits versus risks of getting the shot. As a result, some providers and pharmacies have been reluctant to stock updated COVID-19 vaccines. Many pharmacies have updated stock but are requiring either a prescription from the patient's healthcare provider or an attestation of underlying medical conditions for vaccination. These delays are due to inaction by the ACIP over the summer. The ACIP recommendations in the past have formed the basis of the protocols in Oregon for pharmacists to administer vaccines. What this means is that families are confused, providers are under pressure, pharmacies are under-resourced, and communities have been left more vulnerable.

What is the West Coast Health Alliance?

The Governors of Oregon, California, Hawaii, and Washington have formed the West Coast Health Alliance (WCHA) as a unified regional response to concerns regarding the CDC's credibility and scientific integrity under its current leadership. The WCHA is committed to safeguarding scientific expertise and vaccine access, and leading with clarity, evidence and care so that individuals and families know their options and can access the protection they deserve.

The WCHA has developed Consensus [WCHA 2025-2026 Respiratory Virus Season Immunization Recommendations](#).

What are the West Coast Health Alliance's COVID-19 vaccine recommendations?

The West Coast Health Alliance (WCHA) has recommended that the updated COVID-19 vaccines be available to anyone 6 months or older who wants them at no cost—just as they have been during recent respiratory seasons. The WCHA specifically recommends that the following people at increased risk for severe disease get an updated COVID vaccine:

- Children between 6-23 months of age
 - Adults 65 years and older
 - Anyone over 6 months who is at high risk of severe disease because they have underlying medical conditions
 - Anyone who is planning for pregnancy, pregnant, postpartum, or lactating
 - People with exposure to others who are at high risk
-



2025-2026 Respiratory Virus Vaccine Recommendations Frequently Asked Questions

What are the WCHA's influenza vaccine recommendations?

The WCHA endorses the ACIP's current universal recommendation for the influenza vaccine as of Sept. 17, 2025. All people 6 months of age and older should receive an updated influenza vaccine. These recommendations are unchanged from last year.

What are the WCHA's RSV vaccine recommendations?

As of Sept. 17, 2025, the WCHA also endorses the ACIP's current recommendations for RSV immunization products:

- All infants younger than 8 months born to mothers who did not receive a maternal RSV vaccine should receive either nirsevimab or clesrovimab shortly before or during the RSV season.
- People who are 32-36 weeks pregnant from September through January should receive a maternal RSV vaccine.
- Children 8-19 months with [risk factors](#) for severe disease should receive nirsevimab for severe disease should receive nirsevimab.
- All adults 75 and older should receive a single lifetime dose of RSV vaccine.
- Adults 50-74 with [risk factors](#) for severe RSV disease should also receive a single lifetime dose of RSV vaccine.

To protect young infants, either maternal vaccination or infant immunization with nirsevimab or clesrovimab is recommended. Infants do not need both.

If I administer or prescribe vaccines that are not yet ACIP-approved, will the OMB discipline my license?

The OMB fully supports physicians and PAs in their professional medical decision-making regarding vaccinations. Physicians and PAs should review the [WCHA Recommendations](#), screen patients for contraindications and precautions, and proceed with vaccination based on the provider's clinical expertise and professional judgment of each patient's unique healthcare circumstances and risk factors. Any patient who wants a vaccine should receive a vaccine so long as it's not contraindicated.

The Board will not take disciplinary action against licensees who make appropriate, evidence-based clinical decisions when administering or prescribing vaccines within their scope of practice and in the best interest of patient care, and not otherwise inconsistent with the Oregon Medical Practice Act.

How can I administer vaccines in my clinic?

Physicians and PAs are encouraged to establish standing protocols in accordance with the [WCHA Recommendations](#) within their clinics and institutions for the administration of vaccines.



2025-2026 Respiratory Virus Vaccine Recommendations Frequently Asked Questions

Can all patients receive a vaccine at the pharmacy?

With the exception of the influenza vaccine, children under age 7 will not be able to receive a vaccine at a pharmacy. Therefore, family medicine and pediatrics offices are advised to stock respiratory vaccines and make them available to pediatric patients. Subject to supply, all individuals age 7 and over should be able to receive a vaccine at a pharmacy. Please note children ages six months and up can receive the influenza vaccine at a pharmacy.

If a pharmacist requests a prescription in order to administer a vaccine for my patient, what should I do?

If writing a prescription for a vaccine, physicians and PAs must include the phrase "to administer at pharmacy" or a similar, equivalent phrase. If the patient is under 65 years old, including "medically necessary" or specifying the patient's underlying condition on the prescription may preempt further questions by the pharmacist.

Can my medical staff administer vaccines under delegated authority?

Yes. Nurses and Medical Assistants may administer vaccines if there is a valid prescription, an order, or an approved standing protocol in place.

How can I help my patients find information on accessing respiratory vaccines?

The Oregon Health Authority [provides statewide, general information](#) for patients on vaccine access and insurance coverage. Physician and PA practices should also maintain updated information on clinic websites regarding vaccine availability/stock and appointment scheduling or upcoming vaccine clinics.

How can I stay updated on vaccine access, insurance coverage, and the WCHA?

This FAQ and the OMB [website](#) will be updated as more information becomes available from the West Coast Health Alliance, the Oregon Board of Pharmacy, the Oregon Health Authority, and the Department of Consumer and Business Services. The WCHA will continue to evaluate new evidence and recommendations as they become available and is committed to sharing any updated assessments with our communities.

**FULL BOARD
OCTOBER 2, 2025
VIDEOCONFERENCE**

Informational Items

Member Assigned: Blasi

Subject: New Licensure Count

Initial Licensure Count

May 20 - August 22

