SB 476 – International Trained Physicians (ITP) Workgroup

April 15, 2026, 5-7PM
Videoconference

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Meeting ID: 160 788 0792
Passcode: =NnRJ0BBz2

By Phone: 669-254-5252
Meeting ID: 160 788 0792
Passcode: 3413230377

Meeting Materials: https://omb.oregon.gov/ITP

The public is invited to attend all portions of this meeting and may participate by providing comment during the public comment period (item #4). Members of the public will be muted for all other portions of the meeting.

1. Call to Order and Roll Call, Jill Shaw, DO, Workgroup Chair (5:00-5:05PM)

Workgroup Members:
Jill Shaw, DO – Oregon Medical Board Representative, Workgroup Chair
Thomas Cooney, MD, MACP, FRCP – American College of Physicians Representative
Marianne Parshley, MD, MACP – Oregon Medical Association Representative
Michelle Bowers, MS, CWDP – Oregon Primary Care Association Representative
Ann Klinger, OHSU Health Medical Affairs – Facility Representative
Erich Koch CMPE, FHFMA, Klamath Health Partnership – Facility Representative
Marianne Calnan, MD, DrPH – Internationally Trained Physician
Win Mar Lar Kyin, MB, BS, MPH, MBA – Internationally Trained Physician
Theresa San Agustin, MD (retired) – Community Member
Paula Heimberg, MD – ITP Physician Mentor
Vipul Mahajan, MBBS, FACP, FHM, CPE – ITP Physician Mentor
Lina deMorais, District Director, Senator Kayse Jama – Sponsoring Legislator (ex officio)

Meeting overview:

- This workgroup will gather input from affected parties and experts to help develop rules for Senate Bill 473 (2025).
- The workgroup is advisory only—OMB makes final decisions and consensus is not required.
- Open, honest, and respectful communication is expected at all times.
- This is a public meeting and will be recorded.
- The public may attend and comment during designated times but will be muted otherwise.

Review of February 25, 2026, Workgroup meeting minutes

2. Rule Development Process, OMB Staff (5:05-5:10PM)

Board staff will provide an overview of the rule development process.

3. Review & Discussion of Draft ITP Rules, Jill Shaw, DO, Workgroup Chair (5:10-6:45PM)

The draft rules are not final. Instead, they are intended to assist the Workgroup's discussion and follow the statutory framework established in SB 476.

In this portion of the meeting, Workgroup members will carefully examine and engage in meaningful dialogue about the draft rules. Input received during this phase will inform subsequent revisions and help ensure the final rules effectively serve the program's intended purposes while maintaining compliance and operational efficiency.

- Rule 000 Internationally Trained Physicians
- Rule 100 Definitions
- Rule 110 Qualifications for Provisional Licensure
- Rule 120 Clinical Facilities
- Rule 130 Supervision and Assessment
- Rule 140 Application for Provisional Licensure
- Rule 150 Documents and Forms to be Submitted for Provisional Licensure
- Rule 155 Letters and Official Verifications to be Submitted for Provisional Licensure
- Rule 160 Provisional License Application Withdrawals
- Rule 170 Denial of Provisional Licensure
- Rule 180 Practice Standards and Registration
- Rule 190 Regulations

4. Public Comment (6:45-6:55PM)

We welcome public feedback throughout the development of this program. Public attendees may comment by raising their hand, and OMB staff will call on you. Please state your name and organization (if applicable) before speaking and limit your comments to less than 3 minutes each.
Additional written comments may be emailed to elizabeth.ross@omb.oregon.gov.

5. Closing Discussion, Jill Shaw, DO, Workgroup Chair (6:55-7:00PM)

Workgroup members will provide closing thoughts, and the Workgroup Chair will summarize the meeting discussion and next steps.

- Updates will be posted on the SB 476 webpage.
- Next Virtual Workgroup Meeting: Wednesday, May 13, 5-7PM

- Workgroup members and the public may submit additional written comments to Elizabeth Ross, elizabeth.ross@omb.oregon.gov. Based on date of receipt, written comments will be shared with the ITP Workgroup at their next meeting and posted online.

Agenda Subject to Change: To ensure that the Workgroup makes the best use of meeting time, agenda items may be reviewed out of order. The agenda is subject to change without additional notification. Posted times are provided as an estimate.

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*For questions regarding SB 476/ITP implementation, email Elizabeth Ross, Legislative & Policy Analyst, **elizabeth.ross@omb.oregon.gov**.*

*For information on attending meetings or to request accommodations, contact Gretchen Kingham, Executive Assistant, **gretchen.kingham@omb.oregon.gov** or (971) 673-2700.*

Senate Bill 476 (2025) Excerpts

SECTION 6.

(1) The Oregon Medical Board may issue a provisional license to a qualified internationally trained physician. To be considered for a provisional license under this section, an internationally trained physician must have:

(a) Graduated from a school of medicine with a degree substantially similar to a degree of Doctor of Medicine or Doctor of Osteopathic Medicine, as determined by the board;

(b) Completed a training program that is substantially similar to an approved training program, as determined by the board;

(c) Obtained certification from the Educational Council for Foreign Medical Graduates, or its successor organization, as approved by the board;

(d) Practiced medicine in another country or jurisdiction for at least three years;

(e) An offer of employment at a clinical facility located in this state that will provide supervision and assessment of the applicant in accordance with standards established by the board by rule;

(f) Complied with all board rules that apply to similar applicants for a license to practice medicine in this state; and

(g) Provided evidence, as determined sufficient by the board, that the applicant is of good moral character consistent with the requirements of ORS 677.100 and in good standing in each country or jurisdiction in which the applicant practiced and received education and training.

(2) An applicant for a provisional license under this section shall:

(a) Apply to the board in the form and manner required by the board;

(b) Pay the fee established by the board by rule; and

(c) Provide to the board any further information required by the board.

(3) An internationally trained physician provisionally licensed under this section shall practice:

(a) Under the supervision of a physician licensed under ORS 677.100 who is in good standing with the board and meets the requirements established by the board relating to supervision; and

(b) (A) In a facility in this state with an approved training program;

(B) In a federally qualified health center that provides primary care and other services to underserved populations, as determined by the board; or

(C) In any other clinical location that demonstrates that the location meets the requirements established by the board by rule.

(4) An internationally trained physician provisionally licensed under this section:

(a) Is considered a fully licensed physician in this state for all purposes, including but not limited to credentialing and insurance billing;

(b) Is subject to all the provisions of this chapter and to rules of the board adopted under this chapter; and

(c) Has the same duties and responsibilities, and is subject to the same penalties and sanctions, as any other physician licensed under this chapter.

(5) An internationally trained physician provisionally licensed under this section may, after completion of four years of full-time equivalent practice under subsection (3) of this section, successful completion of a clinical assessment evaluation as determined by the board by rule and satisfaction of the requirements for licensure under ORS 677.100, apply for licensure under ORS 677.100.

(6) The board may adopt rules as necessary to carry out this section

SECTION 7a.

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:

….

(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.

….

(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.

[The following language is new. For readability, it is not bolded/underlined.]
***Notes and References in blue were added to assist the reviewer but will not be filed with the Oregon Secretary of State as part of the rule.**

Division 22: Rules for Licensure of Internationally Trained Physicians

847-022-0000
Internationally Trained Physicians
(1) ORS 677.146 establishes a provisional license allowing qualified internationally trained physicians to practice medicine in Oregon under supervision of licensed physicians, with a pathway to full licensure after four years of successful practice. This approach recognizes the valuable experience and training internationally trained physicians bring while ensuring patient safety through structured oversight.

(2) An internationally trained physician granted a provisional license:

(a) Is subject to all the provisions of the Medical Practice Act (ORS Chapter 677), and to all the administrative rules of the Oregon Medical Board.

(b) Has the same duties and responsibilities and is subject to the same penalties and sanctions as any other physician licensed under ORS Chapter 677.

(3) An internationally trained physician with a provisional license may only practice medicine under supervision and at an approved clinical facility, in compliance with OAR 847-022-0120 and OAR 847-022-0130.

Statutory/Other Authority: ORS 677.265, ORS 677.146
Statutes/Other Implemented: ORS 677.146

847-022-0100
Definitions

(1) "Approved school of medicine" has the meaning given in ORS 677.010.

> **Reference: ORS 677.010(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, 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 has otherwise been determined by the board to meet the association standards as specifically incorporated into board rules.

(2) "Approved training program" has the meaning given in ORS 677.010.

Reference: ORS 677.010(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) "Internationally trained physician" has the meaning given in ORS 677.010.

Reference: ORS 677.010(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.

Statutory/Other Authority: ORS 677.265, ORS 677.146
Statutes/Other Implemented: ORS 677.010, ORS 677.146

847-022-0110
Qualifications for Provisional Licensure

The Board may issue a provisional license to an internationally trained physician provided the applicant satisfactorily meets all the requirements in ORS 677.146(1):

(1) Graduated from an international school of medicine with a degree substantially similar to a degree of Doctor of Medicine or Doctor of Osteopathic Medicine that meets the requirements in OAR 847-020-0130(1).

Reference: OAR 847-020-0130(1) Must have graduated from an international school of medicine:

(a) The medical school must be chartered in the country in which it is located and must provide a resident course of professional instruction, be accredited by an accrediting organization acceptable to the Board, or be recognized by the appropriate civil authorities of the country in which the school is located as an acceptable education program. The Board may determine that the accreditation of an international medical school is not acceptable if the Board

receives documentation that the medical school has had its authorization, accreditation, certification or approval denied or removed by any state, country or territorial jurisdiction or that its graduates were refused a license by any state, country or territorial jurisdiction on the grounds that the school failed or fails to meet reasonable standards for medical education facilities.

(b) The graduate must have attended at least four full terms of instruction of eight months each, with all courses having been completed by physical on-site attendance in the country in which the school is chartered. The requirement for four full terms of instruction of eight months each term may be waived for any applicant for licensure who has graduated from an international school of medicine, has substantially complied with the attendance requirements provided herein, and is certified by a specialty board.

(c) Any clinical clerkships obtained in a country other than that in which the school is chartered must be satisfactorily completed.

(d) If requested, the applicant must provide the Board with documentation to substantiate that the medical school from which the applicant graduated meets the requirements in subsection (1)(a) of this rule.

(2) Completed an international training program that is substantially similar to an approved training program. To determine if a training program is substantially similar, the Board may consider:

(a) If the program is accredited by the Accreditation Council for Graduate Medical Education International (ACGME-I);

(b) If the program is recognized by another state medical board as substantially similar to an approved training program;

(c) If the program's accreditation has been recognized by the World Federation for Medical Education (WFME);

(d) The program's curriculum, oversight, case requirements, evaluation process, supervision, and completion standards, including faculty member credentials and participation, site characteristics, and educational components;

(e) If the program's curriculum included competencies in:

(A) Professionalism,

(B) Patient care and procedural skills,

(C) Medical knowledge,

(D) Practice-based learning and improvement,

(E) Interpersonal and communication skills, and
(F) Systems-based practice.

(3) Obtained current certification from the Educational Council for Foreign Medical Graduates, requiring a passing score on both Step 1 and Step 2 Clinical Knowledge of the United States Medical Licensing Examination (USMLE).

(4) Practiced medicine in another country or jurisdiction for at least three years to the satisfaction of the Board.

(5) Obtained an offer of employment at a clinical facility located in Oregon that will provide supervision and assessment of the applicant in accordance with OAR 847-022-0120 and OAR 847-022-0130.

(6) Complied with all board rules that apply to Oregon licensed physicians, including passing the Medical Practice Act exam.

(7) Provided evidence the applicant is of good moral character consistent with the requirements of ORS 677.100.

(8) Provided evidence the applicant is in good standing in each country or jurisdiction in which the applicant practiced and received education and training. For purposes of this rule "good standing" means the applicant has no active disciplinary proceedings, no encumbered licenses, and no unresolved orders or conditions in each country or jurisdiction in which the applicant practiced and received education and training.

Statutory/Other Authority: ORS 677.265, ORS 677.146
Statutes/Other Implemented: ORS 677.146

847-022-0120
Clinical Facilities

(1) An internationally trained physician must practice in one of the following types of facilities:

(a) In a facility in Oregon with an approved training program or affiliated with an approved training program.

(b) In a federally qualified health center that provides primary care and other services to underserved populations, such as a Community Health Center, a Rural Health Clinic, or

other state-licensed clinical facility that has the capacity and experience with medical education and assessment for supervisory responsibility.

(2) A provisional licensee may not practice in independent practice in Oregon.

Statutory/Other Authority: ORS 677.265, ORS 677.146
Statutes/Other Implemented: ORS 677.146

847-022-0130
Supervision and Assessment

(1) A provisional licensee must be supervised by a physician who is:

(a) Registered at Active status without restrictions and in good standing with the Board,

(b) Participating in a program of recertification or maintenance of certification with the American Board of Medical Specialties (ABMS) or the American Osteopathic Association's Bureau of Osteopathic Specialists (AOA-BOS),

(c) Practicing in the same specialty as the provisional licensee, and

(d) Providing direction and regular review of the medical services provided by a provisional licensee.

(2) To assess, develop, and evaluate the provisional licensee, the clinical facility must incorporate and implement one of the following frameworks:

(a) The March 2025 Curriculum Framework for Onboarding and Orienting International Medical Graduates, published by the Accreditation Council for Continuing Medical Education (ACCME), or

(b) Program Framework adapted from the Accreditation Council for Graduate Medical Education's (ACGME) six Core Competencies.

(3) A provisional licensee must receive an initial competency assessment within one month of issuance of their provisional license, such as an In-Training Exam or equivalent.

Statutory/Other Authority: ORS 677.265, ORS 677.146
Statutes/Other Implemented: ORS 677.146

847-022-0140
Application for Provisional Licensure
Note: similar to OAR 847-020-0110 Application for Licensure

(1) An internationally trained physician who does not meet the requirements for licensure in OAR chapter 847 division 20, may apply for an Oregon provisional license to practice medicine in Oregon.

(2) When applying for provisional licensure, the applicant must submit to the Board the completed application, fees, documents, letters, and any civil penalties or hearing costs that may be due.

(3) A person applying for licensure under these rules who has not completed the licensure process within a 6 month consecutive period must file a new application, documents, letters, and pay a full filing fee as if filing for the first time.

(4) The applicant may be required to appear before the Board for a personal interview regarding information received during the processing of the application. Unless excused in advance, failure to appear before the Board for a personal interview violates ORS 677.190(17) and may subject the applicant to disciplinary action.

Statutory/Other Authority: ORS 677.265, ORS 677.146
Statutes/Other Implemented: ORS 677.146

847-022-0150
Documents and Forms to be Submitted for Provisional Licensure
Note: similar to OAR 847-020-0150 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 application provided by the Board. Required dates must include month, day, and year.

(2) Birth Certificate: A copy of birth certificate or other identity documentation as approved by the Board.

(3) Medical School Diploma: A copy of a diploma showing graduation from an international school of medicine.

(4) 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.

(5) Legible fingerprints as described in OAR 847-008-0068 for the purpose of a criminal records background check.

(6) 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, or the Medical Director 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.

(7) Any other documentation or explanatory statements as required by the Board.

Statutory/Other Authority: ORS 677.265, ORS 677.146
Statutes/Other Implemented: ORS 677.146

847-022-0155
Letters and Official Verifications to be Submitted for Provisional Licensure
Note: similar to OAR 847-020-0160 Letters and Official Verifications to be Submitted for Licensure

The applicant must ensure that official documents are sent to the Oregon Medical Board directly from:

(1) The international school of medicine: Verification of Medical Education which must include degree issued, date of degree, dates of attendance for each year, dates and reason for any leaves of absence or repeated years, and dates, name and location of school of medicine if a transfer student and attach a copy of the transcripts.

(2) The Educational Commission for Foreign Medical Graduates: Verification of certification.

(3) The Director, Chairman, or other official of the substantially similar training program: An evaluation of overall performance, specialty, and specific beginning and ending dates of training, including procedure/case logs or equivalent clinical activity reports for surgical specialties. The

program should also include documentation supporting the program is substantially similar to an approved training program as outlined in OAR 847-022-0110(2).

(4) The Director, professional supervisor, or other official for practice and employment in hospitals, clinics, etc.: A currently dated original letter, sent directly from the hospital or clinic, must include a statement of good standing, level of independent practice, and specific beginning and ending dates of practice and employment, for past three years.

(5) All health licensing boards or regulatory authorities in any jurisdiction where the applicant has ever been licensed, regardless of status: Verification, sent directly from the boards or authorities, must show license number, date issued, examination grades if applicable, and statement of good standing

(6) Official Examination Certifications: An official examination certification showing the examination score is required directly from the National Board of Medical Examiners.

(7) 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, ORS 677.146
Statutes/Other Implemented: ORS 677.146

847-022-0160
Provisional License Application Withdrawals
Note: similar to OAR 847-020-0185 License Application Withdrawals

(1) An applicant may withdraw an application for provisional licensure prior to review by the Board's Administrative Affairs Committee. The Board will not report the withdrawal to the Federation of State Medical Boards. The applicant may submit a new application for licensure at any time.

(2) An applicant may withdraw an application for provisional 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 Federation of State Medical Boards. The applicant may submit a new application for licensure at any time.

(3) An applicant may request to withdraw an application for provisional licensure after review by the Administrative Affairs Committee. If the Board grants the request, the withdrawal will be

reported to the Federation of State Medical Boards. The applicant may submit a new application for provisional licensure no sooner than two years after the date of withdrawal.

(4) An applicant may request to withdraw an application for provisional 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 provisional license denial. The suspension of judgment is based on the applicant's withdrawal of their application and agreement not to reapply for provisional licensure for at least two years after issuance of the Stipulated Order. The order will be reported to the Federation of State Medical Boards and the National Practitioner Databank.

Statutory/Other Authority: ORS 677.265, ORS 677.146
Statutes/Other Implemented: ORS 677.220, ORS 677.265, ORS 677.100, ORS 677.190, ORS 677.146

847-022-0170
Denial of Provisional Licensure
Note: similar to OAR 847-020-0190 Denial of Licensure

(1) An applicant may not be entitled to a provisional license who:

(a) Has failed to pass a medical licensure examination for licensure in the State of Oregon;

(b) Has had a license revoked or suspended in this or any other state or country unless the said license has been restored or reinstated and the applicant's license is in good standing in the state or country which had revoked the same;

(c) Has been refused a license or certificate in any other state or country on any grounds other than failure of a medical licensure examination;

(d) Has been guilty of conduct similar to that which would be prohibited by or to which ORS 677.190 would apply, including omissions or false, misleading or deceptive statements or information on any Board application, affidavit or registration; or

(e) Has been guilty of cheating or attempting to subvert the medical licensing examination process. Evidence of cheating or subverting includes, but is not limited to:
(A) Copying answers from another examinee or permitting one's answers to be copied by another examinee during the examination;
(B) Having in one's possession during the examination any books, notes, written or printed materials or data of any kind, other than examination materials distributed

by examination staff, which could facilitate the applicant in completing the examination;

(C) Communicating with any other examinee during the administration of the examination;

(D) Removing from the examining room any examination materials;

(E) Photographing or otherwise reproducing examination materials.

(2) An applicant whose application has been denied may submit a new application for provisional 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, ORS 677.146
Statutes/Other Implemented: ORS 677.265, ORS 677.190, ORS 677.100, ORS 677.220, ORS 677.146

847-022-0180
Registration
Note: similar to OAR 847-008-0010 Initial Registration

(1) An applicant for provisional licensure whose application file is complete, must submit to the Board the initial registration form and fee prior to being granted a provisional license by the Board.

(2) An applicant for provisional licensure must ensure the license application is complete and accurate throughout the application process. A person applying for licensure must update the Board within 10 business days regarding any changes in information previously provided or any new information that becomes available during the application process.

(3) An application expires if not completed within a 6-month consecutive period.

(4) Once an application expires and per OAR 847-022-0110(3), a person applying for provisional licensure must file a new application, documents, letters and pay a full filing fee as if filing for the first time.

(5) The application is not subject to section (3) once the application is reviewed by the Board or a Committee of the Board.

(6) The Board will provide to all provisional licensees who have complied with this section a certificate of registration, which must be displayed in a prominent place in the provisional

licensee's primary practice location through the end of the last business day of the registration period.

(7) The provisional license is valid for a period of one year, and upon written request may be renewed for three additional one-year periods. The total period may not exceed four consecutive years. The Board may consider extenuating circumstances that do not indicate an inability to safely practice medicine to grant additional time.

(8) A provisional licensee who intends to continue practicing beyond the one-year period granted for the provisional license must submit a provisional license renewal application and fee at least 90 days before the end of the registration period.

(9) To renew a provisional license, a provisional licensee must:

(a) Complete a renewal application provided by the Board, which includes summary of practice over that last year, and

(b) Have their employer, supervising physician, and one other health care provider complete the Board's evaluation form, including a statement regarding eligibility for rehire.

(10) The provisional licensee also may be required to attend an informal meeting with a Board member, the Executive Director, a Board investigator, or the Medical Director to discuss the information provided in (9)(a)-(b) of this rule

Statutory/Other Authority: ORS 677.265, ORS 677.146
Statutes/Other Implemented: ORS 677.146

847-022-0190
Practice Standards and Regulations

(1) An internationally trained physician who obtains a provisional license:

(a) Is considered a fully licensed physician in Oregon for all purposes, including but not limited to credentialing and insurance billing;

(b) Is subject to all the provisions of Oregon Revised Statutes chapters 676 and 677 and to all rules of the Board; and

(c) Has the same duties and responsibilities, including the duty of care in ORS 677.095, and is subject to the same penalties and sanctions, as any other physician licensed by the Board.

(2) A provisional licensee must practice in the same specialty as the area of medicine the as their education, training, and experience.

(3) A provisional licensee must maintain employment and supervision as described in OAR 847-022-0110(5). If a provisional licensee changes employment or supervising physicians, the provisional licensee must notify the Board immediately and may not practice until the conditions in OAR 847-022-0110(5) are reestablished. Failure to notify the Board is grounds for disciplinary action under ORS 677.190(17) and ORS 677.190(18).

(4) If the provisional licensee's employment is terminated prior to the expiration of the provisional license for any reason, the provisional licensee must notify the Board immediately and the provisional license expires. Failure to notify the Board is a violation of ORS 677.415 and OAR 847-010-0073.

(5) A provisional licensee may apply for licensure under ORS 677.100 after:

(a) Completion of four years of full-time equivalent practice under ORS 677.146(3),

(b) Successful completion of a clinical assessment evaluation, and

(c) Satisfying of the requirements for licensure under ORS 677.100.

Note: Once the provisional licensure process is established, the OMB will initiate a rulemaking further specifying these requirements for internationally trained physicians to apply for full license after four years with a provisional license.

Statutory/Other Authority: ORS 677.265, ORS 677.146
Statutes/Other Implemented: ORS 677.146

SB 476 WORKGROUP CHARTER

Purpose

The SB 476 Workgroup will inform draft rules to implement SB 476 (2025) sections 5-9, creating a provisional license for internationally trained physicians (ITPs) starting January 1, 2027.

Members

- 1-2 members of the Oregon Medical Board
- 2 representatives from professional associations or societies representing primary care and/or specialty physicians
- 1-2 representatives of a facility/employer who intends to hire and supervise ITPs
- 1-2 internationally trained physicians
- 1 representative of community organization supporting refugees/immigrants
- 1 community member representing health care consumers (no immediate tie to a healthcare provider/internationally trained physician)
- 1 *ex officio* member of the sponsoring legislator's office

Administrative support will be provided by Oregon Medical Board staff.

Scope

The SB 476 Workgroup will review and advise on new and amended rules and other guidelines or procedures to implement SB 476.

Meetings

Public meetings will be held January-May 2026. Meetings will be subject to public meetings law, including public notice, public records, public access, and public comment. The meetings will be held via teleconference or videoconference and are planned for:

- Wednesday, January 14, 5-7PM
- Wednesday, January 28, 5-7PM
- Wednesday, February 25, 5-7PM
- Wednesday, April 15, 5-7PM
- Wednesday, May 13, 5-7PM
  **dates and times subject to change*.

Objectives

The SB 476 Workgroup may recommend administrative rules, guidelines, or procedures for the purpose of implementing SB 476 (2025).

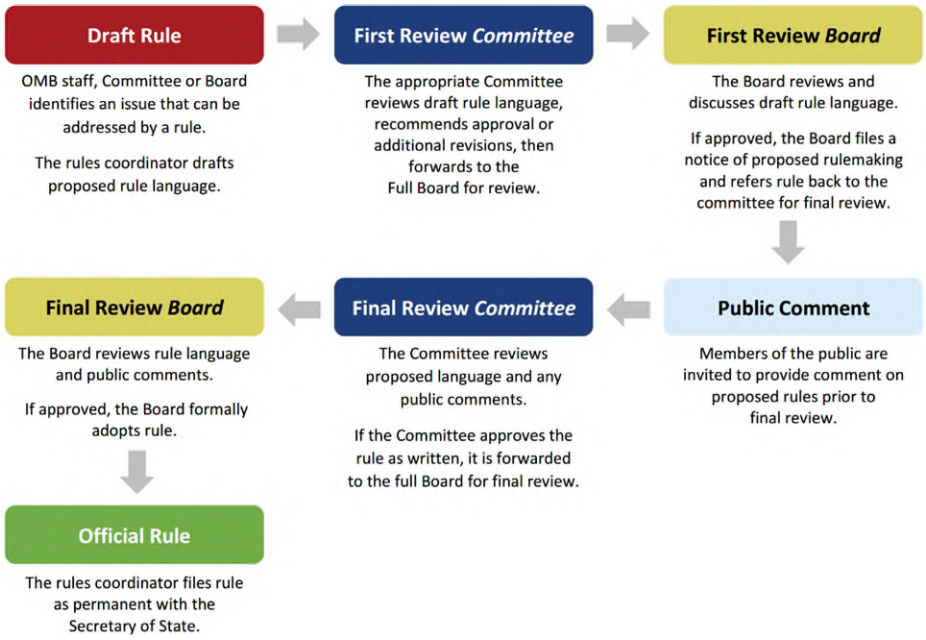
SB 476 Workgroup recommendations will be reviewed by the Administrative Affairs Committee and full Board during 2026 meetings. The Board retains final decision making authority.

Rulemaking Process & Public Meetings Law Overview, Oregon Medical Board

July 31, 2025	SB 476 signed by Governor Tina Kotek
January 14, 5-7PM	ITP Workgroup Meeting, Informational Session
January 28, 5-7PM	ITP Workgroup Meeting
February 25, 5-7PM	ITP Workgroup Meeting
March 11, 5PM	OMB Administrative Affairs Committee reviews the Workgroup's recommendations, makes recommendations to the Board
April 2	Oregon Medical Board reviews all recommendations
April 15, 5-7PM	**ITP Workgroup Meeting**
May 13, 5-7PM	ITP Workgroup Meeting
June 10, 5PM	OMB Administrative Affairs Committee reviews the Workgroup's recommendations, makes recommendations to the Board
July 9	Oregon Medical Board reviews all recommendations, initiates rulemaking
After July 9	OMB files notice of proposed rules; formal public comment period opens
August 18	Public hearing for members of the public to provide oral testimony
September 9	Final review by the Administrative Affairs Committee
October 1	Final review and possible adoption by the Oregon Medical Board
October-December	OMB staff develop program systems (IT, website, forms, etc.)
January 1, 2027	SB 476 sections 4-9 and OMB rules become effective.
January 4, 2027	OMB starts accepting ITP applications

Dates and times subject to change.

Administrative Rule Making Process



Public Meetings

ITP Workgroup meetings are public meetings and will follow Oregon Public Meeting Law. This includes providing public notice, ensuring public access, maintaining meeting minutes, and prohibiting private deliberations among Workgroup members between meetings. All Workgroup review and consensus-building must occur during scheduled meetings.

Oregon
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Approved by the Board on April 2, 2026.

OREGON MEDICAL BOARD
Meeting of the SB 476 Internationally Trained Physicians (ITP) Workgroup
February 25, 2026, 5:00pm • Held via Video Conference

PUBLIC SESSION

Welcome

Jill Shaw, DO, Workgroup Chair, called the meeting to order at 5:00pm and called the roll. A quorum was confirmed.

The following Workgroup Members were present:

Michelle Bowers, MS, CWDP
Marianne Calnan, MD, DrPH
Thomas Cooney, MD, MACP, FRCP
Paula Heimberg, MD
Win Mar Lar Kyin, MB, BS, MPH, MBA (5:20pm)
Ann Klinger
Marianne Parshley, MD, MACP
Theresa San Agustin, MD
Jill Shaw, DO, Workgroup Chair

Erich Koch, Vipul Mahajan, and Lina deMorais were absent.

OMB Staff present:

Nicole Krishnaswami, JD, Executive Director
Elizabeth Ross, JD, Legislative & Policy Analyst
Netia N. Miles, Licensing Manager
Gretchen Kingham, Executive Assistant

Chair Shaw welcomed Workgroup members and the public, discussed ground rules for the meeting, and provided an agenda overview. She also noted that the Workgroup will gather input from affected parties and experts to help develop rules for Senate Bill 476 (2025) and that the Workgroup is advisory only. The Oregon Medical Board makes all final decisions and consensus of the Workgroup is not required.

Follow Up from January 25th Meeting

Chair Shaw asked for discussion regarding the January 25th meeting minutes. There was no discussion.

Workgroup members were provided with additional resources:

- World Directory of Medical Schools, https://wfme.org/world-directory/, currently utilized by the Educational Commission for Foreign Medical Graduates (ECFMG)
- Verification of Credentials and Hospital Affiliations, for example the Joint Commission International: https://www.jointcommission.org/en

Discussion of ITP Practice Requirements

Chair Shaw provided an overview that SB 476 sets requirements for ITP practice:

- Under the supervision of an Oregon licensed physician:
  - Who is in good standing with the board, and
  - Meets the requirements established by the board relating to supervision
- In a clinical facility:
  - With an approved training program,
  - That is a federally qualified health center providing primary care and other services to underserved populations, as determined by the board, or
  - That demonstrates the location meets the requirements established by the board by rule.
- Under supervision and assessment by a clinical facility in accordance with standards established by the board by rule.

Dr. Shaw then opened the discussion to workgroup members only for topics outlined in our agenda related to ITP practice, supervision, and assessment, noting there will be time later in the meeting for members of the public to provide comments.

ITP Supervising Physician Requirements: What requirements, beyond OMB good standing, should the Board establish related to ITP supervisors?

- Should OMB require specialty board certification for ITP supervising physicians?
- Should there be any training or preparation required for physicians who agree to supervise ITPs? Is a formal supervisor training program needed?

The Workgroup discussed whether supervisors should be required to hold specialty board certification. Concerns were raised that requiring full board certification could exclude recently graduated, board-eligible physicians who bring current, up-to-date knowledge. However, members generally agreed that board certification is an appropriate standard for this supervisory context. Members agreed that supervisors themselves would need preparation and training to conduct meaningful assessments. The group also discussed the practical realities of supervision, including power dynamics.

Community-based training programs were discussed as potential supervision sites, particularly in rural areas. Oregon's existing physician shortage was cited as a reason to be cautious about overly strict requirements, and the group discussed a formal online supervisor training program. There was discussion that a phased rollout, using sites that already have supervision experience through residency programs, could be the most prudent approach. Compensation for supervisors was raised as an important consideration to account for the additional time, along with practical benefits including charting assistance and a recruitment tool were noted as informal incentives.

ITP Supervision: What should supervision of an ITP provisional licensee entail?

- Should there be a standard supervisory model, or should supervision be tailored to the needs of the ITP? If tailored, who decides what those needs are?
- What safeguards can we require to ensure that supervision is adequate?
- Is an initial assessment needed?

Members discussed what ITP supervision should actually look like in practice. The group agreed that while there should not be a single rigid model, clear standards are necessary and that effective supervision should be tailored to the individual, consistent with competency-based medical education principles. It was suggested that early in the supervisory period, a supervising physician should initially see patients together with the ITP to establish a baseline understanding of the ITP's skillset, similar to Medicare residency requirements.

The group explored distinctions between "supervisory" and "collaborative" models utilized for other health care providers. It was noted that an initial assessment should help determine the level of supervision each ITP would need. There was strong support for clear, specialty-specific minimum definitions of what supervision means, to prevent inconsistency across providers and facilities. A concern was raised that physicians from British-influenced medical systems may lack outpatient experience entirely, potentially requiring additional training before being placed in a primary care setting. It was also noted that in some countries, whether a physician practiced in public vs. private settings largely determines their ambulatory care experience, making work history just as important as training credentials.

ITP Clinical Facility Requirements: What other clinical facility requirements should OMB consider for ITP practice locations, beyond those listed in SB 476?

- Should there be criteria for the type of facility that can hire an ITP with a provisional license?
- Should the facility be ACGME-affiliated for clinical rotations?
- Should the facility be a certain size, have a minimum level of staffing, or have a minimum number of patient visits?
- Does it matter what specialty the ITP practices?

Workgroup members discussed what criteria should govern which facilities can host ITPs. There was caution against overly restrictive requirements, such as mandatory ACGME affiliation, which could exclude rural and underserved facilities where ITPs are most needed. The group emphasized the value of multi-source evaluations (drawing from physicians, nurses, social workers, and others) and the importance of specialty alignment between the ITP and the facility.

Concerns were raised about the need to review facilities to prevent potential exploitation of ITPs. It was discussed that placement decisions should be dynamic. ITPs performing well could be placed at more remote facilities, while those with identified gaps should start in more resource-rich settings. Board staff confirmed that ITPs must have a job offer before entering the licensure process. The group reiterated that initially, ITPs should be placed only at sites with existing residency supervision experience, with broader expansion possible as the program matures.

Assessment of ITP Practice: What standards, metrics, or tools could a clinical facility utilize to assess an ITP provisional licensee?

- The ACALM guidance recommends assessment in six general competencies: Patient Care and Procedural Skills, Medical Knowledge, Practice-based Learning and Improvement, Interpersonal and Communication Skills, Professionalism, and Systems-based Practice.

    - How well do these competencies capture what is needed for safe practice?
    - Are there competency gaps that may be unique to ITPs?
    - Which of the six competencies do you think would be most challenging for ITPs to demonstrate in a supervisory setting?
    - How could facilities meaningfully incorporate the competency framework, more than just a checkbox requirement?
- At the beginning of the supervisory period, ACALM suggests a needs assessment.
    - How could facilities review clinical experience gained abroad compared to the potential unfamiliarity with U.S. systems, culture, and prevalent disease patterns?
    - Any other considerations?
- ACALM suggests a specialty-specific exam to inform an ITP's learning plan during the supervisory period.
    - Is it appropriate to use an exam for ITPs who may have decades of clinical experience?
    - What type of exam would be a reasonable assessment?
    - What modifications, if any, should be considered?
- ACALM suggests a standardized knowledge assessment, direct observation, multi-source feedback, and medical record audits at regular intervals with a sufficient volume and breadth of cases.
    - How could these thresholds and expectations be defined in the regulations?
    - How should facilities ensure multi-source feedback is evaluated equitably and control for bias due to cultural or communication differences?
    - Should medical record audits be required, noting that they capture documentation rather than direct clinical decision-making?
- How can the Board hold supervisors accountable for fair (to the ITP) and safe (for the public) assessment of the ITP's ability to practice medicine?

The Workgroup discussed how to measure ITP competency. Members endorsed using the existing ACGME six-competency framework and not recreate systems. Members identified cultural and interpersonal skills and systems-based practice, including billing, EHR navigation, and healthcare advocacy as possibly the most challenging areas for ITPs.

In-training specialty exams were recommended as a practical assessment tool, to be taken at the start of the supervisory period and periodically thereafter and viewed as formative rather than punitive. There was broad consensus that existing frameworks should be leveraged rather than creating new ones. Questions were raised about exam timing, minimum score thresholds, and how these elements should be reflected in regulations.

Implicit bias within assessments was identified as a critical issue, with a recommendation that bias training be taken by supervisors and employers. The group stressed the importance of community-building and wellness support for ITPs. One member suggested ITPs should also have opportunities to "teach back," recognizing the mutual learning opportunity they represent.

It was proposed that supervisors hold unrestricted licenses, and that both supervisors and facilities provide annual attestation of their understanding of program standards. The concept of 360-degree feedback, allowing ITPs to evaluate their own supervisors, was raised and received broad support.

Although outside of the Board's scope, it was noted for an ITP to be successful they will need support from their facility but also from the community in which they will practice and live.

Public Comment

Zoraya Novoa, Ecuadorian-trained physician, currently working as a Medical Assistant in Roseburg, Oregon, shared her personal experience and her support of the ITP pathway. She described her own learning curve around US medical systems and technology, highlighted the mutual learning that occurs between ITPs and US colleagues, and spoke to the significant value ITPs could bring to rural communities facing physician shortages. She expressed personal commitment to pursuing board certification.

Closing Remarks

Dr. Shaw thanked the Workgroup members and asked if there were any follow up questions. A question was raised about the relationship between the new ITP pathway and Oregon's existing "Distinguished Professor" (eminence) pathway. Board staff clarified that the Distinguished Professor pathway is limited to two licenses per year for top-tier faculty at Oregon medical schools, while the new ITP pathway is broader and intended for mid-career physicians who need an alternative to repeating a residency program.

Dr. Shaw closed the meeting with a recap of key themes, including the importance of precise language and definitions, incorporating wellness and support into the concept of safeguards, and developing a hybrid approach that combines the best elements of credentialing, privileging, and licensing.

The next meeting was announced for April 15, 2026, where draft rules will be reviewed.

Dr. Shaw adjourned the meeting at 6:48 PM.

From: Tom Cooney [redacted]
Sent: Sunday, April 12, 2026 5:03 PM
To: ROSS Elizabeth * OMB
Subject: Draft ITP rules

Elizabeth,

[redacted] I am hopeful that I will be able to join for most or all our scheduled meeting Wednesday evening.

Given that I might not, I wanted to share my initial thoughts about the draft ITP rules, which follow.

I recognize that the following section (*Qualifications for Provisional Licensure)* is referencing existing rules (OAR 847-020-0130(1)) but as it will be derivative in our draft rules, I think it is important to highlight an issue that may need to be further defined in the new rules.

Qualifications for Provisional Licensure
(b) The graduate must have attended at least four full terms of instruction of eight months each, with all courses having been completed by physical on-site attendance in the country in which the school is chartered. The requirement for four full terms of instruction of eight months each term may be waived for any applicant for licensure who has graduated from an international school of medicine, has substantially complied with the attendance requirements provided herein, and is certified by a specialty board.

Comment: the waiver requirements seem vague or lack clarify. One, what does 'substantially complied' mean? Two, what 'specialty board' is referenced here? ABMS sponsored US boards? There are many so-called 'Boards' out there, outside ABMS alone, that I think this requires much greater specificity.

(c) Any clinical clerkships obtained in a country other than that in which the school is chartered must be satisfactorily completed

Comment: Unsure what the origin of this is. Is this a caveat to the above requirement "*all courses having been completed by physical on-site attendance in the country in which the school is chartered." ?*

Additional issues:

Supervision and Assessment

(1) A provisional licensee must be supervised by a physician who is:

Comment: will use of the singular 'a physician' poses problems given later language in Practice Standards and Regulations, stating, "If a provisional licensee changes employment or **supervising physicians** [pleural form], the provisional licensee must notify the Board immediately and may not

practice…". There is a high probability that there will be turnover (retirement, practice change, extended FMLA,..) in a supervising physician. Similarly, how long can a 'singular' supervising physician be absent for the Board to consider that an issue.

(3) A provisional licensee must receive an initial competency assessment within one month of issuance of their provisional license, such as an In-Training Exam or equivalent.

Comment: you may need some alternative language here as the 'must' here may create unintended problems. In-Training Exams are generally offered only yearly and within certain time windows and there are really few useful alternatives. This means that for most of the year the one-month requirement can't be met.

(4) If the provisional licensee's employment is terminated prior to the expiration of the provisional license for any reason, the provisional licensee must notify the Board immediately and the provisional license expires

Comment: we live in a highly corporatized and commodified health care 'system'. I wonder if we need something to buffer the immediate and automatic expiration of the provisional license to protect these vulnerable physicians who may find themselves caught in the middle of or corporate or private equity mischief. Perhaps 'suspension' pending review by the Board and even allowing time for development of an alternative location.

Thanks to staff for all their thoughtful work on the draft rules.

Best,
Tom

Thomas G. Cooney MD MACP FRCP
Professor of Medicine
Oregon Health and Science University
Staff Physician
Portland VA Medical Center

From: Bharat Gopal [redacted]
Sent: Friday, April 10, 2026 10:23 PM
To: ROSS Elizabeth * OMB
Subject: Written Comments for April 15 Meeting

Dear ITP Workgroup:

My name is Bharat Gopal. I am board-certified Family Physician practicing both inpatient and outpatient primary care in Corvallis. I am also Core Faculty at the Samaritan Family Medicine Residency and have been in medical education for the past 24 years. I've written on various aspects of residency education in the literature including a chapter on resident orientation and onboarding (Resident Integration: Orientation and Onboarding | Springer Nature Link). I am providing these written comments and hope to be present at the meeting to provide any further clarification. I am representing myself as a family physician and educator; I am not writing this on behalf of my employer, Samaritan Health Services or the Samaritan Family Medicine Residency.

Since I learned about SB 476, I've been closely following the workgroup by reading the draft rules, listening to the recordings of previous meetings, and reviewing minutes and linked resources. The need for the State of Oregon is compelling; having trained hundreds of family physicians in my career with many of them practicing in this state, I am acutely aware of the ongoing primary care shortage. I also have trained many ITPs. I am also the son of an international medical graduate; my mother emigrated to the United States in 1970 shortly after completing her medical school in India. While my medical school and residency training was in the United States, I recognize the importance of creating an equitable and compassionate training environment for all, regardless of background and lived experiences.

Currently, many ITPs struggle to get clinical experience in the U.S. Many post-medical school / pre-residency clinical experiences are not meaningful, they are observational with no hands-on work or direct patient care. If there is any experience, it usually as cases, which may consist of chart reviews and clinical presentations. "Observerships" and "externships" are meant primarily to get letters of recommendation, which residency programs use to gauge interest and understanding of their specialty. Often ITPs have to pay for these experiences; some licensed clinicians make quite a side hussle with providing observerships and letters of recommendation. Therefore, I very much appreciate the intent of SB 478, to provide patient care experience to ITPs and a pathway to permanent licensure.

Unless ITPs have clinical experiences in the United States, they often struggle to get into residency training or, once in residency, to acclimate to the various aspects of training. The observership/externship is often not meaningful enough to "bridge the gap" between the clinical training and practice that they experience in other countries and what they need to achieve in the U.S. I am not saying that medicine is different in the U.S. Medicine is still medicine wherever you practice. But the rapidity and acuity, the complexity of disease, the demands and expectations of patients, and the hidden curriculum of the U.S. healthcare system that pushes professional boundaries all add up a "rude awakening" for many ITPs. This is something that we are only able to scratch the surface in a structured, month long integration process at the start of training.

In fact, integration often takes years for all residents including ITPs. I've heard from the workgroup about the use of competency-based medical education (CBME) and milestones as methods to support ITP formative and summative evaluation. CBME and the use of milestones are meant to show that everyone's path in training is unique and graduated. In other words, developmental. Using CBME requires trained and dedicated faculty that approach the journey of training with patience and self-reflection. A supervisor of ITPs under SB 476 must be

themselves trained. They must be provided protected non-clinical time to provide for the training environment. This time must not only be provided under regulation but also assessed through an ongoing quality assurance process.

The ACGME and it's Review Committee in Family Medicine (RC-FM) provide that time to me and my colleagues through their Mission, to ensure that there is a safe learning environment for patients in graduate medical education. My time to train residents is protected by accreditation requirements. For my program with nine positions per year for three years of training, 60% or 24 hours per week of my time is dedicated to supervision of residents in the clinic and hospital; summative and formative evaluation; coaching, advising, and mentoring; curriculum development; didactics; and scholarship. CMS requirements (https://www.cms.gov/files/document/mln006347-guidelines-teaching-physicians-interns-residents.pdf) and ACGME requirements (https://www.acgme.org/globalassets/pfassets/programrequirements/2026-prs/120_familymedicine_2026.pdf) provide a framework for the maximum number of residents that I can supervise at a time, usually no more than four residents for one preceptor in the clinic. CMS also stipulates that residents with more than six months of training in primary care residencies can see some visits with more autonomy and independence. This is called the Primary Care Exception rule and has specific billing modifiers that allow for this exception. Finally CMS and the ACGME both specify that supervisors cannot have any other clinical duties when supervising residents in the clinic.

These "checks" provide for a safe learning environment. Additionally, these precepting methods have the potential to ultimately expand access, as the supervisor can often precept more patient visits than they can personally see. However, there's a learning curve for a trainee, and early training is often a time where the supervisor must provide more hands on training to the trainee, where the majority of care is provided by the attending rather than the resident, and where there will be a small number of residents to one supervisor.

I believe that all of these aspects: flexibility with supervisor to ITP ratio, dedicated non-clinical time, provision of a graduated level of experience, and patience and compassion for the educational and acclimatization process, are all necessary requirements for an approved clinical facilty and supervisor. I also believe that this is entirely possible within the settings so far stipulated in the draft rules. However, as learned from the HRSA-run Teaching Health Center program (https://bhw.hrsa.gov/funding/apply-grant/teaching-health-center-graduate-medical-education), the patient care mission must be joined and equal with the educational mission.

Finally, while I fully support the implementation of an ITP program in Oregon as a means towards providing ITPs another pathway to permanent licensure, I must comment that this pathway does not include a guarantee for board certification. Most board certification in the U.S. still requires residency training. There are options starting to open up, such the pilot through the ABIM, but board certification remains distinct from licensure and may represent a significant hurdle for the ITP program to be financially viable and integrated with rest of Oregon's healthcare system. Board certification or board eligibility is often required for credentialing in large systems. Large healthcare organizations track their percent of board certified physicians as a proxy quality metric. Private insurers often require board certificatation for their contracted physicians. It is my concern that when an ITP gets their permanent license after four years, they may be limited to seeing patients in private practice clinics unaffiliated and uncredentialed to hospitals. They may have to keep low overhead and only have limited services because they can only take public insurances. If the ITP program is not careful, it might lead to a "two tier" structure of physicians in the State of Oregon.

Thank for the opportunity or provide my written comments to the ITP workgroup.

Respectfully Submitted,
Bharat Gopal, MD MPH