



Oregon

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Medical Board

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Date: August 25, 2026

To: Administrative Affairs Committee
Oregon Medical Board

From: Elizabeth Ross, Legislative & Policy Analyst, Hearing Officer

Subject: Hearing Officer's Report on OAR 847 Division 22

Hearing Officer's Report

Hearing Date: August 25, 2026, 2 p.m.

Hearing Location: Oregon Medical Board, videoconference

Rule Number: OAR 847-022-0000, 847-022-0100, 847-022-0110, 847-022-0120, 847-022-0130, 847-022-0140, 847-022-0150, 847-022-0155, 847-022-0160, 847-022-0170, 847-022-0180, 847-022-0190

Rule Title: Implementing SB 476 (2025) to establish provisional licensure for Internationally Trained Physicians.

The rulemaking hearing on the proposed rule convened at 2:01 p.m. Attendees were informed of the procedures for taking comments. They were also told that the hearing was being recorded. The purpose of the hearing was to provide an opportunity for public comment on the rules proposed by the Oregon Medical Board implementing SB 476 (2025), sections 4 through 9, allowing the Board to grant a provisional license to qualified internationally trained physicians to practice under the supervision of an Oregon-licensed physician.

Staff Present:

Elizabeth Ross, JD, Legislative & Policy Analyst
Gretchen Kingham, Executive Assistant
Madison Fahlman-Katler, OMB Student Intern

SUMMARY OF ORAL COMMENTS:

The following persons testified at the hearing. Their testimony is summarized below.

Mark Bonanno, JD, MPH, Oregon Medical Association

No oral comments but the Oregon Medical Association will provide written comments. Mark Bonanno thanked the OMB for holding the public hearing.

Mohamed Khalif, International Medical Graduates Academy

The International Medical Graduates Academy is a national advocacy group for internationally trained physicians. Mohamed Khalif submitted written comments but highlighted the request to expand the types of Oregon facilities where an internationally trained physician could practice under a provisional license. They feel the current rule is too narrow by being limited to facilities with experience running a residency program. They noted the facility limitation may create fewer opportunities for internationally trained physicians to practice in Oregon under this program.

The public hearing adjourned around 2:10 p.m.

WRITTEN COMMENTS:

Written comments were accepted until 5 p.m. on August 25, 2026. Written comments attached below.

Summary of ITP – SB 476 Public Comments & Staff Analysis

The Oregon Medical Board received 13 public comments on the proposed rules implementing SB 476, establishing a provisional licensure pathway for internationally trained physicians (ITPs). The comments are supportive of the rulemaking's goals but note several concerns. This document is a resource but not intended to supplant the Board's review of individual comments. **The two proposed rule changes noted below are not substantive and could be updated during final review. Any other substantive changes should be reviewed more thoroughly and would require additional rulemaking procedures.**

Employer and Supervising Physician Roles

The most frequent comments were regarding OAR 847-022-0130(2)-(4). This rule references an undefined “employer” alongside “supervising physician(s).” Several people warned this rule may allow a non-physician administrator to make clinical supervisory decisions or influence care based on business/productivity interests rather than clinical judgment. The OMA suggested clarifying language to read “supervising physician(s) in appropriate consultation with the employer.” Also, a commenter questioned whether the initial supervision structure is sufficiently defined to determine when an ITP is ready to move to a less-supervised level of independence, and it was suggested to require “quarterly” rather than “routine” reviews.

- Section (3) allows the employer and supervising physician(s) to determine the appropriate level of supervision based on the provisional licensee's education, training, experience, and any lapse in practice. This is intended to provide flexibility and allow the supervising physician(s) to use their professional judgment rather than follow a strict framework outlined in rule. The rule also allows for the level of supervision to be reassessed and adjusted as needed throughout the provisional licensure period.
- Section (2) requires the supervising physician(s) to direct and regularly review the medical services provided by a provisional licensee through routine in-person assessment. A specific timeframe was not outlined to provide flexibility to the supervising physician(s) based on the needs of the ITP; quarterly review may not be frequent enough for some.

➤ **Option to update OAR 847-022-0130(3)-(4):**

(3) The ~~employer and~~ supervising physician(s), in appropriate consultation with the employer, determine the appropriate level of supervision based on the provisional licensee's education, training, experience, and any lapse in practice. The level of supervision may be reassessed and adjusted as needed throughout the provisional licensure period.

(4) The provisional licensee's ~~employer and~~ supervising physician(s), in appropriate consultation with the employer, may designate a temporary supervising physician during periods when the supervising physician(s) are unavailable. A temporary supervising physician must meet the qualifications in section (2) of this rule.

ITP Loss of Employment

Commenters raised concerns that automatic license expiration in OAR 847-022-0190 or a four-year hard cap for a provisional licensee could unfairly penalize ITPs whose employment ends due to clinic closure, contract loss, merger, or other business/organizational change beyond their control. Multiple commenters proposed a grace period in section (4) to find new qualifying employment and urged an administrative suspension while the Board reviews the circumstances of the change in employment. Commenters asked the Board to clarify what happens if a provisional licensee cannot reestablish employment and/or supervision within the required six months.

- Under section (3), if a provisional licensee is unable to return to active status, the provisional license would expire. The provisional licensee would need to reapply for a provisional license.
- During workgroup meetings, OMB staff explained that, per ORS 677.146(1)(e), a provisional license is tied to the supervised employment arrangement, similar to a resident's limited license. If the employment ends, the license condition is no longer met and the license expires automatically. This is not a disciplinary or reportable action. Staff acknowledged the complexity of building in appeals for a condition (employment) that exists outside the Board's statutory authority.
- Staff are working on an FAQ to explain that, when an ITP's provisional license expires under these circumstances, an ITP would not need to resubmit all materials to reapply once a new employer is obtained; rather, the Board may rely on documents submitted in support of the original application. Additionally, the Board may review this circumstance to allow the provisional licensee additional time beyond four consecutive years to hold a provisional license, as provided in draft rule OAR 847-022-0180(7).

Clinical Facility Eligibility

Commenters recommended removing or loosening the requirement that participating facilities have experience in graduate medical education in OAR 847-022-0120, arguing it would exclude FQHCs, rural health clinics, Critical Access Hospitals, and other community-based safety-net providers in underserved areas that lack formal residency programs. One comment recommended expanding eligibility to private practices with at least three full-time board-certified physicians, pointing to Washington State as a model. Additionally, the Board was asked to clarify whether it intends to allow additional categories of clinical locations by future rulemaking.

- ORS 677.146(3) provides that an ITP may practice:
 - (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.

- This was an area the workgroup spent time considering, and it recommended facilities have at least “experience in graduate medical education and assessment for supervisory responsibility” when launching the ITP provisional license as a safeguard to adequately support ITPs entering practice in Oregon.
- As the program develops in Oregon, the OMB may review and expand the criteria for facilities for ITP provisional license practice via rulemaking.

Credential and Document Verification

Several commenters asked the Board to rely on existing national verification bodies (ECFMG certification or FCVS profile administered by the Federation of State Medical Boards) rather than requiring duplicate direct verification from foreign medical schools or licensing boards in OAR 847-022-0155. Comments noted the hardship this creates for applicants from active war or conflict zones and asked for a hardship/conflict-zone waiver.

- Board staff are working on FAQs for this program to explain that, as for any physician applicant, the OMB may accept FCVS profiles as a primary source.
- Staff also work to ensure that any applicant experiencing hardship in locating required documents can work with Board staff to find a reasonable solution. Staff have assisted IMG applicants in this manner.

➤ Option to update OAR 847-022-0155(6) to align with current practice:

(6) Official Examination Certifications: An official examination certification showing Step 1 and Step 2 examination scores directly from the **National Board of Medical Examiners Federation of State Medical Boards**.

Substantially Similar Education & Training Programs

Commenters asked for clarification that graduating from a school listed in the World Directory of Medical Schools and holding a degree recognized by ECFMG certification satisfies the education requirement. Commenters also requested clearer, more predictable criteria and guidance on how “substantially similar” postgraduate training determinations will be made, for example, applicant-by-applicant vs. program-based, and whether ITPs can learn likely outcomes before securing a job offer.

- To satisfy the requirement to graduate from a substantially similar international school of medicine, the proposed rule already requires meeting the requirements in OAR 847-020-0130(1) for International Medical Graduates, which requires ECFMG certification.
- For training programs, the workgroup developed a list of factors in the draft rules that the Board may consider; see draft rule OAR 847-020-0110(2)(a)-(e). The Board will review the training program each applicant completed and may consider the factors listed in (a)-(e). The list is not exclusive; the rule uses “may,” allowing the Board to consider other factors.
- Due to the complexity of the training program review, the Board does not currently have resources to make a predetermination of which international training programs are substantially similar. As the program develops in Oregon, the Board may revisit this topic.

Equity and Access Considerations

It was requested that the Board accommodate applicants whose foreign credentials expired only because their home country was in transition, and that non-discrimination protections be extended to older, experienced ITPs. Commenters also raised concerns that a full-time practice requirement for provisional licensees could disadvantage part-time physicians and recommended allowing part-time practice with a corresponding extension of the supervision period. One commenter asked to add an allowance for three years of physician practice experience (in the U.S. or internationally) to satisfy the training-program requirement, reflecting an apprenticeship model. Also, a commenter asked for flexibility to evaluate clinical currency, so as not to exclude applicants due to gaps caused by immigration, visa processing, or residency requirements.

- *Expired Foreign Credentials:* ITP qualifications require that the applicant have “practiced medicine in another country or jurisdiction for at least three years to the satisfaction of the Board” and be in “good standing in each country or jurisdiction in which the applicant practiced medicine and received medical education and training.” However, as for any physician applicant, this does not require the applicant to currently hold an active license in all relevant jurisdictions. During the application process, as provided in draft rule ORS 847-022-0155(5), the Board will obtain verification of licensure from all health licensing boards or regulatory authorities in any jurisdiction where the applicant has ever been licensed, regardless of status.
- *Considerations for older, experienced ITPs:* The Board reviews all applicants based on the applicant’s qualifications and competency. Also, there are anti-discrimination laws applicable to Oregon employers; please contact the Oregon Bureau of Labor and Industries.
- *Four-year full-time practice requirement:* The statute requires “completion of four years of full-time equivalent practice” before an ITP can apply for licensure under ORS 677.100. In OAR 847-022-0180(7), the draft rule allows for this consideration by stating, “The Board may consider extenuating circumstances that do not indicate an inability to safely practice medicine to grant additional time.” The FAQs for the program can clarify that part-time work would be given consideration under this provision.
- *Apprenticeship:* The Board’s authority to create the ITP provisional license is provided in ORS 677.146 and does not provide an allowance for three years of physician practice experience (apprenticeship) to satisfy the training-program requirement.
- *Clinical Currency Flexibility:* The draft rules do not set any time limits for ITP applicants; the rules specifically state that the employer and supervising physician(s) determine the appropriate level of supervision, and that one factor is any lapse in practice.

Monitoring and Future Review

Commenters recommended that the Board track implementation over time and revisit related statutory reporting requirements with a future workgroup as issues emerge.

- The Board plans to collect data and report as required under ORS 677.149.

From: Aleksandr Morozov <[REDACTED]>
Sent: Tuesday, July 14, 2026 4:53 PM
To: ROSS Elizabeth * OMB
Subject: RE: OMB Internationally Trained Physicians Rulemaking

Follow Up Flag: Follow up
Flag Status: Flagged

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Dear Elizabeth,

Thank you for the opportunity to provide public comment on the proposed rules implementing SB 476. As an internationally trained psychiatrist now working in Oregon and seeking to return to clinical practice as a physician, I greatly appreciate the Board's efforts to expand access to qualified physicians.

I would like to suggest that the Board consider situations in which an applicant's home country has transitioned from one credentialing system to another, resulting in older credentials appearing expired even though the physician may have remained legally eligible to practice under transitional regulations or other applicable laws.

For example, I immigrated to the United States at the end of 2022. My psychiatry specialist certificate was issued in Russia in 2018 and shows an expiration date in 2023. During that period, however, Russia was transitioning from the specialist certificate system to an accreditation system, with multiple transitional regulations affecting physicians' eligibility to practice. As a result, the expiration date printed on an older credential may not accurately reflect whether a physician remained legally authorized to practice under the laws in effect at that time.

For applicants who immigrated to the United States shortly before their foreign credential expired, the Board could consider allowing a reasonable grace period or alternative documentation of recent clinical practice and good standing. In many cases, obtaining immigration status and work authorization can take a year or longer, making renewal of a foreign credential impractical despite the physician remaining qualified and clinically active prior to immigration.

I believe this approach would better reflect the intent of SB 476 by recognizing experienced physicians whose qualifications remain valid under their home country's legal framework while continuing to protect the public through Oregon's provisional licensure and supervised practice requirements.

Please let me know if you have any questions. I'd be happy to help and support the Board and its staff with this important initiative in any way I can.

Sincerely,

Aleksandr Morozov, MD (IMG)

He/Him/His

Clinical Director

Phone: [REDACTED]

Fax: (503) 848-2072

Email: [REDACTED]

Address: 4585 SW 185th Ave., Aloha, OR 97078



From: Walid Attia <[REDACTED]>
Sent: Tuesday, July 14, 2026 5:51 PM
To: ROSS Elizabeth * OMB
Subject: Public Comment on Proposed Rules Implementing SB 476 (2025)
Attachments: PHYSICIAN SHORTAGE - AMA.pdf; physician shortage- AAMC- F.pdf; physician shortage- AHA.pdf

To the Oregon Medical Board,

Thank you for the opportunity to provide comments on the proposed rules implementing SB 476 (2025). I strongly support the creation of a provisional licensure pathway for internationally trained physicians (ITPs). I believe this legislation represents a practical, responsible, and forward-looking approach to addressing one of the most pressing challenges facing healthcare today: physician workforce shortages.

Across the United States, healthcare systems continue to experience significant shortages of physicians. The Association of American Medical Colleges projects that the nation will face a physician shortage of up to 124,000 physicians within the coming decade, driven by population growth, an aging population, and the retirement of many practicing physicians. Surgical specialties are among the areas expected to experience some of the greatest shortages.

The American Hospital Association has similarly emphasized that workforce shortages threaten access to care in communities throughout the country. These shortages extend beyond physicians alone and are expected to persist unless states adopt meaningful workforce solutions.

At the same time, there are many internationally trained physicians living in the United States who possess years—often decades—of clinical experience, specialty training, academic achievement, and leadership. Many have practiced independently in their home countries, completed postgraduate training in the United States, contributed to research and medical education, and remain committed to serving patients. Yet many are unable to practice because existing licensure pathways were not designed to recognize the breadth of their professional experience.

SB 476 offers a thoughtful solution to this problem. Rather than lowering standards, it creates a structured pathway that allows qualified internationally trained physicians to demonstrate their competence within the U.S. healthcare system under appropriate oversight. This approach protects patient safety while making better use of an experienced and underutilized segment of the physician workforce.

For many internationally trained physicians, provisional licensure is not simply an alternative pathway. It is an opportunity to continue careers dedicated to patient care while addressing real healthcare needs within the US. It also allows healthcare organizations to recruit experienced physicians who can contribute immediately, particularly in communities where physician recruitment has been difficult.

I encourage the Oregon Medical Board to implement SB 476 in a manner that is clear, efficient, and accessible. The application process should recognize the value of substantial prior clinical experience, specialty training, academic accomplishments, and demonstrated professional competence. A

transparent and timely review process will help ensure that qualified physicians can begin serving Oregon communities without unnecessary delay while maintaining the Board's commitment to high standards of medical practice.

Oregon has an opportunity to become a national leader by recognizing that physician workforce shortages and internationally trained physician talent are two parts of the same equation. When carefully implemented, provisional licensure can help expand access to care, strengthen the healthcare workforce, and improve outcomes for patients without compromising quality or public trust.

Thank you for your consideration of these comments and for your efforts to strengthen Oregon's physician workforce.

Attached are the references that support the statements and recommendations presented in this commentary.

Walid

Best regards,
Walid Ismail Attia, MD, PhD
Senior Consultant Neurological Spine Surgeon

  www.walidattia.com

From: Tom Cooney <[REDACTED]>
Sent: Tuesday, July 21, 2026 11:26 AM
To: ROSS Elizabeth * OMB
Subject: Public comment on proposed rules implementing SB 476 (2025)

Elizabeth Ross
Legislative & Policy Analyst
Oregon Medical Board
1500 SW 1st Ave, Suite 620, Portland, OR 97201

Elizabeth,

Thanks to you, the staff, and the Board for their further work on the proposed rules. Overall, I believe they set up the ITP program for success while also protecting the public during the initial implementation of SB 476.

I do, however, have remaining concerns that I believe need to be addressed before finalizing the rules. Comments follow that identify the specific section and the concerns.

847-022-0130 Supervision and Assessment

1. I am concerned about the inclusion of the ‘*employer*’ with the ‘*supervising physician(s)*’ in items (3) and (4). I don’t believe ‘*employer*’ is defined anywhere and thus could be an individual without the qualifications to make this judgement. Additionally, the ‘*employer*’ may have interests that conflict such as practice productivity expectations. The recent Eugene ER case highlights this risk (<https://www.npr.org/2026/07/03/nx-s1-5875435/eugene-oregon-corporate-medicine-emergency-doctors>).
2. I remain concerned that we may need to require a higher level of supervision during in initial period (e.g., supervising physician sees all patients in first 2-3 months to verify readiness for next level of supervision). That is what we do in graduate medical education (GME) for first 6 months for patients of the new PGY-1s. The provisions in (3) allow for what I consider lax and risky supervision for a physician new to the U.S. healthcare system.

847-022-0190 Practice Standards and Regulations

3. *(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. The provisional licensee will need to reapply for a provisional license.*

We discussed this item in 2 different meetings and Workgroup members both times expressed concerns that it failed to provide the ITP protections against terminations that have nothing to do with competency and performance. We live in an increasingly corporatized health system where mergers, consolidations, private equity, and profit driven administrative decisions increasingly

dominate changes in the system. This provision, as written, risks making the ITP the victim, rather than protecting the public. We need language that requires the Board to review the circumstances of the termination prior to any revocation. The Board can administratively suspend the license pending review.

I appreciate the original opportunity to serve on the Workgroup and now, the opportunity to comment on the proposed rules.

Sincerely,
Tom

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

From: Jill Shaw <[REDACTED]>
Sent: Thursday, July 23, 2026 12:43 PM
To: ROSS Elizabeth * OMB
Subject: Re: In Support: OMB-ITP Workgroup Update

Hi Elizabeth!

Thank you for all the hard work you and the OMB staff do to make the process so smooth. I support the input of the workgroup on this operationalization of SB476 and found the perspectives of all participants helpful, especially the sharing of experiences from actual ITPs.

Unfortunately, my clinic schedule overlaps the public comment session on 8/25, so I will not be in attendance. My thanks to you and the members of the Board for helping us enact this portion of SB476.

Respectfully,
Jill Shaw

From: ROSS Elizabeth * OMB <elizabeth.ross@omb.oregon.gov>
Sent: Tuesday, 14 July 2026 15:32:02
To: ROSS Elizabeth * OMB <elizabeth.ross@omb.oregon.gov>
Subject: OMB-ITP Workgroup Update

Workgroup Members,

Thank you once again for your work over the past several months. We incorporated feedback from the workgroup meeting in May and updated the draft rules. Following the Oregon Medical Board's review, a notice of proposed rulemaking was filed.

The OMB is now accepting public comments until August 25th, see the [rulemaking summary](#) for details. Workgroup members may submit comments in their own personal capacity.

Updated information is also available on the [ITP webpage](#). Please reach out with any 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

From: Mohamed Khalif [REDACTED]
Sent: Thursday, July 30, 2026 6:03 PM
To: ROSS Elizabeth * OMB
Subject: Comment on proposed rules to implement SB 476
Attachments: Mohamed Edits-Oregon Proposed Rules for Provisional License.docx

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Dear Elizabeth,

Please see my attached comments regarding the **Oregon proposed rules to implement SB 476.**

By way of background, I am an internationally trained physician and the founder of The International Medical Graduates Academy (TIMGA). For more than a decade, I have worked with medical boards, legislators, healthcare leaders, and physician advocates across the country to develop and implement alternative licensing pathways for internationally trained physicians. Through this work, I have helped shape licensing reforms adopted across numerous states and have worked directly with employers on the practical implementation of these pathways.

Today, my team partners with healthcare organizations to operationalize these programs by assisting with licensure, credentialing, malpractice, billing and reimbursement, compliance, and physician workforce integration. My comments are based on lessons learned from working with regulators and employers on the ground, with the goal of helping ensure Oregon's pathway is both effective and practical to implement.

Thank you for the opportunity to provide feedback. I appreciate the Oregon Medical Board's thoughtful work on these rules and would be happy to discuss any of the recommendations or answer any questions.

Sincerely,



EXECUTIVE DIRECTOR



[REDACTED]



<https://timga.org/>



**The International
Medical Graduates**
— A C A D E M Y —

Oregon Proposed Rules for Provisional License:

TIMGA Suggested Changes

Background

My name is Mohamed Khalif. I am an internationally trained physician with more than a decade of experience in legislative advocacy, regulatory strategy, and coalition building focused on expanding physician workforce solutions in the United States.

I founded The International Medical Graduates Academy (TIMGA), where I have led efforts to establish physician licensing pathways for internationally trained physicians (ITPs). These efforts have contributed to licensing reforms in 27 states and the passage of six pieces of physician licensing legislation in Washington State.

Over the past decade, I have worked closely with medical boards, state legislators, healthcare leaders, and physician advocates across the country to help design, implement, and improve alternative physician licensing pathways. My work has focused not only on developing sound regulatory frameworks but also on ensuring those frameworks can be successfully implemented in practice.

Today, I work alongside a team of physicians at WeAreDocs, where we help healthcare employers operationalize these licensing pathways. Our work includes supporting employers through physician recruitment, initial licensure, credentialing, malpractice coverage, billing and reimbursement, regulatory compliance, and workforce integration. This hands-on implementation experience has provided valuable insight into the practical challenges employers and regulators face after legislation is enacted.

The recommendations I submit are based on years of direct experience working with regulators, employers, and internationally trained physicians throughout the implementation process. My goal is to help ensure Oregon's licensing pathway is not only well designed from a regulatory perspective but also practical, effective, and widely utilized by healthcare employers to expand access to high quality physician care for Oregon communities.

847-022-0110

Qualifications for Provisional Licensure:

- 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\(1\)](#).
Graduated from an international medical school that is listed in the World Directory of Medical Schools (WDOMS) and holds a degree recognized by the Educational Commission for Foreign Medical Graduates (ECFMG) as meeting its educational requirements for certification, or otherwise meets the requirements of OAR 847-020-0130(1).
- 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) Accreditation of the program by the Accreditation Council for Graduate Medical Education International (ACGME-I);
 - b) Recognition of the program by another state medical board as substantially similar to an approved training program;
 - c) Recognition of the program's accreditation 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) Inclusion of the following competencies in the program's curriculum:
 - (A) Professionalism,
 - (B) Patient care and procedural skills,
 - (C) Medical knowledge,

Commented [MK1]: After reviewing OAR 847-020-0130(1), I recommend clarifying that graduation from any medical school listed in the **World Directory of Medical Schools (WDOMS)** is acceptable to the Board. Inclusion in WDOMS is the foundation of ECFMG certification and is already a widely recognized standard for verifying the legitimacy of international medical schools. Aligning the rule with this standard would simplify the language, provide greater clarity for applicants, and reduce unnecessary ambiguity while maintaining rigorous educational requirements.

- (D) Practice-based learning and improvement,
- (E) Interpersonal and communication skills, and
- (F) Systems-based practice.

f) Practice experience of 3 years either internationally or in the United States.

847-022-0120 Clinical Facilities

A provisional licensee must practice in one of the following types of facilities:

- (1) A facility in Oregon with an approved training program or affiliated with an approved training program; or
- (2) A Federally Qualified Health Center, Rural Health Clinic, or other state-licensed clinical facility with experience in graduate medical education and assessment for supervisory responsibility
- (3) A Physician employment group or Private Practice with at least 3 Full Time Board Certified Physicians.

847-022-0130 Supervision and Assessment

- (1) A provisional licensee's practice must be supervised by a physician(s).
- (2) The supervising physician(s) must be:
 - (a) Licensed under ORS 677.100, registered at Active status without restrictions, and in good standing with the Board;

Commented [MK2]: I recommend allowing **three years of physician practice experience** to satisfy the training program requirement. In many countries, physicians complete an apprenticeship model after medical school, practicing under the supervision of experienced physicians before becoming independent general practitioners, rather than completing a formal residency program structured like those in the United States.

Recognizing this pathway would expand eligibility to highly qualified physicians who have demonstrated competency through clinical practice while maintaining patient safety. This approach would broaden the pool of experienced physicians eligible for Oregon's pathway and better align the rules with the diverse models of physician training used around the world.

I have included In the United States, because there are many doctors practicing through other provisional ... [1]

Commented [MK3]: I recommend removing the requirement that participating facilities have experience in graduate medical education and assessment. Many Critical Access Hospitals, Federally Qualified Health Centers (FQHCs), and other community based healthcare organizations do not operate residency programs or have formal graduate medical education infrastructure. This requirement would exclude many of the very facilities that face the greatest physician shortages and would otherwise be well positioned to employ internationally trained physicians. Teaching facilities already have significant competition for clinical training opportunities among medical students, residents, physician assistant students, and nurse practitioner students. Limiting internationally trained physicians to these facilities would create an unnecessary barrier to employment and substantially reduce the utilization of this pathway. ... [2]

Commented [MK4]: I recommend expanding eligibility to include physician employment groups and private practices that employ at least **three full time board certified physicians**.

Washington State's decision to allow qualified private practices and physician employment groups to participate was one of the key factors in the successful implementation of its internationally trained physician pathway. Early adoption began in these practice settings before expanding to Federally Qualified Health Centers (FQHCs), hospitals, and large health systems. These organizations demonstrated that internationally trained physicians can be safely and effectively integrated into clinical practice.

The threshold of three full time board certified physicians helps ensure that internationally trained physicians practice in a structured clinical environment with ... [3]

- (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) Directing and regularly reviewing the medical services provided by a provisional licensee through **quarterly** ~~routine~~ in-person assessment, which may be supplemented with synchronous and asynchronous technology when necessary

847-022-0155 Letters and Official Verifications to be Submitted for Provisional 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, Chair, or other official of the substantially similar training program: An evaluation of overall performance, specialty, and specific beginning and ending dates of

Commented [MK5]: I recommend changing the reporting requirement from **routine** to **quarterly**.

The term "routine" is vague and does not provide clear expectations for participating employers. It could be interpreted as requiring reporting on a daily, weekly, or otherwise frequent basis, creating unnecessary uncertainty and administrative burden.

Establishing a **quarterly reporting schedule** would provide clarity and predictability for hiring entities, giving employers greater confidence to participate in the program. It would also align with the evaluation model used in ACGME residency programs, where resident performance is typically reviewed and documented on a quarterly basis. Adopting a similar reporting interval for internationally trained physicians would provide meaningful oversight without creating unnecessary administrative burden.

Clear reporting expectations allow hiring entities to plan resources appropriately, make informed hiring decisions, and encourage broader employer participation while still providing the Board with regular oversight of the program.

Commented [MK6]: I recommend revising this requirement to avoid duplicating primary source verification that has already been completed through nationally recognized credentialing organizations.

International medical graduates who obtain ECFMG certification have already undergone a rigorous primary source verification process for their medical diploma and transcripts before becoming eligible to take the USMLE examinations. In addition, many applicants maintain their verified educational credentials through the Federation Credentials Verification Service (FCVS) administered by the Federation of State Medical Boards (FSMB), which is widely accepted by state medical boards throughout the United States.

Requiring applicants to obtain a second verification directly from their medical school, including transcripts, dates of attendance, leaves of absence, transfers, and other documentation, creates unnecessary duplication, increases costs, and may significantly delay licensure. For some applicants, particularly those from countries affected by war, political instability, or institutional closures, obtaining these documents may be impossible. ECFMG already has established alternative verification pathways for these situations to ensure that educational credentials can still be appropriately validated.

I recommend allowing applicants to satisfy this requirement by submitting an **FCVS profile containing ECFMG verified medical education credentials**, r... [4]

Commented [MK7]: FCVS could be faster option as well, I would include both.

training **or practice experience**, 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)

Commented [MK8]: I would include or practice experience for doctors who were General Practitioner in their country

(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 the past three years**.

Commented [MK9]: The proposed rule in 847-022-0110(4) requires that an applicant have "**practiced medicine in another country or jurisdiction for at least three years to the satisfaction of the Board.**"

(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

I recommend clarifying that the required three years of practice **do not need to be the three years immediately preceding the application.**

As currently written, the language could be interpreted to require recent continuous practice, which would unintentionally exclude many otherwise qualified internationally trained physicians.

(6) Official **USMLE Transcript Examination Certifications**: An official **USMLE transcript examination certification** showing Step 1 and Step 2 examination scores directly from the **Federation of State Medical Boards National Board of Medical Examiners**.

Most international trained physicians spend an average of two or more years preparing for and completing the USMLE examinations. For physicians balancing full time employment, family responsibilities, and childcare, this process often takes even longer.

(7) Offer of Employment: An offer in writing from a clinical facility located in Oregon that will provide supervision and assessment of the applicant, including name(s) of the supervising physician(s), in accordance with OAR 847-022-0120 and OAR 847-022-0130.

During this period, many reduce or discontinue clinical practice in order to prepare for the examinations required for U.S. licensure.

As a result, highly qualified physicians with substantial prior clinical experience could become ineligible solely because they devoted time to meeting U.S. licensing requirements.

(8) Any other documentation as required by the Board, including but not limited to medical records and criminal or civil records.

Clarifying that the three years of practice may be accumulated at any point in an applicant's professional career, subject to the Board's review and satisfaction, would preserve the intent of the rule while preventing the unnecessary exclusion of experienced physicians.

Commented [MK10]: The NBME does not keep or issue USMLE transcripts for International Medical Graduates. The NBME only maintains transcripts for students and graduates of U.S. and Canadian medical schools, the official record-keeper for all IMG transcripts is the Federation of State Medical Boards (FSMB). I have provided language that will correct this.

I recommend allowing **three years of physician practice experience** to satisfy the training program requirement. In many countries, physicians complete an apprenticeship model after medical school, practicing under the supervision of experienced physicians before becoming independent general practitioners, rather than completing a formal residency program structured like those in the United States.

Recognizing this pathway would expand eligibility to highly qualified physicians who have demonstrated competency through clinical practice while maintaining patient safety. This approach would broaden the pool of experienced physicians eligible for Oregon's pathway and better align the rules with the diverse models of physician training used around the world.

I have included In the United States, because there are many doctors practicing through other provisional license around the country who might want to move to Oregon.

I recommend removing the requirement that participating facilities have experience in graduate medical education and assessment.

Many Critical Access Hospitals, Federally Qualified Health Centers (FQHCs), and other community based healthcare organizations do not operate residency programs or have formal graduate medical education infrastructure. This requirement would exclude many of the very facilities that face the greatest physician shortages and would otherwise be well positioned to employ internationally trained physicians.

Teaching facilities already have significant competition for clinical training opportunities among medical students, residents, physician assistant students, and nurse practitioner students. Limiting internationally trained physicians to these facilities would create an unnecessary barrier to employment and substantially reduce the utilization of this pathway.

The goal of this program should be to expand access to care by enabling qualified internationally trained physicians to practice in the communities that need them most. Allowing experienced non teaching facilities to participate, provided they meet all other supervision and quality requirements, will significantly improve implementation of the pathway while maintaining patient safety.

I recommend expanding eligibility to include physician employment groups and private practices that employ at least **three full time board certified physicians**.

Washington State's decision to allow qualified private practices and physician employment groups to participate was one of the key factors in the successful implementation of its internationally trained physician pathway. Early adoption began in these practice settings before expanding to Federally Qualified Health Centers (FQHCs), hospitals, and large health systems. These organizations demonstrated that internationally trained physicians can be safely and effectively integrated into clinical practice.

The threshold of three full time board certified physicians helps ensure that internationally trained physicians practice in a structured clinical environment with adequate supervision, collaboration, and coverage, while also providing flexibility for physician practices that are well equipped to participate.

To date, Washington has licensed the most internationally trained physicians in the country, 133 active licenses as of date, with no complaints related to the pathway reported to the Washington Medical Commission. Oregon has the opportunity to build on this successful model by expanding the number of eligible practice sites. Increasing employer participation will improve implementation of the pathway and help more Oregon patients gain timely access to high quality physician care, particularly in underserved communities.

Page 4: [4] Commented [MK6]

Mohamed Khalif

7/30/2026 5:23:00 PM

I recommend revising this requirement to avoid duplicating primary source verification that has already been completed through nationally recognized credentialing organizations.

International medical graduates who obtain ECFMG certification have already undergone a rigorous primary source verification process for their medical diploma and transcripts before becoming eligible to take the USMLE examinations. In addition, many applicants maintain their verified educational credentials through the Federation Credentials Verification Service (FCVS) administered by the Federation of State Medical Boards (FSMB), which is widely accepted by state medical boards throughout the United States.

Requiring applicants to obtain a second verification directly from their medical school, including transcripts, dates of attendance, leaves of absence, transfers, and other documentation, creates unnecessary duplication, increases costs, and may significantly delay licensure. For some applicants, particularly those from countries affected by war, political instability, or institutional closures, obtaining these documents may be impossible. ECFMG already has established alternative verification pathways for these situations to ensure that educational credentials can still be appropriately validated.

I recommend allowing applicants to satisfy this requirement by submitting an **FCVS profile containing ECFMG verified medical education credentials**, rather than requiring direct resubmission of documentation from the medical school. This approach relies on existing nationally recognized verification systems, reduces administrative burden for both applicants and the Board, and maintains the same high standard of credential verification while improving access to the pathway.

From: Rose Rose <[REDACTED]>
Sent: Thursday, July 30, 2026 8:51 PM
To: ROSS Elizabeth * OMB
Subject: SB 476 ITP Rulemaking Public Comments (Section 4-9)

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

Thank you for the opportunity to provide comments on the proposed rules establishing provisional licensure for internationally trained physicians. I recommend the Oregon Medical Board for its efforts to create a pathway that allows qualified internationally trained physicians to contribute to Oregon's healthcare workforce while maintaining the Board's high standards for patient safety and professional competence.

From: M Parshley <[REDACTED]>
Sent: Sunday, August 9, 2026 8:18 PM
To: ROSS Elizabeth * OMB
Cc: Marianne Parshley
Subject: Re: Public comment on proposed rules implementing SB 476

Elizabeth,

Thanks for your patience and for allowing me to be on this work group! I enjoyed the discussion and process.

Here are my final comments on the proposed rule.

Overall, I think they are great. Just a few additional thoughts and then detailed itemized list.

First, does the rule fully define who has the role of making supervisory decisions. How and when do supervisor and employer definitions overlap or not?

Second, is the structure around supervision initially sufficiently structured so that the assessments are adequate to 'pass' the ITP to the next level of supervision/independence.

Third, how do we keep the ITPs who are provisionally licensed from having to start anew if the corporate practice of medicine goes sideways, or the closing a hospital or clinic where they are working under supervision, or there is a change in management that results in a gap or drop in supervision during their four years of provisional licensure. They need protection from the system which is increasingly not about patient care, rather about the business of medicine. I believe we need the Board to formally examine the reasons for which the ITP being terminated before permanently revoking their provisional licenses. Could there be a suspension of the license while the circumstances are reviewed?

Fourth, a new thought after reading the final language of the proposed rule. Are we perhaps overlooking a potential bias if we require these ITPs to all be full time as provisional licensees?

Itemized list:

847-022-0130

Supervision and Assessment

Section (3)

I worry that the "employer" is placed here and in item 4 without any definition (none that I can find through searching). This potentially leaves decisions about supervision to someone without supervisory qualifications and expertise. Given what happened at Peacehealth in Eugene, that could potentially allow non-physician administrators, without the qualifications to act as a supervisor, to play a

role they are not appropriate for, aka supervisory decision maker. This is a clinical judgement issue, not for administrators.

In addition, this section is pretty loose in terms of how much and what level of initial supervision is needed while assessing the competency of the incoming licensee, as well as their understanding of the U.S. health system which is complex. When is the ITP provisional licensee ready to move from close supervision to more independent practice? There should be some systematic process here to We discussed this in meetings, and I don't see this concern was addressed in the final rule.

Section (4)

Employers need to be defined and not given the responsibility of choosing a temporary supervisory physician. Unless the employer also meets supervisory criteria, they should not be the ones to appoint temporary supervisors in a gap in supervision coverage.

847-022-0180

Registration

Section (7)

If "the total period may not exceed four consecutive years", what happens if there is a corporate, regulatory, or budgetary decision unrelated to the ability or competence or professionalism of the ITP that results in termination of the ITP, or closes a clinic or hospital. (Think Eugene ED physicians or the Oregon Medical Group or what is unfolding with Asante in Jackson Co. Do the ITPs have to start at the beginning again? Yes this does mention extenuating circumstances, however I worry that these types of issues are increasing rapidly and may become more the rule than the exception, putting ITPs at risk, as well as the public they are serving.

847-022-0190

Practice Standards and Regulations

Section (3) and (4):

This did not change in alignment with our recommendations. We discussed this in detail the last two meetings. It still leaves ITPs vulnerable to business changes that may result in their having to change employment or the employment being terminated, regardless of their competency or performance. (say if a hospital administrator decides to fire a local ED group in favor of a national, Georgia based ED coverage organization).

Or if a rural hospital or rural health clinic/ FQHC closes when funding becomes prohibitive, (say if a reduction in Medicaid finding, or denial of State Directed Medicaid Funds are cut, or waivers disappear.....)

Section (6a):

This is a new question/thought after reading the proposed rules.

I believe this is the only place in the rule that mentions full time. I don't see it elsewhere when I search the rule.

As a "part-time" doc my entire career (approx 40-50 hrs a week), who has been a parent and an elder family caregiver, I have to ask if this restriction is potentially based on biased assumptions of the worth of those who are part time physicians with these additional roles (and who are primarily female).

Realizing we are short on physicians in many places and specialties this raises a question for me.

Do all ITPs have to practice full time if on a provisional license??

What if they are a pregnant person or have significant childcare or eldercare responsibilities, and yet could add tremendously to medical care in an underserved area as part time physician?

If they practiced part time, might there be a potential for an extension to make sure the supervision period was adequate. I think if this is a possibility, language needs to be added to the rule, otherwise we will lose the opportunity to add women ITPs to our healthcare work force.

I think many underserved areas would welcome part time ITPs, and I know ITP couples looking for work/job shares.

Marianne

*To bring about change you must not be afraid to take the first step.
We will fail when we fail to try”
- Rosa Parks*

Marianne Parshley, M.D. MACP FAMWA
Past Regent American College of Physicians
Past President Oregon Medical Association.

PMG Gateway Internal Medicine
Suite 100
1321 N.E. 99th Ave.
Portland, OR 97220

From: Theresa San Agustin [REDACTED]
Sent: Thursday, August 13, 2026 7:41 AM
To: ROSS Elizabeth * OMB
Subject: SB476 (ITP) Public Comments

My name is Theresa San Agustin, and I am writing to submit a public comment regarding the proposed rules for the Internationally Trained Physician (ITP) provisional licensure pathway under Senate Bill 476. As a U.S. citizen, an International Medical Graduate (IMG), a community member of the ITP Workgroup, and a concerned coastal resident, I highly anticipate the launch of this program. I applaud the legislature's passage of this bill, which grants a provisional license to qualified ITPs to practice under the supervision of an Oregon-licensed physician after four years.

To ensure the program successfully meets its intended goals, I would like to offer feedback on the following components of the draft rules:

1. **Rule 130 (Supervision and Assessment):** I encourage the Board to ensure that the initial clinical assessment and tiered supervision structures remain accessible, transparent, and streamlined. Applicants who have already achieved ECFMG certification have already proven their foundational medical knowledge. The regulatory oversight framework should focus on safe integration rather than creating redundant administrative bottlenecks.
2. **Clinical Currency Flexibility:** I ask the Board to establish flexible pathways for evaluating clinical currency. Highly qualified graduates should not be inadvertently excluded due to structural gaps in their practice timelines caused solely by the extensive time required to navigate federal immigration, visa processing, or state residency systems.
3. **Age Discrimination Protection for Experienced ITPs:** Older ITPs—including U.S. citizens who trained and practiced successfully abroad for decades—possess vast clinical expertise that would immediately benefit Oregon's strained healthcare system. There is a distinct risk that hospital systems or individual supervising physicians may pass over older, highly qualified candidates in favor of younger applicants based on perceived career longevity rather than objective medical competency. I urge the Board to build explicit non-discrimination guidelines into the rule framework to protect older applicants.
4. **Leveraging Citizen-IMGs and ITPs for Wide-Recruitment Efforts:** To maximize the law's intent of filling critical medical vacancies, the Board's recruitment and implementation strategies should explicitly include and leverage U.S. Citizen-IMGs. Furthermore, the rules should clearly outline pathways allowing previously licensed, fully integrated ITPs to eventually serve as supervising physicians themselves, expanding the program's capacity.

Oregon needs experienced physicians right now, particularly in our underserved coastal and rural communities. Please ensure the final administrative rules actively protect older, qualified ITPs and clear a fair path for U.S. citizen-IMGs. Thank you for your dedicated work in structuring this vital program to safely expand Oregon's medical workforce.

Sincerely,
Theresa San Agustin, MD (retired)
IMG, ITP Workgroup Community Member, & Coastal Oregon Resident

From: Win Kyin <[REDACTED]>
Sent: Friday, August 14, 2026 8:00 AM
To: ROSS Elizabeth * OMB
Subject: Public Comment on Proposed Rule OAR 847-022-0155 – Provisional Licensure Document Requirements & Barriers for IMGs from Conflict Zones

Dear Elizabeth Ross and Members of the Oregon Medical Board,

I hope this email finds you well.

My name is Win Mar Lar Kyin, an Internationally Trained Physician who also participated in your working group as a member. I am currently living in Eureka, CA as a Family Medicine Resident Physician.

I am writing to submit formal public comment regarding the proposed rules implementing SB 476 for provisional licensure of internationally trained physicians, specifically OAR 847-022-0155(1), which mandates that medical education verifications and transcripts be submitted directly from the applicant's international medical school.

While I strongly support Oregon's intent under SB 476 to create pathways for qualified internationally trained physicians to practice under supervision, the strict requirement in OAR 847-022-0155(1) creates an insurmountable barrier for international medical graduates (IMGs) from countries experiencing active war, civil conflict, or severe political instability—such as Myanmar.

The Problem: Administrative Disruption in Conflict Zones

In countries under active conflict or oppressive political regimes, contacting medical schools directly is often impossible or dangerous. Medical school administrative offices in Myanmar are non-operational, unresponsive, or unwilling to process official requests for physicians who have fled or faced political persecution. Requiring direct-from-school documentation effectively excludes highly qualified, safe, and eager physicians solely because of geopolitical circumstances beyond their control.

The Solution: Relying on ECFMG Primary Source Verification

The Educational Commission for Foreign Medical Graduates (ECFMG) already conducts rigorous, standardized Primary Source Verification (PSV) before granting ECFMG Certification. ECFMG directly verifies medical diplomas and transcripts with international institutions through secure, recognized channels, or utilizes alternative verification protocols when primary sources become inaccessible due to war or crisis.

Requiring a redundant direct-from-school submission directly to the Oregon Medical Board penalizes doctors from conflict zones, even when ECFMG has already verified their credentials and background.

Personal Story & Impact

This issue is deeply personal to me. I lived in Oregon, earned my Master of Business Administration in Healthcare Management from Oregon Health & Science University (OHSU), and wanted nothing more than to serve Oregon communities. I relocated to Washington State to take a limited-licensed associate physician position.

If I were still in Oregon today attempting to utilize this provisional licensure pathway, the proposed requirement under OAR 847-022-0155(1) would completely exclude me—despite my ECFMG credentials, U.S. clinical observation experience, and dedicated service in healthcare.

Recommendations

To uphold the spirit of SB 476 and address Oregon's severe physician shortage, I respectfully urge the Oregon Medical Board to amend OAR 847-022-0155 to include:

1. ECFMG Verification as an Alternative: Allow official ECFMG certification/EPIC primary source verification report to satisfy the medical school verification and transcript requirement under subsection (1).
2. Hardship/Conflict Zone Exception: Establish a standard waiver or alternative verification mechanism for applicants from countries designated as active war or crisis zones where direct school communication is unattainable.

Thank you for your time, dedication, and consideration of this critical issue. Providing equitable pathways for IMGs will strengthen Oregon's healthcare workforce and improve patient care across the state.

Sincerely,

Win Mar Lar Kyin,

MD, MPH, MBA (Healthcare Management)

Family Medicine Resident Physician

Providence St Joseph Hospital, Eureka, CA

Former Oregon Resident & OHSU Graduate

From: Funke Giwa <[REDACTED]>
Sent: Tuesday, August 25, 2026 3:03 PM
To: ROSS Elizabeth * OMB
Subject: Comments on ITP Licensure rulemaking.

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

Good afternoon.

I would like to submit the following comments for consideration and further clarification by the committee working on the ITP licensure rulemaking.

1. Kindly provide clarification on the appropriate level of supervision for ITPs, specifically whether this supervision will need to be direct, or if it could be provided at a system level or remotely. Some state boards recommend that the level of supervision be determined based on applicant's skills as determined by an initial evaluation.

- Also, please please confirm if there is a required supervisor-to-ITP ratio or if this is left to the employer/supervisor's discretion.

2. Please clarify how the boards will determine that the ITPs foreign post graduate training is substantially similar to approved training programs. Specifically, we would appreciate knowing if:

- determinations are applicant-by-applicant or program-based (for example, if Family Medicine PGT training from a specific foreign institution is approved, then future applicants from that program are likely to be approved);
- external credential/equivalency evaluators may provide supporting evidence
- OMB will publish recognized programs/accreditation systems or previous determinations
- there is a way for ITPs to understand their PGT determination before securing a job offer.

Thank you.

Sincerely,

Funke Giwa

Founder | CEO
Saltar Workforce Solutions
+1 469 708 8575

www.saltarsolutions.com

"Do all you can while you can - the world awaits"



August 25, 2026

Via Email Elizabeth.Ross@omb.oregon.gov

Elizabeth Ross, Rules Coordinator
Oregon Medical Board
1500 SW 1st Ave, Suite 620
Portland, OR 97201

Re: Proposed Rules Implementing SB 476 (2025) – Provisional Licensure for Internationally Trained Physicians (OAR chapter 847, division 22)

Dear Ms. Ross,

The Oregon Medical Association (OMA) is a nonprofit organization that represents physician and physician associate members in the State of Oregon. We appreciate the opportunity to provide comment on the Oregon Medical Board's proposed rules implementing SB 476 (2025) codified at ORS 677.146, which establish a provisional licensure pathway for internationally trained physicians (ITPs).

The OMA supports the Board's efforts to implement SB 476 and to expand Oregon's physician workforce through a structured, supervised pathway for internationally trained physicians. The proposed rules reflect substantial work by the Board, the ITP Workgroup, and the Administrative Affairs Committee, and we believe they generally strike an appropriate balance between expanding access to qualified physicians and safeguarding patient care through supervision, assessment, and accountability standards.

We offer the following comments and questions in the interest of clarifying certain provisions before the rules are finalized.

OAR 847-022-0120 – Clinical Facilities

ORS 677.146(3)(b) permits a provisional licensee to practice: (A) in a facility with an approved training program; (B) in a federally qualified health center; or (C) in any other clinical location that demonstrates that the location meets the requirements established by the board by rule. The proposed rule appears to adopt categories (A) and (B) but may not include a category for other clinical locations contemplated by subsection (3)(b)(C). We ask the Board to clarify whether it intends to limit approved practice sites to the two categories listed in the proposed rule, or whether it intends to establish, by rule or future rulemaking, additional criteria under which other clinical locations could qualify as contemplated by the statute.

OAR 847-022-0130 – Supervision and Assessment

Paragraphs (3) and (4) both refer to an “employer” which likely means a non-physician. Given SB 476 appears to require a provisional licensee to practice under the supervision of an Oregon physician, we offer a minor edit so that the phrases in each section state something similar to “supervising physician(s) ***in appropriate consultation with the employer...***” to ensure that an employer that is a non-physician is not directing or supervising the care of a provisional licensee.

Paragraph (6) requires a competency assessment during each provisional license period, “which may include an In-Training Exam or equivalent.” Because the term is capitalized, we assume it refers to a



specific, named examination (for example, the ACGME In-Training Examination) rather than a generic in-training assessment. We ask the Board to confirm what exam or exams this term refers to, and to consider defining the term in OAR 847-022-0100 or citing the specific examination(s) that would satisfy this requirement, so that clinical facilities and provisional licensees have clarity on what qualifies as an acceptable assessment.

OAR 847-022-0150 – Documents and Forms to be Submitted for Provisional Licensure

Paragraph (6) provides that an applicant who fails the open-book Medical Practice Act examination three times must attend an informal meeting before being given a fourth and final attempt, and may be denied licensure if the fourth attempt is unsuccessful. We ask the Board to confirm whether this process is identical to the process applied to other license applicants, or whether any accommodation (for example, additional study time or spacing between attempts) is contemplated in light of the fact that ITP applicants are, by definition, physicians who have already practiced medicine for at least three years in another jurisdiction.

OAR 847-022-0160 – Provisional License Application Withdrawals

Paragraph (3) provides that an applicant who withdraws an application after review by the Board's Investigative Committee may do so only through a Stipulated Order of suspended judgment, which is reported to the Federation of State Medical Boards and the National Practitioner Data Bank and carries a two-year bar on reapplication. We ask the Board to confirm that this reporting obligation and reapplication bar are consistent with, and no more restrictive than, the reporting and consequences applied to similarly situated applicants for full licensure under ORS 677.100, given that a provisional license is, by its nature, a conditional and time-limited credential.

OAR 847-022-0180 – Registration

Paragraph (7) limits provisional licensure to a maximum of four consecutive years, subject to the Board's discretion to grant additional time for "extenuating circumstances that do not indicate an inability to safely practice medicine." We appreciate the inclusion of this flexibility. To assist applicants, employers, and Board staff in applying this standard consistently, we ask the Board to consider providing illustrative examples of what may qualify as an extenuating circumstance in rule, guidance, or FAQ form — for example, where the clinical facility or hospital employing the provisional licensee terminates its contract or relationship with the employer through no action of the provisional licensee, requiring the licensee to locate a new qualifying position before continuing supervised practice.

OAR 847-022-0190 – Practice Standards and Regulations

Paragraph (3) requires a provisional licensee who changes employment or supervising physicians to immediately stop practicing and to reestablish the required employment and supervision documentation within six months, but does not state what occurs if the licensee is unable to do so within that window. We ask the Board to clarify whether the provisional license simply lapses or expires under those circumstances, and if so, whether that outcome is intended to be treated the same as a termination under paragraph (4).

Relatedly, paragraph (4) provides that if a provisional licensee's employment is terminated for any reason prior to expiration of the license, the license expires and the licensee must reapply. We ask whether the Board intends for any extenuating-circumstances relief to be available in this context — for example, where a hospital or clinical facility terminates its contract with the provisional licensee's



employer for reasons unrelated to the licensee's performance or conduct, resulting in the loss of the licensee's qualifying position through no fault of their own. We would encourage the Board to consider whether such circumstances might warrant a grace period to secure new qualifying employment and supervision, similar to the six-month window provided in paragraph (3), rather than immediate expiration and a full new application.

Again, we value the work of the Board and the ITP Workgroup and would encourage the Board to review the reports required under ORS 677.149 with a future workgroup along with any issues that emerge from the current rulemaking that might require legislative or rulemaking changes.

We appreciate the opportunity to comment on the proposed rules and would welcome the opportunity to discuss these questions further with the Board or its staff.

Sincerely,

A handwritten signature in black ink, appearing to read "Mark A. Bonanno", with a stylized flourish at the end.

Mark A. Bonanno, JD MPH

General Counsel and Vice President of Health Policy



World Education Services Public Comment Proposed Rules Implementing SB 476

World Education Services (WES) supports the Oregon Medical Board's proposed rules implementing SB 476, which creates a provisional licensure pathway for qualified internationally trained physicians. The proposed rules establish a framework that recognizes the education, training, and experience of physicians trained outside the United States while maintaining appropriate standards for patient safety, supervision, and competency assessment.

The United States currently faces a serious shortage of practicing physicians¹ in both primary and specialty care—a gap that is projected to widen over the coming decade. States across the country are seeking a way to ensure that all citizens, especially those in rural and underserved communities, have sufficient access to medical care. In Oregon, more than 800,000 people live in 150 federally designated primary care Health Professional Shortage Areas (HPSAs). Oregon needs an additional 107 primary care practitioners to meet the state's current health care needs.²

Internationally trained physicians are well-positioned to help alleviate physician shortages across the state. Their cultural competence is also an asset, as studies have found that patient outcomes improve when health care teams are more diverse.³ By establishing a clear and accessible pathway for qualified internationally trained physicians to obtain provisional licensure and ultimately pursue full licensure, the proposed rules will allow Oregon to benefit from the education, skills, and experience of a larger pool of qualified practitioners. Ensuring that implementation remains accessible to a broad range of qualified physicians and clinical facilities will help maximize the impact of SB 476 and strengthen access to care, particularly in underserved and rural communities.

WES believes the proposed rules establish a strong foundation for implementing SB 476 and expanding opportunities for qualified internationally trained physicians to contribute to Oregon's health care workforce.

¹ "AAMC Report Reinforces Mounting Physician Shortage." Association of American Medical Colleges, (June 11, 2021). <https://www.aamc.org/news/press-releases/aamc-report-reinforces-mounting-physician-shortage>.

² "Designated Health Professional Shortage Areas Statistics: First Quarter of Fiscal Year 2024 Designated HPSA Quarterly Summary." Bureau of Health Workforce, Health Resources and Services Administration (HRSA), U.S. Department of Health & Human Services, (December 31, 2024). <https://data.hrsa.gov/default/generatchpsaquarterlyreport>.

³ L E Gomez and Patrick Bernet. "Diversity improves performance and outcomes." National Library of Medicine, National Institutes of Health, (August 2019). <https://pubmed.ncbi.nlm.nih.gov/30765101>.



Two aspects of the proposed rules may benefit from additional clarification to ensure the pathway remains accessible to qualified internationally trained physicians and the clinical facilities best positioned to employ them.

1) Clinical Facility Eligibility

As currently written, OAR 847-022-0120 requires eligible facilities to have "experience in graduate medical education and assessment for supervisory responsibility." This language could unintentionally limit participation to facilities that currently operate, or are formally affiliated with, residency training programs. Such an interpretation would exclude many community-based providers, safety-net organizations, Federally Qualified Health Centers, and rural health facilities that employ highly qualified physicians capable of supervising and assessing internationally trained physicians but do not sponsor residency programs. These facilities are often located in communities facing some of the most significant physician workforce shortages and are therefore among the settings most likely to benefit from the successful implementation of SB 476.

WES encourages the Oregon Medical Board to clarify that eligibility should be determined based on a facility's demonstrated capacity to provide effective supervision and assessment, rather than participation in formal graduate medical education programs. Examples of such capacity may include employing physicians with prior supervisory experience, hosting medical student or physician trainee rotations, participating in physician education and training activities, or other evidence demonstrating the facility's ability to support the supervised practice and assessment of internationally trained physicians. These examples should be illustrative rather than exhaustive to ensure flexibility for qualified facilities to participate in the program.

Current language (OAR 847-022-0120(2)):

"A Federally Qualified Health Center, Rural Health Clinic, or other state-licensed clinical facility with experience in graduate medical education and assessment for supervisory responsibility."

Suggested language:

"A Federally Qualified Health Center, Rural Health Clinic, or other state-licensed clinical facility that demonstrates the capacity to provide supervision and assessment consistent with OAR 847-022-0130. Such capacity may be demonstrated through experience supervising physicians or physician trainees, hosting clinical training rotations,



participation in physician education activities, or other evidence deemed sufficient by the Board."

Please note that the examples listed in this suggested language are illustrative and not intended to be exhaustive, and the Board may consider other evidence demonstrating a facility's capacity to provide appropriate supervision and assessment.

2) Good Standing and Documentation

WES appreciates that the Board defines "good standing" based on professional conduct, specifically whether an applicant has active disciplinary proceedings, encumbered licenses, or unresolved orders or conditions. This approach appropriately focuses on protecting the public while recognizing the qualifications of internationally trained physicians.

However, as currently written, the good-standing requirements in OAR 847-022-0110(8) may unintentionally exclude qualified physicians who left a jurisdiction in good standing but no longer maintain an active license there. Because the rule is written in the present tense, some applicants may be deemed ineligible even when they had no disciplinary history and were in good standing through their last date of practice. Many internationally trained physicians may have allowed their license or registration to become inactive, lapsed, or expired for administrative reasons unrelated to professional conduct. Clarifying that applicants must have been in good standing through their last date of practice in a jurisdiction would better align the rule's language with the Board's stated definition of good standing and avoid unnecessary barriers for otherwise qualified applicants.

WES also recognizes that some internationally trained physicians may face challenges obtaining documentation from jurisdictions affected by conflict or significant governmental disruption. In such cases, otherwise qualified applicants may be unable to obtain verification of their standing despite having no disciplinary history. Providing flexibility for the Board to consider alternative evidence would help ensure that applicants are evaluated based on their qualifications and professional record rather than the availability of documentation beyond their control.

Current language (OAR 847-022-0110(8)):

"Provided evidence the applicant is in good standing in each country or jurisdiction in which the applicant practiced medicine and received medical 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."

Suggested language:

"Provided evidence that the applicant was in good standing through the applicant's last date of practice in each country or jurisdiction in which the applicant practiced medicine and received medical education and training. A license or registration that has become inactive, lapsed, or expired due to non-practice, non-renewal, relocation, or other administrative reasons unrelated to disciplinary action shall not, by itself, constitute a failure to satisfy this requirement. When verification from a regulatory authority is unavailable due to conflict, displacement, governmental disruption, or other circumstances beyond the applicant's control, the Board may accept alternative evidence sufficient to establish good standing."

WES supports the proposed rules implementing SB 476 and respectfully recommends the Oregon Medical Board to adopt the clarifications described above to help ensure the pathway is accessible, effective, and aligned with the law's workforce goals.

Thank you for the opportunity to submit this comment.

WES is a non-profit social enterprise that supports the educational, economic, and social inclusion of immigrants, refugees, and international students. For 50 years, WES has set the standard for international academic credential evaluation, supporting millions of people as they seek to achieve their academic and professional goals. Through decades of experience as a leader in global education, WES has developed a wide range of tools to pursue social impact at scale. From evaluating academic credentials to shaping policy, designing programs, and providing philanthropic funding, we partner with a diverse set of organizations, leaders, and networks to uplift individuals and drive systems change. Together with its partners, WES enables people to learn, work, and thrive in new places.

From: Andrea Lara <[REDACTED]>
Sent: Tuesday, August 25, 2026 4:47 PM
To: ROSS Elizabeth * OMB
Subject: Public Comment on Proposed Rules Implementing SB 476 – Internationally Trained Physicians

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

Dear Members of the Oregon Medical Board,

My name is Dr. Andrea Lara, and I am an internationally trained physician. I have been following the implementation of SB 476 closely and have also attended some of the public meetings on the proposed rules. I wanted to share a few thoughts from my perspective as a physician who completed medical training outside the United States. These comments are my own and do not represent my employer.

First, thank you for the work the Board has put into developing these rules. I believe SB 476 has the potential to create an important pathway for qualified internationally trained physicians to practice in Oregon while prioritizing patient safety and appropriate supervision.

After reviewing the proposed rules, I recommend additional clarity or flexibility to improve the process for both physicians and employers.

1. A Clear Timeline for Application Review

It would be helpful to have a general timeframe for how long the Board expects to take to review a completed application. For example, a 60- to 90-day goal would give applicants and employers a better idea of what to expect.

This is especially important because employers may be planning staffing, start dates, and patient coverage around the licensing process. I understand that some applications may require additional review, but having a general timeline would make the process more predictable for everyone involved.

2. A Grace Period When Employment Ends

I am also concerned about what happens when a provisional licensee loses or changes employment. There are situations in which employment can end for reasons unrelated to the physician's performance, such as a clinic's closure, restructuring, or organizational changes.

In those situations, requiring the physician to restart the application process seems unnecessarily burdensome. I recommend that the Board consider a 90-day grace period to allow the physician time to find another qualifying employer.

Of course, this would not mean that the physician could continue practicing without an approved employer and appropriate supervision. The goal would be to give the physician a reasonable amount of time to transition to another qualifying position without having to restart the licensing process.

3. Flexibility When Credential Verification Is Delayed

For internationally trained physicians, obtaining documents and verification from institutions in other countries can sometimes take longer than expected. Applicants may be waiting on a medical school, training program, government agency, or another institution over which they have no control.

If an applicant has submitted all available documentation and is actively seeking the remaining documentation, I hope the Board will consider granting reasonable extensions. Having to start a new application and pay another fee because an overseas institution did not respond on time could create an unnecessary barrier for otherwise qualified applicants.

4. More Clarity About "Substantially Similar" Training

I would also appreciate more guidance about how the Board will determine whether international postgraduate training is "*substantially similar*" to an approved program.

Training systems can look very different from one country to another, even when physicians receive strong clinical training and have significant experience. Clearer information about what the Board will consider, such as the length of training, clinical responsibilities, supervision, specialty experience, or competencies, would help applicants understand whether they are likely to qualify before beginning the process.

This would also be helpful for Oregon employers who may be interested in hiring internationally trained physicians but need to understand which candidates are eligible for this pathway.

5. Follow How the Pathway Is Working

Finally, because this is a new pathway, I hope the Board will monitor how it works in practice. It would be useful to track things such as how many physicians apply, how long applications take to process, how many are approved, what issues commonly delay applications, and how many physicians eventually transition from provisional to full licensure.

Reviewing this information over time could help the Board identify problems that may not be obvious at the outset and make adjustments as needed.

My intention in sharing these suggestions is to help make SB 476 successful. I believe Oregon can develop a process that upholds high standards and protects patients while also providing qualified internationally trained physicians a realistic opportunity to contribute to the state's healthcare workforce.

As someone who trained internationally, I know that navigating a new medical and licensing system can be complicated. Clear expectations, reasonable timelines, and some flexibility for circumstances outside an applicant's control can make a meaningful difference without lowering the standards expected of physicians.

Thank you for allowing the public to comment on these rules and for considering the perspective of internationally trained physicians.

Sincerely,
Dr. Andrea Lara, MD, MPH