Assistant Physicians: Legislative Developments for Unmatched Medical Graduates in the United States

Provided as an Informational Report to the FSMB House of Delegates, May 2026

Section 1. Introduction

This report is intended to provide helpful information to U.S. state and territorial medical and osteopathic boards and policy makers who may be considering legislation in their jurisdictions to enable additional licensure pathways for unmatched medical graduates who have not yet completed postgraduate training (also known as graduate medical education or GME). It is not intended to be an endorsement of such approaches, and it should be noted that current FSMB policy does not recognize nor endorse an additional licensure pathway for unmatched medical graduates.

Since 2014, 12 states have enacted legislation establishing additional pathways for U.S. and international medical graduates (USMGs and IMGs, respectively) who have not yet completed Accreditation Council for Graduate Medical Education- (ACGME) accredited postgraduate training nor passed the United States Medical Licensing Examination (USMLE) Step 3 or the Comprehensive Osteopathic Medical Licensing Examination of the United States (COMLEX) Level 3. These measures are ostensibly designed to address physician shortages, offer practice opportunities for unmatched graduates, and increase healthcare access in medically underserved regions. Although nine distinct titles exist for this licensure class or related permit (*see* table on p. 3), "assistant physician" (AP) is the most common colloquial designation and is used as a general term throughout this report. The term "licensure" is likewise used for simplicity, even though in certain states APs do not hold a license and instead practice under permits or delegation. There are two primary licensure pathways for APs: a repeatedly renewable license that creates a permanent physician class without requiring completion of standardized exams or residency, and a time-limited "bridge" license for graduates awaiting residency placement. All APs under enacted legislation in the 12 states are expected to practice under supervision and/or under collaborative agreements with supervising physicians, and no states currently permit direct conversion from an AP to an unrestricted medical license. As of October 1, 2025, FSMB records show approximately 354 medical graduates held active AP licenses, with concentrations greatest in Missouri and Arizona, 88 percent of which are IMGs (compared to 23 percent of the overall physician population) and 58 percent are under the age of 40 (compared to 24 percent of the overall physician population).[1]

Section 2. Background

[1] Data accessed from FSMB's Physician Data Center (PDC).

FSMB policy currently states that the minimum requirements for full and unrestricted medical licensure for all physicians should include the completion of at least 36 months of progressive, accredited postgraduate medical training (also termed GME), as well as completion of USMLE Steps 1, 2, and 3 or COMLEX Levels 1, 2, and 3,[2] among other requirements which are paramount to ensure that physicians have a baseline of skills and competence to ensure the safety of patients. More recently, an Advisory Commission on Additional Licensure Pathways that was co-chaired by FSMB, ACGME and Intealth advised completion of postgraduate training as a recommended requirement for internationally trained physicians seeking supervised employment leading to licensure eligibility.[3]

Context and Policy Drivers

The physician workforce shortage — projected in one widely-quoted estimate to reach up to 86,000 by 2036[4] — has prompted legislators in some states to develop additional licensure pathways for medical graduates who do not match into residency programs. Advocates for AP licensure include the Association of Medical Doctor Assistant Physicians, the American Legislative Exchange Council (ALEC), and policy research organizations such as the Cato Institute and Heartland Institute. These organizations argue that restricted residency growth since the Balanced Budget Act of 1997 and limited federal funding for training make additional licensure pathways essential for meeting public health needs, especially in medically underserved communities.

In 2025, nearly 47,200 medical graduates sought to match with one of approximately 37,600 residency positions, leaving roughly 9,600 positions unmatched. Contributing factors for not matching included poor test performance and/or interviews, length of time since medical school graduation[5], medical school reputation/ranking and location, competitive specialty selection, legislative caps on GME funding, and static residency slot growth. Data from the National Resident Matching Program (NRMP) demonstrate that there are significant disparities among the type of applicants and their acceptance rates (NRMP includes data about all residencies, regardless of funding source.[6]).

Breakdown of Residency Match Rate by Applicant Type			
Category	Number of Applicants	Number of Matches	Percent of Matching Applicants
U.S. MD Seniors	20,368	19,044	93.5%
U.S. DO Seniors	8,392	7,773	92.6%
U.S. MD Grads	1,751	803	45.9%
U.S. DO Grads	630	276	43.8%

[2] https://www.fsmb.org/siteassets/advocacy/policies/guidelines-for-structure-function-of-state-medical-and-osteopathic-board-2024.pdf
[3] https://www.fsmb.org/siteassets/communications/acalm-guidance.pdf
[4] https://www.aamc.org/news/press-releases/new-aamc-report-shows-continuing-projected-physician-shortage
[5] https://bmcmededuc.biomedcentral.com/articles/10.1186/s12909-025-07806-3
[6] https://www.nrmp.org/policy/main-residency-match-all-in-policy/

U.S. IMGs	4,587	3,108	67.8%
Non-U.S. IMGs	11,465	6,653	58.0%
Source: https://www.nrmp.org/match-data/2025/05/results-and-data-2025-main-residency-match/			

Both U.S. and non-U.S. IMGs have significantly lower match rates than active, domestic MD and DO applicants (called “U.S. MD Seniors” and “U.S. DO Seniors,” respectively), as do prior MD and DO graduates (called “U.S. MD Grads” and “U.S. DO Grads,” respectively). NRMP provides no further analysis on the duration of time between medical school graduation and successful matching for prior graduate cohorts. Unmatched graduates often face substantial educational debt and limited clinical opportunities as they typically wait another year to apply again. AP licensure may, in such circumstances, support interim participation in supervised clinical practice and is said to improve candidacy for a future residency match.

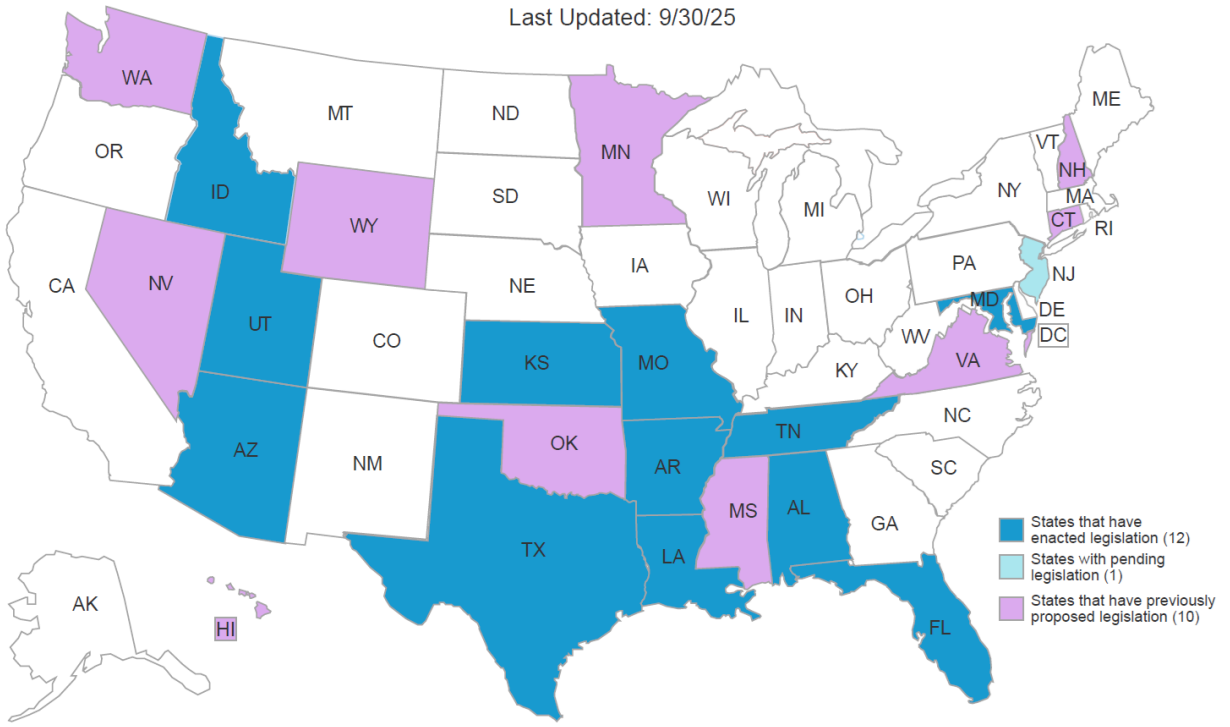
Between 2014 and 2025, 12 states enacted AP legislation, with eleven additional states introducing similar proposals that have not yet been enacted. Applicant requirements, scope of practice, and specific licensure titles vary by jurisdiction, but all share a core objective of permitting unmatched graduates to practice in supervised roles. Opposition from organizations such as the American Medical Association (AMA) and the Association of American Medical Colleges (AAMC) centers on concerns that bypassing residency training, especially if that bypass becomes enduring, undermines the training necessary for independent practice and may diminish support for federal GME funding.

Section 3. Components and Requirements of AP Licensure

Key Requirements

Each state's AP program has unique criteria; however, all require graduation from a recognized medical school, successful completion of USMLE Steps 1 and 2 (or COMLEX Levels 1 and 2), ongoing supervision, and absence of completion of ACGME-accredited residency training (although discrepancies exist on whether states will allow applicants who have ever been accepted into, or have begun, a residency). Applicants must typically apply for such a license within one to three years of their medical school graduation. Only some states limit AP practice to rural or medically underserved areas. Generally, AP licenses are designed to be time-limited.

States with AP Licensure



Components and Requirements of AP Licensure

In some jurisdictions, these are permits, not licenses.

State/ Component	Enacted	Title	Graduation from medical school (within _ years of application)	IMG eligibility	Require USMLE Steps 1+2 (time max after graduation, if applicable)	Allow COMLEX Levels 1 + 2	State residency requirement	In-state medical school requirement
Missouri + SB 718 ('18)	2014	Assistant physician	✓ (within last 3 years)	✓	✓ (3 years)	✓ (not specified)	✓	X
Arkansas	2015	Graduate registered physician	✓ (within last 2 years)	✓ (ECFMG certification)	✓ (2 years, within 3 attempts)	✓	X	X
Kansas	2015	Special permit(ee)	✓	X	*	X	X	✓
Utah	2017	Associate physician	✓ (within last 3 years)	X (LCME graduate)	✓ (2 years)	✓ (not specified)	X	X
Arizona	2021	Transitional training permit(ee)	✓ (within last 2 years)	✓	✓	✓ (DO only)	X	X
Louisiana	2022	Bridge year graduate physician	✓ (within the previous year)	✓ (ECFMG certification)	*	X	X	X
Tennessee	2023	Graduate physician	✓ (within last 3 years)	✓	✓ (2 years)	✓	X	X
Alabama	2023	Bridge year graduate physician	✓ (within the previous year)	X (LCME/ COCA graduate)	✓	✓ (LMCC)	X	X
Idaho	2023	Bridge year physician	✓ (within the previous year)	✓	*	X	X	X
Florida	2024	Graduate assistant physician	✓ (within the previous year)	✓	✓ (Requires all Steps)	✓ (COMLEX – all Steps)	X	X
Maryland	2024	Supervised medical graduate	✓	✓	✓	✓	X	X
Texas	2025	Physician graduate	✓ (within last 2 years)	✓	✓	✓ (LMCC)	✓	X

State/ Component	Renewable license	Time limit, if applicable	Require collaborative practice agreement (CPA) and/or supervision	Practice in rural/ underserved area	Conversion to full license	SMB rulemaking authority	Issued rules	Licenses granted (active licenses)
Missouri + SB 718 ('18)	✓	Unlimited	✓	✓	X	✓	✓	838 (268)
Arkansas	✓	N/A	✓	X	X	✓	✓	14 (N/A)
Kansas	✓	2 years (1 year, 1 possible renewal)	✓	✓	X	✓	N/A	3 (N/A)
Utah	✓	6 years (2 years and 2 possible renewals)	✓	✓	X	✓	✓	11 (1)
Arizona	✓	3 years (1 year, 2 possible renewals)	✓	X	X	✓	✓ (MD) ✓ (DO)	N/A (85)
Louisiana	✓	3 years (1 year, 2 possible renewals)	✓	X	X	✓	✓	14 (N/A)
Tennessee	X	2 years	✓	✓	X	✓	✓ (MD) Not found (DO)	N/A
Alabama	✓	2 years (1 year and 1 possible renewal)	✓	X	X	✓	✓	0
Idaho	X	1 year	✓	X	X	✓	✓	0 (0)
Florida	✓	3 years (2 years and 1 possible 1 year renewal)	✓	X	X	✓	✓ (MD) ✓ (DO)	N/A
Maryland	X	2 years	✓	X	X	✓	✓	0
Texas	✓	Unlimited	✓	✓	X	✓	✓	0

*: Indicates that the category was unstated or unaddressed in legislation or regulation.
N/A: Not available

Section 4. Regulatory Considerations

Pathways to Full Licensure

No state permits direct transition from AP licensure to full and unrestricted licensure without completion of postgraduate residency training and the successful completion of USMLE Step 3 or COMLEX Level 3. FSMB recognizes the importance of residency and examination completion in ensuring that physicians have the necessary skills to practice in an independent setting to enable them to provide quality healthcare to the patients they serve.

Licensure Structure: Time-Limited vs. Permanent Licenses

States vary in terms of offering time-limited versus permanent AP licenses, the level of regulatory oversight, supervision quality, and CME mandates. Time-limits imposed by states vary by duration of licensure, renewal cycles, and number of renewals possible; Missouri and Texas, unlike other jurisdictions, allow unlimited renewals.

Practice Setting

Five states require practice in rural or medically underserved areas. Some experts caution that APs practicing in these areas may risk contributing to the creation of a "second-class" of physician categories concentrated in socioeconomically disadvantaged or geographically isolated areas.[7] Resource and preceptor/supervision deficits, as well as difficulty retaining experienced supervisors in rural or medically underserved areas, will also present challenges to AP competency enhancement.[8]

Supervision

All states that have enacted this type of licensure pathway recognize that robust supervision via a supervision agreement is essential. They require that supervising physicians should be licensed in the same physical location, without prior discipline, and be capable of effectively assessing an AP's competence. However, limited supervision capacity and retention may impede AP practice initiation; in one study, only 25 percent of APs secured necessary supervision.[9]

Section 5. Licensure and Disciplinary Data

AP Licenses Issued in U.S.

Since 2016, a total of 870 AP licenses have been issued by five states, with the number of licenses issued by year shown below:[10]

AP Licenses Issued in the U.S. by Year										
Year	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025
Number	1	107	119	166	168	115	66	54	67	7

USMLE Performance

Comparative USMLE performance from 2010-2025 for MDs categorized as APs and licensed IMGs and USMGs are shown below:

	Assistant Physicians	**IMGs**	**USMGs**
Step 1			
Passing Rate on 1st Attempt	75%	96%	97%

[7] https://www.advisory.com/daily-briefing/2022/08/04/assistant-physicians
[8] https://www.ruralhealthresearch.org/projects/1057
[9] https://www.goldwaterinstitute.org/policy-report/removing-barriers-for-associate-physicians-to-expand-healthcare-access/#:~:text=States%20demonstrated%20significant%20variation%20in,holders%20since%20its%20program%20began
[10] Data accessed from FSMB's Physician Data Center (PDC).

Step 2 CK			
Passing Rate on 1st Attempt	65%	94%	98%
1st Attempt Average Passing Score (Std Dev)	222 (13)	234 (17)	243 (16)

APs typically require more attempts for examination passage and tend to score lower on the USMLE, on average, than their non-AP peers.[11] These findings have implications for training and supervision and appear to be correlated with a lower likelihood that such medical school graduates match into residency training.

AP Matriculation into Residency

A study of current licenses for individuals issued an AP license from 2016-2025 found that 38 percent had ultimately achieved full licensure, meaning that they had matched and subsequently completed GME training; eight percent were in residency training and possessed an active training license; 27 percent had continued practicing with an AP license; 22 percent had no license; and 6 percent had an active, non-physician license.[12]

Section 6. Legislative Considerations

The ongoing physician workforce shortage has prompted some states to expand licensure options for unmatched graduates, particularly to serve underserved communities. Other policy initiatives such as increased federal funding of residencies, the embrace of telemedicine, and the enactment of licensure compacts (i.e., Interstate Medical Licensure Compact and the PA Licensure Compact) may be more sensible and effective. If a state wishes to create an AP licensure pathway, however, consideration should be made to protect both the interests of the unmatched medical graduate and the public at large. Legislation, when proposed, should consider the following points of concern:

- Creating new and unfunded licensure categories may sow confusion among the public and create a two-tiered system of health care delivery by physicians possessing mixed skills and competencies.
- Eligibility should be reserved for applicants who have successfully graduated from an Liaison Committee on Medical Education- (LCME) or Commission on Osteopathic College Accreditation- (COCA) accredited medical school within the last two years and who have successfully completed USMLE Steps 1 and 2, or COMLEX Levels 1 and 2, but have not yet matched into a residency program.
- AP licensure should preferentially serve as an interim bridge option, with time limits, rather than as a permanent or enduring substitute for traditional residency training.
- Legislation should specify active supervision through the requirement of a supervision agreement with fully licensed physicians in the same physical location who have not had any disciplinary action or licensure infractions within the previous five years (A supervision agreement is a formal, written contract that outlines the scope of practice, responsibilities, and procedures that the AP is authorized to perform under physician supervision).

[11] Ibid.
[12] Ibid. Total does not add up to 100 due to rounding.

- There should be ongoing evaluation of the AP during the licensure period by the supervising physician and shared with the state medical board, beginning at the start of their practice period, to identify areas of strength as well as areas where additional support may be needed.
- Rulemaking authority should be delegated, and resources allocated, to the state medical board to implement and evaluate any AP licensure pathway.
- To obtain full licensure, the AP should meet the state's existing licensure requirements related to GME requirements and medical licensure examination completion.
- State medical boards should collect information that will facilitate evaluation of AP licensure in their jurisdiction to ensure it is meeting its intended purpose, including the number of APs who matriculate into residencies, and then full licensure, as well as the specialization and location of AP practice.