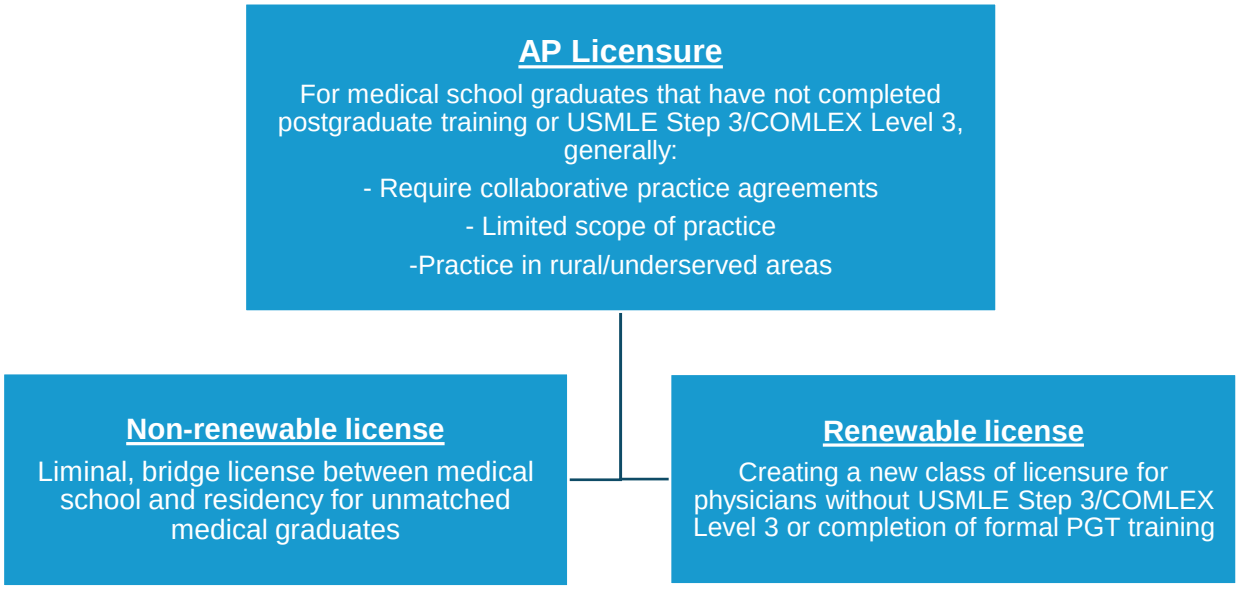
FEDERATION OF STATE MEDICAL BOARDS

States with Enacted and Proposed Associate Physician Legislation

State-by-State Overview

- **Eleven (11) states** have enacted legislation that creates a new category of license for associate physicians, or alternative titles that are similar in practice
  - AL, AZ, AR, FL, ID, KS, LA, MD, MO, TN, and UT
- **Twelve (12) more states** have proposed similar legislation
  - CT, HI, MN, MS, NH, NJ, NV, OK, TX, VA, WA, and WY
- Specific titles:
  - Assistant/associate physician: **Missouri, Utah** (+ introduced in HI, NH, NV, TX, VA, WA, WY)
  - Bridge year physician: **Idaho**
  - Bridge year graduate physician: **Alabama, Louisiana**
  - Graduate physician: Tennessee (+ introduced in CT, NH, NJ)
  - Graduate assistant physician: **Florida**
  - Graduate registered physician: **Arkansas** (+ introduced in MN, MS)
  - Supervised medical graduate: **Maryland**
  - Transitional training permit: **Arizona**
  - Special permit: **Kansas**
  - Provisionally licensed physicians: (Introduced in OK)
  - Deputy physicians: (Introduced in NH)
  - Training physicians: (Introduced in OK)
  - Physician graduates: (Introduced in TX)



Last Updated: August 2024

State	Status	Detail	Citation
AL	Enacted	Effective September 1, 2023, allows the Board to create a one-year "bridge year graduate physician" (BYGPs) license for individuals who completed medical school within the previous year, but have not been accepted into a postgraduate or residency training. The bill created a standing group, convened by the Board, to design the rules and regulations of this licensure class, including creating rules for otherwise qualified applicants (such as those that graduated medical school in the more distant past). BYGPs must practice under the on-site supervision of a licensed physician, who must report on the BYGP's performance and whether they should be recommended for a residency slot. The license is valid for one year, and may be renewed for an additional year (two years total, maximum). On July 31, 2024, the Board announced it was accepting applications for its Bridge Year Graduate Physician Program.	SB 155 (2023)
AZ	Enacted	Creates a one-year "transitional training permit" with two possible one-year renewals (three years total, maximum), to allopathic or osteopathic graduates who were unselected for residencies but have passed USMLE Steps 1 & 2 or the equivalent; and allows permitees to practice, under supervision, at a range of facilities such as FQHCs, assisted living facilities, and long-term care centers, among others.	SB 1271 (2021)
AR	Enacted	Creates a "graduate registered physician" (GRP) license for eligible applicants, a U.S. citizen or a legal resident alien who graduated from an accredited Arkansas allopathic or osteopathic medical school, who resides in Arkansas and is not enrolled in an accredited PGT program. GRPs are dependent medical practitioners allowed to provide healthcare services under the supervision of a physician and under a physician-drafted protocol approved by the Board, which is empowered to describe the protocol.	HB 1162 (2015)
CT	Withdrawn from enacted bill	Original bill would have created a "graduate physician" (GP) license analogous to an assistant physician, for applicants that graduated from a medical school accredited by the LCME, AOA, or the World Directory of Medical Schools; has passed USMLE or COMLEX Steps 1 and 2 within two years of graduating medical school, and is a U.S. citizen or resident alien. GPs must practice under a collaborative practice agreement (with a supervising physician assuming liability for the GP's care) and may only render primary care services. The Board would be empowered to promulgate rules regarding licensure processes including possible additional requirements, fees, supervision requirements, and disciplinary actions. GP licenses are valid for two years and are *not* renewable. The bill eventually became law; however, it was amended to remove the section pertaining to GPs.	SB 1 (2024)
FL	Enacted	Creates a "graduate assistant physician" (GAP) limited license for applicants that have graduated from an allopathic or osteopathic medical school approved by an accrediting agency recognized by the Dept. of Education, passed all parts of the USMLE or NBOME, not received a residency match within the first year of medical school graduation, have "good moral character" and are at least 21 years old, without any "act or offense… which would constitute the basis for disciplining a physician," or be under investigation in another jurisdiction, and submitted a set of fingerprints. Applicants must agree to enter a written protocol specifying their duties and responsibilities – with rules according to criteria established by the Board – with a physician with a full, active, and unencumbered license. The GAP license is two years in duration, with the possibility of one, one-year renewal if the applicant documents their practice under the written protocol and their applications to PGT training programs. GAPs may only provide care under the direct, physical supervision of a physician, supervising physicians may not supervise more than two GAPs, and the supervising physician "is liable for [their] acts or omissions.	SB 7016 (2024)
HI	Failed	SB 61 would have created a licensure class for associate physicians (APs), for applicants that are either U.S. citizens or legal aliens, graduates of LCME or AOA-accredited medical schools, or IMGs with ECFMG or Fifth Pathway certification and English proficiency; that have successfully passed Steps 1 and 2 of the USMLE or an equivalent exam within the last three years, but have not completed a residency. The bill required the Board to promulgate rules regarding license renewal, physician supervision and collaboration requirements, and disciplinary actions. APs must practice in medically underserved rural or urban areas and provide only primary care services under the terms of a collaborative practice agreement. SB 39 would have created a pilot program for licensure and regulation of Assistant Physicians (APs) in the state. However, the language was amended to require the Dept. of Health to establish and convene a working group to conduct a study on whether establishing a new category of professional licensure for APs would help address the physician shortage in the State. HB 1813 would have licensed APs and allowed them to provide primary care in medically underserved communities under limited supervision by a fully licensed physician.	SB 61 (2023) SB 39 (2019) HB 1813 (2018)

State	Status	Detail	Citation
ID	Enacted	Creates a "bridge year physician" (BYP) program for graduates from accredited medical school within a year, specifically for U.S. citizens *or* graduates of U.S. medical schools that were not accepted into an accredited residency program. BYP licenses are one year in length and nonrenewable, with a scope of practice determined by the Board, under the supervision of a licensed physician and a collaborative practice agreement (CPA). BYPs are subject to the same professional discipline, civil and criminal liability as a fully licensed physician.	H 153 (2023)
KS	Enacted	Allows the Board to issue special permits for individuals that have completed undergraduate training at the University of Kansas School of Medicine and not engaged in a full-time approved PGT program, as long as they are sponsored and supervised by a licensed physician. A special permit holder may prescribe drugs, but not controlled substances. The special permit expires when the permitee joins a full-time, approved PGT program *or* one year maximum, whichever occurs first. The special permit is nonrenewable.	HB 2225 (2015)
LA	Enacted	Creates a "bridge year graduate physician" (BYGD) program for graduates of medical school that were not accepted into residency, under the auspices of the Board. BYGDs have year-long certifications, with two possible one-year renewals (three years of practice total), must practice under supervision, have limited prescriptive authority, including with certain controlled substances. The certification explicitly does not confer the right to a full, unrestricted medical license.	SB 439 (2022)
MD	Enacted	Effective from May 2024, the *Bridge to Medical Residency Act* allows supervised medical graduates (SMGs) – defined as a graduate of an accredited medical or osteopathic school that has passed USMLE Steps 1 and 2 – to perform delegated duties under direct physician supervision, in the same medical office and available to provide assistance and guidance during the duration of the delegated duty, without a license. The bill requires the Board to adopt rules and regulations regarding the practice of the SMGs, including limiting the prospective services they may render. Individuals may not practice as a SMG for more than two years.	HB 757 (2024)
MN	Failed	Bills would have created a licensure class "graduate registered physicians" (GRPs) for Minnesota residents that would have required registrants to enter into a protocol with a supervising, physically present physician within six months of licensure. The registration is valid for three years and renewable. Notably, the scope of practice is *not* limited to medically underserved communities.	HF 1635 & SF 1546 (2019)
MO	Enacted	In 2014, the state created a new classification of licensure for "assistant physicians" (APs) becoming a pioneer on this policy. APs must be a Missouri resident and U.S. citizen, *or* a legal resident alien, who has not completed an approved postgraduate residency, but has successfully completed USMLE Steps 1 and 2, or an equivalent, within the previous two years, and is proficient in English. APs may only provide primary care services in medically underserved areas, are required to enter into a collaborative practice agreement (CPA) with a supervising physician within six (6) months of licensure. The supervising physician is required to review 10 percent of an AP's charts every 14 days, as well as review 20 percent of charts where controlled substances are prescribed. Additionally, the supervising physician and the AP must complete one month working together continuously prior to practicing at different locations and they must complete 120 hours – over four months – of on-site practice prior to the AP being allowed to prescribe controlled substances while the supervising physician is off-site. SB 718 (2018) amended the original 2014 bill by extending the period AP applicants have to apply, from two years to three years post completing medical school or USMLE Step 2, whichever is later. The bill increased the number of APs that can be supervised by a single physician from three to six, capped CME requirements at that for physicians, and lowered chart review requirements for supervising physicians to 10 percent per month, maximum; and eased requirements for AP prescription of buprenorphine, among other aspects. Since then, there have been efforts to further ease rules around AP practice. HB 710 (2019), which eventually failed, would have allowed for APRNs and PAs to collaborate with an AP and most notably, would have *created a process for an AP to become a fully licensed physician without the completion of any residency program*, but rather by completing Step 3 of the USMLE within three years of AP licensure and within three test attempts, after five years of continuous, collaborative practice, and 100 hours of didactic training.	SB 716 (2014) SB 718 (2018) HB 710 (2019)
MS	Failed	Bill would have created a "graduate registered physician" (GRP) licensure class for Mississippi residents that are North American medical school graduates *or* accredited international medical schools (listed in the World Directory of Medical Schools) that have "met all of the requirements" of the ECFMG; have passed USMLE (or NBOME) Steps 1 and 2, and no prior license discipline, but did not match into a residency program. GRPs are allowed to provide direct patient care under the supervision of a fully licensed physician, and practice under a physician-drafted protocol approved by the Board.	HB 1107 (2018)

State	Status	Detail	Citation
		GRPs can prescribe and administer Schedule II-V controlled substances and obtain DEA mid-level registration. The registration is renewable, but the Board can promulgate specific rules.	
NH	Withdrawn from enacted bill Failed	Originally, HB 1506 would have created a new licensing category for "assistant physicians" (APs). The bill, however, was amended numerous times throughout the process and the final language of the bill did not create a new licensure class but rather, "established a committee to study allowing medical school graduates who have not completed residency requirements to work in underserved areas of the state." HB 509 would have created a pilot program for the licensure and regulation of "graduate physicians" (GPs) and would have required the Board to license the first five applicants per year who satisfy the requirements, while also allowing the Board to license additional applicants who are graduates of New Hampshire medical schools. The bill would have also created a Graduate Physician Oversight Committee to study whether graduate physicians have expanded access to health care in medically underserved areas in both a safe and cost-effective manner. HB 1427 would have created a licensure class for "deputy physicians" (DPs), for medical school graduates that have passed USMLE Steps 1 and 2 and have English language proficiency, but have yet to complete the state's two year residency requirement. DPs must submit fingerprints and release a notarized criminal history record, practice under a collaborative practice agreement with a physician that "may delegate... the authority to administer or dispense drugs and provide treatment as long as the delivery of such health care services is within the scope of practice of the DP and consistent with [their] skill, training, and competence." The Board would be authorized to promulgate rules regarding DPs scope of practice, application process, aspects of supervision, and maintain and publish a list of licensed DPs. Lastly, licenses can be renewed annually, but there is *no maximum* number of renewals.	HB 1506 (2018) HB 509 (2019) HB 1427 (2024)
NJ	Pending	Bill would create a licensure class "graduate physicians" (GPs) for individuals that are at least 18 years of age, have graduated from a medical school accredited by the LCME, COCA, or International Medical Education Directory, passed USMLE Steps 1 and 2 or COMLEX Levels 1 and 2, not completed a postgraduate residency, have no criminal history, license discipline, a controlled dangerous substance license or permit suspended or revoked, or under active investigation for wrongdoing by a licensing agency or law enforcement authority. GPs would not be required to complete more CME than a physician, adverse license actions for GPs would follow the standard for physician licensees. GP practice is limited to "primary care services in medically underserved areas… and to procedures that are delegated to [them] by a collaborating physician" under the terms of a CPA, which may include prescribing controlled substances and cannabis. Lastly, the Board would be empowered to promulgate rules and regulations regarding licensure and renewal procedures, collaborating physician and CPA guidelines, and licensing fees, among other pertinent issues.	S 1832 (2024)
NV	Failed	Bill would have required the Board to establish a class of licensure, rules and regulations for associate physicians (APs) that are medical school graduates that have passed USMLE Steps 1 & 2 but not 3, nor completed residency, and commit to practicing in underserved areas. The bill also restricted prescribing practices of APs and requires they practice under the supervision and control of a physician and with a CPA. AP licensure is limited to two years but can be renewed.	SB 204 (2023)
OK	Failed	Bill would have permitted the Board to issue "training physician" licenses for applicants that are Oklahoma residents, a U.S. citizen *or* a legal resident alien, proficient in English, that have completed USMLE Steps 1 and 2 (or its equivalent) within two years of applying, but no more than three years after graduating from a Board-approved medical school; and has not completed an approved postgraduate residency. The bill would have required the Board to promulgate rules to implement provisions of the legislation. More recently, SB 1613 was introduced in the 2024 legislative session, which was similar in many ways to HB 712, other than the title for the professional was "provisionally licensed physicians" (PLPs) and applicants were required to have graduated from Oklahoma medical or osteopathic medical schools. PLPs would have practiced under a CPA under the guidance of collaborating physicians that are "responsible… for the oversight of the activities of and accept responsibility" for services rendered, which are limited to primary care services only.	HB 712 (2015) SB 1613 (2024)
TX	Failed	Bills would have required the Board to establish a limited class of licensure, rules and regulations for associate physicians (APs) (HB 2551) or "physician graduates" (PGs) (in HB 2556), that must be Texas residents, U.S. citizens *or* legal permanent residents, medical school graduates within the last two (HB 2556) or three (HB 2551) years from domestic or international schools "deemed acceptable" by the Board, passed USMLE Steps 1 & 2 but not 3, have English proficiency, but not completed residency. APs/PGs must practice under a supervising/collaborative practice agreement, wherein the qualifying	HB 2551 & HB 2556 (2023)

State	Status	Detail	Citation
		sponsoring physician maintains liability for their medical actions, and the PG may only provide services in the sponsor's specialty (HB 2556)/AP provides services consistent with their skill and training (HB 2551), but are prohibited from prescribing Schedule II controlled substances (HB 2556). The Board is empowered to create rules regarding fees, license renewal, CME requirements, and AP/PG supervision. In HB 2556, the limited license is renewable, so long as the PG practiced in accordance with their agreement and completed CME requirements. In HB 2551, the Board must adopt rules to convert AP licensure to full physician licensure for licensees that complete USMLE Step 3 within a year, practice for five years as an AP under the CPA, and achieve a passing score on an "endorsement examination" developed by the Board to "assess… [the] mastery of the knowledge required of general primary care practitioners." The Board, alongside the PA Board, must also adopt rules for the conversion of the AP license to a PA license for those that do not satisfy the above. No time limits are stated, but the Board must adopt rules regarding AP licensure expiration for licensees that do not qualify for full physician or PA licensure.	
TN	Enacted	Effective January 1, 2025, establishes a class of licensure, rules and regulations for "graduate physicians," (GPs) that are medical school graduates that have passed USMLE Steps 1 & 2 but not 3, nor completed residency. GPs must practice to a CPA and in medically underserved areas and have limitations regarding their controlled substance prescriptive authority. GPs may receive credit towards a future residency program upon successful completion of the CPA. These licenses are valid for two years with no option for renewal.	SB 937 & HB 1311 (2023)
UT	Enacted	Creates "associate physician" (AP) restricted licensure for graduates of LCME-accredited medical schools (in Canada or the U.S.) that have passed USMLE Steps 1 and 2 (or the equivalent) within two years of their application for licensure, and within three of their graduation; and are not currently enrolled, or completed a residency program. APs must enter into a collaborative practice agreement before practicing and within six months of licensure, the collaborating physician must document the completion of at least 120 hours in a four-month period of on-site supervision before the AP can prescribe a controlled substance when the collaborating physician is off-site. The licensee's scope of practice is limited to primary care services to medically underserved populations or areas in the state. The license cannot be held for longer than four years. Originally, HB 400 would have modified Utah's AP legislation by removing the six-year limit on AP licensure, however, the amended bill did repeal the restriction that APs only practice in primary care and in medically underserved areas, and amended provisions relating to their collaborative practice arrangements, making them considerably less burdensome, including removing chart reviews and mandates that the supervising physician be on-site with the AP. According to the Utah's *Medical Practice Act* (Utah Code § 58-67-302.8), AP licenses are renewed on a two-year cycle that can be extended to three or shortened to one year by Division of Occupational and Professional Licenses (DOPL) rule. Renewals require licensees to comply with CME requirements among other administrative details, but the total length of licensure is capped at six years.	HB 396 (2017) HB 400 (2022)
VA	Failed	Bill would have authorized the Board to issue a license to an associate physician (AP) applicant who is at least 18 years old, of "good moral character," has graduated from an accredited medical school, has successfully completed USMLE Steps 1 and Step 2 within two years of their application for licensure, and within three of their graduation; and has not completed a medical internship or residency program. All APs would practice in accordance with a written practice agreement including guidelines regarding prescriptive authority promulgated by the Board. There was no time limit on application for applicants that completed all three steps of the USMLE. The legislation omitted length of AP license and whether or not it was renewable. Virginia previously introduced AP legislation – SB 676 (2022) and HB 900 (2016) – the former provided for an unrenewable, two-year licensure as did the latter, which passed one chamber before ultimately failing.	SB 1006 (2023)
WA	Failed	Bill would have created a new class of licensure for "associate physicians" (APs) and "associate osteopathic physicians" (AOPs) for Washington residents that meet all of the requirements for full, unrestricted licensure such as passing Steps 1 & 2 of the USMLE (or its equivalent) and have graduated from a medical school approved by the Board, except for completion of PGT. Applicants must apply within two years of graduation and cannot be subject to discipline for unprofessional conduct.	HB 2343 (2016)

State	Status	Detail	Citation
		APs and AOPs must enter into a collaborative supervision arrangement with a supervising physician prior to practicing. They may provide only primary care services delegated by the physician and prescribe legend drugs and Schedule III-V controlled substances (so long as they are DEA registered) pursuant to the arrangement. The bill would have allowed the Board to determine the length of these licenses, with a maximum of four years.	
WY	Failed	Bill would have created a restricted class of license for associate physicians (APs) that had passed Steps 1 and 2 of the USMLE (or equivalent exam) but never completed residency. Applicants are eligible within three years of graduating from an accredited U.S. or Canadian medical school. The bill would have allowed APs to work under a CPA (which must be entered into within six months of receiving licensure and *before* practicing) and provide primary care services in medically underserved parts of the state. The license lasts one year and can be renewed up to three times (four a total of four years, maximum). Appropriately credentialed APs (with DEA registration) may prescribe Schedule III-V controlled substances, so long as that is within their scope of practice according to their CPA.	HB 262 (2019)

- The accompanying map to this chart can be found here: **Associate Physician Legislation by State (Map)**

For informational purposes only: This document is not intended as a comprehensive statement of the law on this topic, nor to be relied upon as authoritative. Non-cited laws, regulation, and/or policy could impact analysis on a case-by-case or state-by-state basis. All information should be verified independently.

Questions, comments, or corrections? Please contact Andrew Smith (asmith@fsmb.org)