



Allopathic physicians (MD) chapter 246-919 WAC

Rules Workshop
October 12, 2026



Rules Workshop Agenda



**WASHINGTON
Medical
Commission**
Licensing. Accountability. Leadership.

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Virtual via Teams Webinar

Monday, October 12, 2026 – 1:30 pm to 3:30 pm

Allopathic physicians (MD) chapter rule review

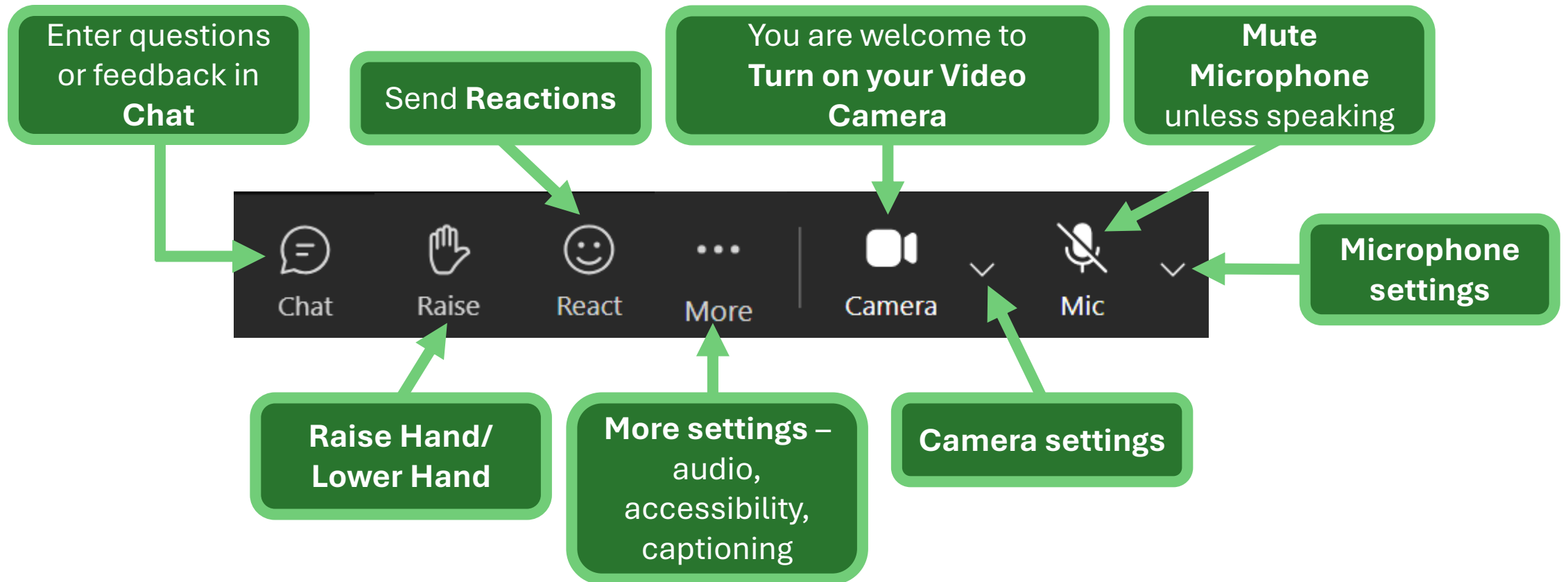
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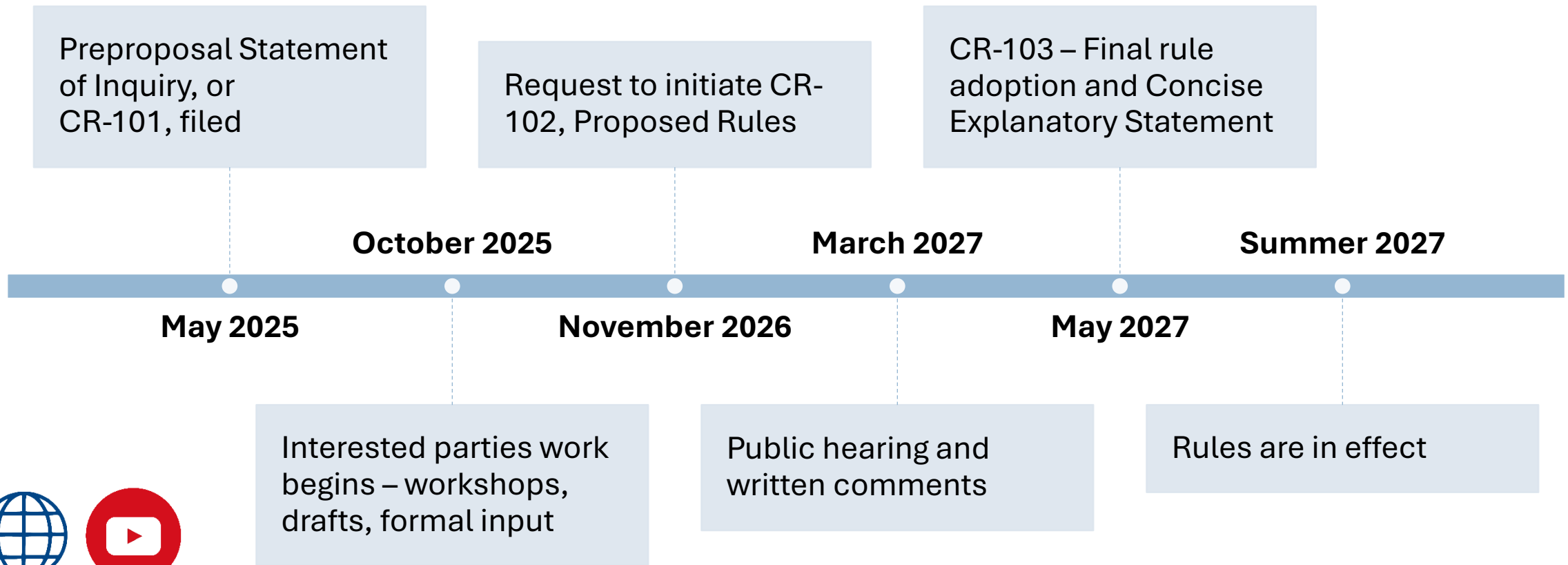
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Teams Features



Proposed Rule Development Timeline



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WAC 246-919-010 Definitions. The definitions in this section apply throughout this chapter unless the context clearly requires otherwise.

(1) "Applicant" is an individual who has completed the application form and has paid the application fee.

(2) "Commission" means the Washington medical commission.

(3) "Delegation" means assigning certain tasks or duties to a qualified and trained individual while retaining ultimate responsibility for patient care outcomes.

Commented [DB1]: Approved 10/23/25

(4) "Direct supervision" means the supervising physician is physically present and immediately available in the facility where services are provided, or, in the case of telemedicine or remote services, available via real-time communication and able to respond promptly.

Commented [DB2]: Approved 10/23/25

(5) "Emergent" means a circumstance calling for immediate action.

(6) "Good standing" means that a license is active and not currently encumbered by disciplinary action, restriction, or condition.

Commented [DB3]: Approved 10/23/25

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(~~74~~) "Hospital" means any health care institution licensed under chapter 70.41 RCW.

(~~85~~) "Intermittent" means providing services on a part-time or full-time nonpermanent basis.

(~~96~~) "Physician" means a person licensed under chapter 18.71 RCW and chapter 18.71B RCW.

E370

(~~117~~) "Unprofessional conduct" means the conduct described in RCW 18.130.180.

[Statutory Authority: RCW 18.71.017 and 18.130.050. WSR 20-22-003, § 246-919-010, filed 10/21/20, effective 11/21/20.

Statutory Authority: RCW 18.71.017, 18.130.250, 18.71.440. WSR 11-05-025, § 246-919-010, filed 2/7/11, effective 3/10/11.

Statutory Authority: RCW 18.71.017 and 18.71A.020. WSR 96-03-073, § 246-919-010, filed 1/17/96, effective 2/17/96.]

WAC 246-919-020 Commission addresses. The commission's official mailing address is:

Washington Medical Commission

Department of Health

P.O. Box 47866

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Olympia, WA 98504-7866

Licensing fees, in the form of a check or money order,
should be sent to:

Department of Health

P.O. Box 1099

Olympia, WA 98507-1099

Commented [DB4]: Approved 10/23/25

[Statutory Authority: RCW 18.71.017 and 18.130.050. WSR 20-22-003, § 246-919-020, filed 10/21/20, effective 11/21/20.

Statutory Authority: RCW 18.71.017 and 18.71A.020. WSR 96-03-073, § 246-919-020, filed 1/17/96, effective 2/17/96.]

WAC 246-919-110 Commission meetings. Regular commission meetings shall be held at least four times yearly. Additional regular or special meetings may be called at the discretion of the chair or by a quorum of the commission.

[Statutory Authority: RCW 18.71.017. WSR 04-04-067, § 246-919-110, filed 2/2/04, effective 3/4/04. Statutory Authority: RCW 18.71.017 and 18.71A.020. WSR 96-03-073, § 246-919-110, filed 1/17/96, effective 2/17/96.]

APPLICATIONS AND EXAMINATIONS

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WAC 246-919-300 Application withdrawals and denial. An

application for a license may not be withdrawn after the commission determines that grounds exist for denial of the license or for the issuance of a conditional license.

Applications that are subject to investigation for unprofessional conduct or impaired practice may not be withdrawn.

(1) The commission shall deny any application, regardless of mitigating circumstances, that contains the following information or conditions: convictions that constitute violations of chapter 9A.32 RCW through chapter 9A.68 RCW (add language - equivalent to these crimes in other states):

- (a) Murder in the 1st degree;
- (b) Murder in the 2nd degree;
- (c) Rape in the 1st degree;
- (d) Rape in the 2nd degree;
- (e) Rape in the 3rd degree;
- (f) Rape of a child in the 1st degree;
- (g) Rape of a child in the 2nd degree;
- (h) Rape of a child in the 3rd degree;

Commented [MM5]: Language on mandatory denials and referrals related to criminal justice, board actions, and personal health issues added.

This is in response to national best practices and previous legislative attempts to require "pre-application determination reviews". This is a needed transparency and consistency measure.

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- (i) Molestation of a child in the 1st degree;
- (j) Molestation of a child in the 2nd degree;
- (k) Molestation of a child in the 3rd degree;
- (l) Human trafficking;
- (m) Kidnapping in the 1st degree ~~of a non-family member;~~
- (n) Abuse of human remains;
- (o) ~~Felony Stalking~~ under RCW 9A.46.110;
- (p) Criminal impersonation, specifically, impersonating a physician or other credentialed health care worker;
- (q) Sexual exploitation of a minor;
- (r) Commercial sex abuse of a minor;
- (s) Promoting commercial sex abuse of a minor;
- (t) Promoting travel or commercial sex abuse of a minor;
- (u) Permitting commercial sex abuse of a minor.

Commented [DB6]: Approved 8/31/26.

~~The commission shall deny any application, regardless of mitigating circumstances, that contains the following information or conditions relating to state regulatory action(s):~~

~~Revocation of license;~~

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~~Current suspension of license;~~

~~Three or more significant disciplinary actions, which do not include:~~

~~Actions mirrored under 18.130.370 RCW;~~

~~Public letters of concern, reprimand, or warning;~~

~~Private letters of concern, reprimand, or warning;~~

~~Actions taken by other states that do not constitute a violation of the Washington Medical Practice act.~~

(2) The commission shall take the following actions on any application that contains the following information or conditions:

(a) Three or greater DUI/DWI arrests, deferred prosecutions, prosecutions, Alford pleas, or convictions in the five (5) years preceding the date of the application shall result in a denial;

(b) Any DUI/DWI arrests, deferred prosecutions, prosecutions, Alford pleas, or convictions in the five (5) years preceding the date of the application shall result in a

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referral to the recognized physician health program for evaluation;

Commented [DB7]: Approved 10/23/25

~~(a) (c) If the commission receives information that an applicant may have a mental, physical, or other health condition, including a substance use disorder, that may impair the applicant's ability to practice medicine with reasonable skill and safety, and the condition is not known to the recognized physician health program in accordance with commission application requirements, the commission shall refer the applicant to the recognized physician health program for evaluation. Any mental, physical or other health condition that is not disclosed to the commission and falls outside of the safe harbor provision of being "known" to the state physician health program shall result in a referral to the recognized physician health program for evaluation.~~

Commented [DB8]: Approved 8/31/26.

[Statutory Authority: RCW 18.71.017 and 18.130.050. WSR 20-22-003, § 246-919-300, filed 10/21/20, effective 11/21/20.]

[Statutory Authority: RCW 18.71.017 and 18.71A.020. WSR 96-03-073, § 246-919-300, filed 1/17/96, effective 2/17/96.]

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WAC 246-919-320 Approved United States and Canadian

medical schools. For the purposes of RCW 18.71.055, the commission approves medical schools accredited by the Liaison Committee on Medical Education and the Committee on Accreditation of Canadian Medical Schools (CACMS).

Commented [DB9]: Approved 10/23/25

[Statutory Authority: RCW 18.71.017 and 18.130.050. WSR 20-22-003, § 246-919-320, filed 10/21/20, effective 11/21/20. Statutory Authority: RCW 18.71.017. WSR 04-04-067, § 246-919-320, filed 2/2/04, effective 3/4/04. Statutory Authority: RCW 18.71.017 and 18.71A.020. WSR 96-03-073, § 246-919-320, filed 1/17/96, effective 2/17/96.]

WAC 246-919-330 Postgraduate medical training. (1)

Postgraduate medical training means clinical training approved by the commission in general medicine or surgery, or a specialty or subspecialty in the field of medicine or surgery as recognized by the American Board of Medical Specialties (ABMS) listed in the 2017-24-2018-25 ABMS Board Certification Report and new specialties or subspecialties approved by the commission.

Commented [DB10]: Approved 10/23/25

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(2) The commission approves only the following postgraduate clinical training courses:

(a) Programs accredited by the Accreditation Council for Graduate Medical Education (ACGME) at the time of residency.

(b) Programs accredited by the Royal College of Physicians and Surgeons of Canada (RCPSC) or the College of Family Physicians of Canada (CFPC), or programs accredited by the RCPSC or CFPC at the time of residency.

(c) Programs resulting in the trainee becoming eligible for ABMS Board Certification.

Commented [DB11]: Approved 7/27/26.

(d) Programs accredited by the Commission on Dental Accreditation (CODA), either for the full duration of the training, or a portion, or accredited by multiple accrediting bodies as approved by the commission.

Commented [DB12]: Approved 10/23/25

(3) Postgraduate medical training includes, but is not limited to, internships, residencies and medical or surgical fellowships.

(4) A physician must complete two years of postgraduate medical training. The physician must acquire this training after completion of a formal course of undergraduate medical

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instruction outlined in RCW 18.71.055. The commission will accept only satisfactory clinical performance evaluations.

(5) Eligibility will be determined on a case-by-case basis at the discretion of the commission.

Commented [DB13]: Approved 7/27/26.

[Statutory Authority: RCW 18.71.017 and 18.130.050. WSR 24-13-019, § 246-919-330, filed 6/6/24, effective 7/7/24; WSR 20-22-003, § 246-919-330, filed 10/21/20, effective 11/21/20.

Statutory Authority: RCW 18.71.017 and 18.71.050. WSR 05-07-024, § 246-919-330, filed 3/7/05, effective 4/7/05. Statutory

Authority: RCW 18.71.017, 18.71.050 and chapter 18.71 RCW. WSR 01-18-087, § 246-919-330, filed 9/5/01, effective 10/6/01.

Statutory Authority: RCW 18.71.017 and 18.71A.020. WSR 96-03-073, § 246-919-330, filed 1/17/96, effective 2/17/96.]

WAC 246-919-340 Additional requirements for international medical school graduates. All graduates of medical schools outside the United States, Canada, or Puerto Rico must satisfy one of the following requirements:

(1) Held a full and unrestricted license to practice medicine in another state prior to 1958. This provision expires January 1, 2030, and no further applicants will be considered after that date. Licensees who previously applied and were

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licensed through this pathway will be deemed valid until the expiration of their license-;

Commented [DB14]: Approved 10/23/25

(1) Held a full and unrestricted license to practice medicine in another state prior to 1958;

(2) Obtained a certificate with an indefinite status granted by the Educational Commission for Foreign Medical Graduates (ECFMG); or

(3) Successfully completed one year of supervised academic clinical training in the United States, commonly referred to as a Fifth Pathway program.

[Statutory Authority: RCW 18.71.017 and 18.130.050. WSR 20-22-003, § 246-919-340, filed 10/21/20, effective 11/21/20. Statutory Authority: RCW 18.71.017, 18.71.050 and chapter 18.71 RCW. WSR 01-18-086, § 246-919-340, filed 9/5/01, effective 10/6/01. Statutory Authority: RCW 18.71.017 and 18.71A.020. WSR 96-03-073, § 246-919-340, filed 1/17/96, effective 2/17/96.]

WAC 246-919-345 Limited physician and surgeon clinical experience license. (1) The commission may issue a limited physician and surgeon clinical experience license to an applicant who does not qualify for licensure under RCW 18.71.050

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or chapter 18.71B RCW and who does meet the requirements established in RCW 18.71.095(6) for the purpose of gaining clinical experience at an approved facility or program. The scope of practice of an individual licensed and practicing under authority of this license shall be defined in the practice agreement between the supervising physician and the licensee. -For purposes of medical practice, employment role definition, malpractice coverage, credentialing, and insurance billing for plans described in, but not limited to, Title 48 RCW, the licensee shall be considered a full scope physician, unless disciplinary action limits the scope of the license held by the licensee or the supervising physician.

(2) An appropriate medical practice, as referenced in RCW 18.71.095 (6) (a), is a practice that meets the following criteria:

(a) The practice is physically located in the state of Washington and is providing clinical care to Washington patients.

(b) The practice falls within one of the following categories:

Commented [MM15]: From 2025 law update. Need this here for clarity and reference.

Commented [DB16R15]: RCW 18.71.095: Limited licenses.

Commented [DB17R15]: Approved 10/23/25

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(i) Is a practice setting within a federal system such as military, Indian health services, tribal health setting, or community health center; or

(ii) Is a practice setting that:

(A) Has three or more physicians for the purposes of delivering direct patient care; and

(B) Has a quality review, improvement, and assurance program for practitioners.

(3) Prior to commencing practice, a limited physician and surgeon clinical experience license holder must file a practice agreement with the commission.

(4) To apply for a limited physician and surgeon clinical experience license, an applicant shall submit to the commission:

(a) An application provided by the commission; and

(b) Applicable fees as established in WAC 246-919-990.

[Statutory Authority: RCW 18.71.017 and 18.130.050. WSR 22-22-038, § 246-919-345, filed 10/25/22, effective 11/25/22.]

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WAC 246-919-355 Examination accepted by the commission.

(1) The commission accepts the United States Medical Licensing Examination (USMLE) as the examination for licensure.

(2) The minimum passing score for each component of any examination combination as defined by USMLE.

~~The minimal passing scores for each component of any approved examination combination shall be defined by the examining authority.~~

Commented [DB18]: Approved 10/23/25

(3) Applicants must have passed all components of the USMLE within seven years after passing the first examination. The commission recognizes that an applicant with a combined degree may require an exception to the seven-year requirement. The commission will review exception requests on a case-by-case basis.

(4) Beginning July 1, 2025, the commission will accept as equivalent passage of the Canadian Medical Licensing Exam in place of a valid USMLE score.

Commented [DB19]: MM: Placeholder until I can find out if our recognition of CAN medical school accreditation translates into USMLE access for them.

Commented [MM20R19]: Update: Confirmed with FSMB that they will not allow Canadian graduates access to USMLE without ECFMG certification.

Commented [DB21R19]: Approved 10/23/25

[Statutory Authority: RCW 18.71.017 and 18.130.050. WSR 20-22-003, § 246-919-355, filed 10/21/20, effective 11/21/20.]

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Statutory Authority: RCW 18.71.017 and 18.71A.020. WSR 96-03-073, § 246-919-355, filed 1/17/96, effective 2/17/96.]

WAC 246-919-360 Examinations accepted for licensure. (1)

The commission may accept certain examinations as a basis for licensure. These examinations include USMLE, Federation Licensure Examination (FLEX), National Boards Examination (NBE), or those given by the other states, or territories of the United States. Those who have taken the Licentiate of the Medical Council of Canada (LMCC) and hold a valid LMCC certification obtained after 1969, may be granted a license without examination.

(2) ~~Examination combination acceptable.~~ Any applicant who has successfully completed Part I (NBE) or Step 1 (USMLE) plus Part II or Step 2 plus Part III or Step 3; or FLEX Component 1 plus Step 3; or Part I or Step 1, plus Part II or Step 2, plus FLEX Component 2 shall be deemed to have successfully completed a medical licensure examination as required by RCW 18.71.070. (For clarification, see Table 1.)

Table 1

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Accepted Examinations taken in Sequence	Other Acceptable Combinations
NBME Part I <i>plus</i> NBME Part II <i>plus</i> NBME Part III	NBME Part I or USMLE Step 1 <i>plus</i> NBME Part II or USMLE Step 2 <i>plus</i> NBME Part III or USMLE Step 3
FLEX Component 1 <i>plus</i> FLEX Component 2	FLEX Component 1 <i>plus</i> USMLE Step 3 or NBME Part I or USMLE Step 1 <i>plus</i> NBME Part II or USMLE Step 2 <i>plus</i> FLEX Component 2
USMLE Step 1 <i>plus</i> USMLE Step 2 <i>plus</i> USMLE Step 3	

[Statutory Authority: RCW 18.71.017 and 18.130.050. WSR 20-22-003, § 246-919-360, filed 10/21/20, effective 11/21/20.

Statutory Authority: RCW 18.71.017, 18.130.050, 18.71.090, and [18.71.]095. WSR 06-18-042, § 246-919-360, filed 8/30/06, effective 9/30/06. Statutory Authority: RCW 18.71.017. WSR 04-04-067, § 246-919-360, filed 2/2/04, effective 3/4/04. Statutory Authority: RCW 18.71.017 and 18.71A.020. WSR 96-03-073, § 246-919-360, filed 1/17/96, effective 2/17/96.]

WAC 246-919-365 FLEX examination standards.

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(1) The Federation Licensing Examination (FLEX) is no longer administered. However, the commission may consider FLEX scores for applicants who took the exam prior to its discontinuation.

(2) The commission accepts a FLEX weighted average score of 75 or higher, as officially reported by the Federation of State Medical Boards (FSMB).

(3) All FLEX scores must be submitted directly to the Commission by FSMB. FLEX scores submitted by other states or third parties will not be accepted.

~~The commission will accept the Federation Licensing Examination (FLEX) weighted average of 75 reported from the Federation of State Medical Boards. All FLEX scores must be submitted directly from the Federation of State Medical Boards. FLEX scores reported by other states will not be accepted.~~

Commented [DB22]: Approved 10/23/25

[Statutory Authority: RCW 18.71.017 and 18.130.050. WSR 20-22-003, § 246-919-365, filed 10/21/20, effective 11/21/20.

Statutory Authority: RCW 18.71.017 and 18.71A.020. WSR 96-03-073, § 246-919-365, filed 1/17/96, effective 2/17/96.]

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WAC 246-919-370 Special purpose examination. (1) The

commission may require an applicant to pass the Special Purpose Examination (SPEX) or any other examination deemed appropriate. An applicant may be required to take an examination when the commission has concerns with the applicant's ability to practice competently for reasons which may include, but are not limited to, the following:

- (a) Resolved or pending malpractice suits;
- (b) Pending action by another state licensing authority;
- (c) Actions pertaining to privileges at any institution; or
- (d) Not having practiced for the immediate two years prior

to the application.

(e) As an alternate examination for International medical Graduates unable to access the USMLE due to hardship as determined by the commission. SPEX exams offered under this process will be approved by commission delegates on a case-by-case basis. |

Commented [DB23]: Approved 7/27/26.

(i) Hardship scenarios the commission may consider include, but are not limited to:

- (A) Refugee status;

Commented [DB24]: MM: SPEX oversight committee granted us this use case authority in 2024.

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(B) Persecution in the home country of the applicant due to beliefs; ethnicity, or other demographic considerations.

(C) Other circumstances that, in the judgement of the commission constitute a hardship that prevents the applicant from accessing the USMLE.

(ii) The commission may not consider as a hardship the inability of the applicant to complete the certification and examination processes administered by the Educational Commission on Foreign Medical Graduates or the failure of required examinations.

Commented [DB25]: Reorganized this list and added (C). Needs review, possible changes, and approval.

(2) The minimum passing score on the SPEX examination shall be seventy-five. The passing score for any other examination under this rule shall be determined by the commission.
[Statutory Authority: RCW 18.71.017 and 18.130.050. WSR 20-22-003, § 246-919-370, filed 10/21/20, effective 11/21/20.
Statutory Authority: RCW 18.71.017 and 18.71A.020. WSR 96-03-073, § 246-919-370, filed 1/17/96, effective 2/17/96.]

WAC 246-919-395 Substantially equivalent licensing

~~standards—Temporary practice permit.~~ (1) An applicant who holds an unrestricted, active license in another state with licensing

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standards substantially equivalent to those in Washington may apply for a temporary practice permit authorizing the applicant to practice as a physician in Washington.

(2) The commission will issue the physician a temporary practice permit if the following requirements are met:

(a) The applicant submits a completed application for a physician and surgeon license on a form provided by the commission on which the applicant indicates that ~~he or she~~they wish~~e~~ to receive a temporary practice permit;

(b) The applicant submits payment of the application fee and temporary practice permit fee under WAC 246-919-990;

(c) The commission receives the American Medical Association's physicians' data profile verifying states in which the applicant is or was licensed;

(d) The commission receives the practitioner profile from the Federation of State Medical Boards;

(e) The applicant requests and the commission receives written verification attesting that the applicant has a license in good standing and is not subject to charges or disciplinary

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action for unprofessional conduct or impairment from all states which the applicant is or was licensed;

(f) The applicant is not subject to denial of a license or issuance of a conditional license under chapter 18.130 RCW; and

~~(g) The applicant is licensed in a state that has licensing standards substantially equivalent to Washington.~~

(3) The temporary practice permit allows the applicant to work in the state of Washington as a physician without restriction until the permit expires. The temporary practice permit is a full scope license to practice medicine and shall be recognized as such for the purposes of credentialing and insurance panel processes.

(4) The temporary practice permit shall expire upon the issuance of a license by the commission; initiation of an investigation by the commission of the applicant; or ninety days after the temporary practice permit is issued, whichever occurs first. The temporary permit will not be renewed, reissued, or extended.

(5) An applicant who receives a temporary practice permit and who does not complete the application process may not

Commented [DB26]: MM: This is stated in (1) of this section. Delete?

Commented [DB27R26]: I believe we can delete this one.

Commented [DB28R26]: Marisa: I am ok with us deleting

Commented [DB29R26]: Approved 10/23/25

Commented [DB30]: Approved 10/23/25

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receive additional temporary practice permits even upon submission of a new application in the future.

[Statutory Authority: RCW 18.71.017 and 18.130.050. WSR 20-22-003, § 246-919-395, filed 10/21/20, effective 11/21/20.

Statutory Authority: RCW 18.71.017 and 18.130.075. WSR 17-18-098, § 246-919-395, filed 9/6/17, effective 10/7/17. Statutory Authority: RCW 18.71.017 and 18.71A.020. WSR 96-03-073, § 246-919-395, filed 1/17/96, effective 2/17/96.]

WAC 246-919-396 Background check—Temporary practice

permit. The commission conducts background checks on applicants to assure safe patient care. Completion of a national criminal background check may require additional time. The commission may issue a temporary practice permit when the applicant has met all other licensure requirements, except the national criminal background check requirement. The applicant must not be subject to denial of a license or issuance of a conditional license under this chapter.

(1) If there are no violations identified in the Washington criminal background check and the applicant meets all other licensure conditions, including receipt by the department of

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health of a completed Federal Bureau of Investigation (FBI) fingerprint card, the commission may issue a temporary practice permit allowing time to complete the national criminal background check requirements.

The commission will issue a temporary practice permit that is valid for six months. A one-time extension of six months will be granted if the national background check report has not been received by the commission.

(2) The temporary practice permit allows the applicant to work in the state of Washington as a physician during the time period specified on the permit. The temporary practice permit is a full scope license to practice medicine and shall be recognized as such for the purposes of credentialing and insurance panel processes.

Commented [DB31]: Approved 10/23/25

(3) The commission issues a license after it receives the national background check report if the report is negative and the applicant otherwise meets the requirements for a license.

(4) The temporary practice permit is no longer valid after the license is issued or action is taken on the application because of the background check.

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[Statutory Authority: RCW 18.71.017 and 18.130.050. WSR 20-22-003, § 246-919-396, filed 10/21/20, effective 11/21/20.

Statutory Authority: RCW 18.130.064 and 18.130.075. WSR 10-05-029, § 246-919-396, filed 2/9/10, effective 2/11/10.]

WAC 246-919-397 How to obtain an expedited temporary

license—Military spouse. A military spouse may receive an expedited temporary license while completing any specific additional requirements that are not related to training or practice standards for physicians under the following conditions.

(1) An expedited temporary license may be issued to an applicant who is a military spouse and:

(a) Is moving to Washington as a result of the military person's transfer to the state of Washington;

(b) Holds an unrestricted, active license in another state or United States territory that the commission currently deems to have substantially equivalent licensing standards for a physician in the state of Washington; and

(c) Is not subject to any pending investigation, charges, or disciplinary action by the regulatory body in any other state

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or United States territory in which the applicant holds a license.

(2) An expedited temporary license grants the applicant the full scope of practice for the physician.

(3) An expedited temporary license expires when any one of the following occurs:

(a) A full or limited license is issued to the applicant;

(b) A notice of decision on the application is mailed to the applicant, unless the notice of decision on the application specifically extends the duration of the expedited temporary license; or

(c) One hundred eighty days after the expedited temporary license is issued.

(4) To receive an expedited temporary license, the applicant must:

(a) Meet all requirements and qualifications for the license that are specific to the training, education, and practice standards for physicians;

(b) Submit a written request for a temporary practice permit; and

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(c) Submit a copy of the military person's orders and a copy of one of the following:

(i) The military-issued identification card showing the military person's information and the applicant's relationship to the military person;

(ii) A marriage license; or

(iii) Documentation of a state registered domestic partnership.

(5) For the purposes of this section the following definitions shall apply:

(a) "Military spouse" is someone married to or in a registered domestic partnership with a military person who is serving in the United States Armed Forces, the United States Public Health Service Commissioned Corps, or the Merchant Marine of the United States; and

(b) "Military person" means a person serving in the United States Armed Forces, the United States Public Health Service Commissioned Corps, or the Merchant Marine of the United States. [Statutory Authority: RCW 18.71.017, 18.130.050, and 2023 c 165. WSR 24-24-098, s 246-919-397, filed 12/3/24, effective 1/3/25.]

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Statutory Authority: RCW 18.71.017 and 18.130.050. WSR 20-22-003, § 246-919-397, filed 10/21/20, effective 11/21/20.]

RENEWAL AND CME REQUIREMENTS

WAC 246-919-421 Two year renewal cycle. A licensed physician shall renew ~~his or her~~their license every two years in compliance with WAC 246-12-030. Prior to the commission authorizing a renewal, A licensed physician must also submit information about ~~his or her~~their current professional practice as required by RCW 18.71.080 (1) (b).

Commented [DB32]: Approved 10/23/25

[Statutory Authority: RCW 18.71.002, 18.71.017, and 18.71.080. WSR 16-16-028, § 246-919-421, filed 7/22/16, effective 8/22/16. Statutory Authority: RCW 18.71.017, 18.130.250, 18.71.440. WSR 11-05-025, § 246-919-421, filed 2/7/11, effective 3/10/11. Statutory Authority: RCW 18.71.017, 18.130.050(1), 18.130.040(4), 18.130.050(12) and 18.130.340. WSR 99-23-090, § 246-919-421, filed 11/16/99, effective 1/1/00.]

WAC 246-919-422 Transition from post-graduate limited license to full license. In order to obtain full license status, a physician with a post-graduate limited Washington license will pay the fee difference between the limited license

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application and the full license application. This license will expire on their second birth date after issuance and every two years thereafter.

[Statutory Authority: RCW 18.71.017 and 18.130.050. WSR 20-22-003, § 246-919-422, filed 10/21/20, effective 11/21/20.

Statutory Authority: RCW 18.71.002, 18.71.017, and 18.71.080. WSR 16-16-028, § 246-919-422, filed 7/22/16, effective 8/22/16.]

WAC 246-919-430 Requirements for maintenance of licensure.

A licensed physician must complete one of the following to satisfy maintenance of licensure requirements during renewal:

(1) Complete ~~two~~one hundred hours of continuing education every ~~four~~two years as required in chapter 246-12 WAC and as described in WAC 246-919-460. Participation in a residency program accredited by the Accreditation Council for Graduate Medical Education or in a fellowship program, accredited or not, may be credited fifty hours of Category I continuing medical education per year of training towards the ~~two hundred~~
~~hour~~one-hundred-hour requirement;

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(2) Obtain a current Physician's Recognition Award from the American Medical Association in at least ~~two~~one of the ~~four~~two years preceding the renewal due date;

(3) Become certified by a member board of the American Board of Medical Specialties in the ~~four~~two years preceding the renewal due date~~.~~⁺

(4) Meet the requirements for participation in maintenance of certification of a member board of the American Board of Medical Specialties at the time of renewal.

(5) If an international medical graduate who is ineligible for ABMS certification, become certified by the American Board of General Practice, within the two years preceding the renewal date.

Commented [DB33]: Approved 7/27/26.

[Statutory Authority: RCW 18.71.002, 18.71.017, and 18.71.080. WSR 16-16-028, § 246-919-430, filed 7/22/16, effective 8/22/16. Statutory Authority: RCW 18.71.017, 18.130.050(1), 18.130.040(4), 18.130.050(12) and 18.130.340. WSR 99-23-090, § 246-919-430, filed 11/16/99, effective 1/1/00. Statutory Authority: RCW 43.70.280. WSR 98-05-060, § 246-919-430, filed 2/13/98, effective 3/16/98. Statutory Authority: RCW 18.71.017 and 18.71A.020. WSR 96-03-073, § 246-919-430, filed 1/17/96, effective 2/17/96.]

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WAC 246-919-435 ~~Training in suicide assessment, treatment, and management~~ Suicide prevention training.

In accordance with RCW 43.70.442, all allopathic physicians licensed under chapter 18.71 RCW, excluding those holding a limited license as defined in RCW 18.71.095(3), must complete a one-time training in suicide assessment, treatment, and management.

(1) The training must be at least six hours in duration and may be completed in one or multiple sessions. It must be included on the model list of approved training programs developed by the Department of Health pursuant to RCW 43.70.442.

(2) The training must be completed by the end of the first full continuing education reporting period after January 1, 2016, or during the first full continuing education reporting period after initial licensure, whichever occurs later.

(3) Allopathic physicians who have brief or limited patient contact, or no patient contact, are exempt from this requirement.

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~~(1) A licensed physician, other than a resident holding a limited license issued under RCW 18.71.095(3), must complete a one-time training in suicide assessment, treatment, and management. The training must be at least six hours in length and may be completed in one or more sessions.~~

~~(2) The training must be completed by the end of the first full continuing education reporting period after January 1, 2016, or during the first full continuing education period after initial licensure, whichever occurs later, or during the first full continuing education reporting period after the exemption in subsection (6) of this section no longer applies. The commission accepts training completed between June 12, 2014, and January 1, 2016, that meets the requirements of RCW 43.70.442 as meeting the one-time training requirement.~~

~~(3) The training must be on the model list developed by the department of health under RCW 43.70.442. The establishment of the model list does not affect the validity of training completed prior to July 1, 2017.~~

~~(4) The hours spent completing training in suicide assessment, treatment, and management count toward meeting~~

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~~applicable continuing education requirements in the same category specified in WAC 246-919-460.~~

~~(5) The commission exempts any licensed physician from the training requirements of this section if the physician has only brief or limited patient contact, or no patient contact.~~

Commented [DB34]: Approved 10/23/25. NOTE: Once these rules are adopted, this section in the PA and AA rules will need to be changed.

[Statutory Authority: RCW 18.71.017 and 18.130.050. WSR 20-22-003, § 246-919-435, filed 10/21/20, effective 11/21/20.

Statutory Authority: RCW 18.71.017 and 43.70.442. WSR 17-07-043, § 246-919-435, filed 3/8/17, effective 4/8/17.]

WAC 246-919-445 Health equity continuing education

training requirements. (1) A physician must complete two hours of health equity continuing education training every four years as described in WAC 246-12-800 through 246-12-830.

(2) The two hours of health equity continuing education a physician completes count toward meeting applicable continuing education requirements in the same category specified in WAC 246-919-460.

[Statutory Authority: RCW 18.71.017, 18.130.050, and 43.70.613. WSR 23-24-033, § 246-919-445, filed 11/29/23, effective 1/1/24.]

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WAC 246-919-460 Categories of creditable continuing

medical education activities. (1) Category I: Continuing

medical education activities with accredited sponsorship. The

licensed physician may earn all two hundred credit hours in

Category I. The commission ~~will accept~~accepts continuing

~~education programs designated for Category I credit and offered~~

~~by an organization or institution that meets the standards of~~

~~the Accreditation Council for Continuing Medical Education~~

~~(ACCME), an ACCME-recognized state accrediting agency, the~~

~~Washington State Medical Association, or a nationally recognized~~

~~medical organization and its affiliates, including but not~~

~~limited to the American Academy of Family Physicians and the~~

~~American Medical Association. attendance at a continuing~~

~~education program that is recognized as Category I credit and is~~

~~offered by an organization or institution that meets the~~

~~standards adopted by the Accreditation Council for Continuing~~

~~Medical Education or its designated interstate accrediting~~

~~agency, the Washington State Medical Association.~~

(2) Category II: Continuing medical education activities

with nonaccredited sponsorship. A licensed physician may earn a

Commented [DB35]: See WSMA Comment #2 and WAFP comment dated 6.17.25.

Commented [DB36]: Defer for interested parties comments.

Commented [DB37]: Revised to meet the request of the WAFP comment dates 6.17.25.

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maximum of eighty credit hours by attendance at continuing medical education programs that are not approved but which are in accordance with the provisions of Category I. Acting as a physician reviewer on regulatory cases, serving as a clinical expert witness, or participating in peer reviews at recognized healthcare institutions may be claimed on an hour for hour basis as category II if not accredited as category I.

Commented [DB38]: Accepted by majority
3/9/2026

(3) **Category III: Teaching of physicians or other allied health professionals.** A licensed physician may earn a maximum of eighty credit hours for serving as an instructor of medical students, house staff, other physicians or allied health professionals from a hospital or institution with a formal training program if the hospital or institution has approved the instruction.

(4) **Category IV: Books, papers, publications, exhibits.** A licensed physician may earn:

(a) A maximum of eighty credit hours under Category IV, with specific subcategories listed below. Credit may be earned

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only during the forty-eight-month period following presentations or publications.

(b) Ten credit hours for a paper, exhibit, publication, or for each chapter of a book that is authored by the licensed physician and published. A paper must be published in a recognized medical journal. A licensed physician who presents a paper at a meeting or an exhibit must present to physicians or allied health professionals. Credit may be claimed only once for the scientific materials presented. Credit should be claimed as of the date materials were presented or published.

Medical editing will not be accepted in this or any other category for credit.

(5) **Category V: Self-directed activities.** A licensed physician may earn:

(a) A maximum of eighty credit hours under Category V.

(b) Self-assessment: Credit hours for completion of a multimedia medical education program.

(c) Self-instruction: Credit hours for the independent reading of scientific journals and books.

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(d) Specialty board examination preparation: Credit hours for preparation for specialty board certification or recertification examinations.

(e) Prior authorization ~~Quality care~~ or utilization review:

Credit hours for participation on a staff committee for ~~quality of care~~ prior authorization or utilization review in a hospital or institution or government agency.

[Statutory Authority: RCW 18.71.002, 18.71.017, and 18.71.080. WSR 16-16-028, § 246-919-460, filed 7/22/16, effective 8/22/16. Statutory Authority: RCW 18.71.017, 18.130.050(1), 18.130.040(4), 18.130.050(12) and 18.130.340. WSR 99-23-090, § 246-919-460, filed 11/16/99, effective 1/1/00. Statutory Authority: RCW 43.70.280. WSR 98-05-060, § 246-919-460, filed 2/13/98, effective 3/16/98. Statutory Authority: RCW 18.71.017 and 18.71A.020. WSR 96-03-073, § 246-919-460, filed 1/17/96, effective 2/17/96.]

WAC 246-919-470 Approval not required. (1) Except as required by law, the commission will not give prior approval for any continuing medical education. The commission will accept any continuing medical education that reasonably falls within these

Commented [MM39]: Moved quality up to Cat 2. We should incentivize that more.

Commented [DB40]: Approved 3/9/2026

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rules and relies upon each individual physician's integrity to comply with this requirement.

(2) The continuing medical education category will depend solely upon the accredited status of the organization or institution. The number of creditable hours may be determined by counting the contact hours of instruction and rounding to the nearest quarter hour. The commission relies upon the integrity of program sponsors to present continuing medical education that constitutes a meritorious learning experience.

[Statutory Authority: RCW 18.71.002, 18.71.017, and 18.71.080. WSR 16-16-028, § 246-919-470, filed 7/22/16, effective 8/22/16. Statutory Authority: RCW 18.71.017 and 18.71A.020. WSR 96-03-073, § 246-919-470, filed 1/17/96, effective 2/17/96.]

WAC 246-919-475 Expired license. (1) If the license has been expired for three years or less, the physician must meet the requirements of chapter 246-12 WAC, Part 2.

(2) If the license has been expired for over three years, the physician must:

(a) Reapply for licensing under current requirements as stipulated in RCW 18.71.050 (1) (b) and WAC 246-919-330; and

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(b) Meet the requirements of chapter 246-12 WAC, Part 2.

(3) An applicant whose license has been expired for more than three years must demonstrate current clinical competence to practice safely to the satisfaction of the commission, which may include but is not limited to:

(a) Evidence of active clinical practice in another jurisdiction;

(b) Completion of continuing medical education sufficient to maintain or restore clinical skills;

(c) Participation in a commission-approved reentry or refresher program;

(d) Recent clinical training, assessment, or supervised practice; or

(e) Other evidence as determined by the commission.

(1) In addition to subsection (3) of this section, applicants who have not engaged in clinical practice in any jurisdiction during the period of license expiration must provide additional evidence of competence, which may include but is not limited to:

(a) a formal assessment;

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(b) supervised practice; or

(c) participation in a reentry program, as determined by the commission.

(5) The applicant must attest to any changes in professional, legal, or health status that may affect the applicant's ability to practice medicine, including but not limited to criminal history, disciplinary actions, or impairment, occurring during the period of license expiration.

(6) Reissuance of a license under this section is not automatic and may be subject to conditions, including denial, as determined by the commission.

[Statutory Authority: RCW 18.71.017 and 18.130.050. WSR 20-22-003, § 246-919-475, filed 10/21/20, effective 11/21/20.

Statutory Authority: RCW 18.71.017. WSR 01-03-115, § 246-919-475, filed 1/22/01, effective 2/22/01.]

Commented [DB41]: Approved 4/20/2026

WAC 246-919-480 Retired status (retired active license).

Commented [DB42]: RCW 18.130.250:

(1) ~~To obtain a retired active license a~~ physician seeking retired status must obtain and maintain a retired active license in accordance with ~~comply with~~ chapter 246-12 WAC, Part 5, excluding WAC 246-12-120 (2)(c) and (d).

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(2) A physician ~~with-holding a-retired active license~~status may not receive compensation for health care services;

(3) A physician ~~with-holding a-retired active license~~status may practice only in emergent or intermittent circumstances; and

(4) A physician ~~with-holding a-retired active license~~status must renew every two years and must report one hundred hours of continuing medical education at every renewal. The commission will accept a maximum of forty hours of continuing medical education in Categories II through V, as defined in WAC 246-919-460, during each renewal period. There is no limit to the number of hours that may be accepted in Category I.

[Statutory Authority: RCW 18.71.017 and 18.130.050. WSR 20-22-003, § 246-919-480, filed 10/21/20, effective 11/21/20.

Statutory Authority: RCW 18.71.017, 18.130.250, 18.71.440. WSR 11-05-025, § 246-919-480, filed 2/7/11, effective 3/10/11.

Statutory Authority: RCW 43.70.280. WSR 98-05-060, § 246-919-480, filed 2/13/98, effective 3/16/98. Statutory Authority: RCW 18.71.017 and 18.71A.020. WSR 96-03-073, § 246-919-480, filed 1/17/96, effective 2/17/96.]

[NEW SECTION]

WAC 246-919-490 Reentry to practice requirements. (1) A physician who has not actively practiced medicine for a period

Commented [DB43]: Approved 6/15/2026

Commented [DB44]: Add RCW 18.130.250:

Commented [DB45]: Approved 6/15/2026

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of at least three years in any jurisdiction in the United States must fulfill one or more of the following, as determined by the commission:

(a) Successfully pass a commission-approved competency evaluation;

(b) Successfully pass a commission-approved exam;

(c) Successfully complete a commission-approved retraining program arranged by the physician; or

(d) Successfully complete a commission approved reentry-to-practice monitoring program.

(2) For a physician who has not actively practiced medicine for more than five years, the commission may require completion of more than one of the requirements listed in subsection (1).

(3) For the purposes of this section, "actively practiced medicine" means engaging in the practice of medicine as defined in RCW 18.71.011.

~~(2)~~(4) The reentry to practice requirements in this section do not apply to physicians with expired licenses.

ADJUDICATIVE PROCEDURES

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WAC 246-919-520 Revocation of a physician's license. A physician may request a review by the commission of its decision to revoke the physician's license under RCW 18.71.019:

(1) If the commission issues a final order revoking a physician's license following an adjudicative proceeding, the physician may request a review of the decision by a review panel of the commission.

(2) The physician shall file a written request with the commission within twenty days of the effective date of the final order. The physician may not request an extension of the twenty-day period to file a request for review.

(3) The physician's request for review of the final order does not change the effective date of the final order.

(4) A review panel shall review the final order. The review panel is composed of the members of the commission who did not:

(a) Review the initial investigation and make the decision to issue a statement of charges against the physician in this matter; or

(b) Hear the evidence at the adjudicative proceeding and issue the final order revoking the physician's license.

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Commented [DB46]: Approved 6/15/2026

(c) The review panel may find that a license holder can never be rehabilitated due to one or more of the following factors that include but are not limited to:

- i. An extensive disciplinary history or pattern of conduct;
- ii. the heinousness of the conduct and vulnerability of the victim(s) or serious criminal conviction(s);
- iii. Conduct that represents an irreparable breach of trust in the eyes of the public or the social contract of the profession;
- iv. failure to comply with Commission orders;
- v. A refusal to acknowledge the need for rehabilitation;
- vi. A lack of remorse, self-reflection and accountability; exploitation and disregard for others; or,
- vii. gross violations of professional and ethical standards that erode public trust in the profession demonstrating an unfitness to bear the

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responsibilities of, and enjoy the privileges of,
the profession.

(5) Within seven days of receipt of the request for review of the final order, a scheduling order is issued setting a date for the review hearing, and a date for the filing of written argument by the parties. The review hearing must take place within sixty days of the physician's request for review of the final order.

(6) The review panel shall convene in person for the review hearing on the date set in the scheduling order. If a commission member is unavailable to meet on the scheduled date, a pro tempore member shall take that person's place on the review panel. At the review hearing, the review panel:

(a) Shall review the final order;

(b) Shall review written argument presented by the parties;

and

(c) May hear oral argument by the parties.

(7) If the review panel determines that revocation of the physician's license is not the appropriate sanction, it shall

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issue an amended order setting the appropriate sanction(s) necessary to protect the public.

(8) If the review panel determines that revocation of the physician's license is appropriate, it shall issue an order confirming that decision.

[Statutory Authority: RCW 18.71.017 and 18.130.050. WSR 20-22-003, § 246-919-520, filed 10/21/20, effective 11/21/20.

Statutory Authority: RCW 18.71.019. WSR 97-21-053, § 246-919-520, filed 10/13/97, effective 11/13/97.]

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WAC 246-919-602 Administration of deep sedation and general anesthesia by physicians in dental offices. (1)

Purpose. The purpose of this section is to govern the administration of deep sedation and general anesthesia by physicians in dental offices. The commission establishes these standards to promote effective perioperative communication and appropriately timed interventions, and mitigate adverse events and outcomes.

(2) Definitions. The definitions in this subsection apply throughout this section unless the context clearly requires otherwise.

(a) "Administering physician" means an individual licensed under chapter 18.71 RCW who administers deep sedation or general anesthesia to a patient in a dental office.

(b) "Deep sedation" has the same meaning as in WAC 246-919-601.

(c) "Dental office" means any facility where dentistry is practiced, as defined in chapter 18.32 RCW, except a hospital licensed under chapter 70.41 RCW or ambulatory surgical facility licensed under chapter 70.230 RCW.

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(d) "General anesthesia" has the same meaning as in WAC 246-919-601.

(e) "Perioperative" includes the three phases of surgery: Preoperative, intraoperative, and postoperative.

(3) An administering physician is responsible for the perioperative anesthetic management and monitoring of a patient and must ensure patient care, recordkeeping, equipment, personnel, facilities, and other related matters are in accordance with acceptable and prevailing standards of care including, but not limited to, the following:

(a) Preoperative requirements. An administering physician shall ensure the patient has undergone a preoperative health evaluation and document review of the evaluation. The physician shall also conduct and document a risk assessment to determine whether a patient is an appropriate candidate for deep sedation or general anesthesia and discussion of the risks of deep sedation or general anesthesia with the patient. For a pediatric patient, this assessment must include:

(i) Whether the patient has specific risk factors that may warrant additional consultation before administration of deep

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sedation or general anesthesia, and how each patient meets criteria for deep sedation or general anesthesia in an outpatient environment. This must include a specific inquiry into whether the patient has signs and symptoms of sleep-disordered breathing or obstructive sleep apnea;

(ii) A discussion with a parent or guardian of a pediatric patient of the particular risks of deep sedation or general anesthesia for a patient who: (A) Is younger than six years old; (B) has special needs; (C) has airway abnormalities; or (D) has a chronic condition. This discussion must include reasoning why the pediatric patient can safely receive deep sedation or general anesthesia in an outpatient environment and any alternatives.

(b) Medical record. The anesthesia record must be complete, comprehensive, and accurate for each patient, including documentation at regular intervals of information from intraoperative and postoperative monitoring. The recordkeeping requirements under WAC 246-919-601 and 246-817-770 apply to an administering physician, including the elements of a separate anesthesia record. The anesthesia record must also include

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temperature measurement and a heart rate and rhythm measured by electrocardiogram. For a pediatric patient, the administering physician shall ensure vital signs are postoperatively recorded at least at five-minute intervals until the patient begins to awaken, then recording intervals may be increased to ten to fifteen minutes.

(c) Equipment. An administering physician shall ensure the requirements for equipment and emergency medications under WAC 246-817-724 and 246-817-770 are met, regardless of any delineated responsibility for furnishing of the equipment or medications in a contract between the physician and dental office. Additionally, for a pediatric patient, an administering physician shall ensure there is a complete selection of equipment for clinical application to the pediatric patient. The physician shall also ensure equipment is available in the recovery area to meet the requirements in this section for monitoring during the recovery period. The physician shall ensure all equipment and medications are checked and maintained on a scheduled basis.

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(d) Recovery and discharge requirements. An administering physician shall ensure that:

(i) A physician licensed under chapter 18.71 RCW capable of managing complications, providing cardiopulmonary resuscitation, and currently certified in advanced cardiac life support measures appropriate for the patient age group is immediately available for a patient recovering from anesthesia. For a pediatric patient, the physician shall also be trained and experienced in pediatric perioperative care;

(ii) At least one licensed health care practitioner experienced in postanesthetic recovery care and currently certified in advanced cardiac life support measures appropriate for the patient age group visually monitors the patient, at all times, until the patient has met the criteria for discharge from the facility. Consideration for prolonged observation must be given to a pediatric patient with an anatomic airway abnormality, such as significant obstructive sleep apnea. A practitioner may not monitor more than two patients simultaneously, and any such simultaneous monitoring must take place in a single recovery room. If a practitioner is qualified

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to administer deep sedation or general anesthesia, the practitioner may not simultaneously administer deep sedation or general anesthesia and perform recovery period monitoring functions. The practitioner shall provide: (A) Continuous respiratory monitoring via pulse oximetry and cardiovascular monitoring via electrocardiography during the recovery period; and (B) monitoring, at regular intervals, during the recovery period of the patient for color of mucosa, skin, or blood, oxygen saturation, blood pressure, and level of consciousness; and (C) measurement of temperature at least once during the recovery period. If a patient's condition or other factor for the patient's health or safety preclude the frequency of monitoring during the recovery period required by this section, the practitioner must document the reason why such a departure from these requirements is medically necessary;

(iii) Emergency equipment, supplies, medications, and services comply with the provisions of WAC 246-817-770 and are immediately available in all areas where anesthesia is used and for a patient recovering from anesthesia. Resuscitative equipment and medications must be age and size-appropriate,

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including for care of a pediatric patient, pediatric defibrillator paddles, and vasoactive resuscitative medications and a muscle relaxant such as dantrolene sodium, which must be immediately available in appropriate pediatric concentrations, as well as a written pediatric dose schedule for these medications. The administering physician shall ensure that support personnel have knowledge of the emergency care inventory. All equipment and medications must be checked and maintained on a scheduled basis; and

(iv) Before discharge, the patient is awake, alert, and behaving appropriately for age and developmental status, normal patient vital signs, and if applicable, a capable parent or guardian present to assume care of the patient.

(e) Emergency care and transfer protocol. An administering physician shall monitor for, and be prepared to treat, complications involving compromise of the airway and depressed respiration, particularly with a pediatric patient. The physician shall ensure that in the event of a complication or emergency, ~~his or her~~their assistive personnel and all dental office clinical staff are well-versed in emergency recognition,

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rescue, and emergency protocols, and familiar with a written and documented plan to timely and safely transfer a patient to an appropriate hospital.

(4) (a) An administering physician shall submit to the commission a report of any patient death or serious perioperative complication, which is or may be the result of anesthesia administered by the physician.

(b) The physician shall notify the commission or the department of health, by telephone, email, or fax within seventy-two hours of discovery and shall submit a complete written report to the commission within thirty days of the incident. The written report must include the following:

(i) Name, age, and address of the patient;

(ii) Name of the dentist and other personnel present during the incident;

(iii) Address of the facility or office where the incident took place;

(iv) Description of the type of anesthetic being utilized at the time of the incident;

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(v) Dosages, if any, of any other drugs administered to the patient;

(vi) A narrative description of the incident including approximate times and evolution of symptoms;

(vii) Additional information which the commission may require or request.

[Statutory Authority: RCW 18.71.017 and 18.130.050. WSR 20-22-003, § 246-919-602, filed 10/21/20, effective 11/21/20.]

STANDARDS FOR PROFESSIONAL CONDUCT

NEW SECTION

WAC 246-919-604 Physicians providing advanced procedure

support to optometrists. This section establishes the qualifications and requirements for physicians entering into agreements with Washington licensed optometrists to facilitate advanced procedures as described in 18.53.010 RCW.

(1) Physicians entering into an agreement must adhere to the following conditions:

Commented [DB1]: Notes from 6/15/26 workshop:
26 states have similar authorization for optometrists.
23 can do lumps and bumps
16 can do laser
None of the 26 have an agreement requirement.

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- (a) Hold an active, unrestricted license to practice medicine and surgery in the state of Washington under chapter 18.71 or 18.71B RCW;
 - (b) Is not currently under an order or a stipulation to informal disposition with the commission;
 - (c) Holds a current and unrestricted certification from the American Board of Ophthalmology or is eligible to do so; and
 - (d) Has a surgical suite on site or holds privileges at a hospital local to the ophthalmologist. Local to the ophthalmologist is considered within thirty to sixty minutes of surface travel.
- (2) A physician meeting the requirements under (1) of this section may provide consultation, supervision, or collaborative care to Washington licensed optometrists consistent with applicable laws and rules governing both professions.
- (3) A physician meeting the requirements under (1) of this section may enter into an allowable agreement under 18.53.010 (5) (iii) RCW with an optometrist who has

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been granted an advanced procedures endorsement by the board of optometry, so long as the physician complies with the following requirements:

a. No more than ten agreements with ten individual optometrists may be active at any time;

i. A physician may petition the commission for a waiver of this limit; however, the physician may not enter into agreements with more optometrists than the physician can adequately collaborate with.

b. No agreement may extend beyond 12-months before requiring updating and renewal;

c. Unless directed by the physician, no valid agreement shall stipulate referral to a primary care practitioner, urgent care, emergency department, or any combination thereof as an appropriate response to complications from advanced procedures performed under the agreement;

d. The physician named in the agreement may not be located more than one hour of surface travel from

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the site of patient care delivery by the
optometrist;

e. Agreements must stipulate the specific procedures
the qualifying physician will rapidly respond to
should complications arise;

f. Agreements must be filed with the commission by the
qualifying physician within fourteen (14) days of
execution. Agreements shall be sent to
medical.commission@wmc.wa.gov or submitted on a form
provided by the commission;

g. The physician shall file a report with the
commission if any rapid response is required under
the agreement. The report:

i. Serves as notification only and is non-
disciplinary;

ii. Shall detail the dates, times, procedure, rapid
response, and outcome for the patient;

iii. Pursuant to RCW 70.02, shall not detail names
or contact information of patients;

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iv. Shall be sent to the commission at
medical.commission@wmc.wa.gov or submitted on a
form provided by the commission within 30 days
of the event.

**WAC 246-919-605 Use of laser, light, radiofrequency, and
plasma devices as applied to the skin.** (1) For the purposes of
this rule, laser, light, radiofrequency, and plasma devices
(hereafter LLRP devices) are medical devices that:

(a) Use a laser, noncoherent light, intense pulsed light,
radiofrequency, or plasma to topically penetrate skin and alter
human tissue; and

(b) Are classified by the federal Food and Drug
Administration as prescription devices.

(2) Because an LLRP device penetrates and alters human
tissue, the use of an LLRP device is the practice of medicine
under RCW 18.71.011. The use of an LLRP device can result in
complications such as visual impairment, blindness,
inflammation, burns, scarring, hypopigmentation and
hyperpigmentation.

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(3) Use of medical devices using any form of energy to penetrate or alter human tissue for a purpose other than the purpose set forth in subsection (1) of this section constitutes surgery and is outside the scope of this section.

PHYSICIAN RESPONSIBILITIES

(4) A physician must be appropriately trained in the physics, safety and techniques of using LLRP devices prior to using such a device, and must remain competent for as long as the device is used.

(5) A physician must use an LLRP device in accordance with standard medical practice.

(6) Prior to authorizing treatment with an LLRP device, a physician must take a history, perform an appropriate physical examination, make an appropriate diagnosis, recommend appropriate treatment, obtain the patient's informed consent (including informing the patient that a nonphysician may operate the device), provide instructions for emergency and follow-up care, and prepare an appropriate medical record.

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(7) Regardless of who performs LLRP device treatment, the physician is ultimately responsible for the safety of the patient.

(8) Regardless of who performs LLRP device treatment, the physician is responsible for assuring that each treatment is documented in the patient's medical record.

(9) The physician must ensure that there is a quality assurance program for the facility at which LLRP device procedures are performed regarding the selection and treatment of patients. An appropriate quality assurance program shall include all ~~of~~ the following:

(a) A mechanism to identify complications and untoward effects of treatment and to determine their cause;

(b) A mechanism to review the adherence of supervised professionals to written protocols;

(c) A mechanism to monitor the quality of treatments;

(d) A mechanism by which the findings of the quality assurance program are reviewed and incorporated into future protocols required by subsection (10)(d) of this section and physician supervising practices; and

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(e) Ongoing training to maintain and improve the quality of treatment and performance of treating professionals.

~~PHYSICIAN DELEGATION OF LLRP TREATMENT~~

(10) A physician who meets the above requirements may delegate an LLRP device procedure to a properly trained and licensed professional, whose licensure and scope of practice allow the use of an LLRP device, provided all the following conditions are met:

(a) The treatment in no way involves surgery as that term is understood in the practice of medicine;

(b) Such delegated use falls within the supervised professional's lawful scope of practice;

(c) The LLRP device is not used on the globe of the eye;

(d) A physician has a written office protocol for the supervised professional to follow in using the LLRP device. A written office protocol must include at a minimum the following:

(i) The identity of the individual physician authorized to use the device and responsible for the delegation of the procedure;

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(ii) A statement of the activities, decision criteria, and plan the supervised professional must follow when performing procedures delegated under this rule;

(iii) Selection criteria to screen patients for the appropriateness of treatments;

(iv) Identification of devices and settings to be used for patients who meet selection criteria;

(v) Methods by which the specified device is to be operated and maintained;

(vi) A description of appropriate care and follow-up for common complications, serious injury, or emergencies; and

(vii) A statement of the activities, decision criteria, and plan the supervised professional shall follow when performing delegated procedures, including the method for documenting decisions made and a plan for communication or feedback to the authorizing physician concerning specific decisions made;

(e) The supervised professional has appropriate training in, at a minimum, application techniques of each LLRP device, cutaneous medicine, indications and contraindications for such procedures, preprocedural and postprocedural care, potential

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complications and infectious disease control involved with each treatment;

(f) The delegating physician ensures that the supervised professional uses the LLRP device only in accordance with the written office protocol, and does not exercise independent medical judgment when using the device;

(g) The delegating physician shall be on the immediate premises during the patient's initial treatment and be able to treat complications, provide consultation, or resolve problems, if indicated. The supervised professional may complete the initial treatment if the physician is called away to attend to an emergency; and

(h) Existing patients with an established treatment plan may continue to receive care during temporary absences of the delegating physician provided that there is a local back-up physician who satisfies the requirements of subsection (4) of this section. The local back-up physician must agree in writing to treat complications, provide consultation or resolve problems if medically indicated. The local back-up physician shall be reachable by phone and able to see the patient within sixty

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minutes. The delegating physician's absence from the site where the treatment occurs must be for brief and intermittent periods of time. The delegating physician's absence from the site where the treatment occurs cannot be an ongoing arrangement.

(11) The use of, or the delegation of the use of, an LLRP device by a physician assistant is covered by WAC 246-918-125. [Statutory Authority: RCW 18.71.017 and 18.130.050. WSR 20-22-003, § 246-919-605, filed 10/21/20, effective 11/21/20. Statutory Authority: RCW 18.71.017, 18.71A.020 and 18.130.050(12). WSR 07-03-177, § 246-919-605, filed 1/24/07, effective 3/1/07.]

WAC 246-919-606 Nonsurgical medical cosmetic procedures.

(1) The purpose of this rule is to establish the duties and responsibilities of a physician who delegates the injection of medication or substances for cosmetic purposes or the use of prescription devices for cosmetic purposes. These procedures can result in complications such as visual impairment, blindness, inflammation, burns, scarring, disfiguration, hypopigmentation and hyperpigmentation. The performance of these procedures is the practice of medicine under RCW 18.71.011(3).

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(2) This rule does not apply to:

(a) Surgery;

(b) The use of prescription lasers, noncoherent light, intense pulsed light, radiofrequency, or plasma as applied to the skin; this is covered in WAC 246-919-605 and 246-918-125;

(c) The practice of a profession by a licensed health care professional under methods or means within the scope of practice permitted by such license;

(d) The use of nonprescription devices; and

(e) Intravenous therapy.

(3) Definitions. The definitions in this subsection apply throughout this section unless the context clearly requires otherwise.

(a) "Nonsurgical medical cosmetic procedure" means a procedure or treatment that involves the injection of a medication or substance for cosmetic purposes, or the use of a prescription device for cosmetic purposes. Laser, light, radiofrequency and plasma devices that are used to topically penetrate the skin are devices used for cosmetic purposes, but

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are excluded under subsection (2)(b) of this section, and are covered by WAC 246-919-605 and 246-918-125.

(b) "Prescription device" means a device that the federal Food and Drug Administration has designated as a prescription device, and can be sold only to persons with prescriptive authority in the state in which they reside.

PHYSICIAN RESPONSIBILITIES

(4) A physician must be fully and appropriately trained in a nonsurgical medical cosmetic procedure prior to performing the procedure or delegating the procedure. The physician must keep a record of ~~his or her~~their training in the office and be available for review upon request by a patient or a representative of the commission.

(5) Prior to authorizing a nonsurgical medical cosmetic procedure, a physician must:

- (a) Take a history;
- (b) Perform an appropriate physical examination;
- (c) Make an appropriate diagnosis;
- (d) Recommend appropriate treatment;

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(e) Obtain the patient's informed consent;

(f) Provide instructions for emergency and follow-up care;

and

(g) Prepare an appropriate medical record.

(6) Regardless of who performs the nonsurgical medical cosmetic procedure, the physician is ultimately responsible for the safety of the patient.

(7) Regardless of who performs the nonsurgical medical cosmetic procedure, the physician is responsible for ensuring that each treatment is documented in the patient's medical record.

(8) The physician must ensure that there is a quality assurance program for the facility at which nonsurgical medical cosmetic procedures are performed regarding the selection and treatment of patients. An appropriate quality assurance program must include the following:

(a) A mechanism to identify complications and untoward effects of treatment and to determine their cause;

(b) A mechanism to review the adherence of supervised health care professionals to written protocols;

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(c) A mechanism to monitor the quality of treatments;

(d) A mechanism by which the findings of the quality assurance program are reviewed and incorporated into future protocols required by subsection (11)(d) of this section and physician supervising practices; and

(e) Ongoing training to maintain and improve the quality of treatment and performance of supervised health care professionals.

(9) A physician may not sell or give a prescription device to an individual who does not possess prescriptive authority in the state in which the individual resides or practices.

(10) The physician must ensure that all equipment used for procedures covered by this section is inspected, calibrated, and certified as safe according to the manufacturer's specifications.

PHYSICIAN DELEGATION

(11) A physician who meets the above requirements may delegate a nonsurgical medical cosmetic procedure to a properly

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trained physician assistant, registered nurse or licensed practical nurse, provided all the following conditions are met:

- (a) The treatment in no way involves surgery as that term is understood in the practice of medicine;
- (b) The physician delegates procedures that are within the delegate's lawful scope of practice;
- (c) The delegate has appropriate training in, at a minimum:
 - (i) Techniques for each procedure;
 - (ii) Cutaneous medicine;
 - (iii) Indications and contraindications for each procedure;
 - (iv) Preprocedural and postprocedural care;
 - (v) Recognition and acute management of potential complications that may result from the procedure; and
 - (vi) Infectious disease control involved with each treatment.
- (d) The physician has a written office protocol for the delegate to follow in performing the nonsurgical medical cosmetic procedure. A written office protocol must include, at a minimum, the following:

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(i) The identity of the physician responsible for the delegation of the procedure;

(ii) Selection criteria to screen patients for the appropriateness of treatment;

(iii) A description of appropriate care and follow-up for common complications, serious injury, or emergencies; and

(iv) A statement of the activities, decision criteria, and plan the delegate shall follow when performing delegated procedures, including the method for documenting decisions made and a plan for communication or feedback to the authorizing physician concerning specific decisions made.

(e) The physician ensures that the delegate performs each procedure in accordance with the written office protocol;

(f) Each patient signs a consent form prior to treatment that lists foreseeable side effects and complications, and the identity and license of the delegate or delegates who will perform the procedure; and

(g) Each delegate performing a procedure covered by this section must be readily identified by a name tag or similar

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means so that the patient understands the identity and license of the treating delegate.

(12) If a physician delegates the performance of a procedure that uses a medication or substance that the federal Food and Drug Administration has not approved, or that the federal Food and Drug Administration has not approved for the particular purpose for which it is used, the physician must be on-site during the entire duration of the procedure.

(13) If a physician delegates the performance of a procedure that uses a medication or substance that is approved by the federal Food and Drug Administration for the particular purpose for which it is used, the physician need not be on-site during the procedure, but must be reachable by phone and able to respond within thirty minutes to treat complications.

(14) If the physician is unavailable to supervise a delegate as required by this section, the physician must make arrangements for an alternate physician to provide the necessary supervision. The alternate supervisor must be familiar with the protocols in use at the site, will be accountable for adequately

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supervising the treatment under the protocols, and must have comparable training as the primary supervising physician.

(15) A physician performing or delegating nonsurgical cosmetic procedures may not sponsor more than three physician assistants at any one time.

(16) A physician may not permit a delegate to further delegate the performance of a nonsurgical medical cosmetic procedure to another individual.

[Statutory Authority: RCW 18.71.017 and 18.130.050. WSR 20-22-003, § 246-919-606, filed 10/21/20, effective 11/21/20.

Statutory Authority: RCW 18.71.017, 18.71A.020 and 18.130.050(4). WSR 10-11-001, § 246-919-606, filed 5/5/10, effective 6/5/10.]

WAC 246-919-610 Use of drugs or autotransfusion to enhance athletic ability. (1) A physician shall not prescribe, administer or dispense anabolic steroids, growth hormones, testosterone or its analogs, human chorionic gonadotropin (HCG), other hormones, or any form of autotransfusion for the purpose of enhancing athletic ability.

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(2) A physician shall complete and maintain patient medical records which accurately reflect the prescribing, administering or dispensing of any substance or drug described in this rule or any form of autotransfusion. Patient medical records must indicate the diagnosis and purpose for which the substance, drug, or autotransfusion is prescribed, administered or dispensed and any additional information upon which the diagnosis is based.

(3) A violation of any provision of this rule constitutes grounds for disciplinary action under RCW 18.130.180(7). A violation of subsection (1) of this section constitutes grounds for disciplinary action under RCW 18.130.180(6).

[Statutory Authority: RCW 18.71.017 and 18.130.050. WSR 20-22-003, § 246-919-610, filed 10/21/20, effective 11/21/20.

Statutory Authority: RCW 18.71.017 and 18.71A.020. WSR 96-03-073, § 246-919-610, filed 1/17/96, effective 2/17/96.]

WAC 246-919-620 Cooperation with investigation. (1) ~~A~~

~~physician must comply with a request, under RCW 70.02.050, for health care records or documents from an investigator who is acting on behalf of the disciplining authority under RCW~~

Commented [DB2]: MM: This is presumable direct quoting the UDA. Do we need to have that here? Delete?

Commented [DB3R2]: -620 doesn't directly quote the UDA. It incorporates requirements from both RCW 70.02.050 and 18.130.050. The timelines in this rule have been established by the WMC. The edits here are my attempt at a rewrite.

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~~18.130.050(2)~~Pursuant to RCW 70.02.050 and RCW ~~18.130.050~~,
~~physicians licensed under this chapter must cooperate fully and
promptly with any investigation or inquiry initiated by the
commission concerning the physician's professional conduct or
fitness to practice.~~

~~(2) Upon request by an investigator acting on behalf of the
commission, the physician shall provide all health care records,
documents, or information maintained, owned, or managed by the
physician within 21 calendar days of receiving the request. If
the physician does not maintain, own, or manage the requested
records, documents, or information, the physician shall notify
the commission within 21 calendar days and, if known, identify
where the records, documents, or information may be obtained.~~

~~(3) A physician may request an extension of time to comply
with a commission request for good cause. A request for an
extension must be submitted before the expiration of the
response period and should briefly describe the circumstances
supporting the request. The commission may grant an extension of
up to 30 calendar days when the physician demonstrates
circumstances that reasonably prevent timely compliance with the~~

Commented [DB4]: 2/25 note from M. Farrell: There is not duty to cooperate in RCW 18.130.050.

Commented [DB5]: Approved 7/27/26.

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request. Requests for additional time beyond an extension granted under this subsection must be submitted to the commission and demonstrate circumstances warranting additional time. [Investigators may extend the time for response if the physician requests an extension for good cause for a period not to exceed thirty calendar days. Other requests for extension may be granted by the commission chair or the commission's executive director.]

Commented [DB6]: Revised as requested at the 7/27/26 workshop.

Commented [DB7]: Approved 8/31/26.

(4) Failure to comply with the requirements of this rule may be grounds for disciplinary action, including the issuance of a statement of charges under RCW 18.130.180(8).

(5) The commission may consider the physician's level of cooperation in an investigation when negotiating a settlement or determining appropriate discipline.

Commented [DB8]: Approved 7/27/26.

~~(a) The physician shall submit the requested items within twenty-one calendar days of receipt of the request by the physician or the physician's attorney, whichever is first. If the physician fails to comply with the request within twenty-one calendar days, the investigator shall contact the physician or the physician's attorney by letter as a reminder.~~

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~~(b) Investigators may extend the time for response if the physician requests an extension for good cause for a period not to exceed thirty calendar days. Other requests for extension may be granted by the commission chair or the commission's executive director.~~

~~(c) If the physician fails to comply with the request within three business days after the receipt of the written reminder, a statement of charges may be issued under RCW 18.130.180(8) and, if there is sufficient evidence to support additional charges, those charges may be included in the statement of charges.~~

~~(d) In negotiating a settlement on a statement of charges based on RCW 18.130.180(8), the commission may take into consideration whether the physician has complied with the request after the statement of charges has been issued.~~

~~(2) A physician shall comply with a request from an investigator who is acting on behalf of the disciplining authority under RCW 18.130.050(2) for information, which may include, but is not limited to:~~

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~~(a) Nonhealth care records or documents including, but not limited to:~~

~~(i) An explanation of the matter under investigation;~~

~~(ii) Curriculum vitae;~~

~~(iii) Continuing medical education credits;~~

~~(iv) Malpractice action summaries; or~~

~~(v) Hospital affiliations.~~

~~(b) The physician shall submit the requested items within twenty-one calendar days of receipt of the request by the physician or the physician's attorney, whichever is first. If the physician fails to comply with the request within twenty-one calendar days, the investigator shall contact the physician or the licensee's attorney by letter as a reminder.~~

~~(c) Investigators may extend the time for response if the physician requests an extension for good cause for a period not to exceed thirty calendar days. Other requests for extension may be granted by the commission chair or the commission's executive director.~~

~~(d) If the physician fails to comply with the request within three business days after the receipt of the written~~

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~~reminder, then a subpoena shall be served upon the physician to obtain the requested items.~~

~~(e) If the physician fails to comply with the subpoena, a statement of charges may be issued under RCW 18.130.180(8) and, if there is sufficient evidence to support additional charges, then those charges may be included in the statement of charges.~~

~~(f) In negotiating a settlement on a statement of charges based on RCW 18.130.180(8), the commission may take into consideration whether the physician has complied with the request after the statement of charges has been issued.~~

[Statutory Authority: RCW 18.71.017 and 18.130.050. WSR 20-22-003, § 246-919-620, filed 10/21/20, effective 11/21/20.

Statutory Authority: RCW 18.71.017 and 18.71A.020. WSR 96-03-073, § 246-919-620, filed 1/17/96, effective 2/17/96.]

WAC 246-919-630 Sexual misconduct. (1) The definitions in

this subsection apply throughout this section unless the context clearly requires otherwise.

(a) "Patient" means a person who is receiving health care or treatment, or has received health care or treatment without a termination of the physician-patient relationship. The

Commented [DB9]: Approved 6/15/2026

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determination of when a person is a patient is made on a case-by-case basis with consideration given to a number of factors, including the nature, extent and context of the professional relationship between the physician and the person. The fact that a person is not actively receiving treatment or professional services is not the sole determining factor.

(b) "Key third party" means immediate family members and others who would be reasonably expected to play a significant role in the health care decisions of the patient or client and includes, but is not limited to, the spouse, domestic partner, sibling, parent, child, guardian and person authorized to make health care decisions of the patient or client.~~means a person in a close personal relationship with the patient and includes, but is not limited to, spouses, partners, parents, siblings, children, and guardians or proxies.~~

(2) A physician shall not engage, or attempt to engage, in sexual misconduct with a current patient or a key third party, inside or outside the healthcare setting. Sexual misconduct shall constitute grounds for disciplinary action. A physician

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engages in sexual misconduct when ~~he or she~~they engages in ~~any~~
~~of~~ the following ~~behaviors~~ with a patient or key third party:

(a) Sexual intercourse ~~or genital to genital contact~~;

(b) Touching the breasts, genitals, anus or any sexualized
body part except as consistent with accepted community standards
of practice for examination, diagnosis, and treatment within the
physician's scope of practice;

(c) Rubbing against a patient or key third party for sexual
gratification;

~~(b) Oral to genital contact;~~

~~(c) Genital to anal contact or oral to anal contact;~~

(d) Kissing ~~in a romantic or sexual manner~~;

(e) Hugging, touching, fondling, or caressing of a romantic
or sexual nature;

~~(c) Touching breasts, genitals, or any sexualized body part
for any purpose other than appropriate examination or treatment;~~

(f) Examination or touching of genitals without using
gloves, except for examinations of an infant or prepubescent
child when clinically appropriate;

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(g) Not allowing a patient the privacy to dress or undress except as may be necessary in emergencies or custodial situations;

(h) Not providing the patient with a gown or draping except as may be necessary in emergencies;

(i) Dressing or undressing in the presence of the patient or key third party;

(j) Removing patient's clothing or gown or draping without consent, emergent medical necessity, or being in a custodial setting;

(k) Encouraging ~~the patient to masturbate~~ or other sex act in the presence of the physician

(l) ~~or~~ ~~M~~Masturbation or other sex act by the physician while the patient is present in the presence of the patient or key third party;

(m) Suggesting or discussing the possibility of a dating, sexual, or romantic relationship after the professional relationship ends;

(n) Terminating a professional relationship for the purpose of dating or pursuing a romantic or sexual relationship;

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~~(i) Offering to provide practice-related services, such as medications, in exchange for sexual favors;~~

~~(o)~~ Soliciting a date with the patient or key third party;

~~or~~

~~(p) Communicating regarding~~Discussing the sexual history, preferences, or fantasies of the physician;

(q) Any behavior, gestures, or expressions that may reasonably interpreted as seductive or sexual;

(r) Making statements regarding the patient or key third party's body, appearance, sexual history, or sexual orientation other than for legitimate health care purposes;

(s) Sexually demeaning behavior including any verbal or physical contact which may reasonably be interpreted as demeaning, humiliating, embarrassing, threatening or harming a patient or key third party;

(t) Photographing or creating a ~~video~~-recording of any kind of the body or any body part or pose of patient or key third party other than for the legitimate health care purposes; or

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(u) Showing a patient or key third party sexually explicit photographs or video recordings, other than for legitimate health care purposes.

(3) Sexual misconduct also includes sexual contact with any person involving force, intimidation, or lack of consent; or a conviction of a sex offense as defined in RCW 9.94A.030.

Commented [DB10]: Be sure this is linked to: RCW 9.94A.030: Definitions. (*Effective until January 1, 2026.*)

(34) A physician shall not:

(a) Offer to provide health care services in exchange for sexual favors;

(b) Use health care information to contact the patient or key third party for the purpose of engaging in sexual misconduct; or

(c) Use health care information or access to health care information to meet or attempt to meet the physician's sexual needs.

(5) A physician shall not engage in any of the conduct described in subsection (2) of this section with a former patient or key third party if ~~the physician~~:

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(a) There is a significant likelihood that the patient or key third party will seek or require additional services from the physician; or

(b) There is an imbalance of power, influence, opportunity or special knowledge of the professional relationship.

~~(a) Uses or exploits the trust, knowledge, influence, or emotions derived from the professional relationship; or~~

~~(b) Uses or exploits privileged information or access to privileged information to meet the physician's personal or sexual needs.~~

~~(4) Sexual misconduct also includes sexual contact with any person involving force, intimidation, or lack of consent; or a conviction of a sex offense as defined in RCW 9.94A.030.~~

(6~~5~~) To determine whether a patient is a current patient or a former patient, the commission will analyze each case individually, and will consider a number of factors including, but not limited to, the following:

(a) Documentation of formal termination;

(b) Transfer of the patient's care to another health care provider;

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(c) The length of time that has passed since the last health care services to the patient;

(d) The length of time of the professional relationship;

(e) The extent to which the patient has confided personal or private information to the physician;

(f) The nature of the patient's health problem; ~~and~~

(g) The degree of emotional dependence and vulnerability of the patient; ~~and,~~

(h) If the code of ethics for the physician specialty in question ever allows for a relationship with a former patient.-

~~(6) This section does not prohibit conduct that is required for medically recognized diagnostic or treatment purposes if the conduct meets the standard of care appropriate to the diagnostic or treatment situation.~~

(7) These rules do not prohibit:

(a) Providing health care services in case of emergency where the services cannot or will not be provided by another health care provider;

(b) Contact that is necessary for legitimate health care purposes and that meets the standard of care.

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(8) It is not a defense that the patient, former patient, or key third party initiated or consented to the conduct, or that the conduct occurred outside the professional setting.

(9) A violation of any provision of this rule constitutes grounds for disciplinary action.

[Statutory Authority: RCW 18.71.017 and 18.130.050. WSR 20-22-003, § 246-919-630, filed 10/21/20, effective 11/21/20.

Statutory Authority: RCW 18.71.017, 18.130.062, and Executive Order 06-03. WSR 16-06-010, § 246-919-630, filed 2/18/16, effective 3/20/16. Statutory Authority: RCW 18.130.180, 18.71.017, and 18.71A.020. WSR 06-03-028, § 246-919-630, filed 1/9/06, effective 2/9/06.]

WAC 246-919-640 Abuse. (1) A physician commits

unprofessional conduct if the physician abuses a patient. A physician abuses a patient when ~~he or she~~they:

(a) Makes statements regarding the patient ~~to~~ or key third party's body, appearance, sexual history, or sexual orientation that have no legitimate medical or therapeutic purpose;

(b) Removes a patient's clothing or gown without consent;

Commented [DB11]: Approved 6.15

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(c) Fails to treat an unconscious or deceased patient's body or property respectfully; or

(d) Engages in any conduct, whether verbal or physical, which unreasonably demeans, humiliates, embarrasses, threatens, or harms a patient or a key third party.

(2) A violation of any provision of this rule shall constitute grounds for disciplinary action.

[Statutory Authority: RCW 18.130.180, 18.71.017, and 18.71A.020. WSR 06-03-028, § 246-919-640, filed 1/9/06, effective 2/9/06.]

MANDATORY REPORTING

WAC 246-919-700 Mandatory reporting. The commission adopts the rules for mandatory reporting in chapter 246-16 WAC. [Statutory Authority: RCW 18.71.017 and 18.130.050. WSR 20-22-003, § 246-919-700, filed 10/21/20, effective 11/21/20. Statutory Authority: RCW 18.71.017 and 18.71A.020. WSR 96-03-073, § 246-919-700, filed 1/17/96, effective 2/17/96.]

June 17, 2025

Washington Medical Commission
Department of Health
P.O. Box 47866
Olympia, WA 98504-7866

Re: American Academy of Family Physicians (AAFP) credit towards CME licensure requirements, WSR 25-12-014

The American Academy of Family Physicians (AAFP) and the Washington Academy of Family Physicians request a modification to the Washington Administrative Code to explicitly recognize AAFP as an accreditor for continuing medical education (CME) activities.

In the United States, physicians may earn CME credit through three organizations:

1. AAFP (American Academy of Family Physicians)
2. AMA (American Medical Association)/ACCME Accreditation Council for Continuing Medical Education
3. AOA (American Osteopathic Association)

AAFP's national Credit/Accreditation System was the first national CME accreditor for physicians in the U.S., predating the Accreditation Council for Continuing Medical Education (ACCME). The AAFP works with more than 1,000 CME provider organizations annually including hospitals, health systems, medical schools, residencies, association chapters, and medical education companies to grant accreditation when their CME activities meet the AAFP's strict accreditation requirements.

In Washington, the Washington Administrative Code (246-919-460), does not explicitly identify the AAFP as an accreditor. This omission has the potential to create unnecessary barriers and confusion, particularly as some states move toward automated continuing education processes. Since the commission announced a review of the associated WAC in WSR 25-12-014, we ask the following:

Request

Appropriately designate AAFP as a CME accreditor for physicians. Our recommendation is listed below. Note that the recommended language is similar to the CME section for osteopathic physicians covered in WAC [246-853-070](#), harmonizing the sections.

WAC 246-919-460

Categories of creditable continuing medical education activities.

(1) **Category I: Continuing medical education activities with accredited sponsorship.** The licensed physician may earn all two hundred credit hours in Category I. The commission will accept attendance at a continuing education program that is recognized as Category I credit and is offered by

an organization or institution that meets the standards adopted by the Accreditation Council for Continuing Medical Education or its designated interstate accrediting agency, the Washington State Medical Association; or nationally recognized organizations and their affiliates including, but not limited to, the American Academy of Family Physicians or the American Medical Association.

We are available to provide additional information as needed. Please contact Kim McCaulou, kim@wafp.net with questions.

Regards,

A handwritten signature in black ink, appearing to read "K McCaulou". The signature is fluid and cursive, with a large initial "K" and the name "McCaulou" written in a similar style.

Kim McCaulou
Executive Vice President

Bridget Bush, MD, FASA
President

Matt Hollon, MD, MPH, MACP
President-Elect

John Bramhall, MD, PhD
Past President

Bindu Nayak, MD
Vice President

John Scott, MD, M.Sc
Secretary-Treasurer

Jennifer Hanscom
Chief Executive Officer

October 22, 2025

Ms. Amelia Boyd
Washington Medical Commission
Department of Health

Re: Allopathic physician rulemaking

Delivered electronically

Dear Amelia,

On behalf of the Washington State Medical Association (WSMA) representing nearly 13,500 physician and physician assistant members, I am writing to provide comment on the Washington Medical Commission's (WMC) proposed revisions to the allopathic physicians (MD) chapter rules. We appreciate the opportunity to contribute to this update, including by sharing several potential implications for continuing medical education (CME), international medical graduates (IMGs), and qualified physicians that the WMC should consider during this process.

We want to note at the outset that the WSMA is still reviewing the proposed rule and seeking feedback from our members. Comparative to previous allopathic chapter revisions there are significant changes contemplated in this draft and we appreciate that the WMC has provided a long timeline for this rulemaking to allow stakeholders like WSMA to gather and share input. We continue to evaluate these proposed changes and will share feedback at future workshops.

Continuing Medical Education (CME)

The draft rule language on CME needs clarification to avoid ambiguity and ensure consistency across various credit types. To avoid confusion, the rule language should clearly designate accepted sources of continuing education credit, aligning with recognized accrediting organizations. This clarity is essential for physicians to understand which CME activities are legitimate and acceptable for license renewal. Specifically, we recommend clarifying the meaning of "recognized providing organization." The WSMA urges WMC to replace this phrase with "recognized accreditor" to refer to organizations designated as accreditors by one of the named organizations and "accredited provider" to denote organizations that have been designated as independent CME programs by one of the named organization.

Finally, regarding the draft language on the health equity CME, the WSMA requests that WMC avoid making changes at this time. As the lead advocate for the legislation that established this requirement, our goal with the requirement for health equity CME was for it to be construed broadly so that physicians are able to complete continuing education credits in topics that are relevant to their

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practice. Mandating one hour of CME on “cultural safety” or other specific topics may unnecessarily narrow parameters and constrain options for physicians that are most relevant for their practice and patient populations. Additionally, since the health equity CME just came online last year, we are concerned that it is premature to make changes at this time.

International Medical Graduates (IMGs)

The WSMA supports incorporating IMGs into the state’s health care workforce, while ensuring appropriate education and training standards. We would like to learn more about the WMC’s experience with the American Board of General Practice (ABGP) under WAC 246-919-430. Upon review, the ABGP’s eligibility criteria allows for medical school and residency approval by the World Health Organization (WHO) and the Accreditation Council for Graduate Medical Education (ACGME). Our understanding is that ACGME only accredits residencies, not medical schools and WHO does not directly accredit or approve any medical school or residency programs, but instead partners with the World Federation for Medical Education on accreditation guidelines for international medical education. Given this discrepancy, it is vital to ensure that any board certification process recognized by the WMC for state licensure requires appropriate education and training and is comparable to other nationally recognized board certifications in the interests of patient safety and transparency.

The WSMA supports the recognition of the equivalency of the Committee on Accreditation of Canadian Medical Schools for the purpose of physician licensure as this change in accreditation processes has been in the works for more than four years and Canada has comparable education and training standards. However, the WSMA is concerned that the proposed revisions go beyond recognizing Canadian medical school graduates to grant the WMC broad authority to approve foreign medical schools specifically without accreditation or loss of accreditation due to “non-quality.” The WMC may not have adequate insight to evaluate whether the education and training requirements are substantially equivalent to the United States and whether accreditation was revoked for “non-quality” for the vast number of medical schools across the world.

The WSMA is in the process of gathering more information on SPEX exams and may provide additional comment in the future on the impact of the proposed rule language. Broadly, we share the WMC’s goals of ensuring any revisions to the rule advance the ability of physicians to enter the workforce prepared to deliver safe, quality care to Washington state patients.

Finally, in WAC 246-919-345(1) the entire citation for [SB 5118](#) includes that “[t]he scope of practice of an individual licensed and practicing under authority of this license shall be defined in the practice agreement between the supervising physician and the licenses.” We request inclusion of the entire statutory citation within the Washington Administrative Code (WAC) to help ensure consistency and clarity.

Non-Clinical Status License

The WSMA would like to better understand why WMC is proposing this license type which appears to establish a different bar for entities like insurance carriers to license physicians to conduct utilization review and prior authorization. The WSMA believes that physicians engaged in activities such as utilization management are effectively practicing medicine as a determination by a physician at an insurance company to delay or deny care is just as impactful to a patient as care that is recommended or authorized by a practicing physician.

Qualified Physicians

The WSMA concurs with the comments submitted by the Washington Academy of Eye Physicians and Surgeons (WAEPS) regarding proposed revisions to “Standards of Professional Conduct,” WAC 246-919-604.

Thank you for the opportunity to provide comments. We look forward to ongoing collaboration on this rulemaking. With any questions, please reach out to Hillary Norris, JD, WSMA policy analyst, at hillary@wsma.org.

Sincerely,

A handwritten signature in cursive script that reads "Hillary Norris".

Hillary Norris
Policy Analyst
Washington State Medical Association

January 20, 2026

Bridget Bush, MD, FASA
President

Matt Hollon, MD, MPH, MACP
President-Elect

John Bramhall, MD, PhD
Past President

Bindu Nayak, MD
Vice President

John Scott, MD, M.Sc
Secretary-Treasurer

Jennifer Hanscom
Chief Executive Officer

Ms. Amelia Boyd
Washington Medical Commission
Department of Health

Re: Allopathic physician rulemaking

Delivered electronically

Dear Amelia,

On behalf of the Washington State Medical Association (WSMA) representing nearly 13,500 physician and physician assistant members, I am writing to provide comment on the Washington Medical Commission's (WMC) proposed revisions to the allopathic physician (MD) chapter rules for consideration at your January 26 meeting.

The WSMA is pleased to see that WMC has updated its draft language to include a full citation to SB 5118 and remove language that would have granted WMC authority to approve non-Canadian international medical schools without accreditation or that have lost accreditation for "non-quality" reasons.

However, we continue to have concerns about several aspects of the current draft. As you read this letter, you may note that some of these points were raised in our previous comment letter. Any points raised again were either not fully addressed in the first rules workshop or include additional considerations for the record based on conversations with physician stakeholders.

WAC 246-919-430 Requirements for maintenance of licensure

After subsequent consultation with our colleagues in medical education, the WSMA would appreciate the opportunity to revisit this section that was reviewed at the October 2025 rules workshop. WSMA is opposed to the proposed changes that incorporate the American Board of General Practice as an acceptable certification for state maintenance of licensure.

Based on our review since the October meeting, the American Board of General Practice does not appear to maintain eligibility, education, training, or assessment requirements that are comparable to those of member boards of the American Board of Medical Specialties (ABMS). As such, we do not believe American Board of General Practice certification provides the same level of assurance to the public

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regarding physician competence, quality, and readiness for independent practice.

The concern with this proposed change is that the American Board of General Practice appears to be presented as a substitute for ABMS certification without sufficient evidence that its standards are equivalent. Creating or endorsing non-equivalent alternatives risks confusing the public, undermining confidence in physician licensure, and eroding long-established professional standards designed to protect patients.

For these reasons, we oppose the proposed changes that reference or rely upon American Board of General Practice and recommend that its inclusion not be accepted.

WAC 246-919-010 Definitions

We also have concerns regarding the proposed definition of “postgraduate training”:

“Postgraduate training” means a period of clinical education and training following graduation from medical school, including internships, residencies, or fellowships, that is recognized by the commission or accredited by an organization recognized by the commission.

As drafted, this language appears to grant the Commission overly broad discretion to define what constitutes acceptable postgraduate training, potentially supplanting established accreditation standards set by the medical profession. The profession has long regulated education and training standards through recognized accrediting bodies. We urge the Commission to retain clear references to established accreditation frameworks rather than expanding its authority in ways that could dilute training requirements.

WAC 246-919-445 Proposed cultural safety mandate added to the health equity continuing medical education (CME) requirement

Mandating that one of the two hours of health equity continuing medical education (CME) required under [WAC 246-12-820](#) be dedicated to “cultural safety” is an unnecessary limitation. The intent of the health equity CME requirement was to allow physicians to engage in training that is relevant to their practices, patient populations, and communities. Nothing about the current language in [WAC 246-12-820](#) prevents physicians from engaging in training on cultural safety, but the legislation contemplates that it is just one of many health equity topics that may be relevant for licensees.

Additionally, the health equity CME requirement only went into effect in January, 2024, so one complete physician licensure cycle with this new requirement in place has yet to occur. The WSMA strongly urges WMC to allow the health equity CME legislation be implemented in accordance with its original intent before attempting to alter it.

WAC 246-919-460 Categories of creditable CME activities

As stated in the WSMA’s previous comment letter, the draft rule language on CME needs clarification to avoid ambiguity and ensure consistency across various credit types. To avoid confusion, the rule language should clearly designate accepted sources of continuing education credit, aligning with recognized accrediting organizations. This clarity is essential for physicians to understand which CME activities are legitimate and acceptable for license renewal.

Specifically, we recommend clarifying the meaning of “recognized providing organization.” The WSMA urges WMC to replace this phrase with “recognized accreditor” to refer to organizations designated as

accreditors by one of the named organizations and “accredited provider” to denote organizations that have been designated as independent CME programs by one of the named organization.

WAC 246-919-490 Proposed granting of non-clinical status licenses

The WSMA would like to better understand why WMC is proposing this license type which appears to establish a different bar for entities like insurance carriers to license physicians to conduct utilization review and prior authorization. The WSMA believes that physicians engaged in activities such as utilization management are effectively practicing medicine as a determination by a physician at an insurance company to delay or deny care is just as impactful to a patient as care that is recommended or authorized by a clinically practicing physician.

New Section: Qualified Physicians

The WSMA concurs with the comments submitted by the Washington Academy of Eye Physicians and Surgeons (WAEPS) on October 9 regarding proposed revisions to “Standards of Professional Conduct,” WAC 246-919-604.

WAC 246-919-370 Special Purpose Examinations (SPEX)

The WSMA supports incorporating international medical graduates (IMGs) into Washington’s health care workforce. IMGs are part of the physician community and play an essential role in addressing workforce shortages. At the same time, we believe it is critical that pathways to licensure for IMGs uphold appropriate education, training, and competency standards that protect patient safety and maintain public trust in the profession.

To that end, we are concerned about the proposed expansion of the Special Purpose Examination (SPEX) to be utilized as an alternate licensure examination for IMGs without clearly identified hardship criteria. SPEX was designed as a re-evaluation tool—primarily for physicians who have previously trained, practiced, and been licensed in the United States, including those returning to practice after time away. It is a [one-day, computer-based assessment](#) administered by the Federation of State Medical Boards (FSMB) and is not intended to substitute for a measure of core medical education or initial licensure examinations. According to [FSMB](#), *you must hold, or have held at some point, an active, unrestricted medical license in the U.S. or Canada in order to apply for SPEX.*

It was helpful to learn at the October workshop that the intent of this provision is to assist IMGs who are experiencing hardship in providing required documents for license applications. That said, it is fundamentally different in purpose from the United States Medical Licensing Examination (USMLE), which is a comprehensive licensing examination designed to assess readiness for unsupervised medical practice. SPEX and USMLE should not be treated as interchangeable, and SPEX should not be used as a mechanism to bypass traditional licensure requirements. As such, the WSMA requests the WMC delineate hardship criteria to ensure SPEX is only utilized as an alternative licensing examination in clearly defined circumstances.

Cooperation with investigations—WAC 246.919.520 (WAC 246-919-620)

We request clarification that physicians are required to provide only records that they have access to or own. The WSMA is particularly concerned with the following language, which may be impractical and unduly burdensome for some physicians:

[...]Upon request by an investigator acting on behalf of the commission, the physician shall provide all relevant health care records, documents, or information within 21 calendar days of receipt of the request [...]

This may not be practical in all cases. For example, a physician might work solely in the hospital setting and would not own or maintain any records. In these cases, all records should be provided by the Health Information Management (HIM) department of the health system.

Additionally, the requirement that physicians comply with an investigator's request within 21 calendar days may not give adequate time for full cooperation. The availability of a 30-day extension is helpful, but we urge the WMC to define the criteria for granting a 30-day extension. The criteria for granting a 30-day extension should be broadly defined and interpreted. The process for requesting a 30-day extension must be streamlined and not unduly burdensome.

Adjudicative procedures—WAC 246.919.520

The factors WMC will consider in determining whether a license holder can never be rehabilitated seem reasonable and intended to protect patient safety. However, the WSMA would like to stress that revocation of license takes away a physician's livelihood and that this action should be taken as an absolute last resort on the part of WMC. Accordingly, the WSMA strongly urges WMC to ensure that all attempts at rehabilitation—along with their justifications—be offered in good faith and well-documented.

[RCW 43.70.041](#)

After careful review and discussion of the draft language, we are concerned that portions of the proposed rule appear to move beyond simplification and updating, and instead create new mechanisms that may bypass established medical education, training, and licensure standards. In particular, we urge the Commission to ensure that this rulemaking aligns with its statutory charge under RCW 43.70.041, which emphasizes simplifying, updating, and clarifying rules.

Thank you for the opportunity to provide comments. We continue to evaluate these comprehensive proposed changes and will share feedback at future workshops as we receive feedback from physician stakeholders. We look forward to ongoing collaboration on this rulemaking. With any questions, please reach out to Hillary Norris, JD, WSMA policy analyst, at hillary@wsma.org.

Sincerely,



Hillary Norris
Policy Analyst
Washington State Medical Association



Chapter 246-919 WAC, Allopathic Physicians

Rule Description:

Chapter 246-919 WAC, Allopathic Physicians

Code Reviser (CR) Document:

-  [CR-101](https://wmc.wa.gov/sites/default/files/rules/CR-101%20ch%20246-919%20WAC%20WSR%2325-12-014%20NS.pdf)
(<https://wmc.wa.gov/sites/default/files/rules/CR-101%20ch%20246-919%20WAC%20WSR%2325-12-014%20NS.pdf>)

RCW-WAC:

- [WAC 246-919-010 through](https://app.leg.wa.gov/wac/default.aspx?cite=246-919-010)
(<https://app.leg.wa.gov/wac/default.aspx?cite=246-919-010>)
- [WAC 246-919-520](https://app.leg.wa.gov/wac/default.aspx?cite=246-919-520)
(<https://app.leg.wa.gov/wac/default.aspx?cite=246-919-520>)
- [WAC 246-919-602 through](https://app.leg.wa.gov/wac/default.aspx?cite=246-919-602)
(<https://app.leg.wa.gov/wac/default.aspx?cite=246-919-602>)
- [WAC 246-919-700](https://app.leg.wa.gov/wac/default.aspx?cite=246-919-700)
(<https://app.leg.wa.gov/wac/default.aspx?cite=246-919-700>)

× Ask Doc!



Public Comments

Susie Tracy (not verified) - Oct 09, 2025 04:14 PM  [Reply \(/comment/reply/876/2870\)](/comment/reply/876/2870)

The Wa. Academy of Eye Physicians and Surgeons wishes to comment on the Wa. Medical Commission's draft rule regarding "Standards for Professional Conduct", WAC 246-919-604. The comments below should be considered "initial comments" and the Academy may revise or re-address them in the future as the rule-making process moves forward. Our review is intended to reflect the Academy's understanding of the Legislature's intent as it passed SSB 5389 in 2023, as well as the Academy's strong and continuing advocacy for patients to receive high quality vision care. We appreciate the WMC's involvement in writing patient-centric rules concerning this issue. (1)a. We concur. (1)b. We concur. (1)c. We concur. (1)d. We suggest that the surface travel distance from an ophthalmologist's office to a surgical site be "30 minutes" rather than 20 minutes, especially given the rural nature of much of Washington. (2). We concur. (3). We suggest the word "advanced" be substituted for the word "expanded" because the word "advanced" is used in the regulating statute. (3)a. We concur. (3)b. We concur. (3)c. While we concur with the apparent intent of this proposal, we would like the sentence to begin with the phrase "Unless directed by a qualified physician", to assure that the most appropriate care under a given circumstance may be undertaken by the involved parties. In addition, we suggest that the word "advanced" be substituted for the word "expanded" because the word "advanced" is used in the regulating statute. (3)d. We concur. (3)e. It is our view that that the word "intervene" is not sufficiently clear, or defined. We suggest that the term "rapidly respond" be substituted, as that is the language used in the regulating statute. To be clear, the only procedures addressed in the statutorily-mandated agreements are those "advanced procedures" referenced in SSB 5389. (3)f. We concur. (3)g. We would again suggest that the term "emergent response" be replaced with "rapid response", reflecting the statute. (3)g)i. We concur. (3)g)ii. We would again suggest the term "intervention" be replaced with the term "rapid response". (3)g)iii. We concur that such reports should not specify patient information but would strongly suggest that this sentence be prefaced by "Pursuant to RCW 70.02 for added assurance about patient privacy. (3)g)iv. We concur. Thank you for your attention to our comments. We intend to formally submit them at a future date. Please let us know of any questions you may have. Stephanie Cramer MD, WAEPS Legislative Chair and Former WAEPS President, submitted on her behalf by Susie Tracy.

[Submit public comment on this rule \(/comment/reply/876#comment-form\)](/comment/reply/876#comment-form)

Ask Doc!

January 16, 2026

ATTN: Amelia Boyd
Washington Medical Commission
P.O. BOX 47866
Olympia, WA 98504-7866
Amelia.Boyd@wmc.wa.gov

To Washington Medical Commission:

RE: Proposed rulemaking WAC 246-919-604, Qualified Physician Under Optometry Law

The Board of Optometry is opposed to the proposed rule, WAC 246-919-604. This new rule is in reference to SSB 5389 that passed in May 2023, which increased the scope of practice for optometrists, allowing them to perform specific advanced procedures. To obtain an advanced procedures endorsement, optometrists must secure a “qualified physician agreement” as one of the criteria. The intent of the law was to increase access to eye care for Washingtonians, especially low income, elderly, minority and rural communities. By passing this law, legislators agreed that the Board of Optometry (BOO), in conjunction with the Department of Health (DOH), would create reasonable rules to implement this law and maintain the safety of the citizens of WA. Both the BOO and the DOH agreed that the definition of “qualified physician” as written in Optometry WAC 246-851-515, section 3, was adequate and appropriate in fulfilling the intent of the law and in protecting the public.

We are curious to know why the WMC felt the need to further qualify and restrict this definition. Given the many stipulations and the risk of disciplinary action for professional misconduct, we are concerned this drafted rule will serve to deter physicians from entering into these agreements with ODs and therefore directly impact and continue to limit access to care for Washingtonians. Additionally, we are of the opinion the drafted rule undermines the intent of the law, and the work legislators and citizens of WA contributed to pass it.

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The portions of the proposed rule we have concerns about are listed below:

- Section (1)(c)** limits the category of allopathic physicians to ophthalmologists only. The Board of Optometry specifically felt narrowing the definition of “qualified physician” to only include ophthalmologists would directly limit access to care. Other physician including but not limited to

plastic surgeons, dermatologists, ER physicians, PCPs, for example, with whom optometrists may already have good working relationships with, and who can safely and adequately respond to complications surrounding these procedures should not be excluded from the definition of a “qualified physician”.

- Section (1)(d)** we do not find it necessary to limit the location of the surgical suite or hospital (where the physician holds privileges) to 20 minutes or less of surface travel from their practice.

- Section (3)(a)** states no more than three agreements with three individual optometrists may be active at a given time. We do not agree a “qualified physician” can only have three individual active agreements at a given time. We believe this because complications are expected to be rare. The number of times a “qualified physician” may be involved in a rapid response may be as rare as once or twice a year, if at all. There are no other states that require a physician agreement. This rule will mainly serve to limit the number of optometrists who may perform these advanced procedures and thereby limit access to care. We request an explanation of the medical reason to limit the agreement to three physicians.

- Section (3)(b)** requires agreements to be updated and renewed every 12 months. We do not renew our license that frequently. If such a restriction is to be implemented, consider updating/renewing along with our license to practice, i.e. every 2 years.

- Section (3)(d)** stating an ophthalmologist must be no “more than fifty (50) miles or one hour of surface travel, whichever is shorter, from the site of patient care delivery by the optometrist.” Due to a lack of ophthalmologists in some rural areas where optometrists are located, the requirement to be within fifty (50) miles or one hour of surface travel would be a barrier to access to care for patients. We do not agree with limiting to surface travel only as in emergencies there are other options than surface travel that can help Washingtonians.

- Section (3)(e)** requires that the specific procedures the qualified physician will rapidly respond to be stipulated in the agreement. We understand that each OD and “qualified physician” may choose to negotiate their own agreements, but we do not believe this should be a requirement of every agreement. This only serves to regulate what procedures ODs can and cannot do.

- Section (3)(f)** requires the “qualified physician” to file the agreements with the medical commission. The DOH in conjunction with the BOO did not find it necessary to submit the agreements but to have it readily available upon request. This stipulation creates incredible confusion when two different entities have different requirements to accomplish the same goal.

- Sections (3)(g)** adds unnecessary work for “qualified physicians” by requiring them to report to the WMC every time a rapid response is required. This is redundant since optometrists are already reporting this information annually to the DOH.

In closing, many of the stipulations in this new proposed law appear to create sufficient obstacles and confusion that will limit the number of physician agreements, thereby limiting the number of optometrists who will be performing these advanced procedures and directly limiting access to care for Washingtonians. The Board of Optometry is concerned the stipulations in this law do not appear to primarily serve as protecting the public, but rather to regulate another profession.

Sincerely,

The Board of Optometry



Optometric Physicians of Washington

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Eatonville, WA 98328
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E-mail: opw@eyes.org
www.eyes.org

February 5, 2026

To Whom it May Concern:

The Optometric Physicians of Washington (OPW) have significant concerns regarding the proposed draft new rule section WAC 246-919-604 and its potential impact on Washingtonians' access to healthcare. We strongly believe that the proposed rule:

- (1) Works against the underlying legislative intent of RCW 18.53.010 (SB 5389, passed May 2023) by limiting access to healthcare for Washingtonians statewide.
- (2) Conflicts with existing language and definitions found in RCW 18.53.010 and WAC 246-851-515, which will create significant confusion impacting patient health and access to care.
- (3) Exceeds the Washington Medical Commission's scope and impedes on the Board of Optometry's authority.

The proposed rule will significantly limit patient access to healthcare across the state.

In May 2023, the legislature passed SB 5389 (codified in RCW 18.53.010) to **expand** access to healthcare in Washington by allowing optometric physicians to perform office-based medical procedures consistent with their training and expertise— training and expertise that the Department of Health's review process for SB 5389 specifically found that optometric physicians received and possessed, thereby rendering them equipped to safely perform the procedures now codified under RCW 18.53.010.

This expansion was designed to help some of the state's most vulnerable populations, including those in rural and underserved areas of the state, by allowing for doctors of optometry to provide certain care in connection with any qualified physician licensed under RCW 18.71 or RCW 18.57. The current draft rule language severely **reduces** patients' access to care by effectively redefining "qualified physician" to include only board-certified ophthalmologists who meet restrictive geographic requirements, and pre-defines the nature of care before the patient is ever seen. This issue is discussed in further detail below.

We recognize that, as with many bills, some groups expressed opposition to SB 5389 within the legislative process. However, it is significant that lawmakers heard and considered this opposition before ultimately voting to pass SB 5389 into law.

SB 5389 has been codified into law. It is now the Medical Commission's role to objectively engage in rulemaking to **implement** the law in support and furtherance of its legislative intent. Instead, the proposed rule language contradicts the statute's goal to increase access to healthcare by effectively limiting doctors of optometry from performing procedures that are permitted by statute.

The proposed rule attempts to redefine "qualified physician" and limits the autonomy of doctors of optometry.

The legislature did not delegate its authority to alter or limit the definition of "qualified physician" to any regulatory or rulemaking body or agency, including the Medical Commission. The term is defined by state statute: to receive a license endorsement to perform the advanced procedures set out under RCW 18.53.010(2), a licensed optometrist must, in relevant part, "[e]nter into an agreement with a qualified physician licensed under chapter 18.71 RCW or an osteopathic physician licensed under chapter 18.57 RCW for rapid response if complications occur during an advanced procedure." RCW 18.53.010(5)(a)(iii). WAC 246-851-515(3)(a) further defines the term as "a physician who is actively licensed under chapter 18.71 or 18.57 RCW and who is trained in and capable of responding to complications which may arise from the optometric advanced procedures." A physician licensed under 18.57 or 18.71 who is capable of handling the complications that may occur from advanced procedures is a "qualified physician" under Washington law, without further limitation.

Despite the fact that the legislature has defined "qualified physician," the proposed rule requires physicians to meet additional elements to be deemed "qualified," which greatly limits which physicians are considered qualified for purposes of the advanced procedure statute. The proposed rule attempts to redefine "qualified physician" as a person who is licensed to practice medicine and surgery in Washington under chapters 18.71 or 18.57B RCW; is not currently under an order or stipulation to informal disposition with the commission; and, most significantly, holds a current and unrestricted certification from the American Board of Ophthalmology (or is eligible to do so) and has a surgical suite on site or holds privileges at a local hospital (defined as within 20 minutes or less of travel).

If the legislature wished to limit "qualified physicians" to those who either have an onsite surgical suite or else hold privileges at a local hospital within twenty minutes' travel distance, it would have provided for these requirements in the state statute. Notably, it did not, and it is outside of the Medical Commission's authority to redefine a term which has already been purposefully crafted by the legislature. The Commission's additions severely limit access to healthcare—the very problem the legislature was trying to cure—for a significant portion of Washingtonians, particularly those living in rural communities.



Optometric Physicians of Washington

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The proposed rule is an impermissible overstep.

We recognize the Washington Medical Commission's independent authority to regulate medical doctors and doctors of osteopathic medicine. However, doctors of optometry are independently regulated by a separate body, the Board of Optometry. These two boards do not have the statutory authority to regulate beyond their individual scopes; their independence from each other is appropriate and beneficial to public health.

The draft language states that unless directed by a qualified physician, "no valid agreement shall stipulate referral to a primary care practitioner, urgent care, emergency department, or any combination thereof as an appropriate response" to advanced procedure complications. Optometrists are not regulated by the Medical Commission and state law does not require optometrists to consult with a physician before referring their patient to a provider or facility that the optometrist deems to be most appropriate for their particular case. Optometrists are appropriately licensed and regulated by the Board of Optometry and are trained to use their medical judgement in these situations. The Commission does not have authority over the practice of optometry and it is therefore outside of the Commission's scope to place certain requirements on optometrists in their practices, including when performing advanced procedures.

While we respect the Medical Commission and the work they do, we believe this proposed rulemaking is an impermissible and unlawful overreach that attempts to directly and indirectly regulate another independent healthcare provider group outside of its own purview – doctors of optometry and the Board of Optometry—and will limit access to healthcare across the state.

Thank you for considering our concerns. Should you have any questions, feedback, or responses to this letter, we urge you to contact Dr. Andrea Morton or Andrea McNeely, OPW's outside counsel, at amcneely@gth-law.com.

Sincerely,

Andrea Morton, OD, MEd/VFL, FOVDR
OPW President
drmortonopw@gmail.com

From: [Douglas Jeske](#)
To: [WMC Medical Rules](#)
Subject: Comments regarding New WMC rules.
Date: Tuesday, February 17, 2026 10:15:07 AM

External Email

To whom it may concern,

I just received an email from the Optometric Physicians of Washington regarding new proposed rules by the Washington Medical Commission to restrict the intent of RCW 18.53.010(5)(a)(3) (originally SB 5389).

After practicing for over 30 years I can tell you without any doubt my patients feel the medical system is severely broken.

My patients cannot even find a primary care doctor to accept them as a patient, it takes way too long to get an appointment, and then when they are able to get appointment they are very unhappy with the care that they received.

As long as are health care system is controlled by both the insurance industry and the medical doctor (MD) community this problem will remain.

This problem of access is only made worse by restricting legitimate alternative health care professionals that attended legitimate, approved and credentialed health care education programs.

Please allow other health care professions, including doctors of optometry, to practice as they are taught to increase access of care to patients in need.

Thank you.

Douglas N Jeske, OD
Tumwater Eye Center Inc
6510 Capitol Blvd SE
Tumwater WA 98501-5566
PH 360-352-6060
Fax 360-357-7339
drjeske@tumwatereye.com

From: [Dr Nick](#)
To: [WMC Medical Rules](#)
Subject: Comment on Draft Rule Section 246-919-604
Date: Tuesday, February 17, 2026 10:19:57 AM

External Email

To the medical commission:

I write to you as a private practice optometrist from Vancouver, WA regarding the rules proposed to you by the Washington Academy of Eye Physician and Surgeons (WAEPS) on rules for RCW 18.53.

After reviewing your proposed rules, I have to comment regarding these rules being against the intent of the law. During the bill's drafting and negotiations, many of the rules that WAEPS have proposed were discussed and considered but were ultimately rejected by the legislators. These were seen as unneeded and would significantly reduce the increase in access to care that the bill was attempting to correct.

For example, the requirement that a qualified physician be an ophthalmologist severely limits the scope of practice of the other physicians your commission oversees. In a world where physicians have full authority and autonomy to dictate their specific scope of practice, it seems odd to suddenly try to police and limit doctors from choosing if they wish to assist with this. There are quite a few cases where rural primary care doctors, dermatologist, and plastic surgeons have agreed to assist optometrists in the event of emergency. Suddenly choosing to limit their scope of practice is rather strange, in my opinion.

But this was specifically discussed and rejected because the legislature felt it was right that other specialists could be willing to assist optometrists if those doctors felt it was something they were comfortable with.

It is also strange that the medical commission is choosing to attempt to make rules about another profession's RCW. This in my opinion is a pretty large overreach in terms of authority as this RCW is specifically optometry law. This is not the medical commissions authority to write rules that impact another RCW.

I have now been officially endorsed for procedures and provided dozens without issue since roughly July of 2025. These proposed requirements would be so cumbersome and burdensome to physicians that they would be unwilling to sign agreements as they may fear retaliation from the medical commission. Suddenly my ability to treat my patients

would likely be gone and the increase in access to care would infringed upon, clearly against the legislative intent of the law.

Thank you for reviewing our comments.

Nick Jankowski, OD FAAO
Mt. View EyeCare Center

From: [Shawn Brittain](#)
To: [WMC Medical Rules](#)
Subject: Comment on Draft Rule Section 246-919-604
Date: Tuesday, February 17, 2026 10:21:58 AM

External Email

DATE: 02/17/2026

TO: Washington Medical Commission

RE: Dr Shawn P Brittain, OD

RE: Comments on draft rule section 246-919-604

Thank you for taking the time to hear me out. I've been practicing for over 30 years and am concerned about the proposed legislation.

As an optometric physician in Washington, I have deep concerns regarding the proposed draft new rule

section 246-919-604 related to a “qualified physician” as that term is reflected in RCW 18.53.010(5)(a)(3)

(originally SB 5389) within the RCW governing optometry.

1) The intent of the legislature at the time of SB 5389’s passage in May of 2023 was to expand healthcare access for Washington’s citizens by allowing optometric physicians to perform office

based medical procedures consistent with their training and expertise. The Department of Health’s sunrise review process for SB 5389 specifically found that optometric physicians received the appropriate training and expertise to safely perform the procedures now codified in

RCW 18.53.010 (optometry’s scope of practice).

2) I recognize that the WAEPS, WSMA and maybe even many on this commission were opposed to

optometrists performing any of the procedures which are now allowable in optometric law. However, lawmakers heard this opposition and evaluated the scope of training for optometrists in passing SB 5389. The role of the Medical Commission now is to objectively assess the necessary rule making to implement the law. The proposed rule language goes beyond this role

and effectively limits optometrists from performing these procedures in a manner contrary to the statute.

3) I further recognize the independence of the Medical Commission to regulate medical doctors

and doctors of osteopathic medicine. Doctors of optometry are independently regulated by the Board of Optometry. These two boards do not have the statutory authority to regulate beyond their individual scope. This independence is appropriate and good for public health.

4) I would also like to acknowledge that the requirement of an agreement between an optometric physician and a “qualified physician” as defined in 18.71 (doctor of medicine) or 18.57 (doctors

of osteopathic medicine) for a rapid response when one is needed is unusual. It is customary for

any health provider in the normal course of providing care to have a network of other

specialists

and subspecialists to refer patients should a different level of care be needed that they are not able to provide themselves. Physicians licensed under any provision refer patients to emergency

services should a life threatening complication occur. Notably, such complications are extremely

rare for the types of procedures allowed under RCW 18.53.010(5)(a)(3).

5) Specifically, these procedures (primarily the removal of benign lid lesions, among a few others)

that are now allowed to be performed by trained and qualified optometric physicians very rarely

result in a complication that might require a rapid response from another provider.

6) The intent of the legislature regarding agreements between optometric physicians and a “qualified physician” was not to place burdensome requirements on either the optometrist or the “qualified physician” in order to discourage agreements between the two parties. Such requirements are not grounded in legitimate patient safety needs and are contrary to the intent of increased access to care.

7) In RCW 18.53.010 the legislature defined “qualified physician” and did not delegate the authority

to alter or limit that definition. By a reasonable standard any physician licensed under 18.57 or 18.71 who is capable of handling the complication that occurs from procedures performed by optometrists should be freely able to sign an agreement without excessively restrictive language

and a threat of unprofessional conduct by either board or commission.

8) While I respect the medical commission and the work they do we also believe this rule making

represents an impermissible overreach by directly and indirectly attempting to regulate another independent health care provider group, optometry, and its board.

--

Dr. Shawn P. Brittain

Westside Eye Center

(360)694-0760

www.WestsideEye.com

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From: [Aaron Banta](#)
To: [WMC Medical Rules](#)
Subject: Opposition to WMC's draft rule section 246-919-604
Date: Tuesday, February 17, 2026 10:38:15 AM
Attachments: [Outlook-4uddnahx](#)

External Email

DATE: 2/17/26

TO: Washington Medical Commission

FROM: Aaron M. Banta, OD

RE: Comments on draft rule section 246-919-604

As an optometric physician in Washington, I have deep concerns regarding the proposed draft new rule section 246-919-604 related to a “qualified physician” as that term is reflected in RCW 18.53.010(5)(a)(3) (originally SB 5389) within the RCW governing optometry.

The whole point of SB 5389 was to improve access to care and reduce healthcare costs for patients of Washington State. Additionally, it brought the scope of practice for Optometric Physicians within the state from nearly 25 years behind the times closer to the level we have all been trained. Placing restrictions on that expanded scope defeats the purpose of SB 5389 and is, quite frankly, a power play by WAEPS to preclude us from accomplishing these goals. These rule changes are unnecessary and undermine the legislature's approval of sound legislation that is in the best interest of patients in this state.

1) The intent of the legislature at the time of SB 5389’s passage in May of 2023 was to expand healthcare access for Washington’s citizens by allowing optometric physicians to perform office based medical procedures consistent with their training and expertise. The Department of Health’s sunrise review process for SB 5389 specifically found that optometric physicians received the appropriate training and expertise to safely perform the procedures now codified in RCW 18.53.010 (optometry’s scope of practice).

2) I recognize that the WAEPS, WSMA and maybe even many on this commission were opposed to optometrists performing any of the procedures which are now allowable in optometric law. However, lawmakers heard this opposition and evaluated the scope of

training for optometrists in passing SB 5389. The role of the Medical Commission now is to objectively assess the necessary rule making to implement the law. The proposed rule language goes beyond this role and effectively limits optometrists from performing these procedures in a manner contrary to the statute.

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5) Specifically, these procedures (primarily the removal of benign lid lesions, among a few others) that are now allowed to be performed by trained and qualified optometric physicians very rarely result in a complication that might require a rapid response from another provider.

6) The intent of the legislature regarding agreements between optometric physicians and a “qualified physician” was not to place burdensome requirements on either the optometrist or the “qualified physician” in order to discourage agreements between the two parties. Such requirements are not grounded in legitimate patient safety needs and are contrary to the intent of increased access to care.

7) In RCW 18.53.010 the legislature defined “qualified physician” and did not delegate the authority to alter or limit that definition. By a reasonable standard any physician licensed under 18.57 or 18.71 who is capable of handling the complication that occurs from procedures performed by optometrists should be freely able to sign an agreement

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8) While I respect the medical commission and the work they do we also believe this rule making represents an impermissible overreach by directly and indirectly attempting to regulate another

Aaron M. Banta, OD

509-783-8383

drbanta@centervisionclinic.org





James P. DeVleming, O.D.
238 East Main
Pullman, WA 99163
(509) 334-1131

DATE: 2/17/2026

TO: Washington Medical Commission

From: James P DeVleming, O.D.

RE: Comments on draft rule section 246-919-604

I am responding to the gross over-reach of one medical board trying to regulate and stifle legislative changes of another independent medical board. Please see the comments below as to why this is very concerning to me and especially to the patients I see in rural Eastern Washington.

As an optometric physician in Washington, I have deep concerns regarding the proposed draft new rule section 246-919-604 related to a "qualified physician" as that term is reflected in RCW 18.53.010(5)(a)(3)(originally SB 5389) within the RCW governing optometry.

1) The intent of the legislature at the time of SB 5389's passage in May of 2023 was to expand healthcare access for Washington's citizens by allowing optometric physicians to perform office based medical procedures consistent with their training and expertise. The Department of Health's sunrise review process for SB 5389 specifically found that optometric physicians received the appropriate training and expertise to safely perform the procedures now codified in RCW 18.53.010 (optometry's scope of practice).

2) I recognize that the WAEPS, WSMA and maybe even many on this commission were opposed to optometrists performing any of the procedures which are now allowable in optometric law. However, lawmakers heard this opposition and evaluated the scope of training for optometrists in passing SB 5389. The role of the Medical Commission now is to objectively assess the necessary rule making to implement the law. The proposed rule language goes beyond this role and effectively limits optometrists from performing these procedures in a manner contrary to the statute.

3) I further recognize the independence of the Medical Commission to regulate medical doctors and doctors of osteopathic medicine. Doctors of optometry are independently regulated by the Board of Optometry. These two boards do not have the statutory authority to regulate beyond their individual scope. This independence is appropriate and good for public health.



Independently Owned and Operated by Local Optometric Physician

4) I would also like to acknowledge that the requirement of an agreement between an optometric physician and a “qualified physician” as defined in 18.71 (doctor of medicine) or 18.57 (doctors of osteopathic medicine) for a rapid response when one is needed is unusual. It is customary for any health provider in the normal course of providing care to have a network of other specialists and subspecialists to refer patients should a different level of care be needed that they are not able to provide themselves. Physicians licensed under any provision refer patients to emergency services should a life threatening complication occur. Notably, such complications are extremely rare for the types of procedures allowed under RCW 18.53.010(5)(a)(3).

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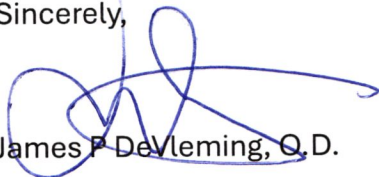
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7) In RCW 18.53.010 the legislature defined “qualified physician” and did not delegate the authority to alter or limit that definition. By a reasonable standard any physician licensed under 18.57 or 18.71 who is capable of handling the complication that occurs from procedures performed by optometrists should be freely able to sign an agreement without excessively restrictive language and a threat of unprofessional conduct by either board or commission.

8) While I respect the medical commission and the work they do, we also believe this rule making represents an impermissible overreach by directly and indirectly attempting to regulate another independent health care provider group, optometry, and its board.

Thanks for the time to read this statement and please feel free to reach out to me with further questions or comments at 509-595-8515 or by email at askdrdev@gmail.com.

Sincerely,



James P. DeVleming, Q.D.

VISION SOURCE

Of Wenatchee

DATE: 2/17/2026

TO: Washington Medical Commission

RE: Jason Barnes

RE: Comments on draft rule section 246-919-604

As an optometric physician in Washington, I have deep concerns regarding the proposed draft new rule section 246-919-604 related to a "qualified physician" as that term is reflected in RCW 18.53.010(5)(a)(3) (originally SB 5389) within the RCW governing optometry.

1) The intent of the legislature at the time of SB 5389's passage in May of 2023 was to expand healthcare access for Washington's citizens by allowing optometric physicians to perform office based medical procedures consistent with their training and expertise. The Department of Health's sunrise review process for SB 5389 specifically found that optometric physicians received the appropriate training and expertise to safely perform the procedures now codified in RCW 18.53.010 (optometry's scope of practice).

2) I recognize that the WAEPS, WSMA and maybe even many on this commission were opposed to optometrists performing any of the procedures which are now allowable in optometric law. However, lawmakers heard this opposition and evaluated the scope of training for optometrists in passing SB 5389. The role of the Medical Commission now is to objectively assess the necessary rule making to implement the law. The proposed rule language goes beyond this role and effectively limits optometrists from performing these procedures in a manner contrary to the statute.

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8) While I respect the medical commission and the work they do I also believe this rule making represents an impermissible overreach by directly and indirectly attempting to regulate another independent health care provider group, optometry, and its board.

Respectfully,

A handwritten signature in black ink, appearing to read 'JB' or 'Jason Barnes', with a stylized flourish extending to the right.

Jason Barnes, OD

From: [Jeremy M](#)
To: [WMC Medical Rules](#)
Subject: Comment on Draft Rule Section 246-919-604
Date: Tuesday, February 17, 2026 12:54:26 PM

External Email

DATE: February 17, 2026

TO: Washington Medical Commission

RE: Jeremy Marcuson OD

RE: Comments on draft rule section 246-919-604

As an optometric physician in Washington, I have deep concerns regarding the proposed draft new rule section 246-919-604 related to a “qualified physician” as that term is reflected in RCW 18.53.010(5)(a)(3) (originally SB 5389) within the RCW governing optometry. I practice in a rural location that has no Ophthalmology services. Frequently, my patients do not get the care they need due to travel restraints. I have been trained to provide many of these services but, am not allowed to provide them in this state. Please allow Optometry to practice to our trained level so that my patients, rural Washington citizens, can be taken care of.

1) The intent of the legislature at the time of SB 5389’s passage in May of 2023 was to expand healthcare access for Washington’s citizens by allowing optometric physicians to perform office based medical procedures consistent with their training and expertise. The Department of Health’s sunrise review process for SB 5389 specifically found that optometric physicians

received the appropriate training and expertise to safely perform the procedures now codified in

RCW 18.53.010 (optometry's scope of practice).

2) I recognize that the WAEPS, WSMA and maybe even many on this commission were opposed to

optometrists performing any of the procedures which are now allowable in optometric law.

However, lawmakers heard this opposition and evaluated the scope of training for optometrists

in passing SB 5389. The role of the Medical Commission now is to objectively assess the necessary rule making to implement the law. The proposed rule language goes beyond this role

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8) While I respect the medical commission and the work they do we also believe this rule making represents an impermissible overreach by directly and indirectly attempting to regulate another independent health care provider group, optometry, and its board.

Jeremy Marcuson OD

From: [Rachel Gilles](#)
To: [WMC Medical Rules](#)
Subject: Comments on draft rule section 246-919-604
Date: Tuesday, February 17, 2026 2:29:33 PM

External Email

DATE: 02/17/2026

TO: Washington Medical Commission

RE: Dr. Rachel Gilles (rural optometrist in Grand Coulee, WA)

RE: Comments on draft rule section 246-919-604

Hello,

As a rural practitioner in Grand Coulee, Washington; I have painfully witnessed the struggles citizens of Washington are having trying to acquire eye care. Prior to purchasing my clinic in 2023, I worked in Spokane at a large dual Ophthalmology/Optometry clinic. Although issues were already emerging, I've especially seen increased difficulties in the last few years as Ophthalmology services have become more and more specialized/limited. Scheduling in with a general Ophthalmologist is not easy. Many clinics, such as Spokane Eye Clinic, require patients be seen by a primary optometrist for an evaluation prior to their Ophthalmologists being willing to see them. There are also limitations to specialty care and referrals even when a patient is seen by Optometry first. I personally have had to refer patients to Seattle, Oregon and Idaho when seeking Ophthalmologic care. Due to these increasing issues with access to care, I believe it is imperative we are doing everything to increase patient access and reduce travel burdens.

Therefore, I have deep concerns regarding the proposed draft new rule section 246-919-604 related to a "qualified physician" as that term is reflected in RCW 18.53.010(5)(a)(3) (originally SB 5389) within the RCW governing optometry.

1) The intent of the legislature at the time of SB 5389's passage in May of 2023 was to expand healthcare access for Washington's citizens by allowing optometric physicians to perform office

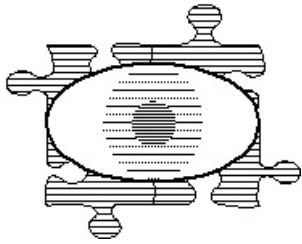
based medical procedures consistent with their training and expertise. The Department of Health's sunrise review process for SB 5389 specifically found that optometric physicians received the appropriate training and expertise to safely perform the procedures now codified in

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- 8) While I respect the medical commission and the work they do we also believe this rule making represents an impermissible overreach by directly and indirectly attempting to regulate another independent health care provider group, optometry, and its board.

Thank you for your time and consideration,
Dr. Rachel Gilles



Vision Northwest

Linking Development, Rehabilitation and Learning

Curtis R. Baxstrom, MA, OD, FAAO, FCOVD, FNORA and Associates

1705 S. 324th Place

Federal Way, WA 98003

Phone 253-661-6005 Fax 253-661-0633

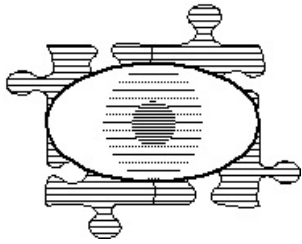
February 17, 2026

TO: Washington Medical Commission

RE: Comments on draft rule section 246-919-604

This is simply a TERRIBLE draft rule. As an optometric physician in Washington, I have deep concerns regarding the proposed draft new rule section 246-919-604 related to a “qualified physician” as that term is reflected in RCW 18.53.010(5)(a)(3) (originally SB 5389) within the RCW governing optometry.

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- 4) I would also like to acknowledge that the requirement of an agreement between an optometric physician and a “qualified physician” as defined in 18.71 (doctor of medicine) or 18.57 (doctors of osteopathic medicine) for a rapid response when one is needed is unusual. It is customary for any health provider in the normal course of providing care to have a network of other specialists and subspecialists to refer patients should a different level of care be needed that they are not able to provide themselves. Physicians licensed under any provision refer patients to emergency services should a life threatening complication occur. Notably, such complications are extremely rare for the types of procedures allowed under RCW 18.53.010(5)(a)(3).
- 5) Specifically, these procedures (primarily the removal of benign lid lesions, among a few others) that are now allowed to be performed by trained and qualified optometric physicians very rarely result in a complication that might require a rapid response from another provider.
- 6) The intent of the legislature regarding agreements between optometric physicians and a “qualified physician” was not to place burdensome requirements on either the optometrist or the “qualified physician” in order to discourage agreements between the two parties. Such requirements are not grounded in legitimate patient safety needs and are contrary to the intent of increased access to care.
- 7) In RCW 18.53.010 the legislature defined “qualified physician” and did not delegate the authority to alter or limit that definition. By a reasonable standard any physician licensed under 18.57 or 18.71 who is capable of handling the complication that occurs from procedures performed by optometrists should be freely able to sign an agreement without excessively restrictive language and a threat of unprofessional conduct by either board or commission.



Vision Northwest

Linking Development, Rehabilitation and Learning

Curtis R. Baxstrom, MA, OD, FAAO, FCOVD, FNORA and Associates

1705 S. 324th Place

Federal Way, WA 98003

Phone 253-661-6005 Fax 253-661-0633

8) While I respect the medical commission and the work they do we also believe this rule making represents an impermissible overreach by directly and indirectly attempting to regulate another independent health care provider group, optometry, and its board.

Sincerely yours,

Curtis R. Baxstrom,OD



To Whom It May Concern:

As an optometric physician in Washington, I have deep concerns regarding the proposed draft new rule section 246-919-604 related to a “qualified physician” as that term is reflected in RCW 18.53.010(5)(a)(3) (originally SB 5389) within the RCW governing optometry.

- 1) The intent of the legislature at the time of SB 5389’s passage in May of 2023 was to expand healthcare access for Washington’s citizens by allowing optometric physicians to perform office based medical procedures consistent with their training and expertise. The Department of Health’s sunrise review process for SB 5389 specifically found that optometric physicians received the appropriate training and expertise to safely perform the procedures now codified in RCW 18.53.010 (optometry’s scope of practice).
- 2) I recognize that the WAEPS, WSMA and maybe even many on this commission were opposed to optometrists performing any of the procedures which are now allowable in optometric law. However, lawmakers heard this opposition and evaluated the scope of training for optometrists in passing SB 5389. The role of the Medical Commission now is to objectively assess the necessary rule making to implement the law. The proposed rule language goes beyond this role and effectively limits optometrists from performing these procedures in a manner contrary to the statute.
- 3) I further recognize the independence of the Medical Commission to regulate medical doctors and doctors of osteopathic medicine. Doctors of optometry are independently regulated by the Board of Optometry. These two boards do not have the statutory authority to regulate beyond their individual scope. This independence is appropriate and good for public health.
- 4) I would also like to acknowledge that the requirement of an agreement between an optometric physician and a “qualified physician” as defined in 18.71 (doctor of medicine) or 18.57 (doctors of osteopathic medicine) for a rapid response when one is needed is unusual. It is customary for any health provider in the normal course of providing care to have a network of other specialists and subspecialists to refer patients should a different level of care be needed that they are not able to provide themselves. Physicians licensed under any provision refer patients to emergency services should a life threatening complication occur. Notably, such complications are extremely rare for the types of procedures allowed under RCW 18.53.010(5)(a)(3).
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requirements are not grounded in legitimate patient safety needs and are contrary to the intent of increased access to care.

7) In RCW 18.53.010 the legislature defined “qualified physician” and did not delegate the authority to alter or limit that definition. By a reasonable standard any physician licensed under 18.57 or 18.71 who is capable of handling the complication that occurs from procedures performed by optometrists should be freely able to sign an agreement without excessively restrictive language and a threat of unprofessional conduct by either board or commission.

8) While I respect the medical commission and the work they do we also believe this rule making represents an impermissible overreach by directly and indirectly attempting to regulate another independent health care provider group, optometry, and its board. If you have any further questions, do not hesitate to contact my office. Thank you for your attention.

Yours sincerely,

Dr. J. Chan
Precision Eye Care
(360) 254-5855

DATE: 2.17.26

TO: Washington Medical Commission

FROM: Michael K. DeRosier, OD

RE: Comments on draft rule section 246-919-604

Practicing over 40 years in a rural setting has allowed me to personally experience the advantages of being able to provide care at the highest level available. Patients are often not in a position to travel the distance required to see an ophthalmologist, nor need to have that level of care, which is a waste of time for all concerned. Please consider that the majority of the rural portions of the state are served by optometrists. There is already a shortage of providers in these areas and the recruitment of providers to these areas is becoming increasingly more difficult. Please do not make this situation worse by placing restrictions on the delivery of services.

As an optometric physician in Washington, I have deep concerns regarding the proposed draft new rule section 246-919-604 related to a “qualified physician” as that term is reflected in RCW 18.53.010(5)(a)(3) (originally SB 5389) within the RCW governing optometry.

1) The intent of the legislature at the time of SB 5389’s passage in May of 2023 was to expand healthcare access for Washington’s citizens by allowing optometric physicians to perform office based medical procedures consistent with their training and expertise. The Department of Health’s sunrise review process for SB 5389 specifically found that optometric physicians received the appropriate training and expertise to safely perform the procedures now codified in RCW 18.53.010 (optometry’s scope of practice).

2) I recognize that the WAEPS, WSMA and maybe even many on this commission were opposed to optometrists performing any of the procedures which are now allowable in optometric law. However, lawmakers heard this opposition and evaluated the scope of training for optometrists in passing SB 5389. The role of the Medical Commission now is to objectively assess the necessary rule making to implement the law. The proposed rule language goes beyond this role and effectively limits optometrists from performing these procedures in a manner contrary to the statute.

3) I further recognize the independence of the Medical Commission to regulate medical doctors and doctors of osteopathic medicine. Doctors of optometry are independently regulated by the Board of Optometry. These two boards do not have the statutory authority to regulate beyond their individual scope. This independence is appropriate and good for public health.

4) I would also like to acknowledge that the requirement of an agreement between an optometric physician and a “qualified physician” as defined in 18.71 (doctor of medicine) or

18.57 (doctors of osteopathic medicine) for a rapid response when one is needed is unusual. It is customary for any health provider in the normal course of providing care to have a network of other specialists and subspecialists to refer patients should a different level of care be needed that they are not able to provide themselves. Physicians licensed under any provision refer patients to emergency services should a life threatening complication occur. Notably such complications are extremely rare for the types of procedures allowed under RCW 18.53.010(5)(a)(3).

5) Specifically, these procedures (primarily the removal of benign lid lesions, among a few others) that are now allowed to be performed by trained and qualified optometric physicians very rarely result in a complication that might require a rapid response from another provider.

6) The intent of the legislature regarding agreements between optometric physicians and a “qualified physician” was not to place burdensome requirements on either the optometrist or the “qualified physician” in order to discourage agreements between the two parties. Such requirements are not grounded in legitimate patient safety needs and are contrary to the intent of increased access to care.

7) In RCW 18.53.010 the legislature defined “qualified physician” and did not delegate the authority to alter or limit that definition. By a reasonable standard any physician licensed under 18.57 or 18.71 who is capable of handling the complication that occurs from procedures performed by optometrists should be freely able to sign an agreement without excessively restrictive language and a threat of unprofessional conduct by either board or commission.

8) While I respect the medical commission and the work they do we also believe this rule making represents an impermissible overreach by directly and indirectly attempting to regulate another independent health care provider group, optometry, and its board.

Sincerely,

Michael K. DeRosier, OD

From: [Dr. Harry Boparai](#)
To: [WMC Medical Rules](#)
Subject: RE: Comments on Draft Rule 246-919-604
Date: Wednesday, February 18, 2026 2:33:22 PM

External Email

DATE: February 18th 2026
TO: Washington Medical Commission
RE: Harry Boparai, OD
RE: Comments on Draft Rule 246-919-604

Dear Members of the Commission,

I am an optometric physician who has practiced for over 20 years in five different states, including in medical and hospital-based settings. I have worked alongside physicians across disciplines and understand both scope boundaries and patient safety responsibilities firsthand.

I strongly oppose draft rule 246-919-604 as written.

SB 5389, codified in RCW 18.53.010, was enacted after full legislative review, including a Department of Health sunrise analysis of optometric education and training. The Legislature made a deliberate policy decision to expand access to limited, office-based procedures performed by qualified optometric physicians.

Rulemaking authority exists to implement statute, not to narrow or condition it.

RCW 18.53.010 explicitly defines “qualified physician.” The statute does not delegate authority to alter, restrict, or discourage that definition. Any rule that adds substantive conditions beyond the plain language of the law exceeds delegated authority.

Doctors of medicine and osteopathic medicine are regulated by this Commission. Doctors of optometry are regulated by the Board of Optometry. That separation is intentional. This rule, as drafted, risks indirectly regulating optometric scope by creating barriers not contemplated by the Legislature.

The procedures authorized under RCW 18.53.010(5)(a)(3) are limited and low risk. There is no demonstrated patient safety crisis that justifies additional burdens. Imposing restrictive requirements on agreements will predictably reduce access to care, directly undermining legislative intent.

The Commission’s role is to implement the law as written.

I respectfully request that draft rule 246-919-604 be revised to align strictly with RCW 18.53.010, without adding conditions, narrowing statutory definitions, or creating indirect disciplinary exposure beyond legislative mandate.

Washington patients deserve faithful implementation of the law enacted on their behalf.

Sincerely,

Harry Boparai, OD
Airis Eye & Wellness
1414 116th Ave NE, Suite B
Bellevue, WA 98004
425-502-7922

From: [Megan Laine](#)
To: [WMC Medical Rules](#)
Subject: Comment on Draft Rule Section 246-919-604
Date: Wednesday, February 18, 2026 3:04:31 PM

External Email

Dear WMC Members,

I write to highlight concerns regarding the proposed draft new rule section 246-919-604 related to a “qualified physician” as that term is reflected in RCW 18.53.010(5)(a)(3) (originally SB 5389) within the RCW governing optometry.

Since 2016 I have worked as an optometrist for multiple offices in the Seattle metro area. I have also volunteered with EYE See Clinic, a mobile vision clinic that provides eye exams for children at schools in rural Washington. In my practice, I have cared for children, adults, and elderly that needed procedures that previously required referral to specialists. Patients could experience months-long waits before seeing the specialist and having the procedure done.

With the passing of SB 5389, my colleagues and I would be able to perform some of these procedures - in which we have the required education and training. When patients can access these procedures at the eye doctor’s office, it improves patients’ experiences by reducing wait times and delays in care. It allows specialists to focus on the advanced procedures for which they have training and expertise.

Unfortunately, the proposed draft rules add levels of complexity and restrictions that would make it harder for me to help patients to the best of my education and training.

Below are the points of concern in more detail. Thank you very much for your consideration.

Sincerely,

Megan Laine OD MS
Optometrist and Clinical Informaticist

- 1) The intent of the legislature at the time of SB 5389’s passage in May of 2023 was to expand healthcare access for Washington’s citizens by allowing optometric physicians to perform office based medical procedures consistent with their training and expertise. The Department of Health’s sunrise review process for SB 5389 specifically found that optometric physicians received the appropriate training and expertise to safely perform the procedures now codified in RCW 18.53.010 (optometry’s scope of practice).
- 2) I recognize that the WAEPS, WSMA and maybe even many on this commission were opposed to optometrists performing any of the procedures which are now allowable in optometric law. However, lawmakers heard this opposition and evaluated the scope of training for optometrists in passing SB 5389. The role of the Medical Commission now is to objectively assess the necessary rule making to implement the law. The proposed rule

language goes beyond this role and effectively limits optometrists from performing these procedures in a manner contrary to the statute.

3) I further recognize the independence of the Medical Commission to regulate medical doctors and doctors of osteopathic medicine. Doctors of optometry are independently regulated by the Board of Optometry. These two boards do not have the statutory authority to regulate beyond their individual scope. This independence is appropriate and good for public health.

4) I would also like to acknowledge that the requirement of an agreement between an optometric physician and a “qualified physician” as defined in 18.71 (doctor of medicine) or 18.57 (doctors of osteopathic medicine) for a rapid response when one is needed is unusual. It is customary for any health provider in the normal course of providing care to have a network of other specialists and subspecialists to refer patients should a different level of care be needed that they are not able to provide themselves. Physicians licensed under any provision refer patients to emergency services should a life threatening complication occur. Notably, such complications are extremely rare for the types of procedures allowed under RCW 18.53.010(5)(a)(3).

5) Specifically, these procedures (primarily the removal of benign lid lesions, among a few others) that are now allowed to be performed by trained and qualified optometric physicians very rarely result in a complication that might require a rapid response from another provider.

6) The intent of the legislature regarding agreements between optometric physicians and a “qualified physician” was not to place burdensome requirements on either the optometrist or the “qualified physician” in order to discourage agreements between the two parties. Such requirements are not grounded in legitimate patient safety needs and are contrary to the intent of increased access to care.

7) In RCW 18.53.010 the legislature defined “qualified physician” and did not delegate the authority to alter or limit that definition. By a reasonable standard any physician licensed under 18.57 or 18.71 who is capable of handling the complication that occurs from procedures performed by optometrists should be freely able to sign an agreement without excessively restrictive language and a threat of unprofessional conduct by either board or commission.

8) While I respect the medical commission and the work they do we also believe this rule making represents an impermissible overreach by directly and indirectly attempting to regulate another independent health care provider group, optometry, and its board.

From: [Alex B](#)
To: [WMC Medical Rules](#)
Subject: Comments on draft rule section 246-919-604
Date: Wednesday, February 18, 2026 9:51:42 PM

External Email

RE: Comments on draft rule section 246-919-604 – Alexander Baldwin

As a rural practicing optometrist in White Salmon, I am writing to express my significant concerns regarding the proposed rule WAC 246-919-604 related to a “qualified physician” as that term is reflected in RCW 18.53.010(5)(a)(3) (originally SB 5389) within the RCW governing optometry. While SB 5389 was enacted to expand healthcare access, the Medical Commission’s proposed restrictions would create administrative barriers that further restrict patient care.

Currently, my patients often face three-month wait times and often travel long distances for appointments. Under the current proposal, a patient requiring a minor, office-based procedure would face a continued status quo: a lengthy wait for a specialist assessment followed by additional weeks for the procedure. This cumulative delay is a significant barrier to health.

The requirement that a "qualified physician" be a board-certified ophthalmologist with hospital privileges within 30 minutes is nearly impossible to meet in a rural setting. These hurdles disproportionately impact vulnerable Medicaid patients and drive up the cost of care. I am fully trained and prepared to perform these procedures. These rules prioritize administrative obstacles under the guise of patient safety—a claim not supported by facts—which ultimately harms patients by delaying care and reducing access.

I would like to submit the following points for your consideration:

1) The intent of the legislature at the time of SB 5389’s passage in May of 2023 was to expand

healthcare access for Washington’s citizens by allowing optometric physicians to perform office

based medical procedures consistent with their training and expertise. The Department of

Health’s sunrise review process for SB 5389 specifically found that optometric physicians

received the appropriate training and expertise to safely perform the procedures now codified in

RCW 18.53.010 (optometry's scope of practice).

2) I recognize that the WAEPS, WSMA and maybe even many on this commission were opposed to

optometrists performing any of the procedures which are now allowable in optometric law.

However, lawmakers heard this opposition and evaluated the scope of training for optometrists

in passing SB 5389. The role of the Medical Commission now is to objectively assess the

necessary rule making to implement the law. The proposed rule language goes beyond this role

and effectively limits optometrists from performing these procedures in a manner contrary to

the statute.

3) I further recognize the independence of the Medical Commission to regulate medical doctors

and doctors of osteopathic medicine. Doctors of optometry are independently regulated by the

Board of Optometry. These two boards do not have the statutory authority to regulate beyond

their individual scope. This independence is appropriate and good for public health.

4) I would also like to acknowledge that the requirement of an agreement between an optometric

physician and a "qualified physician" as defined in 18.71 (doctor of medicine) or 18.57 (doctors

of osteopathic medicine) for a rapid response when one is needed is unusual. It is customary for

any health provider in the normal course of providing care to have a network of other specialists

and subspecialists to refer patients should a different level of care be needed that they are not

able to provide themselves. Physicians licensed under any provision refer patients to emergency

services should a life threatening complication occur. Notably, such complications are

extremely

rare for the types of procedures allowed under RCW 18.53.010(5)(a)(3).

5) Specifically, these procedures (primarily the removal of benign lid lesions, among a few others)

that are now allowed to be performed by trained and qualified optometric physicians very rarely

result in a complication that might require a rapid response from another provider.

6) The intent of the legislature regarding agreements between optometric physicians and a

“qualified physician” was not to place burdensome requirements on either the optometrist or

the “qualified physician” in order to discourage agreements between the two parties. Such

requirements are not grounded in legitimate patient safety needs and are contrary to the intent

of increased access to care.

7) In RCW 18.53.010 the legislature defined “qualified physician” and did not delegate the authority

to alter or limit that definition. By a reasonable standard any physician licensed under 18.57 or

18.71 who is capable of handling the complication that occurs from procedures performed by

optometrists should be freely able to sign an agreement without excessively restrictive language

and a threat of unprofessional conduct by either board or commission.

8) While I respect the medical commission and the work they do we also believe this rule making represents an impermissible overreach by directly and indirectly attempting to regulate another independent health care provider group, optometry, and its board.

Best regards,



Alex Baldwin, OD
WHITE SALMON EYECARE

Office: (509) 493-2020
Mobile: (971) 645-0766

From: [Paul S. Jensen, O.D.](#)
To: [WMC Medical Rules](#)
Subject: Comment on Draft Rule Section 246-919-604
Date: Thursday, February 19, 2026 12:59:56 PM

External Email

I am contacting the Washington Medical Commission as a private citizen and not as a member of the Washington State Board of Optometry.

My comment is regarding the rule making concerning the definition of "qualified physician" for the purposes of entering into an agreement with an optometrist who has been licensed to perform advanced procedures.

Emergency room physicians see a vast array of trauma, including trauma to the face and eyelids ranging from minor to severe. I would expect them to be as qualified to treat an eyelid condition that was the result of injury just as competently as they would a referral from an optometrist.

Such restrictions that are proposed by the Washington State Medical Commission are clearly outside of the legislative intent of increasing access to excellent care.

Sincerely,

Paul S. Jensen, O.D.

He/Him

112 Pelly Ave. N.

Renton Vision Source

Renton, WA 98057-0353

V: 425.255.2020

F: 425.255.2028

rentonvision@gmail.com

www.rentonvision.com/

Past-President, Optometric Physicians of Washington

Founder: NW Dry Eye Center www.NWDryEyeCenter.com nwdryeyecenter@gmail.com



EYE CARE

ASSOCIATES

P 509 926 6800

F 509 926 4041

www.ecaspokane.com

DATE: Feb. 20, 2026

TO: Washington Medical Commission

RE: Helaina Boulrieris, O.D.

RE: Comments on draft rule section 246-919-604

As an optometric physician in Washington, I have deep concerns regarding the proposed draft new rule section 246-919-604 related to a “qualified physician” as that term is reflected in RCW 18.53.010(5)(a)(3) (originally SB 5389) within the RCW governing optometry.

1) The intent of the legislature at the time of SB 5389’s passage in May of 2023 was to expand healthcare access for Washington’s citizens by allowing optometric physicians to perform office based medical procedures consistent with their training and expertise. The Department of Health’s sunrise review process for SB 5389 specifically found that optometric physicians received the appropriate training and expertise to safely perform the procedures now codified in RCW 18.53.010 (optometry’s scope of practice).

2) I recognize that the WAEPS, WSMA and maybe even many on this commission were opposed to optometrists performing any of the procedures which are now allowable in optometric law. However, lawmakers heard this opposition and evaluated the scope of training for optometrists in passing SB 5389. The role of the Medical Commission now is to objectively assess the necessary rule making to implement the law. The proposed rule language goes beyond this role and effectively limits optometrists from performing these procedures in a manner contrary to the statute.

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8) While I respect the medical commission and the work they do we also believe this rule making represents an impermissible overreach by directly and indirectly attempting to regulate another independent health care provider group, optometry, and its board.

Thank you for your consideration.

Helaina YS Boulhieris, O.D.
Spokane, WA

Dr. Celeste Ollieu
16517 SE Mill Plain Blvd.
Vancouver, WA 98683
360-828-3027

DATE: February 22, 2026

TO: Washington Medical Commission

RE: Dr. Celeste Ollieu

RE: Comments on draft rule section 246-919-604

Optometrists have worked hard to be able to provide the best possible medical care to our patients. That is why after our bachelors degree we go on to complete four additional years studying systemic diseases, pharmacology, optics, vision therapy, specialty contact lenses, myopia management, anterior and posterior disease and many other subjects prior to graduation. We have learned how to do injections, treat eye infections, prescribe medications and help our patients to the fullest extent of the law. I kindly ask you to consider not limiting our scope of practice with the changes that have been put forth on our questioning of our qualifications as a doctor. We are treated as doctors after graduation and passage of our boards and deserve to keep with that title. Please allow us to maintain our designation in order to treat our patients with the scope of practice that we are capable of providing.

As an optometric physician in Washington, I have deep concerns regarding the proposed draft new rule section 246-919-604 related to a "qualified physician" as that term is reflected in RCW 18.53.010(5)(a)(3) (originally SB 5389) within the RCW governing optometry.

- 1) The intent of the legislature at the time of SB 5389's passage in May of 2023 was to expand healthcare access for Washington's citizens by allowing optometric physicians to perform office based medical procedures consistent with their training and expertise. The Department of Health's sunrise review process for SB 5389 specifically found that optometric physicians received the appropriate training and expertise to safely perform the procedures now codified in RCW 18.53.010 (optometry's scope of practice).
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- 8) While I respect the medical commission and the work they do we also believe this rule making represents an impermissible overreach by directly and indirectly attempting to regulate another independent health care provider group, optometry, and its board.

Sincerely,

Dr. Celeste Ollieu
Optometrist



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Michael Seward, MD
Gleb Sukhovolskiy, OD
Michael Van Brocklin, OD
Salisa Williams, OD
Matthew Wojcik, OD
Eden Yoon, MD

DATE: February 23, 2026

TO: Washington Medical Commission

RE: Melissa Dacumos, OD

RE: Comments on draft rule section 246-919-604

My name is Melissa Dacumos, OD and while I am currently a member of the Washington State Board of Optometry, I am not acting on behalf of the Board in sending this letter. I am sending this letter as a licensed optometrist, private citizen, and member of the public. If these rules are adopted, many Washingtonians, primarily low-income, minority, elderly and rural communities, will continue to have limited access to care, undermining the intent of the law that was passed in 2023 (originally SSB 5389).

As an optometric physician in Washington, I have deep concerns regarding the proposed draft new rule section 246-919-604 related to a “qualified physician” as that term is reflected in RCW 18.53.010(5)(a)(3) (originally SB 5389) within the RCW governing optometry.

1) The intent of the legislature at the time of SB 5389’s passage in May of 2023 was to expand healthcare access for Washington’s citizens by allowing optometric physicians to perform office based medical procedures consistent with their training and expertise. The Department of Health’s sunrise review process for SB 5389 specifically found that optometric physicians received the appropriate training and expertise to safely perform the procedures now codified in RCW 18.53.010 (optometry’s scope of practice).

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Gleb Sukhovolskiy, OD
Michael Van Brocklin, OD
Salisa Williams, OD
Matthew Wojcik, OD
Eden Yoon, MD

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4) I would also like to acknowledge that the requirement of an agreement between an optometric physician and a “qualified physician” as defined in 18.71 (doctor of medicine) or 18.57 (doctors of osteopathic medicine) for a rapid response when one is needed is unusual. It is customary for any health provider in the normal course of providing care to have a network of other specialists and subspecialists to refer patients should a different level of care be needed that they are not able to provide themselves. Physicians licensed under any provision refer patients to emergency services should a life threatening complication occur. Notably, such complications are extremely rare for the types of procedures allowed under RCW 18.53.010(5)(a)(3).

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8) While I respect the medical commission and the work they do we also believe this rule making represents an impermissible overreach by directly and indirectly attempting to regulate another independent health care provider group, optometry, and its board.

Sincerely,

Melissa Dacumos, OD

From: redwood@visionsource-redwoodeyeclinic.com
To: [WMC Medical Rules](#)
Subject: Comment on Draft Rule Section 246-919-604
Date: Monday, February 23, 2026 3:31:39 PM
Attachments: [image001.png](#)
[WA Medical Commission letter.pdf](#)

External Email

February 23, 2026

TO: Washington Medical Commission

RE: Comments on draft rule section 246-919-604

As an optometric physician in Washington, I have deep concerns regarding the proposed draft new rule section 246-919-604 related to a “qualified physician” as that term is reflected in RCW 18.53.010(5)(a)(3) (originally SB 5389) within the RCW governing optometry.

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8. While I respect the medical commission and the work they do, I also believe this rule making represents an impermissible overreach by directly and indirectly attempting to regulate another independent health care provider group, optometry, and its board.

Regards,

Kim Y. Eng, OD

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18209 Bothell Way NE
Bothell, WA 98011
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DATE: February 23, 2026

TO: Washington Medical Commission

RE: Jeffrey Mattson, OD

RE: Comments on draft rule section 246-919-604

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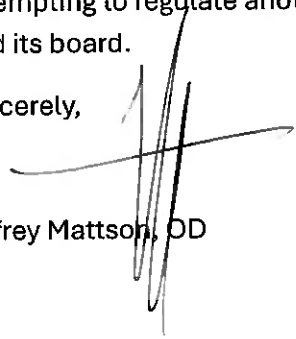
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Sincerely,

Jeffrey Mattson, OD



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From: [Mark Everett](#)
To: [WMC Medical Rules](#)
Subject: Comment on Draft Rule Section 246-919-604
Date: Monday, February 23, 2026 4:43:07 PM

External Email

To Whom it May Concern:

The Optometric Physicians of Washington (OPW) have significant concerns regarding the proposed draft new rule section WAC 246-919-604 and its potential impact on Washingtonians’

access to healthcare. We strongly believe that the proposed rule:

- (1) Works against the underlying legislative intent of RCW 18.53.010 (SB 5389, passed May 2023)
- (2) Conflicts with existing language and definitions found in RCW 18.53.010 and WAC 246-851-515
- (3) Exceeds the Washington Medical Commission’s scope and impedes on the Board of Optometry’s authority.

The proposed rule will significantly limit patient access to healthcare across the state.

In May 2023, the legislature passed SB 5389 (codified in RCW 18.53.010) to expand access to healthcare in Washington by allowing optometric physicians to perform office-based medical procedures consistent with their training and expertise— training and expertise that the Department of Health’s review process for SB 5389 specifically found that optometric physicians

received and possessed, thereby rendering them equipped to safely perform the procedures now codified under RCW 18.53.010.

This expansion was designed to help some of the state’s most vulnerable populations, including

those in rural and underserved areas of the state, by allowing for doctors of optometry to provide certain care in connection with any qualified physician licensed under RCW 18.71 or RCW 18.57. The current draft rule language severely reduces patients’ access to care by effectively redefining “qualified physician” to include only board-certified ophthalmologists who

meet restrictive geographic requirements.

We recognize that, as with many bills, some groups expressed opposition to SB 5389 within the

legislative process. However, it is significant that lawmakers heard and considered this opposition before ultimately voting to pass SB 5389 into law.

SB 5389 has been codified into law. It is now the Medical Commission’s role to objectively engage in rulemaking to implement the law in support and furtherance of its legislative intent.

Instead, the proposed rule language contradicts the statute's goal to increase access to healthcare by effectively limiting doctors of optometry from performing procedures that are permitted by statute.

The proposed rule attempts to redefine "qualified physician" and limits the autonomy of doctors of optometry.

The legislature did not delegate its authority to alter or limit the definition of "qualified physician" to any regulatory or rulemaking body or agency, including the Medical Commission.

The term is defined by state statute: to receive a license endorsement to perform the advanced procedures set out under RCW 18.53.010(2), a licensed optometrist must, in relevant part, "[e]nter into an agreement with a qualified physician licensed under chapter 18.71 RCW or an osteopathic physician licensed under chapter 18.57 RCW for rapid response if complications occur during an advanced procedure." RCW 18.53.010(5)(a)(iii). WAC 246-851-515(3)(a) further defines the term as "a physician who is actively licensed under chapter 18.71 or 18.57 RCW and who is trained in and capable of responding to complications which may arise from the optometric advanced procedures."

A physician licensed under 18.57 or 18.71 who is capable of handling the complications that may occur from advanced procedures is a "qualified physician" under Washington law, without further limitation.

Despite the fact that the legislature has defined "qualified physician," the proposed rule requires physicians to meet additional elements to be deemed "qualified," which greatly limits which physicians are considered qualified for purposes of the advanced procedure statute.

The proposed rule attempts to redefine "qualified physician" as a person who is licensed to practice medicine and surgery in Washington under chapters 18.71 or 18.57B RCW; is not currently under an order or stipulation to informal disposition with the commission; and, most significantly, holds a current and unrestricted certification from the American Board of Ophthalmology (or is eligible to do so) and has a surgical suite on site or holds privileges at a local hospital (defined as within 20 minutes or less of travel).

If the legislature wished to limit "qualified physicians" to those who either have an onsite surgical suite or else hold privileges at a local hospital within twenty minutes' travel distance, it

would have provided for these requirements in the state statute. Notably, it did not, and it is outside of the Medical Commission's authority to redefine a term which has already been purposefully crafted by the legislature. The Commission's additions severely limit access to healthcare—the very problem the legislature was trying to cure—for a significant portion of

Washingtonians, particularly those living in rural communities.

The proposed rule is an impermissible overstep.

We recognize the Washington Medical Commission's independent authority to regulate medical doctors and doctors of osteopathic medicine. However, doctors of optometry are independently regulated by a separate body, the Board of Optometry. These two boards do not have the statutory authority to regulate beyond their individual scopes; their independence from each other is appropriate and beneficial to public health.

The draft language states that unless directed by a qualified physician, "no valid agreement shall stipulate referral to a primary care practitioner, urgent care, emergency department, or any combination thereof as an appropriate response" to advanced procedure complications. Optometrists are not regulated by the Medical Commission and state law does not require optometrists to consult with a physician before referring their patient to a provider or facility that the optometrist deems to be most appropriate for their particular case. Optometrists are appropriately licensed and regulated by the Board of Optometry and are trained to use their medical judgement in these situations. The Commission does not have authority over the practice of optometry and it is therefore outside of the Commission's scope to place certain requirements on optometrists in their practices, including when performing advanced procedures.

While we respect the Medical Commission and the work they do, we believe this proposed rulemaking is an impermissible and unlawful overreach that attempts to directly and indirectly regulate another independent healthcare provider group outside of its own purview – doctors of optometry and the Board of Optometry—and will limit access to healthcare across the state.

Thank you for considering our concerns. Should you have any questions, feedback, or responses

to this letter, we urge you to contact Dr. Andrea Morton or Andrea McNeely, OPW's outside counsel, at amcneely@gth-law.com.

Sincerely,

Mark Everett OD

Mark Everett OD

Pacific Cataract and Laser Institute

16818 E Desmet Ct

Spokane, WA 99216

p 509.456.5380 | f 509.456.5381 | w Mark.Everett@pcli.com

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From: [Sarah Bortz](#)
To: [WMC Medical Rules](#)
Subject: Comments on draft rule section 246-919-604
Date: Tuesday, February 24, 2026 12:08:02 PM
Attachments: [Outlook-cid_image0](#)

External Email

As an optometric physician who sometimes practices in Washington, I have concerns regarding the proposed draft new rule section 246-919-604 related to a "qualified physician" as the term is reflected in RCW 18.53.010(5)(a)(3)(originally SB 5389) within the RCW governing optometry.

It is essential for the citizens of Washington to have access to competent eye care and that is often at the hands of their longstanding family optometrist. The proposed rule language effectively limits optometrists from performing procedures that they are trained to do and is within the statute. These rules do not reflect patients' best interests and can be a detriment to the eye health and welfare of Washingtonians.

Sincerely,

Sarah Bortz, OD, FAAO
Diplomate, American Board of Optometry



DATE: February 25, 2026
TO: Washington Medical Commission
From: Alyanna A. Arzner, OD, FAAO

RE: Comments on draft rule section 246-919-604

To whom it may concern,

I understand there are some newly proposed changes to SB539, and I'm writing to you today to express some of my concerns regarding the proposed draft new rule section 246-919-604 related to a "qualified physician" as that term is reflected in RCW 18.53.010(5)(a)(3) (originally SB 5389) within the RCW governing optometry.

1. The intent of the legislature at the time of SB539's passage in May of 2023 was to expand healthcare access for Washington's citizens by allowing optometric physicians to perform office based medical procedures consistent with their training and expertise. The Department of Health's sunrise review process for SB 5389 specifically found that optometric physicians received the appropriate training and expertise to safely perform the procedures now codified in RCW 18.53.010 (optometry's scope of practice).
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8. While I respect the medical commission and the work they do we also believe this rule making represents an impermissible overreach by directly and indirectly attempting to regulate another independent health care provider group, optometry, and its board.

As an optometric provider practicing in Deer Park, Washington (a rural community outside of Spokane, Washington), I find great value in the cooperation of optometry and ophthalmology. When warranted, I happily refer patients to my ophthalmologist colleagues. Undoubtedly, patients receive the best healthcare when optometry and ophthalmology work together. Unfortunately, even being adjacent to Spokane, ophthalmologists are still in limited supply—this reflects a national trend that Ophthalmology recognizes—and I find my referrals to these colleagues are taking an increasingly longer time to process. It’s not uncommon for patients to have to wait multiple months before having an evaluation, and even longer to receive treatment. As previously mentioned, the goal of the legislature at the time of SB539’s passage in May of 2023 was to help alleviate some of this burden on the patients and healthcare system, and expand healthcare access for Washington’s citizens by allowing optometric physicians to perform office based medical procedures consistent with their training and expertise. Ultimately, I

worry that the proposed changes will undo some productive and necessary changes to healthcare access in Washington, and I urge you to reconsider these proposed changes.

Thank you for your time and consideration of my concerns.

Best regards,

Alyanna A. Arzner, OD, FAAO
Deer Park Vision Source
alyannaa@deerparkvision.com



MCEC
MID COLUMBIA EYECARE CENTER

DATE: 2/22/26

TO: Washington Medical Commission

RE: Nicholas Gubler, OD

RE: Comments on draft rule section 246-919-604

Dear Washington Medical Commission,

As one of only a few optometrists serving Franklin County—an area with no full-time ophthalmologists—the proposed rule would severely limit my ability to provide timely, essential care. My patients already face a two-hour trip to Spokane for specialty services, creating delays that can lead to preventable vision problems. Restricting procedures that state law has deemed safe and within my training would disproportionately harm the rural community I serve.

As an optometric physician in Washington, I have deep concerns regarding the proposed draft new rule section 246-919-604 related to a “qualified physician” as that term is reflected in RCW 18.53.010(5)(a)(3) (originally SB 5389) within the RCW governing optometry.

1) The intent of the legislature at the time of SB 5389’s passage in May of 2023 was to expand healthcare access for Washington’s citizens by allowing optometric physicians to perform office based medical procedures consistent with their training and expertise. The Department of Health’s sunrise review process for SB 5389 specifically found that optometric physicians received the appropriate training and expertise to safely perform the procedures now codified in RCW 18.53.010 (optometry’s scope of practice).

2) I recognize that the WAEPS, WSMA and maybe even many on this commission were opposed to optometrists performing any of the procedures which are now allowable in optometric law. However, lawmakers heard this opposition and evaluated the scope of training for optometrists in passing SB 5389. The role of the Medical Commission now is to objectively assess the necessary rule making to implement the law. The proposed rule language goes beyond this role and effectively limits optometrists from performing these procedures in a manner contrary to the statute.

3) I further recognize the independence of the Medical Commission to regulate medical doctors and doctors of osteopathic medicine. Doctors of optometry are independently regulated by the Board of Optometry. These two boards do not have the statutory authority to regulate beyond their individual scope. This independence is appropriate and good for public health.

4) I would also like to acknowledge that the requirement of an agreement between an optometric physician and a “qualified physician” as defined in 18.71 (doctor of medicine) or 18.57 (doctors of osteopathic medicine) for a rapid response when one is needed is

unusual. It is customary for any health provider in the normal course of providing care to have a network of other specialists and subspecialists to refer patients should a different level of care be needed that they are not able to provide themselves. Physicians licensed under any provision refer patients to emergency services should a life threatening complication occur. Notably, such complications are extremely rare for the types of procedures allowed under RCW 18.53.010(5)(a)(3).

5) Specifically, these procedures (primarily the removal of benign lid lesions, among a few others) that are now allowed to be performed by trained and qualified optometric physicians very rarely result in a complication that might require a rapid response from another provider.

6) The intent of the legislature regarding agreements between optometric physicians and a "qualified physician" was not to place burdensome requirements on either the optometrist or the "qualified physician" in order to discourage agreements between the two parties. Such requirements are not grounded in legitimate patient safety needs and are contrary to the intent of increased access to care.

7) In RCW 18.53.010 the legislature defined "qualified physician" and did not delegate the authority to alter or limit that definition. By a reasonable standard any physician licensed under 18.57 or 18.71 who is capable of handling the complication that occurs from procedures performed by optometrists should be freely able to sign an agreement without excessively restrictive language and a threat of unprofessional conduct by either board or commission.

8) While I respect the medical commission and the work they do we also believe this rule making represents an impermissible overreach by directly and indirectly attempting to regulate another independent health care provider group, optometry, and its board.

DATE: 2/26/2026

TO: Washington Medical Commission

RE: Joseph Lee OD

RE: Comments on draft rule section 246-919-604

My name is Joseph Lee and I am an optometric physician practicing in Monroe, Washington. I have significant concerns regarding WMC's proposed draft rule section 246-919-604 related to a "qualified physician" as that term is reflected in RCW 18.53.010(5)(a)(3) (originally SB 5389) within the RCW governing optometry.

The intent of SB 5389 legislation was to expand healthcare access and provide equity to Washington's citizens. By allowing optometric physicians to perform office based medical procedures consistent with their training and expertise, the legislation significantly reduced the burden on patients to travel for these procedures. The Department of Health's sunrise review process for SB 5389 specifically found that optometric physicians received the appropriate training and expertise to safely perform the procedures now codified in RCW 18.53.010 pertaining to optometry's scope of practice.

The proposed rule language goes beyond objectivity in assessing the implementation of SB 5389. The proposed rules effectively limit optometrists from performing these procedures, as the statute intended.

The requirement of an agreement between an optometric physician and a "qualified physician" as defined in 18.71 (doctor of medicine) or 18.57 (doctors of osteopathic medicine) for a rapid response when one is needed is in itself unusual. It is customary for any health provider in the normal course of providing care to have a network of other specialists and subspecialists to refer patients should a different level of care be needed that they are not able to provide themselves. Physicians licensed under any provision refer patients to emergency services should a life threatening complication occur. Notably, such complications are extremely rare for the types of procedures allowed under RCW 18.53.010(5)(a)(3).

Specifically, these procedures that trained and qualified optometric physicians can now perform after SB 1589's passage very rarely result in a complication that might require a rapid response from another provider.

The intent of the legislature regarding agreements between optometric physicians and a “qualified physician” was not to place burdensome requirements on either the optometrist or the “qualified physician” in order to discourage agreements between the two parties. Such requirements are not grounded in legitimate patient safety needs and are contrary to the intent of increased access to care.

In RCW 18.53.010 the legislature defined “qualified physician” and did not delegate the authority to alter or limit that definition. By a reasonable standard any physician licensed under 18.57 or 18.71 who is capable of handling the complication that occurs from procedures performed by optometrists should be freely able to sign an agreement without excessively restrictive language and a threat of unprofessional conduct by either board or commission.

For these reasons, I believe the Washington Medical Commission’s proposed rules to be worse for patients and their care, causing increased burden on them. If the proposed rules are implemented, health equity and patient care will both worsen.

From: [Nathan L. Scott, OD](#)
To: [WMC Medical Rules](#)
Cc: [Dr. Nathan L Scott](#)
Subject: Comment on Draft Rule Section 246-919-604
Date: Thursday, March 5, 2026 6:26:19 PM

External Email

DATE: March 5, 2026

TO: Washington Medical Commission

SUBMITTED VIA: medical.rules@wmc.wa.gov

RE: Comments on Draft Rule Section 246-919-604

To the Washington Medical Commission,

My name is Nathan Scott, OD, and I am the owner of Spectrum Eye Care in Chelan. I am writing to formally voice my opposition to the proposed draft rule section 246-919-604 concerning the definition of a "qualified physician" under RCW 18.53.010(5)(a)(3).

The Impact of Healthcare Politicization: *I want to be blunt about the consequences of this Commission's actions: The ongoing politicization of healthcare and this transparent interference with my scope of practice here in Washington State are among the primary reasons I have decided to close my practice and leave the state.* My final day of patient care in this state will be this spring. I have accepted a position in another state where I can practice the full scope of optometry for which I was educated and trained, without being hamstrung by protectionist administrative barriers. It is a profound loss for the patients in my community that local access to care is being sacrificed to satisfy a regulatory "turf war."

The Fallacy of the "Qualified Physician" Requirement: My professional background further highlights the absurdity of your proposed restrictions. I am a board-certified optometrist through the American Board of Optometry (ABO) and hold active privileges at our local hospital. I regularly co-manage patients with local clinic and hospital physicians, including emergency room doctors. Despite these credentials and my established history of collaborative clinical care, I would be unable to meet the unreasonable and arbitrary rapid response restrictions you are attempting to codify. *If a board-certified doctor with active hospital privileges is denied the ability to continue my rapid response agreement under the proposed draft rule, it is clear that the rule is designed to exclude qualified providers rather than protect the public.*

Legislative Intent vs. Administrative Overreach: When the legislature passed SB 5389 in 2023, the intent was to expand healthcare access by allowing optometric physicians to perform office-based medical procedures consistent with our expertise. The Department of Health's sunrise review confirmed that optometrists are qualified to perform these procedures safely. ***Your proposed rule creates arbitrary hurdles that effectively gut the statute's purpose.***

Jurisdictional Independence: While I respect your authority over medical doctors, doctors of optometry are independently regulated by the Board of Optometry. This Commission has no statutory authority to indirectly regulate optometry by threatening "unprofessional conduct" against physicians who choose to collaborate with us. This represents an impermissible overreach into the jurisdiction of another independent board.

Barriers to Patient Care: The requirement for a "qualified physician" agreement for rapid response is an unusual mandate. In any other medical context, providers refer to specialists as needed without these codified hurdles. Given that complications for these procedures are extremely rare, these requirements are clearly not grounded in patient safety. Instead, they serve only to discourage physicians from partnering with optometrists, thereby stifling the very access the legislature sought to create.

I urge the Commission to respect the independence of the Board of Optometry and the clear will of the Washington State Legislature by withdrawing this draft.

Regards,

Nathan Scott, OD

Spectrum Eye Care, Inc, PS

Physical Address: 126 East Johnson Ave, Chelan, WA, 98816

Mailing Address: PO Box 3142, Wenatchee, WA 98807-3142

509.682.2708 x 106

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www.spectrumeyecarechelan.com

Please note: Email is not monitored for urgent or emergency communications. For immediate assistance, please call our office, visit the nearest emergency room, or call 911.

This message may have been dictated using voice-recognition software. Please excuse any minor typographical errors. Should any part of this message require clarification, please let me know.

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PACIFIC CATARACT + LASER INSTITUTE

4330 Mitchell Way, Bellingham, WA 98226

Phone: (360) 738-6860 Fax: (360) 738-6853

DATE: March 26th, 2026

TO: Washington Medical Commission

RE: Comments on draft rule section 246-919-604

As an optometrist in Washington, I have deep concerns regarding the proposed draft new rule section 246-919-604 related to a “qualified physician” as that term is reflected in RCW 18.53.010(5)(a)(3) (originally SB 5389) within the RCW governing optometry. The new rules surrounding a, “qualified physician” are unreasonably restrictive, and places an irrational burden on physicians; this will discourage them from entering into any such agreement at all. Who loses in this scenario? The patients. They are the ones that will have to continue to deal with long wait-times and travel far distances for procedures their local optometrist is trained and willing to safely perform.

The “qualified physician” language was added to SB 5389 as a courtesy, to show that optometry is willing to work with our ophthalmology/WMC colleagues. The proposed rules to 246-919-604 are in bad faith, a backdoor way for the Washington Medical Commission to restrict the Optometrists’ scope of practice. For the betterment of our communities, please reconsider these rule changes.

1. The intent of the legislature at the time of SB 5389’s passage in May of 2023 was to expand healthcare access for Washington’s citizens by allowing optometric physicians to perform office based medical procedures consistent with their training and expertise. The Department of Health’s sunrise review process for SB 5389 specifically found that optometric physicians received the appropriate training and expertise to safely perform the procedures now codified in RCW 18.53.010 (optometry’s scope of practice).

2. I recognize that the WAEPS, WSMA and maybe even many on this commission were opposed to optometrists performing any of the procedures which are now allowable in optometric law. However, lawmakers heard this opposition and evaluated the scope of training for optometrists in passing SB 5389. The role of the Medical Commission now is to objectively assess the necessary rulemaking to implement the law. The proposed rule language goes beyond this role and effectively limits optometrists from performing these procedures in a manner contrary to the statute.
3. I further recognize the independence of the Medical Commission to regulate medical doctors and Doctor of Osteopathic Medicine. Doctors of Optometry are independently regulated by the Board of Optometry. These two boards do not have the statutory authority to regulate beyond their individual scope. This independence is appropriate and good for public health.
4. I would also like to acknowledge that the requirement of an agreement between an optometric physician and a “qualified physician” as defined in 18.71 (Doctor of Medicine) or 18.57 (Doctor of Osteopathic Medicine) for a rapid response when one is needed is unusual. It is customary for any health provider in the normal course of providing care to have a network of other specialists and subspecialists to refer patients should a different level of care be needed that they are not able to provide themselves. Physicians licensed under any provision refer patients to emergency services should a life-threatening complication occur. Notably, such complications are extremely rare for the types of procedures allowed under RCW 18.53.010(5)(a)(3).
5. Specifically, these procedures (primarily the removal of benign lid lesions, among a few others) that are now allowed to be performed by trained and qualified optometric physicians very rarely result in a complication that might require a rapid response from another provider.
6. The intent of the legislature regarding agreements between optometric physicians and a “qualified physician” was not to place burdensome requirements on either the optometrist or the “qualified physician” in order to discourage agreements between the two parties. Such requirements are not grounded in legitimate patient safety needs and are contrary to the intent of increased access to care.
7. In RCW 18.53.010 the legislature defined “qualified physician” and did not delegate the authority to alter or limit that definition. By a reasonable standard any physician licensed under 18.57 or 18.71 who is capable of handling the complication that occurs from procedures performed by optometrists should be freely able to sign an agreement without excessively restrictive language and a threat of unprofessional conduct by either board or commission.

8. While I respect the medical commission and the work they do, we also believe this rule making represents an impermissible overreach by directly and indirectly attempting to regulate another independent health care provider group, optometry, and its board.

For the sake of our shared patients and their wellbeing, please reconsider implementing these unnecessarily restrictive rules.

Best regards,

A handwritten signature in black ink, appearing to read "Brett Igbinoba OD". The signature is fluid and cursive, with the "OD" at the end being more distinct.

Brett Igbinoba, OD

Wa. Academy of Eye Physicians and Surgeons
1215 4th Ave., Suite 1901
Seattle, WA 98161
206-441-9762

To: Washington Medical Commission
Medical.rules@wmc.wa.gov

To Whom It May Concern:

Washington Academy of Eye Physicians and Surgeons
Supplemental Comments to the Washington Medical Commission

Proposed Amendments to WAC 246-919-604, Standards for Professional Conduct

The Washington Academy of Eye Physicians and Surgeons (WAEPS) submits these supplemental comments to the Washington Medical Commission (WMC) regarding proposed amendments to WAC 246-919-604, which addresses the designation of ophthalmologists as "qualified physicians" pursuant to SSB 5389, legislation expanding the scope of practice of optometrists.

WAEPS maintains that while the WMC is not positioned to regulate the scope of practice of optometrists, it is entirely appropriate for it to regulate allopathic physicians. The proposed rule does exactly that, and only that, by defining the type of allopathic physician who must be party to co-signing agreements with optometrists before they may undertake the new advanced procedures authorized under SSB 5389.

Before proceeding, WAEPS wishes to be clear: we hold optometrists in high regard. They are an integral and collaborative part of our health care delivery system, and many work within our own practice settings. The views expressed here are not meant to suggest otherwise. Rather, they reflect our deep commitment to patient safety when these new advanced procedures are being undertaken.

The Appropriate Definition of "Qualified Physician"

SSB 5389 is silent on what type of physician may sign the mandated backup agreements. The WMC has appropriately clarified that only ophthalmologists may execute such agreements with optometrists. The Washington State Medical Association concurs with this position, as do WAEPS and other specialty organizations such as the Washington chapter of the American College of Emergency Physicians (WA-ACEP). Representatives of emergency medicine and other specialties have indicated that

physicians outside of ophthalmology do not consider themselves qualified to manage the complications that may arise when an optometrist performs any of the newly authorized advanced procedures.

This is not surprising. In routine practice, internists, dermatologists, plastic surgeons, and otolaryngologists already refer anything eye-related to ophthalmologists. With rare exceptions, physicians in other specialties have neither the training nor the inclination to manage periocular or intraocular complications.

The Availability of Ophthalmologists Statewide

The Board of Optometry has argued for a broader definition of "qualified physician", contending that there may be insufficient numbers of ophthalmologists available to manage complications in certain areas of the state. This contention is not supported by evidence. During the Sunrise Review conducted by the Department of Health prior to the 2023 legislation, Medicare data clearly demonstrated that 96% of Washingtonians live within 30 minutes of an ophthalmologist, and that the remaining 4% are also more than 30 minutes from an optometrist.

These figures have been validated by Medicare claims data and a University of Washington study, and are not based solely on voluntary demographic surveys. There is, therefore, a sufficient number of ophthalmologists available throughout the state to sign agreements and to respond to complications in a timely manner. This data should reassure regulators, patients, and optometrists alike.

Legislative Intent

There has been discussion regarding what the Legislature intended by not specifically defining "qualified physician". While that intent cannot be known with certainty, it is clear that no amendment was offered in either the Senate or the House that explicitly rejected the more specific definition now proposed by the WMC. There is no stated legislative intent precluding either the Board of Optometry or the WMC from further defining the term. WAEPS is pleased that the WMC has recognized the patient safety rationale for providing a specific definition through rulemaking. As the sole body authorized to regulate and direct allopathic physicians in Washington State, the WMC is acting squarely within its authority in doing so.

The Seriousness of the Authorized Advanced Procedures

It has been suggested by optometrists that the procedures authorized by SSB 5389 are generally low risk for serious complications. WAEPS strongly disagrees. We opposed inclusion of these procedures in the legislation, and the fact that they were enacted into law does not render them low risk. The following examples are described in clinical terms, intentionally, to convey the true complexity and risk involved, and to underscore why ophthalmologist-level expertise is the only appropriate backup when complications arise.

1. Anterior Chamber Paracentesis.

This procedure involves inserting a 30-gauge needle into the anterior chamber of the eye to aspirate aqueous fluid. This is done to obtain cultures in suspected infection, or even more rarely, to immediately decompress an acutely elevated intraocular pressure. The anterior chamber is approximately 3 mm in depth and holds roughly 250 microliters of fluid. The roof of this space is the corneal endothelium; inadvertent contact can cause endothelial failure requiring corneal transplantation. The floor is the anterior capsule of the crystalline or intraocular lens; inadvertent puncture can cause traumatic cataract, inflammation, and glaucoma. In a space only 3 mm deep, these complications are entirely foreseeable, particularly in inexperienced hands. During an angle closure glaucoma attack, the anterior chamber may collapse completely leaving zero space between the cornea and the iris or lens making an already challenging situation even riskier.

2. Eyelid Surgery.

Even minor eyelid procedures, such as removal of a small skin tag, carry the risk of retrobulbar hemorrhage, particularly in anticoagulated patients. Bleeding within the eyelids can track posteriorly into the orbit, compressing the optic nerve. Without immediate surgical canthotomy and cantholysis to release orbital pressure, irreversible blindness can result. This risk is significant enough that it appears explicitly on surgical consent forms, and patients undergoing eyelid surgery are given direct contact information for after-hours concerns, including instructions to seek immediate care if the eyelid becomes tense or the eye begins to bulge. In fact, surgical canthotomy and cantholysis is one of the more common consults that ophthalmology is called in to do in the emergency room, as most ER doctors are not comfortable with the procedure.

3. Intrastromal Corneal Injection of Medications.

Injection of medications directly into the corneal stroma is an uncommon procedure reserved for severe, refractory infections that have failed both topical and systemic treatment. It is almost exclusively performed by corneal specialists in tertiary or quaternary care centers. The cornea is approximately 550 microns thick under normal conditions, but in the setting of active infection, the inflammatory process and microbial activity cause stromal thinning, ulceration, and softening that place the globe at imminent risk of perforation. Performing an intrastromal injection in this context requires the judgment and skill of a specialist; this is a last-resort intervention to prevent loss of the eye and should not be performed by healthcare professionals who cannot manage the potential complication of globe penetration with resultant risks

Additional Matters

WAEPS has addressed in prior correspondence other aspects of the proposed rule, including limits on the number of agreements an ophthalmologist may sign annually, geographic proximity requirements between the optometrist and ophthalmologist, and follow-up and reporting obligations. We are pleased that the WMC has incorporated the

substance of our recommendations into the current draft and are supportive of those provisions. Please do not hesitate to contact us with any questions regarding our position on those sections.

We sincerely appreciate the WMC's thorough and thoughtful engagement with these issues over the past several months. This has been a complex process, but both the WMC and WAEPS have remained guided by patient safety and quality of care. We are grateful for that shared commitment.

Sincerely,

Irene Lee, MD

President, Washington Academy of Eye Physicians & Surgeons



Legislative Building
Olympia, WA 98504-0482

Washington State Senate

Phone: (360) 786-7550
FAX: (360) 786-1999

March 6, 2026

To the Members of the Washington Medical Commission,

I understand that the rule-making process for SB 5389 (Access to Eyecare Act), which was passed in 2023, has been completed by the Department of Health's Board of Optometry following public input which included opportunity and input from WAEPS, WSMA, and the Medical Commission before it was finalized and took effect last year.

It has been brought to my attention that although SB 5389 does not require any rule making by the Medical Commission for the adoption of this bill, the Medical Commission has decided to undergo rulemaking of their own regarding specific language within RCW 18.53.010 which defines the scope of practice of optometry.

Specifically section 5(a)(iii) which requires an optometrist who wishes to be endorsed by the Board of Optometry for performing advanced procedures to: "Enter into an agreement with a qualified physician licensed under chapter [18.71](#) RCW or an osteopathic physician licensed under chapter [18.57](#) RCW for rapid response if complications occur during an advanced procedure."

As the prime sponsor of this bill I would like to clarify the intent of this language. The purpose was not to create burdensome requirements between Doctors of Optometry and Doctors of Allopathic or Osteopathic Medicine entering into these agreements, but rather to simply create a pathway of care for patients in the rare event that a complication occurred which could not be managed by the optometrist during or after one of the procedures allowed in RCW 18.53.010. I understand this language is unique given the fact that the procedures the bill allows for are generally at low risk for a serious complication to occur which would require a rapid response. And further, even without having this "rapid response" agreement in place it is a normal practice for any healthcare provider of any type or specialty to have a network of referral sources to be able to consult with and send to should they feel the patient needs care they cannot provide, or is outside of their ability to treat, based on the judgement of the provider performing said procedure or treatment. Including those requiring a rapid or emergent response.

During the legislative process similar language that is now being discussed in the Medical Commission's rule making draft of Chapter 246-919 WAC further defining the definition and requirements of a "qualified physician" and it's relation to the "rapid response" agreement between a physician licensed under RCW 18.71 and 18.57 and an optometrist licensed under RCW 18.53 was considered and rejected by the legislature. It was the intent

of the legislature to leave the definition as it currently stands in statute without changes made by either the Board of Optometry or the Washington State Medical Commission.

As both the Medical Commission and the Board of Optometry are independent of each other, nothing in this bill was intended to diminish or alter the independence of the respective commission/boards from each other, nor to create oversight of one board/commission over the other, either directly or indirectly.

Finally, with the Board of Optometry already having completed and implemented the rule making for this bill and optometrists already having these agreements in place and performing these procedures I have concerns that further rule making which places different and possibly unnecessary requirements upon the allopathic and osteopathic physicians could result in confusion amongst both parties resulting in decreased access to care with no evidence based quality or safety benefit to the public.

I urge the Medical Commission to carefully consider that which is absolutely necessary for patient care, access and safety. Being careful to avoid rules which may be seen as the creation of regulatory hoops meant to discourage any qualified physicians from signing agreements under threat of unprofessional conduct and corresponding disciplinary action thereby indirectly influencing the practice of another independent provider group, in this case Doctors of Optometry.

Sincerely,

A handwritten signature in black ink that reads "Annette Cleveland". The signature is fluid and cursive, with the first name "Annette" and last name "Cleveland" clearly distinguishable.

Annette Cleveland
Washington State Senator
Chair, Senate Health and Long-Term Care Committee
49th Legislative District
Vancouver
(360) 786-7696

April 13, 2026

Ms. Amelia Boyd
Washington Medical Commission
Department of Health

Re: Allopathic physician rulemaking

Delivered electronically

Dear Amelia,

On behalf of the Washington State Medical Association (WSMA) representing nearly 13,500 physician and physician assistant members, I am writing to provide comment on the Washington Medical Commission's (WMC) proposed revisions to the allopathic physician (MD) chapter rules for consideration at your April 20 meeting.

The WSMA appreciated the opportunity to learn more about the board certification process of the American Academy of General Practice (AAGP) representatives at your March 23 meeting. While the discussion was insightful, we have outstanding questions and serious concerns about utilizing the allopathic rule review process to sanction AAGP's pathway to board certification for international medical graduates. We request that this component of the rule be considered separately in a rulemaking to implement Senate Bill 5185, which would allow for more dedicated consideration of this important issue.

Proposed AAGP pathway concerns

Based on the presentation, it appears that the proposed AAGP pathway does not involve a residency and includes only monthly chart reviews, as opposed to the daily or weekly chart reviews standard in the American Board of Medical Specialties (ABMS) pathway. While the AAGP noted that there is "no comparison" between AAGP and ABMS, the draft rule would create de facto equivalency between the two pathways making the opacity regarding how the two pathways diverge deeply troubling. The WSMA is concerned by the continued positioning of AAGP as a substitute for ABMS certification without sufficient evidence that its standards are equivalent. Creating or endorsing non-equivalent alternatives risks confusing the public, undermining confidence in physician licensure, and eroding long-established professional standards designed to protect patients.

Due to the outstanding questions remaining around AAGP certification, the WSMA continues to have concerns that it may not provide an adequate level of assurance to the public regarding physician competence, quality, and readiness for independent practice. Accordingly, the WSMA continues to oppose the proposed changes that reference or rely upon AAGP and requests this component of the rule be held for future rulemaking.

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Past President

Bindu Nayak, MD
Vice President

John Scott, MD, M.Sc
Secretary-Treasurer

Jennifer Hanscom
Chief Executive Officer

AAGP pathway participant employability concerns

Additionally, there is still an open question as to whether and to what extent hospitals, insurance carriers, and other relevant payors and employers accept AAGP certification when making hiring and reimbursement decisions. While Pacific Medical Specialty Group noted that they have not encountered reimbursement issues in their MD-CE program, they represent a small sample size, and their program appears to primarily operate outside of a hospital setting.

Most physicians in Washington state work in hospital settings. In the interest of ensuring that IMGs who obtain certification from AAGP would be able to be employed in these settings, more stakeholdering should be done to validate that this represents a viable pathway to gainful employment.

Interplay with Senate Bill 5185

During the 2026 legislative session, the WSMA worked in collaboration with the WMC and advocates from the IMG community to pass Senate Bill 5185. The law as adopted reflects extensive deliberation and compromise. A key component of the bill is Section 2 (3), which directs the WMC to “engage with the American Board of Medical Specialties to consider a process for board certification for program participants.”

At this time, we feel it would be premature to move forward with changes in rule to sanction an AAGP certification pathway. Given that SB 5185 grants rulemaking authority to establish a primary care license for applicants who have successfully completed the pilot program, we request that certification pathways be considered in the context of that rulemaking.

Thank you for considering. We appreciate the opportunity for ongoing collaboration on this rulemaking. With any questions, please reach out to Hillary Norris, JD, WSMA policy analyst, at hillary@wsma.org.

Sincerely,



Hillary Norris
Policy Analyst
Washington State Medical Association

April 13, 2026

Amelia Boyd
Rules Coordinator
Washington Medical Commission

Bridget Bush, MD, FASA
President

Matt Hollon, MD, MPH, MACP
President-Elect

John Bramhall, MD, PhD
Past President

Bindu Nayak, MD
Vice President

John Scott, MD, M.Sc
Secretary-Treasurer

Jennifer Hanscom
Chief Executive Officer

Dear Amelia,

On behalf of the undersigned medical associations and physician specialty, thank you for the opportunity to provide comment on the Washington Medical Commission's (WMC) allopathic physician rules review – specifically new section WAC 246-919-604. We support the proposed language as it ensures that patients experiencing adverse events in or around the eye following advanced procedures performed by an optometrist receive timely evaluation and management by an ophthalmologist with the training and expertise to recognize and address complications.

Specifically, we support the WMC's draft language requiring that a physician entering into an agreement:

- Hold an active, unrestricted license to practice medicine and surgery in Washington state
- Hold a current and unrestricted certification from the American Board of Ophthalmology or is eligible to do so
- Has a surgical suite on site or holds privileges at a hospital within 30 minutes of the ophthalmologist

We are also supportive of the WMC's draft language stipulating that an ophthalmologist cannot enter into agreements with more than three individual optometrists at a given time and that the physician may not be located more than 50 miles or one hour of travel away from the site of patient care delivery by the optometrist.

These safeguards help ensure that patients experiencing adverse events in or around the eye receive timely care from a practitioner with the training and expertise to appropriately manage such complications. Not all physician specialties have the specific training required to treat complications involving the eye, and many—if not most—of these patients are likely to present initially in the emergency department setting. As noted by the Washington Chapter of the American College of Emergency Physicians (WA-ACEP), emergency physicians would 'diagnose, stabilize, and refer to an ophthalmologist in cases of eye complications.' While emergency physicians are well equipped to diagnose and stabilize these conditions, definitive management of adverse events involving the eye appropriately falls to an ophthalmologist.

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We appreciate the WMC's efforts to ensure patient safety through the inclusion of language addressing adverse events involving the eye. We support the language as drafted in new section WAC 246-919-604.

Sincerely,

Washington State Medical Association

Washington Osteopathic Medical Association

Washington Chapter of the American College of Emergency Physicians



April 14, 2026

Washington Medical Commission
Department of Health
P.O. Box 47866
Olympia, WA 98504-7866

Re: *WAC 246-919-430 Requirements for maintenance of licensure, Allopathic Physicians*

Dear Commission members,

I am writing on behalf of the Washington Academy of Family Physicians to comment on proposed revisions to the allopathic physician chapter rules, specifically the section on maintenance of licensure.

We considered the proposed change to incorporate certification from the American Board of General Practice (ABGP) as an alternative for state maintenance of licensure for IMGs during renewal.

Under the existing subsection (3), a licensed physician may satisfy maintenance of licensure requirements through certification by a member board of the American Board of Medical Specialties. Behind this certification are benchmarks for training and competency that, while not detailed in the WAC, are long-established and understood. It remains unclear to us if ABGP's certification processes maintain equivalent rigor or evaluation to ensure physician readiness for license renewal.

Given this uncertainty, we request the Commission review ABGP's certification requirements and make that information publicly available. This transparency would allow public comment and an opportunity to assess whether ABGP's standards and assessments are sufficient to protect patients and maintain public trust.

We also wonder whether adding ABGP certification to subsection (3) is necessary. Subsection (1) provides a straightforward pathway for renewal through specified continuing medical education without expanding subsection (3) to include ABGP certification.

Finally, we note the workshop process may offer an opportunity to clarify what constitutes a legitimate certification requirement and to establish enduring benchmarks and standards.

Thank you for your consideration.

Regards,

A handwritten signature in black ink, appearing to read "Kim McCaulou".

Kim McCaulou
Executive Vice President



**American Board
of Medical Specialties**

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BY ELECTRONIC MAIL

April 16, 2026

Terry Murphy, MD
Chair
Washington Medical Commission
111 Israel Rd. S.E.
Tumwater, WA 98501

Re: Allopathic Physician Rulemaking- WAC 246-919-430, Requirements for Maintenance of Licensure.

CC: Washington State Medical Association

Dear Dr. Murphy and Members of the Washington Medical Commission:

As the Senior Vice President for Policy and External Relations at the American Board of Medical Specialties (ABMS), I am writing to share recommendations for the proposed revisions to the allopathic physician (MD) chapter of the Washington Administrative Code (WAC) that addresses requirements for retaining licensure, specifically on pathways to receive credit for participating in specialty board certification for physicians in Washington.

American Board of Medical Specialties

Established in 1933, ABMS is responsible for the creation of standards overseeing physician certification in the United States. Dedicated to improving the quality of care to the patients, families, and communities we serve, the 24 ABMS Member Boards develop educational and professional standards and programs of assessment to certify physicians and medical specialists. Currently 24,136 physicians and medical specialists in the state of Washington are certified by one or more of the ABMS Member Boards.

WAC 246-919-430, Requirements for Maintenance of Licensure

Our comments on the proposed rules concerning the requirements for maintenance of licensure, specifically on pathways to specialty board certification, are below.

Physician certification is a voluntary process that builds on the minimum requirements for licensure and reflects higher medical standards than licensure. A medical license does not reflect competence in a medical/surgical specialty. Board certification requires physicians to obtain additional specialty-specific training, pass rigorous examinations to determine competence to practice in the specialty, adhere to high standards of professionalism, and participate in ongoing assessments and education to keep up-to-date and improve quality of care in the specialty throughout their career.

In lieu of listing specific organizations that may or may not be substantially similar to ABMS certification, **we encourage the inclusion of a definition of physician certification that can be used by the Washington Medical Commission (WMC) to determine whether an organization meets the rigorous standards for certifying physicians in a specialty.**

Although certification in a specialty should not be tied to conditions of licensure or re-licensure, demonstrating continuous certification in a specialty is often deemed as one way to meet a state's requirements for continuing medical education. The specialty education environment is broad, and this rule should recognize the evolving landscape of organizations in this space. Additionally, **the rule should ensure that programs and organizations that do not meet minimum standards for physician certification do not qualify for recognition.**

We recommend the Commission remove reference to specific certifying agencies and instead include the following definition of legitimate physician certification that has been adopted in both [state](#) and [federal statute](#). This definition is based on industry standards for professional certification set by the Institute for Credentialing Excellence and reflects definitions of physician certification adopted by the American Medical Association and Federation of State Medical Boards:

1. Maintain a process to define, periodically review, enforce, and update specific standards regarding knowledge and skills of the specialty or subspecialty;
2. Administer a psychometrically valid assessment to determine whether a physician/medical specialist meets standards for initial certification, recertification, or continuing certification;
3. Establish and enforce a code of professional conduct; and
4. Require that a physician/medical specialist satisfy the certifying body's requirements for both initial certification and recertification or continuing certification requirements of the certifying body that granted the initial certification.

The Commission should have the authority to determine which certifying organizations are recognized as acceptable for purposes of satisfying the state's CME requirements for licensure and /re-licensure based on the criteria set forth in this definition.

ABMS certification not only meets but exceeds these requirements. Physicians who meet requirements for staying certified with an ABMS Member Board participate in specialty-specific assessments, complete specialty-specific education and professional development, participate in quality improvement activities, and attest to adhering to professional codes of conduct. We agree with concerns raised by the Washington State Medical Association, in their comments submitted on January 20, 2026, that **creating or endorsing potentially non-equivalent boards risks confusing the public, undermining confidence in physician licensure, and eroding long-established professional standards designed to protect patients.**

Internationally-Trained Physicians (ITPs)

ABMS specialty boards are committed to maintaining the highest standards for the medical profession and protecting public safety. Without access to board certification in a specialty, newly licensed internationally-trained physicians (ITPs) may face disparities in employment opportunities and professional growth. Additionally, patients may be confused about the qualifications of these physicians and their ability to meet current standards for practice in their specialty. ABMS, the Accreditation Council for Graduate Medical Education (ACGME), and national medical specialty societies are dedicated to developing the tools and resources necessary to help ITPs meet national standards for medical/surgical specialties. ABMS is working with its Member Boards on assessing pilot programs for ITPs to have a path to board certification.

We are excited to work with the WMC and other stakeholders to ensure that ITPs serve the needs of patients in underserved areas while developing the clinical knowledge and competencies required to attain board certification after receiving their unrestricted medical license. We look forward to engaging with the Commission in the coming months on the implementation of SB 5815, establishing a pilot program that creates a pathway to physician licensure for ITPs. **We request the Commission extract any reference to licensure and re-licensure requirements for ITPs in WAC 246-919-430 and instead address during rule making for implementation of SB 5815.**

Thank you for your consideration of this additional guidance on behalf of the American Board of Medical Specialties. Please contact me if ABMS can provide additional assistance on this issue.

Sincerely,

A handwritten signature in black ink, appearing to read 'Amy Gibson', is positioned above the typed name and title.

Amy Gibson, MS, RN
Senior Vice President for Policy and External Relations
American Board of Medical Specialties



Feedback on MD chapter rule review

From Katerina LaMarche <katerinal@wsha.org>

Date Mon 4/20/2026 11:20 AM

To Matthews, Micah T (WMC) <micah.matthews@wmc.wa.gov>; Boyd, Amelia (WMC) <Amelia.Boyd@wmc.wa.gov>

External Email

Hi Micah and Amelia,

I'm writing to share the feedback we received from members on the MD chapter rule review:

Maintenance of licensure:

In WAC 246-919-430 (maintenance of licensure), the draft language proposes allowing ABGP certification as a maintenance-of-licensure option only for IMGs who are ineligible for ABMS certification. We understand this is framed as an additional pathway alongside ABMS boards, not a global replacement. We acknowledge the importance of thoughtful IMG and MD-CE pathways for workforce and equity, but our members have indicated that they either will not or do not recognize ABGP certification as equivalent to ABMS board certification for purposes of meeting "board certified/eligible" expectations in credentialing and privileging.

The AMBS is the organization that sets the training program standards for the 24 member boards for physician training, which is one of the minimum eligibility requirements to be consider for medical staff membership to hospitals. Each ABMS training then sets the board certification criteria, and they look to their recommendations based on specialty for certification timing, recertification, and requirements. If a physician has not completed training from an ABMS program, they likely would not meet the requirements and be eligible to apply for membership. There are rare exceptions that might occur, but this would require approval by the board and would have to come with a compelling reason. They are concerned about training sufficiency and safety standards. They are also concerned that allowing non-ABMS certification board for state license may imply or give the false impression that the physician will be able to get hospital privileges when that isn't possible.

Safety training:

There were also concerns with the safety training requirements – making this a requirement for every renewal cycle could be difficult and onerous for physician to fulfill and may jeopardize their renewal.

Do you have an updated link for the meeting materials today? I was using the link but hadn't saved the language and now the link does not work (says "page not found").

Thank you,
Kat

Katerina LaMarche, JD

Policy Director, Government Affairs

Washington State Hospital Association

1201 3rd Ave, Suite 1601 | Seattle, WA 98101

Mobile: (206) 265-1706

Email: katerinal@wsha.org

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Board of Optometry
PO Box 47877
Olympia, WA 98504-7877

August 5, 2026

ATTN: Kyle Karinen
Washington Medical Commission
P.O. BOX 47866
Olympia, WA 98504-7866
Kyle.Karinen@wmc.wa.gov

RE: response to WMC letter dated May 16, 2024, and to WMC draft rule WAC 246-919-604

Dear Mr. Karinen:

Thank you for your time and discussion on both April 20, 2026, and June 15, 2026, regarding the WMC draft rule WAC 246-919-604. Per our conversation, the board would like to directly respond to the WMC letter dated May 16, 2024. Each response will correspond to each statement noted in said letter.

1. We agree that the intent by the Legislature in using the word “qualified” in RCW [18.53.010\(5\)\(a\)\(iii\)](#) does not merely indicate *any* licensed allopathic or osteopathic physician. For example, a cardiologist would not be an appropriate physician to rapidly respond to ophthalmic complications related to advanced procedures. However, I would like to reiterate the point that the term “qualified” can be used to describe more specialties than ophthalmology alone, such as but not limited to dermatology, plastic surgery, primary care medicine and emergency medicine. We would agree the term “partner” does strike a more collaborative tone, though we chose to keep the term “qualified physician” in our language to align with the statute.
2. We recognize that not all physicians may have experience in treating conditions in or around the eyes, however the purpose of the “qualified physician agreement” is to collaborate with an appropriate physician who is comfortable and willing to sign an agreement stating they can and will rapidly respond to ophthalmic complications specifically related to the advanced procedures as defined in [RCW18.53.010 \(2\)\(a\)\(i-vii\)](#). The “qualified physician” can *choose* to enter into such an agreement. They are not obligated to. Therefore, if an appropriate physician does not feel they are adequately skilled to respond to these potential complications, they can choose not to enter into an agreement.
3. To address the WMC’s concerns about referrals to emergency rooms, we would like to reiterate that by keeping the term “qualified” broad and allowing it to include ER doctors, this does not mean that optometrists will be sending their advanced procedures complications directly to the ER indiscriminately. That is not how the language is worded. The optometrist must have established an agreement with the physician, an option being an emergency room doctor, prior to

performing any advanced procedure. Once that agreement is made, then should a complication occur, the patient can be sent to the specific emergency room doctor they entered into an agreement with. This is particularly valuable in rural communities where there are already established relationships between the few or lone optometrists in that community with the few or lone ER doctor at the nearby hospital. These collaborative relationships are already occurring outside of the advanced procedures with regards to other eye care issues.

4. We agree that there are complications that are best treated by a board-certified ophthalmologist but as you pointed out, if another allopathic physician who has significant recent experience treating all of the conditions on your chart that occur in and around a patient's eye, AND agrees to enter into a "qualified physician agreement", then why not allow this agreement to exist?
5. We agree that a "rapid response" requires that the "qualified physician" be readily available. There are time constraints that are detailed in draft rule WAC 246-919-604. Specifically in section (1)(d), which states that the surgical suite or hospital at which the ophthalmologist holds privileges must be within 30-60 minutes of surface travel from their office, and in section (3)(d), which states that the ophthalmologist may not be located more than one hour of surface travel from the site of patient care delivery by the optometrist. While the board does not agree with these time constraints, we can understand that compliance with any federal law is necessary - I believe it was WMC member, Ms. Christine Blake, who stated that the time limits were consistent with the Emergency Medical Treatment and Labor Act (EMTALA). Our understanding of EMTALA is limited, and a more detailed explanation as to how EMTALA and these specific time constraints apply to this agreement would be greatly appreciated.
6. We respectfully disagree that there are an adequate number of board-certified ophthalmologists throughout the state to allow for the intended increase in access to care for Washingtonians. While there are approximately 400 board-certified ophthalmologists in Washington state (as you stated in your letter), the more meaningful piece of information would be the distribution of these ophthalmologists throughout the state. Are there enough ophthalmologists in rural Washington to support these agreements given the constraints of time stated in #5 and the limit of 10 agreements per ophthalmologist? Would the WMC be able to provide a map distribution of board-certified ophthalmologists throughout the state?
7. Currently, there are 26 states that have injection authority outside of treating anaphylaxis. There are 23 states that allow for removal of lumps and bumps on the eyelids. As previously stated at the June 15, 2026, WMC rulemaking workshop, there is *no state in the country other than WA*, that requires an agreement and collaboration with medicine to perform these advanced procedures. We have contacted the Association of Regulatory Boards of Optometry for any documented complication rates for these advanced procedures. A thorough review of the literature does not yield any information specifically stating optometry related complications to these advanced procedures.

In response to the chart of *Potential complications/disorders for treatment of conditions listed under RCW 18.53.010 (2)(a)*

Treatment of the following conditions stated in your chart does not require any advanced procedures and therefore is not applicable to our discussion: acute hordeolum/stye, acute dacryocystitis, acute

dacryoadenitis, and acute or chronic blepharitis. Botox injections are not within our scope of practice. Below is a list of complications for advanced procedures.

Subconjunctival injection:

- discomfort, irritation, redness, chemosis, subconjunctival hemorrhage, conjunctival laceration, persistent subconjunctival hemorrhage or hematoma, ocular hypertension (if substance injected is a corticosteroid), allergic reaction to medication injected
- rare: infection, globe perforation, allergic reaction to medication leading to anaphylaxis

Subcutaneous injection (likely anesthetic or steroid):

- temporary pain/burning/irritation, bleeding, bruising, swelling, edema
- rare: hematoma formation, allergic reaction to medication (including risk of anaphylaxis), infection, failure to achieve desired level of anesthesia or medication efficacy, nerve damage, inadvertent intravascular injection leading to a retinal vascular occlusion.

Chalazion management:

- risks associated with subcutaneous anesthetic injections apply to chalazion management (listed above)
- complications if removed by incision and curettage: recurrence, incomplete removal, infection, scarring of the tarsal plate, loss of eyelashes, eyelid notching, damage to adjacent meibomian glands, bleeding
 - rare: orbital cellulitis, globe perforation, permanent eyelid malposition
- complications if treated with steroid injection: local skin hypopigmentation, skin fat atrophy, infection, recurrence
 - rare: increased intraocular pressure or steroid induced glaucoma, globe perforation, cataract, orbital cellulitis

Removal of benign lid lesions, i.e. skin tags, papillomas, benign cysts:

- risks associated with subcutaneous anesthetic injections apply to lid lesion removal
- redness, bruising, bleeding, recurrence, infection,
- excessive deep cutting or excessive tissue removal, scarring, eyelid notching, loss of lashes, excessive tissue removal requiring suture closure

Trichiasis ablation:

- temporary pain/swelling/redness, bruising, persistent or recurrent trichiasis
 - rare: infection, eyelid notching, loss of adjacent normal lashes, lid margin scarring, hyper or hypopigmentation of skin

Punctal cautery:

- temporary pain/tenderness/foreign body sensation/irritation, localized eyelid/punctal swelling, redness, transient tearing, recanalization, granulation of tissue, canalicular inflammation or scarring, persistent dry eyes, epiphora
- rare: infection, bleeding or hematoma, scarring/eyelid cosmetic changes

Removal of conjunctival lesions, i.e. cyst/concretion removal:

- risks associated with subcutaneous anesthetic injections may apply

- temporary discomfort/foreign body sensation/irritation, infection, persistent bleeding, recurrence or incomplete removal, subconjunctival hemorrhage, chemosis
- rare: localized scarring, infection, granuloma, symblepharon formation

Conjunctivochalasis repair:

- temporary redness/chemosis/foreign body sensation/mild discomfort/irritation, subconjunctival hemorrhage, tearing, recurrence, scarring and fibrosis, incomplete treatment/under-correction, dry eyes, infection
- rare: excessive tissue removal requiring sutures or causing tissue contraction, symblepharon formation, motility restriction

This is not an all-inclusive list of potential advanced procedures, but it does summarize some of the more common and likely advanced procedures to be performed by optometrists.

The board surveyed all the other boards of optometry throughout the country. We were unsuccessful at obtaining complication rates for optometrists who perform these procedures because reporting to the state board was either not required or was only required for laser procedures (which is not included in Washington's advanced procedures). A thorough review of the literature does not yield any applicable complication rates specific to optometry.

As suggested by Mr. Karinen, the board welcomes further discussion regarding implementation of WMC draft rule WAC 246-919-604 and would gladly arrange a time where the Board of Optometry and the WMC can have productive discussion surrounding this topic. We acknowledge that such a meeting would constitute a quorum of the board and will ensure compliance with the Open Public Meetings Act.

Sincerely,



Melissa Dacumos, OD, Chair
Washington Board of Optometry

August 31, 2026

ATTN: Amelia Boyd
Washington Medical Commission
PO BOX 47866
Olympia, WA 98504-7866
Amelia.Boyd@wmc.wa.gov

Re: Proposed WAC 246-919-300 — Referral of Applicants to the Recognized Physician Health Program

delivered electronically

Dear Washington Medical Commission Staff and Commissioners:

Thank you for the opportunity to participate in the August 31, 2026, rules workshop regarding chapter 246-919 WAC. I appreciated the discussion and the clarification that proposed WAC 246-919-300 applies to **physicians applying for licensure in Washington**, rather than to physicians who are already licensed and practicing in the state. I also appreciated the explanation that the Washington Department of Health contracts with the recognized physician health program within a broader framework serving multiple health professions, versus the Washington Medical Commission, which is listed as the referring entity and workshops' sponsor.

Those clarifications are important. However, I remain concerned that the proposed language may create a referral process that is broader and more categorical than necessary for the purpose of determining whether an applicant can practice medicine safely.

The current draft states that an applicant with a DUI/DWI history within the preceding five years "shall" be referred to the recognized physician health program for evaluation. It similarly provides that when information suggests an applicant may have a mental, physical, substance-use, or other health condition that may impair the ability to practice with reasonable skill and safety, the applicant "shall" be referred when the condition is not already known to the recognized physician health program. The draft further provides that certain undisclosed health conditions outside the program's "safe harbor" will result in referral.

I support appropriate evaluation when there is a legitimate concern about an applicant's current ability to practice safely. My concern is whether **every triggering circumstance requires the same pathway**.

Substance use disorder, a well-managed mental health condition, a physical disability, a temporary illness, and evidence of current impairment are not clinically or functionally equivalent. A modern licensing framework should permit differentiation among them.

I therefore encourage the Department and Commission to consider several principles as this language is refined.

First, referrals should be **proportionate to the stated concern and based on current functional risk**. When objective information raises a reasonable concern that a current health condition materially impairs, or creates a significant risk of impairing, an applicant's ability to practice medicine with reasonable skill and safety, any required evaluation should be tailored to that identified concern. A

diagnosis, disability, treatment history, lawful use of health care services, or participation or nonparticipation in a physician health program should not by itself, establish impairment or require referral. Where appropriate, additional information, reasonable accommodation, monitoring by a WA state licensed medical practice, or another less restrictive approach should also be considered in the WAC.

Second, the rules or associated Department standards should provide **clear referral criteria**. Applicants should be able to understand why a referral is required, what question the evaluation is intended to answer, and what level of evaluation is reasonably necessary. A focused assessment may be sufficient in one circumstance while a more comprehensive evaluation may be warranted in another, in every instance the intake process should be clear.

Third, applicants who are required to undergo an evaluation should have basic procedural protection. These should include reasonable access to the information relied upon, an opportunity to correct material factual errors, the ability to provide relevant treating-clinician information, and a meaningful process for obtaining a second opinion or review when significant findings are disputed.

Fourth, the evaluation process where feasible, distinguishing between **assessment and treatment**. An evaluator should answer the regulatory question presented, i.e., whether the applicant can practice safely, and whether any conditions are necessary - without automatically converting every evaluation into an extended treatment or monitoring relationship with the contracted physician health program.

Fifth, cost and access deserve attention. A state-required evaluation can impose significant expenses on an applicant at precisely the point the physician is attempting to enter Washington's workforce. Applicants should receive advanced information about costs and should have reasonable access to qualified evaluators, including local and convenient options.

Finally, I would encourage clarification of what it means for a condition to be "known" to the recognized physician health program and how the proposed "safe harbor" operates. **Participation in a physician health program should not determine whether an applicant receives favorable regulatory treatment; the relevant question should be present ability to practice safely.** Similarly, failure to disclose health information should have regulatory significance only when the information was lawfully required, material to the applicant's current ability to practice safely, and the applicant had adequate notice of the disclosure requirement. The rule should not inadvertently create an incentive for physicians to avoid appropriate medical or mental health care out of concern that seeking treatment itself may later trigger a more burdensome licensing process.

These recommendations do not diminish the state's responsibility to protect patients. Rather, they would help ensure that referrals are **evidence-informed, individualized, proportionate, transparent, and directed toward the actual question of present fitness to practice.**

I appreciate the opportunity to participate in this process and the willingness of the Commission to engage interested parties as these discussions develop.

Sincerely,

Michelle Terry, MD



WASHINGTON
ACADEMY OF
EYE PHYSICIANS
& SURGEONS

October 5, 2026

Washington Medical Commission
ATTN: Kyle Karinen
P.O. BOX 47866
Olympia, WA 98504-7866
Kyle.Karinen@wmc.wa.gov

RE: Supplemental Comments Regarding WAC 246-919-604, SSB 5389

Dear Mr. Karinen,

The Washington Academy of Eye Physicians and Surgeons wishes to supplement its earlier comments regarding the Commission's deliberations on WAC 246-919-604, rules concerning a medical doctor's role in some optometrists' patient care plans. Your proposal is in response to SSB 5389, passed by the Legislature in 2023, addressing increased scope of practice for optometrists. We realize the WMC is not addressing the actual scope of practice for optometrists but instead will only be implementing direction to medical doctors in their role in conjunction with SSB 5389. We will also be commenting on actions that have been taken by the Board of Optometry, as it has created its own rules and procedures concerning the legislation.

To summarize our earlier comments provided to the Commission, WAEPS has been concerned since 2022 when a possible legislative draft was submitted to the Department of Health creating a Sunrise Review of a proposal to significantly increase optometrists' scope of practice. The proposal reviewed at that time by DOH staff (and partially introduced as legislation in 2023) would have permitted optometrists to undertake an extensive list of advanced procedures, including the use of lasers. WAEPS was heavily involved in the Sunrise Review and subsequent legislation, objecting to the scope expansion and the proposed level and type of training that would be required of optometrists. We advocated that the legislation and subsequent rules were inadequate to protect patients. Ultimately the Legislature failed to pass the entirety of the optometrists' legislative proposal, but it did approve provisions we felt were entirely insufficient to protect the public. Since that passage, the Board of Optometry adopted rules in 2024 implementing SSB 5389. WAEPS objected to a number of the proposed rules, but the BOO nevertheless adopted them.

While WAEPS has a variety of concerns about the BOO rules, we are particularly troubled by what we feel are inadequate training and education requirements for optometrists undertaking the statutorily authorized “advanced procedures.” Simply stated, SSB 5389 mandates that training utilize “living patients” and “hands on” education and experience with the expanded procedures. In contrast, the adopted rules authorize what is often called a “weekend course” administered through the University of Oklahoma. Our review of the syllabus does NOT demonstrate hands on training with live patients during this lecture-style course. The rule appears to NOT meet the education requirements of the actual legislation. This should deeply concern the Legislature, the patient community, and the WMC. WAEPS recognizes that the WMC is not in a position to determine the substance of these training requirements, but as it moves toward passage of its own additional rules, we believe the WMC should keep in mind this shortage of training that makes passage of the WMC rules even more crucial.

The Washington Medical Commission has, in the past several years, adopted an interpretive statement which WAEPS felt provided some important guardrails on the authority for optometrists to undertake “advanced procedures.” We have appreciated the WMC’s efforts, and the work it is currently undertaking to adopt the provisions of its interpretive statement into actual rules. We are hopeful that in spite of opposition from the Board of Optometry, the WMC will quickly finalize its proposed provisions.

Before briefly elaborating on specific WAC proposals, we would like to bring to your attention correspondence (dated August 5, 2026) directed to you by the Board of Optometry itemizing a list of possible complications and/or disorders for certain conditions or advanced procedures. We are not certain of the derivation of this list or how it literally interrelates with SSB 5389. We believe the procedures outlined in the BOO letter may be intended to address advanced procedures authorized in SSB 5389, but that is not entirely clear in that the BOO list may not actually parallel the procedures newly authorized in the 2023 law.

The BOO implies that “conjunctivochalasis repair” is a common “advanced procedure,” when it is NOT commonly performed even by ophthalmologists. While conjunctivochalasis is an extremely common and largely age-related condition, with a prevalence exceeding 90% in patients over 60 in hospital-based series, most cases are asymptomatic and require no treatment. Surgery is reserved for the very small subset with symptomatic disease refractory to lubrication and anti-inflammatory therapy, making the surgically treated population a small and poorly quantified fraction. Furthermore, we believe that this procedure, which often involves cautery to the conjunctival surface is a stretch of the interpretation of the rules which we were party to participating in.

We are also concerned that the procedures enumerated in the BOO’s letter to the WMC leave out some of the most risky and technically difficult procedures that are specifically authorized in the bill. Two of the aforementioned procedures include: anterior chamber paracentesis and intrastromal corneal injections of medications. Both the anterior chamber and

the intrastromal space of these anatomic spaces are exceedingly small and make these procedures very difficult to perform even in the best of circumstances. During an anterior chamber paracentesis, a small 30-gauge needle is inserted into the anterior chamber of the eye and aqueous fluid is aspirated either for culture or evacuated to help alleviate elevated intraocular pressure. Intrastromal injections into the cornea for infections is also extremely rare due to the high risk/low benefit in a clinical setting. They are performed only under the most dire circumstances, and almost exclusively done in a tertiary care ophthalmology setting. Assuming that any MD or DO other than an ophthalmologist could serve as a backstop if complications occur during these procedures is concerning.

Moving on to your specific rule proposal, WAEPS strongly endorses everything you are proposing in your current draft. Specifically, SSB 5389 mandates that there be written agreements between an optometrist who is authorized to do advanced procedures and a “qualified physician.” The procedures cannot be undertaken until such an agreement is in place. The BOO now states in its rules that a “qualified physician” may be any MD or DO. WAEPS (and the WMC in its interpretive statement) feels strongly that a qualified physician must be a board-certified ophthalmologist if a rapid response to a complication is necessary. No other MD or OD can respond adequately and quickly to complications that might occur during an advanced procedure involving the eye, nor would most other medical doctors wish to be responsible for attempting to respond. We have appreciated that this mandate is in the WMC interpretive statement and is supported by the WA. State Medical Association, as well as groups such as the WA. Chapter/American College of Emergency Physicians. This is plainly the only means to ensure adequate and appropriate quality patient care. Most specialists such as dermatologists, otolaryngologists, plastic surgeons, and family medicine doctors routinely refer eye issues to ophthalmologists even when they could arguably treat some eye diseases, and they strongly prefer to NOT address eye problems.

The BOO has contended that there are not adequate ophthalmologists available across Washington to meet this requirement. We can easily provide you with data demonstrating that this is not factual. WAEPS and AAO evaluation of the locations and distance to providers in WA State has demonstrated the patients are equally close to both provider groups. The protection that ophthalmology backup can provide is crucial if a problem is created during an optometric “advanced procedure.”

WAEPS supports other provisions of the proposed WMC rules regarding the mandated agreements, including a maximum distance and time between an optometrist’s and an ophthalmologist’s locale, the total number of agreements an ophthalmologist may have with various optometrists, the retention of agreements by the WMC, and the duration of each agreement. These additional provisions will help all parties assure the highest level of patient care and response possible, and we encourage their passage.

We appreciate your continuing dedication to assuring quality eye care in Washington and look forward to making additional comments at your October 12 hearing.

Best regards,

A handwritten signature in black ink that reads "Stephanie Cramer MD". The signature is written in a cursive, flowing style.

Stephanie Cramer MD
WAEPS Legislative Chair
WAEPS Former President
AAO Regional Representative for State Affairs

Optometry Advanced Procedures Annual Report

December 2026

RCW 18.54.800



Prepared by
Office of Health Professions
Health Systems Quality
Assurance



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Dennis E. Worsham
Secretary of Health

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Executive Summary

[RCW 18.53.010](#) allows for the practice of advanced procedures for optometrists who have been issued an endorsement by the Department of Health (department). [RCW 18.54.800](#) requires optometrists with the advanced procedures endorsement to submit information to the board on the outcomes of every advanced procedure the optometrist completed in the previous year. The board is required to coordinate with the department to analyze and report on these outcomes, including any related complications or adverse events.

In 2024, the board adopted [WAC 246-851-515](#) with reporting requirements for advanced procedures authorized under [RCW 18.53.010 \(2\)](#) and developed an online reporting form. The reporting period ends December 31, 2028.

The department has collected data from the reports submitted in 2025. Based on these reports, a total of 28 advanced procedures were completed during 2025 and no adverse events were reported.

Background

In 2023, the legislature passed [Substitute Senate Bill \(SSB\) 5389](#), expanding the optometric scope of practice. The expanded scope, codified as [RCW 18.53.010\(2\)](#), allows for the practice of advanced procedures provided the optometrist has been issued an endorsement by the department.

[RCW 18.54.800](#) required the Board of Optometry (board) to develop a process for optometrists who have been issued the endorsement to submit information to the board on the outcomes, including any complications or adverse events, of every advanced procedure that the optometrist completed in the previous year. Additionally, the board, in coordination with the department, must analyze and report on the outcomes of the advanced procedures, to include any complications or adverse events related to the performance of advanced procedures.

In 2024 the board adopted [WAC 246-851-515](#), “License endorsement to perform advanced procedures.” Subsection (4) of the new rule states “A licensed optometrist shall report every advanced procedure authorized under [RCW 18.53.010 \(2\)](#) and include any complications or adverse events during their annual reporting period. The reporting period ends December 31, 2028.” The board has created an online reporting form for licensed optometrists who hold the endorsement to report all advanced procedures they perform.

Data Collection Process

Data Collection

The department, in coordination with the board, developed an online reporting form for licensed optometrists to report any advanced procedures. This form is embedded in the Healthcare Enforcement and Licensing Management System (HELMS). The department collected and analyzed the data from the reports submitted in 2025.

Data Presentation

This report provides the submitted data in table format. Based on this data:

- Seven (7) types of advanced procedures were itemized
- The total number of procedures were itemized
- The total number of adverse events were itemized

Table 1: Advanced Procedures

Type of Advanced Procedures RCW 18.53.010(2)i-vii	Number of Advanced Procedures completed WAC 246-851-515(4)	Number of Adverse Events Reported WAC 246-851-515(4)
Conjunctival procedures	11	0
Lash procedures	2	0
Lid procedures	9	0
Chalazia procedures	1	0
Lacrimal Procedures	2	0
Injections	0	0
Other procedures	3	0

Next Steps

The board, in coordination with the department, will analyze and report on the outcomes of the advanced procedures that were reported in 2026, as authorized in [RCW 18.53.010](#), for the December 2027 report. The report will include any complications or adverse events related to the performance of the advanced procedures in the 2026 reporting period. The data will be aggregated and will not identify any individual provider, facility, or patient and will not reveal any confidential information.

The board will continue to provide the same online reporting form for licensed optometrists to use to report any advanced procedures.



WSR 25-12-014
PREPROPOSAL STATEMENT OF INQUIRY
DEPARTMENT OF HEALTH
(Washington Medical Commission)
[Filed May 22, 2025, 11:51 a.m.]

Subject of Possible Rule Making: Allopathic physicians (MD) chapter rule review. The Washington medical commission (commission) is considering amending the following rules to modernize language, add clarity, and bring the rules more in line with current practice: WAC 246-919-010 through 246-919-520; and WAC 246-919-602 through 246-919-700.

Statutes Authorizing the Agency to Adopt Rules on this Subject: RCW [18.71.015](#) and [18.130.050](#).

Reasons Why Rules on this Subject may be Needed and What They Might Accomplish: The commission is considering updating rules to more closely align with current industry standards and provide clearer rule language for licensed MDs. In addition, RCW [43.70.041](#) requires the commission to review its administrative rules every five years to ensure that regulations are current and relevant. As part of this effort, the commission is also considering incorporating its interpretive statements into rule to provide greater clarity and consistency. Rule amendments being considered will potentially benefit the public's health by ensuring participating providers are informed and regulated by current national industry and best practice standards.

Process for Developing New Rule: Collaborative rule making.

Interested parties can participate in the decision to adopt the new rule and formulation of the proposed rule before publication by contacting Amelia Boyd, Program Manager, P.O. Box 47866, Olympia, WA 98504-7866, phone 360-918-6336, TTY 711, email amelia.boyd@wmc.wa.gov, website <https://wmc.wa.gov>.

Additional comments: To join the interested parties email list, please visit https://public.govdelivery.com/accounts/WADOH/subscriber/new?topic_id=WADOH_153.

May 19, 2025
Kyle S. Karinen
Executive Director

Comparison of Residency versus MD-CE Residency Equivalent Training Program

	ACGME Approved Internal Medicine Residency Curriculum	ACGME Approved Family Medicine Residency Curriculum	AAGP Approved PSMG MD-CE Post-Acute/Long-Term Care Curriculum (Primary Care track for Internal or Family Medicine	AAGP General Practice Medicine Program for Current Practicing Physicians. NOT for IMG/MD-CE physicians in Washington State
Initial Screening Req.	NO	NO	YES	YES
Interview Req.	Sometimes	Sometimes	YES	Sometimes
Years Req. in Program	3	3	4	0 Based on years in practice
Pre-requisites to apply	Graduate of US Approved medical school	Graduate of US Approved medical school	Graduate of US Approved medical school from overseas	Graduate of US Approved medical school
PGY 1 Curriculum	Inpatient Med (4 Blocks) Ambulatory Medicine (3 Blocks) ICU Critical Care Medicine (1 Block) Medical ICU (1 Block) Cardiology/Pulmonology (1 Block) Nights (1 Block) Elective (1 Block)	Adult Medicine Pediatrics Obstetrics	Introduction to Electronic Medical Records Introduction to patient management in a skilled nursing facility Introduction to clinical Primary Care medicine Introduction to the primary care management of the geriatric patient Introduction to coding and billing Provide medical diagnostic evaluations to assess for and determine medical illness. Diagnoses, recognition, and/or management of: (but not limited to)	N/A

Comparison of Residency versus MD-CE Residency Equivalent Training Program

			a. Simple to complex mood and anxiety disorders i. Bipolar disorders ii. GAD b. Uncomplicated and complex Mental Health disorders/diseases i. Major Depression ii. Psychotic disorders iii. Schizophrenia iv. Disruptive behavior v. Developmental disorders vi. Eating disorders vii. Delirium and dementia viii. Personality disorders c. Substance abuse disorders i. Opioid Addiction/Dependence ii. Alcohol abuse disorder iii. Polysubstance abuse and withdrawal d. Uncomplicated and complex Cardio/vascular related diseases i. Acute myocardial infarction ii. Acute cardiac arrest iii. Status-post coronary artery by-pass grafts (CABG)	
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Comparison of Residency versus MD-CE Residency Equivalent Training Program

			iv. Status-post TAVR procedures v. Cardiac tamponade vi. Acute/Chronic atrial fibrillation vii. Valvular stenosis viii. Essential hypertension ix. Hypertensive crisis x. Hypotension xi. Anemia xii. Iron-deficient anemia xiii. Deep Vein xiv. Thrombosis xv. Dehydration xvi. Congestive Heart Failure e. Uncomplicated and complex Endocrine related diseases i. Hypothyroid ii. Hyperthyroid iii. Parathyroidism iv. Pre-diabetes v. Type I Diabetes Miletus vi. Type II Diabetes Miletus vii. Graves' Disease viii. Cushing's Disease ix. Addison's Disease x. Acute Pancreatitis f. Uncomplicated and complex Pulmonary related diseases	
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Comparison of Residency versus MD-CE Residency Equivalent Training Program

			i. Chronic Obstructive Pulmonary Disease ii. Atelectasis iii. Pneumonia iv. Lung cancer v. Pulmonary effusion vi. Asthma vii. Reactive Airway Disease viii. Pulmonary Embolism g. Uncomplicated and complex Musculo-skeletal disorders i. Osteoporosis ii. Rheumatoid Arthritis iii. Gout iv. Degenerative Joint Disease v. Osteosarcoma vi. Muscle spasms and cramps vii. Rotator cuff disorders viii. Fractures ix. Muscle strains and sprains h. Uncomplicated and complex Gastro-intestinal disorders i. Barrett's Esophagus ii. Gastritis/GERDS iii. H-Pylori iv. Perforated bowel v. Ileus vi. Cirrhosis vii. Cholelithiasis viii. Crohn' Disease	
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Comparison of Residency versus MD-CE Residency Equivalent Training Program

			ix. Enteritis x. Constipation xi. Cholecystitis xii. Hemorrhoids xiii. Diverticulosis/Divertic ulitis xiv. Appendicitis i. Uncomplicated and complex neurological disorders i. Brain tumor ii. Cerebral vascular accident iii. Intracranial hemorrhage iv. Sub-Dural hemorrhage v. Concussion vi. Bell's Palsy vii. Guillain-Barret Disease viii. Neuropathy j. Uncomplicated oncological diseases k. Cancer (with or without l. metastasis) m. Uncomplicated and complex Nephrology disorders/diseases i. Acute kidney injury ii. Chronic Kidney Disease Stage III-IV iii. End Stage Renal Disease iv. Renal calculi v. Nephrotic Syndrome	
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Comparison of Residency versus MD-CE Residency Equivalent Training Program

			vi. Nephritis n. Uncomplicated and complex Urological disorders/disease i. Cystitis ii. Urinary Tract Infections iii. Benign Prostatic Hypertrophy iv. Urinary retention v. Neurogenic bladder vi. Balanitis o. Uncomplicated and complex orthopedic disorders/disease i. Joint replacements ii. Fractures iii. Amputations p. The Post-operative patient q. Uncomplicated ocular disease. i. Scleral hemorrhage ii. Corneal abrasion iii. Seasonal allergies r. Infectious Disease i. HIV/AIDS ii. Covid-19 iii. RSV iv. Influenza v. Sepsis s. Autoimmune Disorders i. Sjogren's Syndrome ii. SLE	
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Comparison of Residency versus MD-CE Residency Equivalent Training Program

			iii. Lupus iv. Ehlers Danlos Syndrome t. Uncomplicated pain management – Other than Opioid prescribing 8. Dealing with the difficult patient and/or family 9. Introduction to Palliative care 10. Introduction to death and dying 11. Nights (1 Block)	
PGY 2	Inpatient Med. (3 Block) Ambulatory Med.(3 Block) ICU Critical Care Medicine (2 Block) Emergency Med (0.5 Block) Neurology/Gastroenterology (1 Block) Nights (1 Block) Elective (3 Block)	Behavioral Health Cardiology Community Medicine Dermatology ENT Geriatrics Gynecology	1. Continuation of expansion of the first-year curriculum. 2. Care and management of the elderly 3. Introduction to assisted living, independent living, memory care settings 4. Teaching Rounds with First Year Physicians 5. Nights (1 Block)	N/A

Comparison of Residency versus MD-CE Residency Equivalent Training Program

PGY 3	Inpatient Medicine (3 Block) Ambulatory Medicine (3 Block) ICU Critical Care Medicine (2 Block) Nights (1 Block) Elective (3 blocks)		1. Continuation and expansion of the first and second year curriculum 2. Introduction and management of the uncomplicated and complex wound 3. Supervision of non-physician providers 4. Teaching Rounds with First- and Second-Year Physicians	N/A
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Comparison of Residency versus MD-CE Residency Equivalent Training Program

Req. to Attend lectures, Grand Rounds, Journal Club	YES Monthly	YES Monthly	YES Monthly	N/A
Training Site(s)	Hospital Based	Hospital, Outpatient Clinics, Private Practices	Skilled Nursing Facilities – Managing hospital acute/post-acute patients & Long-term care patients	

Comparison of Residency versus MD-CE Residency Equivalent Training Program

Req. to take Annual Clinical Competency Examinations covering the entire year of education and training.	NO	NO	YES	N/A
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Comparison of Residency versus MD-CE Residency Equivalent Training Program

Req. to take Board Examination at end of program	YES Upon completion of the PGY 3, Candidates sit for board certification exams in Internal Medicine	YES Upon completion of the PGY 3, Candidates sit for board certification exams in Family Medicine	YES Upon completion of the PGY 3, Candidates sit for board certification exams in General Primary Care Medicine	PART I Candidates must subscribe to Audio Digest. Each candidate must provide the AAGP with copies of test scores documenting successful completion of 70 topics. PART 2 Candidate will prepare ten (10) case histories on a wide variety of patients they have treated. These histories should showcase your critical thinking skills and document your thought process in evaluating and treating the patient. In some circumstances, the AAGP may contact the candidate to orally discuss the case. A candidate must receive a minimum score of 80% on part two of the exam to pass. Physicians who become board certified must complete 60 CME each year to remain board certified.
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Comparison of Residency versus MD-CE Residency Equivalent Training Program

On-going program assessment/evaluation	YES -ACGME	YES – ACGME	YES – AAGP/WMC	N/A
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Comparison of Residency versus MD-CE Residency Equivalent Training Program

Residents/Physicians maintain Log Books of cases managed?	YES	YES	YES	N/A
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Comparison of Residency versus MD-CE Residency Equivalent Training Program

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Comparison of Residency versus MD-CE Residency Equivalent Training Program

PGY 4	N/A		1. Continuation and expansion of the first, second, and third-year curriculum 2. Introduction to Physician Leadership a. Serving as a facility and Pod (Provider cluster) Medical Director b. Working with facility Administrator and Director of Nursing 3. Teaching Rounds with First- and Second-Year Physicians	N/A
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Kadlec Regional Medical Center Program

Richland, WA

Specialty:

Family medicine

ACGME Code:

1205400713

NRMP Code:

1721120C0

[YOG 2STEP 225 - 235DO FriendlyIMG Friendly](#)

[Director/Coordinator Portal](#)

Program Overview

Kadlec Family Medicine Residency (KFMR) is located in Richland, WA, and is operated by the Kadlec Regional Medical Center (KRMC), which has been serving patients since 1944. The residency program was established in 2015 and is fully accredited by the Accreditation Council for Graduate Medical Education (ACGME). It is affiliated with the WWAMI Family Medicine Network, a collaborative effort that encompasses numerous family medicine residency programs across five Northwestern states, emphasizing evidence-based medicine, equity, and inclusion [1](#).

The mission of KFMR is to prepare physicians to be leaders in providing comprehensive, compassionate family medicine and to improve access to family medicine services across the region. KFMR offers unique aspects such as being an unopposed residency program and providing a rural rotation experience [1](#).

Program Highlights

Highlights of the residency program include:

- Located close to Kadlec Regional Medical Center with most training sites within a 15-20 minute drive and several within walking distance.
- Initial training in a supportive environment with an emphasis on hands-on learning, particularly through the integration of osteopathic principles and lifestyle medicine.
- Utilization of EPIC EMR for efficient patient data management.
- Strong collaboration with the community and access to regional healthcare resources.
- Free parking and dedicated residency lounge for comfort and study [1](#).

Curriculum Overview

The curriculum at KFMR is designed to provide broad exposure to Family Medicine through a series of structured rotations, including core rotations and electives.

The residency comprises 13 block rotations, each lasting four weeks. The core rotations include:

- Behavioral Health - involves acquiring knowledge about human behavior and community mental health resources [3](#).
- Cardiology - residents gain experience in outpatient settings, specifically in interpreting EKGs and managing conditions like heart failure [3](#).
- Community Medicine - focuses on providing care to the uninsured/underinsured in free community clinics [3](#).
- Dermatology, ENT, Geriatrics, Gynecology, and more, ensuring diversity in training and patient exposure.

Inpatient Rotations

First-year residents spend significant time on inpatient rotations, including Adult Medicine, Pediatrics, and Obstetrics. This provides hands-on experience in managing acute and complex cases under the supervision of seasoned professionals [4](#).

Training Sites

KFMR provides training in various settings including outpatient clinics, the Kadlec Regional Medical Center, and local private practices. The program's unopposed structure allows residents full access to mentorship throughout the hospital, ensuring comprehensive training [6](#).

Visa Support

Currently, KFMR does not sponsor visas for international medical graduates (IMGs). Applicants should be advised that eligibility for the program requires the completion of requisite US clinical experiences within specified timeframes. The program accepts applications primarily through the Electronic Residency Application Service (ERAS) [7](#).

Upcoming Agenda Items

- November 9 workshop – final
 - Follow up on items from October 12 workshop if needed
 - Crosswalk of comments
 - Finalize draft language – will request to initiate CR-102 at the Commission's November 20 Business meeting



Next Steps

- Additional workshops
 - 8th workshop – November 9, 2026 @ 1:30 pm – [Register Here](#)

Written comments may be posted to this rule's page:
[Chapter 246-919 WAC, Allopathic Physicians | Washington Medical Commission](#)
or emailed to: medical.rules@wmc.wa.gov

