Applicant Report Cover Sheet and Outline
Washington State Department of Health Sunrise Review

COVER SHEET

Legislative proposal being reviewed under the sunrise process (include bill number if available):

HB 1573- This legislation, as drafted, would include school districts in the description of "political subdivisions", and specifically identified the "Washington Interscholastic Activities Association" in the entities not allowed to discriminate in 18.25 RCW. The proposed legislation would also allow doctors of chiropractic to perform sports physicals for school athletes and physicals examinations for commercial truck drivers.

The bill did not move from the House Health Care Committee therefore no amendments were able to be proposed however; we propose the following changes to the initial bill draft:

1. Remove reference to the Washington Interscholastic Activities Association (WIAA); and
2. Apply the proposed legislation to all youth sports; and
3. Propose additional training requirements for those doctors of chiropractic who would be eligible to perform pre-participation physical examinations; and
4. Require Federal Motor Carrier training for doctors of chiropractic performing the physical examinations that would meet the criteria of the Federal Motor Carrier Safety Act.

Name and title of profession the applicant seeks to credential/institute change in scope of practice:

Chiropractic

Applicant's organization:

Washington State Chiropractic Association

Contact person:

Lori Grassi
Executive Director
21400 International Boulevard, Suite 207
SeaTac, WA 98198
LGrassi@chirohealth.org
206-878-6055 (office)
253-988-0500 (cell)

Number of members in the organization:

800

Approximate number of individuals practicing in Washington:

1500-1600

Name(s) and address(es) of national organization(s) with which the state organization is affiliated:

None

Name(s) of other state organizations representing the profession:

None

Outline of Factors to be Addressed

Supporting Documentation Attachments:

Attachment A: Draft bill language

Attachment B: Syllabus for Pre Participation Exam Course

Attachment C: Diplomate of the American Chiropractic Board of Sports

Physicians Candidates Guide

Attachment D: Scope from Other States 2008

Attachment E: Congress of Chiropractic State Associations state by state allowance of PPE, 2013

Attachment F: CCE Standards for Doctor of Chiropractic Programs and Requirements for Institutional Status

Attachment G: Guidance for the Core Curriculum Specifications, Federal Motor Carrier Safety Act, US Department of Transportation

Attachment H: Complete Guide to Medical Examiner Certification

(1) Define the problem and why regulation is necessary:

Regulation is necessary to assure standards of care are met in the performance of physical examinations (PPE) as well as to meet Department of Transportation (DOT) requirements. Regulation assures that a minimum level of competency is obtained by all providers performing these examinations.

The problem identified by the Washington State Chiropractic Association (WSCA) is the arbitrary selection of which health care providers are identified to perform these examinations. Specifically, Doctors of Chiropractic are excluded from the privilege of performing athletic pre-participation examinations (PPE) and Department of Transportation (DOT) examinations in Washington State.

The regulation of DOT professional driver physical examinations are regulated nationally through the Federal Motor Carrier Safety Act (1992). The DOT classifies doctors of chiropractic as health care

providers permitted to perform DOT examinations. The Federal government requires all health care providers, regardless of their terminal degree, to be certified and tested through the National Registry of Certified Medical Examiners and provides the necessary training. The WSCA requests that the federal DOT rules and regulations also be applied in the State of Washington.
Taken from the Federal Motor Carrier Safety Act, Department of Transportation website, frequently asked questions document:

Q: *Who can serve as a Medical Examiner and perform DOT Physical Exams?*

A: Federal Motor Carrier Safety Regulations define Medical Examiner as a person who is licensed, certified and/or registered in accordance with applicable State laws and regulations to perform physical examinations. The term includes but is not limited to doctors of medicine, doctors of osteopathy, physician assistants, advanced practice nurses and doctors of chiropractic.

There are no federal guidelines regarding PPE examinations. States decide on an individual basis who may provide a PPE. Almost half of the states authorize doctors of chiropractic to perform PPE, one State (Colorado) provides for additional certification for interested doctors of chiropractic to become listed on a registry to perform the PPE. Attachments D and E reference application of PPE's in other states.

The WSCA seeks consistency in the scopes of practice in Washington State as compared to others including the Federal Government and States which provide for doctors of chiropractic to perform PPEs.

There is significant demand by the public for these services. The restrictions prohibiting interested chiropractic doctors from providing the care to their patients in a cost effective manner creates delays in health care services and additional expenses for patients because of the shortage of primary care physicians. Additionally, patients have existing and established relationships with their chiropractic doctors. These patient health care provider relationships should not be unnecessary limited in regards to providing cost efficiencies, timeliness and continuity of appropriate health care services.

(a) The nature of the potential harm to the public if the health profession is not regulated, and the extent to which there is a threat to public health and safety.
There is minimal to no additional risk to the public because doctors of chiropractic are regulated by the State of Washington under RCW 18.25.005 and these clinicians provide an important role in health care in the State of Washington. The current regulatory scope of practice does not reflect recent advances in the education of the chiropractic profession including specialty and recent trends in voluntary training to demonstrate additional competencies. This proposal recognizes doctors of chiropractic with specialty training or additional voluntary training specific to these areas of practice provide an important quality assurance measure. This proposal will protect public health and safety through education and training.

(b) The extent to which consumers need and will benefit from a method of regulation identifying competent practitioners, indicating typical employers, if any, of practitioners in the health profession.
Consumers will benefit by greater access to qualified health care providers with specialized training in the pre-participation examination and federal recognition to perform DOT examinations.

Special certification in the PPE is unique to the chiropractic profession as this group of health care providers meets inclusion through voluntary processes to ensure clinical competencies. The WSCA recognizes the variability of clinical expertise on all health care provider groups. To protect the

citizens of Washington the WSCA promotes additional training and measurements of competency for those doctors of chiropractic who are interested in providing additional services to their patients. The voluntary participation and identification of doctors of chiropractic with special training, as recognized by state or federal regulatory bodies, provides for a measure of quality assurance to consumers that meets or exceeds other health care provider groups.

(c) The extent of autonomy a practitioner has, as indicated by: (i) The extent to which the health profession calls for independent judgment and the extent of skill or experience required in making the independent judgment; and (ii) The extent to which practitioners are supervised:
Proposed updates to the scope of practice will benefit the public by proving a mechanism whereby the public can be assured that participating licensed doctors of chiropractic who provide DOT or/and PPE examinations meet and maintain additional training in regards to the new services they provide. This proposal defines the level of education required to maintain such training.

(2) The efforts made to address the problem: (a) Voluntary efforts, if any, by members of the health profession to: (i) Establish a code of ethics; or (ii) Help resolve disputes between health practitioners and consumers; and (b) Recourse to and the extent of use of applicable law and whether it could be strengthened to control the problem:
The proposed changes to scope of practice would clarify current law under RCW 18.25.005 by further defining a subset of doctors of chiropractic specially trained in sports medicine, the performance of a PPE and DOT regulations.

Current law allows for doctors of chiropractic to perform a physical examination, however the PPE is not specifically addressed. The ability to perform the PPE which results in the clearance of athletes to participate in organized sport should be within the scope of practice for trained health care providers including doctors of chiropractic. Due to growth in the profession, there are groups of doctors of chiropractic with special training in certain fields of health care. These fields of specialty training include sports medicine and the performance of DOT examinations. This proposal provides for special acknowledgement in the practice act to define these specially trained doctors of chiropractic.

There are no proposed changes to current law that would affect the current code of ethics of the profession nor changes to RCW 18.130 (Regulation of health professions — uniform disciplinary act).

(3) The alternatives considered: (a) Voluntary efforts, if any, by members of the health profession to: (a) Regulation of business employers or practitioners rather than employee practitioners; (b) Regulation of the program or service rather than the individual practitioners; (c) Registration of all practitioners; (d) Certification of all practitioners; (e) Other alternatives; (f) Why the use of the alternatives specified in this subsection would not be adequate to protect the public interest; and (g) Why licensing would serve to protect the public interest.

Updating RCW 18.25.005 to the standards as proposed in (Attachment A) would serve the public interest by allowing specially trained doctors of chiropractic to perform services in high public demand. Additionally, this proposal serves as a quality assurance measure by identifying a subgroup of the profession with special training and providing a portal for consumers to access a list of providers that hold State or Federal recognition to provide needed services.

There are no provisions in the proposed standards for services to be performed by anyone other than individuals licensed in RCW 18.25.005. A certification requirement by endorsement to the chiropractor's license is the most effective way to manage the training and certification requirements have been met and that those performing these examinations are safe. Due to the autonomous nature of chiropractic practice endorsement by the Chiropractic Quality Assurance Commission is the most appropriate methodology.

(4) The benefit to the public if regulation is granted. Consumers will benefit from the updated standards now being proposed as these standards will allow the practitioner with special training to provide a broader range of services within the current regulating guidelines for doctors of chiropractic.

Primary care medicine is an underserved need in health care. PPEs and DOT examinations have traditionally been performed by primary care health care providers. Allowing for additional providers with special training to provide PPE/DOT examinations, consumers will benefit from greater access to care as well as the right to seek care from the health care providers they choose.
The public will be assured of quality of care by the educational endorsement requirements described in this statute.

Currently the statute does not reflect the growth of the profession or allow for interested practitioners to fully utilize their specialized post-graduate training for the health and enrichment of the public.

Consumers seeking fitness for duty examinations by qualified Medical Examiners, as defined in the Federal Motor Carrier Safety Act, will benefit by having greater access to providers especially in rural areas of Washington State. Currently there are only 24 total providers listed in the National Registry available to perform Department of Transportation examinations for commercial drivers.

(4)(a)The extent to which the incidence of specific problems present in the unregulated health profession can reasonably be expected to be reduced by regulation;

This proposal addresses only regulated health care providers. The educational and knowledge assessment procedures are designed to mitigate known concerns. Therefore, in order for doctors of chiropractic to be allowed to perform these examinations the scope of practice must be specifically defined.

(4)(b) Whether the public can identify qualified practitioners.
The Department of Health (DOH) has an easily navigable and searchable Web-site that lists all practitioners by name and license number so the public can identify qualified doctors of chiropractic. All information regarding a chiropractor's current licensing status or issues involving licensure is clearly marked and for public record. This proposal requests that the DOH Chiropractic Quality Assurance Commission add a section to this web site that clearly identifies doctors of chiropractic with specialty training in the PPE or that the Chiropractic Quality Assurance Commission maintain a list of doctors of chiropractic who have received the endorsement following certification and testing. As an additional resource the Washington State Chiropractic Association is able to maintain a list of providers available to consumers and the designation can be identified on its website when searching for chiropractic services.

The doctors of chiropractic engaged in the Federal Motor Carrier Safety fit for duty examinations will be identified through the National Registry of Certified Medical Examiners (National Registry) is a new Federal Motor Carrier Safety Administration (FMCSA) program. It requires all medical examiners (MEs) who wish to perform physical examinations for interstate commercial motor vehicle (CMV)

drivers to be trained and certified in FMCSA physical qualification standards. Medical examiners who have completed the training and successfully passed the test are included in an online directory on the National Registry website.

(4)(c) The extent to which the public can be confident that qualified practitioners are competent.

Based on the testimony of comments provided at the February 21, 2013, hearing in the House Health Care Committee for the proposed legislation, it is clear that the general public, especially our opposition, is unaware of the base chiropractic education.

By statute, a chiropractic doctor must graduate from a Council on Chiropractic Education (CCE) accredited college or university. CCE accredited institutions require the doctor of chiropractic programs to include training in physical diagnosis through an absolute minimum of 4,200 instructional hours, and include curriculum in the following topics: anatomy; biochemistry; physiology; microbiology, pathology; public health; physical, clinical and laboratory diagnosis; gynecology; obstetrics; pediatrics; geriatrics; dermatology; otolaryngology; diagnostic imaging procedures; psychology; nutrition/dietetics; biomechanics; orthopedics; neurology; first aid and emergency procedures; spinal analysis; principles and practice of chiropractic; clinical decision making; adjustive techniques; research methods and procedures; and professional practice ethics.

The accreditation requirements for CCE can be found in the document titled "Council on Chiropractic Education Standards for Doctor of Chiropractic Programs and Requirements for Institutional Status" A detailed outline of the curriculum pertaining to the physical examination requirements are detailed in attachment F, pages 31-34.

In addition, examinations for license to practice chiropractic shall be developed and administered, or approved, or both, by the commission according to the method deemed by it to be the most practicable and expeditious to test the applicant's qualifications. The commission may approve an examination prepared or administered by a private testing agency or association of licensing authorities. In Washington State the Chiropractic Quality Assurance Commission uses the national examination for chiropractic which is approved by the Council on Chiropractic Education (CCE) and the examination for licensing is administered by National Board of Chiropractic Examiners (NBCE). Examination subjects may include the following: Anatomy, physiology, spinal anatomy, microbiology-public health, general diagnosis, neuromusculoskeletal diagnosis, X-ray, principles of chiropractic and adjusting, as taught by chiropractic schools and colleges, and any other subject areas consistent with chapter 18.25 RCW. The commission shall set the standards for passing the examination. The commission may enact additional requirements for testing administered by the national board of chiropractic examiners.

All examinations are managed by NBCE including Parts 1- IV which includes the following:

Part I

Includes subject examinations in each of six basic science areas: general anatomy, spinal anatomy, physiology, chemistry, pathology, and microbiology. Each subject examination contains 110 standard multiple-choice questions and is allotted 90 minutes of testing time.

Part II

Consists of 110 multiple-choice questions in each of six clinical science areas, including general diagnosis, neuromusculoskeletal diagnosis, diagnostic imaging, principles of chiropractic, chiropractic practice, and associated clinical sciences. Each Part II subject is allotted 90 minutes of testing time, with a 20-minute break between subjects.

Part III

Addresses nine clinical areas: case history, physical examination, neuromusculoskeletal examination, diagnostic imaging, clinical laboratory and special studies, diagnosis or clinical impression, chiropractic techniques, supportive interventions, and case management. The Part III Examination consists of two books, with a total of 110 standard multiple-choice questions and 10 case vignettes, broken down as follows:

- Each book has 55 standard multiple-choice questions, plus five case vignettes
- Each of the five case vignettes contains three extended multiple-choice questions
- Each extended multiple-choice question requires three answers

Each book is allotted two hours of testing time.

Part IV

The NBCE Part IV Examination tests individuals in three major areas:

- x-ray interpretation and diagnosis
- chiropractic technique
- case management

Results of the Part IV Examination may be used by state licensing authorities in lieu of other practical examinations for licensure. The NBCE Part IV Examination is administered in May and November of each year.

In Washington State the CQAC began using Part IV in May of 1999 to replace their x-ray practical examination but still required the Washington State generated chiropractic practical exam. In 2000, Washington State began requiring Part IV for licensure without further state generated practical tests. Presently, Part IV is accepted in all licensing jurisdictions in the United States except for Illinois, which has no requirement for a practical licensure examination.

(4)(c)(i)Whether the proposed regulatory entity would be a board composed of members of the profession and public members, or a state agency, or both, and, if appropriate, their respective responsibilities in administering the system of registration, certification, or licensure, including the composition of the board and the number of public members, if any; the powers and duties of the board or state agency regarding examinations and for cause revocation, suspension, and nonrenewal of registrations, certificates, or licenses; the promulgation of rules and canons of ethics; the conduct of inspections; the receipt of complaints and disciplinary action taken against practitioners; and how fees would be levied and collected to cover the expenses of administering and operating the regulatory system.

The regulatory entity for the chiropractic profession in Washington State is in place and there are no additional boards needed if this proposal is implemented. The current Chiropractic Quality Assurance Commission is already established and receives complaints and manages disciplinary action on all chiropractic matters.

(4)(c)(ii) If there is a grandfather clause, whether such practitioners will be required to meet the prerequisite qualifications established by the regulatory entity at a later date.
No grandfather clause is proposed for the PPE, all doctors participating would be required to meet the PPE examination.

The DOT provides for the measurement of competency in regards to the DOT examination. Individuals meeting the federal requirements should be permitted to provide the DOT physical examination service.

(4)(c)(iii) The nature of the standards proposed for registration, certification, or licensure as compared with the standards of other jurisdictions.
Currently more than 15 states have special regulations regarding the PPE in their chiropractic practice acts. One state, Colorado, currently requires special certification as proposed in this document. A summary of these regulations is enclosed in appendix E.

The Federal government requires all health care providers, regardless of their terminal degree, to be certified and tested through the National Registry of Certified Medical Examiners and provides the necessary training. The WSCA requests that the federal DOT rules and regulations also be applied in the State of Washington. The Guidance for the Core Curriculum Specifications is provided as Attachment G, and the Complete Guide to Medical Examiner Certification is provided as Attachment H. All providers must achieve certification to qualify as a DOT Medical Examiner.

(4)(c)(iv) Whether the regulatory entity would be authorized to enter into reciprocity agreements with other jurisdictions.
This is not applicable to a profession regulated under the Secretary of Health.

(4)(c)(v) The nature and duration of any training including, but not limited to, whether the training includes a substantial amount of supervised field experience; whether training programs exist in this state; if there will be an experience requirement; whether the experience must be acquired under a registered, certificated, or licensed practitioner; whether there are alternative routes of entry or methods of meeting the prerequisite qualifications; whether all applicants will be required to pass an examination; and, if an examination is required, by whom it will be developed and how the costs of development will be met.

The educational coursework and competency testing would be offered at least once annually. There are two tracks available to Doctors of Chiropractic to become registered to perform the PPE:

1. A 18 hour course that prepares the Doctor of Chiropractic to perform the pre-participation examination and make clearance decisions to participate in sport. The course syllabus is attached in Appendix B. The preparatory PPE course is a 12 hour didactic course that delivers specific PPE education through either live or distance based education accompanied

by a minimum of six additional hours of practical education. The education syllabus would be approved by the Washington Quality Assurance Commission.

AND

An outcome evaluation that measures the learner's competency would be provided. A minimum passing score of 80% or better on a written/practical examination.

Current board certification by the American Chiropractic Board of Sports Physicians as a Diplomate of the American Chiropractic of Sports Physicians (DACBSP) would be eligible to challenge the PPE written examination because of their prior training and education in regards to this topic. The educational requirements for the DACBSP are attached in Attachment C.

No additional supervised field experience is required as part of this training program.

All doctors would be required to demonstrate certification in CPR. CPR training will be obtained outside the PPE course and minimally meet the CPR and AED for the professional rescuer.

To ensure continued competence and knowledge of best practices in performing PPEs, all participating doctors will need to recertify every two (2) years through additional training coursework consisting of four hours followed by an additional competency evaluation. The recertification examination will focus on core learning objectives as well as new information regarding PPEs. Learner outcome examinations will be considered successful with an 80% examination score. The recertified doctor's names would then be updated on the PPE DC Registry.

All course content and examinations would be created by Doctors of Chiropractic holding the highest board certification in sports medicine (Diplomate of the American Chiropractic Board of Sports Physicians) and the clinical expertise in the area of the PPE.

Training and examination development costs would be paid for the Washington State Chiropractic Association.

There are existing training programs for the National Registry of Certified Medical Examiners to provide the prerequisite education. The DOT provides for the examination and maintenance of the DOT related recognition.

(4)(c)(vi) What additional training programs are anticipated to be necessary to assure training accessible statewide; the anticipated time required to establish the additional training programs; the types of institutions capable of providing the training; a description of how training programs will meet the needs of the expected work force, including reentry workers, minorities, placebound students, and others.

As described in (4)(c)(v) additional training for the DOT pathway is already in place and for the PPE additional training in the form of live or distance based education would be required. All training courses would be approved by the Washington State Chiropractic Quality Assurance Commission,

be affiliated with CCE approved educational institutions, and instructors would be required to hold an advanced certification in sports medicine (DACBSP required) as well as a minimum of 5 years of experience in the performance and analysis of the PPE. Institutions providing training must include distance based platforms for training in order to reduce educational costs associated with travel.

(4)(d) Assurance of the public that practitioners have maintained their competence.
Assurance of practitioner competence is achieved through the public's ability to freely access licensing and PPE certification information through the Department of Health Web site or by contacting the Department of Health directly. The list of active certificate holders will provide the public with a list of doctors of chiropractic who have been found to be competent in the PPE by written examination within the previous 2 years.

The Federal government requires all health care providers, regardless of their terminal degree, to be certified and tested through the National Registry of Certified Medical Examiners and provides the necessary training.

(4)(d)(i) Whether the registration, certification, or licensure will carry an expiration date.
The current PPE proposal includes an expiration date of 2 years from certification. Renewal will be allowed by challenge examination for those already certified.

The Federal government manages the National Registry of Certified Medical Examiners.

(4)(d)(ii) Whether renewal will be based only upon payment of a fee, or whether renewal will involve reexamination, peer review, or other enforcement.
Renewal will be based on the ability to pass a written examination. A small fee for administration expense related to PPE test and database administration will be required as part of the renewal process.

The Federal government manages the related fees for the National Registry of Certified Medical Examiners.

(5) The extent to which regulation might harm the public.
The regulation will provide quality assurance to the public and reduce risk of harm. The proposed regulations improve quality of care by identifying specially trained providers for a service that is in high demand in the State of Washington. This PPE proposal exceeds requirements of other professions currently providing PPE examinations.

(5)(a) The extent to which regulation will restrict entry into the health profession: (i) Whether the proposed standards are more restrictive than necessary to insure safe and effective performance.
The proposed standards do not restrict entry based on existing or new licensing requirements; there are no proposed changes to existing licensing requirements. The proposed standards are not more restrictive than necessary as they do not require mandatory use of the techniques by practitioners nor application to every patient.

(5)(a)(ii) Whether the proposed legislation requires registered, certificated, or licensed practitioners in other jurisdictions who migrate to this state to qualify in the same manner as state applicants for registration, certification, and licensure when the other jurisdiction has

substantially equivalent requirements for registration, certification, or licensure as those in this state.

Alternative or equivalent certification programs or education requirements are not accepted.

(5)(b) Whether there are similar professions to that of the applicant group which should be included in, or portions of the applicant group which should be excluded from, the proposed legislation.

This regulation is not relevant to any other groups or subgroups.

(6) The maintenance of standards: (a) Whether effective quality assurance standards exist in the health profession, such as legal requirements associated with specific programs that define or enforce standards, or a code of ethics.
The proposed standards do not change the current code of ethics as regulated by the Quality Assurance Commission.

(6)(b) How the proposed legislation will assure quality, (i) The extent to which a code of ethics, if any, will be adopted.
The proposed standards do not change the current code of ethics as regulated by the Quality Assurance Commission.

(6)(b)(ii) The grounds for suspension or revocation of registration, certification, or licensure.
The proposed standards do not change the current code of ethics as regulated by the Quality Assurance Commission.

(7) A description of the group proposed for regulation, including a list of associations, organizations, and other groups representing the practitioners in this state, an estimate of the number of practitioners in each group, and whether the groups represent different levels of practice.

Doctors of chiropractic in the state of Washington, currently number between 1500-1600. There are no different levels of practice within this group.

(8) The expected costs of regulation:
There will be costs associated with this proposal in terms. These include rulemaking costs, website upkeep and certification maintenance costs. The costs related to the proposed regulation would be the obligation of the professionals selecting these endorsements.

We anticipate additional revenue to the state by the purchase of PPE certification and certification renewal costs.

(9) List and describe major functions and procedures performed by members of the profession (refer to titles listed above). Indicate percentage of time typical individual spends performing each function or procedure:
The current scope of practice of doctors of chiropractic is defined in WAC Chapter 246-808. A classification of chiropractic procedures and instruments list is available through the Washington Department of Health: http://www.doh.wa.gov/portals/1/Documents/Pubs/641042.pdf

The use of these procedures is dependent on the practitioner and no valid estimate of procedures across the entire profession is available at this time.

ATTACHMENT

A

H-0828.2

HOUSE BILL 1573

State of Washington 63rd Legislature 2013 Regular Session

By Representatives Harris, Hope, Pettigrew, Green, Walsh, Cody, Moeller, Stonier, and Morrell

Read first time 01/31/13. Referred to Committee on Health Care & Wellness.

AN ACT Relating to clarifying the prohibitions against discriminating against licensed chiropractors; and amending RCW 18.25.0194 and 18.25.0195.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF WASHINGTON:

Sec. 1. RCW 18.25.0194 and 1974 ex.s. c 97 s 3 are each amended to read as follows:

The state and its political subdivisions, <u>including school districts,</u> and all officials, agents, employees, or representatives thereof, are prohibited from in any way discriminating against licensed chiropractors in performing and receiving compensation for services covered by their licenses. <u>Licensed chiropractors must be allowed to perform sports physicals for school athletes and physical examinations required for commercial driver's licenses.</u>

Sec. 2. RCW 18.25.0195 and 1974 ex.s. c 97 s 4 are each amended to read as follows:

Notwithstanding any other provision of law, the state and its political subdivisions, and all officials, agents, employees, or representatives thereof, are prohibited from entering into any

agreement or contract with any individual, group, association, including the Washington interscholastic activities association, or corporation which in any way, directly or indirectly, discriminates against licensed chiropractors in performing and receiving compensation for services covered by their licenses.

--- **END** ---

ATTACHMENT

B

Washington State Chiropractic Course Syllabus

Course Name: **Pre-participation Examination (PPE)**
Hours: **18**

Course Description
This 18 hour course will provide Doctors of Chiropractic with current information concerning performing pre-participation examinations. The course is designed for the general practicing Doctor of Chiropractic. This course contains outcome evaluative measures in the form of a final examination. Participants would be expected to repeat this course every two years.

Course Objectives / Outcomes:

- Understand the proper structure and implementation of a PPE
- Know the standard of care concerning the PPE
- Apply the knowledge of physical examination and history taking to provide for the proper assessment of athlete's eligibility to safely participate in sport.
- Learn the key components of the PPE
- Refine the skills associated with obtaining and evaluating a health history.
- Develop further appreciation of the conditions encountered in the athletic population that involve an individual's ability to safely participate in sport.
- Analyze the history and physical examination to determine clearance to participate in sporting activities.
- Recognize and develop the skills to implement the key components of the cardiovascular examination.
- Analyze heart sounds to determine patient selection for referral or additional studies.
- Evaluate several case studies of athletes and perform synthesis of the case study to determine clearance to participate in sporting activity.

Course Outline:

Hour

1. General information regarding the expected standards of care, including the primary and secondary objectives of the pre-participation examination. The protocol for performing and recording the PPE is described in a step-by-step fashion.
2. Classifications of sports including by contact and by cardiovascular stress are described. Administrative, ethical and legal concerns will be addressed.
3. Review of the formats of the pre-participation examination, to include timing setting and structure. The station based versus 1:1 PPE is described along with the advantages and disadvantages of these formats as well as issues and concerns regarding obtaining and evaluating the patient history for the pre-participation exam. Specific

discussion regards to the care of minors and the recognition of the keys to the participation examination history.

4. Marfan Syndrome characteristic signs and symptoms is discussed as it relates to the PPE and proper referral. The female triad is described along with the formulation of a multiple disciplinary care plan.
5. System Based examinations: Obtaining, reviewing and interpreting vital signs. Discussion on how to manage the deconditioned athlete.
6. The physical examination of the head, neck, skin, peripheral vascular and lymphatic systems.
7. One hour lab on the above topic.
8. The general physical examination.
9. One hour lab on the above topic.
10. The methodology and performance of the musculoskeletal examination is investigated.
11. One hour lab in the above topic.
12. The cardiovascular examination to include pulmonary evaluations and assessment of peripheral pulses.
13. Cardiovascular and pulmonary practical skills workshop.
14. Other disqualifying disorders and conditions are discussed.
15. The importance and methodology determining clearance to participate is provided
16. Examination and case study workshop.

Evaluation Methods: A formal multiple-choice examination is administered at the termination of the course materials. There will be at least three questions for every hour of the class. The learner will also be required listen to evaluate heart and chest sounds and complete multiple case-based studies to determine clearance. The learner must score 75% to receive credit for the course and to be listed on the registry.

ATTACHMENT

C

AMERICAN CHIROPRACTIC BOARD OF SPORTS PHYSICIANS™

DIPLOMATE AMERICAN CHIROPRACTIC BOARD OF SPORTS PHYSICIANS® (DACBSP®)

CANDIDATE HANDBOOK

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INFORMATION AND INSTRUCTIONS

FORMS INCLUDED IN THIS HANDBOOK

AMERICAN CHIROPRACTIC BOARD OF SPORTS PHYSICIANS™
DACBSP® CANDIDATE HANDBOOK

The American Chiropractic Board of Sports Physicians™ (ACBSP™) is a private, non-profit, professional credentialing organization which sponsors both the Certified Chiropractic Sports Physician® (CCSP®) and the Diplomate American Chiropractic Board of Sports Physicians® (DACBSP®) Certification Programs, including the CCSP and the DACBSP Certification Examinations. The purpose and goal of the ACBSP Certification Program is the development, maintenance, evaluation, promotion, and administration of thorough, rigorous, examination-based, professional credentialing programs in the field of chiropractic sports medicine. The ACBSP Certification Program is designed to assess and objectively measure the professional knowledge and competency of chiropractic doctors, physicians, and practitioners engaged in the specialty of chiropractic sports medicine.

In order to become certified as a Certified Chiropractic Sports Physician (CCSP), each candidate must satisfy all educational eligibility requirements established by the ACBSP Board, and must demonstrate an acceptable and appropriate level of understanding and knowledge in all subject areas tested by the CCSP Certification Examination. Any individual seeking Diplomate certification must satisfy all CCSP certification requirements, successfully complete the written and the practical examinations, and fulfill all educational, experiential, and written requirements established by the ACBSP for DACBSP certification. All individuals certified by the ACBSP Certification Program must also demonstrate an ongoing professional commitment to the field of chiropractic sports medicine.

ACBSP Certification Program requirements and eligibility standards are applied fairly, impartially, and consistent with applicable laws. The ACBSP Certification Program will not discriminate against any candidate on the basis of an unlawful reason, and will grant the candidate certification without regard to a candidate's membership or non-membership in any organization, association or other group.

It is the policy of the ACBSP to work affirmatively to ensure that all persons, regardless of race, color, creed, national origin, sex, religion, marital status, age, handicap status or reliance on public assistance, political opinion or affiliation, or military service will be treated fairly and equally in employment or program participation, including certification and recertification.

Eligibility:

1. The applicant must hold the degree of Doctor of Chiropractic from a CCE accredited college.
2. The applicant must be a CCSP in good standing and show evidence of having successfully completed a postgraduate program from a CCE accredited college in a Sports Injury and Physical Fitness curriculum of at least 200 hours. The chiropractic college from which the applicant has completed his/her course of study must certify to the ACBSP that the applicant has satisfactorily completed the appropriate hours of postgraduate instruction.
3. The applicant must possess a license to practice chiropractic and be in good standing with the respective state licensing/registration agency.
4. The candidate must submit an application on a form specified by the ACBSP within the ACBSP's designated deadline (45 days prior to examination).

Fees:

Examination fees will apply as follows:

DACBSP Written:	**First time - $400**	**Retake - $350**
DACBSP Practical:	**First time - $650**	**Retake - $100 per Station**

Examination fees can be paid by money order, cashiers check or personal check made payable to the **ACBSP**; or Visa or MasterCard are accepted. These fees **must** accompany the application form.

Cancellation/Refund Policy:

$50.00 of the examination fee is non-refundable. Without documented medical emergency, no refund will be made unless a written notice of withdrawal is received at least two weeks prior to the exam date. Individuals filing withdrawal notices received 14-28 days prior to the exam will receive a 50% refund.

Application forms and fees from one examination may be carried over or transferred to another examination. Applicants must submit a letter of intent when applying for an examination at a later date.

Name or Address Change:

The ACBSP requests that it be notified promptly in case of a change of name of address.

In the case of name change, examinees must send to the ACBSP office, a copy of the certificate of marriage or court order of name change before ACBSP records can be entered under a new name. Examinees should be sure to use their original name on the application and correspondence, if they have not yet changed their name officially with the ACBSP.

Application Procedures:

An application for all ACBSP examinations is included at the end of this handbook. Candidates may also obtain an application from the ACBSP website at www.acbsp.com or from the ACBSP National Office at:

ACBSP
103 South 6th Street
Estherville, IA 51334-2360
Or by telephone: (712) 362-8860
Or by fax: (712) 362-8609
Or by e-mail: acbsp@myclearwave.net

When submitting an ACBSP examination application, applicants must observe and obey deadlines:

1. *Application Deadline:* The completed, signed application form, exam fee and supporting documents must be received by the ACBSP no later than 45 days prior to the examination date. Applications received after this date WILL NOT BE ACCEPTED UNDER ANY CIRCUMSTANCE.

2. *Cancellation Deadline:* In order to be eligible for a partial refund, written cancellation notice is required no later than 14 days before the test date.
3. *Specific Needs Application Deadline:* Those candidates requiring special accommodations must send a request for such (see form in this handbook) within 90 days prior to the test date.

Applicants are also cautioned to read and follow instructions noted on the application form. Illegible information or improperly completed forms can prevent the processing of an application. *NOTE: Examinee registration requires the submission of properly completed application with appropriate fees. Any improperly completed application, or one without fees, will be returned. The properly completed application must then be resubmitted and postmarked by the application deadline.*

The ACBSP accepts no responsibility for misdirected mail because of illegible address, post office error or failure to promptly notify the ACBSP of address change.

Applicants are encouraged to keep a photocopy of their application for their records in the event that a question may arise.

Approximately 4-5 weeks before the date of the examination administration, the ACBSP's examination service will mail the applicant an admission slip that specifies the test site. This slip, along with a picture ID and a current *professional* level CPR certification card is required for admittance into the testing area. The CPR card must be the original, no photocopies are accepted.

Special Needs Applicants:

The ACBSP will give consideration to applicants requiring special testing arrangements because of a handicap or religious convictions. In order to be eligible, applicants must indicate to the ACBSP that they are requesting special testing arrangements. Applicants must additionally submit an ACBSP Special Needs Application, along with the required substantiating documentation, in accordance with the deadlines. A Special Needs application is included in this manual. The ACBSP reserves the right to review each request and evaluate it on its own individual merits. Additional fees may be assessed to cover necessary special arrangements.

Preparing for the ACBSP Examination:

Candidates for the examination should remember that the purpose of the ACBSP is to conduct certification activities in a manner that upholds standards for competent practice in the health care specialty of chiropractic sports physicians. Postgraduate CCSP and DACBSP programs are the foundation for ACBSP examination preparation. Candidates are encouraged to discuss the rigors of the examination with other certificants, as well as with their course professors and instructors. Individuals are encouraged to take review courses when available. The ACBSP does not conduct or sponsor review courses. Candidates for examination should realize that there are no trick questions or questions in areas that are not specific to the practice of a DACBSP.

Responsibilities to Applicants for Certification or Recertification:

1. The ACBSP complies with all requirements of applicable federal and state laws (e.g. Americans with Disabilities Act of 1990) with respect to all certification and recertification activities and requires compliance of all contractors and/or providers of services for the certification and recertification programs.
2. The ACBSP provides competently proctored written examination sites at least twice annually and at least once annually for the practical examination.
3. The ACBSP shall not accept alternatives to the criteria set forth as required for initial certification. Specifically, the clinical degree and license to practice are essential under the law and cannot be subsumed by any amount of alternative experience. The three hundred (300) hours of study in sports injuries and physical fitness must be completed. To alter this requirement might serve to jeopardize the consumer of quality assured services.
4. The ACBSP, in notification of examination results, provides failing applicants with information on general content areas of deficiency.
5. The ACBSP assures that each applicant's examination results are held confidential. However, the ACBSP will update the public listing of active certificants within three months after each examination so that the consumer may make informed choices about providers according to certification status.
6. The ACBSP publishes, on their website, a current list of those persons certified including their name, certification designation, office address, telephone number and e-mail address. This listing is to assist the public and other certificants in making referrals to certified clinicians and choice of accredited providers. No other information shall be made public.
7. The ACBSP disciplines certificants for conduct deemed harmful to the public or inappropriate to the discipline. Any disciplinary action may be contested through the Ethics or Appeals Procedures.

Written Examination Description:

1. The examination is prepared and scored by an examination service, and administered by the ACBSP.
2. It is written in a multiple choice format, consisting of approximately 250 questions.
3. Please note that only one response should be marked for each item; items that contain two or more marked responses (or no responses) receive no credit.
4. The examination consists of 4 hours of actual testing, with the entire administration taking approximately 5 hours.
5. Individual test questions are selected on an objective, national basis by a test committee composed of the ACBSP, the chiropractic college postgraduate faculty and chiropractic practitioners. Each test question appearing on the examination undergoes extensive review, both before and after the administration.
6. The ACBSP offers two official testing dates per year. The examination may be administered in more than one location simultaneously on those test dates. Determination of test sites is based upon applicant distribution and administrative considerations.
7. Upcoming test dates will be posted on the ACBSP website, www.acbsp.com or are available by contacting the ACBSP Associate Director.
8. The ACBSP reserves the right to relocate and/or cancel an examination administration at one or more test sites for any legitimate reason due to circumstances beyond its control.

Practical Examination Description:

1. The examination is prepared and administered by the ACBSP.
2. The examination has been developed to assess analysis and performance of skills critical to the chiropractic sports physician. The test is designed as an objective structured clinical examination; as such the candidate will rotate through multiple stations. Testing stations will include simulated patients and candidates will assess patients trained to manifest illnesses or injuries common to athletes.
3. The ACBSP offers at least one official testing date per year. Determination of test sites is based upon applicant distribution and administrative considerations.
4. Upcoming test dates will be posted on the ACBSP website, www.acbsp.com or are available by contacting the ACBSP Associate Director.
5. The ACBSP reserves the right to relocate and/or cancel an examination administration at one or more test sites for any legitimate reason due to circumstances beyond its control.

General Exam Administration Regulations and Procedures:

1. The examination will be given on the day and at the time scheduled.
2. Candidates will be assigned a seat.
3. Testing aids and materials are not permitted at the test center. These prohibited materials include, but are not limited to, the following: pens; pagers; beepers; calculators; watch calculators; books; pamphlets; notes; rulers; highlighter pens; stereos or radios with headphones; telephones; cell phones; watch alarms (including those with flashing lights or alarm sounds); stop watches; dictionaries; translators; and any electronic or photographic devices.
4. Candidates may not eat, drink, or use tobacco during testing time.
5. Candidates should dress in such a way that they can adapt to any room temperature.
6. While the test session is in progress or during breaks, candidates may not communicate with anyone other than test center staff concerning the examination.
7. Candidates will not be permitted to leave the test center vicinity during the examination administration session or during breaks.
8. During the test session or during breaks, access to telephones and personal items, such as a cell phone, briefcase, or study materials, will not be permitted.
9. Candidates may not remove, reproduce, and/or disclose test questions or any part of a test by any means (e.g., hard copy, verbally, electronically) to any person or entity.
10. Candidates must report to the test center at least 15 minutes before their scheduled appointment for check-in procedures. If they arrive late, they may not be admitted and their fee will not be refunded.
11. Candidates will be asked to complete a confidentiality statement at the test center. If they do not sign the statement, they cannot sit for the exam, and their fees will NOT be refunded.
12. Other than personal identification, personal items are not allowed in the testing room. Candidates may not have access to any personal items during the test session or during breaks.

13. Test centers do not have large waiting areas. Friends or relative who accompany a candidate to the test center will not be permitted to wait in the test center or be in contact with the candidate while they are taking the test.
14. Exam administration sessions begin at sign-in, end at sign-out, and include breaks. Candidates will be required to sign the test center log before and after the test session and any time they leave or enter the testing room.
15. The test center administrator may provide the candidates with scratch paper that may be replaced as needed during testing. They may not take their own scratch paper to the test, nor may they remove scratch paper from the testing room at any time.
16. If a candidate needs to leave their seat at any time, they must raise their hand and request permission. When granted, the timing of the test will not stop. The candidate must have the administrator's permission to leave the room during the test. Any time lost during an unscheduled break cannot be made up.
17. Repeated unscheduled breaks will be documented and reported to the ACBSP.
18. If at any time during the exam administration a candidate has a problem, or for any reason they need the test center administrator, they must raise their hand.

In rare instances, unanticipated problems may require late starts and/or rescheduling of an examination. The ACBSP is not responsible or liable for any inconvenience, expenses, or other personal damages incurred by examinees because of a late start, rescheduled test, or delay in the reporting of scores.

Termination of Examination Administration/Grounds for Dismissal:

The test center administrator/supervisor or proctor is authorized to dismiss a candidate from an examination administration, and the ACBSP may cancel their scores, or take other appropriate action, where there is a reasonable basis for concluding that the candidate has engaged in any of the following conduct:

1. Using or attempting to use someone else to take the test.
2. Failing to provide acceptable personal identification.
3. Having access to, or using, notes or any prohibited aid related to the test.
4. Creating a disturbance (disruptive behavior in any form will not be tolerated; the test administrator/supervisor has sole discretion in determining whether specific conduct constitutes disruptive behavior).
5. Communicating, in any manner, with another person other than the test administrator/supervisor or proctor, about the test during the administration, including attempting to give or receive assistance.
6. Attempting to remove scratch paper from the testing room.
7. Exceeding time permitted for a scheduled break.
8. Working on any part of the test or marking the answer sheet after time has been called.
9. Eating or drinking in the testing room.
10. Leaving the testing room or test center vicinity without permission.
11. Removing or attempting to remove, examination related materials, or portion of a test in any format from the testing room.
12. Engaging in any dishonest or unethical conduct, such as cheating.
13. Failing to follow any other examination administration regulations: set forth in ACBSP policies; given by the test administrator/supervisor; or specified in any examination materials.

The CCSP and DACBSP Certification Examinations are confidential, and contain copyrighted material. All test materials, including test books and answer documents, are the sole property of the ACBSP and must be returned to the test supervisor after each administration. No portion of such materials may be retained by examinees.

The ACBSP reserves the right to take all action including, but not limited to, barring a candidate from future testing and/or canceling their scores for failure to comply with the test administrator/supervisor's directions. If a candidate's scores are canceled, they will be notified of such action and its basis, and their examination fees will not be refunded.

Although tests are administered under strict supervision and security measures, examination irregularities may sometimes occur. Candidates are required to contact the ACBSP as soon as possible to report any observed behavior that may lead to an invalid score – for example, someone copying from another test taker, taking a test for someone else, having access to test questions before the exam, or using notes or unauthorized aids. All information will be held in confidence.

Cancellation of Scores by the ACBSP:

Test Security Issues. The ACBSP strives to report scores that accurately reflect the performance of every testing candidate. Accordingly, the ACBSP's standards and procedures for administering exams have two primary goals: giving candidates a fair and secure opportunity to demonstrate their abilities; and preventing some candidates from gaining an unfair advantage over others.

To promote these objectives, the ACBSP reserves the right to cancel any examination scores under the following circumstances, as determined by the ACBSP: **(1) examination administration irregularity; (2) discrepancy in candidate personal identification; (3) candidate misconduct; or (4) invalid scores**. Reviews of scores by the ACBSP are confidential.

1. Examination Administration Irregularities. "Examination administration irregularities" refers to problems with the administration of an exam. When examination administration irregularities occur, they may affect an individual or groups of test takers. Such problems include, without limitation, administrative errors (such as improper timing, improper seating, defective materials, and defective equipment); improper access to test content; and other disruptions of exam administrations (including, but not limited to, natural disasters and other emergencies). When examination administration irregularities occur, the ACBSP may decline to score the exam, or may cancel the examination scores. When deemed appropriate, the ACBSP may give affected candidates the opportunity to take the exam again as soon as possible without charge.

2. Personal Identification Discrepancies. When, in the ACBSP's judgment or the judgment of the test center personnel, there is a discrepancy in a candidate's personal identification, the candidate may be dismissed from the test center; in addition, the ACBSP may decline to score the exam, or may cancel the test scores.

3. Candidate Misconduct. When, in the ACBSP's judgment or the judgment of the test center personnel, there is misconduct in connection with an exam or test administration, the candidate may be dismissed from the test center.

Additionally, the ACBSP may decline to score the exam, or may cancel the test scores. Misconduct means a failure to comply with the requirements, procedures, and regulations described in ACBSP policies. Misconduct also includes access to secure test questions prior to the exam administration.

4. Invalid Scores. The ACBSP may also cancel scores if, in its judgment, there is substantial evidence that they are invalid for any reason. Evidence of invalid scores may include, but is not limited to, the following: discrepancies with regard to a candidate's handwriting; unusual answer patterns; and inconsistent performance on different parts of the examination. Before canceling scores pursuant to this paragraph, the ACBSP will: notify the candidate in writing explaining its concerns; provide the candidate with an opportunity to submit information that addresses the concerns explained in such notice; consider any such information submitted by the candidate; and offer the candidate a choice of options. The options may include voluntary score cancellation, a free retest, or arbitration in accordance with ACBSP policies.

Written Examination Grading:

After the administration of the multiple-choice examination, Scantron answer sheets are shipped to the consultant psychometrician for grading. Each examination answer sheet is machine scored. After scoring, a roster of candidate scores for each examination is generated. After the rosters have been generated, a determination of passing and failing scores is made based on the predetermined cut score.

After the scores are generated and verified, each exam form is subject to item analysis procedures. The item analysis program is designed to determine the strength of the test item as it relates to the ability of the test item to discriminate between candidates who know the information and candidates who are deficient. The item analysis program also provides information regarding the performance of individual test items in relation to a candidate's overall performance. An alpha reliability coefficient and the difficulty level of individual items are calculated. If there is an issue surrounding the validity and reliability of the examination form in relation to candidate performance, a standard error of measurement is computed. The rationale for utilizing a standard error of measurement rests on the assumption that a sampling error may occur in the selection of test items from the content areas outlined. If warranted, the standard error of measurement can be utilized to adjust the cut score in either direction.

For those candidates who do not achieve the required cut score, diagnostic score reports will be generated outlining the passing and failing percentage scores in each of the outlined major content areas. All passing candidates will receive a letter indicating their successful achievement on the competency evaluation. Once score reports have been generated and disseminated, aggregate information is assembled into a report summarizing the examination process. All of the information will be reported in aggregate fashion with no breach in confidentiality as it relates to individual candidates and their respective scores.

Written Examination Construction:

All examination materials are copyrighted material of the ACBSP. No reproduction or duplication of these materials is permitted, unless authorized by the ACBSP. All draft materials utilized by examination development committee members are kept secured

in a double locked enclosed area and inventoried regularly. All committee members sign confidentiality agreements when generating and/or reviewing examination materials. Any material considered unusable is shredded prior to disposal.
All duplication of examination materials has been done in a closed environment under secure arrangements. All test documents utilized by exam candidates have unique control numbers. Any examination materials delivered to an examination site by courier service have an inventory list that is signed off prior to delivery and upon opening. Once used and repackaged for courier shipment, the inventory list is completed and initialed again.

All candidates are examined utilizing the same form of the comprehensive written examination. No equivalent forms of the competency evaluation are needed. The ACBSP has established a policy that all examinations will be generated in English. Written translations of the competency evaluation are not available. No adaptations of the evaluation material are utilized at this time. Accommodations for candidates with disabilities are dealt with on an individual basis in accordance with the Americans with Disabilities Act.

Test items utilized in the examination have been keyed to an examination blueprint and validated by the collective judgment of the subject matter experts utilized as item writers, as well as source documents from the sports injury and physical fitness field. All of these activities have been conducted under the direction of a consultant psychometrician subject to standards acceptable to the National Organization of Certification Agencies (USA).

A panel has been utilized outside of the examination development committee to review the work of the committee and to monitor the validation procedures utilized by the committee, the linkages of the test items to the examination blueprint, and associated content specifications. The procedures utilized by the panel minimized content error on the part of the committee and have provided assurances that the committee followed generally accepted principles in item development. Each examination question has undergone this process and the items were entered into an item-banking computerized program, which allows the ACBSP to maintain all of the specifications of the test item relating to its linkage to the examination blueprint, job analysis and content validity.

After a sufficient pool of questions was developed and banked into the software, an assessment was made of the number of test items developed for each content domain to ensure that there was a sufficient pool of items in each major/minor content area. Once satisfied that a sufficient pool of items existed, a form of the examination was generated according to the content specifications. This form was subjected to yet another field reviewed by a selected group of certificants. After signing the appropriate confidentiality forms, the reviewers rated the worthiness of the test and test items according to predetermined criteria. A consultant psychometrician reviewed comments, edits, and recommendations and made necessary changes.

A cut-score committee was assembled to establish the passing point of the examinations. The committee members selected were screened for their qualifications in the field of sports injuries and physical fitness. The members selected did not include any certificants involved in the item development process. The cut-score procedure utilized was a modified Angoff procedure for determining the various passing points on the written exam. Each member of the committee rated each criterion that will be used in the grading of the examinations and a

running mean score was calculated. When completed, the cut score for each of the examinations was determined, including the variance, standard deviation and the standard error of measurement. Each member of the multiple-choice exam Angoff cut-score committee was responsible for determining the passing point as it related to the minimally competent candidate. Prior to their initial rating, committee members were trained on cut-score methodology and provided a worksheet outlining the process with space on the worksheet to be used in describing the minimally competent candidate.

Practical Examination Grading:

Grading of this examination is determined by the number of accurate responses on checklists designed for each station.

Some or all stations may be videotaped. Videotaped stations will be reviewed by independent examiners if a failed station is challenged. The candidate must request this review in writing to the ACBSP, within 30 days of grade receipt. Regrading fees are noted below under Hand Grading. Candidates will be notified in writing of results within 10 weeks of the receipt of such request.

Candidates must pass all stations to successfully complete this examination. Grades will be given as pass/fail. Failing grades will list stations failed. Candidates failing 1-6 stations must repeat these specific stations at the next practical examination.

Reporting of Scores:

1. A passing grade shall be determined by appropriate psychometric standard deviation.
2. Exam results will be mailed directly to all candidates approximately 8-10 weeks after the administration of the examination. Scores will NOT be reported over the telephone. Telephone calls requesting score information or special handling only delay processing.
3. After successfully completing the written and practical examinations, the practical field experience requirement and fulfilling the written requirement, a certificate will be issued in approximately 4-6 weeks.

Rewriting Failed Examination:

1. Failed candidates are eligible to sit for a re-examination at a subsequent test by reapplying.
2. The examination may be taken a maximum of 3 times before additional educational hours are required. At that time, the additional educational hours of postgraduate study in sports injury must be taken and proof of such hours must be submitted to the ACBSP in writing from an accredited chiropractic college. Such educational hours should be in those areas determined as deficient on the failing doctor's previous examination(s).
3. Candidates must successfully complete the written and practical examinations 3 years from the date of completion of the DACBSP program.

Hand Grading:

The ACBSP, in conjunction with their professional examination service, conducts extensive post examination analyses to ensure that reported scores are accurate. Included in these analyses is a comparison of the scores obtained in samples of

answer sheets that have been both mechanically scored and scored by hand. Also, all unsuccessful written examination scores found to be at or near the cut score are hand scored. Thus, it is extremely doubtful that any examination score will be changed from "fail" to "pass" if rescored manually. For this reason, the ACBSP does not encourage examinees to request hand grading for verification of their scores. However, in the event that an applicant feels that an error in scoring may have occurred, the ACBSP will honor a request for hand grading. Such a request must be submitted in writing and because there are expenses involved with regrading a written or practical examination (and is the responsibility of the doctor requesting the regrading) must be accompanied by the currently applicable fee. **Requests for hand grading must be postmarked within 30 days after scores are released to examinees.** This written request should be sent by certified mail to the ACBSP office. The written request for review must contain the following information:

a) Identity and signature of the candidate submitting the request.
b) Reason the request is being made.
c) The specific examination(s) the evaluation is to address.
d) Those requesting review of a practical examination should indicate which station(s) they wish to have regraded.

Within forty-five (45) days of the receipt of a complete, properly written appeal and the proper fees, the candidate will be notified in writing of the results of their regrading, regardless of the outcome. The fees for regrading are as follows:

Written Examination (DACBSP® or CCSP®):	$50.00
Practical Examination (DACBSP®):	$50.00 per station reviewed

Appeals Procedures:

CCSP or DACBSP certificants and candidates seeking certification or recertification agree that: these procedures are a fair process for resolving certification complaint or appeal matters; they will be bound by decisions made pursuant to these procedures; these procedures are governed by the principles of the law of the State of Iowa; and, these procedures do not constitute a contract between the ACBSP Certification Program and the candidate or certificant.

General Provisions

1. Nature of the Process. The ACBSP Certification Program is directed, administered, and supervised by the ACBSP Board of Directors. All challenges regarding actions of and by the ACBSP Certification Program are governed by the comprehensive and exclusive rules contained in these procedures. This appeal process is the only way to resolve all ACBSP application, eligibility, examination, and other certification or recertification challenges, complaints and/or claims of irregularities.

   Because these informal procedures are not legal proceedings, they are designed to operate without the assistance of attorneys. While a party may choose to be represented by an attorney, candidates and certificants are encouraged to communicate directly with the ACBSP Certification Program. If a party has retained an attorney, that lawyer will be directed to communicate with the ACBSP Certification Program through the ACBSP Legal Counsel.

2. Participants. The ACBSP Board Secretary, the Certification Appeals Committee, the ACBSP Board of Directors, and any other authorized representative of the ACBSP Certification Program may be involved in deciding matters to be resolved or arising under these procedures.

3. Time Requirements. The ACBSP Certification Program will make every effort to follow the time requirements noted in these appeal procedures. However, the ACBSP Certification Program's failure to meet a time requirement will not prohibit the handling or final resolution of any matter arising under these procedures. ACBSP candidates or certificants are required to comply with all time requirements specified in this document. Unless provided otherwise, time extensions or postponements may be granted by the ACBSP Certification Program if a timely, written request explaining a reasonable cause is submitted.

4. Litigation/Other Proceedings. The ACBSP Certification Program may accept and resolve a dispute arising under these proceedings when civil or criminal litigation, or other proceedings related to the dispute, are also before a court, regulatory agency, or professional body. The ACBSP Certification Program may also continue or delay the resolution of any appeal, complaint, or other matter.

5. Confidentiality. In order to protect the privacy of all parties involved in matters arising under these procedures, all material prepared by, or submitted to, the ACBSP Certification Program will be confidential. Disclosure of material prepared by, or submitted to, the ACBSP Certification Program is permitted only when specifically authorized by ACBSP Certification Program policy, the Board of Directors, the Certification Appeals Committee, or the Board Secretary. In addition, the identity of the members of the Certification Appeals Committee will remain confidential and will not be released without the specific authorization of each member.

   Among other information, the ACBSP Certification Program will not consider the following materials and documents to be confidential:

   a. Published certification and eligibility criteria;
   b. Records and materials which are disclosed as the result of a legal requirement;
   c. Upon the written request of a candidate or certificant, any certification information concerning certification status or application materials which the candidate or certificant would like made available to other credentialing agencies, professional organizations, or similar bodies; and,
   d. All final published decisions and orders of the Board of Directors, the Certification Appeals Committee, or the Board Secretary.

6. Failure to Disclose/Improper, False, or Misleading Representations. The ACBSP Board Secretary, at the direction of the Board of Directors, may temporarily or permanently prevent and bar an individual from being certified or recertified, or may issue any other appropriate directive(s), where an ACBSP candidate or certificant fails to disclose information related to certification or recertification requested by the ACBSP Certification Program, or where the candidate or certificant makes an improper, false or misleading representation to the ACBSP Certification Program.

Where a penalty, discipline, order, or other directive is issued by the ACBSP Certification Program under this Section, the candidate or certificant involved may seek review and appeal under these procedures.

7. Failure to Cooperate. Where a candidate or certificant fails or refuses to cooperate fully with the ACBSP Certification Program concerning matters arising under, or related to, these procedures, and it is determined that the lack of cooperation is without good cause, the Board of Directors, or other authorized representative, may penalize or discipline the individual. Among other penalties or disciplines, the Board may temporarily or permanently prevent and bar an individual from being certified or recertified, or may issue any other appropriate directive(s).

   Where a penalty, discipline, order, or other directive is issued by the ACBSP Certification Program under this Section, the candidate or certificant involved may seek review and appeal under these procedures.

8. Following notice, and a reasonable opportunity to present a response to the Board of Directors, the ACBSP Board Secretary, at the direction of the Board of Directors, may temporarily or permanently prevent an individual from being certified or recertified, including the termination, suspension, or revocation of ACBSP certification, or may issue any other appropriate directive(s), where the candidate or certificant was the subject of any complaint or similar matter relating to his/her professional activities as a chiropractic practitioner, or where the candidate or certificant is the subject of matters or proceedings involving criminal charges, lesser offenses, or similar matters regardless of: when the alleged violation occurred; and, whether the professional license of the candidate or certificant was in good standing at the time of the ACBSP decision or action. Where a penalty, discipline, order, or other directive is issued by the ACBSP Certification Program under this Section, the candidate or certificant involved may seek review and appeal under these procedures.

<u>Certification Program Actions and Decisions Concerning the Certification Process</u>

1. Certification Application Actions. Under the supervision of the Board Secretary or other authorized representative, the ACBSP Certification Program will make one of the following determinations and decisions with regard to a candidate's application for the ACBSP certification and examination eligibility: (a) accept the application; (b) request additional or supplemental information; or, (c) reject the application on the ground(s) that the candidate does not meet the necessary and specific certification eligibility requirements, or the candidate has violated, or acted contrary to, an ACBSP Certification Program policy or rule.

2. Certification Examination(s) Actions. The ACBSP Certification Program will notify each candidate whether he/she has achieved a passing or failing score on the CCSP or the DACBSP Certification Examination. Where a candidate acts contrary to ACBSP policies during the administration of the CCSP or the DACBSP Certification Examination(s), the candidate may be prevented from taking or completing the Examination(s).

3. Recertification Application Actions. The ACBSP Certification Program will make one of the following decisions with regard to a certificant's

Recertification Application: (a) grant recertification; (b) conditionally accept the Recertification Application, pending satisfactory completion of all Certification Program requirements; (c) request additional information; or, (d) reject the application on the ground(s) that the certificant does not meet the necessary criteria for recertification, or the certificant has violated, or acted contrary to, an ACBSP Certification Program policy or rule.

Circumstances for Review or Appeal of an Adverse Certification Program Decision

1. Appeal Limitations. A candidate or certificant may submit an appeal of an adverse ACBSP Certification Program action, decision, or determination under the following circumstances where certification or recertification has been denied:
   a. The candidate was found to be ineligible to take or complete the CCSP or the DACBSP Certification Examination(s);
   b. The candidate did not pass and successfully complete the CCSP or the DACBSP Certification Examination(s); or,
   c. The candidate or certificant failed to satisfy a CCSP or DACBSP certification or recertification requirement, including those requirements related to qualifications, education, and experience, or was otherwise ineligible for certification or recertification.

Initial Request for Review/Content and Time Period for Submitting a Request for Review to the ACBSP Board Secretary

A candidate or certificant may submit a written request for review of an adverse action or decision **within thirty (30) days** of the date of the action by notifying the Board Secretary in writing and stating with particularity the nature of the request and the specific facts and circumstances supporting the request, including all reasons why the action or decision should be changed or modified. The candidate or certificant must also provide accurate copies of all supporting documents. A request for review may be in letter or other clear written form, must identify the candidate or certificant, and must state that the document is a Request for Review by the Board Secretary.

Informal Review by the ACBSP Board Secretary

1. Board Secretary Actions. Upon receipt, and in the first instance, all requests for review will be considered informally by the ACBSP Board Secretary or other authorized ACBSP representative. Following review of the candidate's or certificant's appeal and request for review, the Board Secretary will acknowledge receipt of the request within thirty (30) days and may take one of the following actions:

   a. Uphold or modify the adverse action or decision, or take other appropriate action, in writing with the approval of the Board of Directors; or,
   b. Refer the matter to the Certification Appeals Committee for review and resolution as an appeal.

2. Referral of Request/First Appeal. In the event that a request for review is referred to the Certification Appeals Committee for resolution, the Board Secretary will provide the Certification Appeals Committee with all relevant materials, including the documents and materials submitted by the candidate or certificant.

First Appeal/Certification Appeals Committee

1. Circumstances and Limitations of First Appeal. Subject to the limitations below, in the following circumstances a first appeal will be heard and resolved by the Certification Appeals Committee where: the matter has been referred by the Board Secretary; or, a candidate or certificant is dissatisfied with the final informal review and action of the Board Secretary, and requests an appeal consistent with these procedures.

   Only the following actions and decisions of the Board Secretary may be appealed by the candidate or certificant:

   a. The candidate was found to be ineligible to sit for the CCSP or the DACBSP Certification Examination(s);
   b. The candidate was barred or otherwise prohibited from taking or completing the CCSP or the DACBSP Certification Examination(s);
   c. The candidate's CCSP or the DACBSP Certification Examination(s) was re-scored and he/she has failed to pass the examination(s);
   d. The candidate was found to be ineligible for certification due to his/her failure to satisfy a certification requirement, including those requirements related to qualifications, education, and experience, or was otherwise ineligible for certification; or,
   e. The certificant was denied recertification based upon his/her Recertification Application or failure to satisfy one or more recertification requirements, or was otherwise ineligible for recertification.

Time Period for Submitting First Appeal

A candidate or certificant seeking to present a first appeal to the Certification Appeals Committee must submit a written appeal consistent with the requirements of these procedures to the ACBSP Certification Program within thirty (30) days of the date of the final action and decision of the Board Secretary. The time for filing the appeal may be enlarged by the Certification Appeals Committee upon written request by the candidate or certificant received at least fifteen (15) days prior to the appeal deadline.

Contents Of and Grounds for First Appeal

1. Required Information For First Appeal. In order for an appeal to be considered by the Certification Appeals Committee, the appeal submission must contain the following information:

   a. The identity and signature of the individual candidate or certificant submitting the appeal;
   b. All objections, corrections, and factual information the candidate or certificant believes to be relevant to the appeal;
   c. The names, addresses, and telephone numbers of any persons with factual information relevant to the appeal, and a clear description of the factual information available from these persons; and,
   d. Copies of any and all relevant documents, exhibits, or other information the candidate or certificant wants to submit in support of the appeal.

2. Grounds for First Appeal. In order for an appeal to be considered by the Certification Appeals Committee, the appeal submission must contain

substantial information supporting at least one of the following grounds, and a detailed explanation of the reasons for the appeal:

a. The candidate's eligibility to sit for the CCSP or the DACBSP Certification Examination(s), or other eligibility for certification, was denied incorrectly;
b. The candidate's CCSP or DACBSP Certification Examination(s) was scored incorrectly, or was not credited with an appropriate response to particular questions, and as a direct result of the incorrect scoring the candidate is entitled to receive a passing score on the examination(s);
c. The candidate was barred or otherwise prohibited incorrectly from taking the CCSP or the DACBSP Certification Examination(s); or,
d. The certificant's Recertification Application was incorrectly rejected under the relevant recertification standards, and the certificant would have qualified for recertification if the correct standards had been applied, or the certificant was otherwise incorrectly found ineligible for recertification.

Requests for Hearing of First Appeal/In-Person, Telephone and Record Hearings

1. In-Person and Telephone Hearings. Within fifteen (15) days of submitting an appeal, a candidate or certificant may request, in writing, an informal in-person or telephone hearing before the Certification Appeals Committee. Any request for an in-person or telephone hearing must contain the following information:

   a. If the candidate or certificant requests a hearing by telephone, the telephone number where the candidate or certificant can be reached on the day and at the time scheduled for the hearing;
   b. If the candidate or certificant intends to appear at the hearing in-person with an attorney or other representative, the name, address, and telephone number of the attorney or representative; and,
   c. If the candidate or certificant intends to present witnesses at the hearing, the names, addresses, and telephone numbers of the proposed witnesses, and a clear description and summary of the information to be offered by such witnesses.

2. Appeal Hearings on the Written Record. In the event that the candidate or certificant does not request an in-person or telephone hearing, the appeal will be resolved and decided based on the appropriate written record, as determined by the Certification Appeals Committee.

First Appeal Hearings

1. Certification Appeals Committee. The ACBSP Board of Directors will appoint authorized representatives of the Certification Program to serve as the Certification Appeals Committee to resolve each certification appeal.

2. Scheduling Of Appeal/Telephone and In-Person Hearings. Within forty-five (45) days of receipt of a complete, proper, and written appeal, the Certification Appeals Committee will schedule a date and time for consideration of the appeal, generally not later than one-hundred twenty (120) days after receipt of the appeal, and notify the candidate or certificant of the appeal date and time. Where the candidate or certificant has requested a telephone or in-person hearing, a designated member of the

Certification Appeals Committee will convene, preside over, and conduct an appeal hearing.

3. Collection and Receipt of Information. The Certification Appeals Committee will conduct an informal hearing designed to collect and weigh all of the available proof and information. The Certification Appeals Committee will receive and consider all information appearing to be relevant to the subject matter of the hearing. No formal or legal rules of evidence and procedure will apply to appeal hearings. The candidate or certificant, or a legal representative, will be permitted to ask questions of witnesses at the discretion of the Certification Appeals Committee. Objections relating to relevance of information and other procedural issues will be decided by the Certification Appeals Committee, and these decisions are not subject to appeal.

4. Candidate/Certificant Presentations. The candidate or certificant may make an oral presentation at a hearing and will respond to questions asked by the Certification Appeals Committee.

5. Legal Counsel. ACBSP Legal Counsel may be present at an appeal hearing and may conduct the hearing with the Certification Appeals Committee. Legal or other representatives of the appealing party do not have the privilege of the floor and are bound by the determinations and rulings of the Certification Appeals Committee and ACBSP Legal Counsel.

6. Witnesses. All witnesses, except the candidate or certificant, will be excluded from the hearing except during presentation of their information. Hearings are confidential and private. No observers are permitted without special permission from the Certification Appeals Committee.

7. Hearing Record. A taped, written, or similar record of the hearing may be made by the Certification Appeals Committee, or another person designated by the Certification Appeals Committee.

8. Expenses. The candidate or certificant will be responsible for her/his own expenses associated with the appeal, including all expenses associated with attendance at the hearing, witnesses, or the duplication of materials. The ACBSP Certification Program will bear other general costs of conducting the hearing, including costs associated with the activities of the Certification Appeals Committee and other Certification Program representatives and staff.

9. Closing of Hearing Record. The hearing and appeal record will be closed following the conclusion of the hearing, unless otherwise directed by the Certification Appeals Committee or other authorized representative. The candidate/certificant or the Certification Appeals Committee may request that the record remain open for up to thirty (30) days for the purpose of receiving additional information or written materials relevant to the appeal. The Certification Appeals Committee may deny requests to keep the record open, and such a denial is not subject to appeal.

<u>First Appeal Determination/Decision of the Certification Appeals Committee</u>

Following the close of the appeal record, the Certification Appeals Committee will review the record of the appeal, including the action or decision of the Board Secretary and the information and materials received from the candidate or certificant. The Certification Appeals Committee will resolve and decide the appeal based on the record, including relevant and credible information presented by the candidate or certificant. The appeal decision will include the findings of the Certification Appeals Committee and a summary of the relevant facts upon which the decision is based. The appeal decision will be prepared and issued under the direction of the Certification Appeals Committee, or other authorized representative, within thirty (30) days of the closing of the first appeal record, or as soon thereafter as is practical.

Final Appeal/Final Appeal to the Board of Directors

1. Grounds for Final Appeal. If a candidate or certificant chooses to challenge and appeal the first appeal decision, a final appeal may be submitted to the Board of Directors. The grounds to appeal a first appeal decision are strictly limited to the following grounds:

    a. Procedural error: The first appeal decision misapplied a procedural rule contained in these rules, and the rule misapplication significantly prejudiced the candidate or certificant with respect to the outcome of the appeal decision;
    b. New or previously undiscovered information: Following the issuance of the first appeal decision, the candidate or certificant located relevant information and facts that were not previously available and that would have significantly affected the outcome of the first appeal decision in the candidate's or certificant's favor;
    c. Misapplication of certification standards: The first appeal decision misapplied the relevant certification or recertification standards, and the misapplication significantly prejudiced the candidate or certificant and the outcome of the appeal decision; or,
    d. Contrary to the information presented: The first appeal decision is clearly contrary to the most substantial information in the record.

    With respect to the grounds listed in Sections 1.a. and 1.c., above, the Board of Directors will consider only arguments that were previously presented to the Certification Appeals Committee in the first appeal.

Time Period for Submitting Final Appeal/Content of Final Appeal

1. Time Period for Submitting Appeal. A candidate or certificant may submit a written appeal, signed by the candidate or certificant, to the Board of Directors within thirty (30) days of the date of the first appeal decision of the Certification Appeals Committee. Any appeals received beyond this date will not be reviewed or considered by the Board of Directors, unless special permission is granted by the Chair of the Board of Directors.

2. Contents of Final Appeal. Consistent with all other requirements, a final appeal to the Board of Directors must state and include the following information:

    a. The identity and signature of the individual candidate or certificant submitting the appeal;

b. A detailed explanation of the reasons and basis for the appeal, as defined and limited by Section M, above;
c. All objections, corrections, and factual information the candidate or certificant believes to be relevant to the appeal, including all documents and exhibits in support of the appeal; and,
d. The names, addresses, and telephone numbers of any person not previously identified with factual information relevant to the appeal, and a clear description of the factual information available from these persons.

Board of Directors Final Appeal Process

1. Scheduling Of Final Appeal. Within sixty (60) days of receipt of a complete and proper written appeal, the Board of Directors will schedule a date, usually not later than the next or second regularly scheduled Board meeting, on which to consider the appeal. The ACBSP Certification Program will notify the candidate or certificant of the date the appeal will be considered.
2. Appeal Review. The Board of Directors will conduct an informal hearing designed to review and consider all of the available proof and information, including the record of the first appeal and the materials submitted by the candidate or certificant.

3. Candidate/Certificant Appearances before the Board. At least thirty (30) days prior to the date scheduled for a final appeal review, a candidate or certificant may request the opportunity to appear before the Board of Directors concerning the appeal. The Board Chair, or other authorized representative(s), will determine whether a request to appear before the Board is accepted. In the event that a request to appear is accepted, the Board of Directors may limit the appearance in any manner, or may require the candidate or certificant to present certain information or materials. Denials of requests to appear before the Board are not subject to appeal.

Final Decision of the Board of Directors

Following the review of a final appeal, the Board of Directors will review the record of the appeal and, thereafter, resolve and decide the appeal based on the record. The Board will consider all relevant information and include a summary of its findings in the appeal decision. The Board may affirm, modify, or reverse the decision of the Certification Appeals Committee based on its findings. The Board will issue its final appeal decision within thirty (30) days of the end of the review of the appeal, or as soon thereafter as is practical.

Finalizing and Closing Appeals

1. Conditions for Closing the Appeal. An appeal will be closed, and all proceedings ended, when any of the following occurs:

   a. An appeal has been resolved and decided by the Board Secretary, the Certification Appeals Committee, or the Board of Directors, and the allowable time period for the filing of an appeal under these procedures and rules has passed or lapsed; or,
   b. The appeal has been withdrawn or terminated by the candidate or certificant

CPR Policy:

All candidates for the CCSP® and DACBSP® Examinations must be certified in CPR. This CPR certification may be obtained as part of a college course. The candidate for the examination is responsible for obtaining the CPR certification on their own, if it is not offered by the college. The following stipulations will apply:

1. It is the responsibility of the college that conducts the 100-Hour CCSP® course to inform their students of this requirement. It is also the responsibility of the college to point out the student's responsibility in obtaining this certification, if it is not being offered by the college itself.

2. **IMPORTANT!** The CPR certification obtained by the students **should** be from one of the following: ***Basic Life Support for the Healthcare Provider*** from the American Heart Association (AHA), or ***Professional Rescuer*** from the American Red Cross. Although there may be other acceptable organizations, it MUST be a level of certification training that is given to health professionals as opposed to the lay public.

   Basic Life Support consists of:
   1 Person CPR
   2 Person CPR
   Infant CPR
   Airway Obstruction
   AED

3. In addition to the above requirements, the CPR class must have a hands-on component where the student demonstrates skills to an instructor.

4. In order to sit for the examination, a candidate must bring their **current** CPR certification card to the test site. This must be the original card, copies will not be accepted. Failure to bring this card will result in an inability to sit for the examination.

5. The ACBSP™ requires that doctors maintain current recertification in CPR. (*Please refer to the ACBSP™ Recertification Policy for additional information*).

AMERICAN CHIROPRACTIC BOARD OF SPORTS PHYSICIANS

CONTENT GUIDELINES FOR THE 200 HOUR PROGRAM LEADING TO THE DIPLOMATE AMERICAN CHIROPRACTIC BOARD OF SPORTS PHYSICIANS®

Revised December 1, 1991

Pre-requisite Information: The information offered in these additional hours is, of course, available to any licensed D.C. who properly enrolls in a postgraduate curriculum. However, in order to qualify for the examination leading to the designation *Diplomate American Chiropractic Board of Sports Physicians* (DACBSP), the D.C. must have completed the initial 100 hour course and passed the examination leading to the designation *Certified Chiropractic Sports Physician* (CCSP). The DACBSP is a designation which encompasses a minimum of 300 total academic contact hours plus completion of the practical and publication requirements outlined in this document.

NOTE: The approval of submitted documentation for completion of practical and written requirements will be carried out by a Board appointed committee. The colleges will be responsible for documentation of academic requirements only.

Content Information: Suggested Guidelines for contents of the additional 200 hours are as follows:

I. ADVANCED EXERCISE PHYSIOLOGY

A. Review of Physiologic Responses to Exercise
   1. Cardiovascular
   2. Muscular

B. Clinical Measurement of Athletic Performance and Physiological Response
   1. Measurement of muscular function
      a. Isokinetic devices, ROM assessment devices
      b. Mechanical influences of muscle function
   2. Measurement of cardiovascular function
      a. Ergometers-VO2, step test,
      b. Spirometry
      c. Blood lactate
   3. Measurement of ergonomic efficiency
      a. Ergonomic analysis
         (1). Gait analysis
         (2). Other analysis
   4. Specificity of training responses in muscle
      a. Defined exercise formats-concentric, eccentric, isokinetic
      b. Fiber recruitment specificity

C. Chemical and Hormonal Effects of Exercise
   1. Hormonal Regulation of Fluid and Electrolytes
      a. Exercise fluid shifts
      b. Renin-angiotensin-aldosterone system

c. Vasopressin/ADH
d. Anterior pituitary hormones

2. Fluid and Electrolytes in Endurance Training
   a. Adaptation of fluid shift
   b. Blood volume responses
3. Stress hormone response to exercise/effect on energy metabolism
   a. Catecholamine activity
   b. Glucagon
   c. Cortisol
   d. Growth hormone
4. Exercise and Endorphins
   a. Principals of endorphin release
   b. Effects of endorphins on physiology and performance

D. Alterations in Physiological Response in Systemic Conditions
1. Asthma
   a. Changes in Cardiovascular Response
      (1) vital capacity
      (2) ventilation
2. Diabetes
   a. Changes in energy utilization
   b. Changes in stress hormone response
   c. Effects upon performance

II. Rehabilitation Concepts and Their Application to Athletes

A. Detailing of Rehabilitation Principals
1. Integration of rehab into clinical practice
2. Special vocabulary applicable to rehab
3. Goals of rehab

B. Relationship between Rehabilitation and Baseline Athletic Conditioning
1. Application of monitoring of safe, challenging programs
2. Proper use of needs analysis
3. Assignment of program variables

C. Specific Rehabilitation Protocols
1. Sports specific
2. Injury specific
3. Application of SAID principle
4. Proper use of proprioceptive challenge
5. Return to sports judgements

D. Sport-Specific Conditioning Programs
1. Off-season
2. Pre-season
3. In-season

E. Designing Practical Rehabilitation Protocols
1. Psychological reactions of the injured athletes
2. Scope and variety of available equipment/programs
3. Dealing with overzealous/overprotective parent/coach
4. Introduction to biomechanical impact as a causative and/or

preventative factor

F. Analysis of Athlete's Strength, Power and Endurance Status
   1. Use of computerized testing equipment
      a. Graph analysis
      b. Normative values
      c. Use of digital testing apparatus
   2. Evaluation by the DeLorme method

III. Sports Specific Biomechanics

A. Detailed Information on the Biomechanical Measurements of each of the Major Sports
   1. Upper extremity/torso -- kinematic upper quadrant
   2. Lower extremity/torso -- kinematic lower quadrant
   3. Contrast/Compare-- analysis of running, throwing, kicking and jumping movement

B. Assessment Methodology of Various Biomechanical Measurements
   1. Phasing skills analysis
   2. High tech vs. low tech methodologies

C. Video and Computer Analysis of Sports Biomechanics; Emphasis on Gait (running) and Pitching/Throwing Mechanics

IV. Advanced Diagnostics in Sports Medicine

A. Imaging Modalities
   1. Plain radiographs
   2. Plain-film tomography
   3. Fluoroscopy
   4. Arthrography
   5. Ultrasonography
   6. Angiography
   7. Nuclear medicine bone scanning
   8. Computed tomography
   9. Magnetic Resonance Imaging (MRI)
   10. Thermography

B. Electrodiagnostics
   1. Electroneuromyography (ENMG)
      a. Nerve Conduction Studies
         (1) Basic
            -Motor Nerve Conductive (MNCV)
            -Sensory Nerve Action Potentials (SNAP)
         (2) Special
            -F-Wave
            -H-Responses
            -Repetitive stimulation
      b. Electromyography (EMG)
         (1) needle electrode examination
      c. Kinesiologic electromyography

C. Intra compartmental Pressure Analysis
   1. Instrumentation
      a. Slit catheter
      b. Solid state Intra compartmental catheter
   2. Compartment Pressure Measurements
      a. Acute compartment syndrome
      b. Chronic exertional compartment syndrome

D. Clinical Laboratory and Drug Testing Protocols
   1. Types of testing
      a. Random testing
      b. Scheduled testing
      c. "Just Cause"
   2. Protocols for obtaining samples
   3. Methods of testing samples
      a. Thin layer chromatography (TLC)
      b. Immunoassay
         (1) Radioimmunoassay (RIA)
         (2) Enzyme-multiplied immunoassay (EMIT)
      c. Gas Chromatography/Mass Spectroscopy
   4. Circumvention Techniques
      a. Masking agents
      b. Determination of drug shelf-life
      c. Substitution of urine

V. Adaptive and Functional Taping and Bracing

A. Therapeutic and prophylactic uses of bracing/taping
   1. Evaluation
   2. Braces
   3. Taping

B. Hands-on Instruction in Taping Procedures for Different Injuries
   1. Sprained ankles
   2. Plantar fascia
   3. Thumb
   4. Wrist

C. Functional vs. Supportive Aspects of Taping
   1. Definition
   2. Prescription guidelines

D. Immobilization Techniques and Principals with Respect to Athletes and Specific Sports
   1. Types of immobilization/immobilizer

E. Orthotics (foot orthoses)
   1. Indications
   2. Biomechanical analysis of athlete
   3. Types of materials
   4. Type of orthotics

IV. Stress Management Principals in Sports Medicine and Beyond

A. Stress and Sports Psychology
   1. Evaluation and assessment of psychological stress
   2. Stressful conditions
   3. Stress related disorders
   4. Intervention strategies
      a. Relaxation training
      b. Visual training
      c. Cognitive training
      d. Hypnosis
      e. Desensitization
      f. Goal setting
      g. Psychological skills training
      h. Other
   5. Future directions in stress management

B. Stress and the Injured Athlete
   1. Additional stresses associated with injury
   2. Personality types and the relationship to injury causation
   3. Intervention strategies for stress related phenomena and pain management

C. Sports Performance
   1. Psychology of winning and losing
   2. Focus of control
   3. Intervention strategies for maximum sports performance

D. Exercise, Stress, and Other Psychological Parameters
   1. Effects of exercise on stress
   2. Depression and exercise
   3. Self-concept and exercise
   4. Intellectual psychologic consequences of exercise
   5. Adverse psychological consequences of exercise

E. Fitness and Stress
   1. Relationship of emotional issues to systemic disease
   2. Relationship of emotional stress to behavior

VII. Sports Equipment and Technology

A. Sports Equipment
   1. Protective Equipment
      a. Materials/mechanical properties
      b. Standards for testing and certification
      c. Equipment for specific body parts (to include head, face (eyes, ears, teeth), upper extremity, lower extremity, and trunk/groin, genitalia
   2. Implements
      a. Grips
      b. Poles
      c. Gloves

d. Racquet
e. Other (bats, etc)

3. Clothing

B. Athletic Shoes
1. Construction/materials
2. Mechanical properties
3. Influence on biomechanics
4. Types (e.g. training, competition)

C. Surfaces
1. Natural-grass/cinders/wooden
2. Artificial-turf/composites, etc.

D. Shoe-surface Interactions
1. Physics of interaction

E. Ergonomics of Various Exercise Equipment
1. Bicycles
2. Wheelchairs
3. Treadmills
4. UBE (Upper Body Ergometer)
5. Weight machines
6. Other (rowing machines, cross country ski machines, etc.)

VIII. Advanced Principals of Extremity Manipulation

The core material in the education for the Diplomate status must relate to and test proficiency in only that which is referenced by accepted sources. The following outline has been based upon such referenced material.

A. Joint Dysfunction
1. Hypermobility/hypomobility
2. Concept of the paraphysiological space and joint cavitation
3. Joint mechanoreceptor
a. Proprioception
b. Gate theory

B. Joint Play Assessment
1. End feel
2. Differential diagnosis of joint trauma

C. Chiropractic manipulation of loss of joint play
1. Upper extremity (including the following joints):

Temporomandibular	Scapulothoracic
Sternoclavicular	Aracromioclavicular
Costochondral	Glenohumeral
Intercostal	Elbow-radiohumeral
Costotransverse	Humeroulnar
Costovertebral	Proximal radioulnar
Radiocarpal	Ulnomeniscotriquetral
Midcarpal	Distal intermetacarpal

fingers-m-ph and interphalangeal

2. Lower extremity (including the following joints):

Coxofemoral	Patellofemoral
Femorotibial	Proximal
Tibiofibular	Subtalar
Foot-tarsometatarsal	Ankle mortise
-midtarsal	
-metatarsalphalangeal	

***Note**:This listing of joints is designed to insure the inclusion of joints which are sometimes neglected. It is not intended to limit instruction to only these joints, since there are obviously others with which the practitioner should be familiar.*

D. Graded Mobilization (e.g. Maitland)

IX. ADVANCED SOFT ISSUE TECHNIQUES (Specific Myofascial Connective Tissue Therapy)

A. Mechanism of Soft Tissue Injuries
   1. Macro-trauma
      a. Intrinsic - pulled/ruptured
         (1) faulty biomechanics
         (2) adaptation/recruitment
         (3) hypertonic-not stretched/warmed up
         (4) imbalance with antagonist
         (5) excessive load
      b. Extrinsic - contusion
   2. Micro-trauma - strain/ _____itis
      a. Intrinsic
         (1) overuse
         (2) faulty biomechanics
         (3) adaptation/recruitment
      b. Extrinsic
         (1) contusion
         (2) faulty biomechanics

B. Pathology of Soft Tissue Injury
   1. Chemistry of injury
   2. Acute vs. Chronic injury states
   3. Repair mechanisms in the soft tissues

C. Transverse Friction Massage

D. Diagnosis of Altered Muscle Firing Orders

E. Diagnosis of Muscular Dysfunction
   1. Structural
      a. Spasticity
      b. Rigidity
   2. Functional
      a. Limbic system dysfunction
      b. Interneuron dysfunction
      c. Reflex contracture
      d. Myofascial trigger points

e. Muscle tightness

F. Treatment of Muscular Dysfunction
1. Structural - medical referral
2. Functional
a. Limbic system dysfunction - psychological referral
b. Interneuron dysfunction - adjustment
c. Reflex contracture - correct cause?EMS
d. Myofascial trigger points
(1) spray and stretch
(2) ischemic compression
(3) post isometric compression - PIR
(4) others

G. Kaltenborn Approach

H. Concepts of Sports Massage
1. Pre-event
2. Post-event
3. Injury rehabilitation

I. Therapeutic Muscle Stretching (TMS - PNF)
1. Types of stretching techniques
2. Indications for TMS
3. Contraindications to TMS

J. Myofascial Release

X. Special Considerations in Specific Athletic Groupings

A. The Young Athlete
1. Physiological Characteristics of this Age Group
a. Endurance-specific differences
b. Musculoskeletal differences
c. Special conditions
(1) scoliosis
(2) Sheuerman's disease
2. Psychological Characteristics of this age group
a. Issues of motivation and burnout
b. Pros and cons of organized sports
c. Issues of competitiveness
3. Preparticipation Screening
a. Age-specific issues
b. The maturity staging controversy
4. Specific Injuries: diagnosis and management
a. Soft tissue injuries-common areas
b. Fractures-common areas
c. Epiphyseal injuries
d. Apophyseal injuries
e. Conditions related to growth asymmetries

B. The Female Athlete
1. Physiologic and Anatomic Gender Differences
a. Skeletal

b. Cardiovascular
c. Thermal/metabolic
d. The role of neuromuscular conditioning in issues such as coordination/dexterity/injury rates.

2. Injury Patterns
   a. Common areas of injury in female athletes
   b. The role of strength and weight training in rehabilitation and prevention
3. Gynecological /Obstetric Considerations
   a. Menstrual problems
      (1) athletic amenorrhea
      (2) dysmenorrhea
   b. Exercise and pregnancy
   c. Post-menopausal exercise
   d. Female steroid and growth hormone use
4. Psychological considerations in female athletes
   a. Issues of societal acceptability/gender identity, psychological aspects of competition.
      (1) effect upon performance/compliance, etc.

C. The Geriatric Athlete
1. Pre-participation Screening
   a. Importance of EKG analysis
   b. Screening for underlying systemic conditions
   c. Issues of musculoskeletal
   d. Fitness in the elderly

AMERICAN CHIROPRACTIC BOARD OF SPORTS PHYSICIANS

DACBSP® WRITTEN TEST PLAN

CATEGORY (PERCENTAGE OF TEST)

I. **Exercise Physiology (6.8%)**

II. **Rehabilitation Concepts and Their Application to Athletes (8.4%)**

III. **Specific Biomechanics (4.8%)**

IV. **Diagnostics in Sports Medicine (6.0%)**

V. **Adaptive and Functional Taping and Bracing (9.6%)**

VI. **Sport and Exercise Psychology (7.2%)**

VII. **Sports Equipment and Technology (7.6%)**

VIII. **Advanced Principles of Extremity Adjusting (10.8%)**

IX. **Advanced Soft Tissue Techniques (Specific Myofascial and Connective Tissue Therapy) (11.2%)**

X. **Special Considerations in Specific Athletic Groupings (12.4%)**

XI. **Emergency Procedures (8.4%)**

XII. **Methodology in Chiropractic Sports Medicine (6.8%)**

*Approximately 250 items on exam; multiple-choice format contained in two booklets with two hours of testing allowed per booklet. Scoring administered by scantron through an independent examination service.

AMERICAN CHIROPRACTIC BOARD OF SPORTS PHYSICIANS™

DACBSP® PRACTICAL EXAMINATION GUIDELINES

**The following information is provided for use in the candidates' preparation for the DACBSP practical examination. The test outline should serve as a guide only and should not be considered as reflective of the entire spectrum of potential test material.*

FORMAT

The examination is constructed to access the candidate's performance on selected skills and to evaluate the candidate's critical thinking. Candidates for the DACBSP should have advanced levels of knowledge in these skills. This is assessed at multiple stations during which the candidate will be engaged in simulated patient scenarios. The candidate is expected to perform tasks and offer verbal interpretations in the following areas: case management, emergency procedures, manual procedures, taping and bracing, and diagnostic imaging. The candidate will be allowed appropriate time to perform the required tasks at each station.

Candidates will be videotaped at each station. Candidates will be presented with a number at registration. The candidate will be directed to the video camera as she/he enters the station and should clearly show and say the number to the camera. Candidates will then receive written instructions regarding the task(s) they are to perform. Examiners will assess candidates in their skill's performance through the use of an objective task checklist. These checklists define the appropriate, step-wise progression in the performance of these tasks.

GRADING

Station grades are calculated from tallying the appropriate responses on these checklists. A passing grade of 70% is required at each station. **Successful completion of all stations is required to pass the examination.** Please refer to specific retake examination policies; available from the ACBSP Board Secretary.

GENERAL INFORMATION

Candidates may need to employ various physical positions and equipment during the course of this examination; therefore, casual attire is encouraged. Candidates may **not** bring beepers, cellular phones, recording or transmitting devices of any kind into the testing area. Once you have finished testing, you will not be permitted to reenter. Testing/registration may last 2-3 hours, although every effort will be made to keep on schedule. Candidates should therefore plan both their meal schedule and transportation arrangements accordingly. Specific information regarding the schedule of testing, directions to the site, etc. will be forwarded as your application is processed.

The following provides a broad outline of the scenarios that will be tested and the tasks the candidate is expected to perform. Candidates may be asked to perform or provide written or oral response in any of these areas. Each station is approximately 14 minutes long. The candidate will be provided with a brief background on the patient in each station except for the Diagnostic Imaging station. This station will be given x-ray studies for evaluation.

STATION OUTLINES

CASE MANAGEMENT - TWO STATIONS: UPPER AND LOWER

Perform a focused examination of the joint. (Do not take more history).

- Mechanism of injury
- Epidemiology
- Risk factors
- Natural history of condition
- Tissue involvement

Examination Procedures

- Determine if advanced studies are needed (Example: X-ray)
- Evaluate for loss of joint play

Differential Diagnosis

Treatment/Management Protocols

- Manual procedures
- Set up for extremity adjustment. Technique will be evaluated for:
- Segmental contact point on patient
- Line of drive
- Set up for soft tissue treatment. Technique will be evaluated for:
- Location of contact point on patient
- Appropriateness of the technique in relation to the physiological goal (e.g. myofascial release to reduce adhesions, transverse fraction massage to stimulate cellular response).
- Exercise/Rehabilitation
- Nutrition/Diet
- Lifestyle modifications
- Management/Referral

Prognosis/Return to play criteria

EMERGENCY MANAGEMENT - SPINAL TRAUMA (*this may include head trauma*).

Assessment of the situation

Performance of a primary survey

Performance of procedures necessary to stabilize the patient

- CPR skills/Airway management
- Spinal trauma/stabilization

Performance of a secondary survey

- Stabilization of these injuries until the point of transfer to the appropriate emergency personnel.
- shock
- fracture management
- abdominal/chest injuries
- thermal/environmental injuries

***All procedures must be performed unless otherwise stated by the examiner (e.g.. palpation of pulse). The examiner will give the results of each procedure to the candidate.**

EMERGENCY MANAGEMENT - HEAD TRAUMA (this may also include spinal trauma).

Assessment of the situation
Performance of an evaluation of the athlete
Provide a clinical impression
Discuss return to play criteria

***All procedures must be performed unless otherwise stated by the examiner (e.g.. palpation of pulse). The examiner will give the results of each procedure to the candidate.**

TAPING AND BRACING

The candidate will be asked to perform two (2) procedures:

1) Ankle taping
2) Taping of one of the following areas:

- wrist
- thumb
- elbow
- lower leg
- arch of the foot
- trunk
- shoulder

The candidate will be evaluated for:

- Indications/contraindications
- Adequate preparation of the area
- Correct position of the body area being taped
- Proper application of the tape (e.g. no crimping or wrinkling of tape)
- Proper removal of the tape

DIAGNOSTIC IMAGING

The candidate will be given x-rays studies for evaluation. The candidate will be evaluated for:

- Interpretation
- Special Studies
- Diagnosis
- Treatment/Management

AMERICAN CHIROPRACTIC BOARD OF SPORTS PHYSICIANS™

DACBSP® RECOMMENDED READING LIST

TEXTBOOKS

Orthopaedic Sports Medicine, DeLee, Drez and Miller (2 volume set) 2nd ED; Saunder 2003; ISBN-10: 0-7216-8845-4; ISBN-13: 9780721688459; Price Range: $263 - $395

Functional Soft Tissue Examination and Treatment by Manual Methods, Warren Hammer 3rd ED 2007; Jones and Bartlett; ISBN-10: 763733105; ISBN-13: 978-0-7637-3310-0; Price Range: $102 - $168

Conservative Management of Sports Injuries; Hyde and Gengenbach, 2nd ED 2007; Jones and Bartlett; ISBN-10: 763732524; ISBN-13: 978-0-7637-3252-3; Price Range: $58 - $158

Orthopaedic Examination, Evaluation and Intervention; Mark Dutton 2nd ED 2008 w/DVD; McGraw-Hill; ISBN-10: 71474013; ISBN-13: 978-0-07-147401-6; Price Range: $63 - $84

Essentials of Skeletal Radiology, 3rd ED, Yochum T, Rowe, L; Lippincott, Williams & Wilkins, 2005 (2 volume set); ISBN-10: 0-7817-3946-2; ISBN-13: 9780781739467; Price Range: $183 - $385

Exercise Physiology: Energy, Nutrition and Human Performance, 5th ED 2001 Lippincott, Williams and Wilkins; ISBN-10: 0-7817-2544-5; ISBN-13: 9780781725446; Price Range: $15 - $81

Essentials of Strength Training and Conditioning, Baechele TR and Earle 3rd ED, 2008 NSCA (Human Kinetics); ISBN-10: 736058036; ISBN-13: 9780736058032; Price Range: $10 - $79

Brady Pre-Hospital Emergency Care, Mistovich and Karren, 8th ED 2008 Pearson, Prentice Hall; ISBN-10: 131741438; ISBN-13: 978-0-13-174143-0; Price Range: $45 - $85

ACSM's Resource Manual for Guidelines for Exercise Testing and Prescription, Kaminsky 6th ED 2006 Lipincott, Williams & Wilkins; ISBN-10: 078176906X; ISBN-13: 978-0781769068; Price Range: $55 - $68

Foundations of Sport and Exercise Psychology, Weinberg and Gould, 4th ED, Human Kinetics; ISBN-10: 736064672; ISBN-13: 978-0-7360-6467-5; Price Range: $50 - $ 97

Physical Agents in Rehabilitation 3rd Ed, Michelle H. Cameron, Saunders / Elsevier 2009; ISBN-10: 1-4160-3257-1; ISBN-13: 9781416032571; Price Range: $40 - $60

Athletic Taping and Bracing 2nd ED, David Perrin; Human Kinetics 2005; ISBN-10: 0-7360-4811-1; ISBN-13: 978-0-7360-4811-8; Price Range: $28 - $52

Sports Injury: Prevention and Rehabilitation, Shamus and Shamus, 2001 McGraw-Hill; ISBN-10: 00-7-135475-1; ISBN-13: 9780071354752; Price Range: $46 - $112

Sport Notes, Field and Clinical Examination Guide by Dawn Gulick 2008 www.fadavis.com; ISBN-13: 9780803618756; Price Range: $27

American Heart Association BLS for Healthcare Providers **OR** American Red Cross CPR/AED for the Professional Rescuer

REFERENCED JOURNALS

Strength and Conditioning, National Strength and Conditioning Association, Human Kinetics; Price: $120/year

Journal of Strength and Conditioning Research, Kraemer WJ Editor, Human Kinetics

Medicine and Science in Sports and Exercise, Official Journal of the American College of Sports Medicine, Williams & Wilkins; Price: $220/year

Journal of Chiropractic Medicine, National University of Health Sciences, Elsevier

RECOMMENDED READING IN CANDIDATE HANDBOOK

American Chiropractic Board of Sports Physicians™ Certification Program Code of Ethics Outline and Structure, 1998

Position Paper on Preparticipation Physical Examinations, American Chiropractic Board of Sports Physicians™, Fall 1998

Position Paper on Weight Loss in Wrestling, American Chiropractic Board of Sports Physicians™, April 1999

Inter-Association Task Force for Appropriate Care of the Spine Consensus Statement, May 1998

Position Paper on Blood Borne Pathogens, ACA Council on Sports Injuries & Physical Fitness

ACSM Position Papers; on www.acbsp.com

Revised Concussion Parameters, American Academy of Neurology, March 1997

Emergency Removal of Football Helmets. Patel MN, Rund DA, The Physician and Sportsmedicine. Vol. 22(9); 57-59, 1994

Position Paper on Prepubescent Strength Training, National Strength and Conditioning Association, 1995

OTHER RECOMMENDED REFERENCES

http://www.nsca-lift.org/videos/displayvideos.asp

AMERICAN CHIROPRACTIC BOARD OF SPORTS PHYSICIANS™
CODE OF ETHICS

Introduction

The American Chiropractic Board of Sports Physicians™ (ACBSP™ or Board) is a voluntary, non-profit, professional credentialing board which certifies qualified chiropractic doctors, physicians, and practitioners engaged in the field of sports medicine who have met the professional knowledge standards established by the Board. Regardless of any other professional affiliation, the ACBSP™ Code of Ethics (Code) applies to: all individuals certified by the ACBSP™ as a Certified Chiropractic Sports Physicians/Practitioner® (CCSP®), or as a Diplomate of the American Chiropractic Board of Sports Physicians® (DACBSP®); and, those individuals seeking ACBSP™ certification (candidates). The Code serves as the minimal ethical standards for the professional behavior of ACBSP™ certificants and candidates.

The Code is designed to provide both appropriate ethical practice guidelines and enforceable standards of conduct for all certificants and candidates. The Code also serves as a professional resource for chiropractic physicians and practitioners, as well as for those served by ACBSP™ certificants and candidates, in the case of a possible ethical violation.

Preamble/General Guidelines

Among other primary goals, the ACBSP™ is dedicated to the implementation of appropriate professional standards designed to serve patient welfare and the profession. First and foremost, ACBSP™ practitioners give priority to patient interests, and act in a manner that promotes integrity and reflects positively on the profession, consistent with accepted moral, ethical and legal standards.

Generally, an ACBSP™ certificant or candidate has the obligation to:

- deal fairly with all patients in a timely fashion, and provide quality chiropractic services to patients, by utilizing all necessary professional resources in a technically appropriate and efficient manner, and by considering the cost-effectiveness of treatments;
- respect and promote the rights of patients by offering only professional services that he/she is qualified to perform, and by adequately informing patients about the nature of their conditions, the objectives of the proposed treatment, treatment alternatives, possible outcomes, and the risks involved;
- maintain the confidentiality of all patient information, unless: the information pertains to illegal activity; the patient expressly directs the release of specific information; or, a court or government agency lawfully directs the release of the information.
- avoid conduct which may cause a conflict with patient interests, and disclose to patients any circumstances that could be construed as a conflict of interest or an appearance of impropriety, or that could otherwise influence, interfere with, or compromise the exercise of independent professional clinical judgment;
- engage in moral and ethical business practices by providing accurate and truthful representations concerning his/her professional qualifications and other relevant information in advertising and other representations; and,
- further the professionalism of the specialty of chiropractic sports medicine by: being truthful with regard to research sources, findings, and related professional activities; maintaining accurate and complete research records; and, respecting the intellectual property and contributions of others.

Section A

Compliance with Laws, Policies, and Rules Relating to the Profession

1. The certificant/candidate will be aware of, and comply with, all applicable federal, state, and local laws and regulations governing the profession. The certificant/candidate will not knowingly participate in, or assist, any acts in violation of applicable laws and regulations governing the profession. Lack of awareness or misunderstanding of these laws and regulations does not excuse inappropriate or unethical behavior. The certificant/candidate will be responsible for understanding these obligations.
2. The certificant/candidate will be aware of, and comply with, all ACBSP™ rules, policies, and procedures. Lack of awareness or misunderstanding of an ACBSP™ rule, policy, or procedure does not excuse inappropriate or unethical behavior. The certificant/candidate will not knowingly participate in, or assist, any acts of violation of any ACBSP™ rules, policies, and procedures. The certificant/candidate will be responsible for understanding these obligations.
3. The certificant/candidate will make appropriate efforts to promote compliance with, and awareness of, all applicable laws, regulations, and ACBSP™ rules and policies governing the profession.
4. The certificant/candidate will make appropriate efforts to prevent violations of all applicable laws, regulations, and ACBSP™ rules and policies governing the profession.
5. The certificant/candidate will provide accurate and truthful representations of all eligibility information, and will submit valid application materials for fulfillment of current certification and recertification requirements.
6. The certificant/candidate will maintain the security, and prevent the disclosure, of ACBSP™ Certification Program examination information and materials.
7. The certificant/candidate will report any possible violations of this Code of Ethics to the appropriate government authority and to the appropriate ACBSP™ representative upon a reasonable and clear factual basis.
8. The certificant/candidate will cooperate fully with the ACBSP™ concerning the review of possible ethics violations and the collection of related information.

Section B

Professional Practice Obligations

1. The certificant/candidate will deliver competent chiropractic treatment or services in a timely manner, and will provide quality patient care applying appropriate professional skill and competence.
2. The certificant/candidate will recognize the limitations of his/her professional ability, and will only provide and deliver professional services for which he/she is qualified. The certificant/candidate will be responsible for determining his/her own professional abilities based on his/her education, knowledge, competency, extent of practice experience in the field, and other relevant considerations.
3. The certificant/candidate will use all health-related resources in a technically appropriate and efficient manner.
4. The certificant/candidate will provide chiropractic services based on patient needs and the cost-effectiveness of treatments, and will avoid unnecessary treatment or services. The certificant/candidate will provide treatment that is both appropriate and necessary to the condition of the patient.
5. The certificant/candidate will exercise diligence and thoroughness in providing patient care, and in making professional diagnoses and recommendations solely for the patient's benefit, free from any prejudiced or biased judgment. The certificant/candidate who offers his/her services to the public will not decline a patient based on age, gender, race, color, sexual orientation, national origin, or any other basis that would constitute unlawful discrimination.

6. The certificant/candidate will provide appropriate professional referrals when it is determined that he/she is unable to provide competent professional medical assistance.
7. The certificant/candidate will prepare and maintain all necessary, required, or otherwise appropriate records concerning his/her professional practice, including all records related to treatment of his/her patients.
8. The certificant/candidate will consult with other health care professionals when such consultation is appropriate, or when requested by the patient.
9. The certificant/candidate will not act in a manner that may compromise his/her clinical judgment or his/her obligation to deal fairly with all patients. The certificant/candidate will not allow medical conditions, personal problems, psychological distress, substance abuse, or mental health difficulties to interfere with his/her professional clinical judgment or performance.
10. The certificant/candidate will be truthful and accurate in all advertising and representations concerning qualifications, experience, competency, and performance of services, including representations related to professional status and/or areas of special competence. The certificant/candidate will not make false or deceptive statements concerning his/her: training, experience, or competence; academic training or degrees; certification or credentials; institutional or association affiliations; services, or, fees for services.
11. The certificant/candidate will not make explicit or implicit false or misleading statements about, or guarantees concerning, any treatment or service, orally or in writing.

Section C

Requirements Related to Research and Professional Activities

1. The certificant/candidate will be accurate and truthful, and otherwise act in an appropriate manner, with regard to research findings and related professional activities, and will make reasonable and diligent efforts to avoid any material misrepresentations.
2. The certificant/candidate will maintain appropriate, accurate, and complete records with respect to research findings and related professional activities.
3. When preparing, developing, or presenting research information and materials, the certificant/candidate will not copy or use, in substantially similar form, materials prepared by others without acknowledging the correct source and identifying the name of the author or publisher of such material.
4. The certificant/candidate will respect and protect the intellectual property rights of others, and will otherwise recognize the professional contributions of others.

Section D

Conflict of Interest and Appearance of Impropriety Requirements

1. The certificant/candidate will not engage in conduct which may cause an actual or perceived conflict between his/her own interests and the interests of his/her patient. The certificant/candidate will avoid conduct which causes an appearance of impropriety.
2. The certificant/candidate will act to protect the interests and welfare of the patient before his/her own interests, unless such action is in conflict with any legal, ethical, or professional obligation. The certificant/candidate will not exploit professional relationships for personal gain.
3. The certificant/candidate will disclose to patients any circumstance that could be construed as a conflict of interest or an appearance of impropriety, or that could otherwise influence or interfere with the exercise of professional judgment.
4. The certificant/candidate will refrain from offering or accepting inappropriate payments, gifts, or other forms of compensation for personal gain, unless in

conformity with applicable laws, regulations, and ACBSP™ rules and policies.

5. The certificant/candidate will avoid conduct involving inappropriate, unlawful, or otherwise unethical monetary gain.

Section E

Compensation and Referral Disclosure Requirements

1. The certificant/candidate will charge fair, reasonable, and appropriate fees for all professional services.
2. The certificant/candidate will charge fees that accurately reflect the services and treatment provided to the patient. When setting fees, the certificant/candidate will consider: the length of time he/she has been practicing in this particular field; the amount of time necessary to perform the service; the nature of the patient's condition; his/her professional qualifications and experience; and, other relevant factors.
3. The certificant/candidate will make all appropriate disclosures to patients and prospective patients regarding any benefit paid to others for recommending or referring his/her services.
4. The certificant/candidate will make all appropriate disclosures to patients and prospective patients regarding any benefit received for recommending or referring the services of another individual.

Section F

Confidentiality Requirements

1. The certificant/candidate will maintain and respect the confidentiality of all patient information obtained in the course of a professional relationship, unless: the information pertains to illegal activity; the patient expressly directs the release of specific information; or, a court or government agency lawfully directs the release of the information.
2. The certificant/candidate will respect and maintain the privacy of his/her patients.

Section G

Misconduct Prohibitions

1. The certificant/candidate will not engage in any criminal misconduct.
2. The certificant/candidate will not engage in any sexual, physical, romantic, or otherwise intimate conduct with a current patient, or with a former patient within two years following the termination of the patient relationship.
3. The certificant/candidate will not engage in conduct involving dishonesty, fraud, deceit, or misrepresentation in professional activities.
4. The certificant/candidate will not engage in unlawful discrimination in professional activities.
5. The certificant/candidate will avoid any behavior clearly in violation of accepted moral, ethical, or legal standards that may compromise the integrity of, or reflect negatively on, the profession.

AMERICAN CHIROPRACTIC BOARD OF SPORTS PHYSICIANS™ POSITION PAPER ON THE PRE-PARTICIPATION PHYSICAL EXAMINATION (PPE)

1. The ACBSP™ endorses the performance of PPEs by chiropractors holding a DACBSP® or CCSP® certificate in good standing. DACBSPs and CCSPs are fully qualified to perform PPEs.

2. The ACBSP™ recommends that any chiropractor who performs PPEs should do so in accordance with the practical guidelines set forth in *Pre-participation Physical Evaluation, 2nd Edition*, published by the AAFP, AAP, AMSSM, AOSSM and AOASM.

   For the purposes of clarity of this position paper, the standard components of history and physical examination are listed below:

   Components of the History
   a. Recent or chronic injury or illness
   b. Hospitalizations or surgeries
   c. Medications
   d. Allergies
   e. Cardiovascular system
   f. Skin
   g. Neurologic system
   h. Heat illness
   i. Pulmonary system, including asthma
   j. Protective devices
   k. Eyes and vision
   l. Musculoskeletal system
   m. Weight and eating disorders
   n. Psychosocial history
   o. Immunizations
   p. Menstrual history

   Components of the Examination
   a. Height and weight
   b. Examination of the head, eyes, ears, nose and throat
   c. Examination of the cardiovascular system
   d. Examination of the lungs
   e. Examination of the abdomen
   f. Examination of the male genitalia
   g. Examination of the skin
   h. Examination of the musculoskeletal system, including posture, range of motion, and joint specific testing
   i. Examination of the neurologic system

3. The goal of the cardiovascular portion of the PPE is to reliably obtain a detailed cardiovascular history, perform a competent screening examination and recognize heart disease. The ACBSP™ endorses the essential components of the cardiovascular history and screening examination as set forth by the American Heart Association. Specifically, the PPE should include history and examination sections as follows:

Cardiovascular History

A. Due to the great importance of accurate family history, the athlete's parents should be responsible for completing the history forms.
B. The cardiovascular history should include questions to ascertain:
    1) prior occurrence of exertional chest pain/discomfort or syncope/near syncope;
    2) prior occurrence of excessive, unexpected or unexplained shortness of breath or fatigue associated with exercise;
    3) past detection of a heart murmur or increased systemic blood pressure;
    4) family history of premature death (sudden or otherwise), or significant disability from cardiovascular disease in close relative(s) under 50 years old;
    5) specific knowledge of the occurrence of the following conditions in the family:
        i) Hypertrophic cardiomyopathy
        ii) Dilated cardiomyopathy
        iii) Long QT syndrome
        iv) Marfan syndrome
        v) Clinically important arrhythmias

Cardiovascular Examination

A. Precordial auscultation in both supine and standing positions to identify heart murmurs characteristic of left ventricular outflow obstruction.
B. Assessment of femoral artery pulses to exclude coarctation of the aorta.
C. Recognition of the physical stigmata of Marfan syndrome.
D. Brachial blood pressure measurement in the sitting position.

4. The ACBSP™ recommends and endorses the clearance guidelines for cardiovascular conditions established by the 26th Bethesda Conference. Definitively identified cardiovascular abnormalities should be judged by a qualified cardiologist, where feasible, for final determination of eligibility for future athletic competition.

5. The ACBSP™ recommends that its certificants work with appropriate national, state and local agencies to promote:

    a) the inclusion of DACBSPs and CCSPs in the performance of PPEs and the clearance of athletes for participation in sport.
    b) the inclusion of the expertise of DACBSPs and CCSPs as consulting specialists when biomechanical, postural, and neuromusculoskeletal problems are encountered in PPEs performed in the primary care office.

6. The ACBSP™ recommends that DACBSP® and CCSP® certificants work professionally and collegially with other health care disciplines in a spirit of cooperation and teamwork for the benefit and welfare of the athlete.

Glossary of Abbreviations

ACBSP™	American Chiropractic Board of Sports Physicians™
PPE	Preparticipation Physical Examination
DACBSP®	Diplomate American Chiropractic Board of Sports Physicians®
CCSP®	Certified Chiropractic Sports Physician®
AAFP	American Academy of Family Physicians

AAP	American Academy of Pediatrics
AMSSM	American Medical Society for Sports Medicine
AOSSM	American Orthopaedic Society for Sports Medicine
AOASM	American Osteopathic Academy of Sports Medicine

Bibliography

1. Hunter S, Rich BSE, Smith DM, Tanner SM, Wilkerson L. Pre-participation physical evaluation, ed. Minneapolis, MN, American Academy of Family Physicians, American Academy of Pediatrics, American Medical Society for Sports Medicine, American Orthopaedic Society for Sports Medicine, American Osteopathic Academy of Sports Medicine, 1997.

2. Maron BJ, Thompson PD, Puffer JC, et al. American Heart Association Scientific Statement: Cardiovascular pre-participation screening of competitive athletes. Med Sci Sports Exerc 1996; 28(12): 1445-52.

3. 26th Bethesda Conference: Recommendations for determining eligibility for competition in athletes with cardiovascular abnormalities. January 6-7, 1994. Med Sci Sports Exerc 1994: 26 (10 suppl):S223-283 [published erratum appears in Med Sci Sports Exerc 1994; 26(12): following table of contents].

AMERICAN CHIROPRACTIC BOARD OF SPORTS PHYSICIANS™

WEIGHT LOSS IN WRESTLING
POSITION PAPER

Summary

The ACBSP™'s primary goal is to ensure that wrestling is safe, healthy and enjoyable for the participating athletes. Rapid weight reduction is still prevalent in wrestling despite large bodies of evidence establishing this as a risky and even dangerous procedure. To enhance the education and reduce the health risks for the participants, the ACBSP™ recommends: a multidisciplinary approach to educate coaches and wrestlers through cooperative efforts of physicians, exercise scientists, dieticians, athletic trainers, athletic administrators, coaches and parents with regards to nutrition and weight control; close monitoring of the athletes body composition throughout the season; and the institution of rules and guidelines which limit weight loss.

Introduction

Health related problems associated with rapid weight loss (weight cutting) among wrestlers have been a growing concern for clinicians and other associated health professionals (12,26,58,66). Studies have shown that high school and collegiate wrestlers who practice rapid weight loss average 2 kg per week and 20% of the wrestlers may exceed 2.7 kg (43,60,64). During a season, this process has been shown to be repeated more than 10 times by 1/3 of high school wrestlers (44,58). The health risks associated with these procedures far outweigh the benefits derived from the outcome.

Discussion

During the season, the average body fat of a wrestler is 6-7% with some as low as 3% (13,18,25,26,38,41,42,45,61). Studies have shown that the body fat percentage for off-season high school wrestlers is 8-11%, which is still well below their peers who average 15% (6,19,63). The primary methods utilized for weight loss in wrestling include exercise, fasting and various dehydration methods. These methods produce minimal fat loss while effecting body water, glycogen content and lean body mass (18,55,59,60,69,71). A small percentage of wrestlers have also used diuretics, stimulants and laxatives to reduce weight (30,43,59).

Weight loss techniques are practiced by wrestlers with the belief that competitive success will increase. However, food restriction combined with fluid deprivation has shown to drastically decrease an athlete's competitive ability (4,13,18,27). Loss of more than 2% of an athletes body weight in less than 24-48 hours will result in a decrease in aerobic performance and endurance (13,17,18,25,27,46,47). Losing more than 5% of an athlete's body weight in less than 72-96 hours will negatively effect power, muscle endurance, aerobic performance, muscle strength (especially in the large muscle groups of the legs) and mental concentration (17,25,27,46,54,64,68). Such weight loss can also decrease the body's thermoregulatory ability (4,33,53,59,67). Fluid reduction or restriction has been shown to be the most detrimental aspect to an athlete's health and performance (4,9,24). It has been shown that adaptation to dehydration is impossible (4,9,67). The greater degree of dehydration the poorer one's performance and the greater risk of health and medical problems (4,9). Research indicates that it is impossible to completely rehydrate the body in less than 24-48 hours (9). The longer the body has been dehydrated, the longer the

rehydration process will take (9,21). Also of note is that water loss due to the taking of diuretics or laxatives takes much longer to replace than water loss due to exercise (4,9). In addition, after the use of diuretics and laxatives, the body retains more fluid upon rehydration thus causing a greater weight gain (4,9).

The effects of rapid weight cutting for wrestlers have been shown to:

- Reduce muscle strength (18,51,68)
- Decrease anaerobic capacity (34,68)
- Lower plasma and blood volume (3,61)
- Increase resting and submaximal heart rate (1,3)
- Decrease cardiac stroke volume (3)
- Reduce endurance capacity (49)
- Lower oxygen consumption (35,59)
- Impair thermoregulatory processes thus increasing the risk of heat illness (1,2,3,13)
- Decrease renal blood flow and kidney filtration of the blood (73,74)
- Deplete muscle (18) and possibly liver glycogen which has been shown to reduce endurance (17,27), the body's ability to maintain blood glucose levels, and accelerate the breakdown of protein (3)
- Deplete electrolytes which can result in impaired muscle function (3,4), coordination and possibly cardiac arrhythmia

In addition, scientific data has suggested that the same weight cutting practices may also alter hormonal status (63); diminish protein nutritional status (16); impede normal growth and development (14); effect psychological state (17,30,36,45,59); impair academic performance (8,11,67) and have severe consequences such as pulmonary emboli (10), pancreatitis (33) and reduced immune function (28).

Conclusions and Recommendations

Because weight cutting by wrestlers has been shown to increase potential health risks and be of little benefit with regards to overall athletic performance, the ACBSP™ makes the following recommendations:

1. Preseason body composition measurements of each wrestler should be performed. Males aged 16 and under with less than 7% body fat with a 3% standard error allowance and males who are sexually mature (Tanner stage 5) with less than 5% body fat should not be allowed to compete without physician clearance . Boys in Tanner stage 2 to 4 should be in the 7% to 8% range. 12-14% body fat is recommended as the minimum safe percentage for female wrestlers (50).

2. Encourage new state associations to work with National Governing Bodies in developing and implementing rules that include an effective monitoring and weight control program.

3. Strongly discourage the use of sweat boxes; whirlpools; rubber, vinyl or plastic type suits or other artificial heating devices; diuretics or other methods of quick weight reduction.

4. Educate parents, wrestlers, and coaches regarding proper nutrition and the effects of fasting and dehydration on physical performance and health.

5. Schedule and chart weigh-ins of all competing athletes 24 hours prior to, and, immediately before each match to yield an athletes true weight.

6. Preseason assessment of an athlete's nutritional demands be determined with education including intake of a balanced diet of carbohydrates, proteins and fats.

7. The ACBSP™ supports requiring wrestlers to weigh in a maximum of one hour and a minimum of one half hour before the time a dual meet is scheduled to begin and a maximum of two hours and a minimum of one half hour before the first session each day of a tournament.

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INTER-ASSOCIATION TASK FORCE FOR APPROPRIATE CARE OF THE SPINE CONSENSUS STATEMENT

In May 1998, the ACBSP™ was able to send a representative to participate in the Inter-Association Task Force for Appropriate Care of the Spine, which was organized by the National Athletic Trainers Association. Drs. Tom Hyde and Andy Klein facilitated the ACBSP™ representation at this meeting. Jay Greenstein, DC, CCSP® represented the ACBSP™ at this multi-disciplinary summit to develop guidelines for the appropriate care of the spine-injured athlete. In addition, the task force identified additional areas of concern and ideas for future projects. The task force will draft a letter to athletic helmet manufacturers, NOCSAE, and sports governing bodies recommending that football helmet face masks should be attached by loop straps and not be bolted on, in order to facilitate appropriate emergency management by medical personnel. They will also be drafting a letter to athletic helmet manufacturers and NOCSAE recommending that loop straps be made of a material that is easy to cut, and the producers of loop straps provide appropriate tools to cut/remove the loop straps that they manufacture. The ACBSP™ has voted to endorse the NATA Position Statement and adopt these preliminary guidelines. The ACBSP™ will continue to contribute in a cooperative effort to the further development of this topic in the future. The ACBSP™ wishes to thank Dr. Greenstein for again representing the profession in an exemplary manner. The first draft was approved by the ACBSP™ Board of Directors and states:

Mission of the Summit:

To develop guidelines for the pre-hospital management of the physically active with suspected spinal injury.

GENERAL GUIDELINES

* Any athlete suspected of having a spinal injury should not be moved and should be managed as though a spinal injury exists.
* The athlete's airway, breathing and circulation, neurological status and level of consciousness should be assessed.
* The athlete should not be moved unless absolutely essential to maintain airway, breathing and circulation.
* If the athlete must be moved to maintain airway, breathing and circulation, the athlete should be placed in a supine position while maintaining spinal immobilization.
* When moving a suspected spine injured athlete, the head and trunk should be moved as a unit. One accepted technique is to manually splint the head to the trunk.
* The Emergency Medical Services system should be activated.

FACE MASK REMOVAL

* The face mask should be removed prior to transportation, regardless of current respiratory status.
* Those involved in the pre-hospital care of injured football players should have the tools for face mask removal readily available.

FOOTBALL HELMET REMOVAL

The athletic helmet and chin strap should only be removed...

* if the helmet and chin strap do not hold the head securely, such that immobilization of the helmet does not also immobilize the head.
* if the design of the helmet and chin strap is such that even after removal of the face mask the airway cannot be controlled, or ventilation provided.
* if the face mask cannot be removed after a reasonable period of time.
* if the helmet prevents immobilization for transportation in an appropriate position.

HELMET REMOVAL

Spinal immobilization must be maintained while removing the helmet.

* Helmet removal should be frequently practiced under proper supervision.
* Specific guidelines for helmet removal need to be developed.
* In most circumstances, it may be helpful to remove cheek padding and/or deflate air padding prior to helmet removal.

EQUIPMENT

Appropriate spinal alignment must be maintained.

* There needs to be a realization that the helmet and shoulder pads elevate an athlete's trunk when in the supine position.
* Should either be removed, or if only one is present, appropriate spinal alignment must be maintained.
* The front of the shoulder pads can be opened to allow access for CPR and defibrillation.

This task force encourages the development of a local emergency care plan regarding the pre-hospital care of the athlete with a suspected spine injury. This plan should include communication with the institution's administration and those directly involved with the assessment and transportation of the injured athlete. All providers of pre-hospital care should practice and be competent in all of the skills identified in these guidelines before they are needed in an emergency situation.

These guidelines were developed as a consensus statement by;

Douglas M. Kleiner, PhD, ATC, FACSM, (Chair), National Athletic Trainers' Association; Jon L. Almquist, ATC, National Athletic Trainers' Association Secondary School Athletic Trainers Committee; Julian Bailes, M.D., American Association of Neurological Surgeons; John C. Biery, DO, FAOASM, FACSM, American Osteopathic Academy of Sports Medicine; Pepper Burruss, ATC, PT, Professional Football Athletic Trainers' Society; Alexander M. Butman, Dsc, REMT-P, National Registry of Emergency Medical Technicians; Jerry Diehl, National Federation of State High School Associations; Robert Domeier, M.D., National Association of Emergency Medical Services Physicians; Kent Falb, ATC, PT, National Athletic Trainers' Association; Henry Feuer, M.D., National Football League Physicians Society; Jay Greenstein, DC, CCSP®, American Chiropractic Board of Sports Physicians™; Letha Y. Griffin, M.D., American Orthopaedic Society for Sports Medicine; National Collegiate Athletic Association Committee on Competitive Safeguards and Medical Aspects of Sports; Bob Hannemann, M.D., American Academy of Pediatrics Committee on Sports Medicine and Fitness; Margaret Hunt, ATC, United States Olympic Committee; Daniel Kraft, M.D., American Medical Society for Sports Medicine; James Laughnane, ATC, National Athletic Trainers' Association College and University Athletic Trainers' Committee; Connie McAdam, MICT, National Association Emergency Medical Technicians; Dennis A. Miller, ATC, PT, National Athletic Trainers' Trainers' Association; Michael Oliver, National Operating Committee on Safety and Equipment; Andrew N. Pollak, M.D., Orthopaedic Trauma Association; Dan Smith, DPT, ATC, American Physical Therapy Association Sports Physical Therapy Section; David Thorson, M.D., American Academy of Family Physicians; Patrick R. Trainor, ATC, National Association of Intercollegiate Athletics; Robert G. Watkins, M.D., American Academy of Orthopaedic Surgeons Committee on the Spine; Stuart Weinstein, M.D., American College of Sports Medicine; North American Spine Society; Physiatric Association of Spine, Sports & Occupational Rehabilitation.

BLOODBORNE PATHOGENS OPINION STATEMENT

AMERICAN CHIROPRACTIC ASSOCIATION
COUNCIL ON SPORTS INJURIES AND PHYSICAL FITNESS

INTRODUCTION:

The Occupational Safety and Health Administration recognizes the need for a regulation that prescribes safeguards to protect workers against the health hazards from exposure to blood and certain body fluids containing bloodborne pathogens, and to reduce their risk to this exposure. There is a rapidly increasing participation and exposure of chiropractors in sports medicine as emergency responders. The chiropractic sports practitioner must have the knowledge and the plan in place prior to the risk of exposure. This document is intended to provide information and guidelines as they relate to sports chiropractic.

DEFINITIONS:

BLOOD:

Under the OSHA rule, blood means human blood, blood products, or blood components. Bloodborne pathogens are microorganisms that are present in blood, blood products, and other potentially infectious materials (OPIM).

OTHER POTENTIALLY INFECTIOUS MATERIALS (OPIM):

Other potentially infectious materials (OPIM), defined by the Centers for Disease Control as:

- semen
- vaginal secretions
- cerebrospinal fluid
- pleural fluid
- peritoneal fluid
- pericardial fluid
- amniotic fluid
- synovial fluid
- breast milk (not all authorities agree)
- saliva in dental procedures.

OCCUPATIONAL EXPOSURE:

Occupational exposure means a "reasonably anticipated skin, eye, mucous membrane, or parenteral contact with blood or other potentially infectious materials that may result from the performance of employees' duties."

UNIVERSAL PRECAUTIONS:

Universal precautions is a method of infection control in which all human blood and certain human body fluids are treated as if known to be infectious for HIV, HBV, and other bloodborne pathogens. Universal precautions are to be observed in all situations where

there is a potential for contact with blood or other potentially infectious material. Under circumstances in which differentiation between body fluid types is difficult or impossible, all body fluids are to be considered potentially infectious.

PERSONAL PROTECTIVE EQUIPMENT (PPE):

Personal protective equipment refers to specialized clothing or equipment worn for protection from exposure to blood or other potentially infectious materials. Personal protective equipment will be considered "appropriate" only if it does not permit blood or other potentially infectious substances and contaminated materials to pass through to or reach a provider's work clothes, street clothes, undergarments, skin, eyes, mouth, or other mucous membranes under normal conditions of use and for the duration of time the protective equipment is in use. Hypoallergenic alternatives (e.g., hypoallergenic or powderless gloves) must be available to people who have an allergic sensitivity to protective equipment. Personal protective equipment consists of, but is not limited to, gloves, face shields, masks, and eye protection, gowns, aprons, and similar items.

GUIDELINES AND PRECAUTIONARY MEASURES:

1. Identify in advance, as much as possible, the type and degree of anticipated exposure that you and other responders are likely to encounter.

2. In work areas where there is a reasonable likelihood of exposure to blood or other potentially infectious materials, one must not engage in activities that can transmit bloodborne pathogens. This includes activities such as, eating, drinking, applying cosmetics or lip balm, smoking, and handling contact lenses.

3. Gloves shall be worn where it is reasonably anticipated that one will have hand contact with blood, other potentially infectious materials, non-intact skin, and mucous membrane. Disposable gloves are not to be washed or decontaminated for re-use and are to be replaced when they become contaminated or as soon as feasible if they are torn, punctured, or when their ability to function as a barrier is compromised. Gloves should be made of latex, nitrile, rubber, or other water impervious materials. If glove material is thin or flimsy, double gloving can provide an additional layer of protection. Always inspect your gloves for tears or punctures before putting them on. If a glove is damaged, don't use it!

4. Masks in combination with eye protection devices, such as goggles or glasses with solid side shield, or chin length face shields, are to be worn whenever splashes, spray, splatter, or droplets of blood or other potentially infectious materials may be generated. They are to be worn when eye, nose, or mouth contamination can reasonably be anticipated.

5. In instances when gross contamination can reasonably be anticipated, appropriate protective clothing shall be worn. This includes:
   - lab coats
   - gowns
   - aprons
   - clinic jackets
   - caps
   - shoe covers

- booties
- similar outer garments

6. All contaminated equipment and work surfaces will be decontaminated after completion of procedures and immediately or as soon as feasible after any spill of blood or other potentially infectious materials. Decontamination will be accomplished by utilizing bleach solutions or EPA registered germicides.

7. Make certain that anyone providing treatment to athletes must check oneself for any cuts, sores, and/or wounds. These must be covered with a bandage or dressings with no fluid seepage. If any open wounds are present, it is best to avoid providing first aid until the wound is healed.

8. Do not contaminate the first aid/trauma bag with blood, it is best that someone else hands you the materials from the bag. Anyone assisting the main provider must also take proper precautions.

9. Equipment that has been contaminated with blood or other potentially infectious materials shall be decontaminated prior to reuse.

10. Handwashing is one of the most important and easiest practices used to prevent transmission of bloodborne pathogens. If you are working on the field, or an area without access to handwashing facilities, you should use an antibacterial cleanser in conjunction with clean cloth/paper towels or antiseptic towelettes. If these alternative methods are used, hands should be washed with soap and running water as soon as feasible.

PROPER CLEAN UP OF A BLOOD SPILL:

1. Wear gloves.

2. If there is debris, remove glass and other sharp materials with brush and dust pan, plastic scoop, etc. Do not use your hands.

3. Be sure to discard all material into a puncture resistant container that is properly labeled for biohazardous waste disposal.

4. Use absorbent materials, such as a paper towel to soak up the spilled materials. Always wipe towards the center of the spill.

5. After removing visual remainders of the spill, clean the area with disinfectant/detergent active against bloodborne pathogens. A solution of 5.25% of sodium hypochlorite (household bleach/Clorox) diluted between 1:10 and 1:100 with water. The standard recommendation is to use at least a quarter cup of bleach per one gallon of water. Allow it to stay in contact with the contaminated area for 20 minutes. If other bacterial/virucidal agent is used, check the label to make sure that it meets the requirement and follow manufacturer's instructions on its proper use.

6. Wipe the area of the disinfectant.

7. Apply disinfectant/detergent a final time, allowing agent to set for 10 minutes to air dry.

8. Place all contaminated items in a properly labeled biohazard bag. All towels or materials used to clean up the spill must be properly disposed of, according to state and federal regulations.

9. Wash your hands.

ASEPTIC TECHNIQUE FOR GLOVE REMOVAL:

1. Grasp the palm of the glove with your opposite hand.

2. Slowly pull of the glove, inside out, being careful not to touch the contaminated areas of your glove with your ungloved hand.

3. Scrunch the glove into a ball with your gloved hand.

4. Carefully slide your index finger inside your remaining glove.

5. Pull off your remaining glove, inside out, over your scrunched glove.

6. Dispose of the gloves in the biohazard trash receptacle and wash your hands immediately.

MEDICAL SUPPLY LIST:

Note: This is a basic list. There are certain sports that may require specific equipment and materials. Suit your medical bag to the specific needs of your sports event, in addition to this list.

Latex or nitrile gloves
Antibacterial hand cleanser
Scissors/trauma shears
Bandages (various sizes and shapes)
Sterile gauze pads (4 x 4)
Abdominal pads
Mass trauma dressing
Adhesive tape
Ziploc bags
Splints, variety of sizes
Pocket mask with oxygen inlet (several)
Household bleach or bacterial/virucidal agent
Bag Valve Mask
Wound cleanser
Antibacterial cream
Portable suction unit
Alcohol swabs
Betadine swabs
BP cuff
Stethoscope
Kling
Normal saline/sterile water
Note pad and pen
Scrub brushes

Pocket mask
Eye protection
Face protection
Liquid proof gowns
Biohazard disposal bags with labels

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Special Needs Application
Specific Accommodation Request Form

The information requested below and any documentation regarding your disability and your need for accommodation in testing will be considered strictly confidential and will not be shared with any outside source without your express written permission.

Name: _____

Address: _____ State _____ Zip _____

Phone: _____ E-mail: _____

Accommodations request for the _____exam administration.

Check all that apply:

_____ Accessible Testing Site
_____ Large print _____ Tape
_____ Reader as accommodation for visual impairment
_____ Scribe/amanuensis as accommodation for visual or motor impaired
_____ Separate testing area
_____ Seated away from doors and walk-ways
_____ Sign Language Interpreter
_____ Extended Time
  _____ Time-and-a-half
  _____ Double time
  _____ More than double time
    Specify: _____
_____ Other _____
_____

Comments:

_____
_____
_____
_____

Documentation of Disability Related Needs

If you have a learning disability, a psychological disability, or other hidden disability that requires an accommodation in testing, please have this section completed by an appropriate professional (education professional, doctor, psychologist, psychiatrist) to certify that your disability condition requires the requested test accommodation.

If you have existing documentation of having the same or similar accommodation provided to you in another test situation, you may submit such documentation instead of having this portion of the form completed.

I have known _____ since _____ in my capacity
(test applicant) (date)
as a _____.
(professional title)

The applicant has discussed with me the nature of the test to be administered. It is my opinion that because of this applicant's disability, he/she should be accommodated by providing the following: (check all that apply)

_____ Taped test
_____ Reader
_____ Separate testing area
_____ Other: (please specify) _____
_____ Large print test
_____ Scribe/amanuensis
_____ Seated away from traffic
_____ Extended time:
  _____ Time-and-a-half
  _____ Double time
  _____ More than double time

Signed: _____ Title: _____

Date: _____ License # (if applicable): _____

Recertification:

In order to protect and serve the public and profession, all ACBSP certificants must recertify their credential on a yearly basis. The recertification program is designed to enhance the continued competence of the certificants. The public listing on the ACBSP website, www.acbsp.com, clearly indicates those that are current with their recertification. The complete ACBSP Recertification and Continuing Education Policy follow:

AMERICAN CHIROPRACTIC BOARD OF SPORTS PHYSICIANS™
RECERTIFICATION AND CONTINUING EDUCATION POLICY

I. Introduction.

Effective January 1, 2001, this policy sets forth information regarding ACBSP recertification requirements, including certain changes in the standards, guidelines and procedures of the ACBSP Policy on Continuing Education. While the objectives of the Continuing Education Program remain the same, these revisions are intended to clarify all requirements and guidelines concerning the ACBSP recertification process and to simplify administrative procedures.

II. Statement of Purposes.

The ACBSP Board of Directors has established a Continuing Education Program as part of the recertification process for ACBSP certificants: Diplomates of the American Chiropractic Board of Sports Physicians (DACBSP) and Certified Chiropractic Sports Physicians/Practitioners (CCSP). Among other purposes, the Recertification and Continuing Education Policy is intended to: promote continued competence by requiring ACBSP certificants to demonstrate a current level of professional knowledge and skills; and, encourage ACBSP certificants to advance and enhance their knowledge and skills within the sports chiropractic profession in order to become recertified.

III. Recertification Process and Requirements.

As explained in this policy, certificants may become recertified by either: retaking and passing the appropriate ACBSP Certification Examination(s); or, meeting the educational and professional activity requirements of the ACBSP Continuing Education Program. Additionally, all ACBSP certificants must maintain current CPR certification in order to maintain certification.

All examination policies, deadlines, fees and site availability rules apply to any examination retake for recertification purposes. A doctor cannot receive his/her certification and recertification from the same examination(s).

A. Certification Examination Retake. Certificants may choose to retake their respective Certification Examination(s) in order to become recertified.

1. CCSP Requirement. **Successful completion of the CCSP Certification Examination.**

2. DACBSP Requirement. **Successful completion of both the written and practical DACBSP Certification Examinations.**

B. Continuing Education Program. Certificants may seek recertification through continuing education activities. A minimum number of continuing education units (CEUs) must be accumulated every one-year period following ACBSP certification, as described below. The ACBSP has established the following CEU requirements:

1. **CCSP Requirements.** Completion of twelve (12) CEUs every one-year period.

2. **DACBSP Requirements.** Completion of twenty-four (24) CEUs every one-year period.

The ACBSP grants CEUs to certificants for participation in educational and practical activities meeting specific criteria, as described in this policy. Credits may only be applied to the one-year period in which they are earned. Therefore, unless otherwise permitted by this policy, credits earned in excess of the requirements may not be applied to the next or a previous one-year period.

C. Maintenance of CPR Certification. In order to become recertified, all certificants must maintain current CPR/AED certification from one of the following organizations: American Heart Association (BLS for the Healthcare Provider) or American Red Cross (Professional Rescuer). CPR recertification must be documented by submitting a photocopy of the renewed card to the ACBSP office.

IV. General Continuing Education Requirements.

The ACBSP has established a yearly (12 month) time period, or cycle, for the completion of recertification requirements. Under the Continuing Education Program, a certificant must earn the required number of CEUs within each one-year period in order to become recertified.

A. Initial Period. The initial period under this policy began January 1, 1996 and ended December 31, 1998.

B. One-Year Period. Effective January 1, 2001, each continuing education unit cycle applicable to all ACBSP certificants will be a one-year period, i.e., January 1, 2001 through December 31, 2001, and each one-year period thereafter. Continuing education requirements become effective January 1 of each year following initial certification, except as otherwise permitted by this policy. The rationale for a one-year period is that protocols for the emergency management of an injured individual are in transition (i.e. traumatic brain injury, concussion) and emergency medicine skills are infrequently required to be used, but mastery of these skills is of very high importance.

C. Application of CCSP Credits to DACBSP Requirement. A CCSP who successfully achieves DACBSP certification within the same one-year period may apply to ACBSP for permission to use CEUs previously credited to the CCSP requirements toward the DACBSP continuing education requirement.

The application must be in writing and must state, in detail, the reasons that the request should be granted.

D. **Reporting Continuing Education Activities/Maintenance of Personal Records.** All certificants must maintain in their possession, documented proof of completion of any applicable continuing education activity, including copies of any documentation submitted to the ACBSP. Renewal forms and documentation should be submitted to the ACBSP within thirty (30) days upon completion of the continuing education activity. A renewal form is available from the ACBSP office upon request; the form is also posted on the ACBSP web site (www.acbsp.com). The ACBSP may request additional information or clarification of a specific program or activity prior to final acceptance and granting of credit, or at a future time.

E. **Fees.** The ACBSP will assess a yearly recertification fee for recording, tracking, maintaining and reporting CEUs to all certificants. An invoice will be sent to the certificant for the fee in the year that it is due. The annual fee will be assessed for the recertification period or year following initial certification. Beginning January 1, 2004, the annual fee must be paid by January 31 in order to maintain active certification/recertification status. Recertification fees will be determined by the Board of Directors on an annual basis.

F. **Reduction or Waiver of CEU Requirements.** The ACBSP will consider requests for the reduction or waiver of recertification fee requirements based on specific, individual, mitigating circumstances, including undue hardships and unforeseen circumstances which prevent timely completion of such requirements. Requests for the reduction or waiver of recertification fee requirements must be submitted in writing and must contain complete information supporting the request for the reduction or waiver. ACBSP retains the sole and exclusive authority to grant or deny a reduction or waiver request. Formal notification of the ACBSP decision will be forwarded to the certificant.

1. **Retired/Disabled/Military Certificants**. Any certificant who has withdrawn from active chiropractic practice due to retirement, disability, or active-duty military services and wishes to keep his/her certification active must immediately notify the ACBSP in writing. Recertification fees will be reduced by 50% for only the time that the certificant is not practicing. CEU requirements will still be required on an annual basis and current CPR certification will be required. Documentation of retirement, disability or active-duty military services must be provided to the ACBSP office for verification.

2. **Full-time Faculty Certificants**. Any certificant who is also a full-time faculty and wishes to keep his/her certification active must immediately notify the ACBSP in writing. Recertification fees will be reduced by 50% for only the time that the certificant is a full-time faculty. CEU requirements will still be required on an annual basis and current CPR certification will be required.

G. **Inactive Certification Status.** A certificant will become inactive and placed on an inactive list of certificants, under the following circumstances:

1. **Withdrawal from Practice/Retired Inactive Status.** Any certificant who has withdrawn from active chiropractic practice must immediately notify the ACBSP and will be placed on an inactive list of retired certificants. Such retired certificants are permitted to retain inactive certification status and may seek to activate certification upon application to the ACBSP, under policies to be established by the Board of Directors.

2. **Failure to Meet Recertification Requirements.** If a certificant fails to meet the appropriate recertification requirements within an established one-year period, the certificant will be placed on an inactive list, unless otherwise permitted by this policy. Such inactive certificants are prohibited from identifying themselves as certified by the ACBSP, until such time as active certification status has been granted by ACBSP, within its sole and exclusive authority, appropriately.

   In order to regain active status, a certificant must make application to the ACBSP, within six (6) months of the date of inactive status. In order to be considered, the certificant is required to: submit a written statement to the ACBSP Board, explaining and detailing a compelling reason/basis for the reactivation; and, complete the appropriate recertification requirements consistent with this policy. If a certificant fails to regain active status following the end of the six-month period, inactive certificants will be removed from all lists of certificants. In the event that active certification status is sought thereafter, the individual must reapply for certification and successfully complete the respective certification process.

V. Continuing Education Activity Guidelines.

All continuing education activities are subject to ACBSP review and approval. Therefore, in order to ensure acceptance of a continuing education activity, certificants are strongly encouraged to contact the ACBSP prior to participating in an activity to confirm whether credit may be granted for completion of such activity.

A. Categories of Acceptable Activities. Unless otherwise noted by this policy, all continuing education activities must be sports medicine or fitness related in order to be accepted by the ACBSP.

1. **Formal Academic Educational Courses.** This category includes participation in educational programs designed to enhance physician knowledge and clinical competency and to improve patient care. Programs must be related to the field of chiropractic sports medicine. Such activities must be completed following initial certification and must satisfy the quality guidelines described in Section V. C, below.

2. **Professional Conferences, Meetings, Seminars, Workshops.** This category includes attendance at qualified professional conferences, meetings, seminars and workshops (events) designed to enhance physician knowledge and clinical competency and to improve patient care. Participation in events must satisfy the quality guidelines described in Section V.C, below. Qualified events may include, but are not limited to: the ACBSP Annual Chiropractic Sports Sciences

Symposium; and, other professional and educational activities, subject to review and approval by the ACBSP.

3. **Scientific Papers and Publications.** This category includes development, authorship and/or presentation of scientific papers, abstracts and publications intended for chiropractic physician education. An original scientific paper is defined as one that reflects a search of literature, appends a bibliography and contains original data gathered by the author. Such activities may include, but are not limited to: a published manuscript in a peer-reviewed journal; and, a book, or chapter of a book related to the field of chiropractic sports medicine. A copy of the paper/publication in finished form must be submitted to the ACBSP for review and approval. Papers and publications will be judged on a case-by-case basis and the number of CEUs granted will not exceed 50% of the annual continuing education requirement.

4. **Professional Services.** This category includes activities involving substantive participation or service related to the review, evaluation, development and application of chiropractic sports physician knowledge and competency. Such activities may include, but are not limited to: service on ACBSP examination committees, including Angoff Value, Item Writer and Item Evaluation Committees; defined service in a specific project as a professional consultant or subject matter expert related to the field of chiropractic sports medicine; and, service on a medical team or as a treating doctor during a nationally recognized athletic event. CEUs for service on a medical team or as a treating doctor during a nationally recognized event will be calculated as 0.25 CEU per hour of active participation with a maximum of 50% of the annual continuing education requirement allowed per year. A verification form is available from the ACBSP office upon request; the form is also posted on the ACBSP web site (www.acbsp.com).

   A DACBSP or CCSP who completes an internship at an Olympic Training Center, or is a member of a medical team for the Goodwill Games, PanAmerican Games or the Olympic Games for the United States will fulfill the entire continuing education requirement for the one-year period in which they served.

5. **DACBSP Mentorship of CCSP.** This category includes participation in activities specifically by CCSPs under the direct supervision of a mentoring DACBSP. Only CCSPs may earn continuing education credit under this category. In order for any activity to be approved and accepted, the CCSP and mentoring DACBSP must submit a detailed plan for ACBSP review at least thirty (30) days prior to the proposed date of the activity, including the following information: the subject and practice area(s) addressed by each proposed activity; the anticipated number of contact hours to be earned for each proposed activity and relevant dates; the number of credits requested upon completion of each activity; the names, addresses and contact information of both the CCSP and DACBSP; and, an express, written and signed statement by both certificants indicating that the mentorship will not involve any type of monetary exchange between parties. CCSPs must maintain a written daily journal, including

detailed explanations of the skills learned and knowledge gained during the mentored experience and may be required to prepare patient summary case reports. CCSPs will be granted 1.0 CEU for every four (4) hours of practical activity completed, with a maximum of 8.0 CEUs that may be earned under this category during any one-year period. Credit is not granted for coffee breaks, social functions, or time allotted to business or administrative matters.

6. **Home Study.** This category includes self-educational activities designed to enhance knowledge and clinical competency and to improve patient care. Such activities may include, but are not limited to: the review and analysis of professional journals recognized by the professional, scientific community, and successful completion of the self test (quiz) included in the journal. Quiz results must be sent in to the ACBSP Board Secretary. All activities must be reviewed and approved by the ACBSP. Certificants will be granted 1.0 CEU per quiz successfully completed and approved. In any given one-year period, CCSPs and DACBSPs may earn a maximum of 3.0 CEUs under this category.

   On-line Course Learning: CEUs can be earned on-line and must satisfy the quality guidelines described in Section V.C, below. In any given one-year period, CCSPs and DACBSPs may earn a maximum of 50% of the annual continuing education requirement per year

7. **Non-ACBSP Certifications and Specialties.** This category includes the satisfaction, completion and maintenance of professional certification(s) in sports-related disciplines, administered by other recognized organizations, including: Athletic Training Certification by the National Athletic Trainer's Association Board of Certification; EMT Certification by an authorized EMT certifying organization; and Certified Strength and Conditioning Specialist by the NSCA Certification Commission. In any given one-year period, CCSPs and DACBSPs will be exempt from ACBSP continuing education requirements, as long as all certification and recertification requirements are completed in compliance with the respective organization's requirements. A request for exemption, including supporting documentation of such other recognized certification(s), must be submitted to the ACBSP for review and approval.

8. **Other Continuing Education Activities.** This category includes other continuing education activities that may be considered for credit by the ACBSP.

B. **Categories of Unacceptable Activities.** Programs comprised of Adjustive techniques will not be approved for CEU credits without the express, written consent of the ACBSP

C. **Quality Program Guidelines and Requirements.** Unless otherwise noted by this policy, all CEU activities accepted by the ACBSP must satisfy the following guidelines and requirements. These rules are provided to assist certificants in evaluating whether a program or activity may satisfy ACBSP Continuing Education requirements. These standards are not intended to

suggest that a program appearing to satisfy these criteria will be approved or disapproved by the ACBSP.

1. **Relevant Content.** The activity must have significant intellectual or practical content, the primary objective of which is to improve the professional competence of participants. The activity must be an organized program of learning designed to provide education in subjects directly relating to sports and/or fitness medicine.

2. **Stated Objectives.** The activity must have stated and printed educational objectives. The objectives must state what the practitioner will know or be able to do upon completion of the activity.

3. **Non-Restricted Participation.** The program must be described in a detailed statement prepared by the sponsor or certificant which explains the type of audience for whom the activity is designed and the relevancy of the program to the professional practice needs of participants. The activity must be non-discriminatory and open to all practitioners interested in the subject matter.

4. **Instructor Competency.** The credentials of the program instructors must be provided to the ACBSP. The instructors must have appropriate expertise and adequate credentials necessary to conduct the program effectively, including knowledge of content area, qualification by relevant experience and competence as an instructor.

5. **Attendance Records.** The sponsor or provider must monitor the CEU activity for attendance and maintain records to assure that participants may be given proper credit for continuing education.

6. **Course Materials.** Each participant must be provided with thorough, high quality and carefully prepared written course materials before or at the time of the activity. Although written materials may not be appropriate to all courses, they are expected to be utilized whenever possible.

7. **Adequate Facilities.** The program must assure that proper facilities and equipment are provided to enable the presenter to teach effectively. The activity must be presented in a suitable setting conducive to education, including the provision of adequate writing space or surface for participants.

D. **Granting Credit.** In all cases, credit is granted only after the educational activity has been completed and documented. Unless stated otherwise in this policy, certificants will be granted 1.0 CEU for each contact hour of professional or educational activity completed, consistent with the terms of this policy. Beyond the initial hour, one-half CEU (0.5) will be granted for completion of at least thirty (30) additional minutes, but less than sixty (60) minutes. Credit is not granted for coffee breaks, social functions, or time allotted to business or administrative matters.

E. **Credit Denial.** The ACBSP reserves the sole and exclusive right to evaluate all programs and activities on an individual basis, and to deny credits at its discretion to those which do not meet the criteria described in this policy.

The number of CEUs indicated for a program by other organizations will be considered by the ACBSP in its evaluation. However, the ACBSP reserves the sole and exclusive right to make final determination of the number of credits granted. The certificant will be notified of a decision where CEUs are reduced or denied, including the basis for such action.

AMERICAN CHIROPRACTIC BOARD OF SPORTS PHYSICIANS™

DACBSP® PRACTICAL REQUIREMENT POLICY

Candidates for the DACBSP® must complete 100 credit hours of practical experience (Practicum) in addition to the 200 hour minimum of course instruction, successful completion of the written and practical examinations and written requirement. Practical experience hours will be accepted from:

1. The point in time the doctor received his/her CCSP® or started the DACBSP program. (The non-CCSP enrolled in the DACBSP program must complete the program before receiving full credit hours);
2. And **up to** three (3) years from completion of the DACBSP program.

The following criteria will apply to the practical hour's requirement:

1. One hundred (100) hours of hands-on experience are required.
2. Experience must be performed outside of the doctor=s personal office.
3. Practical experience is calculated by applying the sliding credit scale in this document.
4. There will be a review committee set up by the ACBSP™ to verify hours and to consider applications of the sliding scale to hours obtained prior to having a CCSP certification.
5. The doctor is expected to submit verified hours prior to receiving their Diplomate certification.

The practical hours may be earned in (but may not be limited to) the following ways:

1. By working at events approved by the ACBSP
2. By working at other regional, national, or international events*
3. By working a Sports Rehabilitation Center +
4. By working as a verified team doctor
5. By assisting a team doctor (No more than 40 hours)
6. By setting up and performing multi-disciplinary pre-participation physical examinations (No more than 40 hours) +
7. By participating in an internship at the Olympic Training Center(s).

* Such events must be appropriately verified (see below)

\+ Special criteria apply (see below)

VERIFICATION PROCESS

1) If time is worked through an event approved by the ACBSP, written verification is performed by the Event Coordinator using the proper form.

2) Verification of events not approved by the ACBSP must be provided by the administrator. No verification will be accepted from coaches. Administrators are athletic directors, school principals, and administrators of various league sports. Verification forms for this purpose will be made available by the ACBSP, and must be notarized prior to submission. Alternate verification will be accepted only at Board discretion.

REHABILITATION CENTERS

1) Rehabilitation centers must be approved by the ACBSP or the postgraduate department of the program sponsoring school.
2) The ACBSP approved rehabilitation centers may include on-campus facilities, private enterprises, or CARF approved facilities.

PRE-PARTICIPATION SPORTS PHYSICAL EXAMINATION

1) Exam program must be multi-station in format and use varied personnel in addition to the candidate. *(Multi-disciplinary approach is highly recommended).*
2) Exams include physical examination and exercise testing.
3) The candidate must attach a written report of the examination process, number of athletes examined and any unusual cases.

OBSERVATION CREDIT

Partial credit may be obtained by the following categories of observation.
Maximum credit is 10 hours per category.

1. Rounds performed with an orthopedic surgeon or physiatrist, whose practice emphasizes sports medicine.
2. Observation time spent riding in an ambulance.
3. Observation time spent in an emergency room.
4. Time spent observing or working in an exercise physiology lab in a University setting.

***The observing doctor must prepare a narrative report of their observations, and submit it to the appropriate committee in order to obtain credit.**

SLIDING SCALE FOR PRACTICUM HOURS

1. A candidate will receive 1.0 credit hour for each 1.0 hour of practical experience obtained after the doctor has received his/her CCSP.
2. A Non-CCSP will receive 1.0 credit hour of practical experience obtained while enrolled in the DACBSP program conforming to the ACBSP Bylaws.
3. A candidate will receive 0.5 credit hour for each 1.0 hour of practical experience obtained prior to receiving their CCSP.

Revised July 31, 1998

DACBSP® PRACTICAL EXPERIENCE LOG

COMPLETION INSTRUCTIONS

The following packet of information is to be used for the completion of your practical experience hours. Please read all the enclosed materials before submitting your hours. Reviewing these guidelines will help to ensure your submitted hours will be accepted.

1. **Enclose a brief typewritten report on each portion of your practical experience, containing information on what you observed or treated and attach it.**

2. Make sure that you have proper verification of the hours. See the attached sheet for further information on the verification process.

3. Do not send your experience log in until you have fully completed your one hundred hours of experience.

4. Send your completed log to:

   ACBSP™
   103 SOUTH 6TH STREET
   ESTHERVILLE, IA 51334-2360

***Remember to submit a brief typewritten description of your duties or observations to support your practical experience log.**

FIELD DOCTOR VERIFICATION FORM

PLEASE TYPE

NAME	
ADDRESS	
CITY	OFFICE PH
STATE	HOME PH
ZIP CODE	CCSP® CERT #
DIPLOMATE COLLEGE	

PRACTICAL EXPERIENCE VERIFICATION

I verify that the information that I have submitted concerning my practical experience hours is true and correct. I understand that if any false information has been included, my postgraduate degree may be withheld.

SIGNED _____ DATE _____

TYPE NAME _____

SPORTS EVENT FIELD DOCTOR PARTICIPATION FORM

NAME _____ PHONE _____

ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

SPORTS DIPLOMATE COLLEGE COMPLETION DATE _____

EVENT _____ DATE _____

OF HOURS _____

RESPONSIBILITIES _____

_____

EVENT COORDINATOR SIGNATURE _____ DATE _____

EVENT COORDINATOR COMMENTS _____

_____

_____

_____

_____

_____

***Please note**: Sports administrators, athletic directors and school principals are authorized to verify participation. Coaching staff are **not** authorized to do so. Please feel free to copy this sheet as often as needed.*

AMERICAN CHIROPRACTIC BOARD OF SPORTS PHYSICIANS™

DACBSP® WRITTEN REQUIREMENT POLICY

Effective June 1, 1992

In order to satisfy the written requirement for certification as a Diplomate American Chiropractic Board of Sports Physicians® (DACBSP), the candidate must complete this requirement and submit it for approval within five (5) years of completion of the DACBSP program. The candidate is required to submit four copies of their materials to the ACBSP™.

Option 1. Provision of acceptable proof of having a paper **accepted for publication** in a referred and indexed research publication/journal. Acceptance for "consideration to publish" does NOT meet the written requirement.

*This paper should be related to the field of chiropractic sports medicine, and must be (or have been) accepted for publication within five (5) years following completion of the DACBSP program.

Publication Requirements Criteria

In general, the American Chiropractic Board of Sports Physicians (ACBSP) has recommended that all papers submitted for publication meet the following general criteria of authorship:

Original Research	No more than 3 authors
Case Presentation	No more than 2 authors
Literature Review	No more than 1 author
Abstract Published at Sports Sciences Symposium	No more than 2 authors
Poster Presentation at Sports Sciences Symposium	No more than 2 authors

Option 2. The candidate may choose a written project from the following list of options. This project must also be completed and approved by the ACBSP within five (5) years of completion of the DACBSP program. All projects must be submitted in standard Vancouver Declaration format (uniform requirements for manuscripts submitted to biomedical journals), and will be reviewed by an ACBSP appointed review committee.

Projects:

1. 1 Literature Review
2. Publish 1 Book or 1 Chapter in a Book
3. 3 Critical Analyses of Journal Articles

Criteria for Evaluation of the Above Projects:

1. Literature Review

   a. Topic relevant to chiropractic sports medicine
   b. Thorough review of subject (all points of view, etc.)
   c. Proper format, including an abstract

d. Method of identifying sources and inclusion of material clearly identified.
e. Critical analysis of variant material, and good combination of materials
f. Clear summary, supported conclusions
g. Properly referenced

2. Publish One Textbook or a Chapter in a Textbook

a. Topic relevant to chiropractic sports medicine
b. Appropriate in detail and length
c. Properly supported conclusions
d. Writing is clear and in a professional style
e. Properly referenced

3. Three Critical Analyses

a. Articles must be chosen from referenced publications and be relevant to chiropractic sports medicine
b. Relevance to chiropractic sports medicine and clinical practice clearly stated
c. Analysis includes critique of design, variable control, hypotheses validity, subject selection and grouping, statistical analysis and reference choice
d. Discussion includes evaluation of clinical and statistical significance, appropriateness of conclusions and consideration of alternative hypotheses or explanation
e. Bibliography is analyzed for appropriateness of content
f. Critique is supported by references which are relevant, current and appropriate
g. Copies of articles analyzed must be submitted along with analysis

Revised May 15, 2003

AMERICAN CHIROPRACTIC BOARD OF SPORTS PHYSICIANS™

RECORDS AND FILE RETENTION POLICY

Effective November 10, 1997

Section 1: The ACBSP™'s Records Management program provides systematic control of information from creation to final disposition. The Records Management program also provides a timetable and consistent procedures for maintaining the ACBSP's information including all media, moving the records to inactive storage when appropriate, and disposing of the records when they are no longer valuable to the organization. The ACBSP™ shall keep current and complete books and records of account and shall also keep minutes of the proceedings of its members and Board of Directors, and shall keep these records at the registered or principal office of record. The ACBSP shall keep the names and addresses of the numbers and the due payment status of each certificant. Any voting member in good

standing may inspect the books and records of the ACBSP at any reasonable time. All files will be held in the strictest confidence.

File contents will not be discussed unofficially at meetings or informally in the office. The Board Secretary shall determine file content. A candidate database will be maintained to ensure consistent documentation of certification criteria. This includes examination scores and any other certification qualifications. ACBSP Board of Director members and all committees appointed by the ACBSP will maintain strict confidentiality of certification files and other candidate information. In addition, file contents will not be available to the public, employers or other certificants. Public information may include whether or not an individual has certification, the date of certification, however, specific examination scores or specific qualifications will not be made public. Information regarding minimum qualifications, which all candidates must satisfy, to be approved may be released.

Section 2: Reason for Policy - The Records Management policy will do the following: reduce the cost of records maintenance; retain records as required by federal, state, and other regulatory agencies; preserve the records that are vital to the ACBSP; and provide needed documentation in the event of litigation.

Section 3: Records Retention Schedule - The ACBSP Records Retention Schedule applies to all ACBSP certification materials. In addition, this retention schedule applies to all formats of information, including but not limited to hard copy paper records, electronic media, and microforms. Electronic records must be maintained according to the following retention schedule and destroyed when the retention period for that format has been met. Electronic records such as word processing documents may be destroyed if a paper copy has been made and filed in the ACBSP's record keeping system.

ACCOUNTS RECEIVABLE RECORDS
This series consists of documentation of charges made (i.e. invoices) and payments received for goods and services provided by the ACBSP. Accounts receivables exist when there is a timing difference between providing the goods or services and the payment of the same.
Recommended retention: 7 fiscal years

ACCREDITATION RECORDS
This consists of reports and supporting information documenting the process of becoming accredited by the ACBSP and/or activities associated with reporting and/or confirming accreditation or certification. These documents include examination applications, their supporting documentation and materials supporting a doctor's achievement of DACBSP®/CCSP® certification.
Recommended retention: Retain records pertaining to current certification as long as the certificant remains current. If the certificant fails to maintain their credential the certificants records will be maintained for two accreditation periods prior to destruction.

ADMINISTRATIVE POLICY RECORDS
This series may include chronological reading files, bound reports, tape recordings, photographs, examination results and other information types, all of which document the activities of the certificant.
Recommended retention: 3 years.

ADMINISTRATIVE SUPPORT RECORDS
This series documents the administrative records that are used to carry out the

functions of the office.
Recommended retention: 3 fiscal years

ADMISSIONS APPLICATIONS
This series consists of applications of candidates that have been denied, declined admission or did not successfully complete the examination.
Recommended retention: 4 years from which application is processed provided no litigation is pending. As long as a candidate is eligible to complete the certification process, their files will be maintained.

ANNOUNCEMENTS AND INFORMATION: ROUTINE
This series consists of information transmitted between parties. This information does not result in the formulation of policy or contract. It may be transmitted electronically or in hard copy; internally between employees, or externally; and may include but is not limited to notices of seminars, conferences or workshops, queries regarding processes or ideas, electronic journals and general information of programs.
Recommended retention: Retain until obsolete, superseded or administrative value is lost.

ASSESSMENT RESULTS AND CANDIDATE SCORES
This series consists of answer sheets, practical grading sheets, cut score reports, job analysis reports and statistical reports.
Recommended retention: Permanently

BALLOTS
This series consists of ballots used by internal departmental or college committees.
Recommended retention: 60 calendar days after ballots counted and results posted.

BANK STATEMENTS
Recommended retention: 1 fiscal year.

BILLING RECORDS - SUBCONTRACTOR
This series consists of subcontractor information regarding billing, and includes monthly reconciliation records, invoices and correspondence.
Recommended retention: 3 fiscal years.

BUDGET FILES
This series consists of internal budget worksheets and files.
Recommended retention: 3 fiscal years.

COMMITTEE FILES
This series documents the service of individuals on ACBSP committees and boards.
Recommended retention: Retain until obsolete, superseded or administrative value is lost.

CONTINUING EDUCATION REQUIREMENTS
These documents are related to the certificant maintaining eligibility through continuing education.
Recommended retention: Documentation will remain in a certificants individual file for a period of three years following the end of each certifying period. It is recommended that each certificant maintain his/her personal file of documentation of certification notice, CCSP® and/or DACBSP® certificate and maintenance of

continuing education requirements. Upon notification that candidate is deceased, their file will be retained for historic records and possible future recognition.

CONTRACT FOR PROFESSIONAL SERVICES
This series consists of contracts for consulting services provided by non-ACBSP sources.
Recommended retention: 3 fiscal years after termination of contract

ENDOWMENT/DONOR/GIFT FILES
This series documents financial contributions received from individual donors and from business and industry sources. Master record maintained at ACBSP offices.
Recommended retention: 5 fiscal years.

EQUIPMENT FILES
This series documents purchases of equipment, and may include but is not limited to warranties and purchase information.
Recommended retention: 4 years after disposal of equipment.

EXPENSE BUDGET / REVENUE FORMS
This series consists of the forms sent to the ACBSP Office, and are used to set up accounts and reimbursements.
Recommended retention: Budget Office: 3 fiscal years.

FINANCIAL REPORTS
This series consists of copies of departmental computer generated fiscal reports.
Recommended retention: Permanently.

GRIEVANCE RECORDS
This series consists of department copies of grievance files.
Recommended retention: 7 years after grievance resolved and appeal process is exhausted.

INFORMATION REQUEST RECORDS
This series consists of correspondence accumulated in answering inquiries from the public, and may be held electronically in word processing files.
Recommended retention: 60 days after response.

MEMORANDA
This series consists of interoffice or interdepartmental communications, which do not subsequently result in the formulation of policies.
Recommended retention: Retain until obsolete, superseded or administrative value is lost.

PAYROLL RECORDS
This series may include but is not limited to copies of payroll records, such as W-2's, Earnings Records, Deduction Registers, and departmental abstracts. Master record maintained at Payroll.
Recommended retention: Payroll Master Record: 7 calendar years.

CERTIFICANT EDUCATION RECORDS
This series consists of departmental copies of exam applications, transcripts, correspondence and certification information. Master record maintained at the ACBSP Office.

Recommended retention: Retain records pertaining to current certification as long as the certificant remains current. If the certificant fails to maintain their credential the certificants records will be maintained for two accreditation periods prior to destruction.

TELEPHONE MESSAGES
This series consists of common telephone message books or slips filled out by employees, and may also include electronic phone messages.
Recommended retention: Retain until obsolete, superseded or administrative value is lost.

VENDOR INVOICE (PV)
This series consists of the vendor invoice used to pay external billings from vendors. Master record maintained at Disbursement Services.
Recommended retention: 7 fiscal years.

WORKSHOP / SYMPOSIUM RECORDS
This series consists of registration fees, publications and correspondence related to workshops conducted or sponsored by the ACBSP.
Recommended retention: 3 fiscal years.

*Please refer to the ACBSP Continuing Education Policy for complete information regarding keeping your certification current and in good standing with the ACBSP.

Revised July 31, 1998
Revised May 1, 2003

ATTACHMENT

D

ABSTRACT 18

A SURVEY OF CHIROPRACTORS ACCESS TO PERFORM PRE-PARTICPATION EXAMINATIONS (PPEs)

Anne Sorrentino, DC, CCSP, Andrea Sciarrillo, DC, CCSP and Richard Rinzler, DC, DACBSP®, FICC

OBJECTIVE: The purpose of this survey is to determine if there is consistency across the United States in allowing chiropractors to perform pre-participation examinations.

METHODS: Addresses for both the state chiropractic boards (SBCs) and the state athletic associations (AAs) were located via the internet. A letter was generated and emailed to each state. The wording in the letters going to the state boards of chiropractic and athletic associations were altered appropriately. Return receipts were requested. If no answer was received within 2 weeks, a second request was sent. If two more weeks went by without a response, a phone call was placed to the individual. Results were then tallied into an Excel spreadsheet, including specific comments. Responses were received form all states.

RESULTS: 70% (35) of the chiropractic boards have policies allowing PPEs by DCs; 26% (13) have no policy; and 4% (2) specifically deny DCs to perform PPEs. 36% (18) AAs have policies allowing PPEs by DCs; 14% (7) leave the decision up to the local school boards; 42% (21) AAs specifically deny DCs; 4% (2) AAs have no policy; and 4% (2) have policies that require legal interpretation. Colorado uniquely requires the chiropractor to be "school physical certified". Oregon and Washington expressed concerns about the chiropractor's ability to detect cardiac pathologies. Washington has handled this by allowing chiropractors only to perform PPEs as part of a team. Rhode Island and Vermont have no PPE policy. Nevada declares the issue is under review. New Hampshire and Nebraska have policies subject to interpretation. The reason for some of the athletic associations refusing DC-performed PPEs is the issue regarding the DC's ability to detect cardio pathology/cardio-monitoring. They believe chiropractors do not know how to do this, or do not do it with enough regularity.

CONCLUSION: The ability for DCs to perform pre-participation examinations (PPEs) is determined by the policies of three entities: state Board of Chiropractic Examiners (BCE), state high school athletic associations (AA), and, at times, the local school board. There is inconsistency between the BCEs and the AAs, as a majority of BCEs permit chiropractic-performed PPEs, but only a fraction of state AAs allow them. Most state boards of chiropractic have a specific policy regarding PPEs. Those state boards allowing chiropractors to do PPEs consider it "within the scope of practice" based on the fact that physical examinations were taught in chiropractic college. While a chiropractic board will permit a PPE to be performed by a chiropractor, it may not always be accepted by the school requesting the exam. The state's school athletic associations can override the state board decisions. Unfortunately there is not always consistency between the two. And, a local school board can override the athletic associations' decision. There are state athletic associations that have devised specific methods and guidelines to handle their individual concerns.

State PPE Information

STATE	BCE	Ed--Athletic Associations
Alabama	Yes	No
Alaska	Yes	No
Arizona	Yes	Up to local school boards
Arkansas	Yes	Yes
California	Yes	Yes/No definition medical practitioner up to local sch boards
Colorado	no policy	If "School physical certified"
Connecticut	Yes	Yes, per local schools
Delaware	No policy	No, only MD/DO
Florida	No Policy	Yes
Georgia	Yes	No
Hawaii	Yes	No
Idaho	Yes	Yes
Illinois	No Policy	No, only those DCs licensed to practice med in all its branches
Indiana	No Policy	No
Iowa	Yes	Yes
Kansas	Yes	Yes
Kentucky	Yes	Yes
Louisiana	No policy	Yes, per local school boards
Maine	No policy	up to local school boards
Maryland	Yes	No
Massachusetts	Yes	No
Michigan	No Policy	No
Minnesota	Yes	Yes
Mississippi	No Policy	No
Missouri	Yes	Yes
Montana	Yes	Yes
Nebraska	Yes	? w/in scope of training, w/in state statutes
Nevada	Yes	no, but they claim they plan on reviewing it
New Hampshire	Yes	? w/in meaning of NH RSA 329 (physicians & surgeons)
New Jersey	no	No
New Mexico	Yes	Yes
New York	Yes	Up to local school boards
North Carolina	Yes	No
North Dakota	Yes	Up to local school boards
Ohio	Yes	Yes
Oklahoma	Yes	Yes
Oregon	Yes	Yes, but concerned about able to detect cardio pathology
Pennsylvania	Yes-no real policy	No, only MDs, Dos, CRNPs, RNs
Rhode Island	No policy but can do bloodwork	No policy
South Carolina	Yes	No, do not recognize a PPE from a DC
South Dakota	Yes	Yes
Tennessee	Yes	No
Texas	Yes	Yes
Utah	Yes	Yes, I think I might move here-nice people, great skiing
Vermont	no policy	No policy
Virginia	no policy	No
Washington	No	Yes, but not individually-only as part of a team-concerned about cardio path
West Virginia	Yes	Yes, actually cited by the Attorney General, but school can say no
Wisconsin	Yes	No
Wyoming	Yes	No

ATTACHMENT

E

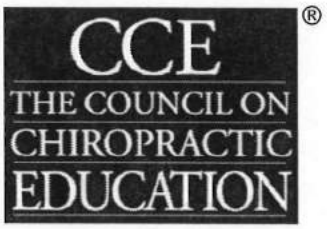
Congress Of Chiropractic State Associations
Responses to Inquiry on Ability to Perform
Pre Participation Examinations

State	Answer
Alabama	NO
Alaska	statute silent, up to school districts
Arizona	NO
California	YES
Colorado	YES
Connecticut	NO
Delaware	NO
Florida	YES
Georgia	NO
Hawaii	NO
Idaho	YES
Illinois	NO
Indiana	NO
Iowa	YES
Kansas	YES
Kentucky	YES
ucky Chiropractic Associatio	YES
Louisiana	statute silent, up to school districts
Maine	NO
Maryland	NO
Massachusetts	NO
Michigan	NO
Minnesota	YES
Mississippi	NO
Missouri	YES
Montana	YES
Nebraska	NO
Nevada	YES
New Jersey	YES
New Mexico	YES
New York	NO
North Carolina	NO
North Dakota	NO
Ohio	YES
Oklahoma	
Oregon	
Pennsylvania	
Rhode Island	YES
South Carolina	NO
South Dakota	YES
Tennessee	YES
Texas	YES
Virginia	NO
Vermont	YES
Washington	NO
West Virginia	YES
Wisconsin	NO
Wyoming	YES

ATTACHMENT

F

The Council on Chiropractic Education®



Standards

for

Doctor of Chiropractic Programs

and

Requirements for Institutional Status

January 2007

8049 N. 85th Way
Scottsdale, Arizona 85258-4321
Tel: 480-443-8877
Fax: 480-483-7333
E-Mail: CCE@CCE-USA.org
Website: www.CCE-USA.org

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Foreword

This manual describes the Council on Chiropractic Education (CCE), its process of accreditation and its educational standards of the CCE for Doctor of Chiropractic Degree Programs (DCP's).

Description and Role of The Council on Chiropractic Education (CCE)

The CCE is an autonomous national organization. It develops its own *Bylaws*, and the requirements and procedures for accreditation of chiropractic programs and institutions, which are applied by the Commission on Accreditation (COA).

The accreditation requirements indicate the minimum education that must be completed by individuals awarded the doctor of chiropractic (D.C.) degree by the accredited programs. The accredited programs are dedicated to the purpose of producing a competent doctor of chiropractic who will provide quality patient care.

The accreditation process for review and evaluation of DCPs emphasizes the use of outcomes assessment measures.

The CCE validates the requirements for accreditation, demonstrating its awareness of the importance of these requirements to the profession and to the public that the profession serves.

The CCE does not seek to define or support any philosophy regarding the practice of chiropractic, nor are the CCE *Standards* intended to support or accommodate any philosophical position. These are the responsibility of the profession and each educational DCP, giving consideration to requirements of the jurisdiction within which the professional may practice, professional associations, and in the final analysis, the practitioner's own philosophy of chiropractic.

Purpose of the Council on Chiropractic Education

The CCE seeks to ensure the quality of chiropractic education in the United States by means of:

1. Accreditation, certifying the quality and integrity of DCPs and continuing to afford institutional status to solitary purpose chiropractic institutions so recognized before 2002.

2. Educational improvement, stimulating educational excellence within DCPs; and

3. Public information, informing the educational community and the public of the nature, quality and integrity of chiropractic education.

To fulfill its mission, the CCE seeks to accomplish the following goals:

1. Overview

   To maintain the CCE as a viable and effective, primarily programmatic, educationally oriented organization consistent with regulations established by the U.S. Secretary of Education.

2. Accreditation

   a. To develop accreditation requirements for the purpose of assessing the effectiveness of DCPs in planning, implementing and evaluating their mission and goals, program objectives, inputs, resources, and outcomes.

   b. To establish an accreditation process for the purpose of determining that DCPs:

      (1) have clearly defined and educationally appropriate objectives;
      (2) maintain conditions under which the achievement of these objectives can reasonably be expected;
      (3) are in fact achieving these objectives substantially; and
      (4) can be expected to continue to achieve these objectives in the future.

   c. To maintain a COA that will certify the quality and integrity of DCPs by interpreting the criteria for and conducting the process of accreditation.

3. Educational Improvement

   a. To support accredited DCPs as they educate and train a competent doctor of chiropractic who will provide quality patient care and serve as a primary care physician;

   b. To provide support to DCPs for the improvement of instruction, research and service; and

   c. To monitor the adequacy and relevance of the *Standards* as measures of effectiveness and the consistency of the accreditation process in order to enhance their effectiveness in certifying the quality and integrity of DCPs.

4. Public Information

   a. To publish a listing of DCPs accredited by the COA; and

   b. To establish a program of public awareness regarding chiropractic education, in general, and the CCE, in particular.

The qualities of DCPs are vested in the:

1. commitment to excellence by the administration and governing board;
2. soundness of the educational programs;
3. ability of the faculty and staff;
4. caliber of the students; and
5. adequacy of the facilities and finances.

Complaint and Contact Information

Complaint procedures are established to protect the integrity of the CCE and to assure the avoidance of improper behavior on the part of those individuals acting on behalf of the CCE, the COA and the CCE-accredited DCPs. By establishing formal complaint procedures, the CCE

provides responsible complainants the opportunity to submit specific grievances and deal with them through a clearly defined process. Complaints may be filed by any voting or non-voting member(s) of the CCE or their authorized representative(s). A copy of the document describing the complaint procedure may be obtained from the CCE Executive Office and is available on the CCE website.

Information describing the organization and operation of the CCE and its COA may be obtained from the CCE Executive Office, 8049 North 85th Way, Scottsdale, AZ 85258-4321, Telephone: 480-443-8877, Toll-Free: 888-443-3506, Fax: 480-483-7333, E-Mail: CCE@CCE-USA.org. Website: www.CCE-USA.org.

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Section 1. Process of Accreditation

I. Accreditation by CCE

Accreditation is granted to DCPs deemed by the COA of the CCE to comply with the CCE *Standards for Doctor of Chiropractic Programs and Requirements for Institutional Status (Standards).*

The COA offers program accreditation to DCPs that are part of institutions regionally accredited by nationally recognized accrediting bodies. The COA will specifically review compliance with all program requirements described in Section 2.III.

The CCE will provide information and guidelines to any DCP wishing to seek accreditation or to groups interested in initiating a DCP.

In addition to program accreditation, institutional status is currently afforded only to remaining solitary-purpose chiropractic institutions with CCE accredited doctor of chiropractic (D.C.) degree programs and not otherwise regionally accredited as an institution. In these cases, the COA will specifically review compliance with all requirements for institutional status described in Section 2.IV.

II. Purpose of Accreditation

The first major goal of accreditation is the assurance of the quality and integrity of the DCP. The second is the improvement of DCPs. Care has been taken to assure that accreditation requirements are consistent with the realities of sound planning practices in DCPs. This reflects a recognition that DCPs exist in different environments. These environments are distinguished by such differing factors as state and local governmental regulations, demands placed on the profession in the areas served by the DCPs, and diverse student bodies requiring varying responses.

The word "requirements" signifies a set of conditions that must be met for CCE accreditation to be awarded. In recognition of their potential uniqueness, DCPs may be given some latitude in the means by which they meet some requirements. However, compliance with all requirements must be fulfilled by each accredited entity.

III. Eligibility for Initial Accreditation

A. Letter of Intent

A DCP seeking initial accreditation or reaffirmation of accreditation must send a letter of intent to the CCE Executive Director stating its desire to achieve or maintain accredited status. A letter in reply from the CCE Executive Director will identify the next step the DCP should take in its quest for initial accreditation or reaffirmation of accreditation.

B. Submission of Evidence of Eligibility

A DCP seeking reaffirmation of accreditation need not resubmit eligibility documentation unless any eligibility factors have changed since the most recent prior COA action.

A DCP seeking initial accreditation must include with its letter of intent written evidence that

it provides education for the D.C. degree and that it has:

a. Formal authorization from the appropriate governmental agency to award the D.C. degree from the state that is considered to be the principal residence of the DCP and it's respective locations for legal purposes.

b. A charter indicating it is incorporated under the laws of the state of its residence as a non-profit, non-proprietary institution exempt from taxation due to its devotion to educational purposes.

c. A governing board that includes representation reflecting the public interest.

d. A full-time chief administrative officer of the DCP who is qualified for the position by education and/or experience.

e. In place for the most recent two-year period, the following items as described in detail in the CCE *Standards*.

(1) Formal action taken by its governing board at a legally constituted meeting that commits the DCP to follow the *Standards, Policies* and procedures for accreditation, as set forth in various official CCE documents.

(2) DCP mission, goals, and objectives that embrace those stated in the *Standards*, Section 2.

(3) A DCP that complies with the *Standards*.

(4) Published statements, available to all interested publics, showing commitment to follow accepted standards of professional ethics, especially with respect to student recruitment and public information.

(5) Published statements, available to all interested publics, regarding admissions requirements in compliance with the *Standards*.

f. A written plan, and a description of a functioning process of planning and evaluation, that identifies and integrates future educational, physical and financial development and incorporates procedures for review and improvement.

C. Evaluation of Evidence of Eligibility

With assistance from the COA staff, the COA Chairperson will review the eligibility documents. If further documentation is necessary, the COA Chairperson will notify the DCP that such documentation must be submitted with the self-study report.

IV. Enforcement of Standards

A. The U.S. Department of Education mandates that areas of noncompliance, referred to as "concerns" by the CCE Standards, must be corrected in two years if the program is at least two years in length.

Sec. 602.20 Enforcement of standards

(a) If the agency's review of an institution or program under any standard indicates that the institution or program is not in compliance with that standard, the agency must ---

(1) Immediately initiate adverse action against the institution or program; or
(2) Require the institution or program to take appropriate action to bring itself into compliance with the agency's standards within a time period that must not exceed -- ...

(iii) Two years, if the program, or the longest program offered by the institution, is at least two years in length.

(b) If the institution or program does not bring itself into compliance within the specified period, the agency must take immediate adverse action unless the agency, for good cause, extends the period for achieving compliance.

(Authority: 20 U.S.C. 1099b)

Adverse accrediting action or adverse action means the denial, withdrawal, suspension, revocation, or termination of accreditation or preaccreditation, or any comparable accrediting action an agency may take against an institution or program.

B. Extensions of Time to Carry Areas of Concern

The U.S. Department of Education mandates that areas of noncompliance, referred to as "concerns" by the CCE *Standards*, must be corrected in two years if the program is at least two years in length. However, the COA is able to extend the timeframe for good cause.

In making a determination to grant an extension of the period for achieving compliance for good cause, the COA will review the rationale for the request and assess whether the program has met the following criteria. The DCP has:

1. Submitted an appropriate plan for achieving compliance within a reasonable time frame.

2. Included a detailed timeline for completion of the plan.

3. Provided evidence that the plan has been implemented according to the established timeline.

4. Provided reasonable assurance that the program will achieve compliance as stated in the plan.

Under no circumstances is the COA required to grant an extension on the basis of the DCP submitting the above criteria. The COA reserves the right to either grant or deny an extension when addressing the issue of good cause.

Extensions of the period of time for achieving compliance are limited to a maximum of two additional years.

V. Actions Toward Achievement of Accredited Status

A. Application

1. Development and Implementation of Self-Study

   The objective of this step is the development and implementation of a comprehensive self-study process that involves all constituencies of the DCP and relates to effectiveness regarding its mission, goals and objectives. The resultant self-study report must provide clear evidence that the DCP is in compliance with the CCE *Standards*. The self-study report must give attention to the ongoing assessment of outcomes for the continuing improvement of academic quality. The self-study report must demonstrate that the DCP has processes in place to ensure that it continues to meet CCE quality standards on an ongoing basis.

2. Submission of Self-Study Report

   The objective of this step is to officially apply to the COA for initial accreditation or reaffirmation of accreditation by submitting a self-study report to the CCE Executive Office.

   If continued institutional status is being sought in addition to program accreditation, the narrative must clearly identify such intent.

   The self-study report must be submitted to the CCE Executive Office and the COA Chairperson no later than:

   a. October 1, in contemplation of action no sooner than the semi-annual (summer) meeting of the COA.

   b. May 1, in contemplation of action no sooner than the annual (winter) meeting of the COA.

   c. The COA may, due to special circumstances, agree to delay the deadline for submission of an application for reaffirmation of accreditation without affecting the accredited status.

B. Review of Self-Study Report

The objective of this step is to assure that the DCP self-study report is properly constructed and contains the types of evidence necessary for the COA to determine if CCE *Standards* are being met.

The COA staff and Chairperson will examine the self-study report for appropriate form and content. If the self-study report has inappropriate form, the COA Chairperson will advise the DCP to resubmit the report using the specified format. If the self-study report lacks sufficient evidence for the COA to determine if the CCE *Standards* are being met, the COA Chairperson will advise the DCP with written identification of the deficiencies and appropriate recommendations.

When the self-study report is determined to be satisfactory in form and content, the COA Chairperson will establish a site team to visit the DCP and provide copies of the self-

study report to COA and site team members. Arrangements for the site visit will be coordinated with the DCP through the COA Chairperson.

C. Evaluation, Review and Determination of Status

The purpose of this phase is for the COA to evaluate and validate the evidence to determine if the DCP complies with CCE accreditation requirements.

1. Examination of Self-Study Report

The objective of this step is to give the COA an opportunity to examine the self-study documentation to ensure that it is complete, that it addresses all of the Standards, and that it can serve as the basis for an effective evaluation by the site team.

2. Site Team Visit and Report to COA

The objective of this step is to have a site team, appointed by the COA Chairperson, in collaboration with the members of the COA, verify the claims contained within the eligibility documentation and self-study report regarding the DCP implementation of the CCE *Standards*. The site team will give particular attention to the DCPs ongoing assessment of outcomes for the continuing improvement of educational quality, and must give more focused attention to specific areas as requested by the COA. The COA is charged with responsibility of evaluating all aspects pertaining to the quality and integrity of the DCPs. It may be necessary, therefore, for the COA to evaluate components of DCP accreditation requirements, as they are applicable to DCP accreditation and the overall charge of the COA. The site team must assist the DCP by making either recommendations or suggestions that identify possible means of improvement, if indicated.

The DCP will provide the site team with full opportunity to inspect its facilities, to interview all persons within the campus community, and to examine all records maintained by or for the DCP and/or institution of which it is a part (including but not limited to financial and corporate records, and records relating to student credentials, grading, advancement in the program, and graduation). An exit interview will be conducted by the team with the DCP chief administrative officer, the institution's CEO, and other personnel as deemed appropriate by the institution CEO.

A first draft of the site team report will be sent by the Site Team Chair to the DCP chief executive officer, team members and COA staff for correction of factual errors only.

The final team report will be distributed by the COA staff to the COA, the DCP chief administrative officer, the institution's CEO, the governing board chair, others as the institution may designate, and all members of the site team. This shall be done prior to the COA status review meeting on the DCP application.

3. DCP Response

The objective of this step is to provide the DCP with an opportunity to clarify previous documentation and to submit additional evidence after reviewing the site team visit report.

The DCP may submit a response to the site team report, and must submit a written

response if the report contains concerns accompanied by recommendations.

Any response must be submitted to the COA staff and all members of the COA no less than 30 days prior to the COA status review meeting.

4. Evaluation of Submitted Documentation

   The objective of this step is for the COA to evaluate the DCP self-study report, the site team report, the DCP response, and all other appropriate documentation relevant to the potential accreditation of the DCP.

   The COA will review all documentation in preparation for the status review meeting with representatives of the DCP.

5. Status Review Meeting

   The objective of the status review meeting is to provide an opportunity for the COA to meet with DCP representatives to discuss potential accreditation. The Site Team Chair or other members of the site team may also be present at the request of the COA Chairperson.

6. COA Decision

   The objective of this step is for the COA to make a decision regarding the application for initial or reaffirmation of accreditation and to complete this phase of the accreditation process.

   Following the status review meeting, the COA will meet in executive session to consider all the documentation and oral presentations, and make a decision regarding accreditation. The COA decision on applications for accreditation will be one of the following:

   a. To award or reaffirm accreditation.

   b. To defer the decision for no longer than one calendar year, pending the review of specific evidence which may include one or all of the following: information in a report indicating compliance with the recommendations; a focused visit by COA representatives; additional consultant's report(s) and/or COA visit(s) with the consultant; a meeting with representatives of the DCP; or other specified conditions.

   c. To deny initial or reaffirmation of accreditation, clearly identifying the specific accreditation requirements not being met.

   d. To impose a Sanction of Notice or Probation if currently accredited.

VI. COA Notifications

A. The COA will convey a written decision to the DCP chief administrative officer, the institution CEO, the governing board chair and others as the program may designate.

B. The COA Chairperson will notify the CCE Board, U.S. Secretary of Education, other appropriate accrediting agencies, and the general public within 30 days of any COA

decision or final action to:

1. Award initial or reaffirmation of accreditation.

2. Deny initial or reaffirmation of accreditation.

3. Accept the withdrawal of an application for initial or reaffirmation of accreditation.

4. Impose a sanction of probation.

The next comprehensive evaluation will be four years following the award of initial accreditation, or eight years following the award of reaffirmation of accreditation.

VII. Other Reports

A. Other Site Visits

1. A DCP may be required to host a focused site visit to its campus by a representative of the COA regarding a special issue of concern, or a substantive change, as determined by the COA.

2. Interim Site visits normally occur at or near the mid-point of the eight-year visit cycle.

B. Reports

A Progress Report must be submitted if the COA:

1. Had previously requested one based upon ongoing concerns; or,

2. Chairperson requests one based upon concerns raised by the review of the DCP PCBR, financial audit reports and/or catalog.

C. A Substantive Change Report must be submitted if a DCP:

1. Has any change in the established mission.
2. Has any change in the legal status, form of control, or ownership.
3. Adds courses or programs that represent a significant departure, in either content or method of delivery, from those offered when the COA last evaluated the DCP.
4. Adds degree programs other than the DCP in a solitary purpose chiropractic institution.
5. Changes the method of awarding course or DCP credit (e.g., a change from use of clock hours to use of credit hours, etc).
6. Experiences a substantial change in the number of clock or credit hours required or awarded for successful completion of a program.
7. Moves a campus from one location to another.
8. Establishes an additional location geographically apart from the campus at which the institution offers at least 50 percent of an educational program.

If required to submit a progress or substantive change report, the report is due in the CCE Executive Office on a date set by the COA.

If required to submit a progress report, the DCP must critically evaluate its efforts in the

areas of concern, initiate measures that will address those concerns, and provide evidence of the degree of its success in rectifying the area(s) of concern.

Failure on the part of a DCP to furnish a progress or substantive change report on the date specified by the COA will constitute cause for sanctions or revocation of accreditation. These actions shall be at the discretion of the COA, following appropriate notification.

See CCE Policy 1 – Substantive Change for more information.

D. Submission of Program Characteristic Biennial Report (PCBR)

Each accredited DCP must submit to the CCE Executive Office, the PCBR, accompanied by financial audit reports for the two recently completed fiscal years, a current academic catalog and supporting documentation.

The PCBR must be submitted to the CCE Executive Office in April or October of alternate years on a date established by the COA Chairperson.

The PCBR requires biennial enrollment, financial and other information to be reported, and requires a DCP to report on the degree to which it has been successful in implementing its strategic plan.

The COA staff will forward to COA Chairperson with the completed PCBR, financial audit reports, a catalog, and a staff analysis. The COA Chairperson in collaboration with the members of the COA will determine if the DCP must submit a progress report and, may require the appearance of DCP representatives at the next meeting of the COA.

VIII. Evaluation of Submitted Documentation

The objective of this step is for the COA to evaluate the progress or substantive change report and the report of any focused site visit. The COA will review all submitted documentation in preparation for a progress review meeting. This meeting must be attended by representatives of the DCP if the COA provides written notice that an appearance is necessary.

IX. Progress Review Meeting

The objective of the progress review meeting is for the COA to discuss: ongoing progress, any issues of concern, financial status, substantive changes that have taken place during the interim, current or potential issues relating to the DCP, the general status of the DCP as revealed on the PCBR, and the sufficiency of documentation provided. If a site visit was made by COA representatives, this site visit report will be discussed.

X. COA Decision and Identification of Additional Interim Reporting Activities

The objective of this step is for the COA to make a decision regarding the adequacy of ongoing progress, the sufficiency of evidence provided regarding progress on issues of concern, whether any other concerns have emerged, and what subsequent interim reporting activities will be required.

Following the progress review meeting, the COA will meet in executive session to consider the information presented to it, and make a decision regarding subsequent interim activities that will be required of the DCP. If a progress report is to be required, the COA will

determine if an appearance, or if participation via conference call, will be necessary by DCP representatives at the next COA meeting. The COA will then send a follow-up letter to the DCP identifying the status of previous concerns, if any, and/or substantive change application, and the requirements for any additional interim activities. The DCP must continue to submit a PCBR, financial audit reports, current academic catalogs and supporting documentation.

XI. Sanctions

Accredited status for a DCP is a privilege, not a right. Sanction may be imposed for cause at any time if conditions exist that warrant a revision of accredited status. If sanctions are imposed, notification of the final action will be made in accordance with CCE *Standards* and *Policies*.

An accredited DCP must be in compliance with the *Standards* and the conditions of eligibility, comply with COA policies and procedures, and provide information as requested by the COA in order to maintain accreditation. When a DCP fails to comply with the *Standards*, or there are indications that future compliance with the *Standards* or conditions of eligibility may be problematic, the COA may impose sanctions of notice or probation.

The COA is authorized to impose the sanctions described below, in order of increasing seriousness.

A. Notice

Notice is a confidential sanction imposed by the COA for a maximum of one year if it determines that a DCP:

1. Could be in non-compliance with the *Standards* or the conditions of eligibility in the future if steps are not taken by the DCP to correct the situation;

2. Is in non-compliance with the *Standards*, and the COA determines that the deficiencies can be corrected by the DCP in a short period of time; and

3. Has failed to comply with COA policies or procedures, or has failed to provide requested information.

B. Probation

Probation is a public sanction imposed by the COA for a maximum of 18 months. Probation is imposed for more serious deficiencies (for failure to comply with the conditions of eligibility, for failure of a DCP to correct deficiencies after being given notice, or for failure to conduct an acceptable self-study), which the COA determines are not serious enough to remove the accreditation of the DCP.

If a DCP has not remedied deficiencies at the end of the maximum eighteen-month probationary period, the COA will remove the accredited status of the DCP, except in rare instances when probation may be extended for a limited period of time. Since placing a DCP on Probation is an adverse action, it may be appealed.

If the deficiencies are serious or are of long standing, or the DCP has failed to comply with COA policies and procedures after identification and notification by the COA, the

DCP may have its accreditation removed without previous imposition of Notice or Probation.

The COA Chairperson will notify the U.S. Secretary of Education, other appropriate accrediting agencies, and the public within 30 days following the final action to place a DCP on Probation.

C. Procedures for Applying Sanctions

Following the decision of the COA to impose a sanction of Notice or Probation, the COA Chairperson will inform the chief administrative officer, the institution's CEO, and the governing board chair in writing of the action. The COA written communication will include the reasons for any sanction. DCPs under sanction will be required to provide semi-annual written reports to the COA.

If there is a strong possibility that a DCP may be placed on Probation, or have its accreditation withdrawn, the DCP chief administrative officer, the institution's CEO and others from the DCP may be invited by the COA Chairperson to appear before the COA to show cause why that action should not be taken. The COA may, however, take those actions without inviting the DCP for an appearance.

An action to place a DCP on Probation, to deny reaffirmation of accreditation, or to remove accredited status, along with the reasons for the action, will be read at the CCE Board of Directors meeting and recorded in the next official listing of accredited DCPs. Actions that may be appealed will be accompanied by a statement that COA actions will not take effect until the time period for filing an appeal has expired or until final action has been taken on the appeal. The COA policy on disclosure is applicable to these actions.

The COA Chairperson will notify the U.S. Secretary of Education, other appropriate accrediting agencies and the public within 30 days following the final action to withdraw DCP accredited status.

Public notice of an adverse decision will not be given until the decision has become final, either due to the expiration of the time period for appeal or to the conclusion of the appeal process, unless the COA states in its decision that there is a compelling reason for immediate public disclosure.

XII. Requested Appearances

Under extraordinary circumstances to be determined by the COA, the COA Chairperson may issue a written directive instructing DCP representatives to appear at a special or regularly scheduled COA meeting. Extraordinary circumstances are those in which substantial violations of CCE accreditation *Standards* are apparent and a compelling need exists for prompt action in order to protect against likely substantial injury to the interests of the various publics that rely upon COA accreditation decisions.

This meeting will take place not less than 30 calendar days from the postmark date of the COA written directive to appear. The purpose of this meeting is to determine if there are substantial violations of CCE accreditation requirements by the DCP. A directive requiring that the DCP submit a special report and/or host a special site visit may precede or follow the directive to appear.

The COA directive to appear will identify the specific accreditation requirements with which the DCP must demonstrate compliance. At the special meeting, the COA will give representatives of the DCP a reasonable opportunity to present oral and written information, demonstrating that it is in compliance with the particular requirements referred to in the COA directive.

After considering all available relevant information, the COA decisions may include the following:

1. Take no action. There is no evidence for a cause of action.

2. Defer the decision, pending the receipt of a focused site team visit report or the receipt of a progress report from the DCP.

3. Impose sanction. A sanction may be imposed during a period of deferral of decision, or during a period of continued accreditation.

4. Revoke the DCP accreditation.

The COA Chairperson will provide the DCP and other interested parties with written notification of the COA decision. Adverse decisions are subject to appeal.

XIII. Special Reports and Site Visits

The COA Chairperson may, at any time, for appropriate reasons require an applicant or accredited DCP to submit a report that addresses DCP compliance with specific CCE accreditation requirements. The DCP will file this requested report within the time specified by the COA, which shall not be less than 15 working days after the postmark on the COA written request to the DCP. The report will fully and completely respond to COA concerns regarding compliance with the accreditation requirements specified.

The COA Chairperson may at any time for appropriate reasons appoint a visiting team to conduct a focused on-site visit to the campus of an applicant or accredited DCP. This team may include COA members, COA staff members, or other persons as the COA Chairperson may appoint.

The only reasonable cause for removal of an individual from the team is evidence demonstrating that service by that individual is unfair or deleterious to the accreditation process. If a factual reason is discovered, evidence and a request for removal should be provided in writing to the COA Chairperson within seven days after receipt of the list of agreement enclosed with the site team membership roster.

The DCP will afford the COA visiting team a full opportunity to examine DCP facilities; to interview members of its faculty, administration, management and staff; and to inspect all records maintained by or for the DCP. These records include, but are not limited to, financial and corporate records, student personnel records relating to credentials, grading, advancement in the program, and graduation. The team shall prepare a draft report of its findings, and provide a copy to the chief administrative officer, the institution's CEO, the governing board, the CCE Executive Director, and the COA Chairperson.

The DCP may provide the COA with a written response to this draft - concerning correction of factual errors only - within the time period established by the COA when

informing it of the necessity of the visit. After considering the DCP written response, the visiting team will prepare and submit to the COA a final report of its findings.

The final site team report will be distributed by the COA staff to the COA, the DCP Chief Administrative Officer, the institution's CEO, the Governing Board Chair, and others as the institution may designate. An invitation will be made to the DCP to review and provide a written response to the site team report prior to the COA meeting. The DCP must submit a response if the report contains concerns accompanied by recommendations. Any response must be submitted to the COA staff and all members of the COA.

The COA will review all documentation in preparation for it's meeting to review concerns regarding the DCP. Representatives from the DCP must attend the COA meeting, unless the COA Chairperson notifies the DCP that an appearance will not be necessary. The DCP will be notified of the time and place for the meeting by the CCE Executive Office staff. The site team chairperson or other members of the site team may also be present at the request of the COA Chairperson.

XIV. Publication of CCE-Accredited DCPs List

The COA will publish annually, at the end of the COA annual (winter) meeting, a list that identifies specifically:

1. DCPs accredited by the COA, along with the corresponding entities that administer these programs and the tentative date of the next COA comprehensive review.

2. Solitary-purpose chiropractic institutions afforded institutional status will be so designated.

3. This list may be updated between annual COA meetings to reflect any changes that occur.

XV. Non-Compliance with Title IV of the Higher Education Act of 1965 as Amended

If the CCE is notified that a DCP under its accreditation, or consideration thereof, is not in compliance with its program responsibilities under Title IV standards, it will take appropriate action to determine whether non-compliance jeopardizes the ability to provide the quality of education expected of CCE-accredited DCPs. Should the COA have reason to believe that any CCE-accredited DCP is failing to meet its Title IV, Health Education Assistance (HEA) program responsibilities, or is engaged in fraud or abuse, the COA shall provide to the U.S. Secretary of Education the name of that DCP, and the reason for concern, within 15 days of discovery. At the same time, the COA will notify the DCP in question of its intent to notify the U.S. Secretary of Education.

XVI. Procedures for Complaints

Policies regarding complaints may be obtained from the CCE Executive Office. The purpose of these policies is to provide a professional, fair and expeditious method of processing complaints. Complaints received by CCE concerning issues unrelated to aforementioned complaint policies will be acknowledged and the complainant will be referred to appropriate agencies.

The COA will review only those written complaints against DCP's having an affixed signature that specifically claim that the CCE accreditation *Standards* or *Policies* have

been violated, and which, in COA opinion, are directly and substantively related to the quality or conduct of the DCP.

The COA does not intervene on behalf of individuals or act as a court of appeal in matters of admission, granting or transferability of credits, fees, disciplinary matters, collective bargaining, faculty appointments and dismissals, or other similar matters.

The COA will not respond to concerns of allegations regarding the personal lives of individuals connected with its affiliated DCPs. COA investigation of complaints is based exclusively upon the CCE accreditation *Standards* and *Policies*.

XVII. Status Description

A DCP accredited by the COA must use the following statement when describing its status publicly:

"The doctor of chiropractic degree program (name of DCP) is accredited by the Commission on Accreditation of the Council on Chiropractic Education, 8049 North 85th Way, Scottsdale, AZ 85258-4321. Tel: 480-443-8877."

A solitary-purpose chiropractic institution afforded institutional status by the COA must use the following statement when describing its status publicly:

"(Name of solitary-purpose chiropractic institution) is afforded institutional status by the Commission on Accreditation of the Council on Chiropractic Education, 8049 North 85th Way, Scottsdale, AZ 85258-4321. Tel: 480-443-8877."

XVIII. Appeal Process

The process of appeal is described in CCE Policy 8, which may be obtained from the CCE Executive Office.

The status of an accredited DCP will not change until either the time for appealing adverse decisions of the COA has passed or until the appeal process has concluded.

Except for notice that the COA may be required to give to the U.S. Secretary of Education, or other governmental bodies and accrediting agencies, public notice shall not be given until the decision has become final unless the COA states in its decision that there is a compelling reason for immediate public disclosure.

XIX. Reinstatement of Accreditation

Any DCP intending to have its accredited status with CCE reinstated must apply for initial program accreditation.

XX. Withdrawal From Accreditation

The following guidelines/procedures must be followed when a DCP chooses to sever its relationship with the CCE-COA.

A. Voluntary Withdrawal of Initial Application

The COA will honor a DCP's decision to withdraw its application for accreditation at any time prior to the COA decision regarding initial accreditation.

B. Voluntary Withdrawal from Accredited Status

An accredited DCP desiring to withdraw from the CCE shall forfeit its accredited status on the date that the COA receives a certified copy of the sponsoring institution board on control' s resolution clearly stating its desire to withdraw the DCP from the CCE. The COA will take immediate action to remove the accredited status upon receipt of notice from the DCP.

C. Withdrawal from Accredited Status

When a DCP fails to submit a timely application for reaffirmation of accredited status, the COA will act at its next meeting to remove the DCP's accredited status. This meeting of the COA will normally occur within six months of the date when the DCP application for reaffirmation was due.

1. Notification

(a) The COA Chairperson will notify the U.S. Secretary of Education, other appropriate agencies and the public within 30 days following withdrawal according to items A, B, and C above.

(b) In cases of voluntary withdrawal and withdrawal by default, the COA will immediately notify the DCP and all interested parties that its accredited status has been terminated.

XXI. Exceptions or Waivers to the Standards

An exception or waiver to the Standards may be granted by the COA to a DCP under rare and extraordinary circumstances as described in CCE Policy 9.

Section 2. Accreditation Information

I. Preface

The DCP incorporates the understanding of chiropractic as a profession practicing primary health care, provides curricular and clinical evidence of that through outcome measures, and consists of education and training to prepare graduates to:

A. Practice direct contact health care as a portal-of-entry provider for patients of all ages and genders;

B. Assess the patient's general health status, complaints and problems leading to a diagnosis. Specific elements of patient assessment minimally include complete health history; review of systems; physical, biomechanical, and neurological examination; the analysis of vertebral and extra-vertebral subluxation; and, when clinically indicated, diagnostic imaging, clinical laboratory, and/or specialized diagnostic procedures;

C. Develop a goal-oriented case management plan that addresses any subluxations or other neurobiomechanical problems, and that may include rehabilitation and/or other therapeutic modalities;

D. Develop appropriate doctor/patient relationships with continuity in the chiropractic management of health problems, and coordination of care with other health care providers; and

E. Promote wellness by assessing health risk and providing problem-related, general and public health information, and lifestyle counseling.

II. Purpose of Chiropractic Education

The purpose of chiropractic professional education is to provide the student with a core of knowledge in the basic and clinical sciences and related health subjects sufficient to perform the professional obligations of a doctor of chiropractic.

A doctor of chiropractic is a primary care physician whose purpose, as a practitioner of the healing arts, is to help meet the health needs of individual patients and of the public, giving particular attention to the structural and neurological aspects of the body.

The application of science in chiropractic concerns itself with the relationship between structure, primarily the spine, and function, primarily coordinated by the nervous system of the human body, as that relationship may affect the restoration and preservation of health.

Further, this application of science in chiropractic focuses on the inherent ability of the body to heal without the use of drugs or surgery.

As a gatekeeper for direct access to the health delivery system, the doctor of chiropractic's responsibilities as a primary care physician include wellness promotion, health assessment, diagnosis and the chiropractic management of the patient's health care needs. When indicated, the doctor of chiropractic consults with, co-manages, or refers to other health care providers.

III. Doctor of Chiropractic Degree Program Accreditation Standards

In order to acquire or maintain program accreditation by the COA, DCPs must comply with all elements of Section 2.III.

A. Mission, Self-Assessment and Planning

1. Mission

   The DCP must have adopted a statement of mission or purpose, which:

   a. Is based on the understanding of chiropractic as stated in Section 2.II. Purpose of Chiropractic Education.

   b. Is consistent with the purpose of the institution housing the program.

   c. Is endorsed by the Governing Board of the institution housing the program.

   d. Provides for:

      (1) An educational program leading to the Doctor of Chiropractic degree;
      (2) The conduct of research and other scholarly activities in chiropractic; and
      (3) Service activities in the field of chiropractic.

2. Goals

   The DCP must have established goals, derived from its mission and giving direction to its activities in education, research and service.

3. Objectives

   The DCP must have developed its goals into objectives that state specific achievements toward which the program is working over a short time frame.

4. Self-Assessment

   The DCP must carry out a periodic self-assessment in which it:

   a. Evaluates how well it is fulfilling its mission and attaining its goals and objectives.

   b. Identifies the manner in which resources are utilized to the fulfillment of mission and attainment of goals and objectives.

   c. Evaluates the success of the DCP in meeting all of the CCE Standards on a continuing basis.

5. Planning

   The DCP must engage in a formal planning activity based on its self-assessment and directed toward:

a. Identifying changes in resources and organization of resources that would provide for more complete fulfillment of the mission and attainment of goals and objectives.

b. Reviewing the mission, goals and objectives to encourage the DCP's continued improvement and respond to changing circumstances of the program and its environment.

Outcomes measurements such as DCP completion rates, success rates on licensing exams, student support services, recruitment and admissions practices and measures of program length and completion must be utilized to guide planning activities.

B. Minimum Requirements of DCP Organization

1. Accreditation

Aside from DCPs operating in solitary-purpose chiropractic institutions afforded institutional status by the COA, the DCP must be a part of, or attempting to become part of; an institution of higher education that is institutionally accredited by a nationally recognized agency, or is a recognized candidate for accreditation by a nationally recognized agency.

2. Conflict of Interest

If the DCP is a part of an institution offering other programs, the governing board of the institution housing the program must have adopted and must follow policies to minimize the possibility of conflict of interest between the activities of the DCP and other programs of the institution, and no member of the governing board may be a member of the board or administrative staff of another program/institution accredited by the COA.

3. Administration

A full-time appointee of the institution must be designated as the individual having primary authority and responsibility for administration of the DCP, and no member of the administrative staff may be a member of the administrative staff or governing board of another program/institution accredited by the COA.

4. Public Disclosure

Each DCP must make available to the public, in print or electronic form, the following information:

a. The DCP's mission and goals.

b. A list of the members of the governing board of the institution in which the DCP exists.

c. The name of the individual designated as the chief administrative officer of the DCP.

d. A list of all administrators, faculty, and professional staff members with their respective academic credentials.

e. A list of each course offered, its contents and value in terms of contact and/or credit hours.

f. A description of admissions requirements, attendance requirements, graduation requirements, and a statement of the CCE requirement that each student awarded the D.C. degree must have earned not less than the final 25% of the total credits required for the degree from the DCP conferring the degree.

g. The disclosure of graduation rates, Title IV loan default rates, student performance on national board examinations, available data on placement rates and the success of program graduates in obtaining jurisdictional licensure. Disclosure of student performance on national board examinations must be placed on the DCP website in accordance with CCE Policy on Public Disclosure.

h. Descriptions of physical facilities and learning resources.

i. Policies and procedures regarding discipline, attendance, examinations, grades, satisfactory academic progress, and procedures for handling student complaints.

j. Tuition, fees, and other mandatory and elective student charges, along with the refund policies and procedures for each such charge.

k. A list of financial resources available to students.

l. A statement indicating where a list of licensing jurisdictions and their requirements is available.

m. The accredited status of the DCP with the CCE.

n. The mailing address and telephone number of the CCE, with identification of CCE as the agency to which complaints about the compliance of the program with the CCE *Standards* should be addressed.

C. Required DCP Curriculum Characteristics

1. Instructional Hours

The DCP must require each student awarded the D.C. degree to have successfully completed not less than 4,200 instructional hours, and must have earned not less than the final 25% of the total credits required for the D.C. degree from the program that confers the degree.

2. Curriculum

The curriculum required for the DCP must include the following subjects (not necessarily in individual courses for each subject): anatomy; biochemistry; physiology; microbiology, pathology; public health; physical, clinical and laboratory diagnosis; gynecology; obstetrics; pediatrics; geriatrics; dermatology; otolaryngology; diagnostic imaging procedures; psychology; nutrition/dietetics; biomechanics; orthopedics; neurology; first aid and emergency procedures; spinal analysis; principles and practice of chiropractic; clinical decision making; adjustive techniques; research methods and procedures; and professional practice ethics. The DCP must

document how each subject appears in the curriculum and is integrated into a coherent degree program.

3. Course Management

   All courses for which credit or hours are given toward completion of the doctor of chiropractic degree must be solely managed, directed and/or taught by properly credentialed individuals who are employed or contracted by the program or institution to provide academic instruction.

D. Required DCP Resources

1. Financial Resources

   DCPs must demonstrate adequacy and stability of financial resources to support the program objectives of their mission and goals. The recent financial history of the institution must also demonstrate the financial stability essential to its successful operation of the DCP. The institution must provide financial statements and related documents, which accurately and appropriately represent the total current and future operation of the DCP. The DCP must demonstrate that it exercises appropriate control over all its financial resources. The DCP must immediately report to the COA any change in its financial aid program approval status by the U.S. Department of Education, including the need for provisional certification or sanctions of limitation, suspension or termination.

2. Learning Resources

   The DCP must have or provide access to a learning resource center and/or library with staff, facilities, collections and services that permit attainment of the goals and objectives of the program.

3. Physical Resources

   The DCP must provide, and adequately manage and maintain, physical facilities, equipment and other physical resources that are necessary and appropriate for meeting the mission, goals, and objectives of the DCP.

E. Programmatic Integrity

The DCP must adhere to high ethical standards in its teaching, scholarship, service, relation to the public and other DCPs, and regulatory and accrediting agencies.

1. The DCP must regularly evaluate and revise as necessary its policies and procedures to ensure integrity throughout the DCP.

2. The DCP must represent itself accurately to all constituencies through its catalogs, websites, publications, and official statements.

3. The DCP must develop and enforce policies that prohibit conflict of interest by its employees and agents.

F. Governing Board Integrity

1. The governing board must be of sufficient size and have the depth and diversity of expertise to effectively set programmatic policy and effectively discharge its fiduciary responsibilities.

2. The governing board must include representatives of the public in its membership.

3. The governing board must regularly evaluate and revise as necessary its policies and procedures to ensure proper oversight and improvement of the DCP.

4. The governing board must establish practices, including adoption of term limits, that ensure both stability of the board as well as the regular replacement of members.

5. The governing board must develop and enforce policies that prohibit conflicts of interest between governing board members and either the DCP or the institution

G. Faculty

The DCP must demonstrate that the faculty cohort is of sufficient size and possess the depth and diversity of expertise and experience necessary to structure, deliver and assess the effectiveness of the program.

1. Education and Licensure Requirements for Faculty

   The persons appointed as members of the faculty and responsible for DCP instruction must be qualified by academic preparation and experience for the teaching to which they are assigned.

   a. Basic Sciences Faculty Requirements

      Each person teaching basic science courses must hold an earned graduate or professional degree in an appropriate discipline from an institution accredited by a nationally recognized agency, or its foreign equivalent.

   b. Clinical Sciences and Clinician Faculty Requirements

      (1) Each person teaching in clinical sciences must hold an earned first professional degree or terminal degree appropriate to the subject field taught from an institution accredited by a nationally recognized agency, or its foreign equivalent.

      (2) Each person teaching clinical subjects that involve the practical application of chiropractic analysis, adjustments or manipulations must have attained chiropractic licensure in at least one jurisdiction and must not have a record of license revocation.

      (3) Each person supervising direct clinical care experiences that include chiropractic analysis, adjustments or manipulations must be appropriately licensed to practice chiropractic in the jurisdiction in which the educational activity and/or clinical experience is offered. Each person supervising other direct clinical care experiences must be appropriately credentialed as a

health-care provider and licensed to practice in the jurisdiction in which the educational activity and/or clinical experience is offered.

2. Professional Development of Faculty

   a. The DCP must provide faculty with opportunities to be engaged in research, scholarship, service, and professional development consistent with the mission, goals, and objectives of the DCP.

   b. The DCP must establish standards of performance for faculty.

3. Course and Curriculum Development Role of Faculty

   The faculty must have a significant role in determining the content of the curricula and courses offered by the institution.

4. Ethics and Integrity Requirement for Faculty

   The institution housing the DCP must develop and enforce policies of ethics and integrity for their full-time, part-time and extension faculty. The ethics and integrity policies shall include, but not be limited to the following:

   a. Expected ethical behavior in academic professionalism, to include issues such as plagiarism, honesty in applications for research or scholarly activities, and integrity in research findings.

   b. Develop and enforce faculty standards that ensure the student's right to privacy and confidentiality.

   c. Prohibiting the abuse or misrepresentation of personal academic accomplishment or academic affiliation with the DCP or other academic institution.

   d. Prohibition of conflicts of interest including those between the DCP and the faculty member.

H. Minimum Admission Requirements for Students

For each student admitted the DCP must document and retain evidence in the student's file regarding the basis upon which the student was judged to be qualified for admission, and clearly inform the student at the time of admission that limitations of practice venue and licensure might occur.

1. Students Admitted to the DCP from United States Institutions

   The DCP must demonstrate that qualifications for student acceptance and resultant enrollment are appropriate to the program objectives, goals and educational mission of the program or institution. Each student admitted to begin the DCP on the basis of academic credentials from institutions within the United States must meet the following requirements:

a. All matriculants must furnish proof of having earned a minimum of 90 semester hour credits of appropriate pre-professional education courses at an institution or institutions accredited by a nationally recognized agency. A national accrediting agency is an agency recognized by the Secretary of the US Department of Education.

   Included in these credits must be a minimum of 48 semester hour credits in the course areas noted in Section 2.III.H.1.b (below). In addition, all matriculants must have earned a cumulative grade point average of at least 2.50 on a scale of 4.00 for the courses listed in Section 2.III.H.1.b, and for the required 90 semester hours. Quarter hour credits may be converted to equivalent semester hour credits. In situations in which one or more courses have been repeated with equivalent courses, the most recent grade(s) may be used for grade point average computation and the earlier grade(s) may be disregarded.

b. All matriculants must present a minimum of 48 semester hours' credit (or the quarter-hour credit equivalents), distributed as follows:

   English Language Skills*.....6 semester hours
   Psychology .....3 semester hours
   Social Sciences or Humanities.....15 semester hours

   Biological Sciences** .....6 semester hours
   Chemistry*** .....12 semester hours
   Physics and related studies**** .....6 semester hours

   In each of the six distribution areas, no grades below 2.00 on a 4.00 scale may be accepted.

   In each of the six distribution areas, if more than one course is taken to fulfill the requirement, the course contents must be unduplicated.

   *English Language Skills requirement includes English composition, Speech, or English literature coursework.

   **The Biological Sciences requirement must include pertinent laboratory experiences that cover the range of material presented in the didactic portions of the course(s).

   ***The chemistry requirement may be met with at least three semester hours of general or inorganic chemistry and at least six hours of organic chemistry and/or biochemistry courses with unduplicated content. At least six semester hours of the chemistry courses must include pertinent related laboratory experiences, which cover the range of material presented in the didactic portions of the courses.

   ****The physics requirement may be met with either one or more physics courses with unduplicated content (of which one must include a pertinent related laboratory that covers the range of material presented in the didactic portions of the course), or three semester hours in physics (with laboratory) and three semester hours in either biomechanics, kinesiology, statistics, or exercise physiology.

   In the event an institution's transcript does not combine laboratory and lecture grades for a single course grade, the admitting institution may calculate a

weighted average of those grades to establish the grade in that science course.

c. Students who have earned a portion of the prerequisite credits through examination or means other than formal course work, as identified by an institution accredited by a nationally recognized agency, which formally has accepted or awarded such credits, may be admitted to the DCP upon receipt of such evidence by the DCP. The DCP must document and retain evidence in the student's file, which identifies how such admission requirements were met.

d. Students who hold a degree leading to licensure/registration in a health science discipline at the baccalaureate level or above with an earned cumulative grade point average of at least 2.50 on a scale of 4.0, or who hold a baccalaureate degree from an institution accredited by a nationally recognized accrediting agency with an earned grade point average of at least 3.25 on a scale of 4.0, may be admitted to the DCP upon presenting evidence that their academic preparation substantially meets the requirements for admission consistent with those noted in Section 2.III.H.1.a.-c.

2. Students Admitted to the DCP from International Institutions

Each student admitted to begin the DCP on the basis of academic credentials from institutions outside the United States must meet the following requirements:

a. Provide evidence of proficiency in reading and writing English, and an understanding of oral communication in English, commensurate with the level of proficiency expectations established by the DCP for successful completion of the DCP.

b. Demonstrate academic preparation substantially equivalent to that possessed by beginning students admitted from United States institutions.

c. Provide evidence of proficiency in the subject matter of each course for which credits are accepted.

d. Provide evidence of having financial resources sufficient to complete at least one full year of full-time attendance in the DCP.

e. Meet all applicable legal requirements for study in the United States.

3. Students Transferring from Another Institution or Seeking Advanced Standing

Each student transferring credits applicable to the DCP must meet the following requirements:

a. The applicant for transfer from one DCP to another must meet the admissions requirements that were in force at the admitting DCP on the date the student originally enrolled in the DCP from which the transfer is being made.

b. Credits considered for transfer must have been awarded for courses taken in a DCP accredited by the CCE or in a program accredited as a first professional degree in one of the health sciences by another nationally recognized accrediting agency, or in a graduate program in an academic discipline closely related to the health sciences offered by an institution which is recognized by a national accrediting agency.

c. Only credits recorded on an official transcript of the issuing institution with an equivalent grade of 2.00 on a 4.00 scale or better may be considered for transfer.

d. Credits accepted for transfer must be determined by the receiving DCP to be substantially equivalent to courses offered by the receiving DCP.

e. Credits accepted for transfer must have been awarded within five years of the date of admission to the receiving DCP, except that the receiving DCP may at its option accept older credits if the entering student holds an earned doctorate in one of the health sciences (e.g., D.C., M.D., D.O., D.D.S., D.P.M.) or a graduate degree in an academic discipline closely related to the health sciences.

f. Credits accepted for transfer from institutions outside the United States must be accompanied by evidence of the individual student's proficiency in the subject matter of each course for which credits are accepted.

I. Outcomes

A DCP must assemble and report biennially to the COA data demonstrating annual: student rates of completion of term courses and completion of the DCP; student and graduate performance on national board examinations and available data on success of program graduates in obtaining jurisdictional licensure. Programs must demonstrate their use of these data, the attainment of performance thresholds established in CCE Policy 56, and the use of other outcome measurements and assessments in planning for ongoing development of the DCP.

J. Clinical Education

1. Core Clinical Training Curriculum Design

a. The DCP must identify to its students the competencies needed for graduation. These competencies must incorporate the quantitative requirements listed in point b. below, the competencies listed in section J.5., and any other competencies established by the DCP which embody the DCP's expected educational outcomes.

b. The DCP must demonstrate that each student completes the following quantitative clinical requirements within the core clinical training program.

(1) A history on 20 different patients (16 must be non-student* patients);

(2) An examination on 20 different patients (16 must be non-student* patients), and clinical examination involving 15 different case types (which may be included among the 20 different patients, or in which the student may assist, observe, or participate in live, paper-based, computer-based, distance-learning, or other reasonable alternative);

(3) Interpretations, while enrolled in both the didactic and clinical phases of the DCP, of clinical laboratory tests to include at least 25 urinalysis, 20 hematology procedures such as blood counts, and ten clinical chemistry, microbiology or immunology procedures or profiles on human blood and/or other body fluids;

(4) 20 radiographic studies (25% must be evaluated for the technical component, 100% must be evaluated for the interpretive component), and interpretation of radiographic studies involving 15 different case types (which may be included among the 20 radiographic studies, or in which the student may assist, observe, or participate in live, paper-based, computer-based, distance-learning, or other reasonable alternative);

(5) A diagnosis on 20 different patients (16 must be non-student* patients), each with defined case management plans, and diagnosis of 15 different case types, each with defined case management plans (which may be included among the 20 different patients, or in which the student may assist, observe, or participate in live, paper-based, computer-based, distance-learning, or other reasonable alternative);

(6) 250 chiropractic adjustments or manipulations, at least 200 of which must be spinal adjustments, provided during 250 separate encounters (200 must be non-student* patients), of which at least 75 must be assessed through direct observation;

(7) Evaluating and managing at least 15 cases (to increase by five every two years to a maximum of 35 after September 2011, i.e., 20 after the beginning of the Fall 2005 term, 25 after the beginning of the Fall 2007 term, 30 after the beginning of the Fall 2009 term and 35 after the beginning of the Fall 2011 term) which, due to their complexity, require a higher order of clinical thinking and integration of data. This would include cases, which demand the application of imaging, lab procedures or other ancillary studies in determining a course of care, or cases in which multiple conditions, risk factors, or psychosocial factors have to be considered. A minimum of ten cases must be live-patient cases (eight of which must be non-student* patients). In the remaining cases, the student may assist, observe, or participate in live, paper-based, computer-based, distance learning, or other reasonable alternative;

* A non-student patient is any patient other than a student of the DCP and a student intern's spouse, parents or children.

The DCP may establish additional or higher requirements in any of the above areas based on individual DCP goals and/or satisfaction or certain jurisdictional licensing requirements; however, these additional requirements may be attained in any clinical or educational setting the DCP deems appropriate.

c. Clinical training that utilizes multiple sites and/or tracks must describe and adhere to the core curriculum in which all students participate. If portions of the core curriculum are offered at distant sites, they must be equivalent in terms of their content, duration, and intensity to non-distant sites. Core clinical training can be provided at sites not owned/operated by the DCP, however there must be a written agreement establishing the educational affiliation between the DCP and the facility.

d. Elective elements of clinical training must relate to the overall DCP mission, goals and objectives.

e. The DCP must provide the opportunity for all students to obtain the adequate

number of patient experiences needed to demonstrate the clinical competencies required of them.

f. The DCP must provide ongoing opportunities for learning, which must include activities based on current active cases with which the student is involved and which may also include small group case-based discussion, observations, directed assignments or other reasonable alternatives. These opportunities must allow students to assume increasing responsibility, under appropriate supervision, according to their level of training, ability and experience, and to participate in continued doctor-patient relationships.

g. The DCP must have a curriculum management plan that ensures:

(1) an ongoing clinical training review and evaluation process which includes input from faculty, students, administration and other appropriate sources;

(2) competencies are periodically reviewed and updated and that the clinical training is evaluated as to its effectiveness in imparting these competencies; and

(3) student participation is included in the evaluation of the effectiveness of clinical training integration with the overall DCP education.

h. There must always be an adequate number of clinic faculty who are immediately available in the clinical setting to oversee, supervise, and take responsibility for student delivery of patient care services.

2. Supplemental Clinical Training Programs and Associated Facilities

A supplemental clinical training program is defined as clinical training activities conducted in health care facilities not owned or managed directly by the DCP. These facilities may provide services other than those found in the core clinical training. Education in these settings must be consistent with the overall educational mission of the DCP.

A supplemental clinical training program must:

a. Have a commitment to education and quality of patient care, and have a mechanism to track the operations of affiliated field offices and other education sites participating in clinical education and training.

b. Employ a mechanism for approving all education sites to which students rotate for a component supplemental training.

c. Describe in a written document the arrangements between the DCP and each affiliated site, signed by the appropriate administrators of the respective supplemental training program. These arrangements must be specific to the supplemental training program and must address the scope of the affiliation, the content and duration of the rotations involved, the duties and patient care responsibilities of the students during these rotations, and the details of the supervision and resident evaluation that will be provided.

d. Utilize faculty for student supervision who are appropriately qualified and hold an appointment consistent with the faculty appointment practices of the DCP.

e. Provide appropriate supervision of students at each education site.

f. Maintain clear, written guidelines that outline the teaching expectations of all faculty in these locations.

g. Provide programs to maintain educational and clinical skills of all faculty and foster their continual professional growth and development.

h. Maintain a patient record system that is designed to promptly and easily provide information on patient care and the students' experiences.

i. Have appropriate diagnostic and therapeutic equipment to meet the basic needs of patient care at that site and that supports the students' educational experiences consistent with the DCP's educational/practice objectives.

j. Include the opportunity for students to attain hands-on or interactive training in areas requiring qualitative assessment, and ensure that a patient population of adequate size, gender/age variation, and range of case types is available in the practice based on the DCP's educational objectives for each particular clinical experience or rotation.

k. Maintain an appropriate working environment and a duty hour schedule consistent with proper patient care and the educational needs of the students. The emphasis of duties must be related to clinical education.

3. Student Assessment and Evaluation

a. The DCP must utilize a system of student assessment and evaluation that is based on the goals, objectives, and competencies established by the DCP, as well as those defined by the CCE *Standards* and appropriate to entry-level chiropractic practice. The system must clearly identify the summative and formative methods used, and the level of performance expected of students in the achievement of these objectives and competencies.

b. Feedback to the student must be useful and accurate. Informal or formal feedback sessions should occur regularly, as soon as possible after an assessment has been made.

c. Assessment tools must be compatible with the domain being assessed:

(1) knowledge must be assessed using appropriate written and oral examinations as well as direct observation;

(2) psychomotor skills must be assessed by direct observation;

(3) communication skills must be assessed by direct observation of student interactions with faculty, colleagues, and patients and their families. Skills may also be assessed by review of any written communications to patients and colleagues including clinical reports, and referral or consultation letters;

(4) interpersonal skills must be assessed by reviewing performance in collaboration with staff, members of the patient care team, and consultations with doctors of chiropractic and other health care providers as appropriate;

(5) attitudes must be assessed by interviews, observations, or evaluations with peers, supervisors, clinic faculty, and patients and their families; and

(6) competence in utilizing the acquired clinical data to arrive at a diagnosis, and develop a case management plan, must be assessed using appropriate written and oral examinations as well as direct observation.

d. The DCP system of assessment and evaluation must provide for the identification of deficiencies in student knowledge, attitude, or skills.

e. The DCP must provide:

(1) an appropriate process for students to review and appeal identified deficiencies in knowledge, attitude, or skills.

(2) a formal system of remediation.

f. Student assessment systems must:

(1) have a clear organizational structure for assessment;

(2) have a clear description of the role of faculty in assessment and how assessment information will be used in student evaluation;

(3) track and document student assessment and progress through the educational program including the integration of classroom performance, clinical performance, and the overall attainment of clinical competencies; and

(4) evaluate the effectiveness of assessment tools.

4. Quality Patient Care

The DCP must:

a. Conduct a formal system of quality assurance for the patient care delivery that demonstrates evidence of:

(1) standards of care with measurable outcomes criteria and ongoing review of a representative sample of patients and patient records to assess the appropriateness, necessity and quality of the care provided; and

(2) patient advocate grievance policies, procedures, outcomes and corrective measures.

b. Include the following characteristics in the quality assurance system:

(1) a clear organizational structure for quality assurance.

(2) a listing and description of each area and item (indicator) of quality assurance that is measured including:
(a) how the item is measured;

(b) how frequently the item will be measured;

(c) how data will be assessed to identify need for improvement;

(d) how improvement efforts will be determined;

(e) how improvement efforts will be followed to ensure implementation and improvement; and

(f) how the effectiveness of implemented changes/improvements will be assessed on an ongoing basis.

(3) methods for communicating quality assurance results to the clinic and larger DCP community.

c. Provide a written statement of patients' rights to all students, faculty, staff and each patient.

d. Provide ongoing training in basic life support and management of common medical emergencies for all students and supervising facility involved in patient care.

e. Maintain and follow written policies and procedures for the safe use of ionizing radiation.

f. Follow federal, regional, state, and local requirements for clinical/laboratory asepsis, infection and biohazard control and disposal of hazardous waste.

g. Follow federal, regional, state, and local requirements regarding the confidentiality of patient information.

h. Meet all federal, state and community standards for chiropractic assessment and care, billing, and financial transactions.

i. Monitor and enforce all professional and legal requirements, inherent in the responsibilities of a licensed doctor of chiropractic.

j. Provide ongoing training in the area of ethics and professional boundaries for students and supervising faculty involved in patient care.

5. Required Clinical Competencies

The DCP must document that each student has acquired these clinical competencies prior to graduation.

The DCP must provide students with the necessary instruction and opportunities to observe, acquire and practice under supervision, the attitudes, knowledge and skills listed in this section.

a. History Taking

The history is that element of patient evaluation in which information regarding the individual's clinical status is obtained and an initial clinical impression is developed. It is generally the first contact the patient has with the doctor and,

consequently, initiates the doctor-patient relationship.

The process employed in history taking and the depth to which the doctor of chiropractic elicits a health history, is a critical factor in building the patient's confidence in the doctor's ability to professionally and effectively provide health care. Eliciting a competent history requires that the clinician have an understanding of pathophysiology and adequate knowledge of the basic and clinical sciences.

(1) Attitudes

The student must demonstrate an ability to:

(a) attend to patient comfort and the environment in which the history is elicited;

(b) appreciate the need for empathy, respect and an awareness of the patient's right for privacy and confidentiality;

(c) recognize patient apprehension, and avoid exclamatory, misleading or inappropriate verbal or physical responses; and

(d) recognize the professional and ethical boundaries expected of the doctor/patient relationship.

(2) Knowledge

The student must demonstrate an ability to:

(a) recognize the importance of obtaining: patient demographic data, chief complaint, history of present illness, family history, past health history, current health status, psychosocial history, and review of systems;

(b) recognize changes in patient presentations or health status during the course of care and apply the appropriate depth and breadth of questioning;

(c) formulate and employ an organized and effective methodology of inquiry when taking the history;

(d) understand and recognize non-verbal diagnostic clues observed during the history; and

(e) select and organize pertinent information leading to the development of a problem and differential diagnosis list.

(3) Skills

The student must demonstrate an ability to:

(a) develop a patient's comprehensive case history to include all elements appropriate to the patient's entering complaint and health status and to the chiropractic analyses;

(b) conduct the history in a clear, concise and organized manner, actively listening and communicating with the patient at an understandable level;

(c) modify and apply history taking skills appropriate to challenging situations and difficult patient interactions;

(d) question the patient with appropriate depth and pursue all relevant health concerns and symptoms; and

(e) accurately record elicited information in an organized fashion and develop an initial problem list.

b. Physical Examination

The physical examination is an element of the evaluation in which information regarding the clinical status is elicited by selecting and applying appropriate examination procedures, including essential instruments and equipment

(1) Attitudes

The student must demonstrate an ability to:

(a) recognize patient apprehension, and avoid exclamatory statements and physical responses that may exacerbate patient concern;

(b) understand the importance of maintaining a clean and safe environment, and follow accepted hygienic procedures; and

(c) recognize the professional and ethical boundaries expected of the doctor/patient relationship.

(2) Knowledge

The student must demonstrate an ability to:

(a) understand and conduct the appropriate examination distinguishing between comprehensive, focused, or screening procedures;

(b) select appropriate procedures, instruments and equipment for use in the examination;

(c) correlate information obtained in the examination with the history;

(d) recognize normal, variant and abnormal findings; and

(e) interpret and assess the clinical importance of significant physical examination findings.

(3) Skills

The student must demonstrate an ability to:

(a) develop objective data from the physical examination appropriate to the

health status and the chiropractic care of the patient;

(b) obtain and record vital signs and examination findings in an organized manner;

(c) conduct an examination using inspection, palpation, percussion and auscultation in a correct, safe and hygienic manner;

(d) use examination instruments, equipment and procedures in an accurate, safe, appropriate and hygienic manner;

(e) recognize and record significant non-verbal signs and behaviors exhibited by the patient;

(f) conduct an examination which provides for efficient patient positioning and comfort; and

(g) provide appropriate and understandable explanations and instructions to the patient relative to the use of procedures and instruments.

c. Neuromusculoskeletal Examination

The neuromusculoskeletal examination is the foundation of the chiropractic approach toward evaluating the patient. Doctors of chiropractic commonly provide care to patients with complaints or health problems associated with the spine and extremities. The spine and its relationship to nervous system function is also viewed as an important factor in the patient's general health.

Because the traditional model of chiropractic care involves spinal adjustment, evaluating the spine and nervous system is a crucial component of the patient examination.

(1) Attitudes

The student must demonstrate an ability to:

(a) appreciate the effect that a patient's pain and discomfort may have on the doctor's ability to conduct a neuromusculoskeletal examination;

(b) appreciate and adapt to patient apprehension in the performance of neuromusculoskeletal examination procedures; and

(c) consider the possibility that the origin of the patient's symptoms may be from a source other than the neuromusculoskeletal system.

(2) Knowledge

The student must demonstrate an ability to:

(a) identify and select appropriate neuromusculoskeletal examination tests and procedures consistent with the patient's complaint or presentation;

(b) understand and select methods for evaluating posture, biomechanical

function, and the presence of spinal or other articular subluxation or dysfunction;

(c) correlate information obtained in the neuromusculoskeletal examination with the information obtained from patient's history and physical examination;

(d) understand the mechanisms of neuromusculoskeletal tests and demonstrate an ability to recognize normal, variant and abnormal findings;

(e) interpret and assess the clinical importance of significant normal and abnormal neuromusculoskeletal examination findings; and

(f) assess the reliability of data elicited in the neuromusculoskeletal examination through repetition and/or selection of confirmatory procedures.

(3) Skills

The student must demonstrate an ability to:

(a) conduct a neuromusculoskeletal examination using inspection, palpation, percussion, range of motion, and appropriate orthopedic and neurologic procedures in a correct, orderly, safe and hygienic manner;

(b) use instruments and equipment during the neuromusculoskeletal examination in an appropriate, safe and hygienic manner;

(c) observe and record verbal and non-verbal diagnostic clues elicited and observed during the neuromusculoskeletal examination;

(d) conduct a neuromusculoskeletal examination in a manner that provides for efficient patient positioning and comfort; and

(e) provide appropriate and understandable explanations and instructions to the patient prior to the use of procedures and instruments.

d. The Psychosocial Assessment

It is important to develop the knowledge and skills necessary to evaluate the psychosocial status of patients. As a component of the patient evaluation, doctors of chiropractic must be able to recognize the interrelationships among the biological, psychological and social factors in patients. Psychosocial factors may influence the health of patients or explain the nature of their complaint. This aspect of evaluation is also important in the context of establishing the doctor-patient relationship. For these reasons, doctors of chiropractic must have a basic understanding of common health behaviors and mental health disorders, and be prepared to conduct general patient assessments.

(1) Attitudes

The student must demonstrate an ability to:

(a) recognize and be willing to explore the patient's psychosocial environment; and

(b) understand and appreciate the role and influence of psychosocial factors in the overall health of the patient.

(2) Knowledge

The student must demonstrate an ability to:

(a) appreciate how lifestyle, health status, behavior and psychological factors contribute to, or affect, patient presentations;

(b) understand how pain and disability can affect patient behavior and well-being;

(c) recognize psychological and social factors that may affect or distort the patient's ability to report symptoms, comply with, or respond to chiropractic care;

(d) recognize verbal and non-verbal clues indicating the need for further psychological and psychosocial assessment;

(e) recognize the clinical indications for referral to or collaborative care with appropriate mental health professionals, agencies or programs;

(f) identify appropriate services, agencies and programs available to assist the patient with psychosocial problems; and

(g) recognize circumstances that legally require doctors to report patient information to appropriate authorities.

(3) Skills

The student must demonstrate an ability to:

(a) identify and administer screening tools for evaluating the patient's psychological and psychosocial status;

(b) modify history taking, examination, and management procedures when caring for patients demonstrating and affected by psychosocial factors;

(c) obtain psychosocial information effectively and legally from family members, or others, when clinically indicated and appropriate;

(d) record psychosocial information in a manner that is accurate, complete and complies with legal standards;

(e) discuss sensitive psychosocial and health behavior issues;

(f) deal effectively with aberrant behavior from a patient in an office setting; and

(g) assess attitudes that negatively impact health and intervene appropriately to educate and motivate the patient to modify behaviors.

e. Diagnostic Studies

Diagnostic studies are those elements of patient evaluation in which objective data regarding the patient's clinical status are elicited, and which include the use of diagnostic imaging, clinical laboratory, and specialized testing procedures.

Doctors of chiropractic must be knowledgeable and skilled in the use of those specialized testing procedures commonly employed in the evaluation of patients with neuromusculoskeletal presentations. They must also have an understanding of diagnostic studies used in the screening of patients with other complaints or health problems in the primary care setting.

(1) Attitudes

The student must demonstrate an ability to:

(a) recognize the importance and necessity of diagnostic studies as they relate to the development of an accurate patient profile; and

(b) recognize the importance of considering benefits, costs and risks in assessing the need for conducting or ordering diagnostic studies.

(2) Knowledge

The student must demonstrate an ability to:

(a) understand the clinical indications for and the relative value of diagnostic studies;

(b) understand the principles, applications, technical and procedural elements of equipment employed in diagnostic imaging, clinical laboratory and other diagnostic studies;

(c) understand the significance of findings, values, and ranges of values adequate to differentiate normal from abnormal findings obtained from laboratory and other diagnostic studies;

(d) integrate findings obtained from diagnostic studies with information obtained from other components of the examination in forming or assessing the diagnosis; and

(e) understand federal and state regulatory guidelines governing procedures and the use of equipment employed in diagnostic studies.

(3) Skills

The student must demonstrate an ability to:

(a) perform and/or order and interpret appropriate imaging examinations;

(b) take, process and interpret plain film radiographs with appropriate attention given to quality and safety;

(c) perform and/or order and interpret appropriate clinical laboratory examinations;

(d) obtain and process laboratory samples with appropriate attention given to patient comfort, hygiene, safety and specimen integrity;

(e) perform and/or order and interpret other relevant procedures indicated by the clinical status of the patient;

(f) order, or conduct, diagnostic studies with attention to following professional protocol, and providing appropriate patient instructions and follow-up; and

(g) record accurately data obtained from diagnostic studies, whether personally conducted or ordered.

f. Diagnosis

Diagnosis is the process which attempts to identify the nature and cause of a patient's complaint and/or abnormal finding, and is essential to the ongoing process of reasoning used by the doctor of chiropractic to direct patient management. The diagnosis may be modified during the course of care as the result of further testing, patient care and changes in the patient's signs and symptoms.

(1) Attitudes

The student must demonstrate an ability to:

(a) understand the importance of collecting sufficient clinical information in order to avoid reaching a premature diagnosis; and

(b) recognize the importance of generating a diagnosis consistent with history and examination findings, prior to initiating care or ordering special studies.

(2) Knowledge

The student must demonstrate an ability to:

(a) exhibit reasoning and understanding in using sources (such as the available literature and clinical experience) to support the diagnosis;

(b) develop the diagnosis by recognizing and correlating significant information; and

(c) identify the pathophysiologic process responsible for the patient's clinical presentation, and understand the natural history of the disorder.

(3) Skills

The student must demonstrate an ability to:

(a) integrate data in a manner that facilitates the formulation of a diagnosis;

(b) develop and prioritize a problem list;

(c) record and convey a diagnosis consistent with history and examination findings; and

(d) recognize when routine diagnostic procedures are insufficient and obtain appropriate advanced studies when indicated.

g. Case Management

Case management includes developing and recording a patient care plan, case follow-up, and the referral and/or collaborative care as necessary in the management of a patient. Doctors of chiropractic must be able to identify a care plan that is consistent with findings obtained from the history, examination and diagnostic studies, and the needs of the patient and must also consider the cost implications of care and choose methods of care that are cost-effective. Doctors of chiropractic must also be able to provide wellness care and to promote health maintenance.

(1) Attitudes

The student must demonstrate an ability to:

(a) recognize the need to develop, record, and communicate a plan for care, and to assess and modify elements of the plan as clinical circumstances dictate;

(b) appreciate the need to obtain the patient's informed consent, cooperation and compliance with care and/or referral recommendations;

(c) consider the patient's physical and psychosocial factors when developing and communicating a plan for care;

(d) identify personal and/or professional care limitations and recognize the need for referral or collaborative care;

(e) be aware of the need to ensure that all records relevant to the patient's management contain adequate, accurate and current information;

(f) be aware of the confidential nature of the doctor-patient relationship, and ensure that appropriate information is properly released only to agencies or individuals authorized for its review;

(g) comply with requests for patient records and reports in an adequate, accurate and timely manner; and

(h) recognize the importance of preventative care and health promotion practices.

(2) Knowledge

The student must demonstrate an ability to:

(a) develop and record an appropriate care plan and prognosis consistent with the diagnosis, and the pathophysiology and/or natural history of the disorder;

(b) evaluate and integrate the patient's health and psychosocial needs in the development of the care plan;

(c) select and employ outcome measures that can aid the doctor in assessing the validity of the initial diagnosis and prognosis, and the effectiveness of the care plan;

(d) understand professionally and legally acceptable methods of recording and organizing patient records including information about the patient history and examination findings, diagnosis and patient care plan, progress notes, correspondence, services provided and care rendered, and financial transactions; and

(e) select appropriate assessments for health maintenance and wellness care.

(3) Skills

The student must demonstrate an ability to:

(a) communicate effectively to the patient the diagnosis, recommended chiropractic care, and alternatives to chiropractic care that may be indicated;

(b) provide patient education on health care needs;

(c) use appropriate forms of communication to ensure that the patient has an adequate understanding of their health status and health care needs;

(d) identify and initiate the appropriate drugless (with the exception of nutritional supplements or supplementation) health care regimen;

(e) perform appropriate chiropractic adjustments and/or manipulations;

(f) refer the patient, when clinically indicated, for consultation, continued study or other care;

(g) initiate referral or collaborative care when appropriate to the needs of the patient;

(h) keep appropriate records of the patient's evaluation and case management;

(i) appropriately respond to changes in patient status, or failure of the patient to respond to care;

(j) construct reports and professional correspondence;

(k) establish clear outcomes for care that can be used to evaluate clinical progress, and recognize when the patient has achieved resolution or maximum therapeutic benefit;

(l) recognize when routine clinical procedures are insufficient and incorporate other procedures when indicated;

(m) perform common screening procedures and wellness assessments in different age groups; and

(n) effectively utilize technology to gather and manage information relative to patient care and practice management.

h. Chiropractic Adjustment or Manipulation

The chiropractic adjustment is a precise procedure that uses controlled force, leverage, direction, amplitude, and velocity directed at specific articulations. Doctors of chiropractic employ adjustive and/or manipulative procedures to influence joint and neurophysiologic function. Other manual procedures may be used in the care of patients.

(1) Attitudes

The student must demonstrate an ability to:

(a) appreciate the need to explain what will be done when administering the chiropractic adjustment or manipulation, discuss risks, and recognize the potential for patient apprehension and concern;

(b) be aware of the need to accommodate patient privacy and modesty in the course of administering chiropractic adjustments or manipulations; and

(c) be aware of the need to reassess and modify chiropractic adjustment or manipulation appropriate to the needs of the patient.

(2) Knowledge

The student must demonstrate an ability to:

(a) appreciate the normal and abnormal structural and functional articular relationships;

(b) be aware of the pathophysiology and methods of evaluating articular biomechanics;

(c) understand the principles and methods of various chiropractic adjustments and manipulations common to the practice of chiropractic;

(d) recognize the clinical indications and rationale for selecting a particular chiropractic adjustment or manipulation;

(e) select and appropriately use equipment and instruments necessary to administer chiropractic adjustment or manipulation; and

(f) recognize the indications and contraindications for, and potential complications of, chiropractic adjustment or manipulation.

(3) Skills

The student must demonstrate an ability to:

(a) palpate specific anatomical landmarks associated with spinal segments and other articulations;

(b) select and effectively utilize palpatory and other appropriate methods to identify subluxations of the spine and/or other articulations;

(c) use effectively equipment and instruments which support chiropractic adjustment or manipulation;

(d) deliver effectively the correct chiropractic adjustments or manipulations which utilize appropriate positioning, alignment, contact and execution;

(e) administer effectively a variety of chiropractic adjustments or manipulations in order to accommodate differences in patient body type and clinical status;

(f) record accurately the method of determining location, specific procedure followed and outcome of the chiropractic adjustment or manipulation;

(g) select and employ palpation and other methods for identifying the effects following chiropractic adjustment or manipulation;

(h) communicate the health benefits of chiropractic adjustment or manipulation to patients;

(i) perform chiropractic adjustment and manipulation in a confident and decisive manner; and

(j) discuss potential immediate or delayed reactions or responses to the chiropractic adjustment or manipulation.

i. Emergency Care

Doctors of chiropractic may encounter clinical situations - within and outside the office setting - that require immediate attention, and must develop the ability to identify an emergency or life-threatening situation and apply the necessary care or procedures.

(1) Attitudes

The student must demonstrate an ability to:

(a) recognize the responsibility to provide emergency care procedures; and

(b) recognize the need for a prompt critical appraisal and response to an emergency situation.

(2) Knowledge

The student must demonstrate an ability to:

(a) recognize an emergency or life-threatening situation;

(b) understand current emergency care and first aid procedures, equipment and instruments;

(c) monitor the effect of emergency care on the patient;

(d) understand the legal implications associated with providing emergency care; and

(e) determine the availability of local emergency care resources and select the appropriate services.

(3) Skills

The student must demonstrate an ability to:

(a) utilize emergency care procedures and equipment effectively in providing first aid and basic cardiac life support;

(b) remain calm, reassure and communicate with the patient, and elicit additional help, as needed;

(c) recognize the need for assistance in an emergency situation and effectively communicate and collaborate with other health care professionals; and

(d) perform appropriate reporting, recording and follow-up procedures.

j. Case Follow-Up and Review

Case follow-up and review involves monitoring the clinical status of the patient and modifying the care plan as new clinical information becomes available. Doctors of chiropractic evaluate patient progress by conducting follow-up examinations, and seek help from clinical consultants when needed.

(1) Attitudes

The student must demonstrate an ability to:

(a) recognize the need to monitor the patient's response to care and modify the care plan, consult with, or refer to another health care provider when indicated;

(b) recognize and respond to patient concerns and apprehension that may result from proposed changes in a care plan or the need for referral or collaborative care; and

(c) appreciate the benefits of appropriate consultation and/or referral in the management of the patient, and be considerate of patient questions regarding second opinions and alternative forms of care.

(2) Knowledge

The student must demonstrate an ability to:

(a) understand how and when to re-evaluate the patient's clinical status to obtain current information;

(b) recognize the need to modify the care plan consistent with current clinical information;

(c) identify referral needs, and how to communicate them to patients; and

(d) evaluate the patient's response to care by identifying appropriate outcomes.

(3) Skills

The student must demonstrate an ability to:

(a) monitor patient's clinical status during and after completion of the health care regimen through follow-up and review appropriate to the patient's health status;

(b) record data relevant to case management decisions in an organized manner;

(c) communicate appropriately when referring to other health care providers; and

(d) conduct a relevant and competent re-evaluation of the patient.

k. Record-Keeping

Record-keeping is that element of case management in which proper documentation of the patient's evaluation, clinical care and other transactions are recorded, accurately maintained and appropriately reported.

(1) Attitudes

The student must demonstrate an ability to:

(a) recognize the need to ensure that all records relevant to the patient's care and management contain legible, accurate, complete and current information;

(b) recognize the patient's right to privacy and ensure that information from the record is released only upon legal and/or written authorization;

(c) be willing to respond to requests for patient records, or information from patient records, in an adequate and timely manner;

(d) recognize the need to ensure patient record security and confidentiality;

(e) be sensitive to the interests that patients may have in accessing their records, and follow accepted legal guidelines when it is deemed necessary to provide or withhold specific information regarding the patient; and

(f) recognize the need to keep abreast of current trends and technologies for record-keeping, communications and data transfer.

(2) Knowledge

The student must demonstrate an ability to:

(a) be aware of and follow accepted procedures and protocols when requesting patient records or information from other health care providers or agencies;

(b) know what elements of the record must be released to the patient, or other health care providers or agencies, and those elements that can be legally withheld;

(c) know and understand those elements essential to the patient record including demographic data, clinical findings and patient care information, financial transactions, reports, correspondence and communications;

(d) be aware of accepted methods and legal requirements for record maintenance, storage and security;

(e) be aware of the need to provide a key with records if abbreviations or symbols are used; and

(f) use accepted coding systems for diagnosis and clinical procedures.

(3) Skills

The student must demonstrate an ability to:

(a) construct the patient record in a manner that is accurate, legible, complete and current, and is neither inflammatory, prejudicial nor degrading to the patient;

(b) enter clinical findings, diagnosis or initial clinical impressions, identity of the doctor and other care providers, care plans, progress notes, and follow-up evaluations in a manner that is legible, accurate, organized and reflects the clinical decision-making process; and

(c) generate clear, concise, and professional narrative reports and correspondence in a timely manner.

I. The Doctor-Patient Relationship

The nature of the relationship between the doctor and the patient has an important influence on the process and outcome of chiropractic care. Doctors of chiropractic are expected to respond to their patients' needs and provide care in an atmosphere of trust and confidence. Accordingly, doctors of chiropractic must be compassionate, sensitive to the bio-psycho-social needs, recognize the importance of good communication skills, and consider the patient to be their partner in the care process.

(1) Attitudes

The student must demonstrate an ability to:

(a) recognize the importance of developing and maintaining professional attitudes and behavior within and outside the office setting;

(b) appreciate the importance of developing a professional relationship with the patient based on trust, confidence, respect, and confidentiality;

(c) recognize and accept the importance and seriousness of the role that doctors of chiropractic have in the care of patients;

(d) be aware of and be willing to respond to the needs, concerns and fears that patients may have relative to their health complaints and problems;

(e) appreciate the importance of compassion, empathy and touch as vital components of healing and factors that influence the outcome of care;

(f) recognize the importance of both the doctor and patient working together as partners in promoting optimum health;

(g) recognize and accept the inherent vulnerability of patients because of the perception of authority that patients attach to care-givers;

(h) recognize the important and frequent role physical contact has within many chiropractic clinical services; and

(i) appreciate and respect the protective boundaries patients secure over their physical and emotional being.

(2) Knowledge

The student must demonstrate an ability to:

(a) recognize the need to appropriately manage patients who may develop unrealistic expectations of and a dependency on chiropractic care;

(b) appreciate and be willing to adapt to the cultural, social, religious, gender and age differences that may exist between the doctor and his or her patients;

(c) know what patient care and office procedures can be employed that will reduce potential risk and professional liability.

(d) recognize the importance of open communication and the need to properly and adequately inform the patient of potential or proposed care;

(e) understand the appropriateness of obtaining informed consent from the patient prior to initiating clinical care; and

(f) recognize the need to establish and maintain appropriate boundaries in doctor-patient interactions which ensure physical and emotional safety.

(3) Skills

The student must demonstrate an ability to:

(a) develop and exhibit behavior and a communication style that project a professional image and enhance the doctor-patient relationship;

(b) use effective and appropriate methods of touch and other non-verbal communication techniques; and

(c) use appropriate techniques that may be employed when managing a patient who exhibits inappropriate behavior.

m. Professional Issues

Health care providers have an obligation to the patients they serve, and to society, to provide competent and effective care, and to do so in a professional manner. Doctors of chiropractic must exhibit ethical values and behaviors, recognize their responsibility to first serve the patient, and to follow sound business practices. It is important that doctors of chiropractic maintain knowledge and clinical skills through continuing education, and be able to access, understand and critically evaluate the research literature.

(1) Attitudes

The student must demonstrate an ability to:

(a) appreciate the importance of supporting and participating in professional activities and organizations;

(b) recognize the need to support and participate in the activities and affairs of the community;

(c) acknowledge the societal obligation of the profession to produce research, and appreciate the importance of research in education, clinical practice and to the growth of the profession;

(d) have a desire and an ability to critically evaluate new and current knowledge;

(e) exhibit ethical attitudes regarding the provision of patient care services, fees, financial arrangements, billing practices and collection procedures; and

(f) identify and acknowledge an obligation to refrain from illegal and unethical patient care and practice management procedures.

(2) Knowledge

The student must demonstrate an ability to:

(a) be aware of and comply with, the professional reporting requirements and procedures of commercial, federal, state and local agencies;

(b) understand the need to maintain a breadth and depth of knowledge and skills necessary for the practice of chiropractic through continuing education;

(c) identify community health care and social service agencies that can assist in meeting patient needs;

(d) know patient care and office procedures which can be employed to reduce potential risk and professional liability;

(e) be aware of the types, policy limits and coverage levels available for professional liability insurance;

(f) develop a knowledge of ethical practice development strategies including marketing, community demographics, and patient management techniques; and

(g) understand the need to follow sound business practices including those involving leases, loans, purchasing, selection of consultants and advisors, financial management, and personnel.

(3) Skills

The student must demonstrate an ability to:

(a) critically review clinical research literature;

(b) develop effective patient rapport by employing oral and written communication skills, and appropriate care procedures; and

(c) use personal computers and other business and communication technologies.

n. Wellness

(1) Attitudes

The student must demonstrate an ability to:

(a) appreciate how lifestyle, health status, behavior, and psychological factors interplay in the overall health and wellness of the patient;

(b) appreciate a multidimensional character of patient wellness including the physical, intellectual, emotional, and spiritual dimensions;
(c) appreciate and accept active patient participation as an essential component of health care;

(d) effectively explain and appropriately emphasize the significant benefits that health promotion measures can have on response to treatment;

(e) appreciate community-level health care issues and the doctor of chiropractic's role in community health care;

(f) recognize and appreciate the significant impact that environmental influences may have on a patient's overall well being; and

(g) appreciate the broad social determinants of health.

(2) Knowledge

The student must demonstrate an ability to:

(a) discuss the basic principles and perspectives of health promotion and wellness;

(b) describe the concepts of health promotion in the context of chiropractic health care;

(c) describe the essential components of health promotion appropriate for the needs of the patient and the public;

(d) describe the role of the doctor of chiropractic in health promotion;

(e) relate the specific needs of patients and the public to the lifestyle changes necessary for their health promotion;

(f) identify the resources materials available to help educate patients and the public about health promotion and wellness

(g) identify the minimum screening activities for health promotion;

(h) describe principal trends evolving in the implementation of, and health impact and affected population for each of the leading health indicators (physical activity, overweight and obesity, tobacco use, substance abuse, responsible sexual behavior, mental health, injury and violence, environmental quality, immunization, and access to health care); and

(i) describe the goals, issues, trends and disparities in the focus areas of increased quality and years of healthy life, and elimination of health disparities;

(3) Skills

The student must demonstrate an ability to:

(a) communicate effectively with patients about aspects of their health including biological, psychological, social, and spiritual as part of comprehensive history taking;

(b) use appropriate techniques to encourage patient participation in a shared responsibility for the patient's health;

(c) implement recommended preventive screening activities;

(d) perform common screening procedures and wellness assessments in different age groups; and

(e) provide patient counseling for health promotion and assess the outcomes of this counseling.

o. Ethics and Integrity

Health care providers have an obligation to their patients and the communities they serve to be of high moral and ethical character and to provide their professional services in an environment of honesty and integrity and non-discrimination. Accordingly, doctors of chiropractic must learn and demonstrate high standards of ethics and integrity

(1) Attitudes

The student must demonstrate an ability to:

(a) recognize the ethical standards expected of a doctor of chiropractic in an academic setting; including, but not limited to cheating, stealing, plagiarism and accuracy in research;

(b) be aware of the ethical standards expected of a doctor of chiropractic in a college clinical setting; including, but not limited to accuracy in clinical charting, HIPPA requirements for privacy, potential conflicts in interest when treating friends and relatives, avoiding dual relationships; and sexual boundaries;

(c) recognize the importance of learning, developing and maintaining high standards of ethics and integrity in personal behavior, both inside and outside the office;

(d) recognize the potential influence and harm caused by improper or illegal use of alcohol and drugs inside and outside of the professional office setting;

(e) recognize the potential harm that may arise to the doctor's objectivity by engaging in unethical and improper practice building activities, including but not limited to such as paying for referrals; fee splitting and billing for professional services through improper corporate structures;

(f) recognize the potential harm and unprofessional nature of placing the needs, desires and goals of the doctor ahead of their clinical responsibilities to their patients.

(2) Knowledge

The student must demonstrate an understanding of:

(a) the ethical standards expected of a doctor of chiropractic in an academic setting; including, but not limited to cheating, stealing, plagiarism and accuracy in research;

(b) the ethical standards expected of a doctor of chiropractic for the billing of professional services to either patients or third parties;

(c) the unethical nature and illegality of acts such as paying for patients, paying for referrals, fee splitting, kickbacks and the delivery of any item of value for direct referrals;

(d) the potential ethical violations and unprofessional conduct associated with many practice building activities, including but not limited to, improper use of diagnostic testing; excessive use of legitimate diagnostic testing, treatment programs not based on a patient's true clinical need and the improper corporate structures in some multi-professional practices;

(e) the role of a fiduciary, and to be able to discuss the improper nature of dual relationships between doctors and patients on all level.

(3) Skills

The student must demonstrate an ability to:

(a) successfully complete the academic work and challenges of the DCP in a manner consistent with expected standards of ethics and integrity by not cheating, stealing, plagiarism or other violations of professional standards expected of health care professionals;

(b) successfully complete the clinical requirements of the DCP in a manner consistent with the responsibilities of a fiduciary expected between a doctor and their patient in the college clinic; and

(c) show the ability to accurately represent professional services for payment.

6. Optional Clinical Competencies Required if the Curriculum Includes Didactic and Laboratory Components in Non-Adjustive Therapeutic Procedures.

Chiropractic care may include the use of procedures and modalities other than the adjustment and manipulation, which may be employed for the purpose of case management, rehabilitation, or wellness care.

(1) Attitudes

The student must demonstrate an ability to:

(a) appreciate the need to explain what will be done when administering therapies, discuss risks, and recognize the potential for patient apprehension and concern;

(b) be aware of the need to accommodate patient privacy and modesty in the course of administering therapies; and

(c) be aware of the need to reassess and modify therapy procedures appropriate to the needs of the patient.

(2) Knowledge

The student must demonstrate an ability to:

(a) understand the principles, physiological effects, and application of various therapeutic procedures common to the practice of chiropractic;

(b) recognize the clinical indications and rationale for selecting a particular therapeutic procedure;

(c) understand the selection and use of equipment and instruments necessary to administer therapeutic procedures; and

(d) recognize the contraindications, and potential complications, of therapeutic procedures.

(3) Skills

The student must demonstrate an ability to:

(a) select and apply appropriate therapeutic instruments or procedures;

(b) explain effectively the clinical benefits and communicate necessary information to the patient concerning the application of therapeutic procedures;

(c) modify the application of therapeutic procedures consistent with the patient's physical and clinical status;

(d) record accurately appropriate information relative to the use of therapeutic procedures; and

(e) discuss potential immediate or delayed reactions or responses to therapeutic procedures.

K. Research and Other Scholarly Activity

1. Purpose Statement

The DCP must establish objectives for and conduct research and scholarly activities that support its mission and goals. When there is more than one (1) campus, there must be active research opportunities and efforts at each campus site.

2. Policies/Procedures

   The DCP must have and follow written policies regarding the conduct of research and scholarly activities, to include protection of human and animal subjects. All DCPs and institutions using animal subjects must comply with the federal standards specified in the Animal Welfare Act (Public Law 89-544, 1966, as amended, (P. L. 91-469 and P. L. 94-279) 7 U.S.C. section 2131 et seq. Implementing regulations are published in the Code of Federal Regulations (CFR), Title 9, Subchapter A. Parts 1, 2, 3 and 4, and are administered by the U.S. Department of Agriculture).

3. Inputs

   The DCP must provide appropriate financial, faculty, physical, and administrative resources for the conduct of research and scholarly activities.

4. Outcomes

   The DCP must compile evidence regarding the extent to which the research and scholarly activity outcomes meet stated research and scholarly activity objectives

L. Service

1. Purpose Statement

   The DCP must establish objectives for and provide service activities, beyond the chiropractic services to patients required of all interns that support its mission and goals.

2. Policies/Procedures

   The DCP must have and follow written policies regarding the provision of services.

3. Inputs

   The DCP must provide appropriate financial, faculty, physical and administrative resources for the conduct of services.

4. Outcomes

   The DCP must compile evidence regarding the extent to which service outcomes meet the stated service objectives.

IV. Requirements for Institutional Status

Review toward continued award of institutional status is provided by the COA upon specific request from solitary purpose chiropractic institutions offering only the doctor of chiropractic degree program (DCP) that have not otherwise achieved institutional accreditation status with a nationally recognized accrediting agency. (CCE no longer accepts application for such status unless the institution held such status before 2002) The DCP must be in compliance with the DCP accreditation requirements of these *Standards* (Section 2.III) and be currently accredited by the COA, and must request review for institutional status when applying for reaffirmation of accreditation. The institution must be in compliance with the specific requirements identified and addressed below in this section of the *Standards* in order to be awarded continued institutional status.

A. Mission and Scope of Service, Self-Assessment and Planning

1. The institution must have a statement of mission adopted by its governing board, and stating that it is an institution of higher education offering only the Doctor of Chiropractic degree; however, the institution also may have educational, research, and service activities other than those within the DCP.

2. The statement of institutional mission must be consistent with the statement of mission of the program leading to the Doctor of Chiropractic degree, and provide for activities in education, research and service.

3. The institution must seek and maintain accreditation of its DCP by the CCE.

4. Institutional self-assessment and planning requirements for institutional accreditation must be consistent with those described for DCP accreditation.

B. Authorization

1. The institution must be incorporated within the United States as a not-for-profit corporation.

2. The institution must hold appropriate legal authorization to grant the Doctor of Chiropractic degree.

3. The institution must meet all legal requirements to conduct its business as an institution of higher education in all jurisdictions in which it operates.

C. Governance

1. The institution must have established a governing board which has legal authority for the institution.

2. The governing board must act in agreement with the following requirements:

   a. The governing board must be composed of representatives of both the chiropractic profession and the public;

   b. No member of the board may serve in any administrative or teaching position at the institution, except for occasional service without compensation; and

   c. No member of the governing board may use board membership for personal or private gain or advantage to the board member, to members of the board member's family, or to any business in which the board member has a substantial interest.

3. The governing board must have adopted bylaws whereby it establishes and periodically reviews the basic policies under which the institution operates. These policies must address at least the following areas of operation:

   a. Conduct of governing board business.

   b. Administration, faculty and staff.

c. Facilities, learning resources and finance.

d. Students and student services.

e. Management, control, and conduct of the academic program, including all courses for credit as well as seminars and other noncredit offerings.

f. Public disclosure.

g. Service.

h. Research.

i. Academic resources.

j. Admissions requirements.

k. Assessment of instructional outcomes and student academic achievement.

D. Administration

1. The governing board must designate a person not a member of the governing board as the Chief Executive Officer of the institution, responsible for the administration of policies adopted by the governing board.

2. The Chief Executive Officer must hold educational credentials and have experience appropriate for the principal administrative officer of an institution of higher education offering the Doctor of Chiropractic degree.
3. Additional administrative staff holding appropriate credentials and having appropriate experience must be appointed by the Chief Executive Officer or by the governing board as specified in the bylaws of the institution.

E. Student Services

1. The institution must establish appropriate admissions requirements and procedures for each educational activity or program to which students are admitted.

2. The institution must provide appropriate learning resources support services for each educational activity to which students are admitted.

3. If the institution participates in activities affected by Title IV of the Higher Education Act of 1965 as amended it must maintain compliance with its program responsibilities, including but not limited to:

   a. Administrative and fiscal standards.

   b. Record-keeping and disclosure requirements.

   c. Default prevention measures, which must include the maintenance of a Federal Family Education Loan Cohort Default Rate that is beneath the threshold established by the United States Secretary of Education.

F. Financial Resources

1. The institution must have an annual fiscal year audit made by an independent certified public accountant conducted in accordance with generally accepted accounting principles.
2. The institution must have all financial aid programs audited as required by federal and state regulations.

G. Public Disclosure

1. In addition to the public disclosure items required to be published for DCPs, the institution must publish in official documents available to the public at least the following:

   a. The institutional statement of mission.

   b. The educational activities conducted by the institution.

   c. A description of admissions requirements, attendance requirements, and graduation requirements for each educational activity.

   d. The accredited status of the institution with the CCE and all other accrediting bodies with which it is affiliated.

2. The institution must make available upon request information that accurately describes its financial condition.

Appendix 1

Glossary

Case types = In this context, "case types" represents a list of diagnostic entities (e.g., lumbar disc herniation, hypertension), patient presentations (e.g., woman with fatigue, patient over 50 with insidious low back pain, patient with radiating arm pain and nerve root deficits), and/or subluxation or joint dysfunction patterns (e.g., T4 syndrome, Maigne's syndrome, upper cervical joint dysfunction causing cervicogenic headache) which will represent the intended training domain of the clinical training phase of the DCP.

Competency evaluation = Any of a variety of methods used to assess students' knowledge, skills and attitudes, with the goals of providing feedback to enhance the educational process, rating performance, and determining the appropriateness of progression in the clinical phase of the DCP.

Diagnosis = An expert opinion based upon the reasoned judgment of the doctor of chiropractic to identify the nature and cause of the patient's subjective complaints and objective findings, which directs clinical care and case management decisions. The diagnostic process is an essential component of chiropractic care and includes the integration and synthesis of all available information obtained from appropriate history, examination findings, laboratory, imaging, and other evaluations, resulting in a recorded opinion of the patient's health problem(s) and status.

At times, there may be insufficient or inconclusive information to render a final diagnosis; however, the initial diagnostic impression should guide the doctor of chiropractic in decisions about further diagnostic evaluation, referral, or initiation of patient care. The diagnosis may be modified during the course of case management as a result of further evaluation, acquisition of additional information, changes in subjective complaints and objective findings, or clinical responses to chiropractic care.

Final diagnostic conclusions may be contingent upon information that is not immediately accessible to the doctor of chiropractic, including results obtained from specialized diagnostic procedures, reports from other health care providers or facilities, data derived from clinical observation, or other knowledge from third party sources.

Educational outcomes = Indicators of the quality of instructional effectiveness.

Health promotion = Maintenance of neurobiomechanical integrity inclusive of subluxation prevention, and general strategies to enhance quality of life and prevent disease, trauma, and illness. This includes aspects of ergonomics, psychosocial support, exercise, diet, nutrition and life style counseling, and health screening.

Information technology = The means for the search for and retrieval of information from electronic sources such as CD ROM, WEB-based information services, and computerized information and patient information storage sites.

May = Indicates a condition allowable within the *Standards*.

Must = Indicates a condition mandatory for accreditation by CCE.

National Accrediting Agency = An agency recognized by the Secretary of the US Department of Education.

Patient review policies = A mechanism to systematically review and effectively deal with patient complaints and reported incidents.

Portal of entry = The opportunity for the doctor of chiropractic to be the first contact a patient may make with a provider to seek health care information and/or services.

Primary Care Chiropractic Physician = An individual who serves as a point for direct access to health care delivery, the doctor of chiropractic's responsibilities include: (1) patient's history; (2) completion and/or interpretation of physical examination and specialized diagnostic procedures; (3) assessment of the patient's general health status and resulting diagnosis; (4) provision of chiropractic care and/or consultation with continuity in the co-management, or referral to other health care providers; and (5) development of sustained health care partnership with patients.

Quality Standards = Quality standards shall mean each of the standards set forth in Section 2 of the Standards for Doctor of Chiropractic Programs and Requirements for Institutional Status. CCE expects compliance with these Standards.

Requirements = Signifies a set of conditions that must be met as one of the requirements for CCE accreditation to be awarded.

Should = Indicates a condition that is desirable but not mandatory for accreditation by CCE.

Wellness = A process of optimal functioning and creative adaptation involving all aspects of life. Health is a state of optimal well being and functioning; wellness is an active process employing a set of values and behaviors that promotes health and enhances quality of life.

ATTACHMENT

G

Guidance for the Core Curriculum Specifications

The guidance for the core curriculum specifications is intended to assist training organizations in developing programs that would be used to fulfill the proposed requirements in the Federal Motor Carrier Safety Administration's (FMCSA) final rule for the National Registry of Certified Medical Examiners (National Registry). The final rule states that a medical examiner must complete a training program. FMCSA explained in the preamble to the final rule that training providers and organizations must follow the core curriculum specifications in developing training programs for medical examiners who apply for listing on the Agency's National Registry. This training prepares medical examiners to:

- Apply knowledge of FMCSA's driver physical qualifications standards and advisory criteria to findings gathered during the driver's medical examination; and
- Make sound determinations of the driver's medical and physical qualifications for safely operating a commercial motor vehicle (CMV) in interstate commerce.

The rule, 49 CFR 390.105(b), lists eight topics which must be covered in the core curriculum specifications. The core curriculum specifications are arranged below by numbered topic, followed by guidance to assist training providers in developing programs based on the core curriculum specifications.

Guidance for Each of the Core Curriculum Specifications

(1) Background, rationale, mission and goals of the FMCSA medical examiner's role in reducing crashes, injuries and fatalities involving commercial motor vehicles.

Mission and Goals of Federal Motor Carrier Safety Administration (FMCSA)

- Discuss the history of FMCSA and its position within the Department of Transportation including its establishment by the Motor Carrier Safety Improvement Act of 1999 and emphasize FMCSA's Mission to reduce crashes, injuries and fatalities involving large trucks and buses.

Role of the Medical Examiner

- Explain the role of the medical examiner as described in 49 CFR 391.43.

(2) Familiarization with the responsibilities and work environment of commercial motor vehicle (CMV) operations.

The Job of CMV Driving

- Describe the responsibilities, work schedules, physical and emotional demands and lifestyle among CMV drivers and how these vary by the type of driving.

- Discuss factors and job tasks that may be involved in a driver's performance, such as:
    - Loading and unloading trailers;
    - Inspecting the operating condition of the CMV; and
    - Work schedules:

- irregular work, rest, and eating patterns / dietary choices.

(3) Identification of the driver and obtaining, reviewing, and documenting driver medical history, including prescription and over-the-counter medications.

Driver Identification and Medical History:

Discuss the importance of driver identification and review of the following elements of the driver's medical history as related to the tasks of driving a CMV in interstate commerce.

- Inspect a State-issued identification document with the driver's photo to verify the identity of the individual being examined; identify the commercial driver's license or other types of driver's license.

- Identify, query and note issues in a driver's medical record and/or health history as available, which may include:
  - specific information regarding any affirmative responses in the history;
  - any illness, surgery, or injury in the last five years;
  - any other hospitalizations or surgeries;
  - any recent changes in health status;
  - whether he/she has any medical conditions or current complaints;
  - any incidents of disability / physical limitations;
  - current medications and supplements, and potential side effects, which may be potentially disqualifying;
  - his/ her use of recreational/addictive substances (e.g., nicotine, alcohol, inhalants, narcotics or other habit-forming drugs);
  - disorders of the eyes (e.g., retinopathy, cataracts, aphakia, glaucoma, macular degeneration, monocular vision);
  - disorders of the ears (e.g., hearing loss, hearing aids, vertigo, tinnitus, implants);
  - cardiac symptoms and disease (e.g., syncope, dyspnea, chest pain, palpitations, hypertension, congestive heart failure, myocardial infarction, coronary insufficiency, or thrombosis);
  - pulmonary symptoms and disease (e.g., dyspnea, orthopnea, chronic cough, asthma, chronic lung disorders, tuberculosis, previous pulmonary embolus, pneumothorax);
  - sleep disorders (e.g., obstructive sleep apnea, daytime sleepiness, loud snoring, other);
  - gastrointestinal disorders (e.g., liver disease, digestive problems, hernias);
  - genitourinary disorders (e.g., kidney stones and other renal conditions, renal failure, hernias);
  - diabetes mellitus:
    - current medications (type, potential side effects, duration on current medication);
    - complications from diabetes; and
    - presence and frequency of hypoglycemic / hyperglycemic episodes/reactions;
  - other endocrine disorders (e.g., thyroid disorders, interventions / treatment);

- musculoskeletal disorders (e.g., amputations, arthritis, spinal surgery);
- neurologic disorders (e.g., loss of consciousness, seizures, stroke / transient ischemic attack, headaches/ migraines, numbness / weakness) ; or
- psychiatric disorders (e.g., schizophrenia, severe depression, anxiety, bipolar disorder, or other conditions) that could impair a driver's ability to safely function.

(4) Performing, reviewing and documenting the driver's medical examination.
Physical Examination (Qualification/Disqualification Standards (§ 391.41 and 391.43))

- Explain the FMCSA physical examination requirements and advisory criteria in relationship to conducting the driver's physical examination of the following:
  - Eyes (§ 391.41(b)(10))
    - equal reaction of both pupils to light;
    - evidence of nystagmus and exophthalmos;
    - evaluation of extra-ocular movements.
  - Ears (§ 391.41(b)(11))
    - abnormalities of the ear canal and tympanic membrane;
    - presence of a hearing aid.
  - Mouth and throat (§ 391.41(b)(5))
    - conditions contributing to difficulty swallowing, speaking or breathing;
  - Neck (§ 391.41(b)(7))
    - range of motion;
    - soft tissue palpation / examination (e.g., lymph nodes, thyroid gland).
  - Heart (§ 391.41(b)(4)and (b)(6))
    - chest inspection (e.g., surgical scars, pacemaker / implantable automatic defibrillator);
    - auscultation for thrills, murmurs, extra sounds, and enlargement;
    - blood pressure and pulse (rate and rhythm);
    - additional signs of disease (e.g., edema, bruits, diaphoresis, distended neck veins.
  - Lungs, chest, and thorax (§ 391.41(b)(5))
    - respiratory rate and pattern;
    - auscultation for abnormal breath sounds;
    - abnormal chest wall configuration / palpation.
  - Abdomen (§ 391.41(a)(3)(i) and 391.43(f))
    - surgical scars;
    - palpation for enlarged liver or spleen, abnormal masses or bruits / pulsation, abdominal tenderness, hernias (e.g., inguinal, umbilical, ventral, femoral or other abnormalities).
  - Spine (§ 391.41(b)(7))
    - surgical scars and deformities;
    - tenderness and muscle spasm ;
    - loss in range of motion and painful motion;
    - spinal deformities.

- Extremities and trunk (§ 391.41(b)(1), (b)(4) and (b)(7))
  - gait, mobility, and posture while bearing his/her weight; limping or signs of pain ;
  - loss, impairment, or use of orthosis;
  - deformities, atrophy, weakness, paralysis, or surgical scars;
  - elbow and shoulder strength, function, and mobility ;
  - handgrip and prehension relative to requirements for controlling a steering wheel and gear shift;
  - varicosities, skin abnormalities, and cyanosis, clubbing, or edema;
  - leg length discrepancy; lower extremity strength, motion, and function
  - other abnormalities of the trunk.
- Neurologic status (§ 391.41(b)(7), (b)(8) and(b)(9))
  - impaired equilibrium, coordination or speech pattern (e.g., ataxia);
  - sensory or positional abnormalities;
  - tremor;
  - radicular signs;
  - reflexes (e.g., asymmetric deep-tendon, normal / abnormal patellar and Babinski).
- Mental status (§ 391.41(b)(9))
  - comprehension and interaction;
  - cognitive impairment;
  - signs of depression, paranoia, antagonism, or aggressiveness that may require follow-up with a mental health professional.

(5) Performing, obtaining and documenting diagnostic tests and obtaining additional testing or medical opinion from a medical specialist or treating physician.
Diagnostic Testing and Further Evaluation

- Describe the FMCSA diagnostic testing requirements and the medical examiner's ability to request further testing and evaluation by a specialist.
  - Urine test for specific gravity, protein, blood and glucose (§ 391.41(a)(3)(i));
  - Whisper or audiometric testing (§ 391.41(b)(11));
  - Vision testing for color vision, distant acuity, horizontal field of vision and presence of monocular vision (§ 391.41(b)(10));
  - Other testing as indicated to determine the driver's medical and physical qualifications for safely operating a CMV.
  - Refer to a specialist a driver who exhibits evidence of any of the following disorders (§ 391.43(e) and (f)):
    - vision (e.g., retinopathy, macular degeneration);
    - cardiac (e.g., myocardial infarction, coronary insufficiency, blood pressure control);
    - pulmonary (e.g., emphysema, fibrosis);
    - endocrine (e.g., diabetes);
    - musculoskeletal (e.g., arthritis, neuromuscular disease);

- neurologic (e.g., seizures);
- sleep (e.g., obstructive sleep apnea);
- mental / emotional health (e.g., depression, schizophrenia); or
- other medical condition(s) that may interfere with ability to safely operate a CMV.

(6) Informing and educating the driver about medications and non-disqualifying medical conditions that require remedial care.

Health Counseling

- Inform course participants of the importance of counseling the driver about:
  - possible consequences of non-compliance with a care plan for conditions that have been advised for periodic monitoring with primary healthcare provider;
  - possible side effects and interactions of medications (e.g., narcotics, anticoagulants, psychotropics) including products acquired over-the-counter (e.g., antihistamines, cold and cough medications or dietary supplements) that could negatively affect his/her driving;
  - the effect of fatigue, lack of sleep, poor diet, emotional conditions, stress, and other illnesses that can affect safe driving;
  - if he/she is a contact lens user, the importance of carrying a pair of glasses while driving;
  - if he/she uses a hearing aid, the importance of carrying a spare power source for the device while driving;
  - if he/she has a history of deep vein thrombosis, the risk associated with inactivity while driving and interventions that could prevent another thrombotic event;
  - if he/she has a diabetes exemption, that he/she should:
    - carry a rapidly absorbable form of glucose while driving;
    - self-monitor blood glucose one hour before driving and at least once every four hours while driving;
    - comply with each condition of his/her exemption;
    - plan to submit glucose monitoring logs for each annual recertification;
  - corrective or therapeutic steps needed for conditions which may progress and adversely impact safe driving ability (e.g., seek follow-up from primary care physician);
  - steps needed for reconsideration of medical certification if driver is certified with a limited interval, e.g., the return date and documentation required for extending the certification time period.

(7) Determining driver certification outcome and period for which certification should be valid.

Assessing the Driver's Qualifications and Disposition

- Explain how to assess the driver's medical and physical qualification to operate a CMV safely in interstate commerce using the medical examination findings

weighed against the physical and mental demands associated with operating a CMV by:

- Considering a driver's ability to
  - move his/her body through space while climbing ladders; bend, stoop, and crouch; enter and exit the cab;
  - manipulate steering wheel;
  - perform precision prehension and power grasping;
  - use arms, feet, and legs during CMV operation;
  - inspect the operating condition of a tractor and/or trailer;
  - monitor and adjust to a complex driving situation; and
  - consider the adverse health effects of fatigue associated with extended work hours without breaks;
- Considering identified disease or condition(s) progression rate, stability, and likelihood of gradual or sudden incapacitation for documented conditions (e.g., cardiovascular, neurologic, respiratory, musculoskeletal and other).

<u>Medical Certificate Qualification/Disqualification Decision and Examination Intervals</u>

- Discuss the medical examiner's obligation to consider potential risk to public safety and the driver's medical and physical qualifications to drive safely when issuing a Medical Examiner's Certificate, when to qualify/disqualify the driver and how to determine the expiration date of the certificate by:
  - using the requirements stated in the FMCSRs, with nondiscretionary certification standards to disqualify a driver
    - with a history of epilepsy;
    - with diabetes requiring insulin control (unless accompanied by an exemption);
    - when vision parameters (e.g., acuity, horizontal field of vision, color) fall below minimum standards unless accompanied by an exemption;
    - when hearing measurements with or without a hearing aid fall below minimum standards;
    - currently taking methadone;
    - with a current clinical diagnosis of alcoholism; or
    - who uses a controlled substance including a narcotic, an amphetamine, or another habit-forming drug without a prescription from the treating physician;
  - using clinical expertise, disqualify a driver when evidence shows a driver has a medical condition that in your opinion will likely interfere with the safe operation of a CMV;
  - certifying a driver for an appropriate duration of certification interval;
  - if he/she has a condition for which the medical examiner is deferring the driver's medical certification or disqualifying the driver, informing the driver of the reasons which may include:
    - a vision deficiency (e.g., retinopathy, macular degeneration);
    - the immediate post-operative period;

- a cardiac event (e.g., myocardial infarction, coronary insufficiency);
- a chronic pulmonary exacerbation (e.g., emphysema, fibrosis);
- uncontrolled hypertension;
- endocrine dysfunctions (e.g., insulin-dependent diabetes);
- musculoskeletal challenges (e.g., arthritis, neuromuscular disease);
- a neurologic event (e.g., seizures, stroke, TIA);
- a sleep disorder (e.g., obstructive sleep apnea); or
- mental health dysfunctions (e.g., depression, bipolar disorder).

(8) FMCSA reporting and documentation requirements.

Documentation of Medical Examination Findings

Demonstrate the required FMCSA medical examination report forms, appropriate methods for recording the medical examination findings and the rationale for certification decisions including:

- Medical Examination Report Form
  - identification of the driver;
  - use of appropriate Medical Examination Report form;
  - assurance that driver completes and signs driver's portion of the Medical Examination Report form;
  - specifics regarding any affirmative response on the driver's medical history;
  - height/weight, blood pressure, pulse;
  - results of the medical examination, including details of abnormal findings;
  - audiometric and vision testing results;
  - presence of a hearing aid and whether it is required to meet the standard;
  - if obtained, funduscopic examination results;
  - the need for corrective lenses for driving;
  - presence or absence of monocular vision and need for a vision exemption;
  - if driver has diabetes mellitus and is insulin dependent, the need for a diabetes exemption;
  - other laboratory, pulmonary, cardiac testing performed; and
  - the reason(s) for the disqualification and/or referral.

- Other supporting documentation
  - if driver has current vision exemption, include the ophthalmologist's or optometrist's report;
  - if a driver has a diabetes exemption, include the endocrinologist's and ophthalmologist's/optometrist's report;
  - treating physician's work release;
  - if obtained, specialist's evaluation report;
  - if the driver has a current Skill Performance Evaluation Certificate, include it; and

- results of Substance Abuse Professional evaluations for alcohol and drug use and/or abuse for a driver with
  - alcoholism who completed counseling and treatment to the point of full recovery.

- Medical Examiner's Certificate
  - certification status, which may require:
    - waiver / exemption;
    - wearing corrective lenses;
    - wearing a hearing aid; or
    - a Skill Performance Evaluation Certificate;
  - complete and accurate documentation on medical certification card including:
    - the examiner's name, examination date, office address, and telephone number and Medical Examiner signature; and
    - the driver's signature.

ATTACHMENT

H

NATIONAL REGISTRY OF CERTIFIED MEDICAL EXAMINERS

Complete Guide to Medical Examiner Certification

DEPARTMENT OF TRANSPORTATION
UNITED STATES OF AMERICA

March 25, 2013

Table of Contents

Introduction

The National Registry of Certified Medical Examiners (hereinafter referred to as the "National Registry") was established in accordance with the final rule published by the Federal Motor Carrier Safety Administration (FMCSA) in the Federal Register on April 20, 2012. This rule requires that all medical examiners who conduct physical examinations for interstate commercial motor vehicle (CMV) drivers:

- Maintain a valid State license to conduct medical examinations;
- Complete required training on FMCSA's physical qualification standards;
- Pass the FMCSA Medical Examiner Certification Test to demonstrate knowledge of FMCSA's physical qualification standards; and
- Complete refresher training every 5 years and recertification testing every 10 years.

Beginning May 21, 2014, all medical certificates issued to interstate truck and bus drivers must come from medical examiners listed on the National Registry.

The National Registry Overview

In August 2005, Congress enacted the Safe, Accountable, Flexible, Efficient Transportation Equity Act: A Legacy for Users (SAFETEA-LU), which authorized FMCSA to establish the National Registry of Certified Medical Examiners (49 U.S. Code 31149).

National Registry Background

The National Registry is designed to improve highway safety by producing trained, certified medical examiners who can determine whether a CMV driver meets FMCSA standards and guidelines.

Objectives

The objectives of the National Registry Program are:

- Improve highway safety;
- Ensure that medical examiners understand FMCSA medical standards and guidelines and how they apply to interstate CMV drivers;
- Maintain training and testing program for medical examiners;
- Promote public confidence in the quality of the medical examiners who certify CMV drivers; and
- Establish an online list of certified medical examiners.

This Guide

This *Complete Guide to Medical Examiner Certification* is designed to help medical examiners apply and prepare for the FMCSA Medical Examiner Certification Test and can be used as a reference tool after certification. The *Guide* provides information about eligibility requirements, applying to take the certification test, the certification testing process, and maintaining certification. It also includes information about FMCSA policies and procedures for listing on the National Registry.

The Certification Test

FMCSA modeled the development of the certification test on recognized processes and procedures established by the National Commission for Certifying Agencies (NCCA), a national accreditation body for a variety of certification programs and organizations that assess professional competency. The NCCA uses a peer review process to establish accreditation standards, evaluate compliance with the standards,

recognize organizations and programs that demonstrate compliance, and serve as a resource on quality certification. FMCSA used these standards for certification test development so medical examiners, the drivers they examine, the motor carriers that employ the drivers and the public would have confidence in the qualifications of FMCSA certified medical examiners.

Test Construction

FMCSA performed an extensive role delineation study to identify the critical knowledge, skills, and abilities needed to perform CMV driver physical examinations in accordance with current FMCSA regulations and advisory criteria. A variety of methods were used to complete the study, including an literature review, direct observations of CMV driver physical examinations, a national survey of medical examiners, and medical examiner expert Working Integrated Product Team (WIPT) meetings. The study results provided a blueprint for the FMCSA Medical Examiner Certification Test and the development of core curriculum specifications for the initial medical examiner training that will be provided by private-sector training organizations.

Test Content

Test Specifications

The final test specifications shown in Table 1 reflect the number of items and cognitive level of questions for each content area on the certification test. These specifications were developed combining medical examiner survey results and consensus of WIPT members. This blend of survey results and consensus among medical examiners is superior to using either element alone.

Table 1: Core Content Areas

FMCSA Medical Examiner Certification Test	Items			
	Cognitive Level			
Content Area	Recall	Application	Analysis	Totals
I. DRIVER'S MEDICAL INFORMATION	**23**	**33**	**14**	**70**
A. Identification and History	4	6	10	20
B. Physical Examination and Evaluation	8	15	2	25
C. Diagnostic Tests and/or Referrals	6	10	2	18
D. Documentation of Ancillary Information	5	2	0	7
II. DETERMINATION OF DRIVER'S QUALIFICATIONS AND DISPOSITION	**7**	**12**	**11**	**30**
A. Health Education Counseling	2	1	1	4
B. Risk Assessment	2	4	8	14
C. Certification Outcomes and Intervals	3	7	2	12
Totals	**30**	**45**	**25**	**100**

Eligibility Requirements

To be eligible to take the FMCSA Medical Examiner Certification Test, the medical examiner candidate must:

- Meet the professional requirements established in 49 CFR 390.103(a) (1): Medical Examiner must "be licensed, certified, or registered in accordance with applicable State laws and regulations to perform physical examinations. The applicant must be an advanced practice nurse, doctor of chiropractic, doctor of medicine, doctor of osteopathy, physician assistant, or other medical professional authorized by applicable State laws and regulations to perform physical examinations."

- Complete required initial medical examiner training on the FMCSA physical qualification standards, guidance and related knowledge for CMV drivers.

Training

Initial medical examiner training must be completed prior to sitting for the FMCSA Medical Examiner Certification Test. The training reviews FMCSA-specific knowledge about CMV drivers and the physical and mental demands of their job. This training is required because specialized knowledge of CMV drivers is not included in healthcare practitioner education and licensure.

Medical examiner training ensures that candidates have baseline instruction in FMCSA's CMV driver physical qualification standards, medical guidelines, and medical examiner responsibilities. Medical scope of practice is defined by each State. It demonstrates the practitioner's clinical knowledge. The medical examiner training builds on that clinical knowledge and applies it to the fitness for duty determination for CMV drivers.

FMCSA provides a list of required training topics to private-sector professional associations, health care organizations, and other for-profit and non-profit training providers. A detailed list of training topics can be found in the *National Registry of Certified Medical Examiners Medical Examiner Training, Guidance for the Core Curriculum Specifications* in Appendix A. Training providers choose the training delivery method, which may include but is not limited to the following: traditional instructor-led classroom instruction; self-paced, computer- or web-based learning; a combination of both; or a guided literature review.

There is no FMCSA requirement for length of training. Training providers are not reimbursed by the Federal government for developing training courses and may charge reasonable fees to those candidates who choose to attend. The training program must meet the following requirements:

- Be conducted by a training provider that is accredited by a nationally-recognized medical profession accrediting organization to provide continuing education units;
- Present course content that addresses the eight topics outlined in the current core curriculum specifications established by FMCSA.
- Provide the medical examiner with proof of training. FMCSA recommends providing medical examiner with a certificate of completion. The training certificate must include the following information:
    - Medical examiner's name and professional title.
    - Date training was completed.
    - Training provider name and contact information.
    - Title of training program.
    - Training program accreditation information, including:
        - Name of accrediting body.
        - Affirmation of accreditation in accordance with the requirements of the accrediting body.

- Accrediting body contact information.

NOTE: The medical examiner can attend a training program accredited by any medical profession accrediting organization (i.e. a physician can complete a training program accredited by a nurse practitioner accrediting organization).

Test Application

Testing Organizations

The FMCSA Medical Examiner Certification Test is delivered only by testing organizations that have been approved by FMCSA and listed on the National Registry Website (https://nationalregistry.fmcsa.dot.gov). Approved testing organizations administer only the currently authorized version of the certification test developed and furnished by FMCSA. To accommodate the number of potential medical examiners and their geographic dispersion, the FMCSA Medical Examiner Certification Test is administered by multiple, private-sector, professional testing organizations. In addition, the Agency is permitting testing organizations to offer online monitored testing. Given the variety of testing organizations and methods used, it is important to maintain common standards of test presentation, facilities, data security, and other factors. These standards must be carefully defined and applied so medical examiners have an equal opportunity to demonstrate their knowledge without concern for the reliability or validity of the test and its administration. 49 CFR 390.107 establishes these standards, and states (in part):

(a) The testing organization has documented policies and procedures that:
   1. Use secure protocols to access, process, store, and transmit all test items, test forms, test data, and candidate information and ensure access by authorized personnel only.
   2. Ensure testing environments are reasonably comfortable and have minimal distractions.
   3. Prevent to the greatest extent practicable the opportunity for a test taker to attain a passing score by fraudulent means.
   4. Ensure that test center staff that interact with and proctor examinees or provide technical support have completed formal training, demonstrate competency, and are monitored periodically for quality assurance in testing procedures.
   5. Accommodate testing of individuals with disabilities or impairments to minimize the effect of the disabilities or impairments while maintaining the security of the test and data.

(b) Testing organizations that offer testing of examinees at locations that are not operated and staffed by the organization by means of remote, computer-based systems, must, in addition to the requirements of paragraph (a), ensure that such systems:

   1. Provide a means to authenticate the identity of the person taking the test.
   2. Provide a means for the testing organization to monitor the activity of the person taking the test
   3. Do not allow the person taking the test to reproduce or record the contents of the test by any means.

(c) The testing organization has submitted its documented policies and procedures as defined in paragraph (a) of this section to FMCSA; and agreed to future reviews by FMCSA to ensure compliance with the criteria listed in this section.

The testing organization administers only the currently authorized version of the FMCSA Medical Examiner Certification Test developed and furnished by FMCSA.

Application Procedures

Registration

Step 1: Create Your Account

- Create your National Registry Account at https://nationalregistry.fmcsa.dot.gov.
- Select "Registration" option.
- Enter requisite information. (You must complete registration or your data will not be saved).
- Verify all information and submit.

Step 2: Accept Rules of Behavior

The following medical examiner Rules of Behavior will be displayed and must be affirmed and submitted before registration is complete:

- Statement of capability and willingness to comply with the FMCSA requirement to transmit CMV driver examination data to FMCSA electronically once every calendar month.
- Statement agreeing to provide copies of certification of training completion, State license(s), certificate(s), or registration(s) to perform physical examinations, completed Medical Examination Reports, and medical examiner certificates to an authorized representative of FMCSA or to an authorized State or local enforcement agency representative upon request.
- Statement agreeing to accept any written communication from FMCSA relating to participation on the National Registry by electronic mail at the email address(es) provided to FMCSA, including any notice of proposed removal from the National Registry and any such information addressing obligations as a certified medical examiner.
- Statement that all information submitted to FMCSA is true, and accepts the terms.
- Statement agreeing to the National Registry/FMCSA Privacy Policy.

Once registration is complete, you will receive a welcome message and a National Registry Number. You will then receive an email with a temporary password and instructions for next steps.

Taking the FMCSA Medical Examiner Certification Test

Scheduling the Test

- Go to https://nationalregistry.fmcsa.dot.gov to find links to testing organizations approved to administer the FMCSA Medical Examiner Certification Test.
- Obtain information about locations and scheduling instructions directly from the testing organizations.
- Schedule a date and time to take the test. Some testing organizations may provide an option to take the test using a secure, remote, computer-based system. If you choose that option, you will need to follow their procedures for making those arrangements.

IMPORTANT: It is your responsibility to keep your contact and licensing information up to date on the National Registry. If your license has expired or your name changes, you MUST put the correct information into the National Registry. Be sure to update the contact (e.g. name, address, etc.) and medical licensing information (e.g. license expires, license number, license state, etc.) you entered when registering on the National Registry website when there are changes. If the contact and medical licensing information you entered during registration on the National Registry website does not match the credentials you present to the test center, you will not be allowed to take the exam.

Test Fees

Although FMCSA reviews the policies and procedures submitted by testing organizations before approving them to provide the test, it does not establish, or regulate the fees established and collected by testing organizations, and does not receive any monies collected by testing organizations or providers.

Testing providers are not reimbursed by the Federal government and may charge fees they deem appropriate for test delivery. The testing provider is responsible for the entire process of fee determination, collection, and refund, if warranted, as well as the advertising of the testing service, determining the testing schedule, and managing applications submitted by candidates taking the certification test.

Test Preparation

As a candidate for the FMCSA Medical Examiner Certification Test, you should review the complete *Detailed Content Outline (DCO)* in Appendix B to understand the scope and complexity of the test. Test items are limited to the critical tasks specified in the DCO, which identifies the following:

- Task
- Cognitive level required to respond to each item
- Number of items by major content domain
- Number of items by cognitive level

Test Taking Tip

CMV driver medical certification is based on comprehensive physical assessment of driver health. This includes the medical examiner's informed judgment about the potential impact of a single medical condition or multiple existing medical conditions on the driver's ability to operate a CMV safely in interstate commerce.

Sample Certification Test Items

Sample test items provide an idea of what to expect on the certification test. Appendix C of this *Guide* provides several sample test items.

Resources

National Registry Website and Listserv

FMCSA developed the National Registry Website and the National Registry Listserv to disseminate information including the latest National Registry developments and to facilitate communication with the program's primary stakeholders: medical professionals interested in becoming certified medical examiners; certified medical examiners; industry professionals; CMV drivers; employers; the general public; and all other interested parties.

The National Registry Website (https://nationalregistry.fmcsa.dot.gov) provides information about FMCSA regulations and other requirements relevant to CMV driver physical examinations. The website will include a continually updated list of certified medical examiners that are authorized by FMCSA to perform physical examinations for interstate CMV drivers.

Medical professionals interested in becoming certified medical examiners and being listed on the National Registry can find information about the medical examiner training and certification process on the National Registry Website.

Resources on the National Registry Website

Sample Training

The *Sample Training is a* comprehensive example of medical examiner training. This document covers the eight training topics in the core curriculum required by FMCSA. Training providers may modify it to suit whatever delivery methodology they choose.

Medical Examiner Handbook

The *Handbook* is an online resource that provides information and guidance for medical examiners who perform physical examinations and certifications for interstate CMV drivers.

Information Manual for Training Organizations

This manual is a complete guide to becoming a National Registry training provider. It outlines the requirements, policies, and procedures that apply to training providers.

Administrative Manual for Testing Organizations

This is a single resource to provide testing organizations with the information needed to properly administer the FMCSA Medical Examiner Certification Test. The manual details the requirements, policies, and procedures for validating test takers, test administration, and transmitting results to the National Registry.

Testing Policies and Procedures

The Day of the Test

When you arrive at the testing center, you must provide your National Registry Number, proof of your medical credential, proof of completion of training, and one form of photo identification. At that time, testing center personnel will verify your eligibility to take the test. If eligibility cannot be verified, you will not be allowed to take the test.

The following are acceptable forms of identification:

- U.S. driver's license with photograph
- State ID card with photograph
- U.S. passport
- U.S. military ID card with photograph
- Permanent resident card with photograph
- Native American tribal ID Card with photograph
- Foreign government-issued passport with photograph
- Canadian provincial driver's license with photograph
- Indian and Northern Affairs Canada card with photograph (INAC)
- Transportation worker ID with photograph (TWIC)

After your eligibility is verified, the testing proctor will provide instructions on how to proceed. All FMCSA-approved testing organizations have agreed to maintain test administration and security standards. These standards ensure that all candidates have the same opportunity to demonstrate their knowledge and prevent testing irregularities or misconduct.

IMPORTANT: It is your responsibility to keep your contact and licensing information up to date on the National Registry. If your license has expired or your name changes, you MUST put the correct information into the National Registry. Be sure to update the contact (e.g. name, address, etc.) and medical licensing information (e.g. license expires, license number, license state, etc.) you entered when

registering on the National Registry website when there are changes. If the contact and medical licensing information you entered during registration on the National Registry website does not match the credentials you present to the test center, you will not be allowed to take the exam.

Security

Testing organizations approved to deliver the FMCSA Medical Examiner Certification Test have provided FMCSA with their documented policies and procedures for ensuring test security. All tests are monitored to ensure the highest level of security. The testing organization will provide information about their policies and procedures at the time the test is schedule. The following security procedures generally apply during the test:

At a test center

The testing organization must monitor every test session to maintain a standardized environment. This ensures that every medical examiner has an equal opportunity to demonstrate his or her knowledge and protects the integrity of the test. The following security procedures must be enforced by the person (proctor) presenting the test.

- No cameras, notes, documents, audio or video recorders, personal digital assistants (PDAs), pagers, cellular phones or calculators are permitted in the testing area.
- No guests, visitors or family members are allowed in the test room.
- Except for keys and wallets, no personal items, including purses, business cases, backpacks, valuables or weapons may be brought into the test room.

During testing the following apply:

- Eating, drinking and smoking are **not** permitted inside the test room.
- Pencils/markers may be provided and may be available during testing.
- Blank scratch paper or dry-erase boards may be provided during testing, and they must be returned to the proctor at test completion. No documents or notes of any kind may be removed from the testing area.
- The proctor may not answer any questions concerning the test content or requests for interpretations during testing.
- No conversations with others during the test (except with proctors/monitors).

Online testing

The security requirements for online testing are similar to those described for administration at a test center. The testing organization must provide monitoring for every test session to the extent possible. This ensures that every medical examiner has an equal opportunity to demonstrate his or her knowledge and protects the integrity of the test. The following security procedures must be enforced by the testing organization:

- No cameras, notes, documents, audio or video recorders, PDAs, pagers, cellular phones or calculators are permitted within view or reaching distance of the test taker.
- No guests, visitors or family members are allowed in the room.
- No conversations with others during the test (except with proctors/monitors).
- No personal items such as purses, business cases, and backpacks are allowed within view or reaching distance of the test taker.

During testing the following apply:

- The use of the internet, books, reference materials etc. is **not** permitted during the exam.
- Pencils/markers may be used.
- Blank scratch paper may be used.
- No conversations with others during the test (except with proctors/monitors).
- No telephone communications are permitted
- The candidate must remain in the room, seated at the computer within range of the webcam.

Timed Test

The FMCSA Medical Examiner Certification Test is a two hour, timed test. The test contains 120 items; 100 are scored and 20 are being evaluated for inclusion on the test at a future date. Once the actual test begins, the two hour test time runs continuously with no pauses.

Misconduct

Testing centers monitor for misconduct during test administration and have policies and procedures in place for addressing the issue. Generally, candidates who engage in misconduct are dismissed from the testing session and their scores are not reported. Testing organizations will report to FMCSA when any applicant for FMCSA medical examiner certification engages in fraudulent means to pass the FMCSA Medical Examiner Certification Test. FMCSA prohibits the applicant from retaking the test for 90 days.

Examples of misconduct include:

- Creating a disturbance, is abusive or is otherwise uncooperative, and disturbs others in the test room;
- Using electronic communications equipment, such as pagers, cellular phones, or PDAs;
- Giving or receiving help or is being suspected of doing so;
- Attempting to record test items or makes notes;
- Attempting to take the certification test for someone else;
- Using notes, books, and other aids;
- Talking to a person other than the proctor/monitor while taking the test.

Test Procedures

The computer tracks the time it takes to complete the test. The computer terminates the test when the time limit is reached, regardless of whether the test is completed. Only one test item is presented at a time, and the answers are identified as A, B, C, or D. Each test center will have its own processes that will be explained prior to the exam.

The number of test items answered is reported at test completion. If you have not answered all questions and time remains, you can go back and answer those questions. It is generally best to try to answer all questions. Your score is based on the total number of correct responses.

Candidate Comments and Feedback

Testing Organizations should refrain from collecting comments about the test from candidates taking the test. Once the candidate has completed the test, the proctor should advise them to submit comments directly to FMCSA. The candidate should be advised that submitting a comment does not affect their score.

Receiving Test Score/Passing the Test

The testing organization notifies the candidate that the results will be sent to FMCSA.

After receiving the test answers from the testing center, FMCSA confirms the grading, ensures the validation of the candidate's credentials and issues a National Registry certificate. The candidate receives official notification via email about his or her certification status. The email includes the medical examiner's National Registry Number, and information about maintaining certification. Medical examiner's contact information will then be listed on the National Registry Website.

Not Passing the Test

A medical examiner who does not pass the test for initial certification, recertification, or reinstatement may take it again by submitting another application to a testing organization and paying the appropriate fee. This is **retesting**. The retest does not have to be performed by the same test provider. The medical examiner must wait 30 days before retaking the test, but there is no limit on the number of times that a medical examiner may take the test. A medical examiner candidate must pass the certification test within 3 years after completing initial training for initial certification or for reinstatement if FMCSA requires the medical examiner candidate to retake the initial training.

If a medical examiner listed on the National Registry fails to pass the certification test prior to the expiration of his or her FMCSA medical examiner certification, FMCSA may issue a notice of proposed removal to the medical examiner. If the medical examiner passes the certification test and meets all the requirements in the notice of proposed removal, FMCSA would issue a new certification. However, if FMCSA has removed the medical examiner from the National Registry, the medical examiner would be required to apply for reinstatement.

Confidentiality

Individual test scores will only be reported to the individual who took the test. Aggregate scores without personally identifiable markers will be used in collaboration with the test consultant to set the passing points for the test and to analyze performance of individual questions.

Information provided to the National Registry may be used for analyses to study certified medical examiners and their practice. Information-sharing will be limited to data reports that are in aggregate form or documents that lack personally identifiable information.

Quick Reference Guide

The *Quick Reference Guide to FMCSA Medical Examiner Certification and Listing on the National Registry of Certified Medical Examiners,* Appendix D of this *Guide,* provides a summary of the certification and recertification processes.

Maintaining Certification

To maintain your FMCSA medical examiner certification credential, you must:

- Be licensed, certified, and/or registered, in accordance with applicable State laws and regulations to perform physical examinations in each state in which examinations are performed.
- Complete periodic training as specified by FMCSA every 5 years, and pass the FMCSA Medical Examiner Certification Test every 10 years.
- Agree to provide proof of eligibility upon FMCSA request.

Upon successful recertification, FMCSA will issue a new FMCSA medical examiner certification credential with a new expiration date. You will maintain the National Registry Number assigned to you at your initial certification as long as you remain an FMCSA certified medical examiner.

You may continue to perform CMV driver physical examinations as long as your current certification has not expired. If you have not passed the FMCSA Medical Examiner Certification Test by the expiration of your FMCSA medical examiner certification, then you must cease performing driver exams until passing the certification test again.

To ensure uninterrupted certification, you should complete the training requirement and pass the certification test within 1 year prior to the certification expiration date—definitely no later than the end of the 30-day grace period following your certification expiration date. If you do not complete successful recertification within the 1-year (plus 30-day grace period) timeframe, the following occurs:

- Your certification expires;
- Your information remains on the National Registry with a date of removal; and
- CMV driver physical examinations performed after certification has expired are not recognized as valid by FMCSA.

Listing on the National Registry

For initial and continued listing on the National Registry, you must successfully complete all of the requirements for medical examiner certification and recertification defined in this *Guide* and summarized in the *Quick Reference Guide* in Appendix D. You must report to FMCSA any changes in application information submitted within 30 days of the change. Additionally, you must comply with the following recordkeeping and reporting requirements.

Driver Examination Reports

Once every calendar month, each medical examiner listed on the National Registry is required to complete and transmit to FMCSA a Form MCSA-5850, *CMV Driver Medical Examination Results*, with the following information about each CMV driver examined during the previous month:

- Name
- Date of birth
- Driver's license number and State
- Date of examination
- An indication of the examination outcome (for example, medically qualified)
- Whether the driver is an intrastate driver only
- Whether the driver is a CDL holder
- Date of driver medical certification expiration
- Any restrictions and variances (for example, wearing corrective lenses or driving within an exempt intra-city zone)

You must submit this data electronically via a secure FMCSA-designated website. In order to continue to be listed on and to continue participation in the National Registry, you need to comply with this requirement on a monthly basis. If you have not conducted any exams during the month, that must be reported as well. Form MCSA-5850 can be found as Appendix E of this *Guide*.

Performance Monitoring

Medical examiners must provide Medical Examination Reports and medical examiner's certificates to an authorized representative, special agent, or investigator of FMCSA or an authorized State or local enforcement agency representative to ensure compliance with FMCSA medical standards and guidelines in performing CMV driver medical examinations. FMCSA monitors medical examiner performance by:

- Conducting periodic reviews of randomly selected medical examiners listed on the National Registry Website to ensure that CMV driver examinations are being conducted properly.

- Periodically reviewing a representative sample of the Medical Examination Reports associated with the name and numerical identifiers of applicants/drivers for errors, omissions, or other indications of improper certification.

To comply with performance monitoring, you must:

- Retain each original (paper or electronic) completed Medical Examination Report and a copy or electronic version of each medical examiner's certificate on file for at least 3 years from the date of the of examination.

- Make all records and information in these files available to an authorized representative of FMCSA or an authorized Federal, State, or local enforcement agency representative, within 48 hours after the request is made for investigations and within 10 days of requests for regular audits.

Auditing

FMCSA will conduct annual medical examiner audits. The purpose of the audit is to check a percentage of medical examiners listed on the National Registry Website to obtain verification of eligibility (e.g., proof of current State medical licensure, registration, or certification to perform physical examinations and proof of completion of required training).

To comply with auditing requirements, you must:

- Maintain documentation of State licensure, registration, or certification to perform physical examinations for each State in which you perform examinations.
- Maintain documentation of completion of all required training.
- Make documentation available to an authorized representative of FMCSA or other authorized representative of Federal, State, or local government within 48 hours of the request for investigations and within 10 days of the request for regular audits of eligibility.

Removal from the National Registry

FMCSA may remove a medical examiner from the National Registry when the medical examiner fails to meet or maintain the qualifications outlined in this *Guide*, the requirements of other Federal regulations applicable to the medical examiner, or does not meet the requirements of 49 U.S.C. 31149.

Reasons for Removal

The reasons for removal may include, but are not limited to:

- Failure of the medical examiner to comply with the requirements for continued listing on the National Registry as described in this *Guide*.
- FMCSA discovers that the medical examiner has made errors or omissions or finds other indications of improper certification in either the completed Medical Examination Reports or medical examiner's certificates.
- FMCSA determines that the medical examiner issued a medical examiner's certificate to an operator of a CMV who failed to meet the applicable standards at the time of the examination.
- Failure of the medical examiner to comply with FMCSA driver examination requirements.
- Failure of the medical examiner to complete training in physical and medical examination standards.

Procedure for Removal

Voluntary Removal

To be removed voluntarily from the National Registry, a medical examiner must submit a request to FMCSA via web account. FMCSA will accept the request and the removal will become effective immediately. However, on and after the date of issuance of a notice of proposed removal from the National Registry, FMCSA will not approve the medical examiner's request for voluntary removal. A medical examiner requesting voluntary removal should submit a final FMCSA Form MCSA-5850 before the removal takes effect.

Involuntary Removal: Notice of Proposed Removal

FMCSA initiates the process for involuntary removal of a medical examiner from the National Registry by issuing a written notice of proposed removal to the medical examiner, stating the reasons that removal is proposed and any corrective actions necessary for the medical examiner to remain listed on the National Registry.

Response to Notice of Proposed Removal and Corrective Action

A medical examiner who has received a notice of proposed removal must submit any written response to FMCSA via web account no later than 30 days after the date of issuance of the notice of proposed removal. The response must indicate either that the medical examiner believes FMCSA has relied on erroneous reasons, in whole or in part, in proposing removal from the National Registry, or that the medical examiner will comply and take any corrective action specified in the notice of proposed removal.

Opposing a Notice of Proposed Removal

If a medical examiner believes FMCSA to have proposed removal based in whole or in part on an erroneous reason, the medical examiner must explain the situation. FMCSA will review the explanation.

- **Withdraw Notice:** If FMCSA determines that the reason for proposing removal from the National Registry is an error, FMCSA will withdraw the notice of proposed removal and notify the medical examiner, in writing, of the determination. If FMCSA determines reliance on a partly erroneous reason for proposing removal from the National Registry, FMCSA will modify the notice of proposed removal and notify the medical examiner, in writing, of the determination. The medical examiner must comply and correct the deficiencies identified in the modified notice of proposed removal no later than 60 days after the date FMCSA modifies a notice of proposed removal.

- **Affirm Notice:** If FMCSA determines there was no reliance on an erroneous reason in proposing removal, FMCSA will affirm the notice of proposed removal and notify the medical examiner, in writing, of the determination. No later than 60 days after the date FMCSA affirms the notice of proposed removal, the medical examiner must comply and correct the deficiencies identified in the notice of proposed removal.

- **Removal:** If the medical examiner does not submit a written response within 30 days of the date of issuance of a notice of proposed removal, the removal becomes effective, and the medical examiner is immediately removed from the National Registry.

Compliance and Corrective Action

- **Compliance:** The medical examiner must comply and complete the corrective actions specified in the notice of proposed removal no later than 60 days after either the date of issuance of the notice of proposed removal or the date FMCSA affirms or modifies the notice of proposed removal, whichever is later. The medical examiner must provide documentation of compliance and completion of the corrective actions to FMCSA. FMCSA may conduct any investigations and request any documentation necessary to verify that the medical examiner has complied and completed the required corrective action(s). FMCSA will notify the medical examiner, in writing, whether he or she has met the requirements to continue to be listed on the National Registry.

- **Failure to Comply:** If the medical examiner fails to complete the proposed corrective action(s) within the 60-day period, the removal becomes effective and the medical examiner is immediately removed from the National Registry. FMCSA will notify the medical examiner, in writing, that he or she has been removed from the National Registry.

- **Resolution:** At any time before a notice of proposed removal from the National Registry becomes final, the medical examiner who received the notice and FMCSA may resolve the matter by mutual agreement.

Request for an Administrative Review

If a medical examiner has been removed from the National Registry, the medical examiner may request an administrative review no later than 30 days after the date the removal becomes effective. The request must be submitted in writing to the FMCSA Associate Administrator for Policy and must explain the error(s) committed in removing the medical examiner from the National Registry, including a list of all factual, legal, and procedural issues in dispute and any supporting information or documents.

- **Additional Procedures for an Administrative Review:** The Associate Administrator may ask the medical examiner to submit additional data or attend a conference to discuss the removal. If the medical examiner does not provide the information requested, or does not attend the scheduled conference, the Associate Administrator may dismiss the request for administrative review.

- **Decision on Administrative Review:** The Associate Administrator will complete the administrative review and notify the medical examiner, in writing, of the decision. The decision represents final Agency action. If the Associate Administrator decides the removal was not valid, FMCSA will reinstate the medical examiner and reissue a certification credential to expire on the expiration date of the certificate that was invalidated. The reinstated medical examiner must continue to meet all requirements defined in this *Guide*.

Emergency Removal

In cases of either willfulness or in which public health, interest, or safety is an issue, the provisions of this section are not applicable and FMCSA may immediately remove a medical examiner from the National Registry and invalidate the FMCSA medical examiner certification credential issued. A medical examiner who has been removed may request an administrative review of that decision.

Reinstatement on the National Registry

A medical examiner who has been removed from the National Registry may apply to FMCSA for reinstatement no sooner than 30 days after the date of removal. The former medical examiner must provide documentation showing compliance with all requirements and completion of any additional corrective actions required in the notice of proposed removal. A medical examiner who has been voluntarily removed may be reinstated by FMCSA after providing documentation showing proof of compliance with all requirements.

Effect of Final Decision by FMCSA

Once removed from the National Registry, the medical examiner's listing is removed and the FMCSA medical examiner certification credential is no longer valid. The medical examiner's information remains publicly available for 3 years, with an indication that he/she is no longer listed on the National Registry as of the date of removal.

Appendices

Appendix A: National Registry of Certified Medical Examiners Medical Examiner Training, Guidance for the Core Curriculum Specifications

The guidance for the core curriculum specifications is intended to assist training organizations in developing programs that would be used to fulfill the proposed requirements in the Federal Motor Carrier Safety Administration's (FMCSA) rule for the National Registry of Certified Medical Examiners (National Registry). The rule states that a medical examiner must complete a training program. FMCSA explained in the preamble to the rule that training providers and organizations must follow the core curriculum specifications in developing training programs for medical examiners who apply for listing on the Agency's National Registry. This training prepares medical examiners to:

- Apply knowledge of FMCSA's driver physical qualifications standards and advisory criteria to findings gathered during the driver's medical examination; and
- Make sound determinations of the driver's medical and physical qualifications for safely operating a commercial motor vehicle (CMV) in interstate commerce.

The rule, 49 CFR 390.105(b), lists eight topics which must be covered in the core curriculum specifications. The core curriculum specifications are arranged below by numbered topic, followed by guidance to assist training providers in developing programs based on the core curriculum specifications.

Guidance for Each of the Core Curriculum Specifications

(1) Background, rationale, mission and goals of the FMCSA medical examiner's role in reducing crashes, injuries and fatalities involving commercial motor vehicles.

Mission and Goals of Federal Motor Carrier Safety Administration (FMCSA)

- Discuss the history of FMCSA and its position within the Department of Transportation including its establishment by the Motor Carrier Safety Improvement Act of 1999 and emphasize FMCSA's Mission to reduce crashes, injuries and fatalities involving large trucks and buses.

Role of the Medical Examiner

- Explain the role of the medical examiner as described in 49 CFR 391.43.

(2) Familiarization with the responsibilities and work environment of commercial motor vehicle (CMV) operations.

The Job of CMV Driving

- Describe the responsibilities, work schedules, physical and emotional demands and lifestyle among CMV drivers and how these vary by the type of driving.
- Discuss factors and job tasks that may be involved in a driver's performance, such as:
    - Loading and unloading trailers;
    - Inspecting the operating condition of the CMV; and
    - Work schedules:
        - Irregular work, rest, and eating patterns / dietary choices.

(3) Identification of the driver and obtaining, reviewing, and documenting driver medical history, including prescription and over-the-counter medications.

Driver Identification and Medical History:

Discuss the importance of driver identification and review of the following elements of the driver's medical history as related to the tasks of driving a CMV in interstate commerce.

- Inspect a State-issued identification document with the driver's photo to verify the identity of the individual being examined; identify the commercial driver's license or other types of driver's license.

- Identify, query and note issues in a driver's medical record and/or health history as available, which may include:

    - specific information regarding any affirmative responses in the history;
    - any illness, surgery, or injury in the last five years;
    - any other hospitalizations or surgeries;
    - any recent changes in health status;
    - whether he/she has any medical conditions or current complaints;
    - any incidents of disability / physical limitations;
    - current medications and supplements, and potential side effects, which may be potentially disqualifying;
    - his/ her use of recreational/addictive substances (e.g., nicotine, alcohol, inhalants, narcotics or other habit-forming drugs);
    - disorders of the eyes (e.g., retinopathy, cataracts, aphakia, glaucoma, macular degeneration, monocular vision);
    - disorders of the ears (e.g., hearing loss, hearing aids, vertigo, tinnitus, implants);
    - cardiac symptoms and disease (e.g., syncope, dyspnea, chest pain, palpitations, hypertension, congestive heart failure, myocardial infarction, coronary insufficiency, or thrombosis);
    - pulmonary symptoms and disease (e.g., dyspnea, orthopnea, chronic cough, asthma, chronic lung disorders, tuberculosis, previous pulmonary embolus, pneumothorax);
    - sleep disorders (e.g., obstructive sleep apnea, daytime sleepiness, loud snoring, other);
    - gastrointestinal disorders (e.g., liver disease, digestive problems, hernias);
    - genitourinary disorders (e.g., kidney stones and other renal conditions, renal failure, hernias);
    - diabetes mellitus:
        - current medications (type, potential side effects, duration on current medication);
        - complications from diabetes; and
        - presence and frequency of hypoglycemic / hyperglycemic episodes/reactions;
    - other endocrine disorders (e.g., thyroid disorders, interventions / treatment);
    - musculoskeletal disorders (e.g., amputations, arthritis, spinal surgery);
    - neurologic disorders (e.g., loss of consciousness, seizures, stroke / transient ischemic attack, headaches/ migraines, numbness / weakness) ; or
    - psychiatric disorders (e.g., schizophrenia, severe depression, anxiety, bipolar disorder, or other conditions) that could impair a driver's ability to safely function.

(4) Performing, reviewing and documenting the driver's medical examination.

Physical Examination (Qualification/Disqualification Standards (§ 391.41 and 391.43))

- Explain the FMCSA physical examination requirements and advisory criteria in relationship to conducting the driver's physical examination of the following:

    - Eyes (§ 391.41(b)(10))
        - equal reaction of both pupils to light;

- evidence of nystagmus and exophthalmos;
- evaluation of extra-ocular movements.

- Ears (§ 391.41(b)(11))
  - abnormalities of the ear canal and tympanic membrane;
  - presence of a hearing aid.

- Mouth and throat (§ 391.41(b)(5))
  - conditions contributing to difficulty swallowing, speaking or breathing;

- Neck (§ 391.41(b)(7))
  - range of motion;
  - soft tissue palpation / examination (e.g., lymph nodes, thyroid gland).

- Heart (§ 391.41(b)(4)and (b)(6))
  - chest inspection (e.g., surgical scars, pacemaker / implantable automatic defibrillator);
  - auscultation for thrills, murmurs, extra sounds, and enlargement;
  - blood pressure and pulse (rate and rhythm);
  - additional signs of disease (e.g., edema, bruits, diaphoresis, distended neck veins.

- Lungs, chest, and thorax (§ 391.41(b)(5))
  - respiratory rate and pattern;
  - auscultation for abnormal breath sounds;
  - abnormal chest wall configuration / palpation.

- Abdomen (§ 391.41(a)(3)(i) and 391.43(f))
  - surgical scars;
  - palpation for enlarged liver or spleen, abnormal masses or bruits / pulsation, abdominal tenderness, hernias (e.g., inguinal, umbilical, ventral, femoral or other abnormalities).

- Spine (§ 391.41(b)(7))
  - surgical scars and deformities;
  - tenderness and muscle spasm;
  - loss in range of motion and painful motion;
  - spinal deformities.

- Extremities and trunk (§ 391.41(b)(1), (b)(4) and (b)(7))
  - gait, mobility, and posture while bearing his/her weight; limping or signs of pain;
  - loss, impairment, or use of orthosis;
  - deformities, atrophy, weakness, paralysis, or surgical scars;
  - elbow and shoulder strength, function, and mobility;
  - handgrip and prehension relative to requirements for controlling a steering wheel and gear shift;
  - varicosities, skin abnormalities, and cyanosis, clubbing, or edema;
  - leg length discrepancy; lower extremity strength, motion, and function
  - other abnormalities of the trunk.

- Neurologic status (§ 391.41(b)(7), (b)(8) and(b)(9))
  - impaired equilibrium, coordination or speech pattern (e.g., ataxia);
  - sensory or positional abnormalities;
  - tremor;
  - radicular signs;
  - reflexes (e.g., asymmetric deep-tendon, normal / abnormal patellar and Babinski).

- Mental status (§ 391.41(b)(9))
  - comprehension and interaction;
  - cognitive impairment;
  - signs of depression, paranoia, antagonism, or aggressiveness that may require follow-up with a mental health professional.

(5) Performing, obtaining and documenting diagnostic tests and obtaining additional testing or medical opinion from a medical specialist or treating physician.

Diagnostic Testing and Further Evaluation

- Describe the FMCSA diagnostic testing requirements and the medical examiner's ability to request further testing and evaluation by a specialist.
  - Urine test for specific gravity, protein, blood and glucose (§ 391.41(a)(3)(i));
  - Whisper or audiometric testing (§ 391.41(b)(11));
  - Vision testing for color vision, distant acuity, horizontal field of vision and presence of monocular vision (§ 391.41(b)(10));
  - Other testing as indicated to determine the driver's medical and physical qualifications for safely operating a CMV.
  - Refer to a specialist a driver who exhibits evidence of any of the following disorders (§ 391.43(e) and (f)):
    - vision (e.g., retinopathy, macular degeneration);
    - cardiac (e.g., myocardial infarction, coronary insufficiency, blood pressure control);
    - pulmonary (e.g., emphysema, fibrosis);
    - endocrine (e.g., diabetes);
    - musculoskeletal (e.g., arthritis, neuromuscular disease);
    - neurologic (e.g., seizures);
    - sleep (e.g., obstructive sleep apnea);
    - mental / emotional health (e.g., depression, schizophrenia); or
    - other medical condition(s) that may interfere with ability to safely operate a CMV.

(6) Informing and educating the driver about medications and non-disqualifying medical conditions that require remedial care.

Health Counseling

- Inform course participants of the importance of counseling the driver about:
  - possible consequences of non-compliance with a care plan for conditions that have been advised for periodic monitoring with primary healthcare provider;
  - possible side effects and interactions of medications (e.g., narcotics, anticoagulants, psychotropics) including products acquired over-the-counter (e.g., antihistamines, cold and cough medications or dietary supplements) that could negatively affect his/her driving;
  - the effect of fatigue, lack of sleep, poor diet, emotional conditions, stress, and other illnesses that can affect safe driving;
  - if he/she is a contact lens user, the importance of carrying a pair of glasses while driving;
  - if he/she uses a hearing aid, the importance of carrying a spare power source for the device while driving;
  - if he/she has a history of deep vein thrombosis, the risk associated with inactivity while driving and interventions that could prevent another thrombotic event;
  - if he/she has a diabetes exemption, that he/she should:
    - carry a rapidly absorbable form of glucose while driving;

        - self-monitor blood glucose one hour before driving and at least once every four hours while driving;
        - comply with each condition of his/her exemption;
        - plan to submit glucose monitoring logs for each annual recertification;
    - corrective or therapeutic steps needed for conditions which may progress and adversely impact safe driving ability (e.g., seek follow-up from primary care physician);
    - steps needed for reconsideration of medical certification if driver is certified with a limited interval, e.g., the return date and documentation required for extending the certification time period.

(7) Determining driver certification outcome and period for which certification should be valid.

Assessing the Driver's Qualifications and Disposition

- Explain how to assess the driver's medical and physical qualification to operate a CMV safely in interstate commerce using the medical examination findings weighed against the physical and mental demands associated with operating a CMV by:
    - Considering a driver's ability to
        - move his/her body through space while climbing ladders; bend, stoop, and crouch; enter and exit the cab;
        - manipulate steering wheel;
        - perform precision prehension and power grasping;
        - use arms, feet, and legs during CMV operation;
        - inspect the operating condition of a tractor and/or trailer;
        - monitor and adjust to a complex driving situation; and
        - consider the adverse health effects of fatigue associated with extended work hours without breaks;
    - Considering identified disease or condition(s) progression rate, stability, and likelihood of gradual or sudden incapacitation for documented conditions (e.g., cardiovascular, neurologic, respiratory, musculoskeletal and other).

Medical Certificate Qualification/Disqualification Decision and Examination Intervals

- Discuss the medical examiner's obligation to consider potential risk to public safety and the driver's medical and physical qualifications to drive safely when issuing a medical examiner's certificate, when to qualify/disqualify the driver and how to determine the expiration date of the certificate by:
    - using the requirements stated in the FMCSRs, with nondiscretionary certification standards to disqualify a driver
        - with a history of epilepsy;
        - with diabetes requiring insulin control (unless accompanied by an exemption);
        - when vision parameters (e.g., acuity, horizontal field of vision, color) fall below minimum standards unless accompanied by an exemption;
        - when hearing measurements with or without a hearing aid fall below minimum standards;
        - currently taking methadone;
        - with a current clinical diagnosis of alcoholism; or
        - who uses a controlled substance including a narcotic, an amphetamine, or another habit-forming drug without a prescription from the treating physician;
    - using clinical expertise, disqualify a driver when evidence shows a driver has a medical condition that in your opinion will likely interfere with the safe operation of a CMV;

- certifying a driver for an appropriate duration of certification interval;
- if he/she has a condition for which the medical examiner is deferring the driver's medical certification or disqualifying the driver, informing the driver of the reasons which may include:
  - a vision deficiency (e.g., retinopathy, macular degeneration);
  - the immediate post-operative period;
  - a cardiac event (e.g., myocardial infarction, coronary insufficiency);
  - a chronic pulmonary exacerbation (e.g., emphysema, fibrosis);
  - uncontrolled hypertension;
  - endocrine dysfunctions (e.g., insulin-dependent diabetes);
  - musculoskeletal challenges (e.g., arthritis, neuromuscular disease);
  - a neurologic event (e.g., seizures, stroke, TIA);
  - a sleep disorder (e.g., obstructive sleep apnea); or
  - mental health dysfunctions (e.g., depression, bipolar disorder).

(8) FMCSA reporting and documentation requirements.

Documentation of Medical Examination Findings

Demonstrate the required FMCSA medical examination report forms, appropriate methods for recording the medical examination findings and the rationale for certification decisions including:

- Medical Examination Report Form
  - identification of the driver;
  - use of appropriate Medical Examination Report form;
  - assurance that driver completes and signs driver's portion of the Medical Examination Report form;
  - specifics regarding any affirmative response on the driver's medical history;
  - height/weight, blood pressure, pulse;
  - results of the medical examination, including details of abnormal findings;
  - audiometric and vision testing results;
  - presence of a hearing aid and whether it is required to meet the standard;
  - if obtained, funduscopic examination results;
  - the need for corrective lenses for driving;
  - presence or absence of monocular vision and need for a vision exemption;
  - if driver has diabetes mellitus and is insulin dependent, the need for a diabetes exemption;
  - other laboratory, pulmonary, cardiac testing performed; and
  - the reason(s) for the disqualification and/or referral.

- Other supporting documentation
  - if driver has current vision exemption, include the ophthalmologist's or optometrist's report;
  - if a driver has a diabetes exemption, include the endocrinologist's and ophthalmologist's/optometrist's report;
  - treating physician's work release;
  - if obtained, specialist's evaluation report;
  - if the driver has a current Skill Performance Evaluation Certificate, include it; and
  - results of Substance Abuse Professional evaluations for alcohol and drug use and/or abuse for a driver with
    - alcoholism who completed counseling and treatment to the point of full recovery.

- Medical Examiner's Certificate
  - certification status, which may require:
    - waiver / exemption;
    - wearing corrective lenses;

    - wearing a hearing aid; or
    - a Skill Performance Evaluation Certificate;
- complete and accurate documentation on medical certification card including:
    - the examiner's name, examination date, office address, and telephone number and Medical Examiner signature; and
    - the driver's signature.

Appendix B: Detailed Content Outline

Using the Detailed Content Outline

Items on the certification test are limited to what the detailed content outline describes, which should make the outline a useful guide for preparing oneself to take the test. The outline contains several pieces of information about the test. Included in this information are answers to the following questions:

- What competencies can the test cover?
- What type of content does the test emphasize?
- How complex will test items be?

A review of information from the first page of the outline can help one to understand these points.

U.S. Department of Transportation
Federal Motor Carrier Safety Administration

National Registry of Certified Medical Examiners (NRCME)
FMCSA Medical Examiner
Detailed Content Outline

Open cells show an examination could include items from indicated cognitive levels.
Shaded cells prevent appearance of items on examinations.

	Items			
	Cognitive Level			
	Recall	Application	Analysis	Totals
I. DRIVER'S MEDICAL INFORMATION	**23**	**33**	**14**	**70**
A. Identification and History	**4**	**6**	**10**	**20**
1. Verify the identity of the driver				
2. Ensure the driver signs the driver's statement about health history				
3. Identify, query, and note issues in a driver's medical record and / or health history as available, which may include				
a. specifics regarding any affirmative responses in the history				

The first (of two) major content domains (indicated with a roman numeral I) will cause the test to assess medical examiners' competencies while they interact with medical information from drivers. Seventy items on the test will assess this type of content. The major domain is subdivided into minor domains (indicated with Arabic letters A, B and so on).

Items covering content in each domain are subdivided among three levels of cognitive complexity. These levels range from simple items based on facts that a medical examiner should have memorized to scenarios describing complicated medical histories. The simple test items focusing on memorized facts are characterized with a label called Recall. The complicated items assessing abilities to solve problems are characterized with a label called Analysis. Between these two types are Application items. These moderately complex items focus on conclusions medical examiners reach about medical information they encounter.

Lastly, by studying each row of the table, a medical examiner will learn that the complexity of assessments of some competencies will be limited. For example, the competency (I.A.2.) in which a medical examiner ensures the driver signs the statement about his or her health history is limited to the recall type of item. Assessment of the competency labeled as I.A.1., which relates to verifying the driver's identity could involve the recall-type or application-type of item. The competency labeled as 1.A.3.a. could be assessed with items at any of the three levels of cognitive complexity.

Medical examiners are encouraged to study the entire outline so they may understand the nature of the items that could appear on the version of the test that he or she takes. Each version is assembled according to the specifications shown in the outline regarding the number of items from each domain and level of cognition.

U.S. Department of Transportation
Federal Motor Carrier Safety Administration

National Registry of Certified Medical Examiners (The National Registry)
FMCSA Medical Examiner
Detailed Content Outline

Open cells show an examination could include items from indicated cognitive levels.
Shaded cells prevent appearance of items on examinations.

	Items			
	Cognitive Level			
	Recall	Application	Analysis	Totals
I. DRIVER'S MEDICAL INFORMATION	**23**	**33**	**14**	**70**
A. Identification and History	**4**	**6**	**10**	**20**
1. Verify the identity of the driver				
2. Ensure the driver signs the driver's statement about health history				
3. Identify, query, and note issues in a driver's medical record and / or health history as available, which may include				
a. specifics regarding any affirmative responses in the history				
b. any illness, surgery, or injury in the last five years				
c. any other hospitalizations or surgeries				
d. any recent changes in health status				
e. whether he / she has any medical conditions or current complaints				
f. any incidents of disability / physical limitations				
g. limitations placed during prior FMCSA exams				
h. current OTC and prescription medications and supplements, and potential side effects, which may be potentially disqualifying				
i. his or her use of recreational / addictive substances (e.g., nicotine, alcohol, inhalants)				
j. weight disorders (e.g., unexplained loss or gain, obesity)				
k. disorders of the eyes (e.g., retinopathy, cataracts, aphakia, glaucoma, macular degeneration, monocular vision)				
l. disorders of the ears (e.g., hearing loss, hearing aids, vertigo, Meniere's, tinnitus, implants)				
m. cardiac symptoms (e.g., syncope, dyspnea, chest pain, palpitations)				
n. cardiovascular diseases (e.g., hypertension, congestive heart failure, myocardial infarction, coronary insufficiency, or thrombosis)				
o. hematologic disorders (e.g., bleeding disorders, anemia, cancer, organ transplant history)				
p. pulmonary symptoms (e.g., dyspnea, orthopnea, chronic cough)				
q. pulmonary diseases (e.g., asthma, chronic lung disorders, tuberculosis, previous pulmonary embolus, pneumothorax)				
r. sleep disorders (e.g., sleep apnea, narcolepsy, insomnia, daytime sleepiness, loud snoring, testing and / or treatments)				
s. gastrointestinal disorders (e.g., pancreatitis, ulcers, ulcerative colitis, cirrhosis, hepatitis, irritable bowel syndrome, hernias)				

U.S. Department of Transportation
Federal Motor Carrier Safety Administration

National Registry of Certified Medical Examiners (The National Registry)
FMCSA Medical Examiner
Detailed Content Outline

Open cells show an examination could include items from indicated cognitive levels.
Shaded cells prevent appearance of items on examinations.

	Items			
	Cognitive Level			
	Recall	Application	Analysis	Totals
t. genitourinary disorders (e.g., polycystic, nephrotic syndrome, kidney stones, renal failure, hernias)				
u. diabetes mellitus				
▪ weight loss ▪ duration on current medications ▪ medication side effects ▪ complications from diabetes ▪ availability of emergency glucose supply ▪ presence and frequency of hypoglycemic / hyperglycemic episodes / reactions				
v. other endocrine disorders (e.g., thyroid disorders, interventions / treatment)				
w. musculoskeletal disorders (e.g., amputations, arthritis, spinal surgery)				
x. neoplastic disorders (e.g., leukemia; brain, bone, breast, and lung cancer)				
y. substance use and abuse (e.g., alcohol, narcotics, illicit or legal drugs)				
z. neurologic disorders (e.g., loss of consciousness, seizures, stroke / TIA, headaches / migraines, numbness / weakness)				
aa. psychiatric disorders (e.g., schizophrenia, depression, anxiety, bipolar, ADHD, interventions / treatment)				
bb. other conditions that could impair a driver's ability to safely function				
B. Physical Examination and Evaluation	**8**	**15**	**2**	**25**
1. Ensure the driver is properly clothed for the physical examination				
2. Record height and weight, and note whether a driver is overweight or underweight				
3. Examine the driver's eyes and note				
a. distant acuity in each and both eyes (Snellen comparable values)				
b. whether corrective lenses are required to meet the standard				
c. horizontal field of vision in each eye				
d. color recognition				
e. presence or absence of monocular vision				
f. reactivity to light and pupillary equality				
g. evidence of nystagmus and exophthalmos				
h. evaluation of extraoccular movements				
i. fundoscopic examination results				
4. Examine the driver's ears and note				
a. abnormalities of the ear canal and tympanic membrane				
b. whisper test and / or audiometric results (in ANSI standard units) as indicated				
c. presence or absence of a hearing aid and whether required to meet the standard				
5. Examine the driver's mouth and throat, and note conditions that may interfere with breathing, speaking, or swallowing				

U.S. Department of Transportation
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National Registry of Certified Medical Examiners (The National Registry)
FMCSA Medical Examiner
Detailed Content Outline

Open cells show an examination could include items from indicated cognitive levels.
Shaded cells prevent appearance of items on examinations.

	Items			
	Cognitive Level			
	Recall	Application	Analysis	Totals
6. Examine the driver's neck and note				
a. range of motion				
b. soft tissue palpation / examination (e.g., lymph nodes, thyroid gland)				
7. Examine the driver's heart				
a. chest inspection (e.g., surgical scars, pacemaker / IAD)				
b. thrills, murmurs, extra sounds, and enlargement				
c. blood pressure and pulse (rate and rhythm)				
d. additional signs of disease (e.g., edema, bruits, diaphoresis, distended neck veins)				
8. Examine the driver's lungs, chest, and thorax, excluding breasts, and note				
a. respiratory rate and pattern				
b. abnormal breath sounds				
c. abnormal chest wall configuration / palpation				
d. scars				
9. Examine the driver's abdomen, and note				
a. surgical scars				
b. an enlarged liver or spleen				
c. abnormal masses or bruits / pulsation				
d. abdominal tenderness				
e. hernias (e.g., inguinal, umbilical, ventral, femoral)				
10. Examine the driver's spine and note				
a. surgical scars and deformities				
b. tenderness and muscle spasm				
c. loss in range of motion and painful motion				
d. kyphosis, scoliosis, or other spinal deformities				
11. Examine the driver's extremities and note				
a. gait, mobility, and posture while bearing his or her weight; limping or signs of pain				
b. loss, impairment, or use of orthosis				
c. deformities, atrophy, weakness, paralysis, surgical scars,				
d. elbow and shoulder strength, function, and mobility				
e. handgrip and prehension relative to requirements for controlling a steering wheel and gear shift				
f. varicosities, skin abnormalities, and cyanosis, clubbing, or edema				
g. leg length discrepancy; lower extremity strength, motion, and function				
12. Examine the driver's neurologic status and note				
a. impaired equilibrium, coordination or speech pattern (e.g., Romberg, finger to nose test)				
b. gait disorders				
c. sensory or positional abnormalities				

U.S. Department of Transportation
Federal Motor Carrier Safety Administration

National Registry of Certified Medical Examiners (The National Registry)
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	Items			
	Cognitive Level			
	Recall	Application	Analysis	Totals
d. tremor				
e. radicular signs				
f. reflexes (e.g., asymmetric deep-tendon, normal / abnormal patellar and Babinski				
13. Test the driver's urine and note specific gravity, protein, blood, and glucose				
14. Examine the driver's mental status and note				
a. comprehension and interaction				
b. cognitive impairment (e.g., orientation, intellect, memory, obsessions, circumstantial / tangential speech)				
c. signs of depression, paranoia, antagonism, or aggressiveness that may require follow-up with a mental health professional				
C. Diagnostic Tests and / or Referrals	**6**	**10**	**2**	**18**
1. Obtain additional information when indicated by				
a. audiometrics				
b. cardiovascular studies (e.g., electrocardiogram, stress test, ejection fraction, vascular studies)				
c. blood analyses (e.g., creatinine, electrolytes, toxicology, lipids, blood chemistries)				
d. chest radiograph				
e. respiratory tests (e.g., spirometry, diffusion, lung volumes, oximetry or arterial blood gas analysis with or without exercise)				
f. sleep studies				
g. drug level monitoring (e.g., digoxin, theophylline)				
h. other tests				
2. Refer a driver who exhibits evidence of any of the following disorders for follow-up care and evaluation by an appropriate specialist or primary care provider				
▪ vision (e.g., retinopathy, macular degeneration) ▪ cardiac (e.g., myocardial infarction, coronary insufficiency, blood pressure control) ▪ pulmonary (e.g., emphysema, fibrosis) ▪ endocrine (e.g., diabetes) ▪ musculoskeletal (e.g., arthritis, neuromuscular disease) ▪ neurologic (e.g., seizures) ▪ sleep (e.g., obstructive sleep apnea) ▪ mental / emotional health (e.g., depression, schizophrenia)				
3. Refer a driver				
a. with limitations in extremity movement for an on-road performance evaluation and / or skill performance evaluation				
b. for conditions not directly related to certification, but detected during the examination				

U.S. Department of Transportation
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	Items			
	Cognitive Level			
	Recall	Application	Analysis	Totals
D. Documentation of Ancillary Information	**5**	**2**	**0**	**7**
1. Record / include results as available with other information about the driver, which may include				
a. audiometrics				
b. cardiovascular studies (e.g., electrocardiogram, stress test, ejection fraction, vascular studies)				
c. blood analyses (e.g., creatinine, electrolytes, toxicology, lipids, blood chemistries)				
d. chest radiograph				
e. respiratory tests (e.g., spirometry, diffusion, lung volumes, oximetry or arterial blood gas analysis with or without exercise)				
f. sleep studies				
g. drug level monitoring (e.g., digoxin, theophylline)				
h. other tests				
i. treating physician's work release				
2. Integrate a specialist's evaluation with other information about the driver				
3. For a driver who was qualified under a vision exemption, include an annual ophthalmologist's or optometrist's report				
4. For a driver who is qualified under a diabetes exemption, include an endocrinologist's and ophthalmologist's / optometrist's report as required				
5. Include if available				
a. a current skill performance evaluation certificate				
b. documentation of intra-city zone exemption				
6. Review results of SAP evaluations for alcohol and drug use and / or abuse for a driver with				
a. alcoholism who completed counseling and treatment to the point of full recovery				
b. prohibited drug use who shows evidence he or she is now free from such use				
II. DETERMINATION OF DRIVER'S QUALIFICATIONS AND DISPOSITION	**7**	**12**	**11**	**30**
A. Health Education Counseling	**2**	**1**	**1**	**4**
1. Explain to a driver consequences of non-compliance with a care plan for conditions that have been advised for periodic monitoring with primary healthcare provider				
2. Advise a driver				
a. regarding side effects and interactions of medications and supplements (e.g., narcotics, anticoagulants, psychotropics) including those acquired over the counter (e.g., antihistamines, cold and cough medications) that could negatively affect his or her driving				

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	Items			
	Cognitive Level			
	Recall	Application	Analysis	Totals
b. that fatigue, lack of sleep, undesirable diet, emotional conditions, stress, and other illnesses can affect safe driving				
c. with contact lenses he or she should carry a pair of glasses while driving				
d. with a hearing aid he / she should possess a spare power source for the device while driving				
e. who has had a deep vein thrombosis event of risks associated with inactivity while driving and interventions that could prevent another thrombotic event				
f. who has diabetes about glucose monitoring frequencies and the minimum threshold while driving				
g. with a diabetes exemption, he / she should				
1) possess a rapidly absorbable form of glucose while driving				
2) self-monitor blood glucose one hour before driving and at least once every four hours while driving				
3) comply with each condition of his / her exemption				
4) plan to submit glucose monitoring logs for each annual recertification				
3. Inform the driver of the rationale for delaying or potentially disqualifying certification, which may include				
▪ the immediate post-operative period after certain procedures ▪ a vision impairment (e.g., retinopathy, macular degeneration) ▪ a cardiac event (e.g., myocardial infarction, coronary insufficiency) ▪ a chronic pulmonary exacerbation (e.g., emphysema, fibrosis) ▪ uncontrolled hypertension ▪ endocrine dysfunction (e.g., diabetes) ▪ musculoskeletal challenges (e.g., arthritis, neuromuscular disease) ▪ a neurologic event (e.g., seizures, stroke, TIA) ▪ a sleep disorder (e.g., obstructive sleep apnea) ▪ mental health dysfunctions (e.g., depression, bipolar) ▪ postoperative complication				
B. Risk Assessment	**2**	**4**	**8**	**14**
1. Consider a driver's ability to				
▪ couple and uncouple trailers from a tractor ▪ load or unload several thousand pounds of freight ▪ install and remove tire chains ▪ manipulate and secure tarpaulins that cover open trailer ▪ move one's own body through space while climbing ladders; bending, stooping, and crouching; entering and exiting the cab ▪ manipulate an oversized steering wheel ▪ shift through several gears using a manual transmission ▪ perform precision prehension and power grasping ▪ use arms, feet, and legs during CMV operation				

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National Registry of Certified Medical Examiners (The National Registry)
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Detailed Content Outline

Open cells show an examination could include items from indicated cognitive levels.
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	Items			
	Cognitive Level			
	Recall	Application	Analysis	Totals
2. Review Skill Performance Evaluation (SPE) cases				
a. identify terms, conditions, and limitations set forth in a driver's SPE Certificate				
b. For a driver who lost a foot, leg, hand, or arm, ensure that an appropriate SPE Certificate from the FMCSA Division Administrator has been granted				
3. Consider a driver's cognitive ability to ▪ plan a travel route ▪ inspect the operating condition of a tractor and / or trailer ▪ monitor and adjust to a complex driving situation ▪ maneuver through crowded areas ▪ quickly alter the course of vehicle to avoid trouble				
4. Consider general health and wellness factors such as				
a. adverse health effects associated with rotating work schedules and irregular sleep patterns				
b. long-term effects of fatigue associated with extended work hours without breaks				
c. risk factors associated with poor dietary choices				
d. stressors likely to be associated with extended time away from a driver's social support system				
e. short- and long-term health effects of stress from ▪ tight pickup and delivery schedules ▪ irregular work, rest, and eating patterns / dietary choices ▪ adverse road, weather, and traffic conditions ▪ exposure to temperature extremes, vibration, and noise ▪ transporting passengers or hazardous products				
5. Integrate FMCSA medical advisory criteria and guidelines regarding a driver's condition into the risk assessment				
6. Consider the rate of progression, degree of control, and likelihood of sudden incapacitation (e.g., cardiovascular, neurologic, respiratory, musculoskeletal) for documented conditions				
7. Support the rationale for using FMCSA guidelines that have not been published in regulations yet				
C. Certification Outcomes and Intervals	**3**	**7**	**2**	**12**
1. As appropriate, certification standards to disqualify a driver				
a. with a history of epilepsy or other seizure history				
b. with insulin-treated diabetes mellitus (unless accompanied by an exemption)				
c. when vision parameters (e.g., acuity, horizontal field of vision, color) fall below minimum standards unless accompanied by an exemption				
d. when hearing measurements with or without a hearing aid fall below minimum standards				
2. Disqualify a driver who				
a. is currently taking methadone				

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	Items			
	Cognitive Level			
	Recall	Application	Analysis	Totals
b. has a current clinical diagnosis of alcoholism				
c. uses a controlled substance including a narcotic, an amphetamine, or another habit-forming drug without a prescription from the treating physician, or as appropriate				
3. Disqualify a driver when evidence shows a condition or treatment that will likely interfere with the safe operation of a CMV, which may include appropriate supporting documents such as test reports, specialist reports etc.				
4. Document the reason(s) for the disqualification and / or referral				
5. Advise a driver of the reasons for a disqualification decision and what a driver could do to become qualified				
6. Certify a driver for an appropriate interval				
7. Indicate certification status, which may require				
▪ waiver / exemption, which the Medical Examiner identifies ▪ wearing corrective lenses ▪ wearing a hearing aid ▪ a Skill Performance Evaluation Certificate				
8. For a driver that is certified with a limited interval, advise them to return for recertification with the appropriate documentation for his or her condition				
9. Complete a medical examination report and medical certificate/card				
▪ ensure use of currently required examination form ▪ ensure the form includes the examiner's name, examination date, office address, and telephone number ▪ ensure the driver signs the medical certificate/card				
Totals	**30**	**45**	**25**	**100**

Appendix C: Sample FMCSA Medical Examiner Certification Test Items

Sample Item 1: This item will be testing Detailed Content Outline (DCO) task IB3f (cognitive level: recall):

I. DRIVER'S MEDICAL INFORMATION
B. Physical Examination and Evaluation
3. Examine the driver's eyes and note
f. reactivity to light and pupillary equality

According to FMCSA regulations, which of the following must the medical examiner evaluate when examining a driver's eyes?

A. Pupil reactivity
B. Iris symmetry
C. Conjunctival injection
D. Corneal thickness

Correct Response:

A. Pupil reactivity
This is the correct response because it is the only option that is included on the Medical Examination Report Form for physical examination of the eyes. This is a cranial nerve test. A positive finding indicates a significant neurological problem that must be worked up or have an explanation that clarifies whether or not the driver has a condition that may interfere with the ability to safely operate a CMV.

Incorrect Responses:

B. Iris symmetry
This is incorrect because determining iris symmetry is not required by FMCSA.

C. Conjunctival injection
This is incorrect because most causes of conjunctival injection would not be disqualifying. Causes that are suspicious for a disqualifying condition need additional evaluation. While this abnormal finding should be explained, with determination of possible effects on safe driving before making a certification decision, it is not a condition that is specified in FMCSA regulations.

D. Corneal thickness
This is incorrect because it is not measured in an office examination except by an eye specialist.

Sample Item 2: This item will be testing DCO task IIC6 (cognitive level: recall):

II. DETERMINATION OF DRIVER'S QUALIFICATIONS AND DISPOSITION

C. Certification Outcomes and Intervals

6. Certify a driver for an appropriate interval

According to FMCSA regulations, medical qualification for two years can be given to a driver who has

A. An SPE certificate for a left below the knee amputation (BKA).
B. Hypertension.
C. A recent diagnosis of Lewy body dementia.
D. Documented medical marijuana use for pain control.

Correct: A. An SPE certificate for a left below the knee amputation.
This is the correct response because in order to obtain the SPE certificate, the driver had to demonstrate the ability to perform all tasks for the commercial driver job description.

Incorrect Responses:

B. Hypertension.
This is not the correct response because drivers with hypertension are only given a medical certificate that is good for one year.

C. A recent diagnosis of Lewy body dementia.
This is not the correct response because this is a progressive, degenerative condition with no known treatment. The effects of Lewy body dementia impact the ability to operate a CMV safely.

D. Documented medical marijuana use for pain control
This is not the correct response because marijuana remains a drug listed in Schedule I of the Controlled Substances Act. It remains unacceptable for any safety sensitive employee subject to drug testing under the drug testing regulations of DOT to use marijuana. Also, FMCSA medical guidelines state that "driving impairment due to marijuana use is well substantiated."

Sample Item 3: This item will be testing DCO task IB11e (cognitive level: application):

I. DRIVER'S MEDICAL INFORMATION
   B. Physical Examination and Evaluation
      11. Examine the driver's extremities and note
         e. handgrip and prehension relative to requirements for controlling a steering wheel and gear shift

During his visit to the medical examiner, a driver complains of severe pain in his finger for the last two weeks after it was punctured. The examination reveals an infected, swollen finger. After the medical examiner inquires, the driver states that the pain is made worse when he grips the steering wheel. Which of the following should the medical examiner do next?

A. Obtain a hand X-ray.
B. Assess capillary refill in the hand.
C. Obtain a culture and sensitivity.
D. Assess the driver's grip strength.

Correct: D. Assess the driver's grip strength.
This is the correct response because the condition does not present a safety risk unless it interferes with the ability of the driver to hold and control the steering wheel.

Incorrect Responses:

A. Obtain a hand X-ray.
This is not the correct response because this is a diagnostic test that a healthcare provider or specialist would perform or order. Your role as a medical examiner is to determine if the condition interferes with the ability of the driver to safely operate a CMV.

B. Assess capillary refill in the hand.
This is not the correct response because given the information in the question it is not the primary consideration for determining if the driver can safely operate a CMV.

C. Obtain a culture and sensitivity.
This is not the correct response because this is an action that a treating healthcare provider or specialist would do in the course workup and treatment. Your role as a medical examiner is to determine if the condition interferes with the ability of the driver to safely operate a CMV.

Sample Item 4: This item will be testing DCO task IIC8 (cognitive level: application):

II. DETERMINATION OF DRIVER'S QUALIFICATIONS AND DISPOSITION

C. Certification Outcomes and Intervals

8. Advise a driver certified with a limited interval to return for recertification with the appropriate documentation for his or her condition

A new driver who had a myocardial infarction six months ago is certified after completing an acceptable exercise tolerance test and is cleared by a cardiologist. According to FMCSA guidelines, which of the following is recommended regarding recertification and exercise tolerance test monitoring intervals?

	Recertification	Exercise tolerance
A.	Every year	Every year
B.	Every two years	Every year
C.	Every year	Every two years
D.	Every two years	Every two years

Correct: C. every year; every two years

This is the correct response because according to FMCSA medical guidelines, when a myocardial infarction is part of the medical history, there is a significant increased risk for another myocardial infarction to occur within six months to a year; therefore, a maximum of one year certification is the guideline. Myocardial infarction guidelines also recommend exercise tolerance testing at least every two years to demonstrate continued ability to safely operate a CMV.

Incorrect Responses:

A. every year; every year

This is not the correct response because the FMCSA medical guidance is to obtain an exercise tolerance test every two years. In this question, there is nothing to indicate that more frequent testing is necessary.

B. every two years; every year

This is not the correct response because it reverses the guidelines. Even if you do not recall the recommendation, logically, one would eliminate this option because having the driver obtain a test every year and then waiting for up to a year to review the test results is not reasonable when unacceptable test results indicate the driver may not be able to safely operate a CMV.

D. every two years; every two years

This is not the correct response because the guideline is to recertify every year. Even if you do not recall the actual guideline, one would logically eliminate this option because this is the maximum recertification period for a driver who meets all qualification requirements. It is appropriate that a driver at increased risk for an incapacitating cardiac event should be monitored more frequently.

Sample Item 5: This item will be testing DCO task IA3a (cognitive level: analysis):

I. DRIVER'S MEDICAL INFORMATION
   A. Identification and History
      3. Identify, query, and note issues in a driver's medical record and / or health history as available, which may include
         a. specifics regarding any affirmative responses in the history

A 46-year-old male driver presents for recertification. He has a history of chronic gastro esophageal reflux disease (GERD). He takes esomeprazole (Nexium) and over-the-counter cimetidine (Tagamet). He states that he feels fine, but has trouble finding foods that do not trigger his GERD when he is on the road. Which of the following should the medical examiner do first?

A. Disqualify the driver until he has a nutritional consultation.
B. Certify the driver and advise him to carry non-triggering foods in a cooler.
C. Contact the driver's physician and request an upper GI study.
D. Correlate the GI history findings with the abdominal examination.

Correct: D. Correlate the GI history findings with the abdominal examination.
This is the correct response because given the information in the question; a medical examiner would need to examine the driver before having sufficient information about the health of the driver to consider any of the other options.

Incorrect Responses:

A. Disqualify the driver until he has a nutritional consultation.
This is not the correct response because until completion of the examination, there is insufficient information to make a certification decision. In addition, there is no regulation or medical guideline that requires a nutritional consultation in order to be certified.

B. Certify the driver and advise him to carry non-triggering foods in a cooler.
This is not the correct response because until completion of the examination, there is insufficient information to make a certification decision.

C. Contact the driver's primary care provider and request an upper-GI study.
This is not the correct response because until completion of the examination, one does not have sufficient information to make a referral decision.

Sample Item 6: This item will be testing DCO task IIC3 (cognitive level: analysis):

II. DETERMINATION OF DRIVER'S QUALIFICATIONS AND DISPOSITION

C. Certification Outcomes and Intervals

3. Disqualify a driver when evidence shows a condition exists that will likely interfere with the safe operation of a CMV, which may include sufficient supporting opinions and information from specialists

A 25-year-old female driver denies a history of any medical problems. She is a nonsmoker who exercises regularly without symptoms. The medical examiner auscultates bilateral wheezes during the examination. The driver's SpO2 is 90 percent in the medical examiner's office. The rest of the examination is normal. The driver should be

A. Temporarily disqualified pending results of a cardiac workup.
B. Qualified since she has no cardiac symptoms.
C. Temporarily disqualified until further evaluation.
D. Qualified because her O2 saturation exceeds the minimum.

Correct: C. Temporarily disqualified until further evaluation.
This is the correct response because the driver has a non-diagnosed respiratory or thoracic illness that might interfere with the ability to safely operate a CMV. The driver should not be certified until the etiology is confirmed and treatment has been shown to be effective, safe, and stable. Also, according to FMCSA medical guidelines, a SpO2 of less than 92 percent warrants obtaining an arterial blood gas analysis.

Incorrect Responses:

A. Temporarily disqualified pending results of a cardiac workup.
This is not the correct response because while it is correct that the driver should not be certified, there is nothing in the question data that indicates evaluation should be limited to the heart.

B. Qualified since she has no cardiac symptoms.
This is not the correct response because the information in the question does not provide sufficient data to rule out the presence of a disqualifying cardiac or other thoracic problem.

D. Qualified because her O2 saturation exceeds the minimum.
This is not the correct response because according to FMCSA guidelines, a SpO2 of less than 92 percent warrants obtaining an arterial blood gas analysis.

Appendix D: Quick Reference Guide

Federal Motor Carrier Safety Administration (FMCSA) Medical Examiner Certification and Listing on the National Registry of Certified Medical Examiners

Follow these steps to be an FMCSA certified medical examiner.

Certification

Registration

Step 1: Create Your Account

- Go to https://nationalregistry.fmcsa.dot.gov to create your National Registry Account.
- Select "Registration" option.
- Enter required information. (Complete registration or data will not be saved.)
- Confirm all information as true and submit entries.
- Accept Rules of Behavior and submit.
- Receive Welcome Message and National Registry Number.
- Receive email with temporary password and instructions.

Training

Step 2: Complete Required Training

- Go to https://nationalregistry.fmcsa.dot.gov to find a list of training providers.
- Complete a training program that:
  - Is conducted by a training provider that is accredited by a nationally recognized medical profession accrediting organization to provide continuing education units.
  - Provides training participants with proof of participation.
  - Provides FMCSA point of contact information to training participants.
  - Covers the current core curriculum specifications established by FMCSA for medical examiner training.

Certification Testing

Step 3: Take the FMCSA Medical Examiner Certification Test

- Go to https://nationalregistry.fmcsa.dot.gov to search for a list of testing organizations approved to administer the FMCSA Medical Examiner Certification Test.
- Obtain information about locations and scheduling instructions directly from the testing organizations.
- Schedule the test. Some testing organizations may provide an option to take the test using a secure, remote, computer-based system.
- Provide your National Registry Number, proof of current medical licensure, proof of completion of training, and one form of photo identification when arriving at the test center.
- Take and pass the FMCSA Medical Examiner Certification Test.

Recertification (required every 10 years)

Training

Step 1: Complete Periodic Training

- Complete periodic training as specified by FMCSA every 5 years.
- Go to https://nationalregistry.fmcsa.dot.gov for information about how to access and complete periodic training.

Certification Testing

Step 2: Take the FMCSA Medical Examiner Certification Test

- Go to https://nationalregistry.fmcsa.dot.gov to:
  - Apply for recertification.
  - Accept Rules of Behavior and submit.
  - Find links to testing organizations approved to administer the FMCSA Medical Examiner Certification Test.
- Obtain information about locations and scheduling instructions directly from the testing organizations.
- Schedule the test.
- Provide your National Registry Number, proof of your medical credential, proof of completion of training, and one form of photo identification when arriving at the test center to take the test.
- Take and pass the FMCSA Medical Examiner Certification Test.

Continued Listing on the National Registry

To continue listing on the National Registry of Certified Medical Examiners, you must comply with the following requirements.

General Requirements

- Report to FMCSA any changes in the application information within 30 days of the change.
- Continue to be licensed, certified, or registered, and authorized to perform physical examinations, in accordance with the applicable laws and regulations of each State in which you perform driver examinations.
- Maintain documentation of State licensure, registration, or certification to perform physical examinations for each State in which you perform examinations and documentation of completion of all required training. You must make this documentation available to an authorized representative of FMCSA or an authorized representative of Federal, State, or local government upon request.

Periodic Training

- Complete periodic training as specified by FMCSA every 5 years.

Recertification

- Complete recertification by taking and passing the FMCSA Medical Examiner Certification Test every 10 years. (Note: FMCSA will issue a new medical examiner certification credential valid for 10 years when you successfully complete the required training and testing).

Submission of Monthly Reports/Commercial Motor Vehicle Driver Medical Examination Results

- Once every calendar month, you must electronically transmit to the Director of Medical Programs, via a secure FMCSA-designated Website, a completed Form MCSA-5850, Medical Examiner Submission of CMV Driver Medical Examination Results.
- The Form must include all information specified for each medical examination conducted during the previous month for any driver who is required to be examined by a medical examiner listed on the National Registry of Certified Medical Examiners.

Appendix E: FMCSA Form MCSA-5850, CMV Driver Medical Examination Results

CMV Driver Medical Examination Results Form

U.S. Department of Transportation
Federal Motor Carrier Safety Administration
OMB Control Number: 2126-0006
Expiration Date: July 31, 2015

Assigned FMCSA Form Number: MCSA-5850
Public Burden Statement:

A Federal agency may not conduct or sponsor, and a person is not required to respond to, nor shall a person be subject to a penalty for failure to comply with a collection of information subject to the requirements of the Paperwork Reduction Act unless that collection of information displays a current valid OMB Control Number. The OMB Control Number for this information collection is 2126-0006. Public reporting for this collection of information is estimated to be approximately 5 minutes per response, including the time for reviewing instructions, gathering the data needed, and completing and reviewing the collection of information. All responses to this collection of information are mandatory. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to: Information Collection Clearance Officer, Federal Motor Carrier Safety Administration, MC-RRA, 1200 New Jersey Avenue, SE, Washington, D.C. 20590.

You are required to submit the following driver medical examination data every month. Complete this form for each driver medical examination concluded.

CMV Driver Name
Use Legal Name as listed on Government Issued Identification

First Name

Middle Name

Please type NMN in the text box if the driver does not have a middle name.

Last Name

Suffix (Jr, Sr, III) *Optional*

Driver's License Information

Number

State

Date of Birth

mm/dd/yyyy

Intrastate Only ☐ CDL Holder ○ Yes ○ No

National Registry of Certified Medical Examiners Privacy Act Statement

This statement is provided pursuant to the Privacy Act of 1974, 5 USC § 552a. The information on the attached Form MCSA-5850 CMV Driver Examination Results is solicited under the authority of Title 49, United States Code (U.S.C.) §§ 40113, 44702, 44703, 44709 and 14 C.F.R. Part 6-7.

With limited exceptions, all drivers who operate commercial motor vehicles (CMVs), as defined in 49 CFR 390.5, in interstate commerce must comply with the qualification requirements of part 391 (§ 391.1). Each driver subject to the physical qualification requirements must be examined and certified by a medical examiner, as defined in § 390.5, at least once every 2 years. For certain drivers, such as those with severe cases of hypertension or other acute medical conditions, more frequent medical re-examination by a medical examiner may be required to determine whether the driver can still be certified.

Medical examiners are required to submit data every month for each driver physical examination conducted. Driver or medical examiner social security number is not required. Incomplete submission may result in removal of a medical examiner from the National Registry Program. The purpose of information is to record results of a driver's physical qualification to operate a CMV in interstate commerce according to the requirement in 49 CFR 391.41-49.

The information will be used to provide data for FMCSA's automated National Registry Data System. The information will become part of an FMCSA Privacy Act system of record. These records and information in these records will be collected and used to link a specific medical examiner to specific driver medical examination outcome data.

The written consent authorization of this form under **OMB Control Number:** 2126-0006 permits FMCSA to request driver physical examination outcome data from medical examiners.