

## 2018 DEADLINE DATES FOR SUBMITTING EVALUATION AND TREATMENT PROTOCOLS TO THE BOARD

All Evaluation and Treatment Protocols must be approved by the Board before athletic trainers may practice athletic training. The Protocols will be placed on the next available Board agenda for approval following the Athletic Trainers Advisory Committee (ATAC) meeting.

The ATAC must review all Evaluation and Treatment Protocols prior to going to the Board for approval. Deadline dates for Board materials are due before the ATAC meets. Therefore, Protocols will be presented at the next available Board meeting for approval after the ATAC has reviewed them.

<u>Deadline Dates*</u>	<u>ATAC Meeting Dates</u>	<u>Board Meeting Dates</u>
December 13, 2017	January 9, 2018	January 24, 2018
January 25, 2018	February 13, 2018	February 28, 2018
February 22, 2018	March 13, 2018	March 28, 2018
March 22, 2018	April 10, 2018	April 25, 2018
April 19, 2018	May 8, 2018	May 23, 2018
May 24, 2018	June 12, 2018	June 27, 2018
June 21, 2018	July 10, 2018	July 25, 2018
July 26, 2018	August 14, 2018	August 22, 2018
August 29, 2018	September 18, 2018	September 26, 2018
September 21, 2018	October 9, 2018	October 17, 2018
October 25, 2018	November 13, 2018	November 28, 2018
November 21, 2018	December 11, 2018	December 19, 2018 ***
December 19, 2018	January 8, 2019	January 30, 2019

The Board of Physicians **MUST** receive the Evaluation and Treatment Protocols, **particularly the Protocols with specialized tasks**, by the published deadline date to be considered for Board approval.

### Reminders:

1. Athletic Trainers, Supervising Physicians and Alternate Supervising Physicians must complete and sign (with original signatures) the appropriate sections of the Evaluation and Treatment Protocol. Unsigned Protocols or Protocols without original signatures will be returned to the athletic trainer. Returning incomplete Protocols will delay the Board approval process.
2. Supporting documentation, i.e., description of education, training and experience, certificates, competencies, credentials, procedure logs, etc., must accompany Evaluation and Treatment Protocols with specialized tasks. The processing of the Protocol will be delayed if the supporting documentation is not included. The tasks must be appropriate

to the practice setting.

3. If the athletic trainer or the supervising physician determines that an athlete's condition is beyond the scope of practice of the athletic trainer, the athletic trainer must refer the athlete to the appropriate licensed health care provider who may provide the appropriate treatment.
4. The athletic trainer shall modify or suspend treatment of an athlete that is not beneficial to the athlete or that the athlete cannot tolerate until the athletic trainer discusses the treatment with his supervising physician or the physician who wrote the order for treatment.
5. If the athletic trainer or the supervising physician terminates the Evaluation and Treatment Protocol, the athletic trainer will cease practicing until another Evaluation and Treatment Protocol is approved by the Board.
6. The supervising physician or the athletic trainer must notify the Board of the termination of the Evaluation and Treatment Protocol within 10 days of the termination.
7. A copy of the approved protocol shall be maintained by the athletic trainer at his/her place of employment at all times.

**\*Deadline dates for submitting protocols to the Board.**

**\*\*Indicates meeting scheduled accordingly due to holidays.**

# MARYLAND BOARD OF PHYSICIANS

P.O. Box 37217  
Baltimore, MD 21297  
[www.mbp.state.md.us](http://www.mbp.state.md.us)

## ATHLETIC TRAINER/SUPERVISING PHYSICIAN EVALUATION AND TREATMENT PROTOCOL

***Before practicing athletic training, all athletic trainers must have a license to practice athletic training and a Board-approved Evaluation and Treatment Protocol with a physician licensed in Maryland. NO EXCEPTIONS!***

**Note: The Athletic Trainer Advisory Committee must provide preliminary approval of all Evaluation and Treatment Protocols. Please note the deadline dates for submitting the protocol and plan accordingly.**

### GENERAL INSTRUCTIONS AND IMPORTANT INFORMATION FOR COMPLETING ATHLETIC TRAINER/SUPERVISING PHYSICIAN EVALUATION AND TREATMENT PROTOCOL

**Fee:** The fee for the evaluation and treatment protocol (protocol) is **\$100.00**. Make all checks or money orders payable to: **Maryland Board of Physicians**. Mail the fee and the protocol to the above address: **P.O. Box 37217, Baltimore, MD 21297**. (There is no charge for adding alternate supervising physicians, additional practice locations or specialized tasks to an existing evaluation and treatment protocol.)

**Evaluation and Treatment Protocols sent to an address, other than the one above, or walked into the Board will delay the processing of your evaluation and treatment protocol.**

**Page 1: Athletic Trainer (AT):** Complete Sections 1 through 7

**Page 2: Supervising Physician (SP):** Complete Sections 8 through 12.

**Section 13—Supervision Mechanism Descriptions—**Check all that apply

**Section 14—Non-Delegated Tasks—**SPs may list the tasks they do not wish to delegate to the AT.

**Page 3: Section 15—Practice Settings—**AT - check only those that apply

**Section 16—Outside Referrals—**If the SP checked this as a mechanism of supervision in **Section 13**, the SP must complete this Section.

**Section 17—Supervising Physician Attestation—**SP must complete the attestation.

**Page 4: Section 18: Athletic Trainer's Attestation—**ATs must sign this section.

**Section 19: Release for Athletic Trainers—**ATs must sign this section

**Section 20: Athletic Trainers/Supervising Physician Affirmation -** Both the AT and SP must sign the affirmation.

**Appendix A: Designated Alternate Supervising Physician (ASP) for Athletic Trainers form.** Supervising physicians may designate one or more ASPs to supervise the athletic trainer in the absence of the supervising physician. The ASP must supervise the athletic trainer in accordance with the Evaluation and Treatment Protocol on file with the Board. Each designated ASP, the supervising physician and the athletic trainer must complete **Appendix A** and submit it to the Board before supervision begins.

**Appendix B:** Describes the basic scope of practice for all ATs. (*Board of Certification 2013. Athletic Trainer Role Delineation Study, 7th Edition.*)

**Appendix C: Specialized Tasks—**These are tasks that require additional education and training beyond the training received in an accredited athletic trainer educational program. SPs complete this form if you intend to delegation specialized tasks to the AT.

**GENERAL INSTRUCTIONS AND IMPORTANT INFORMATION FOR COMPLETING  
ATHLETIC TRAINER/SUPERVISING PHYSICIAN EVALUATION AND TREATMENT  
PROTOCOL CONTINUED**

**IMPORTANT**

**If the athletic trainer or the supervising physician determines that an athlete's condition is beyond the scope of practice of the athletic trainer, the athletic trainer must refer the athlete to the appropriate licensed health care provider who may provide the appropriate treatment.**

**The athletic trainer shall modify or suspend treatment of an athlete that is not beneficial to the athlete or that the athlete cannot tolerate until the athletic trainer discusses the treatment with his supervising physician or the physician who wrote the order for treatment.**

**If the athletic trainer or the supervising physician terminates the Evaluation and Treatment Protocol, the athletic trainer will cease practicing until another Evaluation and Treatment Protocol is approved by the Board.**

**The supervising physician must notify the Board of the termination within 15 days of the termination of employment.**

**A copy of the approved protocol must be maintained by the athletic trainer at his/her place of employment at all times.**

MARYLAND BOARD OF PHYSICIANS  
P.O. BOX 37217  
BALTIMORE, MD 21297  
[www.mbp.state.md.us](http://www.mbp.state.md.us)

FOR BANK USE ONLY

Date \_\_\_\_\_  
Check Number \_\_\_\_\_  
Amt Paid \_\_\_\_\_  
Name Code \_\_\_\_\_  
App ID: 62

Fee: \$100

**ATHLETIC TRAINER/SUPERVISING PHYSICIAN  
EVALUATION AND TREATMENT PROTOCOL**

ATHLETIC TRAINER: TYPE OR PRINT LEGIBLY		
1. Maryland License #:	2. BOC Certification #:	
<b>3. IDENTIFYING INFORMATION:</b>		
Last Name, (Suffix, Jr., III):	First Name:	
Middle Name/Initial:	Maiden Name:	
<b>4. MAILING ADDRESS:</b>		
Street Address 1:		
Street Address 2:		
City:	State:	Zip code:
<b>5. CONTACT INFORMATION:</b>		
Home #:	Work #:	
Cell #:	Email address:	
<b>6. QUALIFICATIONS OF ATHLETIC TRAINER:</b> Please check all that apply.		
<input type="checkbox"/> BOC Certification <input type="checkbox"/> BS/BA in Athletic Training <input type="checkbox"/> MS/MA in Athletic Training		
<b>7. ATHLETIC TRAINER'S PRIMARY EMPLOYER INFORMATION:</b>		
Facility/Employer Name:		
Address:		
City:	State:	Zip code:
Contact Name:	Telephone #:	
Email Address:		

For Board Use Only: Approval Date: \_\_\_\_\_

**SUPERVISING PHYSICIAN:TYPE OR PRINT LEGIBLY**

**8. Maryland License Number:**

**9. Specialty(ies):**

**10. IDENTIFYING INFORMATION:**

**Last Name (Suffix, Jr., III)**

**First Name:**

**Middle Name/Initial:**

**Maiden Name:**

**11. PRACTICE LOCATION:**

**Facility/Business Name:**

**Street Address/Suite #:**

**City:**

**State:**

**Zip code:**

**12. CONTACT INFORMATION:**

**Home #:**

**Work #:**

**Cell #:**

**Email Address:**

**13. SUPERVISION MECHANISM DESCRIPTIONS:** Supervising physician: Describe the method of supervision. Check all that apply.

On-site

Alternate Supervising Physician. *(If this method is chosen, the alternate supervising physician must complete Appendix A attached to the protocol.)*

Written Instructions

Verbal Orders (In Person/Telephone)

Outside referrals from non-supervising physicians/other licensed health care practitioners. *(If this method is chosen, please complete item 16 on page 3.)*

Electronic Communication

**14. NON-DELEGATED TASKS:** Supervising physicians, if there are any tasks in Appendix B, e.g. A5, B3, etc., or other tasks, in general, you do not wish the athletic trainer to perform, please list them below.

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**15. ATHLETIC TRAINER'S PRACTICE SETTINGS: Check only those that apply:**

- |  |   |
|--|---|
| <input type="checkbox"/> Amateur Sports Organization   | <input type="checkbox"/> Health/Fitness Club              |
| <input type="checkbox"/> Clinic or Hospital            | <input type="checkbox"/> Independent Contractor           |
| <input type="checkbox"/> Corporation* (ex: Pivot, ATI) | <input type="checkbox"/> Professional Sports Organization |
| <input type="checkbox"/> Educational Institution       | <input type="checkbox"/> Recreational Sports Organization |
| <input type="checkbox"/> Government Agency*            | <input type="checkbox"/> Sports Camp                      |

\*If you checked corporation or government agency, will you be treating only athletic injuries? (Check one)

- Yes     No    If no, attach your detailed job description.

**16. OUTSIDE REFERRALS FROM NON-SUPERVISING PHYSICIANS AND OTHER LICENSED HEALTH CARE PRACTITIONERS**

The supervising physician may authorize the athletic trainer to accept a referral from a non-supervising physician or other licensed health care practitioner if:

1. The supervising physician specifies in the Protocol that the athletic trainer may accept the referral;
2. The non-supervising physician or other licensed health care practitioner has seen the athlete and has acknowledged in writing that the care will be provided;
3. The duties are within the scope of an athletic trainer; and
4. The duties are among the duties delegated in the evaluation and treatment protocol.

I authorize \_\_\_\_\_ to accept referrals from a non-supervising  
Name of Athletic Trainer  
physician or licensed health care practitioner providing the referral meets the criteria outlined above.

\_\_\_\_\_  
Name of Supervising Physician (Print Legibly)      **Original** Signature of Supervising Physician      Date

**17. SUPERVISING PHYSICIAN ATTESTATION:**

I attest that I accept the responsibility to provide ongoing and immediately available instruction that is adequate to ensure the safety and welfare of a patient and is appropriate to the setting. I have indicated on this form the medical processes and procedures which, \_\_\_\_\_  
Name of Athletic Trainer  
may perform under this evaluation and treatment protocol.

\_\_\_\_\_  
Name of Supervising Physician (Print Legibly)      **Original** Signature of Supervising Physician      Date

**APPENDIX A**

**DESIGNATED ALTERNATE SUPERVISING PHYSICIAN FOR ATHLETIC TRAINERS**

The supervising physician (SP) may designate more than one alternate supervising physician to supervise the athletic trainer in his/her absence. The designated alternate supervising physician (ASP) must supervise the athletic trainer (AT) in accordance with the Evaluation and Treatment Protocol on file with the Board.

**Instructions:** Primary supervising physicians who designate alternate supervising physicians, please:

1. Type or print the name of all designated ASPs and have the ASP sign in the appropriate place. The ASP's signature indicates that the ASP is accepting the responsibility of supervising the athletic trainer in the absence of the SP.
2. Type or print the name of the AT;
3. Sign the SP affirmation.

If the SP chooses to designate more than four alternate supervising physicians, please make as many copies of this form as necessary.

**1. ALTERNATE SUPERVISING PHYSICIAN AFFIRMATION:**

I accept the responsibility of supervising the listed athletic trainer, in accordance with the approved Evaluation and Treatment Protocol, in the absence of the listed supervising physician. I solemnly affirm under penalties of perjury, that the contents of the foregoing document are true to the best of my knowledge, information and belief.

Name of Alternate Supervising Physician (ASP)	ASP License Number	ASP Original Signature

**2. ATHLETIC TRAINER:**

Name/License Number of Athletic Trainer:	Signature of Athletic Trainer:

**3. SUPERVISING PHYSICIAN AFFIRMATION:**

I certify that I have designated the above named alternate supervising physicians and they accept the responsibility of supervising the athletic trainer named above in my absence and in accordance with the evaluation and treatment protocol on file with the Maryland Board of Physicians.

\_\_\_\_\_  
Supervising Physician's Name (Print Legibly)

\_\_\_\_\_  
License Number

\_\_\_\_\_  
Supervising Physician's **Original** Signature

\_\_\_\_\_  
Date



**18. ATHLETIC TRAINER ATTESTATION:**

I attest that I will practice as described in this protocol, under the supervision of \_\_\_\_\_.  
Name of Supervising Physician

In the event that an athlete or patient requires services outside of the scope of this protocol, I will refer the athlete or patient to an appropriate health care provider. I understand that if I wish to expand either locations or procedures described herein, I must discuss this with my supervising physician and submit a revised protocol.

\_\_\_\_\_  
Name of Athletic Trainer (Print Legibly)

\_\_\_\_\_  
**Original** Signature of Athletic Trainer

\_\_\_\_\_  
Date

**19. RELEASE**

I agree that the Maryland Board of Physicians (the Board) and the Athletic Trainer Advisory Committee may request any information necessary to process my Evaluation and Treatment Protocol from any person or agency, including but not limited to former and current employers, government agencies, the National Practitioners Data Bank, the Healthcare Integrity and Protection Data Bank, hospitals and other licensing bodies, and I agree that any person or agency may release to the Board the information requested. I also agree to sign any subsequent releases for information that may be requested by the Board.

\_\_\_\_\_  
Name of Athletic Trainer (Print Legibly)

\_\_\_\_\_  
**Original** Signature of Athletic Trainer

\_\_\_\_\_  
Date

**20. AFFIRMATION:** The athletic trainer and the supervising physician must sign the affirmation.

I solemnly affirm under penalties of perjury, that the contents of the foregoing document are true to the best of my knowledge, information and belief.

\_\_\_\_\_  
Name of Supervising Physician (Print Legibly)

\_\_\_\_\_  
**Original** Signature of Supervising Physician

\_\_\_\_\_  
Date

\_\_\_\_\_  
Name of Athletic Trainer (Print Legibly)

\_\_\_\_\_  
**Original** Signature of Athletic Trainer

\_\_\_\_\_  
Date

**SCOPE OF PRACTICE:** Description of the athletic trainer's basic scope of practice. (Board of Certification 2015. Practice Analysis, 7th Edition.)

**A. Injury or Illness Prevention and Wellness: Promoting healthy lifestyle behaviors with effective education and communication to enhance wellness and minimize the risk of injury and illness**

1. Identify risk factors by administering assessment, pre-participation examination, and other screening instruments and reviewing individual and group history and injury surveillance data.
2. Implement plans to aid in risk reduction using currently accepted and applicable guidelines.
3. Educate all stakeholders about the appropriate use of personal equipment.
4. Minimize the risk of injury and illness by monitoring and implementing plans to comply with regulatory requirements and standard operating procedures for physical environments and equipment.
5. Facilitate personal and group safety by monitoring and responding to environmental conditions (e.g., weather, surfaces, client work setting).
6. Optimize wellness (e.g., social, emotional, spiritual, environmental, occupational, intellectual, physical) for individuals and groups.

**B. Clinical Evaluation and Assessment: Implementing systematic, evidence-based examinations and assessments to formulate valid clinical diagnoses and determine patients' plan of care**

1. Obtain an individual's history through observation, interview, and review of relevant records to assess injuries and illnesses and to identify comorbidities.
2. Perform a physical examination that includes diagnostic testing to formulate differential diagnosis.
3. Formulate a clinical diagnosis by interpreting history and the physical examination to determine the appropriate course of action.
4. Interpret signs and symptoms of injuries, illnesses, or other conditions that require referral using medical history and physical examination to ensure appropriate care.
5. Educate patients and appropriate stakeholders about clinical findings, prognosis, and plan of care to optimize outcomes and encourage compliance.

**C. Immediate and Emergency Response: Integrating best practices in immediate and emergency care for optimal outcomes**

1. Establish, review, and/or revise emergency action plans to guide appropriate and unified response to events and optimize outcomes.
2. Triage to determine if conditions, injuries, or illnesses are life-threatening.
3. Implement appropriate emergency and immediate care procedures to reduce the risk of morbidity and mortality.
4. Implement referral strategies to facilitate the timely transfer of care.

**D. Treatment, Rehabilitation and Reconditioning—Therapeutic Intervention: Rehabilitating and reconditioning injuries, illnesses, and general medical conditions to promote optimal activity level based on core concepts**

1. Optimize patient outcomes by developing, evaluating and updating the plan of care.
2. Educate patients and appropriate stakeholders using pertinent information to optimize treatment and rehabilitation outcomes.
3. Administer therapeutic exercises to patients using appropriate techniques and procedures to aid recovery to optimal function.
4. Administer therapeutic devices to patients using appropriate techniques and procedures to aid recovery to optimal function.
5. Administer manual techniques to patients using appropriate methods and procedures to aid recovery to optimal function.
6. Administer therapeutic interventions for general medical conditions to aid recovery to optimal function.
7. Determine patients' functional status using appropriate techniques and standards to return to optimal activity level.

**E. Organization and Professional Well-being: Integrating best practices in policy construction and implementation, documentation, and basic business practices to promote optimal patient care and employee well-being.**

1. Evaluate organizational, individual, and stakeholder goals and outcomes.
2. Develop, review, and/or revise policies, procedures, and strategies to address risks and organizational needs.
3. Practice within local, state, and national regulations, guidelines, recommendations, and professional standards.
4. Use established documentation procedures to ensure best practice.

**SPECIALIZED TASKS FOR EVALUATION AND TREATMENT PROTOCOLS  
FOR ALL PRACTICE SETTINGS LISTED IN THE EVALUATION AND TREATMENT PROTOCOL**

**Athletic Trainers must have a Board-approved evaluation and treatment protocol prior to completing this form.**

Specialized tasks are tasks the supervising physician authorizes the athletic trainer to perform that requires additional education, training and experience beyond the basic athletic trainer education program required for licensure. The education, training and experience must be appropriate to perform the task and appropriate to the practice setting.

**Instructions for the Supervising Physician:**

- Complete **Appendix C** only if you are planning to delegate tasks to the athletic trainer that are beyond the basic tasks listed in **Appendix B**. Tasks should be appropriate to the setting listed in the evaluation and treatment protocol.
- Provide a detailed description of the task(s) you are authorizing the athletic trainer to perform, including a detailed description of the education and training required to perform the task in the practicing setting.

**Instructions for Athletic Trainer:**

- Attach copies of other competencies, certifications/credentials and/or specialties and procedure logs that support the delegation of the specialized task(s).
- Procedure logs must contain a minimum of five procedures per assigned specialized task.

Name of Athletic Trainer:	License Number:
Name of Supervising Physician:	License Number:

**Supervising physician, describe in detail, the specialized task(s) the athletic trainer will be performing.**


**SUPERVISING PHYSICIAN ATTESTATION:**

I attest that I accept the responsibility to provide ongoing and immediately available instruction that is adequate to ensure the safety and welfare of a patient and is appropriate to the setting. I have indicated on this form the medical processes and procedures which, \_\_\_\_\_  
Name of Athletic Trainer

may perform under this evaluation and treatment protocol.

Name of Supervising Physician (Print Legibly)	<b>Original</b> Signature of Supervising Physician	Date
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