

Physician Re-entry

The AMA defines physician re-entry as “a return to clinical practice in the discipline in which one has been trained or certified following an extended period of clinical inactivity not resulting from discipline or impairment.” Many states have specific rules for physicians seeking to reenter clinical practice, and some require passage of the Special Purpose Examination (SPEX), Comprehensive Osteopathic Medical Variable-Purpose Examination (COMVEX), or similar examinations to prove current competence (Table 25).

In the AMA’s 2011 Physician Licensure Survey, the following questions on re-entry were included; the response rate was 88 percent (57 of the 65 Boards surveyed):

- Does your board require a physician to engage in a certain amount of patient care for relicensure?
7 percent (n=4)
- Does your board ask physicians to provide information on the average amount of time they engage in patient care?
13 percent (n=7)
- Does your board have a policy on physician re-entry for physicians who have left the active practice of medicine and want to re-enter practice?
58 percent (n=33)
- What is the length of time out of practice after which your board requires re-entering physicians to complete a re-entry program?
2.9 years
- Are you keeping records on the number of physicians the board considered for re-entry? (Asked of the 33 boards with re-entry policies only)
24 percent (n=8)
- Is your board currently developing or planning to develop a re-entry policy? (Asked of the 24 boards with re-entry policies only)
50 percent (n=12)

AMA recommendations on physician re-entry

In 2010, the AMA worked with a wide range of stakeholders—including leaders in licensure, board certification and medical education, as well as directors of re-entry programs—to develop the following recommendations on physician re-entry. In particular, the American Academy of Pediatrics and Federation of State Medical Boards contributed to the consensus process leading to these recommendations.

Note: For more information on this and other aspects of physician re-entry, refer to the AMA’s Physician Re-entry website at www.ama-assn.org/go/reentry.

Regulatory policies

Principle: Ensure that there is a comprehensive, transparent and feasible regulatory process for physicians to return to clinical practice.

1. Develop an understanding of the expectations and needs that relevant stakeholder groups—physicians, patients, regulators and the public—have for a physician re-entry system.
2. Develop physician re-entry policy guidelines across state medical licensing jurisdictions that are consistent and evidence-based. These guidelines should clarify:
 - The length of time away from clinical practice which necessitates participating in a re-entry process
 - The definition of how much involvement in clinical care constitutes active clinical practice and the clinical practice requirements for maintaining licensure
 - The impact of loss of specialty board certification on maintenance of licensure
3. Establish mechanisms to permit reentering physicians to engage in clinical practice under supervision as they participate in a re-entry program. These include:
 - A site (medical school, graduate medical education program, teaching hospital and medical home, as well as non-traditional sites such as mental health hospitals and nursing homes) that provides reentering physicians with opportunities for supervised clinical practice in their previous clinical fields
 - Hospital credentialing committees that allow re-entry program participants to work under supervision
 - State medical licensing boards that establish a non-disciplinary licensure status option for reentering physicians during their re-entry education and training
 - Development and validation of a process for previously board certified physicians not eligible for maintenance of certification to participate in re-entry training necessary to return to their field and original scope of clinical practice

4. Work with state medical licensing boards and medical societies to develop a certificate of program completion that meets the need to document physician readiness for clinical practice.

Physician re-entry program policies

Principle: Develop policies that assure the quality of re-entry programs and the readiness to resume practice of their graduates.

5. Increase consistency among re-entry programs by establishing a mechanism by which programs can assess and demonstrate graduates' comparable preparation and readiness for independent practice within the physician's intended scope of practice.
6. Encourage the development of modular programs to meet the specific learning needs of individual reentering physicians.
7. Consider a physician re-entry program accreditation process that includes a review of program outcomes.

Research and evaluation

Principle: Create an evidence base that can be used to inform policymakers, reentering physicians and re-entry program development.

8. Study the feasibility of introducing alternate licensure tracks for reentering physicians that allow a limited scope of practice.
9. Study the relationship between time away from practice and maintenance of clinical knowledge, skills and behaviors.
10. Study new models of organizing physician re-entry programs to include the feasibility of providing physicians with an educational "home" base.
11. Continue to develop valid and reliable assessment tools for physician knowledge and skills. Assessment of reentering physicians should occur at three points: (1) entry to a physician re-entry program, (2) completion of a physician re-entry program, and (3) a standard time after which a physician has returned to active clinical practice.

12. Establish a national physician re-entry database to:

- Provide programmatic information to reentering physicians
- Track trends in re-entry such as number of reentering physicians, program costs and outcomes

13. Study the workforce implications of a system that supports physician re-entry.

Program funding

Principle: Develop means to ensure that a physician re-entry system is financially feasible.

14. Pursue multiple funding streams to support the development, implementation and evaluation of a national physician re-entry system.

Collaboration and communication among stakeholders

Principle: Ensure that all stakeholders participate in planning for a physician re-entry system.

15. Establish process for ongoing communication between medical regulatory bodies, physician re-entry programs, medical associations and societies, and other key stakeholders to further the development of a national re-entry system.
 - Mitigating the cost of physician re-entry programs for physicians and regulatory bodies
 - Supporting the development and maintenance of physician re-entry programs
 - Creating mechanisms for the assessment and evaluation of physician re-entry programs

16. Continue to educate medical students, residents and practicing physicians on career-planning strategies and resources should they need to take a hiatus from clinical practice.

Table 25
Physician Re-entry Regulations

	Board has policy on physician re-entry to practice*	Length of time out of practice after which re-entry program completion is required	Board developing/ planning to develop policy	Decided on Case-by-Case Basis	SPEX/ COMVEX May Be Required	CME May Be Required	Notes
Alabama	No		No	Yes	Yes		
Alaska	No	—	No				Full board interview may be required
Arizona	Yes		—	Yes	Yes	Yes	PACE may also be required
Arizona DO	Yes		—	Yes	Yes	Yes	Practice monitoring may be required, structured as non-disciplinary probation.
Arkansas	Yes		—				
California	No		No	Yes			
California DO	Yes	5 yrs	—			Yes	Under 5 yrs: completion of questionnaire and 20 CME credits required. Over 5 yrs: new application required.
Colorado	Yes	2 yrs	—				Personalized competency evaluation report prepared by Board-approved program, and completion of any education/training that is recommended by the program.
Connecticut	Yes	2 yrs	—				
Delaware	No		No	Yes			
DC	No		Yes			Yes	Physicians not actively practicing for 1 to 5 yrs must submit proof of 50 Category 1 CME credits for each inactive year. To reactivate a paid inactive license after 5 yrs, 1 yr of clinical training in an ACGME- or AOA-accredited program or 300 Category 1 CME credits is required.
Florida	Yes		—	Yes	Yes	Yes	
Florida DO	Yes	4 yrs	—		Yes		Board recommends Univ. of Florida CARES or CAPS program. Applicant required to appear before Board and establish ability to practice in safe manner. Also required: COMVEX; an accounting for activities while not practicing.
Georgia	Yes	Board discretion	—				Demonstrate current knowledge, skill, and proficiency.
Guam							
Hawaii	No		No				
Hawaii DO							
Idaho	No		No	Yes	Yes		
Illinois	Yes	3 yrs	—				See Section 1285.95 of Administrative Rules.
Indiana	No		Yes	Yes			Personal appearance before board is required.
Iowa	Yes	3 yrs	—	Yes			Competency evaluation required.
Kansas	Yes	2 yrs	—				Additional testing, training, or education may be deemed necessary.
Kentucky	Yes	2 yrs	—	Yes			
Louisiana	No		No				Must meet requirements for reinstatement or relicensure.
Maine	No		Yes	Yes			
Maine DO	No		No				
Maryland	Yes	5 yrs	—	Yes	Yes		A physician with license on inactive status or who has failed to renew a license by the 2-month late renewal period and who wishes to practice medicine may apply for reinstatement.
Massachusetts	No		Yes				Must complete "re-entry to practice plan."

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Table 25 (continued)
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Michigan	No		No			Yes	Complete 150 hours of CME with a minimum of 75 hrs AMA Category 1 within immediately previous 3 yrs from date of application.
Michigan DO	No		No			Yes	(See above)
Minnesota	Yes	3 yrs	—	Yes	Yes	Yes	Assessment or mentorship may be required.
Mississippi	Yes	3 yrs	—				Board-approved physician assessment or clinical skills assessment program.
Missouri	No		Yes				
Montana	Yes	2 yrs	—		Yes		
Nebraska	Yes	2 yrs within last 3 yrs	—				If applicant has not practiced in at least 1 of the last 3 years, can apply for license with a non-disciplinary voluntary limitation that requires practice under a Practice Quality Monitor (PQM), with prospective review of the care for a period of time followed by a review of patient care.
Nevada	Yes	1 yr	—		Yes	Yes	PACE, CPEP, peer review, preceptorship, or fellowship may be required.
Nevada DO	Yes		—			Yes	Additional \$500 and proof of CME for inactive yrs required to reactivate practice.
New Hampshire	No		Yes	Yes			
New Jersey	Yes	5 yrs	—	Yes	Yes	Yes	See Board regulation NJAC 13:35-3.14
New Mexico	Yes	2 yrs	—			Yes	Mini-Sabbatical or CPEP may be required.
New Mexico DO							
New York	No		No				A licensed physician in inactive status must re-register.
North Carolina	Yes	2 yrs	—				Completion of re-entry program required. See 21 NCAC 32B.1370
North Dakota	No		Yes	Yes			Re-entry plan developed, as appropriate.
Ohio	Yes	2 yrs	—		Yes		Exam to determine current fitness to practice or Board certification or recertification examination may be required (Sec 4731.222)
Oklahoma	No		Yes				
Oklahoma DO	No		No	Yes			
Oregon	Yes	2 yrs (may differ based on specialty)	—				A physician out of practice more than 12 months may be required to take a competency exam or training. Refer to OAR 847-020-0183.
Pennsylvania	Yes	4 yrs	—		Yes	Yes	Re-entry to practice plan may be required, to include completion of a clinical skills assessment program, refresher training, mentorship program, a mini-residency, passing ABMS board exams, etc.
Pennsylvania DO	No		Yes		Yes	Yes	Additional training may be required, as well as completion of application and payment of fee.
Puerto Rico							
Rhode Island	No		Yes			Yes	Mentorship may be required.
South Carolina	Yes	4 yrs	—				

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South Dakota	No		Yes	Yes		Yes	Re-entry to practice plan may be required, to include completion of a clinical skills assessment program, refresher training, mentorship program, a mini-residency, passing ABMS board exams, etc.
Tennessee	Yes	5 yrs	—	Yes	Yes		Must display clinical competency.
Tennessee DO	Yes	Variable	—	Yes	Yes		Must display clinical competency.
Texas	No	See note					Applicants for licensure must have practiced full time for 1 of the 2 years preceding date of application. Licensees are not required to demonstrate active practice.
Utah	Yes	5 yrs	—		Yes		See R-156-67-302(d)(2).
Utah DO	Yes	5 yrs	—				
Vermont	Yes	3 yrs	—		Yes		
Vermont DO	Yes	1 yr	—		Yes		See Rule 2.3.2
Virgin Islands							
Virginia	Yes	4 yrs	—		Yes		
Washington	Yes	2 yrs (depending on specialty)	—		Yes		After 2 yrs out of practice, an application, fee, and CME credits are required; after 4 yrs, SPEX is usually required
Washington DO	No		No				
West Virginia	No	18 months	No	Yes			
West Virginia DO	No		Yes	Yes			
Wisconsin	No	5 yrs	Yes				Oral examination may be required. If less than 5 yrs, licensure renewal is allowed. Re-registration application is required (\$241).
Wyoming	No		No	Yes	Yes	Yes	Other requirements that may be imposed include preceptorship, supervision, chart review, and evaluation (CPEP).

* As defined by the AMA

Abbreviations**ACGME**—Accreditation Council for Graduate Medical Education**ABMS**—American Board of Medical Specialties**AOA**—American Osteopathic Association**CME**—continuing medical education**COMVEX**—Comprehensive Osteopathic Medical Variable-Purpose Examination**CPEP**—Center for Personalized Education for Physicians**PACE**—Physician Assessment and Clinical Education program**SPEX**—Special Purpose Examination**Note:** *All information should be verified with licensing board; medical licenses are granted to those physicians meeting all state requirements—at the discretion of the board.*