Issue Brief: Additional state licensure pathways for internationally trained physicians

Introduction

International medical graduates (IMGs) are an important and growing part of the U.S. physician workforce often practicing in rural and underserved areas and contributing to the diversity of the physician workforce. According to AMCC data, IMGs account for about a quarter of physicians working in the U.S. Currently, most states require IMGs to complete at least one year of graduate medical education (GME) in a residency program accredited by the Accreditation Council for Graduate Medical Education (ACGME) to obtain a full and unrestricted license to practice medicine, with exceptions granted to highly specialized and experienced physicians. This requirement ensures that IMGs have the skills and knowledge to competently practice medicine in the U.S. The bottleneck in availability of GME residency positions, with a far greater demand from U.S. medical school and graduates of international medical schools than slots available coupled with the pressing physician workforce shortage and maldistribution of physicians, has led to an increase in state legislative activity that would create an additional pathway to state licensure for internationally trained and practicing physicians (ITPs) without requiring the completion of an ACGME residency program.

State legislative activity

To date, state legislation that would create an additional licensing pathway for foreign trained physicians has been enacted in at least seventeen states, including: Arkansas, Florida, Idaho, Illinois, Indiana, Iowa, Louisiana, Massachusetts, Minnesota, Nevada, North Carolina, Oklahoma, Rhode Island, Tennessee, Texas, Virginia, and Wisconsin. While the specifics of each state bill vary, in general they include the following elements:

1. *Require the foreign trained physician to graduate from an international medical school and post-graduate training (PGT) program that is substantially similar to a U.S. program, and/or have experience practicing as a physician for a certain number of years.*

   State legislation varies in the criteria by which "substantially similar programs" are determined. For example, some states leave this up to the state medical board, while others defer to other organizations such as the World Health Organization or the Educational Commission on Foreign Medical Graduates (ECFMG). For example, Virginia's law only applies to applicants who have a medical degree from a WHO-recognized school, while the laws in Arkansas, Iowa, Oklahoma, Rhode Island, and Texas state that international medical programs shall be evaluated by ECFMG.[1]

   Most states require (1) graduation from an international medical school, (2) completion of PGT, and (3) experience practicing as a physician in a foreign country for a certain number of years. In 2024, the Tennessee legislature enacted SB 1936 which included some key amendments to their legislation adopted in 2023. One of those changes was requiring the applicant to have **both** PGT **and** practice experience.

[1]The Cicero Institute has model language that would require medical boards to grant a provisional license to any IMG applicant who is a resident of and licensed to practice in specific countries, including Australia, Ireland, Israel, New Zealand, Singapore, South Africa, Switzerland, The United Kingdom, and Canada. Other countries can be added by the medical board. While some states have introduced legislation similar language – this provision has not been included in any enacted legislation.

Applicants must complete three-years PGT and have practiced as a medical professional performing the duties of a physician for the last three years outside the U.S. This change put Tennessee in line with legislation enacted in most of the other states. States vary in the number of years of practice experience required. For example, Wisconsin requires the individual to have practiced for at least five years post-PGT, with at least one continuous year in the last five before applying through this pathway. Indiana requires the individual to have practiced five of the last six years, Arkansas and Florida would require applicants to have practiced for at least the last four years preceding the application. While Idaho would require the applicant to have practiced for at least three years post-PGT or have 500+ hours of clinical experience under direct physician supervision in a clinical setting in the U.S. Louisiana varies in allowing the individual to have completed a residency or post-graduate training program or have no less than five years practicing as a physician. Nevada requires applicants to have completed postgraduate training program or have practiced within the five years immediately preceding the date of the application. Similarly, North Carolina requires applicants to have completed two years of postgraduate training or actively practiced medicine for at least ten years after graduation. Oklahoma requires completion of a three-year postgraduate training program or verification that the applicant practiced as a physician for at least three of the last five year. Massachusetts, Minnesota, and Virginia are silent on requiring applicants to have completed post-graduate training, rather Massachusetts law only requires an applicant to have practice medicine for at least one year, Minnesota's law requires applicants to have practiced five years within the last 12 years, and Virginia's law only requires the applicant to have practiced medicine for at least five years. Texas is silent on practice experience but requires applicants to have completed a residency or substantially similar postgraduate medical training program and passed the Texas medical jurisprudence examination.

2. *Require applicants to have passed Steps 1, 2, and 3 of the USMLE*

Most states, including Arkansas, Florida, Idaho, Iowa, Massachusetts, Rhode Island, Texas, Virginia, and Wisconsin, require applicants to have passed Steps 1 and 2 of the United States Medical Licensing Examination (USMLE) for the initial license. In addition, Idaho, Massachusetts, Rhode Island, Virginia, and Wisconsin require passage of Step 3 at some point in the process toward obtaining a full license to practice medicine. For example, Idaho requires applicants for a provisional license to have passed Steps 1 and 2 of the USMLE, with those seeking a full license after the provisional period to have completed and passed Step 3. The law in Arkansas and Florida does not explicitly mention USMLE, but requires that applicants obtain ECFMG certification, which includes passing Steps 1 and 2 of the USMLE among its requirements. Finally, Indiana and Nevada require passage of USLME Steps 1, 2, and 3 to obtain a provisional license, while Oklahoma requires passage of Steps 1, 2, and 3 to obtain a full license after the provisional period.

North Carolina varies from other states by allowing a variety of ways for applicants to demonstrate competency including passage of Steps 1-3 of the USMLE, passage of a nationally recognized standard medical licensing examination from a country that is a member of the International Association of Medical Regulatory Authorities and that meets certain requirements, specialty board certification, or submitting to a comprehensive assessment demonstrating clinical competence approved by the board.

3. *Individual ECFMG certification*

Eight states, Arkansas, Florida, Indiana, Minnesota, Massachusetts, Rhode Island, Texas, Virginia, and Wisconsin require the applicant to have ECFMG certification or another credential verification service approved by the board. North Carolina requires applicants to be eligible for ECFMG certification. Applicants with ECFMG certification will have met the following: verification that the individual graduated from a medical school recognized by the World Directory, passage of USMLE Steps 1 and 2, and demonstration of English language proficiency via the Occupational English Test (OET) Medicine.

4. *Have an offer of employment*

   Every state except Illinois requires applicants to have an offer of employment as a physician from a health care facility or provider in the state. Some states provide additional specifics. For example, Idaho requires the physician to have an offer of employment at any sponsoring institution in the state that also employs a supervising physician. Iowa states that the physician must have an offer of employment at a health care facility in the state. Wisconsin indicates that the offer of employment must come from a FQHC, a community health center, a hospital, an ambulatory surgery center, or any other health care facility approved by the board. Tennessee and Oklahoma require the applicant to have an offer of employment as a physician at a health care provider that operates in the state and has an ACGME residency training program. Florida requires the applicant to have an offer of employment as a physician from a "health care provider," which is defined as a health care professional, health care facility or, entity licensed or certified to provide health care services in this state as recognized by the board. Illinois law does not provide many details, rather simply directs the Illinois Department of Financial and Professional Responsibility to adopt regulations, noting that an employment requirement may be included in the final regulations. Finally, some states specify that the offer of employment must be from an employer in a rural or underserved area. Notably, having an offer of employment is a key requirement in obtaining an H1B visa.

   Several states also indicate the applicant must have a work authorization, which would be required of non-U.S. citizens to obtain federal immigration status.

5. *Possess federal immigration status to practice as a physician in the U.S.*

   Many states also indicate that the applicant must possess federal immigration status to practice as a physician in the U.S. For example, Idaho states that the applicant must be eligible to obtain federal immigration status that allows the applicant to practice as a physician in the U.S. Iowa simply states that the applicant must possess federal immigration status. Even if this requirement is not mentioned in the statute, possessing federal immigration status will be required of all non-U.S. citizens practicing medicine in the U.S.

6. *Require supervision of those with provisional license*

   Six states, Idaho, Indiana, Minnesota, Nevada, Oklahoma, and Wisconsin, require internationally trained physicians with a provisional license to be supervised by a fully licensed physician. Idaho's statute indicates that international physicians with a provisional license must have an offer for employment at a sponsoring entity that operates in the state of Idaho and employs a supervising physician who is (1) licensed in Idaho and in good standing with the board; (2) is board-certified; and (3) has institutional privileges. Wisconsin indicates that provisional licensees may practice medicine and surgery only under the supervision of a physician. Indiana specifies that the individual must work in collaboration with a supervising physician. In Oklahoma, the limited licensee must by supervised by the chair of the department within the applicant's intended practice.

7. *Creates a provisional license category that could convert to a full license to practice medicine if licensee meets certain conditions*

   Almost all of these states would create a provisional licensure category for internationally trained physicians who meet the standards and requirements for application. States vary in the length of the provisional license from two to three years. Most of the states indicate that the provisional license may convert to a full license to practice medicine after the provisional stage and certain conditions are met (i.e. no disciplinary actions), leaving discretion up to the state medical board. In Indiana, the provisional license can be renewed biennially but not for more than six years and can be converted to a full license after five years. When Tennessee amended their 2023 law in 2024, they amended the language that would have required a provisional license to automatically convert to a full license to practice medicine, instead providing discretion

to the board. Rhode Island in unique in creating a one-year limited license which can be renewed two times for a total of three years for physicians in primary care and may be renewed additional times for licensees in other specialties to meet the total number of years required for ACGME-accredited residency programs. Wisconsin is one of the only states that would automatically convert a three-year provisional license to a full license to practice medicine, stating "[a] provisional license to practice medicine and surgery … shall be converted into a license to practice medicine and surgery … after the provisional license holder practices medicine and surgery full-time in this state and maintains good standing for three consecutive years."[2] Similarly, North Carolina's law specifies that the board shall grant a full license to an applicant who has completed four years of active practice in North Carolina and meets other requirements.[3] Notably, Florida does not categorize the license as "provisional" but requires the applicant to maintain employment with the original employer or another health care provider in the state for at least two consecutive years after license. Similarly, Louisiana does not categorize the license as provisional and requires the licensee to practice in a facility owned or operated by a hospital licensed in the state. Texas grants an initial provisional license but only allows these individuals to practice in a facility or group practice setting with an ACGME or AOA residency program or an ACGME or AOA affiliated setting. After two years the board can renew the provisional license for individuals who have passed USMLE Steps 1 and 2 and hold a valid certificate issued by ECFMG but limit their practice settings to a rural community or medically underserved area that has a current shortage of physicians.

Advisory Commission on Additional Licensing Models

In response to the escalation of state legislation, the Federation of State Medical Boards (FSMB), the Accreditation Council for Graduate Medical Education (ACGME) and Intealth have created an "Advisory Commission on Additional Licensing Models" aimed at providing guidance on additional licensing pathways of physicians who have completed training and/or practiced medicine outside the U.S. The AMA is represented on the commission by Sanjay Desai, MD, Chief Academic Officer. On Oct. 2, 2024, the Advisory Commission released an initial set of recommendations on the topic and a second set of draft recommendations for comment through July 11, 2025.

[2] Wis. Ann. Stat. 448.04.

[3] North Carolina Gen. Stat. 90-12.03(d).

AMA policy

Licensure for International Medical Graduates Practicing in U.S. Institutions with Restricted Medical Licenses D-255.977

Our AMA will advocate that qualified international medical graduates have a pathway for licensure by encouraging state medical licensing boards and the member boards of the American Board of Medical Specialties to develop criteria that allow: (1) completion of medical school and residency training outside the U.S.; (2) extensive U.S. medical practice; and (3) evidence of good standing within the local medical community to serve as a substitute for U.S. graduate medical education requirement for physicians seeking full unrestricted licensure and board certification.

Policy Timeline: CME Rep. 2, A-21

Abolish Discrimination in Licensure of IMGs H-255.966

1. Our AMA supports the following principles related to medical licensure of international medical graduates (IMGs):

A. State medical boards should ensure uniformity of licensure requirements for IMGs and graduates of U.S. and Canadian medical schools, including eliminating any disparity in the years of graduate medical education (GME) required for licensure and a uniform standard for the allowed number of administrations of licensure examinations.

B. All physicians seeking licensure should be evaluated on the basis of their individual education, training, qualifications, skills, character, ethics, experience and past practice.

C. Discrimination against physicians solely on the basis of national origin and/or the country in which they completed their medical education is inappropriate.

D. U.S. states and territories retain the right and responsibility to determine the qualifications of individuals applying for licensure to practice medicine within their respective jurisdictions.

E. State medical boards should be discouraged from a) using arbitrary and non-criteria-based lists of approved or unapproved foreign medical schools for licensure decisions and b) requiring an interview or oral examination prior to licensure endorsement. More effective methods for evaluating the quality of IMGs' undergraduate medical education should be pursued with the Federation of State Medical Boards (FSMB) and other relevant organizations. When available, the results should be a part of the determination of eligibility for licensure.

2. Our AMA will continue to work with the FSMB to encourage parity in licensure requirements for all physicians, whether U.S. medical school graduates or international medical graduates.

3. Our AMA will continue to work with the Educational Commission for Foreign Medical Graduates and other appropriate organizations in developing effective methods to evaluate the clinical skills of IMGs.

4. Our AMA will work with state medical societies in states with discriminatory licensure requirements between IMGs and graduates of U.S. and Canadian medical schools to advocate for parity in licensure requirements, using the AMA International Medical Graduate Section licensure parity model resolution as a resource.

5. Our AMA will: (a) encourage states to study existing strategies to improve policies and processes to assist IMGs with credentialing and licensure to enable them to care for patients in underserved areas; and (b) encourage the FSMB and state medical boards to evaluate the progress of programs aimed at reducing barriers to licensure--including successes, failures, and barriers to implementation.

Policy Timeline: BOT Rep. 25, A-15Appended: CME Rep. 4, A-21

AMA Principles on International Medical Graduates H-255.988

Our AMA supports:

1. Current U.S. visa and immigration requirements applicable to foreign national physicians who are graduates of medical schools other than those in the United States and Canada.

2. Current regulations governing the issuance of exchange visitor visas to foreign national IMGs, including the requirements for successful completion of the USMLE.

3. The AMA reaffirms its policy that the U.S. and Canada medical schools be accredited by a nongovernmental accrediting body.

4. Cooperation in the collection and analysis of information on medical schools in nations other than the U.S. and Canada.

5. Continued cooperation with the ECFMG and other appropriate organizations to disseminate information to prospective and current students in foreign medical schools. An AMA member, who is an IMG, should be appointed regularly as one of the AMA's representatives to the ECFMG Board of Trustees.

6. Working with the Accreditation Council for Graduate Medical Education (ACGME) and the Federation of State Medical Boards (FSMB) to assure that institutions offering accredited residencies, residency program directors, and U.S. licensing authorities do not deviate from established standards when evaluating graduates of foreign medical schools.

7. In cooperation with the ACGME and the FSMB, supports only those modifications in established graduate medical education or licensing standards designed to enhance the quality of medical education and patient care.

8. The AMA continues to support the activities of the ECFMG related to verification of education credentials and testing of IMGs.

9. That special consideration be given to the limited number of IMGs who are refugees from foreign governments that refuse to provide pertinent information usually required to establish eligibility for residency training or licensure.

10. That accreditation standards enhance the quality of patient care and medical education and not be used for purposes of regulating physician manpower.

11. That AMA representatives to the ACGME, residency review committees and to the ECFMG should support AMA policy opposing discrimination. Medical school admissions officers and directors of residency programs should select applicants on the basis of merit, without considering status as an IMG or an ethnic name as a negative factor.

12. The requirement that all medical school graduates complete at least one year of graduate medical education in an accredited U.S. program in order to qualify for full and unrestricted licensure. State medical licensing boards are encouraged to allow an alternate set of criteria for granting licensure in lieu of this requirement: (a) completion of medical school and residency training outside the U.S.; (b) extensive U.S. medical practice; and (c) evidence of good standing within the local medical community.

13. Publicizing existing policy concerning the granting of staff and clinical privileges in hospitals and other health facilities.

14. The participation of all physicians, including graduates of foreign as well as U.S. and Canadian medical schools, in organized medicine. The AMA offers encouragement and assistance to state, county, and specialty medical societies in fostering greater membership among IMGs and their participation in leadership positions at all levels of organized medicine, including AMA committees and councils, the Accreditation Council for Graduate Medical Education and its review committees, the American Board of Medical Specialties and its specialty boards, and state boards of medicine, by providing guidelines and non-financial incentives, such as recognition for outstanding achievements by either individuals or organizations in promoting leadership among IMGs.

15. Support studying the feasibility of conducting peer-to-peer membership recruitment efforts aimed at IMGs who are not AMA members.

16. AMA membership outreach to IMGs, to include a) using its existing publications to highlight policies and activities of interest to IMGs, stressing the common concerns of all physicians; b) publicizing its many relevant resources to all physicians, especially to nonmember IMGs; c) identifying and publicizing AMA resources to respond to inquiries from IMGs; and d) expansion of its efforts to prepare and disseminate information about requirements for admission to accredited residency programs, the availability of positions, and the problems of becoming licensed and entering full and unrestricted medical practice in the U.S. that face IMGs. This information should be addressed to college students, high school and college advisors, and students in foreign medical schools.

17. Recognition of the common aims and goals of all physicians, particularly those practicing in the U.S., and support for including all physicians who are permanent residents of the U.S. in the mainstream of American medicine.

18. Its leadership role to promote the international exchange of medical knowledge as well as cultural understanding between the U.S. and other nations.

19. Institutions that sponsor exchange visitor programs in medical education, clinical medicine and public health to tailor programs for the individual visiting scholar that will meet the needs of the scholar, the institution, and the nation to which he will return.

20. Informing foreign national IMGs that the availability of training and practice opportunities in the U.S. is limited by the availability of fiscal and human resources to maintain the quality of medical education and patient care in the U.S., and that those IMGs who plan to return to their country of origin have the opportunity to obtain GME in the United States.

21. U.S. medical schools offering admission with advanced standing, within the capabilities determined by each institution, to international medical students who satisfy the requirements of the institution for matriculation.

22. The Federation of State Medical Boards, its member boards, and the ECFMG in their willingness to adjust their administrative procedures in processing IMG applications so that original documents do not have to be recertified in home countries when physicians apply for licenses in a second state.

23. Continued efforts to protect the rights and privileges of all physicians duly licensed in the U.S. regardless of ethnic or educational background and opposes any legislative efforts to discriminate against duly licensed physicians on the basis of ethnic or educational background.

24. Continued study of challenges and issues pertinent to IMGs as they affect our country’s health care system and our physician workforce.

25. Advocacy to Congress to fund studies through appropriate agencies, such as the Department of Health and Human Services, to examine issues and experiences of IMGs and make recommendations for improvements.

Policy Timeline: BOT Rep. Z, A-86Reaffirmed: Res. 312, I-93Modified: CME Rep. 2, A-03Reaffirmation I-11Reaffirmed: CME Rep. 1, I-13Modified: BOT Rep. 25, A-15Modified: CME Rep. 01, A-16Appended: Res. 304, A-17Modified: CME Rep. 01, I-17Reaffirmation: A-19Modified: CME Rep. 2, A-21Modified: CME Rep. 1, A-22Modified: CCB/CLRPD Rep. 1, A-22Reaffirmed: CME Rep. 03, A-23

Credentialing Issues D-275.989

Our AMA encourages state medical licensing boards, the Federation of State Medical Boards, and other credentialing entities to accept certification by the Educational Commission for Foreign Medical Graduates (a member of Intealth) as proof of primary source verification of an IMG's international medical education credentials.

Policy Timeline: CME Rep. 3, A-02Appended: CME Rep. 10, A-11Modified: CME Rep. 1, A-21Modified: CME Rep. 08, A-23

Employment of Non-Certified IMGs H-255.970

Our AMA will: (1) oppose efforts to employ graduates of foreign medical schools who are neither certified by the ECFMG (a member of Intealth) nor have met state criteria for full licensure; and (2) encourage states that have difficulty recruiting doctors to underserved areas to explore the expanded use of incentive programs such as the National Health Service Corps or J-1 or other visa waiver programs.

Policy Timeline: Res. 309, A-03Reaffirmed: CME Rep. 2, A-13Modified: CME Rep. 01, A-23

Alternatives to the Federation of State Medical Boards Recommendations on Licensure H-275.934

Our AMA adopts the following principles:

(1) Ideally, all medical students should successfully complete Steps 1 and 2 of the United States Medical Licensing Examination (USMLE) or Levels 1 and 2 of the Comprehensive Osteopathic Medical Licensing Examination (COMLEX USA) prior to entry into residency training. At a minimum, individuals entering residency training must have successfully completed Step 1 of the USMLE or Level 1 of COMLEX USA. There should be provision made for students who have not completed Step 2 of the USMLE or Level 2 of the COMLEX USA to do so during the first year of residency training.

(2) All applicants for full and unrestricted licensure, whether graduates of U.S. medical schools or international medical graduates, must have completed one year of accredited graduate medical education (GME) in the U.S., have passed all state-required licensing examinations (USMLE or COMLEX USA), and must be certified by their residency program director as ready to advance to the next year of GME and to obtain a full and unrestricted license to practice medicine. State medical licensing boards are encouraged to allow an alternate set of criteria for granting licensure in lieu of this requirement for completing one year of accredited GME in the U.S.: (a) completion of medical school and residency training outside the U.S.; (b) extensive U.S. medical practice; and (c) evidence of good standing within the local medical community.

(3) There should be a training permit/educational license for all resident physicians who do not yet have a full and unrestricted license to practice medicine. To be eligible for an initial training permit/educational license, the resident must have completed Step 1 of the USMLE or Level 1 of COMLEX USA.

(4) Residency program directors shall report only those actions to state medical licensing boards that are reported for all licensed physicians.

(5) Residency program directors should receive training to ensure that they understand the process for taking disciplinary action against resident physicians, and are aware of procedures for dismissal of residents and for due process. This requirement for residency program directors should be enforced through Accreditation Council for Graduate Medical Education accreditation requirements.

(6) There should be no reporting of actions against medical students to state medical licensing boards.

(7) Medical schools are responsible for identifying and remediating and/or disciplining medical student unprofessional behavior, problems with substance abuse, and other behavioral problems. as well as gaps in student knowledge and skills.

(8) The Dean's Letter of Evaluation should be strengthened and standardized, to serve as a better source of information to residency programs about applicants.

Policy Timeline: CME Rep. 8, A-99Reaffirmed: CME Rep. 4, I-01Reaffirmed: CME Rep. 2, A-11Modified: CME Rep. 2, A-12Modified: CME Rep. 2, A-21