LEGISLATIVE RESEARCH & GENERAL COUNSEL

Bill Summary

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4th Substitute S.B. 31: Office of Professional Licensure Review Amendments

4th Substitute S.B. 31, "Office of Professional Licensure Review Amendments" addresses licensing and regulations for a variety of healthcare professionals licensed by the Division of Professional Licensing (DOPL). The professions affected by the bill include physical therapists and occupational therapists, certified registered nurse anesthetists (CRNAs), advanced practice registered nurses (APRNs), registered nurses (RNs), athletic trainers, respiratory care practitioners, physician assistants (PAs), and acupuncturists. This document highlights key provisions in the bill, compares the changes of the bill to current statute and other state laws, and highlights some of the impacts of potential changes.

Key Points

Physical Therapy and Occupational Therapy

- Permits therapists to prescribe durable medical equipment
- Grants physical therapists the ability to order medical imaging
- Addresses scope of practice for physical therapy assistants and aides

Nursing

- Grants limited perioperative prescriptive authority to CRNAs
- Mandates pre-licensure clinical nursing experience for APRNs
- Extends the time an RN student may serve as an apprentice
- Clarifies that minor surgical procedures are within the APRN scope of practice

Athletic Training

- Clarifies the scope of practice regarding occupational injuries and when a trainer is required to collaborate with a licensed physician

Respiratory Care

- Creates a respiratory care apprentice license

Physician Assistance

- Reduces the number of practical hours required for PA licensees to obtain full practice authority
- Clarifies that minor surgical procedures are within the PA scope of practice

Acupuncture

- Grants rulemaking authority to authorize substances for injection therapy
- Allows acupuncturists to delegate supportive tasks to an unlicensed acupuncture aide

Physical & Occupational Therapy

High-Level

This bill would expand the definition of dry needling as allowed under the scope of practice, permit physical therapists to prescribe durable medical equipment (DME), and allow physical therapists to order medical imaging. Additionally, it would modify the scope of practice for physical therapy assistants and aides regarding joint mobilization techniques. For occupational therapists, this bill would permit licensed therapists to prescribe DME and grant rulemaking authority to DOPL to regulate the supervision of occupational therapy assistants.

In 2014[1], dry needling was added to the scope of practice for physical therapists; in 2025[2], it was expanded to occupational therapists. Dry needling, as the bill defines, is the practice of using needles to puncture the skin and underlying tissue for the purpose of evaluating and treating disabilities, movement disorders, neuromusculoskeletal conditions, and pain. This expands the current scope of practice, which permits dry needling only on trigger points.[3] Among states that permit therapists to perform dry needling, Utah is an outlier in terms of adopting this restriction on the practice.[4]

	Physical Therapist	Occupational Therapist
Current Prescribing Authority		
Adaptive Devices	✓	✗
Orthotic Devices	✓	✗
Prosthetic Devices	✓	✗
Expanded Prescribing Authority		
Adaptive Devices		✓
Durable Medical Equipment	✓	✓

Table 1. Prescribing authority for physical therapists and occupational therapists under current law and expanded under the provisions of this bill.[5]

Under the provisions of the bill, physical therapists and occupational therapists would be permitted to prescribe durable medical equipment to patients, and occupational therapists would be permitted to prescribe adaptive devices. Therapists would not be required to consult or request the prescription from a licensed physician. This expansion would add to the list of current prescribing authority for therapists, which is demonstrated by Table 1 on the left.

The final change to scope of practice for physical therapists involves ordering of medical imaging. While physical therapists currently have statutory authority to order X-Ray and MRI imaging[6], it does not encompass the full breadth of imaging and diagnostic practices taught in physical therapy school. The bill would remove the restriction on the type of imaging, effectively permitting a physical therapist to order any imaging study; however, a physical therapist is still bound by statutory requirements to collaborate with a physician, including obtaining an agreement from the physician to accept the imaging and requirements to refer a patient to a licensed physician for anything beyond the therapist's scope of practice.

Lastly, the bill addresses scope of practice for physical therapy aides and assistants regarding joint mobilization techniques. Joint mobilization is a type of manual therapy defined by DOPL as, "a continuum of

[1] Enacted by H.B. 367, "Physical Therapy Scope of Practice Amendments"
[2] Enacted by H.B. 188, "Dry Needling Amendments".
[3] "Trigger point" refers to a painful or irritable band of muscular tissue colloquially described as "knots".
[4] Based on a policy scan conducted by the Office of Professional Licensure Review in their 2025 Periodic Review of Physical Therapy.
[5] Scopes of practice provided for physical therapy and occupational therapy under Utah Code Ann. § 58-24b-102 and Utah Code Ann. § 58-42a-102, respectively.
[6] Utah Code Ann. § 58-54-303

skilled passive movements to a joint or related soft tissue that is applied at varying speeds and amplitudes".[7] Physical therapy assistants and aides[8] are currently prohibited from engaging in any joint mobilization therapy. Under the provisions of the bill, this prohibition would be narrowed to only include **high-thrust** joint mobilization therapies, with an additional restriction placed on physical therapy aides that permits only simple joint distraction, stretching, or mobilization that is part of a home exercise program.

Nursing

High-Level

This bill would grant limited perioperative prescriptive authority to CRNAs, require APRN licensure applicants to obtain a minimum number of hours of clinical nursing experience, increase the amount of time that undergraduate nursing students may serve as a registered nurse apprentice, and clarify that APRNs may perform minor surgical procedures.

In the Office of Professional Licensure Review's 2025 Periodic Review of Advanced Practice Registered Nursing, the office identified circumstances where a patient receives care and is unable to obtain prescription medications for pre- or post-operative care due to a lack of provider ability. The report identified that CRNAs, who often participate in procedures in rural areas and other instances where anesthesiologists are less available, receive graduate training in pharmacology and could supplement CRNAs in a limited window. The bill would permit a CRNA to prescribe medication, including Schedule II-V controlled substances, to a patient in a period not to exceed five days before or after a procedure. The ability to prescribe substances would be restricted to procedures performed in a health care facility[9], private physician office, or a dentist office with the participation of the CRNA that has an established patient record with the patient, and the prescription must be related to the procedure.

For APRN's, the bill would create a new requirement that applicants obtain a minimum of **2,000 hours** of clinical nursing experience before licensure. Clinical nursing experience hours must be obtained as either a registered nurse or as a student in a nursing education program. Based on current accreditation requirements[10], an APRN graduate will obtain approximately 1,250 hours of clinical experience through undergraduate and graduate programs. The remaining 750 hours of experience must be obtained either before or after completing graduate school, or some combination thereof. Figure 1 below shows two possible paths to licensure for an APRN applicant. Finally, the bill would clarify the scope of practice for APRNs to explicitly include "minor surgical procedures".

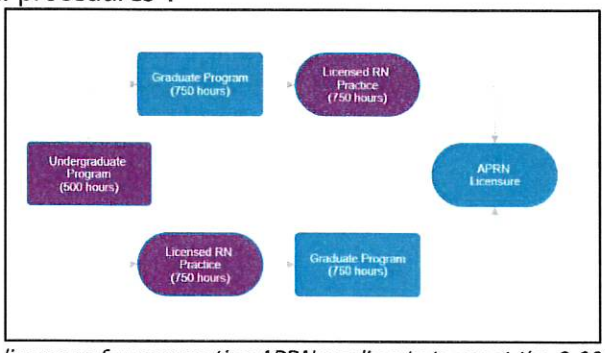

Figure 1. Possible pathways to licensure for prospective APRN applicants to meet the 2,000-hour experience requirement.

[7] Utah Admin. Code R156-24b-102(7)
[8] A physical therapy assistant is a licensed professional that performs physical therapy services under the general supervision of a licensed physical therapist, whereas a physical therapy aide is an unlicensed individual that functions to provide assistance to a physical therapist or physical therapy aide and may not engage in the practice of physical therapy.
[9] As defined under Utah Code Ann. § 26B-2-201(13)
[10] Nursing education programs are accredited by the Commission on Collegiate Nursing Education.

Current RN students may practice under supervision as an RN intern during their final semester of schooling. The bill would permit an RN student to serve as an intern during their final **two** semesters of schooling, similar to the provision added for the respiratory care apprentice license.

Athletic Training

High-Level

This bill would expand the scope of athletic trainer practice to explicitly permit them to work in occupational settings, create new restrictions on athletic trainers that require them to collaborate with a licensed physician for certain types of injuries, and mandate cardiac care certification.

The athletic trainer scope of practice explicitly covers injuries that affect an athlete's performance in "sports, games, recreation, or exercise" or are identified for training services by a licensed physician.[11] It is unclear whether this scope of practice would cover injuries occurring due to occupational activities, potentially removing an opportunity for athletic trainers to provide services for private employees. This bill would expand the scope of practice to explicitly include injuries due to an occupational activity as within the scope of athletic training.

For injuries that are within the scope of practice for trainers, current law requires the trainer to operate under written training protocols or receive orders from a physician before performing rehabilitation. In effect, this requires an athletic trainer to collaborate with a physician prior to treating an injury regardless of the injury's type, severity, or the trainer's relative level of expertise. The bill would remove the requirement for written protocols or plans and replace it with provisions allowing athletic trainers to work independently of a collaborating physician unless the injury presents a level of risk or complexity that requires physician collaboration.

Under the provisions of the bill, an athletic trainer would be required to collaborate with a physician for an injury that meets all of the following:

1. Beyond the scope of practice or expertise of the athletic trainer;
2. A suspected head injury or traumatic brain injury, including concussions; and
3. Unresponsive to current treatment.

For work that requires collaboration with a physician, the collaboration must be recorded by the athletic trainer.

Finally, the bill would require applicants for licensure as an athletic trainer to provide evidence that they have received certification in emergency cardiac care. This education could come as part of their national certification offered through the Board of Certification, or if the applicant chooses an alternative certification approved by DOPL, they may need to obtain an additional third-party certificate to ensure a minimum level of emergency cardiac care competency.

[11] Utah Code Ann. § 58-40a-102(3)

Respiratory Care

High-Level

This bill would reinstate and modify the respiratory care apprentice license, which allows an individual to perform limited respiratory care services under supervision during the final year of education leading towards a respiratory care practitioner license.

Prior to 2006[12], an individual that had graduated from a respiratory care education program but not yet passed their required examinations could practice as a respiratory care practitioner under direct supervision using a respiratory care interim permit. The bill would reinstate this practice and create the respiratory care apprentice license. Whereas the previous interim permit could only be granted post-graduation, the bill would extend this period to a student during the **final year** of their program. A student would be required to receive permission from their school to apply for license, which would remain valid until the licensee received a full license, had their full license application denied, terminated their enrollment, or 60 days after graduation, whichever comes first.

Holders of a respiratory care apprentice license would have a limited scope of practice that would prohibit them from performing high-risk procedures or working on critical care patients. For any care that does fall under the scope of practice, the licensee must work under the indirect supervision[13] of a licensed respiratory care practitioner.[14]

Physician Assistance

High-Level

This bill would grant DOPL rulemaking authority to determine additional accrediting bodies for PA education, decrease the number of post-graduation clinical hours required before a PA obtains full practice authority from 10,000 to 8,500, and clarify that PAs may perform minor surgical procedures.

Currently, only individuals that attend a school accredited by the Accreditation Review Commission on Education for the Physician Assistant (ARC-PA) are eligible for PA licensure. The bill would grant rulemaking authority to DOPL to designate other education accrediting bodies. A student that graduated from a school accredited by one of these accrediting bodies would be equally eligible for licensure. This change mirrors similar language the bill inserts into the practice acts for CRNAs, and nurse midwives.

The bill would also amend the number of post-graduation clinical experience hours a PA licensee would be required to obtain before gaining full practice authority. Under the provisions of the bill, the number of required hours would be decreased from **10,000** to **8,500**. Licensees under the clinical experience threshold are required by statute to operate under written policies with their practice that governs how and when the PA will collaborate with a licensed physician. Finally, the bill would clarify the scope of practice for physician assistants to explicitly include "minor surgical procedures".

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[12] The respiratory care interim permit was repealed by H.B. 262, "Respiratory Care Amendments", which passed during the 2006 General Session.

[13] "Indirect supervision" is defined by rule for various practice acts under Utah Admin. Code R156 and typically requires that the supervisor be available present at the *location* where the service is being performed, but does not necessarily require that the supervisor be in the same room as the supervisee while the service is being performed.

[14] According to the Office of Professional Licensure Review in their 2025 Periodic Review of Respiratory Care, during the time that the state issued interim permits DOPL did not receive any substantiated complaints against an apprentice.

Table 2 on the right shows the number of clinical hours required in states that allow some degree of independent PA practice for comparison to the amended provision the bill provides. While the bill would decrease the number of hours to gain full practice authority, it does **not** amend the statutory requirement for PAs to directly collaborate with a physician for the first 4,000 of post-graduate experience.

State	Hours Required
Wyoming	0[15]
North Dakota	4,000
South Dakota	6,000
Montana	8,000
New Hampshire	8,000
Utah	**10,000 (8,500)**

Table 2. Post-graduate clinical hours required for PA full practice authority among states allowing independent PA practice.[16]

Acupuncture

High-Level

This bill would grant DOPL additional rulemaking authority around injection therapy for acupuncturists, allowing the division to define the minimum coursework and experience to perform injection therapy and add new items to the list of approved sterile substances. Additionally, the bill would allow acupuncturists to delegate supporting services to be carried out by an unlicensed aide under supervision.

Injection therapy is the process of injecting sterile substances under the skin or into muscular tissue at located acupuncture points to deliver a therapeutic benefit. While allowed under current law, acupuncturists are required to obtain certification of clean needle technique from the National Commission for the Certification of Acupuncture and Oriental Medicine (NCCAOM) before providing the therapy. State statute also restricts the types of substances an acupuncturist may inject to seven categories.[17] Under the provisions of the bill, DOPL would have rulemaking authority to determine appropriate coursework and supervised experience for injection therapy rather than relying on NCCAOM certification. Additionally, while the list of permitted substances in statute would remain the same, an additional provision would be added giving rulemaking authority to DOPL to add new substances to the list over time.

In line with eight other states[18], the bill would permit delegation of certain supportive tasks from an acupuncturist to an aide. Aides would not be required to hold licensure but would be required to have some training regarding clean needle technique whether through certification, coursework, or other experience as DOPL deems adequate. The scope of practice for an acupuncture aide would be defined by rule, but at no point may an aide be permitted to perform diagnosis, point location, needle insertion, electrical stimulation, or provide advice to a patient. In carrying out their delegated services, the acupuncture aide would be required to be indirectly supervised by a licensed acupuncturist.

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[15] Under legislation passed in 2021, physician assistants are granted independent practice authority from the moment of licensure and do not require any additional supervisory period.
[16] Based upon data collected by the Office of Professional Licensure Review in their 2025 Periodic Review of Physician Assistants.
[17] Utah Code Ann. § 58-72-102(2)(a) permits injection of a nutritional substance, a local anesthetic, autologous blood (if the acupuncturist also holds a phlebotomy certificate), sterile water, dextrose, sodium bicarbonate, and sterile saline.
[18] Based on a policy scan performed by the Office of Professional Licensure Review in their 2025 Periodic Review of Acupuncturists.