SB 1451 Comments Received during 45-Day Post Notice Period

Nurse Practitioner

1) **LETTER 1 - CALIFORNIA DERMATOLOGY ADVOCACY NETWORK**
2) **LETTER 2 - CALIFORNIA MEDICAL ASSOCIATION**
3) **LETTER 3 - CALIFORNIA STATE ASSOCIATION OF PSYCHIATRISTS**
4) **LETTER 4 – CALIFORNIA SOCIETY OF PHYSICAL MEDICINE AND REHABILITATION**
5) **LETTER 5 – INDIVIDUAL COMMENTER**

California Dermatology
ADVOCACY NETWORK

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August 24, 2026

Marissa Clark
Board of Registered Nursing
1747 N. Market Blvd. Suite 150
Sacramento, CA 95834

RE: Proposed Rules For Nurse Practitioners

Dear Ms. Clark:

On behalf of the California Dermatology Advocacy Network (CDAN), representing dermatologists and dermatologic surgeons throughout California, we write to the California Board of Registered Nursing (BRN) to express several concerns regarding the proposed rules for 103 and 104 nurse practitioners.

The California Board of Nursing has proposed new rules for 103/104 nurse practitioners to "remove barriers to practice" for nurse practitioners to work without standardized procedures or physician supervision in California. Understanding the fundamental flaw in this reasoning requires an examination of the training and practice of nurse practitioners.

Nurse practitioners are registered nurses with master's-level degrees who have been given special dispensation to provide clinical services that are traditionally performed by physicians. These include making patient assessments, ordering and interpreting tests, medications, and devices. Importantly, these services are provided under standardized procedures and the direct supervision of a physician. Although different terminology has been applied to these services performed by nurse practitioners, they fundamentally constitute the supervised practice of medicine. **But once physician supervision and standardized procedures are removed, it is simply the practice of medicine.**

Comment 1-A

Training and Competency

The first nurse practitioners in the 1970s had no standardized training curricula to follow. Informal training was conducted in the clinic by a physician. Accordingly, clinical tasks and the complexity of patients under their care was matched to their training.

Over the past two and one-half decades, nurse practitioner training in the US has become only less rigorous and remains entirely unstandardized. Nurse practitioners do not go to medical school. They receive only a tiny fraction of the clinical training hours that physicians receive. Moreover, nurse practitioners are never given detailed education on the complexity of human disease and treatments as medical students and residents. Most, if not all, of NP training programs can be completed online without ever touching a patient. NP candidates must arrange their own clinical preceptorships to meet a 500-750 self-reported hour requirement to practice (compared to 10,000-17,500 hours for physicians). It is not uncommon for NP graduates to have vastly disparate training experiences and qualifications – even from the same program and graduation year. Indeed, this lack of academic uniformity has raised alarms among nursing educators about the lack of qualifications and competencies of new nurse practitioner graduates entering the clinical workforce[1].

Comment 1-B

Despite the lack of minimum standards and significant variability in their training, nurse practitioners commonly work in fields for which they have received no formal training. Competency in a specialty is generally determined by hours worked rather than through any formal training or evaluation. For physicians, competency is determined by a combination of clinical hours, completion of required curricula, passage of national exams, and observation of skills by faculty and mentors.

Comment 1-B

Without proper preparation for practice and proper assessment of clinical competency, the rules proposed by the BRN would establish a healthcare system where patients are met by practitioners with vastly different qualifications and training. This would result in a two-tiered healthcare system in California, for which there is no justification. The only way we ensure that all Californians receive access to the highest quality health care is to rigorously hold all practitioners to the same standard of competency and care.

Training is not a barrier to clinical practice; it is essential for clinical practice.

AB890/SB1451

Both AB890 (2020) and SB1451 (2023) recognized that nurse practitioners training programs do not give nurse practitioners the credentials and experience to practice independently in California. AB890 called for the creation of a Transition to Practice (TTP). Specifically, that 103 and 104 NP applicants must complete a 3 year or 4600-hour preceptorship in one of six (6) areas of population health focus for which the NP is certified. SB1451 further clarified that the 103/104 applicant need not complete the TTP in the same area of population health focus as the preceptor.

The six areas of population focus category identified by AB890/SB1451:

- Family/individual across the lifespan;
- Adult-gerontology, primary care or acute care;
- Neonatal;
- Pediatrics, primary care or acute care;
- Women's health/gender-related;
- Psychiatric-mental health across the lifespan.

Proposed BRN Rule for Nurse Practitioners holding Pre-2017 Certifications

The BRN has proposed the following changes to section 1481(b)(1):

> (b) Nurse Practitioners who have met the additional training and experience requirements can apply to the board for an expanded scope of practice, and work without standardized procedures, in a population focus category outlined in (a) or a population focus category whose exam was retired before January 1, 2017 by a national certifying body accredited by the National Commission for Certifying Agencies or the American Board of Nursing Specialties under these two categories:
>
> (1) A nurse practitioner practicing pursuant to Section 2837.103 of the code may perform the functions listed in Section 2387.103(c) of the code without standardized procedures only in a group setting ~~and in the category listed in subdivision (a) of this regulation in which the applicant is certified as a nurse practitioner pursuant to Section 2837.103 of the code.~~

The plain reading of this proposed rule is that nurse practitioners whose certification exam was retired prior to 2017 may practice according to Section 2387.103(c) (without standardized procedures) *in any clinical specialty*. **This would constitute a scope expansion via BRN rulemaking for a subset of nurse practitioners whose certification was not considered in either AB890 or SB1451.**

Comment 1-C

Even if the Board believes that the chaptered legislation applies to NPs with pre-2017 certifications, AB890 intended for 103 nurse practitioners to practice in only one of the six categories of population focus. SB1451 permitted the TTP to be completed in a different population health category than the applicant was certified in. Neither of the enacted bills intended for 103 or 104 nurse practitioners to practice in any area outside of the six categories identified in AB890/SB1451.

Comment 1-D

Statutory Authority of the Board

The California Board of Nursing is constrained in its authority under the Nursing Practice Act. As such, it cannot amend chaptered legislation or exploit rulemaking to exceed the stated text and spirit of chaptered regulations.

SB1451 only enabled the BRN to modify the hours that DNP applicants could use toward their 104 applications. Neither SB1451 nor AB890 authorized the BRN to amend the chaptered regulations.

Comment 1-E

If adopted, the addition of the above text to 1481(b)(1) and deletion of text would constitute an excess of the board's statutory authority.

CDAN is very concerned about the proposed amendments to section 1481(b)(1). These changes are inconsistent with the enacted regulations nor the spirit of the original legislation. **CDAN implores the board to restore the original text for subsection 1481(b)(1) in its proposed rules. If the board wishes to expand the chaptered regulations detailed in AB890 and SB1451 to cover another subset of nurse practitioners, it should work with the legislature to effect such changes.**

Comment 1-F

Clarification on the Transition to Practice (TTP)

On its website, the BRN defines the Transition to Practice (TTP) as (ref):

> According to BPC Section 2837.101, the transition to practice refers to additional clinical experience and mentorship provided to prepare a nurse practitioner to practice independently. This includes, but is not limited to, managing a panel of patients, working in a complex health care setting, interpersonal communication, interpersonal collaboration and team-based care, professionalism, and business management of a practice.

Comment 1-G

This definition of clinical practice does not identify minimum competency requirements for independent practice. There is no mandate to log clinical hours, patient cases. There is no requirement to demonstrate competency in particular clinical scenarios or an understanding of important clinical conditions relevant to the category of population focus. Under this broad definition, a TTP could be as rigorous as managing complex patients in an Intensive Care Unit (ICU) or as unregulated as a mobile IV hydration business.

CDAN acknowledges that AB890/SB1451 placed the BRN in an unusual role of creating training requirements for the TTP and tracking 103/104 applicant competency upon completion. This responsibility might be more appropriate for a training program than for a licensing board. However, SB1451 effectively removed all legal liability from the attesting physician/104 NP for the applicant's subsequent actions. *This leaves the BRN itself as a liable entity for certifying the 103/104 applicant to*

practice medicine independently. Without any real metrics to assess applicant's competency prior to entering practice, and no way to verify the attestation for the TTP was truthful, the BRN has no way to defend itself from harm caused to patients by its licensee.

The BRN was directed by statute to ensure that 103 and 104 NPs have the appropriate qualifications for unsupervised practice in their category of population health. In recognizing the training disparities of nurse practitioner 103/104 applicants, **we request that the BRN continue to work with physician and nurse practitioner stakeholders to establish minimum competencies for the TTP.** Comment 1-H

While SB 1451 permitted the completion of the TTP in a different category than the applicant's certification, the legislation still intended for the applicant to complete the TTP in one of the six categories of population health. **We request that the BRN clarify in its rules and on its website, the appropriate population focus categories available for the completion for the TTP in accordance with AB890 and SB1451.** Comment 1-I

Clarification of BRN Website Regarding 103/104 Application

Furthermore, on its website, the BRN indicates that the applicant can obtain their NP certification "during or after" completing the TTP so long as the applicant receives their national certification before submitting the 103 application to the board. (https://www.rn.ca.gov/practice/ab890.shtml) Comment 1-J

This posted information contradicts the enacted regulations that clearly state the TTP must be completed *after* certification of the nurse practitioner by the BRN. It also presents a legal dilemma because (if the BRN website information were correct) the applicant would assume the role of nurse practitioner in the TTP *without the proper credential*. The TTP requires the applicant to practice as a nurse practitioner. The applicant would, in essence, be practicing nursing without a proper license under this scenario.

Verification and Validation of the Transition to Practice

SB1451 clarified that the attestor for the 103/104 NP applicant can only remark about the applicant's completion of the program. The attestor cannot provide commentary on the applicant's competency or performance during the TTP. Furthermore, per statute, the attestor is immune from civil and criminal prosecution for the actions of the applicant.

CDAN requests that the BRN provide clarification for the following:

- **How will the BRN monitor preceptorships of the TTP to verify that they meet the statutory criteria and prepare NPs for practice?** Comment 1-K
- **How will the BRN ensure that a 103/104 NP who trains in one focus category has the competence to practice in another?** Comment 1-L
- **What steps will the BRN take to ensure/verify that a physician/104 NP attestor does not falsify the attestation of a TTP?** Comment 1-M

Medical Title Transparency

The proposed rules allow 103/104 nurse practitioners to use the titles "103 NP" and "104 NP" to identify themselves to patients. However, if the practitioner does not identify themselves as a "nurse practitioner", then how would a patient be expected to know that a 103 or 104 is a nurse practitioner? What meaning does the 103 NP or 104 NP designation communicate to the patient? How will patients **Comment 1-N**

be able to verify the credentials of the nurse practitioner? Will the BRN maintain a registry of 103 and 104 nurse practitioners on its public database?

Comment 1-O

Recent survey data in California has demonstrated significant medical title confusion among patients [2]. Indeed, Californians are demanding to know the meaning of the medical title and the practitioner's qualifications as a precondition for receiving care. This is an essential and necessary component of informed consent. Furthermore, AB890 was drafted in the hopes of bringing health care to California's farming and vulnerable populations, many of whom are non-English speaking. The permission to use "made up" medical titles that do not communicate the practitioner's qualifications will only further harm and confuse these vulnerable citizens in our state.

CDAN strongly encourages the BRN to maintain a public database of all 103 and 104 nurse practitioners with information about their national certification, transition to practice category, and current area of practice.

Comment 1-P

Furthermore, CDAN strongly recommends that the BRN require 103 and 104 nurse practitioners to communicate to patients that they are nurse practitioners, regardless if they use the title of 103/104 colloquially.

Comment 1-Q

The California Dermatology Advocacy Network appreciates the opportunity to raise its concerns about the proposed rules to the Board of Registered Nursing. We welcome continued engagement and feedback so that we can optimize these proposed rules. As dermatologists, we are experts in our practice and look forward to working with your board to ensure that every Californian receives equal access to the highest quality health care.

Warmly,

Ann Haas

Ann F. Haas, MD
Board-Certified Dermatologist
President, California Dermatology Advocacy Network (CDAN)

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[1] Phillips AW, Sites JP, Quenzer FC, Lercher DM. Effects of Non-physician Practitioners on Emergency Medicine Physician Resident Education. West J Emerg Med. 2023 May 3;24(3):588-596. doi: 10.5811/westjem.58759. PMID: 37278773; PMCID: PMC10284528.
[2] Newman EM, Haas AF, Levin PR, Menor CM, Hernandez Conte A. Patient Understanding of Health Care Practitioner Titles -A California Survey. Dermatol Surg. 2026 Mar 1;52(3):273-277. doi: 10.1097/DSS.0000000000004807. Epub 2025 Aug 26. PMID: 40856352; PMCID: PMC12935176.

CALIFORNIA MEDICAL ASSOCIATION

August 25, 2026

Marissa Clark
Board of Registered Nursing
1747 N. Market Blvd. Suite 150
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Sent via e-mail to brn.regulations@dca.ca.gov

RE: Proposed regulatory action concerning Nurse Practitioners, Noticed July 10, 2026

Dear Ms. Clark:

On behalf of our over 50,000 physician and medical student members, the California Medical Association (CMA) submits the following comments in response to the Board of Registered Nursing's (Board) proposed regulatory action related to Nurse Practitioners.

1. Maintain the requirement that 103 NPs practice within their population focus category (§§ 1481(b)(1), 1482.3(a)(12), and 1482.3(b))

CMA urges the Board to retain the existing requirement that a nurse practitioner (NP) practicing pursuant to Business and Professions Code (BPC) section 2837.103 perform functions without standardized procedures only within the category of the NP's national certification. Specifically, the Board should retain the category-alignment language proposed for deletion from sections 1481(b)(1) and 1482.3(a)(12) and require a 103 NP to maintain an active national certification in the category in which the NP practices. Requiring practice within an NP's population focus category is an important patient-safety safeguard consistent with the Board's statutory obligation to make protection of the public its highest priority (BPC § 2708.1). The Board's Initial Statement of Reasons (ISOR) itself explains that licensure and professional certification standards require NPs to achieve and maintain a minimum level of competency that promotes quality of care and patient safety. The Board further states that maintaining an active national certification helps ensure that 103 NPs remain current and competent in their practice. Those protections are substantially weakened if an NP provides care outside the category of their national certification.

Comment 2-A

The work performed by the Office of Professional Examination Services (OPES) further supports retaining this requirement. OPES did not conduct a single, generalized analysis of NP competency. Instead, its occupational analysis expressly sought to identify the critical

competencies necessary for an NP to practice safely and effectively "within their specialty" and produced eight separate "specialty descriptions of practice".[1] The resulting national examination reviews then linked each certification examination to its corresponding California description of practice. For example, OPES evaluated whether the pediatric acute care examination assessed the competencies needed for pediatric acute care practice and whether the adult-gerontology primary care examination assessed the competencies needed for adult-gerontology primary care practice. In each report, OPES supported use of the examination for practice in the corresponding category; it did not conclude that passage of an examination in one category demonstrated competency to practice in another. Removing this requirement would therefore disconnect an NP's practice authority from the competencies actually assessed. Comment 2-B

In support of the proposed deletion, the ISOR states that stakeholders identified the existing limitation as a potential "barrier to care," that removing it would provide flexibility based on the needs of licensees and employers, and that the limitation is not expressly mandated by statute. The absence of an express statutory mandate, however, does not establish that the existing requirement is unnecessary or that removing it is consistent with public protection. The ISOR also does not identify the nature or extent of the asserted barrier, explain which categories are affected, or demonstrate that permitting cross-category practice would not create additional risks to patients. The needs of a licensee or employer do not establish that an individual NP possesses the education and competency necessary to care for a different patient population. Although increasing access to care is an important objective, BPC section 2708.1 requires the Board to make public protection paramount whenever it conflicts with another interest. Access should not be expanded by treating distinct, population-specific certifications as interchangeable without evidence that they assess equivalent competencies.

Maintaining the requirement that an NP practice within the category of their national certification is particularly important because the proposal would also recognize legacy certifications for purposes of 103 NP eligibility. As the ISOR acknowledges, OPES was unable to compare the competencies assessed by the discontinued legacy examinations with the competencies identified in its occupational analysis. SB 1451 exempted examinations discontinued before January 1, 2017, from that assessment, thereby removing the OPES comparison requirement for those examinations. That statutory accommodation does not constitute an affirmative determination that a legacy examination validates competency outside the population focus it covered. Legacy certifications should support practice

[1] Department of Consumer Affairs, Office of Professional Examination Services, *Occupational Analysis of the Nurse Practitioner Practice and Practice Specialties* (July 2022), p. iii, https://www.rn.ca.gov/pdfs/forms/oa_report-np.pdf.

without standardized procedures only within their corresponding population focus and should not serve as a basis for practice in unrelated categories.

Accordingly, CMA requests that the Board retain the language requiring that an NP practice within the category of their national certification proposed for deletion from sections 1481(b)(1) and 1482.3(a)(12) and revise section 1482.3(b) to require a 103 NP to maintain an active national certification corresponding to the category in which the NP practices pursuant to section 2837.103. For an NP relying on a legacy certification, the regulation should similarly limit practice without standardized procedures to the population focus corresponding to that certification. To avoid excluding those applicants, the restored category-alignment language in section 1482.3(a)(12) should be conformed to encompass the legacy population-focus certifications recognized under section 1481(b).

For these reasons, we ask that the Board replace the stricken language in sections 1481(b)(1) and 1482.3(a)(12) with the revised language shown in bold and underline below:

> 1481(b)(1) A nurse practitioner practicing pursuant to Section 2837.103 of the code may perform the functions listed in Section ~~**2387.103(c)**~~ **2837.103(c)** of the code without standardized procedures only in a group setting ~~and in the category listed in subdivision (a) of this regulation in which the applicant is certified as a nurse practitioner pursuant to Section 2837.103 of the code~~ **and in the population focus category in which the applicant is certified as a nurse practitioner pursuant to Section 2837.103 of the code**.
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> 1482.3(a)(12) Proof of holding a certification as a nurse practitioner by a national certification organization accredited by the National Commission for Certifying Agencies or the Accreditation Board for Specialty Nursing Certification (ABSNC) ~~as a nurse practitioner in the category listed in Section 1481(a) in which the applicant seeks certification as a nurse practitioner pursuant to Section 2837.103 of the code~~ **as a nurse practitioner in the population focus category in which the applicant seeks certification as a nurse practitioner pursuant to Section 2837.103 of the code**. Verification of this certification shall be provided directly to the Board by the issuing organization.

Comment 2-A

CMA also requests the following revision to section 1482.3(b):

> (b) Maintenance of an active national certification in a **population focus** category ~~**listed**~~ **described** in Section 1481 **in which the nurse practitioner is certified and practices pursuant to Section 2837.103 of the code** is required to work under the provisions of Section 2837.103. Verification of certification renewal must be maintained by the licensee and provided to the Board or an employer upon request.

2. Require recent qualifying experience for 104 NP certification and limit DNP credit to hours completed while holding a 103 NP certification (§ 1482.4(a)(13))

CMA requests that the Board revise proposed section 1482.4(a)(13) to require the qualifying practice pursuant to BPC section 2837.103, consisting of at least three full-time equivalent years or 4,600 hours in direct patient care, to be completed within the five years preceding the date of application for 104 NP certification, to fulfill the Board's statutory obligation to make protection of the public its highest priority (BPC § 2708.1). Recency of practice is necessary to ensure competent, safe patient care. Any direct patient care hours obtained during a Doctor of Nursing Practice (DNP) program and credited toward that requirement should likewise be subject to the same five-year period. In addition, DNP clinical hours should be eligible for credit only if they were completed while the applicant held a valid and active 103 NP certification. Comment 2-C

The purpose of the three-year or 4,600-hour requirement is to ensure that an applicant has sufficient experience before receiving the broader practice authority available through 104 NP certification. Experience gained many years before an application does not provide the same evidence that an applicant is familiar with current clinical practices, standards of care, and research. Without a defined period in which the experience must be completed, an applicant could qualify based partly or entirely on hours accumulated long before applying for 104 NP certification. Requiring the qualifying experience to have been completed within the preceding five years would ensure that it meaningfully reflects the applicant's current readiness for 104 NP practice.

The Board's ISOR for the original AB 890 rulemaking supports applying a recency requirement here.[2] In that rulemaking, the Board explained that health care is rapidly evolving and that an NP must remain familiar with current best practices, community standards of care, and research. The Board therefore concluded that recent clinical practice is "of the utmost importance" when determining whether an NP is qualified to practice without standardized procedures and that the relevant clinical practice should occur within the preceding five years. That five-year requirement applied to transition-to-practice hours rather than the separate three-year or 4,600-hour requirement, but the same rationale supports requiring the experience used to establish readiness for 104 NP practice to be recent.

The Board should also require that any DNP clinical hours credited toward the three-year or 4,600-hour requirement be completed while the applicant held a valid and active 103 NP certification. Without that limitation, educational experience completed before 103 NP

[2] Board of Registered Nursing, *Initial Statement of Reasons: Categories and Scope of Practice of Nurse Practitioners, Requirements for a Nurse Practitioner Pursuant to Business and Professions Code Sections 2837.103 and 2837.104, and Notice to Consumers* (Sept. 1, 2022), p. 16, https://www.rn.ca.gov/pdfs/regulations/isor-ab890.pdf.

certification could be used to reduce the post-certification experience otherwise required for 104 NP eligibility. This requirement would preserve recognition of qualifying doctoral experience while ensuring that only hours completed after the applicant obtained 103 NP certification are credited.

Because 104 NP certification permits practice without standardized procedures outside the group settings applicable to 103 NPs, the Board should ensure that the experience supporting that additional authority is both recent and appropriately connected to the applicant's progression from 103 NP to 104 NP practice. Applying a five-year period to all qualifying experience and requiring credited DNP hours to have been completed while the applicant held a 103 NP certification would promote protection of the public in accordance with BPC section 2708.1, while continuing to recognize relevant doctoral clinical education.

Thus, CMA requests the following revisions to section 1482.4(a)(13):

> (13) Proof of practice as a nurse practitioner pursuant to Section 2837.103 of the code in good standing for at least three full-time equivalent years or 4600 hours in direct patient care **within five years prior to the date the applicant applies for certification as a nurse practitioner pursuant to Section 2837.104 of the code**.
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> * * *
>
> (B) For an applicant who holds a Doctorate of Nursing Practice degree (DNP), "practice as a nurse practitioner pursuant **to** Section 2837.103 of the code in good standing" also includes any hours of direct patient care that the applicant provided in the course of their doctoral education so long as the direct patient care is ~~**both**~~ **all of the following:** (i) in the applicant's area of National Certification specified in subdivision (a)(12)**,** ~~**and**~~ (ii) provided during the doctoral part of the applicant's doctoral education and not credited towards the applicant's master's degree**, and (iii) provided within the five years preceding the date the applicant applies for certification pursuant to Section 2837.104 of the code while the applicant held a valid and active certification as a nurse practitioner pursuant to Section 2837.103 of the code**. An applicant must provide verification on a form provided by the Board and signed by the Program Director of The Nurse Practitioner Program from the academic institution where the doctoral education was completed as to the number of eligible hours the applicant fulfilled. The form must be submitted to the Board through the Board's online portal accessible through the Board's website.

Comment 2-C

3. Require 104 NPs to verify active national certification at renewal (§ 1482.4(c))

CMA requests that the Board revise proposed section 1482.4(c) to require a 104 NP to submit verification that their national certification remains active at each renewal of the NP's registered nursing license and nurse practitioner certificate, in the interest of prioritizing protection of the public. Under the proposed regulation, verification of national certification renewal would be maintained by the 104 NP and provided to the Board or an employer only upon request. Requiring an NP to retain documentation is not equivalent to requiring the Board to verify compliance. Without routine verification, the Board may have no indication that a national certification has expired and no reason to request the documentation. Comment 2-D

The Board's ISOR recognizes that active national certification helps ensure that 104 NPs remain current and competent. It also explains that renewal of national certification generally requires continuing education, clinical practice, or a combination of both. Verification at renewal would therefore provide the Board with evidence that a 104 NP continues to satisfy a requirement the Board itself identifies as a safeguard for current competency.

Routine verification is particularly important for 104 NPs because they may practice without standardized procedures outside the group settings applicable to 103 NPs. A 104 NP practicing outside a group setting may not be subject to an employer or institutional credentialing process that independently confirms the status of the NP's national certification. Although proposed section 1482.4(c) contemplates that an employer may request verification, that mechanism provides no protection when the 104 NP practices without an employer. The Board should therefore directly verify continued national certification as part of the existing renewal process. This would impose no new substantive qualification and would simply confirm compliance with a condition the regulation already requires.

If the Board declines to require verification from 104 NPs at renewal, the regulation should, at a minimum, establish a regular audit process modeled on the Board's existing audits of continuing-education compliance. Under that approach, each 104 NP should attest at renewal that their national certification remains active, retain supporting documentation, and submit that documentation when selected for audit. Although an audit system would provide less assurance than verification at every renewal, it would create a defined mechanism for monitoring compliance and would be preferable to relying on an unspecified request that may never occur. Comment 2-D

Accordingly, CMA's preferred approach is for the Board to revise proposed section 1482.4(c) as follows:

(c) Maintenance of an active national certification in a **population focus** category ~~listed~~ **described** in Section 1481 in which the applicant seeks certification as a nurse practitioner pursuant to Section 2837.104 of the code, is required to work under the provisions of Section 2837.104. Verification of **an active national** certification ~~renewal~~ must be maintained by the licensee**,** ~~**and**~~ provided to the Board **upon each renewal of the licensee's registered nursing license and nurse practitioner certificate,** ~~or~~ **and provided to** an employer upon request.

Thank you for consideration of CMA's comments. Should you have questions, please do not hesitate to contact me at (916) 444-5532 or levensen@cmadocs.org.

Sincerely,

Lucas Evensen

Lucas Evensen
Associate Director, Strategic Engagement
California Medical Association

CSAP
CALIFORNIA STATE ASSOCIATION OF PSYCHIATRISTS

August 25, 2026

Marissa Clark
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Sent via e-mail to brn.regulations@dca.ca.gov

RE: Proposed regulatory action concerning Nurse Practitioners, Noticed July 10, 2026

Dear Ms. Clark:

On behalf of thousands of psychiatrists in California, the California State Association of Psychiatrists (CSAP) submits the following comments in response to the Board of Registered Nursing's (Board) proposed regulatory action related to Nurse Practitioners (NPs).

Overall, the Board is proposing that the training requirements and verification procedures for 103/104s largely disappear. And this is in happening before even the first 104 has entered practice later this year. The Board should be concerned about regulatory overreach.

The proposed regulations propose to contravene SB 1451 regarding informed consent and title transparency for NPs. For example, you are proposing to remove the requirements to inform patients that the practitioner is an NP and not a physician and remove the requirement to inform patients that they have a right to see a physician. These were hard fought pieces of SB 1451 and there is data to show strong confusion among patients regarding NP vis à vis physician roles in healthcare. The Attorney General's Office can refuse to approve a business name if it is misleading to a reasonable consumer, e.g. "medical corporation" indicates that certain services will be provided with certain qualifications. Given this constraint on medical doctors trying to open corporations, it would seem additionally contradictory as state policy to allow for a different level of regulation when it comes to consumer notification of NPs' qualification / background. Comment 3-A

The BRN cannot ignore statute, nor can it over-interpret statute. Any effort to do so could potentially be subject to challenge. With this in mind, CSAP's specific comments on the proposed regulations are as follows:

1. **§ 1481. Categories and Scope of Practice of Nurse Practitioners**

Removing the requirement for practice in the same category of certification will create concerns regarding clinical competence. The Board should supply an evidentiary bas is Comment 3-B

for its discretionary expansion of cross-category 103 NP practice. Employer demand / stakeholder feedback is not evidence that individual NPs can competently diagnose / treat a substantially different clinical population. If the argument is that NPs obtaining cross-category authority will practice in underserved areas, the Board should disclose the supporting evidence. A less risky alternative would be to define a cross-category bridge pathway involving relevant education, supervised practice, and verification of competency.

2. **§ 1482. Requirements for Certification As a Nurse Practitioner.**

Removing the requirement for equivalency of training to an academically affiliated NP program indicates that any domestic educational program would suffice when it will not. Comment 3-C

3. **§ 1482.3. Requirements for a Nurse Practitioner Certification Pursuant to Business and Professions Code Section 2837.103.**

The proposed regulations would remove the existing requirement for national certification to be in the same specialty category as the intended practice category - again indicating that certification (reflecting a certain amount of training) in a practice category will not be a requirement for independent practice in that category. Based on the proposal, if an NP had focused their training / experience completed TTP and certification in neonatal medicine, but then wanted to switch to practicing in psychiatry, they would be able to do so without obtaining supervised practice hours and national certification in psychiatry. This would be a critical removal of the necessary training and competence standards.

Comment 3-D

Additionally, because the proposal would permit 103 NPs national certification, TTP experience, Board certification category, and current clinical practice area to diverge, no one will truly know a NP's qualifications. Patients, employers, pharmacists, and consulting physicians need a reliable public record of any NP's training qualifications.

Most NP training programs require NP students to seek "hours" of clinical experience anywhere they can get them. There is no clinical / teaching standard for these preceptorships (several nursing journals have published critical positions on this fact). Oftentimes, programs will give some students retroactive "credit" for hours worked in unrelated fields.

4. **§ 1482.4. Requirements for a Nurse Practitioner Certification Pursuant to Business and Professions Code Section 2837.104**

Again, this would inappropriately remove the requirement for same-category national certification as well as the requirement for attestation from a physician or NP regarding transition to practice. This would be a significant reduction in the existing supervision requirement and should be rejected. Comment 3-E

This is one example of where the BRN should be careful not to overstep and attempt to over-interpret statute. SB1451 prohibits the TTP supervisor from commenting on the

competence of the applicant to the BRN but it does NOT eliminate the attestation entirely. If there is no attestation then there is essentially no TTP. Consequently, anyone with an NP degree would a de facto 103/104 just by claiming to be one.

Yes, the Board need not ask an attester to render a global competency opinion prohibited by statute, but it should verify that the required TTP experiences occurred. Comment 3-E

SB 1451 broadened the requirements for 103s to work in virtually any medical setting for the TTP. But it did not do away the restrictions on familial and financial relationships between the attestor and the applicant.

A DNP is an academic credential and does not itself establish experience operating without standardized procedures. The Board should require primary-source documentation describing the setting, supervision, patient population, clinical responsibilities, and number of direct-care hours. Simulation, quality-improvement projects, observation, administrative work, and hours already credited to another degree or transition requirement should be expressly excluded. Comment 3-F

CSAP believes that this would wrongly interpret statute, which directs the circumstances when the NP shall consult and collaborate with a physician. As we hope you are aware, there is a separate section regarding referrals as follows:

"The nurse practitioner shall consult and collaborate with other healing arts providers based on the clinical condition of the patient to whom health care is provided. Physician consultation shall be obtained as specified in the individual protocols and under the following circumstances:
(A) Emergent conditions requiring prompt medical intervention after initial stabilizing care has been started.
(B) Problem which is not resolving as anticipated after an ongoing evaluation and management of the situation. Comment 3-G
(C) History, physical, or lab findings inconsistent with the clinical perspective.
(D) Upon request of patient.
(3) Nurse practitioner consultation with a physician and surgeon alone shall not create a physician-patient relationship. The nurse practitioner shall be solely responsible for the services they provide.
(4) The nurse practitioner shall establish a plan for referral of complex medical cases and emergencies to a physician and surgeon or other appropriate healing arts providers. The nurse practitioner shall have an identified referral plan specific to the practice area, that includes specific referral criteria. The referral plan shall address the following:
(A) Whenever situations arise which go beyond the competence, scope of practice, or experience of the nurse practitioner.
(B) Whenever patient conditions fail to respond or the patient is acutely decompensating in a manner that is not consistent with the progression of the disease and corresponding treatment plan.
(C) Any patient with a rare condition.
(D) Any patient conditions that do not fit the commonly accepted diagnostic pattern for a

disease or disorder.
(E) All emergency situations after initial stabilizing care has been started."

Removing the consumer notification requirements will further contribute to patient confusion regarding practitioner roles; it is very important that patients are told the differences between practitioners, and so that they can make an informed decision regarding whether they want to request care from a physician. Comment 3-H

Thank you for consideration of CSAP's comments. Should you have questions, please do not hesitate to contact me at (916) 446-4656 or paul@syaslpartners.com.

Sincerely,



Paul J. Yoder
Managing Director
California State Association of Psychiatrists

CALIFORNIA **S**OCIETY OF **P**HYSICAL **M**EDICINE AND **R**EHABILITATION

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August 25, 2026

California Board of Registered Nursing
1747 N. Market Blvd., Suite 150
Sacramento, CA 95834

RE: **Public Comment – Deep Concerns Regarding Proposed Scope-of-Practice Changes to 103 and 104 Nurse Practitioner Regulations and Regulatory Process**

To the Members of the California Board of Registered Nursing,
I am writing to formally submit my public comment regarding the Board of Registered Nursing's (BRN) proposed changes to the 103 and 104 Nurse Practitioner regulations. While these regulations significantly alter the landscape of healthcare delivery in California, I must express profound concern regarding both the substance of these scope-of-practice expansions and the administrative process by which they have been introduce.

Scope-of-practice expansions are not mere administrative adjustments—they are major clinical decisions with real, lasting consequences for patient outcomes. When a regulatory body moves significant scope changes forward, it must be done with the utmost transparency and stakeholder engagement. However, the timing of the BRN's recent announcement appears strategically positioned to minimize, if not entirely prevent, formal policy debate. By releasing this major regulatory proposal immediately after the 2026 California Medical Association (CMA) House of Delegates (HOD) resolution window closed, the BRN effectively logistically blocked California physicians from participating in the structured policy-setting processes designed to evaluate patient safety and clinical risk. Comment 4-A

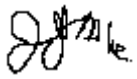
Whether intentional or not, the outcome of compressing these timelines was the exclusion of essential physician voices at the exact moment they were most critical. This situation is not an isolated event; rather, it reflects a broader, deeply concerning pattern of advancing expansions for nurse practitioners while minimizing the involvement of California physicians and the CMA.

Repeatedly bypassing meaningful physician participation signals an underlying intent to reshape healthcare delivery without the input of those most qualified to speak to

diagnostic complexity, clinical risk, and patient safety. This approach actively undermines collaborative practice models and erodes the vital safeguards that protect patients from fragmented or inconsistent standards of care.

California patients deserve a regulatory environment where critical healthcare decisions are made openly, inclusively, and with the highest level of clinical expertise at the table. I urge the Board to pause these advancements and establish a process that guarantees accountability, full transparency, and robust physician participation in all future actions impacting scope of practice.

Sincerely,



Jeffrey Young, MD
CSPM&R- endorses this letter

August 25, 2026

California Board of Registered Nursing
1747 N. Market Blvd., Suite 150
Sacramento, CA 95834

RE: Public Comment – Deep Concerns Regarding Proposed Scope-of-Practice Changes to 103 and 104 Nurse Practitioner Regulations and Regulatory Process

Dear Ms. Clark:

I am writing to formally submit my public comment regarding the Board of Registered Nursing's (BRN) proposed changes to the 103 and 104 Nurse Practitioner regulations. While these regulations significantly alter the landscape of healthcare delivery in California, I must express profound concern regarding both the substance of these scope-of-practice expansions and the administrative process by which they have been introduced.

Scope-of-practice expansions are not mere administrative adjustments—they are major clinical decisions with real, lasting consequences for patient outcomes. When a regulatory body moves significant scope changes forward, it must be done with the utmost transparency and stakeholder engagement. However, the timing of the BRN's recent announcement appears strategically positioned to minimize, if not entirely prevent, formal policy debate. By releasing this major regulatory proposal immediately after the 2026 California Medical Association (CMA) House of Delegates (HOD) resolution window closed, the BRN effectively logistically blocked California physicians from participating in the structured policy-setting processes designed to evaluate patient safety and clinical risk.

Comment 5-A

Whether intentional or not, the outcome of compressing these timelines was the exclusion of essential physician voices at the exact moment they were most critical. This situation is not an isolated event; rather, it reflects a broader, deeply concerning pattern of advancing expansions for nurse practitioners while minimizing the involvement of California physicians and the CMA.

Repeatedly bypassing meaningful physician participation signals an underlying intent to reshape healthcare delivery without the input of those most qualified to speak to diagnostic complexity, clinical risk, and patient safety. This approach actively undermines collaborative practice models and erodes the vital safeguards that protect patients from fragmented or inconsistent standards of care.

California patients deserve a regulatory environment where critical healthcare decisions are made openly, inclusively, and with the highest level of clinical expertise at the table. I urge the Board to pause these advancements and establish a process that guarantees accountability, full transparency, and robust physician participation in all future actions impacting scope of practice.

Sincerely,



LETTER 1 - CALIFORNIA DERMATOLOGY ADVOCACY NETWORK

Comment 1-A
The commenter asserts that removing the requirement for standardized procedures allows nurse practitioners (NP) to practice medicine and appeared to oppose the regulatory proposal. The commenter points to NP functions also performed by physicians such as patient assessments, ordering and interpreting tests, medications, and devices.

Response 1-A
The Board has reviewed and considered the comment and declines to make any amendments to the proposed text based thereon.

Nurse practitioners may only perform the functions authorized within their scope of practice as outlined in California Nursing Practice Act. The existence of overlapping duties among the scope of practice for different types of licensed healthcare providers is common and not unique to nurse practitioners and physicians.

According to Business and Professions Code (BPC) section 2725(a), the Legislature recognizes nursing as a dynamic field that is continually evolving to include more sophisticated patient care activities. BPC section 2725(a) also codifies the Legislature's attempt to recognize the existence of overlapping functions between physicians and registered nurses and to permit additional sharing of functions within organized health care systems that provide for collaboration between physicians and registered nurses.

BPC section 2837.103 and BPC section 2837.104 already allow for certain NPs in certain settings to practice without standardized procedures. To the extent the comment opposes regulatory amendments related to statutory updates, the Board is aligning regulation with statute and has no authority to amend the statute through this regulation package.

Comment 1-B
The commenter opined that NP training has become less rigorous and unstandardized, and they do not go to medical school and receive less training than physicians. There is variance in education and clinical training that has potentially caused educators to question the impact on competency. The commenter claims that regulation amendments would establish a healthcare system with practitioners of different qualifications.

Response 1-B
The Board has reviewed and considered the comment and declines to make any amendments to the proposed text based thereon.

While the regulatory text sections include requirements for certification, the text is being updated to align with statute that the legislature already enacted through passage of Assembly Bill (AB) 890 (Wood, Chapter 265, Statutes of 2020) and SB 1451 (Ashby, Chapter 481, Statutes of 2024). The Board has no authority to amend the statute

through this regulation package.

Comment 1-C
The commenter asserts that the proposed changes to 16 CCR 1481(b)(1), which adds language allowing the acceptance of national certification exams retired before January 1, 2017, and removes language that limited 103 NPs to only practicing without standardized procedures in the population focus category they are nationally certified in, constitutes a scope expansion through regulations for a subset of nurse practitioners whose certification was not considered in either AB 890 or SB 1451.

Response 1-C
The Board has reviewed and considered the comment and declines to make any amendments to the proposed text based thereon.

At the national level, various population focus categories of nurse practitioners have been established over the years (e.g., family, adult-gerontology, neonatal, psychiatric-mental health, etc.). Over time, and with the adoption of the National Council of State Boards of Nursing (NCSBN) Advanced Practice Registered Nurse (APRN) Consensus Model, several categories of NP have been "retired" with new yet similar categories at the population focus level being introduced.

For the categories that have been retired (e.g., acute care, adult, etc.) NPs that have already obtained certifications in those categories can continue to renew and retain them, but other NPs cannot newly obtain those certifications. These retired categories, often referred to as legacy certifications, are still recognized for license renewal, license endorsement, and practice purposes.

AB 890 contained the following requirements under BPC 2837.105(a) related to national NP certification exams:

- The Board shall request the Department of Consumer Affairs (DCA) Office of Professional Examination Services (OPES), or an equivalent organization, to perform an occupational analysis of nurse practitioners performing the functions specified in subdivision (c) of Section 2837.103.

- The Board, together with the DCA OPES, shall assess the alignment of the competencies tested in the national nurse practitioner certification examination required by subparagraph (A) of paragraph (1) of subdivision (a) of Section 2837.103 with the occupational analysis performed according to paragraph (1).

Because the legacy certifications had been phased out, there were no longer national NP certification exams in those categories. Consequently, at the time that OPES did its occupational analysis, it was technically impossible to fulfill the requirement to compare the occupational analysis with the competencies tested in the certification exams for those legacy certifications/exams.

To address this and ensure that legacy certifications would be accepted, SB 1451 amended BPC Section 2837.105(a)(2) to exempt national nurse practitioner certification examinations discontinued before January 1, 2017, from the OPES requirement. This change was made by the Legislature so that NPs that held a national certification within specified population foci whose exam was retired before January 1, 2017, could also be eligible to become 103 and 104 NPs.

To the extent the comment opposes regulatory amendments related to statutory updates, the Board is aligning regulation with statute and has no authority to amend the statute through this regulation package.

Comment 1-D
The commenter states that AB 890 intended for 103 nurse practitioners to practice in only one of the six categories of population focus and SB 1451 permitted the transition to practice (TTP) to be completed in a different population health category than the applicant was certified in. The commenter went on to state that neither bill intended for 103 or 104 nurse practitioners to practice in any area outside of the six categories identified in AB 890 and SB 1451.

Response 1-D
The Board has reviewed and considered the comment and declines to make any amendments to the proposed text based thereon.

Neither AB 890 nor SB 1451 identified specific categories of nurse practitioners. Rather, both bills cross reference BPC Section 2836 when referring to nurse practitioner categories. BPC Section 2836 states that the Board shall establish categories of nurse practitioners and standards for nurses to hold themselves out as nurse practitioners in each category. The Board fulfills this statutory requirement through promulgation of regulations.

The regulations also align with the APRN Consensus Model by only recognizing National Certifying exams at the population focus area of practice. The Board does not recognize any subspecialty area certifications within regulation as those certifications are assessed by the professional organizations, and not the state boards of nursing.

Comment 1-E
The commenter states that SB 1451 only enabled the Board to modify the hours that DNP applicants could use toward their 104 application and that neither SB 1451 nor AB 890 authorized the BRN to amend the chaptered regulations. The commenter states that if adopted, the addition of the above text to 1481(b)(1) and deletion of text would constitute an excess of the board’s statutory authority.

Response 1-E
The Board has reviewed and considered the comment and declines to make any amendments to the proposed text based thereon.

SB 1451 did not amend the provision regarding clinical hours an applicant with a Doctorate in Nursing Practice (DNP) can apply towards certification as a 104 NP. However, SB 1451 did make several other changes that directly conflicted with the current regulations thereby requiring the Board to amend the text for conformity purposes. BPC section 2715(c) grants the Board authority to adopt, amend, or repeal regulations that may be reasonably necessary to implement the Nurse Practice Act.

The Board stated its authority to adopt regulations on the Notice of Proposed Action at BPC section 2715 to implement, interpret, or make specific BPC sections 2837.101, 2837.103, 2837.104, and 2837.105.

Comment 1-F
The commenter expressed concerns that the proposed changes to section 1481(b)(1) are inconsistent with the current regulations and legislative intent. The commenter also stated that if the Board wishes to expand regulations to cover another subset of nurse practitioners, it should work with the legislature to effect such changes.

Response 1-F
The Board has reviewed and considered the comment and declines to make any amendments to the proposed text based thereon.

Please see response to Comment 1-C discussing NP categories and legacy certifications.

Comment 1-G
The commenter opined that the definition of transition to practice in BPC Section 2837.1 is insufficient as it does not identify competency requirements for independent practice, mandate to log clinical hours, or competency in particular clinical scenarios.

Response 1-G
The Board has reviewed and considered the comment and declines to make any amendments to the proposed text based thereon.

Please see response to Comment 1-B discussing the Board's lack of authority to amend the statute through the rulemaking process.

Additionally, BPC 2837.100 establishes Legislative intent for the requirements under Article 8.5 not to be an undue or unnecessary burden to the licensure or practice. It goes on to state that the requirements are intended to ensure the new category of licensed nurse practitioners has the least restrictive amount of education, training, and testing necessary to ensure competent practice.

Comment 1-H
The commenter states that the Board was directed by statute to ensure that 103 and 104 NPs have the appropriate qualifications for unsupervised practice in their category of population health. The commenter requests the Board continue to work with

physician and nurse practitioner stakeholders to establish minimum competencies for the TTP.

Response 1-H
The Board has reviewed and considered the comment and declines to make any amendments to the proposed text based thereon.

AB 890 required the Board to define minimum standards for a TTP through the issuance of regulations. The Board performed widespread outreach and engagement over a two-year period to inform the development of proposed regulatory text after passage of AB 890. Board staff received extensive input on proposed language from Board members, advisory committee members, and a wide variety of stakeholders. Central to this effort was guidance and direction provided by the Nurse Practitioner Advisory Committee (NPAC) which was established by AB 890 and is composed of nurse practitioners, physician members, and a public member.

The commenter did not explicitly suggest an amendment to the text, and no revisions to the text are not necessary.

Comment 1-I
The commenter stated that while SB 1451 permitted the completion of the TTP in a different category than the applicant's certification, the legislation still intended for the applicant to complete the TTP in one of the six categories of population health. The commenter requests the Board clarify in its rules and on its website, the appropriate population focus categories available for the completion for the TTP in accordance with AB 890 and SB 1451.

Response 1-I
The Board has reviewed and considered the comment and declines to make any amendments to the proposed text based thereon.

Please see response to Comment 1-C discussing NP categories and legacy certifications.

Comment 1-J
The commenter states that the Board's website indicates an applicant can obtain their NP certification "during or after" completing the TTP so long as the applicant receives their national certification before submitting their 103 NP application to the Board. The commenter states that this would result in unlicensed practice of NPs.

Response 1-J
The Board has reviewed and considered the comment and declines to make any amendments to the proposed text based thereon.

National certification from a professional organization is separate from certification by the Board in accordance with BPC Section 2835.5. The Board's website states that an

applicant can obtain their national certification during or after their TTP. National certification is only a requirement to practice as a 103 NP and 104 NPs. It is not a requirement to practice as a NP under standardized procedures during the TTP.

Comment 1-K
The commenter asks how the Board will monitor preceptorships of the TTP to verify that they meet the statutory criteria and prepare NPs for practice.

Response 1-K
The Board has reviewed and considered the comment and declines to make any amendments to the proposed text based thereon.

The Board utilizes the 103 NP application process to verify NPs have met the minimum standards of certification as a 103 NP set forth in statute and regulations. However, the clinical competency of individual licensees to perform their duties is validated at the facility level in accordance with Title 22 California Code of Regulations (CCR) Section 70016.1 and 70213.

Comment 1-L
The commenter asks how the Board will ensure that a 103 or 104 NP who trains in one focus category has the competence to practice in another.

Response 1-L
The Board has reviewed and considered the comment and declines to make any amendments to the proposed text based thereon.

For a 103 NP, please see response to Comment 1-K discussing the 103 NP application process.

For a 104 NP, the law states that they can only practice within the limits of their knowledge and experience and national certification.

Comment 1-M
The commenter asks what steps the Board will take to ensure/verify that 103 NP applicant's attestor does not falsify their attestation of a TTP.

Response 1-M
The Board has reviewed and considered the comment and declines to make any amendments to the proposed text based thereon.

The current attestation process requires the attesting provider to sign in through a state portal that verifies their identity using their licensing information. In accordance with BPC Section 2837.103(a)(1)(D)(iv), if the Board receives a complaint related to an attestation being made fraudulently, it will investigate and request documentation or other materials to verify the information that was attested to. If the complaint is substantiated and the attestor is a BRN licensee, then disciplinary action could

potentially be taken. This aligns with the Board's process for any alleged violation of the Nursing Practice Act by a licensee. If the attestor falls under the jurisdiction of another healing arts board, then the complaint would be referred to the appropriate licensing entity and follow their disciplinary pathway.

Comment 1-N
The commenter states that the proposed rules allow a 103 and 104 nurse practitioner to use the titles "103 NP" and "104 NP" to identify themselves to patients, but if the practitioner does not identify themselves as a "nurse practitioner", a patient cannot be expected to know that a 103 or 104 is a nurse practitioner.

Response 1-N
The Board has reviewed and considered the comment and declines to make any amendments to the proposed text based thereon.

The proposed text states that a nurse practitioner practicing pursuant to Section 2837.103 or 2837.104 of the code may be referred to colloquially as a "103 NP" or "104 NP." The term colloquially refers to speaking or writing in an informal way that is common in everyday, casual conversation rather than in formal settings.

These are offered as a shorthand alternative to using the statutory reference of "nurse practitioner practicing pursuant to Section 2837.103 or 2837.104" which is lengthier and potentially more confusing to a lay person. For example, the commenter used the terms 103 NP and 104 NP throughout their letter rather than the statutory terminology.

Title 22 CCR section 73529 requires all personnel and patients serving the public to wear name and title badges, unless otherwise stated by law. Additionally, BPC section 680 requires a health care practitioner to disclose, while working, their name and license status on a name tag in at least 18-point type.

Further, both statute and the proposed text require a 103 and 104 NP to inform all new patients in a language understandable to the patient that a nurse practitioner is not a physician and surgeon. They also require a 103 and 104 NP to post a notice in a conspicuous location accessible to public view that the nurse practitioner is regulated by the Board of Registered Nursing. The notice must include the Board's telephone number and internet website where the nurse practitioner's license may be checked and complaints against the nurse practitioner may be made.

Comment 1-O
The commenter asks how patients can verify the credentials of a nurse practitioner and whether the Board will maintain a registry of 103 and 104 nurse practitioners on its public database with certification information.

Response 1-O
The Board has reviewed and considered the comment and declines to make any amendments to the proposed text based thereon.

The public can access information on any Board licensee through the DCA website, DCA License Search. Each license record reflects whether a license or certification is current, expired, or has been subject to disciplinary action like suspension or revocation. It also provides information on whether a NP has been certified by the Board as 103 NP or 104 NP and the content area(s) of their national certification.

Comment 1-P
The commenter strongly encourages the Board to maintain a public database of all 103 and 104 nurse practitioners with information about their national certification, transition to practice category, and current area of practice.

Response 1-P
The Board has reviewed and considered the comment and declines to make any amendments to the proposed text based thereon.

Please see response to Comment 1-O discussing information publicly available on the Board's website.

Comment 1-Q
The commenter strongly recommends that the Board requires 103 and 104 nurse practitioners to communicate to patients that they are nurse practitioners.

Response 1-Q
The Board has reviewed and considered the comment and declines to make any amendments to the proposed text based thereon.

Please see response to Comment 1-N addressing licensee identification requirements.

LETTER 2 - CALIFORNIA MEDICAL ASSOCIATION

Comment 2-A
The commenter urges the Board to retain the existing requirement that a NP practicing pursuant to BPC section 2837.103 perform functions without standardized procedures only within the category of the NP's national certification. The commenter also states that the Board should retain the category-alignment language proposed for deletion from sections 1481(b)(1) and 1482.3(a)(12) and require a 103 NP to maintain an active national certification in the category in which the NP practices. The commenter asserts that doing so is inconsistent with the Board's charge of public protection.

Specifically, the suggested amendments are:

- Proposed Revision - 1481(b)(1) A nurse practitioner practicing pursuant to Section 2837.103 of the code may perform the functions listed in Section ~~**2387.103(c)**~~ **2837.103(c)** of the code without standardized procedures only in a group setting ~~and~~

~~in the category listed in subdivision (a) of this regulation in which the applicant is certified as a nurse practitioner pursuant to Section 2837.103 of the code~~ **and in the population focus category in which the applicant is certified as a nurse practitioner pursuant to Section 2837.103 of the code**.

- Proposed Revision - 1482.3(a)(12) Proof of holding a certification as a nurse practitioner by a national certification organization accredited by the National Commission for Certifying Agencies or the Accreditation Board for Specialty Nursing Certification (ABSNC) ~~as a nurse practitioner in the category listed in Section 1481(a) in which the applicant seeks certification as a nurse practitioner pursuant to Section 2837.103 of the code~~ **as a nurse practitioner in the population focus category in which the applicant seeks certification as a nurse practitioner pursuant to Section 2837.103 of the code**. Verification of this certification shall be provided directly to the Board by the issuing organization.

- Proposed Revision - 1482.3(b) Maintenance of an active national certification in a **population focus** category ~~listed~~ **described** in Section 1481 **in which the nurse practitioner is certified and practices pursuant to Section 2837.103 of the code** is required to work under the provisions of Section 2837.103. Verification of certification renewal must be maintained by the licensee and provided to the Board or an employer upon request.

Response 2-A
The Board has reviewed and considered the comment and declines to make any amendments to the proposed text based thereon.

The Board agrees with the proposed revision to update references to BPC Section 2387 to instead reference BPC Section 2837, as a non-substantive change to address a drafting error that references a BPC section that does not exist.

The Board declines the other proposed revisions as the statute does not restrict 103 NPs to only practicing within the population focus category of their national certification.

Changes made by SB 1451 allow for TTP experience to be completed in a different category of practice than the national certification held by the NP, reflecting legislative intent that 103 NP preparation and competency development do not need to be restricted to a single certification category.

Further, NPs practicing under standardized procedures have historically not been limited to a population focus category and have operated as generalists. Their clinical duties are determined by demonstrated competency as well as by the credentialing and privileging processes of the hiring facility. The statutory framework for 103 NPs aligns with this model by limiting practice to group settings where facility credentialing and interdisciplinary collaboration are in place. The group settings can determine appropriate clinical duties within the scope allowed by law, which provides sufficient public protection without an additional regulatory limitation.

Relatedly, since the 104 NP pathway removes the built-in quality assurance mechanisms present in a group setting, the law specifically states that they can only practice within the limits of education, training, and national certification. Thus, the proposed revisions are not necessary.

Comment 2-B

The commenter states that the analysis conducted by the DCA OPES supports retaining the requirement that NPs practice only within the category of their national certification. OPES did not perform a generalized evaluation of NP competency; instead, it conducted specialty-specific analyses, producing eight distinct descriptions of practice and confirming that each national certification examination evaluates competencies aligned only with its corresponding specialty. The commenter asserts that allowing NPs to practice outside their certification category would break the link between assessed competencies and authorized practice, thereby undermining patient safety.

Response 2-B

The Board has reviewed and considered the comment and declines to make any amendments to the proposed text based thereon.

Please see response to Comment 2-A which discusses NPs and TTP experience and practice authority allowance in differing categories.

Additionally, the Occupational Analysis (OA) conducted by OPES did not evaluate whether nurse practitioners should be restricted to practicing solely within the population-focus of their national certification. Rather, OPES was directed by AB 890 to determine whether current national certification examinations adequately assess the competencies required for NPs at the point they transition to independent practice or if the Board would have to develop a supplemental exam to do so.

Comment 2-C

The commenter requests that qualifying practice for 104 NP certification (three years or 4,600 hours of direct patient care) be completed within the five years preceding application, to ensure recency and competency. The commenter also recommends that Doctor of Nursing Practice (DNP) clinical hours credited toward this requirement be completed while holding a valid and active 103 NP certification.

Specifically, the suggested amendments are:

- Proposed Revision - 1482.4(a)(13) Proof of practice as a nurse practitioner pursuant to Section 2837.103 of the code in good standing for at least three full-time equivalent years or 4600 hours in direct patient care **within five years prior to the date the applicant applies for certification as a nurse practitioner pursuant to Section 2837.104 of the code**.

* * *

(B) For an applicant who holds a Doctorate of Nursing Practice degree, "practice as a nurse practitioner pursuant **to** Section 2837.103 of the code in good standing" also includes any hours of direct patient care that the applicant provided in the course of their doctoral education so long as the direct patient care is ~~**both**~~ **all of the following:** (i) in the applicant's area of National Certification specified in subdivision (a)(12)**,** ~~**and**~~ (ii) provided during the doctoral part of the applicant's doctoral education and not credited towards the applicant's master's degree**, and (iii) provided within the five years preceding the date the applicant applies for certification pursuant to Section 2837.104 of the code while the applicant held a valid and active certification as a nurse practitioner pursuant to Section 2837.103 of the code**. An applicant must provide verification on a form provided by the Board and signed by the Program Director of the Nurse Practitioner Program from the academic institution where the doctoral education was completed as to the number of eligible hours the applicant fulfilled. The form must be submitted to the Board through the Board's online portal accessible through the Board's website.

Response 2-C
The Board has reviewed and considered the comment and declines to make any amendments to the proposed text based thereon.

The Board declines the proposed revisions as the statute does not include a temporal limit on the qualifying hours for 104 NP certification or any applicable clinical hours completed as part of a DNP program.

Additionally, nursing literature such as Patricia Benner's Novice to Expert framework[1], suggests that many nurses tend to reach a stable, 'competent' level of practice after approximately two to three years of experience, indicating that the existing requirement of three years or 4,600 hours of qualifying direct patient care reflects a meaningful period of professional development without requiring an additional temporal restriction. This experience would be obtained during the TTP period prior to becoming a 103 NP, when recency is required because individuals at that stage function as novices who are still developing foundational skills.

By contrast, applicants for 104 NP certification are experienced practitioners who, consistent with principles of adult learning, maintain and update their competencies through ongoing professional engagement, continuing education, and reflective practice, even when not continuously in direct care roles. Imposing a strict recency mandate could therefore limit qualified applicants without a demonstrated benefit to competency or public safety.

Comment 2-D
The commenter recommends revising regulations to require verification of active

[1] Benner, P. (1984). *From novice to expert: Excellence and power in clinical nursing practice*. Addison-Wesley

national certification at every renewal cycle for 104 NPs. The commenter asserts that retaining documentation and providing it only upon request does not ensure ongoing competency, and that verification is especially important for NPs practicing outside group settings. If verification at each renewal is not adopted, the commenter recommends establishing a regular audit process similar to continuing-education audits.

Specifically, the suggested amendments are:

1482.4(c) Maintenance of an active national certification in a **population focus** category ~~listed~~ **described** in Section 1481 in which the applicant seeks certification as a nurse practitioner pursuant to Section 2837.104 of the code, is required to work under the provisions of Section 2837.104. Verification of **an active national** certification renewal must be maintained by the licensee**,** ~~and~~ provided to the Board **upon each renewal of the licensee's registered nursing license and nurse practitioner certificate,** ~~or~~ **and provided to** an employer upon request.

Response 2-D
The Board has reviewed and considered the comment and declines to make any amendments to the proposed text based thereon.

The Board declines the proposed revisions, since the proposed text already requires 104 NPs to maintain documentation of their active national certification and provide it to the Board or an employer upon request. This allows the Board to request or audit the documentation as is necessary and appropriate.

LETTER 3 - CALIFORNIA STATE ASSOCIATION OF PSYCHIATRISTS

Comment 3-A
The commenter states that the proposed regulations would improperly contradict SB 1451 by removing requirements that nurse practitioners inform patients that they are NPs rather than physicians and removing the requirement to inform patients of their right to see a physician. The commenter states that these provisions were key elements of SB 1451 and were enacted to address documented patient confusion regarding NP and physician roles.

Response 3-A
The Board has reviewed and considered the comment and declines to make any amendments to the proposed text based thereon.

The proposed text conforms with changes made by SB 1451, rather than contradicting them. As explained in the Initial Statement of Reasons (ISOR) on page 12, SB 1451 amended BPC Section 2837.103(e) and BPC Section 2837.104(e) to prohibit the Board from requiring a 103 and 104 NP to tell a patient that they have a right to see a physician and surgeon.

Further, both statute and the proposed text require a 103 and 104 NP to inform all new patients in a language understandable to the patient that a nurse practitioner is not a physician and surgeon. They also require a 103 and 104 NP to post a notice in a conspicuous location accessible to public view that the nurse practitioner is regulated by the Board of Registered Nursing. The notice must include the Board's telephone number and internet website where the nurse practitioner's license may be checked and complaints against the nurse practitioner may be made.

Additionally, see response to Comment 1-O discussing information publicly available on the Board's website and Comment 1-N discussing licensee identification requirements.

Comment 3-B
The commenter states that eliminating the requirement for nurse practitioners to practice within the same category as their national certification raises serious concerns regarding clinical competence. The commenter argues that the Board should provide evidence supporting any expansion of cross-category practice for 103 NPs, emphasizing that employer demand or stakeholder feedback does not demonstrate an individual NP's ability to diagnose and treat a substantially different patient population. The commenter further asserts that, if cross-category practice is intended to improve access in underserved areas, the Board should disclose supporting data.

Response 3-B
The Board has reviewed and considered the comment and declines to make any amendments to the proposed text based thereon.

Please see response to Comment 2-A discussing how NPs are not statutorily restricted to population focus certification category.

Comment 3-C
Regarding the proposed text for Title 16 CCR 1482(b), the commenter states that removing the requirement for equivalency of training to an academically affiliated NP program indicates that any domestic educational program would suffice when it will not.

Response 3-C
The Board has reviewed and considered the comment and declines to make any amendments to the proposed text based thereon.

As explained in the ISOR on page 5, the proposed text removes language referencing the nurse practitioner certification equivalency pathway to become an NP in California. This pathway was previously only available to applicants that did not complete a Board approved NP education program and did not have a National Certification.

Comment 3-D
The commenter states that removing the requirement for national certification in the same specialty category as the intended practice category will permit NPs to practice independently in clinical areas in which they lack supervised experience. The

commenter asserts that allowing national certification, TTP experience, Board certification category, and clinical practice area to diverge will make it impossible to reliably understand an NP's qualifications and that there needs to be a public record of NP training qualifications. The commenter also raises concerns that NP programs lack standardized clinical teaching requirements and may grant retroactive clinical credit in unrelated areas.

Response 3-D
The Board has reviewed and considered the comment and declines to make any amendments to the proposed text based thereon.

Please see responses to Comment 2-A discussing how NPs are not statutorily restricted to population focus certification category and Comment 1-O discussing information publicly available on the Board's website.

Comment 3-E
Regarding the proposed text for 16 CCR 1482.4, the commenter states it would inappropriately remove the requirement for same-category national certification as well as the requirement for attestation from a physician or NP regarding transition to practice. The commenter states this would be a significant reduction in the existing supervision requirement and should be rejected. The commenter states that that this is one example of where the BRN should be careful not to overstep and attempt to over-interpret statute since SB 1451 made some changes to attestation requirements but did not remove the attestation in its entirety.

Response 3-E
The Board has reviewed and considered the comment and declines to make any amendments to the proposed text based thereon.

As explained in the ISOR on page 10, to become a 104 NP an applicant must first be certified by the Board as a 103 NP. To become a 103 NP, an applicant must have already submitted documentation showing they met the national certification and transition to practice requirements. The proposed text does not remove the attestation requirement, rather it removes the redundant reporting requirements for 104 NPs and instead asks them to provide proof of their 103 NP certification.

Comment 3-F
Regarding the proposed text for 16 CCR 1482.4, the commenter states that a DNP is an academic credential and does not itself establish experience operating without standardized procedures. The commenter states that the Board should require primary-source documentation describing the setting, supervision, patient population, clinical responsibilities, and number of direct-care hours. Simulation, quality-improvement projects, observation, administrative work, and hours already credited to another degree or transition requirement should be expressly excluded.

Response 3-F

The Board has reviewed and considered the comment and declines to make any amendments to the proposed text based thereon.

The current regulatory text at 16 CCR 1482.4 states that the Board will only count hours of direct patient care experience in the applicant's area of National Certification that were provided during the doctoral part of the applicant's doctoral education and not credited towards the applicant's master's degree. The proposed text simply clarifies how applicants must submit that information to the Board for it to be considered as part of their 104 NP application.

Comment 3-G
Regarding the proposed text for Title 16 CCR 1482.4, the commenter states this regulation package would wrongly interpret statute, which directs the circumstances when the NP shall consult and collaborate with a physician.

Response 3-G
The Board has reviewed and considered the comment and declines to make any amendments to the proposed text based thereon.

It is unclear what portion of the proposed text in Title 16 CCR 1482.4 the commenter believes wrongly interprets statute as it relates to physician consultation and collaboration.

The current regulatory text of Title 16 CCR 1482.4(b) requires that within 90 days of certification by the Board, a 104 NP must have a written protocol for physician consultation and a written plan for referrals in accordance with BPC Section 2837.104(c)(2). It also states that if the written plan calls for referrals to a specific individual, the plan must include that individual's acknowledgement and consent to the referrals. This text aligns with statutory requirements regarding physician consultation and is not being amended by this package.

Comment 3-H
Regarding the proposed text for Title 16 CCR 1482.4, the commenter states that removing consumer notification requirements will further contribute to patient confusion regarding practitioner roles. The commenter states that it is important that patients are told the differences between practitioners so that they can make an informed decision regarding whether they want to request care from a physician.

Response 3-H
The Board has reviewed and considered the comment and declines to make any amendments to the proposed text based thereon.

The Board believes the commenter meant to direct the above comment towards the proposed text for 16 CCR 1487 rather than 16 CCR 1482.4, which does not address consumer notification requirements.

Please see response to Comment 1-N discussing licensee identification requirements.

LETTER 4 – CALIFORNIA SOCIETY OF PHYSICAL MEDICINE AND REHABILITATION

Comment 4-A
The commenter expresses deep concern about proposed scope-of-practice expansions for 103 and 104 NP regulations, emphasizing that such changes have significant clinical and patient safety implications. The commenter criticizes the timing and process of the regulatory announcement, noting it appears strategically positioned to minimize, if not entirely prevent, formal policy debate since it coincided with the closure of the California Medical Association's policy-setting window. The commenter requests the Board to pause the rulemaking package and establish a transparent process that ensures robust physician participation and accountability in future scope-of-practice actions.

Response 4-A
The Board has reviewed and considered the comment and declines to make any amendments to the proposed text based thereon.

The proposed text does not expand the scope of practice of Nurse Practitioners. The proposed text is updating regulations to conform with statute that has already been enacted by the Legislature and signed into law by the Governor.

Further, the proposed text was publicly noticed as an agenda item and discussed at several Board meetings as it was being developed. It was also discussed at a public meeting of the NPAC whose membership includes nurse practitioners and physicians. This provided full transparency and multiple opportunities for stakeholders to provide feedback. Several changes were ultimately made to the proposed text based on input received from the public during those discussions.

In addition to the Board's public meetings, the purpose of the 45-day public comment period required by the California Administrative Procedure Act is to give the public an opportunity to review and provide written input on proposed regulations before they become law. When the 45-day public comment period begins is determined by statutory timelines, internal review protocols at multiple departments, and the Board meeting schedule, it cannot be dictated by any single stakeholder group's preferred calendar.

LETTER 5 – INDIVIDUAL COMMENTER

Comment 5-A
The commenter expresses deep concern about proposed scope-of-practice expansions for 103 and 104 NP regulations, emphasizing that such changes have significant clinical and patient safety implications. The commenter criticizes the timing and process of the regulatory announcement, noting it appears strategically positioned to minimize, if not

entirely prevent, formal policy debate since it coincided with the closure of the California Medical Association's policy-setting window. The commenter requests the Board to pause the rulemaking package and establish a transparent process that ensures robust physician participation and accountability in future scope-of-practice actions.

Response 5-A
The Board has reviewed and considered the comment and declines to make any amendments to the proposed text based thereon.

See Response to Comment 4-A discussing that the Board is interpreting statute and not expanding scope of practice.