



Nurse Practitioner Advisory Committee Meeting

MEETING MATERIALS

October 20, 2026

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Agenda Item 2.0

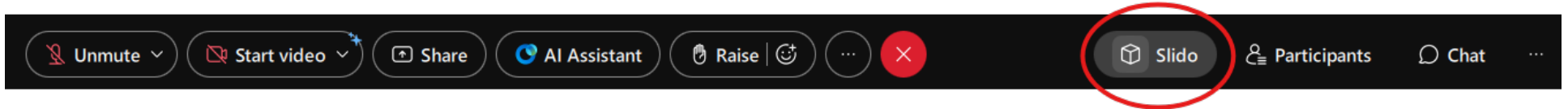
General instructions for the format of a teleconference meeting

Nurse Practitioner Advisory Committee (NPAC) Meeting | October 20, 2026

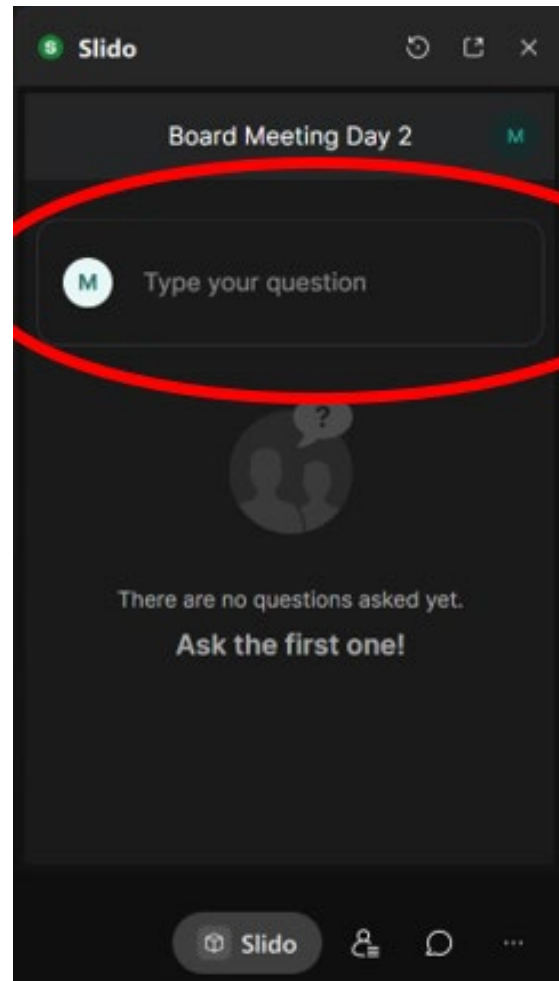
Participating During a Public Comment Period (if joining the meeting remotely via WebEx)

If you would like to make a public comment:

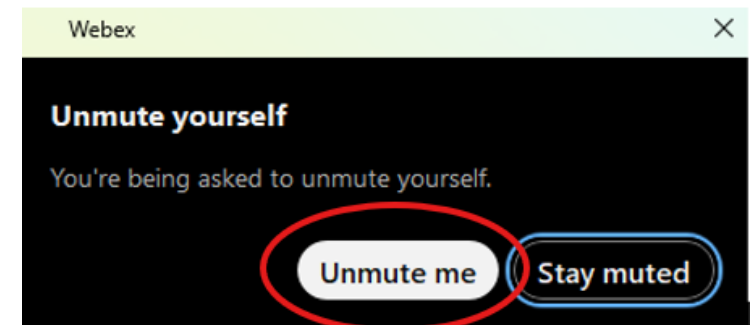
1. Click on the 'Slido' or  button at the lower right of your Webex session (you may need to click the three dots (...) and the Advanced tab to find this option, if joined by smart phone or another mobile device).



2. The 'Slido' panel will appear. (Your screen may look slightly different than pictured depending on Webex version.)



3. In the 'Slido' Q&A panel, type "I would like to make a comment." You will be identified by the name or moniker you used to join the Webex session, and your line will be opened. On the "Unmute yourself" pop-up, click the 'Unmute me' button (this may be hidden behind other open applications). Every effort is made to take comments in the order which they are requested.





Agenda Item 4.1

Review and vote on whether to approve previous meeting's minutes

Nurse Practitioner Advisory Committee (NPAC) Meeting | October 20, 2026

**CALIFORNIA BOARD OF REGISTERED NURSING
NURSE PRACTITIONER ADVISORY COMMITTEE
MEETING MINUTES**

DRAFT

Date: Tuesday, April 28, 2026

Start Time: 1:00 pm

Location: The Nurse Practitioner Advisory Committee meeting was held via remote access in accordance with Government Code section 11123.5. All Committee members joined the meeting remotely.

1:00 pm

1.0 Call to order, roll call, and establishment of a quorum
Samantha Gambles Farr, Chair, called the meeting to order at 1:00 pm, and a quorum was established at 1:01 pm. All committee members were present except Betha Schnelle who joined at 1:10 pm and Andrea Espinosa who joined at 1:14 pm.

Committee Members: Samantha Gambles Farr, RN, MSN, FNP-C, CCRN, RNFA – Chair
Edward Ray, MD, FACS - Vice Chair
Andrea Espinosa, MD
Jan Johnson Griffin, MSN, APRN
Kevin Maxwell, PhD, DNP, FNP-BC, RN
Sally Pham, MSN, RN, FNP-BC
Betha Schnelle, MBA, MPH

Absent:

BRN Staff Loretta (Lori) Melby, RN, MSN – Executive Officer

Present: Reza Pejuhesh – DCA Legal Affairs Division, Attorney

1:02 pm

2.0 General instructions for the format of a teleconference meeting

1:03 pm

3.0 Public comment for items not on the agenda; items for future agendas

**Public Comment
for Agenda Item**

3.0: No public comments

1:05 pm

4.0 Review and vote on whether to approve previous meeting minutes

4.1 September 23, 2025

**Committee
Discussion:** No committee discussion

Motion: **Edward Ray** motioned to approve the minutes from September 23, 2025.

Second: **Kevin Maxwell**

**Public Comment
for Agenda Item**

4.1: No public comments

Vote:	SGF	ER	AE	JJG	KM	SP	BS
	Y	Y	AB	Y	Y	Y	AB
Key: Yes: Y No: N Abstain: A Absent for Vote: AB							

Motion Passed

1:09 pm

5.0

Information and discussion only: Report from the Board of Registered Nursing's Executive Officer regarding updates on activities which may impact nurse practitioners, including policy and procedure changes, regulatory updates, etc.

**Committee
Discussion:**

Loretta Melby reported that the Board's primary legislative priority affecting nurse practitioners (NP) is the sunset bill, Senate Bill (SB) 1302, which is currently moving through the legislative process. While initial bill language has been introduced, she noted that the measure is expected to continue evolving through amendments as it advances. She explained that the Board's sunset report, which is available on the BRN website, contains approximately 33 proposals seeking statutory and regulatory changes. Loretta highlighted several proposals affecting Advanced Practice Registered Nurses (APRNs), including NPs and nurse midwives (NMW). The Board is seeking to grant furnishing privileges upon licensure for both professions, noting that the requirements for furnishing authority are identical and already include completion of advanced pharmacology coursework. Because no additional qualifications are required beyond advanced pharmacology, the Board believes furnishing authority can be streamlined and granted as part of the licensure process. She also noted that the Board has proposed requiring national certification as a condition of licensure. She encouraged interested parties to review Sections 9 and 10 of the Board's sunset report for additional details regarding the Board's proposals. She further explained that during a sunset review year, the Legislature often avoids moving multiple bills on similar topics simultaneously and may instead incorporate related measures into the sunset bill. As a result, stakeholders should not assume a proposal has failed if its standalone bill no longer advances, as it may later be incorporated into SB 1302.

No questions were raised by committee members.

**Public Comment
for Agenda Item**

5.0: No public comments

1:13 pm

6.0

Discussion and possible action: Regarding possible assignment/reassignment of members and/or topics to subcommittees and updates from the following subcommittees: Business and Professions Code (BPC) section 2837.101, Transition to Practice; BPC section 2837.104; and Discipline

Committee Discussion: Samantha Gambles Farr initiated discussion regarding subcommittee updates.

Transition to Practice Subcommittee

Edward Ray reported that the Transition to Practice Subcommittee had no formal updates since its previous meeting but noted ongoing discussions regarding implementation of the nurse practitioner transition-to-practice framework.

Sally Pham stated that NPs holding 103 NP certification who continue practicing under standardized procedures are not eligible to advance to 104 NP status unless they meet the required practice requirements.

Loretta Melby confirmed that this requirement is established in California Code of Regulations (CCR), title 16, section 1482.4, which requires a 103 NP certificate holder to complete three full-time equivalent years, or 4,600 hours, of direct patient care practice as a 103 NP while maintaining good standing with the Board. Loretta explained that obtaining 103 NP certification alone is insufficient; licensees must actively practice under the 103 NP pathway to qualify for 104 NP certification. She further reported that some confusion had arisen among stakeholders and applicants regarding 104 NP eligibility because the original application materials had not been fully updated following amendments enacted through SB 1451. She acknowledged that updates to the 104 NP application are currently being processed through the Board's licensing and information technology systems. In the interim, the Board has worked with stakeholder organizations to publish frequently asked questions and provide clarification regarding the eligibility requirements. Loretta noted that stakeholders have proposed removing the current requirement that transition to practice hours be completed within the preceding five years and have also requested allowing qualifying hours obtained outside California to count toward transition to practice requirements. She explained that these proposals remain under legislative consideration as part of the sunset review process. The Board has expressed concerns regarding implementation, particularly because NP scopes of practice vary among states and would require a reliable method for determining equivalency. Until statutory changes are enacted, current requirements remain

unchanged, including the requirement that transition to practice hours be earned in California and that 103 NP practice experience be obtained before advancing to 104 NP.

Andrea Espinosa asked whether proposed sunset bill changes would affect the existing proof-of-practice requirements contained in CCR section 1482.4.

Loretta Melby clarified that the Board has not requested changes to those requirements and continues to support the regulations established through the NPAC process. She stated that while some external organizations have requested changes through the legislative sunset review process, any modifications would require statutory action by the Legislature.

Andrea Espinosa asked where committee members could review comments and concerns submitted by organizations regarding the sunset bill.

Loretta Melby demonstrated how to access SB 1302 and related bill analyses through the California Legislature's legislative information website. She explained that bill analyses provide information regarding support, opposition, amendments, and stakeholder comments concerning the legislation.

Samantha Gambles Farr noted that implementation of SB 1451 continues to evolve and that the committee should expect additional updates as legislative and regulatory changes occur.

Loretta Melby added that the final form of legislation often changes significantly before enactment and emphasized that the Board typically waits until legislation is signed before developing implementation plans.

Discipline Subcommittee Report

Samantha Gambles Farr and Sally Pham presented the Discipline Subcommittee report and reviewed NP discipline statistics.

Sally Pham reported that California's NP workforce has increased by approximately 82 percent since 2018. While the total number of violations increased during the same period, the violation rate remained consistently low, ranging approximately between 15 percent and 21 percent annually. She stated that no discipline category showed a disproportionate increase relative to workforce growth and concluded that nurse practitioner professional conduct has remained stable despite substantial workforce expansion.

Edward Ray asked whether the discipline statistics reflected the number of complaints filed against nurse practitioners. He questioned whether discipline rates could appear artificially low if investigations were limited by staffing or resource constraints.

Loretta Melby explained that the reported statistics reflect violations and disciplinary actions, not complaint volume. She noted that complaint numbers can be inflated by duplicate complaints, particularly when incidents receive social media attention. She stated that complaints are reviewed individually and that investigations are initiated whenever a complaint falls within the Board's jurisdiction. She further explained that some matters do not require full investigations because they involve criminal convictions, out-of-state discipline, or issues that fall outside the Board's authority. Loretta reported that recent Board data show that qualifying complaints have been investigated despite staffing challenges.

Betha Schnelle asked whether NP discipline rates could be compared with physicians, physician assistants, or other healthcare providers to provide a benchmark for context. She also asked whether malpractice claims, quality of care concerns, or adverse patient outcomes were tracked.

Loretta Melby explained that malpractice-related information is captured through insurance claim reporting requirements and that practice-related violations are tracked separately. She noted that the Board benchmarks discipline data against other APRN categories rather than physicians because physician practice falls outside the Board's jurisdiction and is governed by different legal and regulatory structures. She indicated that broader comparative research exists nationally but is conducted by independent researchers rather than the Board.

Samantha Gambles Farr stated that the Discipline Subcommittee had anticipated questions regarding future discipline trends as 103 NP and 104 NP certifications become more prevalent. She noted that future reports may include distinctions between 103 NP and 104 NP practitioners as the data become available.

Betha Schnelle stated that, from the perspective of healthcare system operations, NPs and physicians often function side-by-side in clinical settings, making comparative outcome data valuable. She emphasized that reduced supervision structures raise questions about benchmarking and patient safety.

Loretta Melby explained that the transition to practice legislation did not expand NP scope of practice but rather modified supervisory structures and practice settings. She reported that the Board has not observed any increase in discipline trends associated with 103 NP or 104 NP implementation and would continue monitoring the data.

Andrea Espinosa agreed that future benchmarking may become more relevant as additional 103 and 104 NP practitioners enter

practice and as implementation of the transition-to-practice framework continues to mature.

Loretta Melby provided additional context regarding the NP practice model. She explained that more than 42,000 of California's approximately 45,000 nurse practitioners continue practicing under standardized procedures. She further noted that only approximately 3,000 practitioners have obtained 103 NP certification and many continue practicing under traditional standardized-procedure arrangements. She emphasized that 104 NP certification does not expand scope of practice but instead limits practice to the individual's education, training, and national certification.

Betha Schnelle clarified that her concerns related primarily to changes in supervisory relationships rather than scope of practice expansion.

Loretta Melby stated that the Board continues to monitor discipline trends and has not identified evidence that reduced supervision has increased disciplinary actions or public safety concerns. She further noted that levels of physician oversight have historically varied widely under standardized procedure arrangements and that the Board takes disciplinary action when collaboration or supervision requirements are not properly followed.

Sally Pham added that approximately 3,800 103 NP certifications had been issued as of early April and reiterated that nurse practitioner scope of practice remains unchanged regardless of whether practitioners work under standardized procedures, 103 NP certification, or 104 NP certification. She stated that discipline data continue to show low rates of violations and no statistically significant increase in risk associated with transition-to-practice implementation.

Samantha Gambles Farr concluded that the committee will continue monitoring discipline trends, workforce growth, and 103/104 NP implementation. She emphasized the committee's commitment to providing transparent data to the public and evaluating emerging trends as more practitioners transition into the new certification pathways.

**Public Comment
for Agenda Item**

6.0: No public comments

**Further
Discussion:**

Sally Pham noted that the committee should remain mindful of the long-term impacts of the COVID-19 pandemic on healthcare education and training programs. She observed that some healthcare professionals, including RNs, NPs, physician assistants, and physicians, completed portions of their clinical training during periods when in-person learning

opportunities were limited. She stated that if future discipline data were to show an increase in violations or complaints, it would be important to consider whether those trends could be associated with broader historical factors affecting healthcare education and training during the pandemic. She explained that any impact related to reduced clinical exposure or training opportunities would likely not be unique to nurse practitioners and could potentially affect multiple healthcare professions. She cited examples such as surgical trainees who may have experienced fewer opportunities for hands-on procedural experience during periods of restricted clinical activity. For that reason, she suggested that any future increase in disciplinary trends should be examined within the broader context of healthcare workforce training and professional development across all disciplines rather than attributing changes to a single profession.

Andrea Espinosa stated that the discussion was not intended to question NP scope of practice or competency. Rather, she noted that the relationship between NPs and physicians changes under the 104 NP model and that the long-term effects of those changes may not be fully apparent until additional 104 NPs enter practice. She emphasized the importance of continuing to monitor how healthcare delivery systems, provider relationships, and organizational practices evolve as the transition-to-practice framework matures. Dr. Espinosa noted that her interest was not focused on identifying errors or deficiencies but rather on understanding how practice environments may change and how those changes might affect nurse practitioners and healthcare organizations.

Sally Pham clarified that there were approximately 54 NPs with 104 NP certification at that time, rather than only one. She emphasized that the committee is actively tracking implementation data and discipline trends and reiterated that any emerging concerns or significant changes would be reported publicly.

Andrea Espinosa asked whether nurse practitioners are named in malpractice actions in the same manner as supervising physicians and whether such cases are reported to the BRN.

Sally Pham indicated that malpractice claims often involve multiple healthcare providers and that liability is not necessarily limited to supervising physicians. She emphasized that the committee's primary focus remains public protection and monitoring NP practice trends.

Samantha Gambles Farr added that NPs, like physicians and other healthcare providers, may be named in lawsuits and are professionally accountable for their own practice. She reiterated that the Board's responsibility is to monitor professional conduct and ensure public protection regardless of provider type. Dr. Espinosa clarified that her comments were not intended to be adversarial and explained that her concern centered on how healthcare systems and provider relationships may evolve as NPs gain greater autonomy under existing

law. She stated that changes in workplace structures and organizational policies should be monitored to ensure that nurse practitioners are fully supported as they transition into expanded practice environments.

Samantha Gambles Farr noted that independent NP practice is not a new concept nationally, as numerous other states have already implemented similar practice models. She stated that California can learn from the experiences of other states and use available information to evaluate implementation and outcomes while maintaining a focus on safe, high-quality patient care.

Edward Ray thanked the presenters for the report and expressed support for continuing to monitor NP discipline data. He cautioned against drawing conclusions from limited or isolated data points or making direct comparisons to other professions without sufficient context. Dr. Ray noted that meaningful comparisons would require a more detailed analysis of the nature of complaints, investigations, and practice environments rather than relying solely on aggregate discipline statistics.

Loretta Melby provided further information regarding malpractice-related reporting under Section 801 requirements. She explained that when malpractice settlements or insurance payouts are reported to the Board, settlement information identifies the license types involved and the portion of the settlement attributed to each provider. The Board reviews reports involving nurse practitioners and registered nurses and coordinates with the appropriate regulatory boards, including the Medical Board, when other licensed professionals are involved. She stated that these reports may result in separate investigations by the applicable licensing agencies.

Betha Schnelle thanked the committee for the discussion and explained that, as a public member representing a healthcare operations perspective, she seeks additional context to better understand NP practice trends and outcomes. She stated that benchmarking and research data are commonly used in healthcare operations to evaluate performance and quality and expressed interest in learning more about research, experiences from other states, and published studies related to nurse practitioner independent practice. She noted that such information would help her make more informed contributions during committee discussions.

Samantha Gambles Farr acknowledged the value of additional background information and suggested that committee members could benefit from reviewing publicly available research and information related to NP practice, quality outcomes, and implementation experiences in other states. She indicated a willingness to help identify relevant resources, if appropriate, to support members' understanding of the topic.

Edward Ray asked how additional benchmarking or research information would directly support the committee's responsibilities and what specific purpose such information would serve in the committee's work.

Betha Schnelle stated that access to additional research and contextual information would help her better understand issues outside her primary area of expertise and enable her to participate more effectively in discussions as a board member.

Edward Ray reiterated that any use of comparative research should be approached carefully and with a clear understanding of its purpose.

Samantha Gambles Farr clarified that she was not proposing a formal benchmarking project but rather suggesting that committee members have access to publicly available information and studies relevant to the issues being discussed.

7.0 Discussion and possible action: Update on the Board discussion of statutory limitations preventing registered nurses and advanced practice registered nurses from independently compounding medications

Committee Discussion: Loretta Melby introduced the discussion regarding medication compounding, noting that the issue has become increasingly controversial and was previously discussed at an NPAC meeting. She explained that RNs and APRNs are currently prohibited from compounding medications under California law. She emphasized that compounding restrictions originate primarily from pharmacy law and related regulations rather than solely from BRN regulations. Loretta explained that California's compounding requirements are derived from federal United States Pharmacopeia (USP) standards and implemented through regulations administered by the California Board of Pharmacy. She reviewed the Pharmacy Board's "immediate use compounding" provisions and noted that such compounding is limited to situations involving immediate patient need where failure to administer treatment could result in loss of life or intense suffering. She explained that immediate-use compounded products must be patient-specific and administered within strict time requirements. Loretta stated that confusion has arisen because many nurses and NPs are unaware of the distinction between admixing medications according to manufacturer instructions and compounding medications. She explained that activities commonly performed in clinical practice, such as combining two medications in a single syringe, may technically meet the definition of compounding under current law. She reported that the Board became aware of the issue through increasing concerns involving IV hydration clinics, med spas, and similar outpatient settings where nurses and nurse practitioners routinely combine medications before administration. She indicated that many practitioners appeared genuinely unaware that those activities could fall outside their legal scope of practice. Because of this concern, the Board developed

educational materials, website updates, social media messaging, and licensee communications designed to clarify existing legal requirements. She advised that current law only permits compounding by specifically authorized individuals, generally pharmacists and, in limited circumstances, physicians. As a result, RNs and NPs may not perform compounding even when following a physician order or standardized procedure. She emphasized that physician delegation does not authorize activities that fall outside a nurse's legal scope of practice. Loretta noted that several stakeholder organizations, including the California Association for Nurse Practitioners (CANP), have raised concerns regarding current compounding restrictions and have requested review of the issue during the sunset process. However, she clarified that the BRN itself has not proposed legislative changes related to compounding and currently views its primary responsibility as educating licensees regarding existing legal requirements. She further explained that even if nursing statutes were modified in the future, additional changes to pharmacy law would likely be necessary because current pharmacy regulations continue to restrict immediate-use compounding to limited circumstances involving emergency or life-preserving situations. Therefore, many IV hydration clinic practices would remain impermissible under existing pharmacy regulations.

Edward Ray asked whether any specific compounding-related changes were being proposed through the sunset bill process.

Loretta Melby clarified that the BRN has not requested any statutory changes related to compounding. She stated that stakeholder organizations have advocated for allowing APRNs to perform limited compounding in certain circumstances, but such proposals did not originate from the Board. She explained that the Board's current focus is education because many common nursing practices may technically qualify as compounding. She cited examples such as drawing up different insulin formulations into a single syringe, noting that such practices have long been taught and performed clinically despite falling within the technical definition of compounding. She acknowledged that revisions to current law may be worth exploring because certain limited compounding activities appear consistent with safe patient care and everyday nursing practice. Nevertheless, she emphasized that the Board must enforce current law as written and cannot disregard violations simply because a practice is common. Loretta further reported that the Board has observed an increase in complaints involving compounding activities, particularly in med spas and IV hydration clinics. Inspections conducted by the Board of Pharmacy revealed that many practitioners openly demonstrated medication preparation techniques because they did not realize their activities fell outside of nursing scope of practice. This reinforced the Board's view that education, rather than punishment, should be the immediate priority. She stated that the Board's goal is to provide clear guidance before practitioners inadvertently place their licenses at risk. Potential long-term solutions could include legislative clarification, revised regulations, or pharmaceutical manufacturers providing pre-mixed

medication products that nurses could legally administer without compounding.

Andrea Espinosa noted that physicians themselves possess only limited authority to compound medications. She explained that physician compounding authority is narrowly defined, patient-specific, and subject to oversight through Medical Board regulations. She suggested that future discussions could explore whether limited authority similar to that afforded physicians might eventually be considered for nurses and nurse practitioners.

Loretta Melby agreed that such discussions may occur at the legislative level but reiterated that current nursing statutes expressly prohibit compounding and that any change would require legislative action rather than regulatory modification by the BRN.

Kevin Maxwell asked whether complaints are increasing because patients are being harmed or simply because practitioners are engaging in technically prohibited compounding activities. Loretta Melby stated that the Board has observed both circumstances but indicated that direct patient harm appears less common than practitioners unknowingly engaging in prohibited activities. She expressed concern regarding businesses and consulting entities that market med spa and IV hydration clinic business models to nurses and nurse practitioners while incorrectly suggesting that certain compounding practices are permissible. She characterized this as harmful because licensees may face disciplinary action despite relying on inaccurate guidance from third-party business operators. She stressed that licensees remain responsible for understanding applicable laws and regulations governing their practice. She expressed concern that practitioners may invest significant financial resources in business ventures based on flawed legal advice and subsequently become subject to complaints or discipline.

Kevin Maxwell asked whether legislative changes would require action by both the BRN and the Board of Pharmacy.

Loretta Melby replied that multiple statutory and regulatory changes would likely be required. She noted that nursing statutes, pharmacy regulations, and definitions regarding immediate-use compounding would all need to be considered. She emphasized that current pharmacy regulations continue to limit immediate-use compounding to emergency situations involving preservation of life or limb and would therefore not support most med spa or IV hydration clinic practices.

Betha Schnelle observed that many IV hydration clinics appear to believe they are operating legally and asked how the Board plans to educate practitioners without creating unnecessary disruption for existing businesses.

Loretta Melby explained that the Board has prepared educational materials, listserv communications, social media messaging, and website content that have already received Board approval. However, the Board has delayed release of those materials while developing additional guidance regarding lawful alternatives and implementation strategies. She stated that the goal is to educate practitioners and provide workable compliance options rather than simply force businesses to close. Loretta suggested that clinics may be able to restructure operations through collaboration with compounding pharmacies, physician involvement, or other legally permissible approaches. She emphasized that the Board wants to provide practical pathways forward while remaining consistent with current law.

Edward Ray asked whether the BRN could directly contact or inspect clinics to ensure compliance rather than relying primarily on educational announcements.

Loretta Melby replied that the BRN currently lacks statutory authority to conduct the type of inspections performed by the Board of Pharmacy. She noted that the Board has requested additional enforcement authority through its sunset legislation proposal but does not presently have the legal authority to conduct proactive compliance inspections. She added that California has one of the nation's highest concentrations of med spas and IV hydration clinics, making the issue particularly significant within the state.

Betha Schnelle suggested collaborating with organizations such as the California Medical Association (CMA) and other professional groups to distribute educational messaging, noting that communications affecting professional licenses often receive greater attention.

Loretta Melby reported that the Board is already participating in a Department of Consumer Affairs Med Spa/IV Hydration Task Force that includes the Medical Board of California, Osteopathic Medical Board of California, Physician Assistant Board, Board of Vocational Nursing and Psychiatric Technicians, Board of Barbering and Cosmetology, Chiropractic Examiners Board, California Board of Naturopathic Medicine, and other regulatory entities. She stated that these organizations are working collaboratively to develop consistent messaging and educational outreach regarding scope of practice issues.

Andrea Espinosa asked whether educational information could be prominently posted on the BRN website.

Loretta Melby confirmed that website updates have already been drafted and approved by the Board. She reported that the Board is considering release of the educational materials later in the year after further stakeholder engagement and after gaining a clearer understanding of whether sunset legislation may address any compounding-related issues.

Kevin Maxwell asked whether anticipated sunset legislation might address the compounding issue before the Board releases its educational materials.

Loretta Melby stated that by the anticipated release timeframe the Board should have a clearer understanding of the likely final language of the sunset bill. She indicated that if legislation appears likely to address compounding directly, the Board may reevaluate the timing and content of its educational communications before publication.

**Public Comment
for Agenda Item**

7.0:

Cynthia Sanchez, nurse practitioner since 1999: Shared her experience practicing under 103 NP certification. She stated that her medical director supports practicing without standardized procedures and noted that obtaining 103 NP status has not changed her day-to-day clinical practice, prescribing habits, ordering practices, or consultation patterns. She expressed concern that some healthcare organizations refuse to recognize 103 NP status and, in some cases, discourage nurse practitioners from applying for 103 NP certification. Ms. Sanchez questioned why advancement to 104 NP requires documented practice as a 103 NP when many practitioners may be performing the same work regardless of whether their employer formally recognizes the designation.

Loretta Melby explained that the distinction is not based on the clinical care being delivered but rather on the administrative and regulatory framework under which services are provided. She reviewed the extensive requirements of standardized procedures, including documentation requirements, competency evaluations, supervision provisions, recordkeeping standards, and periodic review processes. She noted that while some organizations may maintain similar safeguards even after 103 NP implementation, those requirements are not uniformly applied across all practice settings. As a result, California law requires the nurse practitioner to practice in a 103 NP setting rather than simply hold the certification.

Cynthia Sanchez responded that the original intent of the law appeared to be ensuring adequate clinical experience and safe practice rather than requiring practitioners to change employers. She expressed concern that practitioners working safely and competently in organizations that do not acknowledge 103 NP certification are effectively prevented from qualifying for 104 NP status.

Loretta Melby acknowledged the concern and stated that, under current law, a nurse practitioner who wishes to accumulate qualifying 103 NP experience must practice in an environment that recognizes and implements the 103 NP framework. She explained that California's transition to practice pathway was designed as a stepwise progression from standardized procedures to 103 NP practice within specified

settings, and ultimately to 104 NP independent practice. Any modification to that structure would require statutory change.

Cynthia Sanchez asked whether changing this requirement would require legislative action.

Loretta Melby confirmed that a statutory change would be required.

Cynthia Sanchez stated that, throughout her nursing career, including service in a major teaching hospital, nurses routinely prepared medications for immediate administration by combining medications in syringes or IV solutions. She expressed concern that restricting this practice would negatively affect patient care, increase delays, and require pharmacists or physicians to perform tasks traditionally handled by nurses. She emphasized that hospital nurses commonly mix medications for immediate administration rather than for future storage or distribution and questioned how the current interpretation of compounding laws could realistically accommodate patient care needs.

Loretta Melby acknowledged those concerns and emphasized that the Board is not proposing a new restriction. Rather, the Board has become aware that many longstanding clinical practices may conflict with existing compounding laws that have not historically been well understood or widely discussed. She noted that similar workflow changes have occurred in the past through manufacturer-prepared products and medication delivery systems. Loretta agreed that the issue extends far beyond med spas and IV hydration clinics and has implications for hospitals and other healthcare settings as well. She stated that the Board became involved after seeing an increase in complaints and concerns related to compounding practices. She emphasized that the Board's goal is proactive education rather than punishment and acknowledged that many nurses were trained in practices that are now being interpreted as compounding under current law. She agreed that further legislative and regulatory discussions may be needed to align laws with modern clinical practice.

Cynthia Sanchez urged the BRN and other healthcare organizations to support legislative efforts that would allow safe and practical medication preparation practices while maintaining patient protection and cost-effective care.

Loretta Melby explained that the BRN's statutory mission is public protection rather than advocacy for scope of practice expansion. She stated that proposals to expand or modify professional scope typically originate from stakeholder organizations, professional associations, labor groups, or healthcare organizations rather than the Board itself. If legislation were introduced, the Board could consider a formal support or opposition position, but the Board does not generally initiate scope-expansion proposals.

Jeffery requested an update regarding modifications to the 104 NP application process. He referenced previous discussions concerning the two pathways to 104 NP eligibility, including three years of 103 NP practice and the required direct patient care hours, and asked when the application process would be updated to reflect current requirements.

Loretta Melby confirmed receipt of his prior correspondence and explained that the requested changes have been submitted through the DCA's technology update process. She stated that modifications require updates to the BRN's Breeze licensing system and must be prioritized among technology projects affecting multiple boards and bureaus. Although the request has been submitted and remains active, no implementation timeline is currently available.

Cynthia Jovanov requested clarification regarding prior comments that 104 NP practice is limited by education, training, and national certification. She noted that nurse practitioner certification is population focused rather than specialty-specific and expressed concern that comments regarding practice limitations could be misinterpreted by nurse practitioners, employers, and physician colleagues. She also questioned statements suggesting employers are not required to implement 103 NP or 104 NP models when those pathways are authorized by statute.

Loretta Melby explained that the BRN establishes scope of practice but does not regulate employer hiring decisions, workplace privileges, or credentialing policies. While California law authorizes 103 NP and 104 NP practice pathways, healthcare organizations retain authority to determine how those practitioners are utilized within their facilities. Regarding certification requirements, Loretta clarified that 104 NP practitioners must practice in alignment with their education, training, knowledge, experience, and national certification. She explained that some NPs currently practice in areas that extend beyond the population focus of their original certification under standardized procedure models. Using a pediatric NP working in an adult specialty practice as an example, she noted that such arrangements may be permissible under standardized procedures or 103 NP practice but could become more restrictive under 104 NP requirements because statute specifically ties 104 NP practice to education, training, and national certification. She acknowledged the clarification and emphasized that implementation challenges continue to create confusion among healthcare organizations. She highlighted the importance of distinguishing between statutory "settings" identified in the law and clinical specialty settings discussed in healthcare organizations, noting that the terminology is often interpreted differently by stakeholders. She also observed that many institutions continue to revise bylaws and credentialing policies as they work to implement California's transition to practice framework.

Loretta Melby reiterated that the 103 NP statute identifies specific practice settings, while 104 NP practice is tied to knowledge,

experience, education, training, and national certification requirements established in statute. She acknowledged that interpretation and implementation questions will likely continue as employers, healthcare systems, and regulatory bodies gain more experience with the 103 NP and 104 NP pathways.

Samantha Gambles Farr reminded participants that the committee was discussing Agenda Item 7.0 regarding compounding and requested that subsequent comments remain focused on that agenda topic.

8.0 Discussion and possible action: Discussion regarding legislation impacting Nurse Practitioners (NP), including Assembly Bill 1973, and possible action to make a recommendation to the Nursing Practice Committee/Board to take a position on the legislation

Committee Discussion: Marissa Clark, Chief of Legislative Affairs, provided an overview of AB 1973. She explained that the bill seeks to expand access to abortion services by broadening the types of abortion procedures that may be performed by qualified nurse practitioners, certified nurse midwives, and physician assistants. Under current law, these practitioners may perform first-trimester aspiration abortions after completing specific clinical and didactic training. AB 1973 would replace references to aspiration abortions with the broader term “procedural abortions,” which could include additional procedures, such as those used during the second trimester, provided practitioners complete the required competency-based training. The bill also requires nurse practitioners and nurse midwives performing these procedures to maintain consultation, collaboration, referral, and transfer procedures for situations involving complications or conditions beyond their education, training, or experience. Marissa noted that California nursing laws have historically prohibited RNs and APRNs from performing surgery and observed that some procedures contemplated by the bill may contain surgical components. She further stated that California would be among the first states to explicitly authorize advanced practice clinicians to perform some of these procedures beyond the first trimester.

Edward Ray asked who was sponsoring the bill and whether it originated from the medical community.

Marissa Clark reported that the bill was sponsored by multiple organizations, including the California Nurse-Midwives Association, Planned Parenthood Affiliates of California, Black Women for Wellness Action Project, Essential Access Health, Reproductive Freedom for All California, and other reproductive healthcare advocacy organizations.

Edward Ray expressed support for expanding access to abortion services but raised concerns regarding patient safety and the performance of procedures that may involve surgical risks. He noted that complications such as uterine perforation and hemorrhage can

occur during procedural abortions and questioned whether the proposed training requirements would provide sufficient preparation to manage those complications. Dr. Ray stated that, in his view, the committee should not recommend supporting the bill because of concerns about maintaining standards of care and ensuring appropriate clinical training.

Marissa Clark clarified that the bill requires both clinical and didactic training and not solely classroom-based instruction.

Andrea Espinosa sought clarification regarding the training requirements and whether the bill applied broadly to all NPs, NMWs, and physician assistants who complete the specified education and competency requirements.

Marissa Clark explained that eligibility would remain contingent upon completion of approved competency-based clinical and didactic training programs described in existing law. She noted that the bill expands the procedures that trained practitioners may perform but does not automatically authorize all nurse practitioners or nurse midwives to perform them.

Andrea Espinosa also asked how practitioners would obtain training for procedures that are not traditionally included in nurse practitioner education programs.

Marissa Clark acknowledged that some training programs may need to be developed or expanded to accommodate the procedures contemplated by the bill and indicated that she could not speak to the current availability of such programs.

Betha Schnelle shared her previous experience working in healthcare leadership at Planned Parenthood and stated that, based on her experience, the organization's physicians are highly focused on safety, quality, and risk management. She expressed confidence that support for the bill was based on extensive consideration of training, clinical competency, and patient safety. She stated that she supported the bill because of ongoing access-to-care challenges, particularly for reproductive healthcare services.

Sally Pham expressed support for the bill and stated that NPs who seek to perform these procedures would likely undergo substantial clinical and didactic training. She emphasized the importance of maintaining access to reproductive healthcare while ensuring that appropriately trained practitioners provide those services.

Edward Ray reiterated that his concern was not whether NPs could learn the procedures themselves, but rather whether they would have adequate resources and support available when serious complications arise. He expressed concern about situations in which a procedural abortion might be performed in a setting without immediate surgical

backup and stated that patient safety should remain the committee's primary consideration.

Betha Schnelle observed that complications occurring in ambulatory surgical settings are commonly managed through established emergency response protocols and transfers to higher levels of care when necessary.

Motion: **Betha Schnelle** motioned to recommend support for AB 1973.

Second: **Sally Pham**

	SGF	ER	AE	JJG	KM	SP	BS
Vote:	Y	Y	Y	Y	Y	Y	Y
Key: Yes: Y No: N Abstain: A Absent for Vote: AB							

Motion Passed

Additional Discussion: Loretta Melby clarified that the committee's discussion, including concerns raised by Dr. Ray regarding patient safety, training, and management of complications, would also be summarized and provided to the Board as part of the legislative review process.

Edward Ray emphasized that his opposition should not be interpreted as opposition to reproductive healthcare access. Rather, his concern centered on ensuring that expanded access is implemented in a manner that maintains appropriate safeguards and protections for patients.

Reza Pejuhesh advised the committee that public comment typically should occur before a formal vote. He noted that the committee could revisit the motion if public testimony raised information that caused members to reconsider their positions.

Samantha Gambles Farr acknowledged the procedural oversight and thanked counsel for the clarification before proceeding to public comment.

Public Comment for Agenda Item

8.0: No public comments

9.0 **Information and discussion only:** Update on implementation of BPC 2837.104, including but not limited to 104 NP application process and clarification of transition to practice requirements

Committee Discussion: Loretta Melby provided an update on the 104 NP application and explained that the 103 NP and 104 NP applications were originally developed in the Breeze licensing system at the same time, based on

the requirements then in effect. Although the 104 NP application was held from public release until January 2026, it was not revised after SB 1451 changed the pathway from 103 NP to 104 NP. Loretta acknowledged that the oversight resulted in the release of an outdated and inaccurate application. The issue became apparent after applicants began contacting the Board and was further identified through discussions with the California Association for Nurse Practitioners. She reported that the Board has since reviewed the full sequence of nurse practitioner applications, including the initial NP application, furnishing application, Schedule II application, 103 NP application, and 104 NP application. Staff are working to align the applications so that they function consistently as an applicant progresses through each stage. The Board intends to begin with corrections to the 104 NP application and then work backward through the other applications. The necessary changes must move through the Department of Consumer Affairs technology process, where system updates are prioritized among requests from multiple boards and bureaus. She also described a new verification form for Doctor of Nursing Practice clinical hours. The form may be submitted to the director of the applicant's NP program, who can certify the number of direct patient care clinical hours completed beyond those required for the applicant's master's degree and initial NP licensure. Hours that satisfy the applicable regulatory requirements may be credited toward the 4,600-hour requirement for 104 NP eligibility. Loretta stated that the Board is working to correct the application but could not provide a firm completion date. In the meantime, eligible applicants may access and submit the existing 104 NP application. Applicants who encounter problems should contact APRN licensing staff for manual assistance. She cautioned that manual processing requires additional staff review and may not be immediate. The intended future process is for the application and approval to become more automated once the required attestations and system updates are in place.

Sally Pham asked whether eligible practitioners should wait for the computer-system updates before applying for 104 NP certification.

Loretta Melby stated that she could not recommend that qualified applicants delay applying because doing so could restrict access to the certification. She advised that applicants who believe they are eligible may submit the current application and follow up with the licensing unit if they encounter problems. She noted that the licensing unit must manage these requests along with a large volume of other licensee communications, but confirmed that applications can still be processed manually while system corrections are pending.

**Public Comment
for Agenda Item**

9.0: No public comments

10.0 Information and discussion only: Overview of in-state and out-of-state NP programs, including but not limited to approval processes, use of clinical facilities, etc.

Committee Discussion: Samantha Gambles Farr introduced an informational item concerning NP students enrolled in California and out-of-state educational programs who seek clinical placements in California. She explained that the issue affects first-time NP students as well as practicing nurse practitioners pursuing additional certifications or doctoral education.

Loretta Melby explained that California began requiring formal approval of in-state and out-of-state NP programs following regulatory changes adopted in 2019. The Board began approving out-of-state programs in fall 2020. Approval of an out-of-state program does not represent a general endorsement of the institution. Rather, it indicates that the program is considered equivalent to California requirements and allows California-licensed RNs enrolled in the program to complete NP clinical education within the state. She stated that the Board has been identifying and bringing programs into compliance as it learns that they are placing students in California. She reported that the process has produced an unanticipated result: the number of students from out-of-state programs completing clinical education in California now exceeds the number of students enrolled in California programs. The Board does not want to disrupt the future healthcare provider pipeline, particularly because many California RNs attend out-of-state programs due to limited in-state capacity and the availability of online didactic education. At the same time, the volume of out-of-state students may make it more difficult for California programs to obtain clinical placements and expand enrollment. Loretta explained that the Board can determine whether an out-of-state program meets California's requirements and can approve or withdraw approval for clinical placements within California. However, the Board does not control the total enrollment of an out-of-state institution. One option under consideration is limiting the number of students from a particular out-of-state program who may complete clinical education in California. Under that approach, the school could continue enrolling additional California students, but those students might need to complete their clinical education outside the state. She emphasized that no final solution had been identified and that the item was presented for information rather than action.

Andrea Espinosa asked why students would attend an out-of-state school but complete their clinical education in California.

Loretta Melby explained that access is a primary factor. California had 35 in-state NP programs, while 41 out-of-state programs had already received approval to place students in California and nine additional programs had applications pending. Many out-of-state programs offer online coursework, allowing California RNs to complete didactic education remotely and pursue clinical placements near their homes or current workplaces. She stated that this flexibility makes out-of-state

education attractive, particularly when comparable California programs are unavailable or have limited capacity.

Samantha Gambles Farr added that the issue also affects practicing nurse practitioners seeking a second certification, particularly in specialties such as acute care, for which California has limited educational options. She explained that these practitioners may complete online coursework through an out-of-state institution while seeking clinical experiences in California. The same concern may apply to students pursuing Doctor of Nursing Practice degrees or other advanced education requiring clinical hours. She noted that healthcare organizations are increasingly verifying whether an out-of-state school has BRN approval before allowing its students to participate in clinical placements.

Loretta Melby provided examples illustrating the difference between in-state and out-of-state enrollment. She reported five in-state neonatal NP students compared with 34 out-of-state students, 51 in-state women's health NP students compared with 94 out-of-state students, and 342 in-state adult-gerontology primary or acute care students compared with 876 out-of-state students. She stated that the Board would continue reviewing the issue and that information concerning approved programs, educational tracks, enrollment numbers, and approval requirements is publicly available through the BRN.

Kevin Maxwell stated that California educational institutions already experience significant difficulty obtaining clinical placements. He reported that his school had been unable to maintain some programs because it could not secure placements, despite employing a full-time staff member dedicated to that work. He expressed support for prioritizing California schools and encouraging more practitioners and facilities to serve as preceptors.

Loretta Melby acknowledged the concern and explained that current regulations do not clearly allow the Board to deny an otherwise qualified out-of-state program solely because of placement competition. Regulatory changes may therefore be needed. In the interim, the Board is reviewing historical placement numbers when considering applications and attempting to prevent large, sudden increases that could destabilize California's existing clinical education infrastructure.

Betha Schnelle described the operational burden associated with accepting students for clinical placements. She noted that healthcare organizations already devote substantial resources to onboarding and training their own employees and may have difficulty absorbing the additional cost of training students who will not necessarily remain with the organization. She suggested considering monetary or nonmonetary incentives to encourage facilities to offer more placements.

Loretta Melby stated that the BRN does not have authority to provide such incentives and that decisions regarding whether to accept

students generally rest with individual healthcare facilities and their educational partners.

Andrea Espinosa asked whether available California placements could be limited to California residents rather than students coming from outside the state.

Loretta Melby clarified that students completing NP clinical education in California must already hold a California RN or NP license. However, licensure does not necessarily establish California residency because individuals may live in neighboring states while holding a California license. She further explained that many students enrolled in out-of-state programs are themselves California licensees seeking to complete clinical education near home. Therefore, the issue generally involves the same California workforce rather than a simple distinction between California and non-California students. Loretta concluded that the Board had not identified a straightforward resolution because limiting out-of-state placements could protect California educational programs while also restricting educational access for California nurses.

**Public Comment
for Agenda Item**

10.0: No public comments

**Additional
Discussion:**

Andrea Espinosa asked whether the need for additional NP clinical placement sites could be highlighted publicly and whether clinicians willing to precept students could help address the shortage. Drawing on her prior experience precepting family nurse practitioner students for UCLA, she asked whether the Board could advertise the need for additional clinical sites.

Samantha Gambles Farr indicated that clinical placement coordination generally occurs through educational institutions rather than the Board.

Loretta Melby encouraged interested clinicians to contact local nurse practitioner programs directly and offer themselves as preceptors, noting that schools would welcome additional clinical placement opportunities. However, she stated that coordinating clinical placements and recruiting preceptors falls within the responsibility of educational programs rather than the Board of Registered Nursing.

Andrea Espinosa reiterated her question regarding whether awareness of the clinical placement shortage could be promoted more broadly.

Loretta Melby explained that such outreach would more appropriately fall within the jurisdiction of schools and educational programs that manage placement needs and recruit clinical preceptors.

Samantha Gambles Farr agreed and stated that responsibility for identifying and securing clinical sites primarily rests with educational institutions rather than the Board.

4:18 pm

11.0 Adjournment

Samantha Gamble Farr, Chair, adjourned the meeting at 4:18 pm.

Submitted by:

Approved by:

McCaulie Feusahrens

Assistant Executive Officer
California Board of Registered Nursing

**Samantha Gambles Farr, RN, MSN,
FNP-C, CCRN, RNFA**

Chair
Nurse Practitioner Advisory Committee

Loretta Melby, MSN, RN

Executive Officer
California Board of Registered Nursing



Agenda Item 5.0

Discussion and possible action: Regarding election of Chair and Vice Chair positions

Nurse Practitioner Advisory Committee (NPAC) Meeting | October 20, 2026

**BOARD OF REGISTERED NURSING
Nurse Practitioner Advisory Committee Meeting
Agenda Item Summary**

AGENDA ITEM: 5.0
DATE: October 20, 2026

ACTION REQUESTED: Discussion and possible action: Regarding election of Chair and Vice Chair positions

REQUESTED BY: Loretta Melby, Executive Officer

BACKGROUND:

NPAC members will nominate and vote on a committee Chair and Vice Chair to facilitate meetings in collaboration with the Board's Executive Officer. The Chair will develop the meeting agendas in collaboration with the Board's Executive Officer, staff liaison, and other Board support staff. The Vice Chair has the authority to perform the committee Chair's duties in the Chair's absence and is knowledgeable regarding issues that impact NPAC and the policies and procedures by which the committee must be run. Members must be available for telephone and email consultation with BRN staff relative to program work and other program issues.

RESOURCES:

NEXT STEPS:

FISCAL IMPACT, IF ANY: None

PERSON(S) TO CONTACT: McCaulie Feusahrens
Assistant Executive Officer
California Board of Registered Nursing
mccaulie.feusahrens@dca.ca.gov



Agenda Item 6.0

Discussion and possible action: Regarding meeting dates for 2026

Nurse Practitioner Advisory Committee (NPAC) Meeting | October 20, 2026

**BOARD OF REGISTERED NURSING
Nurse Practitioner Advisory Committee Meeting
Agenda Item Summary**

AGENDA ITEM: 6.0
DATE: October 20, 2026

ACTION REQUESTED: Discussion and possible action: Regarding meeting dates for 2027

REQUESTED BY: Loretta Melby, Executive Officer

BACKGROUND:

The NPAC will meet twice per year. Meetings will be open to the public and adhere to the Bagley-Keene Open Meeting Act requirements. Special meetings may be held at such times as the Board may elect, or on the call of the Board President or the Executive Officer.

A proposed schedule is included in the meeting materials.

RESOURCES:

NEXT STEPS:

FISCAL IMPACT, IF ANY: None

PERSON(S) TO CONTACT: McCaulie Feusahrens
Assistant Executive Officer
California Board of Registered Nursing
mccaulie.feusahrens@dca.ca.gov

Board, Committee, and Advisory Committee Meetings in 2027

January 20, 2027	Board Advisory Committee Meeting Nursing Education and Workforce Advisory Committee
February 10-11, 2027	Board Committee Meetings Nursing Practice Committee Education/Licensing Committee Enforcement, Investigations, and Intervention Committee Legislative Committee
March 24, 2027	Board Meeting
April 6, 2027	Board Advisory Committee Meeting Clinical Nurse Specialist Advisory Committee Certified Registered Nurse Anesthetist Advisory Committee
April 27, 2027	Board Advisory Committee Meeting Nurse-Midwifery Advisory Committee Nurse Practitioner Advisory Committee
May 12-13, 2027	Board Committee Meetings Nursing Practice Committee Education/Licensing Committee Enforcement, Investigations, and Intervention Committee Legislative Committee
June 23, 2027	Board Meeting
July 28, 2027	Board Advisory Committee Meeting Nursing Education and Workforce Advisory Committee
August 4-5, 2027	Board Committee Meetings Nursing Practice Committee Education/Licensing Committee Enforcement, Investigations, and Intervention Committee Legislative Committee
September 22, 2027	Board Meeting
October 5, 2027	Board Advisory Committee Meetings Clinical Nurse Specialist Advisory Committee Certified Registered Nurse Anesthetist Advisory Committee
October 19, 2027	Board Advisory Committee Meetings Nurse-Midwifery Advisory Committee Nurse Practitioner Advisory Committee
November 3-4, 2027	Board Committee Meetings Nursing Practice Committee Education/Licensing Committee Enforcement, Investigations, and Intervention Committee Legislative Committee
December 8, 2027	Board Meeting



Agenda Item 7.0

Report from the Board of Registered Nursing's Executive Officer on activities which may impact nurse practitioners, including policy and procedure changes, regulatory updates, etc.

Nurse Practitioner Advisory Committee (NPAC) Meeting | October 20, 2026

**BOARD OF REGISTERED NURSING
Nurse Practitioner Advisory Committee Meeting
Agenda Item Summary**

AGENDA ITEM: 7.0
DATE: October 20, 2026

ACTION REQUESTED: **Discussion and possible action:** Report from the Board of Registered Nursing's Executive Officer on activities which may impact nurse practitioners, including policy and procedure changes, regulatory updates, etc.

REQUESTED BY: Loretta Melby, RN, MSN
Executive Officer

BACKGROUND:

Loretta Melby, Executive Officer for the Board of Registered Nursing, will provide updates on Board activities which may impact nurse practitioners.

RESOURCES:

NEXT STEPS:

FISCAL IMPACT, IF ANY: None

PERSON(S) TO CONTACT: McCaulie Feusahrens
Assistant Executive Officer
California Board of Registered Nursing
mccaulie.feusahrens@dca.ca.gov



Agenda Item 8.0

Regarding possible assignment/reassignment of members and/or topics to subcommittees and updates from the following subcommittees: Business and Professions Code (BPC) section 2837.101, Transition to Practice; BPC section 2837.104; and Discipline

Nurse Practitioner Advisory Committee (NPAC) Meeting | October 20, 2026

BOARD OF REGISTERED NURSING
Nurse Practitioner Advisory Committee Meeting
Agenda Item Summary

AGENDA ITEM: 8.0
DATE: October 20, 2026

ACTION REQUESTED: **Discussion and Possible Action:** Regarding possible assignment/reassignment of members and/or topics to subcommittees and updates from the following subcommittees: Business and Professions Code (BPC) section 2837.101, Transition to Practice; BPC section 2837.104; and Discipline

REQUESTED BY: Samantha Gambles Farr, RN, MSN, FNP-C, CCRN, RNFA
NPAC Chair

BACKGROUND:

The three NPAC subcommittees will provide updates on work conducted:

- 2837.101 Transition to Practice
- 2837.104
- Discipline

Additionally, the members of the Discipline subcommittee will provide updates on the work conducted and any trends/issues with final dispositions of disciplinary cases against NPs. Discipline data for the past eight (8) years is included in the two charts below:

Nurse Practitioner (NP) Discipline Statistics

Type of Discipline	2018	2019	2020	2021	2022	2023	2024	2025	2026 (as of 10/1/26)
Public Repeal	13	11	5	10	5	17	19	28	19
Probation	14	16	23	30	24	24	28	31	9
Surrender	15	19	9	6	7	8	8	14	11
Voluntary Surrender during Probation	3	3	3	3	3	6	2	3	0
Revocation	5	6	12	8	9	15	15	12	6
Reinstatement	1	0	0	0	0	0	0	0	0
Total	51	55	52	57	48	70	72	88	45
Active NP Licenses	25,297	26,305	27,640	29,699	32,616	36,092	39,919	43,800	47,957
Percentage of NPs Disciplined	0.20%	0.21%	0.19%	0.19%	0.15%	0.19%	0.18%	0.20%	0.09%

NP Discipline Statistics – Violation Types

Violation Type	2018	2019	2020	2021	2022	2023	2024	2025	2026 (as of 10/1/26)
Practice	26	27	21	30	17	27	23	27	12
801 Practice	7	3	1	7	6	1	4	5	3
Out-of-State Discipline (OSD)	8	14	7	3	5	16	12	25	11
Conviction	7	6	12	6	7	13	19	19	11
Substance Use Disorder (SUD)	3	4	5	4	3	3	5	3	2
Sexual Misconduct	0	0	0	2	3	1	2	0	0
Other	0	1	6	5	7	9	7	9	6
Total	51	55	52	57	48	70	72	88	45
Active NP Licenses	25,297	26,305	27,640	29,699	32,616	36,092	39,919	43,800	47,957
Percentage of NPs Disciplined	0.20%	0.21%	0.19%	0.19%	0.15%	0.19%	0.18%	0.20%	0.09%

Active Licenses by Fiscal Year

Fiscal Year	18/19	19/20	20/21	21/22	22/23	23/24	24/25	25/26	26/27 (1 Qtr)
Registered Nurse	451,934	458,165	466,704	480,568	524,129	534,035	549,040	568,132	573,152
Clinical Nurse Specialist	3,458	3,391	3,323	3,137	3,209	3,042	3,029	2,969	2,925
Certified Registered Nurse Anesthetist	2,585	2,682	2,772	2,841	3,069	3,218	3,337	3,465	3,491
Nurse Midwife	1,346	1,349	1,368	1,352	1,427	1,432	1,460	1,509	1,491
Nurse Practitioner	26,305	27,640	29,699	32,616	36,092	39,919	43,800	47,069	47,957

The committee may assign/reassign members and/or topics to subcommittees, if needed.

RESOURCES:

BRN Disciplinary Guidelines: <https://www.rn.ca.gov/pdfs/enforcement/discguide.pdf>

NEXT STEPS:

FISCAL IMPACT, IF ANY:

None

PERSON(S) TO CONTACT:

McCaulie Feusahrens
Assistant Executive Officer
California Board of Registered Nursing
mccaulie.feusahrens@dca.ca.gov



Agenda Item 9.0

Information and discussion only: Review and possible updates to the NPAC Charter

Nurse Practitioner Advisory Committee (NPAC) Meeting | October 20, 2026

**BOARD OF REGISTERED NURSING
Nurse Practitioner Advisory Committee Meeting
Agenda Item Summary**

AGENDA ITEM: 9.0

DATE: October 20, 2026

ACTION REQUESTED: **Discussion and possible action:** Review and possible updates to the NPAC Charter

REQUESTED BY: Samantha Gambles Farr, RN, MSN, FNP-C, CCRN, RNFA
NPAC Chair

BACKGROUND:

The NPAC members will review the NPAC Charter and make recommendations for updates, if applicable.

RESOURCES:

NEXT STEPS:

FISCAL IMPACT, IF ANY: None

PERSON(S) TO CONTACT: McCaulie Feusahrens
Assistant Executive Officer
California Board of Registered Nursing
mccaulie.feusahrens@dca.ca.gov

The California Board of Registered Nursing's Nurse Practitioner Advisory Committee

The mission of the California Board of Registered Nursing (Board or BRN) is to protect the health, safety, and well-being of the public through the fair and consistent application of the statutes and regulations governing nursing practice and education in California. The Board values include effectiveness, integrity, transparency, collaboration and equity.

Background

In 2018, the Senate Committee on Business, Professions and Economic Development and the Assembly Business and Professions Committee requested the Board to establish an Advanced Practice Registered Nursing Advisory Committee (APRNAC) with a goal to survey existing laws and regulations to determine what is lacking for regulation of Advance Practice Registered Nurses (APRNs) including the direction to seek legislation, promulgate regulations, and develop advisories to ensure APRNs have sufficient guidance in all practice settings. This advisory committee was later sunset in 2022 to allow for greater focus on role specific needs and reaffirmed the Nurse Practice committee will advise the Board on matters related to nursing practice, including common nursing practice and advanced practice issues related to the APRN roles.

On September 29, 2020, Governor Newsom signed Assembly Bill (AB) 890 into law which established the Nurse Practitioner Advisory Committee (NPAC). ~~AB 890 made changes to the Business and Professions Code (BPC) and, in summary, does the following:~~

- ~~• Established the Nurse Practitioner Advisory Committee (NPAC) to advise and give recommendations to the Board on matters relating to nurse practitioners and provide recommendations or guidance to the Board when the Board is considering disciplinary action against a Nurse Practitioner (NP).~~
- ~~• Requires the Board, by regulation, to define minimum standards for a NP to transition to practice independently.~~
- ~~• Authorizes a NP who meets certain education, experience, and certification requirements to perform, in certain settings or organizations, specified functions without standardized procedures, including ordering, performing, and interpreting diagnostic procedures, certifying disability, and prescribing, administering, dispensing, and furnishing controlled substances. Beginning January 1, 2023, authorizes a NP to perform those functions without standardized procedures outside of specified settings or organizations in accordance with specified conditions and requirements if the nurse practitioner holds an active certification issued by the Board.~~
- ~~• Requires the Board to request the Department of Consumer Affairs' Office of Professional Examination Services, or an equivalent organization, to perform an occupational analysis of NPs performing certain functions to be completed by January 1, 2023.~~
- ~~• Requires the Board to take specified measures to identify and assess competencies.~~
- ~~• Requires the Board to identify and develop a supplemental examination for licensees if needed based on the assessment.~~
- ~~• Exempts a peer review body from the requirement to file an 805 report for an action taken as a result of a revocation or suspension, without stay, of a NP's license by the Board or a licensing agency of another state.~~
- ~~• Requires the action or proceeding to be brought by the Board if the person who failed to file an 805 report is a licensed NP.~~

On February 9, 2021 and March 16, 2021, the Board appointed the initial members to the NPAC.

The Board recognizes that nurse practitioner (NP) practice is a dynamic field that continues to evolve as patient care grows increasingly complex and sophisticated. The Board further acknowledges that applicable statutes and regulations may be amended from time to time to reflect changes in healthcare practice, legal requirements, and public policy. In amending this charter, the Board intends to provide clear legal authority for the functions, procedures, and governance of the NPAC. This charter is intended to support the NPAC's ongoing ability to carry out its duties effectively within the framework of applicable laws and regulations as they may be revised in the future.

NPAC Purpose/Charge

Pursuant to BPC section [2837.102](#) the Board is authorized to appoint qualified NPs, physicians and public members to NPAC to advise and make recommendations to the Board on all matters relating to NPs, including but not limited to, education, appropriate standard of care, and other matters specified by the board. The NPAC shall provide recommendations or guidance to the Board when the Board is considering disciplinary action against an NP.

Relationship to the Board

NPAC is an advisory committee of the Board. NPAC meetings are conducted pursuant to the Bagley-Keene Open Meeting Act as set forth in Government Code (GOV) sections [11120-11132](#).

NPAC information and recommendations may be forwarded to the Nursing Practice Committee, where Board members assigned to that committee will hear and refer the information to the full Board. The Board's Executive Officer (EO) or NPAC staff liaison will facilitate the referral of NPAC recommendations. If time does not allow information and recommendations to be forwarded to the Nursing Practice Committee, referral may be made to the full Board. Referral to the Nursing Practice Committee or the full Board will depend on the relevance of the topic/issue to laws and regulations, the Board's public protection mandate, time-sensitivity, and other factors. Referred recommendations may be information-only or may request Board action in some instances.

Membership

In accordance with BPC section [2837.102\(b\)](#), the NPAC shall be composed of the following:

- Four (4) qualified NPs,
- Two (2) qualified physicians and surgeons with demonstrated experience working with NPs, and
- One (1) public member.

Except as provided below, all appointments shall be for a term of four years and vacancies shall be filled for the unexpired term. No person shall serve more than two consecutive terms.

The initial appointments shall be for the following terms:

- Two of the four licensed NPs shall serve a term of four years. One licensed NP shall serve a term of three years and the remaining NP shall serve a term of two years.
- One of the two physicians/surgeons shall serve a term of three years and the other shall serve a term of four years.
- The public member shall serve a term of four years.

NPAC members will identify and vote on a committee Chair and Vice-Chair to facilitate NPAC meetings in collaboration with the Board's EO or NPAC staff liaison. The NPAC Chair will develop the meeting agendas in collaboration with the Board's EO, NPAC staff liaison, and other Board support staff. Only appointed NPAC committee members vote on meeting agenda items when a vote is required. This may include items such as approval of minutes and specific recommendations to be moved forward to Board Committees or the full Board. The NPAC Vice-Chair has the authority to perform the committee Chair's duties in the Chair's absence and is knowledgeable regarding issues that impact NPAC and the policies and procedures by which the committee must be run. Members must be available for telephone and email consultation with BRN staff relative to program work and other program issues.

A listing of NPAC members will be maintained by the BRN and include appointment start and end dates. A public listing of the NPAC members will be posted on the [BRN website](#). Appointed members resigning before their appointed term ends are asked to submit a letter of resignation directed to the attention of the NPAC Chair and the Board's EO. The Board's EO or designee will facilitate the application process to fill committee vacancies and submit for Board appointment, as needed. Committee members may be removed by the Board

prior to expiration of their term for dereliction of duties as a committee member, misconduct, or other good cause.

Meetings

The NPAC meets up to four times per year, ~~generally, the day before a Board meeting, with~~—The meetings will typically be scheduled for ~~two hours~~ 90 minutes. Meetings and will be held virtually and/or at various locations throughout the state. All NPAC meetings will be open to the public and will adhere to the Bagley-Keene Open Meeting Act requirements.

Special meetings may be held at such times as the board may elect, or on the call of the Board President or the Board's EO. The NPAC agenda and materials are posted on the [BRN website](#) per GOV section [11125](#). Committee members will be asked to provide agenda items, a brief agenda item summary, and meeting materials in advance of meetings according to the requested submission timelines established by BRN staff. Meeting materials will be posted on the BRN website in the same location as the specific meeting agenda, meeting location, minutes etc. Meeting materials received during or after a meeting will subsequently be posted on the BRN website along with other already posted meeting materials and will be labeled as addenda/supplemental materials.

Meeting agenda items will be discussed using standard meeting management procedures. Members of the public and other interested parties will be provided opportunities to speak during public comment periods or as requested by committee members during meetings. Time allocated for public comment may be limited by the NPAC meeting chair to facilitate effective meeting time management consistent with GOV section [11125.7](#).

NPAC meeting minutes are prepared by the designated BRN staff. The Board EO or designee, Legal Counsel and NPAC Chair will review meeting minutes for accuracy and needed edits in advance of submission to the NPAC members. The Committee will vote to approve draft minutes at NPAC meetings. Finalized meeting minutes will be signed and dated by the EO or designee and NPAC Chair and subsequently posted on the [BRN website](#) in the same section as the meeting agenda and the meeting materials.

Quorum:

Four NPAC members at any NPAC meeting constitutes a quorum.

Board Staff:

BRN staff will regularly support the committee by providing meeting assistance, advice, consultation, reports/presentations and other forms of help as requested. Such staff include: the Board EO, the Assistant EO, the Chief of Licensing, the Chief of Enforcement, the NPAC staff liaison, Nursing Education Consultants (NEC)/Supervising NECs, and other staff as needed.

Review of NPAC Advisory Committee:

All advisory committees of the Board are required to engage in a self-evaluation annually. Annual review of the original goals of the committee should be completed to ensure the work of the committee continues to be relevant to the BRN, licensees, and the public. The terms of the committee members and the Chair and Vice-chair should be reviewed, and the committee should vote on an election process and determine if any exceptions are applicable based on the original mandate of the committee.

Additionally, the NPAC shall periodically review and update this document to ensure the document remains relevant to current statutes, regulations, the Board's mission and strategic plan, NP practice and workforce changes/updates, etc. At minimum, it will be reviewed and re-approved by the NPAC membership at least every four years from the last effective approval date. This document will include a signature page for the Board's EO and the NPAC Chair and Vice-Chair to sign and date once this document is approved by the membership in each review cycle.



Agenda Item 10.0

Discussion and possible action: Review and discussion of existing NP 103 and NP 104 Frequently Asked Questions (FAQs), including identification of any new FAQs for addition

Nurse Practitioner Advisory Committee (NPAC) Meeting | October 20, 2026

**BOARD OF REGISTERED NURSING
Nurse Practitioner Advisory Committee Meeting
Agenda Item Summary**

AGENDA ITEM: 10.0
DATE: October 20, 2026

ACTION REQUESTED: **Discussion and possible action:** Review and discussion of existing NP 103 and NP 104 Frequently Asked Questions (FAQs), including identification of any new FAQs for addition

REQUESTED BY: Samantha Gambles Farr, RN, MSN, FNP-C, CCRN, RNFA
NPAC Chair

BACKGROUND:

The NPAC members will review the 103 NP and 104 NP Frequently Asked Questions (FAQs) posted on the BRN website and discuss any new FAQs that should be added, if applicable.

RESOURCES:

Frequently Asked Questions: <https://www.rn.ca.gov/practice/ab890.shtml>

NEXT STEPS:

FISCAL IMPACT, IF ANY: None

PERSON(S) TO CONTACT: McCaulie Feusahrens
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California Board of Registered Nursing
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Frequently Asked Questions

Laws and Regulations

- **What is AB 890?**

In September 2020, Governor Gavin Newsom signed Assembly Bill (AB) 890 (Wood, Chapter 265, Statutes of 2020) into law which created two new categories of Nurse Practitioners (NPs) that could function within a defined scope of practice without standardized procedures. The bill also defined education, training, national certification, regulatory, and medical staff governance requirements for these two NP categories.

Certain provisions of the bill were later amended by passage of [SB 1451 \(Ashby, Chapter 481, Statutes of 2024\)](#).

- **What is the difference between statute and regulations?**

Statutes, also referred to as codes, are laws that are written and passed by the Legislature and signed by the Governor (or approved by the voters as a ballot measure). Regulations, also referred to as rules, are written by state agencies (e.g., Board of Registered Nursing), approved by the Office of Administrative Law and filed with the Secretary of State. Regulations are drafted to implement, interpret, or make specific the statute. Both statutes and regulations carry the force of law.

Most of the Board's statutes are housed within the Business and Professions Code (BPC). The statutory requirements of AB 890 are listed under [Division 2, Chapter 6, Article 8.5 of the BPC](#). Most of the Board's regulations are housed within Title 16 of the Code of California Regulations (CCR). The regulatory requirements of AB 890 are listed under [Title 16, Division 14, Article 8 of the CCR](#).

- **What are the two new NP categories?**

The two new categories established under AB 890 are commonly referred to as 103 NPs and 104 NPs. While they do not significantly extend or alter the current NPs scope of practice, the new categories do have additional authority to work without standardized procedures.

A 103 NP will work under the provisions outlined in [BPC Section 2837.103](#). This new category of NP can work without standardized procedures, in a group setting with at least one physician and surgeon.

A 104 NP will work under the provisions outlined in [BPC Section 2837.104](#). This new category of NP may work without standardized procedures, outside of a group setting, within the population focus of their National Certification.

103 NP Eligibility

- **Do I have to become a 103 NP?**

No. A move to a 103 or 104 NP is not required; it is just an option. The traditional role of the NP in California remains. If they wish to, NPs can continue to work under physician supervision with the use of standardized procedures in their existing settings.

There is also no requirement for facilities to employ 103 NPs and no requirement for NPs to certify as 103 NPs to retain employment. Furthermore, the ability to work under standardized procedures remains whether or not the licensee is a 103 or 104 NP. It is up to each licensee/facility/employer as to the extent the expanded authority is utilized.

In some instances, a NP may choose to continue practicing in a traditional role under standardized procedures because their current job or business setting is not included in the list of group settings that a 103 NP is required to work within. For example, an NP that works in a nursing corporation cannot practice as a 103 NP without standardized procedures or physician oversight.

- **What are the eligibility requirements to become a 103 NP?**

According to BPC Section 2837.103, the following criteria must be met to become a 103 NP:

- Is certified as a NP by the California Board of Registered Nursing.
- Holds a National Certification by a national certifying body accredited by the National Commission for Certifying Agencies or the American Board of Nursing Specialties and recognized by the Board.
- Has completed a transition to practice within the category of the National Certification in California of a minimum of three full-time equivalent years of practice or 4600 hours within 5 years of the date of your application.

- **Will NPs that do not meet 103 NP eligibility requirements still need a standardized procedures collaboration agreement?**

Yes, a standard NP must continue to practice under standardized procedures.

- **Can I obtain my national board certification during or after I complete my transition to practice hours?**

Yes, the 103 NP applicant can obtain their national board certification during or after completing the transition to practice (TTP) hours as long as the applicant receives their national certification prior to submitting their 103 NP application to the Board.

Transition to Practice

- **What is a transition to practice?**

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.

- **What criteria must the transition to practice experience meet?**

The transition to practice requirement is defined as 4600 hours or three full-time equivalent years of clinical practice experience and mentorship that are:

- Completed in California.
- Completed within five years prior to the date the applicant applies for certification as a 103 NP.
- Completed after certification by the Board of Registered Nursing as a NP.
- Completed in direct patient care.

- **How does the Board verify an applicant has completed their transition to practice?**

As a part of the application process, the applicant will be asked to submit information of the provider(s) who can attest to the completion of the 4,600 hours of the direct patient care hours that meet the TTP requirements. The Board will then send an email to the provider(s) listed asking for an attestation.

The attestor cannot have a familiar or financial relationship with the applicant and will be attesting to the applicant's completion of the transition to practice requirement under penalty of perjury. If a complaint about the accuracy of the reported hours or the attestors relationship to the applicant is received, it will be investigated through the Board's established enforcement process.

- **What will the 103 NP's mentoring provider have to attest to?**

The mentoring provider(s) identified by the 103 NP applicant as an attester, will be asked to attest to the following:

- That the 103 NP applicant completed all or a specified portion of the 4600 hours.
- That they do not have a familial or financial interest with the 103 NP applicant.
- That the facts to which they are attesting are correct, under penalty of perjury.

- **Is there any liability associated with providing an attestation on behalf of a 103 NP applicant?**

According to BPC Section 2837.103, a licensed physician and surgeon or a 104 NP who attests to the completion of a transition to practice is not required to verify competence, clinical expertise, or any other standards related to the practice of the applicant and shall only attest to the completion of the transition to practice.

Further, a licensed physician and surgeon or a 104 NP who attests to the completion of a transition to practice shall not be subject to civil, criminal, administrative, disciplinary, employment, credentialing, professional discipline, contractual liability, or medical staff action, sanction, or penalty or other liability for providing an attestation or refusing to provide an attestation, unless the attestation was produced fraudulently.

- **How does the TTP attestation occur?**

Once an NP submits their 103 NP application via the BreEZe online portal and identifies their attester(s) by license number, the BreEZe system will send a system-generated email to each identified attester.

When the attester(s) clicks on the link provided in the email they will be directed to an online portal where they can review the information provided by the 103 NP applicant including the number of TTP hours the applicant completed.

The attester can then indicate whether they approve or disapprove (or partially approve) of the 103 NP applicant's completion of those hours.

- **Can a Doctor of Osteopathy (DO) attest to the completion of TTP hours?**

Yes, a DO can attest to the completion of TTP hours.

- **Can a 103 NP or 104 NP attest to the completion of TTP hours?**

Yes, a 103 NP or 104 NP can attest to the completion of TTP hours.

Application Process

- **How do I apply to become a 103 NP?**

A new 103 NP application is now available in BreEZe. To access the 103 NP application and view step by step instructions, please visit the following page on the Board website: [Advanced Practice and Public Health Nurse Certification](#). Once on the page, please scroll down to the heading titled, "Nurse Practitioner Practicing Without Standardized Procedures in a Group Setting (103 NP)."

- **Do I need to apply for a separate furnishing license as a 103 NP?**

It depends. If you already have a furnishing license, you do not need to apply for a new one as a 103 NP. However, if you do not have a furnishing license and would like to be able to furnish without standardized procedures under your 103 NP certification, you will need to apply for one since the 103 NP certification does not automatically provide furnishing authority.

- **Does the 103 NP application have a fee?**

No. Currently, there is no fee to apply for certification as a 103 NP.

- **How should I submit proof of my national board certification to the Board?**

The Board requires proof of national board certification to be provided through primary source data. Please contact the national certifying body for information on their verification processes.

Practicing as a 103 NP

- **What setting can a 103 NP practice in?**

According to BPC Section 2837.103 (a)(2), a 103 NP may only practice in one of the following settings or organizations in which one or more physicians and surgeons practice with the nurse practitioner without standardized procedures:

- a) A clinic, as defined in [Section 1200 of the Health and Safety Code](#).
- b) A health facility, as defined in [Section 1250 of the Health and Safety Code](#), except for the following:
 - a. A correctional treatment center, as defined in paragraph (1) of subdivision (j) of [Section 1250 of the Health and Safety Code](#).
 - b. A state hospital, as defined in [Section 4100 of the Welfare and Institutions Code](#).
- c) A facility described in [Chapter 2.5 \(commencing with Section 1440\) of Division 2 of the Health and Safety Code](#).
- d) A medical group practice, including a professional medical corporation, as defined in [Section 2406](#), another form of corporation controlled by physicians and surgeons, a medical partnership, a medical foundation exempt from licensure, or another lawfully organized group of physicians and surgeons that provides health care services.
- e) A home health agency, as defined in [Section 1727 of the Health and Safety Code](#).
- f) A hospice facility licensed pursuant to [Chapter 8.5 \(commencing with Section 1745\) of Division 2 of the Health and Safety Code](#).

- **How can the public verify if a licensee has been certified as 103 NP?**

Once certified by the Board, an individual's authority to practice as a 103 NP or 104 NP will be displayed along with their RN license status through DCA's License Search. The DCA License Search is an online search tool that is available to the public and is used to verify a professional license issued by the various Boards and Bureaus under DCA.

To view this search tool, please visit: [DCA License Search](#).

- **Can a 103 NP still practice under standardized procedures?**

A 103 NP is authorized to practice without standardized procedures in specified settings. However, an employer can still require a 103 NP to practice under standardized procedures.

- **What are the consumer notification requirements for 103 NP and 104 NPs?**

The following consumer notification requirements are mandatory for 103 NPs and 104 NPs. They are optional for all other NPs.

Except when working in facilities under the California Department of Corrections and Rehabilitation, a 103 or 104 NP engaged in providing healthcare services shall do all the following:

Prominently post a notice, in at least 48-point Arial font, in a conspicuous location accessible to public view on the premises where the nurse practitioner provides the healthcare services, containing the following information:

NOTICE
Nurse practitioners are licensed and regulated by the
Board of Registered Nursing
(916) 322-3350
www.rn.ca.gov

Verbally inform all new patients in a language understandable to the patient that a nurse practitioner is not a physician and surgeon.

- **What happens if a 103 NP's national board certification expires?**

If their national board certification expires, the NP must immediately begin practicing under standardized procedures. The NP can only resume practicing as a 103 NP without standardized procedures once they have regained their national board certification.

- **Should a 103 NP or 104 NP list any new initials on their academic credentials?**

No, the Board chose not to create additional initials or make any title changes associated with certification as a 103 NP or 104 NP.

104 NP Eligibility

- **How long do I have to work as a 103 NP before I can become a 104 NP?**

According to 16 CCR 1482.4, a 103 NP must practice in good standing for at least three full-time equivalent years or 4600 hours in direct patient care before they can become a 104 NP. The term, "in good standing" means practice conducted under a current, active, and unrestricted license. The term "unrestricted" means the applicant was not subject to a disciplinary action by the Board, including probation, suspension, or public reproof.

If a 104 NP applicant holds a Doctor of Nursing Practice (DNP), they may apply any hours of direct patient care they provided in the course of their doctoral education toward the three-year requirement mentioned above, so long as the direct patient care experience is in the applicant's area of National Certification and provided during the doctoral part of the applicant's doctoral education and not credited towards the applicant's master's degree.

Practicing as a 104 NP

- **Can I open an independent practice as a 104 NP?**

Yes. A 104 NP can practice without standardized procedures outside of a group setting. However, they cannot practice beyond the scope of their clinical and professional education and training, including specific areas of concentration. A 104 NP can only practice within the limits of their knowledge and experience and national certification.

In addition, BPC Section 2837.104(c) requires a 104 NP to conduct a certain level of consultation, collaboration, and referral to other healing arts providers based on the clinical condition of the patient receiving care.