Date of Hearing: June 30, 2026

ASSEMBLY COMMITTEE ON BUSINESS AND PROFESSIONS
Marc Berman, Chair
SB 1302 (Wahab) – As Amended April 23, 2026

SENATE VOTE: 38-0

SUBJECT: Nursing

SUMMARY: Makes various changes to the regulation of registered nurses (RNs) and advanced practice registered nurses (APRNs) recommended as part of the joint sunset review oversight of the Board of Registered Nursing (BRN).

EXISTING LAW:

1) Regulates the practice of nursing through the licensure of RNs and the approval of RN training programs under the Nursing Practice Act. (Business and Professions Code (BPC §§ 2700-2838.4)

2) Establishes the BRN within the Department of Consumer Affairs to administer and enforce the Nursing Practice Act until January 1, 2027. (Business and Professions Code (BPC §§ 2700-2717*)*

3) Declares that protection of the public shall be the highest priority for the BRN in exercising its licensing, regulatory, and disciplinary functions. Whenever the protection of the public is inconsistent with other interests sought to be promoted, the protection of the public shall be paramount. (BPC § 2708.1)

4) Requires the BRN to meet at least once every three months, and meetings must be held in both Northern and Southern California, as specified. (BPC § 2709)

5) Defines an APRN, as those licensed RNs who have met specified requirements for registration as Nurse Practitioners, Nurse Anesthetists, Nurse Midwives, and Clinical Nurse Specialists, as specified. (BPC § 2725.5)

6) Requires written examinations for licensure, but in the discretion of the BRN may be supplemented by an oral examination in subjects determined by the BRN, as specified. (BPC § 2740)

7) Permits nursing services to be rendered by a student when those services are incidental to the course of study when a student is enrolled in a BRN-approved prelicensure program or school of nursing, or a nurse licensed in another state is taking a BRN-approved CE course or post-licensure course. (BPC § 2729)

8) Authorizes an RN whose license has been suspended, revoked, or placed on probation to petition the BRN for reinstatement or modification, after a period not less than the following minimum periods has elapsed from the effective date of the decision, as specified:

a) At least three years for reinstatement of a license that was revoked, except that the board may, in its sole discretion, specify in its order a lesser period of time provided that the period shall be not less than one year.

b) At least two years for early termination of a probation period of three years or more.

c) At least one year for modification of a condition, or reinstatement of a license revoked for mental or physical illness, or termination of probation of less than three years. (BPC § 2760.1)

9) Requires the BRN to establish one or more Intervention Evaluation Committees (IEC), and each IEC must have five members, who cannot be a member of the BRN. (BPC § 2770.2)

10) Requires whenever the Governor declares a state of emergency for a county in which an agency or facility used by an approved nursing program for direct patient care clinical practice is no longer available, the director may submit a request to the BRN to, among other accommodations, reduce the number of direct patient care hours to 50% in geriatrics and medical-surgical and to 25% in mental health-psychiatric nursing, obstetrics, and pediatrics if specified conditions are met. (BPC § 2786.3(a)(3))

11) States that it is the duty of the BRN, through its EO, to inspect all schools of nursing in this state at such times the BRN deems necessary; and written reports of the EO's visits are to be made to the BRN, as specified. (BPC § 2788)

12) Requires an NP to obtain a furnishing number from the BRN to furnish drugs or devices, as specified and permits the BRN issue a furnishing number upon initial application and, if approved by the board, the applicant is not required to make a separate application. (BPC § 2836.3)

13) Defines a "transition to practice" to means additional clinical experience and mentorship provided to prepare a NP to practice independently, and 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. (BPC § 2837.101(c))

THIS BILL:

1) Extends the operations of the BRN and its authority to appoint an executive officer by four years, until January 1, 2031.

2) Requires the BRN to make a list of approved schools of nursing available on its website.

3) Revises the requirement for the BRN to meet in northern and southern California and allows the BRN to meet in appropriate locations that are necessary to transact its business.

4) Requires the BRN's inspection criteria to be consistent with the 2020 Nursing Education Approved Guidelines established by the National Council of State Board of Nursing

(NCSBN) or its successor as approved by the BRN.

5) Deletes the requirement for licensure examinations to be written and the authorization for the BRN to offer a supplemental oral or practical examination.

6) Combines the renewal and furnishing application for CNMs, and NPs.

7) Replaces the percentage requirement for clinical experience with an hourly requirement during a declared state of emergency, as specified.

8) Requires any clinical practice hours that are not required to be in direct patient care and are provided using simulation experience to be based on the best practices published by the International Nursing Association for Clinical Simulation and Learning, the National Council of State Boards of Nursing, the Society for Simulation in Healthcare, or equivalent standards approved by the BRN.

9) Allows the transition to practice qualification for NPs to be completed in another state, in addition to California.

10) Repeals outdated references to fee floors, as specified.

11) Makes additional technical and clarifying changes.

FISCAL EFFECT: According to the Senate Appropriations Committee, the 2026-27 Governor's Budget provides approximately $64.53 million (BRN Fund) and 219.8 positions to support the continued operation of the BRN's licensing and enforcement activities.

BRN does not anticipate any additional fiscal impacts.

COMMENTS:

Purpose. This bill is sponsored by the author. According to the author, "this bill is necessary to make changes to the BRN to improve oversight of the regulated professions under its jurisdiction."

Background. Each year, the Assembly Committee on Business and Professions and the Senate Committee on Business, Professions, and Economic Development hold joint sunset review oversight hearings to review the licensing entities under the Department of Consumer Affairs (DCA). The DCA boards, bureaus, and other entities are responsible for protecting consumers and the public and regulating the professionals they license. The sunset review process provides an opportunity for the legislature, DCA, licensing entities, and stakeholders to discuss the entities' performance and make recommendations for improvements.

Each licensing entity subject to review has an enacting statute with a repeal date, meaning their authority must be extended by the legislature before the repeal date, otherwise the entity will lose its statutory mandate. This bill is a "sunset" bill, intended to extend the repeal date of the RCB, as well as incorporate the recommendations from the sunset review oversight hearings. This year there are ten boards up for review, each with their own sunset bill. This year, five of the sunset

review bills are authored by the chair of the Assembly Committee on Business and Professions and the other five are authored by the chair of the Senate Committee on Business, Professions, and Economic Development.

BRN. The BRN is responsible for administering and enforcing the Nursing Practice Act, which establishes the board and contains the regulatory framework for the practice of nursing. The BRN licenses and regulates over 500,000 nurse-licensees in California, which is typically one of the highest population of nurses in any state. In addition to licensing RNs, the BRN issues certificates to APRNs which include NPs, Certified Registered Nurse Anesthetists (CRNAs), Certified Nurse Midwives (CNMs), and Clinical Nurse Specialists (CNSs).

The BRN is responsible for determining educational standards for all prelicensure nursing programs, approving such programs, approving continuing education providers, evaluating and licensing applicants, administering discipline, managing an intervention program for licensees with substance use disorders or mental illness, and providing stakeholder information and outreach. The BRN is a special fund agency that obtains its revenues from licensing, renewal and other fees. The BRN does not receive funding from the General Fund.

To be eligible for licensure in California, an individual must complete an education program approved by the BRN. Today, approved RN programs are offered at various academic institutions throughout California including Community Colleges, California State Universities, California Universities, and private for-profit institutions regulated by the Bureau of Private Postsecondary Education. All programs are required to meet the BRN's regulatory requirements for approved programs and curriculum and the BRN must determine the areas of course work required for each program through regulations.

Current Related Legislation. AB 2771 (Committee on Business and Professions) is the sunset review bill for the Bureau of Private Postsecondary Education. *AB 2771 is pending in the Senate.*

AB 2772 (Committee on Business and Professions) is the sunset review bill for the California Council for Interior Design Certification. *AB 2772 is pending in the Senate.*

AB 2773 (Committee on Business and Professions) is the sunset review bill for the California Board of Occupational Therapy. *AB 2773 is pending in the Senate.*

AB 2774 (Committee on Business and Professions) is the sunset review bill for the Physical Therapy Board of California. *AB 2774 is pending in the Senate.*

AB 2775 (Committee on Business and Professions) is the sunset review bill for the State Board of Chiropractic Examiners BCE. *AB 2775 is pending in the Senate.*

SB 1303 (Wahab) is the sunset review bill for the California Board of Naturopathic Medicine. *SB 1303 is pending in this Committee*.

SB 1304 (Wahab) is the sunset review bill for the California Respiratory Care Board. *SB 1304 is pending in this Committee*.

SB 1363 (Wahab) is the sunset review bill for the California Board of Barbering and Cosmetology. *SB 1363 is pending in this Committee*.

SB 1368 (Wahab) is the sunset review bill for the California Speech-Language Pathology & Audiology & Hearing Aid Dispensers Board. *SB 1368 is pending in this Committee*.

Prior Related Legislation. AB 876 (Flora), Chapter 169, Statutes of 2025, defined anesthesia services for purposes of clarifying the authority of a CRNA to practice pursuant to an order in a patient's chart, as specified.

SB 1451 (Ashby), Chapter 481, Statutes of 2024, among other things unrelated to nursing, made changes to the requirements for NPs practicing independent of standardized procedures, as specified.

AB 2578 (Flora) of 2024 would have authorized a student who is a resident of the state and enrolled in a prelicensure distance education nursing program based at an out-of-state private postsecondary educational institution to provide supervised nursing services that are incidental to the course of study for the purpose of gaining clinical experience in a clinical setting if specified criteria are met. *AB 2578 was held on the Senate Committee on Appropriations suspense file*.

SB 1042 (Roth) of 2024, among various other provisions, would have required a defined health facility that offers clinical placement slots, upon the request of an approved school of nursing or an approved program, to meet with representatives of the school or program to discuss the clinical placement needs, among other provisions. *SB 1042 was held on the Assembly Committee on Appropriations suspense file*.

SB 1015 (Cortese) Chapter 776, Statutes of 2024, required the BRN to study and recommend standards regarding how approved schools of nursing or nursing programs manage or coordinate clinical placements and to annually collect, analyze, and report information related to the coordination of clinical placements.

AB 2015 (Schiavo) Chapter 370, Statutes of 2024, authorized the BRN to approve an individual to serve as a member, director, or assistant director of faculty of a school of nursing or nursing program.

AB 1577 (Low), Chapter 680, Statutes of 2023, required hospitals that offer pre-licensure clinical training slots to work in good faith with community college nursing programs to meet their clinical training needs.

AB 2684 (Berman), Chapter 413, Statutes of 2022, made changes to address the lack of clinical placements, including establishing a lower 500 minimum number of clinical experience hours, authorizing clinical placements to take place in the academic term immediately following theory, prohibiting nursing schools and programs from paying for clinical placements, and requiring the BRN to utilize data from available regional or individual institution databases in collecting information related to the number of clinical placement slots available to nursing students.

AB 2288 (Low), Chapter 282, Statutes of 2020, authorized the director of an approved nursing program, during a state of emergency, to make requests to the BRN for the following: 1) use of a

clinical setting without meeting specified requirements; 2) use of preceptorships without having to maintain specified written policies; 3) use of clinical simulation up to 50% for medical-surgical and geriatric courses; 4) use of clinical simulation up to 75% for psychiatric-mental health nursing, obstetrics, and pediatrics courses; and 5) allowing clinical placements to take place in the academic term immediately following theory.

AB 1015 (Blanca Rubio), Chapter 591, Statutes of 2021, required the BRN to incorporate regional forecasts into its biennial analyses of the nursing workforce, develop a plan to address regional areas of shortage identified by its nursing workforce forecast, as specified, and annually collect, analyze, and report information related to the number of clinical placement slots that are available and the location of those clinical placement slots within the state.

ARGUMENTS IN SUPPORT:

The *California Association of Nurse Anesthesiology* writes in support:

> CANA is grateful for the BRN's hard work, transparency, and thoughtful stakeholder engagement throughout the sunset review process. The Board plays a critical role in protecting the public while ensuring that California's nursing workforce can meet the growing and evolving health care needs of our communities. The proposals included in the Sunset Bill reflect careful consideration of operational realities, workforce demands, and patient safety.
>
> CANA is especially supportive of including clarification related to APRN to RN Delegation [Sunset Issue #13]. This provision clarifies current practice and provides explicit statutory authority to ensure that Advanced Practice Registered Nurses (APRNs) may continue to direct Registered Nurses (RNs) in a manner consistent with safe, efficient, and modern clinical practice.

The *California Association for Nurse Practitioners* writes in support of the BRN and several issues that have been raised in sunset review. Of those that are included in the bill:

> **Merging the NP and NP Furnishing Certificates**
>
> CANP supports the Board's recommendation to remove the requirement for a separate furnishing certificate and allow prescriptive authority to be granted upon licensure for NPs. The integration of prescriptive authority into the core licensure process will streamline regulatory requirements, reduce administrative burden, and better reflect the advanced education and clinical training practitioners receive. Both the furnishing certificate and the nomenclature used to describe it (i.e., "furnishing") have become antiquated and are no longer necessary.
>
> **[Out-of-State Transition to Practice]**
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> CANP recommends that if an NP who was educated and trained outside of California can demonstrate that they have the requisite information and can attest to such, those out-of-state NPs should also qualify to apply for a BRN 103 NP certificate. Nurse Practitioners should be recognized for their hands-on patient

care experience, and that experience should be recognized in other states, not discarded by California.

ARGUMENTS IN OPPOSITION:

The *California Medical Association* is opposed to this bill unless it is amended to delete an NP's ability to complete a transition to practice (Sunset Issue #7) in another state, writing:

> California has a unique regulatory framework for nurse practitioner independent practice that seeks to prioritize patient safety, education and training. California established a phased transition process intended to ensure that practitioners seeking expanded authority gain experience within the state's health care delivery system, regulatory environment, patient safety standards, prescribing requirements, and referral networks. Allowing out-of-state experience to automatically satisfy these requirements undermines the purpose of that transition.
>
> California standards differ from other states. Nurse practitioner scope-of-practice laws vary significantly across the country. Clinical experience accumulated under a different regulatory structure may not adequately prepare a practitioner for California's requirements, standards of care, or patient population. A California-specific transition period remains important to ensure consistency and accountability.
>
> This bill lacks a sufficient clinical experience verification mechanism. An individual nurse practitioner attesting to completion of the transition period is not required to verify competence, clinical expertise, or other professional standards and is only attesting that the required three years of experience was completed. Time in practice alone should not be viewed as a substitute for meaningful evaluation of clinical competency.
>
> Additionally, this bill may encourage applicants to obtain qualifying experience in states with less rigorous oversight and then use that experience to obtain broader authority in California. This could create inconsistencies in preparation and training among practitioners exercising the same authority.
>
> Due to the concerns listed above we respectfully request amendments to remove the provision which would allow nurse practitioners to use practice experience completed outside California to count toward the transition-to-practice requirement in California.
>
> California patients deserve assurance that health care professionals receiving expanded practice authority have demonstrated competency under California's standards, not merely accumulated hours in another state.

SUNSET ISSUES FOR CONSIDERATION:

In preparation for the sunset hearings, committee staff publish background papers that identify outstanding issues related to the entity being reviewed. All background papers are available on the committee's website: https://abp.assembly.ca.gov/hearings/joint-sunset-review-oversight-hearings. While every issue discussed in the background papers remain available for discussion, the following are being addressed in the amendments to this bill or are being actively discussed.

1) *Issue #2: Geographic Meeting Requirements*. Existing law requires the BRN to meet at least once every three months in both Northern and Southern California. The mandate for the BRN to meet once every three months has been in statute since inception of the board. However, the requirement to meet in specific regions of the state was added by SB 122 (Price), Chapter 789, Statutes of 2012. In the mid-2000s, regulatory board meetings were conducted in-person, with limited web access or availability. Requiring board meetings to be available in different regions of the state was likely to ensure that a wide representation of stakeholders would be able to attend and participate.

   The BRN reports that meetings outside of Sacramento cost approximately $38,000 per meeting for travel, lodging, and hotel contracts (normally for rooms to host the meetings). Eliminating the traveling requirement for meetings may reduce BRN expenditures.

   Staff Background Paper Recommendation: The BRN should advise the Committees of any potential fiscal and/or administrative savings by moving to remote meetings and should note whether this could limit public participation and public access to the BRN's important work.

   BRN Response:

   > The BRN has evaluated the fiscal, administrative, and public-access implications of transitioning away from the statutory requirement that meetings be held in both Northern and Southern California. Based on recent experience, the Board anticipates that moving to a model that does not require statewide travel, while maintaining a virtual attendance option, would result in meaningful cost savings and improved operational efficiency.
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   > Virtual meeting options have significantly broadened public access and engagement. Remote attendance allows working nurses, educators, and consumers to participate more consistently without the barriers of travel, cost, or scheduling conflicts. Because most stakeholders are working professionals who rely on the ability to join meetings while fulfilling their responsibilities, virtual participation has become the most practical and accessible way for the public to engage with the Board's work.
   >
   > As noted, meetings held outside Sacramento cost approximately $38,000 per meeting due to travel, lodging, and facility expenses. Eliminating the requirement to alternate between Northern and Southern California would allow these funds, and the associated staff time, to be redirected toward initiatives that more directly support the Board's mission of public protection. Additionally, the BRN does not believe that eliminating the regional meeting requirement would diminish public

> participation. In fact, current attendance patterns demonstrate that remote participation far exceeds in-person attendance. The Board remains committed to ensuring transparency, accessibility, and robust public participation regardless of the meeting format.

Sunset Recommendation: This bill modifies the BRN's existing mandate to allow the BRN flexibility to determine when and where it is appropriate to meet to help ensure the greatest amount of public participation. To accommodate stakeholders that still prefer a physical location, the amendment regarding meeting locations at the end of this analysis clarifies that, while the BRN does not have to meet in any specific region, it should attempt, to the extent practicable, to meet in geographically diverse areas of the state. Committee staff will continue to discuss this language with the BRN to ensure it still reduces the burden on the BRN while preserving physical access.

2) *Issue #7: Transition to Practice Acceptance: Experience Gained in Another State*. AB 890 (Wood), Chapter 256, Statutes of 2020, authorized certain NPs to practice independently of physician supervision. AB 890 created a tiered framework for NPs to practice in California. Under current law, NPs may practice independent of physician supervision in a defined health care setting (i.e. general acute care hospital, intermediate care facility, nursing facility), outside of one of those defined settings (a private practice), or NPs may practice in any healthcare facility under established protocols and procedures with physician supervision.

   AB 890 specified education and experience requirements for an NP to be eligible to practice independent of physician supervision. NPs who seek independent practice in a defined healthcare setting are referred to as "103 NPs". Applicants for a 103 NP designation are required to pass a national NP examination, obtain certification as an NP from an accredited national certifying body, and complete a transition to practice (TTP). Notably, the law limits these individuals to having to complete the TTP in California. The TTP consists of a minimum of three full-time equivalent years of practice or 4,600 hours. NPs who want to practice independently outside of a defined healthcare setting, are referred to as "104 NPs." 104 NPs are required to meet additional requirements and provide proof of practice for three-years as a 103 NP in good standing, in addition to satisfying the TTP requirement. Twenty-seven states allow NPs to practice independently of physician supervision. However, the scope and level of independence of each state varies.

   Staff Background Paper Recommendation: The BRN should advise the Committees on how NPs from other states complete the TTP requirements in California. The Committees may wish to delete the requirement that the TTP be completed in California in order to facilitate additional practice opportunities for qualified NPs.

   BRN Response:

   > Currently, under Business and Professions Code (BPC) section 2837.103(a)(1)(D), nurse practitioners (NP) licensed in other states must complete 4,600 hours or three years of clinical experience in California within five years of applying. This direct patient care mentorship-based experience must occur in California and be attested to by a physician or a 103/104 NP. At this time,

California does not permit completion of the transition-to-practice (TTP) requirement in another state. However, the BRN would support removing this restriction and allowing NPs to satisfy TTP requirements through equivalent supervised experience obtained outside California. Allowing NPs to meet TTP requirements through equivalent experience obtained in other states would expand practice opportunities for qualified NPs and reduce unnecessary barriers to licensure.

However, it's important to note the Board's current process for attesting to the completion of TTP hours is completed through a system that only recognizes California based licensees. Currently the 103 NP applicant is asked to submit information of the provider(s) who can attest to the completion of the 4,600 hours of direct patient care that meet the TTP requirements. The Board then verifies the attesting provider has an active California license using the California Medical Board's Identify Verification and License Access (IDEAL) system. The IDEAL system then sends an email to the attesting provider(s) asking them to validate that the applicant completed the required hours.

The system is only used for healthcare providers with California licenses. It cannot be accessed by the general public or healthcare providers from other states.

Therefore, the only way the Board could utilize this current attestation system to validate transition to practice experience obtained in another state would be to require the applicant who worked out of state to find a California licensed physician or 103/104NP to review their portfolio and attest to the completion of the required hours.

Sunset Recommendation: This bill authorizes TTP to be completed in California or another state. In response to concerns from the opposition around varying standards across states, the amendments to this provision at the end of this analysis require the BRN to maintain an up-to-date list of states that it determines have independent practice standards that would meet the requirements of an in-state transition to practice.

3) *Issue #10*: *CE Documentation Verification*. The Nursing Practice Act requires all RNs to complete 30-hours of CE every two years to be eligible for licensure renewal. The BRN is required to establish the standards for CE through regulations. Current regulations include a variety of formats to complete CE such as online, academic studies, in-service education, institutes, seminars, lectures, conferences and workshops among others. CE courses must be relevant to the practice of nursing or related to the direct patient care of a client and enhance the knowledge of the RN at a level above that required for licensure. The BRN is responsible for both approving CE providers and auditing CE providers to ensure that coursework providers are adhering to the BRN's regulatory requirements. Certain APRNs (NPs) who provide primary care to a patient population which 25% is 65 years of age or older, must complete at least 20% or 7.5 hours of CE coursework in gerontology, the special care needs of patients with dementia, or the care of older patients at the time of renewal. Otherwise, licensees have discretion in the types and subject of the CE they obtain.

During the licensure renewal process, licensees must submit proof to the BRN of successful completion of the required CE hours. Currently, licensees provide "proof" to the BRN by signing a statement under penalty of perjury indicating compliance. Licensees are required to keep certificates of completion or other records of attendance for four years. Licensees do not need to submit completion records at the time of renewal; however, if the BRN requests the documentation, a licensee is required to submit upon request.

To ensure compliance with the CE mandates, the BRN conducts random audits of its licensee population. At the time of an audit (after the renewal license has been issued) the BRN may request the records of CE compliance from the licensee. Unfortunately, the BRN has not been successful in the last four FYs with conducting audits and verifying completion of CE. As reported in the BRN's 2026 Sunset Review Report, "The Board is unable to provide a complete set of statistics for its CE audits because staffing issues/limitations and management constraints impeded data collection. These operational challenges restricted the board's ability to validate audit results, leaving verified counts and outcomes available only for March 2025 forward."

In the BRN's 2020 Sunset Review Report, the BRN reported more consistent audit numbers, averaging over 8,700 CE audits for the FYs 2016/17-2019/2020. According to these past figures, the BRN was conducting audits of only slightly over 2% of its licensing population.

If a licensee fails an audit of CE compliance (which may occur after the licensure renewal), they may be subject to a citation and or fine. Since 1996, the BRN has issued citations and fines to RNs who violate the CE requirements. The fine amounts are $1,500 for submitting fraudulent CE certificates and $250 for RNs who cannot provide evidence of CE course completion; however, current statue and regulations do not provide clear language on how fines are assessed so the BRN reports that it has been issuing citations without fines. Serious violations are referred to the AG for disciplinary action.

Given that audits are time consuming for the BRN to conduct when there are multiple steps in the process including contacting a licensee, waiting for a response, receiving documentation that must be verified, could the process be streamlined if licensees were required or allowed to submit completion of CE at the time of renewal? This would likely eliminate the need for audits as CE would be verifiable at the time of renewal.

Staff Background Paper Recommendation: The BRN should advise the Committees on any process updates that might ensure greater compliance and accountability with CE mandates. Would it be beneficial for licensees to submit proof of completion at the time of renewal? Should fine amounts for CE compliance violations be increased in statute?

BRN Response:

> The BRN supports process improvements that would strengthen compliance and accountability with continuing education (CE) requirements. Currently, BreEZe allows, but does not require, licensees to upload CE documentation at the time of renewal. Making this submission mandatory would meaningfully enhance oversight and may require a regulatory update. The California Code of Regulations (CCR), title 16, section 1451(d) specifies that licensees must retain

CE certificates for four years and provide them to the Board upon request. Requiring CE documents to be uploaded at renewal would allow staff to conduct random audits directly through BreEZe without requesting additional materials from licensees. It would also allow BreEZe to serve as the official repository for the four-year retention period, improving efficiency, reducing administrative burden, and ensuring more consistent verification of CE compliance.

With respect to fine amounts, the BRN is willing to work with the Committees to assess whether statutory fines would further support compliance; however, the Board does not believe such changes are necessary at this time. Strengthening the documentation process through BreEZe would address the primary operational challenges, and any adjustments to fine levels could serve only as a supplemental measure to reinforce the importance of meeting CE requirements.

Sunset Recommendation: The amendments regarding CE proof at the end of this analysis will require licensees to submit their CE documentation at the time of renewal as requested by the BRN. In addition to allowing the BRN to more easily audit, actively uploading documentation may help incentivize compliance and deter fraud.

Separately, Committee staff continue to engage the BRN on improvements to its approval process in response to stakeholder concerns around the BRN's ability to effectively screen the individual courses offered by course providers for evidence-based content. Due to issues stemming from prior executive leadership, BRN staff report having to restart the process it began in 2019 as a result of an identical issue identified in an earlier sunset review. Currently, the BRN reports the following progress:

- The first step was to ensure regulatory alignment to require coursework offered to be evidenced based – This was completed with two regulatory packages on the topic of CEs 16 CCR 1452 effective July 1, 2024, and 16 CCR 1450, 1456 effective Oct 1, 2022.

- The second step is to map current processes. Board staff is in the process of mapping the current CE audit process with the Department of Consumer Affairs Organizational Improvement Office to help identify the best path forward.

- The third step is to create a CE unit that can complete the work and have the structure and internal monitoring that is needed (the reorg is with OHR). The Board received approval to change the SNEC in the unit to a SSM I who can hire in staff to do the work and help to envision and set up the structure. This position is currently being advertised.

BRN staff notes that, once the business mapping is complete, the goal would be to establish a CE registry that will make it easier for licensees to verify content and BRN approval.

4) *Issue #11*: *Furnishing Number and Streamlining the renewal process for NPs and CNMs*. In California, CNMs and NPs may prescribe or furnish certain drugs and substances. CNMs and NPs may prescribe according to specified protocols and procedures while 103 and 104 NPs

are authorized to prescribe independently. Both CNMs and NPs are restricted to only furnish those drugs or substances which fall within the scope of practice of their respective certification level. Furthermore, for an NP whose furnishing is subject to standardized procedures and protocols, they must be supervised by a physician and surgeon.

NPs and CNMs must also register with the DEA to prescribe schedule II medications and for all prescriptions to be filled by pharmacies. Those seeking furnishing authority must meet specified coursework in pharmacology covering the drugs or devices to be furnished by the licensee. Current law requires NPs that hold a furnishing number to register with the DEA and authorizes them to furnish Schedule II controlled substances either through protocols and procedures or by holding a 103 or 104 designation, and also requires them, as part of CE, to complete a course that includes Schedule II controlled substances and the risks of addiction associated with their use based on the standards developed by the BRN. CNMs must also complete this Schedule II substances CE. CNMs are authorized to furnish or order schedule II or III controlled substances pursuant to policies and procedures mutually agreed upon with a physician and surgeon.

AB 2684 (Berman), Chapter 413, Statutes of 2022, authorized the BRN to combine the application for a furnishing number into the same application for BRN-certification as an NP and CNM. Pursuant to BPC §§ 2746.51 and 2836.3, the BRN may issue a furnishing number upon initial application and, if approved by the BRN, the applicant is not required to make a separate application. However, the change does not affect renewal applications.

The BRN would like to streamline the application process to allow for furnishing upon NP and CNM licensure without issuing a separate furnishing number with their appropriate APRN application. The BRN notes that this would align with all other states and DEA, as the DEA currently utilizes the NP license number and not the furnishing license number, as they are the same in their system.

Staff Background Paper Recommendation: The BRN should advise the Committees on the cost saving and time saving efficiencies associated with combining the renewal application. The BRN should advise the Committee on any potential stakeholder concerns.

BRN Response:

> Currently, APRNs must renew their RN license, their APRN certification, and their furnishing number separately, which requires multiple applications and multiple fee payments. Although the BRN consolidated the initial NP application and furnishing application during the last sunset review to streamline the licensing process, the corresponding renewal processes were inadvertently left off. Combining the APRN renewal and furnishing number renewal into a single application would extend the same efficiencies achieved on the initial application and could provide meaningful cost-saving and time-saving benefits for both licensees and the Board. When the initial application was combined, applicants saved $400. Combining of the renewal application would provide an additional savings of $150. The BRN would continue to collect the Controlled Substance Utilization Review and Evaluation System (CURES) fee on renewal.

From an operational standpoint, combining these processes would reduce the number of separate transactions processed by the BRN, simplify data management, and decrease duplicative administrative workload associated with issuing and tracking multiple renewals for the same licensee. Streamlining these functions can improve processing times, reduce the likelihood of errors or incomplete submissions, and allow staff resources to be allocated more efficiently across licensing program. Additionally, a single, unified application can lower printing, mailing, and system maintenance costs, particularly as the BRN continues to expand and rely on the BreEZe system. For APRNs, a unified renewal process would create a clearer and more predictable renewal cycle, reduce the risk of missed deadlines, and minimize the need to submit overlapping documentation across multiple applications.

Overall, the BRN is supportive of efforts to streamline the renewal process and would work closely with stakeholders to ensure that any transition to a combined renewal process maintains clarity, minimizes disruption, and preserves necessary regulatory oversight.

Sunset Recommendation: This bill authorizes the BRN to combine the renewal application for both furnishing and licensing into one application, similar to what is permitted for initial authorization. This bill would also remove unnecessary fees.

5) *Issue #13*: *Authority for RNs to Delegate*. RNs are required to operate pursuant to standardized procedures as defined in the Act. This allows RNs and APRNs to delegate certain tasks, including the ordering of nursing services, as determined through the standardized procedures both at a facility and the standardized procedures between some NPs and supervising physicians. However, as recent legislative changes have granted authority for APRNs, including NPs, CRNAs, and CNMs to operate independent of standardized procedures, BRN believes there is ambiguity related to independently practicing APRNs and their authority to delegate or order tasks to other RNs. The BRN noted in its 2026 Sunset Review Report, "From both an operational and access-to-care standpoint, the ability for APRNs to direct RNs is critical. Consequently, nurse scope of practice needs to be updated to make clear that APRNs can still direct RNs without the use of standardized procedures."

   The BRN recommends the Act be amended to allow an APRN to direct the RN to provide direct and indirect patient care services including, but not limited to, the administration of medications and therapeutic agents, necessary to implement a treatment, disease prevention, or rehabilitative regimen. It would be helpful for the Committees to understand how current law limits the ability for APRNs to work with partner RNs in practice settings governed by various employment requirements and other facility-specific rules.

   Staff Background Paper Recommendation: The BRN should advise the Committees on discussions with stakeholders and provide the proposed statutory updates that would provide clarity.

BRN Response:

BPC section 2725 establishes RN scope of practice. It states that RNs can provide direct and indirect patient care services, including, but not limited to, the administration of medications and therapeutic agents, necessary to implement a treatment, disease prevention, or rehabilitative regimen, but only when ordered by a physician, dentist, podiatrist, or clinical psychologist. Historically NPs and nurse midwives (NMW) could also initiate orders to RNs using standardized procedures which allowed the NP and NMW to act as an "agent of the physician." This is not an employer-based decision, it is the only way that is currently outlined in statute that allows the RN to practice nursing. An RN may perform specified functions only after receiving an appropriate order. Updating this section to clarify that an RN may also follow an order issued by an APRN who currently has the ability to order or under the direction of an APRN that does not currently possess that authority is necessary for the RN to continue to practice within their scope.

The passage of Assembly Bill (AB) 890 (Wood, Chapter 265, Statutes of 2020) provided 103 NPs and 104 NPs with the ability to order, perform, and interpret diagnostic procedures, prescribe, order, administer, dispense, procure, and furnish therapeutic measures without the use of standardized procedures. Passage of Senate Bill 1237 (Dodd, Chapter 88, Statutes of 2020) provided NMWs with the ability to order drugs and devices, laboratory and diagnostic testing without the use of standardized procedures. Consequently, statute needs to be updated to make clear that RNs can receive orders from NPs and NMWs that are no longer working under standardized procedures and acting as an agent of the physician.

Relatedly, passage of AB 876 (Flora, Chapter 169, Statues of 2025) codified that Certified Registered Nurse Anesthetists (CRNA) can select and administer medication, including controlled substances, for preoperative, intraoperative, and postoperative care and for pain management purposes pursuant to an order by a physician, dentist, or podiatrist. While CRNAs are technically still acting as the "agent of the physician," it would reduce confusion to clarify they also can direct an RN provide treatment for conditions related to the administration of anesthesia, pursuant to an order for anesthesia services by a physician, dentist, or podiatrist. Although these statutory updates have advanced APRN practice, they have created an unintended risk for RNs by leaving gaps in the structures that guide RN practice. Without corresponding updates, RNs may be placed in situations where they are expected to act without the statutory clarity needed to ensure they remain within their legal scope, potentially exposing them to disciplinary action.

The BRN is in ongoing conversations with stakeholders around proposed text that would maintain the existing level of care without inadvertently expanding APRN scope of practice.

Sunset Recommendation: Committee staff continue to work with the BRN and stakeholders on a statutory change that avoids expanding scope of practice while clarifying that an order from an APRN authorized to do so under the Nursing Practice Act and the Pharmacy Law is

sufficient authority for another RN to rely on when providing care and administering medication. The following language is being proposed:

> **2725.** (b) The practice of nursing within the meaning of this chapter means those functions, including basic health care, that help people cope with difficulties in daily living that are associated with their actual or potential health or illness problems or the treatment thereof, and that require a substantial amount of scientific knowledge or technical skill, including all of the following:
>
> (1) Direct and indirect patient care services that ensure the safety, comfort, personal hygiene, and protection of patients; and the performance of disease prevention and restorative measures.
>
> (2) Direct and indirect patient care services, including, but not limited to, the administration of medications and therapeutic agents, necessary to implement a treatment, disease prevention, or rehabilitative regimen ordered by and within the scope of licensure of a physician, dentist, podiatrist, *nurse practitioner practicing pursuant to Section 2837.103 or 2837.104, certified nurse midwife practicing pursuant to 2746.5, 2746.51, or 2746.52,* or clinical psychologist, as defined by Section 1316.5 of the Health and Safety Code.
>
> (3) The performance of skin tests, immunization techniques, and the withdrawal of human blood from veins and arteries.
>
> (4) Observation of signs and symptoms of illness, reactions to treatment, general behavior, or general physical condition, and (A) determination of whether the signs, symptoms, reactions, behavior, or general appearance exhibit abnormal characteristics, and (B) implementation, based on observed abnormalities, of appropriate reporting, or referral, or standardized procedures, or changes in treatment regimen in accordance with standardized procedures, or the initiation of emergency procedures.
>
> *(5) Administration of medications and therapeutic agents, necessary to implement a treatment, disease prevention, or rehabilitative regimen as directed by an advanced practice registered nurse to the extent allowable within the advanced practice registered nurse's scope of practice as established under Article 2.5 (commencing with Section 2746), Article 7 (commencing with Section 2825), Article 8 (commencing with Section 2834), or Article 9 (commencing with Section 2838).*

The goal of the proposal is to effectuate the intent of existing law, that an RN may administer medications upon lawful order of an independent NP or CNM, who are authorized to prescribe and order under their respective APRN acts and the Pharmacy Law. An RN may also act under the direction of other APRNs who are not authorized to order but may nonetheless be providing care to a patient who has a diagnosis but there is no order specific to that episode of care. Committee staff are in discussion with stakeholders regarding the necessity of outstanding requests, including from the *California Society of Anesthesiologists*, who are support if amended to this bill.

6) *Issue #19*: *Uniform Standards for Clinical Practice Hours and Simulation-based Learning Guidelines*. During the COVID-19 pandemic, when education and access to clinical settings became unattainable, AB 2288 (Low, Chapter 282, Statutes of 2020), authorized the director of an approved nursing program, during a state of emergency, to make requests to the BRN to revise the number of required clinical experience needed and allow greater flexibility to use clinical simulation. AB 2288 permitted the following: use of clinical simulation up to 50% for medical-surgical and geriatric courses; and up to 75% for psychiatric mental health nursing, obstetrics, and pediatrics courses, among other provisions. The goal was to provide nursing programs with flexibility in meeting clinical placement needs during a declared state of emergency. The designation in percentages was because at the time, the BRN's regulations required that 75% of a nursing student's clinical hours had to be in a direct patient care model. Direct patient care means providing services to a live patient, which can include both in-person and telehealth. The changes in AB 2288 are specific to a state of emergency and do not affect overall requirements when there is no state of emergency declaration. In addition, AB 2288 required for the substitute clinical practice hours that are simulation experiences to be based on the best practices published by the International Nursing Association for Clinical Simulation and Learning, the National Council of State Boards of Nursing, the Society for Simulation in Healthcare, or equivalent standards approved by the BRN.

   The following year, during the BRN's sunset review discussions, the issue of simulation learning was once again raised. As a result, AB 2684 (Berman), Chapter 413, Statutes of 2022, revised the acceptance of simulation learning by replacing the percentage requirement of direct patient care clinical hours with a new 500-hour minimum number of direct patient care clinical hours that an approved nursing school or nursing program must meet with a minimum of 30 hours of supervised direct patient care clinical hours dedicated to each nursing area.

   The changes based on AB 2684 have made the emergency provisions specified in statute inconsistent with existing practice. The BRN no longer has a "percentage based" mechanism for direct clinical care requirements and instead relies on hours.

   Also, when AB 2864 was contemplated, matching language that simulation learning meets national association standards, which is currently required for simulation used during a state of emergency, was not included for general simulation learning. In the BRN's 2026 Sunset Review Report, the BRN requested updates to the Act to replace percentages with actual clinical hours permitted during a state of emergency for consistency purposes, and also specify that any and all clinical simulation reflect national standards for simulation learning from International Nursing Association for Clinical Simulation and Learning, the NCSBN, the Society for Simulation in Healthcare, or equivalent standards approved by the BRN (regardless of when the simulation is being utilized during a state of emergency or for general education purposes.

   Staff Background Paper Recommendation: The BRN should provide the Committees and stakeholders with the statutory updates needed to align simulation requirements and ensure that all authorized clinical simulation follows national guidelines.

BRN Response:

> The BRN acknowledges the need to align California's simulation-based learning requirements with current practice and national standards. Updating the statutory framework is essential to ensure that all simulation experiences used for nursing education follow nationally recognized guidelines, such as those developed by the International Nursing Association of Clinical Simulation and Learning (INACSL), the Society for Simulation in Healthcare (SSH) and the National Council of State Boards of Nursing (NCSBN). These updates should clarify expectations related to scenario design, duration, fidelity, debriefing, instructor qualifications, and integration of simulation into program curricula.
>
> The BRN is currently reviewing the Nursing Practice Act and developing proposed statutory language to better align and standardize simulation requirements, which will be provided to the Committees as recommended revisions once complete. These updates will help ensure consistent, high-quality simulation experiences across programs, strengthen educational standards, and enhance overall patient safety.

Sunset Recommendation: This bill specifically requires that anytime simulation is used for clinical experience, simulated learning meets the best practices published by the International Nursing Association for Clinical Simulation and Learning, the NCSBN, the Society for Simulation in Healthcare, or equivalent standards approved by the BRN. In addition, this bill removes any references to percentages for simulation learning and instead replaces those numbers with the corresponding hours necessary to meet the BRN's requirements.

7) *Issue #21*: *Nursing Program Directors*. If an approved prelicensure nursing program does not hold national accreditation, they must obtain BRN faculty approval prior to hiring. Pursuant to current regulations, the BRN requires nursing program faculty, the director, and the assistant director be approved by the BRN. Nursing education programs are required to report to the changes in the nursing program's director and assistant director of nursing positions to the BRN. Faculty members, program directors, and assistant directors must have an active license, in good-standing, and meet certain qualifications, of which they may need additional time to meet the qualifications.

   In acknowledgement of friction around the prior faculty and program director approval process, the BRN sponsored AB 2015 (Schiavo), Chapter 370, Statutes of 2023. AB 2015 did two things: it provided a pathway for an RN to proactively be approved by the BRN as a faculty, director, or assistant director and established a temporary faculty approval process, allowing an RN up to one year to remediate any deficient requirements under a plan accepted by the BRN.

   However, AB 2015 did not include in a similar remediation pathway or any conditional approval process for nursing program directors or assistant directors even though they have similar approval requirements. This issue was raised this year as part of the comprehensive sunset review oversight process.

The Committees have been advised that some programs located in smaller, rural colleges offering prelicensure programs face challenges finding program directors that meet all four of the BRN requirements. Although the BRN does consider equivalent experience, there is no further remediation process for those who still do not meet the standards, essentially precluding that candidate until they can meet the criteria on their own.

Staff Background Paper Recommendation: The BRN should advise the Committees on efforts to assist colleges when program directors' qualifications are insufficient.

BRN Response:

The California Code of Regulations (CCR), title 16, section 1425(a) outlines the requirements for nursing program directors, including a master's degree in nursing, education, or administration; one year of administrative experience; and two years of teaching experience in a pre- or post-licensure RN program. Most nursing programs are able to grow internally through their faculty development processes. Faculty members who hold an instructor-level designation become eligible for the assistant director role after two years of teaching. After serving as an assistant director for one year, they then qualify to advance into the director position. This creates a structured, step-in progression: two years of instructional experience to qualify as an assistant director, followed by one year of administrative experience to qualify as a program director.

The NECs encourage academic institutions to maintain strong succession plans, including having more than one approved assistant director in training at all times to allow for smooth employment transitions. The assistant director role is typically a faculty member with a set release time to learn the administrative duties.

When an academic institution is unable to identify an internal candidate, the BRN's existing regulatory framework and support processes allow for a nursing program to remain operational. During this time, an assistant director may step into the program director role or a program director can be temporarily loaned from another academic institution, as there is no regulatory requirement for the program director to be physically present or on campus.

When a proposed external candidate for director or assistant director does not fully meet the required qualifications, the BRN allows programs to work directly with their assigned Nursing Education Consultant (NEC) to determine whether the candidate may qualify through equivalent education or experience under CCR, title 16, section 1425(a)(5). In situations where a prospective leader does not yet meet all criteria, the NEC will meet with the program director applicant to discuss other viable options for approval. These conversations focus on identifying viable options the candidate can pursue to gain the necessary qualifications, including potential training, experience, or developmental steps that would allow them to meet the requirements for program director approval.

These established processes enable the Board to assist colleges proactively who may be facing shortages of fully qualified director candidates, helping them stay on track for compliance without compromising regulatory standards.

Sunset Recommendation: To accommodate situations where the existing exceptions are insufficient, this bill creates a remediation pathway for director candidates.

8) *Issue #22*: *School Approval Standards and Conformance with NCSBN Guidelines*. The BRN has received criticism for using outdated, inefficient, and inconsistent standards when providing initial and continuing approval to nursing programs. To help establish more consistency and efficiency in the program approval process, the BRN seeks to revise some of its current standards and replace them with evidence-based standards that are recognized at the national level developed through the NCBSN.

Nationally, all state boards of nursing are engaged in the initial approval and subsequent review of prelicensure nursing education programs. States are similar in approach, however, each state board of nursing is individually responsible for the core elements required for each program and thus determines the curriculum requirements, faculty requirements, clinical and simulation standards, among others. This led to multiple approaches for initial approval, continued approval or enrollment increases. The core indicators of a prelicensure educational program's success include NCLEX pass rates, graduation rates, and employment rates.

In response to state boards of nursing searching for consistency of educational programs approval process and success rates, the NCSBN conducted three national studies of nursing education outcomes and a literature review. Based on the NCSBN's work, a panel of representatives from state boards of nursing, the College of Nurses Ontario, the National League for Nursing, the American Association of Colleges for Nursing, the Organization of Associate Degree Nursing and NCSBN staff developed guidelines to help guide state boards of nursing in their approval of prelicensure programs and to understand potential warning signs in the process. In 2020, the NCSBN published Guidelines for Prelicensure Nursing Approval. The guidelines were created to help regulatory boards identify quality indicators while recognizing warning signs at the same time and when they should intervene and provide technical assistance to a program prior to them falling below standards.

Staff Background Paper Recommendation: The BRN should specify the statutory changes necessary to implement recommendations from the NCSBN. The BRN should advise the Committees on its communication plans with nursing education providers if there are any changes or updates.

BRN Response: The BRN did not include this issue in its responses.

Sunset Recommendation: This bill requires the BRN, in its inspection and oversight authority of prelicensure nursing programs, to be sure any inspections are consistent with the national guidelines established by the NCSBN.

9) *Issue #25*: *Intervention Program and Uniform Standards*. In 1984, state law established the Diversion Program (now Intervention Program) as an alternative to discipline. The law charges the BRN to seek ways and means to identify and rehabilitate registered nurses whose

competency may be impaired due to substance use disorder or mental illness, rehabilitate those nurses, and return them to practice in a manner that does not endanger public health and safety. The IP is a voluntary and confidential recovery and monitoring program for RNs whose practice may be impaired by substance use disorder or mental illness. BRN says that the IP protects the public by providing RNs access to effective treatment services, monitoring their recovery through an individualized plan, and returning them to safe practice.

SB 1441 (Ridley-Thomas), Chapter 548, Statutes of 2008, required the DCA to develop uniform and specific standards to be used by each health professional licensing board in dealing with licensees facing substance use disorders in the following 16 specified areas: (1) clinical and diagnostic evaluation of the licensee; (2) temporary removal of the licensee from practice; (3) communication with licensee's employer about licensee status and condition; (4) testing and frequency of testing while participating in a diversion program or while on probation; (5) group meeting attendance and qualifications for facilitators; (6) determining what type of treatment is necessary; (7) worksite monitoring; (8) procedures to be followed if a licensee tests positive for a banned substance; (9) procedures to be followed when a licensee is confirmed to have ingested a banned substance; (10) consequences for major violations and minor violations of the standards and requirements; (11) return to practice on a full-time basis; (12) reinstatement of a health practitioner's license; (13) use and reliance on a private-sector vendor that provides diversion services; (14) the extent to which participation in a diversion program shall be kept confidential; (15) audits of a private-sector vendor's performance and adherence to the uniform standards and requirements; and (16) measurable criteria and standards to determine how effective diversion programs are in protecting patients and in assisting licensees in recovering from substance abuse in the long term.

As part of the SB 1441 implementation, the DCA convened the Substance Abuse Coordination Committee (SACC), which consisted of representatives from all of the health professional licensing boards. A series of meetings, subject to the Bagley-Keene Open Meeting Act, were held from 2009 to 2011 to discuss and develop the standards. The "Uniform Substance Abuse Standards" (Uniform Standards) were finally adopted in early 2010, with the exception of the frequency of drug testing. The DCA reconvened the SACC in March 2011, where a final vote was taken on an amended schedule for drug testing frequency.

At that time, all of the health care boards were asked to adopt and implement the standards. In response to questions regarding whether adoption of the standards was optional or mandatory, three different legal opinions were issued that opined that the boards were mandated to adopt all of the standards. The only standard that needed statutory authority dealt with the cease practice requirement. SB 1172 (Negrete McLeod, Chapter 517, Statutes of 2010) was enacted, and among other provisions, required healing arts boards to order a licensee to cease practice if the licensee tests positive for any prohibited substance under the terms of the licensee's probation or diversion program.

Concerns have been raised to the BRN that pertain specifically to Uniform Standard 12 which specifies the criteria that a licensee must meet to petition the board for reinstatement of their license. As specified under Uniform Standard 12, a licensee must meet the following criteria to request the return to a full and unrestricted license:

- Demonstrated sustained compliance with the terms of the disciplinary order, if applicable.

- Demonstrated successful completion of recovery program, if required.

- Demonstrated consistent and sustained participation in activities that promote and support their recovery including, but not limited to, ongoing support meetings, therapy, counseling, relapse prevention plan, and community activities.

- Demonstrated that they can practice safely.

- Continuous sobriety for three (3) to five (5) years.

The BRN notes concerns pertaining to demonstration of safe practice, and reports variances in how a licensee may demonstrate that they can practice safely. The BRN notes there are variances in determining what may constitute sufficient evidence of safe practice without specific criteria. In addition, under current law, IEC members are required to evaluate RNs who request participation in the program, review and designate treatment services for participants, review information about RNs, consider the case of each RN participant and whether they may continue with safety or resume the practice of nursing. The consideration of what constitutes "resume to practice safely" with limited specification as to what acts may qualify likely leads to varying determinations by the IECs. In addition, under current law (BPC § 2770.8) which specifies the duties of the IEC members, IEC members are charged with "considering cases of RNs in the IP and whether they may safety continue or resume the practice of nursing. Consistency may be needed to identity the standards necessary to determine what is "safe to resume practice".

In the BRN's *Sunset Review 2026* report, the BRN recommends updating statute to clarify that successful completion of the IP "may or may not require a participant to work as a RN in a direct patient care role or if, upon review, a participant is found to have mitigating circumstances, such as a disability, health condition, retirement, or a career path that does not involve direct patient care, program completion may still be granted without employment. This clarification would provide greater flexibility in evaluating participant progress and ensure the program accommodates a broader range of professional circumstances while maintaining its rehabilitative intent."

Staff Background Paper Recommendation: The BRN should advise the Committees of its work to broadly discuss provisions in the Uniform Standards to ensure they remain Uniform. The BRN should provide an update on the IP and how it balances patient safety and public protection with program administration.

BRN Response:

> The Board currently attends a monthly meeting with the Intervention Program vendor and all other Boards under DCA that have a recovery program to discuss cross-board issues and alignment of policies and procedures.

> The Board also holds weekly meetings with the Intervention Program vendor to discuss BRN-specific updates, best practices, training needs, and case collaboration. A common topic of discussion at these meetings is how to ensure that the Board's IP program is flexible enough to accommodate participants in their individual recovery journeys, while still having the level of structure and consistency necessary to protect the public.
>
> The Board agrees that any amendments or changes to the Uniform Standards require cross-board collaboration, since the implications are wide reaching. Therefore, rather than amending the Uniform Standards to address work requirements, the Board proposes to instead amend Article 3.1 of the Nursing Practice Act which establishes statutory guidance for the Board's IP. One option is to update BPC section 2770.12 to state that it is up to the committee's discretion as to whether a participant must practice nursing prior to successful completion of the program.

Sunset Recommendation: The intervention program amendment at the end of this analysis authorizes the intervention committee to determine whether the requiring the participant to practice nursing is in the interest of patients and the recovery of the participant.

10) *Issue #26*: *Timeline for Reinstatement*. The Nursing Practice Act establishes mandatory wait periods for RNs seeking reinstatement after revocation: 1) at least three years for reinstatement of a license that was revoked, except that the board may, in its sole discretion, specify in its order a lesser period of time provided that the period shall be not less than one year; 2) at least two years for early termination of a probation period of three years or more; or, 3) At least one year for modification of a condition, or reinstatement of a license revoked for mental or physical illness, or termination of probation of less than three years. The typical outcome is that a licensee must wait at least three years before they can attempt to get their license reinstated if the license was revoked.

    As noted by the BRN in its *Sunset Review 2026* report, "while in most cases the three-year timeline is both sufficient and appropriate, the BRN is experiencing a growing number of cases where a licensee is revoked by default." This means their license was revoked by the BRN because the licensee failed to respond to the accusation or participate in a legal hearing to challenge the BRN's action against them, leading to a ruling against the licensees without their input.

    Under the current disciplinary procedures in California, the disciplinary process begins with the filing of an accusation. The accusation provides the licensee with the acts or omissions engaged by the licensee for which the board seeks to discipline. When a licensee receives the accusation, they are advised to respond to the BRN within 15-calendar days if they seek to have a hearing over the accusations. If the license holder fails to respond within the fifteen days, the BRN is authorized to revoke the license through the "default decision" process. Once the license is revoked, the license holder is subject to the timeframes specified above for reinstatement.

    The license remains revoked unless a petition for reinstatement is granted. Occasionally, a license holder will contact the BRN shortly after their license has been revoked through a

default decision, stating they were unaware of the disciplinary action until after the revocation became effective. According to the BRN, this typically occurs when the licensee did not receive mailings from the BRN regarding the accusation, often due to being on a traveling contract assignment, an extended leave/vacation, or having recently moved without yet updating their address of record with the Board, etc. Unlike various other boards under the DCA, the BRN does not have statutory authority to require licensees to provide their email address (if available) to the BRN for ease of communication; however, the BRN does require licensees to provide the BRN with address changes within 30 days.

According to the BRN, due to the increasing ways that modern RN practice can lead to revocations by default, particularly when the license is obtained through a travel nurse agency, three years is excessive. In these types of scenarios, the BRN would prefer to have the discretion to engage with the licensee and proceed through the standard disciplinary process. However, the BRN currently lacks the statutory authority to set aside a default revocation and reopen the case administratively to allow for a potential lesser enforcement action (maybe probation instead of revocation).

Staff Background Paper Recommendation: The BRN should advise the Committees on the number of individuals that would be eligible for licensure reinstatement earlier than three years if current law was updated. In addition, the BRN should advise the Committees what the eligibility criteria would be to reinstate a license earlier than three years.

BRN Response:

> The Board is requesting additional flexibility for reinstatements when a license is revoked by default because the licensee was not aware of the disciplinary action against them.
>
> The Board estimates that approximately 175 licensees would be eligible each year to seek relief under this type of scenario. Of that number, the BRN estimates around 50-75 may request to pursue this option.
>
> In evaluating these petitions, the BRN would apply similar criteria to what is established under Government Code section 11520(c) for vacating a decision and granting a hearing. These criteria could include, but are not limited to:
>
> - Failure of a licensee to receive notice served by the Board.
> - Mistake, inadvertence, surprise, or excusable neglect.

Sunset Recommendation: The amendment to the reinstatement timelines at the end of this analysis specify that the one- to three-year timelines only apply when the discipline is "for cause," allowing those disciplined for procedural reasons, such as default, to petition immediately.

11) *Issue #32*: *Technical Changes may Improve the Act*. There are likely a number of provisions contained in the Act which need updates, revisions or technical changes to address outdated, unnecessary or inconsistent language.

For example, Pursuant to BPC § 2788, the BRN is required, through its EO, to inspect all schools of nursing at the times deemed necessary. The EO is required to provide written reports of those visits to the BRN.

Although the BRN should maintain the requirement to inspect schools, this is no longer a task that the BRN's EO conducts on their own. NECs and other education staff are delegated the authority to conduct school visits, education and curriculum review, faculty approval, etc., while the nursing education and licensing committee and the full board consider the approvals, denials, reapprovals, enrollment increases and decreases, and any curriculum changes of BRN-approved educational providers. As a result, this statute, which was last amended in 1983, should be revised to more appropriately clarify the BRN's EO role in school approvals.

BPC § 2796 states that it is unlawful for any person or persons not licensed or certified as provided in this chapter to use the title "registered nurse," the letters "R.N.," or the words "graduate nurse," trained nurse," or "nurse anesthetist." The BRN reports that investigators have recently encountered cases where unlicensed individuals use the designation "RN" without periods, rather than "R.N." as specified in BPC § 2796. To ensure effective enforcement of existing laws prohibiting unlicensed practice, it is important to clarify that any variation of the title, such as "RN," "R.N.," or similar representations, is unlawful when used by individuals who are not licensed nurses. This bill makes a number of technical updates to improve the Act.

12) *Issue #33*: *Continued Regulation by the BRN*. The health, safety and welfare of consumers are protected by the presence of a strong licensing and regulatory BRN with oversight of RN and APRN professions. The BRN's role in school approval processes should remain but continue to be periodically assessed to ensure that students are able to enter and graduate from a prelicensure nursing program with the credentials and training necessary for licensure and the requisite preparedness for gainful employment in the nursing workforce.

Sunset Recommendation. This bill extends the sunset of the BRN and its authority to appoint an executive officer by four years, until January 1, 3031.

AMENDMENTS:

1) *Issue #2: Geographic Meeting Requirements*. To accommodate stakeholders around the state that still prefer a physical location, amend the bill as follows:

SEC. [X] Amend Section 2709 of the Business and Professions Code to read:

2709. The ~~board~~ *board,* for the purpose of transacting its ~~business~~ *business,* shall meet at least once every three months in *locations that are, to the extent practicable, geographically diverse.* ~~appropriate locations necessary to transact its business.~~

2) *Issue #7: Transition to Practice Acceptance: Experience Gained in Another State*. To address concerns from the opposition around varying standards across states, amend the bill to require the BRN to maintain an up-to-date list of states that it pre-determines have

independent practice standards that would meet the requirements of an in-state transition to practice:

SEC. [X] Amend Section 2837.103 of the Business and Professions Code to read:

2837.103(a)(1)(D) Has completed a transition to practice in ~~California~~ *California,* or another state *identified by the board pursuant to clause (v) of this subparagraph,* of a minimum of three full-time equivalent years of practice or 4600 hours. A nurse practitioner who has been practicing as a nurse practitioner in direct patient care for a minimum of three full-time equivalent years or 4,600 hours within the last five years, as indicated on the application, may be deemed to have satisfied this requirement. For purposes of this subparagraph:

[i-iv omitted]

(v) For purposes of transition to practice completed in another state, the board shall do all of the following:

(I) By July 1, 2027, identify the states where practice experience would meet or exceed the requirements under this article if obtained in this state.

(II) Maintain the list of identified states on its website.

(III) Establish a process for identifying changes to the relevant laws in the identified states.

(IV) Periodically review the list and add or remove states as necessary.

3) *Issue #10*: *CE Documentation Verification*. To authorize the BRN to more easily audit CEs, amend the bill to require licensees to submit their CE documentation at the time of renewal as requested by the BRN:

SEC. [X] Amend Section 2811.5 of the Business and Professions Code to read:

2811.5. (a) *(1)* Each person renewing their license under Section 2811 shall submit proof satisfactory to the board that, during the preceding two-year period, they have been informed of the developments in the registered nurse field or in any special area of practice engaged in by the licensee, occurring since the last renewal thereof, either by pursuing a course or courses of continuing education in the registered nurse field or relevant to the practice of the licensee, and approved by the board, or by other means deemed equivalent by the board.

(2) Beginning January 1, 2029, both of the following apply:

(A) The board shall require each licensee to submit the proof specified in paragraph (1) at the time of renewal.

(B) The proof shall include, but not be limited to, documentation verifying the completion of continuing education requirements during the preceding renewal period or the preceding two years.

4) *Issue #25: Intervention Program and Uniform Standards*. To authorize the BRN intervention committees to determine whether a practice requirement is in the best interest of patients and the recovery of participants, amend the bill as follows:

SEC. [X] Amend Section 2709 of the Business and Professions Code to read:

2770.11. (a) Each registered nurse who requests participation in an intervention program shall agree to cooperate with the rehabilitation program designed by the committee and approved by the program manager. *In developing the rehabilitation program, the committee shall determine whether a participant is required to practice nursing prior to completion of the program.* Any failure to comply with a rehabilitation program may result in termination of the registered nurse's participation in a program. The name and license number of a registered nurse who is terminated for any reason, other than successful completion, shall be reported to the board's enforcement program.

5) *Issue #26*: *Timeline for Reinstatement*. To allow RNs disciplined for procedural reasons, such as default, to petition immediately, amend the bill to limit the mandatory wait periods to discipline for cause:

SEC. [X] Amend Section 2709 of the Business and Professions Code to read:

2760.1 (a) A registered nurse whose license has been revoked or suspended or who has been placed on probation *who, for cause, has had their license revoked or suspended, or has been placed on probation,* may petition the board for reinstatement or modification of penalty, including reduction or termination of probation, after a period not less than the following minimum periods has elapsed from the effective date of the decision ordering that disciplinary action, or if the order of the board or any portion of it is stayed by the board itself or by the superior court, from the date the disciplinary action is actually implemented in its entirety, or for a registered nurse whose initial license application is subject to a disciplinary decision, from the date the initial license was issued:

(1) Except as otherwise provided in this section, at least three years for reinstatement of a license that was revoked, except that the board may, in its sole discretion, specify in its order a lesser period of time provided that the period shall be not less than one year.

(2) At least two years for early termination of a probation period of three years or more.

(3) At least one year for modification of a condition, or reinstatement of a license revoked for mental or physical illness, or termination of probation of less than three years.

REGISTERED SUPPORT:

California Association of Nurse Anesthesiology
California Association for Nurse Practitioners
1 individual

REGISTERED OPPOSITION:

The California Medical Association (unless amended)

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