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# Bridging Physician Shortages in the United States: Supervised Practice Routes for International Medical Graduates

Sohail Rao, MD, MA, DPhil[1]

[1]Chair, University Scientific Board, Dow University of Health Sciences, Baba-E-Urdu Road, Karachi 74200, Pakistan

[1]Corresponding Author Email: srao@duhs.edu.pk

**ABSTRACT:**

**Background**: To mitigate physician shortages, especially in rural and Health Professional Shortage Areas (HPSAs), a growing number of U.S. states have created supervised licensure pathways that recognize verified foreign training and experience while requiring time-limited, structured supervision before independent practice. These routes aim to expand access without compromising patient safety.

**Objective**: To describe the design of these state pathways, synthesize standard eligibility, supervision, and conversion models, and translate them into practical access steps for internationally trained physicians (international medical graduates, IMGs).

**Methods**: We conducted a rapid policy scan of publicly available sources, including the Federation of State Medical Boards (FSMB) tracking resources, state statutes and medical board rules/webpages, and policy journalism. For each state pathway, we abstracted the entry criteria, supervision structure (including duration, site, and oversight requirements), and conditions for conversion to full licensure, and then performed a descriptive synthesis.

**Results**: Since 2023, at least 17–18 states have enacted "additional pathway" or analogous supervised practice options. Programs converge on: (1) ECFMG recognition and USMLE Step 1–2 at entry (with Step 3 commonly required before unrestricted licensure); (2) verification of 3–5 years of prior clinical practice and/or foreign postgraduate training; (3) employment at approved facilities often an ACGME-affiliated hospital, Federally-Qualified Health Center (FQHC), or HPSA/rural site under a named supervising physician with a filed practice/supervision agreement; and (4) 2–4 years of supervised practice plus clean evaluations and exam completion for conversion. Implementation status, terminology, and reporting obligations vary by state (Figure 1).

**Conclusion**: Supervised pathways are a credible and safety-conscious mechanism for adding physician capacity where the need is greatest. Their impact will depend on several key factors, including clear "how-to-apply" guidance, supervisor capacity and support, timely board rulemaking/portals, alignment with immigration/visa timelines, and standardized outcome reporting (applicant volume, placement, conversion rates, and patient-safety indicators).

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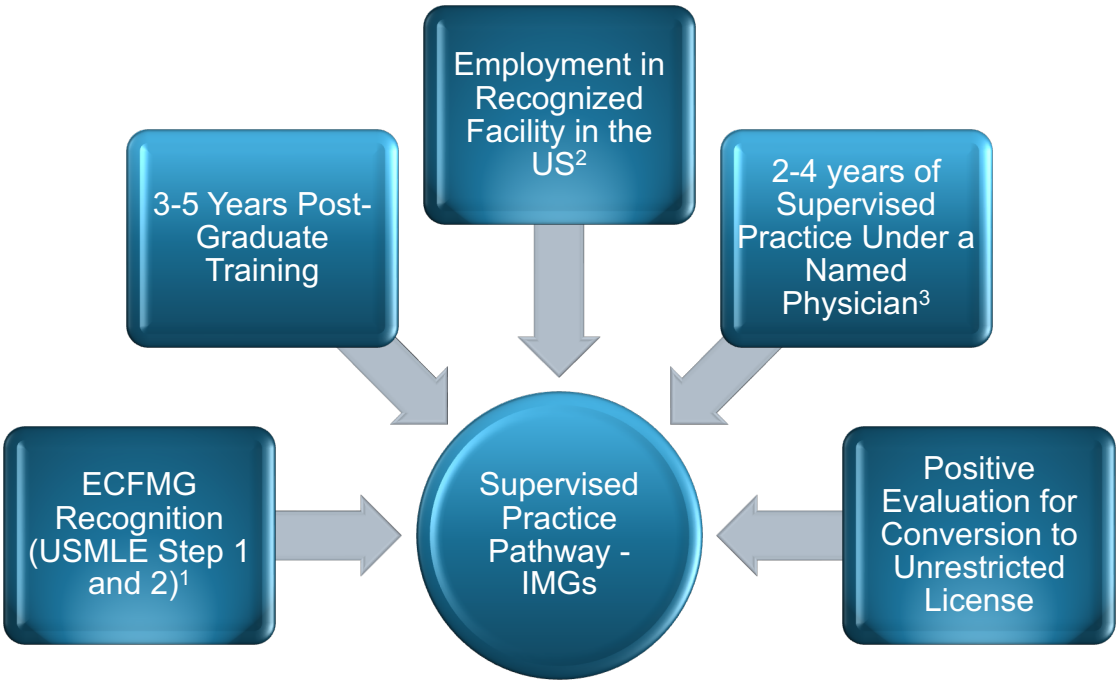
***KEYWORDS:*** *International medical graduates, supervised licensure, physician workforce, state medical boards, IMG policy; FQHC; ECFMG; USMLE; ACGME; FSMB, Health Professional Shortage Areas; HPSA*

## INTRODUCTION:

IMGs constitute roughly one quarter of the active U.S. physician workforce and are disproportionately represented in primary care, safety-net facilities, and geographically underserved communities (FSMB, 2025). Yet for decades, most states required IMGs to repeat substantial portions of training, typically completion of an ACGME-accredited U.S. residency, before obtaining an unrestricted license, regardless of prior postgraduate training or years in independent practice abroad. This approach protected patients but constrained supply by channeling qualified IMGs through a limited number of residency positions and by extending time to practice (FSMB, 2025).

**Figure 1:** Core Standard Requirements for the Analogous Supervised Practice Pathway for IMGs in the United States (Some Requirements Vary by State):




[1]USMLE Step 3 is commonly required before issuance of an unrestricted license

[2]ACGME-affiliated hospital, FQHC, or HPSA/Rural site

[3]With Practice/Supervision agreement

Beginning in 2023, a growing number of states have enacted supervised licensure pathways that acknowledge verified foreign training and experience while requiring time-limited, structured oversight before independent practice (KFF Health News/Stateline, 2025). These "additional pathways" generally pair provisional or limited licenses with explicit guardrails eligibility screens (e.g., ECFMG credentials,

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USMLE Steps 1–2), named supervisors and approved practice sites (often ACGME-affiliated hospitals, FQHCs, or HPSA/rural facilities), and conversion milestones such as satisfactory evaluations and completion of Step 3 (FSMB, 2025). The policy rationale is twofold: to mitigate access gaps without compromising safety and to create a transparent, auditable on-ramp that is faster than repeating a full residency yet more protective than unsupervised recognition of foreign credentials (FSMB, 2025; KFF Health News/Stateline, 2025).

Despite rapid adoption, implementation remains heterogeneous. Terminology (provisional, restricted, international physician registration), supervision duration (often 2–4 years), reporting obligations, and conversion requirements vary by jurisdiction; several states are mid-rulemaking or building portals and forms (FSMB, 2025). In parallel, practical barriers, such as supervisor capacity, employer readiness, and alignment with immigration/visa timelines, shape whether these statutory pathways translate into clinicians at the bedside (KFF Health News/Stateline, 2025).

In this manuscript, we synthesize state practice pathways enacted since 2023, compare standard eligibility, supervision, and conversion models, and critically translate them into practical access steps that IMGs and employers can use to navigate entry and progression (FSMB, 2025).

**METHODS:**

We conducted a rapid policy scan of U.S. state pathways that enable supervised clinical practice for IMGs without repeating a full ACGME residency. The scan focused on pathways enacted and actively implemented with the state (statute + rules + board guidance) as the unit of analysis. We defined a "supervised pathway" as a time-limited license (e.g., provisional, restricted, international physician registration) that (a) requires verified foreign credentials and exams, (b) mandates named supervision at an approved site, and (c) specifies conversion milestones for full/unrestricted licensure (Federation of State Medical Boards [FSMB], 2025). Primary sources of data were: (1) FSMB's public trackers and key-issue summaries on "additional IMG pathways" and GME requirements (FSMB, 2025); (2) state primary materials, enrolled bills/statutes, administrative codes, medical-board webpages, FAQs, and application portals; and (3) policy journalism offering enactment context and implementation timelines (KFF Health News/Stateline, 2025).

Search terms combined the state name with phrases such as *international medical graduate*, *provisional license*, *restricted license*, *supervised practice*, *international physician registration*, *clinical experience license*, and *IMG pathway*. When boards linked to PDFs or forms, those were reviewed to confirm operational details (e.g., attestation templates, supervision agreements). Where terminology differed (e.g., *MD Clinical Experience* in Washington), we included the pathway if it met the supervision and conversion criteria above (Washington Medical Commission, 2025).

In this manuscript, we included states with enacted authority. We published implementation (rules and/or board operational guidance) that permit supervised practice for IMGs outside standard residency, with a defined route to conversion or advancement. We excluded states with bills not signed into law, temporary executive waivers, programs that only permit observerships/shadowing, and rules limited to traditional training (e.g., residency permits) without a distinct supervised-practice license.

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We conducted a descriptive synthesis, summarizing the number of states with active pathways and tabulating common elements (eligibility, supervision, sites, conversion). To reduce abstraction error, a second reviewer spot-checked 25–30% of entries against the original sources; disagreements were resolved by returning to the board webpage or rule text. When FSMB summaries and state pages diverged (e.g., due to recent rule updates), we privileged the state board source and noted the discrepancy (FSMB, 2025).

Rapid scans risk incomplete capture and temporal drift as boards finalize rules and portals. Heterogeneous terminology complicates cross-state comparisons, and we did not assess clinical outcomes or patient safety events linked to these pathways. Readers should confirm current requirements on the relevant state medical board site before acting (FSMB, 2025; Washington Medical Commission, 2025). All data were publicly available policy materials; no human participants were involved, so IRB review was not required. The abstraction spreadsheet and link compendium are available on request to facilitate replication and future updates.

**RESULTS:**

As of May 2025, FSMB tracking identified roughly 17–18 states with enacted "additional pathway" statutes or rules that authorize supervised practice for internationally trained physicians, with several more jurisdictions in active rulemaking. Most programs issue a provisional or limited license that allows clinical work under approved supervision for a defined period, typically two to four years, after which candidates who meet milestones become eligible to apply for unrestricted licensure. While naming conventions vary, the core design across states is a staged, time-limited on-ramp that pairs service delivery with structured oversight.

Entry requirements generally include ECFMG recognition and passage of USMLE Step 1 and Step 2, with Step 3 commonly required before conversion to a full license. States also verify prior competence, most often through documentation of three to five years of post-licensure clinical practice and/or completion of foreign postgraduate training substantially equivalent to U.S. residency.

Employment must be secured at an approved site, frequently ACGME-affiliated hospitals, federally qualified health centers, or facilities located in HPSA/rural areas—with a named supervising physician and a filed practice/supervision agreement that specifies duties, oversight intensity, and reporting intervals (often every 6 or 12 months). Conversion to unrestricted licensure typically requires satisfactory evaluations or attestations from the supervisor, completion of the statutory supervision period, Step 3, where applicable, and a clean disciplinary record.

Florida's 2024 health-workforce legislation expands options for experienced foreign-trained physicians and delegates operational details to the medical board. Tennessee authorizes a temporary/provisional license for qualified IMGs practicing at ACGME-affiliated facilities and ties conversion to successful supervised service. Virginia permits a two-year provisional license, renewable in underserved areas, with conversion contingent on examination and evaluation. Illinois implements a two-stage approach—an initial two-year limited supervised license followed by restricted independent practice in HPSAs, culminating in eligibility for a full license after approximately four years, with IDFPR publishing step-by-step FAQs (Table 1).

Washington's MD Clinical Experience (MDCE) license structures supervised practice under a filed agreement and WAC 246-919-345; it can provide U.S. experience even when it is not a guaranteed bridge

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to full licensure. Iowa's Chapter 148J establishes a provisional license with defined conversion steps once supervision is completed.

**Table 1:** U.S. State Supervised-Practice Pathways for Internationally Trained Physicians

Note: Summarized from state statutes/rules and medical-board webpages. Requirements and implementation details may change. Verify on the relevant board site before applying.

| State | License Category/Name | Entry Eligibility | Supervised Practice (Target) | Approved Sites (Examples) | Conversion Milestones | Notes (Verify Board Page) |
|---|---|---|---|---|---|---|
| Florida | Provisional/limited (per CS/SB 7016; board rule) | ECFMG; USMLE Step 1–2 | Often 2–4 yrs (board rule details) | ACGME-affiliated hospitals; FQHC/HPSA (as designated locally) | Supervisor evals; Step 3; clean record | Framework enacted; operational specifics via medical board rule. |
| Tennessee | Temporary/Provisional license (SB 1451) | ECFMG; USMLE Step 1–2 | Defined supervised term (commonly multi-year) | ACGME-affiliated facilities | Supervisor attestation; Step 3 for unrestricted | Explicit pathway from supervised practice to full license. |
| Virginia | Provisional license (HB 995) | ECFMG; USMLE Step 1–2 | Up to 2 yrs; renewable (esp. underserved) | Approved facilities incl. underserved placements | Exams completed; favorable evaluation; clean record | Renewal options linked to service in underserved areas. |
| Illinois | Two-stage: Limited (2y) → Restricted (HPSA) → Full | ECFMG; USMLE Step 1–2 | Approx. 4 yrs total (2y supervised + restricted practice) | HPSA/rural for restricted stage | Supervisor evals; Step 3; no discipline | IDFPR FAQs provide detailed checklists and forms. |
| Washington | MD Clinical Experience (MDCE) license | ECFMG; USMLE Step 1–2 | Defined by filed practice agreement | Sites per agreement; board approval | Not always a direct bridge; evaluations as specified | Structured U.S. experience; WAC 246-919-345 governs. |
| Iowa | Provisional license (Ch. 148J) | ECFMG; USMLE Step 1–2 | Multi-year supervised period | Approved facilities (board-defined) | Supervisor attestation; Step 3 | Statute enacted; follow board for operational details. |
| Wisconsin | International Physician Provisional License (Med 27) | ECFMG; USMLE Step 1–2 | Supervision per rule; typically, multi-year | Board-approved settings; often ACGME/FQHC/HPSA | Evaluations; Step 3; clean record | Criteria specified in Act 214 and Med 27 rule. |
| Oregon | Provisional license under SB 476 | ECFMG; USMLE Step 1–2 | 4 yrs full-time supervised practice | Board-approved facilities; public-interest placements | Satisfactory evaluations; Step 3; clean record | OMB publishes staged implementation timeline. |
| Texas | Two-year provisional; physician-graduate category (HB 2038) | ECFMG; USMLE Step 1–2 | 2 yrs (provisional) + any board-set conditions | Board-approved settings | Supervisor sign-off; Step 3; rule-defined | Implementation via Texas Medical Board rulemaking. |

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|---|---|---|---|---|---|---|
| Rhode Island | International Physician Registration (IPR) | ECFMG; USMLE Step 1–2 | Mentored practice (multi-year) | Board-approved facilities | Evaluations; Step 3; transition to full | Enacted June 2025; follow board for forms and guidance. |

Wisconsin's 2023 Act 214 and Med 27 create the International Physician Provisional License with rule-based supervision and conversion criteria. Oregon's SB 476 (2025) provides a provisional license and sets a four-year full-time supervised practice requirement; the Oregon Medical Board publishes an implementation timeline. Texas's HB 2038 (2025) creates two-year provisional licenses and a physician-graduate category, with rulemaking delegated to the Texas Medical Board. Rhode Island's H 5108A/S 347A (2025) establishes International Physician Registration that formalizes mentored practice and a pathway to full licensure (Table 1).

Candidates should begin by using the FSMB pathway map to select target states and confirm whether the pathway is enacted and operational. Next, they should identify the precise category of license (e.g., provisional, limited, MDCE, or IPR) and carefully review the board's application checklist and forms. Securing employment at an eligible facility and a committed supervising physician is essential; many boards require a signed practice/supervision agreement before submission. Documentation generally includes an ECFMG certificate, USMLE transcripts (Step 1/2 at entry, with Step 3 often later), proof of foreign licensure and years in practice, background checks and fingerprints, and certified translations where needed. Applications are filed through the board portal. After filing, candidates must maintain compliance by renewing on schedule, submitting supervisor evaluations, and tracking eligibility dates and requirements to convert to restricted or full licensure as soon as they qualify (Table 2).

**Table 2:** Step-by-Step Roadmap for IMGs to Access Supervised Practice Pathways in the United States

| Step (s) | Action | Remarks |
|---|---|---|
| I | Identify Eligible States | FSMB's interactive chart lists states with enacted pathways. IMGs should start with the state(s) they intend to practice in. |
| II | Contact State Medical Boards | Each board publishes application requirements, forms, and checklists. Examples: Illinois IDFPR FAQ (IMG licensure process), Virginia Board of Medicine provisional license portal, Tennessee Board of Medical Examiners forms. |
| III | Secure Employment Sponsorship | Most pathways require an employment contract with a qualifying healthcare institution (often in shortage areas). Boards typically require the employer to file a supervision agreement. |
| IV | Document Credentials | IMGs must submit ECFMG verification, official transcripts, translations, proof of prior practice (employment letters, licenses abroad), and USMLE transcripts. |
| V | Submit Application | Application is filed through the state board's portal with fees; boards often require background checks and fingerprinting. |
| VI | Board Review & Approval | Provisional/limited license issued after credentialing and verification of supervision. |
| VII | Maintain Compliance | Ongoing reporting by supervisors; renewal applications may require progress documentation. |
| VIII | Transition to Full Licensure | After the statutory period and exams, IMGs reapply/convert to an unrestricted license. |

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## DISCUSSION:

States adopting supervised licensure pathways largely converge on a phased-independence model. These frameworks acknowledge verifiable prior training, embed practice within approved institutions under a named supervisor, and require objective milestones, time under supervision, competency attestations, and examination completion before progression to an unrestricted license. In policy terms, the pathways are positioned as access-expanding yet safety-preserving: they direct skilled IMGs into high-need settings while maintaining graduated oversight and measurable competency thresholds.

Practical implementation will determine whether the promise translates into patient access. Three constraints dominate. First, supervisor capacity and institutional readiness: hosting IMG clinicians requires protected supervisory time, privileging workflows, malpractice coverage, EHR access rules, and quality oversight. Without funding for supervision and clear indemnification, institutions may be reluctant to participate. Second, candidate navigation across heterogeneous state rules is burdensome. Differences in eligibility (exam timing, years of experience, setting restrictions) and documentation (translations, primary source verification, employment offers) can delay entry for otherwise qualified physicians. Third, immigration/visa alignment outside the control of state boards can stall placement or limit portability even when licensure criteria are met.

To mitigate these barriers, early outreach and employer sponsorship are critical. Health systems and FQHCs can pre-identify service lines, pair candidates with trained supervisors, and standardize onboarding checklists (see Appendix A). Boards can publish plain-language roadmaps, model supervision agreements, and FAQs to reduce friction (Appendix B). Ethics guidance should emphasize non-exploitation: market-rate compensation, clear promotion pathways, due-process protections for adverse decisions, and explicit prohibitions on substituting supervision for residency where residency is the only safe route.

Programs should embed a prospective evaluation framework from inception. Beyond basic counts, standardized public reporting ought to track applicant volume and characteristics; placement sites (rural/HPSA vs urban); time to first patient contact; exam completion rates; progression and conversion to full licensure; patient-safety indicators (complaints, peer-review events), quality metrics, and patient experience; supervisor workload and burnout; and retention in underserved communities at 1–3 years (Appendix C). Comparative analyses with similarly situated clinicians (e.g., new residency graduates in the same specialties and geographies) will help isolate pathway effects.

Stakeholders should anticipate unintended consequences. If poorly designed, pathways could concentrate IMGs in narrow roles, displace residency opportunities, or create perceptions of a “second-tier” workforce. Conversely, high supervision demands without funding may crowd out teaching time for residents and APPs. Implementing clear guardrails on supervisee-to-supervisor ratios, ensuring portability after meeting milestones, and conducting sunset reviews tied to outcomes can help mitigate these risks.

To ensure that this program is successful, we recommend that (1) dedicated funding or incentive mechanisms for supervisory effort (e.g., grants or enhanced reimbursement add-ons for designated sites); (2) standardized, competency-based milestones recognized across states to improve portability; (3) transparent dashboards updating pathway metrics quarterly; (4) alignment with federal agencies on visa

categories suited to supervised practice; and (5) periodic independent evaluations with public comment to refine statutes and rules.

This review is limited by rapidly evolving statutes and heterogeneity across states; immigration issues and federal payment policy were beyond the scope. Nonetheless, the emerging evidence and early operational experience suggest that supervised pathways can responsibly expand access when coupled with resourced supervision, transparent milestones, and rigorous outcome reporting. Building these elements in from the start will determine whether these programs deliver on both equity and safety.

## CONCLUSION:

Supervised licensure pathways for internationally trained physicians are evolving from isolated pilots into a durable, state-level strategy to expand access to care without lowering standards. Their typical architecture, rigorous credential verification, time-bounded practice within approved institutions, and competency-based milestones for conversion to full licensure create a phased-independence model that can safely integrate experienced clinicians into high-need settings. The promise, however, depends on execution: supervision must be real, resourced, and outcomes-oriented rather than nominal or purely administrative.

States and institutions should therefore move beyond statutory text to operational readiness. That includes protected time and training for supervisors, clear indemnification and malpractice coverage, standardized onboarding (privileging, EHR access, quality metrics), and transparent expectations for both supervisors and supervisees. Boards can reduce friction by publishing plain-language roadmaps, model supervision agreements, and checklists that align eligibility, documentation, and timelines. Because many candidates will navigate immigration processes in parallel, early coordination with employers and counsel is essential, so visa status does not become a hidden bottleneck after licensure criteria are met.

To ensure equity and public trust, pathways should embed safeguards against exploitation and “second-tier” tracks. Programs ought to mandate market-rate compensation, due-process protections for adverse decisions, portability of credit once milestones are met, and sensible caps on supervisee-to-supervisor ratios to prevent burnout and protect teaching time for residents and advanced practitioners. Interstate standardization of milestones and primary-source verification would further support portability and help states learn from one another.

Finally, the field needs transparent, comparable data. From inception, states should maintain public dashboards reporting applicant characteristics, placement sites (with attention to rural/HPSA areas), time to first patient contact, exam completion, progression and conversion to full licensure, safety and quality indicators, patient experience, supervisor workload, and one- to three-year retention. Wherever possible, outcomes should be benchmarked against similar cohorts (e.g., recent residency graduates in the same specialties). With adequate resources, guardrails, and rigorous evaluations, supervised pathways can responsibly convert latent clinical talent into timely patient access while preserving safety and trust. Done poorly, they risk entrenching inequities and exhausting supervisors. The difference lies in meticulous implementation and radical transparency.

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