

Medical Spa Legislation, Regulations, and Guidelines in the United States

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BACKGROUND The growing popularity of medical spas in the United States (US), which combine medical procedures with spa-like services, has led to increased regulatory scrutiny. These facilities operate in a complex legal environment with varying state-level regulations governing ownership, operation, and scope of practice for nonphysician providers (NPPs).

OBJECTIVE To summarize the legislative landscape governing medical spas across the US, identify common regulatory challenges, and explore implications for dermatologists, dermatologic surgeons, and medical spa operators, and present a toolkit to help stakeholders navigate the regulatory environment.

MATERIALS AND METHODS A review was conducted using state statutes, administrative codes, case law, and professional board guidance, including resources from the American Society for Dermatologic Surgery Association (ASDSA). Data were collected from legal databases, state documents, scholarly articles, and ASDSA materials to identify key legislative themes and trends.

RESULTS Significant variability exists in state regulations regarding medical spa ownership, roles of physician supervisors, and scope of practice for NPPs. Key challenges include inconsistent standards, regulatory gaps, and patient protection concerns.

CONCLUSION The fragmented regulatory landscape poses challenges for physicians and patients. Standardizing state laws, strengthening training and certification requirements, and enhancing patient protections are recommended to ensure medical spas operate safely and ethically.

The medical spa industry has experienced tremendous growth in recent years, driven by increasing patient demand for nonsurgical cosmetic procedures.¹ Services offered by medical spas often include injectables (e.g., botulinum toxin and soft tissue fillers), laser hair removal, chemical peels, and microneedling. These treatments carry potential risks. For example, dermal filler injections can cause serious or potentially life-threatening complications, including skin necrosis, blindness, and stroke due to vascular administration and filler embolization.² Improper laser use is associated with burning, scarring, infection, and eye damage.³ The risks of medical spa procedures necessitate appropriate oversight.

In the United States (US), regulation of medical spas falls under state jurisdiction and varies significantly from state to

state. The absence of uniform standards has resulted in a patchwork of state laws determining who can own and operate medical spas, who can perform procedures, and how these facilities are licensed and inspected. This has created challenges for both physicians and patients, raising concerns about patient safety, quality of care, and ethical business practices. Previous studies have revealed that the extent of physician oversight varies tremendously at medical spas and differs by state or region.^{4,5}

Research exploring medical spa legislation and guidelines is sparse, with most studies focusing on individual state policies or specific aspects of medical spa operations.^{4–6} The lack of comprehensive nationwide analyses highlights a significant gap in the literature, underscoring the need for broader investigations to inform consistent regulatory frameworks and improve patient safety across the US.

In this study, the authors provide a comprehensive review of the medical and legal literature evaluating the current status of medical spa regulations in the US. It is the authors' belief that this review will provide a helpful reference tool that summarizes the current medicolegal landscape of medical spas for dermatologists, dermatologic surgeons, and medical spa operators and practitioners alike.

Methods

Search Strategy

A comprehensive search was conducted to identify existing legislation and regulations governing medical

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Supported by the 2023 American Society for Dermatologic Surgery Cutting Edge Research Grant.

The authors have indicated no significant interest with commercial supporters.

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Supplemental digital content is available for this article. Direct URL citations appear in the printed text and are provided in the HTML and PDF versions of this article on the journal's Web site (www.dermatologicsurgery.org).

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Dermatol Surg 2025;51:785–790

<http://dx.doi.org/10.1097/DSS.0000000000004648>

spas in the US. The search strategy involved querying multiple legal and medical databases, including Westlaw, LexisNexis, PubMed, and Google Scholar, for relevant statutes, administrative codes, case law, and scholarly articles. In addition, resources from the American Society of Dermatologic Surgery Association (ASDSA), including the 2023 Med Spa Law Summary and Patient Safety Resources, were reviewed alongside referenced source materials, such as state government documents and websites.

Search criteria prioritized legislation and guidelines relevant to medical spas as institutions. Regulations specific to individual cosmetic procedures, such as laser and injectable treatments, will be examined in greater detail in future reviews.

Keywords used in searches included “medical spa” or “aesthetic spa.” Westlaw results were filtered by content type, including “cases,” “statutes & court rules,” “regulations,” “proposed & adopted regulations,” and “proposed & enacted legislation.” LexisNexis results were filtered to include “cases,” “statutes and legislation,” and “administrative codes and regulations.” Keywords “medical spa” or “aesthetic spa” were used in conjunction with “legislation,” “regulation,” or “state laws” using PubMed and Google Scholar search engines to refine search results. Titles of individual articles were reviewed and abstracts examined where applicable to determine whether content met inclusion criteria.

Searches were limited to documents published in English from January 2000 to October 2024. The review was performed independently by 2 reviewers with conflicts resolved by discussion. If data were duplicated in multiple studies or documents, the most recent and complete information was included. This study was exempt from institutional review board approval, as data were gathered from published literature.

Inclusion criteria included:

1. Legislation: State statutes and administrative codes related to medical spas or cosmetic procedure oversight in the US.
2. Case law: Judicial decisions interpreting or enforcing state regulations pertinent to medical spas or cosmetic procedure oversight.
3. Professional guidelines: Documents from professional boards, such as state medical boards, nursing boards, and ASDSA content, that provide regulatory guidance for medical spa operations or cosmetic procedure oversight.
4. Scholarly articles: Peer-reviewed journal articles discussing the regulatory landscape of medical spas or cosmetic procedure oversight.

Exclusion criteria included:

1. Non-US legislation: Laws and regulations from countries or locales outside the US.
2. Nonmedical aesthetic facilities: Documents focused solely on beauty salons or nonmedical aesthetic services.
3. Outdated or inactive legislation: Statutes or regulations that were repealed or bills that failed to pass.

The initial search yielded 2,053 results, of which 1,851 were excluded, resulting in 202 that met inclusion criteria for the review. One hundred thirty-one results were

obtained from West Law, of which 21 were included for review. Five hundred seventy-one results were obtained from LexisNexis, of which 173 were included for review. Two hundred ninety results were obtained from PubMed searches, of which 1 was included for review. One thousand sixty-one results were obtained from Google Scholar, of which 7 were included for review. In addition to database and search engine queries, ASDSA Medical Spa Law Summary 2023 and ASDSA Patient Safety Resources (comprising 51 webpages corresponding to 50 states and 1 federal district) yielded an additional 126 sources for review.

Data were categorized into key themes: ownership and operation, role of medical directors, scope of practice and supervision requirements for nonphysician providers (NPPs), and patient protection. The results were presented in both tabular and narrative formats to provide a clear overview of the regulatory landscape across the US.

Results

Role of Medical Directors

Medical directors ensure medical procedures are performed in accordance with state laws and ethical standards. However, the educational and training requirements, specific responsibilities, and oversight of medical directors vary by state.

Only a few states specifically define “medical director.” Several of these states require a physician (Doctor of Medicine [MD]/Doctor of Osteopathic Medicine [DO]) medical director, including Iowa, Oklahoma, Rhode Island, and Tennessee (Table 1, see **Supplemental Digital Content 1**, Table 1, Figure 1, <http://links.lww.com/DSS/B632>).

The state of Arizona allows NPPs to act as medical directors (Table 1, see **Supplemental Digital Content 1**, Table 1, <http://links.lww.com/DSS/B632>). Similarly, in Connecticut, physicians, PAs, or APRNs must be employed for medical oversight (Table 1, see **Supplemental Digital Content 1**, Table 1, <http://links.lww.com/DSS/B632>).

In other states, the role and educational background of medical directors is less clear. For example, in Nebraska, medical spas can be supervised by a “physician or medical director,” creating ambiguity about whether medical directors must be physicians or if NPPs can fulfill this role. Even when medical spas or medical directors are not specifically defined, many states establish general requirements for evaluation of patients before cosmetic procedures. In Alaska, Idaho, Illinois, Louisiana, Maryland, New Mexico, Washington, and West Virginia, patient consultations must be with a physician (Table 1, see **Supplemental Digital Content 1**, Table 1, Figure 1, <http://links.lww.com/DSS/B632>). In other states including Connecticut, Georgia, Kentucky, Nebraska, New Hampshire, North Carolina, North Dakota, Oklahoma, and Texas, consultations can be performed by NPPs (Table 1, see **Supplemental Digital Content 1**, Table 1, Figure 1, <http://links.lww.com/DSS/B632>).

TABLE 1. Role of Medical Directors and Physicians at Medical Spas by State

State	Medical Director Regulations
Alabama	None identified
Alaska	According to the Alaska State Medical Board, initial patient consultations must be performed by a physician ⁷
Arizona	APRNs can act as a medical director and/or a LIP, according to the Arizona State Board of Nursing ⁸
Arkansas	None identified
California	Physicians may not contract as a medical director for a non-physician-owned medical spa ⁹
Colorado	None identified
Connecticut	Medical spas must employ a physician, PA, or APRN, thus positioning them at the same level. A physician, PA, or APRN must perform an initial in-person patient consultation and assessment ¹⁰
Delaware	None identified
District of Columbia	None identified
Florida	None identified
Georgia	Facilities that provide cosmetic laser services (other than laser hair removal or IPL) must designate a consulting physician. Patient examinations for laser services other than laser hair removal or IPL must be performed by a physician or delegated to a PA or APRN with a cosmetic laser practitioner license ¹¹
Hawaii	None identified

APRN, Advanced Practice Registered Nurse; IPL, intense pulsed light; LIP, licensed independent practitioner; PA, physician assistant.

Scope of Practice and Supervision of Nonphysician Providers

The scope of practice for NPPs in medical spas is a critical focus of legislation. State laws vary widely regarding what procedures NPPs can perform and under what conditions. Some states have clear guidelines outlining specific procedures NPPs are allowed to perform at medical spas or restricting cosmetic procedures to specific providers. These include District of Columbia, Tennessee, and Utah (Table 2, see **Supplemental Digital Content 1**, Table 2, Figure 2, <http://links.lww.com/DSS/B632>). Medical spa-specific regulations for scope of practice and supervision are included in Table 2, see **Supplemental Digital Content 1**, Table 2, <http://links.lww.com/DSS/B632>.

Other states establish general requirements for scope of practice for cosmetic medical procedures independent of medical spa or cosmetic medical facility designation. These include Alabama, Arizona, Georgia, Kentucky, Nebraska, Tennessee, and Utah, while other states defer to the discretion of supervising physicians (Table 2, see **Supplemental Digital Content 1**, Table 2, Figure 2, <http://links.lww.com/DSS/B632>). In states such as Arizona, NPPs have full practice authority, meaning they can perform and oversee medical spa procedures independently without physician supervision (Table 2, see **Supplemental Digital Content 1**, Figure 2, <http://links.lww.com/DSS/B632>). This

autonomy extends to prescribing medications, performing laser treatments, and administering injectables.

Many states have specific requirements regarding delegation of cosmetic procedures to NPPs. In states such as Alabama, NPPs must work under the supervision of, or in collaboration with, a physician (Table 2, see **Supplemental Digital Content 1**, Table 2, Figure 2, <http://links.lww.com/DSS/B632>). These states typically define the tasks that NPPs can perform independently and those that require oversight by a physician.

In Alaska, Colorado, and South Carolina, physicians are required to provide direct on-site supervision for all or some cosmetic treatments, meaning they must be physically present when specific procedures are performed to address complications that may arise (Table 2, see **Supplemental Digital Content 1**, Table 2, <http://links.lww.com/DSS/B632>). In states such as Illinois, Kansas, and North Carolina, supervision requirements are designated only for certain cosmetic procedures (Table 2, see **Supplemental Digital Content 1**, Table 2, Figure 2, <http://links.lww.com/DSS/B632>).

These requirements contrast significantly with states such as Missouri, in which there is no legal requirement for the physical presence of a physician and/or medical director during the administration of cosmetic procedures.

TABLE 2. Limitations on Scope of Practice for NPPs and Requirements for Physician Oversight by State

State or Territory	Scope of Practice Regulations and Supervision Requirements
Alabama	Level 1 delegates, including PAs, NPs, and RNs, can operate nonablative lasers under locally remote supervision. Level 2 delegates, including LPNs, medical assistants, aestheticians, cosmetologists, and laser technicians, must have on-site supervision by a physician ¹²
Alaska	Physicians must be present on site during administration of cosmetic procedures ⁷
Arizona	The Arizona State Board of Nursing distinguishes between tiers of aesthetic procedures—Level I, II, or III—based on complexity and invasiveness, and restricts training and scope of practice accordingly. APRNs are considered licensed independent practitioners ⁸
Arkansas	According to the Arkansas State Medical Board, physicians can delegate use of lasers for “minor procedures” ¹³
California	None identified
Colorado	Physicians must be on premises to provide supervision to delegates ¹⁴
Connecticut	Only physicians, PAs, APRNs, or RNs can perform cosmetic medical procedures at medical spas ¹⁰
Delaware	Cosmetologists are restricted from laser hair removal ¹⁵
District of Columbia	The Board of Medicine categorizes aesthetic procedures into three tiers—Level I, II, or III—based on the complexity and invasiveness of the procedure. The board defines a “medical spa” as “any facility in which level II or level III aesthetic medical procedures are conducted.” Level II and III procedures are restricted to those “authorized to practice medicine.” ¹⁶ This is an informal guideline and not mandatory
Florida	A physician providing remote supervision for an APRN or PA at a practice primarily providing “aesthetic skin care services” is limited to supervising one office other than the physician’s primary practice; however, medical spas are not directly mentioned or defined in this regulation. The supervising physician must be a dermatologist or plastic surgeon ¹⁷
Georgia	Distinguishes between “assistant laser practitioners” and “senior laser practitioners.” Assistant laser practitioners require on-site supervision by senior laser practitioners to perform nonablative laser treatments other than laser hair removal and IPL ¹¹
Hawaii	Lasers may not be delegated to unlicensed medical assistants or technicians ¹⁸

APRN, Advanced Practice Registered Nurse; NP, Nurse Practitioner; PA, physician assistant; RN, registered nurse; LPN, licensed practical nurse.

Ownership and Operation of Medical Spas

Ownership requirements for medical spas stem from the corporate practice of medicine doctrine, which prohibits NPPs from owning medical practices to protect patient care from commercial influences. Importantly, states differ in the rigor of their ownership models.

Most states do not impose ownership requirements. However, in California, strict laws require medical spas to be owned by licensed physicians (see **Supplemental Digital Content 1, Table 3**, <http://links.lww.com/DSS/B632>). Similarly, per the District of Columbia Board of Medicine, medical spas in the District of Columbia are defined by physician ownership or most shares held by physicians (see **Supplemental Digital Content 1, Table 3**, <http://links.lww.com/DSS/B632>).

Other states allow NPPs to own medical spas, provided they employ licensed medical directors to oversee medical services. These states typically require a formal agreement

between the medical spa owner and the medical director or consulting physician outlining supervisory responsibilities and liability. See “Role of Medical Directors,” and “Scope of Practice and Supervision for NPPs.” Notably, in Tennessee, medical spas are distinguished from practices owned by physicians (see **Supplemental Digital Content 1, Table 3**, <http://links.lww.com/DSS/B632>). Additional ownership guidelines are provided in **Supplemental Digital Content 1, Supplement 3**, <http://links.lww.com/DSS/B632>.

Licensing and Inspection

Licensing and inspection requirements for medical spas vary, with some states requiring medical spas to obtain specific licenses beyond those required for traditional medical practices. For example, Tennessee requires that medical spas register with the state (see **Supplemental Digital Content 1, Table 4**, <http://links.lww.com/DSS/B632>). In states without

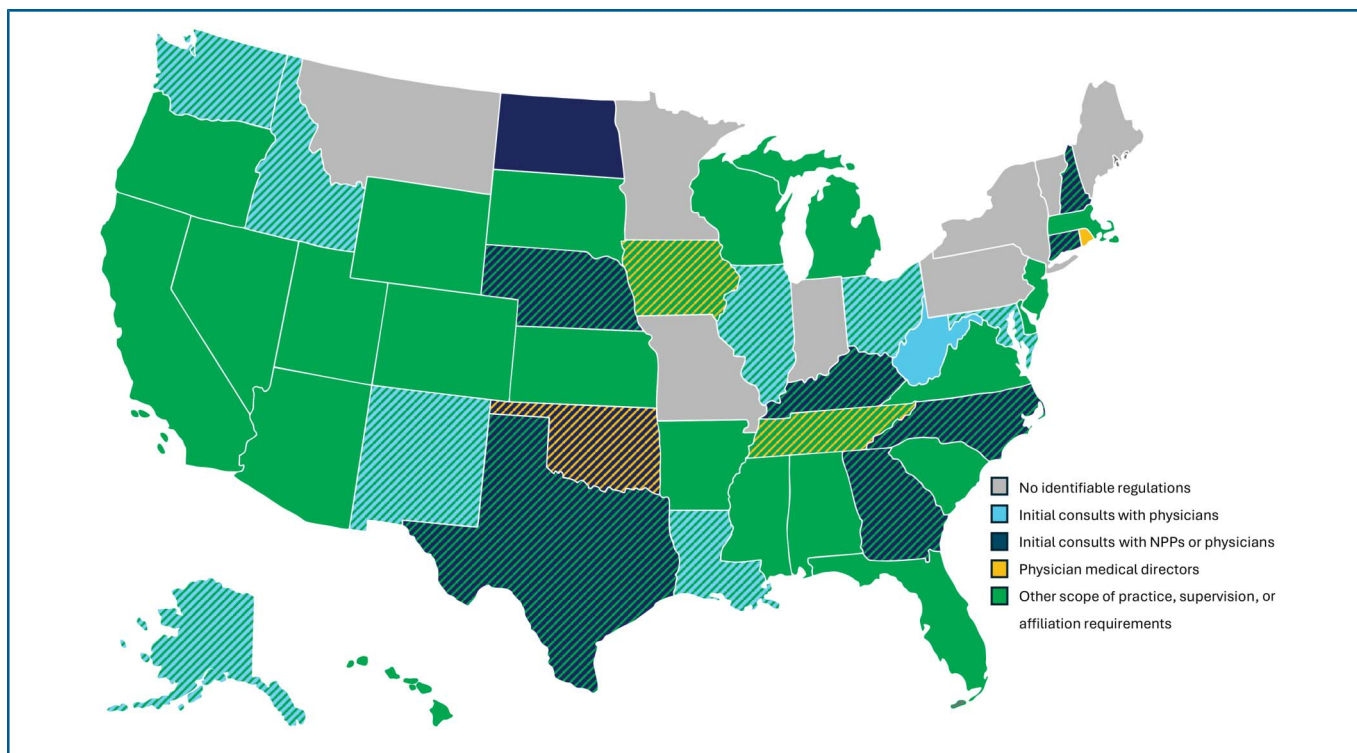


Figure 1. Map of United States depicting state-specific medical spa regulations or lack thereof.

specific licensing for medical spas, such as Nebraska and Missouri, these facilities operate under general medical practice regulations (see **Supplemental Digital Content 1**, Table 4, <http://links.lww.com/DSS/B632>). In these states, medical spas must comply with the same regulations as any other medical practice, including those related to patient privacy (Health Insurance Portability and Accountability Act of 1996 or HIPAA), infection control, and recordkeeping. State-specific licensure requirements for medical spas are included in **Supplemental Digital Content 1**, Table 4, <http://links.lww.com/DSS/B632>.

Patient Protection

Several states have regulations or requirements surrounding patient education regarding service provider background and informed consent. Connecticut, Iowa, New Mexico, Tennessee, and Wisconsin require that information regarding service provider background, such as details regarding educational background and relevant certifications, be made available to patients (see **Supplemental Digital Content 1**, Table 5, <http://links.lww.com/DSS/B632>).

Summary

Several states have no identifiable medical spa or related oversight: Indiana, Maine, Minnesota, Missouri, Montana, New York, Pennsylvania, and Vermont (Figure 1).

Discussion

This review highlights key trends in medical spa legislation in the US and emphasizes the lack of existing uniform

standards across states. In the absence of a unified regulatory framework, each state independently establishes its own rules, resulting in significant variability. This inconsistency can result in confusion for physicians, NPPs, and patients alike and often contributes to variability in standards of care.

Legislative gaps are particularly evident in ownership and operational requirements, as California is the only state to enforce strict physician ownership mandates (Table 1). In addition, Tennessee stands alone as the only state requiring medical spas to register with the state government (see **Supplemental Digital Content 1**, Table 4, <http://links.lww.com/DSS/B632>). Scope of practice and physician oversight are the most commonly regulated areas of legislation, with some states limiting specific cosmetic procedures to designated providers and mandating oversight by physicians.

Notably, there are many US states that have no identifiable regulations or requirements surrounding medical spas in any of these domains. The lack of sufficient medicolegal regulation or oversight can lead to disparate patient outcomes, including higher rates of patient-related complications.

In recent years, several states have proposed, repealed, or amended legislation affecting medical spas, including California, Kentucky, Louisiana, Massachusetts, New Hampshire, Rhode Island, Texas, Mississippi, and Maryland. This ongoing legislative activity reflects the contentious nature of medical spa regulation and underscores the growing relevance of these establishments to public health at large.

Differences in state legislation mean that a procedure legally performed in one state without adequate

supervision, evaluation, or assessment may be restricted or prohibited in another, complicating the operations of multistate medical spa businesses and creating regulatory challenges in ensuring consistent training and certification for all providers.

Recommendations for Regulatory Reform

Regulatory reform for medical spas in the US should focus on establishing consistent standards across states to improve patient safety and care quality. To address these inconsistencies, overarching guidelines could provide states with a baseline regulatory structure, ensuring uniform standards for licensing, training, and operation. This would enable states to adopt regulations that are both comprehensive and adaptable, allowing for state-specific needs while ensuring baseline safety and practice standards.

In addition, regulations should prioritize physician oversight in medical spa operations, particularly in areas involving high-risk procedures such as laser treatments, dermal fillers, and injectable neurotoxin. By requiring physician supervision and enforcing specific training standards for NPPs, states can better safeguard patients against complications associated with improperly administered treatments.

Regulators should also focus on enhancing patient protections, particularly in the areas of informed consent and advertising, to help protect patients from misleading or harmful practices. In addition, states could consider implementing mandatory reporting requirements for adverse events associated with medical spa treatments, similar to those in place for other medical facilities.

Conclusion

The medical spa industry in the US operates within a complex and increasingly fragmented regulatory environment. Although the growth of this industry has provided patients with increased access to cosmetic treatments, it has also raised important questions about patient safety, quality of care, and ethical business practices. The variability in state regulations presents challenges for both providers and patients, highlighting the need for regulatory reform. Although some states have developed robust frameworks for ensuring patient safety and professional accountability, significant gaps and challenges remain, particularly in areas of uniformity, training, and patient protection. By standardizing state laws, strengthening training and certification requirements, and enhancing patient protections, states can help ensure that medical spas operate safely and ethically, providing high-quality care to all patients.

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