ATHLETIC TRAINER PRACTICE PROTOCOL

As a condition of performing the functions and duties of an athletic trainer in this state, each athletic trainer must submit a practice protocol to the Board. The practice protocol shall be signed by the athletic trainer and the responsible MD, DO, or DC who will delegate the responsibilities that constitute the practice of the healing arts. A practice protocol is required for each responsible MD, DO, or DC. For all supervision requirements, see K.A.R. 100-69-9.

Email the completed practice protocol to KSBHA_Licensing@ks.gov or mail directly to the Board. It is highly recommended that both the athletic trainer and responsible MD, DO, or DC make and keep copies of all practice protocols submitted to the Board. Confirmation will be sent via email after the agreement has been processed.

Name of AT: _____

License Number (if applicable): _____

Name of ATs Employer: _____

Address of ATs Employer: _____

Name of Responsible MD, DO, or DC: _____

License Number: _____ License Type: MD ☐ DO ☐ DC ☐

TO BE COMPLETED BY THE RESPONSIBLE MD, DO, OR DC

Under my delegation, including in my absence, the above-named athletic trainer has the authority to act on my behalf and provide the following care:

1.	Perform evaluations, emergency care, and transportation.	Yes ☐	No ☐
2.	Perform the application of preventative and protective measures designed to prevent injuries or protect existing injuries including taping, padding bandaging, dressing skin wounds, and splinting.	Yes ☐	No ☐
3.	Initiate standard treatment procedures of applying cold, compression, elevation, and rest to injured body parts.	Yes ☐	No ☐
4.	Application of cryotherapy such as cold/ice packs, cold water immersion, ice massage, and spray coolants.	Yes ☐	No ☐
5.	Application of thermotherapy such as topical analgesics, moist hot packs, heating pads, infrared heat, and paraffin baths.	Yes ☐	No ☐
6.	Application of hydrotherapy such as whirlpool and contrast bath.	Yes ☐	No ☐
7.	Application of therapeutic exercise common to athletic training such as stretching, conditioning, strengthening, and muscle testing.	Yes ☐	No ☐
8.	Application of additional clinical contemporary therapeutic modalities including patient preparation, set up, determination of dosage and treatment, including but not limited to, diathermy (shortwave, microwave, ultrasound) and muscle stimulation.	Yes ☐	No ☐
9.	Application of rehabilitation procedures for post-operative injuries and non-operative injuries.	Yes ☐	No ☐
10.	Act as an advisor concerning diet, rest, hydration, hygiene, sanitation, injury/illness prevention, and physical fitness development.	Yes ☐	No ☐

By signing below, I certify that I have read, understand, and agree to comply with the requirements and responsibilities of a responsible MD, DO, or DC and athletic trainer in Kansas. Furthermore, I certify if there are any changes or amendments to the Athletic Trainer Practice Protocol, the Board will be notified within 10 days. Effective date signed.

_____ _____
Signature of Responsible MD, DO, or DC Date

_____ _____
Signature of Athletic Trainer Date

Kansas State Board of Healing Arts
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