March 17, 2025

The Honorable Derek S. Maltz
Acting Administrator
Drug Enforcement Administration
600 Army Navy Drive
Arlington, VA 22202

Submitted electronically via regulations.gov

RE: RIN 1117-AB40; Special Registrations for Telemedicine and Limited State Telemedicine Registrations

Dear Acting Administrator Maltz:

On behalf of the American Academy of Family Physicians (AAFP), which represents 128,300 physicians and medical students nationally, I write in response to the Drug Enforcement Administration's (DEA) notice of proposed rulemaking (NPRM) to amend the Ryan Haight Online Pharmacy Consumer Protection Act of 2008 (the ''Ryan Haight Act'') by establishing a Special Registration framework. The AAFP supports several of the goals in this proposed rule and appreciates DEA attempting to update existing standards to expand patients' access to controlled substance medications via telemedicine and mitigate risks associated with medication diversion.

Family physicians provide high-quality, person-centered, continuous primary care for patients across the lifespan. Their broad scope of practice is both unique and valuable, as they can modify their personal focus and scope of practice to meet the needs of their communities. Family physicians practice in a wide variety of settings, from primary care practices to hospitals, skilled nursing facilities, emergency departments, urgent care centers, and hospice facilities. Family physicians are trained to provide continuing and comprehensive medical care, health maintenance including management of chronic conditions, and preventive services to all patients, which requires them to prescribe a wide variety of controlled substances for the treatment of a broad range of conditions.

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As the usual source of care for patients across the lifespan, family physicians are trained to practice across care settings, including offering care by their patient's preferred and most appropriate modality. This has more frequently included care delivered via telehealth, which has seen increased utilization as a result of the COVID-19 pandemic. According to a recent AAFP survey, nine in 10 family physicians practice telehealth today.

Prior to the COVID-19 public health emergency (PHE), the Ryan Haight Act required patients to receive an in-person medical evaluation to receive a prescription for a controlled medication. Congress also directed DEA to promulgate regulations establishing a special registration for the prescribing of controlled substances via a telehealth encounter, but these regulations were not developed before the COVID-19 pandemic. During the PHE, DEA established flexibilities to allow for virtual prescribing of controlled substances without an in-person visit requirement. This helped ensure timely access to care for patients while also helping to keep primary care practices open and minimizing patient and physician exposure to COVID-19. This NPRM proposes new federal regulations for the prescribing of controlled substances via telehealth encounters after the current flexibilities end on December 31, 2025.

The AAFP appreciates DEA proposing regulations to permanently enable telehealth prescribing of controlled substances, and we agree that a continuous care relationship enables physicians to provide patient-centered care and can help guard against medication misuse and diversion. However, **the AAFP has serious concerns regarding some of the provisions outlined in this proposed rule, especially those that would inappropriately interfere with patient care and clinical decision making. We strongly urge DEA not to finalize this rule as proposed, as we do not believe it can be implemented as written without needlessly restricting patients' access to care. Instead, the AAFP urges DEA to either make significant changes or withdraw the proposed rule. We stand ready to collaborate with DEA, the Department of Health and Human Services (HHS), and all other stakeholders to find effective, achievable, and affordable ways to guarantee patients' access to care and physicians' clinical autonomy while simultaneously minimizing medication diversion in our health care system**.

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The AAFP opposes action that limits patients' access to pharmaceuticals prescribed by a physician using appropriate clinical training and knowledge, and **we oppose any actions by pharmaceutical companies, public or private health insurers, legislators, government agencies, or any other entity that may have the effect of limiting any physician medical specialty's ability to prescribe any pharmaceutical product**. This proposed rule directly conflicts with AAFP policy and the broader health care system's collective goal of improving and expanding patients' access to care. **Among other recommendations detailed below, the AAFP urges DEA to**:

- **Include audio-only telehealth visits in this regulation, which would support patients' access to care, particularly in rural areas;**
- **Remove mid-level practitioners from being eligible for the Telemedicine Prescribing Registration and the Advanced Telemedicine Prescribing Registration;**
- **Include family medicine and all other physicians on the list of "qualified specialized physicians" who can be authorized under the Advanced Telemedicine Prescribing Registration to prescribe Schedule II-V controlled substances via telemedicine; and**
- **Focus efforts to prevent medication diversion primarily on law enforcement tactics instead of establishing specific standards of care through rulemaking.**

Promoting Patient-Physician Relationships

The AAFP deeply appreciates that this proposed rule would only apply in situations where an in-person medical evaluation has not taken place and the clinician intends to prescribe a controlled substance. We support the expanded use of telehealth and telemedicine as an appropriate and efficient means of improving health, when conducted within the context of appropriate standards of care. Telehealth technologies can enhance patient-physician collaborations, increase access to care, improve health outcomes, and decrease costs when utilized as a component of longitudinal care. We believe any permanent expansion of telehealth

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should be structured to not only increase access to care but also promote high-quality, comprehensive, continuous care, as outlined in the joint principles for telehealth policy put forward by the AAFP, the American Academy of Pediatrics, and the American College of Physicians. **The appropriateness of a telemedicine service should be dictated by the standard of care and not by arbitrary policies**. Available technology capabilities, as well as an existing physician-patient relationship, impact whether the standard of care can be achieved for a specific patient encounter type.

When implemented thoughtfully, telehealth can improve the quality and comprehensiveness of patient care and expand access to care for rural and under-resourced communities and vulnerable populations. As discussed in the Academy's comments on the CY24 Medicare Physician Fee Schedule proposed rule and our aforementioned joint principles, the AAFP strongly believes telehealth policies should advance care continuity and the patient-physician relationship. Telehealth should also enable higher-quality, more personalized care by making care more convenient and accessible for patients. Expanding telehealth services in isolation, without regard for a previous patient-physician relationship, medical history, or the eventual need for a follow-up, hands-on physical examination can undermine the central value offered by a usual source of primary care—a continuous and comprehensive patient-physician relationship.

Minimizing Physician Administrative Burden

Administrative functions and regulatory compliance already overburden family physicians at the point of care and after patient care hours, making it one of the driving factors fueling health care consolidation and forcing many primary care practices to either sell or close their doors altogether. Studies have estimated that primary care physicians spend nearly 50 percent of their time on cumbersome administrative tasks, which we know the current administration is working actively to alleviate.[i,ii] **The AAFP requests DEA not increase the already overwhelming administrative burdens physicians face each day. We urge DEA to deeply consider how the application processes outlined here can be streamlined and incorporated into physicians' existing workstreams and DEA-related responsibilities instead of adding new deadlines and increasing workloads**. Physicians are already

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overburdened, particularly in small and rural practices, and we encourage DEA to work both internally and with other agencies to harmonize licensing requirements and minimize administrative challenges for prescribers.

The AAFP urges DEA to focus on addressing diversion and improving oversight of telehealth companies instead of imposing complex, burdensome regulations on physicians. While we have advocated to permanently expand coverage and payment for telehealth services and strongly support patients' ability to access telehealth services from their usual source of care, the AAFP has also repeatedly shared concerns that services provided by direct-to-consumer (DTC) telehealth companies may drive care fragmentation and pose significant patient safety risks. Most helpful for family physicians would be increased oversight on telehealth provided by companies that are not part of a patient's usual source of care. Better, more targeted oversight will be more effective than burdensome reporting mandates or duplicative licensing requirements. **We urge DEA to focus its efforts on addressing diversion and stopping bad actors through law enforcement activities—not health care regulations**.

Including Audio-Only Telemedicine Services

Telehealth can be a lifeline for many rural residents, who may encounter significant barriers such as distance, financial, insurance coverage, or lack of transportation to easily access in-person care. However, existing barriers also continue to hinder the ability for individuals in rural communities to access quality telehealth services. The lack of modern broadband infrastructure has proven to be a primary barrier to telehealth and digital health access for rural Americans, who are ten times more likely to lack broadband access than their urban counterparts, leading to fewer audio/video visits. [iii]

The AAFP strongly agrees with the federal government's long-held belief that all patients deserve access to comprehensive health care services regardless of where they live. In many instances, family physicians have reported that some of their patients, particularly seniors, are most comfortable with or can only access audio-only telehealth visits. A recent AAFP survey found that 90 percent of family

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physicians are providing telehealth services, with more than 80 percent providing audio-only telehealth services. Patients and physicians agree – and the latest available evidence confirms – that telehealth is a valuable modality of care that will be essential to facilitating equitable access to care after the current flexibilities expire. Therefore, permanent telehealth policies must include audio-only telehealth services. While we were glad to see audio-only services included in the recently published "Expansion of Buprenorphine Treatment via Telemedicine Encounter" final rule, the AAFP firmly believes that audio-only technology should be permitted for services beyond opioid use disorder and mental health services when a patient is unable or unwilling to have an audio/video telehealth visit. Family physicians are more likely than other physicians to practice in rural and other underserved areas, and they have repeatedly shared that telehealth has removed barriers to care for many patients. **We urge DEA to include audio-only telehealth visits under these regulations, which would support patients' access to care—particularly in rural areas**.

Telemedicine Prescribing Registration

DEA proposes permitting physicians and board-certified "mid-level practitioners" to apply for a special registration to prescribe Schedule III-V drugs when the clinician anticipates treating patients for whom requiring an in-person medical evaluation prior to prescribing a Schedule III-V drug could impose significant burden, including patients living in remote areas or dealing with severe weather conditions. Examples of mid-level practitioners include but are not limited to nurse practitioners, nurse anesthetists, and physician assistants.[iv]

The AAFP does not support mid-level practitioners – also known as non-physician clinicians (NPCs) – having prescribing powers, and we urge DEA to amend this proposal accordingly. Though NPCs are crucial members of the care team, the skills and acumen obtained by physicians throughout their extensive education and training make them uniquely qualified to oversee and supervise patients' care. Studies have shown that patients are 15 percent more likely to be prescribed antibiotics by NPCs than physicians, and 8.4 percent of physician assistants prescribed opioids to over half of their patients, compared to 1.3 percent of physicians.[v,vi] Furthermore, unnecessary prescriptions and procedures may lead to

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the unintended consequence of increasing overall health care spending, which would deeply conflict with one of the top goals of this presidential administration.

While the AAFP supports a wide variety of efforts by policy makers to improve access to health care services, including the innovative utilization of NPCs, we believe physician-led, team-based primary care is what's best for patient care and outcomes. Patients are best served when their care is provided by an interprofessional, interdependent team led by a physician to support comprehensive care delivery and achieve better health, better care, and lower costs. **Though some state statutes allow NPCs independent prescribing authority, the AAFP supports NPCs prescribing only within physician-led care teams. We believe that only licensed doctors of medicine, osteopathy, dentistry, and podiatry should have the statutory authority to prescribe drugs for human consumption**.

Advanced Telemedicine Prescribing Registration

DEA proposes permitting only physicians and mid-level practitioners who specialize and are board certified in the following limited circumstances or practice specialties be eligible to prescribe Schedule II controlled substances via telemedicine: 1) psychiatrists; 2) hospice care physicians; 3) palliative care physicians; 4) physicians rendering treatment at long term care facilities; 5) pediatricians; 6) neurologists; and 7) mid-level practitioners and physicians from other specialties who are board certified in the treatment of psychiatric or psychological disorders, hospice care, palliative care, pediatric care, or neurological disorders unrelated to the treatment and management of pain. For the seventh category, DEA proposes that both physicians and mid-level practitioners be required to provide specific information regarding their training and experience when applying for the special registration, with mid-level practitioners explicitly required to be board certified in one of those areas. Physicians, meanwhile, would have slightly more flexibility in demonstrating expertise in one of the listed areas, including specialized training that occurred outside of a board certification process.

The AAFP is strongly opposed to this proposal, and we deeply disagree with DEA's assertion that mid-level practitioners board-certified in specific types of care are

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better positioned than family physicians to provide expert care for specific, vulnerable patient populations. The AAFP also strongly disagrees with DEA's assertion that other types of physicians are more appropriately or better positioned than family physicians to provide excellent, comprehensive care—including prescribing Schedule II drugs as they see fit. We urge DEA to include family medicine and all other physicians in this proposal. Primary care physicians in particular provide holistic care to patients of all ages and should have the ability to prescribe drugs, including controlled substances, as they determine appropriate for an individual patient based on their clinical training and expertise.

Family medicine is the medical specialty that provides first contact in a large proportion of American communities, offering health care for individuals, families, and communities across their entire lifespan. This specialty is distinctive in its broad integration of biological, clinical, and behavioral sciences and is often considered the most versatile of all physician specialties. Additionally, family physicians provide more care for America's underserved and rural populations than any other medical specialty. Seventeen percent of our members live and work in rural areas, the highest percentage of any medical specialty, and they are often the only physician embedded in the community. This proposal places patients nationwide at risk of losing access to needed health care, which directly conflicts with the current administration's stated goals.

Family physicians are uniquely trained and positioned to holistically address patients' health care needs in the context of their communities, including by managing multiple chronic and acute conditions. Our nation's patients deserve high-quality, accessible health care delivered by a physician-led care team that can fully address patient needs, communicate effectively, and empower care team members to utilize their skills, training, and abilities to the full extent of their professional capacity. This should include physicians being permitted to practice the full scope of their training and licensure, including the ability to prescribe Schedule II controlled substances in the situations where they see fit.

While NPCs are an integral part of physician-led health care teams, the AAFP does not believe they should be eligible for an Advanced Telemedicine Prescribing

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Registration. Mid-level practitioners cannot substitute for physicians, especially when it comes to diagnosing complex medical conditions, developing comprehensive treatment plans, ensuring that procedures are properly performed, and managing highly involved and complicated patient cases. Though the AAFP greatly values the contribution of all non-physicians, no other health care professionals come close to the four years of medical school, three-to-seven-years of residency training, and 12,000-16,000 hours of clinical training that is required of physicians. By contrast, physician assistant programs are two-to-three years in length; have no residency requirement; and require only 2,000 hours of clinical care, while nurse practitioner programs are two-to-four years long with no residency requirement and only 500-750 hours of clinical care.[vii]

We urge DEA not to finalize this proposal as written, and we also request DEA clarify if this proposal is intended to expand the controlled substance prescribing power of NPCs board-certified in specific types of care to include Schedule II drugs nationwide, given that NPCs are not currently permitted to prescribe Schedule II drugs in some states. The AAFP urges DEA to respect states' individual scope of practice and licensure laws for NPCs and not unilaterally expand NPCs' prescribing power.

Telemedicine Platform Registration

DEA proposes to authorize DTC companies, referred to as "covered online telemedicine platforms" in this rule, to issue controlled substance prescriptions if they can demonstrate a "legitimate need" for a special registration. DEA defines a covered online telemedicine platform as an entity that facilitates audio-video patient-clinician connections for a patient's diagnosis and treatment but is not a "hospital, clinic, local in-person medical practice, or insurance provider." Four additional qualifying factors are outlined; if a DTC company meets any one of the four factors included, they would then need to apply for this special registration. DEA states this definition is intended to limit the special registration requirements to DTC telemedicine vendors that play a substantial role in the remote dispensing of controlled substances. This framework is deemed to be necessary given the pivotal role DTC companies sometimes occupy in delivering health care via telemedicine.

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As we've shared throughout this letter, the AAFP strongly believes telehealth is most appropriate when provided by a patient's usual source of care. We have significant concerns about the rapid proliferation of DTC telehealth vendors and the resulting interference with the established patient-physician relationship. In the last several years we've seen new and different types of DTC telehealth vendors emerge, including many for-profit start-ups that market themselves in ways that lead a patient to believe they are providing true, person-centered health care. The dangers of these types of companies extends beyond disrupting the established patient-physician relationship and can range from misusing patient data to making patients vulnerable to medical misinformation—potentially leading to patient harm.[viii]

Years of neglect and chronic underinvestment in the health care system has left primary care in a position where it is increasingly unable to meet patients' needs, particularly in rural and other underserved communities. This combination of worsening primary care access and sicker patients has created a vicious cycle, and we are concerned DTC telehealth companies are attempting to fill that gap with less comprehensive patient care. Coordinated federal commitment to and investment in primary care would help effectively address the physician workforce supply and training challenges the U.S. is currently facing.

Studies have shown that DTC telehealth can lead to increased utilization and may ultimately increase overall health care spending. In July 2022, the Office of the Inspector General (OIG) released a Special Fraud Alert regarding fraud schemes where telemedicine companies offer kickbacks for prescribing medically unnecessary items and services for individuals with whom the clinician often does not have a relationship. As noted by the OIG, "These types of volume-based fees not only implicate and potentially violate the Federal and anti-kickback statute, but they also may corrupt medical decision-making, drive inappropriate utilization, and result in patient harm."

The AAFP remains concerned about the lack of regulation and transparency DTC telehealth companies are subject to and how that might impact patient care and outcomes, and we appreciate DEA outlining this special registration process. DTC telehealth cannot replace in-person care and is not an adequate replacement for a

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longitudinal patient-physician relationship, especially for patients with complex medical conditions. Implementing additional guardrails on DTC telehealth vendors would help ensure high-quality services are being delivered to patients without unduly restricting access to care, while also safeguarding program integrity. **The AAFP agrees with DEA that DTC telehealth companies can pose significant risks to patients, and we recommend DEA prioritize patient safety while preventing diversion by conducting rigorous oversight of those that are granted this type of special registration**.

State Telemedicine Registration

DEA proposes that, in addition to the three prescribing registrations outlined in this regulation, registrants would also be required to obtain a State Telemedicine Registration for every state in which they intend to write prescriptions for controlled substances to patients via telemedicine. This would be a separate DEA-issued registration, not a registration issued by individual states. DEA proposes the application fee for a Platform Practitioner State Telemedicine registration – applicable to those working for DTC telehealth companies – be $888, while the Clinician Practitioner State Telemedicine registration fee would be $50 for each state in which the clinician sought a registration. DEA asserts this price differential is due to the expected lower volume of telemedicine that would be conducted by clinicians than by telemedicine platforms.

While the AAFP agrees that those applying for Platform Practitioner State Telemedicine registrations should be charged more than physicians practicing in non-DTC care settings, we do not believe an $888 registration fee is appropriate or adequate. A start-up DTC telehealth company faces significantly fewer costs and regulatory challenges than a new, traditional brick-and-mortar physician practice, and we support DTC telehealth vendors having to demonstrate their commitment to providing quality health care, including through strict adherence to increased documentation and financial requirements. **The AAFP recommends the fee for Platform Practitioner State Telemedicine registration applications be significantly increased, and we support the Clinician Practitioner State Telemedicine registration fee being finalized at $50 per state as outlined in this proposal**.

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"Special Registration" Application Process

DEA proposes a new special registration application, Form 224S, to oversee the three types of special registration outlined in this regulation: Telemedicine Prescribing, Advanced Telemedicine Prescribing, and Telemedicine Platform. This special registration would cost $888 for any of the three kinds of registration available, and it would need to be renewed every three years once granted. Applicants would be required to provide a physical address where all recordkeeping for the applicant would be maintained, attest to "all employment, contractual relationships, and professional affiliations," and notify DEA within 14 days if any of the information on their original Form 224S changes. If seeking the Advanced Telemedicine Prescribing registration, details regarding an applicant's qualifying specialty and related training would also be required.

While the AAFP does not object to the broader application terms proposed here regarding disclosure of applicants' business arrangements and the three-year timeframe outlined, **we disagree with the three types of special registration applicants being charged the same fee under this proposal. Thus, we urge DEA to increase the registration fee for Telemedicine Platform registrants**. As detailed earlier in this letter, DTC telehealth companies should be held to higher and more stringent standards than physician practices that offer traditional, relationship-based health care, specifically because of the danger posed to the continuity of patient care through this care modality, and we do not believe an $888 registration fee is appropriate or adequate. A start-up DTC telehealth company faces significantly fewer costs and regulatory challenges than a new, traditional brick-and-mortar physician practice, and we support DTC telehealth vendors having to demonstrate their commitment to providing quality health care, including through strict adherence to increased documentation and financial requirements. We therefore strongly disagree with DEA's proposal that those working for DTC telehealth companies should pay the same registration fee as those applying for Telemedicine Prescribing or Advanced Telemedicine Prescribing registrations. **The AAFP respects DEA's responsibility in preventing drug diversion, and we recommend DEA consider in depth the risks**

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irresponsible DTC telehealth companies can cause and amend registration fees accordingly.

Manner of Issuance of Special Registration Prescriptions

DEA proposes to require all special registration prescriptions be issued through electronic prescribing for controlled substances (EPCS), stating that EPCS offers a robust and accountable system that prevents misuse and diversion of controlled substances. DEA proposes clinician special registrants be required to conduct a prescription drug monitoring program (PDMP) check before issuing a controlled substance prescription, asserting that a nationwide PDMP check would be required three years from the effective date of a final rule. This is due to there being no currently available, nationwide PDMP. In the interim, DEA proposes clinician special registrants be required to check the PDMPs for: 1) the state or territory where the patient is located; 2) the state or territory where the clinician practitioner is located; and 3) any state or territory with PDMP reciprocity agreements with either the state or territory where the patient or clinician practitioner is located.

DEA proposes additional restrictions for prescribing Schedule II controlled substances beyond those detailed earlier in this letter, including requiring that the clinician special registrant be physically located in the same state as the patient when issuing a prescription for a Schedule II controlled substance. DEA also proposes requiring the average number of prescriptions for Schedule II controlled substances constitute less than 50 percent of the total number of Schedule II prescriptions issued by the clinician special registrant in their telemedicine and non-telemedicine practice in a calendar month.

The AAFP supports EPCS and national-level guidelines to avert a patchwork of policies that ultimately result in greater administrative burden for physicians and delay access to necessary prescriptions. **We request clarification from DEA as to whether the existing exceptions to the EPCS program will apply to those granted special registrations, as those exceptions are critical for family physicians in independent practice**. Family physicians that work in a small or independent practice environment have unique needs and may require specific, targeted support to be successful. We

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urge DEA to consider and prioritize these physicians' needs when determining EPCS and special registration regulations.

The AAFP encourages physicians to attempt to access their state PDMP before prescribing any potentially misused pharmaceutical product, and we agree such requirements should apply to telehealth prescribing of controlled substances. However, the success of such efforts depends on state reporting systems that are accessible, timely, interoperable, and comprehensive. State investments in PDMP systems vary widely and directly impact the effectiveness and accessibility of PDMPs. To ensure this provision fulfills the intended goal of helping clinicians identify potential diversion risks, co-prescribing concerns, and inappropriate prescribing by other clinicians, the AAFP strongly encourages DEA to work with states to improve the functionality, utility, and interoperability of PDMPs. **We also urge DEA to focus its efforts on preventing diversion on law enforcement tactics instead of establishing specific standards of care through DEA rulemaking. The appropriateness of a telemedicine service should be dictated by the standard of care, not by arbitrary policies.**

The AAFP does not support the proposed PDMP requirements outlined in this regulation, and we do not support codifying requirements that have little likelihood of coming to fruition. While the AAFP would deeply appreciate the creation and existence of a functional, nationwide PDMP, we agree with DEA's assertion that it is "currently unlikely that any one healthcare provider has access to all PDMPs nationwide." Without it being legally mandated or incentivized, we do not foresee a nationwide PDMP being built in the near-term. We urge DEA not to finalize regulations based on a concept that has little chance of becoming reality on the given timeline, and we instead urge DEA to work with HHS and other stakeholders to incentivize the creation of a nationwide PDMP.

The AAFP strongly objects to the additional proposal for prescribing Schedule II controlled substances requiring a patient and clinician be located in the same state, as well as the proposal that the total number of Schedule II prescriptions issued by a clinician constitute less than 50 percent of their practice in a calendar month. The AAFP supports streamlined licensure processes for obtaining several

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medical licenses that would facilitate the ability of physicians to provide telemedicine services in multiple states. We encourage states to engage in reciprocity compacts for physician licensing, especially to permit the use of telemedicine, and we urge DEA to work with states to ease licensing-related regulatory burdens.

We again strongly urge DEA to focus its efforts on preventing medication diversion through law enforcement tactics instead of establishing specific standards of care through DEA rulemaking. As a law enforcement agency, DEA does not have the expertise to determine appropriate standards of care for patients. Physicians are uniquely trained and positioned to address patients' health care needs, and **they should be permitted to practice the full scope of their training and licensure—including the ability to prescribe Schedule II controlled substances in situations they deem appropriate**.

Conclusion

Thank you for the opportunity to provide comments on this proposed rule; the AAFP appreciates DEA's ongoing efforts to uphold safe prescribing practices and to ensure patients' continuous access to care. We again urge this regulation either be withdrawn as soon as possible or finalized only if the significant changes outlined above are incorporated. The AAFP looks forward to continuing to partner with DEA, HHS, and other stakeholders to find effective, achievable, and affordable ways to guarantee patients' access to care and physicians' clinical autonomy while also minimizing medication diversion in our health care system. Should you have any questions, please contact Mandi Neff, Regulatory and Policy Strategist, at 202-655-4928 or mneff2@aafp.org.

Sincerely,

Steve Furr, M.D., FAAFP

Steven Furr, MD, FAAFP
American Academy of Family Physicians, Board Chair

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