



UTAH DEPARTMENT
OF COMMERCE

Office of Professional Licensure Review

2025 Periodic Review

Licensed Practical and Registered Nursing

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Executive Summary

Background

The practice of nursing consists of caring for the sick, infirm, and disabled as well as educating individuals on preventative health measures. A licensed practical nurse (LPN) provides direct patient care (e.g. collecting and monitoring patient vital signs, cleaning wounds and administering medications) under the direction of other providers. Registered nurses (RNs) are trained to perform additional, more complex tasks requiring judgment such as assessing and triaging patients, developing care plans, coordinating patient care, and managing central lines.

Utah licenses both LPNs and RNs. Entry requirements, including graduating from an accredited education program and passing an examination, are highly standardized throughout the U.S. There are slight differences in the LPN scope of practice between states regarding delegation and the explicit inclusion of IV therapy. Utah also issues an RN apprentice license that allows students to work in a clinical setting under indirect supervision.

Regulatory Model Recommendation: *Continue to license LPNs and RNs*

- Improper care from an LPN or RN may exacerbate existing health issues and introduce new issues, including infection, loss of blood, and medication complications. This risk is greater for RNs, who perform more complex tasks and exercise independent judgement. This risk is present despite employer oversight.
- LPNs and RNs work with vulnerable patients, including the sick and injured in hospitals and the elderly and disabled in long-term care settings.

Recommended Regulatory Adjustments: *None*

- Given a lack of evidence of widespread unsafe practice, OPLR does not recommend increasing entry requirements for LPNs or RNs.
- Decreasing entry requirements is also not advisable. Entry requirements are in line with other states. Data indicates that Utah has sufficient numbers of RNs. Utah's low supply of LPNs has more to do with employer choices than licensing policy.
- LPN and RN scope of practice is broad, consistent with their training and in line with other states.

Additional Recommendation: *Extend the length of time a student can work as a registered nurse apprentice (from the last semester or quarter to the last two semesters or quarters)*

- Employers expressed positive experiences using RN apprentices, and DOPL complaint data does not indicate significant safety concerns.
- Increased time as an RN apprentice may better prepare students for employment upon graduation and will make the RN apprentice role more useful to employers.

Context

Consistent with its legislative mandate,¹ the Office of Professional Licensure Review (OPLR) reviewed Utah's licensing laws for licensed practical nurses and registered nurses. The review evaluated how well current regulations:

1. Protect the public from present and consequential physical and financial harm
2. Balance public and practitioner access to the occupation
3. Limit the economic impact of regulation on consumers, practitioners and the state²

OPLR's research for this review included analysis of Utah's current laws and rules, licensing and complaint data from the Division of Professional Licensing (DOPL), licensee survey results, academic literature, as well as laws and policies in other states. OPLR also conducted interviews and focus groups with employers, educators, and DOPL employees. See [Appendix 1](#) for more information.

Background

Profession Overview

The practice of nursing consists of caring for the sick, infirm, and disabled as well as educating individuals on preventative health measures. Nurses are on the front lines of health care, actively working with patients to ensure comfort, promote healing, and manage disease.³ They work with patients of varying acuity in a wide range of settings, from hospitals and surgical centers to assisted living facilities and schools.

Licensed practical nurses (LPNs) and registered nurses (RNs) have distinct roles within the healthcare system. An LPN provides direct patient care under the direction of other providers (e.g. RNs, nurse practitioners, physicians etc.). This consists of a wide variety of tasks, including collecting and monitoring patient vital signs, cleaning wounds and administering medications. RNs similarly engage in direct patient care, although they are trained to perform additional, higher complexity tasks requiring judgment such as assessing and triaging patients, developing care plans, coordinating patient care, and managing central lines. An RN may delegate certain tasks to LPNs and unlicensed assistive personnel (e.g. certified nursing assistants and personal care aides).

Profession in Utah

LPNs and RNs are both licensed professions in Utah, overseen by DOPL.

¹ [UCA 13-1b-203\(2\)](#)

² [UCA 13-1b-302](#)

³ For the official definitions of 'nursing' and 'a nurse' from the International Council of Nurses, see "[Current Nursing Definitions.](#)"

At the time of OPLR's review, Utah had 2,513 licensed LPNs.⁴ To become an LPN in the state, an applicant must complete an accredited LPN education program, pass the National Council Licensure Examination for Practical Nurses (NCLEX-PN) administered by the National Council of State Boards of Nursing (NCSBN), and pass a background check. Alternatively, an individual can apply if they have passed the NCLEX-PN and either 1) completed an accredited RN program and taken the NCLEX-RN exam or 2) completed coursework in an accredited RN program equivalent to the coursework of an LPN program.⁵ These latter cases allow individuals to work as an LPN while they are in the process of obtaining licensure as an RN.

RNs represent a major segment of both Utah's licensed workforce and its healthcare workforce. At the time of OPLR's review, there were 47,411 RNs in the state, the largest number of any single license type overseen by DOPL.⁶ Applicants for an RN license must graduate from an accredited RN education program, pass the National Council Licensure Examination for Registered Nurses (NCLEX-RN) administered by the NCSBN, and pass a background check.⁷ Utah law allows for graduates of both associate- and bachelor-level RN programs to become licensed, though there is a concerted effort within the nursing community to increase the ratio of bachelor-prepared RNs relative to associate-prepared RNs.⁸ RNs licensed in Utah who completed their education in the last 10 years were more likely to have qualified for licensure with a bachelor's degree than those who completed their education more than 10 years ago.⁹

LPNs and RNs must renew their license every two years. To qualify for renewal, a licensee must show proof of either 1) at least 400 hours of practice in the previous two years, 2) at least 200 hours of practice in the previous two years and 15 hours of continuing education, or 3) 30 hours of continuing education.¹⁰

Although the scope of practice for an LPN is defined in broad terms by the Nurse Practice Act, it is limited compared to the scope of an RN. An LPN can contribute to and perform "appropriate aspects of the strategy of care" that are within their competence, but must work under the direction of another healthcare practitioner (i.e. physician, physician-assistant or nurse practitioner, RN).¹¹ For example, LPNs may only perform limited "focused nursing assessments"

⁴ DOPL Licensee Data, accessed January 2025

⁵ [UCA 58-31b-302\(2\)](#); [UCA 58-31b-302\(6\)](#); [R156-31b-302b\(1\)](#)

⁶ DOPL Licensee Data, accessed January 2025; [DOPL Active Licensee Count](#), accessed on September 12, 2025, shows that RN licenses represent almost 14% of all active licenses from DOPL.

⁷ [UCA 58-31b-302\(4\)](#); [UCA 58-31b-302\(6\)](#); [R156-31b-302d\(1\)](#)

⁸ OPLR Interview Series. The [Accreditation Commission for Education in Nursing \(ACEN\)](#) approves both associate and bachelor RN programs, while the [Commission on Collegiate Nursing Education \(CCNE\)](#) only approves bachelor RN programs. Since at least 1996, the [American Association of Colleges of Nursing's \(AACN\) stated position](#) has been that bachelor's degree should be the minimum standard for RN preparation. The [2011 Future of Nursing Report](#) set a goal to see 80% of nurses nationally obtain a bachelor's degree by 2020, and the [2021 Future of Nursing Report](#) indicated that this goal was achieved.

⁹ DOPL LPN & RN Licensee Renewal Survey, November 2023; 49% of respondents who qualified for licensure in the last 10 years did so with a bachelor's degree, compared to 37% of those who qualified for licensure more than 10 years ago.

¹⁰ [UCA 58-31b-305](#); [R156-31b-303](#); licensees must also watch a suicide prevention video.

¹¹ [UCA 58-31b-102\(13\)](#); [R156-31b-703b\(1\)](#).

that gather patient data for other providers to interpret.¹² They can, however, delegate tasks to an unlicensed individual.¹³

An RN's scope of practice is more expansive than an LPN's and allows RNs to exercise greater independent clinical judgement. RN scope includes "assessing the health status of individuals and groups," "identifying health care needs," "planning a strategy of care," "implementing the strategy of care", and delegating tasks to LPNs and unlicensed individuals¹⁴ DOPL rules allow an RN to do a more in-depth assessment of patients, known as a "comprehensive nursing assessment."¹⁵ However, RNs may not diagnose disease or prescribe medication. RNs typically work in care teams with advanced providers and play a central role in coordinating and delivering patient care.¹⁶

DOPL also issues RN apprentice licenses to RN students who are in the last semester or quarter of their program.¹⁷ This allows them to work as a nurse under the indirect supervision of an RN, nurse practitioner, or doctor.¹⁸ At the time of OPLR's review, there were 292 RN apprentices licensed in Utah.¹⁹

Approaches in Other Jurisdictions

Licensing requirements for LPNs and RNs are highly standardized throughout the country. All states require both professions to be licensed, though the name of the license occasionally differs (for example, LPNs in California and Texas are called Licensed Vocational Nurses). Requirements, including completion of an approved LPN or RN education program and passing the associated NCLEX examination, are similar in every state.²⁰ All states allow RN licensure with an associate or bachelor's degree, though New York passed a law in 2017 to require associate-trained RNs to complete a bachelor's degree within 10 years of initial licensure.²¹

Renewal requirements do vary by state. Some require continuing education (CE) hours (20), some require both CEs and time working as a nurse (2), and some allow CEs and/or time working as options among others (21). Seven states do not require any CEs. The median CE hours required (or given as an option) is 12 annualized per year, and the median time working required (or given as an option) is 200 hours annualized per year.²²

¹² [R156-31b-703b\(1\)\(a\)](#): A "focused nursing assessment" is more limited than a "comprehensive nursing assessment." See [R156-31b-102\(13\)&\(20\)](#).

¹³ [R156-31b-703b\(1\)\(f\)\(ii\)](#)

¹⁴ [UCA 58-31b-102\(14\)](#)

¹⁵ [R156-31b-703b\(2\)](#); [R156-31b-102\(13\)](#)

¹⁶ DOPL LPN & RN Licensee Renewal Survey, November 2023; Only 2% of licensed RNs working in Utah reported being self-employed or working as a consultant.

¹⁷ [UCA 58-31b-302\(3\)](#)

¹⁸ [UCA 58-31b-102\(15\)](#)

¹⁹ DOPL Licensee Data, accessed January 2025

²⁰ OPLR Policy Scan

²¹ [New York State Education Department; NY Law Article 139 Section 6905](#)

²² OPLR Policy Scan

The scopes of practice for LPNs and RNs are largely similar between states. There are slight distinctions, however, among LPN scopes of practice related to the LPN's ability to delegate services to other providers, including unlicensed team members, (30 states allow, 20 do not) and the explicit mention of IV therapy (20 states explicitly allow it, usually with additional training, while 30 states do not explicitly mention it in the LPN scope).²³

Utah is one of 43 states that has adopted the Nurse Licensure Compact.²⁴ An LPN or RN in a compact state can apply for a multistate license, which allows them to practice in any compact state. Nurses save time and money, avoiding multiple applications for each state where they may want to practice.²⁵ To qualify for a multistate license, a nurse must meet their own state's licensure requirements, graduate from a nursing program, pass the appropriate NCLEX exam, submit to a background check, and be free of felonies and misdemeanors.²⁶

Regulatory Model Assessment

The Framework

In an effort to standardize how appropriate regulatory models are determined for each profession (e.g. license, registry, no regulation, etc.), OPLR developed a framework which incorporates its statutory review criteria.²⁷ Appropriate models are determined principally by an evaluation of the potential for harm and related factors that may aggravate or mitigate the potential for harm. These factors include the availability of consumer choice, vulnerability of patients, and independence of practice. See [Appendix 2.1](#) for potential regulatory models and the factors in OPLR's framework.

Potential for Harm

Nurses, both licensed practical (LPN) and registered (RN), provide medical care that, if performed poorly, could exacerbate existing health concerns as well as introduce new issues, including infection, loss of blood, and medication complications. The severity of these issues can range from low (e.g. minor cuts or bruises) to life-threatening (e.g. adverse reactions to medications or issues stemming from ill-timed care or poor communication).²⁸ RNs perform higher risk procedures, including inserting central line catheters, heightening the risk associated with the profession. The U.S. Department of Labor's O*Net Consequence of Error Ranking, which estimates and ranks the severity of harm that could arise from different professions,

²³ OPLR Policy Scan

²⁴ ["Nurse Licensure Compact." NCSBN](#)

²⁵ ["How it Works." Nurse Licensure Compact](#)

²⁶ [UCA 58-31e-102](#)

²⁷ Among other criteria, OPLR is required to evaluate "whether the regulation of the occupation is necessary to address a present, recognizable, and significant harm to the health, safety, or financial welfare of the public" and consider "potentially less burdensome alternatives to the... existing regulation". [UCA 13-1b-302](#)

²⁸ ["Patient Safety Surveillance and Improvement Program \(PSSIP\)." DHHS](#)

places an LPN at 61 and an RN at 74, out of 100.²⁹ For RNs in particular, this is comparable to potential for harm from some other more advanced healthcare practitioners.

Both professions commonly work with vulnerable individuals. LPNs work mostly in long-term care settings, hospitals (particularly community-based), and ambulatory care centers. RNs work predominantly in hospitals followed by ambulatory care centers.³⁰ Patients in these settings are more susceptible to further harm and are less able to tolerate improper care. Additionally, both LPNs and RNs commonly engage in tasks that require frequent and often intimate physical touching of patients in private settings, which increases the potential for physical harm and abuse.

Related Harm Factors

Market forces cannot adequately mitigate the harm inherent in the work performed by LPNs and RNs, in part because patients do not choose their provider. When patients enter a hospital, skilled nursing, or similar setting, the facility assigns an LPN or RN to care for them. Even if they could choose their nurse, information that would help patients evaluate a potential provider, beyond licensure status, is not readily available.

The independent clinical judgement that RNs exercise also heightens the potential for harm. RNs use patient information (e.g. vital signs, symptoms, etc.) to make and implement a plan of care for a patient, and they delegate tasks to LPNs and unlicensed personnel to help execute this plan. Additionally, while most RNs work in hospitals where sophisticated employers and advanced healthcare providers can monitor their work, some RNs work with high levels of autonomy day-to-day in certain settings, such as assisted living facilities. By contrast, LPNs must work under the direction of other providers and may not exercise independent judgement. While these restrictions mitigate the harm that could be caused by LPNs, the underlying potential for harm remains.

It could be argued that individual professional licensure of LPNs and RNs is potentially duplicative and unnecessary. LPNs and RNs work as employees, typically within sophisticated healthcare facilities that may terminate employment for cause and which are subject to facility-level licensing by the Utah Department of Health and Human Services (DHHS). DHHS facility requirements include protections such as facility inspections and incident reporting and have some rules that touch on individual practice.³¹ However, individual licensing provides additional benefits for a workforce, like nursing, that is large and highly mobile. Individual professional licensure enables a practitioner to be removed from practice (if warranted) and prohibited from future practice within and outside Utah. This protects public safety and welfare more broadly.

²⁹ [O*Net Consequence of Error Ranking](#)

³⁰ DOPL LPN & RN Licensee Renewal Survey, November 2023. LPNs in Utah tend to work in nursing homes or other long-term care facilities (39%), hospitals (17%), and ambulatory care centers (10%), and RNs in Utah tend to work in primarily hospitals (58%) and ambulatory care centers (13%).

³¹ DHHS facility licensing rules can be found in Utah Administrative Rule R432.

For more detail on OPLR’s analysis of LPNs and RNs according to the framework, see [Appendix 2.2](#).

Recommendation

After considering these factors, OPLR concludes that the LPN and RN professions warrant continued licensure.

Model Adjustments

After determining an appropriate regulatory model, OPLR’s framework also evaluates whether adjustments should be made within a recommended model to address any material and existing safety and access issues affecting the Utah public and practitioners. Regulatory model adjustments may include changing entry qualifications, the scope of practice, unprofessional or unlawful conduct, and/or supervision and independence provisions (see [Appendix 3.1](#)).

Safety Issues

Available data indicates that licensed practical nurses (LPNs) and registered nurses (RNs) in Utah are practicing safely. One primary measure is substantiated public complaints about licensees to DOPL. Both professions have comparatively low rates of substantiated complaints: 1.8 per 100 practitioners between 2017 and 2022 for LPNs and 1.5 for RNs.³² These complaint rates seem in-line with professions adjacent to LPNs and RNs, such as advanced nurse practitioners (who have greater scope and independence and a higher complaint rate) and respiratory care practitioners (who have a more focused scope and a lower complaint rate).³³ See [Appendix 3.2](#) for information on how OPLR uses DOPL complaint data.

Focus groups with administrators from various healthcare settings reported generally safe practice for LPNs and RNs. Some issues were raised, mostly related to general inexperience of new LPNs and RNs in the workforce, particularly in hospital settings. Specific concerns included RNs being trained by other RNs without extensive training themselves and RNs not receiving enough hands-on training with IV administration in school.³⁴

Access Issues

Utah’s supply of LPNs is low, though this is due more to choices made by employers than Utah’s licensing policy. The number of LPNs in Utah has declined over the past decade, fluctuating between a high of 3,837 in 2014 to a low of 3,540 in 2017 (see [Appendix 3.3](#)).³⁵ Supply and demand modeling from the Federal Health Resources Service Administration

³² DOPL Complaint Data

³³ DOPL Complaint Data

³⁴ OPLR Focus Groups with Administrators from Various Facility Types, July 2025.

³⁵ DOPL Licensee Data

(HRSA) estimates that Utah's supply of LPNs meets only 45% of demand (applying typical industry care ratios), though this is predicted to grow to 64% by 2037.³⁶ Additionally, Utah has far fewer LPNs as a ratio of the population than most other states. Nationally, the median number of LPNs per 100,000 people is 170, but Utah has an estimated 48.³⁷

However, healthcare industry members point out that the low use of LPNs is, in part, a result of the decision by major healthcare employers in Utah to move away from hiring LPNs, particularly in acute care settings. This move was, in part, influenced by major industry reports such as *The Future of Nursing*, which advocated for a bachelor-trained nursing workforce.³⁸ Employers also mentioned that an LPN's more limited scope of practice can work against optimal hospital care team staffing.³⁹ Given the decline in the LPN workforce over time, some traditional activities performed by LPNs are likely performed now by certified nursing assistants (CNAs) and medical assistants (MAs) with delegation from an RN or physician.⁴⁰ The combined result of these factors is that the LPN role is viewed now more as a stepping stone towards becoming an RN, rather than an end career point in many settings. DOPL licensee data reflects this change, showing more than two-thirds of LPNs in Utah advance quickly to RN licensure.⁴¹

The number of RNs in Utah appears to be roughly sufficient. Between 2014 and 2024, the number of RNs grew an average of 4.3% annually, strongly outpacing Utah's population growth (see [Appendix 3.3](#)).⁴² HRSA modeling estimates that Utah's supply of RNs covers demand currently (99% adequacy) and that by 2037 supply will significantly exceed demand (123% adequacy).⁴³ While Utah does have a lower rate of RNs to population than the U.S. generally, Utah's population is younger and healthier than other states, an indicator that demand for nursing services may be lower.⁴⁴ OPLR places more weight on HRSA modeling projections than

³⁶ [Health Resources Service Administration Workforce Projections](#)

³⁷ OPLR Analysis of data from "[Utah...](#)" [U.S. Bureau of Labor Statistics](#) and "[State Population...](#)" [U.S. Census Bureau](#).

³⁸ The [2011 Future of Nursing Report](#) set a goal to see 80% of nurses nationally obtain a bachelor's degree by 2020. The [2021 Future of Nursing Report](#) indicated that this goal was achieved.

³⁹ OPLR Interview Series. Employer considerations include: the optimal ratio of RNs to LPNs and CNAs in care teams, the level of education needed for patient acuity, and whether a CNA can adequately perform lower-level tasks.

⁴⁰ CNAs perform basic care tasks and assist with activities of daily living (such as clothing and bathing patients) under the direction of nurses and are required to register with the state. MAs perform care tasks under the direction of a physician and are an unlicensed role. Utah has more MAs as a ratio of the population than the U.S. generally; OPLR Analysis of data from "[Utah...](#)" [U.S. Bureau of Labor Statistics](#) and "[State Population...](#)" [U.S. Census Bureau](#).

⁴¹ DOPL Licensee Data; The median time spent as an LPN before becoming an RN is approximately a year in Utah.

⁴² DOPL Licensee Data; Utah experienced 1.9% annualized population growth between 2014 and 2024 ([Public Health Indicator Based Information System, DHHS](#)).

⁴³ [Health Resources Service Administration Workforce Projections](#)

⁴⁴ OPLR Analysis of data from "[Utah...](#)" [U.S. Bureau of Labor Statistics](#) and "[State Population...](#)" [U.S. Census Bureau](#); Utah has approximately 725 RNs per 100,000 people, while the U.S. generally has almost 1,000 RNs per 100,000 people. However, Utah's population has the lowest average age of any state (see [World Population Review](#)), Utah has a much lower current and projected old-age dependency ratio than the U.S. average (see "Labor Market Update," Utah Department of Workforce Services & "[Utah State and County Short-Term Planning Projections, 2024-2033](#)" [Kem C. Gardner Policy Institute](#)), and

provider to population ratios because HRSA takes the state's unique population demographics into account when estimating demand. Additionally, OPLR's finding that Utah's RN workforce is generally adequate was supported by employer feedback about hiring conditions.⁴⁵ Despite this, some geographic areas (rural) and some settings (long-term care) have reported difficulty in hiring RNs.⁴⁶ See [Appendix 3.4](#) for a more in-depth discussion on access to RNs in different parts of the state.

Utahns have robust access to nursing education. There are a substantial number of LPN and RN programs in the state, with 11 LPN programs and 23 RN programs (9 associate programs and 14 bachelor's degree programs).⁴⁷ A majority of licensed LPNs were educated in Utah, as were more than three-quarters of licensed RNs.⁴⁸

LPN programs can be a relatively affordable option for individuals entering the nursing profession. The average in-state tuition cost for an LPN program is roughly \$3,000 for a public program and \$20,000 for a private program.⁴⁹ Almost half of Utah LPNs graduated with no debt, and almost three-quarters graduated with less than \$20,000 of debt.⁵⁰ The median salary of an LPN in Utah is about \$62,000.⁵¹

RNs face higher barriers to entry into the profession, but also earn more. Average in-state tuition costs range from \$16,500 (public programs) to \$56,000 (private programs) for an associate degree in nursing and from \$31,500 (public programs) to \$64,500 (private programs) for a bachelor's degree.⁵² More than a third of RNs licensed in the state graduated with no debt, and a majority graduated with less than \$20,000.⁵³ RNs in the state have a median salary of just over \$82,000.⁵⁴

Nursing has a fairly well-defined and effective education and career ladder enabling students to work while they pursue studies towards the next level. Additionally, many employers subsidize the education of their nursing workforce.⁵⁵ This helps ease both entry into and progression

[United Health Foundation's 2024 America's Health Rankings](#) placed Utah as the sixth healthiest state in the country.

⁴⁵ OPLR Interview Series; conversations with major health care employers and Talent Ready Utah.

⁴⁶ OPLR Interview Series

⁴⁷ [DOPL LPN NCLEX Pass Rates](#); [DOPL RN NCLEX Pass Rates](#). This does not include the LPN programs at Salt Lake Community College and Snow College, which have not produced any NCLEX candidates in the past several years.

⁴⁸ DOPL LPN & RN Licensee Renewal Survey, November 2023; 59% of LPN respondents were educated in Utah, as were 77% of RN respondents.

⁴⁹ OPLR analysis of tuition costs for four LPN programs (two public and one private).

⁵⁰ DOPL LPN & RN Licensee Renewal Survey, November 2023; 43% of LPN respondents graduated with no debt, and 73% graduated with less than \$20,000 of debt.

⁵¹ ["Licensed Practical and Licensed Vocational Nurses." Utah Department of Workforce Services](#)

⁵² OPLR analysis of tuition costs for four associate RN programs (three public and one private) and seven bachelor RN programs (three public and four private).

⁵³ DOPL LPN & RN Licensee Renewal Survey, November 2023; 38% of RN respondents graduated with no debt, and 58% graduated with less than \$20,000 of debt.

⁵⁴ ["Registered Nurses." Utah Department of Workforce Services](#)

⁵⁵ OPLR Interview Series

through nursing careers.

Discussion

Utah's licensing laws for LPNs and RNs are sufficiently rigorous. Complaint data and interviews with administrators indicate that these professionals are generally providing safe and competent care. Anecdotal concerns regarding new RN inexperience may be a result of the large, steady increase in the number of RNs in Utah and may resolve naturally as the workforce becomes more seasoned. The concern expressed about a lack of hands-on IV experience in RN programs was raised in only one interview. In both cases, employers are in a position to address these kinds of concerns, for example by adapting workplace practices or collaborating with local nursing programs on clinical training. Utah allows accredited nursing education programs to enter the state without additional requirements.⁵⁶ As a result, new programs and program expansion has likely assisted Utah in addressing nurse shortage issues. However, it may have also contributed to some of the inexperience expressed in interviews, illustrating a tradeoff made by the State's current policy. For a more detailed discussion about Utah regulation of nursing programs, see OPLR's 2024 ['Legislative Inquiry Report: Nursing Education Oversight.'](#)

Requirements for LPNs and RNs are not overly burdensome. Utah's entry requirements for licensure are consistent with other states. While Utah does have a low number of LPNs relative to U.S. averages, this has been driven more by industry choices than Utah's licensure requirements and many employers appear to have adjusted to this change by making greater use of other roles, such as MAs, instead. OPLR considered several ideas to expand the scope of LPNs but ultimately decided against recommending them (see 'Other Considerations' below). Utah's supply of RNs is roughly meeting demand. While an RN bachelor's degree can be expensive, particularly from private schools, associate degrees also qualify individuals for an RN license and are a more affordable option.

Finally, workforce issues affecting nurses influence perceptions about the sufficiency of access. This includes nursing compensation relative to cost-of-living increases, the structure of shifts and work hours and other workplace concerns such as burnout. While these factors are having an impact on Utah's nursing workforce, they are outside licensure requirements and are more appropriately addressed with employers. Additionally, these factors do not appear to be leading to concerning levels of disengagement or retirement. For example, on a survey of current RNs and LPNs in Utah, most respondents reported active employment within the profession (83% of RNs and 77% of LPNs), a majority of those working in Utah work more than 33 hours per week (64% of RNs and 68% of LPNs), and very few of those working in Utah plan to decrease the number of hours they work, seek employment in another field, or retire in the next two years (7% of both RNs and LPNs).⁵⁷

⁵⁶ See [UCA 58-31b-601](#) for Utah's nurse education program requirements.

⁵⁷ DOPL LPN & RN Licensee Renewal Survey, November 2023

Recommendation

OPRL recommends no substantial changes to the licensing policies of both LPNs and RNs.

Additional Recommendations

Extend the length of time a student can work as a registered nurse apprentice

OPLR recommends extending the time an RN student can work as an apprentice from the last semester of their program to the last *two* semesters. Rural hospital administrators spoke positively about their experiences with RN apprentices. One said that without these licensees, they would likely have to hire traveling nurses to fill positions.⁵⁸ One nurse administrator with a major health care provider in the state told OPLR that the semester RN apprentices are allowed to work goes very quickly, and that the apprenticeship would be more useful if it could start earlier.⁵⁹

Allowing RN students to work as an apprentice during the final two semesters of their program is unlikely to cause significant safety issues. Such a change would not obligate employers to take RN students early—rather it provides that flexibility for those employers where additional nurse apprentice time would be valuable. RN apprentices must work under the indirect supervision of another RN, nurse practitioner, or doctor who can help ensure safe practice.⁶⁰ In 2022, there were four complaints brought against RN apprentices to DOPL. However, none of these were substantiated.⁶¹ Nurse education leaders told OPLR that, while allowing students to work as an apprentice for their last calendar year would likely be excessive, allowing work for the last two semesters is reasonable.

Allowing RN students to become apprentices sooner may help address care gaps in certain settings and facility types by enlarging the potential pool of apprentices, though the impact would likely be limited. Additionally, apprentices would have more time to work in this capacity, allowing them increased time to grow into the role of an RN.

Other Considerations

OPLR considered, but ultimately decided against recommending, the following policies:

Allowing LPNs to Perform Initial Resident Assessments in Assisted Living

DHHS assisted living facility (ALF) rules mandate that facilities assess the health of residents when they first enter the facility and every six months afterwards.⁶² These assessments are

⁵⁸ OPLR Focus Group with Rural Hospital Administrators, July 2, 2025

⁵⁹ OPLR Interview Series

⁶⁰ [UCA 58-31b-102\(15\)](#)

⁶¹ DOPL Complaint Data

⁶² [R432-270-12\(1\)](#)

important because ALFs use them to ensure a potential resident's condition is appropriate for that setting and to develop the care plan for them.⁶³ DHHS rules require these assessments be performed by a "licensed health care professional", which is defined as "a registered nurse, physician assistant, advanced practice registered nurse, or physician licensed."⁶⁴ While DHHS rules do not label the ALF resident assessment as either focused or comprehensive, the required aspects of the assessment align more closely with the definition of a comprehensive assessment, which only an RN can perform.⁶⁵

OPLR heard from various administrators in ALFs that this rule creates problems for them due to difficulties hiring RNs in this setting. Some administrators posited that an LPN's education prepares them to perform ALF resident assessments safely and that allowing LPNs to do this would open up career opportunities for that profession.⁶⁶

To determine whether LPNs could safely perform these assessments, OPLR interviewed two LPN education program directors in Utah and two academics who have researched LPN scope of practice in long-term care. Feedback from LPN program directors did not support this expansion in LPN practice. LPN education is not aligned with performing comprehensive assessments. One director expressed confidence that LPNs could perform these assessments with some involvement from an RN. The other expressed trepidation, particularly about a new LPN's capabilities.⁶⁷ Limited academic research indicates that a broader scope for LPNs is generally associated with worse resident outcomes in long-term care settings.⁶⁸ Two of the academics involved in these studies stressed to OPLR the importance of having an RN involved in the assessment process because they are trained to put together the elements of an assessment to make judgements about appropriate care for an individual.⁶⁹

The ALF industry approached DHHS about a rule change on this topic in the past. DHHS declined to change their facility rules to support LPNs conducting resident assessments. This is another factor in OPLR's decision not to recommend expanding an LPN's assessment privileges at this time.⁷⁰

Explicitly Listing Intravenous Therapy in the LPN Scope of Practice

Utah's LPN scope of practice is broad. Rather than a comprehensive list of specific tasks an LPN can perform, the statute allows LPNs to perform duties such as "implementing appropriate aspects of the strategy of care."⁷¹ DOPL rule allows LPNs to perform tasks that are "within limits

⁶³ OPLR Interview Series

⁶⁴ [R432-270-12\(2\)](#); [R432-270-3\(10\)](#)

⁶⁵ [R432-270-3\(3\)](#); [R156-31b-102\(13\)](#)

⁶⁶ OPLR Interview Series & Facility Administrator Focus Groups

⁶⁷ OPLR Interview Series.

⁶⁸ See, for example, [Corazzini et al. \(2011\)](#) & [Corazzini et al. \(2013\)](#).

⁶⁹ OPLR Interview Series

⁷⁰ OPLR Interview Series

⁷¹ [UCA 58-31b-102\(13\)\(c\)](#)

of competency.”⁷² Neither Utah statute nor rule explicitly allows nor disallows the practice of IV therapy for LPNs, in effect leaving it up to nursing schools or employers whether to train LPNs in this skill.

Utah LPN education program directors confirm that their programs include some IV training limited to non-complex procedures. They indicated this was common for the technical schools in Utah. There appears to be demand for IV-trained LPNs in hospitals and other settings, and education programs in the state are responding to that demand.⁷³

Accordingly, it is unnecessary for IV therapy to be added explicitly to the scope of practice for an LPN in statute or rule. Law already allows LPNs to undertake IVs to the level of their training, and schools appear to be including it in their curriculum. Employers may decide whether to utilize LPNs in this manner or not.

Rule Review

In accordance with Utah Code 13-1b-203(5), OPLR conducted an in-depth review of DOPL’s LPN and RN rules, found in R156-31b.

The rule review covered potential rule changes needed to:

1. address specific rules that may be either overly burdensome (e.g., for individuals seeking to practice a profession or given the potential risk to public safety from a profession, etc) or insufficient (e.g., to ensure safe practice);
2. address rules misaligned with statutory language;
3. clarify language and correct references to statute or other rules; or
4. support OPLR’s recommendations.

OPLR’s review of R156-31b found:

1. one rule that may be overly burdensome for licensees. This is outlined in [Appendix 4.1](#);
2. no rules misaligned with statutory language;
3. three related instances of outdated language, two incorrect references, and one instance of unclear language. These are outlined in [Appendix 4.2](#), [Appendix 4.3](#), and [Appendix 4.4](#) respectively;
4. no rule changes or additions need to be made to support OPLR recommendations.

⁷² [R156-31b-703b\(1\)\(b\)](#)

⁷³ OPLR Interview Series

Appendix

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1 Context

1.1 General Methodology

OPLR's methodology combines qualitative and quantitative methods with robust stakeholder engagement. Methods include:

- Analyzing data from workforce surveys administered by the Department of Professional Licensing (DOPL) as part of licensure renewal
- Conducting quantitative analysis of DOPL licensee and complaint data and publicly available data from other state and federal government entities (e.g., Utah Department of Workforce Services, Health Resources and Services Administration, National Practitioner Database)
- Reviewing academic literature and reports on a profession's practice, efficacy and safety
- Scanning education and credentialing requirements, programs and content
- Reviewing state occupational regulation policies across the U.S.
- Engaging with a wide range of stakeholders, including: Utah and other state governments and agencies, industry organizations, researchers, practitioners, and business owners and employers within a variety of settings (e.g., acute inpatient hospital, private outpatient, hospital system outpatient, home health, and skilled nursing facilities)

1.2 DOPL LPN & RN Licensee Renewal Survey

Survey overview

OPLR utilized a DOPL survey available to LPNs and RNs during their 2024/25 renewal period for information on the workforce in Utah. This survey is administered by DOPL for use by the Health Workforce Information Center (HWIC) to inform legislators and the public about workforce trends and projections. For more information regarding the information collected, the survey instrument can be found [here](#).

Survey Limitations

The survey was available to all LPN and RN licensees during the license renewal process so results were not affected by sampling bias. The response rate was relatively low for LPNs (29%) but high for RNs (61%). Results may be affected by non-response bias (e.g., if those who chose to respond to the survey shared characteristics not representative of the true population). LPN respondents were, on average, older and further along in their career than non-respondents. RN respondents were more likely to be female, younger, living in Utah, and further along in their career than non-respondents.

Other possible limitations include measurement error (which occurs when questions do not accurately measure the variable interest due to errors in question design) and recall bias (where respondents misremember and inaccurately answer questions). For example, recall bias may

impact the estimates of hours worked per week or debt at graduation. All of these potential errors may cause some variability or systematic bias.

OPLR uses this to provide background understanding of a profession, outline patterns, and identify general trends rather than to provide exact estimates. Therefore, the limitations articulated above should not unduly impact OPLR's findings or recommendations.

1.3 LPN & RN Policy Scans

To better understand the regulatory environment for LPNs and RNs, OPLR conducted a review of state occupational regulation in the U.S. OPLR utilized Notebook LM to create the first draft of these policy scans, though all data was verified by an analyst. The validated sources were then used to map the national policy landscape, find patterns in regulation, make cross-state comparisons, and discover outliers. OPLR also used the data to help inform recommendations.

OPLR uploaded relevant statutes and rules for all states to Notebook LM and then interacted with the AI platform to determine how jurisdictions differ on their approach to very specific policies. Specifically, OPLR used Notebook LM to determine state licensure requirements, renewal requirements, and whether states allow LPNs to delegate and perform IV therapy. The following is an example of a prompt used to research LPN IV therapy scope of practice for each state:

“For each state, please indicate if they explicitly allow LPNs to do IV therapy, if they explicitly do not allow LPNs to do IV therapy, or if they are silent on the issue.”

OPLR analysts then verified Notebook LM's results for every state.

This approach does contain limitations related to normal human error. It is possible that there is slight misreporting of some data due to limited accessible state information, errors in data entry, or mistakes made by Notebook LM that were not caught by OPLR's manual verification.

2 Regulatory Model Assessment & Recommendation

2.1 Menu of Regulatory Models and Factors Considered in Framework

Please see [this working document](#), OPLR's Occupational Regulation Framework, for a more detailed explanation of OPLR's approach to assessing occupational regulation and evaluating different regulatory models.⁷⁴

⁷⁴ The document is also available on OPLR's website in the "About OPLR" section, accessible here: <https://oplr.utah.gov/about-oplr/>

2.2 Model Assessment of Licensed Practical and Registered Nursing

The following tables summarize OPLR’s analysis of licensed practical and registered nursing, respectively, according to factors that OPLR determined should influence the appropriate regulatory model for an occupation. Factors that OPLR considered as particularly determinative in its assessment of licensed practical and registered nursing are highlighted in bold.

Model Assessment of Licensed Practical Nurses (LPNs)	
Harm Factors	
Mechanism of Harm	LPNs provide direct care to people who are sick, injured, or infirm. They can exacerbate underlying health issues or cause new ones, such as infection or adverse reactions to medication.
Severity, Permanence, and Likelihood of Harm	Potential harms tend to be moderately severe and can be addressed through further medical attention. The harms are somewhat likely if services are provided by someone who is untrained, given the need for knowledge on topics such as medications and understanding vital signs.
Consequence of Error	61 out of 100*
Downstream Impact	Related to the severity of potential harm. if an LPN provides improper care, a patient may require further medical attention, including hospitalization, or even emergency intervention.
Consumer & Setting Factors	
Patient Vulnerability	LPNs often provide care to vulnerable individuals. This includes the elderly and disabled in long-term care settings as well as the sick and injured in hospital settings.
Frequency of Physical Touch	LPNs frequently touch their patients as they provide care.
Frequency of Private Setting	LPNs frequently spend time alone with patients, sometimes of long duration, as they provide care.
Information Asymmetry	Patients may not understand all that an LPN does to help care for them, including the medications LPNs administer.
Related factors	
Independence	LPNs must work under the direction of other providers (RNs, nurse practitioners, physicians) and thus do not work independently. LPNs exercise only limited discretion in their role. Mainly, they provide information to and take directions from other providers.

Patient Choice	Patients do not choose their LPN. They are assigned one from the facility.
Information Availability	Patients receive little information, beyond licensure, about the quality of the LPN caring for them.
Level of Oversight	<p><i>Employers:</i> Because LPNs cannot work independently, other providers and employers monitor the quality of their work.</p> <p><i>Government:</i> Beyond DOPL licensure, LPNs are subject to regulation through DHHS facility rules which have facility and some individual requirements. For example, DHHS rules for assisted living facilities do not allow an LPN to perform resident assessments.**</p> <p><i>Private Bodies:</i> There are no organizations that certify LPNs. Utah has adopted the Nurse Licensure Compact, which provides a way for states to track licensees across states.</p>

* [O*Net Consequence of Error Ranking](#)

** [R432-270-12\(2\)](#); [R432-270-3\(10\)](#)

Model Assessment of Registered Nurses (RNs)	
Harm Factors	
Mechanism of Harm	Beyond the harm an LPN can cause, an RN's error in care planning can result in a patient not receiving the care they need or receiving care that causes further harm.
Severity, Permanence, and Likelihood of Harm	Improper care from an RN can lead to moderate or severe harm that could require further medical intervention or could result in death. Harm is likely if these services are provided by someone without rigorous training.
Consequence of Error	74 out of 100*
Downstream Impact	Related to the severity of potential harm, if an RN provides improper care, a patient may require further medical attention, including hospitalization.
Consumer & Setting Factors	
Patient Vulnerability	RNs work with sick and injured patients in hospitals and ambulatory care settings. They also play an important role in long-term care, where they assess care for and interact with elderly and disabled individuals.
Frequency of Physical Touch	RNs frequently touch their patients as they provide care.

Frequency of Private Setting	RNs frequently spend time alone with patients, sometimes of long duration, as they provide care.
Information Asymmetry	RNs perform more complex care tasks that require specialized knowledge. The typical patient would not understand all that RNs do.
Related factors	
Independence	RNs typically work in care teams in hospitals. However, they may be the highest trained individual present day-to-day in a long-term care facility. RNs exercise clinical judgement when caring for their patients. They create, coordinate and help execute care plans for patients/residents.
Patient Choice	Patients do not choose their RN. They are assigned one from the facility.
Information Availability	Patients receive little information, beyond licensure, about the quality of the RN caring for them.
Level of Oversight	<i>Employers:</i> RNs overwhelmingly work in care teams with peer and employer oversight, though some RNs work with a high level of independence in settings such as long-term care. <i>Government:</i> Beyond DOPL licensure, RNs are subject to regulation through DHHS facility rules which have facility and some individual requirements. For example, DHHS rules for hospitals require RNs to document any nursing care given to patients and outlines what the documentation must include.** <i>Private Bodies:</i> There are no organizations that certify RNs. Utah has adopted the Nurse Licensure Compact, which provides a way for states to track licensees across states.

* [O*Net Consequence of Error Ranking](#)

** [R432-100-13\(4\)](#)

3 Regulatory Model Adjustments & Recommendations

3.1 Possible Adjustments

Please see [this working document](#), OPLR’s Occupational Regulation Framework, for a more detailed explanation of how OPLR approaches whether adjustments should be made within a recommended regulatory model.⁷⁵

⁷⁵ The document is also available on OPLR’s website in the “About OPLR” section, accessible here: <https://oplr.utah.gov/about-oplr/>

3.2 DOPL Complaint Data

The Division of Professional Licensing (DOPL) receives complaints from individuals, other state agencies, co-workers, professional associations, and licensing boards. DOPL is required to “investigate unlicensed practice in regulated professions, acts or practices inconsistent with recognized standards of conduct, allegations of gross negligence or incompetence, and patterns of gross negligence or incompetence”.⁷⁶ Violations that meet the criteria for investigation are then prioritized and assigned to an investigator. DOPL may resolve investigations in a variety of ways, including: closing an investigation due to a lack of evidence; referring the case to another agency or to law enforcement if appropriate; carrying out informal or formal administrative sanctions or stipulated agreements; issuing a citation; or denying, suspending, or revoking an individual’s license.

To analyze complaints sent to DOPL, OPLR used My License Office (MLO) to access closed complaints investigated by DOPL between 2017-2022 for all licenses/professions. This data contains information on the license name, the complaint type, and the disposition of the complaint, among many other data fields not relevant to OPLR’s analysis. DOPL personnel helped code the complaint dispositions as either substantiated, unsubstantiated, or no jurisdiction. Substantiated complaints are those where a disposition includes some type of disciplinary action, whether formal or informal (e.g., letter of concern, verbal warning, surrender of license). Unsubstantiated complaints have dispositions without a disciplinary action (e.g., dismissed, lack of evidence, unfounded). ‘No jurisdiction’ complaints are complaints that may or may not have basis, but DOPL was not able to take action on the case.

OPLR filtered complaints to exclude any likely duplicates and then used substantiated complaints to calculate the number of complaints per license type or profession. OPLR estimated the complaint rate for each license type by dividing the number of substantiated complaints by the number of unique individuals who held that license type over the same period.

Complaint Case Notes Analysis

A more detailed analysis of historical case notes was conducted on a sample of 22 LPN complaints and 34 RN complaints closed between 2017-2022. A rough stratified random sample was pulled from all ‘substantiated’, ‘pending’, or ‘no jurisdiction’ complaints,⁷⁷ with stratification based on complaint type. OPLR chose to oversample complaints labeled ‘client harm or endangerment’ given that the intent of the analysis was to get a sense of the type of harm caused by these professions. In the end, OPLR randomly chose 11 LPN and 18 RN ‘unprofessional conduct’ cases, 6 LPN and 6 RN ‘client harm or endangerment’ cases, 3 LPN

⁷⁶ DOPL, [An Explanation of the Complaint Handling Process for the Division of Occupational and Professional Licensing](#)

⁷⁷ No jurisdiction complaints were included in the case note analysis and not the complaint rate analysis because they are not complaints where DOPL took an action, but they may include legitimate client harm that DOPL had to refer to another agency. Although they can not be classified as “substantiated”, OPLR felt these complaints could help contextualize client harm resulting from LPNs and RNs.

and 7 RN ‘substance abuse’ cases, and 2 LPN and 3 RN ‘scope violation’ cases. The cases represent about 16% of all LPN complaints and about 4% of RN complaints during this time. DOPL investigators then analyzed these cases and pulled specific information, such as whether a patient was harmed from the incident and how long the individual had been licensed when it occurred.

Limitations

There are significant limitations to this analysis, and the information collected should not be interpreted as a precise estimate of harm caused by LPNs and RNs. DOPL data likely underestimates true harm, as many instances of harm may be handled in other ways (e.g., directly by employers), reported to other entities, or may never be reported. Additionally, some unsubstantiated complaints may have resulted in harm but the necessary evidence was not produced.

There could also be latent factors correlated with both the likelihood of complaint and the profession, systematically biasing the comparisons across professions. This is especially true in healthcare, as certain professions, by their nature, include a greater potential for harm and may generate more complaints. For example, surgeons have a higher likelihood of causing severe harm to a patient than nurses because surgery is inherently far riskier, not because surgeons are “less safe” or less competent than nurses.

For these reasons, OPLR uses DOPL complaint data as directionally informative, but avoids direct comparisons across professions wherever possible. Fine comparisons across professions are unwarranted and unsupported by this data.

3.3 DOPL Licensee Data

OPLR used DOPL licensee data queried in January of 2025 to conduct analyses on the number of licensees per year, inflow and outflow of licensees, overlap of licenses, and time with license. The dataset included individuals first licensed after 1970 to those actively licensed as of January 2025. Each row in this dataset was a unique combination of individual and license type and contained information regarding when the license was issued, the status of the license, the date the status was last updated, and the sex and year of birth of the individual. OPLR estimated the number of licensees in each year by summing the number of unique individuals whose licenses were active during any point in each year. Additionally, OPLR excluded any individual with a null or incorrect value for their license issue date and license expiration date, as OPLR could not determine how long or for what years they were actively licensed. License counts may slightly underestimate the true number of licensees due to this, but the effect is fairly negligible given OPLR’s use of the data to determine trends over time rather than estimate with precision for specific dates.

3.4 Registered Nurse Supply by Region

OPLR estimated the distribution of RNs across Utah using employment data from the U.S. Bureau of Labor Statistics (BLS) and population data from the U.S. Census Bureau. Estimates show that the number of RNs per 100,000 people differs across BLS-defined regions in Utah. Estimates for the U.S., Utah, and BLS-defined regions in Utah are as follows:⁷⁸

- Salt Lake: ~1,035
- United States: ~985⁷⁹
- St. George: ~885
- Whole State: ~725
- Logan: ~575
- Ogden-Clearfield: ~575
- Eastern Utah: ~535
- Central Utah: ~440
- Provo-Orem: ~440

A lower concentration of RNs in Utah compared to the U.S. generally does not necessarily indicate a nursing shortage in Utah. The demand for health care in Utah is likely distinct from the other areas of the country due to its demographics. In reaching its conclusions, OPLR relied on supply adequacy estimates from sources such as HRSA. OPLR also used input from employers in different settings and different regions across Utah to test overall conclusions about the adequacy of Utah's nursing workforce and to understand where pockets of need may still remain.

4 Rule Review

4.1 Potential Rule Burdens

DOPL rule currently requires applicants for an LPN or RN license who graduated from a nonapproved nursing program to prove the equivalency of their education through the Commission on Graduates of Foreign Nursing Schools (CGFNS).⁸⁰ CGFNS (now called TruMerit) compares education programs and verifies their equivalency, specifically for health care professions.⁸¹ However, there are many organizations that perform these services. For example, the National Association of Credential Evaluation Services (NACES) is a collection of 18 of these organizations.⁸² Rules requiring applicants to use only one organization for this service limits choice and competition which may impact cost.

⁷⁸ ["Utah..." U.S. Bureau of Labor Statistics](#); ["State Population..." U.S. Census Bureau](#)

⁷⁹ ["Registered Nurses," U.S. Bureau of Labor Statistics](#); ["U.S. Population Trends..." U.S. Census Bureau R156-31b-302f](#)

⁸¹ ["About TruMerit \(CGFNS International\)," TruMerit](#)

⁸² [NACES](#); ["Members," NACES](#)

4.2 Outdated Language

DOPL rule refers to the Commission on Graduates of Foreign Nursing Schools (CGFNS) three times:

- R156-31b-102(9)
- R156-31b-302f(1)(a)
- R156-31b-302f(2)(a)

Earlier this year, CGFNS changed its name to TruMerit. All references to CGFNS should be changed accordingly.⁸³

4.3 Incorrect References

OPLR identified the following incorrect references in the Nurse Practice Act Rule:

Rule	Incorrect Reference	Correct Reference
R156-31b-302b(1)(b)	R156-31b-301g	R156-31b-302g
Intro sentence of R156-31b-701a	R156-31b-102(14)	R156-31b-102(15)

4.4 Unclear Language

The rules outlining requirements for an LPN or RN license in Utah for those who have a lapsed, out-of-state license are inconsistent. These are found in R156-31b-302b(5) and R156-31b-302d(5), respectively. LPN applicants are required to meet the basic education and exam requirements and must comply with the same requirements imposed on those with a lapsed Utah LPN license. RN applicants are required to prove that their education is equivalent to approved programs in Utah and must comply with the same requirements imposed on those with a lapsed Utah RN license. The RN requirements do not refer to exam requirements like the LPN requirements do, and the LPN and RN sections point to different parts of rule when referring to education requirements. To ensure clarity and consistency, DOPL should consider rewriting the rules to require the following of both LPN and RN applicants with lapsed, out-of-state licenses:

- Prove equivalency of training using CGFNS (now TruMerit) or another approved education credentialing organization. Both sections should refer to R156-31b-302f.
- Show that they have passed the NCLEX-PN or NCLEX-RN. Both sections should refer to R156-31b-302g.
- Meet requirements imposed on those with a Utah lapsed license, which are laid out in subsection (4) of R156-31b-302b for LPNs and R156-31b-302d for RNs.

⁸³ ["CGFNS International to Change Its Name to TruMerit." NewsWire](#)

5 Stakeholder Engagement

5.1 OPLR Interview & Focus Group Series

OPLR relied heavily on stakeholder engagement and qualitative interview data, combined with OPLR's other analysis, to conduct this review and develop recommendations. OPLR engaged with employers, educators, industry associations, Utah legislators, and Utah and other state regulators. OPLR prioritized diversity of perspective and relevance to the industry in selecting stakeholders.

Interviews were conducted in person, over the phone, and via video conferencing using semi-structured interview methods; they were conducted one-on-one and with multiple members. Extensive notes were taken for all interviews.

OPLR conducted initial interviews to understand the nursing industry, determine the largest issues related to safety and access, and identify potential areas for change. OPLR engaged with stakeholders later in its review to test initial findings from analysis and preliminary recommendations. OPLR reflected on and synthesized feedback across multiple discussion sessions to develop clear and achievable evidence-based recommendations.

Additionally, OPLR conducted six focus groups with administrators from various health care facility types: rural hospitals (eight administrators), rural health clinics (five administrators), ambulatory surgical centers (two administrators), skilled nursing facilities (four administrators), assisted living facilities (eight administrators), and home health and hospice companies (five administrators). Industry association leaders helped OPLR identify participants for these focus groups. Before the sessions, OPLR sent participants a short survey to identify any hiring and safety concerns for the nursing and related professions covered in this year's review. During the focus groups, OPLR asked participants follow-up questions on these topics. Insights from the focus groups were used to direct OPLR's analysis and help refine recommendations.

Limitations

This interview sample was not randomly selected and, therefore, is not completely representative. OPLR spoke to individuals most likely to represent the broad aims and concerns of their groups. Additionally, OPLR did not contact "consumers" of LPNs and RNs (patients), so their perspectives were not incorporated into this review. Thus, the stakeholder engagement and findings from these interviews should not be understood to be fully representative of the views of all Utahns, nurses, employers or any other person, group, or population.

Note that stakeholders' views are not always reflected in OPLR's recommendations. OPLR is directed by Utah Code 13-1b-302 to apply specific review criteria. These can and do lead to recommendations that diverge from stakeholder preferences. A stakeholder's appearance here is not an endorsement of OPLR's recommendations as such.

5.2 Stakeholder Engagement Summary

The following is a comprehensive list of those OPLR engaged with throughout the review of nursing and related professions. Professional credentials (such as MD and DNP) were omitted for simplicity. Those who contributed to the LPN and RN review specifically are highlighted in gray.

Stakeholder Engagement Summary	
Utah State Legislature	
Legislative Working Group	<p> Rep. Bridger Bolinder Rep. Steve Eliason Rep. Katy Hall Rep. Cory Maloy Rep. Logan Monson Rep. Angela Romero Rep. Douglas Welton Sen. Luz Escamilla Sen. Keith Grover Sen. Ann Millner Sen. Jen Plumb Sen. Evan Vickers Seth Anderson, Policy Analyst, LRGC Brian Bean, Senior Policy Advisor, Utah Senate Greg Gun, Associate General Counsel, LRGC Alan Houston, Associate General Counsel, LRGC Tyler Moore, Associate General Counsel, LRGC Rohnin Randles, Policy Analyst, LRGC Lisa Sorenson, Policy Analyst, LRGC Chris Williams, Associate General Counsel, LRGC Robert Wood, Policy Analyst, LRGC </p>
Other Government Stakeholders	
Utah Department of Commerce	<p> Margaret Busse, Executive Director Carolyn Dennis, Deputy Director Jacob Hart, Deputy Director Mark Steinagel, Managing Director & Director, Division of Professional Licensing Deborah Blackburn, Assistant Division Director, Division of Professional Licensing Jana Johansen, Assistant Division Director, Division of Professional Licensing Connie Kitchens, Assistant Division Director, Division of Professional Licensing Benjamin Baker, Chief Investigator, Division of Professional Licensing Jeff Busjahn, Licensing Administrator, Division of Professional Licensing Camille Farley, Chief Investigator, Division of Professional Licensing </p>

	<p>James Garfield, Bureau Manager, Division of Professional Licensing Dean Healey, Investigator, Division of Professional Licensing Larry Marx, Licensing Administrator, Division of Professional Licensing Sharilee Scheller, Investigator, Division of Professional Licensing Kirsten Shumway, Legal Analyst, Division of Professional Licensing</p>
<p>Division of Professional Licensing (DOPL) Boards</p>	<p>David Escobar, Board Member, Respiratory Care Board William Hamilton, Board Member, Medical Board Erica Nelson, Board Member, Nursing Board Curtis Nielsen, Board Member, Nursing Board Marie Pittman Cherrington, Medical Board Ralph Pittman, Board Member, Nursing Board Wendy Rusin, Board Member, Nursing Board Sheryl Steadman, Board Chair, Nursing Board Shane Yardley, Board Member, Nursing Board</p>
<p>Utah Department of Health & Human Services</p>	<p>Nate Checketts, Deputy Director Heather Borski, Assistant Deputy Director Laurie Baksh, Director, Office of Maternal & Child Health Stacey Bank, Medical Director Kendyl Brockman, Health Workforce Policy Analyst, Office of Primary Care & Rural Health Jared Brown, Program Manager, Office of Licensing Trent Brown, Assistant Director, Office of Reimbursement Continued Care & Audit Matt Cottrell, Research Analyst, Health Workforce Information Center Liz Craker, Health Program Coordinator, Office of Primary Care & Rural Health John Curless, Director, Office of Reimbursement, Coordinated Care & Audit Jessica Fiedel, Licensing Manager, Office of Licensing Heather Flint, Licensing Manager, Office of Licensing Michelle Geller, Policy Specialist, Office of Primary Care & Rural Health Eric Grant, Director, Office of Financial Services Shanna Jagers, Research Consultant, Office of Research & Evaluation Rick Little, Director, Office of Research & Evaluation Kyle Lunt, Director, Office of Data, Systems & Evaluation Stephanie McVicars, Director, Early Hearing Detection & Intervention (EHDI); Cytomegalovirus (CMV) Public Health Initiative; Children's Hearing Aid Program (CHAP) Ashley Moretz, Director, Health Access Division Nune Phillips, Senior Policy Advisor Mary Rindler, Manager, Newborn Screening Program Heather Sarin, Quality Improvement Director, Utah Women & Newborns Quality Collaborative Florencia Schapira De Grout, Director, Office of Licensing Suzanne Smith, Coordinator, Perinatal Mortality Review Jim Stamos, Director, Office of Healthcare Policy & Authorization Jennifer Strohecker, Director, Division of Integrated Healthcare &</p>

	<p>State Medicaid Heidi Sylvester, Outreach Coordinator, Perinatal Mortality Review Greg Trollan, Director, Office of Managed Healthcare Marc Watterson, Director, Office of Primary Care & Rural Health Anna West, Workforce Development Coordinator, Office of Primary Care & Rural Health</p>
Utah Department of Workforce Services	<p>Ben Crabbe, Chief Economist Dave Forgerty, Assistant Director, Division of Workforce Research & Analysis Chris Williams, Director, Division of Workforce Research & Analysis</p>
Government Employees from Other States	<p>Amanda Boulay, Assistant Executive Director, Maine Board of Nursing Emma Cozart, Data Consultant, Washington Board of Nursing Angela Duvall, Manager for Health Education & Training Unit, Missouri Department of Health & Senior Services Mary Sue Gorski, Director of Research in Advanced Practice, Washington Board of Nursing Ruby Grantham, Manger, Laboratory & In-Home Services Unit, Florida Agency for Health Care Administration Andrea Hager, Program Information Manager, Maryland Prescription Drug Monitoring Program Roberta Hills, Program Director, Colorado Board of Nursing Tamara McDaniel, Executive Director, Kentucky Board of Respiratory Care Patricia McNamee, Nursing Practice Coordinator, Massachusetts Board of Nursing Carol Moreland, Executive Administrator, Kansas Board of Nursing Sarah Wickenhagen, Policy Analyst, Oregon State Board of Nursing</p>
Industry Stakeholders	
Industry Associations	<p>Bonnie Baker, Director of Professional Accountability, Utah Midwives Organization Amy Bard, Associate Executive Director, Utah Academy of Physician Assistants Fara Bitter, Vice President, Utah Midwives Organization Michelle Buck, APRN Senior Policy Advisor, National Council of State Boards of Nursing Brittany Carver, Executive Director, Utah Assisted Living Association Liz Close, Executive Director, Utah Nurses Association Ranae Cowley, Partner, Foxley & Pignanelli Jon Cox, Principal, Utah Public Affairs Julia Dieperink, State Policy Analyst, American Association of Nurse Practitioners Lynsey Drew, President, Utah Academy of Family Physicians Leslie Fabian, President, Utah Academy of Physician Assistants Joan Gallegos, Co-Lead, Utah Action Coalition for Health Teresa Garrett, Co-Lead, Utah Action Coalition for Health Cheryl Gerdy, President, Utah Organization of Nurse Leaders</p>

	<p>David Gessel, Executive Vice President, Utah Hospital Association</p> <p>Francis Gibson, President/CEO, Utah Hospital Association</p> <p>Matt Hansen, Executive Director, Homecare & Hospice Association of Utah</p> <p>Bryanna Hazelwood, President, Utah Midwives Organization</p> <p>Melissa Hinton, Interim President & Legislative Committee Chair, Utah Nurse Practitioner Association</p> <p>Colby Jacobsen, President, Utah Association of Nurse Anesthetists</p> <p>Tay Kopanos, Vice President of State/National Government Affairs, American Association of Nurse Practitioners</p> <p>Viet Le, Past President, Utah Academy of Physician Assistants</p> <p>Nicole Livanos, Director of Government Affairs, National Council of State Boards of Nursing</p> <p>Stan Lockhart, Executive Director, Utah Academy of Physician Assistants</p> <p>Daniel Logsdon, Director, National Center for Interstate Compacts, The Council of State Governments</p> <p>Maryann Martindale, CEO, Utah Academy of Family Physicians</p> <p>Matthew McCullough, Rural Hospital Improvement Director, Utah Hospital Association</p> <p>Michelle McOmber, CEO, Utah Medical Association</p> <p>Abigail Mortell, Policy Analyst, National Center for Interstate Compacts, The Council of State Governments</p> <p>Miriam O'Day, Senior Vice President, American Association for Respiratory Care</p> <p>Michell Oki, President, Utah Society for Respiratory Care</p> <p>Ron Pasewald, Co-Chair, Respiratory Care Interstate Compact</p> <p>Camille Plowman, Executive Director, Utah Association of Nurse Anesthetists</p> <p>Nancy Sechrest, Owner, Sechrest Consulting</p> <p>Carl Sims, Deputy Director, National Center for Interstate Compacts, The Council of State Governments</p> <p>Daniel Sowards, VP of Operations, Utah Health Care Association</p> <p>Allison Spangler, President/CEO, Utah Health Care Association</p> <p>Matt Holton, Partner, Stokes Strategies</p> <p>Sherri Vasas, Vice President, Utah Society for Respiratory Care</p> <p>Sarah Woolsey, Medical Director, Association for Utah Community Health; Speaker of the House, Utah Medical Association</p>
<p>Employers</p>	<p>Larson Alder, Executive Director, Symbii Home Health and Hospice</p> <p>Greg Atwood, VP of Clinical Operations, Avista Senior Living</p> <p>Clint Barney, Executive Director, Western States Lodging</p> <p>Grant Barraclough, Chief Clinical Officer, Ashley Regional Medical Center</p> <p>Brenda Bartholomew, Chief Administrative Officer, Gunnison Valley Hospital</p> <p>Randall Bennett, VP of Human Resources, Uintah Basin Medical Center</p> <p>Heather Brace, Chief HR Officer, Intermountain Health</p> <p>Colten Bracken, Owner, Main Street Family Medicine</p> <p>Danelle Brinkerhoff, Uintah Basin Medical Center</p> <p>DeAnn Brown, President, Garfield Memorial Hospital and Nursing</p>

	<p>Home</p> <p>Jesse Buntjer, VP of Clinical Operations, Avista Senior Living</p> <p>Angela Chavez, Student Programs Director, Intermountain Health</p> <p>Amy Christensen, Chief Nursing Operator, Intermountain Health Canyons Region</p> <p>Jeff Christensen, Executive Director, Millard Care & Rehabilitation</p> <p>Julie Christensen, Office Manager, Beaver and Parowan Medical Clinics</p> <p>Dave Clarke, Owner/COO, Covington Senior Living</p> <p>Esmeralda Comer, Practice Manager, Coalville and Kamas Health Centers</p> <p>Reuben Evans, Chief Nursing Officer, Intermountain Health St. George Hospital</p> <p>Kurt Forsyth, President, Delta and Fillmore Community Hospitals</p> <p>Frank Fox, CEO, Surgery Center at South Ogden, SCA Health</p> <p>Nicholas Fox, San Juan Health</p> <p>Kris Friedli, Nurse Administrator, Sunshine Home Health</p> <p>Greg Gardiner, Chief Nursing Officer, Uintah Basin Medical Center</p> <p>Amanda Hartman, Administrator, Uintah Basin Rehab and Senior Villa</p> <p>Clayton Holt, CEO, San Juan Health</p> <p>Joleen Huber, Owner, Caregiver Support Network</p> <p>Kelly Jensen, Assistant Vice President of Respiratory-Sleep-EEG Services, Intermountain Health Canyons, Desert, Peaks Regions</p> <p>Ryan Kidman, Administrator, The Lodge at Riverton and Jordan River</p> <p>Shawn Kinross, Advanced Practice Director of Anesthesia, Intermountain Health</p> <p>Sulane Knight, Chief Nursing Officer, Blue Mountain Hospital</p> <p>Tiffany Lipscomb, VP of Human Resources, Intermountain Health</p> <p>Kurt Loveless, CEO, Kane County Hospital</p> <p>Heather Mills, Pediatric Director, Harmony Home Health and Hospice</p> <p>Scott Monson, CEO/Partner, SAL Management Group</p> <p>Miranda Moss, Executive Director, Legacy Village of Sugar House</p> <p>Tracey Nixon, Chief Nursing Officer, University of Utah Health</p> <p>Kim Nuttal, HR Director, Kane County Hospital</p> <p>Jerry Olson, Administrator, Southern Utah Veterans Home</p> <p>Brett Ottley, Executive Director, Monument Health</p> <p>Susan Robel, President, Canyons Region, Intermountain Health</p> <p>Angel Roundy, Chief Nursing Officer, Sevier Valley Hospital, Intermountain Health</p> <p>Brent Schmidt, President, Sevier Valley Hospital, Intermountain Health</p> <p>Rachel Seamons, Partner, Wasatch Senior Living</p> <p>Will Shakespeare, Senior Medical Director for Anesthesia, Intermountain Health</p> <p>Beau Sorenson, COO, First Choice Home Health and Hospice</p> <p>Bethany Taylor, Avista Senior Living</p> <p>Shaylynn Uresk, Director of Payroll, Uintah Basin Medical Center</p> <p>Carrie Winberg, Operations Director for Respiratory Care Services, Intermountain Health</p> <p>Lori Wright, CEO, Family Healthcare</p>
Higher Education	Jonathan Baird , Assistant Program Director for the Physician

Assistant Program, Rocky Mountain University
Jodie Butters, LPN Program Coordinator, Davis Technical College
Cherie Crezee, Director, Utah Nursing Assistant Registry at Davis Technical College
Marla De Jong, Dean, University of Utah College of Nursing
Eric Haskell, LPN Program Coordinator, Bridgerland Technical College
Vic Hockett, Associate Commissioner, Talent Ready Utah
Michelle Hofmann, Senior Associate Dean, Spencer Fox Eccles School of Medicine, University of Utah
Jane Lassetter, Dean, Brigham Young University College of Nursing
Timothy McCreary, Psychiatry Concentration Track Director of Doctor of Medical Science, Rocky Mountain University
Rita Osborne, Executive Director, Utah Center for Rural Health, Southern Utah University
Lauren Stanford, Director of Didactic Education for the Physician Assistant Program, Rocky Mountain University
Carrie Torgersen, Assistant Director, Utah Center for Rural Health, Southern Utah University

Subject-Matter Experts

Academics, Practitioners & Researchers

Melanie Beagley, Senior Health Research Analyst, Kem C. Gardner Policy Institute
Trent Bell, Uintah Basin Medical Center
Kevin Byrne, Huntsman Mental Health Institute, University of Utah
Erin Clark, Associate Professor of Obstetrics & Gynecology,, Spencer Fox Eccles School of Medicine, University of Utah
Kirsten Corazzini, Dean, College of Health & Human Services, University of New Hampshire
Tim Dall, Managing Director for Life Sciences Consulting, GlobalData
Jessica Davidson, Assistant Professor in Neonatology, University of Utah and Co-Medical Director of NICU at Intermountain Medical Center
Trish Hentre-Barrus, Riverwoods Behavioral Health
Lydia Howes, Assistant Librarian, Eccles Health Sciences Library, University of Utah
Louise Kaplan, University of Washington Center for Health Workforce Studies
Sri Koduri, Consultant, SiriS Consulting
Benjamin Lewis, Huntsman Mental Health Institute, University of Utah
Jonathan Martin, Intermountain Health
Carissa Monroy, Sacred Circle Healthcare
Christine Mueller, University of Minnesota (retired)
Patricia Pittman, Director, Fitzhugh Mullan Institute for Health Workforce Equity, George Washington University
Benjamin McMichael, Associate Professor, The University of Alabama School of Law
John Poelman, Director of Innovation, One Utah Health Collaborative
Amber Rasmussen, Sacred Circle Healthcare
Brett Richards, Orthopedic Surgeon, Ogden Clinic

Lee Rogers, Community Health Centers
Clark Ruttinger, Health Workforce Consulting Director, GlobalData
Nena Schvaneveldt, Associate Librarian, Eccles Health Sciences Library, University of Utah
Georgianna Sergakis, Director, Master of Respiratory Therapy Program, The Ohio State University
Laura Summers, Director of Industry Research, Kem C. Gardner Policy Institute
Matthew Wells, South Market OBGYN Medical Director, Canyon Region, Intermountain Health
Jamie Wissler, Executive Director, One Utah Health Collaborative

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