



Department of Commerce
Office of Professional Licensure Review

2026 Periodic Review

Medical Language Interpreter

Published September 2026

Executive Summary

Background

Medical Language Interpreters (MLIs) provide verbal language interpretation services between a healthcare provider and a person with limited English proficiency (LEP). Federal regulations require healthcare entities to provide qualified interpretation services free of charge.

Utah established a voluntary state certificate for MLIs in 2009. This means the scope of practice for MLIs is not protected, as individuals without the certification are still able to act as interpreters in medical settings. Instead, individuals cannot represent themselves as a state-certified MLI without achieving the qualification. There are two tiers of certification. To receive a tier 1 certificate, applicants must act as an interpreter between English and at least one other language, pass an oral and written examination, and agree to the national standards of MLI practice. For less common languages, an oral exam may not be available, in which case, an applicant meeting the other qualifications would be given a tier 2 certification. To qualify for the written and oral tests, applicants must complete medical interpreting training.

Only three states, including Utah, regulate the MLI profession. The other states follow federal regulations, which provide flexibility for market players to meet high medical language interpreting standards.

Regulatory Model Recommendation: Repeal Voluntary State Certification

- While medical language interpreting requires some regulation, potential for harm is moderate, is typically reversible, and has limited downstream impacts in most cases
- Federal regulations already set a high bar for MLIs, which Utah employers are able to meet through avenues outside of Utah's voluntary certification
- Patient risk appears to be well managed by employers based on data from major healthcare systems; state certification does not contribute meaningfully to safety
- Demand for language services in Utah is high yet participation in Utah's voluntary certification is low. OPLR does not believe that broadening the certification will solve concerns about MLI pay, recognition, or employer friction sourcing niche languages
- Almost no other states impose additional regulations on MLIs

Recommended Regulatory Adjustments: Not Applicable

Context

Consistent with its legislative mandate,¹ the Office of Professional Licensure Review (OPLR) reviewed Utah's laws for medical language interpreters. 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), academic literature, regulations in other states, and other secondary analyses. OPLR also conducted interviews with prominent stakeholders. See [Appendix 1](#) for more information.

Background

Profession Overview

Medical language interpreters (MLIs) provide verbal language interpretation services between a healthcare provider and a person with limited English proficiency (LEP). Federal regulations via Title VI of the Civil Rights Act of 1964 and Section 1557 of the Affordable Care Act (ACA) of 2010 prohibit discrimination on the basis of national origin and require covered entities to take reasonable steps to provide qualified interpreters to individuals with LEP free of charge and in a timely manner.³ A qualified interpreter is someone who has demonstrated proficiency in speaking and understanding both English and at least one other language and is able to interpret effectively, accurately, and impartially using any necessary specialized vocabulary.⁴ Additionally, qualified interpreters must adhere to generally accepted ethics principles, including patient confidentiality. Ultimately, the MLI's role is to facilitate effective and accurate communication between an LEP patient and a medical provider.

All medical language interpreting takes place in medical or healthcare facilities; however, the employment type varies. Nationally, MLIs predominantly work as freelancers or independent contractors (40%) or as staff interpreters (employees) in a healthcare organization (39%). The remaining roughly 20% work as staff interpreters in a large language service company (8%), as a combination of staff interpreter and independent contractor (7%), as bilingual clinical healthcare professionals (2%), as bilingual non-clinical staff (1%), or in a different setting (3%).⁵ Furthermore, MLIs work in a variety of modalities, with in-person being the most frequent modality nationally, followed by over-the-phone interpreting (OPI) and video remote interpreting

¹ UCA 13-1b-203(2)

² UCA 13-1b

³ Please find more information in the *Approaches in Other Jurisdictions* section.

⁴ Based on guidance from the U.S. Department of Health and Human Services Office for Civil Rights. U.S. Department of Health and Human Services, "Language Access Provisions."

⁵ Certification Commission for Healthcare Interpreters, Global Workforce Survey; See [Appendix 1.3](#) for more details.

(VRI).⁶ However, among Utah's prominent healthcare organizations, OPI and VRI modalities accounted for between about 60% and 80% of all language interpretation encounters within a 12-month period.⁷

Two prominent national organizations, the Certification Commission for Healthcare Interpreters (CCHI) and National Board of Certification for Medical Interpreters (NBCMI), certify MLIs. These national organizations develop and administer certification programs and examinations that assess the competence of interpreters. For an MLI to become certified by either of these organizations, candidates must have a high school diploma or equivalent, completed a training specific to medical interpreting (e.g., 40-hour training, academic course), and have linguistic proficiency in English and the language for which they are interpreting. Upon completing these prerequisites, candidates must complete the appropriate written exam and oral exam.⁸ Obtaining certification from these organizations costs about \$500, excluding the cost of a 40-hour medical interpreting training prerequisite course or academic course.⁹ As described in the next section, to become certified as a MLI in Utah, applicants must have passed an examination administered by either the CCHI or the NBCMI.

Profession in Utah

In Utah, an MLI is defined as “a person who, for compensation, performs verbal language interpretation services between a health care provider who speaks English and another person for the purpose of assisting the person in seeing or obtaining medical advice, diagnoses, or treatment.”¹⁰

Medical language interpreting is a voluntary certification in Utah that was established in 2009.¹¹ This means the scope of practice for MLIs is not protected, as individuals without the certification are still able to act as interpreters in medical settings. Instead, individuals cannot represent themselves as a state-certified MLI without achieving the qualification.

In part because the certification is voluntary, there were only 66 actively certified MLIs as of October 2025 (See [Appendix 2.1](#)).¹² However, as of June 2026, the number of actively certified MLIs was 41.¹³ This decline is likely attributable to MLIs allowing their state certification to lapse following the renewal deadline of March 31, 2026.

⁶ Certification Commission for Healthcare Interpreters, Global Workforce Survey. See [Appendix 1.4](#) for more details.

⁷ Language interpretation encounters volume data provided by two of Utah's prominent healthcare providers. For the healthcare system that reported OPI and VRI modalities accounting for 80% of interpreter encounters, they note that prior to the COVID-19 pandemic, these modalities accounted for about 65% of encounters.

⁸ Not all languages have an oral exam component available. For languages without an oral exam, candidates obtain a different credential and just have to complete the prerequisites and the written exam.

⁹ The cost of a 40-hour training course varies from free, as provided by Utah State University's Medical Interpreter Training Community Course, to about \$785. Utah State University, "Medical Interpreter Training."

¹⁰ UCA 58-80a-102(4)

¹¹ The voluntary certification was created by H.B. 144 Medical Language Interpreter Act during the 2009 General Session.

¹² Using licensee data through October 2025, the compound annual growth rate (CAGR) from 2020 to 2024 shows a roughly 10% decline in MLI certifications. There is an even sharper decline when the analysis is extended into 2025.

¹³ Utah Division of Occupational and Professional Licensing, "Active Licensee Count."

State certification includes two tiers. To acquire state certification as a tier 1 MLI, an individual must:

- Act as an interpreter between English and at least one other language;
- Pass an oral and a written examination (e.g., the CCHI or NBCMI); and^{14, 15}
- Sign a statement agreeing to abide by the national standards of practice.

If, however, an oral examination is not available for a language, an individual would qualify for a lower tier 2 certification if they pass the written portion of an examination and complete all of the other requirements under a tier 1 certification, including interpreting between English and at least one other language and agreeing to abide by the national standards or practice. The certification is valid for three years, but neither Utah statute nor rule require proof of continuing education for renewal.¹⁶

Approaches in Other Jurisdictions

A variety of federal laws require healthcare entities to provide patients who have limited English proficiency with access to qualified interpreters. Nearly all states rely on these federal regulations and do not impose separate state regulation or requirements on medical language interpreters.

Section 1557 is the civil rights provision of the Affordable Care Act of 2010 which provides the most specific and recent federal regulation regarding language interpretation.¹⁷ This section prohibits discrimination on the basis of race, color, national origin,¹⁸ sex, age, and disability. Furthermore, the provision applies to every health program or activity that receives, directly or indirectly, federal financial assistance (e.g., Medicaid, Medicare, State and Federal Marketplace, subcontractors of covered entities), which encompasses nearly all healthcare providers. Under 45 CFR 92.201, a covered healthcare entity must provide language assistance free of charge in an accurate and timely manner and in a manner that protects the privacy and the independent decision-making ability of the individual with limited English proficiency.¹⁹ Additionally, when

¹⁴ Per UCA 58-80a-303, the oral and written examinations shall be administered by the division, a person under contract with the division, a national certification organization, or a person approved by the division by rule. Additionally, the examination should test basic English fluency with respect to the language for which the individual applies for certification, basic medical terminology (e.g., human body parts, internal human organs, etc.), basic cultural competency relating to medical care beliefs and practices, knowledge and understanding of national standards of practice, and basic understanding of medical confidentiality requirements.

¹⁵ Per R156-80a-303, applicants for either a tier 1 or tier 2 certification shall provide verification that the examination passed by the applicant are administered by either the National Board of Certification for Medical Interpreters (NBCMI) or the Certification Commission for Healthcare Interpreters (CCHI).

¹⁶ Those applying for renewal or reinstatement must submit a renewal form, which asks applicants whether they have had a change in their criminal record and if they certify that they are qualified for the renewal or reinstatement. Utah Division of Occupational and Professional Licensing, "Renewal/Reinstatement Form."

¹⁷ 42 U.S.C. § 18116, 45 CFR Part 92

¹⁸ 45 C.F.R. § 92.4. "National origin", national origin includes, but is not limited to, a person's linguistic characteristics of a national origin group.

¹⁹ 45 CFR 92.201(a)

interpretation services are required, a covered entity must offer a “qualified interpreter”.^{20, 21}

In addition to Section 1557 of the ACA, Title VI of the Civil Rights Act of 1964 prohibits discrimination on the basis of race, color, and national origin in programs and activities receiving federal financial assistance.²² Various U.S. Supreme Court and other subsequent court decisions have found that failing to provide meaningful access to persons with limited English proficiency constitutes national origin discrimination under Title VI.²³ Furthermore, under Title VI and the U.S. Department of Health and Human Services (HHS) regulations, 45 C.F.R. Section 80.3(b)(2), recipients of federal financial assistance must take reasonable steps to ensure meaningful access to their programs and activities by persons with limited English proficiency.²⁴

A March 1, 2025 Executive Order “Designating English as the Official Language of the United States” revoked a prior longstanding Executive Order (EO 13166) that had directed federal agencies to eliminate discrimination against individuals with limited English proficiency.²⁵ Despite this change in U.S. executive policy, language access remains federal law under both Section 1557 of the ACA and Title VI of the Civil Rights Act of 1964.²⁶

Very few states regulate medical language access through certification, or any other occupational regulation. Only Utah, Oregon and Washington regulate medical language interpreters at the state level. While Utah’s MLI certification is voluntary, Oregon and Washington require that healthcare providers use interpreters from a state-administered registry of at least minimally-qualified interpreters.^{27,28, 29} Minnesota maintains a voluntary roster of spoken-language interpreters, but there is no certification available in the state for health care interpreters and Minnesota does not require the national certification.³⁰

Oregon has two levels of credentialing: qualification and voluntary certification.^{31, 32} A qualified

²⁰ 45 CFR 92.201(c)(1)

²¹ Per 45 CFR 92.4 “Qualified interpreter for an individual with limited English proficiency”, a qualified interpreter has demonstrated proficiency in speaking and understanding both spoken English and at least one other spoken language, is able to interpret effectively, accurately, and impartially to and from such language and English, using any necessary specialized vocabulary or terms without changes, omissions, or additions and while preserving the tone, sentiment, and emotional level of the original oral statement, and adheres to accepted interpreter ethics principles, including client confidentiality.

²² Title VI Statute, 42 U.S.C §§ 2000d

²³ U.S. Department of Justice, “Commonly Asked Questions.”

²⁴ U.S. Department of Health and Human Services, “Summary of Guidance.”

²⁵ Youdelman, “Despite New Executive Order.”

²⁶ Youdelman, “Despite New Executive Order.”

²⁷ ORS 413.550

²⁸ ORS 413.559; Except as provided in subsection (2) of this section, a health care provider shall work with a health care interpreter from the health care interpreter registry administered by the Oregon Health Authority under ORS 413.558 (Procedures for testing, qualifications and certification of health care interpreters) when communicating with a patient who prefers to communicate in a language other than English, unless the health care provider is a doctor or clinician who is proficient in the patient’s preferred language.

²⁹ Per WAC 388-03-010 and WAC 388-03-020, rules for certified and authorized interpreters in Washington apply to those seeking employment with the department of social and health services (DSHS), wishing to provide services to DSHS as a contracted interpreter, or working as a non-DSHS county agency/program that contracts with the DSHS.

³⁰ Minnesota Department of Health, “Health Care Interpreter Roster.”

³¹ Certification is voluntary, while qualification is the required entry standard.

³² Oregon Health Authority, Requirements for Spoken Languages.

healthcare interpreter is a person that must have: a high school diploma (or equivalent) or higher, at least 60 hours of formal health care interpreter training, language proficiency demonstrated via testing in English and the target language. To achieve certification as a healthcare interpreter the individual must have all the requirements of a qualified interpreter and proof of passing a certification test from a state or national organization.³³ In Oregon, these credentials are both valid for four years and require completing 24-hours of continuing education.

In Washington, a person is considered certified or authorized once they have taken the required two-hour minimum DSHS interpreter orientation training, the required two-hour minimum interpreter professional ethics training, and have passed either a higher or lower required written and oral examination for interpreters.^{34, 35} Washington requires certified and authorized interpreters to earn a minimum of 20-hours of continuing education hours every four years.³⁶

Other states rely on the federal laws and regulations described above to dictate requirements for providing “qualified interpreters” to patients with limited English proficiency, leaving the implementation details to market players.

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. 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 3.1](#) for potential regulatory models and the factors in OPLR’s framework.

³³ Certification tests are accepted from the following organizations: the National Board of Certification for Medical Interpreters (NBCMI), Certification Commission for Healthcare Interpreters (CCHI), National Center for State Courts Court Interpreter Oral Examination, Oregon Court Interpreter Certification, or Federal Court Interpreter Certification exams.

³⁴ WAC 388-03-112

³⁵ Washington distinguishes between certified and authorized based on the availability of a written and oral test instrument. Certified languages, resulting in a certification, are those in which interpreters go through conventional modalities of testing; however, screened languages, resulting in authorization, are those that only use a screening test. Washington State Department of Social and Health Services, “Certified Languages and Screened Languages.”

³⁶ WAC 388-03-160

Potential for Harm

OPLR's analysis of a profession's potential for harm considers the severity, probability, and permanence of harm to the health, safety and financial welfare of the public.³⁷

Based upon OPLR's analysis of these factors, OPLR characterized the potential for harm by a medical language interpreter as moderate. The potential for harm arises primarily from miscommunications in interpreting between a practitioner and patient. These miscommunications may result in medical errors, such as misdiagnosis and treatment errors, poorer quality of care, delayed care, care based on incomplete or inaccurate information, errors in medication prescription, increased costs, or ethical issues around consent and privacy (e.g., HIPAA violations).^{38, 39, 40}

Academic literature shows that adverse events involving physical harm occur among both LEP and English speaking populations, although to varying rates. Additional research, as described below, also shows that harm is not always consequential and often results in no harm or minimal temporary harm. Finally, harm is typically reversible.

One prominent study found that the proportion of errors of potential consequence was significantly lower for professional interpreters (12%) versus ad hoc interpreters (22%) versus no interpreters (20%).⁴¹ Additionally, another study published before the passage of the ACA found that about 49% of LEP patient adverse events involved some physical harm compared to about 30% for patients who speak English.^{42,43} In 7% of cases where LEP patient adverse events resulted in detectable physical harm, patients suffered severe temporary harm or worse compared with 5% of the adverse events for English speaking patients.⁴⁴ This study was conducted prior to the ACA increases in federal requirements regarding medical interpreting, however a contemporaneous study reported that roughly half of LEP patients did not receive interpreter services.⁴⁵ Since federal requirements now require covered healthcare entities to provide qualified interpreters free of charge in an accurate and timely manner (see *Approaches in Other Jurisdictions* section), the percentage of LEP patients receiving interpreter services has increased.

The potential for harm is typically reversible, with limited downstream impacts.^{46, 47} To reduce the

³⁷ UCA 13-1b-302(2)

³⁸ Lindholm et al., "Professional Language Interpretation."

³⁹ Karliner et al., "Do Professional Interpreters Improve."

⁴⁰ Flores et al., "Errors of Medical Interpretation."

⁴¹ Flores et al., "Errors of Medical Interpretation."

⁴² Divi et al., "Language Proficiency and Adverse Events."

⁴³ Physical harm in this analysis ranged from minimal temporary harm, defined as detectable harm, lasting for a limited time only, resulting in no permanent injury, and minimal in severity, to death.

⁴⁴ Divi et al., "Language Proficiency and Adverse Events."

⁴⁵ Flores et al., "Errors in Medical Interpretation."

⁴⁶ In Butow et al., the authors found that 70% of nonequivalent interpretations were inconsequential or positive, while 10% could result in misunderstanding. Butow et al., "Interpretation in Consultations." This finding was consistent with stakeholders OPLR interviewed.

⁴⁷ From the Divi et al. study, no harm or no detectable harm was detected in 51% of LEP patients. Additionally, about 77% of LEP patients experienced between no harm and minimal temporary harm.

risk of downstream impacts compounding and accumulating, it is common practice for patients to receive a new interpreter for different appointments. As a result, if one interpreter makes a mistake, it could be corrected in a future encounter. However, there are rare cases—typically from anecdotes—where the impact of using an untrained interpreter could result in life-altering harm or could presumably result in death.⁴⁸

While patients in a medical setting can be very vulnerable, and this is exacerbated by language barriers, MLIs act as a third party in a medical interaction, which can provide benefits to patients with limited English proficiency beyond interpretation. This includes being able to assess body language during an interaction and provide additional clarification and advocacy, if needed. The National Council on Interpreting in Health Care (NCIHC) code of ethics requires that, when a patient's health, well-being, or dignity is at risk, an interpreter may act as an advocate, which is an action taken on behalf of an individual that goes beyond facilitating communication, with the intention of supporting good health outcomes.⁴⁹

The specific setting and consumer expectations also mitigate the potential for harm. Given the setting in which MLIs work and their clear purpose, there is no need for physical touch between an MLI and a patient. MLIs typically enter the room with the practitioner, which limits the frequency of interactions occurring in a private setting one on one. Additionally, the prominent use of over-the-phone and video remote modalities in Utah further limits risks from one-on-one time between an interpreter and patient.

Taking both the potential for harm and mitigating factors into account, OPLR views medical language interpreting as having moderate potential for harm to a patient in the absence of any regulation.

Related Factors

Healthcare systems have structured their MLI programs to comply with the federal laws and regulations described above (i.e., ACA and Civil Rights Act). As a result, medical language interpreters, either hired directly by a healthcare organization or hired as an independent contractor, experience a high degree of oversight. The healthcare organizations must ensure that the medical language interpreters they use comply with the federal regulations and are qualified interpreters.

⁴⁸ Please see the “Public Harm” section of Colorado Office of Policy, Research and Regulatory Reform, 2017 Sunrise Review.

⁴⁹ National Council on Interpreting in Health Care, National Code of Ethics.

In addition to the federal regulations, employers set their own standards and manage the quality of MLIs through both hiring staff directly and managing contract terms with vendors.⁵⁰ As an example, Utah Medicaid contracts with roughly 20 vendors to provide language interpretation services to its members. In the contract with these vendors, Utah Medicaid stipulates specific terms, such as requiring contractors to ensure its interpreters participate in Bridging the Gap or a similar training program, pass a contractor established testing and training plan, and complete either continuing education or a specified number of hours of interpreting.⁵¹ Additionally, in conversations with OPLR, Intermountain Health expressed the necessity of checking the adequacy of interpreter qualifications, especially given their reliance on contractors for low-volume languages. While it may be challenging for hospital systems to manage the performance of all contracted MLIs, it is evident that they confer a high level of oversight to this service for patients with limited English proficiency.

Model Assessment Discussion

In conclusion, there is a body of evidence showing a moderate potential for harm associated with the MLI profession, particularly when comparing professional interpreters to ad hoc or no interpreters or outcomes for LEP patients compared to English speakers. However, there is no evidence that Utah's heightened qualifications for certification are supplying the market with more competent and safe MLIs compared to what the federal laws mandate. This can be inferred from the low uptake of the State's voluntary certification (requiring the more costly CCHI and NBCMI credentials) and the willingness of employers to rely on the more affordable 40-hour MLI training (separate from the CCHI and NBCMI or state certification). Therefore, the existence of a voluntary state certification is not driving safety for LEP patients; rather, the federal requirements, with much broader adoption, are in practice driving safety for LEP patients instead.

When analyzing the potential for harm and related factors collectively, OPLR finds that there is a potentially less burdensome regulatory alternative to the State's voluntary certification in the form of the existing federal regulation.

For more details on OPLR's analysis of MLIs according to the framework, see [Appendix 3.2](#).

⁵⁰ A certificate from a 40-hour training program, such as Bridging the Gap, is frequently required by employers as a required qualification, while a CCHI or NBCMI certification is a preferred qualification. Further, Utah State University offers a free 40-hour training certification that provides interpreters with a first step toward a national certification through CCHI or NBCMI.

⁵¹ Contract provisions stipulate that contractors have an established test and training plan in place for interpreters they employ or contract with. Further, it requires that the plan, at a minimum, seek to: develop objective language tests that screen for competence in both English and the interpreter's target language, develop interpreter skills programs and require that all interpreters complete annual skills development instruction, specify the number of interpreter hours and number of continuing education hours, and shall ensure that all medical interpreters participate in the nationally recognized, Bridging the Gap Medical Interpreter Training or similar training.

Regulatory 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 4.1](#)).

Safety Issues

There is no evidence from available data that certified MLIs are causing concerning levels of harm to patients. During the 2017-2022 and 2023-2024 time periods, there were no relevant substantiated DOPL complaints about certified MLIs in Utah.^{52,53, 54}

Furthermore, an analysis of the Certification Commission for Healthcare Interpreters's (CCHI) disciplinary sanctions over the past five years showed that, nationally, only 11 CCHI certified MLIs received a publicly reported sanction from that national organization.^{55, 56} The publicly available CCHI disciplinary data does not provide comprehensive information about the state in which the sanctioned MLIs worked. Of the sanctioned interpreters where a state was listed (7), none were in Utah. Nationally, the most frequently cited sanction was for misrepresenting the CCHI credential, followed by making false, knowingly misleading, or deceptive statements. There were two instances, which appear related, of financial fraud or deceit.⁵⁷

Anecdotal data from one of the major Utah healthcare systems suggest that there are few major patient safety incidents from MLIs overall. Additionally, this healthcare system reported that most safety issues related to language services are caught before a bad outcome occurs. This low rate of safety incidents includes a majority of MLIs who are not state certified, but have met a lower level of training.⁵⁸

Access Issues

There is a strong need for medical language interpreting services in Utah. Roughly 440,000 Utahns older than five years old (or 15%) speak a language other than English at home.⁵⁹ Of

⁵² OPLR used two time periods (2017-22 and 2023-24) to account for a system change that altered how the complaint data were captured.

⁵³ While there were no substantiated complaints, during the 2017-2022 time period, there was one complaint in which DOPL had no jurisdiction. Upon reviewing the case notes for this complaint, it was evident that it was unrelated to the medical setting.

⁵⁴ See [Appendix 4.2](#) for OPLR's analysis of DOPL complaints

⁵⁵ Publicly reported disciplinary sanctions from the Certification Commission for Healthcare Interpreters. Certification Commission for Healthcare Interpreters, "Disciplinary Sanctions."

⁵⁶ According to the CCHI's annual reports, there were an average of 4,900 active CCHI certifications between 2020-2024.

⁵⁷ Please see [Appendix 4.3](#) for more details on this analysis.

⁵⁸ Although difficult to estimate, as complaints do not always escalate, one of the major healthcare employers in Utah shared that they only recalled two instances of actual harm in the past year out of over 800,000 encounters annually which involved client harm violations.

⁵⁹ Jinadasa et al., Utah Language Data Report (2022).

this group, roughly 30% speak English less than “very well.”⁶⁰ Additionally, Utah’s two largest health systems report over 1 million interpreter encounters per year. One healthcare system experienced a 3.0% annual increase in language interpreter encounters from 2024 to 2025 in Utah.

The need for interpreters is especially true for major languages spoken in Utah (e.g., Spanish, Chinese) and for more recently emerged and less prevalent languages (e.g., Swahili, Amharic, Somali, Nepali).⁶¹ To meet these needs, healthcare entities in Utah rely on a mix of staff interpreters (for major languages) and contracts with independent contractors and vendors (for non-standard hours or less frequent languages) across various modalities.

The mismatch between the number of MLIs actively certified in Utah (roughly 40) and the number of individuals with limited English proficiency, reflects, in part, barriers to obtaining certification. Nearly all of the stakeholders OPLR spoke with during this review shared that the current requirements for state certification were too burdensome for most MLIs. The barrier to obtaining certification is mainly a function of the cost of obtaining certification relative to the return an interpreter might earn from that qualification. This is particularly the case for low-volume languages which do not have a constant and high demand for interpreting services.

The market has already responded to provide access to interpreting services, particularly given Federal mandates.⁶² Healthcare organizations that directly employ staff interpreters,⁶³ have developed their own requirements for training and hiring interpreters, and typically rely on a 40-hour certification course alone (separate from the CCHI and NBCMI or state certification).⁶⁴ Additionally, Utah has responded to the need for language interpreters by creating a free, 40-hour medical interpreter training certification course at Utah State University (separate from the CCHI and NBCMI or state certification). This training program provides Utahns with access to a medical language interpretation curriculum and training program that prepares students for immediate entry into the workforce or serves as the first step toward a national certification (i.e., CCHI or NBCMI).

⁶⁰ Jinadasa et al., Utah Language Data Report (2022).

⁶¹ The top languages spoken in Utah include Spanish (297,926), Chinese (including Mandarin, Cantonese) (16,328), and Ilocano, Somoan, Hawaiian, or other Austronesian languages (13,034). Jinadasa et al., Utah Language Data Report (2022).

⁶² Per 45 CFR 92.201(e)(2), unqualified adults must not be relied on for interpretation except: as a temporary measure, or while finding a qualified interpreter in an emergency where there is no qualified interpreter immediately available, or where the individual with limited English proficiency specifically requests, with additional stipulations, that an accompanying adult interpret or facilitate communication.

⁶³ These staff interpreter roles are typically reserved for Spanish, as this is the language with the highest prevalence in the state and utilization of MLI services.

⁶⁴ Intermountain’s required qualifications for a Spanish medical interpreter include: completion of a pre-hire assessment, excellent oral and written command of both source and target language as to obtain a “Professional Proficiency” or Level 3 in the ILR scale (or equivalent as approved by Manager), perform consecutive, simultaneous, and sight translations with accuracy, and certificate of completion from a 40-hour Professional Medical Interpreter course. If a candidate does not have a certificate for the Professional Medical Interpreter course, a candidate may be considered if s/he has an interpreting certification in a different field, holds a college degree in translation or the working language, or has two years of experience as a professional interpreter.

To provide interpretation for non-Spanish or lower-prevalence languages,⁶⁵ or for healthcare organizations that do not have the resources to hire full-time, staff interpreters (e.g., rural hospitals, private practice physician offices), vendors offer a range of services (i.e., in-person, over-the-phone, video remote). OPLR's research found that the majority of interactions are now remote (VRI or OPI modalities), most often provided by such vendors. Nationally, there are 10-15 major vendors and hundreds of smaller, regional agencies that offer a range of services and modalities. Rural hospital administrators OPLR spoke to that utilize medical language interpreting services via tablet and vendor services were pleased with their experience and had success accessing MLIs on a 24-hour basis.

Recommendation: Remove State Regulation of Medical Language Interpreters

After reviewing the current regulatory structure, OPLR recommends repealing the voluntary state certification for Medical Language Interpreters (MLIs).

As detailed above, medical interpreting does require regulation because there is some risk to the public of a well-meaning but untrained individual providing interpreting services in a medical context. Medical language interpreting should be provided by qualified, professional interpreters. However, OPLR finds that the current federal and employer oversight adequately addresses the risk to patients:

- **Federal rules are working:** Healthcare facilities are already required by federal law (like the Civil Rights Act and the Affordable Care Act) to provide qualified interpreters. These facilities manage interpreter quality through their own hiring standards and contracts. This oversight is already protecting patients, making extra state-level certification redundant or of very limited benefit.
- **The patient risk is well managed:** While communication errors in healthcare can cause patient harm, the actual data show that serious harm is rare and usually reversible. OPLR can find no evidence that the current state certification process prevents these issues in a way that is materially better than the existing federal requirements.
- **State certification does not solve the "supply" problem:** Stakeholders have expressed a concern that the medical interpreting field needs more recognition and better pay, which are valid concerns for the occupation—but they are best addressed by those within the healthcare system, not the State via occupational regulation. Utah's voluntary certification program has very low participation, and does not attract enough interpreters to meet the high demand for language services, especially for rare languages. Thus any improvements in pay and recognition will come through

⁶⁵ One of the major Utah healthcare systems reports having language interpretation encounters for about 160 different languages in 2025.

reimbursement policies and employer demand, not state regulation.⁶⁶ In addition, any state certification with broad adoption has the effect of reducing supply, increasing cost, or both.

- **Efficiency:** Because hospitals and clinics are already successfully finding and hiring qualified interpreters through their own vetting processes (without state certification), the State's regulation is an administrative burden that is unlikely to add significant benefits to employers or patients, but is likely to add cost to the healthcare system overall.

Ultimately, very few states impose additional regulations on MLIs for the reasons outlined above. OPLR recommends removing Utah's voluntary certification and not regulating this profession at the state level.

Rule Review

In accordance with Utah Code 13-1b-203(5), OPLR conducted an in-depth review of DOPL's medical language interpreter rules, found in R156-80a.

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 R156-80a found:

1. No overly burdensome rules.
2. No rules misaligned with statutory language.
3. One incorrect reference to a rule. Rule 156-80a-104 makes reference to Section R156-1-107. This reference does not exist.
4. Rules would not be necessary if the medical language certification is removed.

⁶⁶ See U.S. Department of the Treasury et al., Occupational Licensing. The report recommends several best practices to ensure licensing protects consumers without placing additional burdens on employment, innovation, or access.

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1. Context

1.1 General Research Methodology

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

- Conducting quantitative analysis of DOPL licensee and complaint data and publicly available data from other state and federal government entities and private entities
- 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 governments and agencies, industry organizations, researchers, practitioners, and business owners and employers within a variety of settings.

1.2 Medical Language Interpreter Policy Scan

To better understand the regulatory environment for medical language interpreters, OPLR conducted a review of state occupational regulation in the U.S. OPLR utilized AI tools offered by LexisNexis and WestLaw to create the first draft of these policy scans, though a subset of the data was verified by an analyst. The data was 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.

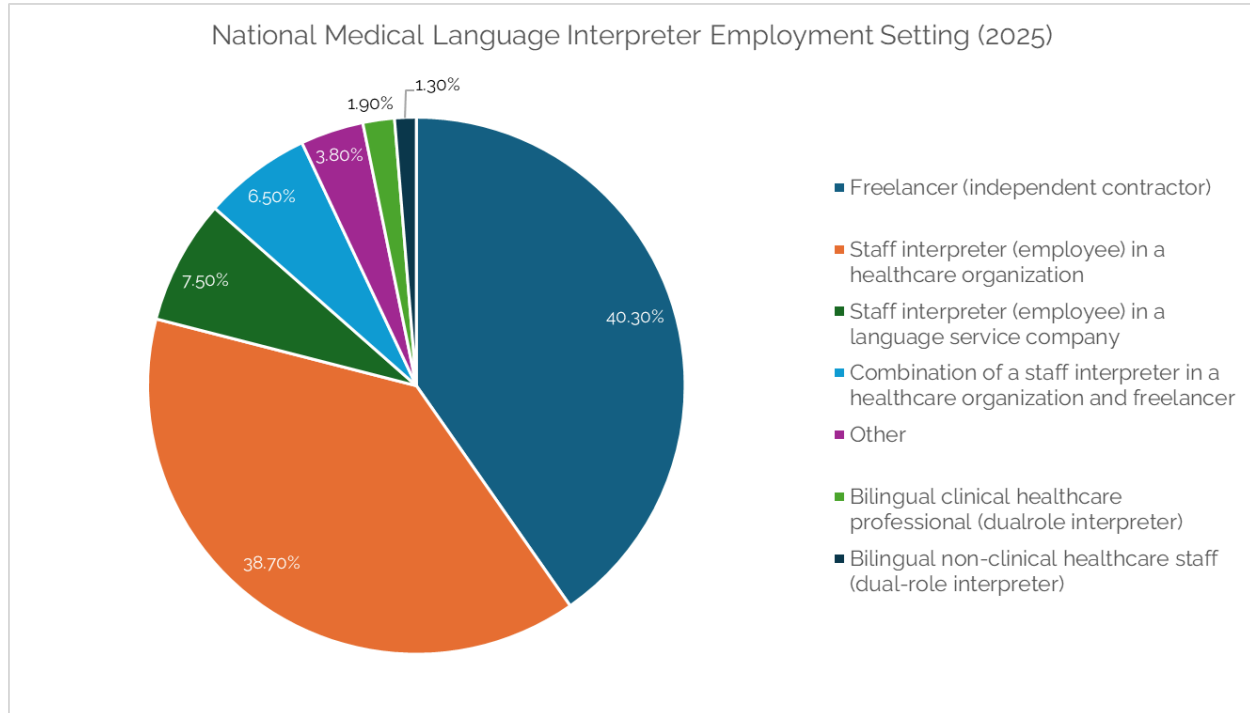
For each policy scan, OPLR began by manually finding the answers to relevant policy scan questions for a small subset of states (5-7 states). An analyst then prompted AI (LexisNexis and WestLaw) to look for the answers to the question(s) in the same group of states and compared the AI's answers to the manual answers. If there was a low level of accuracy, the analyst would adjust the prompt and run the test again. Once a high level of accuracy was achieved, the analyst prompted the AI to answer the question(s) for all 50 states.

The analyst then checked the AI-generated answers for an additional five states to ensure accuracy within the 50-state dataset. For any states where the AI prompt did not return relevant information, the analyst interacted with AI in a more targeted way or manually found the answers.

This approach does contain limitations related to normal human and AI-related 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 LexisNexis or WestLaw AI tools that were not caught by OPLR's manual verification.

1.3 Medical Language Interpreter Practice Setting

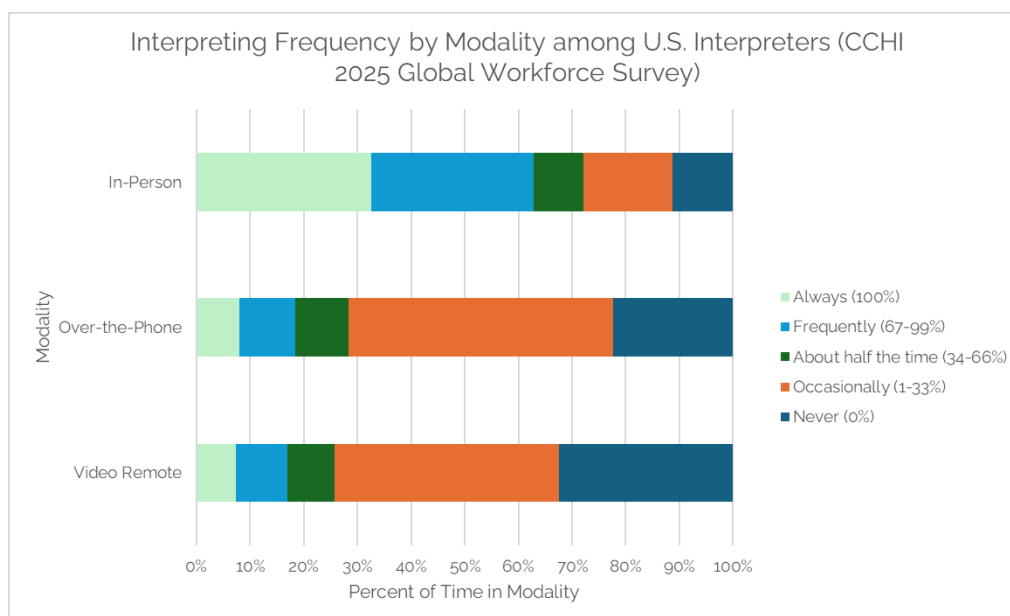
This analysis is based on the CCHI's Global Workforce Survey of Health Interpreters.⁶⁷ The employment status of U.S. based interpreters surveyed indicates that most work either as a freelancer/independent contractor or as a staff interpreter in a healthcare organization.



⁶⁷ Certification Commission for Healthcare Interpreters, Global Workforce Survey.

1.4 Medical Language Interpreter Practice Modality

This analysis is based on the CCHI's Global Workforce Survey of Health Interpreters.⁶⁸ The practice modality of U.S.-based interpreters surveyed indicates that roughly 30% always work in-person. However, there is significant variation in the frequency and time spent working in the various modalities.



2. Background

2.1 DOPL Licensee Data

OPLR used DOPL licensee data queried in October of 2025 to conduct analyses on the number of licensees per year and the inflow and outflow of licensees. The dataset included individuals first licensed after 1970 to those actively licensed as of October 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.

⁶⁸ Certification Commission for Healthcare Interpreters, Global Workforce Survey.

Between 2014-2024, the number of medical language interpreter certifications in Utah grew with a Compound Annual Growth Rate (CAGR) of 15.1%, which far outpaced the growth in the population of Utah during that period (1.8%).⁶⁹ However, since 2020, the number of MLIs has dropped significantly and was roughly 40 in the first half of 2026.

3. Regulatory Model Assessment & Recommendation

3.1 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.⁷⁰

3.2 Assessment of Medical Language Interpreter

The following table summarizes OPLR's analysis of MLIs 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 MLIs are highlighted in bold.

Model Assessment of Medical Language Interpreters	
Harm Factors	
Mechanism of Harm	Harm may occur if an interpreter provides inaccurate translations, excludes information, or if there is a miscommunication. There are also ethical risks, such as HIPAA violations.
Severity, Permanence, and Likelihood of Harm	Harm is typically moderate and reversible, like a miscommunication, but could presumably be life altering in some cases or, in rare cases, result in death.
Consequence of Error	64 out of 100 ⁷¹
Downstream Impact	Downstream impacts are limited and rare and can typically be reversed (e.g., correcting a miscommunication).
Consumer & Setting Factors	
Patient Vulnerability	MLIs work with vulnerable patients, given they are in a medical setting and have limited English proficiency.
Frequency of Physical	There should be no physical touch between a patient and an MLI.

⁶⁹ Utah Department of Health and Human Services, "IBIS-PH."

⁷⁰ The document is also available on OPLR's website in the "About OPLR" section, accessible here: <https://oplr.utah.gov/about-oplr/>

⁷¹ The interpreter and translator O*NET category is not specific to medical language interpreting. This score encompasses American Sign Language (ASL) interpreters and Court interpreters.

Touch	
Frequency of Private Setting	MLIs work across various modalities (in-person, over-the-phone, or video remote). MLI protocol calls for interpreters to only be present when a practitioner is present. Additionally, the use of over-the-phone and video remote interpreting limits the frequency of interacting in a private setting.
Information Asymmetry	Information asymmetry is high in a medical interaction, due to a language barrier. However, the role of the MLI is clear to everyone involved and can benefit a patient beyond interpreting (e.g., clarifying, advocating if necessary).
Related factors	
Independence	MLIs act independently, as they are the only interpreter, but they always work in a setting with a practitioner present and with significant employer oversight.
Patient Choice	Patients are assigned an MLI prior to their appointment by the healthcare facility. A patient typically does not choose their MLI.
Information Availability	The patient would have an idea regarding the competence of their interpreter via native language and body language.
Level of Oversight	Government: Oversight is high. Federal regulations are stringent and require covered healthcare entities to provide language assistance free of charge in an accurate and timely manner and in a manner that protects the privacy and the independent decision-making ability of the individual with limited English proficiency. Employers: Oversight is high. MLIs are most frequently employed as staff in a healthcare facility or are independent contractors. Larger healthcare facilities have developed their own requirements for staff interpreters, while MLIs working as independent contractors have oversight via contracts. These requirements and contracts developed by employers provide significant oversight to ensure healthcare entities are following federal laws. Private: There is limited private oversight, since national certification is voluntary and often not required for employment.

*O*NET score is not specific to medical interpreting.

4. Regulatory Model Adjustments & Recommendation

4.1 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.⁷²

4.2 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".⁷³ 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) and Salesforce to access closed complaints investigated by DOPL between 2017-2024. 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.

⁷² The document is also available on OPLR's website in the "About OPLR" section. Utah Office of Professional Licensure Review, Occupational Regulation Framework.

⁷³ Utah Division of Occupational and Professional Licensing, Complaint Handling Process.

Complaint Case Notes Analysis

A more detailed analysis of historical case notes was conducted on MLI complaints closed between 2017-2024. OPLR analysts read through case notes from all complaints and for each complaint summarized the issue, noted whether or not client harm occurred or potentially occurred, and if harm was present, the type and severity.

Limitations

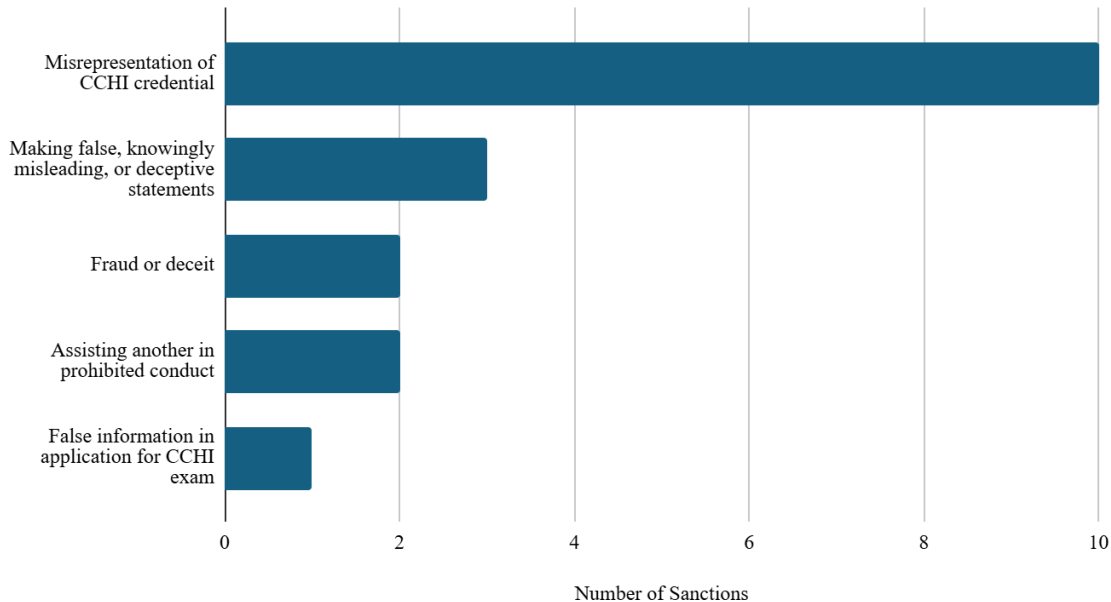
There are significant limitations to this analysis, and the information collected should not be interpreted as a precise estimate of harm caused by MLIs. DOPL data likely underestimates true harm, as many instances of harm may be handled in other ways (e.g., directly by employers), reported to other 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 MLIs because surgery is inherently far riskier, not because surgeons are “less safe” or less competent than MLIs.

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 these data.

4.3 CCHI Disciplinary Sanction Analysis

National CCHI Public Sanctions Since 2020



5. Stakeholder Engagement

5.1 OPLR Stakeholder 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 MLIs, MLI employers, MLI educators, industry associations, Utah legislators, and Utah and other state regulators. OPLR prioritized diversity of perspective and relevance to the industry in selecting stakeholders. Variety in practice setting was also prioritized.

Interviews were conducted 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 MLI 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.

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 medical language interpreting services (i.e. 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, MLIs, MLI 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.

OPLR Stakeholder Series Summary - Medical Language Interpreter	
Government Stakeholders	
Utah Department of Commerce	Deborah Blackburn , Assistant Director, Division of Professional Licensing Larry Marx , Bureau Manager, Division of Professional Licensing Mark Steinagel , Director, Division of Professional Licensing
Utah Department of Health and Human Services	Edwin Espinal , Public Information Officer Kirk Poulsen , Health Program Manager Jim Stamos , Director, Office of Healthcare Policy and Authorization
Utah State Courts	Jessica Leavitt , Language Access Program Manager, Administrative Office of the Courts
Utah Department of Workforce Services	Jes Nelson-Julander , Program Manager, Utah Interpreter Program
Industry Stakeholders	
Industry Associations	Carlos Martinez-Morales , President, Utah Translators and Interpreters Association Tung Tran , Director, Interpreting Services, Asian Association of Utah
National Certification Bodies	Joanna Larson , Chair, The National Board of Certification for Medical Interpreters Natalya Mytareva , Executive Director, Certification Commission for Healthcare Interpreters (CCHI)
Employers	Sydney Bright , COO, Vamos Health Jordan Daines , Account Manager, Linguistica International Rob Kistler , Associate Executive Director, Support Services, University of Utah Health

	Thanh Le , Resource Development Manager, Proxima Careers Carlos Martinez-Morales , Director of Language Services, Intermountain Health Sabrina Morales , CEO, Linguistica International Jafet Quezada , Patient Services Manager, University of Utah Chis Shirley , Director of Support Services, University of Utah Health John Woolley , CEO, Vamos Health Cameron Wright , COO, Proxima Careers
Higher Education	Elsa Perez , Assistant Professor, Co-Director Translation & Interpretation Studies, Utah State University
Subject-Matter Experts	
Academics, Researchers, & Clinicians	Sammie Cox , Chief Nursing Officer, Central Valley Medical Center Greg Gardiner , Chief Nursing Officer, Uintah Basin Medical Center / Uintah Basin Healthcare

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