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Ohio Hospital Association
HOSPITAL LAW HANDBOOK
8th Edition (Fall 2017)

A compendium of select Ohio statutes and regulations

This handbook is not legal advice or comprehensive and is not intended as a primary or sole source of law. Users should consult an attorney and check the web or other statute and regulation sources including checking for any additions, modifications, or corrections. The handbook also does not address the interpretation of law, such as through case law or administrative rulings.

Editors: Richard L. Sites and Brian D. Sites

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How to use this Handbook:

Welcome to the Ohio Hospital Association Hospital Law Handbook’s 8th Edition. This book provides a concise collection of hospital-related provisions for quick reference. Additionally, its chapters and sections allow for easy navigation to specific topic areas and laws. This Handbook is designed to contain the statutes and regulations that are most pertinent to health care entity operations. However, it does not contain every statute or regulation that a health care professional might address, and it is not intended to be used for legal decision making. The Handbook is intended for quick reference and for locating relevant provisions to begin research efforts, not as a primary source of law. Appendixes to regulations are not displayed due to space limitations, and most provisions related to reimbursement are not included. For important matters, consult a primary source of law and an attorney.

This Handbook is divided into twelve chapters, each centered around a broad topic. Each topic is then divided into parts that cover major issues under that topic. Listed under these are subheadings, in italics, on specific issues. Finally, under these are the statute and regulation section numbers and titles—statutory titles and many rule titles were created by the editors for your convenience. Any section number with hyphens is a regulation from the Ohio Administrative Code; for example “3701-1-01” or “3701:1-1-01.” Those without hyphens are statutes from the Ohio Revised Code; for example, “3701.01.” You will also find editorial comments, marked as “[Editor’s Note].” Because each provision is listed only once in the Handbook—but might pertain to multiple topics and thus could have been listed in more than one of the twelve chapters—a sequential list of provisions as well as an index have been provided.

When navigating the Handbook, you will find the chapter number and, if the chapter has multiple parts, the part number in the upper left hand corner of each page. At the bottom-inside corner of the page, you will also find the subheading title or, if the section has no subheading, a descriptive term or phrase to assist your navigation.

The regulations and statutes in this Handbook reflect the versions effective as of fall 2017 unless otherwise noted. After consulting the Handbook, you should check to see if the law has changed. One way to check for changes is by searching for specific rule numbers at the Register of Ohio (www.registerofohio.state.oh.us/) or by consulting the State of Ohio’s Codes Website (http://codes.ohio.gov) for both statutes and regulations. Be aware that statutes listed on the Codes website are not immediately updated following a legislative enactment, but you can search for recent statutory changes on the Ohio legislative website (https://www.legislature.ohio.gov). Legal professionals often use online subscription-based services to identify recent changes (such as WestlawNext).

If you have any questions, please do not hesitate to contact Sean McGlone or Bryn Hunt at 614-221-7614.

Richard L. Sites, J.D., M.S.
Brian D. Sites, J.D., LL.M.
Editors
December 2017
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Chapter 1. General Hospital Provisions

Part I: General Hospital Operations

Hospital Agencies

140.01 Definitions; hospital agencies.

As used in this chapter:

(A) “Hospital agency” means any public hospital agency or any nonprofit hospital agency.

(B) “Public hospital agency” means any county, board of county hospital trustees established pursuant to section 339.02 of the Revised Code, county hospital commission established pursuant to section 339.14 of the Revised Code, municipal corporation, new community authority organized under Chapter 349 of the Revised Code, joint township hospital district, state or municipal university or college operating or authorized to operate a hospital facility, or the state.

(C) “Nonprofit hospital agency” means a corporation or association not for profit, no part of the net earnings of which inures or may lawfully inure to the benefit of any private shareholder or individual, that has authority to own or operate a hospital facility or provides or is to provide services to one or more other hospital agencies.

(D) “Governing body” means, in the case of a county, the board of county commissioners or other legislative body; in the case of a board of county hospital trustees, the board; in the case of a county hospital commission, the commission; in the case of a municipal corporation, the council or other legislative authority; in the case of a new community authority, its board of trustees; in the case of a joint township hospital district, the joint township district hospital board; in the case of a state or municipal university or college, its board of trustees or board of directors; in the case of a nonprofit hospital agency, the board of trustees or other body having general management of the agency; and, in the case of the state, the director of development services or the Ohio higher educational facility commission.

(E) “Hospital facilities” means buildings, structures and other improvements, additions thereto and extensions thereof, furnishings, equipment, and real estate and interests in real estate, used or to be used for or in connection with one or more hospitals, emergency, intensive, intermediate, extended, long-term, or self-care facilities, diagnostic and treatment and out-patient facilities, facilities related to programs for home health services, clinics, laboratories, public health centers, research facilities, and rehabilitation facilities, for or pertaining to diagnosis, treatment, care, or rehabilitation of sick, ill, injured, infirm, impaired, disabled, or handicapped persons, or the prevention, detection, and control of disease, and also includes education, training, and food service facilities for health professions personnel, housing facilities for such personnel and their families, and parking and service facilities in connection with any of the foregoing; and includes any one, part of, or any combination of the foregoing; and further includes site improvements, utilities, machinery, facilities, furnishings, and any separate or connected buildings, structures, improvements, sites, utilities, facilities, or equipment to be used in, or in connection with the operation or maintenance of, or supplementing or otherwise related to the services or facilities to be provided by, any one or more of such hospital facilities.

(F) “Costs of hospital facilities” means the costs of acquiring hospital facilities or interests in hospital facilities, including membership interests in nonprofit hospital agencies, costs of constructing hospital facilities, costs of improving one or more hospital facilities, including reconstructing, rehabilitating, remodeling, renovating, and enlarging, costs of equipping and
furnishing such facilities, and all financing costs pertaining thereto, including, without limitation thereto, costs of engineering, architectural, and other professional services, designs, plans, specifications and surveys, and estimates of cost, costs of tests and inspections, the costs of any indemnity or surety bonds and premiums on insurance, all related direct or allocable administrative expenses pertaining thereto, fees and expenses of trustees, depositories, and paying agents for the obligations, cost of issuance of the obligations and financing charges and fees and expenses of financial advisors, attorneys, accountants, consultants and rating services in connection therewith, capitalized interest on the obligations, amounts necessary to establish reserves as required by the bond proceedings, the reimbursement of all moneys advanced or applied by the hospital agency or others or borrowed from others for the payment of any item or items of costs of such facilities, and all other expenses necessary or incident to planning or determining feasibility or practicability with respect to such facilities, and such other expenses as may be necessary or incident to the acquisition, construction, reconstruction, rehabilitation, remodeling, renovation, enlargement, improvement, equipment, and furnishing of such facilities, the financing thereof, and the placing of the same in use and operation, including any one, part of, or combination of such classes of costs and expenses, and means the costs of refinancing obligations issued by, or reimbursement of money advanced by, nonprofit hospital agencies or others the proceeds of which were used for the payment of costs of hospital facilities, if the governing body of the public hospital agency determines that the refinancing or reimbursement advances the purposes of this chapter, whether or not the refinancing or reimbursement is in conjunction with the acquisition or construction of additional hospital facilities.

(G) “Hospital receipts” means all moneys received by or on behalf of a hospital agency from or in connection with the ownership, operation, acquisition, construction, improvement, equipping, or financing of any hospital facilities, including, without limitation thereto, any rentals and other moneys received from the lease, sale, or other disposition of hospital facilities, and any gifts, grants, interest subsidies, or other moneys received under any federal program for assistance in financing the costs of hospital facilities, and any other gifts, grants, and donations, and receipts therefrom, available for financing the costs of hospital facilities.

(H) “Obligations” means bonds, notes, or other evidences of indebtedness or obligation, including interest coupons pertaining thereto, issued or issuable by a public hospital agency to pay costs of hospital facilities.

(I) “Bond service charges” means principal, interest, and call premium, if any, required to be paid on obligations.

(J) “Bond proceedings” means one or more ordinances, resolutions, trust agreements, indentures, and other agreements or documents, and amendments and supplements to the foregoing, or any combination thereof, authorizing or providing for the terms, including any variable interest rates, and conditions applicable to, or providing for the security of, obligations and the provisions contained in such obligations.

(K) “Nursing home” has the same meaning as in division (A)(1) of section 5701.13 of the Revised Code.

(L) “Residential care facility” has the same meaning as in division (A)(2) of section 5701.13 of the Revised Code.

(M) “Independent living facility” means any self-care facility or other housing facility designed or used as a residence for elderly persons. An “independent living facility” does not include a residential facility, or that part of a residential facility, that is any of the following:

(1) A hospital required to be certified by section 3727.02 of the Revised Code;

(2) A nursing home or residential care facility;

(3) A facility operated by a hospice care program licensed under section 3712.04 of the Revised Code and used for the program’s hospice patients;

(4) A residential facility licensed by the department of mental health and addiction services under section 5119.34 of the Revised Code that provides accommodations,
supervision, and personal care services for three to sixteen unrelated adults;

(5) A residential facility licensed by the department of mental health and addiction services under section 5119.34 of the Revised Code that is not a residential facility described in division (M)(4) of this section;

(6) A facility licensed to provide methadone treatment under section 5119.391 of the Revised Code;

(7) A community addiction services provider, as defined in section 5119.01 of the Revised Code;

(8) A residential facility licensed under section 5123.19 of the Revised Code or a facility providing services under a contract with the department of developmental disabilities under section 5123.18 of the Revised Code;

(9) A residential facility used as part of a hospital to provide housing for staff of the hospital or students pursuing a course of study at the hospital.

140.02 Cooperation of Hospital Agencies.

The authorizations granted in this chapter, as well as those granted under sections 3702.51 to 3702.62 of the Revised Code, are granted for the public purpose of better providing for the health and welfare of the people of the state by enhancing the availability, efficiency, and economy of hospital facilities and the services rendered thereby, by providing for cooperation of hospital agencies in the utilization of shared facilities and services to obtain economies in operation and more effective health service, facilitating participation of hospital agencies in federal financial assistance provided by Title IV of the "Public Health Service Act," 60 Stat. 1041 (1946), 42 U.S.C. 291, as amended, and by other federal programs for assistance in meeting the costs of hospital facilities or the financing thereof, providing efficient operation of hospital facilities through leasing to hospital agencies and facilitating the financing of hospital facilities to be available to or for the service of the general public without discrimination by reason of race, creed, color, or national origin, provided that nothing in this chapter shall be construed to authorize anything prohibited by section 4723.44, 4731.41, 4731.43, 4731.60, or 4755.48 of the Revised Code.

140.03 Facility agreements between hospitals; powers of hospital agencies; funds.

(A) Two or more hospital agencies may enter into agreements for the acquisition, construction, reconstruction, rehabilitation, remodeling, renovating, enlarging, equipping, and furnishing of hospital facilities, or the management, operation, occupancy, use, maintenance, and repair of hospital facilities, or for participation in programs, projects, activities, and services useful to, connected with, supplementing, or otherwise related to the services provided by, or the operation of, hospital facilities operated by one or more participating hospital agencies, including any combination of such purposes, all in such manner as to promote the public purpose stated in section 140.02 of the Revised Code. A city health district; general health district; board of alcohol, drug addiction, and mental health services; county board of developmental disabilities; the department of mental health and addiction services; the department of developmental disabilities; or any public body engaged in the education or training of health professions personnel may join in any such agreement for purposes related to its authority under laws applicable to it, and as such a participant shall be considered a public hospital agency or hospital agency for the purposes of this section.

(B) An agreement entered into under authority of this section shall, where appropriate, provide for:

(1) The manner in which the title to the hospital facilities, including the sites and interest in real estate pertaining thereto, is to be held, transferred, or disposed of;
(2) Unless provided for by lease pursuant to section 140.05 of the Revised Code, the method by which such hospital facilities are to be acquired, constructed, or otherwise improved and by which they shall be managed, occupied, maintained, and repaired, including the designation of one of the hospital agencies to have charge of the details of acquisition, construction, or improvement pursuant to the contracting procedures prescribed under the law applicable to one of the participating public hospital agencies;

(3) The management or administration of any such programs, projects, activities, or services, which may include management or administration by one of said hospital agencies or a board or agency thereof;

(4) Annual, or more frequent, reports to the participating hospital agencies as to the revenues and receipts pertaining to the subject of the agreement, the expenditures thereof, the status and application of other funds contributed under such agreement, and such other matters as may be specified by or pursuant to such agreement;

(5) The manner of apportionment or sharing of costs of hospital facilities, any other applicable costs of management, operation, maintenance, and repair of hospital facilities, and costs for the programs, projects, activities, and services forming the subject of the agreement, which apportionment or sharing may be prescribed in fixed amounts, or determined by ratios, formulas, or otherwise, and paid as service charges, rentals, or in such other manner as provided in the agreement, and may include amounts sufficient to meet the bond service charges and other payments and deposits required under the bond proceedings for obligations issued to pay costs of hospital facilities. A hospital agency may commit itself to make such payments at least for so long as any such obligations are outstanding. In the apportionment, different classes of costs or expenses may be apportioned to one or more, all or less than all, of the participating hospital agencies as determined under such agreement.

(C) An agreement entered into under authority of this section may provide for:

(1) An orderly process for making determinations or advising as to planning, execution, implementation, and operation, which may include designating one of the hospital agencies, or a board thereof, for any of such purposes, provisions for a committee, board, or commission, and for representation thereon, or as may otherwise be provided;

(2) Securing necessary personnel, including participation of personnel from the respective hospital agencies;

(3) Standards or conditions for the admission or participation of patients and physicians;

(4) Conditions for admittance of other hospital agencies to participation under the agreement;

(5) Fixing or establishing the method of determining charges to be made for particular services;

(6) The manner of amending, supplementing, terminating, or withdrawal or removal of any party from, the agreement, and the term of the agreement, or an indefinite term;

(7) Designation of the applicants for or recipients of any federal, state, or other aid, assistance, or loans available by reason of any activities conducted under the agreement;

(8) Designation of one or more of the participating hospital agencies to maintain, prepare, and submit, on behalf of all parties to the agreement, any or all records and reports with regard to the activities conducted under the agreement;

(9) Any incidental use of the hospital facilities, or services thereof, by participating public hospital agencies for any of their lawful purposes, which incidental use does not impair the character of the facilities as hospital facilities for any purpose of this chapter;

(10) Such other matters as the parties thereto may agree upon for the purposes of division (A) of this section.

(D) For the purpose of paying or contributing its share under an agreement made under this section, a public hospital agency may:
(1) Expend any moneys from its general fund, and from any other funds not otherwise restricted by law, but including funds for permanent improvements of hospital facilities of such public hospital agency where the contribution is to be made toward the costs of hospital facilities under the agreement, and including funds derived from levies for, or receipts available for, operating expenses of hospital facilities or services of such public hospital agency where the contribution or payment is to be made toward operating expenses of the hospital facilities or services under the agreement or for the services provided thereby;

(2) Issue obligations under Chapter 133 or section 140.06, 339.14, 339.15, 513.12, or 3345.12 of the Revised Code, or Section 3 of Article XVIII, Ohio Constitution, if applicable to such public hospital agency, to pay costs of hospital facilities, or issue obligations under any other provision of law authorizing such public hospital agency to issue obligations for any costs of hospital facilities;

(3) Levy taxes under Chapter 5705 or section 513.13 or 3709.29 of the Revised Code, if applicable to such public hospital agency, provided that the purpose of such levy may include the provision of funds for either or both permanent improvements and current expenses if required for the contribution or payment of such hospital agency under such agreement, and each such public hospital agency may issue notes in anticipation of any such levy, pursuant to the procedures provided in section 5705.191 of the Revised Code if the levy is solely for current expenses, and in section 5705.193 of the Revised Code if the levy is all or in part for permanent improvements;

(4) Contribute real and personal property or interest therein without necessity for competitive bidding or public auction on disposition of such property.

(E) Any funds provided by public hospital agencies that are parties to an agreement entered into under this section shall be transferred to and placed in a separate fund or funds of such participating public hospital agency as is designated under the agreement. The funds shall be applied for the purposes provided in such agreement and are subject to audit. Pursuant to any determinations to be made under such agreement, the funds shall be deposited, invested, and disbursed under the provisions of law applicable to the public hospital agency in whose custody the funds are held. This division is subject to the provisions of any applicable bond proceedings under section 133.08, 140.06, 339.15, or 3345.12 of the Revised Code or Section 3 of Article XVIII, Ohio Constitution. The records and reports of such public hospital agency under Chapter 117 of the Revised Code and sections 3702.51 to 3702.62 of the Revised Code, with respect to the funds shall be sufficient without necessity for reports thereon by the other public hospital agencies participating under such agreement.

(F)(1) Prior to its entry into any such agreement, the public hospital agency must determine, and set forth in a resolution or ordinance, that the contribution to be made by it under such agreement will be fair consideration for value and benefit to be derived by it under such agreement and that the agreement will promote the public purpose stated in section 140.02 of the Revised Code.

(2) If the agreement is with a board of county commissioners, board of county hospital trustees, or county hospital commission and is an initial agreement for the acquisition or operation of a county hospital operated by a board of county hospital trustees under section 339.06 of the Revised Code, the governing body of the public hospital agency shall submit the agreement, accompanied by the resolution or ordinance, to the board of county commissioners for review pursuant to section 339.091 of the Revised Code. The agreement may be entered into only if the board of county commissioners adopts a resolution under that section. The requirements of division (F)(2) of this section do not apply to the agreement if one or more hospitals classified as general hospitals by the director of health under section 3701.07 of the Revised Code are operating in the same county as the county hospital.
140.04 Nursing care agreements with hospital agencies.

A public hospital agency may enter into agreements with other hospital agencies, or with homes providing skilled nursing care which are licensed as nursing homes under Chapter 3721 of the Revised Code, to provide or arrange for extended care services to patients of a hospital of such public hospital agency when such services are medically appropriate for them. Such agreements may require such extended care services to be provided under the supervision of the professional staff of the hospital of such public hospital agency or, where such facility in which the extended care is to be provided has an organized medical staff, for transfer arrangements with the hospital of such public hospital agency, or may make other arrangements to assure adequate extended care services for such patients.

140.05 Leasing hospital agency facilities to others.

(A)(1) A public hospital agency may lease any hospital facility to one or more hospital agencies for use as a hospital facility, or to one or more city or general health districts; boards of alcohol, drug addiction, and mental health services; county boards of developmental disabilities; the department of mental health and addiction services; or the department of developmental disabilities, for uses which they are authorized to make thereof under the laws applicable to them, or any combination of them, and they may lease such facilities to or from a hospital agency for such uses, upon such terms and conditions as are agreed upon by the parties. Such lease may be for a term of fifty years or less and may provide for an option of the lessee to renew for a term of fifty years or less, as therein set forth. Prior to entering into such lease, the governing body of any public hospital agency granting such lease must determine, and set forth in a resolution or ordinance, that such lease will promote the public purpose stated in section 140.02 of the Revised Code and that the lessor public hospital agency will be duly benefited thereby.

(2) If the lease is with a board of county commissioners, board of county hospital trustees, or county hospital commission and is an agreement for the initial lease of a county hospital operated by a board of county hospital trustees under section 339.06 of the Revised Code, the governing body of the public hospital agency shall submit the agreement, accompanied by the resolution or ordinance, to the board of county commissioners for review pursuant to section 339.091 of the Revised Code. The agreement may be entered into only if the board of county commissioners adopts a resolution under that section. The requirements of division (A)(2) of this section do not apply to the lease if one or more hospitals classified as general hospitals by the director of health under section 3701.07 of the Revised Code are operating in the same county as the county hospital.

(B) Any lease entered into pursuant to this section shall provide that in the event that the lessee fails faithfully and efficiently to administer, maintain, and operate such leased facilities as hospital facilities, or fails to provide the services thereof without regard to race, creed, color, or national origin, or fails to require that any hospital agency using such facilities or the services thereof shall not discriminate by reason of race, creed, color, or national origin, after an opportunity to be heard upon written charges, said lease may be terminated at the time, in the manner and with consequences therein provided. If any such lease does not contain terms to the effect provided in this division, it shall nevertheless be deemed to contain such terms which shall be implemented as determined by the governing body of the lessor.

(C) Such lease may provide for rentals commencing at any time agreed upon, or advance rental, and continuing for such period therein provided, notwithstanding and without diminution, rebate, or setoff by reason of time of availability of the hospital facility for use, delays in construction, failure of completion, damage or destruction of the hospital facilities, or for any other reason.
(D) Such lease may provide for the sale or transfer of title of the leased facilities pursuant to an option to purchase, lease-purchase, or installment purchase upon terms therein provided or to be determined as therein provided, which may include provision for the continued use thereof as a hospital facility for some reasonable period, taking into account efficient useful life and other factors, as is provided therein.

(E) Such lease may be entered as part of or in connection with an agreement pursuant to section 140.03 of the Revised Code. Any hospital facilities which are the subject of an agreement entered into under section 140.03 of the Revised Code may be leased pursuant to this section.

(F) If land acquired by a public hospital agency for a hospital facility is adjacent to an existing hospital facility owned by another hospital agency, the public hospital agency may, in connection with such acquisition or the leasing of such land and hospital facilities thereon to one or more hospital agencies, enter into an agreement with the hospital agency which owns such adjacent hospital facility for the use of common walls in the construction, operation, or maintenance of hospital facilities of the public hospital agency. For the purpose of construction, operation, or maintenance of hospital facilities, a public hospital agency may acquire by purchase, gift, lease, lease with option to purchase, lease-purchase, or installment purchase, easement deed, or other agreement, real estate and interests in real estate, including rights to use space over, under or upon real property owned by others, and support, access, common wall, and other rights in connection therewith. Any public hospital agency or other political subdivision or any public agency, board, commission, institution, body, or instrumentality may grant such real estate, interests, or rights to any hospital agency upon such terms as are agreed upon without necessity for competitive bidding or public auction.

140.051 Lease to nonprofit hospital agency; facilities not exempt from regulations.

If the costs of the hospital facilities are to be paid with funds derived from revenue obligations issued pursuant to section 140.06 of the Revised Code and with other funds derived from the nonprofit hospital agency, a public hospital agency, pursuant to negotiation and in the manner determined in its sole discretion by the governing body of the public hospital agency, may enter into a contract for the acquisition, construction, improvement, equipment, or furnishing of a hospital facility that is to be leased pursuant to section 140.05 of the Revised Code by a public hospital agency to a nonprofit hospital agency. Any requirement of competitive bidding, other restriction, or other procedures that are imposed on a public hospital agency with respect to contracts is not applicable to any contract entered into pursuant to this section.

A hospital facility is not exempt from applicable zoning, planning, and building regulations by reason of being financed from the proceeds of obligations issued pursuant to this chapter.

140.06 Revenue obligations.

(A) A public hospital agency may issue revenue obligations as provided in this section to pay the costs of hospital facilities. Such revenue obligations shall be authorized by resolution or ordinance of the governing body of the public hospital agency.

(B) Revenue obligations may be secured by a pledge of and lien on all or such part of the hospital receipts of the public hospital agency as provided in the bond proceedings, subject to any pledge of such hospital receipts previously made to the contrary and any existing restrictions on the use thereof. Such obligations may be additionally secured by covenants of the public hospital agency to make, fix, adjust, collect, and apply such charges, rates, fees, rentals, and other items of hospital receipts as will produce pledged hospital receipts sufficient to meet bond service charges, reserve, and other requirements provided for in the bond.
(C) Such revenue obligations shall not be general obligations, debt, or bonded indebtedness of any public hospital agency. The holders or owners of the obligations shall not be given the right, and have no right, to have excises or taxes levied by a public hospital agency for the payment of bond service charges thereon, and each such obligation shall bear on its face a statement to that effect and to the effect that the right to such payment is limited to the hospital receipts and special funds pledged to such purpose under the bond proceedings.

(D) The bond proceedings for such obligations shall provide for the purpose thereof, the principal amount, the principal maturity or maturities, the interest rate or rates, the date of the obligations and the dates of payment of interest thereon, their denominations, the manner of sale thereof, and the establishment within or without the state of a place or places of payment of bond service charges on such obligations. The bond proceedings shall also provide for a pledge of and lien on hospital receipts of the public hospital agency as provided in division (B) of this section, and a pledge of and lien on such fund or funds provided in the bond proceedings arising from hospital receipts, which pledges and liens may provide for parity with obligations theretofore or thereafter issued by the hospital agency. The hospital receipts so pledged and thereafter received by the public hospital agency and the funds so pledged are immediately subject to the lien of such pledge without any physical delivery thereof or further act, and the lien of any such pledge is valid and binding against all parties having claims of any kind against the hospital agency, irrespective of whether such parties have notice thereof, and create a perfected security interest for all purposes of Chapter 1309 of the Revised Code, without the necessity for separation or delivery of funds or for the filing or recording of the bond proceedings by which such pledge is created or any certificate, statement or other document with respect thereto. The pledge of such available receipts and funds shall be effective and the money therefrom and thereof may be applied to the purposes for which pledged without necessity for any further act of appropriation.

(E) The bond proceedings may contain additional provisions as to:

(1) The acquisition, construction, reconstruction, equipment, furnishing, improvement, operation, leasing, alteration, enlargement, maintenance, insurance, and repair of hospital facilities, and the duties of the hospital agency with reference thereto;

(2) The terms of the obligations, including provisions for their redemption prior to maturity at the option of the hospital agency at such price or prices and under such terms and conditions as are provided in the bond proceedings;

(3) Limitations on the purposes to which the proceeds of the obligations may be applied;

(4) The rates or rentals or other charges for the use of or right to use the facilities financed by the obligations, or other properties the revenues or receipts from which are pledged to the obligations, and regulations for assuring use and occupancy thereof, including limitations upon the right to modify such rates, rentals, other charges, or regulations;

(5) The use and expenditure of the pledged hospital receipts in such manner and to such extent as shall be determined;

(6) Limitations on the issuance of additional obligations;

(7) The terms of any trust agreement or indenture securing the obligations or under which the same may be issued;

(8) The deposit, investment, and application of funds, and the safeguarding of funds on hand or on deposit without regard to Chapter 131 or 135 of the Revised Code, and any bank or trust company which acts as depository of any moneys under the bond proceedings shall furnish such indemnifying bonds or shall pledge or hypothecate such securities as required by the bond proceedings or otherwise by the hospital agency;

(9) The binding effect of any or every provision of the bond proceedings upon such officer, board, commission, authority, agency, department, or other person or body as may from time to time have the authority under law to take such actions as may be necessary to perform
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all or any part of the duty required by such provision;
(10) Any provision which may be made in a trust agreement or indenture under division (I) of this section;
(11) Any other or additional agreements with respect to the hospital facilities of the hospital agency, their operation, the hospital receipts and funds pledged, and insurance of hospital facilities and of the hospital agency, its officers and employees.
(F) Such obligations may have the seal of the public hospital agency or a facsimile thereof affixed thereto or printed thereon and shall be executed by such officer or officers as are designated in the bond proceedings, which execution may be by facsimile signatures. Any obligations may be executed by an officer who, on the date of execution, is the proper officer although on the date of such obligations such person was not the proper officer. In case any officer whose signature or a facsimile of whose signature appears on any such obligations ceases to be such officer before delivery thereof, such signature or facsimile is valid and sufficient for all purposes as if he had remained such officer until such delivery; and in case the seal of the hospital agency has been changed after a facsimile of the seal has been imprinted on such obligations, such facsimile seal continues to be sufficient as to such obligations and obligations issued in substitution or exchange therefor.
(G) All such obligations are negotiable instruments and securities under Chapter 1308 of the Revised Code, subject to the provisions of the bond proceedings as to registration. The obligations may be issued in coupon or in registered form, or both. Provision may be made for the registration of any obligations with coupons attached thereto as to principal alone, for the registration of obligations as to both principal and interest and the exchange of coupon obligations for obligations so registered, and for the conversion or reconversion into obligations with coupons attached thereto of any obligations registered as to both principal and interest, and for reasonable charges for such registration, exchange, conversion, and reconversion.
(H) Pending preparation of definitive obligations, the public hospital agency may issue interim receipts or certificates which shall be exchanged for such definitive obligations.
(I) Such obligations may be secured additionally by a trust agreement or indenture between the public hospital agency and a corporate trustee which may be any trust company or bank having the powers of a trust company within or without this state but authorized to exercise trust powers within this state. Any such agreement or indenture may contain, as part thereof, any of the bond proceedings, and may contain any provisions that may be included in the bond proceedings as authorized by this section, and other provisions which are customary or appropriate in an agreement or indenture of such type, including but not limited to:
(1) The maintenance of each pledge, trust agreement, indenture and mortgage, or other instrument comprising part of the bond proceedings until the hospital agency has fully paid the bond service charges on the obligations secured thereby, or provision therefor has been made;
(2) In the event of default in any payments required to be made by the bond proceedings, or any other agreement of the hospital agency made as a part of the contract under which the obligations were issued, enforcement of such payments or agreement by mandamus, the appointment of a receiver, foreclosure, or any other legal remedy;
(3) The rights and remedies of the holders of obligations and of the trustee, and provisions for protecting and enforcing them, including limitations on rights of individual holders of obligations;
(4) The replacement of any obligations which become mutilated or are destroyed, lost, or stolen;
(5) Such other provisions as the trustee and the hospital agency agree upon, including limitations, conditions, or qualifications relating to any of the foregoing.
(J) Each duty of the public hospital agency and its officers or employees, undertaken pursuant to the bond proceedings or any agreement or lease made under authority of this chapter, is hereby established as a duty of such hospital agency, and of each such officer or
employee having authority to perform such duty, specially enjoined by law resulting from an office, trust, or station within the meaning of section 2731.01 of the Revised Code. The persons who are at the time the members of the governing body of the public hospital agency or its officers or employees shall not be liable in their personal capacities on such obligations, bond proceedings, lease, or other agreement of the public hospital agency.

(K) The authority to issue such obligations includes authority to issue obligations in the form of bond anticipation notes and to renew the same from time to time by the issuance of new notes. Such notes are payable solely from the hospital receipts and funds that may be pledged to the payment of such bonds, or from the proceeds of such bonds or renewal notes, or both, as the public hospital agency provides in its resolution or ordinance authorizing such notes. Such notes may be additionally secured by covenants of the hospital agency to the effect that it will do such or all things necessary for the issuance of such bonds or renewal notes in appropriate amount, and either exchange such bonds or renewal notes therefor or apply the proceeds thereof to the extent necessary, to make full payment of the principal of and interest on such notes at the time or times contemplated as provided in such resolution or ordinance. Subject to this division, all references to obligations in this section are applicable to such anticipation notes.

(L) The authority to issue such obligations includes authority to issue revenue obligations to refund, including funding and retirement of, obligations previously issued to pay costs of hospital facilities whether issued under authority of this section or other law authorizing their issuance. Such refunding obligations may be issued in amounts sufficient for payment of the principal amount of the obligations to be so refunded, any redemption premiums thereon, principal maturities of any obligations maturing prior to the redemption of the obligations to be so refunded, interest accrued or to accrue to the maturity date or dates of redemption of such obligations, and any expenses incurred or to be incurred in connection with such refunding or the issuance of the obligations.

(M) Nothing in this section is intended to limit or restrict the authority of municipal corporations to issue, under authority of Section 3 of Article XVIII, Ohio Constitution, and without regard to this section, revenue bonds and notes to pay costs of hospital facilities.

140.07 Lawful investments.

Obligations issued under section 133.08, 140.06, or 339.15 of the Revised Code or Section 3 of Article XVIII, Ohio Constitution, to pay costs of hospital facilities or to refund such obligations are lawful investments for entities enumerated in division (A)(1) of section 133.03 of the Revised Code, and are eligible as security for the repayment of the deposit of public moneys.

140.08 Tax exempt.

(A) Except as otherwise provided in divisions (B)(1) and (2) of this section, all hospital facilities purchased, acquired, constructed, or owned by a public hospital agency, or financed in whole or in part by obligations issued by a public hospital agency, and used, or to be used when completed, as hospital facilities, and the income therefrom, are exempt from all taxation within this state, including ad valorem and excise taxes, notwithstanding any other provisions of law, and hospital agencies are exempt from taxes levied under Chapters 5739 and 5741 of the Revised Code. The obligations issued hereafter under section 133.08, 140.06, or 339.15 of the Revised Code or Section 3 of Article XVIII, Ohio Constitution, to pay costs of hospital facilities or to refund such obligations, and the transfer thereof, and the interest and other income from such obligations, including any profit made on the sale thereof, is free from taxation within the state.

(B)(1) Division (A) of this section does not exempt independent living facilities from taxes
levied on property or taxes levied under Chapters 5739 and 5741 of the Revised Code. If an independent living facility or part of such facility becomes on or after January 10, 1991, a nursing home, residential care facility, or residential facility described in division (M)(4) of section 140.01 of the Revised Code, that part of the independent living facility that is a nursing home, residential care facility, or residential facility described in division (M)(4) of section 140.01 of the Revised Code is exempt from taxation subject to division (B)(2) of this section on and after the date it becomes a nursing home, residential care facility, or residential facility described in division (M)(4) of section 140.01 of the Revised Code.

(2) Division (A) of this section exempts nursing homes, residential care facilities, and residential facilities described in division (M)(4) of section 140.01 of the Revised Code from taxes levied on property and taxes levied under Chapters 5739 and 5741 of the Revised Code only until all obligations issued to finance such homes or facilities, or all refunding or series of refundings of those obligations, are redeemed or otherwise retired.

140.09 Computation of debt; exclusions.

(A) If obligations, otherwise subject to the limits of section 133.05 or 133.07 of the Revised Code, are issued by a public hospital agency to pay costs of a hospital facility with respect to which such public hospital agency is to receive payments under a lease or agreement entered into by such public hospital agency pursuant to section 140.03, 140.05, 339.09, 339.14, or 749.35 of the Revised Code, then at all times after the time of entering such lease or agreement such bonds or notes shall not be considered in ascertaining the limits of net indebtedness of section 133.05 or 133.07 of the Revised Code, to the extent that the prescribed amounts of such payments to be made, together with any other hospital receipts of such public hospital agency, will cover the interest charges and provide for the retirement of such bonds as they become due, after deducting from such payments only such amounts, if any, as such hospital agency is required to pay for the operating expenses of such hospital facilities under such agreement or lease. The exclusion provided by this section is in addition to any other exemption or exclusion otherwise provided by law, and not in derogation thereof.

(B) An agreement by a public hospital agency to make payments beyond the current fiscal year under any such lease or agreement referred to in division (A) of this section, shall be a continuing contract for the purposes of sections 5705.41 and 5705.44 of the Revised Code, if such section 5705.41 is applicable to the public hospital agency, and such agreement, and the obligation to make payments thereunder, will not constitute indebtedness, bonded or otherwise, of such public hospital agency for purposes of Chapter 133 of the Revised Code or the Ohio Constitution.

Professional Associations

1785.01 Professional Associations; definitions.

As used in this chapter:

(A) “Professional service” means any type of professional service that may be performed only pursuant to a license, certificate, or other legal authorization issued pursuant to Chapter 4701., 4703., 4705., 4715., 4723., 4725., 4729., 4730., 4731., 4732., 4733., 4734., 4741., 4755., or 4757 of the Revised Code to certified public accountants, licensed public accountants, architects, attorneys, dentists, nurses, optometrists, pharmacists, physician assistants, doctors of medicine and surgery, doctors of osteopathic medicine and surgery, doctors of podiatric medicine and surgery, practitioners of the limited branches of medicine specified in section 4731.15 of the Revised Code, mechanotherapists, psychologists, professional engineers, chiropractors, chiropractors practicing acupuncture through the state chiropractic board,
veterinarians, physical therapists, occupational therapists, licensed professional clinical counselors, licensed professional counselors, independent social workers, social workers, independent marriage and family therapists, and marriage and family therapists.

(B) “Professional association” means an association organized under this chapter for the sole purpose of rendering one of the professional services authorized under Chapter 4701., 4703., 4705., 4715., 4723., 4725., 4729., 4730., 4731., 4732., 4733., 4734., 4741., 4755., or 4757 of the Revised Code, a combination of the professional services authorized under Chapters 4703 and 4733 of the Revised Code, or a combination of the professional services of optometrists authorized under Chapter 4725 of the Revised Code, chiropractors authorized under Chapter 4734 of the Revised Code to practice chiropractic or acupuncture, psychologists authorized under Chapter 4732 of the Revised Code, registered or licensed practical nurses authorized under Chapter 4723 of the Revised Code, pharmacists authorized under Chapter 4729 of the Revised Code, physical therapists authorized under sections 4755.40 to 4755.56 of the Revised Code, occupational therapists authorized under sections 4755.04 to 4755.13 of the Revised Code, mechanotherapists authorized under section 4731.151 of the Revised Code, doctors of medicine and surgery, osteopathic medicine and surgery, or podiatric medicine and surgery authorized under Chapter 4731 of the Revised Code, and licensed professional clinical counselors, licensed professional counselors, independent social workers, social workers, independent marriage and family therapists, or marriage and family therapists authorized under Chapter 4757 of the Revised Code.

1785.02 Professional individuals and groups; who may incorporate.

An individual or group of individuals each of whom is licensed, certificated, or otherwise legally authorized to render within this state the same kind of professional service, a group of individuals each of whom is licensed, certificated, or otherwise legally authorized to render within this state the professional service authorized under Chapter 4703 or 4733 of the Revised Code, or a group of individuals each of whom is licensed, certificated, or otherwise legally authorized to render within this state the professional service authorized under Chapter 4725 of the Revised Code, chiropractors authorized under Chapter 4734 of the Revised Code to practice chiropractic or acupuncture, psychologists authorized under Chapter 4732 of the Revised Code, physical therapists authorized under sections 4755.40 to 4755.56 of the Revised Code, occupational therapists authorized under sections 4755.04 to 4755.13 of the Revised Code, mechanotherapists authorized under section 4731.151 of the Revised Code, doctors of medicine and surgery, osteopathic medicine and surgery, or podiatric medicine and surgery authorized under Chapter 4731 of the Revised Code, registered or licensed practical nurses authorized under Chapter 4723 of the Revised Code, pharmacists authorized under Chapter 4729 of the Revised Code, physical therapists authorized under sections 4755.40 to 4755.56 of the Revised Code, occupational therapists authorized under sections 4755.04 to 4755.13 of the Revised Code, mechanotherapists authorized under section 4731.151 of the Revised Code, doctors of medicine and surgery, osteopathic medicine and surgery, or podiatric medicine and surgery authorized under Chapter 4731 of the Revised Code, or licensed professional clinical counselors, licensed professional counselors, independent social workers, social workers, independent marriage and family therapists, or marriage and family therapists authorized under Chapter 4757 of the Revised Code may organize and become a shareholder or shareholders of a professional association. Any group of individuals described in this section who may be rendering one of the professional services as an organization created otherwise than pursuant to this chapter may incorporate under and pursuant to this chapter by amending the agreement establishing the organization in a manner that the agreement as amended constitutes articles of incorporation prepared and filed in the manner prescribed in section 1785.08 of the Revised Code and by otherwise complying with the applicable requirements of this chapter.
1785.03 Prohibiting control of individual practitioner’s clinical judgment.

A professional association may render a particular professional service only through officers, employees, and agents who are themselves duly licensed, certificated, or otherwise legally authorized to render the professional service within this state. As used in this section, “employee” does not include clerks, bookkeepers, technicians, or other individuals who are not usually and ordinarily considered by custom and practice to be rendering a particular professional service for which a license, certificate, or other legal authorization is required and does not include any other person who performs all of that person’s employment under the direct supervision and control of an officer, agent, or employee who renders a particular professional service to the public on behalf of the professional association.

No professional association formed for the purpose of providing a combination of the professional services, as defined in section 1785.01 of the Revised Code, of optometrists authorized under Chapter 4725 of the Revised Code, chiropractors authorized under Chapter 4734 of the Revised Code to practice chiropractic or acupuncture, psychologists authorized under Chapter 4732 of the Revised Code, registered or licensed practical nurses authorized under Chapter 4723 of the Revised Code, pharmacists authorized under Chapter 4729 of the Revised Code, physical therapists authorized under sections 4755.40 to 4755.56 of the Revised Code, occupational therapists authorized under sections 4755.04 to 4755.13 of the Revised Code, mechanotherapists authorized under section 4731.151 of the Revised Code, doctors of medicine and surgery, osteopathic medicine and surgery, or podiatric medicine and surgery authorized under Chapter 4731 of the Revised Code, and licensed professional clinical counselors, licensed professional counselors, independent social workers, social workers, independent marriage and family therapists, or marriage and family therapists authorized under Chapter 4757 of the Revised Code shall control the professional clinical judgment exercised within accepted and prevailing standards of practice of a licensed, certificated, or otherwise legally authorized optometrist, chiropractor, chiropractor practicing acupuncture through the state chiropractic board, psychologist, nurse, pharmacist, physical therapist, occupational therapist, mechanotherapist, doctor of medicine and surgery, osteopathic medicine and surgery, or podiatric medicine and surgery, licensed professional clinical counselor, licensed professional counselor, independent social worker, social worker, independent marriage and family therapist, or marriage and family therapist in rendering care, treatment, or professional advice to an individual patient.

This division does not prevent a hospital, as defined in section 3727.01 of the Revised Code, insurer, as defined in section 3999.36 of the Revised Code, or intermediary organization, as defined in section 1751.01 of the Revised Code, from entering into a contract with a professional association described in this division that includes a provision requiring utilization review, quality assurance, peer review, or other performance or quality standards. Those activities shall not be construed as controlling the professional clinical judgment of an individual practitioner listed in this division.

Department of Health Requirements and Powers

3701.01 Department of Health; definitions.

As used in sections 3701.01, 3701.04, 3701.08, 3701.09, and 3701.37 to 3701.45 of the Revised Code:
(B) "The surgeon general" means the surgeon general of the public health service of the United States or such other officer or employee of the United States responsible for
administration of the federal act.

(C) "Hospital" includes public health centers and general, mental, chronic disease, and other types of hospitals, and related facilities, such as laboratories, outpatient departments, nurses' home facilities, extended care facilities, self-care units, and central service facilities operated in connection with hospitals, and also includes education and training facilities for health professions personnel operated as an integral part of a hospital, but does not include any hospital furnishing primarily domiciliary care.

(D) "Public health center" means a publicly owned facility for the housing of the public health services of a community and one which makes available equipment to aid physicians in the prevention, diagnosis, and treatment of disease.

(E) "Nonprofit hospital," or "nonprofit" as applied to a facility, means any hospital or facility owned and operated by one or more nonprofit corporations or associations no part of the net earnings of which inures, or may lawfully inure, to the benefit of any private shareholder or individual.

(F) "Medical facilities" means outpatient facilities, rehabilitation facilities, and facilities for long-term care, including nursing homes, as those terms are defined in the federal act, and such other facilities for which federal aid may be authorized under the federal act.

3701.04 Ohio department of health authority to investigate; organize volunteers for emergencies.

(A) The director of health shall:

(1) Require reports and make inspections and investigations that the director considers necessary;

(2) Provide administration, appoint personnel, make reports, and take other action as necessary to comply with the requirements of the “Construction and Modernization of Hospitals and Other Medical Facilities Act,” Title VI of the “Public Health Service Act,” 60 Stat. 1041 (1946), 42 U.S.C. 291, as amended, and the regulations adopted under that act;

(3) Procure by contract the temporary or intermittent services of experts, consultants, or organizations when those services are to be performed on a part-time or fee-for-service basis and do not involve the performance of administrative duties;

(4) Enter into agreements for the utilization of the facilities and services of other departments, agencies, and institutions, public or private;

(5) On behalf of the state, solicit, accept, hold, administer, and deposit in the state treasury to the credit of the general operations fund created in section 3701.83 of the Revised Code, any grant, gift, devise, bequest, or contribution made to assist in meeting the cost of carrying out the director's responsibilities and expend the grant, gift, devise, bequest, or contribution for the purpose for which made. Fees collected by the director in connection with meetings and conferences shall also be credited to the fund and expended for the purposes for which paid.

(6) Make an annual report to the governor on activities and expenditures, including recommendations for such additional legislation as the director considers appropriate to furnish adequate hospital, clinic, and similar facilities to the people of this state.

(B) The director, in accordance with Chapter 119 of the Revised Code, shall adopt rules jointly with the executive director of the emergency management agency to do both of the following, as required by section 5502.281 of the Revised Code:

(1) Advise, assist, consult with, and cooperate with agencies and political subdivisions of this state to establish and maintain a statewide system for recruiting, registering, training, and deploying volunteers reasonably necessary to respond to an emergency declared by the state or a political subdivision;

(2) Establish fees, procedures, standards, and requirements necessary for recruiting,
registering, training, and deploying the volunteers.

(C) The director of health may enter into agreements to sell services offered by the department of health to boards of health of city and general health districts and to other departments, agencies, and institutions of this state, other states, or the United States. Fees collected by the director for the sale of services shall be deposited into the state treasury to the credit of the general operations fund created in section 3701.83 of the Revised Code.

3701.043 Evaluation for licensure, certification, or registration; fees.

If authorized by federal statute or regulation, the director of health may establish and collect fees for conducting the initial certification of any person or entity as a provider of health services for purposes of the medicare program established under Title XVIII of the Social Security Act, 49 Stat. 620 (1935), 42 U.S.C.A. 301, as amended. The fee established for conducting an initial medicare certification shall not exceed the actual and necessary costs incurred by the department of health in conducting the certification.

All fees collected under this section shall be deposited into the state treasury to the credit of the medicare initial certification fund, which is hereby created. Money credited to the fund shall be used solely to pay the costs of conducting initial medicare certifications.

3701.06 Director’s or director’s agent’s right of entry to investigate violations.

The director of health and any person the director authorizes may, without fee or hindrance, enter, examine, and survey all grounds, vehicles, apartments, buildings, and places in furtherance of any duty laid upon the director or department of health or where the director has reason to believe there exists a violation of any health law or rule.

3701.07 Rules for reports to health department; hospitals and dispensaries registration; residents’ rights advocates.

(A) The director of health shall adopt rules in accordance with Chapter 119 of the Revised Code defining and classifying hospitals and dispensaries and providing for the reporting of information by hospitals and dispensaries. Except as otherwise provided in the Revised Code, the rules providing for the reporting of information shall not require inclusion of any confidential patient data or any information concerning the financial condition, income, expenses, or net worth of the facilities. The rules may require the reporting of information in the following categories:

1. Information needed to identify and classify the institution;
2. Information on facilities and type and volume of services provided by the institution;
3. The number of beds listed by category of care provided;
4. The number of licensed or certified professional employees by classification;
5. The number of births that occurred at the institution the previous calendar year;
6. Any other information that the director considers relevant to the safety of patients served by the institution.

Every hospital and dispensary, public or private, annually shall register with and report to the department of health. Reports shall be submitted in the manner prescribed in rules adopted under this division.

(B) Every governmental entity or private nonprofit corporation or association whose employees or representatives are defined as residents’ rights advocates under divisions (E)(1) and (2) of section 3721.10 of the Revised Code shall register with the department of health on forms furnished by the director of health and shall provide such reasonable identifying information as the director may prescribe.
Chapter 1. General Hospital Provisions
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The department shall compile a list of the governmental entities, corporations, or associations registering under this division and shall update the list annually. Copies of the list shall be made available to nursing home administrators as defined in division (C) of section 3721.10 of the Revised Code.

3701.071 Records and registration for nonprofit shelter or health care facility.

(A) As used in this section:
(1) “Free clinic” means a nonprofit organization exempt from federal income taxation under section 501(c)(3) of the “Internal Revenue Code of 1986,”1 as amended, or a program component of a nonprofit organization, to which both of the following apply:
   (a) Its primary mission is to provide health care services for free or for a minimal administrative fee to individuals with limited resources.
   (b) It facilitates the delivery of health care services through the use of volunteer health care professionals and voluntary care networks.
(2) “Indigent and uninsured person” has the same meaning as in section 2305.234 of the Revised Code.
(3) “Nonprofit shelter or health care facility” means a charitable nonprofit corporation organized and operated pursuant to Chapter 1702 of the Revised Code, or any charitable organization not organized and not operated for profit, that provides shelter, health care services, or shelter and health care services to indigent and uninsured persons. “Nonprofit shelter or health care facility” includes any such shelter or facility that is operated as or includes a free clinic. “Nonprofit shelter or health care facility” does not include a hospital, as defined in section 3727.01 of the Revised Code, a facility licensed under Chapter 3721 of the Revised Code, or a medical facility that is operated for profit.

(B) A nonprofit shelter or health care facility operating in this state shall register on the first day of January each year with the department of health. The immunity provided by division (E) of section 2305.234 of the Revised Code is not available to a nonprofit shelter or health care facility until the shelter or facility registers with the department in accordance with this section.

(C) A nonprofit shelter or health care facility operating in this state shall keep records of all patients who receive medical, dental, or other health-related diagnosis, care, or treatment at the shelter or facility. The department of health shall monitor the quality of care provided to patients at nonprofit shelters or health care facilities. The monitoring program may be conducted by contracting with another entity or through any other method authorized by law. The department may solicit and accept funds from private sources to fund the monitoring program.

(D) A free clinic operating in this state shall compile information on medicaid eligibility and application requirements and procedures and display copies of that information in a prominent location for the benefit of persons who seek or receive services from the clinic.

3701.072 Free clinics awareness.

(A) As used in this section, “free clinic” has the same meaning as in section 3701.071 of the Revised Code.

(B) The department of health, on its internet web site, shall make information available regarding free clinics. The information shall include all of the following:
   (1) A description of what constitutes a free clinic;
   (2) The benefits that free clinics provide to the state’s health care system, including the services they make available to both patients and health care providers;
   (3) A directory of free clinics, including for each clinic its address and contact information and its hours of operation;
   (4) A notice each time that a new free clinic is opened.
(C) Each year, the department shall promote the designation under section 5.252 of the Revised Code of December as “Free Clinic Appreciation Month.” The promotion shall include the selection of a free clinic to be named as “free clinic of the year” and the selection of a physician, nurse, and dentist to be named as “free clinic volunteer of the year” in the respective professions.

In conducting its promotion activities, the department may consult with entities that have interests in the services provided by and the benefits of free clinics, including the Ohio association of free clinics.

3701.33 The Ohio Public Health Advisory Board.

(A) The Ohio public health advisory board shall review and make recommendations to the director of health on all of the following:

(1) Developing and adopting proposed rules under Chapters 3701 and 3717 of the Administrative Code;
(2) Prescribing proposed fees for services provided by the office of vital statistics and the bureau of environmental health;
(3) Any proposed policy changes that pertain to entities serving or seeking to serve as vendors under the WIC program, as defined in section 3701.132 of the Revised Code, that are not addressed pursuant to division (A)(1) of this section.
(4) Issues to improve public health and increase awareness of public health issues at the state level, local level, or both;
(5) Any other public health issues that the director requests the board to consider.

(B) For purposes of division (A)(1) of this section, all of the following apply:

(1) Prior to filing a proposed rule with the joint committee on agency rule review, the department of health shall provide each board member with a copy of the proposed rule, copies of public comments received by the department during the public comment period, and written evidence of stakeholder involvement.
(2) Prior to board meetings, copies of proposed rules shall be provided to members. On request of a member, the department shall ensure that appropriate department employees attend board meetings to answer questions concerning proposed rules.
(3)(a) Not later than sixty days after receiving a copy of a proposed rule, the board shall recommend approval or disapproval of the rule and submit its recommendation by board action to the director. In making its recommendation, the board may consider public comments provided to the department or the board.
(b) If the board fails to make a recommendation within sixty days of receiving a copy of the proposed rule, the director may file the proposed rule.
(4) Except as provided in division (B)(3)(b) of this section, the director shall consider the board's recommendation before filing a proposed rule. On request of the board, the director shall meet with the board to discuss the board's recommendation.
(5) If the director disagrees with the board's recommendation, the director shall inform the board in writing of the director's decision and the reason for the decision prior to the next quarterly meeting. The director or the director's designee may meet with the board at the next quarterly meeting to answer questions regarding why the director disagreed with the board's recommendation.
(6) To the extent the board believes that a proposed rule does not comply with requirements established by the joint committee on agency rule review or the common sense initiative office, nothing in this section prohibits the board, in carrying out its duties under division (A)(1) of this section, from contacting the joint committee on agency rule review or the common sense initiative office.

(C) For purposes of division (A)(2) of this section, the board and the department shall
develop a cost methodology, subject to approval by the director, regarding proposed fees for services provided by the department's bureau of environmental health.

(D) For purposes of division (A)(3) of this section, a proposed WIC program policy change shall be treated as if it were a proposed rule subject to division (A)(1) of this section and the board and other entities involved in reviewing and making recommendations regarding the change may follow all or part of the procedures described in division (B) of this section.

(E) This section does not apply to the following:

(1) A proposed rule that is to be refiled with the joint committee on agency rule review solely because of technical or other nonsubstantive revisions;
(2) The emergency adoption, amendment, or rescission of a rule under division (G) of section 119.03 of the Revised Code.

3701.34 The Ohio Public Health Advisory Board; duties.

(A) The Ohio public health advisory board shall review and make recommendations to the director of health on all of the following:

(1) Developing and adopting proposed rules under Chapters 3701 and 3717 of the Administrative Code;
(2) Prescribing proposed fees for services provided by the office of vital statistics and the bureau of environmental health;
(3) Issues to improve public health and increase awareness of public health issues at the state level, local level, or both;
(4) Any other public health issues that the director requests the board to consider.

(B) In making recommendations to the director under division (A)(1) of this section, all of the following apply:

(1) Prior to filing a proposed rule with the joint committee on agency rule review, the department of health shall provide each board member with a copy of the proposed rule, copies of public comments received by the department during the public comment period, and written evidence of stakeholder involvement.
(2) Prior to board meetings, copies of proposed rules shall be provided to members. On request of a member, the department shall ensure that appropriate department employees attend board meetings to answer questions concerning proposed rules.
(3)(a) Not later than sixty days after receiving a copy of a proposed rule, the board shall recommend approval or disapproval of the rule and submit its recommendation by board action to the director. In making its recommendation, the board may consider public comments provided to the department or the board.
(b) If the board fails to make a recommendation within sixty days of receiving a copy of the proposed rule, the director may file the proposed rule.
(4) Except as provided in division (B)(3)(b) of this section, the director shall consider the board's recommendation before filing a proposed rule. On request of the board, the director shall meet with the board to discuss the board's recommendation.
(5) If the director disagrees with the board's recommendation, the director shall inform the board in writing of the director's decision and the reason for the decision prior to the next quarterly meeting. The director or the director's designee may meet with the board at the next quarterly meeting to answer questions regarding why the director disagreed with the board's recommendation.

(C) To the extent the board believes that a proposed rule does not comply with requirements established by the joint committee on agency rule review or the common sense initiative office, nothing in this section prohibits the board, in carrying out its duties under division (A)(1) of this section, from contacting the joint committee on agency rule review or the common sense initiative office.
(D) In making recommendations under division (A)(2) of this section for prescribing proposed fees for services provided by the bureau of environmental health, the board and the department shall develop a cost methodology subject to approval by the director.

(E) This section does not apply to the following:

1. A proposed rule that is to be refiled with the joint committee on agency rule review solely because of technical or other nonsubstantive revisions;

2. The emergency adoption, amendment, or rescission of a rule under division (F) of section 119.03 of the Revised Code.

3701.71 Department of Health to set hospital minimum standards.

To comply with the Social Security Act Amendments of 1950, known as Public Law 734-81st Congress, the Ohio department of health is hereby designated as the state authority responsible for establishing and maintaining minimum standards for voluntary and governmental hospitals and in units providing medical and nursing care in city and county institutions.

3701.72 Rules and regulations to establish minimum standards.

Subject to the provisions of sections 119.01 to 119.13 inclusive, of the Revised Code, the Ohio department of health shall have the power to adopt reasonable rules and regulations to establish and maintain such minimum standards.

3701.73 Exceptions for institutions.

Sections 3701.71 and 3701.72 of the Revised Code shall not be applicable to institutions licensed or approved under other existing statutes.

3727.01 HMO, hospital, joint commission; definitions.

(A) As used in this section, “health maintenance organization” means a public or private organization organized under the law of any state that is qualified under section 1310(d) of Title XIII of the “Public Health Service Act,” 87 Stat. 931 (1973), 42 U.S.C. 300e-9, or that does all of the following:

1. Provides or otherwise makes available to enrolled participants health care services including at least the following basic health care services: usual physician services, hospitalization, laboratory, x-ray, emergency and preventive service, and out-of-area coverage;

2. Is compensated, except for copayments, for the provision of basic health care services to enrolled participants by a payment that is paid on a periodic basis without regard to the date the health care services are provided and that is fixed without regard to the frequency, extent, or kind of health service actually provided;

3. Provides physician services primarily in either of the following ways:

   a. Directly through physicians who are either employees or partners of the organization;

   b. Through arrangements with individual physicians or one or more groups of physicians organized on a group-practice or individual-practice basis.

(B) As used in this chapter:

1. “Children's hospital” means any of the following:

   a. A hospital registered under section 3701.07 of the Revised Code that provides general pediatric medical and surgical care, and in which at least seventy-five per cent of annual inpatient discharges for the preceding two calendar years were individuals less than eighteen years of age;

   b. A distinct portion of a hospital registered under section 3701.07 of the Revised Code
that provides general pediatric medical and surgical care, has a total of at least one hundred fifty registered pediatric special care and pediatric acute care beds, and in which at least seventy-five per cent of annual inpatient discharges for the preceding two calendar years were individuals less than eighteen years of age;
   (c) A distinct portion of a hospital, if the hospital is registered under section 3701.07 of the Revised Code as a children’s hospital and the children’s hospital meets all the requirements of division (B)(1)(a) of this section.

(2) “Hospital” means an institution classified as a hospital under section 3701.07 of the Revised Code in which are provided to inpatients diagnostic, medical, surgical, obstetrical, psychiatric, or rehabilitation care for a continuous period longer than twenty-four hours or a hospital operated by a health maintenance organization. “Hospital” does not include a facility licensed under Chapter 3721 of the Revised Code, a health care facility operated by the department of mental health and addiction services or the department of developmental disabilities, a health maintenance organization that does not operate a hospital, the office of any private licensed health care professional, whether organized for individual or group practice, or a clinic that provides ambulatory patient services and where patients are not regularly admitted as inpatients. “Hospital” also does not include an institution for the sick that is operated exclusively for patients who use spiritual means for healing and for whom the acceptance of medical care is inconsistent with their religious beliefs, accredited by a national accrediting organization, exempt from federal income taxation under section 501 of the Internal Revenue Code of 1986,1 100 Stat. 2085, 26 U.S.C.A. 1, as amended, and providing twenty-four hour nursing care pursuant to the exemption in division (E) of section 4723.32 of the Revised Code from the licensing requirements of Chapter 4723 of the Revised Code.

(3) “Joint commission” means the commission formerly known as the joint commission on accreditation of healthcare organizations or the joint commission on accreditation of hospitals.

3727.02 Required certification or accreditation to operate hospital.

(A) No person and no political subdivision, agency, or instrumentality of this state shall operate a hospital unless it is certified under Title XVIII of the “Social Security Act,” 49 Stat. 620 (1935), 42 U.S.C. 301, as amended, or is accredited by a national accrediting organization approved by the centers for medicare and medicaid services.

(B) No person and no political subdivision, agency, or instrumentality of this state shall hold out as a hospital any health facility that is not certified or accredited as required in division (A) of this section.

3727.03 Proof of certification or accreditation to Department of Health.

The director of health shall adopt, and may amend or rescind, rules in accordance with Chapter 119 of the Revised Code establishing procedures under which hospitals shall provide the department of health in a timely fashion with proof of the certification or accreditation required by division (A) of section 3727.02 of the Revised Code and under which the department shall institute proceedings to close a hospital upon ascertaining that it is not thus certified or accredited.

3727.04 Inspections; Director’s right.

In addition to any other inspections authorized by law, the director of health may inspect any hospital if there are substantial allegations or evidence of a significant deficiency or deficiencies that would, if found to be present, adversely affect the health or safety of its patients.
and may make such other inspections as are necessary to enforce this chapter.

3727.06 Patient admission and supervision requirements.

(A) As used in this section:
   (1) “Doctor” means an individual authorized to practice medicine and surgery or osteopathic medicine and surgery.
   (2) “Podiatrist” means an individual authorized to practice podiatric medicine and surgery.

(B)(1) Only the following may admit a patient to a hospital:
   (a) A doctor who is a member of the hospital's medical staff;
   (b) A dentist who is a member of the hospital's medical staff;
   (c) A podiatrist who is a member of the hospital's medical staff;
   (d) A clinical nurse specialist, certified nurse-midwife, or certified nurse practitioner if all of the following conditions are met:
      (i) The clinical nurse specialist, certified nurse-midwife, or certified nurse practitioner has a standard care arrangement entered into pursuant to section 4723.431 of the Revised Code with a collaborating doctor or podiatrist who is a member of the medical staff;
      (ii) The patient will be under the medical supervision of the collaborating doctor or podiatrist;
      (iii) The hospital has granted the clinical nurse specialist, certified nurse-midwife, or certified nurse practitioner admitting privileges and appropriate credentials.
   (2) Prior to admitting a patient, a clinical nurse specialist, certified nurse-midwife, certified nurse practitioner, or physician assistant shall notify the collaborating or supervising doctor or podiatrist.

(C) All hospital patients shall be under the medical supervision of a doctor, except that services that may be rendered by a licensed dentist pursuant to Chapter 4715 of the Revised Code provided to patients admitted solely for the purpose of receiving such services shall be under the supervision of the admitting dentist and that services that may be rendered by a podiatrist pursuant to section 4731.51 of the Revised Code provided to patients admitted solely for the purpose of receiving such services shall be under the supervision of the admitting podiatrist. If treatment not within the scope of Chapter 4715 or section 4731.51 of the Revised Code is required at the time of admission by a dentist or podiatrist, or becomes necessary during the course of hospital treatment by a dentist or podiatrist, such treatment shall be under the supervision of a doctor who is a member of the medical staff. It shall be the responsibility of the admitting dentist or podiatrist to make arrangements with a doctor who is a member of the medical staff to be responsible for the patient's treatment outside the scope of Chapter 4715 or section 4731.51 of the Revised Code when necessary during the patient's stay in the hospital.

3727.99 Penalty for noncompliance with hospital certification or accreditation requirement.

Whoever violates division (A) of section 3727.02 of the Revised Code is guilty of a
misdemeanor of the first degree and shall be liable for an additional penalty of one thousand dollars for each day of operation in violation of such division.

3701-59-01 Department of Health; general definitions.

As used in this chapter:

(A) “Active medical staff” means staff with clinical privileges who are designated as active pursuant to the bylaws or other governing prescript of the hospital.

(B) “Alcohol and drug hospital” means a hospital engaged primarily in providing specialized care to inpatients with alcoholism or chemical dependency rehabilitative service needs.

(C) “Alcohol or drug abuse rehabilitation bed” means a hospital bed that is staffed and equipped for care of inpatients whose primary diagnosis is alcoholism or other chemical dependency.

(D) “Associate medical staff” means staff with clinical privileges who are designated as associate pursuant to the bylaws or other governing prescript of the hospital.

(E) “Average daily census” means total patient days for a given calendar year divided by the number of days in the year.

(F) “Beds in use” means the sum of the number of beds staffed and available for patient care on the last day of each month of the calendar year, divided by twelve.

(G) “Board certified physician” means an individual licensed under Chapter 4731 of the Revised Code to practice medicine and surgery or osteopathic medicine and surgery who has passed an examination given by a medical specialty board and has been certified by that board as a specialist. “Board certified” does not include board eligible physicians. For physicians certified by more than one board, “board certified”: includes only the primary certification board.

(H) “Burn care bed” means a hospital bed that is staffed and equipped for care of inpatients whose primary diagnosis is burn-related.

(I) “Burn care hospital” means a hospital engaged primarily in providing inpatient care to patients requiring specialized burn-related diagnostic or therapeutic services.

(J) “Cancer hospital” means a hospital that is classified as a cancer hospital under 42 C.F.R. 412.23(f) (1985) and is organized primarily for treatment and research on cancer.

(K) “Cardiac catheterization” means all anatomic or physiologic studies of interventions, both diagnostic and therapeutic, in which the heart or coronary arteries are entered via a systemic vein or artery using a catheter that is manipulated under fluoroscopic visualization. This definition does not include studies of cardiac function performed using flow directed catheters that are positioned without the use of fluoroscopy.

(L) “Critical access hospital” means a hospital that is certified by the federal government as meeting the conditions of participation in the medicare program under 42 C.F.R. part 485, subpart F (1993).

(M) “Department” means the department of health of the state of Ohio.

(N) “Direct care services” means any in-person patient contact where health care or personal care is provided in the hospital.

(O) “Director” means the director of health or the director's designated representative.

(P) “Discharge” means a patient who is formally released from a hospital including deaths. Discharge does not include temporary transfers to other settings.

(Q) “Full-time equivalent” means at least one thousand eight hundred and twenty hours per calendar year.

(R) “General hospital” means a hospital that primarily functions to furnish the array of diagnostic and therapeutic services needed to provide care for a variety of medical conditions, such as diagnostic X-ray, clinical laboratory, and operating room services.

(S) “Heart hospital” means a hospital primarily engaged in providing inpatient care to
patients requiring specialized cardiac diagnostic or therapeutic services.

(T) “Hospice beds” means the inpatient beds of a hospice care program as defined in division (A) of section 3712.01 of the Revised Code.

(U) “Hospital” means an institution located at a single site engaged primarily in providing to inpatients, by or under the supervision of an organized medical staff of physicians licensed under Chapter 4731 of the Revised Code, diagnostic services and therapeutic services for medical diagnosis and treatment or rehabilitation of injured, disabled, or sick persons. “Hospital” also means an inpatient facility, located at the same site as another institution required to register under section 3701.07 of the Revised Code, that is medicare certified as a separate hospital, or operated by or on behalf of another hospital. “Hospital” does not mean an institution that is operated by the United States government or by the Ohio department of mental health.

(V) “Hospital bed” or “bed” means a bed in a hospital with the attendant physical space, fixtures, and equipment for use in caring primarily for inpatients. “Hospital bed” includes beds used in caring for patients who stay for less than twenty-four hours, but the primary use of such beds is for care of inpatients.

(W) “House staff” means interns, residents, and fellows receiving stipends from the hospital who are in training positions approved by the accreditation council of graduate medical education, the American osteopathic association, or the American dental association.

(X) “Inpatient” means a patient whose length of stay is twenty-four hours or more.

(Y) “Inpatient surgical operating room” means a room in a hospital used to perform any operative or manual procedure undertaken for the diagnosis or treatment of a disease or other disorder.

(Z) “Long term acute care hospital”, or LTACH, means a hospital that is classified as a long-term care hospital under 42 C.F.R. 412.23(e) (1985), that is engaged primarily in providing medically necessary specialized acute hospital care for medically complex patients who are critically ill or have multi-system complications or failures, and that has an average length of stay of forty-five days or less.

(AA) “Long term acute care hospital bed” means a bed in a long term acute care hospital.

(BB) “Maternity unit” means a distinct portion of a hospital in which inpatient care is provided to women during all or part of the maternity cycle.

(CC) “Medical/surgical bed” means a hospital bed in a medical or surgical unit where general medical/surgical services are provided.

(DD) “Multi-hospital system” means two or more hospitals that are subject to the control and direction of one common owner responsible for the operational decisions of the entire system or that have integrated administrative functions and medical staff that report to one governing body as the result of a formal legal or contractual obligation.

(EE) “Number of admissions” means the number of patients accepted for inpatient service of twenty-four hours or more, including transfers by a service within the hospital.

(FF) “Number of inpatient surgical cases” means number of patients treated on an inpatient basis after surgery in an operating room.

(GG) “Open heart surgery” means any surgery performed on the heart muscle, valves, arteries, or other structures in which the chest is opened and a cardiopulmonary bypass is performed using extracorporeal circulation (heart-lung machine).

(HH) “Outpatient” means a patient who is not admitted as an inpatient and whose length of stay is less than twenty-four hours.

(II) “Outpatient surgical operating room” means a room in a hospital designed to perform an operative or manual procedure undertaken for the diagnosis or treatment of a disease or other disorder on non-inpatients.

(JJ) “Patient” means an individual who receives diagnostic or therapeutic services for medical diagnosis treatment, or rehabilitation. “Patient” also includes an individual receiving
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palliative care.

(KK) “Patient days of care” means annual total number of inpatients in a hospital on a daily count at a specific uniform time of day.

(LL) “Pediatric cardiovascular surgery” means any open or closed heart surgical procedures performed on a pediatric patient, including surgical procedures on the heart muscle, valves, arteries, or other structures, and surgical correction of both congenital and acquired heart conditions such as ventricular septal defects (VSD), atrial septal defects (ASD), patent ductus arteriosus (excluding neonates) and valve defects. “Pediatric cardiovascular surgery” does not mean heart transplantation.

(MM) “Pediatric patient” means any patient less than twenty-two years of age.

(NN) “Physical rehabilitation bed” means a hospital bed that is staffed and equipped for care of inpatients requiring intensive, multi-disciplinary physical restorative services.

(OO) “Physical rehabilitation hospital” means a hospital engaged primarily in providing specialized care to inpatients with intensive, multi-disciplinary physical restorative service needs.

(PP) “Psychiatric care bed” means a hospital bed that is staffed and equipped for care of inpatients whose primary diagnosis in mental illness.

(QQ) “Psychiatric hospital” means a hospital engaged primarily in providing specialized care to inpatients diagnosed with mental illness.

(RR) “Register” means to report to the department on an annual basis information required under section 3701.07 of the Revised Code and rule 3701-59-05 of the Administrative Code.

(SS) “Satellite unit” means a unit owned and operated by a hospital that is providing diagnostic, therapeutic, or rehabilitative services on an outpatient basis at a geographically separate location from the hospital that owns and operates it. “Satellite unit” does not include facilities that are licensed under section 3702.30 of the Revised Code, inpatient facilities at the same geographic location that are certified as a separate hospital, or facilities providing inpatient services at a different location or different street address from the hospital that owns and operates it.

(TT) “Special care bed” means a hospital bed in which special medical/surgical services, beyond general medical/surgical care and including intensive care or coronary care, are provided.

(UU) “Total number of beds” means the total number of beds in which patient care may be provided, whether or not the bed is staffed and available. Beds in temporarily closed units are included in the total. Beds that are temporarily unavailable as the result of building renovations are included in the total. A temporary increase in the number of beds in use that is caused by unusually high volumes of admissions is not included in the total, where “temporary increase” means the average daily census exceeds registered capacity for less than forty-five days in any six month period.

3701-59-03 Operation of hospitals, reporting accreditation, certification or withdrawal.

(A) No person and no political subdivision, agency, or instrumentality of this state shall operate a hospital as defined in section 3727.01 of the Revised Code unless it is certified under Title XVIII of the Social Security Act, 49 Stat. 620 (1935), 42 U.S.C. 301, as amended (1981) or is accredited by a national accrediting organization approved by the centers for medicare and medicaid services.

(B) Each hospital defined in section 3727.01 of the Revised Code shall annually report to the department its accreditation and certification status on a form or in a format prescribed by the director.

(C) Any hospital defined in section 3727.01 of the Revised Code that voluntarily
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withdraws or is involuntarily terminated from certification or accreditation as required in paragraph (A) of this rule shall notify the director of health in writing within ten days after the effective date of such withdrawal or termination.

3701-59-04 Director’s investigation of violations; legal action.

(A) The director shall make an investigation of any hospital or health facility to determine if there is a violation of section 3727.02 of the Revised Code and rule 3701-59-03 of the Administrative Code whenever the director has reason to believe that there may be a violation of section 3727.02 of the Revised Code or rule 3701-59-03 of the Administrative Code.

(B) If the director ascertains that there is a violation of section 3727.02 of the Revised Code or rule 3701-59-03 of the Administrative Code, the director shall petition the court of common pleas of the county in which the hospital or health facility is located for an order enjoining such violation or shall institute legal proceedings under section 3727.99 of the Revised Code, or both, as appropriate.

3701-59-05 Hospital registration and reporting requirements.

Every hospital, public or private, shall, by the first of March of each year, register with and report to the department of health the following information for the previous calendar year in a manner prescribed by the director. A facility providing inpatient services at a geographically separate location that is not part of the main hospital or is located at a different street address from the hospital that owns and operates it, and a facility that is certified by the centers for medicare and medicaid services independently from the hospital in which it is located, shall register with and report to the department of health separately.

(A) Information needed to identify and classify the hospital, include the following:

(1) Hospital identifying information, including:
   (a) The name of the hospital;
   (b) The hospital number assigned by the department;
   (c) The name the hospital uses for medicare, if different than the hospital name in paragraph (A)(1)(a) of this rule, the hospital's national provider identifier, and centers for medicare and medicaid services certification number;
   (d) The hospital's address, mailing address if different than the address, and the county in which the hospital is located; and
   (e) The telephone number, e-mail address, and legal name of the business entity that controls the operation of the hospital, if different than the hospital name in paragraph (A)(1)(a) of this rule;

(2) The name and title of president/chief executive officer;

(3) The name, title, and telephone number of individual responsible for submitting hospital registration information to the department;

(4) Accreditation/certification status (accrediting organization name; medicare deemed status, if applicable; and date of most current accrediting organization survey);

(5) Name, address, county, and zip code of satellite units;

(6) Type of entity that controls operation of the hospital, such as not-for-profit, for profit, government, or other;

(7) Name of multi-hospital system of which the hospital is a part, if applicable and names and addresses of other Ohio hospitals within the multi-hospital system;

(8) If applicable, the hospital's medicare provider type classification, as specified in the hospital's provider agreement with the centers for medicare and medicaid services, from one of the following categories:
   (a) Short term acute care hospital;
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(b) Psychiatric hospital;
(c) Rehabilitation hospital;
(d) Critical access hospital;
(e) Long-term acute care hospital; or
(f) Children’s hospital.

(9) The hospital's specialty or primary classification from one of the following categories if different from the medicare provider type classification, or if the hospital is not medicare certified:
   (a) General hospital;
   (b) Alcohol and drug hospital;
   (c) Burn care hospital;
   (d) Cancer hospital;
   (e) Heart hospital;
   (f) Children's hospital as defined in division (B)(1) of section 3727.01 of the Revised Code;
   (g) Rehabilitation hospital;
   (h) Psychiatric hospital; or
   (i) Other.

(10) The business name, and medicare certification number or state licensure number, or both, of the following entities contained within the hospital, as applicable:
   (a) Distinct part psychiatric unit;
   (b) Distinct part rehabilitation unit;
   (c) Transplant center; or
   (d) Maternity unit and newborn care nursery.

(B) Information on the type and volume of services provided by the hospital, including but not limited to the following:
   (1) Number of inpatient surgical cases;
   (2) Number of outpatient surgical cases;
   (3) Number of pediatric and adult cardiac catheterizations performed;
   (4) Number of adult open heart surgical procedures and the number of pediatric cardiovascular surgery procedures performed;
   (5) Number of surgical operating rooms in the following categories;
      (a) Inpatient;
      (b) Outpatient; and
      (c) Dual purpose (inpatient and outpatient);
   (6) Number of patients treated in the emergency room and released;
   (7) Number of patients treated in the emergency room who were admitted to the hospital;
   (8) Level designation, if institution is a trauma center verified by the American college of surgeons;
   (9) Level designation, if institution is a pediatric trauma center verified by the American college of surgeons;
   (10) Level designation of obstetric service, if applicable; and
   (11) Level designation of newborn service, if applicable.

Information on the location, type and volume of services provided by satellite units, including the following:
   (a) Types of services provided; and
   (b) Total number of patients treated (on an outpatient basis) for each type of service provided.

(C) The total number of beds listed by category of inpatient care provided. Report number of admissions (including individuals transferred from another unit within the hospital),
number of patient days of care, and number of beds in use for each category of care listed in
this paragraph. Beds shall be reported in the following categories:
   (1) Alcohol or drug abuse rehabilitation;
   (2) Burn care;
   (3) Hospice;
   (4) Level I neonatal care service;
   (5) Level II neonatal care service;
   (6) Level III neonatal care service;
   (7) Level I obstetric care service;
   (8) Level II obstetric care service;
   (9) Level III obstetric care service;
   (10) Long term acute care;
   (11) Long term, reported in the following categories:
      (a) Skilled nursing facility beds certified under Title XVIII of the Social Security Act, 49
          Stat. 620 (1935), 42 U.S.C. 301, as amended (1981) and which are not licensed under Chapter
          3721 of the Revised Code;
      (b) Nursing facility beds certified under Title XIX of the Social Security Act, 49 Stat. 620
          (1935), 42 U.S.C. 301, as amended (1981) and which are not licensed under Chapter 3721
          of the Revised Code;
      (c) Nursing facility beds certified under Title XVIII of the Social Security Act, 49 Stat. 620
          (1935), 42 U.S.C. 301, as amended (1981) and which are not licensed under Chapter 3721
          of the Revised Code; or
      (d) Special skilled nursing beds certified as skilled nursing facility beds under Title XVIII
          of the Social Security Act, 49 Stat. 620 (1935), 42 U.S.C. 301, as amended (1981) that were
          originally authorized by and are operated in accordance with section 3702.521 of the Revised
          Code or its predecessor;
   (12) Medical/surgical - general;
   (13) Pediatric intensive care, (beds in a separate and distinct pediatric intensive care unit
        where pediatric patients suffering from critical illness receive care;
   (14) Pediatric - general (services for patients less than twenty-two years of age are
        provided);
   (15) Physical rehabilitation;
   (16) Psychiatric care;
   (17) Special care;
   (18) Swing beds (hospital beds in a hospital or critical access hospital that has a swing
        bed agreement with the centers for medicare and medicaid services to provide either acute care
        or post hospital skilled nursing care).
   (D) The number of inpatient discharges for each of the following categories:
      (1) Discharges to home, without referral to home care or hospice services;
      (2) Discharges to home, with a referral to home care services;
      (3) Discharges to home, with a referral to hospice care program;
      (4) Transfers to inpatient service of a hospice care program;
      (5) Transfers to other hospitals;
      (6) Transfers to a home licensed as a nursing home under Chapter 3721 of the Revised
          Code or a facility certified under Title XVIII of the Social Security Act, 49 Stat. 620 (1935), 42
          U.S.C. 301, as amended (1981);
      (7) Total patients expired in the hospital; and
      (8) Total patients discharged.
   (E) The number of employees, including contract employees, by employee type within
      each of the hospital service categories listed below. Report the number of employees in each
type providing patient care services. Report the number of employees as total number of employees and total full-time equivalents.

(1) Physician services including interns, residents, salaried physicians, and contracted physicians;

(2) Dental services including dentists and dental residents;

(3) Nursing services including registered nurses, certified nurse practitioners, clinical nurse specialists, certified nurse-midwives, certified registered nurse anesthetists (CRNA), licensed practical nurses, and nursing assistants;

(4) Pharmacy services including pharmacists and pharmacy technicians;

(5) Clinical laboratory including medical technologists, medical technicians and other licensed or certified laboratory personnel;

(6) Dietary services including registered or licensed dietitians and dietetic technicians;

(7) Radiological services including technologists, technicians, and other licensed or certified radiological personnel;

(8) Therapeutic services including occupational therapists, physical therapists, physician assistants, respiratory therapists, speech/audiology therapists, and medical social workers;

(9) Mental health services including psychologists and psychiatric social workers; and

(10) All other services to include certified or licensed health professional and technical personnel.

(F) Numbers of medical staff delineated by primary area of specialization and category as follows:

(1) Area of specialization:
   (a) Medical: allergy/immunology, anesthesiology, cardiology, dentistry, dermatology, emergency medicine, family practice, gastroenterology, internal medicine, general practice, hematology, neonatology neurology, nuclear medicine, obstetrics and gynecology, oncology, ophthalmology, otorhinolaryngology, pathology, pediatrics, physical medicine, podiatry, psychiatry, radiology, rheumatology, urology, general medicine rotation program, and any other medical specialty; or
   (b) Surgical: cardiovascular, colon and rectal, general neurological, orthopedic, plastic, thoracic, surgery rotation program, and any other surgical specialty.

(2) Categories:
   (a) Active and associate medical staff;
   (b) Active and associate medical staff who are board certified;
   (c) House staff;
   (d) House staff who are in training positions approved by the accreditation council of graduate medical education or the American osteopathic association; and
   (e) House staff who are in training positions approved by the American dental association.

(G) County (or state if other than Ohio) of resident of patients at the time of admission, reported in the aggregate.

3701-75-04 Confidentiality statutes.

The following federal statutes or regulations or state statutes and administrative rules make personal information maintained by the agency confidential and identify the confidential personal information within the scope of rules promulgated by this agency in accordance with section 1347.15 of the Revised Code:


(C) Protected health information: section 3701.17 of the Revised Code.
(D) Information related to testing for the human immunodeficiency virus ("HIV"), acquired immunodeficiency syndrome ("AIDS"), and AIDS-related condition: section 3701.243 for the Revised Code.
(E) Identifying quality-of-care data: section 3702.18 of the Revised Code.
(F) Information related to an adoption: section 3705.12 of the Revised Code and rule 3701-5-12 of the Administrative Code.
(G) Birth defects information: section 3705.32 of the Revised Code and rule 3701-57-04 of the Administrative Code.
(H) Information for medical or health use only of a birth record: section 3705.23 of the Revised Code.
(I) Criminal record check related to hospice care workers: section 3712.09 of the Revised Code.
(J) The identity of or information that would tend to identify any patient or resident of a home, complainant, or any person who provided information regarding an investigation of a home: section 3721.031 of the Revised Code.
(K) Criminal record check related to long-term care workers: section 3721.121 of the Revised Code.
(L) The identity of or information that would tend to identify any complainant, or any person who provided information regarding an investigation of abuse, neglect, or misappropriation in a long-term care or residential care facility: section 3721.25 of the Revised Code.
(N) Criminal record check related to an adult care facility worker: section 3722.151 of the Revised Code.
(O) Criminal background check of a home health agency worker: section 3701.881 of the Revised Code.
(P) The name of a complainant concerning any radon tester, mitigation specialist, mitigation contractor, or operator of a radon laboratory or an approved training course: section 3723.10 of the Revised Code.
(Q) The name of a complainant concerning a lead inspector, a lead abatement contractor, a lead risk assessor, a lead abatement project designer, a lead abatement worker, a clearance technician, a clinical laboratory, an environmental lead analytical laboratory, or a training course: section 3742.15 of the Revised Code.
(R) Information concerning lead that is reported and are medical records: section 3742.03 of the Revised Code.
(V) Records and documents relating to certifications, recertifications or medical histories of employees or employees' family members created for “Family Medical Leave Act” (“FMLA”) purposes: 29 CFR 825.500.
(W) Information obtained for purposes of the “American with Disabilities Act (“ADA”), as amended by ADA Amendments Act of 2008” or of the “Rehabilitation Act of 1973” regarding the medical condition or history of an applicant or employee: 29 CFR 1630.14.
(X) Certain data contained in the “Automated Survey Processing Environment” (“ASPEN”) and “Automated Complaint/Incidents Tracking” (“ACTS”) system of records for health care facilities
3727.21 Hospital negotiations to allocate equipment or services.

(A) Acting through their boards of directors or boards of trustees, a group of hospitals may conduct discussions or negotiations concerning the allocation of health care equipment or health care services, provided that the discussions or negotiations do not involve price-fixing or predatory pricing and are designed to achieve one or more of the following goals:

1. Reducing health care costs for consumers;
2. Improving access to health care services;
3. Improving the quality of patient care.

Directors or trustees who participate in the discussions or negotiations authorized by this division and the hospitals they represent are immune from civil enforcement action and criminal prosecution for violations of Chapter 1331 of the Revised Code that might otherwise result from the discussions or negotiations.

(B) Directors or trustees who participate in discussions or negotiations that exceed the scope of discussions or negotiations authorized by division (A) of this section and the hospitals they represent are not immune from civil enforcement or criminal prosecution for violations of Chapter 1331 of the Revised Code that may result from such discussions or negotiations.

3727.22 Cooperative agreements; requirements, updates and immunity.

(A) If directors or trustees who participated in discussions or negotiations authorized by section 3727.21 of the Revised Code wish to have the hospitals they represent undertake a cooperative action proposed as a result of the discussions or negotiations, they may submit a request to the director of health on behalf of the hospitals for approval of an agreement to undertake the cooperative action. The request shall include all of the following:

1. A copy of the proposed agreement;
2. An implementation plan that states how and when the cooperative action identified in the agreement will meet one or more of the goals specified in division (A) of section 3727.21 of the Revised Code;
3. Any additional information the boards of directors or boards of trustees wish to present to the director;
4. Any additional information the director of health considers necessary to make the determination required by division (B) of this section.

(B) If the director of health determines, on the basis of the information submitted by the directors or trustees, that one or more of the goals set forth in division (A) of section 3727.21 of the Revised Code is likely to be met through the implementation of a cooperative agreement and that the benefits resulting from the cooperative agreement are likely to outweigh the disadvantages attributable to any reduction in competition, the director shall submit the request for approval of an agreement to undertake cooperative action to the attorney general for review. The attorney general shall review the request not later than thirty days after he receives it. The attorney general may advise the director, in writing, to approve or deny the request. Failure by the attorney general to advise the director regarding his review within thirty days of his receipt of the request shall constitute his approval of the request.

If the attorney general advises the director to deny a request, he shall state the reasons for such denial. Reasons for advising the director to deny a request include a determination that
the implementation of the agreement will result in price-fixing or predatory pricing.

On receipt of the advice of the attorney general, or at the end of the thirty-day period, the director of health shall issue an order in accordance with Chapter 119 of the Revised Code approving or denying the cooperative agreement. The director's order to approve or deny a cooperative agreement is not subject to appeal.

(C) A group of hospitals that is the subject of an order approving a cooperative agreement issued under division (B) of this section is immune from civil enforcement action and criminal prosecution for actions that might otherwise violate Chapter 1331 of the Revised Code taken in furtherance of the cooperative agreement. Directors and trustees who participate in the implementation of an approved cooperative agreement also are immune from civil enforcement action and criminal prosecution for actions that might otherwise violate Chapter 1331 of the Revised Code taken in furtherance of the cooperative agreement.

(D) The director of health may request periodic written updates of the progress of the approved cooperative agreement. If updates are requested, the director shall specify the intervals at which they must be submitted, which shall be not less than every ninety days. The attorney general may request the director to provide copies of any updates the director receives.

(E) The director of health may rescind an order approving a cooperative agreement by issuing a rescission order in accordance with Chapter 119 of the Revised Code if updates of the progress of the approved cooperative agreement are not provided to him as requested, if he determines that the approved cooperative agreement is not meeting one or more of the goals specified in division (A) of section 3727.21 of the Revised Code, or if he determines that the benefits resulting from the cooperative agreement do not outweigh the disadvantages attributable to any reduction in competition. A rescission order may be appealed in accordance with Chapter 119 of the Revised Code by any of the hospitals that are parties to the cooperative agreement. Any affected person may intervene in the appeal.

(F) Nothing in this section shall limit the authority of the attorney general to initiate civil enforcement action or criminal prosecution if he determines that the hospitals or their directors or trustees have exceeded the scope of the cooperative agreement approved under division (B) of this section.

(G) Nothing in sections 3727.21 to 3727.23 of the Revised Code shall oblige the boards of directors or boards of trustees of a group of hospitals to submit a request for approval under this section. Any person who implements any cooperative action or agreement without securing the approval of the director of health under this section is subject to any civil or criminal enforcement action for violations of Chapter 1331 of the Revised Code that may result from such action.

3727.24 State’s role in cooperative agreements.

It is the intent of sections 3727.21 to 3727.23 of the Revised Code to require the state, through the director of health and attorney general, to provide direction, supervision, and control over approved cooperative agreements entered into under section 3727.22 of the Revised Code. To achieve the goals specified in section 3727.21 of the Revised Code, this state direction, supervision, and control of cooperative agreements will provide state action immunity under federal antitrust laws to the members of boards of directors or boards of trustees of a group of hospitals who participate in discussions or negotiations authorized by section 3727.21 of the Revised Code, and to persons authorized by such directors or trustees to implement cooperative agreements approved under section 3727.22 of the Revised Code.
339.01 County authority to own hospitals

(A) As used in sections 339.01 to 339.17 of the Revised Code:
(1) "Hospital facilities" has the meaning given in section 140.01 of the Revised Code.
(2) "County hospital" includes all of the county hospital's branches and hospital facilities, wherever located.
(3) "Outpatient health facility" means a facility where medical care and preventive, diagnostic, therapeutic, rehabilitative, or palliative items or services are provided to outpatients by or under the direction of a physician or dentist.

(B) A board of county commissioners may purchase, acquire, lease, appropriate, and construct a county hospital or hospital facilities thereof. After a county hospital or hospital facilities have been fully completed and sufficiently equipped for occupancy, any subsequent improvements, enlargements, or rebuilding of any such facility shall be made by the board of county hospital trustees or a hospital commission appointed pursuant to section 339.14 of the Revised Code.

(C)(1) A board of county commissioners, board of county hospital trustees, or hospital commission may purchase, acquire, lease, appropriate, or construct an outpatient health facility in another county to serve as a branch of the county hospital. The outpatient health facility may include office space for physicians. The facility shall be operated pursuant to the law that regulates the operation of the county hospital.

(2) When a proposal to establish an outpatient health facility in another county is made by a board of hospital trustees or a hospital commission, all of the following apply:
   (a) The board of county hospital trustees or hospital commission shall give written notice to its board of county commissioners and to the board of county commissioners of the county where the facility is to be located. The board of county commissioners where the facility is to be located, by resolution adopted within forty days after receipt of the notice, may object to the proposed facility. The resolution shall include an explanation of the objection and may make any recommendations the board considers necessary. The board shall send a copy of the resolution to the board of county hospital trustees or the hospital commission and to the board of county commissioners of the county that proposes to locate the facility in the other county.
   (b) Except as provided in division (C)(2)(c) of this section, the board of county hospital trustees or the hospital commission may establish and operate the facility, unless the board of county commissioners of the county proposing to locate the facility in the other county, not later than twenty days after receiving a resolution of objection from the other county's board of county commissioners pursuant to division (C)(2)(a) of this section, adopts a resolution denying the trustees or commission the right to establish the facility.
   (c) If a board of county commissioners provides a subsidy for uncompensated care to a board of county hospital trustees or hospital commission, the board of county hospital trustees or hospital commission may establish and operate the outpatient health facility only if that board of county commissioners approves the establishment of the facility.

(D) A county hospital may be designated as a monument to commemorate the services of the soldiers, sailors, marines, and pioneers of the county.
board of county commissioners first determines by resolution to establish a county hospital. Copies of such resolution shall be certified to the probate judge of the county senior in point of service and to the judge, other than a probate judge, of the court of common pleas of the county senior in point of service. The board of county commissioners together with the probate judge of the county senior in point of service and the judge of the court of common pleas of the county senior in point of service shall, within ten days after such certification, appoint a board of county hospital trustees.

(C) In making appointments to a board of county hospital trustees, both of the following apply with respect to the individuals who may be appointed:

1. Members shall be electors and representative of the area served by the hospital, except that not more than two members may be electors of the area served by the hospital that is outside the county in which the hospital is located.

2. A physician may serve as a member, including a physician who is authorized to admit and treat patients at the hospital, except as follows:
   a. Not more than two physicians may serve as members at the same time;
   b. No physician who is employed by the hospital may serve as a member.

(D) A board of county hospital trustees shall be composed of six members, unless the board of county commissioners determines that the board of trustees can more effectively function with eight or ten members in which case there may be eight or ten members, as designated by the board of county commissioners.

(E) With respect to the initial appointment of members to a board of county hospital trustees, all of the following apply:

1. When the board is composed of six members, their terms of office shall be one for one year, one for two years, one for three years, one for four years, one for five years, and one for six years from the first Monday of March thereafter.

2. When the board is composed of eight members, their terms of office shall be one for one year, one for two years, two for three years, one for four years, one for five years, and two for six years from the first Monday of March thereafter.

3. When the board is composed of ten members, their terms of office shall be two for one year, two for two years, two for three years, two for four years, one for five years, and two for six years from the first Monday of March thereafter.

(F) Except as provided in division (G)(2) of this section, all of the following apply with respect to vacancies on a board of county hospital trustees:

1. Annually, on the first Monday of March, the board of county commissioners together with the probate judge of the county senior in point of service and the judge of the court of common pleas of the county senior in point of service shall appoint or reappoint for a term of six years a sufficient number of members to replace those members whose terms have expired.

2. The appointing authority shall fill a vacancy not later than six months after the vacancy occurs. If the vacancy remains unfilled on that date, the remaining members of the board, by majority vote, shall appoint an individual to fill the vacancy.

3. The appointing authority may fill a vacancy by seeking nominations from a selection committee consisting of one county commissioner designated by the board of county commissioners, the chair of the board of county hospital trustees, and the county hospital administrator. If nominations for filling a vacancy are sought from a selection committee, the committee shall nominate at least three individuals for the vacancy. The appointing authority may fill the vacancy by appointing one of the nominated individuals or by appointing another individual selected by the appointing authority.

4. Any member appointed to fill a vacancy occurring prior to the expiration date of the term for which the member's predecessor was appointed shall hold office as a member for the remainder of that term.
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(G)(1) The board of county commissioners together with the probate judge senior in point of service and the judge of the court of common pleas senior in point of service in any county in which a board of county hospital trustees has been appointed may expand the number of members to eight or to ten. When the number of members is increased to eight, one shall be appointed for a three-year and one for a six-year term from the first Monday of March thereafter. When the number of members is increased from six to ten, the term for additional members shall be: one for one year, one for three years, one for four years, and one for six years from the first Monday of March thereafter. When the number of members is increased from eight to ten, the term for additional members shall be: one for one year and one for four years from the first Monday of March thereafter. Thereafter, except as provided in division (G)(2) of this section, upon the expiration of the term of office of each member, the vacancy shall be filled in the manner specified in division (F) of this section.

(2) The board of county commissioners together with the probate judge senior in point of service and the judge of the court of common pleas senior in point of service may reduce the number of members of a board of county hospital trustees to eight or to six. The reduction shall occur on expiration of a member’s term of office, at which time no appointment shall be made. While the board of county commissioners and the judges are in the process of reducing the number of members, the board of county hospital trustees may consist of nine or seven members for one year.

(H) Any member of a board of county hospital trustees may be removed from office by the appointing authority for neglect of duty, misconduct, or malfeasance in office. The member shall be informed in writing of the charges and afforded an opportunity for a hearing before the appointing authority. The appointing authority shall not remove a member from office for political reasons.

(I) The board of county commissioners may provide members of a board of county hospital trustees a stipend for their service or require the members to serve without compensation. The members shall be allowed their necessary and reasonable expenses incurred in the performance of their duties, including the cost of their participation in any continuing education programs or developmental programs that the members consider necessary. Allowable stipends and expenses shall be paid out of the funds provided for the county hospital.

(J) The persons selected to be members of a board of county hospital trustees shall forthwith be notified, by mail, of their appointment. When a board is initially appointed, the notice shall state a time, not more than ten days later, when such board shall meet at the county seat of such county to organize. On the date stated, the board shall meet and organize.

(K) A board of county hospital trustees shall organize by electing one of its number as chairperson and such other officers as specified in the board’s rules. Four members of a six-member board constitute a quorum, five members constitute a quorum of an eight-member board, and six members constitute a quorum of a ten-member board.

A board of county hospital trustees shall hold meetings at least quarterly, shall adopt necessary rules of procedure, and shall keep a record of its proceedings and a strict account of all its receipts, disbursements, and expenditures. On completion of the construction and equipping of a county hospital, the board shall file such account with the board of county commissioners and make final settlement with the board of county commissioners for the construction and equipping of the hospital.

Members of the board of county hospital trustees may attend board meetings by means of communications equipment authorized under this division by rule of the board, including by video conference or teleconference. Notwithstanding division (C) of section 121.22 of the Revised Code, board members who attend a board meeting by means of authorized communications equipment shall be considered present in person at the meeting, shall be
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permitted to vote, and shall be counted for purposes of determining whether a quorum is present at the meeting.

The board of county hospital trustees shall maintain a record of any vote or other action taken at a board meeting conducted by means of authorized communications equipment. The record also shall identify the members attending the board meeting by means of authorized communications equipment.

The board of county hospital trustees shall adopt rules designating the communications equipment that is authorized for use during board meetings. The board also shall adopt rules that establish procedures and guidelines for using authorized communications equipment during board meetings and that ensure verification of the identity of any board members attending board meetings by such means.

339.03 Authority of board.

The board of county hospital trustees shall have complete charge of the selection and purchase or lease of a site or sites for a county hospital, taking title or leasehold interest to such site or sites in the name of the county, the selection of plans and specifications, the determination and erection of all necessary buildings on such site or sites, and of the selection and installation of all necessary and proper furniture, fixtures, and equipment.

The board of county hospital trustees may make capital improvements, including the purchase of equipment and vehicles, and may finance such improvements through hospital revenues or other hospital funds.

The board of county hospital trustees may issue revenue obligations, pursuant to section 140.06 or 339.15 of the Revised Code, or revenue bonds pursuant to section 133.08 of the Revised Code.

The board of county hospital trustees may construct an addition to the county hospital, acquire an existing structure for the purpose of leasing office space to local physicians, or lease real property to any person to construct facilities for providing medical services other than inpatient hospital services if the board of county hospital trustees determines that such purpose is reasonably related to the proper operation of the county hospital.

339.04 Hospital building fund.

Notwithstanding section 135.351 of the Revised Code, all funds, including any and all interest income, arising from a special tax levy or general obligation bond issue for the purchase, appropriation, or construction of a county hospital, and contributions thereto, shall be placed in the county treasury to the credit of a fund to be known as the "county hospital building fund." Such fund shall be paid out on the order of the board of county hospital trustees, certified by the chairman of the board.

339.05 Purchasing procedures.

(A) A board of county hospital trustees may adopt, annually, bidding procedures and purchasing or leasing policies provided through a joint purchasing arrangement sponsored by a nonprofit organization, for services, supplies, and equipment, that are routinely used in the operation of the hospital and that cost in excess of the amount specified in section 307.86 of the Revised Code as the amount above which purchases must be competitively bid. If a board of county hospital trustees adopts those policies and procedures, and if the board of county commissioners approves them, the board of county hospital trustees may follow those policies and procedures in lieu of following the competitive bidding procedures of sections 307.86 to 307.92 of the Revised Code.
(B) Notwithstanding section 307.86 of the Revised Code, the board of county hospital trustees is exempt from competitive bidding as required under that section if the board, by a unanimous vote of its members, makes a determination that a real and present emergency exists, and either of the following applies:

1. The estimated cost is less than one hundred thousand dollars.
2. There is actual physical damage to structures or equipment.

The board shall enter the determination of emergency and the reasons for it in the minutes of its proceedings.

(C) For purposes of this section, a vote is unanimous if all members of a board of county hospital trustees are present, or a lesser number of members of the board if not all members are present, provided that the number of members present constitutes a quorum. Board members participating in a vote by means of authorized communications equipment in accordance with section 339.02 of the Revised Code are considered to be present in person and may vote on matters under this section.

(D) Whenever a contract of purchase, lease, or construction is exempted from competitive bidding because the estimated cost is less than one hundred thousand dollars, but the estimated cost is fifty thousand dollars or more, the board shall solicit informal estimates from not fewer than three persons who could perform the contract, before awarding the contract. With regard to each such contract, the board shall maintain a record of the informal estimates, including the name of each person from whom an informal estimate was solicited. The board shall maintain the record for the longer of at least one year after the contract is awarded or an amount of time required by the federal government.

339.06 Board's operation of hospital.

[Editor's Note: This version of the statute is effective until 1/1/2018. The version effective subsequently is included next.]

  (A) The board of county hospital trustees, upon completion of construction or leasing and equipping of a county hospital, shall assume and continue the operation of the hospital.
  (B) The board of county hospital trustees shall have the entire management and control of the county hospital. The board may in writing delegate its management and control of the county hospital to the administrator of the county hospital employed under section 339.07 of the Revised Code. The board shall establish such rules for the hospital's government, management, control, and the admission of persons as are expedient.
  (C) The board of county hospital trustees has control of the property of the county hospital, including management and disposal of surplus property other than real estate or an interest in real estate.
  (D) With respect to the use of funds by the board of county hospital trustees and its accounting for the use of funds, all of the following apply:
    1. The board of county hospital trustees has control of all funds used in the county hospital's operation, including moneys received from the operation of the hospital, moneys appropriated for its operation by the board of county commissioners, and moneys resulting from special levies submitted by the board of county commissioners as provided for in section 5705.22 of the Revised Code.
    2. Of the funds used in the county hospital's operation, all or part of any amount determined not to be necessary to meet current demands on the hospital may be invested by the board of county hospital trustees or its designee in any classifications of securities and obligations eligible for deposit or investment of county moneys pursuant to section 135.35 of the Revised Code, subject to the approval of the board's written investment policy by the county investment advisory committee established pursuant to section 135.341 of the Revised Code. If
a county hospital is based in a county that has adopted a charter under Section 3 of Article X, Ohio Constitution, such funds may be invested by the board of county hospital trustees as provided in this division or in an ordinance adopted by the legislative authority of the county, in either case subject to approval by the county investment advisory committee, or as provided in section 339.061 of the Revised Code.

(3) Annually, not later than sixty days before the end of the fiscal year used by the county hospital, the board of county hospital trustees shall submit its proposed budget for the ensuing fiscal year to the board of county commissioners for that board’s review. The board of county commissioners shall review and approve the proposed budget by the first day of the fiscal year to which the budget applies. If the board of county commissioners has not approved the budget by the first day of the fiscal year to which the budget applies, the budget is deemed to have been approved by the board on the first day of that fiscal year.

(4) The board of county hospital trustees shall not expend funds received from taxes collected pursuant to any tax levied under section 5705.22 of the Revised Code or the amount appropriated to the county hospital by the board of county commissioners in the annual appropriation measure for the county until its budget for the applicable fiscal year is approved in accordance with division (C)(3) of this section. At any time the amount received from those sources differs from the amount shown in the approved budget, the board of county commissioners may require the board of county hospital trustees to revise the county hospital budget accordingly.

(5) Funds under the control of the board of county hospital trustees may be disbursed by the board, consistent with the approved budget, for the uses and purposes of the county hospital; for the replacement of necessary equipment; for the acquisition, leasing, or construction of permanent improvements to county hospital property; or for making a donation authorized by division (E) of this section. Each disbursement of funds shall be made on a voucher signed by signatories designated and approved by the board of county hospital trustees.

(6) The head of a board of county hospital trustees is not required to file an estimate of contemplated revenue and expenditures for the ensuing fiscal year under section 5705.28 of the Revised Code unless the board of county commissioners levies a tax for the county hospital, or such a tax is proposed, or the board of county hospital trustees desires that the board of county commissioners make an appropriation to the county hospital for the ensuing fiscal year.

(7) All moneys appropriated by the board of county commissioners or from special levies by the board of county commissioners for the operation of the hospital, when collected shall be paid to the board of county hospital trustees on a warrant of the county auditor and approved by the board of county hospital trustees.

(8) The board of county hospital trustees shall provide for the conduct of an annual financial audit of the county hospital. Not later than thirty days after it receives the final report of an annual financial audit, the board shall file a copy of the report with the board of county commissioners.

(E) For the public purpose of improving the health, safety, and general welfare of the community, the board of county hospital trustees may donate to a nonprofit entity any of the following:

(1) Moneys and other financial assets determined not to be necessary to meet current demands on the hospital;
(2) Surplus hospital property, including supplies, equipment, office facilities, and other property that is not real estate or an interest in real estate;
(3) Services rendered by the hospital.

(F)(1) For purposes of division (F)(2) of this section:
(a) “Bank” has the same meaning as in section 1101.01 of the Revised Code.
(b) “Savings and loan association” has the same meaning as in section 1151.01 of the
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(c) “Savings bank” has the same meaning as in section 1161.01 of the Revised Code.

(2) The board of county hospital trustees may enter into a contract for a secured line of credit with a bank, savings and loan association, or savings bank if the contract meets all of the following requirements:

(a) The term of the contract does not exceed one year, except that the contract may provide for the automatic renewal of the contract for up to four additional one-year periods if, on the date of automatic renewal, the aggregate outstanding draws remaining unpaid under the secured line of credit do not exceed fifty per cent of the maximum amount that can be drawn under the secured line of credit.

(b) The contract provides that the bank, savings and loan association, or savings bank shall not commence a civil action against the board of county commissioners, any member of the board, or the county to recover the principal, interest, or any charges or other amounts that remain outstanding on the secured line of credit at the time of any default by the board of county hospital trustees.

(c) The contract provides that no assets other than those of the county hospital can be used to secure the line of credit.

(d) The terms and conditions of the contract comply with all state and federal statutes and rules governing the extension of a secured line of credit.

(3) Any obligation incurred by a board of county hospital trustees under division (F)(2) of this section is an obligation of that board only and not a general obligation of the board of county commissioners or the county within the meaning of division (Q) of section 133.01 of the Revised Code.

(4) Notwithstanding anything to the contrary in the Revised Code, the board of county hospital trustees may secure the line of credit authorized under division (F)(2) of this section by the grant of a security interest in any part or all of its tangible personal property and intangible personal property, including its deposit accounts, accounts receivable, or both.

(5) No board of county hospital trustees shall at any time have more than one secured line of credit under division (F)(2) of this section.

(G) The board of county hospital trustees shall establish a schedule of charges for all services and treatment rendered by the county hospital. It may provide for the free treatment in the hospital of soldiers, sailors, and marines of the county, under such conditions and rules as it prescribes.

(H) The board of county hospital trustees may designate the amounts and forms of insurance protection to be provided, and the board of county commissioners shall assist in obtaining such protection. The expense of providing the protection shall be paid from hospital operating funds.

(I) The board of county hospital trustees may authorize a county hospital and each of its units, hospital board members, designated hospital employees, and medical staff members to be a member of and maintain membership in any local, state, or national group or association organized and operated for the promotion of the public health and welfare or advancement of the efficiency of hospital administration and in connection therewith to use tax funds for the payment of dues and fees and related expenses but nothing in this section prohibits the board from using receipts from hospital operation, other than tax funds, for the payment of such dues and fees.

(J) The following apply to the board of county hospital trustees in relation to its employees and the employees of the county hospital:

(1) The board shall adopt the wage and salary schedule for employees.

(2) The board may employ the hospital’s administrator pursuant to section 339.07 of the Revised Code, and the administrator may employ individuals for the hospital in accordance with that section.
(3) The board may employ assistants as necessary to perform its clerical work, superintend properly the construction of the county hospital, and pay the hospital's expenses. Such employees may be paid from funds provided for the county hospital.

(4) The board may hire, by contract or as salaried employees, such management consultants, accountants, attorneys, engineers, architects, construction managers, and other professional advisors as it determines are necessary and desirable to assist in the management of the programs and operation of the county hospital. Such professional advisors may be paid from county hospital operating funds.

(5) Notwithstanding section 325.19 of the Revised Code, the board may grant to employees any fringe benefits the board determines to be customary and usual in the nonprofit hospital field in its community, including, but not limited to:

(a) Additional vacation leave with full pay for full-time employees, including full-time hourly rate employees, after service of one year;

(b) Vacation leave and holiday pay for part-time employees on a pro rata basis;

(c) Leave with full pay due to death in the employee's immediate family, which shall not be deducted from the employee's accumulated sick leave;

(d) Premium pay for working on holidays listed in section 325.19 of the Revised Code;

(e) Moving expenses for new employees;

(f) Discounts on hospital supplies and services.

(6) The board may provide holiday leave by observing Martin Luther King day, Washington-Lincoln day, Columbus day, and Veterans' day on days other than those specified in section 1.14 of the Revised Code.

(7) The board may grant to employees the insurance benefits authorized by section 339.16 of the Revised Code.

(8) Notwithstanding section 325.19 of the Revised Code, the board may grant to employees, including hourly rate employees, such personal holidays as the board determines to be customary and usual in the hospital field in its community.

(9) The board may grant to employees the recruitment and retention benefits specified under division (K) of this section.

(K) Notwithstanding sections 325.191 and 325.20 of the Revised Code, the board of county hospital trustees may provide, without the prior authorization of the board of county commissioners, scholarships for education in the health care professions, tuition reimbursement, and other staff development programs to enhance the skills of health care professionals for the purpose of recruiting or retaining qualified employees. The board of county hospital trustees may pay reasonable expenses for recruiting or retaining physicians and other appropriate health care practitioners.

(L) The board of county hospital trustees may retain counsel and institute legal action in its own name for the collection of delinquent accounts. The board may also employ any other lawful means for the collection of delinquent accounts.

339.06 Board's operation of hospital.

[Editor's Note: This version of the statute is effective 1/1/2018. The version effective prior to that date is included previously.]

(A) The board of county hospital trustees, upon completion of construction or leasing and equipping of a county hospital, shall assume and continue the operation of the hospital.

(B) The board of county hospital trustees shall have the entire management and control of the county hospital. The board may in writing delegate its management and control of the
county hospital to the administrator of the county hospital employed under section 339.07 of the Revised Code. The board shall establish such rules for the hospital's government, management, control, and the admission of persons as are expedient.

(C) The board of county hospital trustees has control of the property of the county hospital, including management and disposal of surplus property other than real estate or an interest in real estate.

(D) With respect to the use of funds by the board of county hospital trustees and its accounting for the use of funds, all of the following apply:

(1) The board of county hospital trustees has control of all funds used in the county hospital's operation, including moneys received from the operation of the hospital, moneys appropriated for its operation by the board of county commissioners, and moneys resulting from special levies submitted by the board of county commissioners as provided for in section 5705.22 of the Revised Code.

(2) Of the funds used in the county hospital's operation, all or part of any amount determined not to be necessary to meet current demands on the hospital may be invested by the board of county hospital trustees or its designee in any classifications of securities and obligations eligible for deposit or investment of county moneys pursuant to section 135.35 of the Revised Code, subject to the approval of the board's written investment policy by the county investment advisory committee established pursuant to section 135.341 of the Revised Code. If a county hospital is based in a county that has adopted a charter under Section 3 of Article X, Ohio Constitution, such funds may be invested by the board of county hospital trustees as provided in this division or in an ordinance adopted by the legislative authority of the county, in either case subject to approval by the county investment advisory committee, or as provided in section 339.061 of the Revised Code.

(3) Annually, not later than sixty days before the end of the fiscal year used by the county hospital, the board of county hospital trustees shall submit its proposed budget for the ensuing fiscal year to the board of county commissioners for that board's review. The board of county commissioners shall review and approve the proposed budget by the first day of the fiscal year to which the budget applies. If the board of county commissioners has not approved the budget by the first day of the fiscal year to which the budget applies, the budget is deemed to have been approved by the board on the first day of that fiscal year.

(4) The board of county hospital trustees shall not expend funds received from taxes collected pursuant to any tax levied under section 5705.22 of the Revised Code or the amount appropriated to the county hospital by the board of county commissioners in the annual appropriation measure for the county until its budget for the applicable fiscal year is approved in accordance with division (C)(3) of this section. At any time the amount received from those sources differs from the amount shown in the approved budget, the board of county commissioners may require the board of county hospital trustees to revise the county hospital budget accordingly.

(5) Funds under the control of the board of county hospital trustees may be disbursed by the board, consistent with the approved budget, for the uses and purposes of the county hospital; for the replacement of necessary equipment; for the acquisition, leasing, or construction of permanent improvements to county hospital property; or for making a donation authorized by division (E) of this section. Each disbursement of funds shall be made on a voucher signed by signatories designated and approved by the board of county hospital trustees.

(6) The head of a board of county hospital trustees is not required to file an estimate of contemplated revenue and expenditures for the ensuing fiscal year under section 5705.28 of the Revised Code unless the board of county commissioners levies a tax for the county hospital, or such a tax is proposed, or the board of county hospital trustees desires that the board of county commissioners make an appropriation to the county hospital for the ensuing fiscal year.
(7) All moneys appropriated by the board of county commissioners or from special levies by the board of county commissioners for the operation of the hospital, when collected shall be paid to the board of county hospital trustees on a warrant of the county auditor and approved by the board of county commissioners.

(8) The board of county hospital trustees shall provide for the conduct of an annual financial audit of the county hospital. Not later than thirty days after it receives the final report of an annual financial audit, the board shall file a copy of the report with the board of county commissioners.

(E) For the public purpose of improving the health, safety, and general welfare of the community, the board of county hospital trustees may donate to a nonprofit entity any of the following:

(1) Moneys and other financial assets determined not to be necessary to meet current demands on the hospital;
(2) Surplus hospital property, including supplies, equipment, office facilities, and other property that is not real estate or an interest in real estate;
(3) Services rendered by the hospital.

(F)(1) For purposes of division (F)(2) of this section, “bank” has the same meaning as in section 1101.01 of the Revised Code.

(2) The board of county hospital trustees may enter into a contract for a secured line of credit with a bank if the contract meets all of the following requirements:

(a) The term of the contract does not exceed one year, except that the contract may provide for the automatic renewal of the contract for up to four additional one-year periods if, on the date of automatic renewal, the aggregate outstanding draws remaining unpaid under the secured line of credit do not exceed fifty per cent of the maximum amount that can be drawn under the secured line of credit.

(b) The contract provides that the bank shall not commence a civil action against the board of county commissioners, any member of the board, or the county to recover the principal, interest, or any charges or other amounts that remain outstanding on the secured line of credit at the time of any default by the board of county hospital trustees.

(c) The contract provides that no assets other than those of the county hospital can be used to secure the line of credit.

(d) The terms and conditions of the contract comply with all state and federal statutes and rules governing the extension of a secured line of credit.

(3) Any obligation incurred by a board of county hospital trustees under division (F)(2) of this section is an obligation of that board only and not a general obligation of the board of county commissioners or the county within the meaning of division (Q) of section 133.01 of the Revised Code.

(4) Notwithstanding anything to the contrary in the Revised Code, the board of county hospital trustees may secure the line of credit authorized under division (F)(2) of this section by the grant of a security interest in any part or all of its tangible personal property and intangible personal property, including its deposit accounts, accounts receivable, or both.

(5) No board of county hospital trustees shall at any time have more than one secured line of credit under division (F)(2) of this section.

(G) The board of county hospital trustees shall establish a schedule of charges for all services and treatment rendered by the county hospital. It may provide for the free treatment in the hospital of soldiers, sailors, and marines of the county, under such conditions and rules as it prescribes.

(H) The board of county hospital trustees may designate the amounts and forms of insurance protection to be provided, and the board of county commissioners shall assist in obtaining such protection. The expense of providing the protection shall be paid from hospital operating funds.
(I) The board of county hospital trustees may authorize a county hospital and each of its units, hospital board members, designated hospital employees, and medical staff members to be a member of and maintain membership in any local, state, or national group or association organized and operated for the promotion of the public health and welfare or advancement of the efficiency of hospital administration and in connection therewith to use tax funds for the payment of dues and fees and related expenses but nothing in this section prohibits the board from using receipts from hospital operation, other than tax funds, for the payment of such dues and fees.

(J) The following apply to the board of county hospital trustees in relation to its employees and the employees of the county hospital:

1. The board shall adopt the wage and salary schedule for employees.
2. The board may employ the hospital's administrator pursuant to section 339.07 of the Revised Code, and the administrator may employ individuals for the hospital in accordance with that section.
3. The board may employ assistants as necessary to perform its clerical work, superintend properly the construction of the county hospital, and pay the hospital's expenses. Such employees may be paid from funds provided for the county hospital.
4. The board may hire, by contract or as salaried employees, such management consultants, accountants, attorneys, engineers, architects, construction managers, and other professional advisors as it determines are necessary and desirable to assist in the management of the programs and operation of the county hospital. Such professional advisors may be paid from county hospital operating funds.
5. Notwithstanding section 325.19 of the Revised Code, the board may grant to employees any fringe benefits the board determines to be customary and usual in the nonprofit hospital field in its community, including, but not limited to:
   a. Additional vacation leave with full pay for full-time employees, including full-time hourly rate employees, after service of one year;
   b. Vacation leave and holiday pay for part-time employees on a pro rata basis;
   c. Leave with full pay due to death in the employee's immediate family, which shall not be deducted from the employee's accumulated sick leave;
   d. Premium pay for working on holidays listed in section 325.19 of the Revised Code;
   e. Moving expenses for new employees;
   f. Discounts on hospital supplies and services.
6. The board may provide holiday leave by observing Martin Luther King day, Washington-Lincoln day, Columbus day, and Veterans' day on days other than those specified in section 1.14 of the Revised Code.
7. The board may grant to employees the insurance benefits authorized by section 339.16 of the Revised Code.
8. Notwithstanding section 325.19 of the Revised Code, the board may grant to employees, including hourly rate employees, such personal holidays as the board determines to be customary and usual in the hospital field in its community.
9. The board may provide employee recognition awards and hold employee recognition dinners.
10. The board may grant to employees the recruitment and retention benefits specified under division (K) of this section.

(K) Notwithstanding sections 325.191 and 325.20 of the Revised Code, the board of county hospital trustees may provide, without the prior authorization of the board of county commissioners, scholarships for education in the health care professions, tuition reimbursement, and other staff development programs to enhance the skills of health care professionals for the purpose of recruiting or retaining qualified employees.
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The board of county hospital trustees may pay reasonable expenses for recruiting or retaining physicians and other appropriate health care practitioners.

(L) The board of county hospital trustees may retain counsel and institute legal action in its own name for the collection of delinquent accounts. The board may also employ any other lawful means for the collection of delinquent accounts.

339.07 Hospital administration responsibilities.

(A) The board of county hospital trustees shall provide for the administration of the county hospital by directly employing a hospital administrator or by entering into a contract for the management of the hospital under which an administrator is provided. When an administrator is employed directly, the board shall adopt a job description delineating the administrator's powers and duties and the board may pay the administrator's salary and other benefits from funds provided for the hospital.

(B) During the construction and equipping of the hospital, the administrator shall act in an advisory capacity to the board of county hospital trustees. After the hospital is completed, the administrator shall serve as the chief executive officer and shall carry out the administration of the county hospital according to the policies set forth by the board and any written delegation.

The administrator shall administer the county hospital, make reports, and take any other action that the administrator determines is necessary for the operation of the hospital.

At the end of each fiscal year, the administrator shall submit to the board a complete financial statement showing the receipts, revenues, and expenditures in detail for the entire fiscal year.

The administrator shall ensure that the hospital has such physicians, nurses, and other employees as are necessary for the proper care, control, and management of the county hospital and its patients. The physicians, nurses, and other employees may be suspended or removed by the administrator at any time the welfare of the hospital warrants suspension or removal. The administrator may obtain physicians, nurses, and other employees by direct employment, entering into contracts, or granting authority to practice in the hospital. Persons employed directly shall be in the unclassified civil service, pursuant to section 124.11 of the Revised Code.

339.08 Hospital trust requirements.

The board of county hospital trustees may receive any gift, bequest, or devise of real or personal property in trust for the erection, improvement, or support of the county hospital, and administer the said property and the proceeds thereof in the manner required by law or the instrument creating such trust. Before receiving such trust property, the board shall give additional bond in such amount as the board of county commissioners or a court requires.

Any corporation or association holding property in trust for the erection, improvement, or support of a county hospital may make application to the court of common pleas of such county for permission to resign from and relinquish the obligations of such trust. Before receiving such trust property, the board shall give additional bond in such amount as the board of county commissioners or a court requires.

The court shall set a time for a hearing, and give notice of the hearing to the donors, if living, and to the next of kin of deceased donors, residing within the state, and notice shall also be given by publication in a newspaper published in and of general circulation within the county for three consecutive weeks. Upon hearing, with consent of the board of county hospital trustees and upon its giving such additional bond as is ordered, the court may authorize said trust property to be delivered over to said board of county hospital trustees as successor trustees. Upon delivering said trust property and making a full accounting of the administration of it to the satisfaction of the court, the former board may be discharged and any bonds or obligations for performance of its duties as such board shall be canceled.
All money held in trust by the board shall be kept in a separate fund to be known as "the hospital trust fund." The board of county hospital trustees shall make a complete report of its administration of all property and funds held in trust to the board of county commissioners with its annual report of operation of the hospital.

339.09 Lease of hospital.

When the county hospital has been fully completed and sufficiently equipped for occupancy, in lieu of sections 339.06 to 339.08 of the Revised Code, the board of county commissioners of any county, on adoption of a resolution under section 339.091 of the Revised Code, may, upon such terms as are agreed upon between the board and a constituted and empowered nonsectarian Ohio corporation, organized for charitable purposes and not for profit, a majority of whose members reside in the county, enter into an agreement to lease for use as a hospital or hospital facilities, the lands, the buildings, and equipment of any hospital owned by said county. Such lease may be from year to year or may provide for a term of not more than thirty years and may provide that such board has the option to renew such lease at the expiration thereof for a further term of not more than thirty years upon such terms as are provided for in such lease. In the event that said nonprofit corporation fails to faithfully and efficiently administer, maintain, and operate such hospital as a public hospital, admitting patients without regard to race, creed, or color, then, after an opportunity is given to be heard upon written charges, said agreement shall terminate and the control and management of said hospital, together with all additions, improvements, and equipment, shall revert to and become the property of the county to be operated as provided by law.

339.091 Lease of hospital resolution.

Before the board of county commissioners, board of county hospital trustees, or county hospital commission may enter into an initial agreement for the acquisition, operation, or lease under section 140.03, 140.05, 339.09, or 339.14 of the Revised Code of a county hospital operated by a board of county hospital trustees under section 339.06 of the Revised Code, the board of county commissioners shall review the agreement. If it finds that the agreement will meet the needs of the residents of the county for hospital service, the board of county commissioners may adopt a resolution authorizing the board of county commissioners, board of county hospital trustees, or county hospital commission to enter into the agreement. On adoption of the resolution, the board of county commissioners, board of county hospital trustees, or county hospital commission may enter into the agreement. The requirements of this section do not apply to an agreement if one or more hospitals classified as general hospitals by the director of health under section 3701.07 of the Revised Code are operating in the same county as the county hospital.

339.11 Contract for care of sick.

The board of county commissioners may enter into an agreement with one or more corporations or associations organized for charitable purposes or for the purpose of maintaining and operating a hospital in any county in which such hospital has been established, for the care of the indigent sick and disabled, including indigent persons receiving the tuberculosis treatment specified in section 339.73 of the Revised Code. The document used to verify the agreement shall specify the terms that have been agreed upon by the board and such corporations or associations. Such board shall provide for the payment of the amount agreed upon in one payment, or installments, or so much from year to year as the parties stipulate. This section does not authorize the payment of public funds to a sectarian institution, except when the
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339.15 Bond issue.

The hospital commission of any county or the board of county hospital trustees established pursuant to section 339.02 of the Revised Code may issue revenue obligations of the county pursuant to section 140.06 of the Revised Code.

339.16 Employee insurance and benefits.

(A) A board of trustees of any county hospital may contract for, purchase, or otherwise procure on behalf of any or all of its employees, the employees of the hospital, or such employees and their immediate dependents the following types of fringe benefits:

(1) Group or individual insurance contracts which may include life, sickness, accident, disability, annuities, endowment, health, medical expense, hospital, dental, surgical and related coverage or any combination thereof;

(2) Group or individual contracts with health insuring corporations or other providers of professional services, care, or benefits duly authorized to do business in this state.

(B) A board of trustees of any county hospital may contract for, purchase, or otherwise procure insurance contracts which provide protection for the trustees, the board's employees, and the employees of the hospital against liability, including professional liability, provided that this section or any insurance contract issued pursuant to this section shall not be construed as a waiver of or in any manner affect the immunity of the hospital or county.

(C) All or any portion of the cost, premium, fees, or charges for the insurance benefits specified in divisions (A) and (B) of this section may be paid in such manner or combination of manners as the board of trustees may determine, including direct payment by an employee, and, if authorized in writing by an employee, by the board of trustees with moneys made available by deduction from or reduction in salary or wages or by the foregoing of a salary or wage increase.

Notwithstanding sections 3917.01 and 3917.06 of the Revised Code, the board of trustees may purchase group life insurance authorized by this section by reason of payment of premiums therefor by the board of trustees from its funds, and such group life insurance may be issued and purchased if otherwise consistent with sections 3917.01 to 3917.06 of the Revised Code.

339.17 Relationship to other code sections.

(A) Sections 140.03 and 140.05 of the Revised Code are alternatives to sections 339.02 to 339.13 of the Revised Code. Sections 339.02 to 339.14 of the Revised Code are not applicable with respect to hospital facilities and services provided for under leases or agreements entered into pursuant to section 140.03 or 140.05 of the Revised Code, except to the extent made applicable by section 140.03 or 140.05 of the Revised Code and the leases and agreements made thereunder.

(B) Notwithstanding division (A) of this section, the requirements of section 339.091 of the Revised Code apply to an initial agreement with a board of county commissioners, board of county hospital trustees, or county hospital commission for the acquisition, operation, or lease of a county hospital operated by a board of county hospital trustees under section 339.06 of the Revised Code, entered into pursuant to section 140.03 or 140.05 of the Revised Code, but not
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to any amendment or renewal of such agreement.

Contracts and Payment

2305.06 Statute of limitations for action based on written contract.

Except as provided in sections 126.301 and 1302.98 of the Revised Code, an action upon a specialty or an agreement, contract, or promise in writing shall be brought within eight years after the cause of action accrued.

2329.66 Collection of health care services debt based on property lien or garnishment.

[Editor’s Note: This version of the statute is effective until 12/31/2017. The version effective on that date is included subsequently.]

(A) Every person who is domiciled in this state may hold property exempt from execution, garnishment, attachment, or sale to satisfy a judgment or order, as follows:

(1)(a) In the case of a judgment or order regarding money owed for health care services rendered or health care supplies provided to the person or a dependent of the person, one parcel or item of real or personal property that the person or a dependent of the person uses as a residence. Division (A)(1)(a) of this section does not preclude, affect, or invalidate the creation under this chapter of a judgment lien upon the exempted property but only delays the enforcement of the lien until the property is sold or otherwise transferred by the owner or in accordance with other applicable laws to a person or entity other than the surviving spouse or surviving minor children of the judgment debtor. Every person who is domiciled in this state may hold exempt from a judgment lien created pursuant to division (A)(1)(a) of this section the person's interest, not to exceed one hundred twenty-five thousand dollars, in the exempted property.

(b) In the case of all other judgments and orders, the person's interest, not to exceed one hundred twenty-five thousand dollars, in one parcel or item of real or personal property that the person or a dependent of the person uses as a residence.

(c) For purposes of divisions (A)(1)(a) and (b) of this section, “parcel” means a tract of real property as identified on the records of the auditor of the county in which the real property is located.

(2) The person's interest, not to exceed three thousand two hundred twenty-five dollars, in one motor vehicle;

(3) The person's interest, not to exceed four hundred dollars, in cash on hand, money due and payable, money to become due within ninety days, tax refunds, and money on deposit with a bank, savings and loan association, credit union, public utility, landlord, or other person, other than personal earnings.

(4)(a) The person’s interest, not to exceed five hundred twenty-five dollars in any particular item or ten thousand seven hundred seventy-five dollars in aggregate value, in household furnishings, household goods, wearing apparel, appliances, books, animals, crops, musical instruments, firearms, and hunting and fishing equipment that are held primarily for the personal, family, or household use of the person;

(b) The person’s aggregate interest in one or more items of jewelry, not to exceed one thousand three hundred fifty dollars, held primarily for the personal, family, or household use of the person or any of the person’s dependents.

(5) The person’s interest, not to exceed an aggregate of two thousand twenty-five dollars, in all implements, professional books, or tools of the person’s profession, trade, or business, including agriculture;
(6) (a) The person's interest in a beneficiary fund set apart, appropriated, or paid by a benevolent association or society, as exempted by section 2329.63 of the Revised Code;
(b) The person's interest in contracts of life or endowment insurance or annuities, as exempted by section 3911.10 of the Revised Code;
(c) The person's interest in a policy of group insurance or the proceeds of a policy of group insurance, as exempted by section 3917.05 of the Revised Code;
(d) The person's interest in money, benefits, charity, relief, or aid to be paid, provided, or rendered by a fraternal benefit society, as exempted by section 3921.18 of the Revised Code;
(e) The person's interest in the portion of benefits under policies of sickness and accident insurance and in lump sum payments for dismemberment and other losses insured under those policies, as exempted by section 3923.19 of the Revised Code.
(7) The person's professionally prescribed or medically necessary health aids;
(8) The person's interest in a burial lot, including, but not limited to, exemptions under section 517.09 or 1721.07 of the Revised Code;
(9) The person's interest in the following:
(a) Moneys paid or payable for maintenance or rights, as exempted by section 3304.19 of the Revised Code;
(b) Workers’ compensation, as exempted by section 4123.67 of the Revised Code;
(c) Unemployment compensation benefits, as exempted by section 4141.32 of the Revised Code;
(d) Cash assistance payments under the Ohio works first program, as exempted by section 5107.75 of the Revised Code;
(e) Benefits and services under the prevention, retention, and contingency program, as exempted by section 5108.08 of the Revised Code;
(f) Disability financial assistance payments, as exempted by section 5115.06 of the Revised Code;
(g) Payments under section 24 or 32 of the “Internal Revenue Code of 1986,” 100 Stat. 2085, 26 U.S.C. 1, as amended.
(10) (a) Except in cases in which the person was convicted of or pleaded guilty to a violation of section 2921.41 of the Revised Code and in which an order for the withholding of restitution from payments was issued under division (C)(2)(b) of that section, in cases in which an order for withholding was issued under section 2907.15 of the Revised Code, in cases in which an order for forfeiture was issued under division (A) or (B) of section 2929.192 of the Revised Code, and in cases in which an order was issued under section 2929.193 or 2929.194 of the Revised Code, and only to the extent provided in the order, and except as provided in sections 3105.171, 3105.63, 3119.80, 3119.81, 3121.02, 3121.03, and 3123.06 of the Revised Code, the person's rights to or interests in a pension, benefit, annuity, retirement allowance, or accumulated contributions, the person's rights to or interests in a participant account in any deferred compensation program offered by the Ohio public employees deferred compensation board, a government unit, or a municipal corporation, or the person's other accrued or accruing rights or interests, as exempted by section 143.11, 145.56, 146.13, 148.09, 742.47, 3307.41, 3309.66, or 5505.22 of the Revised Code, and the person's rights to or interests in benefits from the Ohio public safety officers death benefit fund;
(b) Except as provided in sections 3119.80, 3119.81, 3121.02, 3121.03, and 3123.06 of the Revised Code, the person's rights to receive or interests in receiving a payment or other benefits under any pension, annuity, or similar plan or contract, not including a payment or benefit from a stock bonus or profit-sharing plan or a payment included in division (A)(6)(b) or (10)(a) of this section, on account of illness, disability, death, age, or length of service, to the extent reasonably necessary for the support of the person and any of the person's dependents, except if all the following apply:
(i) The plan or contract was established by or under the auspices of an insider that
employed the person at the time the person's rights or interests under the plan or contract arose.

(ii) The payment is on account of age or length of service.

(iii) The plan or contract is not qualified under the “Internal Revenue Code of 1986,” 100 Stat. 2085, 26 U.S.C. 1, as amended.

(c) Except for any portion of the assets that were deposited for the purpose of evading the payment of any debt and except as provided in sections 3119.80, 3119.81, 3121.02, 3121.03, and 3123.06 of the Revised Code, the person's rights or interests in the assets held in, or to directly or indirectly receive any payment or benefit under, any individual retirement account, individual retirement annuity, “Roth IRA,” account opened pursuant to a program administered by a state under section 529 or 529A of the “Internal Revenue Code of 1986,” 100 Stat. 2085, 26 U.S.C. 1, as amended, or education individual retirement account that provides payments or benefits by reason of illness, disability, death, retirement, or age or provides payments or benefits for purposes of education or qualified disability expenses, to the extent that the assets, payments, or benefits described in division (A)(10)(c) of this section are attributable to or derived from any of the following or from any earnings, dividends, interest, appreciation, or gains on any of the following:

(i) Contributions of the person that were less than or equal to the applicable limits on deductible contributions to an individual retirement account or individual retirement annuity in the year that the contributions were made, whether or not the person was eligible to deduct the contributions on the person's federal tax return for the year in which the contributions were made;

(ii) Contributions of the person that were less than or equal to the applicable limits on contributions to a Roth IRA or education individual retirement account in the year that the contributions were made;

(iii) Contributions of the person that are within the applicable limits on rollover contributions under subsections 219, 402(c), 403(a)(4), 403(b)(8), 408(b), 408(d)(3), 408A(c)(3)(B), 408A(d)(3), and 530(d)(5) of the “Internal Revenue Code of 1986,” 100 Stat. 2085, 26 U.S.C.A. 1, as amended;

(iv) Contributions by any person into any plan, fund, or account that is formed, created, or administered pursuant to, or is otherwise subject to, section 529 or 529A of the “Internal Revenue Code of 1986,” 100 Stat. 2085, 26 U.S.C. 1, as amended.

(d) Except for any portion of the assets that were deposited for the purpose of evading the payment of any debt and except as provided in sections 3119.80, 3119.81, 3121.02, 3121.03, and 3123.06 of the Revised Code, the person's rights or interests in the assets held in, or to receive any payment under, any Keogh or “H.R. 10” plan that provides benefits by reason of illness, disability, death, retirement, or age, to the extent reasonably necessary for the support of the person and any of the person's dependents.

(e) The person's rights to or interests in any assets held in, or to directly or indirectly receive any payment or benefit under, any individual retirement account, individual retirement annuity, “Roth IRA,” account opened pursuant to a program administered by a state under section 529 or 529A of the “Internal Revenue Code of 1986,” 100 Stat. 2085, 26 U.S.C. 1, as amended, or education individual retirement account that a decedent, upon or by reason of the decedent's death, directly or indirectly left to or for the benefit of the person, either outright or in trust or otherwise, including, but not limited to, any of those rights or interests in assets or to receive payments or benefits that were transferred, conveyed, or otherwise transmitted by the decedent by means of a will, trust, exercise of a power of appointment, beneficiary designation, transfer or payment on death designation, or any other method or procedure.

(f) The exemptions under divisions (A)(10)(a) to (e) of this section also shall apply or otherwise be available to an alternate payee under a qualified domestic relations order (QDRO) or other similar court order.
(g) A person's interest in any plan, program, instrument, or device described in divisions (A)(10)(a) to (e) of this section shall be considered an exempt interest even if the plan, program, instrument, or device in question, due to an error made in good faith, failed to satisfy any criteria applicable to that plan, program, instrument, or device under the "Internal Revenue Code of 1986," 100 Stat. 2085, 26 U.S.C. 1, as amended.

(11) The person's right to receive spousal support, child support, an allowance, or other maintenance to the extent reasonably necessary for the support of the person and any of the person's dependents;

(12) The person's right to receive, or moneys received during the preceding twelve calendar months from, any of the following:

(a) An award of reparations under sections 2743.51 to 2743.72 of the Revised Code, to the extent exempted by division (D) of section 2743.66 of the Revised Code;

(b) A payment on account of the wrongful death of an individual of whom the person was a dependent on the date of the individual's death, to the extent reasonably necessary for the support of the person and any of the person's dependents;

(c) Except in cases in which the person who receives the payment is an inmate, as defined in section 2969.21 of the Revised Code, and in which the payment resulted from a civil action or appeal against a government entity or employee, as defined in section 2969.21 of the Revised Code, a payment, not to exceed twenty thousand two hundred dollars, on account of personal bodily injury, not including pain and suffering or compensation for actual pecuniary loss, of the person or an individual for whom the person is a dependent;

(d) A payment in compensation for loss of future earnings of the person or an individual of whom the person is or was a dependent, to the extent reasonably necessary for the support of the debtor and any of the debtor's dependents.

(13) Except as provided in sections 3119.80, 3119.81, 3121.02, 3121.03, and 3123.06 of the Revised Code, personal earnings of the person owed to the person for services in an amount equal to the greater of the following amounts:

(a) If paid weekly, thirty times the current federal minimum hourly wage; if paid biweekly, sixty times the current federal minimum hourly wage; if paid semimonthly, sixty-five times the current federal minimum hourly wage; or if paid monthly, one hundred thirty times the current federal minimum hourly wage that is in effect at the time the earnings are payable, as prescribed by the "Fair Labor Standards Act of 1938," 52 Stat. 1060, 29 U.S.C. 206(a)(1), as amended;

(b) Seventy-five per cent of the disposable earnings owed to the person.

(14) The person's right in specific partnership property, as exempted by the person's rights in a partnership pursuant to section 1776.50 of the Revised Code, except as otherwise set forth in section 1776.50 of the Revised Code;

(15) A seal and official register of a notary public, as exempted by section 147.04 of the Revised Code;

(16) The person's interest in a tuition unit or a payment under section 3334.09 of the Revised Code pursuant to a tuition payment contract, as exempted by section 3334.15 of the Revised Code;

(17) Any other property that is specifically exempted from execution, attachment, garnishment, or sale by federal statutes other than the "Bankruptcy Reform Act of 1978," 92 Stat. 2549, 11 U.S.C.A. 101, as amended;

(18) The person's aggregate interest in any property, not to exceed one thousand seventy-five dollars, except that division (A)(18) of this section applies only in bankruptcy proceedings.

(B) On April 1, 2010, and on the first day of April in each third calendar year after 2010, the Ohio judicial conference shall adjust each dollar amount set forth in this section to reflect any increase in the consumer price index for all urban consumers, as published by the United
States department of labor, or, if that index is no longer published, a generally available comparable index, for the three-year period ending on the thirty-first day of December of the preceding year. Any adjustments required by this division shall be rounded to the nearest twenty-five dollars.

The Ohio judicial conference shall prepare a memorandum specifying the adjusted dollar amounts. The judicial conference shall transmit the memorandum to the director of the legislative service commission, and the director shall publish the memorandum in the register of Ohio. (Publication of the memorandum in the register of Ohio shall continue until the next memorandum specifying an adjustment is so published.) The judicial conference also may publish the memorandum in any other manner it concludes will be reasonably likely to inform persons who are affected by its adjustment of the dollar amounts.

(C) As used in this section:
(1) “Disposable earnings” means net earnings after the garnishee has made deductions required by law, excluding the deductions ordered pursuant to section 3119.80, 3119.81, 3121.02, 3121.03, or 3123.06 of the Revised Code.
(2) “Insider” means:
(a) If the person who claims an exemption is an individual, a relative of the individual, a relative of a general partner of the individual, a partnership in which the individual is a general partner, a general partner of the individual, or a corporation of which the individual is a director, officer, or in control;
(b) If the person who claims an exemption is a corporation, a director or officer of the corporation; a person in control of the corporation; a partnership in which the corporation is a general partner; a general partner of the corporation; or a relative of a general partner, director, officer, or person in control of the corporation;
(c) If the person who claims an exemption is a partnership, a general partner in the partnership; a general partner of the partnership; a person in control of the partnership; a partnership in which the partnership is a general partner; or a relative in, a general partner of, or a person in control of the partnership;
(d) An entity or person to which or whom any of the following applies:
(i) The entity directly or indirectly owns, controls, or holds with power to vote, twenty per cent or more of the outstanding voting securities of the person who claims an exemption, unless the entity holds the securities in a fiduciary or agency capacity without sole discretionary power to vote the securities or holds the securities solely to secure to debt and the entity has not in fact exercised the power to vote.
(ii) The entity is a corporation, twenty per cent or more of whose outstanding voting securities are directly or indirectly owned, controlled, or held with power to vote, by the person who claims an exemption or by an entity to which division (C)(2)(d)(i) of this section applies.
(iii) A person whose business is operated under a lease or operating agreement by the person who claims an exemption, or a person substantially all of whose business is operated under an operating agreement with the person who claims an exemption.
(iv) The entity operates the business or all or substantially all of the property of the person who claims an exemption under a lease or operating agreement.
(e) An insider, as otherwise defined in this section, of a person or entity to which division (C)(2)(d)(i), (ii), (iii), or (iv) of this section applies, as if the person or entity were a person who claims an exemption;
(f) A managing agent of the person who claims an exemption.
(3) “Participant account” has the same meaning as in section 148.01 of the Revised Code.
(4) “Government unit” has the same meaning as in section 148.06 of the Revised Code.

(D) For purposes of this section, “interest” shall be determined as follows:
(1) In bankruptcy proceedings, as of the date a petition is filed with the bankruptcy court
commencing a case under Title 11 of the United States Code;

(2) In all cases other than bankruptcy proceedings, as of the date of an appraisal, if necessary under section 2329.68 of the Revised Code, or the issuance of a writ of execution.

An interest, as determined under division (D)(1) or (2) of this section, shall not include the amount of any lien otherwise valid pursuant to section 2329.661 of the Revised Code.

2329.66 Collection of health care services debt based on property lien or garnishment.

[Editor’s Note: This version of the statute is effective 12/31/2017. The version effective prior to that date is included previously.]

(A) Every person who is domiciled in this state may hold property exempt from execution, garnishment, attachment, or sale to satisfy a judgment or order, as follows:

(1)(a) In the case of a judgment or order regarding money owed for health care services rendered or health care supplies provided to the person or a dependent of the person, one parcel or item of real or personal property that the person or a dependent of the person uses as a residence. Division (A)(1)(a) of this section does not preclude, affect, or invalidate the creation under this chapter of a judgment lien upon the exempted property but only delays the enforcement of the lien until the property is sold or otherwise transferred by the owner or in accordance with other applicable laws to a person or entity other than the surviving spouse or surviving minor children of the judgment debtor. Every person who is domiciled in this state may hold exempt from a judgment lien created pursuant to division (A)(1)(a) of this section the person's interest, not to exceed one hundred twenty-five thousand dollars, in the exempted property.

(b) In the case of all other judgments and orders, the person's interest, not to exceed one hundred twenty-five thousand dollars, in one parcel or item of real or personal property that the person or a dependent of the person uses as a residence.

(c) For purposes of divisions (A)(1)(a) and (b) of this section, “parcel” means a tract of real property as identified on the records of the auditor of the county in which the real property is located.

(2) The person's interest, not to exceed three thousand two hundred twenty-five dollars, in one motor vehicle;

(3) The person's interest, not to exceed four hundred dollars, in cash on hand, money due and payable, money to become due within ninety days, tax refunds, and money on deposit with a bank, savings and loan association, credit union, public utility, landlord, or other person, other than personal earnings.

(4)(a) The person's interest, not to exceed five hundred twenty-five dollars in any particular item or ten thousand seven hundred seventy-five dollars in aggregate value, in household furnishings, household goods, wearing apparel, appliances, books, animals, crops, musical instruments, firearms, and hunting and fishing equipment that are held primarily for the personal, family, or household use of the person;

(b) The person’s aggregate interest in one or more items of jewelry, not to exceed one thousand three hundred fifty dollars, held primarily for the personal, family, or household use of the person or any of the person's dependents.

(5) The person's interest, not to exceed an aggregate of two thousand twenty-five dollars, in all implements, professional books, or tools of the person's profession, trade, or business, including agriculture;

(6)(a) The person's interest in a beneficiary fund set apart, appropriated, or paid by a benevolent association or society, as exempted by section 2329.63 of the Revised Code;

(b) The person's interest in contracts of life or endowment insurance or annuities, as exempted by section 3911.10 of the Revised Code;
(c) The person's interest in a policy of group insurance or the proceeds of a policy of group insurance, as exempted by section 3917.05 of the Revised Code;
(d) The person's interest in money, benefits, charity, relief, or aid to be paid, provided, or rendered by a fraternal benefit society, as exempted by section 3921.18 of the Revised Code;
(e) The person's interest in the portion of benefits under policies of sickness and accident insurance and in lump sum payments for dismemberment and other losses insured under those policies, as exempted by section 3923.19 of the Revised Code.
(7) The person's professionally prescribed or medically necessary health aids;
(8) The person's interest in a burial lot, including, but not limited to, exemptions under section 517.09 or 1721.07 of the Revised Code;
(9) The person's interest in the following:
(a) Moneys paid or payable for maintenance or rights, as exempted by section 3304.19 of the Revised Code;
(b) Workers' compensation, as exempted by section 4123.67 of the Revised Code;
(c) Unemployment compensation benefits, as exempted by section 4141.32 of the Revised Code;
(d) Cash assistance payments under the Ohio works first program, as exempted by section 5107.75 of the Revised Code;
(e) Benefits and services under the prevention, retention, and contingency program, as exempted by section 5108.08 of the Revised Code;
(10)(a) Except in cases in which the person was convicted of or pleaded guilty to a violation of section 2921.41 of the Revised Code and in which an order for the withholding of restitution from payments was issued under division (C)(2)(b) of that section, in cases in which an order for withholding was issued under section 2907.15 of the Revised Code, in cases in which an order for forfeiture was issued under division (A) or (B) of section 2929.192 of the Revised Code, and in cases in which an order was issued under section 2929.193 or 2929.194 of the Revised Code, and only to the extent provided in the order, and except as provided in sections 3105.171, 3105.63, 3119.80, 3119.81, 3121.02, 3121.03, and 3123.06 of the Revised Code, the person's rights to or interests in a pension, benefit, annuity, retirement allowance, or accumulated contributions, the person's rights to or interests in a participant account in any deferred compensation program offered by the Ohio public employees deferred compensation board, a government unit, or a municipal corporation, or the person's other accrued or accruing rights or interests, as exempted by section 143.11, 145.56, 146.13, 148.09, 742.47, 3307.41, 3309.66, or 5505.22 of the Revised Code, and the person's rights to or interests in benefits from the Ohio public safety officers death benefit fund;
(b) Except as provided in sections 3119.80, 3119.81, 3121.02, 3121.03, and 3123.06 of the Revised Code, the person's rights to receive or interests in receiving a payment or other benefits under any pension, annuity, or similar plan or contract, not including a payment or benefit from a stock bonus or profit-sharing plan or a payment included in division (A)(6)(b) or (10)(a) of this section, on account of illness, disability, death, age, or length of service, to the extent reasonably necessary for the support of the person and any of the person's dependents, except if all the following apply:
(i) The plan or contract was established by or under the auspices of an insider that employed the person at the time the person's rights or interests under the plan or contract arose.
(ii) The payment is on account of age or length of service.
(iii) The plan or contract is not qualified under the "Internal Revenue Code of 1986," 100 Stat. 2085, 26 U.S.C. 1, as amended.
(c) Except for any portion of the assets that were deposited for the purpose of evading
the payment of any debt and except as provided in sections 3119.80, 3119.81, 3121.02, 3121.03, and 3123.06 of the Revised Code, the person's rights or interests in the assets held in, or to directly or indirectly receive any payment or benefit under, any individual retirement account, individual retirement annuity, "Roth IRA," account opened pursuant to a program administered by a state under section 529 or 529A of the "Internal Revenue Code of 1986," 100 Stat. 2085, 26 U.S.C. 1, as amended, or education individual retirement account that provides payments or benefits by reason of illness, disability, death, retirement, or age or provides payments or benefits for purposes of education or qualified disability expenses, to the extent that the assets, payments, or benefits described in division (A)(10)(c) of this section are attributable to or derived from any of the following or from any earnings, dividends, interest, appreciation, or gains on any of the following:

(i) Contributions of the person that were less than or equal to the applicable limits on deductible contributions to an individual retirement account or individual retirement annuity in the year that the contributions were made, whether or not the person was eligible to deduct the contributions on the person's federal tax return for the year in which the contributions were made;

(ii) Contributions of the person that were less than or equal to the applicable limits on contributions to a Roth IRA or education individual retirement account in the year that the contributions were made;

(iii) Contributions of the person that are within the applicable limits on rollover contributions under subsections 219, 402(c), 403(a)(4), 403(b)(8), 408(b), 408(d)(3), 408A(c)(3)(B), 408A(d)(3), and 530(d)(5) of the "Internal Revenue Code of 1986," 100 Stat. 2085, 26 U.S.C.A. 1, as amended;

(iv) Contributions by any person into any plan, fund, or account that is formed, created, or administered pursuant to, or is otherwise subject to, section 529 or 529A of the "Internal Revenue Code of 1986," 100 Stat. 2085, 26 U.S.C. 1, as amended.

(d) Except for any portion of the assets that were deposited for the purpose of evading the payment of any debt and except as provided in sections 3119.80, 3119.81, 3121.02, 3121.03, and 3123.06 of the Revised Code, the person's rights or interests in the assets held in, or to receive any payment under, any Keogh or "H.R. 10" plan that provides benefits by reason of illness, disability, death, retirement, or age, to the extent reasonably necessary for the support of the person and any of the person's dependents.

(e) The person's rights to or interests in any assets held in, or to directly or indirectly receive any payment or benefit under, any individual retirement account, individual retirement annuity, "Roth IRA," account opened pursuant to a program administered by a state under section 529 or 529A of the "Internal Revenue Code of 1986," 100 Stat. 2085, 26 U.S.C. 1, as amended, or education individual retirement account that a decedent, upon or by reason of the decedent's death, directly or indirectly left to or for the benefit of the person, either outright or in trust or otherwise, including, but not limited to, any of those rights or interests in assets or to receive payments or benefits that were transferred, conveyed, or otherwise transmitted by the decedent by means of a will, trust, exercise of a power of appointment, beneficiary designation, transfer or payment on death designation, or any other method or procedure.

(f) The exemptions under divisions (A)(10)(a) to (e) of this section also shall apply or otherwise be available to an alternate payee under a qualified domestic relations order (QDRO) or other similar court order.

(g) A person's interest in any plan, program, instrument, or device described in divisions (A)(10)(a) to (e) of this section shall be considered an exempt interest even if the plan, program, instrument, or device in question, due to an error made in good faith, failed to satisfy any criteria applicable to that plan, program, instrument, or device under the "Internal Revenue Code of 1986," 100 Stat. 2085, 26 U.S.C. 1, as amended.

(11) The person's right to receive spousal support, child support, an allowance, or other
maintenance to the extent reasonably necessary for the support of the person and any of the person's dependents;

(12) The person's right to receive, or moneys received during the preceding twelve calendar months from, any of the following:
(a) An award of reparations under sections 2743.51 to 2743.72 of the Revised Code, to the extent exempted by division (D) of section 2743.66 of the Revised Code;
(b) A payment on account of the wrongful death of an individual of whom the person was a dependent on the date of the individual's death, to the extent reasonably necessary for the support of the person and any of the person's dependents;
(c) Except in cases in which the person who receives the payment is an inmate, as defined in section 2969.21 of the Revised Code, and in which the payment resulted from a civil action or appeal against a government entity or employee, as defined in section 2969.21 of the Revised Code, a payment, not to exceed twenty thousand two hundred dollars, on account of personal bodily injury, not including pain and suffering or compensation for actual pecuniary loss, of the person or an individual for whom the person is a dependent;
(d) A payment in compensation for loss of future earnings of the person or an individual of whom the person is or was a dependent, to the extent reasonably necessary for the support of the debtor and any of the debtor's dependents.

(13) Except as provided in sections 3119.80, 3119.81, 3121.02, 3121.03, and 3123.06 of the Revised Code, personal earnings of the person owed to the person for services in an amount equal to the greater of the following amounts:
(a) If paid weekly, thirty times the current federal minimum hourly wage; if paid biweekly, sixty times the current federal minimum hourly wage; if paid semimonthly, sixty-five times the current federal minimum hourly wage; or if paid monthly, one hundred thirty times the current federal minimum hourly wage that is in effect at the time the earnings are payable, as prescribed by the “Fair Labor Standards Act of 1938,” 52 Stat. 1060, 29 U.S.C. 206(a)(1), as amended;
(b) Seventy-five per cent of the disposable earnings owed to the person.

(14) The person's right in specific partnership property, as exempted by the person's rights in a partnership pursuant to section 1776.50 of the Revised Code, except as otherwise set forth in section 1776.50 of the Revised Code;

(15) A seal and official register of a notary public, as exempted by section 147.04 of the Revised Code;

(16) The person's interest in a tuition unit or a payment under section 3334.09 of the Revised Code pursuant to a tuition payment contract, as exempted by section 3334.15 of the Revised Code;

(17) Any other property that is specifically exempted from execution, attachment, garnishment, or sale by federal statutes other than the “Bankruptcy Reform Act of 1978,” 92 Stat. 2549, 11 U.S.C.A. 101, as amended;

(18) The person's aggregate interest in any property, not to exceed one thousand seventy-five dollars, except that division (A)(18) of this section applies only in bankruptcy proceedings.

(B) On April 1, 2010, and on the first day of April in each third calendar year after 2010, the Ohio judicial conference shall adjust each dollar amount set forth in this section to reflect any increase in the consumer price index for all urban consumers, as published by the United States department of labor, or, if that index is no longer published, a generally available comparable index, for the three-year period ending on the thirty-first day of December of the preceding year. Any adjustments required by this division shall be rounded to the nearest twenty-five dollars.

The Ohio judicial conference shall prepare a memorandum specifying the adjusted dollar amounts. The judicial conference shall transmit the memorandum to the director of the
legislative service commission, and the director shall publish the memorandum in the register of Ohio. (Publication of the memorandum in the register of Ohio shall continue until the next memorandum specifying an adjustment is so published.) The judicial conference also may publish the memorandum in any other manner it concludes will be reasonably likely to inform persons who are affected by its adjustment of the dollar amounts.

(C) As used in this section:

(1) “Disposable earnings” means net earnings after the garnishee has made deductions required by law, excluding the deductions ordered pursuant to section 3119.80, 3119.81, 3121.02, 3121.03, or 3123.06 of the Revised Code.

(2) “Insider” means:

(a) If the person who claims an exemption is an individual, a relative of the individual, a relative of a general partner of the individual, a partnership in which the individual is a general partner, a general partner of the individual, or a corporation of which the individual is a director, officer, or in control;

(b) If the person who claims an exemption is a corporation, a director or officer of the corporation; a person in control of the corporation; a partnership in which the corporation is a general partner; a general partner of the corporation; or a relative of a general partner, director, officer, or person in control of the corporation;

(c) If the person who claims an exemption is a partnership, a general partner in the partnership; a general partner of the partnership; a person in control of the partnership; a partnership in which the partnership is a general partner; or a relative in, a general partner of, or a person in control of the partnership;

(d) An entity or person to which or whom any of the following applies:

(i) The entity directly or indirectly owns, controls, or holds with power to vote, twenty per cent or more of the outstanding voting securities of the person who claims an exemption, unless the entity holds the securities in a fiduciary or agency capacity without sole discretionary power to vote the securities or holds the securities solely to secure to debt and the entity has not in fact exercised the power to vote.

(ii) The entity is a corporation, twenty per cent or more of whose outstanding voting securities are directly or indirectly owned, controlled, or held with power to vote, by the person who claims an exemption or by an entity to which division (C)(2)(d)(i) of this section applies.

(iii) A person whose business is operated under a lease or operating agreement by the person who claims an exemption, or a person substantially all of whose business is operated under an operating agreement with the person who claims an exemption.

(iv) The entity operates the business or all or substantially all of the property of the person who claims an exemption under a lease or operating agreement.

(e) An insider, as otherwise defined in this section, of a person or entity to which division (C)(2)(d)(i), (ii), (iii), or (iv) of this section applies, as if the person or entity were a person who claims an exemption;

(f) A managing agent of the person who claims an exemption.

(3) “Participant account” has the same meaning as in section 148.01 of the Revised Code.

(4) “Government unit” has the same meaning as in section 148.06 of the Revised Code.

(D) For purposes of this section, “interest” shall be determined as follows:

(1) In bankruptcy proceedings, as of the date a petition is filed with the bankruptcy court commencing a case under Title 11 of the United States Code;

(2) In all cases other than bankruptcy proceedings, as of the date of an appraisal, if necessary under section 2329.68 of the Revised Code, or the issuance of a writ of execution. An interest, as determined under division (D)(1) or (2) of this section, shall not include the amount of any lien otherwise valid pursuant to section 2329.661 of the Revised Code.
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3901.38 Punctual payment to providers; definitions.

As used in this section and sections 3901.381 to 3901.3814 of the Revised Code:

(A) "Beneficiary" means any policyholder, subscriber, member, employee, or other person who is eligible for benefits under a benefits contract.

(B) "Benefits contract" means a sickness and accident insurance policy providing hospital, surgical, or medical expense coverage, or a health insuring corporation contract or other policy or agreement under which a third-party payer agrees to reimburse for covered health care or dental services rendered to beneficiaries, up to the limits and exclusions contained in the benefits contract.

(C) "Hospital" has the same meaning as in section 3727.01 of the Revised Code.

(D) "Provider" means a hospital, nursing home, physician, podiatrist, dentist, pharmacist, chiropractor, or other health care provider entitled to reimbursement by a third-party payer for services rendered to a beneficiary under a benefits contract.

(E) "Reimburse" means indemnify, make payment, or otherwise accept responsibility for payment for health care services rendered to a beneficiary, or arrange for the provision of health care services to a beneficiary.

(F) "Third-party payer" means any of the following:

(1) An insurance company;
(2) A health insuring corporation;
(3) A labor organization;
(4) An employer;
(5) An intermediary organization, as defined in section 1751.01 of the Revised Code, that is not a health delivery network contracting solely with self-insured employers;
(6) An administrator subject to sections 3959.01 to 3959.16 of the Revised Code;
(7) A health delivery network, as defined in section 1751.01 of the Revised Code;
(8) Any other person that is obligated pursuant to a benefits contract to reimburse for covered health care services rendered to beneficiaries under such contract.

3901.381 Punctual payments to providers; third party payers.

(A) Except as provided in sections 3901.382, 3901.383, 3901.384, and 3901.386 of the Revised Code, a third-party payer shall process a claim for payment for health care services rendered by a provider to a beneficiary in accordance with this section.

(B)(1) Unless division (B)(2) or (3) of this section applies, when a third-party payer receives a claim on the standard claim form prescribed in rules adopted by the superintendent of insurance under section 3902.22 of the Revised Code, the third-party payer shall pay or deny the claim not later than thirty days after receipt of the claim. When a third-party payer denies a claim, the third-party payer shall notify the provider and the beneficiary. The notice shall state, with specificity, why the third-party payer denied the claim.

(2)(a) Unless division (B)(3) of this section applies, when a provider or beneficiary has used the standard claim form, but the third-party payer determines that reasonable supporting documentation is needed to establish the third-party payer's responsibility to make payment, the third-party payer shall pay or deny the claim not later than forty-five days after receipt of the claim. Supporting documentation includes the verification of employer and beneficiary coverage under a benefits contract, confirmation of premium payment, medical information regarding the beneficiary and the services provided, information on the responsibility of another third-party payer to make payment or confirmation of the amount of payment by another third-party payer, and information that is needed to correct material deficiencies in the claim related to a diagnosis or treatment or the provider's identification.
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Not later than thirty days after receipt of the claim, the third-party payer shall notify all
relevant external sources that the supporting documentation is needed. All such notices shall
state, with specificity, the supporting documentation needed. If the notice was not provided in
writing, the provider, beneficiary, or third-party payer may request the third-party payer to
provide the notice in writing, and the third-party payer shall then provide the notice in writing. If
any of the supporting documentation is under the control of the beneficiary, the beneficiary shall
provide the supporting documentation to the third-party payer.

The number of days that elapse between the third-party payer's last request for
supporting documentation within the thirty-day period and the third-party payer's receipt of all of
the supporting documentation that was requested shall not be counted for purposes of
determining the third-party payer's compliance with the time period of not more than forty-five
days for payment or denial of a claim. Except as provided in division (B)(2)(b) of this section, if
the third-party payer requests additional supporting documentation after receiving the initially
requested documentation, the number of days that elapse between making the request and
receiving the additional supporting documentation shall be counted for purposes of determining
the third-party payer's compliance with the time period of not more than forty-five days.

(b) If a third-party payer determines, after receiving initially requested documentation,
that it needs additional supporting documentation pertaining to a beneficiary's preexisting
condition, which condition was unknown to the third-party payer and about which it was
reasonable for the third-party payer to have no knowledge at the time of its initial request for
documentation, and the third-party payer subsequently requests this additional supporting
documentation, the number of days that elapse between making the request and receiving the
additional supporting documentation shall not be counted for purposes of determining the third-
party payer's compliance with the time period of not more than forty-five days.

(c) When a third-party payer denies a claim, the third-party payer shall notify the provider
and the beneficiary. The notice shall state, with specificity, why the third-party payer denied the
claim.

(d) If a third-party payer determines that supporting documentation related to medical
information is routinely necessary to process a claim for payment of a particular health care
service, the third-party payer shall establish a description of the supporting documentation that
is routinely necessary and make the description available to providers in a readily accessible
format.

Third-party payers and providers shall, in connection with a claim, use the most current
CPT code in effect, as published by the American medical association, the most current ICD-10
code in effect, as published by the United States department of health and human services, the
most current CDT code in effect, as published by the American dental association, or the most
current HCPCS code in effect, as published by the United States health care financing
administration.

(3) When a provider or beneficiary submits a claim by using the standard claim form
prescribed in the superintendent's rules, but the information provided in the claim is materially
deficient, the third-party payer shall notify the provider or beneficiary not later than fifteen days
after receipt of the claim. The notice shall state, with specificity, the information needed to
correct all material deficiencies. Once the material deficiencies are corrected, the third-party
payer shall proceed in accordance with division (B)(1) or (2) of this section.

It is not a violation of the notification time period of not more than fifteen days if a third-
party payer fails to notify a provider or beneficiary of material deficiencies in the claim related to
a diagnosis or treatment or the provider's identification. A third-party payer may request the
information necessary to correct these deficiencies after the end of the notification time period.
Requests for such information shall be made as requests for supporting documentation under
division (B)(2) of this section, and payment or denial of the claim is subject to the time periods specified in that division.

(C) For purposes of this section, if a dispute exists between a provider and a third-party payer as to the day a claim form was received by the third-party payer, both of the following apply:

1. If the provider or a person acting on behalf of the provider submits a claim directly to a third-party payer by mail and retains a record of the day the claim was mailed, there exists a rebuttable presumption that the claim was received by the third-party payer on the fifth business day after the day the claim was mailed, unless it can be proven otherwise.

2. If the provider or a person acting on behalf of the provider submits a claim directly to a third-party payer electronically, there exists a rebuttable presumption that the claim was received by the third-party payer twenty-four hours after the claim was submitted, unless it can be proven otherwise.

(D) Nothing in this section requires a third-party payer to provide more than one notice to an employer whose premium for coverage of employees under a benefits contract has not been received by the third-party payer.

(E) Compliance with the provisions of division (B)(3) of this section shall be determined separately from compliance with the provisions of divisions (B)(1) and (2) of this section.

(F) A third party payer shall transmit electronically any payment with respect to claims that the third party payer receives electronically and pays to a contracted provider under this section and under sections 3901.383, 3901.384, and 3901.386 of the Revised Code. A provider shall not refuse to accept a payment made under this section or sections 3901.383, 3901.384, and 3901.386 of the Revised Code on the basis that the payment was transmitted electronically.

3901.3810 Punctual payments to providers; written complaints and retaliation.

(A) A provider or beneficiary aggrieved with respect to any act of a third-party payer that the provider or beneficiary believes to be a violation of sections 3901.381 to 3901.388 of the Revised Code may file a written complaint with the superintendent of insurance regarding the violation.

(B) A third-party payer shall not retaliate against a provider or beneficiary who files a complaint under division (A) of this section. If a provider or beneficiary is aggrieved with respect to any act of the third-party payer that the provider or beneficiary believes to be retaliation for filing a complaint under division (A) of this section, the provider or beneficiary may file a written complaint with the superintendent regarding the alleged retaliation.

3963.01 Health care contracts; definitions.

As used in this chapter:

(A) “Affiliate” means any person or entity that has ownership or control of a contracting entity, is owned or controlled by a contracting entity, or is under common ownership or control with a contracting entity.

(B) “Basic health care services” has the same meaning as in division (A) of section 1751.01 of the Revised Code, except that it does not include any services listed in that division that are provided by a pharmacist or nursing home.

(C) “Contracting entity” means any person that has a primary business purpose of contracting with participating providers for the delivery of health care services.

(D) “Credentialing” means the process of assessing and validating the qualifications of a provider applying to be approved by a contracting entity to provide basic health care services, specialty health care services, or supplemental health care services to enrollees.
(E) “Edit” means adjusting one or more procedure codes billed by a participating provider on a claim for payment or a practice that results in any of the following:
   (1) Payment for some, but not all of the procedure codes originally billed by a participating provider;
   (2) Payment for a different procedure code than the procedure code originally billed by a participating provider;
   (3) A reduced payment as a result of services provided to an enrollee that are claimed under more than one procedure code on the same service date.
(F) “Electronic claims transport” means to accept and digitize claims or to accept claims already digitized, to place those claims into a format that complies with the electronic transaction standards issued by the United States department of health and human services pursuant to the “Health Insurance Portability and Accountability Act of 1996,” 110 Stat. 1955, 42 U.S.C. 1320d, et seq., as those electronic standards are applicable to the parties and as those electronic standards are updated from time to time, and to electronically transmit those claims to the appropriate contracting entity, payer, or third-party administrator.
(G) “Enrollee” means any person eligible for health care benefits under a health benefit plan, including an eligible recipient of medicaid, and includes all of the following terms:
   (1) “Enrollee” and “subscriber” as defined by section 1751.01 of the Revised Code;
   (2) “Member” as defined by section 1739.01 of the Revised Code;
   (3) “Insured” and “plan member” pursuant to Chapter 3923 of the Revised Code;
   (4) “Beneficiary” as defined by section 3901.38 of the Revised Code.
(H) “Health care contract” means a contract entered into, materially amended, or renewed between a contracting entity and a participating provider for the delivery of basic health care services, specialty health care services, or supplemental health care services to enrollees.
(I) “Health care services” means basic health care services, specialty health care services, and supplemental health care services.
(J) “Material amendment” means an amendment to a health care contract that decreases the participating provider's payment or compensation, changes the administrative procedures in a way that may reasonably be expected to significantly increase the provider's administrative expenses, or adds a new product. A material amendment does not include any of the following:
   (1) A decrease in payment or compensation resulting solely from a change in a published fee schedule upon which the payment or compensation is based and the date of applicability is clearly identified in the contract;
   (2) A decrease in payment or compensation that was anticipated under the terms of the contract, if the amount and date of applicability of the decrease is clearly identified in the contract;
   (3) An administrative change that may significantly increase the provider's administrative expense, the specific applicability of which is clearly identified in the contract;
   (4) Changes to an existing prior authorization, precertification, notification, or referral program that do not substantially increase the provider’s administrative expense;
   (5) Changes to an edit program or to specific edits if the participating provider is provided notice of the changes pursuant to division (A)(1) of section 3963.04 of the Revised Code and the notice includes information sufficient for the provider to determine the effect of the change;
   (6) Changes to a health care contract described in division (B) of section 3963.04 of the Revised Code.
(K) “Participating provider” means a provider that has a health care contract with a contracting entity and is entitled to reimbursement for health care services rendered to an enrollee under the health care contract.
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(L) “Payer” means any person that assumes the financial risk for the payment of claims under a health care contract or the reimbursement for health care services provided to enrollees by participating providers pursuant to a health care contract.

(M) “Primary enrollee” means a person who is responsible for making payments for participation in a health care plan or an enrollee whose employment or other status is the basis of eligibility for enrollment in a health care plan.

(N) “Procedure codes” includes the American medical association’s current procedural terminology code, the American dental association’s current dental terminology, and the centers for medicare and medicaid services health care common procedure coding system.

(O) “Product” means one of the following types of categories of coverage for which a participating provider may be obligated to provide health care services pursuant to a health care contract:

(1) A health maintenance organization or other product provided by a health insuring corporation;
(2) A preferred provider organization;
(3) Medicare;
(4) Medicaid;
(5) Workers’ compensation.

(P) “Provider” means a physician, podiatrist, dentist, chiropractor, optometrist, psychologist, physician assistant, advanced practice registered nurse, occupational therapist, massage therapist, physical therapist, licensed professional counselor, licensed professional clinical counselor, hearing aid dealer, orthotist, prosthetist, home health agency, hospice care program, pediatric respite care program, or hospital, or a provider organization or physician-hospital organization that is acting exclusively as an administrator on behalf of a provider to facilitate the provider’s participation in health care contracts. “Provider” does not mean a pharmacist, pharmacy, nursing home, or a provider organization or physician-hospital organization that leases the provider organization’s or physician-hospital organization’s network to a third party or contracts directly with employers or health and welfare funds.

(Q) “Specialty health care services” has the same meaning as in section 1751.01 of the Revised Code, except that it does not include any services listed in division (B) of section 1751.01 of the Revised Code that are provided by a pharmacist or a nursing home.

(R) “Supplemental health care services” has the same meaning as in division (B) of section 1751.01 of the Revised Code, except that it does not include any services listed in that division that are provided by a pharmacist or nursing home.

3963.02 Health care contracts; arbitration, prohibitions, and termination.

(A)(1) No contracting entity shall sell, rent, or give a third party the contracting entity’s rights to a participating provider’s services pursuant to the contracting entity’s health care contract with the participating provider unless one of the following applies:

(a) The third party accessing the participating provider’s services under the health care contract is an employer or other entity providing coverage for health care services to its employees or members, and that employer or entity has a contract with the contracting entity or its affiliate for the administration or processing of claims for payment for services provided pursuant to the health care contract with the participating provider.

(b) The third party accessing the participating provider’s services under the health care contract either is an affiliate or subsidiary of the contracting entity or is providing administrative services to, or receiving administrative services from, the contracting entity or an affiliate or subsidiary of the contracting entity.

(c) The health care contract specifically provides that it applies to network rental arrangements and states that one purpose of the contract is selling, renting, or giving the
contracting entity's rights to the services of the participating provider, including other preferred provider organizations, and the third party accessing the participating provider's services is any of the following:
(i) A payer or a third-party administrator or other entity responsible for administering claims on behalf of the payer;
(ii) A preferred provider organization or preferred provider network that receives access to the participating provider's services pursuant to an arrangement with the preferred provider organization or preferred provider network in a contract with the participating provider that is in compliance with division (A)(1)(c) of this section, and is required to comply with all of the terms, conditions, and affirmative obligations to which the originally contracted primary participating provider network is bound under its contract with the participating provider, including, but not limited to, obligations concerning patient steerage and the timeliness and manner of reimbursement.
(iii) An entity that is engaged in the business of providing electronic claims transport between the contracting entity and the payer or third-party administrator and complies with all of the applicable terms, conditions, and affirmative obligations of the contracting entity's contract with the participating provider including, but not limited to, obligations concerning patient steerage and the timeliness and manner of reimbursement.

(2) The contracting entity that sells, rents, or gives the contracting entity's rights to the participating provider's services pursuant to the contracting entity's health care contract with the participating provider as provided in division (A)(1) of this section shall do both of the following:
(a) Maintain a web page that contains a listing of third parties described in divisions (A)(1)(b) and (c) of this section with whom a contracting entity contracts for the purpose of selling, renting, or giving the contracting entity's rights to the services of participating providers that is updated at least every six months and is accessible to all participating providers, or maintain a toll-free telephone number accessible to all participating providers by means of which participating providers may access the same listing of third parties;
(b) Require that the third party accessing the participating provider's services through the participating provider's health care contract is obligated to comply with all of the applicable terms and conditions of the contract, including, but not limited to, the products for which the participating provider has agreed to provide services, except that a payer receiving administrative services from the contracting entity or its affiliate shall be solely responsible for payment to the participating provider.

(3) Any information disclosed to a participating provider under this section shall be considered proprietary and shall not be distributed by the participating provider.

(4) Except as provided in division (A)(1) of this section, no entity shall sell, rent, or give a contracting entity's rights to the participating provider's services pursuant to a health care contract.

(B)(1) No contracting entity shall require, as a condition of contracting with the contracting entity, that a participating provider provide services for all of the products offered by the contracting entity.

(2) Division (B)(1) of this section shall not be construed to do any of the following:
(a) Prohibit any participating provider from voluntarily accepting an offer by a contracting entity to provide health care services under all of the contracting entity's products;
(b) Prohibit any contracting entity from offering any financial incentive or other form of consideration specified in the health care contract for a participating provider to provide health care services under all of the contracting entity's products;
(c) Require any contracting entity to contract with a participating provider to provide health care services for less than all of the contracting entity's products if the contracting entity does not wish to do so.
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(3)(a) Notwithstanding division (B)(2) of this section, no contracting entity shall require, as a condition of contracting with the contracting entity, that the participating provider accept any future product offering that the contracting entity makes.

(b) If a participating provider refuses to accept any future product offering that the contracting entity makes, the contracting entity may terminate the health care contract based on the participating provider’s refusal upon written notice to the participating provider no sooner than one hundred eighty days after the refusal.

(4) Once the contracting entity and the participating provider have signed the health care contract, it is presumed that the financial incentive or other form of consideration that is specified in the health care contract pursuant to division (B)(2)(b) of this section is the financial incentive or other form of consideration that was offered by the contracting entity to induce the participating provider to enter into the contract.

(C) No contracting entity shall require, as a condition of contracting with the contracting entity, that a participating provider waive or forego any right or benefit expressly conferred upon a participating provider by state or federal law. However, this division does not prohibit a contracting entity from restricting a participating provider’s scope of practice for the services to be provided under the contract.

(D) No health care contract shall do any of the following:

(1) Prohibit any participating provider from entering into a health care contract with any other contracting entity;

(2) Prohibit any contracting entity from entering into a health care contract with any other provider;

(3) Preclude its use or disclosure for the purpose of enforcing this chapter or other state or federal law, except that a health care contract may require that appropriate measures be taken to preserve the confidentiality of any proprietary or trade-secret information.

(E)(1) In addition to any other lawful reasons for terminating a health care contract, a health care contract may only be terminated under the circumstances described in division (A)(3) of section 3963.04 of the Revised Code.

(2) If the health care contract provides for termination for cause by either party, the health care contract shall state the reasons that may be used for termination for cause, which terms shall be reasonable. Once the contracting entity and the participating provider have signed the health care contract, it is presumed that the reasons stated in the health care contract for termination for cause by either party are reasonable. Subject to division (E)(3) of this section, the health care contract shall state the time by which the parties must provide notice of termination for cause and to whom the parties shall give the notice.

(3) Nothing in divisions (E)(1) and (2) of this section shall be construed as prohibiting any health insuring corporation from terminating a participating provider’s contract for any of the causes described in divisions (A), (D), and (F)(1) and (2) of section 1753.09 of the Revised Code. Notwithstanding any provision in a health care contract pursuant to division (E)(2) of this section, section 1753.09 of the Revised Code applies to the termination of a participating provider’s contract for any of the causes described in divisions (A), (D), and (F)(1) and (2) of section 1753.09 of the Revised Code.

(4) Subject to sections 3963.01 to 3963.11 of the Revised Code, nothing in this section prohibits the termination of a health care contract without cause if the health care contract otherwise provides for termination without cause.

(F)(1) Disputes among parties to a health care contract that only concern the enforcement of the contract rights conferred by section 3963.02, divisions (A) and (D) of section 3963.03, and section 3963.04 of the Revised Code are subject to a mutually agreed upon arbitration mechanism that is binding on all parties. The arbitrator may award reasonable attorney’s fees and costs for arbitration relating to the enforcement of this section to the prevailing party.
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3963.03 Health care contracts; requirements; confidentiality.

A) Each health care contract shall include all of the following information:

   (1)(a) Information sufficient for the participating provider to determine the compensation or payment terms for health care services, including all of the following, subject to division (A)(1)(b) of this section:

      (i) The manner of payment, such as fee-for-service, capitation, or risk;

      (ii) The fee schedule of procedure codes reasonably expected to be billed by a participating provider's specialty for services provided pursuant to the health care contract and the associated payment or compensation for each procedure code. A fee schedule may be provided electronically. Upon request, a contracting entity shall provide a participating provider with the fee schedule for any other procedure codes requested and a written fee schedule, that shall not be required more frequently than twice per year excluding when it is provided in connection with any change to the schedule. This requirement may be satisfied by providing a clearly understandable, readily available mechanism, such as a specific web site address, that allows a participating provider to determine the effect of procedure codes on payment or compensation before a service is provided or a claim is submitted.

      (iii) The effect, if any, on payment or compensation if more than one procedure code applies to the service also shall be stated. This requirement may be satisfied by providing a clearly understandable, readily available mechanism, such as a specific web site address, that allows a participating provider to determine the effect of procedure codes on payment or compensation before a service is provided or a claim is submitted.

   (b) If the contracting entity is unable to include the information described in division (A)(1)(a)(ii) and (iii) of this section, the contracting entity shall include both of the following types of information instead:

      (i) The methodology used to calculate any fee schedule, such as relative value unit system and conversion factor or percentage of billed charges. If applicable, the methodology disclosure shall include the name of any relative value unit system, its version, edition, or publication date, any applicable conversion or geographic factor, and any date by which compensation or fee schedules may be changed by the methodology as anticipated at the time of contract.

      (ii) The identity of any internal processing edits, including the publisher, product name, version, and version update of any editing software.

   (c) If the contracting entity is not the payer and is unable to include the information described in division (A)(1)(a) or (b) of this section, then the contracting entity shall provide by
telephone a readily available mechanism, such as a specific web site address, that allows the participating provider to obtain that information from the payer.

(2) Any product or network for which the participating provider is to provide services;

(3) The term of the health care contract;

(4) A specific web site address that contains the identity of the contracting entity or payer responsible for the processing of the participating provider's compensation or payment;

(5) Any internal mechanism provided by the contracting entity to resolve disputes concerning the interpretation or application of the terms and conditions of the contract. A contracting entity may satisfy this requirement by providing a clearly understandable, readily available mechanism, such as a specific web site address or an appendix, that allows a participating provider to determine the procedures for the internal mechanism to resolve those disputes.

(6) A list of addenda, if any, to the contract.

(B)(1) Each contracting entity shall include a summary disclosure form with a health care contract that includes all of the information specified in division (A) of this section. The information in the summary disclosure form shall refer to the location in the health care contract, whether a page number, section of the contract, appendix, or other identifiable location, that specifies the provisions in the contract to which the information in the form refers.

(2) The summary disclosure form shall include all of the following statements:

(a) That the form is a guide to the health care contract and that the terms and conditions of the health care contract constitute the contract rights of the parties;

(b) That reading the form is not a substitute for reading the entire health care contract;

(c) That by signing the health care contract, the participating provider will be bound by the contract's terms and conditions;

(d) That the terms and conditions of the health care contract may be amended pursuant to section 3963.04 of the Revised Code and the participating provider is encouraged to carefully read any proposed amendments sent after execution of the contract;

(e) That nothing in the summary disclosure form creates any additional rights or causes of action in favor of either party.

(3) No contracting entity that includes any information in the summary disclosure form with the reasonable belief that the information is truthful or accurate shall be subject to a civil action for damages or to binding arbitration based on the summary disclosure form. Division (B)(3) of this section does not impair or affect any power of the department of insurance to enforce any applicable law.

(4) The summary disclosure form described in divisions (B)(1) and (2) of this section shall be in substantially the following form:

“SUMMARY DISCLOSURE FORM

(1) Compensation terms

(a) Manner of payment

[ ] Fee for service

[ ] Capitation

[ ] Risk

[ ] Other ____________________________

See ____________________________

(b) Fee schedule available at ____________________________

(c) Fee calculation schedule available at ____________________________
(d) Identity of internal processing edits available at
________________________________________

(e) Information in (c) and (d) is not required if information in (b) is provided.

(2) List of products or networks covered by this contract
[ ] __________________________________________________
[ ] __________________________________________________
[ ] __________________________________________________
[ ] __________________________________________________
[ ] __________________________________________________

(3) Term of this contract ____________________________________________

(4) Contracting entity or payer responsible for processing payment available at
_______________________________________________________________

(5) Internal mechanism for resolving disputes regarding contract terms available at
_______________________________________________________________

(6) Addenda to contract

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(7) Telephone number to access a readily available mechanism, such as a specific web site address, to allow a participating provider to receive the information in (1) through (6) from the payer.

IMPORTANT INFORMATION--PLEASE READ CAREFULLY

The information provided in this Summary Disclosure Form is a guide to the attached Health Care Contract as defined in section 3963.01(G) of the Ohio Revised Code. The terms and conditions of the attached Health Care Contract constitute the contract rights of the parties. Reading this Summary Disclosure Form is not a substitute for reading the entire Health Care Contract. When you sign the Health Care Contract, you will be bound by its terms and conditions. These terms and conditions may be amended over time pursuant to section 3963.04 of the Ohio Revised Code. You are encouraged to read any proposed amendments that are sent to you after execution of the Health Care Contract.

Nothing in this Summary Disclosure Form creates any additional rights or causes of action in favor of either party.”

(C) When a contracting entity presents a proposed health care contract for consideration by a provider, the contracting entity shall provide in writing or make reasonably available the information required in division (A)(1) of this section.

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(D) The contracting entity shall identify any utilization management, quality improvement, or a similar program that the contracting entity uses to review, monitor, evaluate, or assess the services provided pursuant to a health care contract. The contracting entity shall disclose the policies, procedures, or guidelines of such a program applicable to a participating provider upon request by the participating provider within fourteen days after the date of the request.

(E) Nothing in this section shall be construed as preventing or affecting the application of section 1753.07 of the Revised Code that would otherwise apply to a contract with a participating provider.

(F) The requirements of division (C) of this section do not prohibit a contracting entity from requiring a reasonable confidentiality agreement between the provider and the contracting entity regarding the terms of the proposed health care contract. If either party violates the confidentiality agreement, a party to the confidentiality agreement may bring a civil action to enjoin the other party from continuing any act that is in violation of the confidentiality agreement, to recover damages, to terminate the contract, or to obtain any combination of relief.

3963.04 Health care contract amendments; notice, exceptions.

(A)(1) If an amendment to a health care contract is not a material amendment, the contracting entity shall provide the participating provider notice of the amendment at least fifteen days prior to the effective date of the amendment. The contracting entity shall provide all other notices to the participating provider pursuant to the health care contract.

(2) A material amendment to a health care contract shall occur only if the contracting entity provides to the participating provider the material amendment in writing and notice of the material amendment not later than ninety days prior to the effective date of the material amendment. The notice shall be conspicuously entitled “Notice of Material Amendment to Contract.”

(3) If within fifteen days after receiving the material amendment and notice described in division (A)(2) of this section, the participating provider objects in writing to the material amendment, and there is no resolution of the objection, either party may terminate the health care contract upon written notice of termination provided to the other party not later than sixty days prior to the effective date of the material amendment.

(4) If the participating provider does not object to the material amendment in the manner described in division (A)(3) of this section, the material amendment shall be effective as specified in the notice described in division (A)(2) of this section.

(B)(1) Division (A) of this section does not apply if the delay caused by compliance with that division could result in imminent harm to an enrollee, if the material amendment of a health care contract is required by state or federal law, rule, or regulation, or if the provider affirmatively accepts the material amendment in writing and agrees to an earlier effective date than otherwise required by division (A)(2) of this section.

(2) This section does not apply under any of the following circumstances:
   (a) The participating provider’s payment or compensation is based on the current medicaid or medicare physician fee schedule, and the change in payment or compensation results solely from a change in that physician fee schedule.
   (b) A routine change or update of the health care contract is made in response to any addition, deletion, or revision of any service code, procedure code, or reporting code, or a pricing change is made by any third party source.

For purposes of division (B)(2)(b) of this section:
   (i) “Service code, procedure code, or reporting code” means the current procedural terminology (CPT), current dental terminology (CDT), the healthcare common procedure coding system (HCPCS), the international classification of diseases (ICD), or the drug topics redbook average wholesale price (AWP).
(ii) “Third party source” means the American medical association, American dental association, the centers for medicare and medicaid services, the national center for health statistics, the department of health and human services office of the inspector general, the Ohio department of insurance, or the Ohio department of medicaid.

(C) Notwithstanding divisions (A) and (B) of this section, a health care contract may be amended by operation of law as required by any applicable state or federal law, rule, or regulation. Nothing in this section shall be construed to require the renegotiation of a health care contract that is in existence before June 25, 2008, until the time that the contract is renewed or materially amended.

3963.05 Standard credentialing form.

(A) The department of insurance shall prescribe the credentialing application form used by the council for affordable quality healthcare (CAQH) in electronic or paper format for physicians. The department of insurance also shall prepare the standard credentialing form for all other providers and shall make the standard credentialing form as simple, straightforward, and easy to use as possible, having due regard for those credentialing forms that are widely in use in the state by contracting entities and that best serve these goals.

(B) No contracting entity shall fail to use the applicable standard credentialing form described in division (A) of this section when initially credentialing or recredentialing providers in connection with policies, health care contracts, and agreements providing basic health care services, specialty health care services, or supplemental health care services.

(C) No contracting entity shall require a provider to provide any information in addition to the information required by the applicable standard credentialing form described in division (A) of this section in connection with policies, health care contracts, and agreements providing basic health care services, specialty health care services, or supplemental health care services.

(D) The credentialing process described in this section does not prohibit a contracting entity from limiting the scope of any participating provider’s basic health care services, specialty health care services, or supplemental health care services.

(E) The requirement that the department of insurance prepare the standard credentialing form for all other providers does not include preparing the standard credentialing form for a hospital.

3963.06 Incomplete credentialing form.

(A) If a provider, upon the oral or written request of a contracting entity to submit a credentialing form, submits a credentialing form that is not complete, the contracting entity that receives the form shall notify the provider of the deficiency electronically, by facsimile, or by certified mail, return receipt requested, not later than twenty-one days after the contracting entity receives the form.

(B) If a contracting entity receives any information that is inconsistent with the information given by the provider in the credentialing form, the contracting entity may request the provider to submit a written clarification of the inconsistency. The contracting entity shall send the request described in this division electronically, by facsimile, or by certified mail, return receipt requested.

(C)(1) Except as otherwise provided in division (C)(2) of this section, the credentialing process under this section starts when a provider initially submits a credentialing form upon the oral or written request of a contracting entity, and the provider shall submit the credentialing form to the contracting entity electronically, by facsimile, or by certified mail, return receipt requested. Subject to division (C)(3) of this section, a contracting entity shall complete the credentialing process not later than ninety days after the contracting entity receives that
credentialing form from the provider. The contracting entity shall allow the provider to submit a credentialing application prior to the provider’s employment. A contracting entity that does not complete the credentialing process within the ninety-day period specified in this division is liable for either a civil penalty payable to the provider in the amount of five hundred dollars per day, including weekend days, starting at the expiration of that ninety-day period until the provider’s credentialing application is granted or denied or retroactive reimbursement to the provider according to the terms of the contract for any basic health care services, specialty health care services, or supplemental health care services the provider provided to enrollees starting at the expiration of that ninety-day period until the provider’s credentialing application is granted or denied. When the credentialing process of the contracting entity exceeds the ninety-day period, the contracting entity shall select the liability to which the contracting entity is subject and shall inform the provider of the contracting entity’s selection.

(2) The credentialing process for a medicaid managed care plan starts when the provider submits a credentialing form and the provider’s national provider number issued by the centers for medicare and medicaid services.

(3) The requirement that the credentialing process be completed within the ninety-day period specified in division (C)(1) of this section does not apply to a contracting entity if a provider that submits a credentialing form to the contracting entity under that division is a hospital.

(D) Any communication between the provider and the contracting entity shall be electronically, by facsimile, or by certified mail, return receipt requested.

(E) If the state medical board or its agent has primary source verified the medical education, graduate medical education, and examination history of the physician, or the status of the physician with the educational commission for foreign medical graduates, if applicable, the contracting entity may accept the documentation of primary source verification from the state medical board’s web site or from its agent and is not required to perform primary source verification of the medical education, graduate medical education, and examination history of the physician or the status of the physician with the educational commission for foreign medical graduates, if applicable, as a condition for initially credentialing or recredentialing the physician.

3963.11 Prohibition against use of most favored nation clauses.

(A) No contracting entity shall do any of the following:

(1) Offer to a provider a health care contract that includes a most favored nation clause;

(2) Enter into a health care contract with a provider that includes a most favored nation clause;

(3) Amend or renew an existing health care contract previously entered into with a provider so that the contract as amended or renewed adds or continues to include a most favored nation clause.

(B) As used in this section:

(1) “Contracting entity,” “health care contract,” “health care services,” “participating provider,” and “provider” have the same meanings as in section 3963.01 of the Revised Code.

(2) “Most favored nation clause” means a provision in a health care contract that does any of the following:

(a) Prohibits, or grants a contracting entity an option to prohibit, the participating provider from contracting with another contracting entity to provide health care services at a lower price than the payment specified in the contract;

(b) Requires, or grants a contracting entity an option to require, the participating provider to accept a lower payment in the event the participating provider agrees to provide health care services to any other contracting entity at a lower price;
(c) Requires, or grants a contracting entity an option to require, termination or renegotiation of the existing health care contract in the event the participating provider agrees to provide health care services to any other contracting entity at a lower price;
(d) Requires the participating provider to disclose the participating provider’s contractual reimbursement rates with other contracting entities.

5162.80 Health services cost estimates.
(A) A provider of medical services licensed, accredited, or certified under Chapter 3721., 3727., 4715., 4731., 4732., 4734., 4747., 4753., 4755., 4757., or 4779 of the Revised Code shall provide in writing, before products, services, or procedures are provided, a reasonable, good-faith estimate of all of the following for the provider's non-emergency products, services, or procedures:
(1) The amount the provider will charge the patient or the consumer's health plan issuer for the product, service, or procedure;
(2) The amount the health plan issuer intends to pay for the product, service, or procedure;
(3) The difference, if any, that the consumer or other party responsible for the consumer's care would be required to pay to the provider for the product, service, or procedure.
(B) Any health plan issuer contacted by a provider described in division (A) of this section in order for the provider to obtain information so that the provider can comply with division (A) of this section shall provide such information to the provider within a reasonable time of the provider’s request.
(C) As used in this section, “health plan issuer” means an entity subject to the insurance laws and rules of this state, or subject to the jurisdiction of the superintendent of insurance, that contracts, or offers to contract, to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services under a health benefit plan, including a sickness and accident insurance company and a health insuring corporation. “Health plan issuer” also includes a managed care organization under contract with the department of medicaid and, if the services are to be provided on a fee-for-service basis, the Medicaid program.
(D) The medicaid director shall adopt rules, in accordance with Chapter 119 of the Revised Code, to carry out this section.

5168.05 Hospital cost report.
[Editor’s Note: This statute is repealed effective 10/16/2019.]
(A) Except as provided in division (C) of this section, each hospital, on or before the first day of July of each year or at a later date approved by the medicaid director, shall submit to the department of medicaid a financial statement for the preceding calendar year that accurately reflects the income, expenses, assets, liabilities, and net worth of the hospital, and accompanying notes. A hospital that has a fiscal year different from the calendar year shall file its financial statement within one hundred eighty days of the end of its fiscal year or at a later date approved by the director. The financial statement shall be prepared by an independent certified public accountant and reflect an official audit report prepared in a manner consistent with generally accepted accounting principles. The financial statement shall, to the extent that the hospital has sufficient financial records, show bad debt and charity care separately from courtesy care and contractual allowances.
(B) Except as provided in division (C) of this section, each hospital, within one hundred eighty days after the end of the hospital's cost reporting period, shall submit to the department a cost report in a format prescribed in rules adopted under section 5168.02 of the Revised Code.
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The department shall grant a hospital an extension of the one hundred eighty day period if the health care financing administration of the United States department of health and human services extends the date by which the hospital must submit its cost report for the hospital's cost reporting period.

(C) The director may adopt rules under section 5168.02 of the Revised Code specifying financial information that must be submitted by hospitals for which no financial statement or cost report is available. The rules shall specify deadlines for submitting the information. Each such hospital shall submit the information specified in the rules not later than the deadline specified in the rules.

5168.14 Individual, basic services and poverty line.

[Editor's Note: This version of the statute is effective until 12/31/2017. The version effective subsequently is included next.]

(A) Each hospital that receives funds distributed under sections 5168.01 to 5168.14 of the Revised Code shall provide, without charge to the individual, basic, medically necessary hospital-level services to individuals who are residents of this state, are not medicaid recipients, and whose income is at or below the federal poverty line. Recipients of disability financial assistance provided under Chapter 5115 of the Revised Code qualify for services under this section. The medicaid director shall adopt rules under section 5168.02 of the Revised Code specifying the hospital services to be provided under this section.

(B) Nothing in this section shall be construed to prevent a hospital from requiring an individual to apply for the medicaid program before the hospital processes an application under this section. Hospitals may bill any third-party payer for services rendered under this section. Hospitals may bill the medicaid program, in accordance with state statutes governing the medicaid program and rules adopted under those statutes, for medicaid services rendered under this section if the individual becomes a medicaid recipient. Hospitals may bill individuals for services under this section if all of the following apply:

1. The hospital has an established post-billing procedure for determining the individual's income and canceling the charges if the individual is found to qualify for services under this section.

2. The initial bill, and at least the first follow-up bill, is accompanied by a written statement that does all of the following:

   a. Explains that individuals with income at or below the federal poverty line are eligible for services without charge;
   
   b. Specifies the federal poverty line for individuals and families of various sizes at the time the bill is sent;
   
   c. Describes the procedure required by division (C)(1) of this section.

3. The hospital complies with any additional rules adopted under section 5168.02 of the Revised Code.

Notwithstanding division (B) of this section, a hospital providing care to an individual under this section is subrogated to the rights of any individual to receive compensation or benefits from any person or governmental entity for the hospital goods and services rendered.

(C) Each hospital shall collect and report to the department of medicaid, in the form and manner prescribed by the department, information on the number and identity of patients served pursuant to this section.

(D) This section applies beginning May 22, 1992, regardless of whether rules specifying the services to be provided have been adopted. Nothing in this section alters the scope or limits the obligation of any governmental entity or program, including the program awarding reparations to victims of crime under sections 2743.51 to 2743.72 of the Revised Code and the...
program for medically handicapped children established under section 3701.023 of the Revised Code, to pay for hospital services in accordance with state or local law.

**5168.14 Individual, basic services and poverty line.**

[Editor's Note: This version of the statute is effective 12/31/2017. The version effective previously is included in the prior pages.]

(A) Each hospital that receives funds distributed under sections 5168.01 to 5168.14 of the Revised Code shall provide, without charge to the individual, basic, medically necessary hospital-level services to individuals who are residents of this state, are not medicaid recipients, and whose income is at or below the federal poverty line. The medicaid director shall adopt rules under section 5168.02 of the Revised Code specifying the hospital services to be provided under this section.

(B) Nothing in this section shall be construed to prevent a hospital from requiring an individual to apply for the medicaid program before the hospital processes an application under this section. Hospitals may bill any third-party payer for services rendered under this section. Hospitals may bill the medicaid program, in accordance with state statutes governing the medicaid program and rules adopted under those statutes, for medicaid services rendered under this section if the individual becomes a medicaid recipient. Hospitals may bill individuals for services under this section if all of the following apply:

1. The hospital has an established post-billing procedure for determining the individual's income and canceling the charges if the individual is found to qualify for services under this section.
2. The initial bill, and at least the first follow-up bill, is accompanied by a written statement that does all of the following:
   a. Explains that individuals with income at or below the federal poverty line are eligible for services without charge;
   b. Specifies the federal poverty line for individuals and families of various sizes at the time the bill is sent;
   c. Describes the procedure required by division (C)(1) of this section.
3. The hospital complies with any additional rules adopted under section 5168.02 of the Revised Code.

Notwithstanding division (B) of this section, a hospital providing care to an individual under this section is subrogated to the rights of any individual to receive compensation or benefits from any person or governmental entity for the hospital goods and services rendered.

(C) Each hospital shall collect and report to the department of medicaid, in the form and manner prescribed by the department, information on the number and identity of patients served pursuant to this section.

(D) This section applies beginning May 22, 1992, regardless of whether rules specifying the services to be provided have been adopted. Nothing in this section alters the scope or limits the obligation of any governmental entity or program, including the program awarding reparations to victims of crime under sections 2743.51 to 2743.72 of the Revised Code and the program for medically handicapped children established under section 3701.023 of the Revised Code, to pay for hospital services in accordance with state or local law.

**5160-2-23 Cost reports.**

(A) For cost-reporting purposes, the medicaid program requires each eligible provider, as defined in rule 5160-2-01 of the Administrative Code, to submit periodic reports that generally cover a consecutive twelve-month period of the provider's operations. Failure to submit all
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necessary items and schedules will delay processing and may result in a reduction of payment or termination as a provider as described in paragraph (A)(7) of this rule.

Effective for medicaid cost reports filed for cost-reporting periods ending in state fiscal year (SFY) 2003, and each cost-reporting period thereafter, any hospital that fails to submit cost reports on or before the dates specified by ODM shall be fined one thousand dollars for each day after the due date that the information is not reported.

The hospital shall complete and submit the ODM 02930 “Ohio Medicaid Hospital Cost Report” that is applicable to the state fiscal year in which the hospital’s cost reporting period ends. The hospital’s cost report must:

1. Be prepared in accordance with medicare principles governing reasonable cost reimbursement set forth in the providers' reimbursement manual “CMS Publications, 15-1 and 15-2”, as applicable to the hospital's reporting period.
2. Include all information necessary for the proper determination of costs payable under medicaid, including financial records and statistical data.
3. Be submitted in accordance with the cost report instructions and include an electronic copy of the medicare cost report, which must be identical in all respects to the cost report submitted to the medicare fiscal intermediary.
4. Include the cost report certification executed by an officer of the hospital attesting to the accuracy of the cost report and to the accuracy of the OBRA survey. In addition, all subsequent revisions to the cost report must include an executed certification.
5. Effective for medicaid cost reports filed for cost-reporting periods ending in SFY 2003, and each cost-reporting period thereafter, the executed certification shall require the officer of the hospital to acknowledge that an independent, certified public accountant, has successfully verified the data reported on “Schedule F” of the cost report in accordance with the procedures included in the cost report instructions. In addition, all subsequent revisions to “Schedule F” shall also be successfully verified by an independent, certified public accountant in accordance with the recertification procedures included in the cost report instructions.
6. For hospital reporting periods ending between January first and June thirtieth the cost report must be postmarked on or before December thirty-first of the same calendar year. For hospital reporting periods ending between July first and December thirty-first, the cost report must be postmarked on or before June thirtieth of the following calendar year.
   (a) Extensions may be granted as specified in the cost report instructions.
   (b) The department may grant a blanket extension that affects one or both of the due dates described in paragraph (A)(6) of this rule. When the department grants a blanket extension, hospitals may still request an extension as specified in paragraph (A)(6)(a) of this rule.
7. Hospitals that fail to submit cost reports timely as described in paragraph (A) of this rule will receive a delinquency letter from ODM and are subject to notification that thirty days following the date on which the cost report was due, payments for hospital services will be suspended. Suspension of payments will be terminated on the fifth working day following receipt of the delinquent cost report. At the beginning of the third month following the month in which the hospital cost report became overdue, if the cost report has not yet been submitted, termination of the provider from the program will be proposed in accordance with Chapter 5160-1 of the Administrative Code.
8. Hospitals shall separately report all supplemental payments received for services provided during the cost report period, including “Upper Limit Payments and Medicaid Managed Care Incentive Payments,” as established by Section 309.30.33 of Am Sub. H.B. 153 of the 129th General Assembly, and continued as a baseline program.

(B) Hospitals having a distinct part psychiatric or rehabilitation unit recognized by medicare in accordance with the provisions of 42 C.F.R. 412.25 effective as of October 1, 2014, 42 C.F.R. 412.27 effective as of October 1, 2014, and 42 C.F.R. 412.29 effective as of October
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1, 2014, must identify distinct part unit costs separately within the cost report as described in paragraph (A) of this rule.

(C) Ohio hospitals performing ambulatory surgery within the hospital outpatient setting must identify ambulatory surgery costs and charges separately within the cost report as described in paragraph (A) of this rule.

(D) Ohio hospitals providing services to medicaid managed care plan (MCP) enrollees must identify MCP costs, charges and payments separately within the cost report as described in paragraph (A) of this rule.

(E) It is not necessary for the hospital to wait for the medicare (Title XVIII) audit in order to file the initial cost report for the stated time period. The interim cost report filing can be audited by ODM prior to any applicable final adjustment and settlement. If an amount is due ODM as a result of the filing, payment must be forwarded, in accordance with the cost report instructions, at the time the cost report is submitted for it to be considered a complete filing. Any revised interim cost report must be received within thirty days of the mailing of the interim cost settlement. A desk audit will be performed by the hospital audit section on all as filed and interim cost reports. An interim cost settlement by ODM does not preclude the finding of additional cost exceptions in a final settlement for the same cost-reporting period.

(1) If an amended medicare cost report is filed with the medicare fiscal intermediary, a copy of the amended medicare cost report must be filed with the hospital audit section. Information contained in the amended medicare cost report will be incorporated into the interim cost report, as originally filed, if received prior to interim settlement; otherwise, it is subject to the provisions of paragraph (E) of this rule.

(2) Adjustments may be made to the interim cost report as described in rule 5160-2-24 of the Administrative Code.

(F) Out-of-state providers that are paid on a non-diagnostic related groups (DRG) prospective payment basis as described in rule 5160-2-22 of the Administrative Code and provide inpatient and/or outpatient services to eligible Ohio Title XIX recipients will be required to file the cost report identified in this rule.

5160-2-07.17 Provision of basic, medically necessary hospital-level services.

Under the provisions of section 5168.14 of the Revised Code, each hospital that receives payment under the provisions of Chapter 5168 of the Revised Code, shall provide, without charge to the individual, basic, medically necessary hospital-level services to the individual who is a resident of this state, is not a recipient of the medicaid program and whose income is at or below the federal poverty line. Residence is established by a person who is living in Ohio voluntarily and who is not receiving public assistance in another state. Current recipients of the disability assistance (DA) program as defined in Chapter 5115 of the Revised Code or its successor program, qualify for services under the provisions of this rule.

(A) Definitions.

(1) “Basic, medically necessary hospital level services” are defined as all inpatient and outpatient services covered under the medicaid program in Chapter 5160-2 of the Administrative Code with the exception of transplantation services and services associated with transplantation. These covered services must be ordered by an Ohio licensed physician and delivered at a hospital where the physician has clinical privileges, and where such services are permissible to be provided by the hospital under its certificate of authority granted under Chapters 3711., 3727., and/or 5119 of the Revised Code. Hospitals will be responsible for providing basic, medically necessary hospital-level services to those persons described in paragraph (B) of this rule.
(2) “Third-party payer” means any private or public entity or program that may be liable by law or contract to make payment to or on behalf of an individual for health care services. Third-party payer does not include a hospital.

(B) Determination of eligibility.

A person is eligible for basic, medically necessary hospital-level services under the provisions of this rule if the person is a current recipient of the DA program or its successor program, or the person's individual or family income is at or below the current poverty guideline issued by the department of health and human services (available at: http://www.medicaid.ohio.gov/FOROHIOANS/FinancialRequirements. The current poverty guideline that applies to the individual or family is calculated using either of the methods described in paragraphs (B)(2)(a) and (B)(2)(b) of this rule on the date these services were provided.

(1) For purposes of this rule, a “family” shall include the patient, the patient's spouse (regardless of whether they live in the home), and all of the patient's children, natural or adoptive, under the age of eighteen who live in the home. If the patient is under the age of eighteen, the “family” shall include the patient, the patient's natural or adoptive parent(s) (regardless of whether they live in the home), and the parent(s)' children, natural or adoptive, under the age of eighteen who live in the home. If the income of a spouse or parent who does not live in the home cannot be obtained, or the absent spouse or parent does not contribute income to the family, determination of eligibility shall proceed with the available income information. If the patient is the child of a minor parent who still resides in the home of the patient's grandparents, the “family” shall include only the parent(s) and any of the parent(s)' children, natural or adoptive, who reside in the home.

(2) “Income” shall be defined as total salaries, wages, and cash receipts before taxes; cash receipts that reflect reasonable deductions for business expenses shall be counted for both farm and non-farm self-employment. Income will be calculated by:

(a) Multiplying the person's or family's income by four, as applicable, for the three months preceding the date hospital services were provided;

(b) Using the person's or family's income, as applicable, for the twelve months preceding the date hospital services were provided.

(3) For outpatient hospital services, a hospital may consider an eligibility determination to be effective for ninety days from the initial service date, during which a new eligibility determination need not be completed. Eligibility for inpatient hospital services must be determined separately for each admission, unless the patient is readmitted within forty-five days of discharge for the same underlying condition. Eligibility for recipients of the DA program or its successor program must be verified on a monthly basis.

(4) A complete application for the hospital care assurance program is required prior to determination of eligibility. Each hospital shall develop an application that, at a minimum, must document income, family size and eligibility for the medicaid program. The patient or a legal representative is required to sign the application. An unsigned application can be deemed acceptable if the patient is physically unable to sign the application or does not live in the vicinity of the hospital and is unable to return a signed application by mail. In these situations, the hospital representative shall complete all questions on the application, sign the application, and must document why the patient is unable to sign the application.

(5) The hospital shall accept application for services without charge until three years from the date of the follow-up notice, as described in paragraphs (C)(2) and (C)(3) of this rule, has elapsed.

(6) Applicants shall cooperate in supplying information about health insurance or medical benefits available so a hospital may determine any potential third-party resources that may be available.
(7) Nothing in this rule shall be construed to prevent a hospital from assisting and/or requiring an individual to apply for medicaid before the hospital processes an application under this rule.

(C) Billing requirements.
Hospitals may bill any third-party payer that has a legal liability to pay for services rendered under the provisions of this rule. Hospitals may bill the medicaid program in accordance with Chapter 5164 of the Revised Code and the rules adopted under that chapter for services rendered under the provisions of this rule if the individual becomes a recipient of the medicaid program. Hospitals may bill individuals for services if all of the following apply:

(1) The hospital has an established post-billing procedure for determining the individual’s income and canceling the charges if the individual is found to qualify for services under the provisions of this rule;
(2) The initial bill, and at least the first follow-up bill, is accompanied by a written statement that does all of the following:
   (a) Explains that individuals with income at or below the federal poverty guidelines are eligible for services without charge;
   (b) Specifies the federal poverty guideline for individuals and families of various sizes at the time the bill is sent; and
   (c) Describes the procedure required by paragraph (C)(1) of this rule.
(3) If the written statement as described in paragraph (C)(2) of this rule is printed on the back of the hospital’s bill or data-mailer, the hospital must reference the statement on the front of the bill or data-mailer; and
(4) Notwithstanding paragraph (B) of this rule, a hospital providing care to an individual under the provisions of this rule is subrogated to the rights of any individual to receive compensation or benefits from any person or governmental entity for the hospital goods and services rendered.

(D) Notice requirements.
Each hospital that receives payment under Chapter 5168 of the Revised Code shall post notices in appropriate areas of their facility, which include the admissions areas, the business office, and the emergency room; the posted notices are not limited to these areas. The posted notices must specify the rights of persons with incomes at or below the federal poverty line to receive, without charge to the individual, basic, medically necessary hospital-level services at the hospital.

Posted notices must contain all of the following in order to comply with the requirement as described in this paragraph:
(1) At a minimum, the posted notices must specify the rights of these individuals to receive without charge, basic, medically necessary hospital-level services;
(2) The wording of the posted notice must be clear and in simple terms understandable by the population serviced;
(3) Posted notice must be printed in English and other languages that are common to the population of the area serviced;
(4) The posted notice must be clearly readable at a distance of twenty feet or the expected vantage point of the patrons; and
(5) The facility shall make reasonable efforts to communicate the contents of the posted notice to persons it has reason to believe cannot read the notice.

(E) Documentation requirements.
Each hospital shall establish and maintain a written policy outlining its internal policy for administration of the hospital care assurance program in compliance with this rule and with rule 5160-2-23 of the Administrative Code. Each hospital may change its written policy as needed, but policy changes may not be implemented retroactively. The written policy shall include, but is not limited to, the following:
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(1) Procedure for taking applications and a copy of the current application in use as described in paragraph (B) of this rule; and

(2) Procedure for eligibility determination including the determination of family size and determination of income. If the hospital requires verification of income other than the application, the written policy should describe what constitutes acceptable income documentation.

(F) Reporting requirements.
Each hospital shall collect and report to the department information on the number and categorical identity of persons served under the provisions of this rule.

(1) This information will be reported on the ODM 02930, schedule F, which must be submitted annually along with a certification of the accuracy of this reported data as required by rule 5160-2-23 of the Administrative Code. The ODM 02930 and instructions for completion are available on the department's website.

(2) The use of estimation methods to determine amounts for charges related to non-hospital level services or to determine the health insurance status of patients charges on patient accounts is not permitted.

(3) Each hospital shall maintain, make available for department review and provide to the department on request, any records necessary to document its compliance with the provisions of this rule, including:

(a) Any documents, including medical records of the population served, from which the information required to be reported on the ODM 02930 was obtained;

(b) Accounts that clearly segregate the services rendered under the provisions of this rule from other accounts;

(c) Copies of the determinations of eligibility under paragraph (B) of this rule; and

(d) A copy of the disability assistance card or other evidence of eligibility for any person who is a recipient of the DA program or its successor program at the time the services defined in paragraph (A) of this rule were delivered.

(4) Hospitals must retain these records for a period of six years from the date of receipt of payment based upon those records or until any audit initiated within the six year period is completed.

(G) This rule in no way alters the scope or limits the obligation of any governmental entity or program, including the program awarding reparations to victims of crime under sections 2743.51 to 2743.72 of the Revised Code and the program for medically handicapped children established under section 3701.023 of the Revised Code, to pay for hospital services in accordance with state or local law.

5160-2-08.1 Assessment rates.

The provisions of this rule are applicable for the program year(s) specified in this rule for all hospitals as defined under section 5168.01 of the Revised Code.

(A) Applicability.
The requirements of this rule apply as long as the United States centers for medicare and medicaid services (CMS) determines that the assessment imposed under section 5168.06 of the Revised Code is a permissible health care related tax. Whenever the department of medicaid is informed that the assessment is an impermissible health care-related tax, the department shall promptly refund to each hospital the amount of money currently in the hospital care assurance match fund that has been paid by the hospital, plus any investment earnings on that amount.

(B) The program years to which this rule applies are identified in paragraphs (B)(1) to (B)(3) of this rule. When the department is notified by the centers for medicare and medicaid services that an additional disproportionate share allotment is available for a prior program year, the department may amend the assessment rates for the prior program year.
(1) The assessment rates applicable to the program year that ends in calendar year 2016 are specified in paragraph (C) of this rule.
(2) The assessment rates applicable to the program year that ends in calendar year 2017 are specified in paragraph (D) of this rule.
(3) The revised assessment rates applicable to the program year that ends in calendar year 2014 are specified in paragraph (E) of this rule.

(C) Calculation of assessment amounts.
The calculations described in this rule will be based on cost-reporting data described in rule 5160-2-23 of the Administrative Code that reflect the most recently completed interim settled medicaid cost report for all hospitals. For non-medicaid participating hospitals, the calculations shall be based on the most recent as-filed medicare cost report.
The assessment is calculated as follows:
(1) Determine each hospital's adjusted total facility costs as the amount calculated in paragraph (A)(17) of rule 5160-2-08 of the Administrative Code.
(2) For hospitals with adjusted total facility costs, as described in paragraph (C)(1) of this rule, that are less than or equal to $216,372,500, multiply the hospital's adjusted total facility costs as described in paragraph (C)(1) of this rule by 0.008354365. The product will be each hospital's assessment amount. For hospitals with adjusted total facility costs, as described in paragraph (C)(1) of this rule, that are greater than $216,372,500, multiply a factor of 0.008354365 times the hospital's adjusted total facility costs as described in paragraph (C)(1) of this rule, up to $216,372,500. Multiply a factor of 0.00668 times the hospital's adjusted total facility costs as described in paragraph (C)(1) of this rule, that are in excess of $216,372,500. The sum of the two products will be each hospital's assessment amount.
(3) The assessment amounts calculated in paragraph (C)(2) of this rule are subject to adjustment under the provisions of paragraph (G) of this rule.

(D) Calculation of assessment amounts.
The calculations described in this rule will be based on cost-reporting data described in rule 5160-2-23 of the Administrative Code that reflect the most recently completed interim settled medicaid cost report for all hospitals. For non-medicaid participating hospitals, the calculations shall be based on the most recent as-filed medicare cost report.
(1) Determine each hospital's adjusted total facility costs as the amount calculated in paragraph (A)(17) of rule 5160-2-08 of the Administrative Code.
(2) For hospitals with adjusted total facility costs, as described in paragraph (D)(1) of this rule, that are less than or equal to $216,372,500, multiply the hospital's adjusted total facility costs as described in paragraph (D)(1) of this rule by one and one half per cent. The product will be each hospital's assessment amount. For hospitals with adjusted total facility costs, as described in paragraph (D)(1) of this rule, that are greater than $216,372,500, multiply a factor of one and one half per cent times the hospital's adjusted total facility costs as described in paragraph (D)(1) of this rule, up to $216,372,500. Multiply a factor of one per cent times the hospital's adjusted total facility costs as described in paragraph (D)(1) of this rule, that are in excess of $216,372,500. The sum of the two products will be each hospital's assessment amount.
(3) The assessment amounts calculated in paragraph (D)(2) of this rule are subject to adjustment under the provisions of paragraph (G) of this rule.
(4) The department may establish a rate lower than the rates described in paragraph (D)(2) of this rule through the notification and reconsideration procedures described in paragraph (G) of this rule.

(E) For the program year specified in paragraph (B)(3) of this rule, the assessment rates specified in rule 5160-2-08.1 of the Administrative Code, effective June 25, 2015 are revised in paragraphs (E)(1) to (E)(3) of this rule.
(1) The original adjusted total facility cost threshold of $216,372,500 is unchanged.
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(2) The original tier one assessment rate of 0.008401502 is increased to 0.0084150187.
(3) The original tier two assessment rate of 0.00663 is unchanged.

(F) Determination of intergovernmental transfer amounts.
The department may require governmental hospitals, as described in paragraph (A)(2) of rule 5160-2-08 of the Administrative Code, to make intergovernmental transfers each program year.

The department shall notify each governmental hospital of the amount of the intergovernmental transfer it is required to make during the program year.

Each governmental hospital shall make intergovernmental transfers in periodic installments, executed by electronic funds transfer.

(G) Notification and reconsideration procedures.

(1) The department shall mail by certified mail, return receipt requested, the results of the determinations made under paragraphs (C) and (D) of this rule to each hospital. If no hospital submits a request for reconsideration as described in paragraph (G)(2) of this rule, the preliminary determinations constitute the final reconciliation of the amounts that each hospital must pay under this rule.

(2) Not later than fourteen days after the department mails the preliminary determinations as described in paragraphs (C) and (D) of this rule, any hospital may submit to the department a written request for reconsideration of the preliminary determination made under paragraphs (C) and (D) of this rule. The request must be accompanied by written materials setting forth the basis for the reconsideration.

If one or more hospitals submit such a request, the department shall hold a public hearing in Columbus, Ohio not later than thirty days after the preliminary determinations have been mailed by the department for the purpose of reconsidering its preliminary determinations. The department shall mail written notice of the date, time, and place of the hearing to every hospital at least ten days before the date of the hearing.

On the basis of the evidence submitted to the department or presented at the public hearing, the department shall reconsider and may adjust the preliminary determinations. The result of the reconsideration is the final reconciliation of the amounts that each hospital must pay under the provisions of this rule.

(3) The department shall mail each hospital written notice of the amount it must pay under the final reconciliation as soon as practical. Any hospital may appeal the amount it must pay to the court of common pleas of Franklin county.

(4) In the course of any program year, the department may adjust the assessment rate defined in paragraphs (C) and (D) of this rule or adjust the amount of the intergovernmental transfers required under paragraph (F) of this rule, and, as a result of the adjustment, adjust each hospital's assessment and intergovernmental transfer, to reflect refinements made by the CMS during that program year.

5160-2-30 Hospital franchise fee program.

This rule sets forth the hospital franchise fee assessment applicable for the assessment program year that ends in calendar year 2016, and for each program year thereafter, for the hospital franchise fee program implemented under sections 5168.20 to 5168.28 of the Revised Code.

(A) Definitions

For purposes of the hospital franchise fee program only, "total facility costs" are as defined in section 5168.20 of the Revised Code, and also exclude a hospital's costs associated with providing care to recipients of the medicare program as shown on the cost-reporting data used for purposes of determining the hospital's assessment under section 5168.21 of the Revised Code.
(B) Assessment
The amount of each hospital's franchise fee assessment for the assessment program year that ends in calendar year 2016, and for each program year thereafter, shall be two and sixty-six hundredths per cent of the hospital's total facility costs as defined in paragraph (A) of this rule.

(C) Hospitals not enrolled as medicaid providers
(1) Hospitals, as defined in section 5168.20 of the Revised Code, that are not enrolled in the medicaid program shall, upon request, submit to the department an electronic copy of the hospital's medicare cost report (CMS 2552-10) or audited financial statements for the period described in section 5168.21 of the Revised Code.
(2) Hospitals not enrolled as medicaid providers shall be assessed a hospital franchise fee as described in paragraph (B) of this rule.
(3) Each hospital that is not enrolled as a medicaid provider shall pay the assessment according to a schedule established by the department at the time the department mails its written notice of the final determination of the hospital's assessment.

Miscellaneous

109.34 Notice of proposed conversion of nonprofit hospital or entity to for-profit hospital or entity.

(A) As used in this section and in section 109.35 of the Revised Code:
(1) “Fair market value” means the price that the assets being transferred would bring in a competitive and open market under a fair sale with the buyer and seller acting prudently, knowledgeably, and in their own best interest and a reasonable time being allowed for exposure in the market.
(2) “Nonprofit health care entity” means any of the following that was created for any charitable or social welfare purpose related to health care:
   (a) A hospital, as defined in section 3727.01 of the Revised Code, that is owned or operated by a corporation organized under Chapter 1702 of the Revised Code or the nonprofit corporation law of another state;
   (b) Either of the following that is or has been exempt from taxation under section 501(a) of the Internal Revenue Code:
      (i) An entity that is or has been granted a certificate of authority under Chapter 1742 of the Revised Code;
      (ii) An entity that is authorized or has been authorized to transact business in this state under Title XXXIX of the Revised Code, that is in the business of providing sickness and accident insurance, and that was previously a hospital service association under former Chapter 1739 of the Revised Code or Chapter 669 of the General Code, has merged or otherwise consolidated with a former hospital service association, or any of whose predecessors in interest has merged or otherwise consolidated with a former hospital service association.
(3) “Party” includes a nonprofit health care entity that is the subject of a transaction or proposed transaction, an acquiring person, and the resulting entity, if any.
(4) “Transaction” means a transfer of ownership or control of assets of a nonprofit health care entity, whether by purchase, merger, consolidation, lease, gift, joint venture, or other transfer, including any binding obligation in furtherance of the transaction, that is equal to at least twenty per cent of the assets of the entity and occurs in the twenty-four-month period prior to the date notice is submitted to the attorney general in accordance with division (B) of this section. “Transaction” also means a transfer of ownership or control of any assets of a nonprofit health care entity, whether by purchase, merger, consolidation, lease, gift, joint venture, or other transfer, including any binding obligation in furtherance of the transaction, if the entity is unable
to fulfill its stated or actual purpose without the assets. “Transaction” does not include either of the following:

(a) A transfer of ownership or control of assets of a nonprofit health care entity between nonprofit health care entities and persons exempt from taxation under section 501(a) of the “Internal Revenue Code of 1986,” 100 Stat. 2085, 26 U.S.C. 501, as amended;

(b) A transfer of ownership or control of assets of a nonprofit health care entity in relation to which the nonprofit health care entity, prior to the effective date of this section, has entered into a consent decree with the attorney general that requires distribution of the charitable assets of the entity to an appropriate health-related charity. The exemption in division (A)(4)(b) of this section does not limit the authority of the attorney general to seek remedies for breaches of fiduciary duty or other violations of law.

(B) A nonprofit health care entity proposing to enter into a transaction shall provide notice of the proposed transaction to the attorney general and obtain written approval of the transaction in accordance with this section. The nonprofit health care entity shall submit the notice on forms provided by the attorney general, and the notice shall include all of the following:

(1) The names and addresses of the parties, including a list of all individuals who are or have been chosen as directors, officers, or board members of the parties;

(2) The terms of the proposed transaction, including a summary of all contracts or other agreements of the parties;

(3) The amount, source, and nature of consideration to be paid to the nonprofit health care entity, its directors, officers, board members, executives, or experts retained by the nonprofit health care entity.

(4) A statement acknowledging that the nonprofit health care entity is under a continuing duty to notify the attorney general of any changes in the information contained in the notice or other documents required by this section and that a violation of this duty may delay approval of the proposed transaction. The statement shall be signed by a representative of the nonprofit health care entity at the time the notice is submitted to the attorney general.

(C) In addition to the notice described in division (B) of this section, the nonprofit health care entity shall submit all of the following:

(1) Audited financial statements for the nonprofit health care entity for the three fiscal years prior to the date the nonprofit health care entity submitted the notice to the attorney general;

(2) A valuation statement prepared by an independent, qualified expert, including an investment banker, actuary, appraiser, certified public accountant, or other expert, that assesses the full and fair market value of the nonprofit health care entity;

(3) Copies of all contracts and other agreements between the parties or their officers, directors, board members, or other fiduciaries, including any contracts or other final agreements relating to the close of the proposed transaction;

(4) Any additional information the attorney general considers necessary to value the nonprofit health care entity’s assets as required in rules adopted by the attorney general in accordance with Chapter 119 of the Revised Code.

(D) The notice and all other documents or materials submitted pursuant to this section are public records provided they meet the definition set forth in section 149.43 of the Revised Code.

(E) Not later than two business days after the discovery of any changes in information contained in the notice or other documents required by this section, the nonprofit health care entity shall provide copies to the attorney general of any documents and other material relevant to the changes. In addition to the ninety-day extension authorized by division (A) of section 109.35 of the Revised Code, the attorney general for good cause may delay approval of the proposed transaction up to thirty days following receipt of the documents and other material.
relevant to the changes.

(F) Not later than seven days after submitting the notice and other documents required by this section, the nonprofit health care entity shall publish notice of the proposed transaction in at least one daily newspaper of general circulation in the county where the nonprofit health care entity has its principal place of business. The notice shall state the names of the parties and a description of the proposed transaction.

(G) Notwithstanding division (A)(4)(a) of this section, as used in this division, “nonprofit combination” means a transaction between a nonprofit health care entity and another unrelated nonprofit health care entity.

Not less than sixty days before the closing of a nonprofit combination, a nonprofit health care entity that is a party to the combination and is the party to be acquired shall provide notice of the nonprofit combination to the attorney general by submitting the information described in divisions (B)(1) and (3) of this section.

Not later than seven days after the information required by this section is submitted to the attorney general, each of the nonprofit health care entities that is a party to a nonprofit combination shall publish the notice described in division (F) of this section.

109.35 Attorney general approval or disapproval of nonprofit hospital or entity conversion to for-profit one.

(A) Not later than sixty days after receipt of a notice and other documents required by section 109.34 of the Revised Code, the attorney general shall approve or disapprove the proposed transaction, except that the attorney general for good cause may extend this period an additional ninety days.

(B) In determining whether to approve or disapprove a proposed transaction, the attorney general shall consider:

1. Whether the proposed transaction will result in a breach of fiduciary duty, as determined by the attorney general, including conflicts of interest related to payments or benefits to officers, directors, board members, executives, and experts employed or retained by the parties;

2. Whether the nonprofit health care entity will receive full and fair market value for its charitable or social welfare assets;

3. Whether the proceeds of the proposed transaction will be used consistent with the nonprofit health care entity's original charitable purpose;

4. Any other criteria the attorney general considers necessary to determine whether the nonprofit health care entity will receive full and fair market value for its charitable or social welfare assets as required in rules adopted by the attorney general in accordance with Chapter 119 of the Revised Code.

(C) The attorney general may retain, at the nonprofit health care entity's expense, one or more independently qualified experts, including an investment banker, actuary, appraiser, certified public accountant, or other expert, as the attorney general considers reasonably necessary to provide assistance in making a decision under this section. The nonprofit health care entity shall promptly reimburse the attorney general for the cost of retaining experts. The cost of retaining an expert shall not exceed an amount that is reasonable and necessary to make a determination under this section. The contract to retain an expert is exempt from Chapter 125 of the Revised Code.

At any time while considering a proposed transaction under this section, the attorney general may request any additional information from the nonprofit health care entity that the attorney general considers appropriate to the valuation of the entity's charitable or social welfare assets. The nonprofit health care entity shall provide the information not later than ten days after the date of the request. The attorney general for good cause may delay approval of the
proposed transaction up to thirty days, in addition to the ninety-day extension authorized by division (A) of this section, following receipt of documents and other material containing the information requested.

(D) The attorney general shall approve or disapprove a proposed transaction on the basis of the criteria set forth in division (B) of this section. Once a proposed transaction is approved, any substantial alteration is a new transaction subject to approval by the attorney general.

The nonprofit health care entity may resubmit a notice and other documents seeking approval of a proposed transaction disapproved by the attorney general but may not submit a notice and other documents that are identical or substantially similar to the original submission.

If the attorney general disapproves the proposed transaction, the nonprofit health care entity may appeal the disapproval pursuant to division (H) of this section.

(E) If the attorney general approves the proposed transaction, the nonprofit health care entity shall hold a public hearing to receive comment on the proposed use of the proceeds of the transaction. The hearing shall be held in the county where the nonprofit health care entity has its principal place of business not later than forty-five days after receipt of written notice of the attorney general's approval.

At least thirty days prior to the date set for the hearing, the nonprofit health care entity shall publish notice of the hearing in at least one daily newspaper of general circulation in the county where the nonprofit health care entity has its principal place of business. The notice shall include a statement that a transaction has been approved by the attorney general, the names of the parties, a description of the proposed transaction, and the date, time, and place of the hearing.

(F)(1) The proceeds of an approved transaction shall be dedicated and transferred to one or more existing or new charitable organizations exempt from taxation under section 501(a) and described in section 501(c)(3) of the “Internal Revenue Code of 1986,” 100 Stat. 2085, 26 U.S.C.A. 501, as amended.

(2) The attorney general may authorize a dedication and transfer to a person exempt from taxation under section 501(a) and described in section 501(c)(4) of the “Internal Revenue Code of 1986,” 100 Stat. 2085, 26 U.S.C.A. 501, as amended, if all of the following conditions are met:

(a) The attorney general determines that the dedication and transfer is necessary to ensure effective management and monetization of the equity ownership, if any, in the nonprofit health care entity;

(b) The person described in division (F)(2) of this section agrees to all of the following conditions:

(i) The person described in division (F)(2) of this section will receive from the nonprofit health care entity only the amount of proceeds of the transaction as are necessary to fund the level of activity necessary to preserve the person's tax-exempt status;

(ii) No proceeds of the transaction, or any other funds or resources controlled by the person described in division (F)(2) of this section, will be disbursed for campaign contributions, lobbying expenditures, or other political activity;

(iii) The person described in division (F)(2) of this section agrees to abide by any requirements imposed on persons exempt from taxation under section 501(a) and described in section 501(c)(3) of the “Internal Revenue Code of 1986,” 100 Stat. 2085, 26 U.S.C.A. 501, as amended, that the attorney general determines appropriate.

(G)(1) No nonprofit health care entity shall enter into a transaction subject to this section without the approval of the attorney general granted in accordance with this section.

(2) No person who is an officer, director, board member, or other fiduciary of a nonprofit health care entity shall receive anything of substantial value that relates to a transaction described in this section and section 109.34 of the Revised Code and is of such a character as
to manifest a substantial and improper influence on the person with respect to the person's duties.

(3) The attorney general may institute and prosecute a civil or criminal action to enforce this section and section 109.34 of the Revised Code in the court of common pleas of the county in which the nonprofit health care entity has its principal place of business or the Franklin county court of common pleas. In addition to any civil remedies that exist under common law or the Revised Code, a court may rescind the transaction, grant injunctive relief, assess a civil penalty in an amount not exceeding ten million dollars, or impose any combination of these remedies.

(H) A nonprofit health care entity that is a party to a proposed transaction that has been disapproved by the attorney general may appeal the disapproval only by following the procedure set forth in this division. The disapproval may be appealed to the court of common pleas of the county in which the nonprofit health entity has its principal place of business. The court of common pleas may reverse, vacate, or modify the attorney general's decision to disapprove a transaction if the court finds that the decision was unlawful or unreasonable. This appeal shall proceed as an appeal de novo. To bring an appeal under this division, a nonprofit health care entity shall file a notice of appeal with the court and the attorney general not later than fifteen days after the entity's receipt of notice of the attorney general's disapproval of the transaction. Not later than thirty days after receipt of the notice of appeal, the attorney general shall prepare and certify to the court of common pleas a complete record of all of the documents submitted by the nonprofit health care entity to the attorney general and any documents generated by consultants at the request of the attorney general or other materials produced by the attorney general as part of the attorney general's determination of whether to approve or disapprove the transaction.

The judgment of the court of common pleas is final unless reversed, vacated, or modified on appeal. An appeal may be taken by either the nonprofit health care entity or the attorney general, shall proceed as in the case of appeals in civil actions, and shall be pursuant to the rules of appellate procedure and, to the extent not in conflict with those rules, Chapter 2505 of the Revised Code.

(I)(1) The powers of the attorney general under this section and section 109.34 of the Revised Code are in addition to the attorney general's powers held at common law and under sections 109.23 to 109.33 of the Revised Code.

This section and section 109.34 of the Revised Code do not limit or otherwise affect any of the following:

(a) Any other civil or criminal right, claim, or defense that the attorney general or parties may assert under common law or the Revised Code;
(b) The authority of the attorney general to institute and prosecute an action to enforce sections 109.23 to 109.33 of the Revised Code;
(c) The authority of the attorney general to investigate and prosecute violations of any state or federal antitrust law.

(2) Nothing in this section shall be construed to grant to the attorney general any authority of the superintendent of insurance under Title XVII or Title XXXIX of the Revised Code relating to the superintendent's review of an entity described in division (A)(2)(b) of section 109.34 of the Revised Code.

(3) Nothing in this section or section 109.34 of the Revised Code shall be construed to limit the independent authority of the attorney general to protect charitable trusts and charitable assets in this state.

119.14 Waiver of penalties for first-time small business regulatory paperwork.

(A) For any small business that engages in a paperwork violation, the state agency or regulatory authority that regulates the field of operation in which the business operates shall
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waive any and all administrative fines or civil penalties on that small business for the violation, if the paperwork violation is a first-time offense.

(B) When an agency or regulatory authority waives an administrative fine or civil penalty under this section, the state agency or regulatory authority shall require the small business to correct the violation within a reasonable period of time.

(C) Notwithstanding this section, a state agency or regulatory authority may impose administrative fines or civil penalties on a small business for a paperwork violation that is a first-time offense for any of the following reasons:

(1) The violation has the potential to cause serious harm to the public interest as determined by a state agency or regulatory authority director;

(2) The violation involves a small business knowingly or willfully engaging in conduct that may result in a felony conviction;

(3) Failure to impose an administrative fine or civil penalty for the violation would impede or interfere with the detection of criminal activity;

(4) The violation is of a law concerning the assessment or collection of any tax, debt, revenue, or receipt;

(5) The violation presents a direct danger to the public health or safety, results in a financial loss to an employee as defined in section 4111.03 of the Revised Code, or presents the risk of severe environmental harm, as determined by the head of the agency or regulatory authority;

(6) The violation is a failure to comply with a federal requirement for a program that has been delegated from the federal government to a state agency or regulatory authority and where the federal requirement includes a requirement to impose a fine.

(D)(1) Nothing in this section shall prohibit a state agency or regulatory authority from waiving administrative fines or civil penalties incurred by a small business for a paperwork violation that is not a first-time offense.

(2) Any administrative fine or civil penalty that is waived under this section, may be reinstated and imposed in addition to any additional fines or penalties associated with a subsequent violation for noncompliance with the same paperwork requirement.

(E) This section shall not apply to any violation by a small business of a statutory or regulatory requirement mandating the collection of information by a state agency or regulatory body if that small business previously violated any such requirement mandating the collection of information.

(F) Nothing in this section shall be construed to diminish the responsibility for any citizen or business to apply for and obtain a permit, license, or authorizing document that is required to engage in a regulated activity, or otherwise comply with state or federal law.

(G) As used in this section:

(1) “Small business” has the same meaning as defined by the Code of Federal Regulations, Title 13, Chapter 1, Part 121.

(2) “Paperwork violation” means the violation of any statutory or regulatory requirement in the Revised Code mandating the collection of information by a state agency or regulatory body.

(3) “First-time offense” means the first instance of a violation of the particular statutory or regulatory requirement mandating the collection of information by a state agency or regulatory body.

121.22 Open meetings in government.

(A) This section shall be liberally construed to require public officials to take official action and to conduct all deliberations upon official business only in open meetings unless the subject matter is specifically excepted by law.
(B) As used in this section:
(1) “Public body” means any of the following:
   (a) Any board, commission, committee, council, or similar decision-making body of a state agency, institution, or authority, and any legislative authority or board, commission, committee, council, agency, authority, or similar decision-making body of any county, township, municipal corporation, school district, or other political subdivision or local public institution;
   (b) Any committee or subcommittee of a body described in division (B)(1)(a) of this section;
   (c) A court of jurisdiction of a sanitary district organized wholly for the purpose of providing a water supply for domestic, municipal, and public use when meeting for the purpose of the appointment, removal, or reappointment of a member of the board of directors of such a district pursuant to section 6115.10 of the Revised Code, if applicable, or for any other matter related to such a district other than litigation involving the district. As used in division (B)(1)(c) of this section, “court of jurisdiction” has the same meaning as “court” in section 6115.01 of the Revised Code.
(2) “Meeting” means any prearranged discussion of the public business of the public body by a majority of its members.
(3) “Regulated individual” means either of the following:
   (a) A student in a state or local public educational institution;
   (b) A person who is, voluntarily or involuntarily, an inmate, patient, or resident of a state or local institution because of criminal behavior, mental illness, an intellectual disability, disease, disability, age, or other condition requiring custodial care.
(4) “Public office” has the same meaning as in section 149.011 of the Revised Code.
(C) All meetings of any public body are declared to be public meetings open to the public at all times. A member of a public body shall be present in person at a meeting open to the public to be considered present or to vote at the meeting and for purposes of determining whether a quorum is present at the meeting.
   The minutes of a regular or special meeting of any public body shall be promptly prepared, filed, and maintained and shall be open to public inspection. The minutes need only reflect the general subject matter of discussions in executive sessions authorized under division (G) or (J) of this section.
(D) This section does not apply to any of the following:
   (1) A grand jury;
   (2) An audit conference conducted by the auditor of state or independent certified public accountants with officials of the public office that is the subject of the audit;
   (3) The adult parole authority when its hearings are conducted at a correctional institution for the sole purpose of interviewing inmates to determine parole or pardon;
   (4) The organized crime investigations commission established under section 177.01 of the Revised Code;
   (5) Meetings of a child fatality review board established under section 307.621 of the Revised Code, meetings related to a review conducted pursuant to guidelines established by the director of health under section 3701.70 of the Revised Code, and meetings conducted pursuant to sections 5153.171 to 5153.173 of the Revised Code;
   (6) The state medical board when determining whether to suspend a certificate without a prior hearing pursuant to division (G) of either section 4730.25 or 4731.22 of the Revised Code;
   (7) The board of nursing when determining whether to suspend a license or certificate without a prior hearing pursuant to division (B) of section 4723.281 of the Revised Code;
   (8) The state board of pharmacy when determining whether to suspend a license without a prior hearing pursuant to division (D) of section 4729.16 of the Revised Code;
   (9) The state chiropractic board when determining whether to suspend a license without a hearing pursuant to section 4734.37 of the Revised Code;
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(10) The executive committee of the emergency response commission when
determining whether to issue an enforcement order or request that a civil action, civil penalty
action, or criminal action be brought to enforce Chapter 3750 of the Revised Code;
(11) The board of directors of the nonprofit corporation formed under section 187.01 of
the Revised Code or any committee thereof, and the board of directors of any subsidiary of that
corporation or a committee thereof;
(12) An audit conference conducted by the audit staff of the department of job and family
services with officials of the public office that is the subject of that audit under section 5101.37 of
the Revised Code;
(13) The occupational therapy section of the occupational therapy, physical therapy, and
athletic trainers board when determining whether to suspend a license or limited permit without
a hearing pursuant to division (D) of section 4755.11 of the Revised Code;
(14) The physical therapy section of the occupational therapy, physical therapy, and
athletic trainers board when determining whether to suspend a license without a hearing
pursuant to division (E) of section 4755.47 of the Revised Code;
(15) The athletic trainers section of the occupational therapy, physical therapy, and
athletic trainers board when determining whether to suspend a license without a hearing
pursuant to division (D) of section 4755.64 of the Revised Code.
(E) The controlling board, the tax credit authority, or the minority development financing
advisory board, when meeting to consider granting assistance pursuant to Chapter 122 or 166
of the Revised Code, in order to protect the interest of the applicant or the possible investment
of public funds, by unanimous vote of all board or authority members present, may close the
meeting during consideration of the following information confidentially received by the authority
or board from the applicant:
(1) Marketing plans;
(2) Specific business strategy;
(3) Production techniques and trade secrets;
(4) Financial projections;
(5) Personal financial statements of the applicant or members of the applicant's
immediate family, including, but not limited to, tax records or other similar information not open
to public inspection.
The vote by the authority or board to accept or reject the application, as well as all
proceedings of the authority or board not subject to this division, shall be open to the public and
governed by this section.
(F) Every public body, by rule, shall establish a reasonable method whereby any person
may determine the time and place of all regularly scheduled meetings and the time, place, and
purpose of all special meetings. A public body shall not hold a special meeting unless it gives at
least twenty-four hours' advance notice to the news media that have requested notification,
except in the event of an emergency requiring immediate official action. In the event of an
emergency, the member or members calling the meeting shall notify the news media that have
requested notification immediately of the time, place, and purpose of the meeting.
The rule shall provide that any person, upon request and payment of a reasonable fee,
may obtain reasonable advance notification of all meetings at which any specific type of public
business is to be discussed. Provisions for advance notification may include, but are not limited
to, mailing the agenda of meetings to all subscribers on a mailing list or mailing notices in self-
addressed, stamped envelopes provided by the person.
(G) Except as provided in divisions (G)(8) and (J) of this section, the members of a
public body may hold an executive session only after a majority of a quorum of the public body
determines, by a roll call vote, to hold an executive session and only at a regular or special
meeting for the sole purpose of the consideration of any of the following matters:
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(1) To consider the appointment, employment, dismissal, discipline, promotion, demotion, or compensation of a public employee or official, or the investigation of charges or complaints against a public employee, official, licensee, or regulated individual, unless the public employee, official, licensee, or regulated individual requests a public hearing. Except as otherwise provided by law, no public body shall hold an executive session for the discipline of an elected official for conduct related to the performance of the elected official's official duties or for the elected official's removal from office. If a public body holds an executive session pursuant to division (G)(1) of this section, the motion and vote to hold that executive session shall state which one or more of the approved purposes listed in division (G)(1) of this section are the purposes for which the executive session is to be held, but need not include the name of any person to be considered at the meeting.

(2) To consider the purchase of property for public purposes, the sale of property at competitive bidding, or the sale or other disposition of unneeded, obsolete, or unfit-for-use property in accordance with section 505.10 of the Revised Code, if premature disclosure of information would give an unfair competitive or bargaining advantage to a person whose personal, private interest is adverse to the general public interest. No member of a public body shall use division (G)(2) of this section as a subterfuge for providing covert information to prospective buyers or sellers. A purchase or sale of public property is void if the seller or buyer of the public property has received covert information from a member of a public body that has not been disclosed to the general public in sufficient time for other prospective buyers and sellers to prepare and submit offers.

If the minutes of the public body show that all meetings and deliberations of the public body have been conducted in compliance with this section, any instrument executed by the public body purporting to convey, lease, or otherwise dispose of any right, title, or interest in any public property shall be conclusively presumed to have been executed in compliance with this section insofar as title or other interest of any bona fide purchasers, lessees, or transferees of the property is concerned.

(3) Conferences with an attorney for the public body concerning disputes involving the public body that are the subject of pending or imminent court action;

(4) Preparing for, conducting, or reviewing negotiations or bargaining sessions with public employees concerning their compensation or other terms and conditions of their employment;

(5) Matters required to be kept confidential by federal law or regulations or state statutes;

(6) Details relative to the security arrangements and emergency response protocols for a public body or a public office, if disclosure of the matters discussed could reasonably be expected to jeopardize the security of the public body or public office;

(7) In the case of a county hospital operated pursuant to Chapter 339 of the Revised Code, a joint township hospital operated pursuant to Chapter 513 of the Revised Code, or a municipal hospital operated pursuant to Chapter 749 of the Revised Code, to consider trade secrets, as defined in section 1333.61 of the Revised Code;

(8) To consider confidential information related to the marketing plans, specific business strategy, production techniques, trade secrets, or personal financial statements of an applicant for economic development assistance, or to negotiations with other political subdivisions respecting requests for economic development assistance, provided that both of the following conditions apply:

(a) The information is directly related to a request for economic development assistance that is to be provided or administered under any provision of Chapter 715., 725., 1724., or 1728 or sections 701.07, 3735.67 to 3735.70, 5709.40 to 5709.43, 5709.61 to 5709.69, 5709.73 to 5709.75, or 5709.77 to 5709.81 of the Revised Code, or that involves public infrastructure improvements or the extension of utility services that are directly related to an economic development project.
(b) A unanimous quorum of the public body determines, by a roll call vote, that the executive session is necessary to protect the interests of the applicant or the possible investment or expenditure of public funds to be made in connection with the economic development project.

If a public body holds an executive session to consider any of the matters listed in divisions (G)(2) to (8) of this section, the motion and vote to hold that executive session shall state which one or more of the approved matters listed in those divisions are to be considered at the executive session.

A public body specified in division (B)(1)(c) of this section shall not hold an executive session when meeting for the purposes specified in that division.

(H) A resolution, rule, or formal action of any kind is invalid unless adopted in an open meeting of the public body. A resolution, rule, or formal action adopted in an open meeting that results from deliberations in a meeting not open to the public is invalid unless the deliberations were for a purpose specifically authorized in division (G) or (J) of this section and conducted at an executive session held in compliance with this section. A resolution, rule, or formal action adopted in an open meeting is invalid if the public body that adopted the resolution, rule, or formal action violated division (F) of this section.

(I)(1) Any person may bring an action to enforce this section. An action under division (I)(1) of this section shall be brought within two years after the date of the alleged violation or threatened violation. Upon proof of a violation or threatened violation of this section in an action brought by any person, the court of common pleas shall issue an injunction to compel the members of the public body to comply with its provisions.

(2)(a) If the court of common pleas issues an injunction pursuant to division (I)(1) of this section, the court shall order the public body that it enjoins to pay a civil forfeiture of five hundred dollars to the party that sought the injunction and shall award to that party all court costs and, subject to reduction as described in division (I)(2) of this section, reasonable attorney's fees. The court, in its discretion, may reduce an award of attorney's fees to the party that sought the injunction or not award attorney's fees to that party if the court determines both of the following:

(i) That, based on the ordinary application of statutory law and case law as it existed at the time of violation or threatened violation that was the basis of the injunction, a well-informed public body reasonably would believe that the public body was not violating or threatening to violate this section;

(ii) That a well-informed public body reasonably would believe that the conduct or threatened conduct that was the basis of the injunction would serve the public policy that underlies the authority that is asserted as permitting that conduct or threatened conduct.

(b) If the court of common pleas does not issue an injunction pursuant to division (I)(1) of this section and the court determines at that time that the bringing of the action was frivolous conduct, as defined in division (A) of section 2323.51 of the Revised Code, the court shall award to the public body all court costs and reasonable attorney's fees, as determined by the court.

(3) Irreparable harm and prejudice to the party that sought the injunction shall be conclusively and irrebuttably presumed upon proof of a violation or threatened violation of this section.

(4) A member of a public body who knowingly violates an injunction issued pursuant to division (I)(1) of this section may be removed from office by an action brought in the court of common pleas for that purpose by the prosecuting attorney or the attorney general.

(J)(1) Pursuant to division (C) of section 5901.09 of the Revised Code, a veterans service commission shall hold an executive session for one or more of the following purposes unless an applicant requests a public hearing:

(a) Interviewing an applicant for financial assistance under sections 5901.01 to 5901.15 of the Revised Code;
(b) Discussing applications, statements, and other documents described in division (B) of section 5901.09 of the Revised Code;
(c) Reviewing matters relating to an applicant's request for financial assistance under sections 5901.01 to 5901.15 of the Revised Code.

(2) A veterans service commission shall not exclude an applicant for, recipient of, or former recipient of financial assistance under sections 5901.01 to 5901.15 of the Revised Code, and shall not exclude representatives selected by the applicant, recipient, or former recipient, from a meeting that the commission conducts as an executive session that pertains to the applicant's, recipient's, or former recipient's application for financial assistance.

(3) A veterans service commission shall vote on the grant or denial of financial assistance under sections 5901.01 to 5901.15 of the Revised Code only in an open meeting of the commission. The minutes of the meeting shall indicate the name, address, and occupation of the applicant, whether the assistance was granted or denied, the amount of the assistance if assistance is granted, and the votes for and against the granting of assistance.

149.43 Public records availability.

(A) As used in this section:
(1) “Public record” means records kept by any public office, including, but not limited to, state, county, city, village, township, and school district units, and records pertaining to the delivery of educational services by an alternative school in this state kept by the nonprofit or for-profit entity operating the alternative school pursuant to section 3313.533 of the Revised Code. “Public record” does not mean any of the following:
(a) Medical records;
(b) Records pertaining to probation and parole proceedings or to proceedings related to the imposition of community control sanctions and post-release control sanctions;
(c) Records pertaining to actions under section 2151.85 and division (C) of section 2919.121 of the Revised Code and to appeals of actions arising under those sections;
(d) Records pertaining to adoption proceedings, including the contents of an adoption file maintained by the department of health under sections 3705.12 to 3705.124 of the Revised Code;
(e) Information in a record contained in the putative father registry established by section 3107.062 of the Revised Code, regardless of whether the information is held by the department of job and family services or, pursuant to section 3111.69 of the Revised Code, the office of child support in the department or a child support enforcement agency;
(f) Records specified in division (A) of section 3107.52 of the Revised Code;
(g) Trial preparation records;
(h) Confidential law enforcement investigatory records;
(i) Records containing information that is confidential under section 2710.03 or 4112.05 of the Revised Code;
(j) DNA records stored in the DNA database pursuant to section 109.573 of the Revised Code;
(k) Inmate records released by the department of rehabilitation and correction to the department of youth services or a court of record pursuant to division (E) of section 5120.21 of the Revised Code;
(l) Records maintained by the department of youth services pertaining to children in its custody released by the department of youth services to the department of rehabilitation and correction pursuant to section 5139.05 of the Revised Code;
(m) Intellectual property records;
(n) Donor profile records;
(o) Records maintained by the department of job and family services pursuant to section
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3121.894 of the Revised Code;
(p) Peace officer, parole officer, probation officer, bailiff, prosecuting attorney, assistant prosecuting attorney, correctional employee, community-based correctional facility employee, youth services employee, firefighter, EMT, investigator of the bureau of criminal identification and investigation, or federal law enforcement officer residential and familial information;
(q) In the case of a county hospital operated pursuant to Chapter 339 of the Revised Code or a municipal hospital operated pursuant to Chapter 749 of the Revised Code, information that constitutes a trade secret, as defined in section 1333.61 of the Revised Code;
(r) Information pertaining to the recreational activities of a person under the age of eighteen;
(s) In the case of a child fatality review board acting under sections 307.621 to 307.629 of the Revised Code or a review conducted pursuant to guidelines established by the director of health under section 3701.70 of the Revised Code, records provided to the board or director, statements made by board members during meetings of the board or by persons participating in the director's review, and all work products of the board or director, and in the case of a child fatality review board, child fatality review data submitted by the board to the department of health or a national child death review database, other than the report prepared pursuant to division (A) of section 307.626 of the Revised Code;
(t) Records provided to and statements made by the executive director of a public children services agency or a prosecuting attorney acting pursuant to section 5153.171 of the Revised Code other than the information released under that section;
(u) Test materials, examinations, or evaluation tools used in an examination for licensure as a nursing home administrator that the board of executives of long-term services and supports administers under section 4751.04 of the Revised Code or contracts under that section with a private or government entity to administer;
(v) Records the release of which is prohibited by state or federal law;
(w) Proprietary information of or relating to any person that is submitted to or compiled by the Ohio venture capital authority created under section 150.01 of the Revised Code;
(x) Financial statements and data any person submits for any purpose to the Ohio housing finance agency or the controlling board in connection with applying for, receiving, or accounting for financial assistance from the agency, and information that identifies any individual who benefits directly or indirectly from financial assistance from the agency;
(y) Records listed in section 5101.29 of the Revised Code;
(z) Discharges recorded with a county recorder under section 317.24 of the Revised Code, as specified in division (B)(2) of that section;
(aa) Usage information including names and addresses of specific residential and commercial customers of a municipally owned or operated public utility;
(bb) Records described in division (C) of section 187.04 of the Revised Code that are not designated to be made available to the public as provided in that division;
(cc) Information and records that are made confidential, privileged, and not subject to disclosure under divisions (B) and (C) of section 2949.221 of the Revised Code;
(dd) Personal information, as defined in section 149.45 of the Revised Code;
(ee) The confidential name, address, and other personally identifiable information of a program participant in the address confidentiality program established under sections 111.41 to 111.47 of the Revised Code, including the contents of any application for absent voter's ballots, absent voter's ballot identification envelope statement of voter, or provisional ballot affirmation completed by a program participant who has a confidential voter registration record, and records or portions of records pertaining to that program that identify the number of program participants that reside within a precinct, ward, township, municipal corporation, county, or any other geographic area smaller than the state. As used in this division, "confidential address" and "program participant" have the meaning defined in section 111.41 of the Revised Code.
(ff) Orders for active military service of an individual serving or with previous service in the armed forces of the United States, including a reserve component, or the Ohio organized militia, except that, such order becomes a public record on the day that is fifteen years after the published date or effective date of the call to order.

(2) “Confidential law enforcement investigatory record” means any record that pertains to a law enforcement matter of a criminal, quasi-criminal, civil, or administrative nature, but only to the extent that the release of the record would create a high probability of disclosure of any of the following:
   (a) The identity of a suspect who has not been charged with the offense to which the record pertains, or of an information source or witness to whom confidentiality has been reasonably promised;
   (b) Information provided by an information source or witness to whom confidentiality has been reasonably promised, which information would reasonably tend to disclose the source's or witness's identity;
   (c) Specific confidential investigatory techniques or procedures or specific investigatory work product;
   (d) Information that would endanger the life or physical safety of law enforcement personnel, a crime victim, a witness, or a confidential information source.

(3) “Medical record” means any document or combination of documents, except births, deaths, and the fact of admission to or discharge from a hospital, that pertains to the medical history, diagnosis, prognosis, or medical condition of a patient and that is generated and maintained in the process of medical treatment.

(4) “Trial preparation record” means any record that contains information that is specifically compiled in reasonable anticipation of, or in defense of, a civil or criminal action or proceeding, including the independent thought processes and personal trial preparation of an attorney.

(5) “Intellectual property record” means a record, other than a financial or administrative record, that is produced or collected by or for faculty or staff of a state institution of higher learning in the conduct of or as a result of study or research on an educational, commercial, scientific, artistic, technical, or scholarly issue, regardless of whether the study or research was sponsored by the institution alone or in conjunction with a governmental body or private concern, and that has not been publicly released, published, or patented.

(6) “Donor profile record” means all records about donors or potential donors to a public institution of higher education except the names and reported addresses of the actual donors and the date, amount, and conditions of the actual donation.

(7) “Peace officer, parole officer, probation officer, bailiff, prosecuting attorney, assistant prosecuting attorney, correctional employee, community-based correctional facility employee, youth services employee, firefighter, EMT, investigator of the bureau of criminal identification and investigation, or federal law enforcement officer residential and familial information” means any information that discloses any of the following about a peace officer, parole officer, probation officer, bailiff, prosecuting attorney, assistant prosecuting attorney, correctional employee, community-based correctional facility employee, youth services employee, firefighter, EMT, investigator of the bureau of criminal identification and investigation, or federal law enforcement officer:

   (a) The address of the actual personal residence of a peace officer, parole officer, probation officer, bailiff, assistant prosecuting attorney, correctional employee, community-based correctional facility employee, youth services employee, firefighter, EMT, investigator of the bureau of criminal identification and investigation, or federal law enforcement officer;
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bureau of criminal identification and investigation, or federal law enforcement officer resides;
(b) Information compiled from referral to or participation in an employee assistance program;
(c) The social security number, the residential telephone number, any bank account, debit card, charge card, or credit card number, or the emergency telephone number of, or any medical information pertaining to, a peace officer, parole officer, probation officer, bailiff, prosecuting attorney, assistant prosecuting attorney, correctional employee, community-based correctional facility employee, youth services employee, firefighter, EMT, investigator of the bureau of criminal identification and investigation, or federal law enforcement officer;
(d) The name of any beneficiary of employment benefits, including, but not limited to, life insurance benefits, provided to a peace officer, parole officer, probation officer, bailiff, prosecuting attorney, assistant prosecuting attorney, correctional employee, community-based correctional facility employee, youth services employee, firefighter, EMT, investigator of the bureau of criminal identification and investigation, or federal law enforcement officer's employer;
(e) The identity and amount of any charitable or employment benefit deduction made by the peace officer's, parole officer's, probation officer's, bailiff's, prosecuting attorney's, assistant prosecuting attorney's, correctional employee's, community-based correctional facility employee's, youth services employee's, firefighter's, EMT's, investigator of the bureau of criminal identification and investigation, or federal law enforcement officer's employer from the peace officer's, parole officer's, probation officer's, bailiff's, prosecuting attorney's, assistant prosecuting attorney's, correctional employee's, community-based correctional facility employee's, youth services employee's, firefighter's, EMT's, investigator of the bureau of criminal identification and investigation, or federal law enforcement officer's compensation unless the amount of the deduction is required by state or federal law;
(f) The name, the residential address, the name of the employer, the address of the employer, the social security number, the residential telephone number, any bank account, debit card, charge card, or credit card number, or the emergency telephone number of the spouse, a former spouse, or any child of a peace officer, parole officer, probation officer, bailiff, prosecuting attorney, assistant prosecuting attorney, correctional employee, community-based correctional facility employee, youth services employee, firefighter, EMT, investigator of the bureau of criminal identification and investigation, or federal law enforcement officer;
(g) A photograph of a peace officer who holds a position or has an assignment that may include undercover or plain clothes positions or assignments as determined by the peace officer's appointing authority.

As used in divisions (A)(7) and (B)(9) of this section, “peace officer” has the same meaning as in section 109.71 of the Revised Code and also includes the superintendent and troopers of the state highway patrol; it does not include the sheriff of a county or a supervisory employee who, in the absence of the sheriff, is authorized to stand in for, exercise the authority of, and perform the duties of the sheriff.

As used in divisions (A)(7) and (B)(9) of this section, "correctional employee" means any employee of the department of rehabilitation and correction who in the course of performing the employee's job duties has or has had contact with inmates and persons under supervision.

As used in divisions (A)(7) and (B)(9) of this section, “youth services employee” means any employee of the department of youth services who in the course of performing the employee's job duties has or has had contact with children committed to the custody of the department of youth services.

As used in divisions (A)(7) and (B)(9) of this section, “firefighter” means any regular, paid
or volunteer, member of a lawfully constituted fire department of a municipal corporation, township, fire district, or village.

As used in divisions (A)(7) and (B)(9) of this section, “EMT” means EMTs-basic, EMTs-I, and paramedics that provide emergency medical services for a public emergency medical service organization. “Emergency medical service organization,” “EMT-basic,” “EMT-I,” and “paramedic” have the same meanings as in section 4765.01 of the Revised Code.

As used in divisions (A)(7) and (B)(9) of this section, “investigator of the bureau of criminal identification and investigation” has the meaning defined in section 2903.11 of the Revised Code.

As used in divisions (A)(7) and (B)(9) of this section, “federal law enforcement officer” has the meaning defined in section 9.88 of the Revised Code.

(8) “Information pertaining to the recreational activities of a person under the age of eighteen” means information that is kept in the ordinary course of business by a public office, that pertains to the recreational activities of a person under the age of eighteen years, and that discloses any of the following:

(a) The address or telephone number of a person under the age of eighteen or the address or telephone number of that person’s parent, guardian, custodian, or emergency contact person;
(b) The social security number, birth date, or photographic image of a person under the age of eighteen;
(c) Any medical record, history, or information pertaining to a person under the age of eighteen;
(d) Any additional information sought or required about a person under the age of eighteen for the purpose of allowing that person to participate in any recreational activity conducted or sponsored by a public office or to use or obtain admission privileges to any recreational facility owned or operated by a public office.

(9) “Community control sanction” has the same meaning as in section 2929.01 of the Revised Code.

(10) “Post-release control sanction” has the same meaning as in section 2967.01 of the Revised Code.

(11) “Redaction” means obscuring or deleting any information that is exempt from the duty to permit public inspection or copying from an item that otherwise meets the definition of a “record” in section 149.011 of the Revised Code.

(12) “Designee” and “elected official” have the same meanings as in section 109.43 of the Revised Code.

(B)(1) Upon request and subject to division (B)(8) of this section, all public records responsive to the request shall be promptly prepared and made available for inspection to any person at all reasonable times during regular business hours. Subject to division (B)(8) of this section, upon request, a public office or person responsible for public records shall make copies of the requested public record available at cost and within a reasonable period of time. If a public record contains information that is exempt from the duty to permit public inspection or to copy the public record, the public office or the person responsible for the public record shall make available all of the information within the public record that is not exempt. When making that public record available for public inspection or copying that public record, the public office or the person responsible for the public record shall notify the requester of any redaction or make the redaction plainly visible. A redaction shall be deemed a denial of a request to inspect or copy the redacted information, except if federal or state law authorizes or requires a public office to make the redaction.

(2) To facilitate broader access to public records, a public office or the person responsible for public records shall organize and maintain public records in a manner that they can be made available for inspection or copying in accordance with division (B) of this section. A
public office also shall have available a copy of its current records retention schedule at a location readily available to the public. If a requester makes an ambiguous or overly broad request or has difficulty in making a request for copies or inspection of public records under this section such that the public office or the person responsible for the requested public record cannot reasonably identify what public records are being requested, the public office or the person responsible for the requested public record may deny the request but shall provide the requester with an opportunity to revise the request by informing the requester of the manner in which records are maintained by the public office and accessed in the ordinary course of the public office’s or person’s duties.

(3) If a request is ultimately denied, in part or in whole, the public office or the person responsible for the requested public record shall provide the requester with an explanation, including legal authority, setting forth why the request was denied. If the initial request was provided in writing, the explanation also shall be provided to the requester in writing. The explanation shall not preclude the public office or the person responsible for the requested public record from relying upon additional reasons or legal authority in defending an action commenced under division (C) of this section.

(4) Unless specifically required or authorized by state or federal law or in accordance with division (B) of this section, no public office or person responsible for public records may limit or condition the availability of public records by requiring disclosure of the requester’s identity or the intended use of the requested public record. Any requirement that the requester disclose the requester’s identity or the intended use of the requested public record constitutes a denial of the request.

(5) A public office or person responsible for public records may ask a requester to make the request in writing, may ask for the requester’s identity, and may inquire about the intended use of the information requested, but may do so only after disclosing to the requester that a written request is not mandatory and that the requester may decline to reveal the requester’s identity or the intended use and when a written request or disclosure of the identity or intended use would benefit the requester by enhancing the ability of the public office or person responsible for public records to identify, locate, or deliver the public records sought by the requester.

(6) If any person chooses to obtain a copy of a public record in accordance with division (B) of this section, the public office or person responsible for the public record may require that person to pay in advance the cost involved in providing the copy of the public record in accordance with the choice made by the person seeking the copy under this division. The public office or the person responsible for the public record shall permit that person to choose to have the public record duplicated upon paper, upon the same medium upon which the public office or person responsible for the public record keeps it, or upon any other medium upon which the public office or person responsible for the public record determines that it reasonably can be duplicated as an integral part of the normal operations of the public office or person responsible for the public record. When the person seeking the copy makes a choice under this division, the public office or person responsible for the public record shall provide a copy of it in accordance with the choice made by the person seeking the copy. Nothing in this section requires a public office or person responsible for the public record to allow the person seeking a copy of the public record to make the copies of the public record.

(7)(a) Upon a request made in accordance with division (B) of this section and subject to division (B)(6) of this section, a public office or person responsible for public records shall transmit a copy of a public record to any person by United States mail or by any other means of delivery or transmission within a reasonable period of time after receiving the request for the copy. The public office or person responsible for the public record may require the person making the request to pay in advance the cost of postage if the copy is transmitted by United States mail or the cost of delivery if the copy is transmitted other than by United States mail, and
to pay in advance the costs incurred for other supplies used in the mailing, delivery, or transmission.

(b) Any public office may adopt a policy and procedures that it will follow in transmitting, within a reasonable period of time after receiving a request, copies of public records by United States mail or by any other means of delivery or transmission pursuant to division (B)(7) of this section. A public office that adopts a policy and procedures under division (B)(7) of this section shall comply with them in performing its duties under that division.

(c) In any policy and procedures adopted under division (B)(7) of this section:

(i) A public office may limit the number of records requested by a person that the office will physically deliver by United States mail or by another delivery service to ten per month, unless the person certifies to the office in writing that the person does not intend to use or forward the requested records, or the information contained in them, for commercial purposes;

(ii) A public office that chooses to provide some or all of its public records on a web site that is fully accessible to and searchable by members of the public at all times, other than during acts of God outside the public office’s control or maintenance, and that charges no fee to search, access, download, or otherwise receive records provided on the web site, may limit to ten per month the number of records requested by a person that the office will deliver in a digital format, unless the requested records are not provided on the web site and unless the person certifies to the office in writing that the person does not intend to use or forward the requested records, or the information contained in them, for commercial purposes.

(iii) For purposes of division (B)(7) of this section, “commercial” shall be narrowly construed and does not include reporting or gathering news, reporting or gathering information to assist citizen oversight or understanding of the operation or activities of government, or nonprofit educational research.

(8) A public office or person responsible for public records is not required to permit a person who is incarcerated pursuant to a criminal conviction or a juvenile adjudication to inspect or to obtain a copy of any public record concerning a criminal investigation or prosecution or concerning what would be a criminal investigation or prosecution if the subject of the investigation or prosecution were an adult, unless the request to inspect or to obtain a copy of the record is for the purpose of acquiring information that is subject to release as a public record under this section and the judge who imposed the sentence or made the adjudication with respect to the person, or the judge’s successor in office, finds that the information sought in the public record is necessary to support what appears to be a justiciable claim of the person.

(9)(a) Upon written request made and signed by a journalist on or after December 16, 1999, a public office, or person responsible for public records, having custody of the records of the agency employing a specified peace officer, parole officer, probation officer, bailiff, prosecuting attorney, assistant prosecuting attorney, correctional employee, community-based correctional facility employee, youth services employee, firefighter, EMT, investigator of the bureau of criminal identification and investigation, or federal law enforcement officer shall disclose to the journalist the address of the actual personal residence of the peace officer, parole officer, probation officer, bailiff, prosecuting attorney, assistant prosecuting attorney, correctional employee, community-based correctional facility employee, youth services employee, firefighter, EMT, investigator of the bureau of criminal identification and investigation, or federal law enforcement officer and, if the peace officer’s, parole officer’s, probation officer’s, bailiff’s, prosecuting attorney’s, assistant prosecuting attorney’s, correctional employee’s, community-based correctional facility employee’s, youth services employee’s, firefighter’s, EMT’s, investigator of the bureau of criminal identification and investigation’s, or federal law enforcement officer’s spouse, former spouse, or child is employed by a public office, the name and address of the employer of the peace officer’s, parole officer’s, probation officer’s, bailiff’s, prosecuting attorney’s, assistant prosecuting attorney’s, correctional employee’s, community-based correctional facility employee’s, youth services employee’s, firefighter’s, EMT’s,
investigator of the bureau of criminal identification and investigation's, or federal law enforcement officer's spouse, former spouse, or child. The request shall include the journalist's name and title and the name and address of the journalist's employer and shall state that disclosure of the information sought would be in the public interest.

(b) Division (B)(9)(a) of this section also applies to journalist requests for customer information maintained by a municipally owned or operated public utility, other than social security numbers and any private financial information such as credit reports, payment methods, credit card numbers, and bank account information.

(c) As used in division (B)(9) of this section, “journalist” means a person engaged in, connected with, or employed by any news medium, including a newspaper, magazine, press association, news agency, or wire service, a radio or television station, or a similar medium, for the purpose of gathering, processing, transmitting, compiling, editing, or disseminating information for the general public.

(C)(1) If a person allegedly is aggrieved by the failure of a public office or the person responsible for public records to promptly prepare a public record and to make it available to the person for inspection in accordance with division (B) of this section or by any other failure of a public office or the person responsible for public records to comply with an obligation in accordance with division (B) of this section, the person allegedly aggrieved may do only one of the following, and not both:

(a) File a complaint with the clerk of the court of claims or the clerk of the court of common pleas under section 2743.75 of the Revised Code;

(b) Commence a mandamus action to obtain a judgment that orders the public office or the person responsible for the public record to comply with division (B) of this section, that awards court costs and reasonable attorney's fees to the person that instituted the mandamus action, and, if applicable, that includes an order fixing statutory damages under division (C)(2) of this section. The mandamus action may be commenced in the court of common pleas of the county in which division (B) of this section allegedly was not complied with, in the supreme court pursuant to its original jurisdiction under Section 2 of Article IV, Ohio Constitution, or in the court of appeals for the appellate district in which division (B) of this section allegedly was not complied with pursuant to its original jurisdiction under Section 3 of Article IV, Ohio Constitution.

(2) If a requester transmits a written request by hand delivery or certified mail to inspect or receive copies of any public record in a manner that fairly describes the public record or class of public records to the public office or person responsible for the requested public records, except as otherwise provided in this section, the requester shall be entitled to recover the amount of statutory damages set forth in this division if a court determines that the public office or the person responsible for public records failed to comply with an obligation in accordance with division (B) of this section.

The amount of statutory damages shall be fixed at one hundred dollars for each business day during which the public office or person responsible for the requested public records failed to comply with an obligation in accordance with division (B) of this section, beginning with the day on which the requester files a mandamus action to recover statutory damages, up to a maximum of one thousand dollars. The award of statutory damages shall not be construed as a penalty, but as compensation for injury arising from lost use of the requested information. The existence of this injury shall be conclusively presumed. The award of statutory damages shall be in addition to all other remedies authorized by this section.

The court may reduce an award of statutory damages or not award statutory damages if the court determines both of the following:

(a) That, based on the ordinary application of statutory law and case law as it existed at the time of the conduct or threatened conduct of the public office or person responsible for the requested public records that allegedly constitutes a failure to comply with an obligation in accordance with division (B) of this section and that was the basis of the mandamus action, a
well-informed public office or person responsible for the requested public records reasonably would believe that the conduct or threatened conduct of the public office or person responsible for the requested public records did not constitute a failure to comply with an obligation in accordance with division (B) of this section;

(b) That a well-informed public office or person responsible for the requested public records reasonably would believe that the conduct or threatened conduct of the public office or person responsible for the requested public records would serve the public policy that underlies the authority that is asserted as permitting that conduct or threatened conduct.

(3) In a mandamus action filed under division (C)(1) of this section, the following apply:

(a)(i) If the court orders the public office or the person responsible for the public record to comply with division (B) of this section, the court shall determine and award to the relator all court costs, which shall be construed as remedial and not punitive.

(ii) If the court makes a determination described in division (C)(3)(b)(iii) of this section, the court shall determine and award to the relator all court costs, which shall be construed as remedial and not punitive.

(b) If the court renders a judgment that orders the public office or the person responsible for the public record to comply with division (B) of this section or if the court determines any of the following, the court may award reasonable attorney's fees to the relator, subject to the provisions of division (C)(4) of this section:

(i) The public office or the person responsible for the public records failed to respond affirmatively or negatively to the public records request in accordance with the time allowed under division (B) of this section.

(ii) The public office or the person responsible for the public records promised to permit the relator to inspect or receive copies of the public records requested within a specified period of time but failed to fulfill that promise within that specified period of time.

(iii) The public office or the person responsible for the public records acted in bad faith when the office or person voluntarily made the public records available to the relator for the first time after the relator commenced the mandamus action, but before the court issued any order concluding whether or not the public office or person was required to comply with division (B) of this section. No discovery may be conducted on the issue of the alleged bad faith of the public office or person responsible for the public records. This division shall not be construed as creating a presumption that the public office or the person responsible for the public records acted in bad faith when the office or person voluntarily made the public records available to the relator for the first time after the relator commenced the mandamus action, but before the court issued any order described in this division.

(c) The court shall not award attorney's fees to the relator if the court determines both of the following:

(i) That, based on the ordinary application of statutory law and case law as it existed at the time of the conduct or threatened conduct of the public office or person responsible for the requested public records that allegedly constitutes a failure to comply with an obligation in accordance with division (B) of this section and that was the basis of the mandamus action, a well-informed public office or person responsible for the requested public records reasonably would believe that the conduct or threatened conduct of the public office or person responsible for the requested public records did not constitute a failure to comply with an obligation in accordance with division (B) of this section;

(ii) That a well-informed public office or person responsible for the requested public records reasonably would believe that the conduct or threatened conduct of the public office or person responsible for the requested public records would serve the public policy that underlies the authority that is asserted as permitting that conduct or threatened conduct.

(4) All of the following apply to any award of reasonable attorney's fees awarded under division (C)(3)(b) of this section:
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(a) The fees shall be construed as remedial and not punitive.
(b) The fees awarded shall not exceed the total of the reasonable attorney's fees incurred before the public record was made available to the relator and the fees described in division (C)(4)(c) of this section.
(c) Reasonable attorney's fees shall include reasonable fees incurred to produce proof of the reasonableness and amount of the fees and to otherwise litigate entitlement to the fees.
(d) The court may reduce the amount of fees awarded if the court determines that, given the factual circumstances involved with the specific public records request, an alternative means should have been pursued to more effectively and efficiently resolve the dispute that was subject to the mandamus action filed under division (C)(1) of this section.
(5) If the court does not issue a writ of mandamus under division (C) of this section and the court determines at that time that the bringing of the mandamus action was frivolous conduct as defined in division (A) of section 2323.51 of the Revised Code, the court may award to the public office all court costs, expenses, and reasonable attorney's fees, as determined by the court.

(D) Chapter 1347 of the Revised Code does not limit the provisions of this section.

(E)(1) To ensure that all employees of public offices are appropriately educated about a public office’s obligations under division (B) of this section, all elected officials or their appropriate designees shall attend training approved by the attorney general as provided in section 109.43 of the Revised Code. In addition, all public offices shall adopt a public records policy in compliance with this section for responding to public records requests. In adopting a public records policy under this division, a public office may obtain guidance from the model public records policy developed and provided to the public office by the attorney general under section 109.43 of the Revised Code. Except as otherwise provided in this section, the policy may not limit the number of public records that the public office will make available to a single person, may not limit the number of public records that it will make available during a fixed period of time, and may not establish a fixed period of time before it will respond to a request for inspection or copying of public records, unless that period is less than eight hours.

(2) The public office shall distribute the public records policy adopted by the public office under division (E)(1) of this section to the employee of the public office who is the records custodian or records manager or otherwise has custody of the records of that office. The public office shall require that employee to acknowledge receipt of the copy of the public records policy. The public office shall create a poster that describes its public records policy and shall post the poster in a conspicuous place in the public office and in all locations where the public office has branch offices. The public office may post its public records policy on the internet web site of the public office if the public office maintains an internet web site. A public office that has established a manual or handbook of its general policies and procedures for all employees of the public office shall include the public records policy of the public office in the manual or handbook.

(F)(1) The bureau of motor vehicles may adopt rules pursuant to Chapter 119 of the Revised Code to reasonably limit the number of bulk commercial special extraction requests made by a person for the same records or for updated records during a calendar year. The rules may include provisions for charges to be made for bulk commercial special extraction requests for the actual cost of the bureau, plus special extraction costs, plus ten per cent. The bureau may charge for expenses for redacting information, the release of which is prohibited by law.

(2) As used in division (F)(1) of this section:
   (a) “Actual cost” means the cost of depleted supplies, records storage media costs, actual mailing and alternative delivery costs, or other transmitting costs, and any direct equipment operating and maintenance costs, including actual costs paid to private contractors for copying services.
   (b) “Bulk commercial special extraction request” means a request for copies of a record
for information in a format other than the format already available, or information that cannot be extracted without examination of all items in a records series, class of records, or database by a person who intends to use or forward the copies for surveys, marketing, solicitation, or resale for commercial purposes. “Bulk commercial special extraction request” does not include a request by a person who gives assurance to the bureau that the person making the request does not intend to use or forward the requested copies for surveys, marketing, solicitation, or resale for commercial purposes.

(c) “Commercial” means profit-seeking production, buying, or selling of any good, service, or other product.

d) “Special extraction costs” means the cost of the time spent by the lowest paid employee competent to perform the task, the actual amount paid to outside private contractors employed by the bureau, or the actual cost incurred to create computer programs to make the special extraction. “Special extraction costs” include any charges paid to a public agency for computer or records services.

(3) For purposes of divisions (F)(1) and (2) of this section, “surveys, marketing, solicitation, or resale for commercial purposes” shall be narrowly construed and does not include reporting or gathering news, reporting or gathering information to assist citizen oversight or understanding of the operation or activities of government, or nonprofit educational research.

(G) A request by a defendant, counsel of a defendant, or any agent of a defendant in a criminal action that public records related to that action be made available under this section shall be considered a demand for discovery pursuant to the Criminal Rules, except to the extent that the Criminal Rules plainly indicate a contrary intent. The defendant, counsel of the defendant, or agent of the defendant making a request under this division shall serve a copy of the request on the prosecuting attorney, director of law, or other chief legal officer responsible for prosecuting the action.

149.431 Governmental funds; financial records requirement; patient and client record confidentiality.

(A) Except as provided in sections 9.833, 2744.081, and 3345.203 of the Revised Code, any governmental entity or agency and any nonprofit corporation or association, except a corporation organized pursuant to Chapter 1719 of the Revised Code prior to January 1, 1980 or organized pursuant to Chapter 3941 of the Revised Code, that enters into a contract or other agreement with the federal government, a unit of state government, or a political subdivision or taxing unit of this state for the provision of services shall keep accurate and complete financial records of any moneys expended in relation to the performance of the services pursuant to such contract or agreement according to generally accepted accounting principles. Such contract or agreement and such financial records shall be deemed to be public records as defined in division (A)(1) of section 149.43 of the Revised Code and are subject to the requirements of division (B) of that section, except that:

(1) Any information directly or indirectly identifying a present or former individual patient or client or such an individual patient's or client's diagnosis, prognosis, or medical treatment, treatment for a mental or emotional disorder, treatment for a developmental disability, treatment for drug abuse or alcoholism, or counseling for personal or social problems is not a public record;

(2) If disclosure of the contract or agreement or financial records is requested at a time when confidential professional services are being provided to a patient or client whose confidentiality might be violated if disclosure were made at that time, disclosure may be deferred if reasonable times are established when the contract or agreement or financial records will be disclosed.

(3) Any nonprofit corporation or association that receives both public and private funds in
fulfillment of any such contract or other agreement is not required to keep as public records the financial records of any private funds expended in relation to the performance of services pursuant to the contract or agreement.

(B) Any nonprofit corporation or association that receives more than fifty per cent of its gross receipts excluding moneys received pursuant to Title XVIII of the “Social Security Act,” 49 Stat. 620 (1935), 42 U.S.C. 301, as amended, in a calendar year in fulfillment of a contract or other agreement for services with a governmental entity shall maintain information setting forth the compensation of any individual serving the nonprofit corporation or association in an executive or administrative capacity. Such information shall be deemed to be public records as defined in division (A)(1) of section 149.43 of the Revised Code and is subject to the requirements of division (B) of that section.

Nothing in this section shall be construed to otherwise limit the provisions of section 149.43 of the Revised Code.

341.192 County and state to pay prisoner expenses.

(A) As used in this section:

(1) “Jail” means a county jail, or a multicounty, municipal-county, or multicounty-municipal correctional center.

(2) “Medical provider” means a physician, hospital, laboratory, pharmacy, or other health care provider that is not employed by or under contract to a county, municipal corporation, township, the department of youth services, or the department of rehabilitation and correction to provide medical services to persons confined in a jail or state correctional institution, or is in the custody of a law enforcement officer.

(3) “Necessary care” means medical care of a nonelective nature that cannot be postponed until after the period of confinement of a person who is confined in a jail or state correctional institution, or is in the custody of a law enforcement officer without endangering the life or health of the person.

(B) If a physician employed by or under contract to a county, municipal corporation, township, the department of youth services, or the department of rehabilitation and correction to provide medical services to persons confined in a jail or state correctional institution determines that a person who is confined in the jail or state correctional institution or who is in the custody of a law enforcement officer prior to the person's confinement in a jail or state correctional institution requires necessary care that the physician cannot provide, the necessary care shall be provided by a medical provider. The county, municipal corporation, township, the department of youth services, or the department of rehabilitation and correction shall pay a medical provider for necessary care an amount not exceeding the authorized reimbursement rate for the same service established by the department of medicaid under the medicaid program.

749.34 Municipal hospital report to legislative authority.

On the first Monday in January of each year, the board of hospital trustees shall make a report to the legislative authority of the municipal corporation of its proceedings, with a detailed statement of its receipts and expenditures during the year. The board shall also, at the proper time, submit to the legislative authority a detailed estimate of the amount necessary to maintain and improve such hospital for the ensuing year.

753.02 Municipal authorities to pay prisoner expenses

(A) The legislative authority of a municipal corporation shall provide by ordinance for sustaining all persons sentenced to or confined in a prison or station house at the expense of
the municipal corporation, and in counties where prisons or station houses are in quarters leased from the board of county commissioners, may contract with the board for the care and maintenance of those persons by the sheriff or other person charged with the care and maintenance of county prisoners. On the presentation of bills for food, sustenance, and necessary supplies, to the proper officer, certified by the person whom the legislative authority designates, the officer shall audit the bills under the rules prescribed by the legislative authority, and draw the officer's order on the treasurer of the municipal corporation in favor of the person presenting the bill.

(B) Pursuant to section 2929.37 of the Revised Code, the legislative authority of the municipal corporation may require a person who was convicted of an offense and who is confined in a prison or station house as provided in division (A) of this section, or a person who was convicted of an offense and who is confined in the county jail as provided in section 1905.35 of the Revised Code, to reimburse the municipal corporation for its expenses incurred by reason of the person’s confinement.

(C) Notwithstanding any contrary provision in this section or section 2929.18, 2929.28, or 2929.37 of the Revised Code, the legislative authority of the municipal corporation may establish a policy that complies with section 2929.38 of the Revised Code and that requires any person who is not indigent and who is confined in a prison or station house to pay a reception fee, a fee for any medical treatment or service requested by and provided to that person, or the fee for a random drug test assessed under division (E) of section 753.33 of the Revised Code.

(D) If a person who has been convicted of or pleaded guilty to an offense is sentenced to a term of imprisonment in a prison or station house as described in division (A) of this section, or if a person who has been arrested for an offense, and who has been denied bail or has had bail set and has not been released on bail is confined in a prison or station house as described in division (A) of this section pending trial, at the time of reception and at other times the person in charge of the operation of the prison or station house determines to be appropriate, the person in charge of the operation of the prison or station house may cause the convicted or accused offender to be examined and tested for tuberculosis, HIV infection, hepatitis, including, but not limited to, hepatitis A, B, and C, and other contagious diseases. The person in charge of the operation of the prison or station house may cause a convicted or accused offender in the prison or station house who refuses to be tested or treated for tuberculosis, HIV infection, hepatitis, including, but not limited to, hepatitis A, B, and C, or another contagious disease to be tested and treated involuntarily.

**1751.60 Subscribee and enrollee liability to providers or facilities.**

(A) Except as provided for in divisions (E) and (F) of this section, every provider or health care facility that contracts with a health insuring corporation to provide health care services to the health insuring corporation's enrollees or subscribers shall seek compensation for covered services solely from the health insuring corporation and not, under any circumstances, from the enrollees or subscribers, except for approved copayments and deductibles.

(B) No subscriber or enrollee of a health insuring corporation is liable to any contracting provider or health care facility for the cost of any covered health care services, if the subscriber or enrollee has acted in accordance with the evidence of coverage.

(C) Except as provided for in divisions (E) and (F) of this section, every contract between a health insuring corporation and provider or health care facility shall contain a provision approved by the superintendent of insurance requiring the provider or health care facility to seek compensation solely from the health insuring corporation and not, under any circumstances, from the subscriber or enrollee, except for approved copayments and deductibles.
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(D) Nothing in this section shall be construed as preventing a provider or health care facility from billing the enrollee or subscriber of a health insuring corporation for noncovered services.

(E) Upon application by a health insuring corporation and a provider or health care facility, the superintendent may waive the requirements of divisions (A) and (C) of this section when, in addition to the reserve requirements contained in section 1751.28 of the Revised Code, the health insuring corporation provides sufficient assurances to the superintendent that the provider or health care facility has been provided with financial guarantees. No waiver of the requirements of divisions (A) and (C) of this section is effective as to enrollees or subscribers for whom the health insuring corporation is compensated under a provider agreement or risk contract entered into under the medicaid program.

(F) The requirements of divisions (A) to (C) of this section apply only to health care services provided to an enrollee or subscriber prior to the effective date of a termination of a contract between the health insuring corporation and the provider or health care facility.

3701.351 Standards, procedures, and privileges for hospital staff; discrimination prohibited.

(A) The governing body of every hospital shall set standards and procedures to be applied by the hospital and its medical staff in considering and acting upon applications for staff membership or professional privileges. These standards and procedures shall be available for public inspection.

(B) The governing body of any hospital, in considering and acting upon applications for staff membership or professional privileges within the scope of the applicants' respective licensures, shall not discriminate against a qualified person solely on the basis of whether that person is certified to practice medicine, osteopathic medicine, or podiatry, is licensed to practice dentistry or psychology, or is licensed to practice nursing as an advanced practice registered nurse. Staff membership or professional privileges shall be considered and acted on in accordance with standards and procedures established under division (A) of this section. This section does not permit a psychologist to admit a patient to a hospital in violation of section 3727.06 of the Revised Code.

(C) The governing body of any hospital that is licensed to provide maternity services, in considering and acting upon applications for clinical privileges, shall not discriminate against a qualified person solely on the basis that the person is authorized to practice nurse-midwifery. An application from a certified nurse-midwife who is not employed by the hospital shall contain the name of a physician member of the hospital's medical staff who holds clinical privileges in obstetrics at that hospital and who has agreed to be the collaborating physician for the applicant in accordance with section 4723.43 of the Revised Code.

(D) Any person may apply to the court of common pleas for temporary or permanent injunctions restraining a violation of division (A), (B), or (C) of this section. This action is an additional remedy not dependent on the adequacy of the remedy at law.

(E)(1) If a hospital does not provide or permit the provision of any diagnostic or treatment service for mental or emotional disorders or any other service that may be legally performed by a psychologist licensed under Chapter 4732 of the Revised Code, this section does not require the hospital to provide or permit the provision of any such service and the hospital shall be exempt from requirements of this section pertaining to psychologists.

(2) This section does not impair the right of a hospital to enter into an employment, personal service, or any other kind of contract with a licensed psychologist, upon any such terms as the parties may mutually agree, for the provision of any service that may be legally performed by a licensed psychologist.
3701.073 Critical access hospital.

(A) The department of health is hereby designated as the state agency responsible for administering the medicare rural hospital flexibility program, as established in 42 U.S.C. 1395i-4, as amended.

(B) The director of health shall designate as a critical access hospital a hospital registered as an acute care hospital with the department under section 3701.07 of the Revised Code if the hospital meets the following requirements:

1. Has not more than twenty-five acute care and swing beds in use at any time for the furnishing of extended care or acute care inpatient services;
2. Has a length of stay not more than ninety-six hours per patient, on an annual average basis;
3. Provides inpatient, outpatient, emergency, laboratory, radiology, and twenty-four hour emergency care services;
4. Has network agreements in place for patient referral and transfer, a communication system for telemetry systems, electronic sharing of patient data, provision for emergency and non-emergency transportation, and assures credentialing and quality assurance;
5. Was certified as a critical access hospital by the centers for medicare and medicaid services between January 1, 2001, and December 31, 2005, or is located in a rural area as identified below:
   a. An area within an Ohio metropolitan area designated as a rural area by the United States department of health and human services, office of rural health policy, in accordance with 42 C.F.R. 412.103 regarding rural urban commuting area codes four through ten in effect on the effective date of this section;
   b. A non-metropolitan county as designated in United States office of management and budget bulletin no. 93-17, June 30, 1993, and its attachments;
   c. A rural zip code within a metropolitan county as designated in United States office of management and budget bulletin no. 93-17, June 30, 1993, and its attachments.

3717.41 Retail food service operation; license requirement.

Except as provided in section 3717.42 of the Revised Code, no person or government entity shall operate a food service operation without a license. A separate license is required for each food service operation a person or government entity operates.

No person or government entity shall fail to comply with any other requirement of this chapter applicable to food service operations.

4928.112 Hospital priority in power restoration.

(A) In the event of an interruption of electric service during a period of emergency or disaster, an electric distribution utility’s service restoration plan shall give priority to hospitals that are customers of the electric distribution utility.

(B) If requested by a hospital that is its customer, an electric distribution utility shall confer at least biennially with that hospital regarding power quality issues and concerns related to the utility’s facilities, including voltage sags, spikes, and harmonic disturbances, in an effort to minimize those events or their impact on the hospital.

(C) The public utilities commission shall adopt rules to carry out this section.

Part II. Pharmacies and Controlled Substances

[Editor’s Note: Additional statutes and regulations governing pharmacists and pharmacies are
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available at [http://pharmacy.ohio.gov/](http://pharmacy.ohio.gov/)

3719.05 Pharmacist dispensing rules; sale of discontinued stock.

(A) A pharmacist may dispense controlled substances to any person upon a prescription issued in accordance with section 3719.06 of the Revised Code. When dispensing controlled substances, a pharmacist shall act in accordance with rules adopted by the state board of pharmacy and in accordance with the following:

1. The prescription shall be retained on file by the owner of the pharmacy in which it is filled for a period of three years, so as to be readily accessible for inspection by any public officer or employee engaged in the enforcement of Chapter 2925, 3719, or 4729 of the Revised Code.

2. Each oral prescription shall be recorded by the pharmacist and the record shall show the name and address of the patient for whom, or of the owner of the animal for which the controlled substance is dispensed, the full name, address, and registry number under the federal drug abuse control laws of the prescriber, the name of the controlled substance dispensed, the amount dispensed, and the date when dispensed. The record shall be retained on file by the owner of the pharmacy in which it is filled for a period of three years.

3. A schedule II controlled substance shall be dispensed only upon a written prescription, except that it may be dispensed upon an oral prescription in emergency situations as provided in the federal drug abuse control laws.

4. A prescription for a schedule II controlled substance shall not be refilled.

5. Prescriptions for schedule III and IV controlled substances may be refilled not more than five times in a six-month period from the date the prescription is given by a prescriber.

(B) The legal owner of any stock of schedule II controlled substances in a pharmacy, upon discontinuance of dealing in those drugs, may sell the stock to a manufacturer, wholesaler, or owner of a pharmacy registered under the federal drug abuse control laws pursuant to an official written order.

3719.061 Prescribing opioids to minors.

(A)(1) As used in this section:

(a) “Another adult authorized to consent to the minor’s medical treatment” means an adult to whom a minor’s parent or guardian has given written authorization to consent to the minor’s medical treatment.

(b) “Medical emergency” means a situation that in a prescriber’s good faith medical judgment creates an immediate threat of serious risk to the life or physical health of a minor.

(c) “Minor” means an individual under eighteen years of age who is not emancipated.

(2) For purposes of this section, an individual under eighteen years of age is emancipated only if the individual has married, has entered the armed services of the United States, has become employed and self-sustaining, or otherwise has become independent from the care and control of the individual’s parent, guardian, or custodian.

(B) Except as provided in division (C) of this section, before issuing for a minor the first prescription in a single course of treatment for an opioid analgesic, regardless of whether the dosage is modified during that course of treatment, a prescriber shall do all of the following:

1. As part of the prescriber’s examination of the minor, assess whether the minor has ever suffered, or is currently suffering, from mental health or substance abuse disorders and whether the minor has taken or is currently taking prescription drugs for treatment of those disorders;

2. Discuss with the minor and the minor’s parent, guardian, or another adult authorized to consent to the minor’s medical treatment all of the following:
(a) The risks of addiction and overdose associated with opioid analgesics;
(b) The increased risk of addiction to controlled substances of individuals suffering from both mental and substance abuse disorders;
(c) The dangers of taking opioid analgesics with benzodiazepines, alcohol, or other central nervous system depressants;
(d) Any other information in the patient counseling information section of the labeling for the opioid analgesic required under 21 C.F.R. 201.57(c)(18).

(3) Obtain written consent for the prescription from the minor’s parent, guardian, or, subject to division (E) of this section, another adult authorized to consent to the minor’s medical treatment.

The prescriber shall record the consent on a form, which shall be known as the “Start Talking!” consent form. The form shall be separate from any other document the prescriber uses to obtain informed consent for other treatment provided to the minor. The form shall contain all of the following:

(a) The name and quantity of the opioid analgesic being prescribed and the amount of the initial dose;
(b) A statement indicating that a controlled substance is a drug or other substance that the United States drug enforcement administration has identified as having a potential for abuse;
(c) A statement certifying that the prescriber discussed with the minor and the minor’s parent, guardian, or another adult authorized to consent to the minor’s medical treatment the matters described in division (B)(2) of this section;
(d) The number of refills, if any, authorized by the prescription;
(e) The signature of the minor’s parent, guardian, or another adult authorized to consent to the minor’s medical treatment and the date of signing.

(C)(1) The requirements in division (B) of this section do not apply if the minor’s treatment with an opioid analgesic meets any of the following criteria:
(a) The treatment is associated with or incident to a medical emergency.
(b) The treatment is associated with or incident to surgery, regardless of whether the surgery is performed on an inpatient or outpatient basis.
(c) In the prescriber’s professional judgment, fulfilling the requirements of division (B) of this section with respect to the minor’s treatment would be a detriment to the minor’s health or safety.
(d) Except as provided in division (D) of this section, the treatment is rendered in a hospital, emergency facility, ambulatory surgical facility, nursing home, pediatric respite care program, residential care facility, freestanding rehabilitation facility, or similar institutional facility.

(2) The requirements in division (B) of this section do not apply to a prescription for an opioid analgesic that a prescriber issues to a minor at the time of discharge from a facility or other location described in division (C)(1)(d) of this section.

(D) The exemption in division (C)(1)(d) of this section does not apply to treatment rendered in a prescriber’s office that is located on the premises of or adjacent to a facility or other location described in that division.

(E) If the individual who signs the consent form required by division (B)(3) of this section is another adult authorized to consent to the minor’s medical treatment, the prescriber shall prescribe not more than a single, seventy-two-hour supply and indicate on the prescription the quantity that is to be dispensed pursuant to the prescription.

(F) A signed “Start Talking!” consent form obtained under this section shall be maintained in the minor’s medical record.
3719.07 Controlled substances handled; records.

(A) As used in this section, “description” means the dosage form, strength, and quantity, and the brand name, if any, or the generic name, of a drug or controlled substance.

(B)(1) Every licensed health professional authorized to prescribe drugs shall keep a record of all controlled substances received and a record of all controlled substances administered, dispensed, or used other than by prescription. Every other person, except a pharmacist or a manufacturer, wholesaler, or other person licensed under section 4729.52 of the Revised Code, who is authorized to purchase and use controlled substances shall keep a record of all controlled substances purchased and used other than by prescription. The records shall be kept in accordance with division (C)(1) of this section.

(2) Manufacturers, wholesalers, and other persons licensed under section 4729.52 of the Revised Code shall keep records of all controlled substances compounded, mixed, cultivated, grown, or by any other process produced or prepared by them, and of all controlled substances received or sold by them. The records shall be kept in accordance with division (C)(2) of this section.

(3) Every category III terminal distributor of dangerous drugs shall keep records of all controlled substances received or sold. The records shall be kept in accordance with division (C)(3) of this section.

(4) Every person who sells or purchases for resale schedule V controlled substances exempted by section 3719.15 of the Revised Code shall keep a record showing the quantities and kinds thereof received or sold. The records shall be kept in accordance with divisions (C)(1), (2), and (3) of this section.

(C)(1) The records required by divisions (B)(1) and (4) of this section shall contain the following:

(a) The description of all controlled substances received, the name and address of the person from whom received, and the date of receipt;

(b) The description of controlled substances administered, dispensed, purchased, sold, or used; the date of administering, dispensing, purchasing, selling, or using; the name and address of the person to whom, or for whose use, or the owner and species of the animal for which the controlled substance was administered, dispensed, purchased, sold, or used.

(2) The records required by divisions (B)(2) and (4) of this section shall contain the following:

(a) The description of all controlled substances produced or prepared, the name and address of the person from whom received, and the date of receipt;

(b) The description of controlled substances sold, the name and address of each person to whom a controlled substance is sold, the amount of the controlled substance sold to each person, and the date it was sold.

(3) The records required by divisions (B)(3) and (4) of this section shall contain the following:

(a) The description of controlled substances received, the name and address of the person from whom controlled substances are received, and the date of receipt;

(b) The name and place of residence of each person to whom controlled substances, including those otherwise exempted by section 3719.15 of the Revised Code, are sold, the description of the controlled substances sold to each person, and the date the controlled substances are sold to each person.

(D) Every record required by this section shall be kept for a period of three years. The keeping of a record required by or under the federal drug abuse control laws, containing substantially the same information as specified in this section, constitutes compliance with this section.

Every person who purchases for resale or who sells controlled substance preparations...
exempted by section 3719.15 of the Revised Code shall keep the record required by or under the federal drug abuse control laws.

3719.12 Conviction; reporting suspension or revocation of license.

Unless a report has been made pursuant to section 2929.42 of the Revised Code, on the conviction of a manufacturer, wholesaler, terminal distributor of dangerous drugs, pharmacist, pharmacy intern, dentist, chiropractor, physician, podiatrist, registered nurse, licensed practical nurse, physician assistant, optometrist, or veterinarian of the violation of this chapter or Chapter 2925 of the Revised Code, the prosecutor in the case promptly shall report the conviction to the board that licensed, certified, or registered the person to practice or to carry on business. The responsible board shall provide forms to the prosecutor. Within thirty days of the receipt of this information, the board shall initiate action in accordance with Chapter 119 of the Revised Code to determine whether to suspend or revoke the person's license, certificate, or registration.

3719.121 Controlled substance; suspension of licenses; registrations of addicts.

(A) Except as otherwise provided in section 4723.28, 4723.35, 4730.25, 4731.22, 4734.39, or 4734.41 of the Revised Code, the license, certificate, or registration of any dentist, chiropractor, physician, podiatrist, registered nurse, advanced practice registered nurse, licensed practical nurse, physician assistant, pharmacist, pharmacy intern, pharmacy technician trainee, registered pharmacy technician, certified pharmacy technician, optometrist, or veterinarian who is or becomes addicted to the use of controlled substances shall be suspended by the board that authorized the person's license, certificate, or registration until the person offers satisfactory proof to the board that the person no longer is addicted to the use of controlled substances.

(B) If the board under which a person has been issued a license, certificate, or evidence of registration determines that there is clear and convincing evidence that continuation of the person's professional practice or method of administering, prescribing, preparing, distributing, dispensing, or personally furnishing controlled substances or other dangerous drugs presents a danger of immediate and serious harm to others, the board may suspend the person's license, certificate, or registration without a hearing. Except as otherwise provided in sections 4715.30, 4723.281, 4729.16, 4730.25, 4731.22, and 4734.36 of the Revised Code, the board shall follow the procedure for suspension without a prior hearing in section 119.07 of the Revised Code. The suspension shall remain in effect, unless removed by the board, until the board's final adjudication order becomes effective, except that if the board does not issue its final adjudication order within ninety days after the hearing, the suspension shall be void on the ninetieth day after the hearing.

(C) On receiving notification pursuant to section 2929.42 or 3719.12 of the Revised Code, the board under which a person has been issued a license, certificate, or evidence of registration immediately shall suspend the license, certificate, or registration of that person on a plea of guilty to, a finding by a jury or court of the person's guilt of, or conviction of a felony drug abuse offense; a finding by a court of the person's eligibility for intervention in lieu of conviction; a plea of guilty to, or a finding by a jury or court of the person's guilt of, or the person's conviction of an offense in another jurisdiction that is essentially the same as a felony drug abuse offense; or a finding by a court of the person's eligibility for treatment or intervention in lieu of conviction in another jurisdiction. The board shall notify the holder of the license, certificate, or registration of the suspension, which shall remain in effect until the board holds an adjudicatory hearing under Chapter 119 of the Revised Code.
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3719.172 Handling hypodermics; rules.

(A) Possession of a hypodermic is authorized for the following:
   (1) A manufacturer or distributor of, or dealer in, hypodermics or medication packaged in hypodermics, and any authorized agent or employee of that manufacturer, distributor, or dealer, in the regular course of business;
   (2) A terminal distributor of dangerous drugs, in the regular course of business;
   (3) A person authorized to administer injections, in the regular course of the person's profession or employment;
   (4) A person, when the hypodermic was lawfully obtained and is kept and used for the purpose of self-administration of insulin or other drug prescribed for the treatment of disease by a licensed health professional authorized to prescribe drugs;
   (5) A person whose use of a hypodermic is for legal research, clinical, educational, or medicinal purposes;
   (6) A farmer, for the lawful administration of a drug to an animal;
   (7) A person whose use of a hypodermic is for lawful professional, mechanical, trade, or craft purposes.

(B) No manufacturer or distributor of, or dealer in, hypodermics or medication packaged in hypodermics, or their authorized agents or employees, and no terminal distributor of dangerous drugs, shall display any hypodermic for sale. No person authorized to possess a hypodermic pursuant to division (A) of this section shall negligently fail to take reasonable precautions to prevent any hypodermic in the person's possession from theft or acquisition by any unauthorized person.

(C) No person other than one of the following shall sell or furnish a hypodermic to another person:
   (1) A manufacturer or distributor of, or dealer in, hypodermics or medication packaged in hypodermics, or their authorized agents or employees;
   (2) A terminal distributor of dangerous drugs;
   (3) A person under the direct supervision of a pharmacist;
   (4) A licensed health professional authorized to prescribe drugs, acting in the regular course of business and as permitted by law;
   (5) An individual who holds a current license, certificate, or registration issued under Title 47 of the Revised Code and has been certified to conduct diabetes education by a national certifying body specified in rules adopted by the state board of pharmacy under section 4729.68 of the Revised Code, but only if diabetes education is within the individual's scope of practice under statutes and rules regulating the individual's profession.

(D) No person shall sell or furnish a hypodermic to another whom the person knows or has reasonable cause to believe is not authorized by division (A) of this section to possess a hypodermic.

3719.27 Inspecting files and records upon written request.

(A) Persons required by Chapter 3719 of the Revised Code to keep files or records shall, upon the written request of an officer or employee designated by the state board of pharmacy, make such files or records available to such officer or employee, at all reasonable hours, for inspection and copying, and accord to such officer or employee full opportunity to check the correctness of such files or records, including opportunity to make inventory of all stocks of controlled substances on hand. No person shall fail to make such files or records available or to accord such opportunity to check their correctness.

(B) Persons required by Chapter 3719 of the Revised Code to keep files or records shall, upon the written request of an employee designated by the director of mental health and
addiction services, make such files or records available to the employee for the purpose of section 5119.367 of the Revised Code, at all reasonable hours, for inspection and copying, and accord to such employee full opportunity to check the correctness of such files or records. No person shall fail to make such files or records available or to accord such opportunity to check their correctness.

3719.33 Labeling poisons for delivery or sale.

No person shall sell or deliver to another a substance named in section 3719.32 of the Revised Code without having first learned by due inquiry that such person is aware of the poisonous character of such substance and that it is desired for a lawful purpose; or without plainly labeling "poison," and the names of two or more antidotes therefor, upon the box, bottle, or package containing it; or deliver such substance without recording in a book kept for the purpose, the name thereof, the quantity delivered, the purpose for which it is alleged to be used, the date of its delivery, the name and address of the purchaser, and the name of the dispenser; or fail to preserve said book for five years and submit it at all times for inspection to proper officers of the law.

3719.81 Drug samples.

(A) As used in this section, "sample drug" has the same meaning as in section 2925.01 of the Revised Code.

(B) A person may furnish another a sample drug, if all of the following apply:

(1) The sample drug is furnished free of charge by a manufacturer, manufacturer's representative, or wholesale dealer in pharmaceuticals to a licensed health professional authorized to prescribe drugs, or is furnished free of charge by such a professional to a patient for use as medication;

(2) The sample drug is in the original container in which it was placed by the manufacturer, and the container is plainly marked as a sample;

(3) Prior to its being furnished, the sample drug has been stored under the proper conditions to prevent its deterioration or contamination;

(4) If the sample drug is of a type which deteriorates with time, the sample container is plainly marked with the date beyond which the sample drug is unsafe to use, and the date has not expired on the sample furnished. Compliance with the labeling requirements of the "Federal Food, Drug, and Cosmetic Act," 52 Stat. 1040 (1938), 21 U.S.C.A. 301, as amended, shall be deemed compliance with this section.

(5) The sample drug is distributed, stored, or discarded in such a way that the sample drug may not be acquired or used by any unauthorized person, or by any person, including a child, for whom it may present a health or safety hazard.

(C) Division (B) of this section does not do any of the following:

(1) Apply to or restrict the furnishing of any sample of a nonnarcotic substance if the substance may, under the "Federal Food, Drug, and Cosmetic Act" and under the laws of this state, otherwise be lawfully sold over the counter without a prescription;

(2) Authorize a licensed health professional authorized to prescribe drugs who is a clinical nurse specialist, certified nurse-midwife, certified nurse practitioner, optometrist, or physician assistant to furnish a sample drug that is not a drug the professional is authorized to prescribe.

(3) Prohibit a licensed health professional authorized to prescribe drugs, manufacturer of dangerous drugs, wholesale distributor of dangerous drugs, or representative of a manufacturer of dangerous drugs from furnishing a sample drug to a charitable pharmacy in accordance with section 3719.811 of the Revised Code.
(4) Prohibit a pharmacist working, whether or not for compensation, in a charitable pharmacy from dispensing a sample drug to a person in accordance with section 3719.811 of the Revised Code.

(D) The state board of pharmacy shall, in accordance with Chapter 119 of the Revised Code, adopt rules as necessary to give effect to this section.

4729.01 Pharmacist scope of practice; immunizations.

As used in this chapter:
(A) “Pharmacy,” except when used in a context that refers to the practice of pharmacy, means any area, room, rooms, place of business, department, or portion of any of the foregoing where the practice of pharmacy is conducted.

(B) “Practice of pharmacy” means providing pharmacist care requiring specialized knowledge, judgment, and skill derived from the principles of biological, chemical, behavioral, social, pharmaceutical, and clinical sciences. As used in this division, “pharmacist care” includes the following:

(1) Interpreting prescriptions;
(2) Dispensing drugs and drug therapy related devices;
(3) Compounding drugs;
(4) Counseling individuals with regard to their drug therapy, recommending drug therapy related devices, and assisting in the selection of drugs and appliances for treatment of common diseases and injuries and providing instruction in the proper use of the drugs and appliances;
(5) Performing drug regimen reviews with individuals by discussing all of the drugs that the individual is taking and explaining the interactions of the drugs;
(6) Performing drug utilization reviews with licensed health professionals authorized to prescribe drugs when the pharmacist determines that an individual with a prescription has a drug regimen that warrants additional discussion with the prescriber;
(7) Advising an individual and the health care professionals treating an individual with regard to the individual's drug therapy;
(8) Acting pursuant to a consult agreement with one or more physicians authorized under Chapter 4731 of the Revised Code to practice medicine and surgery or osteopathic medicine and surgery, if an agreement has been established;
(9) Engaging in the administration of immunizations to the extent authorized by section 4729.41 of the Revised Code;
(10) Engaging in the administration of drugs to the extent authorized by section 4729.45 of the Revised Code.

(C) “Compounding” means the preparation, mixing, assembling, packaging, and labeling of one or more drugs in any of the following circumstances:

(1) Pursuant to a prescription issued by a licensed health professional authorized to prescribe drugs;
(2) Pursuant to the modification of a prescription made in accordance with a consult agreement;
(3) As an incident to research, teaching activities, or chemical analysis;
(4) In anticipation of orders for drugs pursuant to prescriptions, based on routine, regularly observed dispensing patterns;
(5) Pursuant to a request made by a licensed health professional authorized to prescribe drugs for a drug that is to be used by the professional for the purpose of direct administration to patients in the course of the professional's practice, if all of the following apply:

(a) At the time the request is made, the drug is not commercially available regardless of the reason that the drug is not available, including the absence of a manufacturer for the drug or the lack of a readily available supply of the drug from a manufacturer.
(b) A limited quantity of the drug is compounded and provided to the professional.
(c) The drug is compounded and provided to the professional as an occasional exception to the normal practice of dispensing drugs pursuant to patient-specific prescriptions.
(D) “Consult agreement” means an agreement that has been entered into under section 4729.39 of the Revised Code.
(E) “Drug” means:
(1) Any article recognized in the United States pharmacopoeia and national formulary, or any supplement to them, intended for use in the diagnosis, cure, mitigation, treatment, or prevention of disease in humans or animals;
(2) Any other article intended for use in the diagnosis, cure, mitigation, treatment, or prevention of disease in humans or animals;
(3) Any article, other than food, intended to affect the structure or any function of the body of humans or animals;
(4) Any article intended for use as a component of any article specified in division (E)(1), (2), or (3) of this section; but does not include devices or their components, parts, or accessories.
(F) “Dangerous drug” means any of the following:
(a) Under the “Federal Food, Drug, and Cosmetic Act,” 52 Stat. 1040 (1938), 21 U.S.C.A. 301, as amended, the drug is required to bear a label containing the legend “Caution: Federal law prohibits dispensing without prescription” or “Caution: Federal law restricts this drug to use by or on the order of a licensed veterinarian” or any similar restrictive statement, or the drug may be dispensed only upon a prescription;
(b) Under Chapter 3715 or 3719 of the Revised Code, the drug may be dispensed only upon a prescription.
(2) Any drug that contains a schedule V controlled substance and that is exempt from Chapter 3719 of the Revised Code or to which that chapter does not apply;
(3) Any drug intended for administration by injection into the human body other than through a natural orifice of the human body;
(4) Any drug that is a biological product, as defined in section 3715.01 of the Revised Code.
(G) “Federal drug abuse control laws” has the same meaning as in section 3719.01 of the Revised Code.
(H) “Prescription” means all of the following:
(1) A written, electronic, or oral order for drugs or combinations or mixtures of drugs to be used by a particular individual or for treating a particular animal, issued by a licensed health professional authorized to prescribe drugs;
(2) For purposes of sections 2925.61, 4723.488, 4729.44, 4730.431, and 4731.94 of the Revised Code, a written, electronic, or oral order for naloxone issued to and in the name of a family member, friend, or other individual in a position to assist an individual who is at risk of experiencing an opioid-related overdose.
(3) For purposes of sections 4723.4810, 4729.282, 4730.432, and 4731.93 of the Revised Code, a written, electronic, or oral order for a drug to treat chlamydia, gonorrhea, or trichomoniasis issued to and in the name of a patient who is not the intended user of the drug but is the sexual partner of the intended user;
(4) For purposes of sections 3313.7110, 3313.7111, 3314.143, 3326.28, 3328.29, 4723.483, 4729.88, 4730.433, 4731.96, and 5101.76 of the Revised Code, a written, electronic, or oral order for an epinephrine autoinjector issued to and in the name of a school, school district, or camp;
(5) For purposes of Chapter 3728 and sections 4723.483, 4729.88, 4730.433, and 4731.96 of the Revised Code, a written, electronic, or oral order for an epinephrine autoinjector...
issued to and in the name of a qualified entity, as defined in section 3728.01 of the Revised Code.

(I) “Licensed health professional authorized to prescribe drugs” or “prescriber” means an individual who is authorized by law to prescribe drugs or dangerous drugs or drug therapy related devices in the course of the individual’s professional practice, including only the following:

(1) A dentist licensed under Chapter 4715 of the Revised Code;
(2) A clinical nurse specialist, certified nurse-midwife, or certified nurse practitioner who holds a current, valid license to practice nursing as an advanced practice registered nurse issued under Chapter 4723 of the Revised Code;
(3) An optometrist licensed under Chapter 4725 of the Revised Code to practice optometry under a therapeutic pharmaceutical agents certificate;
(4) A physician authorized under Chapter 4731 of the Revised Code to practice medicine and surgery, osteopathic medicine and surgery, or podiatric medicine and surgery;
(5) A physician assistant who holds a license to practice as a physician assistant issued under Chapter 4730 of the Revised Code, holds a valid prescriber number issued by the state medical board, and has been granted physician-delegated prescriptive authority;
(6) A veterinarian licensed under Chapter 4741 of the Revised Code.

(J) “Sale” or “sell” includes any transaction made by any person, whether as principal proprietor, agent, or employee, to do or offer to do any of the following: deliver, distribute, broker, exchange, gift or otherwise give away, or transfer, whether the transfer is by passage of title, physical movement, or both.

(K) “Wholesale sale” and “sale at wholesale” mean any sale in which the purpose of the purchaser is to resell the article purchased or received by the purchaser.

(L) “Retail sale” and “sale at retail” mean any sale other than a wholesale sale or sale at wholesale.

(M) “Retail seller” means any person that sells any dangerous drug to consumers without assuming control over and responsibility for its administration. Mere advice or instructions regarding administration do not constitute control or establish responsibility.

(N) “Price information” means the price charged for a prescription for a particular drug product and, in an easily understandable manner, all of the following:

(1) The proprietary name of the drug product;
(2) The established (generic) name of the drug product;
(3) The strength of the drug product if the product contains a single active ingredient or if the drug product contains more than one active ingredient and a relevant strength can be associated with the product without indicating each active ingredient. The established name and quantity of each active ingredient are required if such a relevant strength cannot be so associated with a drug product containing more than one ingredient.
(4) The dosage form;
(5) The price charged for a specific quantity of the drug product. The stated price shall include all charges to the consumer, including, but not limited to, the cost of the drug product, professional fees, handling fees, if any, and a statement identifying professional services routinely furnished by the pharmacy. Any mailing fees and delivery fees may be stated separately without repetition. The information shall not be false or misleading.

(O) “Wholesale distributor of dangerous drugs” or “wholesale distributor” means a person engaged in the sale of dangerous drugs at wholesale and includes any agent or employee of such a person authorized by the person to engage in the sale of dangerous drugs at wholesale.

(P) “Manufacturer of dangerous drugs” or “manufacturer” means a person, other than a pharmacist or prescriber, who manufactures dangerous drugs and who is engaged in the sale of those dangerous drugs.
(Q) “Terminal distributor of dangerous drugs” or “terminal distributor” means a person who is engaged in the sale of dangerous drugs at retail, or any person, other than a manufacturer, repackager, outsourcing facility, third-party logistics provider, wholesale distributor, or pharmacist, who has possession, custody, or control of dangerous drugs for any purpose other than for that person's own use and consumption. “Terminal distributor” includes pharmacies, hospitals, nursing homes, and laboratories and all other persons who procure dangerous drugs for sale or other distribution by or under the supervision of a pharmacist or licensed health professional authorized to prescribe drugs.

(R) “Promote to the public” means disseminating a representation to the public in any manner or by any means, other than by labeling, for the purpose of inducing, or that is likely to induce, directly or indirectly, the purchase of a dangerous drug at retail.

(S) “Person” includes any individual, partnership, association, limited liability company, or corporation, the state, any political subdivision of the state, and any district, department, or agency of the state or its political subdivisions.

(T) “Animal shelter” means a facility operated by a humane society or any society organized under Chapter 1717 of the Revised Code or a dog pound operated pursuant to Chapter 955 of the Revised Code.

(U) “Food” has the same meaning as in section 3715.01 of the Revised Code.

(V) “Pain management clinic” has the same meaning as in section 4731.054 of the Revised Code.

(W) “Investigational drug or product” means a drug or product that has successfully completed phase one of the United States food and drug administration clinical trials and remains under clinical trial, but has not been approved for general use by the United States food and drug administration. “Investigational drug or product” does not include controlled substances in schedule I, as established pursuant to section 3719.41 of the Revised Code, and as amended.

(X) “Product,” when used in reference to an investigational drug or product, means a biological product, other than a drug, that is made from a natural human, animal, or microorganism source and is intended to treat a disease or medical condition.

(Y) “Third-party logistics provider” means a person that provides or coordinates warehousing or other logistics services pertaining to dangerous drugs including distribution, on behalf of a manufacturer, wholesale distributor, or terminal distributor of dangerous drugs, but does not take ownership of the drugs or have responsibility to direct the sale or disposition of the drugs.

(Z) “Repackager of dangerous drugs” or “repackager” means a person that repacks and relabels dangerous drugs for sale or distribution.

(AA) “Outsourcing facility” means a facility that is engaged in the compounding and sale of sterile drugs and is registered as an outsourcing facility with the United States food and drug administration.

4729.29 Requirements related to prescriptions of controlled drugs; exceptions.

Divisions (A) and (B) of section 4729.01 and section 4729.28 of the Revised Code do not do any of the following:

(A) Apply to a licensed health professional authorized to prescribe drugs who is acting within the prescriber's scope of professional practice;

(B) Prevent a prescriber from personally furnishing the prescriber's patients with drugs, within the prescriber's scope of professional practice, that seem proper to the prescriber, as long as the drugs are furnished in accordance with section 4729.291 of the Revised Code;

(C) Apply to an individual who personally furnishes a supply of naloxone under authority conferred by a physician under section 4731.941 of the Revised Code or prevent that individual...
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from personally furnishing the supply of naloxone in accordance with a protocol established by the physician under section 4731.941 of the Revised Code;

(D) Apply to the sale of oxygen, the sale of peritoneal dialysis solutions, or the sale of drugs that are not dangerous drugs by a retail dealer, in original packages when labeled as required by the “Federal Food, Drug, and Cosmetic Act,” 52 Stat. 1040 (1938), 21 U.S.C.A. 301, as amended.

4729.291 Requirements related to prescriptions of controlled drugs.

(A) Except when provided under section 4731.97 of the Revised Code, when a licensed health professional authorized to prescribe drugs personally furnishes drugs to a patient pursuant to division (B) of section 4729.29 of the Revised Code, the prescriber shall ensure that the drugs are labeled and packaged in accordance with state and federal drug laws and any rules and regulations adopted pursuant to those laws. Records of purchase and disposition of all drugs personally furnished to patients shall be maintained by the prescriber in accordance with state and federal drug statutes and any rules adopted pursuant to those statutes.

(B) When personally furnishing to a patient RU-486 (mifepristone), a prescriber is subject to section 2919.123 of the Revised Code. A prescription for RU-486 (mifepristone) shall be in writing and in accordance with section 2919.123 of the Revised Code.

(C)(1) Except as provided in divisions (D) and (E) of this section, no prescriber shall do either of the following:

(a) In any thirty-day period, personally furnish to or for patients, taken as a whole, controlled substances in an amount that exceeds a total of two thousand five hundred dosage units;

(b) In any seventy-two-hour period, personally furnish to or for a patient an amount of a controlled substance that exceeds the amount necessary for the patient's use in a seventy-two-hour period.

(2) The state board of pharmacy may impose a fine of not more than five thousand dollars on a prescriber who fails to comply with the limits established under division (C)(1) of this section. A separate fine may be imposed for each instance of failing to comply with the limits. In imposing the fine, the board's actions shall be taken in accordance with Chapter 119 of the Revised Code.

(D) None of the following shall be counted in determining whether the amounts specified in division (C)(1) of this section have been exceeded:

(1) Methadone personally furnished to patients for the purpose of treating drug dependence or addiction, if the prescriber meets the conditions specified in 21 C.F.R. 1306.07;

(2) Buprenorphine personally furnished to patients for the purpose of treating drug dependence or addiction as part of an opioid treatment program that possesses a terminal distributor of dangerous drugs license issued under section 4729.54 of the Revised Code, is the subject of a current, valid certification from the substance abuse and mental health services administration of the United States department of health and human services pursuant to 42 C.F.R. 8.11, and meets either of the following criteria:

(a) Buprenorphine and methadone are personally furnished by physicians treating patients participating in the program.

(b) Buprenorphine, but not methadone, is personally furnished by physicians treating patients participating in the program, the program is accredited by a national accrediting organization approved by the substance abuse and mental health services administration, the service of personally furnishing buprenorphine has, notwithstanding section 5119.361 of the Revised Code, been certified by the department of mental health and addiction services under section 5119.36 of the Revised Code, and the program maintains in the record of a patient to
whom buprenorphine has been administered or personally furnished a copy of the physician's signed and dated written order for that act.

(c) Controlled substances personally furnished to research subjects by a facility conducting clinical research in studies approved by a hospital-based institutional review board or an institutional review board accredited by the association for the accreditation of human research protection programs.

(E) Division (C)(1) of this section does not apply to a prescriber who is a veterinarian.

**4729.39 Pharmacists consulting agreement with physician.**

(A) One or more pharmacists may enter into a consult agreement with one or more physicians authorized under Chapter 4731 of the Revised Code to practice medicine and surgery or osteopathic medicine and surgery if all of the following conditions are met:

1. Each physician has an ongoing physician-patient relationship with each patient whose drug therapy is being managed.
2. The diagnosis for which each patient has been prescribed drug therapy is within the scope of each physician's practice.
3. Each pharmacist has training and experience related to the particular diagnosis for which drug therapy is prescribed.

(B) With respect to consult agreements, all of the following apply:

1. Under a consult agreement, a pharmacist is authorized to do both of the following, but only to the extent specified in the agreement, this section, and the rules adopted under this section:
   a. Manage drug therapy for treatment of specified diagnoses or diseases for each patient who is subject to the agreement, including all of the following:
      i. Changing the duration of treatment for the current drug therapy;
      ii. Adjusting a drug's strength, dose, dosage form, frequency of administration, or route of administration;
      iii. Discontinuing the use of a drug;
      iv. Administering a drug;
   b. (i) Order blood and urine tests and evaluate results related to the drug therapy being managed.
   (ii) A pharmacist's authority to evaluate blood and urine tests under division (B)(1)(b)(i) of this section does not authorize the pharmacist to make a diagnosis.
2. (a) A consult agreement, or the portion of the agreement that applies to a particular patient, may be terminated by any of the following:
   i. A pharmacist who entered into the agreement;
   ii. A physician who entered into the agreement;
   iii. A patient whose drug therapy is being managed;
   iv. An individual who consented to the treatment on behalf of a patient or an individual authorized to act on behalf of a patient.
   (b) The pharmacist or physician who receives the notice of a patient's termination of the agreement shall provide written notice to every other pharmacist or physician who is a party to the agreement. A pharmacist or physician who terminates a consult agreement with regard to one or more patients shall provide written notice to all other pharmacists and physicians who entered into the agreement and to each individual who consented to treatment under the agreement. The termination of a consult agreement with regard to one or more patients shall be recorded by the pharmacist and physician in the medical records of each patient to whom the termination applies.
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(3) A consult agreement shall be made in writing and shall include all of the following:
   (a) The diagnoses and diseases being managed under the agreement, including whether each disease is primary or comorbid;
   (b) A description of the drugs or drug categories the agreement involves;
   (c) A description of the procedures, decision criteria, and plan the pharmacist is to follow in acting under a consult agreement;
   (d) A description of how the pharmacist is to comply with divisions (B)(5) and (6) of this section.

(4) The content of a consult agreement shall be communicated to each patient whose drug therapy is managed under the agreement.

(5) A pharmacist acting under a consult agreement shall maintain a record of each action taken for each patient whose drug therapy is managed under the agreement.

(6) Communication between a pharmacist and physician acting under a consult agreement shall take place at regular intervals specified by the primary physician acting under the agreement. The agreement may include a requirement that a pharmacist send a consult report to each consulting physician.

(7) A consult agreement is effective for two years and may be renewed if the conditions specified in division (A) of this section are met.

(8) A consult agreement does not permit a pharmacist to manage drug therapy prescribed by a physician who has not entered into the agreement.

(C) The state board of pharmacy, in consultation with the state medical board, shall adopt rules to be followed by pharmacists, and the state medical board, in consultation with the state board of pharmacy, shall adopt rules to be followed by physicians, that establish standards and procedures for entering into a consult agreement and managing a patient's drug therapy under a consult agreement. The boards shall specify in the rules any categories of drugs or types of diseases for which a consult agreement may not be established. Either board may adopt any other rules it considers necessary for the implementation and administration of this section. All rules adopted under this division shall be adopted in accordance with Chapter 119 of the Revised Code.

(D)(1) Subject to division (D)(2) of this section, both of the following apply:
   (a) A pharmacist acting in accordance with a consult agreement regarding a physician's change in a drug for a patient whose drug therapy the pharmacist is managing under the agreement is not liable in damages in a tort or other civil action for injury or loss to person or property allegedly arising from the change.
   (b) A physician acting in accordance with a consult agreement regarding a pharmacist's change in a drug for a patient whose drug therapy the pharmacist is managing under a consult agreement is not liable in damages in a tort or other civil action for injury or loss to person or property allegedly arising from the change unless the physician authorized the specific change.

(2) Division (D)(1) of this section does not limit a physician's or pharmacist's liability in damages in a tort or other civil action for injury or loss to person or property allegedly arising from actions that are not related to the physician's or pharmacist's change in a drug for a patient whose drug therapy is being managed under a consult agreement.

4729.41 Administration of immunizations

(A)(1) A pharmacist licensed under this chapter who meets the requirements of division (B) of this section, and a pharmacy intern licensed under this chapter who meets the requirements of division (B) of this section and is working under the direct supervision of a pharmacist who meets the requirements of that division, may do any of the following:
   (a) Administer immunizations for influenza to individuals who are seven years of age or older;
(b) Only pursuant to a prescription, administer to individuals who are seven years of age or older but not more than thirteen years of age any of the immunizations included in division (A)(2) of this section;
(c) Administer to individuals who are thirteen years of age or older any of the immunizations included in division (A)(2) of this section.

(2) A pharmacist or pharmacy intern may administer in accordance with divisions (A)(1)(b) and (c) of this section either of the following:
(a) Any immunization that on the effective date of this amendment is included in either of the following immunization schedules recommended by the advisory committee on immunization practices of the centers for disease control and prevention in the United States department of health and human services:
(i) The recommended immunization schedule for persons aged zero through eighteen years;
(ii) The recommended adult immunization schedule.
(b) Any other immunization specified in rules adopted under division (E)(1)(d) of this section.

(3) As part of engaging in the administration of immunizations or supervising a pharmacy intern's administration of immunizations, a pharmacist may administer epinephrine or diphenhydramine, or both, to individuals in emergency situations resulting from adverse reactions to the immunizations administered by the pharmacist or pharmacy intern.

(B) For a pharmacist or pharmacy intern to be authorized to engage in the administration of immunizations pursuant to division (A) of this section, the pharmacist or pharmacy intern shall do all of the following:
(1) Successfully complete a course in the administration of immunizations that has been approved by the state board of pharmacy as meeting the standards established for such courses by the centers for disease control and prevention;
(2) Receive and maintain certification to perform basic life-support procedures by successfully completing a basic life-support training course certified by the American red cross or American heart association;
(3) Practice in accordance with a definitive set of treatment guidelines specified in a protocol established by a physician and approved by the state board of pharmacy.

(C) The protocol required by division (B)(3) of this section shall include provisions for implementation of the following requirements:
(1) The pharmacist or pharmacy intern who administers an immunization shall observe the individual who receives the immunization to determine whether the individual has an adverse reaction to the immunization. The length of time and location of the observation shall comply with the standards specified in rules adopted by the state board of pharmacy under division (E) of this section for the approval of protocols. The protocol shall specify procedures to be followed by a pharmacist when administering epinephrine, diphenhydramine, or both, to an individual who has an adverse reaction to an immunization administered by the pharmacist or a pharmacy intern.
(2) For each immunization administered to an individual by a pharmacist or pharmacy intern, other than an immunization for influenza administered to an individual eighteen years of age or older, the pharmacist or pharmacy intern shall notify the individual's family physician or, if the individual has no family physician, the board of health of the health district in which the individual resides or the authority having the duties of a board of health for that district under section 3709.05 of the Revised Code. The notice shall be given not later than thirty days after the immunization is administered.
(3) For each immunization administered by a pharmacist or pharmacy intern to an individual younger than eighteen years of age pursuant to division (A)(1) of this section, the pharmacist or a pharmacy intern shall obtain permission from the individual's parent or legal
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guardian in accordance with the procedures specified in rules adopted under division (E) of this section.

(D)(1) No pharmacist shall do either of the following:
   (a) Engage in the administration of immunizations unless the requirements of division (B) of this section have been met;
   (b) Delegate to any person the pharmacist's authority to engage in or supervise the administration of immunizations.

(2) No pharmacy intern shall engage in the administration of immunizations unless the requirements of division (B) of this section have been met.

(E)(1) The state board of pharmacy shall adopt rules to implement this section. The rules shall be adopted in accordance with Chapter 119 of the Revised Code and shall include the following:
   (a) Provisions for approval of courses in administration of immunizations;
   (b) Provisions for approval of protocols to be followed by pharmacists and pharmacy interns in engaging in the administration of immunizations, including protocols that contain provisions specifying the locations at which a pharmacist or pharmacy intern may engage in the administration of immunizations;
   (c) Procedures to be followed by pharmacists and pharmacy interns in obtaining from the individual's parent or legal guardian permission to administer immunizations to an individual younger than eighteen years of age pursuant to division (A)(1) of this section;
   (d) Provisions specifying any immunizations that may be administered under division (A)(2)(b) of this section.

(2) Prior to adopting rules regarding approval of protocols to be followed by pharmacists and pharmacy interns in engaging in the administration of immunizations, the state board of pharmacy shall consult with the state medical board and the board of nursing.

(3) Prior to adopting rules specifying any immunizations that may be administered under division (A)(2)(b) of this section, the state board of pharmacy shall consult with the state medical board.

(F) In addition to the rules it adopts under division (E) of this section, the board may adopt rules that change the immunizations authorized by division (A)(2)(a) of this section to reflect changes in the recommendations of the advisory committee on immunization practices. The rules shall be adopted in accordance with Chapter 119 of the Revised Code.

4729.42 Pharmacy technician requirements, limitations, criminal records check.

[Editor’s Note: This statute is repealed effective 4/6/2018.]

(A) As used in this section, “qualified pharmacy technician” means a person who is under the personal supervision of a pharmacist and to whom all of the following apply:
   (1) The person is eighteen years of age or older.
   (2) The person possesses a high school diploma, possesses a certificate of high school equivalence, or was employed prior to April 8, 2009, as a pharmacy technician without a high school diploma or a certificate of high school equivalence.
   (3) The person has passed an examination approved by the state board of pharmacy to determine a person's competency to perform services as a pharmacy technician.
   (4) Except as otherwise provided in this section, the person has submitted to a criminal records check in accordance with section 4776.02 of the Revised Code as if the person was an applicant for an initial license who is subject to that section, and the results of the criminal records check provided as described in that section and section 4776.04 of the Revised Code do not show that the person previously has been convicted of or pleaded guilty to any felony in this state, any other state, or the United States.
(B) Except as provided in division (F) of this section, no person who is not a pharmacist, pharmacy intern, or qualified pharmacy technician shall do any of the following in a pharmacy or while performing a function of a pharmacy:

(1) Engage in the compounding of any drug;
(2) Package or label any drug;
(3) Prepare or mix any intravenous drug to be injected into a human being.

(C) No pharmacist shall allow any person employed or otherwise under the control of the pharmacist to violate division (B) of this section.

(D) No person who owns, manages, or conducts a pharmacy shall allow any person employed or otherwise under the control of the person who owns, manages, or conducts the pharmacy to violate division (B) of this section.

(E) No person who submits to a criminal records check in accordance with section 4776.02 of the Revised Code for the purpose of satisfying the criterion set forth in division (A)(4) of this section and who obtains a report pursuant to section 4776.02 or 4776.04 of the Revised Code containing the results of the criminal records check and any information provided by the federal bureau of investigation shall modify or alter, or allow any other person to modify or alter, any item, record, or information contained in the report and thereafter use the modified or altered report for the purpose of satisfying the criterion set forth in division (A)(4) of this section or otherwise submit or use it for any purpose or in any manner identified in division (A) of section 2921.13 of the Revised Code.

(F)(1) Division (B) of this section does not prohibit a health care professional authorized to engage in the activities specified in division (B)(1), (2), or (3) of this section while acting in the course of the professional's practice.

(2) Division (B) of this section does not prohibit the activities performed by a student as an integral part of a pharmacy technician training program that is operated by a vocational school district or joint vocational school district, certified by the department of education, or approved by the Ohio board of regents.

(3) In the case of a person employed after April 8, 2009, division (B) of this section does not prohibit the person's activities for the first twelve months following the initial date of employment, if both of the following apply:

(a) The person is participating in or has completed a pharmacy technician training program that meets the board's standards for those programs and is making substantial progress in preparation to take a pharmacy technician examination approved by the board.
(b) The results of the person's criminal records check provided as described in sections 4776.02 and 4776.04 of the Revised Code show that the person previously has not been convicted of or has not pleaded guilty to any felony in this state, any other state, or the United States.

(4) In the case of a person who completes a pharmacy technician training program that is operated by a vocational school district or joint vocational school district, division (B) of this section does not prohibit the person's activities for the first twelve months following the date of completing the program, if both of the following apply:

(a) The person is making substantial progress in preparation to take a pharmacy technician examination approved by the board.
(b) The results of the person's criminal records check show that the person previously has not been convicted of or has not pleaded guilty to any felony in this state, any other state, or the United States.

(5) In the case of a person employed on April 8, 2009, in the capacity of a pharmacy technician, division (B) of this section does not do either of the following:

(a) Require the person to undergo a criminal records check if the person has been employed for five years or longer;
(b) Prohibit the person's activities until the earlier of either of the following:
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(i) If the person has not passed an examination described in division (A)(3) of this section, eighteen months after April 8, 2009;
(ii) If a criminal records check is required because the person has not been employed for five years or longer, the date on which the person and the employer receive the results of a criminal records check provided as described in sections 4776.02 and 4776.04 of the Revised Code that show the person previously has been convicted of or pleaded guilty to any felony in this state, any other state, or the United States.

(G) If, pursuant to rules adopted under section 4729.26 of the Revised Code, the board requires a person that develops or administers a pharmacy technician examination to submit examination materials to the board for approval, any examination materials that are submitted shall not be public records for purposes of section 149.43 of the Revised Code.

4729.44 Naloxone may be dispensed without prescription; immunity.

(A) As used in this section:
   (1) “Board of health” means a board of health of a city or general health district or an authority having the duties of a board of health under section 3709.05 of the Revised Code.
   (2) “Physician” means an individual authorized under Chapter 4731 of the Revised Code to practice medicine and surgery, osteopathic medicine and surgery, or podiatric medicine and surgery.

(B) If use of the protocol developed pursuant to rules adopted under division (G) of this section has been authorized under section 3707.56 or 4731.942 of the Revised Code, a pharmacist or pharmacy intern may dispense naloxone without a prescription to either of the following in accordance with that protocol:
   (1) An individual who there is reason to believe is experiencing or at risk of experiencing an opioid-related overdose;
   (2) A family member, friend, or other person in a position to assist an individual who there is reason to believe is at risk of experiencing an opioid-related overdose.

(C) A pharmacist or pharmacy intern who dispenses naloxone under this section shall instruct the individual to whom naloxone is dispensed to summon emergency services as soon as practicable either before or after administering naloxone.

(D) A pharmacist may document the dispensing of naloxone by the pharmacist or a pharmacy intern supervised by the pharmacist on a prescription form. The form may be assigned a number for record-keeping purposes.

(E) This section does not affect the authority of a pharmacist or pharmacy intern to fill or refill a prescription for naloxone.

(F) A board of health that in good faith authorizes a pharmacist or pharmacy intern to dispense naloxone without a prescription in accordance with a protocol developed pursuant to rules adopted under division (G) of this section is not liable for or subject to any of the following for any action or omission of the individual to whom the naloxone is dispensed: damages in any civil action, prosecution in any criminal proceeding, or professional disciplinary action.

A physician who in good faith authorizes a pharmacist or pharmacy intern to dispense naloxone without a prescription in accordance with a protocol developed pursuant to rules adopted under division (G) of this section is not liable for or subject to any of the following for any action or omission of the individual to whom the naloxone is dispensed: damages in any civil action, prosecution in any criminal proceeding, or professional disciplinary action.

A pharmacist or pharmacy intern authorized under this section to dispense naloxone without a prescription who does so in good faith is not liable for or subject to any of the following for any action or omission of the individual to whom the naloxone is dispensed: damages in any civil action, prosecution in any criminal proceeding, or professional disciplinary action.
(G) The state board of pharmacy shall, after consulting with the department of health and state medical board, adopt rules to implement this section. The rules shall specify a protocol under which pharmacists or pharmacy interns may dispense naloxone without a prescription.

All rules adopted under this section shall be adopted in accordance with Chapter 119 of the Revised Code.

4729.45 Pharmacists administering drugs.

(A) As used in this section, “physician” means an individual authorized under Chapter 4731 of the Revised Code to practice medicine and surgery or osteopathic medicine and surgery.

(B)(1) Subject to division (C) of this section, a pharmacist licensed under this chapter may administer by injection any of the following drugs as long as the drug that is to be administered has been prescribed by a physician and the individual to whom the drug was prescribed has an ongoing physician-patient relationship with the physician:

(a) An opioid antagonist used for treatment of drug addiction and administered in a long-acting or extended-release form;
(b) An antipsychotic drug administered in a long-acting or extended-release form;
(c) Hydroxyprogesterone caproate;
(d) Medroxyprogesterone acetate;
(e) Cobalamin.

(2) As part of engaging in the administration of drugs by injection pursuant to this section, a pharmacist may administer epinephrine or diphenhydramine, or both, to an individual in an emergency situation resulting from an adverse reaction to a drug administered by the pharmacist.

(C) To be authorized to administer drugs pursuant to this section, a pharmacist must do all of the following:

(1) Successfully complete a course in the administration of drugs that satisfies the requirements established by the state board of pharmacy in rules adopted under division (H)(1)(a) of this section;

(2) Receive and maintain certification to perform basic life-support procedures by successfully completing a basic life-support training course certified by the American Red Cross or American Heart Association;

(3) Practice in accordance with a protocol that meets the requirements of division (F) of this section.

(D) Each time a pharmacist administers a drug pursuant to this section, the pharmacist shall do all of the following:

(1) Obtain permission in accordance with the procedures specified in rules adopted under division (H) of this section and comply with the following requirements:

(a) Except as provided in division (D)(1)(c) of this section, for each drug administered by a pharmacist to an individual who is eighteen years of age or older, the pharmacist shall obtain permission from the individual.

(b) For each drug administered by a pharmacist to an individual who is under eighteen years of age, the pharmacist shall obtain permission from the individual's parent or other person having care or charge of the individual.

(c) For each drug administered by a pharmacist to an individual who lacks the capacity to make informed health care decisions, the pharmacist shall obtain permission from the person authorized to make such decisions on the individual's behalf.
(2) In the case of an opioid antagonist described in division (B) of this section, obtain in accordance with division (E) of this section test results indicating that it is appropriate to administer the drug to the individual if either of the following is to be administered:
   (a) The initial dose of the drug;
   (b) Any subsequent dose, if the administration occurs more than thirty days after the previous dose of the drug was administered.
   (3) Observe the individual to whom the drug is administered to determine whether the individual has an adverse reaction to the drug;
   (4) Notify the physician who prescribed the drug that the drug has been administered to the individual.

(E) A pharmacist may obtain the test results described in division (D)(2) of this section in either of the following ways:
   (1) From the physician;
   (2) By ordering blood and urine tests for the individual to whom the opioid antagonist is to be administered.

If a pharmacist orders blood and urine tests, the pharmacist shall evaluate the results of the tests to determine whether they indicate that it is appropriate to administer the opioid antagonist. A pharmacist's authority to evaluate test results under this division does not authorize the pharmacist to make a diagnosis.

(F) All of the following apply with respect to the protocol required by division (C)(3) of this section:
   (1) The protocol must be established by a physician who has a scope of practice that includes treatment of the condition for which the individual has been prescribed the drug to be administered.
   (2) The protocol must satisfy the requirements established in rules adopted under division (H)(1)(b) of this section.
   (3) The protocol must do all of the following:
      (a) Specify a definitive set of treatment guidelines;
      (b) Specify the locations at which a pharmacist may engage in the administration of drugs pursuant to this section;
      (c) Include provisions for implementing the requirements of division (D) of this section, including for purposes of division (D)(3) of this section provisions specifying the length of time and location at which a pharmacist must observe an individual who receives a drug to determine whether the individual has an adverse reaction to the drug;
      (d) Specify procedures to be followed by a pharmacist when administering epinephrine, diphenhydramine, or both, to an individual who has an adverse reaction to a drug administered by the pharmacist.

(G) A pharmacist shall not do either of the following:
   (1) Engage in the administration of drugs pursuant to this section unless the requirements of division (C) of this section have been met;
   (2) Delegate to any person the pharmacist's authority to engage in the administration of drugs pursuant to this section.

(H) The state board of pharmacy shall adopt rules to implement this section. The rules shall be adopted in accordance with Chapter 119 of the Revised Code and include all of the following:
   (a) Requirements for courses in administration of drugs;
   (b) Requirements for protocols to be followed by pharmacists in administering drugs pursuant to this section;
   (c) Procedures to be followed by a pharmacist in obtaining permission to administer a drug to an individual.
(2) The board shall consult with the state medical board before adopting rules regarding requirements for protocols under this section.

4729.51 Requirements related to prescriptions of controlled drugs; dangerous drug distribution.

(A) No person other than a licensed manufacturer of dangerous drugs, outsourcing facility, third-party logistics provider, repackager of dangerous drugs, or wholesale distributor of dangerous drugs shall possess for sale, sell, distribute, or deliver, at wholesale, dangerous drugs or investigational drugs or products, except as follows:

(1) A licensed terminal distributor of dangerous drugs that is a pharmacy may make occasional sales of dangerous drugs or investigational drugs or products at wholesale.

(2) A licensed terminal distributor of dangerous drugs having more than one licensed location may transfer or deliver dangerous drugs from one licensed location to another licensed location owned by the terminal distributor if the license issued for each location is in effect at the time of the transfer or delivery.

(3) A licensed terminal distributor of dangerous drugs that is not a pharmacy may make occasional sales of naloxone at wholesale.

(B) No licensed manufacturer, outsourcing facility, third-party logistics provider, repackager, or wholesale distributor shall possess for sale, sell, or distribute, at wholesale, dangerous drugs or investigational drugs or products to any person other than the following:

(1) Subject to division (D) of this section, a licensed terminal distributor of dangerous drugs;

(2) Subject to division (C) of this section, any person exempt from licensure as a terminal distributor of dangerous drugs under section 4729.541 of the Revised Code;

(3) A licensed manufacturer, outsourcing facility, third-party logistics provider, repackager, or wholesale distributor;

(4) A terminal distributor, manufacturer, outsourcing facility, third-party logistics provider, repackager, or wholesale distributor that is located in another state, is not engaged in the sale of dangerous drugs within this state, and is actively licensed to engage in the sale of dangerous drugs by the state in which the distributor conducts business.

(C) No licensed manufacturer, outsourcing facility, third-party logistics provider, repackager, or wholesale distributor shall possess for sale, sell, or distribute, at wholesale, dangerous drugs or investigational drugs or products to either of the following:

(1) A prescriber who is employed by either of the following:

(a) A pain management clinic that is not licensed as a terminal distributor of dangerous drugs with a pain management clinic classification issued under section 4729.552 of the Revised Code;

(b) A facility, clinic, or other location that provides office-based opioid treatment but is not licensed as a terminal distributor of dangerous drugs with an office-based opioid treatment classification issued under section 4729.553 of the Revised Code if such a license is required by that section.

(2) A business entity described in division (A)(2) or (3) of section 4729.541 of the Revised Code that is, or is operating, either of the following:

(a) A pain management clinic without a license as a terminal distributor of dangerous drugs with a pain management clinic classification issued under section 4729.552 of the Revised Code;

(b) A facility, clinic, or other location that provides office-based opioid treatment without a license as a terminal distributor of dangerous drugs with an office-based opioid treatment classification issued under section 4729.553 of the Revised Code if such a license is required by that section.
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(D) No licensed manufacturer, outsourcing facility, third-party logistics provider, repackager, or wholesale distributor shall possess dangerous drugs or investigational drugs or products for sale at wholesale, or sell or distribute such drugs at wholesale, to a licensed terminal distributor of dangerous drugs, except as follows:

1. In the case of a terminal distributor with a category II license, only dangerous drugs in category II, as defined in division (A)(1) of section 4729.54 of the Revised Code;
2. In the case of a terminal distributor with a category III license, dangerous drugs in category II and category III, as defined in divisions (A)(1) and (2) of section 4729.54 of the Revised Code;
3. In the case of a terminal distributor with a limited category II or III license, only the dangerous drugs specified in the license.

(E) Except as provided in division (E)(2) of this section, no person shall do any of the following:

(a) Sell or distribute, at retail, dangerous drugs;
(b) Possess for sale, at retail, dangerous drugs;
(c) Possess dangerous drugs.

(2)(a) Divisions (E)(1)(a), (b), and (c) of this section do not apply to any of the following:
(i) A licensed terminal distributor of dangerous drugs;
(ii) A person who possesses, or possesses for sale or sells, at retail, a dangerous drug in accordance with Chapters 3719., 4715., 4723., 4725., 4729., 4730., 4731., and 4741 of the Revised Code;
(iii) Any of the persons identified in divisions (A)(1) to (5) and (13) of section 4729.541 of the Revised Code, but only to the extent specified in that section.

(b) Division (E)(1)(c) of this section does not apply to any of the following:
(i) A licensed manufacturer, outsourcing facility, third-party logistics provider, repackager, or wholesale distributor;
(ii) Any of the persons identified in divisions (A)(6) to (12) of section 4729.541 of the Revised Code, but only to the extent specified in that section.

(F) No licensed terminal distributor of dangerous drugs or person that is exempt from licensure under section 4729.541 of the Revised Code shall purchase dangerous drugs or investigational drugs or products from any person other than a licensed manufacturer, outsourcing facility, third-party logistics provider, repackager, or wholesale distributor, except as follows:

1. A licensed terminal distributor of dangerous drugs or person that is exempt from licensure under section 4729.541 of the Revised Code may make occasional purchases of dangerous drugs or investigational drugs or products that are sold in accordance with division (A)(1) or (3) of this section.
2. A licensed terminal distributor of dangerous drugs having more than one licensed location may transfer or deliver dangerous drugs or investigational drugs or products from one licensed location to another licensed location if the license issued for each location is in effect at the time of the transfer or delivery.

(G) No licensed terminal distributor of dangerous drugs shall engage in the retail sale or other distribution of dangerous drugs or investigational drugs or products or maintain possession, custody, or control of dangerous drugs or investigational drugs or products for any purpose other than the distributor’s personal use or consumption, at any establishment or place other than that or those described in the license issued by the state board of pharmacy to such terminal distributor.

(H) Nothing in this section shall be construed to interfere with the performance of official duties by any law enforcement official authorized by municipal, county, state, or federal law to collect samples of any drug, regardless of its nature or in whose possession it may be.
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Controlled Substances

(I) Notwithstanding anything to the contrary in this section, the board of education of a city, local, exempted village, or joint vocational school district may distribute epinephrine autoinjectors for use in accordance with section 3313.7110 of the Revised Code and may distribute inhalers for use in accordance with section 3313.7113 of the Revised Code.

4729.541 Requirements related to prescriptions of controlled drugs; exempt entities.

(A) Except as provided in divisions (B) to (D) of this section, all of the following are exempt from licensure as a terminal distributor of dangerous drugs:

(1) A licensed health professional authorized to prescribe drugs;

(2) A business entity that is a corporation formed under division (B) of section 1701.03 of the Revised Code, a limited liability company formed under Chapter 1705 of the Revised Code, or a professional association formed under Chapter 1785 of the Revised Code if the entity has a sole shareholder who is a prescriber and is authorized to provide the professional services being offered by the entity;

(3) A business entity that is a corporation formed under division (B) of section 1701.03 of the Revised Code, a limited liability company formed under Chapter 1705 of the Revised Code, a partnership or a limited liability partnership formed under Chapter 1775 of the Revised Code, or a professional association formed under Chapter 1785 of the Revised Code, if, to be a shareholder, member, or partner, an individual is required to be licensed, certified, or otherwise legally authorized under Title XLVII of the Revised Code to perform the professional service provided by the entity and each such individual is a prescriber;

(4) An individual who holds a current license, certificate, or registration issued under Title XLVII of the Revised Code and has been certified to conduct diabetes education by a national certifying body specified in rules adopted by the state board of pharmacy under section 4729.68 of the Revised Code, but only with respect to insulin that will be used for the purpose of diabetes education and only if diabetes education is within the individual's scope of practice under statutes and rules regulating the individual's profession;

(5) An individual who holds a valid certificate issued by a nationally recognized S.C.U.B.A. diving certifying organization approved by the state board of pharmacy under rules adopted by the board, but only with respect to medical oxygen that will be used for the purpose of emergency care or treatment at the scene of a diving emergency;

(6) With respect to epinephrine autoinjectors that may be possessed under section 3313.7110, 3313.7111, 3314.143, 3326.28, or 3328.29 of the Revised Code, any of the following: the board of education of a city, local, exempted village, or joint vocational school district; a chartered or nonchartered nonpublic school; a community school established under Chapter 3314 of the Revised Code; a STEM school established under Chapter 3326 of the Revised Code; or a college-preparatory boarding school established under Chapter 3328 of the Revised Code;

(7) With respect to epinephrine autoinjectors that may be possessed under section 5101.76 of the Revised Code, any of the following: a residential camp, as defined in section 2151.011 of the Revised Code; a child day camp, as defined in section 5104.01 of the Revised Code; or a child day camp operated by any county, township, municipal corporation, township park district created under section 511.18 of the Revised Code, park district created under section 1545.04 of the Revised Code, or joint recreation district established under section 755.14 of the Revised Code;

(8) With respect to epinephrine autoinjectors that may be possessed under Chapter 3728 of the Revised Code, a qualified entity, as defined in section 3728.01 of the Revised Code;

(9) With respect to inhalers that may be possessed under section 3313.7113, 3313.7114, 3314.144, 3326.30, or 3328.30 of the Revised Code, any of the following: the board of education of a city, local, exempted village, or joint vocational school district; a chartered or
nonchartered nonpublic school; a community school established under Chapter 3314 of the Revised Code; a STEM school established under Chapter 3326 of the Revised Code; or a college-preparatory boarding school established under Chapter 3328 of the Revised Code;

(10) With respect to inhalers that may be possessed under section 5101.77 of the Revised Code, any of the following: a residential camp, as defined in section 2151.011 of the Revised Code; a child day camp, as defined in section 5104.01 of the Revised Code; or a child day camp operated by any county, township, municipal corporation, township park district created under section 511.18 of the Revised Code, park district created under section 1545.04 of the Revised Code, or joint recreation district established under section 755.14 of the Revised Code;

(11) With respect to naloxone that may be possessed under section 2925.61 of the Revised Code, a law enforcement agency and its peace officers;

(12) With respect to naloxone that may be possessed under section 4729.514 of the Revised Code, a service entity, as defined in that section;

(13) A facility that is owned and operated by the United States department of defense, the United States department of veterans affairs, or any other federal agency.

(B) If a person described in division (A) of this section is a pain management clinic or is operating a pain management clinic, the person shall hold a license as a terminal distributor of dangerous drugs with a pain management clinic classification issued under section 4729.552 of the Revised Code.

(C) If a person described in division (A) of this section is operating a facility, clinic, or other location described in division (B) of section 4729.553 of the Revised Code that must hold a category III terminal distributor of dangerous drugs license with an office-based opioid treatment classification, the person shall hold a license with that classification.

(D) Any of the persons described in divisions (A)(1) to (12) of this section shall hold a license as a terminal distributor of dangerous drugs in order to possess, have custody or control of, and distribute any of the following:

(1) Dangerous drugs that are compounded or used for the purpose of compounding;

(2) A schedule I, II, III, IV, or V controlled substance, as defined in section 3719.01 of the Revised Code.

4729.552 Requirements related to prescriptions of controlled drugs; dangerous drugs.

(A) To be eligible to receive a license as a category III terminal distributor of dangerous drugs with a pain management clinic classification, an applicant shall submit evidence satisfactory to the state board of pharmacy that the applicant's pain management clinic will be operated in accordance with the requirements specified in division (B) of this section and that the applicant meets any other applicable requirements of this chapter.

If the board determines that an applicant meets all of the requirements, the board shall issue to the applicant a license as a category III terminal distributor of dangerous drugs and specify on the license that the terminal distributor is classified as a pain management clinic.

(B) The holder of a terminal distributor license with a pain management clinic classification shall do all of the following:

(1) Be in control of a facility that is owned and operated solely by one or more physicians authorized under Chapter 4731 of the Revised Code to practice medicine and surgery or osteopathic medicine and surgery;

(2) Comply with the requirements for the operation of a pain management clinic, as established by the state medical board in rules adopted under section 4731.054 of the Revised Code;
(3) Ensure that any person employed by the facility complies with the requirements for the operation of a pain management clinic established by the state medical board in rules adopted under section 4731.054 of the Revised Code;

(4) Require any person with ownership of the facility to submit to a criminal records check in accordance with section 4776.02 of the Revised Code and send the results of the criminal records check directly to the state board of pharmacy for review and decision under section 4729.071 of the Revised Code;

(5) Require all employees of the facility to submit to a criminal records check in accordance with section 4776.02 of the Revised Code and ensure that no person is employed who has previously been convicted of, or pleaded guilty to, either of the following:

   (a) A theft offense, described in division (K)(3) of section 2913.01 of the Revised Code, that would constitute a felony under the laws of this state, any other state, or the United States;

   (b) A felony drug abuse offense, as defined in section 2925.01 of the Revised Code.

(6) Maintain a list of each person with ownership of the facility and notify the state board of pharmacy of any change to that list.

(C) No person shall operate a facility that under this chapter is subject to licensure as a category III terminal distributor of dangerous drugs with a pain management clinic classification without obtaining and maintaining the license with the classification. No person who holds a category III license with a pain management clinic classification shall fail to remain in compliance with the requirements of division (B) of this section and any other applicable requirements of this chapter.

(D) The state board of pharmacy may impose a fine of not more than five thousand dollars on a person who violates division (C) of this section. A separate fine may be imposed for each day the violation continues. In imposing the fine, the board's actions shall be taken in accordance with Chapter 119 of the Revised Code.

(E) The state board of pharmacy shall adopt rules as it considers necessary to implement and administer this section. The rules shall be adopted in accordance with Chapter 119 of the Revised Code.

4729.79 Reporting of controlled substance or dangerous drug prescription.

(A) If the state board of pharmacy establishes and maintains a drug database pursuant to section 4729.75 of the Revised Code, each licensed health professional authorized to prescribe drugs, except as provided in division (C) of this section, who personally furnishes to a patient a controlled substance or other dangerous drug the board includes in the database pursuant to rules adopted under section 4729.84 of the Revised Code shall submit to the board the following information:

   (1) Prescriber identification;

   (2) Patient identification;

   (3) Date drug was furnished by the prescriber;

   (4) Indication of whether the drug furnished is new or a refill;

   (5) Name, strength, and national drug code of drug furnished;

   (6) Quantity of drug furnished;

   (7) Number of days' supply of drug furnished;

   (8) Source of payment for the drug furnished;

   (9) Identification of the owner of the drug furnished.

(B)(1) The information shall be transmitted as specified by the board in rules adopted under section 4729.84 of the Revised Code.

(2) The information shall be submitted electronically in the format specified by the board, except that the board may grant a waiver allowing the prescriber to submit the information in another format.
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(3) The information shall be submitted in accordance with any time limits specified by the board, except that the board may grant an extension if either of the following occurs:
(a) The prescriber’s transmission system suffers a mechanical or electronic failure, or the prescriber cannot meet the deadline for other reasons beyond the prescriber’s control.
(b) The board is unable to receive electronic submissions.
(C)(1) The information required to be submitted under division (A) of this section may be submitted on behalf of the prescriber by the owner of the drug being personally furnished or by a delegate approved by that owner.
(2) The requirements of this section to submit information to the board do not apply to a prescriber who is a veterinarian.
(D) If the board becomes aware of a prescriber’s failure to comply with this section, the board shall notify the government entity responsible for licensing the prescriber.

4729.88 Pharmacist dispensing epinephrine autoinjectors.

Notwithstanding any provision of this chapter or rule adopted by the state board of pharmacy, a pharmacist may dispense epinephrine autoinjectors pursuant to a prescription issued under section 4723.483, 4730.433, or 4731.96 of the Revised Code.
A pharmacist who in good faith dispenses epinephrine autoinjectors under this section is not liable for or subject to any of the following for any action or omission of an entity to which an epinephrine autoinjector is dispensed: damages in any civil action, prosecution in any criminal proceeding, or professional disciplinary action.

4729.91 Pharmacy tech supervised by pharmacist.

(A) A registered pharmacy technician may, under the direct supervision of a pharmacist, engage in the following activities at a location licensed as a terminal distributor of dangerous drugs to the extent that the activities do not require the exercise of professional judgment:
(1) Accepting new written or electronic prescription orders from a prescriber or a prescriber’s agent;
(2) Entering information into and retrieving information from a database or patient profile;
(3) Preparing and affixing labels;
(4) Stocking dangerous drugs and retrieving those drugs from inventory;
(5) Counting and pouring dangerous drugs into containers;
(6) Placing dangerous drugs into patient storage containers;
(7) Non-sterile drug compounding as authorized by the state board of pharmacy in rules adopted under section 4729.94 of the Revised Code;
(8) Other activities specified by the board in rules adopted under section 4729.94 of the Revised Code.
(B) A certified pharmacy technician may, under the direct supervision of a pharmacist, engage in the following activities at a location licensed as a terminal distributor of dangerous drugs to the extent that the activities do not require the exercise of professional judgment:
(1) Any activity listed in division (A) of this section;
(2) Accepting or requesting refill authorizations for dangerous drugs that are not controlled substances from a prescriber or the prescriber’s agent, so long as there is no change from the original prescription;
(3) Sterile and non-sterile drug compounding as authorized by the board in rules adopted under section 4729.94 of the Revised Code;
(4) Other activities specified by the board in rules adopted under section 4729.94 of the Revised Code.
4731.054 Pain management clinics.

(A) As used in this section:
(1) “Chronic pain” has the same meaning as in section 4731.052 of the Revised Code.
(2) “Controlled substance” has the same meaning as in section 3719.01 of the Revised Code.
(3) “Hospital” means a hospital registered with the department of health under section 3701.07 of the Revised Code.
(4) “Owner” means each person included on the list maintained under division (B)(6) of section 4729.552 of the Revised Code.

(B) Each owner shall supervise, control, and direct the activities of each individual, including an employee, volunteer, or individual under contract, who provides treatment of chronic pain at the clinic or is associated with the provision of that treatment. The supervision, control, and direction shall be provided in accordance with rules adopted under this section.

(C) The state medical board shall adopt rules in accordance with Chapter 119 of the Revised Code that establish all of the following:
(1) Standards and procedures for the operation of a pain management clinic;
(2) Standards and procedures to be followed by a physician who provides care at a pain management clinic;
(3) For purposes of division (A)(5)(a)(i) of this section, the other drugs used to treat chronic pain that identify a facility as a pain management clinic;
(4) For purposes of division (A)(5)(a)(ii) of this section, the other criteria that identify a facility as a pain management clinic;
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(5) For purposes of division (B) of this section, standards and procedures to be followed by an owner in providing supervision, direction, and control of individuals at a pain management clinic.

(D) The board may impose a fine of not more than twenty thousand dollars on a physician who fails to comply with rules adopted under this section. The fine may be in addition to or in lieu of any other action that may be taken under section 4731.22 of the Revised Code. The board shall deposit any amounts received under this division in accordance with section 4731.24 of the Revised Code.

(E)(1) The board may inspect either of the following as the board determines necessary to ensure compliance with this chapter and any rules adopted under it regarding pain management clinics:

(a) A pain management clinic;
(b) A facility or physician practice that the board suspects is operating as a pain management clinic in violation of this chapter.

(2) The board's inspection shall be conducted in accordance with division (F) of section 4731.22 of the Revised Code.

(3) Before conducting an on-site inspection, the board shall provide notice to the owner or other person in charge of the facility or physician practice, except that the board is not required to provide the notice if, in the judgment of the board, the notice would jeopardize an investigation being conducted by the board.

4729-5-01 Definitions.

As used in Chapter 4729 of the Revised Code:

(A) “Practice of pharmacy” is as defined in division (B) of section 4729.01 of the Revised Code.

(B) The term “dispense” means the final association of a drug with a particular patient pursuant to the prescription, drug order, or other lawful order of a prescriber and the professional judgment of and the responsibility for: interpreting, preparing, compounding, labeling, and packaging a specific drug. In the case of an automated drug delivery system meeting the requirements of rule 4729-5-35 of the Administrative Code, the final association with the name of a particular patient will be deemed to have occurred when the pharmacist has given final approval to the patient specific prescription in the system.

(C) The term “compounding” has the same meaning as defined in division (C) of section 4729.01 of the Revised Code.

(D) “Interpret prescriptions” means the professional judgment of a pharmacist when reviewing a prescription order of a prescriber for a patient.

(E) “To participate in drug selection” means selecting and dispensing a drug product pursuant to sections 4729.38 and 4729.381 of the Revised Code.

(F) “To participate with prescribers in reviews of drug utilization” means monitoring the appropriate use of drugs through communication with the prescriber(s) involved.

(G) “Pharmacist” means an individual who holds a current pharmacist identification card pursuant to section 4729.08 or 4729.09 of the Revised Code; or, pursuant to section 4729.12 of the Revised Code.

(H) “Original prescription” means the prescription issued by the prescriber in writing, an oral or electronically transmitted prescription recorded in writing by the pharmacist, a prescription transmitted by use of a facsimile machine, or a prescription transmitted by a board approved electronic prescription transmission system, each of which is pursuant to rule 4729-5-30 of the Administrative Code.

(I) “Personal supervision” or “direct supervision” means a pharmacist shall be physically present in the pharmacy, or in the area where the practice of pharmacy is occurring, and
provide personal review and approval of all professional activities.

(J) “Preprinted order” is defined as a patient specific, definitive set of drug treatment directives to be administered to an individual patient who has been examined by a prescriber and for whom the prescriber has determined that the drug therapy is appropriate and safe when used pursuant to the conditions set forth in the preprinted order. Preprinted orders may be used only for inpatients in an institutional facility as defined in Chapter 4729-17 of the Administrative Code.

(K) “Standing order” will mean the same as the term “protocol”.

(L) “Protocol” is defined as:

(1) A definitive set of written treatment guidelines that include definitive orders for drugs and their specified dosages which have been authorized by a prescriber and have been approved by the state board of pharmacy pursuant to section 4729.54 of the Revised Code. A protocol may be used only by licensed health care professionals when providing limited medical services to individuals in an emergency situation when the services of a prescriber are not immediately available; or

(2) A definitive set of written treatment guidelines that include definitive orders for drugs and their specified dosages which have been authorized by a prescriber and have been approved by the state board of pharmacy pursuant to section 4729.54 of the Revised Code. A protocol may be used only by licensed health care professionals when administering biologicals or vaccines to individuals for the purpose of preventing diseases; or

(3) A definitive set of written treatment guidelines that include definitive orders for drugs and their specified dosages which have been authorized by a prescriber and have been approved by the state board of pharmacy pursuant to section 4729.54 of the Revised Code. A protocol may be used only by licensed healthcare professionals when administering vitamin K for prevention of vitamin K deficient bleeding in newborns; or

(4) A definitive set of written treatment guidelines that include definitive orders for drugs and their specified dosages which have been authorized by a prescriber and have been approved by the state board of pharmacy pursuant to section 4729.54 of the Revised Code. A protocol may be used only by licensed healthcare professionals when administering erythromycin for prevention of ophthalmia neonatorum; or

(5) A definitive set of written treatment guidelines that include patient specific and dose specific orders for the administration of a specific drug that have been authorized by a prescriber to be used when the services of that prescriber are not immediately available. The state board of pharmacy must approve the treatment guidelines prior to implementation. To be considered for approval by the board, the treatment guidelines must meet the following requirements:

(a) The drugs shall only be administered by an individual authorized by law to administer the drugs that are listed in the treatment guidelines.

(b) A prescriber must complete an assessment and make a diagnosis prior to ordering a set of treatment guidelines.

(c) The treatment guidelines:

(i) Can only be initiated upon the order of a prescriber, and the prescriber, utilizing positive identification, must create an order in the patient record to acknowledge and document an adjustment made pursuant to the treatment guidelines before another dose or frequency adjustment can be made;

(ii) Shall only apply to adjusting the dose or frequency of the administration of a specific drug that has been previously ordered by a prescriber;

(iii) Apply only to those drugs that may require calculations for specific dose and frequency adjustments which shall be based on objective measures;

(iv) Apply only to those drugs for which the therapeutic dose is significantly lower than the dose expected to cause detrimental adverse effects;
(v) Do not apply to those drugs for which a dosage change selected within the usual normal dose range could cause detrimental adverse effects;
(vi) Can be performed without requiring the exercise of medical judgment;
(vii) Will lead to results that are reasonably predictable and safe;
(viii) Can be performed safely without repeated medical assessments;
(ix) If performed improperly, would not present a danger of immediate and serious harm to the patient.

A protocol may be used only by individuals authorized by law to administer the drugs and to perform the procedures included in the protocol. Protocols submitted for approval by the state board of pharmacy may be reviewed with the appropriate health care related board prior to any approval by the state board of pharmacy.

(M) “Prescriber” means any of the following:
(1) A person authorized by the revised code to prescribe dangerous drugs as part of their professional practice; or
(2) A pharmacist authorized to manage drug therapy pursuant to a consult agreement but only if specifically authorized in the agreement and to the extent specified in the agreement.

(N) “Positive identification” means a method of identifying an individual who prescribes, administers, or dispenses a dangerous drug.
(1) A method may not rely solely on the use of a private personal identifier such as a password, but must also include a secure means of identification such as the following:
(a) A manual signature on a hard copy record;
(b) A magnetic card reader;
(c) A bar code reader;
(d) A biometric method;
(e) A proximity badge reader;
(f) A board approved system of randomly generated personal questions;
(g) A printout of every transaction that is verified and manually signed within a reasonable period of time by the individual who prescribed, administered, or dispensed the dangerous drug. The printout must be maintained for three years and made available on request to those individuals authorized by law to review such records; or
(h) Other effective methods for identifying individuals that have been approved by the board.
(2) A method relying on a magnetic card reader, a bar code reader, a proximity badge reader, or randomly generated questions for identification must also include a private personal identifier, such as a password, for entry into a secure mechanical or electronic system.

(O) “Originating pharmacy”, as it relates to central fill pharmacies, means the pharmacy that received the original prescription.
(P) “Personally furnish” means the distribution of drugs by a prescriber to the prescriber’s patients for use outside the prescriber’s practice setting.
(Q) “OARRS report” means a report of information related to a specific person generated by the drug database established and maintained pursuant to section 4729.75 of the Revised Code.
(R) “Reported drugs” means all the drugs listed in rule 4729-37-02 of the Administrative Code that are required to be reported to the drug database established and maintained pursuant to section 4729.75 of the Revised Code.

4729-5-30 Manner of issuance of a prescription.

[Editor’s Note: This version is effective until 12/29/2017. The version effective subsequently is included next.]
(A) A prescription, to be valid, must be issued for a legitimate medical purpose by an individual prescriber acting in the usual course of his/her professional practice. The responsibility for the proper prescribing is upon the prescriber, but a corresponding responsibility rests with the pharmacist who dispenses the prescription. An order purporting to be a prescription issued not in the usual course of bona fide treatment of a patient is not a prescription and the person knowingly dispensing such a purported prescription, as well as the person issuing it, shall be subject to the penalties of law.

(B) All prescriptions issued by a prescriber shall:

1. Be dated as of and on the day when issued.
2. Contain the manually printed, typewritten, or preprinted full name, professional title, and address of the prescriber.
3. Indicate a telephone number where the prescriber can be personally contacted during normal business hours.
4. Indicate the full name and residential address of the patient.
5. Indicate the drug name and strength.
6. Indicate the quantity to dispense.
7. Indicate the appropriate and explicit directions for use.
8. Specify the number of times or the period of time for which the prescription may be refilled. If no such authorization is given, the prescription may not be refilled except in accordance with section 4729.281 of the Revised Code. A prescription marked “Refill P.R.N.” or some similar designation is not considered a valid refill authorization.
10. Authorize refills for schedules III and IV controlled substances only as permitted by section 3719.05 of the Revised Code.
11. Not authorize a refill beyond one year from the date of issuance for schedule V controlled substances and for dangerous drugs that are not controlled substances.
12. Identify the trade name or generic name of the drug(s) in a compounded prescription.
13. Not be coded in such a manner that it cannot be dispensed by any pharmacy of the patient's choice.
14. For prescriptions issued to a patient by a prescriber, be:
   a. Manually signed on the day issued by the prescriber in the same manner as he/she would sign a check or legal document.
   b. Issued in compliance with rule 4729-5-13 of the Administrative Code.
15. For a controlled substance, indicate the drug enforcement administration registration number of the prescriber pursuant to Title 21 CFR 1306.05 (enacted on June 23, 2005).
16. If issued by a clinical nurse specialist, certified nurse-midwife, or certified nurse practitioner with prescriptive authority, contain the nurse's prescriber number found on the certificate to prescribe issued by the state board of nursing pursuant to rule 4723-9-09 of the Administrative Code.
17. If issued by a physician assistant with prescriptive authority, contain the certificate number of the physician assistant's certificate to prescribe pursuant to rule 4730-2-07 of the Administrative Code.
18. Be issued in compliance with all applicable federal and state laws, rules, and regulations.
19. When forms are used that create multiple copies of a prescription issued to a patient by a prescriber, the original prescription that bears the actual signature of the prescriber must be issued to the patient for dispensing by a pharmacist.
20. Oral transmission by the prescriber or the prescriber's agent of original prescriptions and refills authorized by a prescriber, pursuant to the requirements of this rule, may be...
transmitted by telephone only to:

(1) A pharmacist.
(2) A recording device within the pharmacy if the pharmacist is unavailable. The pharmacist must remove the prescription from the recorder and reduce it to writing. The pharmacist is responsible for assuring the validity of the prescription removed from the recorder.
(3) A licensed pharmacy intern if the pharmacist on duty who is supervising the activity of the intern determines that the intern is competent to receive telephone prescriptions.

The prescriber's agent must provide his/her full name when transmitting an oral prescription.

(E) Original written prescriptions authorized and signed by a prescriber may be transmitted by the prescriber or the prescriber's agent by facsimile machine to a pharmacy pursuant to the following:

(1) The facsimile of the prescription must include the full name of the prescriber and if applicable the full name of the prescriber's agent transmitting the prescription to the pharmacy.
(2) The original prescription signed by the prescriber from which the facsimile is produced shall not be issued to the patient. The original prescription signed by the prescriber must remain with the patient's records at the prescriber's office or the institutional facility where it was issued.
(3) Prescriptions for schedule II controlled substances may not be transmitted by facsimile except for:
   (a) A resident of a long term care facility pursuant to rule 4729-17-09 of the Administrative Code.
   (b) A narcotic substance issued for a patient enrolled in a hospice. The original prescription must indicate that the patient is a hospice patient. The facsimile transmission must also meet the other requirements of this rule.
   (c) A compounded sterile product prescription for a narcotic substance pursuant to rule 4729-16-03 of the Administrative Code.
(4) A facsimile of a prescription received by a pharmacy in any manner other than transmission directly from the prescriber or the prescriber's agent shall not be considered a valid prescription.

(5) The facsimile of the prescription must include header information identifying the origin of the facsimile.

(F) A prescription may be transmitted by means of a board approved electronic prescription transmission system provided that:

(1) The system requires positive identification of the prescriber as defined in rule 4729-5-01 of the Administrative Code and the full name of any authorized agent of the prescriber who transmits the prescription.
(2) The computer data is retained for a period of three years at the prescriber's office.
(3) An electronic prescription transmission system meeting the requirements of 21 C.F.R. 1311 for both controlled substance and non-controlled substance prescriptions shall be considered approved by the state board of pharmacy.

(G) Pursuant to section 4729.38 of the Revised Code if a prescriber does not want a pharmacist to select a generically equivalent drug the prescriber must handwrite “dispense as written” or “DAW” on the prescription, or if ordering electronically or orally the prescriber specifies that the prescribed drug is medically necessary.

4729-5-30 Manner of issuance of a prescription.

[Editor’s Note: This version is effective 12/29/2017. The version effective previously is included in the prior pages.]
(A) A prescription, to be valid, must be issued for a legitimate medical purpose by an individual prescriber acting in the usual course of the prescriber’s professional practice. The responsibility for the proper prescribing is upon the prescriber, but a corresponding responsibility rests with the pharmacist who dispenses the prescription. An order purporting to be a prescription issued not in the usual course of bona fide treatment of a patient is not a prescription and the person knowingly dispensing such a purported prescription, as well as the person issuing it, shall be subject to the penalties of law.

(B) All prescriptions issued by a prescriber shall:
1. Be dated as of and on the day when issued.
2. Contain the manually printed, typewritten, or preprinted full name, professional title, and address of the prescriber. The prescriber’s address shall include the physical address of the prescriber’s practice location.
3. Indicate a telephone number where the prescriber can be personally contacted during normal business hours.
4. Indicate the full name and residential address of the patient. The patient’s residential address shall include the patient’s physical street address.
5. Indicate the drug name and strength.
6. Indicate the quantity to dispense.
7. Indicate the appropriate and explicit directions for use.
8. Specify the number of times or the period of time for which the prescription may be refilled. If no such authorization is given, the prescription may not be refilled except in accordance with section 4729.281 of the Revised Code. A prescription marked “Refill P.R.N.” or some similar designation is not considered a valid refill authorization.
10. Authorize refills for schedules III and IV controlled substances only as permitted by section 3719.05 of the Revised Code.
11. Not authorize a refill beyond one year from the date of issuance for schedule V controlled substances and for dangerous drugs that are not controlled substances.
12. Identify the trade name or generic name of the drug(s) in a compounded prescription.
13. Not be coded in such a manner that it cannot be dispensed by any pharmacy of the patient’s choice.
14. For a controlled substance:
   a. Indicate the drug enforcement administration registration number of the prescriber pursuant to Title 21 CFR 1306.05 (3/31/2010).
   b. Except for veterinarians licensed pursuant to Chapter 4741 of the Revised Code, indicate either:
      i. The ICD-10-CM medical diagnosis code of the primary disease or condition that the controlled substance is being used to treat. The code shall, at a minimum, include the first four characters of the ICD-10-CM medical diagnosis code, sometimes referred to as the category and the etiology (ex. M16.5).
      ii. For dentists licensed pursuant to Chapter 4715 of the Revised Code, the Code on Dental Procedures and Nomenclature (CDT Code), as published by the American Dental Association, of the dental treatment requiring the controlled substance prescription.
15. Except for veterinarians licensed under Chapter 4741 of the Revised Code, for all controlled substances and products containing gabapentin:
   a. Indicate the days’ supply of the prescription.
   b. For a managing pharmacist acting as an agent of a physician pursuant to section 4729.38 of the Revised Code and rules adopted thereunder, the prescription shall include the full name of the managing pharmacist.
16. Be issued in compliance with all applicable federal and Ohio laws, rules, and
regulations.

(C) A pharmacist may make the following modifications to a prescription in accordance with this paragraph.

(1) A pharmacist may add or change the patient's address upon verification with the patient or patient's caregiver.

(2) For a schedule II controlled substance prescription, a pharmacist may add or change the dosage form, drug strength, drug quantity, directions for use, or issue date only after consultation with and agreement of the prescriber.

(3) For a schedule III-V controlled substance prescription, a pharmacist may add or change the dosage form, drug strength, drug quantity, directions for use, or issue date only after consultation with and agreement of the prescriber or agent of the prescriber.

(4) Except as provided for in paragraph (C)(7) of this rule, for a non-controlled substance prescription, a pharmacist may add or change the dosage form, drug strength, drug quantity, directions for use, or issue date only after consultation with and agreement of the prescriber or agent of the prescriber.

(5) For all prescriptions, a pharmacist may add or change the days' supply, ICD-10-CM medical diagnosis code, or code on dental procedures and nomenclature only after consultation with and agreement of the prescriber or agent of the prescriber.

(6) A pharmacist may modify a prescription to specify if “dispense as written” or another phrase or indicator having a similar meaning applies to the following only after consultation with and agreement of the prescriber or agent of the prescriber:

(a) Selection of a generically equivalent drug or interchangeable biological product in accordance with section 4729.38 of the Revised Code.

(b) Dispensing a quantity or amount of a drug that varies from the quantity or amount of the drug that otherwise would be dispensed pursuant to the prescription in accordance with section 4729.40 of the Revised Code.

(7) For a non-controlled substance prescription, a pharmacist may change the dosage form, drug strength, drug quantity and directions for use without consultation with and agreement of the prescriber or agent of the prescriber in accordance with the following:

(a) The drug selected must have the same active chemical ingredients of equivalent strength, frequency and duration of therapy as the prescribed drug;

(b) The prescription is for a human patient;

(c) No modifications shall be made pursuant to this paragraph if “dispense as written” or another phrase or indicator having a similar meaning is indicated on the prescription pursuant to paragraphs (I) and (J) of this rule;

(d) The pharmacist who selects the drug to be dispensed pursuant to this paragraph shall assume the same responsibility for selecting the dispensed drug as would be incurred in filling a prescription for a drug using the prescribed form; and

(e) The pharmacist shall not permit substitution between long-acting and short-acting forms of a drug with the same chemical ingredients or between one drug product and two or more drug products with the same chemical ingredients.

(8) All consultations and corresponding changes performed in accordance with this paragraph shall be noted by the pharmacist on the prescription or in the patient's profile and shall be communicated to the patient or patient's caregiver.

(9) A pharmacist shall not make changes to the patient's name, dangerous drug prescribed, except for generic substitution permitted by Ohio law, or the prescriber's signature.

(D) All prescriptions issued on paper to a patient by a prescriber shall be:

(1) Manually signed on the day issued by the prescriber in the same manner as the prescriber would sign a check or legal document.

(2) Issued in compliance with rule 4729-5-13 of the Administrative Code.

(E) When forms are used that create multiple copies of a prescription issued to a patient...

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by a prescriber, the original prescription that includes the actual signature of the prescriber must be issued to the patient for dispensing by a pharmacist.

(F) Oral transmission by the prescriber or the prescriber’s agent of original prescriptions and refills authorized by a prescriber, pursuant to the requirements of this rule, may be transmitted by telephone only to:

1. A pharmacist.
2. A recording device within the pharmacy if the pharmacist is unavailable. The pharmacist must remove the prescription from the recorder and reduce it to writing. The pharmacist is responsible for ensuring the validity of the prescription removed from the recorder.
3. A licensed pharmacy intern if the pharmacist on duty who is supervising the activity of the intern determines that the intern is competent to receive telephone prescriptions.
4. A certified pharmacy technician registered in accordance with section 4729.90 of the Revised Code but only with respect to accepting refill authorizations for dangerous drugs that are not controlled substances from a prescriber or the prescriber’s agent, so long as there is no change from the original prescription.
5. For any prescription transmitted by an agent of a prescriber, the prescriber’s agent must provide the agent’s full name when transmitting an oral prescription.

(G) Original written prescriptions authorized and signed by a prescriber may be transmitted by the prescriber or the prescriber’s agent by facsimile machine to a pharmacy pursuant to the following:

1. The facsimile of the prescription must include the full name of the prescriber and, if applicable, the full name of the prescriber’s agent transmitting the prescription to the pharmacy.
2. The original prescription signed by the prescriber from which the facsimile is produced shall not be issued to the patient. The original prescription signed by the prescriber must remain with the patient’s records at the prescriber’s office or the institutional facility where it was issued.
3. If a prescription is transmitted from an institutional facility where it was not originally issued, only an individual licensed pursuant to Chapter 4723., 4729., 4730 or 4731 of the Revised Code may transmit the prescription as an agent of the prescriber.
4. Prescriptions for schedule II controlled substances may not be transmitted by facsimile except for:
   a. A resident of a long term care facility pursuant to rule 4729-17-09 of the Administrative Code.
   b. A narcotic substance issued for a patient enrolled in a hospice. The original prescription must indicate that the patient is a hospice patient. The facsimile transmission must also meet the other requirements of this rule.
   c. A compounded sterile product prescription for a narcotic substance pursuant to rule 4729-16-03 of the Administrative Code.
5. A facsimile of a prescription received by a pharmacy in any manner other than transmission directly from the prescriber or the prescriber’s agent shall not be considered a valid prescription.
6. The facsimile of the prescription must include header information identifying the origin of the facsimile.

(H) Electronic prescription transmission systems.

1. Except as provided in paragraph (H)(3) of this rule, outpatient prescriptions may be transmitted by means of an electronic prescription transmission system that complies with the requirements of paragraph (B) of this rule.
   If applicable, an outpatient prescription transmitted by means of an electronic prescription transmission system shall include the full name of the prescriber’s agent transmitting the prescription.
2. A controlled substance outpatient prescription shall only be transmitted by means of
an electronic prescription transmission system if the system meets the requirements of 21 CFR 1311 (3/31/2010).

(3) An institutional facility, as defined in rule 4729-17-01 of the Administrative Code, may only transmit inpatient prescriptions by means of a board approved electronic prescription transmission system provided that:

(a) The system requires positive identification of the prescriber as defined in rule 4729-5-01 of the Administrative Code and the full name of any authorized agent of the prescriber who transmits the prescription.

(b) The computer data is retained for a period of three years.

(c) The approved system complies with the rule 4729-17-09 of the Administrative Code.

(4) Except as provided in paragraphs (H)(5) and (H)(6) of this rule, no prescriptions may be transmitted by means of an electronic prescription transmission system that converts the prescription into a computer-generated fax or scanned image.

(5) A non-controlled prescription may be transmitted by means of an electronic prescription transmission system that converts the prescription into a computer-generated fax or scanned image if all the following apply:

(a) The transmission is conducted by means of a board approved system that meets the prescription requirements in accordance with this rule; and

(b) The prescription transmission system operates within a closed-system. A closed system includes a system whereby prescription information is transmitted directly between:

(i) Any division, subsidiary, parent or affiliated or related company under the common ownership and control.

(ii) One or more contracted entities. Contracted means having a written agreement (to include business associate agreements) between one or more prescribers and a pharmacy and shall not include a third-party intermediary unless otherwise approved by the board.

(iii) Any other entities as approved by the board.

(6) A non-controlled prescription may be converted into a computer-generated fax by a board approved third-party intermediary only if the conversion is necessitated by a temporary telecommunication outage of the third-party intermediary or receiving pharmacy.

(I) Pursuant to section 4729.38 of the Revised Code, a pharmacist shall not select a generically equivalent drug or interchangeable biological product if either of the following applies:

(1) In the case of a written or electronic prescription, including a computer-generated prescription, the prescriber handwrites or actively causes to display on the prescription “dispense as written,” “D.A.W.,” “do not substitute,” “brand medically necessary,” or any other statement or numerical code that indicates the prescriber’s intent to prevent substitution. Such a designation shall not be preprinted or stamped on the prescription, but a reminder to the prescriber of the designation procedure may be preprinted or displayed on the prescription form or electronic system the prescriber uses to issue the prescription.

(2) In the case of an oral prescription, the prescriber or the prescriber’s agent specifies that the drug as prescribed is medically necessary or otherwise indicates the prescriber’s intent to prevent substitution.

(J) Pursuant to section 4729.40 of the Revised Code, a pharmacist shall not dispense a quantity or amount of a drug that varies from the quantity or amount of the drug that otherwise would be dispensed pursuant to the prescription if the following applies:

The prescriber included “dispense as written” or another phrase having a similar meaning on the prescription, or, when issuing a prescription electronically or orally, the prescriber did not specify that the quantity or amount of the drug to be dispensed may not vary from the quantity or amount specified in the prescription.

(K) Failure of a prescription to contain the requirements set forth in paragraphs (B)(14) (b) and (B)(15) of this rule or of the pharmacist to obtain the information set forth in paragraphs
(B)(14)(b) and (B)(15) of this rule shall not render the prescription, if dispensed in good faith, to be invalid.

4729-5-38 Immunization and vaccine administration.

(A) A pharmacist or pharmacy intern acting under the direct supervision of a pharmacist may administer in accordance with section 4729.41 of the Revised Code the following:

(1) Any immunization or vaccine that is included in either of the following schedules and is administered according to those schedules:

(a) The immunization schedule for persons aged zero through eighteen years recommended by the advisory committee on immunization practices of the centers for disease control and prevention in the United States department of health and human services (8/17/2015).

(b) Except as listed in paragraph (A)(2) of this rule, the adult immunization schedule recommended by the advisory committee on immunization practices of the centers for disease control and prevention in the United States department of health and human services (8/17/2015).

(2) The zoster vaccine according to the age criteria specified in the F.D.A. approved labeling.

(3) Except as provided in paragraphs (A)(4) and (A)(5) of this rule, any other immunization or vaccine recommended by the advisory committee on immunization practices of the centers for disease control and prevention in the United States department of health and human services if administered in accordance with the recommendations adopted by the committee.

(4) The rabies vaccine for post exposure if all the following are met:

(a) A pharmacist or pharmacy intern does not provide the initial dose of the rabies post exposure vaccine;

(b) Follow-up doses are administered pursuant to a prescription issued by a prescriber; and

(c) The follow-up doses are administered in accordance with recommendations adopted by the advisory committee on immunization practices of the centers for disease control and prevention in the United States department of health and human services (8/17/2015).

(5) The requirements listed in paragraph (A)(4) of this rule do not apply to the rabies vaccine for preexposure if administered in accordance with recommendations adopted by the advisory committee on immunization practices of the centers for disease control and prevention in the United States department of health and human services (8/17/2015).

(B) A pharmacist or pharmacy intern shall obtain informed consent to administer an immunization or vaccination pursuant to paragraph (O) of rule 4729-5-27 of the Administrative Code.

(C) A pharmacist or pharmacy intern shall comply with the vaccine information statement requirements of the National Vaccine Childhood Injury Act, 42 U.S.C. Section 300aa-26 (8/17/2015).

(D) A pharmacist or pharmacy intern who engages in the administration of an immunization or vaccination shall do so in accordance with rules 4729-5-36 and 4729-5-37 of the Administrative Code.

(E) An immunization or vaccine specified in this rule shall not be administered to any individual who is less than thirteen years of age, except in the following situations:

(1) The immunization for influenza is administered to individuals who are seven years of age or older; or

(2) Pursuant to a prescription from a licensed prescriber, an immunization or vaccine is administered to individuals who are seven years of age or older but not more than thirteen years.
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of age.

(F) For each immunization administered to an individual by a pharmacist or pharmacy intern, other than an immunization for influenza administered to an individual eighteen years of age or older, the pharmacist or pharmacy intern shall notify the individual's family physician or, if the individual has no family physician, the board of health of the health district in which the individual resides or the authority having the duties of a board of health for that district under section 3709.05 of the Revised Code. The notice shall be given not later than thirty days after the immunization is administered.

4729-5-39 Dispensing of naloxone.

(A) A pharmacist or pharmacy intern under the direct supervision of a pharmacist may dispense naloxone without a prescription to either of the following in accordance with an approved protocol specified in paragraph (B) of this rule:

(1) An individual who there is reason to believe is experiencing or at risk of experiencing an opioid-related overdose;

(2) A family member, friend, or other person in a position to assist an individual who there is reason to believe is at risk of experiencing an opioid-related overdose.

(B) To be considered an approved protocol pursuant to section 4729.44 of the Revised Code, the physician-established protocol for the dispensing of naloxone by a pharmacist or pharmacy intern under the direct supervision of a pharmacist shall include, but is not limited to, the following:

(1) A description of the clinical pharmacology of naloxone.

(2) Indications for use of naloxone as rescue therapy, including criteria for identifying persons eligible to receive naloxone under the protocol.

(3) Precautions and contraindications concerning dispensing naloxone.

(4) Assessment and follow-up actions by the pharmacist or pharmacy intern.

(5) Naloxone products authorized to be dispensed, including all of the following information:

(a) Name of product;
(b) Dose;
(c) Route of administration and required delivery device; and
(d) Directions for use.

(6) Any patient instructions in addition to the counseling specified in paragraphs (C) and (D) of this rule.

(C) A pharmacist or pharmacy intern under the direct supervision of a pharmacist who dispenses naloxone pursuant to this rule shall instruct the individual to whom naloxone is dispensed verbally or in writing to summon emergency services as soon as practicable either before or after administering naloxone.

(D) A pharmacist, pharmacy intern under the direct supervision of a pharmacist, or a pharmacist's designee that is appropriately trained shall personally provide in-person training and written educational materials to the individual to whom naloxone is dispensed, appropriate to the dosage form of naloxone dispensed, including, but not limited to, all of the following:

(1) Risk factors of opioid overdose;
(2) Strategies to prevent opioid overdose;
(3) Signs of opioid overdose;
(4) Steps in responding to an overdose;
(5) Information on naloxone;
(6) Procedures for administering naloxone;
(7) Proper storage and expiration of naloxone product dispensed; and
(8) Information on where to obtain a referral for substance abuse treatment.
(E) If training conducted pursuant to paragraph (D) of this rule is offered by a pharmacist's designee, the pharmacist shall not be required to counsel a patient or caregiver pursuant to rule 4729-5-22 of the Administrative Code if the patient or caregiver refuses the offer of counseling or does not respond to the written offer to counsel. In this situation, when counseling is refused, the pharmacist or their designee shall ensure that such refusal is documented in the presence of the patient or the patient's caregiver.

(F) The pharmacy's responsible person shall ensure that all pharmacists and pharmacy interns that dispense naloxone pursuant to this rule are appropriately trained on the use of naloxone and can meet the training requirements listed in paragraphs (C) and (D) of this rule.

(G) The terminal distributor and the pharmacy's responsible person shall ensure that all pharmacist designees are appropriately trained on the use of naloxone and can meet the training requirements listed in paragraph (D) of this rule.

(H) A pharmacist may document the dispensing of naloxone by the pharmacist or a pharmacy intern supervised by the pharmacist on a prescription form. The form may be assigned a number for record-keeping purposes.

(I) Paragraph (L) of this rule does not apply to institutional pharmacies that provide naloxone to inpatients or patients upon discharge.

(J) A licensed terminal distributor of dangerous drugs may make occasional sales of naloxone at wholesale pursuant to rule 4729-9-10 of the Administrative Code to a state or local law enforcement agency if the terminal distributor is any of the following:

1. A pharmacy;
2. A board of health of a city or general health district;
3. An authority having the duties of a board of health under section 3709.05 of the Revised Code; or
4. A health department operated by such a board or authority.

(K) All physician-established protocols shall be signed and dated by the physician prior to implementation and maintained by the pharmacy's responsible person. The protocol shall be made readily available to the dispensing pharmacist or pharmacy intern under the direct supervision of a pharmacist.

(L) Any pharmacy that dispenses naloxone pursuant to this rule, shall notify the board, in a manner prescribed by the board, within thirty days of establishing an approved protocol. A pharmacy that no longer dispenses naloxone pursuant to this rule shall notify the board, in a manner prescribed by the board, within thirty days of discontinuation.

4729-17-01 Definitions; institutional facility.

As used in Chapter 4729-17 of the Administrative Code:

(A) “Institutional facility” means a hospital as defined in section 3727.01 of the Revised Code, or a facility licensed by the state board of pharmacy and the Ohio department of health, the Ohio department of rehabilitation and correction, the Ohio department of developmental disabilities, or the Ohio department of mental health and addiction services at which medical care is provided on site and a medical record documenting episodes of care, including medications ordered and administered, is maintained, including, the following:

1. Convalescent homes;
2. Developmental facilities;
3. Long term care facilities;
4. Nursing homes;
5. Psychiatric facilities;
6. Rehabilitation facilities;
7. Developmental disability facilities;
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(8) Level III sub-acute detoxification facilities certified by the Ohio department of mental health and addiction services;
(9) State or local correctional facilities, as defined in section 5163.45 of the Revised Code;
(10) Any other facility as determined by the board.

(B) “Inpatient” means any person who receives drugs for use while within the institutional facility.

(C) “Inpatient prescription” means a written, electronic, or oral order for a drug to be dispensed for use in treating an inpatient.

(D) “Dispensing of a drug pursuant to an inpatient prescription” means the professional review by a pharmacist required to place a specific drug in final association with the name of a particular inpatient pursuant to the lawful order of a prescriber. In the case of an automated drug delivery system meeting the requirements of rule 4729-5-35 of the Administrative Code, the final association with the name of a particular inpatient will be deemed to have occurred when the pharmacist has given final approval to the patient specific order in the system.

(E) “Contingency drugs” are those drugs which may be required to meet the therapeutic needs of inpatients when a licensed pharmacist is not available and personally in full and actual charge of the institutional pharmacy.

(F) “Emergency drugs” are those drugs which are required to meet the immediate therapeutic needs of inpatients in order to sustain life in an emergency situation.

(G) “Outpatient” means any person who receives drugs for use outside of the institutional facility.

(H) “Electronic drug record keeping system” means a system of storing drug records electronically and capturing the positive identification of the person responsible for a specific drug transaction including, but not limited to, the prescribing, administering, or dispensing of a drug.

(I) “Positive identification” has the same meaning as paragraph (N) of rule 4729-5-01 of the Administrative Code except that a specific hospital having a closed electronic drug record keeping system may be permitted to use identifiers utilizing both a password combined with a personal identifier to document the positive identification of each user for, but not limited to, the prescribing and administration of a drug if approved by the board of pharmacy.

(1) At a minimum, the following items will be considered during the approval process:
(a) Audit controls are in place to detect and deter drug diversion;
(b) Access controls are in place to ensure the identity of a user and to assign accountability of the user for any drug transaction;
(c) Safeguards are in place to prevent and detect the unauthorized use of an individual's password and personal identifier;
(d) An ongoing quality assurance program is in place to ensure that paragraphs (I)(1)(a) to (I)(1)(c) of this rule are being fulfilled and reviewed; and
(e) Policies and procedures are in place to address all of the items in paragraphs (I)(1)(a) to (I)(1)(d) of this rule.

(2) Positive identification pursuant to paragraph (N) of rule 4729-5-01 of the Administrative Code shall always be used to document the:
(a) Dispensing, compounding, or repackaging of a drug;
(b) Removal and possession of a controlled substance to administer to a patient;
(c) Waste of a controlled substance.

(J) “Password” means a private identification that is created by a user to obtain access to an electronic drug record keeping system.

(K) “Personal identifier” means a unique user name or number for identifying and tracking a specific user's access to an electronic drug record keeping system such as social security number, user identification number, or employee number.
(L) “Point of care location” means a location within an institutional facility that stores dangerous drugs and all of the following apply:
(1) The point of care location is licensed as a terminal distributor of dangerous drugs;
(2) The dangerous drugs are not owned by the institutional facility where the point of care location is located;
(3) The dangerous drugs stored are owned by another institutional facility licensed as a terminal distributor of dangerous drugs; and
(4) The location may be used for the administration, personally furnishing or dispensing of dangerous drugs, including controlled substances.

(M) “Outpatient institutional pharmacy” means a pharmacy located within or on the campus of an institutional facility that provides outpatient pharmacy services which is physically separate from, and not contiguous to, the area in which inpatient pharmacy services are provided. An outpatient institutional pharmacy shall have a separate terminal distributor of dangerous drugs license in addition to the license for the institutional facility.

4729-17-02 Responsible person for an institutional pharmacy.

Each institutional pharmacy shall be directed by a pharmacist who holds a current identification card to practice pharmacy in Ohio pursuant to the provisions of section 4729.12 of the Revised Code.

(A) The institutional pharmacy director or designated pharmacist shall be the pharmacist-in-charge pursuant to section 4729.27 of the Revised Code, the responsible person pursuant to rule 4729-5-11 of the Administrative Code, and the pharmacist responsible for maintaining supervision and control over the possession and custody of all dangerous drugs acquired by the institutional facility pursuant to division (B) of section 4729.55 of the Revised Code.

(B) A pharmacist shall be the responsible person for no more than one pharmacy except with written permission from the state board of pharmacy unless granted permission in accordance with paragraph (E) of rule 4729-5-11 of the Administrative Code.

(C) The responsible person shall:
(1) Be responsible for the practice of pharmacy performed within the institution;
(2) Develop, implement, supervise, and coordinate all services provided by the pharmacy;
(3) In conjunction with the appropriate interdisciplinary committees, be responsible for the development of written policies and procedures which are consistent with this chapter of the Administrative Code and other applicable federal and state laws and rules governing the legal distribution of drugs, ensure adherence to these policies and procedures in order to provide for the safe and efficient distribution of drugs in all areas of the institution, and make available a current copy of these written policies and procedures for inspection and/or copying by an employee of the state board of pharmacy;
(4) Be responsible for the security and control of all drugs within the institution;
(5) Be responsible for the maintenance of all records, required by state or federal law to be kept at the licensed location, of the acquisition, use, distribution, and disposition of all drugs.

(D) Any change of the responsible person shall be done in accordance with rule 4729-5-11 of the Administrative Code.

4729-17-03 Security and control of drugs in an institutional facility

(A) In the absence of a licensed pharmacist, drugs ordered by a prescriber for patient treatment may be obtained in the following manner:
(1) Where a licensed pharmacist is not present twenty-four hours-a-day, drugs for
patient treatment may be made available to licensed health care professionals authorized pursuant to the Revised Code to administer drugs in the course of their professional practice by the use of contingency drug supplies pursuant to the provisions of paragraph (A)(2) of this rule. A licensed pharmacist shall be available for emergencies when the institutional pharmacy is closed.

(2) Contingency drugs shall be used only in the absence of a licensed pharmacist, and shall be stored in a locked cabinet(s) or other enclosure(s) constructed and located outside of the institutional pharmacy. The storage area must be sufficiently secure to deny access, without obvious damage, to unauthorized persons. The responsible person shall:

(a) Designate those who may obtain access to the drug supply;
(b) Determine, in conjunction with the appropriate interdisciplinary committees, the drugs that are to be included in the contingency drug supply;
(c) Ensure that such drugs are properly labeled and packaged in sufficient quantities to provide drug therapy during the period when the institutional pharmacy is not open;
(d) Provide controls adequate to prevent diversion of the drugs, and institute record keeping procedures to account adequately for the drugs when used and the positive identification of the person who obtained the drugs from the drug supply;
(e) Provide procedures for the inspection of the contingency drug inventory to ensure proper utilization and replacement of the drug supply.

(3) For a pharmacy located on the premises of the institutional facility, when a drug is not available from the contingency drug supply and such drug is required to treat the immediate needs of an inpatient or outpatient whose health would otherwise be jeopardized, such drug may be obtained from the institutional pharmacy pursuant to written policies and procedures implemented by the responsible person.

(a) The policies and procedures shall:
(i) Identify the personnel authorized to access the pharmacy and the conditions under which access may be gained to the pharmacy;
(ii) Ensure a minimum of two employees of the institution, one of whom shall be a health care professional licensed pursuant to Chapter 4723. (Nursing Practice Act) or 4731. (Medical Practice Act) of the Revised Code and authorized by such chapter to administer drugs in the course of their professional practice, to accompany each other when accessing the pharmacy;
(iii) Provide a written record documenting emergency access to the pharmacy. Such record shall include the names, titles, and positive identification of all institutional personnel accessing the pharmacy, date and time of access, the name and quantity of drugs obtained, the name of the patient, and the name of the ordering prescriber.
(b) The written record of each access to the institutional pharmacy when it is closed and a pharmacist is not present shall be filed, within twenty-four hours, with the responsible person and maintained in the pharmacy for three years.

(B) Supplies of dangerous drugs may be maintained in patient care areas according to written policies and procedures developed and implemented by the responsible person. The policies and procedures shall:

(1) Provide for a limited quantity of dangerous drugs to be maintained at any one location;
(2) Provide for the proper storage and labeling of all such drugs;
(3) Provide for storage in a secure area. If dangerous drugs cannot be stored in a secure area, they shall be stored in a container which is sealed with a tamper-evident seal that must be broken to gain access to the drugs;
(4) Provide for notification of the responsible person, or designated pharmacist, when the dangerous drug supply has been accessed and/or drugs used;
(5) Provide for replacement of the drugs used, and the dangerous drug supply to be re-sealed;
(6) Provide for inspection of the dangerous drug supply, on a regular basis, to detect unauthorized use of such drugs and which drugs have exceeded their expiration or beyond use date;

(7) Provide adequate record keeping procedures to document the disposition of drugs from the supply.

(C) Security

(1) All areas occupied by an institutional pharmacy shall be capable of being secured by key, or other effective mechanism, so as to prevent access by unauthorized personnel.

(2) In the absence of a licensed pharmacist, all areas occupied by an institutional pharmacy shall be secured so as to prevent access by unauthorized personnel.

(3) The responsible person shall develop and implement policies and procedures which will detect and deter the diversion and/or adulteration of drugs.

4729-17-04 Records; institutional pharmacy.

All drug records shall be maintained for a period of three years pursuant to section 4729.37 of the Revised Code. All drug records must be readily retrievable within three working days, excluding holidays and weekends, of all drug transactions within the previous three years. Electronic drug record keeping systems, computerized record keeping systems, or subsequent storage of such records, must be readily retrievable via digital display, hard copy printout, or other mutually agreeable transfer medium. If an electronic drug record keeping system is being utilized as defined in paragraph (H) of rule 4729-17-01 of the Administrative Code the method(s) of achieving positive identification must be approved by the state board of pharmacy prior to implementation pursuant to paragraph (I) of rule 4729-17-01 of the Administrative Code. The responsible person shall be responsible for maintaining the following records:

(A) A record of all drugs purchased, the quantity received, and the name, address, and wholesale distributor registration number of the person from whom the drugs were purchased.

(B) All drug orders and records relating to the practice of pharmacy.

(1) Records of drugs dispensed shall include, but are not limited to:

(a) The name, strength, and quantity of drugs dispensed;

(b) The date of dispensing;

(c) The name of the inpatient to whom, or for whose use, the drug was dispensed; and

(d) Positive identification of all pharmacists involved in the dispensing.

(2) All other records relating to the practice of pharmacy other than dispensing shall include, but are not limited to:

(a) The name of the inpatient to whom, or for whose benefit, the activity was performed;

(b) The practice of pharmacy activity performed;

(c) The results of the activity, if applicable; and

(d) Positive identification of all pharmacists involved in the activity, identifying the function performed by each pharmacist.

(3) Records of drugs dispensed for outpatients shall be maintained pursuant to rule 4729-5-27 of the Administrative Code.

(C) A record of all drugs compounded or repackaged for use only within the institution, which shall include at least the following:

(1) Name of drug, strength, quantity, and dosage form;

(2) Manufacturer’s or distributor’s control number;

(3) Manufacturer’s or distributor’s name, if a generic drug is used;

(4) Pharmacy control number;

(5) Manufacturer’s or distributor’s expiration date;

(6) The pharmacy’s expiration date or beyond-use date;

(7) Positive identification of the pharmacist responsible for the compounding or
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repackaging of the drug.
(D) A record of the distribution of dangerous drugs to other areas of the institution for administration or use as described in paragraph (B) of rule 4729-17-03 of the Administrative Code, which shall include at least the following:
   (1) The name, strength, dosage form, and amount of drug distributed;
   (2) The area receiving the drug;
   (3) The date distributed;
   (4) Positive identification of the individual receiving the drug if it is a controlled substance;
   (5) The area of the institution receiving the dangerous drug shall make a record of all such drugs administered to patients. Such records shall include at least the following:
      (a) Name of the patient;
      (b) Name, dosage form, and strength when applicable of the drug;
      (c) Date and time the drug was administered;
      (d) Quantity administered;
      (e) Positive identification of the personnel administering the drug.
(E) A log that must be maintained of all changes made to a drug record in an electronic drug record keeping system or a computerized record keeping system after a drug transaction has been made. Such log may be accessible for review, but shall be protected from being altered in any way. The log must contain at least, but is not limited, to the following:
   (1) Date and time of change;
   (2) Changes made;
   (3) Person making the change.

4729-17-05 Controlled substance recordkeeping.

(A) All controlled substances dispensed to inpatients in an institutional facility in quantities exceeding a seventy-two-hour supply shall be dispensed and maintained according to the following requirements:
   (1) All controlled substances dispensed in quantities exceeding a seventy-two-hour supply shall be packaged in tamper-evident, unit-of-use containers except multidose liquids and injectables where unit-of-use packaging is not available;
   (2) The drugs shall be stored in a secure location with access limited to authorized individuals;
   (3) A proof-of-use sheet or other board-approved recordkeeping system shall be maintained for each drug and shall include at least, but is not limited to, the following information:
      (a) Patient name,
      (b) Date and time of access,
      (c) Drug name, strength, and quantity obtained,
      (d) The positive identification of the person doing the administration, and, if applicable,
      (e) The positive identification of both the person and the witness who waste a partial dose of a controlled substance;
   (4) At every change of shift, a reconciliation must be conducted by both the leaving and arriving licensed health care professional responsible for the security of these drugs in the area in which they are stored and must include at least the following:
      (a) A physical count and reconciliation of the controlled substances and proof-of-use sheets, if applicable, to ensure the accountability of all doses,
      (b) An inspection of the packaging to ensure its integrity,
      (c) The positive identification of the persons conducting the reconciliation, and
      (d) The immediate reporting of any unresolved discrepancy to the appropriate people
within the institution. A pharmacist at the pharmacy department responsible for the terminal distributor of dangerous drugs license must be one of those notified.

(B) All controlled substances maintained as stock in areas outside of the pharmacy pursuant to paragraph (B) of rule 4729-17-03 of the Administrative Code shall meet the following requirements, unless they are stored in a secure, automated storage system that meets the requirements of paragraph (C) of this rule:

1. The drugs shall be stored in a secure location with access limited to authorized individuals;
2. A proof-of-use sheet or other board approved recordkeeping system shall be maintained for each drug and shall include at least, but is not limited to, the following information:
   a. Patient name,
   b. Date and time of access,
   c. Drug name, strength, and quantity obtained,
   d. The positive identification of the person doing the administration, and, if applicable,
   e. The positive identification of both the person and the witness who waste a partial dose of a controlled substance;
3. At every change of shift, a reconciliation must be conducted by both the leaving and arriving licensed health care professional responsible for the security of these drugs in the area in which they are stored and must include at least the following:
   a. A physical count and reconciliation of the controlled substances and proof-of-use sheets, if applicable, to ensure the accountability of all doses,
   b. An inspection of the packaging to ensure its integrity,
   c. The positive identification of the persons conducting the reconciliation, and
   d. The immediate reporting of any unresolved discrepancy to the appropriate people within the institution. A pharmacist at the pharmacy department responsible for the terminal distributor of dangerous drugs license must be one of those notified;
4. All controlled substances shall be packaged in tamper-evident containers except multidose liquids and injectables where unit-of-use packaging is not available.

(C) All controlled substances maintained as stock in areas outside of the pharmacy pursuant to paragraph (B) of rule 4729-17-03 of the Administrative Code that are stored in a secure, automated storage system shall be handled as in paragraph (B) of this rule unless the automated storage system meets all of the following requirements:

1. The drugs shall be stored in a secure location with access limited to authorized individuals;
2. The system shall document the positive identification of every person accessing the system and shall record the date and time of access;
3. A recordkeeping system shall be maintained that shall include at least, but is not limited to, the following information:
   a. Patient name,
   b. Date and time of access,
   c. Drug name, strength, and quantity removed,
   d. The positive identification of the person removing the drug, and, if applicable,
   e. The positive identification of both the person and the witness who waste a partial dose of a controlled substance;
4. Periodically, the responsible person shall cause a reconciliation of the automated storage system to be conducted which must include at least the following:
   a. A physical count and reconciliation of the controlled substances to ensure the accountability of all doses,
   b. An inspection of the packaging to ensure its integrity,
   c. The positive identification of the persons conducting the reconciliation,
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(d) The immediate reporting of any unresolved discrepancy to the appropriate people within the institution. A pharmacist at the pharmacy department responsible for the terminal distributor of dangerous drugs license must be one of those notified;

(5) Access to all controlled substances stored in the automated storage system shall be limited to one drug and strength at a time;

(6) All controlled substances stored in the automated storage system shall be packaged in tamper-evident containers, unless the system only allows access to one dose at a time.

4729-17-08 Minimum standards for an institutional pharmacy.

(A) Resources
(1) All pharmacists working in a pharmacy must be able to access all current federal and state laws, regulations, and rules governing the legal distribution of drugs in Ohio;
(2) The pharmacy shall have access to the references necessary to conduct a pharmacy in a manner that is in the best interest of the patients served and to comply with all state and federal laws, rules and regulations; and
(3) Telephone number of a poison control center.

(B) Drug inventory, fixtures, and space
(1) The inventory of drugs and equipment shall be commensurate with the scope of pharmacy services provided, and housed in suitable, well-lighted and well-ventilated room(s), in a clean and sanitary area.
(2) All areas where drugs are stored shall be maintained at temperatures which will ensure the integrity of the drugs prior to their dispensing or administration as stipulated by the USP/NF and/or the manufacturer's or distributor's labeling.
(3) All areas where drugs are stored shall provide adequate physical security to deter and detect their diversion and/or adulteration.

(C) Personnel
The pharmacy shall be appropriately staffed to operate in a safe and effective manner pursuant to section 4729.55 of the Revised Code. An employee of a pharmacy that may have contact with patients or the general public must be identified by a nametag that includes the employee’s job title.

4729-17-09 Drug orders for patients of an institutional facility.

(A) Drugs shall be dispensed by a pharmacist for inpatients pursuant to an original patient specific order issued by a prescriber.
(1) Drug orders for inpatients of an institutional facility transmitted to a pharmacist by use of an electronic drug record keeping system may be considered an original order for the dispensing of drugs. Access to such system for entering and transmitting original orders shall be restricted to licensed health care professionals using positive identification. If the licensed health care professional entering the order into the system is not the prescriber, there shall be a system in place requiring the positive identification of the prescriber for each order within a reasonable period of time which shall be available in a readily retrievable fashion.
(2) Oral orders issued by a prescriber for inpatients of an institutional facility may be transmitted to a pharmacist by personnel authorized by, and in accordance with, written policies and procedures of the facility. Such orders shall be recorded by the pharmacist, noting the full name(s) of the authorized personnel transmitting the order. Oral orders issued by a prescriber and transmitted by authorized personnel shall be verified by the prescriber using positive identification within a reasonable time and as required by the written policies and procedures of the facility.
(3) Drug orders for inpatients of an institutional facility transmitted to a pharmacist by use
of a facsimile machine to facsimile machine transfer shall be transmitted by personnel authorized by, and in accordance with, written policies and procedures of the facility. The pharmacist receiving the facsimile shall have in place written policies and procedures allowing only authorized personnel access to the drug order facsimile. The pharmacist shall maintain the facsimile showing the origin of the order as a part of the drug order record. This facsimile must be maintained if it is the only record showing the pharmacist responsible for dispensing the drug.

(B) All orders for drugs for inpatients shall include, but are not limited to, at least the following:
   (1) Name of patient;
   (2) Name, strength, and dosage form of drug;
   (3) Directions for use, including route of administration;
   (4) Date prescribed; and
   (5) Prescriber's positive identification.

(C) Drugs shall be dispensed for outpatients pursuant to an original order of a prescriber. All orders for the dispensing of drugs to outpatients shall, at a minimum, conform to rule 4729-5-30 of the Administrative Code, shall be labeled in accordance with rule 4729-5-16 of the Administrative Code, and the records shall be maintained in accordance with rule 4729-5-27 of the Administrative Code.

(D) An original signed prescription for a schedule II controlled substance prepared in accordance with federal and state requirements and issued for a resident in a long term care facility may be transmitted by the prescriber or the prescriber's agent to the dispensing pharmacy by facsimile. The facsimile shall serve as the original written prescription and shall be received and maintained pursuant to rules 4729-5-21 and 4729-5-30 of the Administrative Code. The original signed prescription must remain with the patient's records at either the prescriber's office or the long term care facility.

4729-17-10 Labeling of prescriptions for patients of an institutional facility.

(A) All dangerous drugs dispensed for use by inpatients in an institutional facility, whereby the drug is not in the possession of the ultimate user prior to administration, shall meet the following requirements:
   (1) The label of a single unit package of an individual-dose or unit-dose system of packaging of drugs shall include:
      (a) The non-proprietary or proprietary name of the drug;
      (b) The route of administration, if other than oral;
      (c) The strength and volume, where appropriate, expressed in the metric system whenever possible;
      (d) The control number and expiration date;
      (e) Identification of the manufacturer, packer or distributor, or if the repackager is the dispensing pharmacy identification of the repackager, shall be by name or by the final seven digits of their terminal distributor of dangerous drugs license number, and such identification shall be clearly distinguishable from the rest of the label;
      (f) Special storage conditions, if required.
   (2) When a multiple-dose drug distribution system is utilized, including dispensing of single unit packages, the drugs shall be dispensed in a container to which is affixed a label containing the following information:
      (a) Identification of the dispensing pharmacy;
      (b) The patient's full name;
      (c) The date of dispensing;
      (d) The non-proprietary and/or proprietary name of the drug;
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(e) The strength, expressed in the metric system whenever possible.
(3) Multiple drugs may be packaged in the same container such that the different drugs
are in contact with each other only under the following conditions:
(a) The number of drugs placed in one package cannot exceed the capability of the
receptacle to prevent damage to the dosage forms.
(b) The quantity dispensed may not be more than a thirty-one-day supply.
(c) The labels must be of sufficient size to properly and clearly label a thirty-one-day or
less supply with all information required by state and federal law including accessory labels.
(d) Each individual package must include a beyond-use date of not more than sixty days
from the date the drugs were placed in the package.
(e) Medications which have been packaged in multi-dose packaging may not be returned
to stock or redispensed when returned to the pharmacy for any reason.
(f) When the drugs are not in the possession of the ultimate user and any one drug
within each individual package has been discontinued, all drugs in the individual package are
deemed adulterated and they may not be administered unless otherwise approved by the board
of pharmacy.
(g) The packaging is tamper-evident.
(h) Any pharmacist/pharmacy using multi-dose packaging must implement policies and
procedures which will exclude drugs having the following characteristics from such packaging:
(i) The U.S.P. monograph or official labeling requires dispensing in the original container;
(ii) The drugs or dosage forms are incompatible with packaging components or each
other;
(iii) The drugs are therapeutically incompatible when administered simultaneously;
(iv) The drug products require special packaging.
(4) At least the name of the patient must be placed on all medication containers too
small to bear a complete label and dispensed in a container bearing a complete label.
(B) All drugs dispensed to inpatients for self-administration shall be labeled in
accordance with paragraphs (A), (B), and (C) of rule 4729-5-16 of the Administrative Code.
(C) Whenever any drugs are added to parenteral solutions, such admixtures shall bear a
distinctive label indicating:
(1) The patient's full name;
(2) The name and amount of the parenteral solution;
(3) The name and amount of the drug(s) added;
(4) The expiration date or beyond-use date;
(5) The name and address of the institutional facility pharmacy;
(6) Cautionary statements, if required.
(D) All drugs dispensed for use by outpatients of an institutional facility shall be labeled
in accordance with paragraphs (A), (B), and (C) of rule 4729-5-16 of the Administrative Code
except as noted in paragraph (A) of rule 4729-17-10 of the Administrative Code.

4729-17-13 D.E.A. numbers for hospital employed prescribers.

(A) A person authorized to write prescriptions pursuant to rule 4729-5-15 of the
Administrative Code who is employed as a staff prescriber of a hospital, is not individually
registered under the provisions of the controlled substances act and, therefore, does not
possess a “Drug Enforcement Administration” (D.E.A.) number, may administer, dispense, and
prescribe controlled substances under the registration of the hospital.
(B) A person pursuing an approved training program within the jurisdiction of the hospital
and authorized to write prescriptions pursuant to paragraph (B) of rule 4729-5-15 of the
Administrative Code may administer, dispense, or prescribe controlled substances under the
registration of the hospital. Persons pursuing such approved training programs may function in
sites outside the physical confines of the hospital only if such sites are part of the training program and the persons are under the employment and jurisdiction of the hospital administering the approved program. While functioning in the outside sites, such persons may continue to use the internal code assigned by the hospital administering the approved program, upon mutual agreement of the hospital and the outside site.

(C) The administering, dispensing, or prescribing must be done in the usual course of his/her professional practice and only within the scope of his/her employment.

(D) Each person so authorized must be assigned a specific internal code number by the hospital which will be used as a suffix to the hospital D.E.A. registration number. Such internal code number shall consist of numbers, letters, or a combination thereof, shall be preceded by a hyphen, and no more than ten characters in length, excluding the hyphen. A list of the internal codes and the corresponding individual prescribers must be kept by the hospital and made available at all times to other registrants, state board of pharmacy designated agents, investigators of the state medical board, and federal, state, county, or municipal law enforcement agencies for verification. An initial list of internal codes and the corresponding individual prescribers must be electronically submitted to the state board of pharmacy, in a format prescribed by the board, within thirty days of the effective date of this rule. Additions, deletions or changes to the list must be submitted to the state board of pharmacy within five business days of any such addition, deletion or change.

4729-37-04 Information required for submission.

[Editor's Note: This version of the statute is effective until 12/29/2017. The version effective subsequently is included next.]

(A) Pharmacies pursuant to paragraphs (A) and (B) of rule 4729-37-03 of the Administrative Code that dispense drugs identified in rules 4729-37-02 and 4729-37-12 of the Administrative Code to outpatients residing in this state must report the following dispensing information to the board of pharmacy:

1. Pharmacy drug enforcement administration registration number. If not applicable, another mutually acceptable identifier;
2. Pharmacy name;
3. Pharmacy address;
4. Pharmacy telephone number;
5. Patient full name;
6. Patient residential address;
7. Patient telephone number;
8. Patient date of birth;
9. Patient gender;
10. Prescriber's full name (first name and last name);
11. Prescriber's drug enforcement administration registration number. If not applicable, another mutually acceptable identifier;
12. Date prescription was issued by the prescriber;
13. Date the prescription was dispensed by the pharmacy;
14. Indication of whether the prescription dispensed is new or a refill;
15. Number of the refill being dispensed;
16. National drug code of the actual drug dispensed;
17. Quantity of drug dispensed;
18. Number of days’ supply of drug dispensed;
19. Serial or prescription number assigned to the prescription order;
20. Source of payment for the prescription that indicates one of the following: private
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pay (cash), medicaid, medicare, commercial insurance, or workers’ compensation;
   (21) Pharmacy national provider identification (NPI) number; and
   (22) Prescriber’s national provider identification (NPI) number, unless the prescriber is a
licensed veterinarian as defined in section 4741.01 of the Revised Code.

(B) Prescribers pursuant to paragraph (E) of rule 4729-37-03 of the Administrative Code
that personally furnish drugs identified in rules 4729-37-02 and 4729-37-12 of the Administrative
Code to outpatients must report the following dispensing information to the board of pharmacy:
(1) Prescriber drug enforcement administration registration number. If not applicable,
another mutually acceptable identifier;
   (2) Prescriber full name (first and last name);
   (3) Prescriber address;
   (4) Prescriber telephone number;
   (5) Patient full name;
   (6) Patient residential address;
   (7) Patient telephone number;
   (8) Patient date of birth;
   (9) Patient gender;
   (10) Date the drug was personally furnished by the prescriber;
   (11) National drug code of the actual drug dispensed;
   (12) Quantity of drug dispensed;
   (13) Number of days’ supply of drug dispensed; and
   (14) Source of payment for the prescription that indicates one of the following: private
pay (cash), medicaid, medicare, commercial insurance, or workers’ compensation.

(C) Wholesalers and pharmacies pursuant to paragraphs (C) and (D) of rule 4729-37-03
of the Administrative Code that sell drugs identified in rules 4729-37-02 and 4729-37-12 of the
Administrative Code at wholesale must at least report the following information to the board of
pharmacy in the format described in rule 4729-37-06 of the Administrative Code:
(1) Wholesaler or pharmacy drug enforcement administration registration number. If not
applicable, then another mutually acceptable identifier;
(2) Purchaser’s drug enforcement administration registration number. If not applicable,
then another mutually acceptable identifier;
   (3) National drug code number of the actual drug sold;
   (4) Quantity of the drug sold;
   (5) Date of sale; and
   (6) Transaction identifier or invoice number.

4729-37-04 Information required for submission.

[Editor's Note: This version of the statute is effective 12/29/2017. The version effective prior to
that date is included in the prior pages.]

(A) Pharmacies pursuant to paragraphs (A) and (B) of rule 4729-37-03 of the
Administrative Code that dispense drugs identified in rules 4729-37-02 and 4729-37-12 of the
Administrative Code to outpatients residing in this state must report the following dispensing
information to the board of pharmacy:
   (1) Pharmacy drug enforcement administration registration number. If not applicable,
another mutually acceptable identifier;
   (2) Pharmacy name;
   (3) Pharmacy address;
   (4) Pharmacy telephone number;
   (5) Patient full name;
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(6) Patient residential address;
(7) Patient telephone number;
(8) Patient date of birth;
(9) Patient gender;
(10) Prescriber's full name (first name and last name);
(11) Prescriber's drug enforcement administration registration number. If not applicable, another mutually acceptable identifier;
(12) Date prescription was issued by the prescriber;
(13) Date the prescription was dispensed or sold by the pharmacy;
(14) Indication of whether the prescription dispensed is new or a refill;
(15) Number of the refill being dispensed;
(16) National drug code of the actual drug dispensed;
(17) Quantity of drug dispensed;
(18) Number of days' supply of drug dispensed as indicated by the prescriber pursuant to rule 4729-5-30 of the Administrative Code, except as follows:
   (a) If a days' supply is not indicated by the prescriber, the pharmacy shall calculate and report the number of days' supply of drug dispensed;
   (b) If the quantity of drug dispensed is different from the quantity indicated on the prescription, the pharmacy shall calculate and report the number of days' supply of drug dispensed.
(19) Serial or prescription number assigned to the prescription order;
(20) Source of payment for the prescription that indicates one of the following: private pay (cash), medicaid, medicare, commercial insurance, or workers' compensation;
(21) Pharmacy national provider identification (NPI) number;
(22) Prescriber's national provider identification (NPI) number, unless the prescriber is a licensed veterinarian as defined in section 4741.01 of the Revised Code; and
(23) Any of the following as indicated by the prescriber pursuant to rule 4729-5-30 of the Administrative Code:
   (a) The ICD-10-CM medical diagnosis code of the primary disease or condition that the controlled substance drug is being used to treat. The code shall, at a minimum, include the first four characters of the ICD-10-CM medical diagnosis code, sometimes referred to as the category and the etiology (ex. M16.5);
   (b) For dentists licensed pursuant to Chapter 4715 of the Revised Code, the Code on Dental Procedures and Nomenclature (CDT Code), as published by the American dental association, of the dental treatment requiring the controlled substance prescription;
   (c) If no such code is indicated on the prescription, the pharmacy shall indicate “NC” in the diagnosis data field.

B) Prescribers pursuant to paragraph (E) of rule 4729-37-03 of the Administrative Code that personally furnish drugs identified in rules 4729-37-02 and 4729-37-12 of the Administrative Code to outpatients must report the following information to the board of pharmacy:
(1) Prescriber drug enforcement administration registration number. If not applicable, another mutually acceptable identifier;
(2) Prescriber full name (first and last name);
(3) Prescriber address;
(4) Prescriber telephone number;
(5) Patient full name;
(6) Patient residential address;
(7) Patient telephone number;
(8) Patient date of birth;
(9) Patient gender;
(10) Date the drug was personally furnished by the prescriber;
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(11) National drug code of the actual drug personally furnished;
(12) Quantity of drug personally furnished;
(13) Number of days' supply of drug personally furnished; and
(14) Source of payment for the prescription that indicates one of the following: private pay (cash), medicaid, medicare, commercial insurance, or workers' compensation.

(15) Either of the following:
(a) The ICD-10-CM medical diagnosis code of the primary disease or condition that the controlled substance drug is being used to treat. The code shall, at a minimum, include the first four characters of the ICD-10-CM medical diagnosis code, sometimes referred to as the category and the etiology (ex. M16.5);
(b) For dentists licensed pursuant to Chapter 4715 of the Revised Code, the Code on Dental Procedures and Nomenclature (CDT Code), as published by the American dental association, of the dental treatment requiring the controlled substance prescription.

(C) Wholesalers and pharmacies pursuant to paragraphs (C) and (D) of rule 4729-37-03 of the Administrative Code that sell drugs identified in rules 4729-37-02 and 4729-37-12 of the Administrative Code at wholesale must at least report the following information to the board of pharmacy in the format described in rule 4729-37-06 of the Administrative Code:
(1) Wholesaler or pharmacy drug enforcement administration registration number. If not applicable, then another mutually acceptable identifier;
(2) Purchaser's drug enforcement administration registration number. If not applicable, then another mutually acceptable identifier;
(3) National drug code number of the actual drug sold;
(4) Quantity of the drug sold;
(5) Date of sale; and
(6) Transaction identifier or invoice number.

4729-37-05 Electronic format required for the transmission of dispensing information.

[Editor's Note: This version of the statute is effective until 12/29/2017. The version effective subsequently is included next.]

(A) All pharmacy dispensing information or prescriber personally furnishing information required to be submitted to the board of pharmacy pursuant to rule 4729-37-04 of the Administrative Code must be transmitted in the format specified by the “American Society for Automation in Pharmacy” (ASAP) for prescription monitoring programs.

(B) In the event that a pharmacy or a prescriber cannot electronically transmit the required information pursuant to rule 4729-37-04 of the Administrative Code they must immediately contact the board of pharmacy to determine a mutually acceptable method of reporting. The pharmacy or prescriber must document in writing to the board of pharmacy the reasons for their inability to submit the required information.

4729-37-05 Electronic format required for the transmission of dispensing information.

[Editor's Note: This version of the statute is effective 12/29/2017. The version effective previously is included in the prior pages.]

(A) All pharmacy dispensing information or prescriber personally furnishing information required to be submitted to the board of pharmacy pursuant to rule 4729-37-04 of the Administrative Code must be transmitted in the following format specified by the “American Society for Automation in Pharmacy” (ASAP) for prescription monitoring programs:
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(B) In the event that a pharmacy or a prescriber cannot electronically transmit the required information pursuant to rule 4729-37-04 of the Administrative Code, the pharmacy or prescriber shall immediately contact the board of pharmacy to determine a mutually acceptable method of reporting. The pharmacy or prescriber must document in writing to the board of pharmacy the reasons for the inability to submit the required information.

4731-29-01 Standards and procedures for the operation of a pain management clinic.

(A) For the purposes of this rule:

(1) "Board" means state medical board of Ohio.

(2) “Chronic pain” means pain that has persisted after reasonable medical efforts have been made to relieve the pain or cure its cause and that has continued, either continuously, or episodically, for longer than three continuous months. “Chronic pain” does not include pain associated with a terminal condition or with a progressive disease that, in the normal course of progression, may reasonably be expected to result in a terminal condition.

(3) "Hospital" means a hospital registered with the department of health under section 3701.07 of the Revised Code.

(4) “Informed consent” means a process of communication between a patient and physician that results in the patient's signed authorization or agreement to undergo a specific medical intervention after all of the following subjects are discussed:

(a) The patient's diagnosis;
(b) The nature and purpose of the proposed treatment or procedure;
(c) The risks and benefits of a proposed treatment or procedure;
(d) Alternatives regardless of their costs or the extent to which the treatment options are covered by health insurance;
(e) The risks and benefits of the alternative treatment or procedure; and
(f) The risks and benefits of not receiving or undergoing a treatment or procedure.

(5) “Owner” means each person included on the list maintained under division (B)(5) of section 4729.552 of the Revised Code.

(6) “Pain management clinic” means a facility in which the majority of patients of the prescribers at the facility are provided treatment for chronic pain that includes the use of controlled substances. In determining whether the facility meets the requirements of this paragraph:

(a) Calculation of the majority of patients will be based upon the number of patients treated in a calendar month;
(b) Patients receiving controlled substances for treatment of an injury or illness that lasts or is expected to last thirty days or less shall not be considered in the calculation of the majority.

(7) “Pain management clinic” does not include the following:

(a) A hospital;
(b) A facility operated by a hospital for the treatment of pain or chronic pain;
(c) A physician practice owned or controlled, in whole or in part, by a hospital or by an entity that owns or controls, in whole or in part, one or more hospitals;
(d) A school, college, university, or other educational institution or program to the extent that it provides instruction to individuals preparing to practice as physicians, podiatrists, dentists, nurses, physician assistants, optometrists, or veterinarians or any affiliated facility to the extent that it participates in the provision of that instruction;

(e) A hospice program licensed under Chapter 3712 of the Revised Code;
(f) An ambulatory surgical facility licensed under section 3702.30 of the Revised Code;
(g) An interdisciplinary pain rehabilitation program with three-year accreditation from the commission on accreditation of rehabilitation facilities;
(h) A nursing home licensed under section 3721.02 of the Revised Code or by a political
subdivision certified under section 3721.09 of the Revised Code; or

(i) A facility conducting only clinical research that may use controlled substances in studies approved by a hospital-based institutional review board or an institutional review board accredited by the association for the accreditation of human research protection programs.

(8) “Physician” means an individual authorized under Chapter 4731 of the Revised Code to practice medicine and surgery or osteopathic medicine and surgery.

(9) “Prescriber” has the same meaning as in section 4729.01 of the Revised Code.

(B) In the operation of a pain management clinic, the following requirements shall be met:

(1) The pain management clinic shall be owned and operated by one or more physicians. Each physician owner of a pain management clinic shall complete at least twenty hours of category I continuing medical education in pain medicine every two years, to include one or more courses addressing the potential for addiction. The courses completed in compliance with this rule shall be accepted toward meeting the category I requirement for certificate of registration renewal for the physician.

(2) Each physician owner of a pain management clinic must meet one of the following requirements:

(a) Hold current subspecialty certification in pain medicine by the American board of medical specialties, or hold a current certificate of added qualification in pain medicine by the American osteopathic association bureau of osteopathic specialists; or

(b) Hold current subspecialty certification in hospice and palliative medicine by the American board of medical specialties, or hold a current certificate of added qualification in hospice and palliative medicine by the American osteopathic association bureau of osteopathic specialists; or

(c) Hold current board certification by the American board of pain medicine; or

(d) Hold current board certification by the American board of interventional pain physicians; or

(e) Meet both of the following:

(i) Hold current board certification in anesthesiology, psychiatry, neurology, physical medicine and rehabilitation, occupational medicine, or rheumatology by the American board of medical specialties or hold current primary certification in anesthesiology, psychiatry, neurology, physical medicine and rehabilitation, occupational medicine, or rheumatology by the American osteopathic association bureau of osteopathic specialists.

(ii) Demonstrate conformance with the minimal standards of care.

(3) To demonstrate conformance with the minimal standards of care pursuant to paragraph (B)(2)(e)(ii) of this rule, the board shall conduct an inspection of the facility pursuant to division (E) of section 4731.054 of the Revised Code.

(4) The pain management clinic shall be licensed as a category III terminal distributor of dangerous drugs with a pain management clinic classification under section 4729.552 of the Revised Code.


(6) The pain management clinic shall have proper equipment, materials, and personnel on premises to provide appropriate medical treatment, as required by the minimal standards of care.

(C) Each physician who provides care at a pain management clinic shall complete at least twenty hours of category I continuing medical education in pain medicine every two years, to include one or more courses addressing the potential for addiction. The courses completed in compliance with this rule shall be accepted toward meeting the category I requirement for certificate of registration renewal for the physician.
(D) No physician owner of a pain management clinic, employee of the clinic, or person with whom the clinic contracts for services shall:

1. Have ever been denied a license to prescribe, dispense, administer, supply, or sell a controlled substance by the drug enforcement administration or appropriate issuing body of any state or jurisdiction, based, in whole or in part, on the prescriber’s inappropriate prescribing, dispensing, administering, supplying or selling a controlled substance or other dangerous drug.
2. Have held a license issued by the drug enforcement administration or a state licensing agency in any jurisdiction, under which the person may prescribe, dispense, administer, supply or sell a controlled substance, that has ever been restricted, based, in whole or in part, on the prescriber’s inappropriate prescribing, dispensing, administering, supplying, or selling a controlled substance or other dangerous drug.
3. Have been subject to disciplinary action by any licensing entity that was based, in whole or in part, on the prescriber’s inappropriate prescribing, dispensing, diverting, administering, supplying or selling a controlled substance or other dangerous drug.

(E) In providing supervision, direction, and control of individuals at a pain management clinic the physician owner shall establish and ensure compliance with the following:

1. A requirement that a log of patients be maintained for each day the clinic is in operation.
   a. Each log sheet shall contain the month, day, and year;
   b. Each log entry shall include the legible first and last name of each patient;
   c. Each patient shall be required to sign the log at each visit; and
   d. Patient logs shall be maintained for seven years.
2. A requirement that providers obtain informed consent for each patient prior to the commencement of treatment.
3. An on-going quality assurance program that objectively and systematically monitors and evaluates the quality and appropriateness of patient care, evaluates methods to improve patient care, identifies and corrects deficiencies within the clinic, and provides the opportunities to improve the clinic’s performance and quality of care.
4. A requirement that the background, training, certification, and licensure of all clinical staff be documented. Verification of certification and licensure shall be made on an annual basis.
5. A requirement that adequate billing records are maintained for all patients and made available to the board, immediately upon request.
   a. Billing records shall include the amount paid, method of payment, description of services, sufficient information to identify the patient, and the amounts charged to the patient for each date of service;
   b. Billing records shall be maintained for seven years from the last date of treatment of the patient.
6. A requirement that adequate patient records are maintained for all patients and made available to the board, immediately upon request.
   a. Patient records shall contain sufficient information to identify the patient, support the diagnosis, justify the treatment and document the course and results of treatment accurately, by including, at a minimum:
      i. Patient history and physical examination, including history of drug abuse or dependence;
      ii. Diagnostic, therapeutic, and laboratory results, including drug testing results;
      iii. Reports of evaluations, consultations, and hospitalizations;
      iv. Treatment objectives, including discussion of risks and benefits;
      v. Records of drugs prescribed, dispensed or administered, including the date, type, and dosage;
      vi. Treatments;
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(vii) Receipt and assessment of drug database or prescription monitoring program reports;
(viii) Copies of records or reports or other documentation obtained from other health care practitioners at the request of the physician and relied upon by the physician in determining the appropriate treatment of the patient. Records provided by the patient shall be designated as such.

(b) Patient records shall be maintained for seven years from the last date of treatment of the patient.
(c) In the treatment of chronic pain the patient records shall contain the information required in rule 4731-21-02 of the Administrative Code in lieu of the requirements of paragraphs (E)(6)(a)(i) to (E)(6)(a)(vi) of this rule.

4731-32-01 Definition of terms.

(A) “Annual report” means the annual compilation of information a physician holding a certificate to recommend medical marijuana must submit to the board that describes the physician's observation regarding the efficacy of treatment with medical marijuana.
(B) “Board” means the state medical board of Ohio.
(C) “Caregiver” means an individual registered under section 3796.08 of the Revised Code to assist a registered patient in the use or administration of medical marijuana.
(D) “Certificate to recommend medical marijuana” means the certificate issued by the board authorizing a physician to recommend treatment with medical marijuana.
(E) “Drug database” means the database established and maintained by the board of pharmacy pursuant to section 4729.75 of the Revised Code.
(F) “Marijuana” means marihuana as defined in section 3719.01 of the Revised Code.
(G) “Medical marijuana” means marihuana that is cultivated, processed, dispensed, tested, possessed, or used for a medical purpose. Medical marijuana is a schedule II controlled substance pursuant to division (B) of section 3796.01 of the Revised Code.
(H) “Medical marijuana entity” means a medical marijuana cultivator, processor, or testing laboratory licensed by the department of commerce under section 3796.09 of the Revised Code, or a retail dispensary licensed by the board of pharmacy under section 3796.10 of the Revised Code.
(I) “Patient” means an individual diagnosed with a qualifying medical condition as defined in division (A) of section 3796.01 of the Revised Code and who is seeking to use medical marijuana.
(J) “Physician” means an individual authorized under Chapter 4731 of the Revised Code to practice medicine and surgery or osteopathic medicine and surgery.

4731-32-03 Standard of care.

In order to practice within the minimal standards of care when recommending treatment with medical marijuana, a physician shall comply with all of the following requirements:
(A) The physician shall establish and maintain a bona fide physician-patient relationship with the patient for the provision of medical services that is established in an in-person visit that complies with this rule and for which there is an expectation that the physician will provide care to the patient on an ongoing basis.
(B) The physician shall create and maintain a medical record that documents the provision of medical services. The documentation shall include all of the following:
(1) Patient’s name and date or dates of office visits or treatments;
(2) A description of the patient’s current medical condition;
(3) Documented assessment of the patient’s medical history, including relevant
prescription history and any history of substance use disorder;
(4) Documented review of any available relevant diagnostic test results;
(5) Documented review of prior treatment and the patient's response to the treatment;
(6) Documented review of the patient's current medication to identify possible drug interactions, including benzodiazepines and opioids.
(7) Documented review that standard medical treatment has been attempted or considered. If standard medical treatment is not attempted, the physician must document the reasons that standard medical treatment is not appropriate for this patient;
(8) Based on evidence or behavioral indications of addiction or drug abuse, the physician may obtain a drug screen on the patient. It is within the physician's discretion to decide the nature of the screen and which type of drug to be screened;
(9) The physician's performance of a physical examination relevant to the patient's current medical condition;
(10) The physician's diagnosis of the patient's medical condition; and
(11) If the patient has been previously diagnosed with a qualifying medical condition as defined in section 3796.01 of the Revised Code, by a physician licensed to practice medicine under section 4731.14 or 4731.29 of the Revised Code, the physician may confirm the diagnosis so long as the physician obtains a copy of the medical records or a detailed written summary indicating the diagnosis and the physician is satisfied that he or she can rely on those records to confirm diagnosis of a qualifying condition. The practitioner shall maintain a copy of any record or report of any physician on which the physician relied for purposes of meeting the requirements under this paragraph.
(C) If the physician diagnoses or confirms the diagnosis of a qualifying medical condition, as that term is defined in section 3796.01 of the Revised Code, the physician shall document in the medical record compliance with all of the following actions when recommending treatment with medical marijuana:
(1) Development of a treatment plan, including consideration of whether treatment with medical marijuana is complementary to standard medical treatment.
(2) The review of the report concerning the patient obtained from the drug database established and maintained by the board of pharmacy pursuant to section 4730.75 of the Revised Code. The report shall cover at least the twelve months immediately preceding the date of the report.
(3) Discussion with the patient regarding any indicators of possible abuse or diversion of controlled substances that are reflected on the drug database report obtained from the board of pharmacy.
(4) The explanation of the risks and benefits of treatment with medical marijuana as it pertains to the patient's qualifying medical condition and medical history.
(5) The patient's consent prior to completing a recommendation for treatment with medical marijuana. If the patient is a minor, the physician shall obtain the consent of the patient's parent or legal representative prior to completing a recommendation for treatment with medical marijuana for the patient.
(6) Whether the patient needs a caregiver to assist in the use or administration of medical marijuana. If the patient needs a caregiver, the physician shall document the name of the caregiver designated by the patient or the patient's legal representative.
(D) In recommending treatment with medical marijuana, the physician or the physician's delegate shall determine from the medical marijuana patient registry established and maintained by the board of pharmacy whether the patient has an active registration for medical marijuana.
(1) If the patient is not registered or if the patient's registration will expire within thirty days, the physician or physician's delegate shall submit the patient's application for registration or renewal in compliance with the requirements of section 3796.04 of the Revised Code and the rules of the board of pharmacy adopted under section 3796.06 of the Revised Code.
(2) The recommendation for treatment with medical marijuana shall include a statement from the physician certifying the following:
(a) A bona fide physician-patient relationship exists between the physician and patient;
(b) The patient has been diagnosed with at least one qualifying medical condition;
(c) Description of the qualifying medical condition(s) and indication whether the qualifying condition is a terminal illness for which the patient has a life expectancy of six months or less;
(d) The physician or physician's delegate has requested from the drug database a report of information related to the patient that covers at least the twelve months immediately preceding the date of the report; and
(e) The physician has informed the patient of the risks and benefits of medical marijuana as it pertains to the patient's qualifying medical condition and medical history.
(E) A physician who recommends treatment with medical marijuana shall be available to provide follow-up care and treatment to the patient, including physical examinations relevant to the patient's condition to determine the efficacy of medical marijuana in treating the patient's qualifying medical condition. If the qualifying condition was indicated as a terminal illness in the prior six months, the physician shall confirm whether the patient's condition continues to be a terminal illness.
(F) The physician shall terminate or decline to issue a new recommendation for medical marijuana under any of the following circumstances:
(1) The patient no longer has the diagnosis of or symptoms of the qualifying medical condition.
(2) The physician no longer has a valid certificate to recommend medical marijuana.
(3) Based on the physician's clinical judgement, the patient or caregiver is abusing or diverting medical marijuana.
(4) The patient is deceased.
(G) The records required for the recommendation of medical marijuana may be kept with the patient's other medical records and shall be retained for at least three years following the last office visit by the patient.
(H) The physician shall submit to the board an annual report describing the physician's observations regarding the effectiveness of medical marijuana in treating patients. The report shall not contain patient-identifying information.

Part III. Drug Take-Back Events

General Provisions

4729.69 Drug take-back events.

(A) The state board of pharmacy, in collaboration with the director of mental health and addiction services and attorney general, shall establish and administer a drug take-back program under which drugs are collected from the community for the purpose of destruction or disposal of the drugs.
(B) The program shall be established and administered in such a manner that it does both of the following:
(1) Complies with any state or federal laws regarding the collection, destruction, or disposal of drugs;
(2) Maintains the confidentiality of individuals who submit or otherwise provide drugs under the program.
(C) In consultation with the director of mental health and addiction services and attorney general, the board shall adopt rules governing the program. The rules shall be adopted in accordance with Chapter 119 of the Revised Code. In adopting the rules, the board shall specify all of the following:

1. The entities that may participate;
2. Guidelines and responsibilities for accepting drugs by participating entities;
3. Drugs that may be collected;
4. Record-keeping requirements;
5. Proper methods to destroy unused drugs;
6. Privacy protocols and security standards;
7. Drug transportation procedures;
8. The schedule, duration, and frequency of the collections of drugs, except that the first collection shall occur not later than one year after May 20, 2011;
9. Any other standards and procedures the board considers necessary for purposes of governing the program.

(D) In accordance with state and federal law, the board may adopt rules to allow an entity participating in the program to return any unused drugs to the pharmacy that originally dispensed the drug. The rules shall include procedures to be followed to maintain the confidentiality of the person for whom the drug was dispensed.

(E) Rules adopted under this section may not do any of the following:
1. Require any entity to establish, fund, or operate a drug take-back program;
2. Establish any new licensing requirement or fee to participate in the program;
3. Require any entity to compile data on drugs collected.

(F) The board may compile data on the amount and type of drugs collected under the program. For purposes of this division, the board may cooperate with a public or private entity in obtaining assistance in the compilation of data. An entity providing the assistance shall not be reimbursed under the program for any costs incurred in providing the assistance.

(G) If the board compiles data under division (F) of this section, the board shall submit a report to the governor and, in accordance with section 101.68 of the Revised Code, the general assembly. The report, to the extent possible, shall include the following information:
1. Total weight of drugs collected, both with and without packaging;
2. The weight of controlled substances;
3. The amount of all of the following as a per cent of total drugs collected:
   a. Controlled substances;
   b. Brand name drugs;
   c. Generic drugs;
   d. Prescription drugs;
   e. Non-prescription drugs.
4. The amount of vitamins, herbal supplements, and personal care products collected;
5. If provided by the person who submitted or otherwise donated drugs to the program, the reasons why the drugs were returned or unused.

(H) No entity is required to participate in a drug take-back program established under this section, and no entity shall be subject to civil liability or professional disciplinary action for declining to participate.

(I) The board may accept grants, gifts, or donations for purposes of the program. Money received under this division shall be deposited into the drug take-back program fund established under section 109.90 of the Revised Code.

4729-8-01 Definitions.

As used in Chapter 4729-8 of the Administrative Code:
(A) “Authorized collector” means a registered manufacturer, distributor, reverse distributor, narcotic treatment program, hospital/clinic with an on-site pharmacy, or retail pharmacy that is authorized by the United States drug enforcement administration to receive controlled substances for the purpose of destruction.

(B) “Controlled substances” has the same meaning as defined in division (C) of section 3719.01 of the Revised Code.

(C) “Dangerous drugs” has the same meaning as defined in division (F) of section 4729.01 of the Revised Code.

(D) “Drug collection receptacle” means a secured, lined receptacle into which prescription medications, including controlled substances, dangerous drugs, and over-the-counter medications can be deposited by ultimate users for the purposes of collecting unused or expired drugs. Except for a law enforcement agency, a drug collection receptacle shall meet the requirements specified in 21 CFR 1317.75 (10/09/2014).

(E) “Drug” has the same meaning as defined in division (E) of section 4729.01 of the Revised Code.

(F) “Law enforcement agency” means a government entity that employs peace officers to perform law enforcement duties or a federal law enforcement agency.

(G) “Law enforcement officer” has the same meaning as 21 CFR 1300.05 (10/09/2014).

(H) “Mail-back program” means a program operated by an authorized collector or law enforcement agency that accepts prescription medications, including controlled substances, dangerous drugs, and over-the-counter medications from ultimate users through the mail for purposes of collecting unused or expired drugs. Except for a law enforcement agency, a mail-back program shall meet the requirements specified in 21 CFR 1317.70 (10/09/2014).

(I) “Non-retrievable” means the condition or state to which a drug shall be rendered following a process that permanently alters that drug’s physical or chemical condition or state through irreversible means and thereby renders the drug unavailable and unusable for all practical purposes.

(J) “Take-back event” means a one-day program operated by a law enforcement agency through which ultimate users may safely dispose of unused or expired prescription medications, including controlled substances, dangerous drugs, and over-the-counter medications. A take-back event shall meet the requirements specified in 21 CFR 1317.65 (10/09/2014).

(K) “Ultimate user” means a person who has lawfully obtained, and who possesses, a pharmaceutical drug for their own use or for the use of a member of their household or for an animal owned by an individual or a member of their household. It also includes any person lawfully entitled to dispose of a decedent’s property.

4729-8-02 Authorized collectors.


(B) If an authorized collector operates a drug collection receptacle for the collection of non-controlled substances only, they shall meet all of the requirements specified in paragraph (A) of this rule.

(C) A long-term care facility may dispose of prescription medications, including controlled substances, dangerous drugs, and over-the-counter medications on behalf of an ultimate user who resides, or has resided, at that long-term care facility pursuant to 21 CFR 1317.80.

(E) If an authorized collector operates a mail-back program for the collection of non-controlled substances only, they shall meet all of the requirements specified in paragraph (D) of this rule.

(F) An authorized collector shall indicate on a mail-back package or drug collection receptacle that the collection of any of the following is prohibited:

1. Medical sharps and needles (e.g., insulin syringes), iodine-containing medications, mercury-containing thermometers, radiopharmaceuticals, antineoplastic agents (cancer chemotherapy drugs, cytotoxic drugs), and compressed cylinders or aerosols (e.g., asthma inhalers); and

2. Schedule I controlled substances.

(G) An authorized collector shall not dispose of their inventory or stock of controlled substances, dangerous drugs or over-the-counter medications in a drug collection receptacle or through a mail-back program.

(H) An authorized collector shall maintain the confidentiality of the ultimate user pursuant to all applicable state and federal laws, rules, and regulations.

(I) An authorized collector shall not operate a take-back event as defined in rule 4729-8-01 of the Administrative Code.

4729-8-03 Prescription drug collection events.

(A) Law enforcement agencies may operate a drug collection receptacle if all of the following apply:

1. The receptacle is located inside the premises of the law enforcement agency.

2. The receptacle is placed in a location that is accessible to the public during posted hours.

3. The receptacle is placed within reasonable view of law enforcement personnel or under continuous video surveillance.

4. The receptacle is securely fastened to a permanent structure so that it cannot be removed and must be locked to prevent the unauthorized retrieval of its contents.

5. The receptacle is clearly marked indicating the following information:

   a. No needles, syringes, or lancets shall be placed in the receptacle.

   b. No iodine-containing medications, mercury-containing thermometers, radiopharmaceuticals, antineoplastic agents (cancer chemotherapy drugs, cytotoxic drugs), and compressed cylinders or aerosols (e.g., asthma inhalers) shall be placed in the receptacle.

6. If a law enforcement agency chooses to limit the types of drugs that are acceptable for return, such limitations shall be clearly stated on or near the drug collection receptacle.

7. The law enforcement agency shall check the drug collection receptacle regularly and remove deposits to prevent the receptacle from reaching capacity.

8. The law enforcement agency shall maintain the confidentiality of the ultimate user disposing of the drugs pursuant to all applicable state and federal laws, rules, and regulations.

9. The drugs collected shall be stored in a manner that prevents the diversion of controlled substances and is consistent with that agency's standard procedures for storing illicit controlled substances.

10. The law enforcement agency shall maintain custody and control of the contents deposited in the drug collection receptacle until the drugs are destroyed pursuant to rule 4729-8-04 of the Administrative Code.

11. The law enforcement agency shall maintain any records of removal, storage, or destruction of the drugs collected in a manner that is consistent with that agency's recordkeeping requirements for illicit controlled substances evidence.

(B) Law enforcement agencies may conduct a mail-back program if all of the following apply:
(1) Packages are made available (for sale or for free) for the collection of pharmaceutical drugs by common or contract carrier.
(2) The packages made available meet the following specifications:
   (a) The package must be nondescript and shall not include any markings or other information that might indicate that the package contains pharmaceutical drugs;
   (b) The package must be water- and spill-proof; tamper-evident; tear-resistant; and sealable;
   (c) The package must be preaddressed with and delivered to the participating law enforcement's physical address;
   (d) The cost of shipping the package shall be postage paid;
   (e) The package must include instructions for the user that indicate the process for mailing back the package, the substances that can be sent, notice that packages may only be mailed from within the customs territory of the United States (the fifty states, the District of Columbia, and Puerto Rico), and notice that only packages provided by the collector will be accepted for destruction.
   (f) The instructions for the package shall indicate the following information:
       No medical sharps and needles (e.g., insulin syringes), iodine-containing medications, mercury-containing thermometers, radiopharmaceuticals, antineoplastic agents (cancer chemotherapy drugs, cytotoxic drugs), and compressed cylinders or aerosols (e.g., asthma inhalers) shall be placed in the package;
   (g) If a law enforcement agency chooses to limit the types of drugs that are acceptable for return, such limitations shall be clearly stated on the package instructions.
(3) The law enforcement agency shall maintain custody and control of the sealed packages until the packages are disposed of pursuant to rule 4729-8-04 of the Administrative Code.
(4) The law enforcement agency shall maintain the confidentiality of the ultimate user disposing of the drugs pursuant to all applicable state and federal laws, rules, and regulations.
   (5) The sealed mail-back packages shall be stored in a manner that prevents the diversion of controlled substances and is consistent with that agency's standard procedures for storing illicit controlled substances.
   (6) The law enforcement agency shall maintain any records of removal, storage, or destruction of the drugs collected in a manner that is consistent with that agency's recordkeeping requirements for illicit controlled substances evidence.
(C) Law enforcement agencies may operate a take-back event if all of the following apply:
   (1) A law enforcement agency shall appoint a law enforcement officer employed by the agency to oversee the collection. Law enforcement officers employed and authorized by the law enforcement agency or law enforcement component of a federal agency conducting a take-back event shall maintain control and custody of the collected drugs from the time the drugs are collected from the ultimate user until secure transfer, storage, or destruction of the drugs has occurred.
   (2) Each take-back event shall have at least one receptacle for the collection of drugs. The collection receptacle should be a securely locked, substantially constructed container with an outer container and a removable inner liner.
   (3) Ultimate users disposing of unused or expired drugs shall place them directly into the drug collection receptacle or hand them directly to a law enforcement officer.
   (4) No needles, syringes or lancets shall be collected. A bulk sharps disposal container may be provided at each take-back event for the disposal of sharps.
   (5) No iodine-containing medications, mercury-containing thermometers, radiopharmaceuticals, antineoplastic agents (e.g., cancer chemotherapy drugs, cytotoxic drugs), compressed cylinders or aerosols (e.g., asthma inhalers) shall be collected.
(6) At the conclusion of the collection event, the drugs shall be removed from the event location and either:
(a) Stored in a manner that prevents the diversion of controlled substances and is consistent with that agency’s standard procedures for storing illicit controlled substances; or
(b) Destroyed pursuant to rule 4729-8-04 of the Administrative Code.
(7) The law enforcement agency shall maintain any records of removal, storage, or destruction of the drugs collected in a manner that is consistent with that agency’s recordkeeping requirements for illicit controlled substances evidence.
(D) The law enforcement agency shall ensure that the confidentiality of the ultimate user is maintained pursuant to applicable state and federal laws, rules, and regulations.
(E) Law enforcement agencies that participate in a take-back event pursuant to this rule are not subject to rule 4729-9-06 of the Administrative Code.

4729-8-04 Procedure for disposal of collected drugs.

(A) All drugs collected pursuant to this chapter shall be destroyed in compliance with applicable federal, state, tribal, and local laws and regulations and shall be rendered non-retrievable.
(B) The method of destruction shall ensure that the confidentiality of the ultimate user is maintained pursuant to applicable state and federal laws, rules, and regulations.

Part IV. Tax

General Provisions

5701.14 Tax exempt and limited liability company.

For purposes of Title LVII of the Revised Code:
(A) In order to determine a limited liability company’s nonprofit status, an entity is operating with a nonprofit purpose under section 1705.02 of the Revised Code if that entity is organized other than for the pecuniary gain or profit of, and its net earnings or any part of its net earnings are not distributable to, its members, its directors, its officers, or other private persons, except that the payment of reasonable compensation for services rendered, payments and distributions in furtherance of its nonprofit purpose, and the distribution of assets on dissolution permitted by section 1702.49 of the Revised Code are not pecuniary gain or profit or distribution of net earnings. In no event shall payments and distributions in furtherance of an entity’s nonprofit purpose deprive the entity of its nonprofit status as long as all of the members of that entity are operating with a nonprofit purpose.
(B) A single member limited liability company that operates with a nonprofit purpose, as described in division (A) of this section, shall be treated as part of the same legal entity as its nonprofit member, and all assets and liabilities of that single member limited liability company shall be considered to be that of the nonprofit member. Filings or applications for exemptions or other tax purposes may be made either by the single member limited liability company or its nonprofit member.

5709.12 Taxes; exemption of property used for charitable or public purposes.

(A) As used in this section, “independent living facilities” means any residential housing facilities and related property that are not a nursing home, residential care facility, or residential facility as defined in division (A) of section 5701.13 of the Revised Code.
(B) Lands, houses, and other buildings belonging to a county, township, or municipal corporation and used exclusively for the accommodation or support of the poor, or leased to the state or any political subdivision for public purposes shall be exempt from taxation. Real and tangible personal property belonging to institutions that is used exclusively for charitable purposes shall be exempt from taxation, including real property belonging to an institution that is a nonprofit corporation that receives a grant under the Thomas Alva Edison grant program authorized by division (C) of section 122.33 of the Revised Code at any time during the tax year and being held for leasing or resale to others. If, at any time during a tax year for which such property is exempted from taxation, the corporation ceases to qualify for such a grant, the director of development shall notify the tax commissioner, and the tax commissioner shall cause the property to be restored to the tax list beginning with the following tax year. All property owned and used by a nonprofit organization exclusively for a home for the aged, as defined in section 5701.13 of the Revised Code, also shall be exempt from taxation.

(C)(1) If a home for the aged described in division (B)(1) of section 5701.13 of the Revised Code is operated in conjunction with or at the same site as independent living facilities, the exemption granted in division (B) of this section shall include kitchen, dining room, clinic, entry ways, maintenance and storage areas, and land necessary for access commonly used by both residents of the home for the aged and residents of the independent living facilities. Other facilities commonly used by both residents of the home for the aged and residents of independent living units shall be exempt from taxation only if the other facilities are used primarily by the residents of the home for the aged. Vacant land currently unused by the home, and independent living facilities and the lands connected with them are not exempt from taxation. Except as provided in division (A)(1) of section 5709.121 of the Revised Code, property of a home leased for nonresidential purposes is not exempt from taxation.

(2) Independent living facilities are exempt from taxation if they are operated in conjunction with or at the same site as a home for the aged described in division (B)(2) of section 5701.13 of the Revised Code; operated by a corporation, association, or trust described in division (B)(1)(b) of that section; operated exclusively for the benefit of members of the corporation, association, or trust who are retired, aged, or infirm; and provided to those members without charge in consideration of their service, without compensation, to a charitable, religious, fraternal, or educational institution. For the purposes of division (C)(2) of this section, “compensation” does not include furnishing room and board, clothing, health care, or other necessities, or stipends or other de minimis payments to defray the cost thereof.

(D)(1) A private corporation established under federal law, as defined in 36 U.S.C. 1101, Pub. L. No. 102-199, 105 Stat. 1629, as amended, the objects of which include encouraging the advancement of science generally, or of a particular branch of science, the promotion of scientific research, the improvement of the qualifications and usefulness of scientists, or the increase and diffusion of scientific knowledge is conclusively presumed to be a charitable or educational institution. A private corporation established as a nonprofit corporation under the laws of a state that is exempt from federal income taxation under section 501(c)(3) of the Internal Revenue Code of 1986, 100 Stat. 2085, 26 U.S.C.A. 1, as amended, and that has as its principal purpose one or more of the foregoing objects also is conclusively presumed to be a charitable or educational institution.

The fact that an organization described in this division operates in a manner that results in an excess of revenues over expenses shall not be used to deny the exemption granted by this section, provided such excess is used, or is held for use, for exempt purposes or to establish a reserve against future contingencies; and, provided further, that such excess may not be distributed to individual persons or to entities that would not be entitled to the tax exemptions provided by this chapter. Nor shall the fact that any scientific information diffused by the organization is of particular interest or benefit to any of its individual members be used to deny the exemption granted by this section, provided that such scientific information is available
to the public for purchase or otherwise.

(2) Division (D)(2) of this section does not apply to real property exempted from taxation under this section and division (A)(3) of section 5709.121 of the Revised Code and belonging to a nonprofit corporation described in division (D)(1) of this section that has received a grant under the Thomas Alva Edison grant program authorized by division (C) of section 122.33 of the Revised Code during any of the tax years the property was exempted from taxation.

When a private corporation described in division (D)(1) of this section sells all or any portion of a tract, lot, or parcel of real estate that has been exempt from taxation under this section and section 5709.121 of the Revised Code, the portion sold shall be restored to the tax list for the year following the year of the sale and, except in connection with a sale and transfer of such a tract, lot, or parcel to a county land reutilization corporation organized under Chapter 1724 of the Revised Code, a charge shall be levied against the sold property in an amount equal to the tax savings on such property during the four tax years preceding the year the property is placed on the tax list. The tax savings equals the amount of the additional taxes that would have been levied if such property had not been exempt from taxation.

The charge constitutes a lien of the state upon such property as of the first day of January of the tax year in which the charge is levied and continues until discharged as provided by law. The charge may also be remitted for all or any portion of such property that the tax commissioner determines is entitled to exemption from real property taxation for the year such property is restored to the tax list under any provision of the Revised Code, other than sections 725.02, 1728.10, 3735.67, 5709.40, 5709.41, 5709.45, 5709.62, 5709.63, 5709.71, 5709.73, 5709.78, and 5709.84, upon an application for exemption covering the year such property is restored to the tax list filed under section 5715.27 of the Revised Code.

(E)(1) Real property held by an organization organized and operated exclusively for charitable purposes as described under section 501(c)(3) of the Internal Revenue Code and exempt from federal taxation under section 501(a) of the Internal Revenue Code, 26 U.S.C.A. 501(a) and (c)(3), as amended, for the purpose of constructing or rehabilitating residences for eventual transfer to qualified low-income families through sale, lease, or land installment contract, shall be exempt from taxation.

The exemption shall commence on the day title to the property is transferred to the organization and shall continue to the end of the tax year in which the organization transfers title to a qualified low-income family. In no case shall the exemption extend beyond the second succeeding tax year following the year in which the title was transferred to the organization. If the title is transferred to the organization and from the organization to a qualified low-income family in the same tax year, the exemption shall continue to the end of that tax year. The proportionate amount of taxes that are a lien but not yet determined, assessed, and levied for the tax year in which title was transferred to the organization shall be remitted by the county auditor for each day of the year that title is held by the organization.

Upon transferring the title to another person, the organization shall file with the county auditor an affidavit affirming that the title was transferred to a qualified low-income family or that the title was not transferred to a qualified low-income family, as the case may be; if the title was transferred to a qualified low-income family, the affidavit shall identify the transferee by name. If the organization transfers title to the property to anyone other than a qualified low-income family, the exemption, if it has not previously expired, shall terminate, and the property shall be restored to the tax list for the year following the year of the transfer and a charge shall be levied against the property in an amount equal to the amount of additional taxes that would have been levied if such property had not been exempt from taxation. The charge constitutes a lien of the state upon such property as of the first day of January of the tax year in which the charge is levied and continues until discharged as provided by law.

The application for exemption shall be filed as otherwise required under section 5715.27 of the Revised Code, except that the organization holding the property shall file with its
application documentation substantiating its status as an organization organized and operated exclusively for charitable purposes under section 501(c)(3) of the Internal Revenue Code and its qualification for exemption from federal taxation under section 501(a) of the Internal Revenue Code, and affirming its intention to construct or rehabilitate the property for the eventual transfer to qualified low-income families.

As used in this division, “qualified low-income family” means a family whose income does not exceed two hundred per cent of the official federal poverty guidelines as revised annually in accordance with section 673(2) of the “Omnibus Budget Reconciliation Act of 1981,” 95 Stat. 511, 42 U.S.C.A. 9902, as amended, for a family size equal to the size of the family whose income is being determined.

(2) Real property constituting a retail store, including the land on which the retail store is located, that is owned and operated by an organization described in division (E)(1) of this section shall be exempt from taxation if the retail store sells primarily donated items suitable for residential housing purposes and if the proceeds of such sales are used solely for the purposes of the organization.

(F)(1) Real property that is acquired and held by a county land reutilization corporation organized under Chapter 1724 of the Revised Code and that is not exempt from taxation under Chapter 5722 of the Revised Code shall be deemed real property used for a public purpose and shall be exempt from taxation until sold or transferred by the corporation. Notwithstanding section 5715.27 of the Revised Code, a county land reutilization corporation is not required to apply to any county or state agency in order to qualify for the exemption.

(2) Real property that is acquired and held by an electing subdivision other than a county land reutilization corporation on or after April 9, 2009, for the public purpose of implementing an effective land reutilization program or for a related public purpose, and that is not exempt from taxation under Chapter 5722 of the Revised Code, shall be exempt from taxation until sold or transferred by the electing subdivision. Notwithstanding section 5715.27 of the Revised Code, an electing subdivision is not required to apply to any county or state agency in order to qualify for an exemption with respect to property acquired or held for such purposes on or after such date, regardless of how the electing subdivision acquires the property.

As used in this section, “electing subdivision” and “land reutilization program” have the same meanings as in section 5722.01 of the Revised Code, and “county land reutilization corporation” means a county land reutilization corporation organized under Chapter 1724 of the Revised Code and any subsidiary wholly owned by such a county land reutilization corporation that is identified as “a wholly owned subsidiary of a county land reutilization corporation” in the deed of conveyance transferring title to the subsidiary.

In lieu of the application for exemption otherwise required to be filed as required under section 5715.27 of the Revised Code, a county land reutilization corporation holding the property shall, upon the request of any county or state agency, submit its articles of incorporation substantiating its status as a county land reutilization corporation.

(G) Real property that is owned by an organization described under section 501(c)(3) of the Internal Revenue Code and exempt from federal income taxation under section 501(a) of the Internal Revenue Code and that is used by that organization exclusively for receiving, processing, or distributing human blood, tissues, eyes, or organs or for research and development thereof shall be exempt from taxation.

(H) Real property that is owned by an organization described under section 501(c)(3) of the Internal Revenue Code and exempt from federal income taxation under section 501(a) of the Internal Revenue Code and that received a loan from the federal small business administration as a participating intermediary in the federal microloan program under 15 U.S.C. 636(m) shall be exempt from taxation if the property is used by that organization primarily for small business lending, economic development, job training, entrepreneur education, or associated administrative purposes as such a participating intermediary.
Chapter 1. General Hospital Provisions
Part IV. Tax

5709.121 Property used exclusively for charitable or public purposes.

(A) Real property and tangible personal property belonging to a charitable or educational institution or to the state or a political subdivision, shall be considered as used exclusively for charitable or public purposes by such institution, the state, or political subdivision, if it meets one of the following requirements:

(1) It is used by such institution, the state, or political subdivision, or by one or more other such institutions, the state, or political subdivisions under a lease, sublease, or other contractual arrangement:

(a) As a community or area center in which presentations in music, dramatics, the arts, and related fields are made in order to foster public interest and education therein;
(b) As a children’s, science, history, or natural history museum that is open to the general public;
(c) For other charitable, educational, or public purposes.

(2) It is made available under the direction or control of such institution, the state, or political subdivision for use in furtherance of or incidental to its charitable, educational, or public purposes and not with the view to profit.

(3) It is used by an organization described in division (D) of section 5709.12 of the Revised Code. If the organization is a corporation that receives a grant under the Thomas Alva Edison grant program authorized by division (C) of section 122.33 of the Revised Code at any time during the tax year, “used,” for the purposes of this division, includes holding property for lease or resale to others.

(B)(1) Property described in division (A)(1)(a) or (b) of this section shall continue to be considered as used exclusively for charitable or public purposes even if the property is conveyed through one conveyance or a series of conveyances to an entity that is not a charitable or educational institution and is not the state or a political subdivision, provided that all of the following conditions apply with respect to that property:

(a) The property was listed as exempt on the county auditor's tax list and duplicate for the county in which it is located for the tax year immediately preceding the year in which the property is conveyed through one conveyance or a series of conveyances;
(b) The property is conveyed through one conveyance or a series of conveyances to an entity that does any of the following:

(i) Leases at least forty-five per cent of the property, through one lease or a series of leases, to the entity that owned or occupied the property for the tax year immediately preceding the year in which the property is conveyed or to an affiliate of that entity;
(ii) Contracts, directly or indirectly to have renovations performed as described in division (B)(1)(d) of this section and is at least partially owned by a nonprofit organization described in section 501(c)(3) of the Internal Revenue Code1 that is exempt from taxation under section 501(a) of that code.2
(c) The property includes improvements that are at least fifty years old;
(d) The property is being renovated in connection with a claim for historic preservation tax credits available under federal law;
(e) All or a portion of the property continues to be used for the purposes described in division (A)(1)(a) or (b) of this section after its conveyance; and
(f) The property is certified by the United States secretary of the interior as a “certified historic structure” or certified as part of a certified historic structure.

(2) Notwithstanding section 5715.27 of the Revised Code, an application for exemption from taxation of property described in division (B)(1) of this section may be filed by either the owner of the property or an occupant.

(C) For purposes of this section, an institution that meets all of the following requirements is conclusively presumed to be a charitable institution:
(1) The institution is a nonprofit corporation or association, no part of the net earnings of which inures to the benefit of any private shareholder or individual;
(2) The institution is exempt from federal income taxation under section 501(a) of the Internal Revenue Code;
(3) The majority of the institution’s board of directors are appointed by the mayor or legislative authority of a municipal corporation or a board of county commissioners, or a combination thereof;
(4) The primary purpose of the institution is to assist in the development and revitalization of downtown urban areas.
(D) For purposes of division (A)(1)(b) of this section, the status of a museum as open to the general public shall be conclusive if the museum is accredited by the American alliance of museums or a successor organization.

5739.02 Tax on retail sales.

For the purpose of providing revenue with which to meet the needs of the state, for the use of the general revenue fund of the state, for the purpose of securing a thorough and efficient system of common schools throughout the state, for the purpose of affording revenues, in addition to those from general property taxes, permitted under constitutional limitations, and from other sources, for the support of local governmental functions, and for the purpose of reimbursing the state for the expense of administering this chapter, an excise tax is hereby levied on each retail sale made in this state.

(A)(1) The tax shall be collected as provided in section 5739.025 of the Revised Code. The rate of the tax shall be five and three-fourths per cent. The tax applies and is collectible when the sale is made, regardless of the time when the price is paid or delivered.
(2) In the case of the lease or rental, with a fixed term of more than thirty days or an indefinite term with a minimum period of more than thirty days, of any motor vehicles designed by the manufacturer to carry a load of not more than one ton, watercraft, outboard motor, or aircraft, or of any tangible personal property, other than motor vehicles designed by the manufacturer to carry a load of more than one ton, to be used by the lessee or renter primarily for business purposes, the tax shall be collected by the vendor at the time the lease or rental is consummated and shall be calculated by the vendor on the basis of the total amount to be paid by the lessee or renter under the lease agreement. If the total amount of the consideration for the lease or rental includes amounts that are not calculated at the time the lease or rental is executed, the tax shall be calculated and collected by the vendor at the time such amounts are billed to the lessee or renter. In the case of an open-end lease or rental, the tax shall be calculated by the vendor on the basis of the total amount to be paid during the initial fixed term of the lease or rental, and for each subsequent renewal period as it comes due. As used in this division, “motor vehicle” has the same meaning as in section 4501.01 of the Revised Code, and “watercraft” includes an outdrive unit attached to the watercraft.

A lease with a renewal clause and a termination penalty or similar provision that applies if the renewal clause is not exercised is presumed to be a sham transaction. In such a case, the tax shall be calculated and paid on the basis of the entire length of the lease period, including any renewal periods, until the termination penalty or similar provision no longer applies. The taxpayer shall bear the burden, by a preponderance of the evidence, that the transaction or series of transactions is not a sham transaction.

(3) Except as provided in division (A)(2) of this section, in the case of a sale, the price of which consists in whole or in part of the lease or rental of tangible personal property, the tax shall be measured by the installments of that lease or rental.

(4) In the case of a sale of a physical fitness facility service or recreation and sports club service, the price of which consists in whole or in part of a membership for the receipt of the
benefit of the service, the tax applicable to the sale shall be measured by the installments thereof.

(B) The tax does not apply to the following:

1. Sales to the state or any of its political subdivisions, or to any other state or its political subdivisions if the laws of that state exempt from taxation sales made to this state and its political subdivisions;

2. Sales of food for human consumption off the premises where sold;

3. Sales of food sold to students only in a cafeteria, dormitory, fraternity, or sorority maintained in a private, public, or parochial school, college, or university;

4. Sales of newspapers and sales or transfers of magazines distributed as controlled circulation publications;

5. The furnishing, preparing, or serving of meals without charge by an employer to an employee provided the employer records the meals as part compensation for services performed or work done;

6. Sales of motor fuel upon receipt, use, distribution, or sale of which in this state a tax is imposed by the law of this state, but this exemption shall not apply to the sale of motor fuel on which a refund of the tax is allowable under division (A) of section 5735.14 of the Revised Code; and the tax commissioner may deduct the amount of tax levied by this section applicable to the price of motor fuel when granting a refund of motor fuel tax pursuant to division (A) of section 5735.14 of the Revised Code and shall cause the amount deducted to be paid into the general revenue fund of this state;

7. Sales of natural gas by a natural gas company or municipal gas utility, of water by a water-works company, or of steam by a heating company, if in each case the thing sold is delivered to consumers through pipes or conduits, and all sales of communications services by a telegraph company, all terms as defined in section 5727.01 of the Revised Code, and sales of electricity delivered through wires;

8. Casual sales by a person, or auctioneer employed directly by the person to conduct such sales, except as to such sales of motor vehicles, watercraft or outboard motors required to be titled under section 1548.06 of the Revised Code, watercraft documented with the United States coast guard, snowmobiles, and all-purpose vehicles as defined in section 4519.01 of the Revised Code;

9. (a) Sales of services or tangible personal property, other than motor vehicles, mobile homes, and manufactured homes, by churches, organizations exempt from taxation under section 501(c)(3) of the Internal Revenue Code of 1986, or nonprofit organizations operated exclusively for charitable purposes as defined in division (B)(12) of this section, provided that the number of days on which such tangible personal property or services, other than items never subject to the tax, are sold does not exceed six in any calendar year, except as otherwise provided in division (B)(9)(b) of this section. If the number of days on which such sales are made exceeds six in any calendar year, the church or organization shall be considered to be engaged in business and all subsequent sales by it shall be subject to the tax. In counting the number of days, all sales by groups within a church or within an organization shall be considered to be sales of that church or organization.

(b) The limitation on the number of days on which tax-exempt sales may be made by a church or organization under division (B)(9)(a) of this section does not apply to sales made by student clubs and other groups of students of a primary or secondary school, or a parent-teacher association, booster group, or similar organization that raises money to support or fund curricular or extracurricular activities of a primary or secondary school.

(c) Divisions (B)(9)(a) and (b) of this section do not apply to sales by a noncommercial educational radio or television broadcasting station.

10. Sales not within the taxing power of this state under the Constitution or laws of the United States or the Constitution of this state;
(11) Except for transactions that are sales under division (B)(3)(r) of section 5739.01 of the Revised Code, the transportation of persons or property, unless the transportation is by a private investigation and security service;

(12) Sales of tangible personal property or services to churches, to organizations exempt from taxation under section 501(c)(3) of the Internal Revenue Code of 1986, and to any other nonprofit organizations operated exclusively for charitable purposes in this state, no part of the net income of which inures to the benefit of any private shareholder or individual, and no substantial part of the activities of which consists of carrying on propaganda or otherwise attempting to influence legislation; sales to offices administering one or more homes for the aged or one or more hospital facilities exempt under section 140.08 of the Revised Code; and sales to organizations described in division (D) of section 5709.12 of the Revised Code.

“Charitable purposes” means the relief of poverty; the improvement of health through the alleviation of illness, disease, or injury; the operation of an organization exclusively for the provision of professional, laundry, printing, and purchasing services to hospitals or charitable institutions; the operation of a home for the aged, as defined in section 5701.13 of the Revised Code; the operation of a radio or television broadcasting station that is licensed by the federal communications commission as a noncommercial educational radio or television station; the operation of a nonprofit animal adoption service or a county humane society; the promotion of education by an institution of learning that maintains a faculty of qualified instructors, teaches regular continuous courses of study, and confers a recognized diploma upon completion of a specific curriculum; the operation of a parent-teacher association, booster group, or similar organization primarily engaged in the promotion and support of the curricular or extracurricular activities of a primary or secondary school; the operation of a community or area center in which presentations in music, dramatics, the arts, and related fields are made in order to foster public interest and education therein; the production of performances in music, dramatics, and the arts; or the promotion of education by an organization engaged in carrying on research in, or the dissemination of, scientific and technological knowledge and information primarily for the public.

Nothing in this division shall be deemed to exempt sales to any organization for use in the operation or carrying on of a trade or business, or sales to a home for the aged for use in the operation of independent living facilities as defined in division (A) of section 5709.12 of the Revised Code.

(13) Building and construction materials and services sold to construction contractors for incorporation into a structure or improvement to real property under a construction contract with this state or a political subdivision of this state, or with the United States government or any of its agencies; building and construction materials and services sold to construction contractors for incorporation into a structure or improvement to real property that are accepted for ownership by this state or any of its political subdivisions, or by the United States government or any of its agencies at the time of completion of the structures or improvements; building and construction materials sold to construction contractors for incorporation into a horticulture structure or livestock structure for a person engaged in the business of horticulture or producing livestock; building materials and services sold to a construction contractor for incorporation into a house of public worship or religious education, or a building used exclusively for charitable purposes under a construction contract with an organization whose purpose is as described in division (B)(12) of this section; building materials and services sold to a construction contractor for incorporation into a building under a construction contract with an organization exempt from taxation under section 501(c)(3) of the Internal Revenue Code of 1986 when the building is to be used exclusively for the organization’s exempt purposes; building and construction materials sold for incorporation into the original construction of a sports facility under section 307.696 of the Revised Code; building and construction materials and services sold to a construction contractor for incorporation into real property outside this state if such materials and services, when sold to a construction contractor in the state in which the real property is located for
incorporation into real property in that state, would be exempt from a tax on sales levied by that state; building and construction materials for incorporation into a transportation facility pursuant to a public-private agreement entered into under sections 5501.70 to 5501.83 of the Revised Code; and, until one calendar year after the construction of a convention center that qualifies for property tax exemption under section 5709.084 of the Revised Code is completed, building and construction materials and services sold to a construction contractor for incorporation into the real property comprising that convention center;

(14) Sales of ships or vessels or rail rolling stock used or to be used principally in interstate or foreign commerce, and repairs, alterations, fuel, and lubricants for such ships or vessels or rail rolling stock;

(15) Sales to persons primarily engaged in any of the activities mentioned in division (B)(42)(a), (g), or (h) of this section, to persons engaged in making retail sales, or to persons who purchase for sale from a manufacturer tangible personal property that was produced by the manufacturer in accordance with specific designs provided by the purchaser, of packages, including material, labels, and parts for packages, and of machinery, equipment, and material for use primarily in packaging tangible personal property produced for sale, including any machinery, equipment, and supplies used to make labels or packages, to prepare packages or products for labeling, or to label packages or products, by or on the order of the person doing the packaging, or sold at retail. “Packages” includes bags, baskets, cartons, crates, boxes, cans, bottles, bindings, wrappings, and other similar devices and containers, but does not include motor vehicles or bulk tanks, trailers, or similar devices attached to motor vehicles. “Packaging” means placing in a package. Division (B)(15) of this section does not apply to persons engaged in highway transportation for hire.

(16) Sales of food to persons using supplemental nutrition assistance program benefits to purchase the food. As used in this division, “food” has the same meaning as in 7 U.S.C. 2012 and federal regulations adopted pursuant to the Food and Nutrition Act of 2008.1

(17) Sales to persons engaged in farming, agriculture, horticulture, or floriculture, of tangible personal property for use or consumption primarily in the production by farming, agriculture, horticulture, or floriculture; or material and parts for incorporation into any such tangible personal property for use or consumption in production; and of tangible personal property for such use or consumption in the conditioning or holding of products produced by and for such use, consumption, or sale by persons engaged in farming, agriculture, horticulture, or floriculture, except where such property is incorporated into real property;

(18) Sales of drugs for a human being that may be dispensed only pursuant to a prescription; insulin as recognized in the official United States pharmacopoeia; urine and blood testing materials when used by diabetics or persons with hypoglycemia to test for glucose or acetone; hypodermic syringes and needles when used by diabetics for insulin injections; epoetin alfa when purchased for use in the treatment of persons with medical disease; hospital beds when purchased by hospitals, nursing homes, or other medical facilities; and medical oxygen and medical oxygen-dispensing equipment when purchased by hospitals, nursing homes, or other medical facilities;

(19) Sales of prosthetic devices, durable medical equipment for home use, or mobility enhancing equipment, when made pursuant to a prescription and when such devices or equipment are for use by a human being.

(20) Sales of emergency and fire protection vehicles and equipment to nonprofit organizations for use solely in providing fire protection and emergency services, including trauma care and emergency medical services, for political subdivisions of the state;

(21) Sales of tangible personal property manufactured in this state, if sold by the manufacturer in this state to a retailer for use in the retail business of the retailer outside of this
state and if possession is taken from the manufacturer by the purchaser within this state for the sole purpose of immediately removing the same from this state in a vehicle owned by the purchaser;

(22) Sales of services provided by the state or any of its political subdivisions, agencies, instrumentalities, institutions, or authorities, or by governmental entities of the state or any of its political subdivisions, agencies, instrumentalities, institutions, or authorities;

(23) Sales of motor vehicles to nonresidents of this state under the circumstances described in division (B) of section 5739.029 of the Revised Code;

(24) Sales to persons engaged in the preparation of eggs for sale of tangible personal property used or consumed directly in such preparation, including such tangible personal property used for cleaning, sanitizing, preserving, grading, sorting, and classifying by size; packages, including material and parts for packages, and machinery, equipment, and material for use in packaging eggs for sale; and handling and transportation equipment and parts therefor, except motor vehicles licensed to operate on public highways, used in intraplant or interplant transfers or shipment of eggs in the process of preparation for sale, when the plant or plants within or between which such transfers or shipments occur are operated by the same person. “Packages” includes containers, cases, baskets, flats, fillers, filler flats, cartons, closure materials, labels, and labeling materials, and “packaging” means placing therein.

(25)(a) Sales of water to a consumer for residential use;

(b) Sales of water by a nonprofit corporation engaged exclusively in the treatment, distribution, and sale of water to consumers, if such water is delivered to consumers through pipes or tubing.

(26) Fees charged for inspection or reinspection of motor vehicles under section 3704.14 of the Revised Code;

(27) Sales to persons licensed to conduct a food service operation pursuant to section 3717.43 of the Revised Code, of tangible personal property primarily used directly for the following:

(a) To prepare food for human consumption for sale;

(b) To preserve food that has been or will be prepared for human consumption for sale by the food service operator, not including tangible personal property used to display food for selection by the consumer;

(c) To clean tangible personal property used to prepare or serve food for human consumption for sale.

(28) Sales of animals by nonprofit animal adoption services or county humane societies;

(29) Sales of services to a corporation described in division (A) of section 5709.72 of the Revised Code, and sales of tangible personal property that qualifies for exemption from taxation under section 5709.72 of the Revised Code;

(30) Sales and installation of agricultural land tile, as defined in division (B)(5)(a) of section 5739.01 of the Revised Code;

(31) Sales and erection or installation of portable grain bins, as defined in division (B)(5)(b) of section 5739.01 of the Revised Code;

(32) The sale, lease, repair, and maintenance of, parts for, or items attached to or incorporated in, motor vehicles that are primarily used for transporting tangible personal property belonging to others by a person engaged in highway transportation for hire, except for packages and packaging used for the transportation of tangible personal property;

(33) Sales to the state headquarters of any veterans’ organization in this state that is either incorporated and issued a charter by the congress of the United States or is recognized by the United States veterans administration, for use by the headquarters;

(34) Sales to a telecommunications service vendor, mobile telecommunications service vendor, or satellite broadcasting service vendor of tangible personal property and services used directly and primarily in transmitting, receiving, switching, or recording any interactive, one- or
two-way electromagnetic communications, including voice, image, data, and information, through the use of any medium, including, but not limited to, poles, wires, cables, switching equipment, computers, and record storage devices and media, and component parts for the tangible personal property. The exemption provided in this division shall be in lieu of all other exemptions under division (B)(42)(a) or (n) of this section to which the vendor may otherwise be entitled, based upon the use of the thing purchased in providing the telecommunications, mobile telecommunications, or satellite broadcasting service.

(35)(a) Sales where the purpose of the consumer is to use or consume the things transferred in making retail sales and consisting of newspaper inserts, catalogues, coupons, flyers, gift certificates, or other advertising material that prices and describes tangible personal property offered for retail sale.

(b) Sales to direct marketing vendors of preliminary materials such as photographs, artwork, and typesetting that will be used in printing advertising material; and of printed matter that offers free merchandise or chances to win sweepstake prizes and that is mailed to potential customers with advertising material described in division (B)(35)(a) of this section;

(c) Sales of equipment such as telephones, computers, facsimile machines, and similar tangible personal property primarily used to accept orders for direct marketing retail sales.

(d) Sales of automatic food vending machines that preserve food with a shelf life of forty-five days or less by refrigeration and dispense it to the consumer.

For purposes of division (B)(35) of this section, “direct marketing” means the method of selling where consumers order tangible personal property by United States mail, delivery service, or telecommunication and the vendor delivers or ships the tangible personal property sold to the consumer from a warehouse, catalogue distribution center, or similar fulfillment facility by means of the United States mail, delivery service, or common carrier.

(36) Sales to a person engaged in the business of horticulture or producing livestock of materials to be incorporated into a horticulture structure or livestock structure;

(37) Sales of personal computers, computer monitors, computer keyboards, modems, and other peripheral computer equipment to an individual who is licensed or certified to teach in an elementary or a secondary school in this state for use by that individual in preparation for teaching elementary or secondary school students;

(38) Sales to a professional racing team of any of the following:

(a) Motor racing vehicles;

(b) Repair services for motor racing vehicles;

(c) Items of property that are attached to or incorporated in motor racing vehicles, including engines, chassis, and all other components of the vehicles, and all spare, replacement, and rebuilt parts or components of the vehicles; except not including tires, consumable fluids, paint, and accessories consisting of instrumentation sensors and related items added to the vehicle to collect and transmit data by means of telemetry and other forms of communication.

(39) Sales of used manufactured homes and used mobile homes, as defined in section 5739.0210 of the Revised Code, made on or after January 1, 2000;

(40) Sales of tangible personal property and services to a provider of electricity used or consumed directly and primarily in generating, transmitting, or distributing electricity for use by others, including property that is or is to be incorporated into and will become a part of the consumer's production, transmission, or distribution system and that retains its classification as tangible personal property after incorporation; fuel or power used in the production, transmission, or distribution of electricity; energy conversion equipment as defined in section 5727.01 of the Revised Code; and tangible personal property and services used in the repair and maintenance of the production, transmission, or distribution system, including only those motor vehicles as are specially designed and equipped for such use. The exemption provided in this division shall be in lieu of all other exemptions in division (B)(42)(a) or (n) of this section to
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which a provider of electricity may otherwise be entitled based on the use of the tangible personal property or service purchased in generating, transmitting, or distributing electricity.

(41) Sales to a person providing services under division (B)(3)(r) of section 5739.01 of the Revised Code of tangible personal property and services used directly and primarily in providing taxable services under that section.

(42) Sales where the purpose of the purchaser is to do any of the following:
(a) To incorporate the thing transferred as a material or a part into tangible personal property to be produced for sale by manufacturing, assembling, processing, or refining; or to use or consume the thing transferred directly in producing tangible personal property for sale by mining, including, without limitation, the extraction from the earth of all substances that are classed geologically as minerals, production of crude oil and natural gas, or directly in the rendition of a public utility service, except that the sales tax levied by this section shall be collected upon all meals, drinks, and food for human consumption sold when transporting persons. Persons engaged in rendering services in the exploration for, and production of, crude oil and natural gas for others are deemed engaged directly in the exploration for, and production of, crude oil and natural gas. This paragraph does not exempt from “retail sale” or “sales at retail” the sale of tangible personal property that is to be incorporated into a structure or improvement to real property.
(b) To hold the thing transferred as security for the performance of an obligation of the vendor;
(c) To resell, hold, use, or consume the thing transferred as evidence of a contract of insurance;
(d) To use or consume the thing directly in commercial fishing;
(e) To incorporate the thing transferred as a material or a part into, or to use or consume the thing transferred directly in the production of, magazines distributed as controlled circulation publications;
(f) To use or consume the thing transferred in the production and preparation in suitable condition for market and sale of printed, imprinted, overprinted, lithographic, multilithic, blueprinted, photostatic, or other productions or reproductions of written or graphic matter;
(g) To use the thing transferred, as described in section 5739.011 of the Revised Code, primarily in a manufacturing operation to produce tangible personal property for sale;
(h) To use the benefit of a warranty, maintenance or service contract, or similar agreement, as described in division (B)(7) of section 5739.01 of the Revised Code, to repair or maintain tangible personal property, if all of the property that is the subject of the warranty, contract, or agreement would not be subject to the tax imposed by this section;
(i) To use the thing transferred as qualified research and development equipment;
(j) To use or consume the thing transferred primarily in storing, transporting, mailing, or otherwise handling purchased sales inventory in a warehouse, distribution center, or similar facility when the inventory is primarily distributed outside this state to retail stores of the person who owns or controls the warehouse, distribution center, or similar facility, to retail stores of an affiliated group of which that person is a member, or by means of direct marketing. This division does not apply to motor vehicles registered for operation on the public highways. As used in this division, “affiliated group” has the same meaning as in division (B)(3)(e) of section 5739.01 of the Revised Code and “direct marketing” has the same meaning as in division (B)(35) of this section.
(k) To use or consume the thing transferred to fulfill a contractual obligation incurred by a warrantor pursuant to a warranty provided as a part of the price of the tangible personal property sold or by a vendor of a warranty, maintenance or service contract, or similar agreement the provision of which is defined as a sale under division (B)(7) of section 5739.01 of the Revised Code;
(l) To use or consume the thing transferred in the production of a newspaper for distribution to the public;

(m) To use tangible personal property to perform a service listed in division (B)(3) of section 5739.01 of the Revised Code, if the property is or is to be permanently transferred to the consumer of the service as an integral part of the performance of the service;

(n) To use or consume the thing transferred primarily in producing tangible personal property for sale by farming, agriculture, horticulture, or floriculture. Persons engaged in rendering farming, agriculture, horticulture, or floriculture services for others are deemed engaged primarily in farming, agriculture, horticulture, or floriculture. This paragraph does not exempt from “retail sale” or “sales at retail” the sale of tangible personal property that is to be incorporated into a structure or improvement to real property.

(o) To use or consume the thing transferred in acquiring, formatting, editing, storing, and disseminating data or information by electronic publishing;

(p) To provide the thing transferred to the owner or lessee of a motor vehicle that is being repaired or serviced, if the thing transferred is a rented motor vehicle and the purchaser is reimbursed for the cost of the rented motor vehicle by a manufacturer, warrantor, or provider of a maintenance, service, or other similar contract or agreement, with respect to the motor vehicle that is being repaired or serviced.

As used in division (B)(42) of this section, “thing” includes all transactions included in divisions (B)(3)(a), (b), and (e) of section 5739.01 of the Revised Code.

(43) Sales conducted through a coin operated device that activates vacuum equipment or equipment that dispenses water, whether or not in combination with soap or other cleaning agents or wax, to the consumer for the consumer’s use on the premises in washing, cleaning, or waxing a motor vehicle, provided no other personal property or personal service is provided as part of the transaction.

(44) Sales of replacement and modification parts for engines, airframes, instruments, and interiors in, and paint for, aircraft used primarily in a fractional aircraft ownership program, and sales of services for the repair, modification, and maintenance of such aircraft, and machinery, equipment, and supplies primarily used to provide those services.

(45) Sales of telecommunications service that is used directly and primarily to perform the functions of a call center. As used in this division, “call center” means any physical location where telephone calls are placed or received in high volume for the purpose of making sales, marketing, customer service, technical support, or other specialized business activity, and that employs at least fifty individuals that engage in call center activities on a full-time basis, or sufficient individuals to fill fifty full-time equivalent positions.

(46) Sales by a telecommunications service vendor of 900 service to a subscriber. This division does not apply to information services, as defined in division (FF) of section 5739.01 of the Revised Code.

(47) Sales of value-added non-voice data service. This division does not apply to any similar service that is not otherwise a telecommunications service.

(48)(a) Sales of machinery, equipment, and software to a qualified direct selling entity for use in a warehouse or distribution center primarily for storing, transporting, or otherwise handling inventory that is held for sale to independent salespersons who operate as direct sellers and that is held primarily for distribution outside this state;

(b) As used in division (B)(48)(a) of this section:

(i) “Direct seller” means a person selling consumer products to individuals for personal or household use and not from a fixed retail location, including selling such product at in-home product demonstrations, parties, and other one-on-one selling.

(ii) “Qualified direct selling entity” means an entity selling to direct sellers at the time the entity enters into a tax credit agreement with the tax credit authority pursuant to section 122.17 of the Revised Code, provided that the agreement was entered into on or after January 1, 2007.
Neither contingencies relevant to the granting of, nor later developments with respect to, the tax credit shall impair the status of the qualified direct selling entity under division (B)(48) of this section after execution of the tax credit agreement by the tax credit authority.

(c) Division (B)(48) of this section is limited to machinery, equipment, and software first stored, used, or consumed in this state within the period commencing June 24, 2008, and ending on the date that is five years after that date.

(49) Sales of materials, parts, equipment, or engines used in the repair or maintenance of aircraft or avionics systems of such aircraft, and sales of repair, remodeling, replacement, or maintenance services in this state performed on aircraft or on an aircraft's avionics, engine, or component materials or parts. As used in division (B)(49) of this section, “aircraft” means aircraft of more than six thousand pounds maximum certified takeoff weight or used exclusively in general aviation.

(50) Sales of full flight simulators that are used for pilot or flight-crew training, sales of repair or replacement parts or components, and sales of repair or maintenance services for such full flight simulators. “Full flight simulator” means a replica of a specific type, or make, model, and series of aircraft cockpit. It includes the assemblage of equipment and computer programs necessary to represent aircraft operations in ground and flight conditions, a visual system providing an out-of-the-cockpit view, and a system that provides cues at least equivalent to those of a three-degree-of-freedom motion system, and has the full range of capabilities of the systems installed in the device as described in appendices A and B of part 60 of chapter 1 of title 14 of the Code of Federal Regulations.

(51) Any transfer or lease of tangible personal property between the state and JobsOhio in accordance with section 4313.02 of the Revised Code.

(52)(a) Sales to a qualifying corporation.

(b) As used in division (B)(52) of this section:

(i) “Qualifying corporation” means a nonprofit corporation organized in this state that leases from an eligible county land, buildings, structures, fixtures, and improvements to the land that are part of or used in a public recreational facility used by a major league professional athletic team or a class A to class AAA minor league affiliate of a major league professional athletic team for a significant portion of the team’s home schedule, provided the following apply:

(I) The facility is leased from the eligible county pursuant to a lease that requires substantially all of the revenue from the operation of the business or activity conducted by the nonprofit corporation at the facility in excess of operating costs, capital expenditures, and reserves to be paid to the eligible county at least once per calendar year.

(II) Upon dissolution and liquidation of the nonprofit corporation, all of its net assets are distributable to the board of commissioners of the eligible county from which the corporation leases the facility.

(ii) “Eligible county” has the same meaning as in section 307.695 of the Revised Code.

(53) Sales to or by a cable service provider, video service provider, or radio or television broadcast station regulated by the federal government of cable service or programming, video service or programming, audio service or programming, or electronically transferred digital audiovisual or audio work. As used in division (B)(53) of this section, “cable service” and “cable service provider” have the same meanings as in section 1332.01 of the Revised Code, and “video service,” “video service provider,” and “video programming” have the same meanings as in section 1332.21 of the Revised Code.

(54) Sales of investment metal bullion and investment coins. “Investment metal bullion” means any bullion described in section 408(m)(3)(B) of the Internal Revenue Code, regardless of whether that bullion is in the physical possession of a trustee. “Investment coin” means any coin composed primarily of gold, silver, platinum, or palladium.

(55) Sales of a digital audio work electronically transferred for delivery through use of a machine, such as a juke box, that does all of the following:
(a) Accepts direct payments to operate;
(b) Automatically plays a selected digital audio work for a single play upon receipt of a payment described in division (B)(55)(a) of this section;
(c) Operates exclusively for the purpose of playing digital audio works in a commercial establishment.

(C) For the purpose of the proper administration of this chapter, and to prevent the evasion of the tax, it is presumed that all sales made in this state are subject to the tax until the contrary is established.

(D) The levy of this tax on retail sales of recreation and sports club service shall not prevent a municipal corporation from levying any tax on recreation and sports club dues or on any income generated by recreation and sports club dues.

(E) The tax collected by the vendor from the consumer under this chapter is not part of the price, but is a tax collection for the benefit of the state, and of counties levying an additional sales tax pursuant to section 5739.021 or 5739.026 of the Revised Code and of transit authorities levying an additional sales tax pursuant to section 5739.023 of the Revised Code. Except for the discount authorized under section 5739.12 of the Revised Code and the effects of any rounding pursuant to section 5703.055 of the Revised Code, no person other than the state or such a county or transit authority shall derive any benefit from the collection or payment of the tax levied by this section or section 5739.021, 5739.023, or 5739.026 of the Revised Code.

5713.08 Tax-exempt property and county auditor.

(A) The county auditor shall make a list of all real and personal property in the auditor's county that is exempted from taxation. Such list shall show the name of the owner, the value of the property exempted, and a statement in brief form of the ground on which such exemption has been granted. It shall be corrected annually by adding thereto the items of property which have been exempted during the year, and by striking therefrom the items which in the opinion of the auditor have lost their right of exemption and which have been reentered on the taxable list, but no property shall be struck from the exempt property list solely because the property has been conveyed to a single member limited liability company with a nonprofit purpose from its nonprofit member or because the property has been conveyed by a single member limited liability company with a nonprofit purpose to its nonprofit member. No additions shall be made to such exempt lists and no additional items of property shall be exempted from taxation without the consent of the tax commissioner as is provided for in section 5715.27 of the Revised Code or without the consent of the housing officer under section 3735.67 of the Revised Code, except for property exempted by the auditor under that section or qualifying agricultural real property, as defined in section 5709.28 of the Revised Code, that is enrolled in an agriculture security area that is exempt under that section. The commissioner may revise at any time the list in every county so that no property is improperly or illegally exempted from taxation. The auditor shall follow the orders of the commissioner given under this section. An abstract of such list shall be filed annually with the commissioner, on a form approved by the commissioner, and a copy thereof shall be kept on file in the office of each auditor for public inspection.

An application for exemption of property shall include a certificate executed by the county treasurer certifying one of the following:

(1) That all taxes, interest, and penalties levied and assessed against the property sought to be exempted have been paid in full for all of the tax years preceding the tax year for which the application for exemption is filed, except for such taxes, interest, and penalties that may be remitted under division (C) of this section;
(2) That the applicant has entered into a valid delinquent tax contract with the county treasurer pursuant to division (A) of section 323.31 of the Revised Code to pay all of the delinquent taxes, interest, and penalties charged against the property, except for such taxes, interest, and penalties that may be remitted under division (C) of this section. If the auditor receives notice under section 323.31 of the Revised Code that such a written delinquent tax contract has become void, the auditor shall strike such property from the list of exempted property and reenter such property on the taxable list. If property is removed from the exempt list because a written delinquent tax contract has become void, current taxes shall first be extended against that property on the general tax list and duplicate of real and public utility property for the tax year in which the auditor receives the notice required by division (A) of section 323.31 of the Revised Code that the delinquent tax contract has become void or, if that notice is not timely made, for the tax year in which falls the latest date by which the treasurer is required by such section to give such notice. A county auditor shall not remove from any tax list and duplicate the amount of any unpaid delinquent taxes, assessments, interest, or penalties owed on property that is placed on the exempt list pursuant to this division.

(3) That a tax certificate has been issued under section 5721.32 or 5721.33 of the Revised Code with respect to the property that is the subject of the application, and the tax certificate is outstanding.

(B) If the treasurer’s certificate is not included with the application or the certificate reflects unpaid taxes, penalties, and interest that may not be remitted, the tax commissioner or county auditor with whom the application was filed shall notify the property owner of that fact, and the applicant shall be given sixty days from the date that notification was mailed in which to provide the tax commissioner or county auditor with a corrected treasurer’s certificate. If a corrected treasurer’s certificate is not received within the time permitted, the tax commissioner or county auditor does not have authority to consider the tax exemption application.

(C) Any taxes, interest, and penalties which have become a lien after the property was first used for the exempt purpose, but in no case prior to the date of acquisition of the title to the property by the applicant, may be remitted by the commissioner or county auditor, except as is provided in division (A) of section 5713.081 of the Revised Code.

(D) Real property acquired by the state in fee simple is exempt from taxation from the date of acquisition of title or date of possession, whichever is the earlier date, provided that all taxes, interest, and penalties as provided in the apportionment provisions of section 319.20 of the Revised Code have been paid to the date of acquisition of title or date of possession by the state, whichever is earlier. The proportionate amount of taxes that are a lien but not yet determined, assessed, and levied for the year in which the property is acquired, shall be remitted by the county auditor for the balance of the year from date of acquisition of title or date of possession, whichever is earlier. This section shall not be construed to authorize the exemption of such property from taxation or the remission of taxes, interest, and penalties thereon until all private use has terminated.

**Tax-Exempt Registration and Reporting**

109:1-1-01 Tax-exempt registration definitions.


(B) This chapter is necessary to administer sections 109.23 to 109.33 of the Revised Code to:

(1) Ensure that fiduciaries managing charitable trusts are maintaining the charitable purposes of said trusts;
2. Ensure that fiduciaries of charitable trusts as defined in section 109.23 of the Revised Code comply with their fiduciary obligations;
3. Facilitate investigations by the office of the attorney general as authorized by section 109.24 of the Revised Code; and
4. Implement the registration and reporting requirements and purposes of sections 109.26 and 109.31 of the Revised Code.

(C) Each rule and every part of each rule is an independent rule and part of a rule, and the holding of any rule or part of a rule to be unconstitutional, void, or ineffective for any cause does not affect the validity or constitutionality of any other rule or part of a rule.

(D) Definitions. As used in this chapter:
1. The term “annual federal return” means a return as defined in subsection 6103(b)(1), Internal Revenue Code, required to be filed with the internal revenue service on an annual basis.
2. The term “charitable organization” means a charitable trust that is also a nonprofit corporation or association formed under the laws of this state or another state.
4. The term “property” means anything of value, whether real or personal, tangible or intangible, and includes but is not limited to securities, notes, receipts, drafts, checks, bonds, money, and rights in action.

109:1-1-02 Tax-exempt registration.

(A) Registration. Unless exempted under section 109.26 of the Revised Code or under paragraph (B) of this rule, all charitable trusts are required to register with the attorney general within six months after the creation of the charitable trust or within six months after occurrence of an event by reason of which such charitable trust is required to register, whichever is first.

(B) Exemptions. The following charitable trusts are exempt from registration with the attorney general:
1. Any governmental unit. For purposes of this paragraph, “governmental unit” means a political subdivision, agency, department, county, parish, municipal corporation, instrumentality or other unit of the government of the United States, a state, or a foreign country.
2. Organizations which are organized and operated exclusively for religious purposes. These include churches, conventions and associations of churches, or integrated auxiliaries of a church.
3. Educational institutions which normally maintain a regular faculty and curriculum and normally have a regular body of pupils or students in attendance at the place where its educational activities are carried on.
4. Charitable trusts in which all charitable interests are contingent, revocable, or subject to an unlimited power of invasion for purposes other than charitable purposes.
5. Charitable trusts which are not located in Ohio. For purposes of this paragraph, a charitable trust is located in Ohio and must register if not otherwise exempt if it is incorporated or otherwise organized in Ohio, conducts program services in Ohio or has assets in Ohio. For the purpose of this paragraph, “assets” includes cash, inventory, equipment, real estate, securities, investments, financial accounts and any other property.

(C) Registration. All charitable trusts required to register shall register through the attorney general’s website at: www.ohioattorneygeneral.gov/charitableregistration.

(D) All charitable trusts required to register shall provide the following documents to the attorney general:
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109:1-1-03 Tax-exempt registration.

(A) A charitable trust, which is required to register with the attorney general under section 109.26 of the Revised Code and is the central organization which has been issued a group exemption letter by the internal revenue service and which files a group return for federal tax purposes, may file a group registration form through the attorney general's on-line registration and filing system, and thereafter a group annual report, for any charitable trust that is included as a subordinate organization within the group exemption letter and also required to register under that section.

(B) Yearly, a charitable trust which files a group registration form shall provide a list of all chapters or charitable trusts that are included as subordinate organizations within the group exemption letter issued by the internal revenue service and that are incorporated or otherwise organized in Ohio, filed a return or other document with the internal revenue service indicating that the chapter or charitable trust is located in Ohio, conduct program services in Ohio or have assets in Ohio, and include the employer identification number of each individual chapter or charitable trust in the group. For the purpose of this paragraph, “assets” includes cash, inventory, equipment, real estate, securities, investments, financial accounts and any other property.

(C) A community trust or community foundation, which is required to register with the attorney general under section 109.26 of the Revised Code, and which files a consolidated return for federal tax purposes, may file a consolidated registration form through the attorney general's on-line registration and filing system and thereafter a consolidated annual report, for any charitable trust that is included as a component fund within the consolidated return and also required under that section.


(A) Any charitable trust which is required to register with the attorney general pursuant to rule 109:1-1-02 of the Administrative Code, must file an annual report for any taxable year in which such trust has gross receipts of more than twenty-five thousand dollars or gross assets of more than twenty-five thousand dollars.

All charitable trusts required to file an annual report with the attorney general, including trusts that are exempt from filing financial information with the internal revenue service, shall file a form prescribed by the attorney general.

(B) The annual report shall be filed with the attorney general on or before the fifteenth day of the fifth month following the close of the trust's taxable year or at the same time as the federal return is required by the internal revenue service, taking into account any applicable extension of the federal filing date.

(C) The following fees shall accompany the annual report:

<table>
<thead>
<tr>
<th>Assets</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than $25,000</td>
<td>-0-</td>
</tr>
</tbody>
</table>
Filing fees must be paid by check or by electronic forms of payment acceptable to the attorney general, payable to the treasurer, state of Ohio.

Part V. Hospital Data Disclosure

3727.42 Hospital price information list.

(A) Every hospital shall compile and make available for inspection by the public a price information list containing the information specified in division (B) of this section and shall periodically update the list to maintain current information. The price information list shall be compiled and made available in a format that complies with the electronic transaction standards and code sets adopted by the United States secretary of health and human services under 42 U.S.C. 1320d-2.

(B) Each price information list required by division (A) of this section shall contain all of the following information:

(1) The usual and customary room and board charges for each level of care within the hospital, including but not limited to private rooms, semiprivate rooms, other multiple patient rooms, and intensive care and other specialty units;

(2) Rates charged for nursing care, if the hospital charges separately for nursing care;

(3) The usual and customary charges, stated separately for inpatients and outpatients if different charges are imposed, for any of the following services provided by the hospital:
   (a) The thirty most common x-ray and radiological procedures;
   (b) The thirty most common laboratory procedures;
   (c) Emergency room services;
   (d) Operating room services;
   (e) Delivery room services;
   (f) Physical, occupational, and pulmonary therapy services;
   (g) Any other services designated as high volume services by a rule which shall be adopted by the director of health.

(4) The hospital's billing policies, including whether the hospital charges interest on an amount not paid in full by any person or government entity and the interest rate charged;

(5) Whether or not the charges listed include fees for the services of hospital-based anesthesiologists, radiologists, pathologists, and emergency room physicians and, if a charge does not include such fees, how such fee information can be obtained.

(C) Every hospital shall do all of the following with the price information list required by this section:

(1) At the time of admission, or as soon as practical thereafter, inform each patient of the availability of the list and on request provide the patient with a free copy of the list;

(2) On request, provide a paper copy of the list to any person or governmental agency, subject to payment of a reasonable fee for copying and processing;

(3) Make the list available free of charge on the hospital's internet web site.

3727.43 Disclosure of overcharge and refund statutory remedy.

Each hospital shall provide a full disclosure of the provisions of section 3924.21 of the Revised Code to every beneficiary who receives services at the hospital.
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3924.21 Overcharge and refund procedure.

(A) As used in this section:
(1) "Beneficiary," "hospital," and "third-party payer" have the same meanings as in section 3901.38 of the Revised Code.
(2) "Overcharged" means charged more than the usual and customary charge, rate, or fee that is charged by the provider or hospital for a particular item or service.
(3) "Provider" has the same meaning as in section 3902.11 of the Revised Code.
(B) If a beneficiary identifies on the billing statement of a provider or hospital any item or service for which the beneficiary was overcharged by more than five hundred dollars and the beneficiary notifies the third-party payer of the error at any time after the thirty-day period immediately following the date on which the third-party payer makes payment to the provider or hospital for the item or service, the provider or hospital shall refund to the beneficiary an amount equal to fifteen per cent of the amount overcharged.
(C) A provider or hospital shall not be required to comply with division (B) of this section if, at the time the third-party payer receives notice of the overcharge from the beneficiary, the provider, hospital, or third-party payer is in the process of correcting the error and such process can be documented.

3901-1-64 Medical liability data collection.

(A) Purpose
The purpose of this rule is to establish procedures and requirements for the reporting of specific medical, dental, optometric and chiropractic claims data to the Ohio department of insurance.
(B) Authority
This rule is promulgated pursuant to the authority vested in the superintendent under sections 3901.041 and 3929.302 of the Revised Code.
(C) Definitions
(1) “Medical, dental, optometric and chiropractic claims” include those claims asserted against a risk located in this state that either:
   (a) Meet the definition of “medical claim,” “dental claim,” “optometric claim,” or “chiropractic claim” in section 2305.113 of the Revised Code, or
   (b) Have not been asserted in any civil action, but that otherwise meet the definition of “medical claim,” “dental claim,” “optometric claim,” or “chiropractic claim” in section 2305.113 of the Revised Code.
   (2) “Risk retention group” has the same meaning as in section 3960.01 of the Revised Code.
   (3) “Surplus lines insurer” means an insurer that is not licensed to do business in this state, but is nonetheless approved by the department to offer insurance because coverage is not available through licensed insurers.
   (4) “Self-insurer” means any person or persons who set aside funds to cover liability for future medical, dental, optometric or chiropractic claims or that otherwise assume their own risk or potential loss for such claims. “Self-insurer” includes captives.
   (D) Each authorized insurer, surplus lines insurer, risk retention group, self-insurer, the medical liability underwriting association if created under section 3929.63 of the Revised Code, or any other entity that offers medical malpractice insurance to, or that otherwise assumes liability to pay medical, dental, optometric or chiropractic claims for, risks located in this state, shall report at least annually to the superintendent of insurance, or to the superintendent's designee, information regarding any medical, dental, optometric, or chiropractic claim asserted against a risk located in this state, if the claim resulted in:
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(1) A final judgment in any amount,
(2) A settlement in any amount, or
(3) A final disposition of the claim resulting in no indemnity payment on behalf of the covered person or persons.

(E) The report required by paragraph (D) of this rule shall include for each claim:
(1) The name, address and specialty coverage of each covered person;
(2) The insured's policy number, if applicable;
(3) The date of the occurrence that created the claim;
(4) The name and address of the injured person;
(5) The date the claim was reported and the claim number;
(6) The injured person's age and sex;
(7) If the medical, dental, optometric, or chiropractic claim was filed with the court, the case number and the name and location of the court;
(8) In the case of a judgment, the date and amount of the judgment and, if the judgment is subject to the itemization requirements in division (B) of section 2323.43 of the Revised Code, a description of the portion of the judgment that represents economic loss, non-economic loss and punitive damages, if any;
(9) In the case of a settlement, the date and amount of the settlement and, if known, the injured person's incurred medical expense, wage loss, and other expenses;
(10) Any loss adjustment expenses allocated to the claim or, if known, the amount allocated to each covered person;
(11) The loss adjustment expense, broken down between fees and expenses, paid to defense counsel;
(12) The date and reason for final disposition, if no judgment or settlement, and the type of disposition;
(13) Unless disclosure is otherwise prohibited by state or federal law, a summary of the occurrence which created the claim which shall include:
(a) The name of the institution, if any, and the location at which the injury occurred;
(b) The operation, diagnosis, treatment, procedure or other medical event or incident giving rise to the alleged injury;
(c) A description of the principal injury giving rise to the claim.

(F) Frequency
The report(s) required by this rule shall be filed with the superintendent, or the superintendent's designee, on or before May first of each year, and shall contain information for the previous calendar year.

(G) Noncompliance
Any person listed in paragraph (D) of this rule that fails to timely submit the report required under this section shall be subject to a fine not to exceed five hundred dollars.

(H) Confidentiality
Information reported to the superintendent or the superintendent's designee pursuant to this rule shall be confidential and privileged and is not a public record as defined in section 149.43 of the Revised Code. The information provided under this section is not subject to discovery or subpoena and shall not be made public by the superintendent or any other person, including any rating organizations or other agencies designated by the superintendent to gather and/or compile the information.

(I) The requirements of this rule do not apply to reinsurers, reinsurance contracts, reinsurance agreements, or reinsurance claims transactions.

(J) Severability
If any paragraph, term or provision of this rule is adjudged invalid for any reason, the judgment shall not affect, impair or invalidate any other paragraph, term or provision of this rule, but the remaining paragraphs, terms and provisions shall be and continue in full force and
effect.
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3711.01 Maternity homes; definitions.

As used in this chapter:
(A) “Board of health” means a board of health of a city or general health district or the authority having the duties of a board of health under section 3709.05 of the Revised Code.
(B) “Maternity home” means a facility for pregnant girls and women where accommodations, medical care, and social services are provided during the prenatal and postpartal periods. “Maternity home” does not include a private residence where obstetric or newborn services are received by a resident of the home.
(C) “Maternity unit” means a distinct portion of a hospital in which inpatient care is provided to women during all or part of the maternity cycle.
(D) “Newborn care nursery” means a distinct portion of a hospital in which inpatient care is provided to infants. “Newborn care nursery” includes a distinct portion of a hospital in which intensive care is provided to infants.

3711.02 Maternity license requirement.

(A) Except as provided in division (B) of this section, no person shall operate any of the following, unless the person holds the appropriate license issued under this chapter and the license is valid:
(1) A maternity unit;
(2) A newborn care nursery;
(3) A maternity home.
(B) Division (A) of this section does not apply to a health care facility as defined in division (A)(4) of section 3702.30 of the Revised Code.

3711.04 License application.

Each person seeking to operate a maternity unit, newborn care nursery, or maternity home shall apply to the director of health for a license under this chapter. The application shall be submitted in the form and manner prescribed by the director in rules adopted under section 3711.12 of the Revised Code.

A single application and license is required if an applicant will operate both a maternity unit and newborn care nursery.

3711.05 Application process.

(A) The director of health shall review all applications received under section 3711.04 of the Revised Code. On receipt of a complete application, the director shall send a copy of the application to the board of health of the city or general health district in which the maternity unit, newborn care nursery, or maternity home is to be operated.

Unless the board finds that an applicant is not in compliance with an applicable health regulation adopted by the board, the board shall approve the application. The board shall notify the director of its determination to approve or disapprove the application. If the board does not notify the director of its determination by the end of the thirtieth day after the board receives the
copy of the application, the application is deemed to have been approved by the board.

(B) The director shall issue a license to an applicant if all of the following requirements are met:

(1) The board of health approves the application or the application is deemed to have been approved;
(2) The applicant meets the standards specified in rules adopted under section 3711.12 of the Revised Code;
(3) The applicant passes the inspection required by section 3711.06 of the Revised Code.

(C) On issuance of a license, the director shall notify the board of health to which the application was sent under division (A) of this section. In the notice, the director shall specify the terms that apply to the license.

3711.06 License inspections.

The director of health shall inspect each maternity unit, newborn care nursery, or maternity home for which a person has applied for an initial license under section 3711.04 of the Revised Code prior to issuing the license. Inspections shall be conducted in accordance with inspection criteria, procedures, and guidelines adopted by the director under section 3711.12 of the Revised Code.

3711.08 License duration and fee.

A license issued under this chapter is valid for three years, unless earlier revoked or suspended under section 3711.14 of the Revised Code. The license may be renewed in the manner prescribed by the director of health in rules adopted under section 3711.12 of the Revised Code. The license renewal fee specified in the rules shall be paid not later than sixty days after the director of health mails an invoice for the fee to the license holder. A penalty of ten per cent of the amount of the renewal fee shall be assessed for each month the fee is overdue.

3711.10 Inspection scheduled or random.

The director of health shall monitor compliance with this chapter and the rules adopted under it. The director may conduct inspections of a maternity unit, newborn care nursery, or maternity home as necessary to adequately monitor compliance with this chapter and the rules adopted under it. The inspections may be scheduled or random.

The board of health of the city or general health district in which a maternity unit, newborn care nursery, or maternity home is located may conduct inspections of the unit, nursery, or home as necessary to adequately monitor compliance with any applicable health regulation adopted by the board. The inspections may be scheduled or random.

3711.12 Director shall adopt rules.

(A) The director of health shall adopt rules in accordance with Chapter 119 of the Revised Code as the director considers necessary to implement the requirements of this chapter for licensure and operation of maternity units, newborn care nurseries, and maternity homes. The rules shall include provisions for the following:

(1) Licensure application forms and procedures;
(2) Renewal procedures, including procedures that address the right of the director of health, at the director's sole discretion, to conduct an inspection prior to renewal of a license;
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(3) Initial license fees and license renewal fees;
(4) Fees for inspections conducted by the director under section 3711.10 of the Revised Code;
(5) Safety standards, quality-of-care standards, and quality-of-care data reporting requirements;
(6) Reporting and auditing requirements;
(7) Inspection criteria, procedures, and guidelines;
(8) Application forms to be used and procedures to be followed in applying under section 3711.13 of the Revised Code for a variance or waiver of any of the requirements of the rules adopted under this section regarding the operation of a maternity home;
(9) Any other rules necessary to implement this chapter.

(B) When adopting rules under this section, the director shall give consideration to recommendations regarding obstetric and newborn care issued by the American college of obstetricians and gynecologists; American academy of pediatrics; American academy of family physicians; American society of anesthesiologists; American college of nurse-midwives; United States centers for disease control and prevention; association of women's health, obstetric and neonatal nurses; and association of perioperative registered nurses, or their successor organizations. The director shall also consider the recommendations of the maternity and newborn advisory council established in section 3711.20 of the Revised Code.

3711.14 Penalties.

(A) In accordance with Chapter 119 of the Revised Code, the director of health may do any of the following:

(1) Impose a civil penalty of not less than one thousand dollars and not more than two hundred fifty thousand dollars on a person who violates a provision of this chapter or the rules adopted under it;
(2) Summarily suspend, in accordance with division (B) of this section, a license issued under this chapter if the director believes there is clear and convincing evidence that the continued operation of a maternity unit, newborn care nursery, or maternity home presents a danger of immediate and serious harm to the public;
(3) Revoke a license issued under this chapter if the director determines that a violation of a provision of this chapter or the rules adopted under it has occurred in such a manner as to pose an imminent threat of serious physical or life-threatening danger.

(B) If the director suspends a license under division (A)(2) of this section, the director shall issue a written order of suspension and cause it to be delivered by certified mail or in person in accordance with section 119.07 of the Revised Code. The order shall not be subject to suspension by the court while an appeal filed under section 119.12 of the Revised Code is pending. If the individual subject to the suspension requests an adjudication, the date set for the adjudication shall be within fifteen days but not earlier than seven days after the individual makes the request, unless another date is agreed to by both the individual and the director. The summary suspension shall remain in effect, unless reversed by the director, until a final adjudication order issued by the director pursuant to this section and Chapter 119 of the Revised Code becomes effective.

The director shall issue a final adjudication order not later than ninety days after completion of the adjudication. If the director does not issue a final order within the ninety-day period, the summary suspension shall be void, but any final adjudication order issued subsequent to the ninety-day period shall not be affected.

(C) If the director issues an order revoking or suspending a license issued under this chapter and the license holder continues to operate a maternity unit, newborn care nursery, or maternity home, the director may ask the attorney general to apply to the court of common
pleas of the county in which the person is located for an order enjoining the person from operating the unit, nursery, or home. The court shall grant the order on a showing that the person is operating the unit, nursery, or home.

3711.16 Fees to state general revenue fund.

All initial license fees, renewal fees, late renewal penalties, fees for inspections conducted by the director of health, and civil penalties collected under this chapter shall be deposited in the state treasury to the credit of the general operations fund created under section 3701.83 of the Revised Code. The moneys shall be used solely for purposes of administering and enforcing this chapter and the rules adopted under it.

3711.20 Maternity advisory council.

(A) As used in this section:
(1) “Board-certified” means that a physician has been certified in an area of practice by a medical specialty board of the American medical association or the American osteopathic association.
(2) “Registered nurse” has the meaning defined in section 4723.01 of the Revised Code.
(B) There is hereby created the maternity and newborn advisory council within the department of health. The governor, with the advice and consent of the senate, shall appoint the following members:
(1) Two board-certified obstetricians;
(2) A board-certified pediatrician;
(3) Three registered nurses who provide newborn care;
(4) Three registered nurses who provide obstetric care;
(5) A licensed dietitian with knowledge of newborn nutrition;
(6) A licensed social worker with knowledge of newborn psychosocial and family support services;
(7) A lactation consultant certified by the international board of lactation consultant examiners;
(8) An individual to represent the public;
(9) A board-certified perinatologist;
(10) A board-certified neonatologist;
(11) A certified nurse-midwife, certified nurse practitioner, clinical nurse specialist, or certified registered nurse anesthetist;
(12) A board-certified anesthesiologist;
(13) A board-certified family practice physician who delivers children or provides newborn care.
(C) The governor shall make the initial appointments to the council not later than sixty days after September 1, 2008. Of the initial appointments, six shall be for a term of three years, six for a term of four years, and six for a term of five years. Thereafter, terms of office shall be five years with each term ending on the same day of the same month as the term it succeeds. Each member shall hold office from the date of the member's appointment until the end of the term for which the member was appointed. Members may be reappointed. Vacancies shall be filled in the manner provided for original appointment. Any member appointed to fill a vacancy prior to the expiration of the term for which the member's predecessor was appointed shall hold office for the remainder of that term. A member shall continue in office subsequent to the expiration of the member's term or until a period of sixty days has elapsed, whichever occurs first.
(D) The council shall hold four meetings in the first year after the initial appointments to
the council are made under division (B) of this section. Thereafter, the council shall hold two meetings each year. Additional meetings may be held at the call of the chairperson or the director of health.

The chairperson shall be selected annually by members of the council. Following each meeting, the chairperson may submit a report to the director summarizing the activities, discussion, and recommendations of the council. Eight voting members of the council constitute a quorum.

(E) Members of the council shall be reimbursed for actual and necessary expenses incurred in the performance of their official duties.

(F) The department of health shall provide the council the administrative support necessary to execute its duties.

3711.21 Council duties.

The maternity and newborn advisory council shall do all of the following:
(A) Advise and consult with the director of health in the development of rules to be adopted under this chapter;
(B) Advise and consult with the director concerning the implementation and enforcement of this chapter;
(C) Advise and consult with the director in the development of inspection criteria, procedures, and guidelines to be used in enforcement of this chapter;
(D) Advise and consult with the director regarding recommendations regarding improving maternity and newborn care in this state;
(E) Prepare and submit to the director an annual report evaluating the department's enforcement of this chapter.

3711.22 Council committees.

The maternity and newborn advisory council may establish committees to focus on specific components of the enforcement of this chapter. Chairpersons of the committees shall be appointed by the chairperson of the council and shall be members of the council. Other members of the committees shall be appointed by the chairperson of the council and may include individuals who are not members of the council.

The membership and responsibilities of each committee established under this section shall be subject to the approval of the director of health. Members of the committees shall be reimbursed for actual and necessary expenses incurred in the performance of their official duties.

Committee reports shall be presented to the council at each regular meeting of the council.

3711.30 Opioid-dependent newborn reporting.

(A) As used in this section, “opioid” means opium, opium derivatives, and synthetic opium substitutes.
(B) Each maternity unit, newborn care nursery, and maternity home shall report to the department of health the number of newborns born to residents of this state in the unit, nursery, or home during the preceding calendar quarter that were diagnosed as opioid dependent at birth. The reports shall be submitted not later than thirty days after the end of each quarter and shall not include any patient-identifying information.
(C) The department shall establish standards and procedures for reporting the information required by this section. The information reported under this section shall not be
used for law enforcement purposes or disclosed to law enforcement authorities.

(D) The department shall compile the information submitted under this section and make a summary of that information available to the public not later than ninety days after the end of each calendar year.

3701-7-01 Maternity units: definitions.

(A) “Administrator” means the person responsible for the overall daily management of the maternity unit, or newborn care nursery, or both.

(B) “Advanced practice nurse” means an individual who holds a valid certificate of authority under Chapter 4723 of the Revised Code to practice nursing as a certified registered nurse anesthetist, clinical nurse specialist, certified nurse-midwife, or certified nurse practitioner.

(C) “Anesthesiologist” means a physician who has completed a residency training program in anesthesiology accredited by the accreditation council for graduate medical education or the American osteopathic association.

(D) “Anesthesiologist assistant” means an individual who holds a valid certificate of registration under Chapter 4760 of the Revised Code to practice as an anesthesiologist assistant.

(E) “Available for consultation” means an individual is capable of rendering advice, opinions, recommendations, suggestions, and counsel in evaluating a patient upon notice by the requesting physician and in accordance with the medical needs of the patient. This may be done by telemedicine or e-medicine in accordance with acceptable standards of practice.

(F) “Certified nurse-midwife” means a registered nurse who holds a valid certificate of authority issued under Chapter 4723 of the Revised Code that authorizes the practice of nursing as a certified nurse-midwife in accordance with section 4723.43 of the Revised Code and rules adopted by the board of nursing.

(G) “Certified nurse practitioner” means a registered nurse who holds a valid certificate of authority issued under Chapter 4723 of the Revised Code that authorizes the practice of nursing as a certified nurse practitioner in accordance with section 4723.43 of the Revised Code and rules adopted by the board of nursing.

(H) “Department” means the Ohio department of health.

(I) “Director” means the director of the department of health or his duly authorized representative.

(J) “Donor human milk” means milk from a lactating mother or lactating mothers, other than the milk of the mother of the newborn, that has been screened pursuant to the guidelines issued by the “Human milk bank association of North America.”

(K) “Feeding preparation area” means a designated clean area within the newborn care nursery that is specifically for the storage and preparation of human milk, donor human milk, or commercial infant formula.

(L) “Fetal death” means death prior to the complete expulsion or extraction from its mother of a product of conception, which after such expulsion or extraction, does not breathe or show any other evidence of life such as beating of the heart, pulsation of the umbilical cord, or definite movement of voluntary muscles. “Fetal death” does not include termination of the pregnancy.

(M) “Guidelines for perinatal care” means the sixth edition of the “Guidelines for perinatal care” issued by the American academy of pediatrics and the American congress of obstetricians and gynecologists.

(N) “Gynecologic patient” means a woman with or suspected of having a disorder related to her reproductive organs.

(O) “Hospital” means an institution required to be registered under section 3701.07 of the Revised Code.

(P) “Human milk” means the milk produced by a mother to feed her newborn.
Q) “Lactation consultant” means an individual who holds credentials as an “International board certified lactation consultant.”

R) “Level classification” means the level designation of the maternity unit and newborn care nursery that determines the services that may be provided.

S) “Licensee” or “license holder” means the individual, corporation, partnership, board, association or entity licensed by the director under Chapter 3711 of the Revised Code and rule 3701-7-03 of the Administrative Code to maintain a maternity unit, newborn care nursery, or maternity home.

T) “Licensed capacity” means the maximum number of patients that the maternity unit, newborn care nursery, or maternity home is authorized to accommodate under its license.

U) “Licensed dietitian” means an individual licensed under Chapter 4759 of the Revised Code to practice as a licensed dietitian.

V) “Licensed practical nurse” means an individual licensed under Chapter 4723 of the Revised Code to practice nursing as a licensed practical nurse.

W) “Maternity home” means a facility for pregnant girls and women where accommodations, medical care, and social services are provided during the prenatal and postpartal periods. Maternity home does not include a private residence where obstetric or newborn services are received by a resident of the home.

X) “Maternity unit” means a distinct portion of a hospital in which inpatient care is provided to women during all or part of the maternity cycle.

Y) “Medical director” means the physician who is responsible for managing and directing the provision of medical services at the maternity unit or newborn care nursery.

Z) “Neonatal resuscitation program” means the neonatal resuscitation program developed by the American heart association and American academy of pediatrics, or an equivalent program approved by the director.

AA) “Newborn care nursery” means a distinct portion of a hospital in which inpatient care is provided to infants. Newborn care nursery includes a distinct portion of a hospital in which intensive care is provided to infants.

BB) “Nurse” means either a licensed practical nurse or a registered nurse.

CC) “Nursing staff” means registered nurses, licensed practical nurses, and other staff that render care under the supervision of a registered nurse.

DD) “Obstetric and newborn care service” means the staff, equipment, physical space, and support services required to care for pregnant women, fetuses, women who have recently delivered a child, and newborns.

EE) “On-call” means an individual is capable of being reached by telephone or other electronic device and able to return to the maternity unit or newborn care nursery in accordance with facility policies.

FF) “On-duty” means in the maternity unit, newborn care nursery, or maternity home, alert and responsive to patient needs.

GG) “On-site” means in the building in which the maternity unit or newborn care nursery is located, or in the case of campus settings, in a nearby building and able to immediately respond to the maternity unit or newborn care nursery.

HH) “On-staff” means a member of the formal organization of physicians and other health professionals approved by the governing body with the delegated responsibility to provide for the quality of all medical care, and other health care as appropriate, provided to patients.

II) “Patient” means any individual who receives health care services.

JJ) “Pharmacist” means an individual registered under Chapter 4729 of the Revised Code to practice pharmacy.

KK) “Physician” means an individual who is licensed under Chapter 4731 of the Revised Code to practice medicine and surgery, or osteopathic medicine and surgery.
(LL) “Physician assistant” means an individual who holds a valid certificate to practice issued under Chapter 4730 of the Revised Code to provide services to patients as a physician assistant under the supervision, control, and direction of one or more physicians who are responsible for the physician assistant's performance.

(MM) “Registered nurse” means an individual who is licensed under section 4723.09 of the Revised Code to practice as a licensed registered nurse.

(NN) “Resident” means a woman or a newborn to whom the maternity home provides accommodations, medical care, or social services.

(OO) “Resident representative” means either a person acting on behalf of a resident with the consent of the resident or the resident’s legal guardian.

(PP) “Social worker” means an individual licensed to practice social work under Chapter 4757 of the Revised Code.

(QQ) “Special delivery services” means services provided by a freestanding children’s hospital that does not offer typical obstetric services as a level I obstetric service, level II obstetric service, or level III obstetric service, but is licensed as a level III neonatal care service, and is designed and equipped to provide delivery services to pregnant women as part of a comprehensive multidisciplinary program of fetal and neonatal care when it is determined that the fetus, once delivered, will require immediate highly subspecialty neonatal intensive care or neonatal surgery typically provided by a level IIIB or level IIIC neonatal care service.

(RR) “Staff member” or “staff” means the administrator and individuals providing direct care to patients on a full-time, part-time, temporary, contract, or voluntary basis. Staff member or staff does not include volunteers who are family members of a patient.

**3701-7-02 Maternity units: general license provisions and prohibitions.**

(A) Except as provided in paragraph (B) of this rule, no person shall operate any of the following unless the person holds the appropriate valid license issued under this chapter:

1. A maternity unit as defined in division (C) of section 3711.01 of the Revised Code;
2. A newborn care nursery as defined in division (D) of section 3711.01 of the Revised Code; and
3. A maternity home as defined in division (B) of section 3711.01 of the Revised Code.

(B) Paragraph (A) of this rule does not apply to a freestanding birthing center licensed or a freestanding birthing center exempted from licensure under Chapter 3702 of the Revised Code and Chapter 3701-83 of the Administrative Code.

**3701-7-03 Maternity units: admission, infection control, and patient care plans.**

(A) Application for a license to operate a maternity unit and newborn care nursery, a newborn care nursery, a maternity home, or renewal of an existing license, shall be made in writing on a form provided by the director and signed by the applicant or the applicant's agent, and shall include the following:

1. A nonrefundable application or renewal fee based upon the level classification as follows:
   a. Level I obstetrical service and level I neonatal care service, one thousand two hundred fifty dollars;
   b. Level II obstetrical service and level II neonatal care service, one thousand seven hundred fifty dollars;
   c. Level III obstetrical service and level III neonatal care service, two thousand two hundred fifty dollars;
   d. Freestanding children's hospital with a level III neonatal care service, two thousand two hundred fifty dollars; or
(e) Maternity home, seven hundred fifty dollars;
(2) The name to appear on the license;
(3) The particular premises in which the business will be carried out;
(4) The proposed licensed capacity; and
(5) For a level II neonatal care service or a level III neonatal care service, the proposed
sublevel classification.

(B) The license renewal fee specified in paragraph (A) of this rule shall be paid not later
than sixty days after the director of health mails an invoice for the fee to the license holder. A
penalty of ten per cent of the amount of the renewal fee shall be assessed for each month the
fee is overdue.

(C) Upon receipt of a completed application, the director shall send a copy of the
application to the board of health of the health district in which the maternity unit and newborn
care nursery, newborn care nursery, or maternity home is located. The board of health of the
health district shall:

(1) Approve the application, unless the maternity unit, newborn care nursery, or
maternity home is in noncompliance with any applicable local health regulation; and
(2) Notify the director of its determination within thirty days of receipt of the application.

(D) If the board of health of the health district does not provide the notice required by
paragraph (C)(2) of this rule, the application will be deemed to be approved by the board of
health of the health district.

(E) The director shall issue a license to the applicant if it is determined that the applicant
is in compliance with Chapter 3711 of the Revised Code and applicable rules within Chapter
3701-7 of the Administrative Code. The license shall state the following:

(1) The name of the licensee;
(2) The licensed capacity;
(3) The particular premises in which the business will be carried out; and
(4) For a level II neonatal care service or a level III neonatal care service, the sublevel
classification.

(F) The license shall be valid for a period of three years, with review as often as deemed
necessary, but at least once every three years, in a fashion deemed appropriate by the director
to determine whether the maternity unit, newborn care nursery, or maternity home is in
compliance with rules 3701-7-01 to 3701-7-17 of the Administrative Code.

(G) A license issued for a maternity unit and newborn care nursery, newborn care
nursery, or maternity home is valid only for the premises provided on the license in accordance
with paragraph (E) of this rule.

(H) The licensee shall promptly notify the director in writing of any change in
administrator, primary agent, location, or name of the maternity unit and newborn care nursery,
newborn care nursery, or maternity home.

(I) The licensee shall notify the director within seven days in writing of the voluntary
suspension of operation, closing, or sale of the maternity unit and newborn care nursery,
newborn care nursery, or maternity home, and return the license to the director.

(J) The license shall be posted conspicuously at the entrance to the maternity unit and
newborn care nursery, newborn care nursery, or maternity home.

(K) The licensee shall ensure that patient or resident occupancy does not exceed the
licensed capacity. The licensee shall develop and follow policies and procedures for handling
patients or residents that temporarily exceed the licensed capacity due to factors outside the
control of the licensee.

(L) The licensee shall notify the director in writing prior to any construction,
modernization, major acquisition, or significant alteration that would change the licensed
capacity, or that affects the level, volume, or scope of services.

(M) The department of health may revoke a license pursuant to section 3711.14 of the
Chapter 2. Regulated Healthcare Facilities
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Revised Code in accordance with Chapter 119 of the Revised Code.

3701-7-04 Maternity unit: facilities and equipment minimum standards.

(A) Upon the effective date of rules in this chapter, no person or agency of state or local government shall operate a maternity unit, newborn care nursery, or maternity home that does not comply with the provisions of this chapter of the Administrative Code.
(B) No person or agency of state or local government shall:
   (1) Interfere with an inspection or investigation of a hospital maternity unit, newborn care nursery, or maternity home by the director. As used in this paragraph, “interfere” means to obstruct directly or indirectly any individual conducting an authorized inspection or investigation from carrying out his or her duties, including:
      (a) Harassment;
      (b) Intimidation;
      (c) Refusal to permit the director upon presentation of official department identification, to inspect or investigate the operation of a maternity unit, newborn care nursery, or maternity home; or
      (d) Refusal to permit the director upon presentation of official department identification to enter and inspect records that are kept concerning the operations of the hospital maternity unit, newborn care nursery, or maternity home for information necessary to determine compliance with the applicable rules of this chapter.
   (2) Materially misrepresent any information provided to the director pursuant to section 3711.10 of the Revised Code and Chapter 3701-7 of the Administrative Code.
(C) Each provider of a hospital maternity unit, newborn care nursery, or maternity home shall ensure that the building or structure where it is located is in compliance with all applicable federal, state and local laws and regulations.
(D) Nothing in this chapter shall be construed as authorizing individuals to provide services outside their licensed scope of practice.
(E) A new maternity unit, newborn care nursery, or maternity home shall provide the service in compliance with all applicable provisions of Chapter 3701-7 of the Administrative Code, unless a waiver or variance is granted under the provisions of rule 3701-7-17 of the Administrative Code for all provisions not met.

3701-7-05 Maternity unit: nursery minimum standards.

(A) The director of health shall monitor compliance with Chapter 3711 of the Revised Code and Chapter 3701-7 of the Administrative Code. The director may conduct inspections of a maternity unit, newborn care nursery, or maternity home as often as deemed necessary based upon the compliance history of the maternity unit, newborn care nursery, or maternity home, but at least once every three years, to adequately monitor compliance. The inspections may be scheduled and announced or random and unannounced as follows:
   (1) The triennial inspection shall be scheduled and announced; and
   (2) All other inspections may be random and unannounced.
(B) The director may conduct an inspection to investigate alleged violations of Chapter 3711 of the Revised Code and Chapter 3701-7 of the Administrative Code. The director shall inform the complainant and the facility of the results of the inspection.
(C) The fee for inspections conducted by the director pursuant to Chapter 3711 of the Revised Code shall be as follows:
   (1) Inspection fee:
      (a) Level I service, one thousand seven hundred fifty dollars;
      (b) Level II service, two thousand seven hundred fifty dollars;
(c) Level III service, three thousand seven hundred fifty dollars;
(d) Freestanding children's hospital with a level III neonatal care service, three thousand seven hundred fifty dollars; or
(e) Maternity home, seven hundred fifty dollars;
(2) Complaint inspection fee of seven hundred fifty dollars.
(D) If the director determines the existence of a violation of any provision of Chapter 3711 of the Revised Code or Chapter 3701-7 of the Administrative Code, the director may request the licensee to submit an acceptable plan of correction to the director stating the actions being taken or to be taken to correct a violation, the time frame for completion and the means by which continuing compliance will be monitored; and may:
(1) In accordance with Chapter 119 of the Revised Code, impose a civil penalty based on the severity of the violation as follows:
   (a) For violations that present an imminent threat of serious physical or life threatening danger, or an immediate serious threat to the emotional health, safety or security of one or more patients or residents, a civil penalty of not less than one hundred thousand dollars and not more than two hundred and fifty thousand dollars;
   (b) For violations that directly threaten physical or emotional health, safety, or security of one or more patients or residents, a civil penalty of not less than ten thousand dollars and not more than one hundred thousand dollars;
   (c) For violations that indirectly threaten or potentially threaten the physical or emotional health, safety, or security of one or more patients or residents, a civil penalty of not less than one thousand dollars and not more than ten thousand dollars.
(2) Summarily suspend, in accordance with paragraph (D)(3) of this rule, a license issued under this chapter if the director believes that there is clear and convincing evidence that the continued operation of the maternity unit, newborn care nursery, or maternity home present a danger of immediate and serious harm to patients or residents.
(3) If the director suspends a license under paragraph (D)(2) of this rule, the director shall issue a written order of suspension and cause it to be delivered by certified mail or in person in accordance with section 119.07 of the Revised Code. The order shall not be subject to suspension by the court while an appeal filed under section 119.12 of the Revised Code is pending. If the license holder subject to the suspension requests an adjudication, the date set for the adjudication shall be within fifteen days but not earlier than seven days after the license holder makes the request, unless another date is agreed to by both the license holder and the director. The summary suspension shall remain in effect, unless reversed by the director, until a final adjudication order issued by the director pursuant to this chapter and Chapter 119 of the Revised Code becomes effective. The director shall issue a final adjudication order not later than ninety days after completion of the adjudication. If the director does not issue a final order within the ninety-day period, the summary suspension shall be void, but any final adjudication order issued subsequent to the ninety-day period shall not be affected.
(4) Revoke a license issued under this chapter if the director determines that a violation of a rule under this chapter has occurred in such a manner as to pose an imminent threat of serious physical or life-threatening danger to one or more patients or residents.
(5) In accordance with Chapter 119 of the Revised Code, for a second or subsequent violation of Chapter 3711 of the Revised Code or this chapter, or for an initial violation the director determines has caused or poses an imminent threat of serious physical or life-threatening danger, issue an order that the unit or home cease operation.
(E) If the director issues an order revoking or suspending a license issued under this rule and the license holder continues to operate a maternity unit, newborn care nursery, or maternity home, the director may ask the attorney general to apply to the court of common pleas of the county in which the person is located for an order enjoining the person from operating the unit, nursery, or home. The court shall grant the order on a showing that the person is operating the
maternity unit, newborn care nursery, or maternity home.

(F) In determining which of the actions to take under paragraph (D) of this rule, the director may consider, but is not limited to, the following factors:

(1) The danger of serious physical or life-threatening harm to one or more patients or residents utilizing the healthcare service;
(2) The nature, duration, gravity, and extent of the violation;
(3) The number, if any, of patients or residents directly affected by the violation;
(4) Whether the violation directly relates to patient or resident care and the extent of the actual or potential harm to patients or residents;
(5) The number of staff involved in the violation;
(6) The actions taken by the maternity unit, newborn care nursery, or home to correct the violation; and
(7) The compliance history of the maternity unit, newborn care nursery, or maternity home.

3701-7-06 Maternity units: variances and waivers from minimum standards.

(A) This rule shall not be construed to require any maternity unit licensed on or before March 20, 1997, to alter, upgrade, or otherwise improve the structure or fixtures of the maternity unit in order to comply with the requirements of this rule, unless one of the following applies:

(1) The maternity unit initiates or has, after March 20, 1997, initiated a construction, renovation, or a reconstruction project that involves a capital expenditure of at least fifty thousand dollars, not including expenditures for equipment or staffing or operational costs, and that directly involves the area in which the existing maternity unit is located;
(2) The maternity unit initiates or has, after March 20, 1997, initiated a service level designation change under rule 3701-7-07 of the Administrative Code or prior Chapter 3701-84 of the Administrative Code; or
(3) The director determines or has determined, by clear and convincing evidence, that failure to comply would create an imminent risk to the health and welfare of any patient.

(B) Each maternity unit, newborn care nursery, or maternity home shall ensure that the building or structure where the maternity unit, newborn care nursery, or maternity home is located:

(1) Has a certificate of use from a local, certified building department or from the Ohio department of commerce as meeting applicable requirements of Chapters 3781 and 3791 of the Revised Code and any rules adopted thereunder;
(2) Complies with the state fire code; and
(3) Complies with the applicable provisions of Chapter 3737 of the Revised Code and the rules adopted under it.

(C) The maternity unit, newborn care nursery, or maternity home shall develop and follow a disaster preparedness plan including evacuation in the event of a fire. Evacuation procedures shall be reviewed at least annually, and practice drills shall be conducted quarterly on each shift.

(D) The maternity unit, newborn care nursery, or maternity home shall develop and follow policies for ensuring the safety and security of all patients, including infant security drills for locating missing newborns. The policies shall be reviewed at least annually, and practice infant security drills shall be conducted on each shift at least once every six months.

(E) Each maternity unit, newborn care nursery, or maternity home shall label, store and dispose all poisons, hazardous wastes and flammable materials in a safe manner that does not jeopardize patient or resident health or safety, and in accordance with state and federal laws and regulations.

(F) Minimum space or square footage requirements specified in this chapter are of clear
floor space and exclusive of fixed or wall mounted cabinets, desks, wardrobes, and closets that are floor based.

(G) Each maternity unit constructed on or after the effective date of this rule that utilizes separate antepartum areas shall provide space for the provision of services and shall provide:

1. Single occupancy rooms with a minimum of one hundred twenty square feet of open floor space. Each room shall provide space for the mother and a support person;
2. A private toilet and shower or tub for each room; and
3. Two medical gas, medical air, and vacuum outlets available in each room.

(H) Each maternity unit’s labor-delivery-recovery or labor-delivery-recovery-postpartum area shall provide space for the provision of services and the following:

1. Single occupancy rooms with a minimum of two hundred fifty square feet of open floor space and a minimum room width or length of thirteen feet. Each room shall provide space for the mother, newborn and a support person;
2. A private toilet and shower or tub for each room;
3. A distinct area within the room for newborn resuscitation and stabilization. The distinct area shall be equipped with one medical gas, medical air, and vacuum outlet available to each mother and one medical gas, medical air, and vacuum outlet available to each newborn;
4. A minimum of six total air changes per hour with the ability to provide fifteen air changes per hour during the performance of a cesarean delivery where that room is designated as such. Maternity units constructed on or after the effective date of this rule shall provide a minimum of six total air changes per hour with the ability to provide twenty air changes per hour during the performance of a cesarean delivery where that room is designated as such; and
5. Immediately accessible examination lights.

(I) Each maternity unit that utilizes separate labor rooms shall provide space for the provision of services and shall provide:

1. A minimum area of one hundred square feet per bed. Each maternity unit constructed on or after the effective date of this rule shall have private occupancy labor rooms. Maternity units constructed on or after the effective date of this rule shall provide a minimum area of two hundred square feet per bed;
2. One medical gas, one medical air and one vacuum outlet accessible to each mother’s bed; and
3. A minimum of two total air changes per hour with the ability to provide twenty air changes per hour during the performance of a cesarean delivery where that room is designated as such. Maternity units constructed on or after the effective date of this rule shall provide a minimum of six total air changes per hour with the ability to provide twenty air changes per hour during the performance of a cesarean delivery where that room is designated as such.

(J) Each maternity unit that utilizes separate recovery rooms shall provide space for the provision of services and shall provide:

1. A minimum of two recovery room beds;
2. Space for the newborn, mother and support person; and
3. A minimum of six total air changes per hour per recovery room.

(K) Each maternity unit that utilizes separate postpartum areas shall provide space for the provision of services and shall provide:

1. A minimum of one hundred square feet of clear floor space per bed in semiprivate rooms and one hundred and twenty square feet of clear floor space in private rooms. Postpartum rooms existing on or before March 20,1997 shall provide at least eighty square feet of clear space per bed in semiprivate rooms and one hundred square feet in private rooms; and
2. Patient access to a bathroom with toilet and shower or tub, without entering the main corridor. Bathrooms in postpartum rooms existing before the effective date of this rule may serve no more than two postpartum beds. Postpartum rooms constructed on or after the effective date of this rule shall have one bathroom with toilet and shower or tub for each patient.
(L) Each maternity unit shall provide at least one cesarean delivery room in every obstetrical area. Each cesarean delivery area shall provide space for services and shall provide:

1. Cesarean delivery rooms with a minimum of three hundred and sixty square feet of open floor space and a minimum room width or length of sixteen feet. Any additional delivery rooms without cesarean delivery capability shall have a minimum open floor area of three hundred square feet;

2. Space for newborn resuscitation that meets one of the following:
   a. A minimum of an additional forty square feet of open floor space within the cesarean delivery room. Cesarean delivery areas rooms constructed on or after the effective date of this rule shall provide a minimum an additional eighty square feet of open floor space within the cesarean delivery room; or
   b. An area of one hundred and fifty square feet in a separate room immediately accessible to the cesarean delivery room;

3. A minimum of twenty air changes per hour per cesarean delivery area.

(M) Each maternity unit shall provide the necessary equipment and supplies for the complete care of the newborn in the location where the physiologic transition period occurs. Equipment shall include:

1. Heat source equipment;
2. Oxygen, suction, and air outlets;
3. Oxygen blender available for delivery;
4. Resuscitation equipment;
5. Equipment necessary for physiologic monitoring; and
6. Transport conveyance.

(N) Each maternity unit shall provide at least one airborne infection isolation room in or near each nursery. The room shall be enclosed and separated from the nursery with the ability to observe the infant from adjacent nurseries or control area and shall be consistent with current infection control guidelines, issued by the United States centers for disease control and prevention.

(O) The maternity unit shall provide separate areas as necessary to support the services provided including:

1. The consultation, or demonstration of breast feeding or breast pumping; and
2. Family waiting.

(P) Each newborn nursery room shall provide a floor area of twenty-four square feet for each newborn station with a minimum of two feet between newborn stations. Maternity units providing care to newborns requiring close observation shall conform to the requirements for the level designation and classification of that newborn service, and shall, at a minimum provide a floor area of fifty square feet with a distance of four feet between and at all sides of newborn stations. Maternity units constructed on or after the effective date of this rule that provide care to newborns requiring close observation shall conform to the requirements for the level designation and classification of that newborn service and shall provide a minimum of one hundred twenty square feet of open floor space for each newborn station with additional space based on the acuity level of the newborn.

(Q) Each newborn nursery room or newborn care nursery shall conform to the requirements for the level designation and classification of that newborn service and provide space for procedures, equipment, and staff functions and shall provide:

1. Medical gas, medical air, and vacuum outlets accessible to each newborn;
2. At least one door capable of being locked in each newborn nursery room that exits to the main corridor;
3. At least one sink, capable of hands free operation, for each eight newborn stations;
4. Observation windows to permit the viewing of newborns from public areas,
workrooms and adjacent nursery rooms;
(5) A system for storage and distribution of emergency drugs and routine medications;
(6) A minimum of six total air changes per hour in all newborn nursery rooms or newborn care units; and
(7) Lighting capable of varying from indirect to high intensity.
(R) Maternity units may replace newborn nursery rooms with baby holding nurseries in postpartum and labor-delivery-recovery-postpartum areas. The holding nursery shall meet the requirements of paragraphs (P) and (Q) of this rule.
(S) In addition to the requirements of paragraphs (N) and (P) of this rule, each maternity unit or newborn care nursery licensed as a level IIA, level IIB, level IIIA, level IIIB, or level IIIC neonatal care service shall provide:
(1) A group patient or open bay area with a clearly identified entrance large enough to accommodate portable x-ray equipment, and a reception area for families. The reception area shall permit visual observation and contact by the staff of all individuals entering the unit. A hand washing area shall be provided at each family entrance to the newborn care area;
(2) At least one door to each nursery room shall be large enough to accommodate portable x-ray equipment;
(3) A system to provide efficient and controlled access to the nursery from the labor and delivery area, the emergency room, and other referral entry points as may be applicable;
(4) Work areas, in addition to newborn care space;
(5) A minimum of one hundred square feet of open floor space for each newborn station. Additional space shall be provided based on acuity level of the newborn. There shall be an aisle adjacent to each newborn station with a minimum width of three feet to accommodate movement through the nursery without disturbing newborn care. Newborn care nurseries constructed on or after the effective date of this rule shall provide a minimum of two hundred twenty square feet of open floor space for each newborn station with additional space based on the acuity level of the newborn. An aisle adjacent to each newborn station with a minimum width of four feet to accommodate movement through the nursery without disturbing newborn care shall also be provided;
(6) A minimum of three medical gas, three medical air, three vacuum outlets, and seven duplex-grounded electrical receptacles organized in an accessible and safe manner for each newborn station. Fifty per cent of electrical outlets must be connected to the emergency system power and be so labeled. Newborn care nurseries constructed on or after the effective date of this rule shall provide sixteen single or duplex-grounded electrical receptacles organized in an accessible and safe manner for each newborn station. Fifty per cent of electrical outlets must be connected to the emergency system power and be so labeled;
(7) A respiratory therapy work area and storage area within the newborn care area or in close proximity;
(8) A transition room that allows parents and infant extended private time together in close proximity to the nursery. The room shall have a sink and toilet fixtures, a bed for parents, sufficient space for an infant bed and equipment, communication linkage with newborn intensive care nursery staff, and electric, air, vacuum, and medical gas outlets. The transition room may be used for other purposes when not required for use by parents and infant or infants; and
(9) Newborn care nurseries that utilize single patient private or semi-private rooms within the nursery shall meet the requirements of paragraphs (R)(5) and (R)(6) of this rule.
(T) Equipment and technology required under this rule may be replaced by newer technology and equipment with equivalent or superior capability. In assessing new equipment and technology, consideration shall be given to the recommendations of recognized professional societies and accrediting bodies.
(U) Each maternity unit or newborn care nursery shall provide hands-free hand washing fixtures in all areas for staff use where patient care is provided.
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(V) Each maternity unit or newborn care nursery shall provide a system of communication that interconnects all areas in which patient care is provided and that effectively alerts staff members of emergencies or patient needs. Each toilet, or shower, or both, used by patients shall have an emergency communications system capable of alerting staff of emergencies or patient needs.

(W) Each maternity unit or newborn care nursery shall provide appropriate safety features including handrails, emergency power, and electrical outlets for the services provided.

(X) Maternity home facilities and equipment shall include at least the following:

1. Equipment, lighting, and means of regulating indoor temperature and indoor air quality to provide a safe and comfortable living environment and working conditions in the maternity home;
2. Adequate facilities for the delivery of housekeeping and other supportive services;
3. Handrails in all stairwells, and grab bars in bathrooms and showers;
4. Secure office space for maintenance, preparation, and storage of resident medical records and medications;
5. Separate toilet facilities for personnel;
6. A dining area;
7. Adequate storage areas;
8. A means for the sanitary disposal of waste and soiled linen;
9. A relaxation area not readily accessible to the casual visitor;
10. Private office space for resident consultation;
11. Laundry facilities for residents;
12. At least one separate, private room for the examination and treatment of residents;
13. Equipment and supplies necessary for routine and emergency care of residents;
14. Each resident bedroom shall house no more than four beds and have at least one attached toilet room.

(Y) Each maternity home that offers newborn services shall maintain a newborn nursery appropriate to the number of newborns to be cared for at any one time. Each newborn nursery room shall be equipped with the following:

1. A floor area of twenty-four square feet for each newborn station with a minimum of two feet between newborn stations;
2. Maternity homes providing care to newborns requiring close observation shall provide a minimum floor area of fifty square feet with a minimum of four feet between and at all sides of newborn stations;
3. At least one door capable of being locked that exits to a main corridor; and
4. At least one sink capable of hands-free operation.

(Z) Each maternity home that offers newborn services shall develop and follow policies and procedures to ensure the safety and security of all patients, including infant security drills for locating missing newborns. The policies shall be reviewed at least annually, and practice infant security drills shall be conducted on each shift at least once every six months.

3701-7-07 Maternity homes: definitions and requirements.

(A) As used in this rule “service” means obstetrical and neonatal care services as may be found in a hospital maternity unit, including antepartum, intrapartum and postpartum care, or neonatal care services as may be found in a children's hospital. Obstetrical and newborn care services do not include services performed in a maternity home, a freestanding birthing center licensed or a freestanding birthing center exempted from licensure under Chapter 3702 of the Revised Code and Chapter 3701-83 of the Administrative Code, or services performed in an individual's home.

(B) Each service provider shall:
(1) Designate in writing to the director the level classification it provides or intends to provide;
(2) Designate in writing to the director the scope of services provided within the level classification;
(3) Meet the requirements of this chapter for the service level designated;
(4) Not hold itself out to any person or government entity by means of signage, advertising, or other promotional efforts as having a specific level classification unless the provider meets the requirements for that level classification;
(5) Provide direct care staff to accommodate the acuity level of the patient population and the volume of patients served; and have a system in place to adjust staffing levels based on changes in patient acuity levels and volumes;
(6) Establish minimum competency requirements for staff in accordance with recognized national standards and ensure that all staff are competent to perform services based on education, experience and demonstrated ability. Services that allow for the use of advanced practice nurses, anesthesiologist assistants, or physician assistants, shall develop and follow written policies and procedures;
(7) Develop and follow policies and procedures that address the following:
   (a) Admission;
   (b) Laundering or disposal of newborn linens, including diapers;
   (c) Integration of non-infectious gynecologic patients to the service; and
   (8) Notify the director when planning to change the level classification sixty days prior to implementing the level classification.
(C) Each provider of an obstetrics care service shall provide neonatal care services commensurate with the level of obstetrical care services provided and in accordance with the "Guidelines for perinatal care." Except as provided for in rule 3701-7-12 of the Administrative Code, no neonatal care service shall operate without a commensurate level of obstetrical care service.
(D) Each maternity unit shall provide newborn nursery facilities appropriate to the number of newborns that do not remain with their mothers during the postpartum stay, the average daily delivery volume, and the level designation of the newborn service.
(E) Staffing requirements for each service may be met by individuals with equal or greater qualifications, if the replacement's scope of practice encompasses the duties of the required staff.
(F) In accordance with the obstetric service admission and infection control policies and procedures and consistent with current infection control guidelines issued by the United States centers for disease control and prevention, provided the patient to be admitted does not pose a risk to the health or safety of other patients in the unit, a maternity unit obstetric service may only admit the following:
   (1) Women at any stage of the maternity cycle for the treatment of any health condition whether related to the maternity condition or not;
   (2) Non-infectious gynecologic patients; and
   (3) Non-infectious female surgical patients in accordance with policies and procedures approved by the service's director.
(G) Maternity units and newborn care nurseries shall develop and follow policies and procedures that address:
   (1) Admission;
   (2) Infection control, consistent with current infection control guidelines issued by the United States centers for disease control and prevention; and
   (3) Individual patient care plans.
(H) Each maternity home shall:
   (1) Have the ancillary and support staff necessary for the provision of the maternity
home’s services; and

(2) Ensure all staff members provide services in accordance with applicable, current and accepted standards of practice and the clinical capabilities of the maternity home.

(I) Each maternity home shall develop and follow infection control policies and procedures consistent with current infection control guidelines issued by the United States centers for disease control and prevention.

(J) Prior to admission, the maternity home shall provide the following in writing to the prospective resident or the prospective resident’s representative:

(1) An itemized list of fees for all services provided by the home;
(2) A list of the services provided at the maternity home, to include at least the following:
   (a) Medical services;
   (b) Nursing services; and
   (c) Social services.
(3) A list of services available to the resident within the home or outside of the home within a reasonable proximity, along with instructions on how to obtain such services.

(K) The maternity home shall designate a person as administrator to be responsible for day to day operations of the home, ensuring that resident needs are met at all times and for assuring compliance with Chapter 3711 of the Revised Code and Chapter 3701-7 of the Administrative Code.

(L) The maternity home shall retain the services of a medical director. The medical director shall be a physician licensed to practice in Ohio and qualified in obstetrical care. The medical director shall be responsible for the initiation and maintenance of policies and procedures for the prenatal and, where applicable, postpartum care of maternity home residents in the home.

(M) If the maternity home operates a nursery, a physician qualified in pediatrics shall be retained to direct the care of the infants including the initiation and maintenance of policies and procedures necessary for this care.

(N) The maternity home shall retain the services of a registered nurse to direct the nursing activities, including the initiation and maintenance of policies and procedures dealing with nursing care.

(O) A nurse shall be on duty at all times when the nursery is occupied in a maternity home that operates a nursery.

3701-7-08 Patient care standards and maternity units.

(A) Each maternity unit shall develop and follow a written service plan for the care of pregnant women and newborns. The plan shall include protocols based on the current guidelines for perinatal care appropriate for the level of care designation of the unit and for the services provided.

(B) Each maternity unit shall develop and follow a written service plan for the following:
   (1) Discharge of patients and follow-up patient care;
   (2) Inter-service transfers;
   (3) Administration of blood and blood products, including protocols for the administration of blood and blood products to newborns requiring intervention. The service shall provide the appropriate equipment and supplies necessary to administer blood and blood products. At a minimum:
      (a) Units providing blood transfusions shall have a blood pressure monitor, infusion pump, and appropriate intravenous equipment;
      (b) Units providing partial exchange transfusions shall meet the requirements of paragraph (B)(3) of this rule and have umbilical catheter trays, umbilical catheters, a blood drainage system, and intravenous fluids or volume expanders; and
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(c) Units providing exchange transfusions shall meet the requirements of paragraphs (B)(3) and (B)(7) of this rule and have a blood warmer and pulse oximeter;
(4) Provision of phototherapy including maintaining the necessary equipment and supplies;
(5) Preparation, administration, maintenance and management of complications of respiratory therapy. The maternity unit shall maintain the necessary equipment, supplies and support services for the administration of oxygen. At a minimum:
   (a) Equipment required for the administration of oxygen shall include a flow meter, bag and mask set-up, humidification, pulse oximeter, and suction equipment. A cardiorespiratory monitor shall be maintained if a newborn requires oxygen therapy for more than stabilization;
   (b) Units shall have the capability of providing blood gas analysis and portable x-ray;
   (c) Units providing oxygen administration by nasal cannula shall have a low flow meter;
   (d) Units providing oxygen administration using an oxygen hood shall have an oxygen analyzer, a heat source, and a thermometer;
   (e) Units providing incubator oxygen shall have appropriate tubing and an oxygen analyzer;
   (f) Units providing oxygen by a continuous positive airway pressure/ventilator shall have intubation equipment, endotracheal tubes, nasal prongs, and an oxygen analyzer; and
   (g) Units shall have the capability of treating pneumothorax;
   (6) Unit-based surgeries and surgical suite-based surgeries. The plan shall include the type of surgical procedures authorized to be performed on the unit and in surgical suites. The maternity unit shall maintain equipment appropriate to patient size; and

   (7) Insertion, maintenance, monitoring and complication management of peripheral, central, and arterial lines. Each maternity unit shall provide the appropriate staff, equipment, supplies, and support services for the insertion, maintenance, and monitoring of lines in accordance with the written service plan. The written plan shall require that infusion pumps regulating flow to newborns be capable of regulating flow to one-tenth cubic centimeter.

3701-7-09 Maternity homes: services, staff and records.

(A) A level I obstetrical service shall, consistent with paragraph (B) of this rule, provide:
   (1) Antepartum care to include obstetrical care for uncomplicated pregnancies and the management of emergencies;
   (2) Intrapartum care to include obstetrical care for the management of uncomplicated labor and delivery patients, selected complicated labor and delivery patients, unanticipated complications of labor and delivery, and emergencies; and
   (3) Postpartum care to include obstetrical care consistent with the antepartum and intrapartum care provided and the management of unanticipated postpartum complications and emergencies.
   (B) A level I obstetrical service shall not admit as an obstetrical patient any pregnant woman at less than thirty five weeks of her pregnancy for intrapartum care except where an emergency medical condition exists as evidenced by the following:
      (1) The mother is having contractions;
      (2) When, in the clinical judgment of a qualified obstetrical practitioner working under that practitioner's scope of practice, there is inadequate time to effect a safe transfer of the mother to an appropriate higher level hospital before delivery; and
      (3) The transfer will pose a threat to the health or safety of either the mother or the fetus.
   (C) Paragraph (B) of this rule does not preclude the admission of a less than thirty five weeks gestation pregnant woman to the maternity unit for care or services for a non-obstetrical issue, but that may require monitoring of health of the mother, the fetus, or both.
(D) A level I neonatal care service shall be organized with the personnel and equipment to perform neonatal resuscitation, evaluate and provide postnatal care of healthy newborn infants, stabilize and provide care for other newborns until transfer to a facility that can provide the appropriate level of neonatal care. Level I neonatal care services may provide for the management of newborns with selected complicated conditions including:

1. Moderately ill newborns with problems that are expected to resolve rapidly; and
2. Convalescing newborns that can be appropriately transferred from another service provider.

(E) Consistent with paragraph (D) of this rule, a level I neonatal care service shall effect a transfer a newborn that is less than thirty-five weeks gestation to an appropriate level II, level III neonatal care service, or freestanding children’s hospital with a level IIII neonatal care service, unless all of the following conditions are met:

1. The level I neonatal care service has in place a valid memorandum of agreement with one or more level II neonatal care service, level III neonatal care service, or freestanding children’s hospital with a level III neonatal care service, providing for consultation on the retention of the infant between the level I neonatal care service attending physician and a neonatologist on the staff of the level II, level IIII neonatal care service, or freestanding children’s hospital with a level III neonatal care service;
2. The consultation with, and the concurrence of, the neonatologist on the staff of the level II neonatal care service, level IIII neonatal care service, or freestanding children’s hospital with a level IIII neonatal care service, is documented by the level I neonatal care service in the patient medical record and as otherwise may be determined by the service. Such documentation shall be made available to the director upon request; and
3. The risks and benefits to the newborn for both retention at the level I neonatal care service and transfer of the newborn to a level II neonatal care service, level IIII neonatal care service, or freestanding children’s hospital with a level IIII neonatal care service, are discussed with the parent, parents, or legal guardian of the newborn and appropriately documented. Such documentation shall be made available to the director upon request.

(F) When discussing transfer of a pregnant woman or a newborn to another facility in accordance with this rule, the transferring service shall provide the patient or legal guardian with:

1. The recommendations from any consultations with a higher-level service;
2. The risks and benefits associated with the transfer of the patient; and
3. Any other information required by the hospitals’ polices and procedures.

(G) In the event the patient or patient’s legal guardian refuses transfer to a recommended hospital, the service shall document the refusal of transfer and provide treatment to the patient or patients in accordance with hospital policies and procedures. The service shall update the patient or patient’s legal guardian as the patient’s condition warrants.

(H) Each provider shall, using licensed health care professionals acting within their scopes of practice:

1. Develop and follow a written service plan for the care of patients;
2. Provide for the appropriate range of services for the patient population it serves;
3. Provide or have a written referral policy for obtaining public health, dietetic, genetic, and toxicology services;
4. Establish written criteria for determining those conditions that can be routinely managed by the service. The criteria shall be based on staff education, staff competence, the amount of staff experience with the listed conditions, and support services available to the service;
5. Provide a formal education program for staff, including the neonatal resuscitation program and a post resuscitation program;
(6) Conduct a risk assessment of obstetric and newborn patients to ensure identification of appropriate consultation requirements or referral for high-risk patients;
(7) Provide follow-up services to patients or refer patients for appropriate follow-up;
(8) Provide education for mothers regarding personal care and nutrition, newborn care and nutrition, and newborn feeding;
(9) Provide for consultation or referral of obstetric transports as needed. A system shall be in place to prepare and efficiently transport the patient consistent with the “Guidelines for perinatal care”;
(10) Provide for consultation or referral of neonatal transports as needed. A system shall be in place to prepare and efficiently transport the patient consistent with the “Guidelines for perinatal care”;
(11) Establish criteria for the acceptance of neonatal transports from other services based on demonstrated capability to provide the appropriate services consistent with the “Guidelines for perinatal care,” including the acceptance of newborns from level II or level III neonatal care services who otherwise do not meet the gestational age and weight restrictions; and
(12) Have the capability to resuscitate and stabilize newborns in the nursery consistent with the neonatal resuscitation program.
(I) Each provider shall have the ability to perform all of the following:
(1) An emergency cesarean delivery within thirty minutes of the time that the decision is made to perform the procedure on a twenty-four hour per day basis;
(2) Fetal monitoring; and
(3) Resuscitation and stabilization of newborns and emergency care for the mother and newborn in each delivery room.
(J) Each provider shall have the staff and support services to meet the needs of patients. Staff necessary to provide services shall be available on-call on a twenty-four hour basis.
(K) In addition to the requirements of paragraph (H) of this rule, each provider shall have, on a twenty-four hour basis, the following services available on-site:
(1) Clinical laboratory services capable of providing necessary testing;
(2) Diagnostic x-ray services capable of providing portable x-ray services;
(3) Portable ultrasound visualization equipment and services for diagnosis and evaluation;
(4) Pharmacy services;
(5) Anesthesia services; and
(6) Blood, blood products and substitutes.
(L) Each provider shall have on-staff or available for consultation, qualified staff appropriate for the services provided including:
(1) Co-directors of the obstetric and neonatal care service responsible for the overall operation of the respective care service;
(a) One co-director shall be a board certified obstetrician or board certified family physician with experience in obstetrics; and
(b) One co-director shall be a board certified pediatrician or a board certified family physician with experience in pediatrics;
(2) Physician coverage for the management and delivery of patients not under the private care of another physician;
(3) A physician or a certified nurse-midwife in attendance at all deliveries and responsible for ascertaining that the newborn adaptations to extrauterine life are proceeding normally and for ensuring immediate post delivery care of the newborn;
(4) A single, dedicated registered nurse responsible for leading the organization and supervision of nursing services in the obstetric and newborn care services; and
(5) A certified lactation consultant.
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(M) Each provider shall have qualified staff on-duty appropriate for the services provided including:
   (1) A registered nurse competent in obstetric and neonatal care;
   (2) A registered nurse with obstetric and neonatal experience for each patient in the second stage of labor;
   (3) A registered nurse to circulate for the cesarean birth deliveries; and
   (4) Additional registered nurses with the appropriate education and demonstrated competence, commensurate with the acuity and volume of patients served, to provide direct supervision of patients.

(N) At least one member of the nursing staff shall be in attendance for newborns when they are not with the mother or her designee.

(O) Each provider shall have an individual who has successfully completed the neonatal resuscitation program and who is capable of initiating and completing full resuscitation present at each delivery.

(P) Each provider shall maintain the ability to obtain the services of a physician to assist the primary physician or certified nurse-midwife in case of unavoidable delivery of a high-risk patient, emergency cesarean delivery, or unexpected fetal or neonatal stress.

(Q) Each provider shall provide for a licensed social worker with knowledge of obstetric and neonatal psychosocial and family support services.

(R) Each provider shall maintain a licensed dietitian either on-staff or as a consultant.

3701-7-10 Maternity homes: level II service standards.

(A) A level II obstetrical service shall provide:
   (1) Antepartum care to include obstetrical care for all uncomplicated patients, selected complicated patients, selected high-risk patients, and the management of emergencies;
   (2) Intrapartum care to include obstetrical care for the management of labor and delivery of all uncomplicated patients, selected complicated patients, selected high-risk patients, unanticipated complications of labor and delivery, and emergencies; and
   (3) Postpartum care to include postpartum care consistent with the antepartum and intrapartum care provided and management of unanticipated postpartum complications and emergencies.

(B) A level II obstetrical service shall not admit as an obstetrical patient any pregnant woman at less than thirty two weeks of her pregnancy for intrapartum care except where an emergency medical condition exists as evidenced by the following:
   (1) The mother is having contractions;
   (2) When, in the clinical judgment of a qualified obstetrical practitioner working under that practitioner's scope of practice, there is inadequate time to effect a safe transfer of the mother to an appropriate higher level hospital before delivery; and
   (3) The transfer will pose a threat to the health or safety of either the mother or the fetus.

(C) Paragraph (B) of this rule does not preclude the admission of a less than thirty two weeks gestation pregnant woman to the maternity unit for care or services for a non-obstetrical issue, but that may require monitoring of health of the mother, the fetus, or both.

(D) A level IIA neonatal care service or a level IIB neonatal care service shall be equipped to provide care and services to normal newborns, moderately ill newborns, selected extremely ill newborns, newborns with uncomplicated conditions, and to newborns that require emergency resuscitation or stabilization for transport. A level IIB neonatal care service may provide mechanical ventilation for brief durations of less than twenty-four hours or continuous positive airway pressure. A level IIA neonatal care service or a level IIB neonatal care service may provide for the management of newborns with selected complicated conditions including newborns:
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(1) With physiologic immaturity such as apnea of prematurity;
(2) An inability to maintain body temperature,
(3) An inability to take oral feedings;
(4) Who are moderately ill with problems that are expected to resolve rapidly and are not anticipated to need subspecialty services on an urgent basis; and
(5) Who are convalescing from intensive care.

(E) Consistent with paragraph (D) of this rule, a level II neonatal care service shall effect a transfer of a newborn that is less than thirty two weeks gestation and weighing less than one thousand five hundred grams to level III neonatal care service or freestanding children's hospital with a level III neonatal care service unless all of the following conditions are met:

(1) The level II neonatal care service has in place a valid memorandum of agreement with one or more level III neonatal care service or freestanding children's hospital with a level III neonatal care service providing for consultation on the retention of the infant between the level II neonatal care service attending physician and a neonatologist on the staff of the level III neonatal care service or freestanding children's hospital with a level III neonatal care service;

(2) The consultation with, and the concurrence of, the neonatologist on the staff of the level III neonatal care service or freestanding children's hospital with a level III neonatal care service is documented by the level II neonatal care service in the patient medical record and as otherwise may be determined by the service. Such documentation shall be made available to the director upon request; and

(3) The risks and benefits to the newborn for both retention at the level II neonatal care service and transfer of the newborn to a level IIIB neonatal care service, level IIIC neonatal care service, level IIIB neonatal care service, level III neonatal care service, or to a freestanding children's hospital with a level III neonatal care service are discussed with the parent, parents, or legal guardian of the newborn and appropriately documented. Such documentation shall be made available to the director upon request.

(F) When discussing transfer of a pregnant woman or a newborn to another facility in accordance with this rule, the transferring service shall provide the patient or legal guardian with:

(1) The recommendations from any consultations with a higher-level service;
(2) The risks and benefits associated with the transfer of the patient; and
(3) Any other information required by the hospitals' polices and procedures.

(G) In the event the patient or patient's legal guardian refuses transfer to a recommended hospital, the service shall document the refusal of transfer and provide treatment to the patient or patients in accordance with hospital policies and procedures. The service shall update the patient or patient's legal guardian as the patient's condition warrants.

(H) Each provider shall, using licensed health care professionals acting within their scopes of practice:

(1) Develop and follow a written service plan for the care of patients;
(2) Provide for the range of services for the patient population it serves consistent with the “Guidelines for perinatal care”;
(3) Provide or have a written referral policy for obtaining public health, dietetic, genetic, and toxicology services not available in-house;
(4) Establish criteria for determining those conditions that can be routinely managed by the service. The criteria shall be based on staff education, competence, and experience with the conditions, and the support services available to the service;
(5) Provide a formal education program for staff, including the neonatal resuscitation program and a post resuscitation program;
(6) Conduct a risk assessment of obstetric and neonatal patients to ensure identification of appropriate consultation requirements for high-risk patients;
(7) Provide follow-up services to patients or refer patients for appropriate follow-up;
(8) Provide education for mothers regarding personal care and nutrition, newborn care and nutrition, and newborn feeding;

(9) Have the capability to resuscitate and stabilize newborns in the nursery consistent with the neonatal resuscitation program;

(10) Provide for consultation or referral or obstetric transports as needed. A system shall be in place to prepare and efficiently transport the patient consistent with the “Guidelines for perinatal care”;

(11) Establish criteria for the acceptance of obstetric transports from other services based on demonstrated capability to provide the appropriate services consistent with the “Guidelines for perinatal care”;

(12) Provide for consultation or referral of neonatal transports as needed. A system shall be in place to prepare and efficiently transport the patient consistent with the “Guidelines for perinatal care.” This may include newborns that are below the gestational age and weight limitations for the receiving service;

(13) Establish criteria for the acceptance of neonatal transports from other services based on demonstrated capability to provide the appropriate services consistent with the “Guidelines for perinatal care,” including the acceptance of newborns from level III neonatal care services who otherwise do not meet the gestational age and weight restrictions;

(14) Provide for telephone consultation for maternal-fetal medicine on a twenty-four hour basis; and

(15) Provide developmental follow-up of at-risk newborns in the service or refer such newborns at-risk to appropriate programs.

(I) Each provider shall have the ability to perform all of the following:

(1) An emergency cesarean delivery within thirty minutes of the time that the decision is made to perform the procedure on a twenty-four hour basis;

(2) Fetal monitoring; and

(3) Resuscitation and stabilization of newborns and emergency care for the mother and newborn in each delivery room.

(J) Each provider shall be capable of providing on a twenty-four hour basis:

(1) Clinical laboratory services capable of providing any necessary testing;

(2) Diagnostic radiologic services, including x-ray, computed tomography, magnetic resonance imaging and fluoroscopy;

(3) Portable ultrasound visualization equipment for diagnosis and evaluation;

(4) Pharmacy services;

(5) Respiratory therapy services and pulmonary support services;

(6) Anesthesia services;

(7) Blood, blood products, and substitutes; and

(8) Biomedical engineering services.

(K) Each provider shall have either on-staff or available for consultation, qualified staff appropriate for the services provided including:

(1) A board certified obstetrician and a board certified pediatrician as co-directors of the obstetric and neonatal care service. The co-directors shall establish procedures for patients and shall integrate and coordinate a system for consultation, in-service education and communication with referring obstetric and neonatal care services;

(2) A second physician or certified nurse practitioner (neonatal) to attend to newborns at high-risk deliveries;

(3) A neonatologist or a pediatrician in consultation with an on-staff neonatologist, to manage the care of the newborn and to provide for:

(a) A system for consultation and referral;

(b) Continuing education programs;

(c) Communication and coordination with the obstetric care service; and
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(d) The defining and establishing of appropriate policies, protocols, and procedures for the unit nursery or nurseries and neonatal follow-up as may be indicated;

(4) A director of anesthesia services who is a board eligible or board certified anesthesiologist;

(5) A single, designated, full-time registered nurse with a bachelor’s degree in nursing responsible for leading the organization and supervision of nursing services in the obstetric care service. Individuals employed in this position on the effective date of these rules who do not meet the qualifications of this rule shall have five years from the effective date of this rule to come into compliance with the degree requirement;

(6) A single, designated, full-time registered nurse with a bachelor’s degree in nursing responsible for leading the organization and supervision of nursing services in the neonatal care service. Individuals employed in this position on the effective date of these rules who do not meet the qualifications of this rule shall have five years from the effective date of this rule to come into compliance with the degree requirement;

(7) A registered nurse to provide clinical obstetrical nursing expertise commensurate with the patient acuity and services provided. Expertise may be demonstrated through education, certification or a minimum of five years obstetric experience;

(8) A registered nurse to provide clinical neonatal nursing expertise commensurate with the patient acuity and services provided. Expertise may be demonstrated through education, certification or a minimum of five years neonatal experience;

(9) A licensed social worker to provide psychosocial assessments and family support services. Additional social workers shall be provided based upon the size and needs of the patient population;

(10) A licensed dietitian with knowledge of maternal and newborn nutrition and knowledge of parenteral/enteral nutrition management of at-risk newborns; and

(11) A certified lactation consultant.

(L) Each provider shall have medical, surgical, radiology and pathology specialists on-call based upon the medical needs of the patients.

(M) Each provider shall have a physician or certified nurse practitioner (neonatal) with experience in newborn airway management and diagnosis and management of air leaks on-site if a newborn is on mechanical ventilation.

(N) Each provider shall have on-duty, qualified staff appropriate for the services provided including:

(1) A multidisciplinary team of staff of which two members shall have successfully completed the neonatal resuscitation program and be capable of complete neonatal resuscitation;

(2) Registered nurses with the appropriate education and demonstrated competence, commensurate with the acuity and volume of newborns served, to provide direct supervision of newborns;

(3) A registered nurse with obstetric and neonatal experience for each patient in the second stage of labor;

(4) A registered nurse to circulate for the cesarean section deliveries;

(5) At least two registered nurses for labor and delivery;

(O) At least one member of the nursing staff shall attend to newborns when they are not with the mother or her designee.

3701-7-11 Maternity homes: level III service standards.

(A) A level III obstetrical service shall provide:

(1) Antepartum care to include obstetrical care for all uncomplicated patients, complicated patients, high-risk patients, and the management of emergencies;
Intrapartum care to include care and management of all uncomplicated, complicated, and high-risk labor and delivery patients, the unanticipated complications of labor and delivery, and the management of emergencies;

Postpartum care to include postpartum care consistent with the antepartum and intrapartum care provided and management of unanticipated postpartum complications and emergencies; and

Referral to other level III services as appropriate and consistent with the “Guidelines for perinatal care.”

B A level III obstetrical service that is associated with a level IIIA neonatal care service shall not admit as an obstetrical patient any pregnant woman at less than twenty eight weeks of her pregnancy for intrapartum care except where an emergency medical condition exists as evidenced by the following:

1. The mother is having contractions;
2. When, in the clinical judgment of a qualified obstetrical practitioner working under that practitioner’s scope of practice, there is inadequate time to effect a safe transfer of the mother to an appropriate higher level hospital before delivery; and
3. The transfer will pose a threat to the health or safety of either the mother or the fetus.

C Paragraph (B) of this rule does not preclude the admission of a less than twenty eight weeks pregnant woman to the maternity unit for care or services for a non-obstetrical issue, but that may require monitoring of health of the mother, the fetus, or both.

D A level IIIA neonatal care service, a level IIIB neonatal care service, or a level IIIC neonatal care service shall be organized with personnel and equipment to provide continuous life support and comprehensive care for extremely high risk newborn infants and those with complex and critical illness. Consistent with the “Guidelines for Perinatal Care,” the three sublevel classifications are differentiated by the capability to provide advanced medical and surgical care as may be required:

1. A level IIIA neonatal care service can:
   a. Provide care for infants with birth weight of more than one thousand grams and gestational age of more than twenty eight weeks;
   b. Provide continuous life support, but is limited to conventional mechanical ventilation;
   c. Perform minor surgery.
2. A level IIIB neonatal care service has all of the capabilities of a level IIIA neonatal care service and can provide:
   a. Comprehensive care for extremely low birth weight infants;
   b. Advanced respiratory care such as high-frequency ventilation and inhaled nitric oxide;
   c. Prompt access to a full range of pediatric medical subspecialists;
   d. Advanced imaging with interpretation on an urgent basis, including computed tomography, magnetic resonance imaging, and echocardiography; and
   e. Pediatric surgical subspecialists and pediatric anesthesiologists on-site or at a nearby closely related hospital or institution to perform major surgery.
3. A level IIIC neonatal care service has all of the capabilities of a level IIIB neonatal care service and is located within a hospital or other institution that can provide extracorporeal oxygenation and surgical repair of serious congenital cardiac malformations that require cardiopulmonary bypass.

E Consistent with paragraph (D)(1) of this rule, a level IIIA neonatal care service shall effect a transfer of a newborn that is less than one thousand grams or with a gestational age of less than twenty eight weeks to an appropriate level IIIB neonatal care service, level IIIC neonatal care service, or freestanding children’s hospital with a level III neonatal care service, unless all of the following conditions are met:
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(1) The level IIIA neonatal care service has in place a valid memorandum of agreement with one or more level IIIB neonatal care service, level IIIC neonatal care service, or freestanding children's hospital with a level III neonatal care service, providing for consultation on the retention of the infant between the level IIIA neonatal care service attending physician and the neonatologist on the staff of the level IIIB neonatal care service, level IIIC neonatal care service, or freestanding children's hospital with a level III neonatal care service;

(2) The consultation with, and the concurrence of, the neonatologist on the staff of the level IIIB neonatal care service, level IIIC neonatal care service, or freestanding children's hospital with a level III neonatal care service, is documented by the level IIIA neonatal care service in the patient medical record and as otherwise may be determined by the service. Such documentation shall be made available to the director upon request; an

(3) The risks and benefits to the newborn for both retention at the level IIIA neonatal care service and transfer of the newborn to a level IIIB neonatal care service, level IIIC neonatal care service, or to a freestanding children's hospital with a level III neonatal care service are discussed with the parent, parents, or legal guardian of the newborn and appropriately documented. Such documentation shall be made available to the director upon request.

(F) When discussing transfer of a pregnant woman or a newborn to another facility in accordance with this rule, the transferring service shall provide the patient or legal guardian with:

(1) The recommendations from any consultations with another service;
(2) The risks and benefits associated with the transfer of the patient; and
(3) Any other information required by the hospitals' policies and procedures.

(G) In the event the patient or patient's legal guardian refuses transfer to a recommended facility, the service shall document the refusal of transfer and provide treatment to the patient or patients in accordance with hospital policies and procedures. The service shall update the patient or patient's legal guardian as the patient's condition warrants.

(H) Each provider shall, using licensed health care professionals acting within the scopes of their practice:

(1) Develop and follow a written service plan for the care of patients;
(2) Provide for the range of services for the patient population it serves consistent with the “Guidelines for perinatal care”;
(3) Provide or have a written referral policy for obtaining public health, dietetic, genetic, and toxicology services not available in-house;
(4) Establish criteria for determining those conditions that can be routinely managed by the service. The criteria shall be based on staff education, competence, and experience with the conditions, and the support services available to the service;
(5) Provide a formal education program for staff that includes the neonatal resuscitation program and a post resuscitation program;
(6) Conduct a risk assessment of obstetric and neonatal patients to ensure identification of appropriate consultation requirements for high-risk patients;
(7) Provide follow-up services to patients or refer patients for appropriate follow-up;
(8) Provide education for mothers regarding personal care and nutrition, newborn care and nutrition, and newborn feeding;
(9) Have the capability to resuscitate and stabilize newborns in the nursery consistent with the neonatal resuscitation program;
(10) Provide for consultation or referral of obstetric transports as needed. A system shall be in place to prepare and efficiently transport the patient consistent with the “Guidelines for perinatal care”;
(11) Provide for consultation or referral of neonatal transports as needed. A system shall be in place to prepare and efficiently transport the patient consistent with the “Guidelines for perinatal care”;

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(12) On a twenty-four hour basis, coordinate and facilitate obstetric and neonatal transports from referring services consistent with the "Guidelines for perinatal care";

(13) Develop and follow policies and procedures for the transport of newborns to another neonatal care service when medically appropriate. This may include newborns that are below the gestational age and weight limitations for the receiving service;

(14) Provide consultation for maternal-fetal medicine on a twenty-four hour basis and shall be capable of having maternal-fetal medicine on-site within thirty minutes;

(15) Provide developmental follow-up of at-risk newborns in the service or refer such newborns to appropriate programs;

(16) Provide or coordinate continuing education for referring services;

(17) Provide opportunities for graduate medical education such as pediatric or obstetrics-gynecology residencies and neonatal or maternal-fetal medicine fellowships;

(18) Provide opportunities for clinical experience for purposes of graduate nursing education, or continuing education, or both;

(19) Participate, on an ongoing basis, in basic or clinical obstetrics or neonatology research;

(20) Conduct ongoing continuing education; and

(21) Provide multi-disciplinary planning relating to management and therapy through the postpartum period.

(I) Each provider shall have the ability to perform all of the following:

(1) An emergency cesarean delivery within thirty minutes of the time that the decision is made to perform the procedure on a twenty-four hours basis;

(2) Fetal monitoring; and

(3) Resuscitation and stabilization of newborns and emergency care for the mother and newborn in each delivery room.

(J) Each provider shall be capable of providing on a twenty-four hour basis:

(1) Clinical laboratory services capable of providing any necessary testing;

(2) Diagnostic radiologic services, including x-ray, computed tomography, magnetic resonance imaging and fluoroscopy;

(3) Portable ultrasound visualization equipment for diagnosis and evaluation;

(4) Pharmacy services;

(5) Respiratory therapy services and pulmonary support services;

(6) Anesthesia services;

(7) Blood, blood products, and substitutes; and

(8) Biomedical engineering services.

(K) Each provider shall have either on-staff or available for consultation, qualified staff appropriate for the services provided including:

(1) A board certified maternal-fetal medicine subspecialist and a board certified neonatologist as co-directors for the obstetric and newborn care service. The co-directors shall coordinate and integrate the following:

(a) A system for consultation;

(b) In-service education programs;

(c) Coordination and communication with support services and other obstetric care services;

(d) Defining and establishing, in collaboration with other members of the obstetric team, appropriate protocols and procedures for obstetric patients; and

(e) Treatment of patients in the neonatal intensive care unit who are not under the care of other physicians;

(2) A single, designated registered nurse with a bachelor's degree in nursing and a master's degree responsible for leading the organization and supervision of nursing services in the obstetric care service. Individuals employed in this position on the effective date of these
rules who do not meet the qualifications of this rule shall have five years from the effective date of this rule to come into compliance with the degree requirement;

(3) A single, designated registered nurse with a bachelor's degree in nursing and a master's degree responsible for leading the organization and supervision of nursing services in the neonatal care service. Individuals employed in this position on the effective date of these rules who do not meet the qualifications of this rule shall have five years from the effective date of this rule to come into compliance with the degree requirement;

(4) A registered nurse with a master's degree in nursing and an area of specialization in newborn health to provide clinical nursing expertise commensurate with the patient acuity and services provided;

(5) A registered nurse with a master's degree in nursing and an area of specialization in obstetrics or women's health to provide clinical nursing expertise commensurate with the patient acuity and services provided;

(6) A biomedical engineer;

(7) An American college of medical genetics certified or eligible geneticist or genetics counselor to:

(a) Identify families at risk for genetic abnormalities;
(b) Obtain family genetic history;
(c) Provide genetic counseling in complicated cases; and
(d) If necessary, refer complicated cases to an on-staff medical geneticist;

(8) A director of obstetric anesthesia services who is a board eligible or board certified anesthesiologist;

(9) A licensed dietitian with knowledge of maternal and newborn nutrition and knowledge of parenteral/enteral nutrition management of at-risk newborns;

(10) A licensed social worker to provide psychosocial assessments, family support services, and medical social work. Additional social workers shall be provided based upon the needs of the patients; and

(11) A certified lactation consultant. Additional certified lactation consultants shall be provided based upon the needs of the patients.

(L) Each provider shall have qualified staff available for consultation appropriate for the services provided including:

(1) Medical-surgical subspecialists based upon the medical needs of the patient;
(2) Pediatric subspecialists, that may include nephrology, hematology, metabolic, endocrinology, gastroenterology, nutrition, immunology, and pharmacology; and
(3) Pediatric subspecialists that may include cardiovascular surgeons, neurosurgeons, and orthopedic, urologic, and otolaryngologic surgeons shall be available for patient care, if necessary.

(M) Each provider shall have medical, surgical, radiological and pathology specialists on-call based on the medical needs of the patients.

(N) Each provider shall have an attending physician qualified in obstetrics on-site.

(O) Each provider shall have qualified staff on-duty including:

(1) A multi disciplinary team of staff. Two members of the team shall have successfully completed the neonatal resuscitation program and be capable of complete neonatal resuscitation;

(2) A second physician or certified nurse practitioner (neonatal) to attend to newborns at high-risk deliveries; and

(3) Registered nurse staffing including:
(a) A registered nurse competent in obstetric and neonatal care;
(b) A registered nurse with obstetric and neonatal experience for each patient in the second stage of labor;
(c) A registered nurse to circulate for cesarean deliveries; and
(d) At least two registered nurses for labor and delivery.
(P) Each level IIIA neonatal care service, level IIIB neonatal care service, and level IIIC neonatal care service shall have a neonatal intensive care unit staffed and equipped to provide care for critically ill newborns and an intermediate care unit for convalescing and moderately ill newborns. The availability of highly technical expertise and specialized physicians at another newborn nursery care service shall be considered by a level III neonatal care service for purposes of decisions concerning the need for consultation and possible transfer.

3701-7-12 Maternity home: nursery minimum standards.

(A) Freestanding children's hospitals with a level IIIA, level IIIB, or level IIIC neonatal care service shall have continuously available personnel and equipment to provide required life support and comprehensive care as long as may be needed for newborn infants who are at extreme high risk and those with complex and critical illness or those receiving specialized services such as cardiac surgery, organ transplants and treatments of rare inborn metabolic errors, fetuses needing intrauterine transfusion surgery and extracorporeal membrane oxygenation.

(B) Freestanding children's hospitals that operate a primary newborn care nursery designated as a neonatal intensive care unit may additionally operate an appropriately staffed and equipped intermediate care nursery or continuing care nursery for moderately ill and convalescing newborns. Newborns who are no longer indicated to need intensive care or care at the intermediate care level or continuing care level may be transported to another appropriate health care facility or discharged to an appropriate setting.

(C) Freestanding children's hospitals with a level IIIA, level IIIB, or level IIIC neonatal care service shall meet the level classification of neonatal care designated by the freestanding children's hospital consistent with the “Guidelines for perinatal care” for the services provided.

(D) Using licensed health professionals acting within their scope of practice, each freestanding children's hospital with a level IIIA, level IIIB, or level IIIC neonatal care service shall:

1. Develop and follow a written service plan for the care of patients;
2. Provide for the range of services for the patient population it serves consistent with the “Guidelines for perinatal care”;
3. Provide or have a written referral policy for obtaining public health, dietetic, genetic, and toxicology services not available in-house;
4. Establish criteria for determining those conditions that can be routinely managed by the service. The criteria shall be based on staff education, competence, and experience with the conditions, and the support services available to the service;
5. Provide a formal education program for staff that includes the neonatal resuscitation program and a post resuscitation program;
6. Conduct risk assessments for identification of and appropriate consultation for high risk patients;
7. Provide follow-up services to patients or refer patients for appropriate follow-up;
8. Provide consultation and accept newborn referrals on a twenty-four hour basis;
9. Have the capability to resuscitate and stabilize newborns in the nursery consistent with the neonatal resuscitation program;
10. Coordinate and facilitate high risk neonatal transports from referring services consistent with the “Guidelines for perinatal care”;
11. Develop and follow policies and procedures for the transport of newborns to another neonatal care service when medically appropriate. This may include newborns that are below the gestational age and weight limitations for the receiving service;
12. Provide developmental follow-up of at-risk newborns in the service or refer such
newborns to appropriate programs;

(13) Provide or coordinate ongoing continuing education for referring services;

(14) Provide opportunities for clinical experience for purposes of graduate nursing education, or continuing education, or both;

(15) Participate on an ongoing basis in basic or clinical neonatology research; and

(16) Provide multidisciplinary planning related to management and therapy for newborn care.

(E) Each freestanding children's hospital with a level IIIA, level IIIB, or level IIIC neonatal care service shall be capable of providing the following:

(1) Clinical laboratory services capable of providing necessary testing;

(2) Diagnostic radiologic services, including x-ray, computer tomography, magnetic resonance imaging, fluoroscopy or other specialized diagnostic services;

(3) Portable ultrasound visualization equipment and services for diagnosis and evaluation;

(4) Pharmacy services;

(5) Respiratory therapy services and pulmonary support services;

(6) Anesthesia services;

(7) Blood, blood products and substitutes; and

(8) Biomedical engineering services.

(F) Each freestanding children's hospital with a level IIIA, level IIIB, or level IIIC neonatal care service shall have either on-staff or available for consultation, qualified staff appropriate for the services provided including:

(1) A board certified neonatologist as director. The director shall coordinate and integrate the following including:

(a) A system for consultation;

(b) In-service education programs;

(c) Coordination and communication with support services;

(d) In collaboration with other members of the neonatal team, define and establish appropriate protocols and procedures for newborn patients; and

(e) Treatment of patients in the neonatal intensive care unit who are not under the care of other physicians.

(2) A single, designated registered nurse with a bachelor's degree in nursing and a master's degree responsible for leading the organization and supervision of nursing services in the neonatal care service. Individuals employed in this position on the effective date of rules in this chapter who do not meet the qualifications of this rule shall have five years from the effective date of this rule to come into compliance with the degree requirement.

(3) A registered nurse with a master's degree in nursing and an area of specialization in neonatal health to provide clinical nursing expertise commensurate with the patient acuity and services provided;

(4) Pediatric surgeons, cardiologists, neurologists, ophthalmologists, and geneticists;

(5) A licensed dietitian with knowledge of maternal nutrition, newborn nutrition, and knowledge of parenteral/enteral nutrition management of at-risk newborns;

(6) At least one licensed social worker to provide psychosocial assessments, family support services, and medical social work. Additional social workers shall be provided based upon the size and needs of the patient population; and;

(7) A certified lactation consultant. Additional certified lactation consultants shall be provided based upon the size and needs of the patient population

(G) Medical, surgical, radiological and pathology specialists shall be on-call based on the medical needs of the patients.

(H) Each freestanding children's hospital with a level IIIA, level IIIB, or level IIIC neonatal care service shall have qualified staff available for consultation appropriate for the services.
provided including:

(1) Pediatric sub-specialists that may include nephrologists, hematologists, metabolologists, endocrinologists, gastroenterologists, nutritionists, infectious disease specialists, pulmonologists, immunologists, and pharmacologists; and

(2) Pediatric surgical sub-specialists that may include cardiovascular surgeons, neurosurgeons and orthopedic, urologic and otolaryngologic surgeons available for care, if necessary;

(I) Each freestanding children's hospital with a level IIIA, level IIIB, or level IIIC neonatal care service shall have a registered nurse competent in neonatal care on-duty.

(J) In addition to the requirements of paragraphs (F) to (I) of this rule, each freestanding children's hospital when actively providing special delivery services shall provide level III obstetrical services consistent with the “Guidelines for perinatal care” and shall have:

(1) Either on-staff or through arrangement, qualified staff appropriate for the services provided:

(a) Medical and pediatric surgical subspecialists that may include surgery, pulmonology, infectious disease, internal medicine, and endocrinology; and

(b) Pediatric sub-specialists that may include cardiology, neurology, surgery, ophthalmology, and genetics;

(2) Qualified staff on-site including:

(a) Maternal-fetal medicine or fetal surgeon during operative procedures; and

(b) A multidisciplinary team of staff for deliveries. Two members of the team shall have successfully completed the neonatal resuscitation program, and be capable of complete neonatal resuscitation;

(3) Qualified staff on-duty including:

(a) A second physician or certified nurse practitioner (neonatal) to attend to newborns at time of delivery;

(b) A registered nurse competent in obstetrical care;

(c) A registered nurse competent in neonatal care;

(d) A registered nurse with obstetric and neonatal experience for each patient in the second stage of labor;

(e) A registered nurse to circulate for cesarean deliveries; and

(f) At least two registered nurses available for labor and delivery.

(K) Each freestanding children's hospital that provides special delivery services shall meet the following:

(1) Rooms in which special delivery services are provided shall meet all requirements for labor, delivery, and recovery rooms as set forth in rule 3701-7-06 of the Administrative Code; and

(2) Provide for cesarean deliveries through the provision of an operating room in or in close proximity to the area in which special delivery services are provided.

(L) When being used for delivery, each freestanding children's hospital that provides special delivery services shall have the ability to perform all the following:

(1) An emergency cesarean delivery within thirty minutes of the time that the decision is made to perform the procedure;

(2) Fetal monitoring; and

(3) Resuscitation and stabilization of newborns and emergency care for the mother and newborn.

3701-7-13 Maternity homes: safety standards.

(A) All persons whose work or service responsibilities involve continuing activities in the maternity home shall have a health evaluation by a licensed physician or other licensed health
professional operating within their scope of practice, which shall include establishing the absence of conditions transmissible to others, prior to their having access to the home.

(B) The maternity home shall establish and follow written infection control policies and procedures for the surveillance, control and prevention, and reporting of communicable disease organisms by both the contact and airborne routes which shall be consistent with current infection control guidelines issued by the United States centers for disease control and prevention. The policies and procedures shall address:

1. The utilization of protective clothing and equipment;
2. The storage, maintenance and distribution of sterile supplies and equipment;
3. The disposal of biological waste, including blood, body tissue, and fluid in accordance with Ohio law;
4. Universal precautions body substance isolation or equivalent; and
5. Tuberculosis and other airborne diseases.

(C) The maternity home shall not knowingly permit a staff member or volunteer to provide services if the individual has a communicable disease capable of being transmitted during the performance of his or her duties.

(D) The maternity home shall require each staff member to be tested for tuberculosis in accordance with current tuberculosis testing guidelines issued by the United States centers for disease control and prevention.

(E) A maternity home shall document any complications and adverse events impacting the health, safety, or well-being of any resident.

(F) The maternity home shall comply with Chapter 3701-3 of the Administrative Code pertaining to reportable disease notification.

3701-7-14 Maternal and newborn nutrition.

(A) Each maternity unit or newborn care nursery shall develop and follow written service plans for the following:

1. Administration of donor human milk and donor human milk products, if used, including protocols, equipment, and supplies for the administration of donor milk and donor milk products to newborns requiring intervention; and
2. Maintenance of newborn nutrition services to ensure that newborn nutritional needs are met.

(B) Each maternity unit or newborn care nursery that provides parenteral nutrition shall develop and follow a written service plan for the preparation and administration of parenteral nutrition, including:

1. Appropriate staff;
2. Equipment;
3. Supplies; and
4. A laminar flow hood, which need not be located in the newborn care nursery.

(C) If the maternity unit or newborn care nursery does not provide for onsite preparation of parenteral nutrition, the maternity unit or newborn care nursery shall develop and follow a written service plan for the outsourcing of the preparation of parenteral nutrition.

(D) Each maternity unit or newborn care nursery shall provide the necessary support to assess and monitor patients receiving parenteral nutrition.

(E) Maternity units, newborn care nurseries, and maternity homes using commercial formula, human milk, donor human milk, or donor human milk products, shall provide for the storage and handling of the formula, or human milk, or donor human milk, or donor human milk products, or any combination thereof.

(F) Maternity units and newborn care nurseries that prepare newborn formula on-site shall provide an appropriately equipped, designated feeding preparation area. If any formula or
human milk requires the addition of more than two measured ingredients, or requires the addition of an ingredient not routinely available in a nursery, a separate formula room shall be provided and maintained in accordance with guidelines issued by the American dietetic association.

(1) The formula room may be an area outside the maternity unit or newborn care nursery that is on-site and has qualified staff and policies and procedures for the safe handling of commercial formulas, human milk, donor human milk, and donor human milk products for formula preparation.

(2) The formula room may include outsourcing from the facility that has an enteral formulary room and has qualified staff and policies and procedures for the safe handling of commercial formulas, human milk, donor human milk, and donor human milk products for formula preparation.

3701-7-15 Complaints; quality assurance.

(A) Each maternity unit, newborn care nursery, or maternity home shall develop and follow policies and procedures to effectively receive, investigate, and report findings of complaints regarding the quality or appropriateness of care and services. The documentation of complaints shall, at a minimum, include the following:

(1) The date complaint was received;
(2) The identity, if provided, of the complainant;
(3) A description of the complaint allegations;
(4) The identity of persons, or provider of the services, or both, involved;
(5) The findings of the investigation; and
(6) The resolution of the complaint.

(B) Each maternity unit, newborn care nursery, and maternity home shall post the department's toll free complaint hotline in a conspicuous place.

(C) Each maternity unit or newborn care nursery shall establish a quality assessment and improvement program designed to systematically monitor and evaluate the quality of patient care provided in each maternity unit or newborn care nursery, pursue opportunities to improve patient care, ensure compliance with the applicable quality standards set forth in Chapter 3701-7 of the Administrative Code, and resolve identified problems.

(D) The quality assessment and improvement program shall do all of the following:

(1) Monitor and evaluate all aspects of care including effectiveness, appropriateness, accessibility, continuity, efficiency, patient outcome, and patient satisfaction;
(2) Establish expectations, develop plans, and implement procedures to assess and improve the quality of care and resolve identified problems;
(3) Establish expectations, develop plans, and implement procedures to assess and improve the maternity unit and newborn care nursery's governance, management, clinical and support processes;
(4) Establish information systems and appropriate data management processes to facilitate the collection, management, and analysis of data needed for quality improvement;
(5) Internally document and report findings, conclusions, actions taken, and the results of any actions taken to the health care service's management and medical director;
(6) Document and review all unexpected complications and adverse events, being serious injury or death resulting from medical management, which arise during the provision of the service or during the hospital stay; and
(7) Hold regular meetings, chaired by the medical director of the maternity unit or newborn care nursery, or designee, as necessary, but at least within sixty days after a death or complication, to review all deaths and complications and to report findings. Any pattern that might indicate a problem shall be investigated and remedied, if necessary.
(E) Each maternity unit, newborn care nursery, and maternity home shall, on a form
prescribed by the director, report to the department:
(1) Fetal death, to include all fetuses of twenty weeks gestation or greater that showed
evidence of life at any point from the mother’s admission through delivery;
(2) Neonatal death, to include all liveborn neonates before twenty-eight days of age,
from delivery or admission through transfer or discharge;
(3) Infant death, to include all liveborn infants twenty-eight days of age through one year
of age, from delivery or admission through transfer or discharge;
(4) Maternal death, to include the death of a woman from any cause related to or
aggravated by pregnancy or its management, from the woman’s admission and care at the
delivering hospital through transfer or discharge;
(5) Neonatal or infant abduction; and
(6) Discharge of a neonate or infant to the wrong family or organization.

3701-7-16 Licensure recordkeeping requirements.

(A) Each maternity unit or newborn care nursery shall maintain a medical record for each
patient that documents, in a timely manner and in accordance with acceptable standards of
practice, the patient's needs and assessments, and services rendered. Each medical record
shall be legible and readily accessible to staff for use in the ordinary course of treatment.
(B) Each maternity unit or newborn care nursery shall not disclose individual medical
records except as authorized by the patient, the parent or guardian of an infant or minor, or as
allowed by state and federal laws and regulations, including but not limited to the provisions of
this chapter of the Administrative Code.
(C) Each maternity unit or newborn care nursery shall:
(1) Systematically review records for conformance with acceptable standards of practice
and the requirements of this chapter of the Administrative Code;
(2) Maintain an adequate medical record keeping system and take appropriate
measures to ensure the confidentiality of patient medical records;
(3) Maintain fetal monitoring strips in a format that maintains the record for the period of
time required for medical record retention; and
(4) Maintain medical records as necessary to verify the information and reports required
by statute or regulation for five years from the date of discharge.
(D) The medical records of the maternal residents of a maternity home shall include, but
not be limited to, prenatal history, physical examination, and treatment and medication orders.
(E) The medical records of the infant residents of a maternity home, where applicable,
shall include, but not be limited to, a history of gestation, delivery and immediate postnatal
periods, physical examinations, and treatment and medication orders.
(F) A maternity home shall keep all records and reports for not less than five years and
such records and reports shall be available for inspection by the director.

3701-7-17 Waivers and variances.

(A) Upon written request of a hospital maternity unit, newborn care nursery, or maternity
home the director may grant:
(1) A variance from any requirement in rules 3701-7-01 to 3701-7-16 of the
Administrative Code if the director determines that the intent of the requirement has been met in
an alternative manner; or
(2) A waiver from any requirement in rules 3701-7-01 to 3701-7-16 of the Administrative
Code if the director determines that the strict application of the requirement would cause an
undue hardship to the maternity unit and that granting the waiver would not jeopardize the
health and safety of any patient or resident.

(B) In granting a variance or waiver, the director shall stipulate a time period for which the variance and waiver is to be effective and shall establish conditions the maternity unit must meet for the variance or waiver to be operative.

(C) The decision regarding a variance or waiver is a discretionary act by the director and an informal procedure not subject to Chapter 119 of the Revised Code. The director's decision shall be based on documentation of the following:

(1) In the case of a variance request, the alternative means by which the hospital maternity unit, newborn care nursery, or maternity home is meeting the intent of the requirement; and

(2) In the case of a waiver request, the undue hardship caused by the requirement and the reasons why a waiver of the requirement will not jeopardize the health and safety of any patient or resident.

(D) The granting of a variance or waiver by the director shall not be construed as constituting precedent for the granting of any other variance or waiver. All variance or waiver requests shall be considered on a case-by-case basis.

(E) The provider whose request for a waiver or variance under this rule is denied may request reconsideration of the decision by the director. A request for reconsideration must:

(1) Be received in writing by the director within thirty days of receipt of the director's denial of a waiver or variance request;

(2) Present significant, relevant information not previously submitted to the director by the provider because it was not available to the provider at the time the waiver or variance request was filed; or

(3) Demonstrate that there have been significant changes in factors or circumstances relied upon by the director in reaching the initial decision.

(F) A decision on an appropriately filed request for reconsideration shall be issued within forty-five days of the director's receipt of the request for reconsideration and all information determined necessary by the director to make a decision.

(G) The reconsideration process is an informal procedure not subject to Chapter 119 of the Revised Code. The director's decision on reconsideration is final.

Part II. Freestanding Healthcare Facilities

3702.30 Quality standards for ambulatory facilities.

(A) As used in this section:

(1) "Ambulatory surgical facility" means a facility, whether or not part of the same organization as a hospital, that is located in a building distinct from another in which inpatient care is provided, and to which any of the following apply:

(a) Outpatient surgery is routinely performed in the facility, and the facility functions separately from a hospital's inpatient surgical service and from the offices of private physicians, podiatrists, and dentists.

(b) Anesthesia is administered in the facility by an anesthesiologist or certified registered nurse anesthetist, and the facility functions separately from a hospital's inpatient surgical service and from the offices of private physicians, podiatrists, and dentists.

(c) The facility applies to be certified by the United States centers for medicare and medicaid services as an ambulatory surgical center for purposes of reimbursement under Part B of the medicare program, Part B of Title XVIII of the "Social Security Act," 79 Stat. 286 (1965), 42 U.S.C.A. 1395, as amended.

(d) The facility applies to be certified by a national accrediting body approved by the
centers for medicare and medicaid services for purposes of deemed compliance with the conditions for participating in the medicare program as an ambulatory surgical center.

(e) The facility bills or receives from any third-party payer, governmental health care program, or other person or government entity any ambulatory surgical facility fee that is billed or paid in addition to any fee for professional services.

(f) The facility is held out to any person or government entity as an ambulatory surgical facility or similar facility by means of signage, advertising, or other promotional efforts.

“Ambulatory surgical facility” does not include a hospital emergency department.

(2) “Ambulatory surgical facility fee” means a fee for certain overhead costs associated with providing surgical services in an outpatient setting. A fee is an ambulatory surgical facility fee only if it directly or indirectly pays for costs associated with any of the following:

(a) Use of operating and recovery rooms, preparation areas, and waiting rooms and lounges for patients and relatives;
(b) Administrative functions, record keeping, housekeeping, utilities, and rent;
(c) Services provided by nurses, orderlies, technical personnel, and others involved in patient care related to providing surgery.

“Ambulatory surgical facility fee” does not include any additional payment in excess of a professional fee that is provided to encourage physicians, podiatrists, and dentists to perform certain surgical procedures in their office or their group practice's office rather than a health care facility, if the purpose of the additional fee is to compensate for additional cost incurred in performing office-based surgery.

(3) “Governmental health care program” has the same meaning as in section 4731.65 of the Revised Code.

(4) “Health care facility” means any of the following:

(a) An ambulatory surgical facility;
(b) A freestanding dialysis center;
(c) A freestanding inpatient rehabilitation facility;
(d) A freestanding birthing center;
(e) A freestanding radiation therapy center;
(f) A freestanding or mobile diagnostic imaging center.

(5) “Third-party payer” has the same meaning as in section 3901.38 of the Revised Code.

(B) By rule adopted in accordance with sections 3702.12 and 3702.13 of the Revised Code, the director of health shall establish quality standards for health care facilities. The standards may incorporate accreditation standards or other quality standards established by any entity recognized by the director.

In the case of an ambulatory surgical facility, the standards shall require the ambulatory surgical facility to maintain an infection control program. The purposes of the program are to minimize infections and communicable diseases and facilitate a functional and sanitary environment consistent with standards of professional practice. To achieve these purposes, ambulatory surgical facility staff managing the program shall create and administer a plan designed to prevent, identify, and manage infections and communicable diseases; ensure that the program is directed by a qualified professional trained in infection control; ensure that the program is an integral part of the ambulatory surgical facility's quality assessment and performance improvement program; and implement in an expeditious manner corrective and preventive measures that result in improvement.

(C) Every ambulatory surgical facility shall require that each physician who practices at the facility comply with all relevant provisions in the Revised Code that relate to the obtaining of informed consent from a patient.

(D) The director shall issue a license to each health care facility that makes application for a license and demonstrates to the director that it meets the quality standards established by
the rules adopted under division (B) of this section and satisfies the informed consent compliance requirements specified in division (C) of this section.

(E)(1) Except as provided in division (H) of this section and in section 3702.301 of the Revised Code, no health care facility shall operate without a license issued under this section.

(2) If the department of health finds that a physician who practices at a health care facility is not complying with any provision of the Revised Code related to the obtaining of informed consent from a patient, the department shall report its finding to the state medical board, the physician, and the health care facility.

(3) This division does not create, and shall not be construed as creating, a new cause of action or substantive legal right against a health care facility and in favor of a patient who allegedly sustains harm as a result of the failure of the patient’s physician to obtain informed consent from the patient prior to performing a procedure on or otherwise caring for the patient in the health care facility.

(F) The rules adopted under division (B) of this section shall include all of the following:

(1) Provisions governing application for, renewal, suspension, and revocation of a license under this section;

(2) Provisions governing orders issued pursuant to section 3702.32 of the Revised Code for a health care facility to cease its operations or to prohibit certain types of services provided by a health care facility;

(3) Provisions governing the imposition under section 3702.32 of the Revised Code of civil penalties for violations of this section or the rules adopted under this section, including a scale for determining the amount of the penalties;

(4) Provisions specifying the form inspectors must use when conducting inspections of ambulatory surgical facilities.

(G) An ambulatory surgical facility that performs or induces abortions shall comply with section 3701.791 of the Revised Code.

(H) The following entities are not required to obtain a license as a freestanding diagnostic imaging center issued under this section:

(1) A hospital registered under section 3701.07 of the Revised Code that provides diagnostic imaging;

(2) An entity that is reviewed as part of a hospital accreditation or certification program and that provides diagnostic imaging;

(3) An ambulatory surgical facility that provides diagnostic imaging in conjunction with or during any portion of a surgical procedure.

3702.301 Freestanding birthing centers; religious exception.

(A) Except as provided in division (C) of this section, a freestanding birthing center is not required to obtain a license under section 3702.30 of the Revised Code if all of the following are the case:

(1) A religious denomination, sect, or group owns and operates the center.

(2) Requiring that the center be licensed significantly abridges or infringes on the religious practices or beliefs of that religious denomination, sect, or group.

(3) The center provides care only during low-risk pregnancy, delivery, and the immediate postpartum period exclusively to women who are members of that religious denomination, sect, or group.

(4) The center monitors and evaluates the care provided to its patients in accordance with at least the minimum patient safety monitoring and evaluation requirements established in rules adopted under division (D) of this section.

(5) The center meets the quality assessment and improvement standards established in rules adopted under division (D) of this section.
(B) If the director determines that a freestanding birthing center is no longer exempt from the requirement to obtain a license under section 3702.30 of the Revised Code because the center ceases to comply with division (A)(4) or (5) of this section, the director may order the center to come into compliance. In the order, the director may do all of the following:
   (1) Identify what the center is not in compliance with and what the center needs to do to come into compliance;
   (2) Require that the center come into compliance within a period of time specified in the order;
   (3) Require that the center provide the director a written notice within a period of time specified in the order that contains all of the following:
      (a) Certification that the center has come into compliance;
      (b) The signature of the center's administrator or medical director and certification that the administrator or medical director, whichever signs the notice, is the center's authorized representative;
      (c) Certification that the information contained in the notice and in any accompanying documentation is true and accurate;
      (d) Any other information or documentation that the director may require to verify that the center has come into compliance.
(C) If the director issues an order to a freestanding birthing center under division (B) of this section and the center fails to comply with the order within the time specified in the order, the director may issue a second order that requires the center to cease operations until the center obtains a license under section 3702.30 of the Revised Code.
(D) The director of health shall adopt rules in accordance with Chapter 119 of the Revised Code as necessary to implement this section. The rules shall establish all of the following:
   (1) Minimum patient safety monitoring and evaluation requirements;
   (2) Quality assessment and improvement standards;
   (3) Procedures for determining whether freestanding birthing centers are in compliance with the rules.

3702.302 License renewal.

In the case of an ambulatory surgical facility not certified by the centers for medicare and medicaid services as an ambulatory surgical center, the director of health shall conduct an inspection of the facility each time the facility submits an application for license renewal. The director shall not renew the license unless all of the following conditions are met:
   (A) The inspector conducting the inspection completes each item on the following, as applicable:
      (1) Until the director adopts rules under division (F) of section 3702.30 of the Revised Code, the form approved by the director on the effective date of this section;
      (2) The form specified by the director pursuant to rules adopted under division (F) of section 3702.30 of the Revised Code.
   (B) The inspection demonstrates that the ambulatory surgical facility complies with all quality standards established by the director in rules adopted under division (B) of section 3702.30 of the Revised Code.
   (C) The director determines that the most recent version of the updated written transfer agreement filed in accordance with division (B) of section 3702.303 of the Revised Code is satisfactory, unless the director has granted a variance from the written transfer agreement requirement as permitted by section 3702.304 of the Revised Code.
3702.303 Transfer arrangements.

(A) Except as provided in division (C) of this section, an ambulatory surgical facility shall have a written transfer agreement with a local hospital that specifies an effective procedure for the safe and immediate transfer of patients from the facility to the hospital when medical care beyond the care that can be provided at the ambulatory surgical facility is necessary, including when emergency situations occur or medical complications arise. A copy of the agreement shall be filed with the director of health.

(B) An ambulatory surgical facility shall update a written transfer agreement every two years and file a copy of the updated agreement with the director.

(C) The requirement for a written transfer agreement between an ambulatory surgical facility and a hospital does not apply if either of the following is the case:

1. The facility is a provider-based entity, as defined in 42 C.F.R. 413.65(a)(2), of a hospital and the facility’s policies and procedures to address situations when care beyond the care that can be provided at the ambulatory surgical facility are approved by the governing body of the facility’s parent hospital and implemented;

2. The director of health has, pursuant to the procedure specified in section 3702.304 of the Revised Code, granted the facility a variance from the requirement.

3702.304 Transfer arrangement variance.

(A)(1) The director of health may grant a variance from the written transfer agreement requirement of section 3702.303 of the Revised Code if the ambulatory surgical facility submits to the director a complete variance application, prescribed by the director, and the director determines after reviewing the application that the facility is capable of achieving the purpose of a written transfer agreement in the absence of one. The director’s determination is final.

(2) Not later than sixty days after receiving a variance application from an ambulatory surgical facility, the director shall grant or deny the variance. A variance application that has not been approved within sixty days is considered denied.

(B) A variance application is complete for purposes of division (A)(1) of this section if it contains or includes as attachments all of the following:

1. A statement explaining why application of the requirement would cause the facility undue hardship and why the variance will not jeopardize the health and safety of any patient;

2. A letter, contract, or memorandum of understanding signed by the facility and one or more consulting physicians who have admitting privileges at a minimum of one local hospital, memorializing the physician or physicians’ agreement to provide back-up coverage when medical care beyond the level the facility can provide is necessary;

3. For each consulting physician described in division (B)(2) of this section:

   (a) A signed statement in which the physician attests that the physician is familiar with the facility and its operations, and agrees to provide notice to the facility of any changes in the physician’s ability to provide back-up coverage;

   (b) The estimated travel time from the physician’s main residence or office to each local hospital where the physician has admitting privileges;

   (c) Written verification that the facility has a record of the name, telephone numbers, and practice specialties of the physician;

   (d) Written verification from the state medical board that the physician possesses a valid license to practice medicine and surgery or osteopathic medicine and surgery issued under Chapter 4731 of the Revised Code;

   (e) Documented verification that each hospital at which the physician has admitting privileges has been informed in writing by the physician that the physician is a consulting physician for the ambulatory surgical facility and has agreed to provide back-up coverage for the
facility when medical care beyond the care the facility can provide is necessary.

(4) A copy of the facility's operating procedures or protocols that, at a minimum, do all of the following:
   (a) Address how back-up coverage by consulting physicians is to occur, including how back-up coverage is to occur when consulting physicians are temporarily unavailable;
   (b) Specify that each consulting physician is required to notify the facility, without delay, when the physician is unable to expeditiously admit patients to a local hospital and provide for continuity of patient care;
   (c) Specify that a patient's medical record maintained by the facility must be transferred contemporaneously with the patient when the patient is transferred from the facility to a hospital.
   (5) Any other information the director considers necessary.

(C) The director's decision to grant, refuse, or rescind a variance is final.

(D) The director shall consider each application for a variance independently without regard to any decision the director may have made on a prior occasion to grant or deny a variance to that ambulatory surgical facility or any other facility.

3702.305 Variance conditions.

The director of health may impose conditions on any variance the director has granted under section 3702.304 of the Revised Code. The director may, at any time, rescind the variance for any reason, including a determination by the director that the facility is failing to meet one or more of the conditions or no longer adequately protects public health and safety. The director's decision to rescind a variance is final.

3702.306 Variance term.

A variance the director of health grants under section 3702.304 of the Revised Code is effective for the period of time specified by the director, except that it shall not be effective beyond the date the ambulatory surgical facility's license expires. If a variance is to expire on the date the facility's license expires, the facility may submit to the director an application for a new variance with its next license renewal application.

3702.307 Notice to ODH.

An ambulatory surgical facility shall notify the director of health when any of the following occurs:

(A) The facility modifies any provision of its most recent written transfer agreement filed with the director under section 3702.303 of the Revised Code. Notification under these circumstances shall occur not later than the business day after the modification is finalized. As used in this division, “business day” means a day of the week excluding Saturday, Sunday, and a legal holiday as defined in section 1.14 of the Revised Code.

(B) The facility modifies its operating procedures or protocols described in division (B)(4) of section 3702.304 of the Revised Code. Notification under these circumstances shall occur not later than forty-eight hours after the modification is made.

(C) The ambulatory surgical facility becomes aware of an event, including disciplinary action by the state medical board pursuant to section 4731.22 of the Revised Code, that may affect a consulting physician's license to practice medicine and surgery or osteopathic medicine and surgery or the physician's ability to admit patients to a hospital identified in a variance application, as described in division (B)(3)(e) of section 3702.304 of the Revised Code. Notification under these circumstances shall occur not later than one week after the facility becomes aware of the event's occurrence.
**3702.309 ODH director variance action.**

(A) If a variance application is denied under section 3702.304 of the Revised Code, the license of such an ambulatory surgical facility is automatically suspended. The director of health shall reinstate the license if one of the following occurs:

1. The facility files with the director a copy of a written transfer agreement that meets the requirements of section 3702.303 of the Revised Code.
2. The director grants the facility a variance pursuant to the requirements and procedures under section 3702.304 of the Revised Code;
3. The license is required to be reinstated pursuant to an order issued in accordance with sections 119.01 to 119.13 of the Revised Code.

(B) If a facility's license remains under suspension pursuant to this section after the expiration date of the license, in order to operate as an ambulatory surgical facility it must apply for a new license under section 3702.30 of the Revised Code.

**3702.3010 Local hospital location.**

A local hospital shall not be further than thirty miles from an ambulatory surgical facility:

(A) With which the local hospital has a written transfer agreement under section 3702.303 of the Revised Code; or
(B) Whose consulting physicians under a variance granted under section 3702.304 of the Revised Code have admitting privileges at the local hospital.

**3727.60 Public hospital abortion limitations.**

(A) As used in this section:

1. “Ambulatory surgical facility” has the same meaning as in section 3702.30 of the Revised Code.
2. “Nontherapeutic abortion” has the same meaning as in section 9.04 of the Revised Code.
3. “Political subdivision” means any body corporate and politic that is responsible for governmental activities in a geographic area smaller than the state.
4. “Public hospital” means a hospital registered with the department of health under section 3701.07 of the Revised Code that is owned, leased, or controlled by this state or any agency, institution, instrumentality, or political subdivision of this state. “Public hospital” includes any state university hospital, state medical college hospital, joint hospital, or public hospital agency.
5. “Written transfer agreement” means an agreement described in section 3702.303 of the Revised Code.

(B) No public hospital shall do either of the following:

1. Enter into a written transfer agreement with an ambulatory surgical facility in which nontherapeutic abortions are performed or induced;
2. Authorize a physician who has been granted staff membership or professional privileges at the public hospital to use that membership or those privileges as a substitution for, or alternative to, a written transfer agreement for purposes of a variance application described in section 3702.304 of the Revised Code that is submitted to the director of health by an ambulatory surgical facility in which nontherapeutic abortions are performed or induced.

**3701-83-01 General definitions.**

As used in this chapter:
Chapter 2. Regulated Healthcare Facilities
Part II. Freestanding Healthcare Facilities

(A) “Accreditation award letter” means an official letter stating the accreditation status and effective dates issued to a health care facility by an entity that the director has determined as having standards and a process for assessing compliance which equal or exceed the requirements of section 3702.30 of the Revised Code and the applicable requirements of Chapter 3701-83 of the Revised Code.

(B) “Administrator” means the person responsible for the overall daily management of the health care facility.

(C) “Advanced directives” means a written document executed in accordance with section 2133.02 or section 1337.12 of the Revised Code.

(D) “Current procedural terminology” or “CPT” means the comprehensive listing of medical terms and codes published by the American medical association for the uniform designation of diagnostic and therapeutic procedures in surgery, medicine and the specialties.

(E) “Dentist” means a person licensed under Chapter 4715 of the Revised Code to practice dentistry.

(F) “Department” means the Ohio department of health.

(G) “Dialysis station” or “station” means the equipment used to provide chronic maintenance dialysis for a single patient at a given time, including equipment used for self-dialysis and isolation stations.

(H) “Director” means the director of health or any official or employee of the department designated by the director of health.

(I) “Health care facility” or “HCF” means any of the following:
   1. An ambulatory surgical facility as defined in rule 3701-83-15 of the Administrative Code;
   2. A freestanding dialysis center as defined in rule 3701-83-23 of the Administrative Code;
   3. A freestanding inpatient rehabilitation facility as defined in rule 3701-83-25 of the Administrative Code;
   4. A freestanding birthing center as defined in rule 3701-83-33 of the Administrative Code;
   5. A freestanding radiation therapy center as defined in rule 3701-83-43 of the Administrative Code; and
   6. A freestanding or mobile diagnostic imaging center as defined in rule 3701-83-51 of the Administrative Code.

(J) “Hospital” means an institution required to be registered under section 3701.07 of the Revised Code.

(K) “Licensed practical nurse” or “LPN” means a person licensed under Chapter 4723 of the Revised Code to practice nursing as a licensed practical nurse.

(L) “Medical director” means the physician who is responsible for managing and directing the provision of medical services at the health care facility unless otherwise indicated in Chapter 3701-83 of the Administrative Code.

(M) “Nurse” means either a licensed practical nurse or a registered nurse.

(N) “Owner” means any person who holds a legal, equitable, or possessory interest of any kind in a health care facility, including, without limitation, a trust, vendor, vendee, lessor, or lessee. Owner does not include a person who holds indicia of ownership primarily to protect the person's security interest in the health care facility.

(O) “Patient” means any individual who receives services in a health care facility.

(P) “Patient representative” means either a person acting on behalf of a patient with the consent of the patient or the patient’s legal guardian.

(Q) “Personnel” means all individuals working in the health care facility.

(R) “Physician” means a person who is licensed under Chapter 4731 of the Revised Code to practice medicine and surgery, or osteopathic medicine and surgery.
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Part II. Freestanding Healthcare Facilities

Freestanding Healthcare Facilities

- General Provisions

(S) “Podiatrist” means a person licensed to practice podiatry under Chapter 4731 of the Revised Code.

(T) “Registered nurse” or “RN” means a person who is licensed under section 4723 of the Revised Code to practice nursing as a registered nurse.

(U) “Staff member” or “staff” means the administrator and individuals providing direct care to patients on a full-time, part-time, temporary, contract or voluntary basis. “Staff member” does not include a volunteer who provides direct care only to a member of his or her family.

(V) “Surgery” means any medical procedure performed upon the body of a living human being, regardless of the length of time the procedure takes, involving the invasion, alteration, cutting, disruption, destruction, resection, or removal of human tissue or bone by use of sharp-edged instruments, lasers, electrical cautery, cryoprobe, or any other medically accepted means for the purposes of preserving health, diagnosing or curing disease, repairing injury, correcting deformity or defects, prolonging life, relieving suffering, or for aesthetic, reconstructive, or cosmetic purposes. “Surgery” does not include the suturing of minor lacerations.

3701-83-02 Applicability of rules to types of freestanding facilities.

(A) Except as provided in section 3702.301 of the Revised Code and paragraph (B) of rule 3701-83-03 of the Administrative Code, all health care facilities shall comply with rules 3701-83-02 to 3701-83-14 of the Administrative Code. In addition, all:
   (1) Ambulatory surgical facilities shall comply with rules 3701-83-15 to 3701-83-22 of the Administrative Code;
   (2) Freestanding dialysis centers shall comply with rules 3701-83-23 to 3701-83-24 of the Administrative Code;
   (3) Freestanding inpatient rehabilitation facilities shall comply with rules 3701-83-25 to 3701-83-32 of the Administrative Code;
   (4) Freestanding birthing centers shall comply with rules 3701-83-33 to 3701-83-42 of the Administrative Code;
   (5) Freestanding radiation therapy centers shall comply with rules 3701-83-43 to 3701-83-50 of the Administrative Code; and
   (6) Freestanding or mobile diagnostic imaging centers shall comply with rules 3701-83-51 to 3701-83-55 of the Administrative Code.

(B) Freestanding birthing centers exempted from licensure under section 3702.301 of the Revised Code and paragraph (B) of rule 3701-83-03 of the Administrative Code shall comply with rules 3701-83-56 to 3701-83-59 of the Administrative Code.

3701-83-03 Requirements and prohibitions.

(A) Except as provided in section 3702.301 of the Revised Code and paragraph (B) of this rule, no person or agency of state or local government shall operate an HCF without a current valid license issued by the director under section 3702.30 of the Revised Code or operate an HCF when the license has been suspended or revoked.

(B) Except as provided in division (C) of section 3702.301 of the Revised Code and paragraph (C) of rule 3701-83-59 of the Administrative Code, a freestanding birthing center is not required to obtain a license under section 3702.30 of the Revised Code if all of the following are the case:
   (1) A religious denomination, sect, or group owns and operates the center and has provided written notice to the director of the following:
      (a) An attestation by the administrator or director that the center will be owned and operated by members of a religious denomination, sect, or group and that requiring that the
center be licensed significantly abridges or infringes on the religious practices and beliefs of that religious denomination, sect, or group;

(b) An attestation by the administrator or director that the center will be admitting, retaining, and providing care exclusively to women members of a religious denomination, sect, or group that owns and operates the center;

(c) The name of owner(s) and identification of what religious denomination, sect, or group they are members of;

(d) The name of proposed administrator or director of patient services and identification of what religious denomination, sect, or group they are members of;

(e) The name of board members and identification of what religious denomination, sect, or group they are members of;

(f) The name of the Ohio-licensed physician(s) who will provide obstetrical and/or pediatric consultation and oversight of the center;

(g) The number and type of staff (e.g., traditional midwives, certified professional midwives, apprentice midwives, state-licensed health care professionals) who will provide services in the center;

(h) The number of admissions and deliveries at the center to date if services have commenced at the center prior to providing this notice;

(i) What arrangements are in place with a hospital for transfer of a mother or newborn in the event of medical complications; and

(j) How and by whom each expectant mother will be assessed prior to admission.

(2) The center provides care only during low-risk pregnancy, delivery, and the immediate postpartum period exclusively to women who are members of that religious denomination, sect, or group;

(3) The center monitors and evaluates the care provided to its patients in accordance with at least the minimum patient safety monitoring and evaluation requirements of rule 3701-83-57 of the Administrative Code; and

(4) The center meets the quality assessment and improvement standards established in rule 3701-83-58 of the Administrative Code.

(C) No person or agency of state or local government shall:

(1) Interfere with an inspection or investigation of an HCF by the director; or

(2) Materially misrepresent any information provided to the director pursuant to section 3702.30 of the Revised Code and Chapter 3701-83 of the Administrative Code.

(D) Each HCF shall comply with all applicable state and federal laws and regulations.

(E) Nothing in this chapter shall be construed to alter or affect the law with respect to the corporate practice of medicine and surgery, osteopathic medicine and surgery, or dentistry.

(F) The HCF shall have an identifiable governing body responsible for the following:

(1) The development and implementation of policies and procedures and a mission statement for the orderly management of the HCF;

(2) The evaluation of the HCF's quality assessment and performance improvement program on an annual basis; and

(3) The development and maintenance of a disaster preparedness plan, including evacuation procedures.

(G) Each HCF shall either maintain documentation of appropriate liability insurance coverage of the staff and consulting specialists or inform patients that the staff member or consulting specialist does not carry malpractice insurance.

(H) No HCF shall permit any person to smoke inside the HCF. The HCF shall post a notice in a conspicuous place within the HCF stating that smoking is prohibited inside the HCF.

(I) Nothing in this chapter shall be construed as authorizing individuals to provide services outside their licensed scope of practice.

(J) The owner, administrator, and medical director shall be competent to perform the
respective responsibilities.

(K) An HCF may arrange for services to be provided through a contract with an outside resource. The HCF shall retain professional management responsibility for contracted services and shall ensure that those services are furnished in a safe and effective manner.

3701-83-04 Application for license and renewal requirements, contents.

(A) A person or agency of state or local government seeking a license to operate an HCF shall submit to the director an application, on a form and in a manner prescribed by the director and shall include the following:

(1) A statement of ownership containing the following information:
   (a) The name, address, and telephone number of the HCF.
   (i) If the owner is an individual, the owner's name, address, telephone number, business address, and business telephone number.
   (ii) If the owner is an association, corporation, limited liability company, or partnership, the legal business entity name, address, and telephone number of the entity and the name of every person who has an ownership interest of five per cent or more in the entity. The corporate name; if any, and the names, titles, addresses and telephone numbers of its officers and statutory agent.
   (iii) If the applicant is an agency of state or local government, the name, address and telephone number of the individual authorized to enter into agreements on behalf of the agency of state or local government.
   (b) The name of the administrator;
   (c) The name and physician license number or dentist license number of the medical director of the HCF;
   (d) The name and address of any of the following facilities which either the owner, administrator or medical director has been affiliated through ownership or employment in the five years prior to the date of the application:
      (i) A nursing home, residential care facility, or home for the aging as defined in section 3721.01 of the Revised Code;
      (ii) A residential facility for the mentally ill licensed by the department of mental health under section 5119.22 of the Revised Code;
      (iii) A facility licensed to provide methadone treatment under section 3793.11 of the Revised Code;
      (iv) A residential facility licensed under section 5123.19 of the Revised Code or otherwise regulated by the department of developmental disabilities;
      (v) A terminal care facility for the homeless that has entered into an agreement with a hospice care program under section 3712.07 of the Revised Code;
      (vi) A health insuring corporation as defined by section 1751.01 of the Revised Code;
      (vii) A hospital; or
   (e) Information about any criminal conviction, civil judgment or administrative adjudication of the owner, administrator or medical director for an offense related to the provision of care or bearing a direct or substantial relationship to the job responsibilities he or she is to carry out.

(2) If applicable, a copy of the fire inspection report required under paragraph (C) of rule 3701-83-06 of the Administrative Code and if applicable, the certificate of use and occupancy
required under rule 3701-83-10 of the Administrative Code;

(3) The type of HCF license for which the applicant is applying; in addition:
   (a) An ASF shall specify the number of operating rooms, or procedure rooms, or both;
   (b) A freestanding dialysis center shall specify the number of dialysis stations, including the number of hemodialysis stations and peritoneal stations;
   (c) A freestanding inpatient rehabilitation facility shall specify the number of patient care beds;
   (d) A freestanding birthing center shall specify the number of birth rooms;
   (e) A freestanding or mobile diagnostic imaging center shall specify whether the radiopharmaceuticals being proposed for use are for use as delineated in rule 3701:1-58-32, 3701:1-58-34, 3701:1-58-37 or 3701:1-58-53 of the Administrative Code and the number and type of radiation-generating or detecting equipment;
   (f) A freestanding radiation therapy center shall specify the number and type of radiation-generating or detecting equipment being proposed for use and whether radiopharmaceuticals or sealed sources being proposed for use are for use as delineated in rule 3701:1-58-43 or 3701:1-58-55 of the Administrative Code

(4) A complete copy of the HCF’s current accreditation award letter, if applicable.

(B) A person or agency of state or local government seeking renewal of an HCF license shall submit to the director an application for renewal each year during the month specified on the HCF’s license. A person or agency of state or local government seeking renewal of an HCF license, or an amended license under paragraph (F) of this rule, shall submit to the director an application on a form and in a manner prescribed by the director, and shall include the following:

(1) The name, address, and telephone number of the facility;
(2) The type of facility for which the applicant is seeking license renewal;
(3) Any changes or updates to the information required by paragraph (A) of this rule, including a copy of the most recent accreditation award letter, if applicable, unless the department has been previously notified;
(4) Copies of all inspections, agreements, or approvals required by Chapter 3701-83 of the Administrative Code, that have been conducted since submittal of the HCF’s previous application;
(5) Any other information the director may require regarding the owner’s ability to operate the facility.

(C) An application for an HCF license, license renewal or amended license shall include the following:

(1) Attestation that to the best of the applicant’s knowledge, the information in the application and any accompanying material is true and accurate;
(2) Attestation by the medical director and the administrator that to the best of their knowledge, the information in the application submitted pursuant to paragraph (A)(1)(c) of this rule is true and accurate;
(3) Attestation that the applicant, if not the owner, is the authorized representative of the owner, and
(4) A nonrefundable application fee of three hundred dollars for an HCF license or license renewal or a nonrefundable fee of one hundred and fifty dollars for an amended HCF license payable to the “Treasurer, State of Ohio.”

(D) The director at any time may request additional information the director determines to be necessary to assess compliance with the applicable criteria, standards, and requirements established by section 3702.30 of the Revised Code and Chapter 3701-83 of the Administrative Code. The applicant shall submit any additional information requested by the director within thirty days of the date of the director’s request.

(E) The HCF shall notify the director in writing no later than thirty days of:

(1) Any changes in the information contained in the statement of ownership made
pursuant to paragraph (A) of this rule; and
    (2) Any change in the HCF's accreditation status.
    (F) The HCF shall apply for an amended license if:
      (1) In the case of an ASF, there is any increase or a permanent decrease in the number
          of operating or procedure rooms;
      (2) In the case of a freestanding dialysis center, there is any increase or a permanent
          decrease in the number of dialysis stations;
      (3) In the case of a freestanding inpatient rehabilitation facility, there is any increase or a
          permanent decrease in the number of patient care beds;
      (4) In the case of a freestanding birthing center, there is any increase or a permanent
          decrease in the number of birthing rooms;
      (5) In the case of a freestanding or mobile diagnostic imaging center, there is any
          increase in the number or change in the type of radiation-generating or detecting equipment
          or any change in the radiopharmaceuticals being used pursuant to rule 3701:1-58-32, 3701:1-58-34,
          3701:1-58-37, or 3701:1-58-53 of the Administrative Code; and
      (6) In the case of a freestanding radiation therapy center, there is any increase in the
          number or change in the type of radiation-generating or detecting equipment being used or any
          change in the radiopharmaceuticals or sealed sources being used pursuant to rule 3701:1-58-43 or
    (G) The HCF shall not use any additional room, station, bed or equipment until an
        amended HCF license has been issued, or the HCF has received other verifiable approval by
        the department.

3701-83-05 Issuance of license.

    (A) The director shall issue or renew a license to an HCF that submits an application for
        license in accordance with rule 3701-83-04 of the Administrative Code and that demonstrates to
        the director it meets the requirements of section 3702.30 of the Revised Code and the
        requirements of Chapter 3701-83 of the Administrative Code. Nothing herein shall exempt any
        HCF from the data reporting requirements of Chapter 3701-83 of the Administrative Code, the
        fee requirements of paragraph (C) of rule 3701-83-04 of the Administrative Code, and any other
        applicable state or federal law or regulation.
        (1) The director may renew an HCF license without conducting an onsite inspection if:
            (a) The HCF is accredited by a national accrediting body approved by the centers for
                medicare and medicaid services, as documented by a current award letter from the accrediting
                body;
            (b) The HCF is deemed to meet or exceed the applicable medicare program
                requirements for health care facilities as set forth in this chapter, as documented by a current
                award letter from the accrediting body or an approval letter from the centers for medicare and
                medicaid services; or
            (c) The HCF, on the facility's most recent centers for medicare and medicaid services
                survey, has been determined to be in compliance with the medicare program participation
                requirements by virtue of a department conducted medicare certification or recertification
                survey.
        (2) Notwithstanding paragraph (A) of this rule, the director may conduct an on-site
            inspection prior to issuing a renewal license.
        (3) The director shall only issue one license of the same type at a given location for the
            following types of health care facilities:
            (a) Ambulatory surgical facility;
            (b) Freestanding inpatient rehabilitation facility;
            (c) Freestanding birthing center; or
(d) Freestanding dialysis center.
(B) Any license issued to an HCF:
(1) Shall contain the name and address of the facility for which it was issued, the
effective date of the license, and the month the HCF must apply for renewal of the license. In
addition:
(a) The license for an ambulatory surgical facility shall specify the maximum number of
operating rooms, or procedure rooms, or both;
(b) The license for a freestanding dialysis center shall specify the maximum number of
dialysis stations;
(c) The license for a freestanding inpatient rehabilitation facility shall specify the
maximum number of patient care beds;
(d) The license for a freestanding birthing center shall specify the number of birth rooms;
(e) The license for a freestanding or mobile diagnostic imaging center shall specify the
number and type of equipment.
(f) The license for a freestanding or mobile radiation therapy center shall specify the
number and type of equipment.
(2) Is valid unless revoked or suspended pursuant to Chapter 119 of the Revised Code,
or voided at the request of the owner, or the HCF fails to timely apply for a renewal in
accordance with paragraph (B) of rule 3701-83-04 of the Administrative Code; and
(3) Is valid only for the facility specified on the license at the listed address.
(C) The director shall, in accordance with Chapter 119 of the Revised Code, deny an
application for a license or an application for amendment or renewal of a license if:
(1) The HCF fails to make application for a license in accordance with rule 3701-83-04 of
the Administrative Code;
(2) Fails to demonstrate to the director that the HCF meets or continues to meet the
requirements of section 3702.30 of the Revised Code and Chapter 3701-83 of the
Administrative Code; or
(3) The director determines that the owner, administrator, or medical director is not
competent to operate an HCF based on review of information pertaining to paragraphs (A)(1)(c)
and (A)(1)(d) of rule 3701-83-04 of the Administrative Code.
(D) The HCF shall notify the director in writing within thirty days of termination of an
accreditation.
(E) In addition to any other provision of Chapter 3701-83 of the Administrative Code, if
the director granted a license based on the HCF demonstrating compliance through submittal of
an accreditation award letter and one of the events listed in this paragraph occurs, the director
may inspect or request additional information from the HCF to determine whether the HCF
meets the requirements of section 3702.30 of the Revised Code and the applicable
requirements of Chapter 3701-83 of the Administrative Code.
(1) The HCF’s accreditation is terminated; or
(2) The HCF’s accreditation expires and is not renewed.

3701-83-05.1 Compliance actions, revocation, and operating without a license.

(A) If the director determines that an HCF is operating without a license in violation of
division (E)(1) of section 3702.30 of the Revised Code, the director shall do one or more of the
following:
(1) Notify the HCF that it is operating without a license and issue a written order that the
HCF apply for a license. The order shall specify the time frame for filing a complete application
in accordance with rule 3701-83-04 of the Administrative Code that shall not exceed thirty days
after the date of the order;
(2) Issue a written order that the HCF cease its operations. The department shall deliver
the written order issued under section 3702.32 of the Revised Code to the HCF. The order shall be effective no later than fifteen days after the facility receives the order, and shall stay in effect until such time as specified by the director or until a license is issued;

(3) Issue a written order that prohibits the HCF from performing certain types of services. The department shall deliver the written order issued under section 3702.32 of the Revised Code to the HCF. The order shall be effective on the date specified in the order and shall stay in effect until such time as specified by the director or until a license is issued;

(4) Impose a civil penalty as provided under paragraph (A) of rule 3701-83-05.2 of the Administrative Code. The civil penalty shall not be less than one thousand dollars and not more than two hundred fifty thousand dollars;

(5) Impose an additional civil penalty as provided under paragraph (D) of rule 3701-83-05.2 of the Administrative Code. The civil penalty shall not be less than one thousand dollars and not more than ten thousand dollars for each day that the HCF continues to operate without a license in violation of an order issued under paragraph (A) of this rule.

(B) The director may file a petition in the court of common pleas of the county in which a HCF is located for an injunction enjoining the facility from operating if the HCF is subject to an order issued:

(1) Under paragraph (A)(1) of this rule but the HCF continues to operate in violation of such order after the time frame specified for filing an application; or

(2) Under paragraph (A)(2) of this rule but the HCF continues to operate or provide services in violation of such order.

(C) If the director determines that the HCF is not complying with any provision of section 3702.30 of the Revised Code, other than a violation under division (E)(1) or (E)(2) of that section, any provision of Chapter 3701-83 of the Administrative Code, or any other rule adopted by the director under section 3702.30 of the Revised Code, the director may do any or all of the following:

(1) Provide an opportunity to correct the violation within a specified period of time;

(2) Revoke, suspend, or refuse to renew the license;

(3) Prior to or during the pendency of an administrative hearing under Chapter 119 of the Revised Code, issue an order that prohibits the HCF from performing certain types of services. The order shall be effective on the date specified in the order;

(4) Impose a civil penalty as provided under paragraph (A) of rule 3701-83-05.2 of the Administrative Code. The civil penalty shall not be less than one thousand dollars and not more than two hundred fifty thousand dollars;

(5) Impose an additional civil penalty as provided under paragraph (E) of rule 3701-83-05.2 of the Administrative Code. The civil penalty shall not be less than five hundred dollars and not more than ten thousand dollars for each day that the HCF fails to correct the violation.

(D) In determining which of the actions to take under paragraph (C) of this rule, the director may consider, but is not limited to, any or all of the following factors:

(1) The danger of serious physical or life threatening harm to one or more patients of the HCF;

(2) The nature, duration, gravity, and extent of the violation;

(3) Whether the violation directly relates to patient care;

(4) The number, if any, of patients directly affected by the violation;

(5) The extent of any actual or potential harm to patients;

(6) The actions taken by the HCF to correct the violation; and

(7) The compliance history of the HCF.

(E) The director may file a petition in the court of common pleas of the county in which the facility is located for an injunction enjoining:

(1) A HCF that is operating without a license from performing certain types of services if the HCF is subject to an order issued under paragraph (A)(3) of this rule but continues to
perform the types of services prohibited by the order; or

(2) A licensed HCF from performing certain types of services if the HCF is subject to an order issued under paragraph (C)(3) of this rule but continues to perform the types of services prohibited by the order.

(F) If, after reporting under division (E)(2) of section 3702.30 of the Revised Code that a physician failed to obtain informed consent under any provision of the Revised Code, the department finds that the physician has continued to engage in a pattern of violating the same informed consent provision at the HCF and that the HCF has failed to take reasonable steps to ensure that the physician does not continue the same violation at the HCF, the department may, after providing the HCF an opportunity for a hearing pursuant to Chapter 119 of the Revised Code, impose a civil penalty on the HCF. The penalty shall be not less than one thousand dollars and not more than fifty thousand dollars. For the purpose of this paragraph, “pattern” means a violation of the same provision of the Revised Code that reasonably could have been prevented by a facility’s corrective action and was determined by the department to have occurred at least twice after the department made its report as provided in division (E)(2) of section 3702.30 of the Revised Code.

3701-83-05.2 Civil penalties.

(A) Except as provided under paragraph (B) of this rule, civil penalties imposed under paragraph (A)(4) or paragraph (C)(4) of rule 3701-83-05.1 of the Administrative Code for a violation of section 3702.30 of the Revised Code, Chapter 3701-83 of the Administrative Code, or any other rule adopted by the director under section 3702.30 of the Revised Code shall be imposed as follows:

(1) If no harm has occurred to any patient, one thousand to fifty thousand dollars;
(2) If harm has occurred to one or more patients, fifty-one thousand to one hundred thousand dollars;
(3) If there has been permanent injury to one or more patients, one hundred thousand to one hundred fifty thousand dollars; and
(4) If death has occurred to one or more patients, one hundred fifty thousand to two hundred fifty thousand dollars.

(B) Except as otherwise required by law, if there has been a history of uncorrected violations of section 3702.30 of the Revised Code, Chapter 3701-83 of the Administrative Code, or any other rule adopted under section 3702.30 of the Revised Code that caused no actual harm to a patient, but had the potential to cause more than minimal harm, a fine of up to two hundred fifty thousand dollars may be imposed.

(C) In determining the level of civil monetary penalties imposed under this paragraph, the total amount of fines for violations discovered during one inspection shall not exceed two hundred fifty thousand dollars.

(D) Additional civil penalties imposed under paragraph (A)(5) of rule 3701-83-05.1 of the Administrative Code shall be imposed on a per day basis of one thousand to ten thousand dollars for each day that the HCF continues to operate without a license in violation of a written order issued under paragraph (A) of rule 3701-83-05.1 of the Administrative Code.

(E) Additional civil penalties imposed under paragraph (C)(5) of rule 3701-83-05.1 of the Administrative Code shall be imposed on a per day basis of five hundred to ten thousand dollars for each day the HCF fails to correct the violation.

(F) Civil penalties imposed under paragraph (F) of rule 3701-83-05.1 of the Administrative Code shall be imposed as follows:

(1) If a physician failed to obtain informed consent from less than ten patients, but no patients were harmed, one thousand to twenty-five thousand dollars;
(2) If a physician failed to obtain informed consent from ten or more patients, but no
patients were harmed, twenty-six thousand to fifty thousand dollars; and
(3) If harm occurs to one or more patients as a result of a physician’s failure to obtain
informed consent, thirty thousand to fifty thousand dollars per patient.
(G) In determining the amount of civil penalties imposed under paragraphs (A) and (F) of
this rule, the director may consider, but is not limited to, any or all of the following factors:
(1) The compliance history of the HCF;
(2) The number of patients directly affected;
(3) The impact of the noncompliance on the patient or patients;
(4) Whether the violation is repetitive in nature or is similar to previous violations;
(5) The length or duration of the violation; and
(6) The time period between the current violation and any similar previous violation.
(H) Except for civil penalties imposed upon an HCF under paragraph (A)(4) of rule 3701-
83-05.1 of the Administrative Code, the HCF may appeal the imposition of civil penalties
imposed under this rule in accordance with Chapter 119 of the Revised Code. If the HCF
obtains a license or comes into compliance and waives the right to a hearing provided under
Chapter 119 of the Revised Code, the civil penalty may be reduced up to fifty percent but shall
not be less than one thousand dollars.
(I) If the department issues more than one order, any administrative hearing resulting
from such orders may be consolidated into one hearing. Consolidation of the hearings does not
affect any effective dates prescribed in the orders.

3701-83-06 Inspections.

(A) The director may make announced or unannounced inspections as the director
considers necessary to determine compliance with section 3702.30 of the Revised Code and
the applicable requirements of Chapter 3701-83 of the Administrative Code. The director may
notify ASFs, freestanding dialysis centers, freestanding inpatient rehabilitation facilities, and
freestanding birth centers prior to conducting announced inspections for initial and renewal
licensing. Such prior notification shall be no earlier than thirty days and no later than two weeks
prior to start date of the survey.
(B) Immediately upon request, each HCF shall provide the director access to its
premises, facility and patient records, including medical records, and staff to enable the director
to determine compliance with section 3702.30 of the Revised Code and the applicable
requirements of Chapter 3701-83 of the Administrative Code.
(C) Prior to the issuance of an initial license the HCF shall obtain documentation from
the state fire marshal or fire prevention officer of a municipal, township, or other legally
constituted fire department approved by the fire marshal that the HCF is in compliance with the
state fire code. In the case of an HCF regulated by the state fire code, following the initial
license the HCF shall obtain documentation, every twelve months and at any other time
requested by the director, that the HCF continues to be in compliance with the state fire code.
(D) Information obtained by the director pertaining to specific patients is confidential.
Information may be released in summary, statistical, or other form which does not disclose the
identity of an individual patient.
(E) The director may conduct an inspection to investigate alleged violations of section
3702.30 of the Revised Code and Chapter 3701-83 of the Administrative Code. The director
shall inform the complainant and the HCF of the results of the inspection.
(F) For purposes of this paragraph “follow-up inspection” means an inspection
conducted by the department to determine whether an HCF has corrected a violation or
violations cited on a previous inspection and to verify whether an HCF is in compliance with the
applicable criteria, standards, and requirements established by section 3702.30 of the Revised
Code and Chapter 3701-83 of the Administrative Code. “Validation inspection” means an
inspection of an HCF that submitted an acceptable accreditation award letter or an approval letter. The HCF fee for inspections conducted by the director pursuant to section 3702.30 of the Revised Code and paragraphs (A) and (E) of this rule shall be as follows:

1. Inspection fee of one thousand seven hundred fifty dollars;
2. Complaint inspection fee of eight hundred seventy-five dollars;
3. Follow-up inspection fee of eight hundred seventy-five dollars;
4. Validation inspection fee of one thousand seven hundred fifty dollars; and
5. Desk audit or compliance review inspection fee of two hundred fifty dollars.

(G) Notwithstanding the requirements of paragraph (F) of this rule, the fee for an inspection of a free-standing radiation therapy center or a free-standing diagnostic or mobile imaging center shall be determined as follows. To the extent practicable, inspections done to determine compliance with Chapter 3748 of the Revised Code shall be done concurrently with inspections to determine compliance with Chapter 3701-83 of the Administrative Code.

1. Inspection fee of nine hundred fifty dollars;
2. Follow-up inspection fee of four hundred seventy-five dollars;
3. Complaint fee of four hundred seventy-five dollars; and
4. Desk audit or compliance review inspection fee of two hundred fifty dollars.

(H) The director shall provide to each HCF inspected pursuant to section 3702.30 of the Revised Code and paragraph (A) or (E) of this rule a written statement of the fee established in paragraph (F) or (G) of this rule. The statement shall itemize the total costs incurred.

(I) Each HCF shall forward the total amount of the fee to the director payable to the “Treasurer, State of Ohio” within fifteen days after receiving a statement of the fee issued under paragraph (F) or (G) of this rule.

(J) The director shall deposit HCF fees into the quality monitoring and inspection fund created in the state treasury pursuant to division (A) of section 3702.31 of the Revised Code.

3701-83-07 Patient care policies.

(A) The HCF shall develop and follow comprehensive and effective patient care policies that include the following requirements:

1. Each patient shall be treated with consideration, respect, and full recognition of dignity and individuality, including privacy in treatment and personal care needs;
2. Each patient shall be allowed to refuse or withdraw consent for treatment;
3. Each patient shall have access to his or her medical record, unless access is specifically restricted by the attending physician for medical reasons;
4. Each patient's medical and financial records shall be kept in confidence; and
5. Each patient shall receive, if requested, a detailed explanation of facility charges including an itemized bill for services received.

(B) The HCF shall inform each patient of the following:

1. The HCF's policy on advance directives and do-not-resuscitate (DNR) orders; and
2. The name of the attending physician or individual supervising the patient's care and the manner in which that individual may be contacted.

(C) The HCF shall implement a patient satisfaction survey program.

3701-83-08 Personnel and staffing requirements.

[Editor’s Note: Appendix A to this rule can be found at www.registerofohio.state.oh.us/.]

(A) Each HCF shall utilize personnel that have appropriate training and qualifications for the services that they provide. Any staff member who functions in a professional capacity shall meet the standards applicable to that profession, including but not limited to possessing a
current Ohio license, registration, or certification, if required by law, and working within his or her scope of practice. Copies of current Ohio licenses, registrations and certifications shall be kept in the employee's personnel files or the provider of the HCF shall have an established system of records necessary for the director to ascertain that all individuals employed at the HCF who function in a professional capacity meet the standards applicable to that profession, including, but not limited to, possessing a current Ohio license, registration, or other certification if required by law.

(B) Each HCF shall develop and follow a tuberculosis control plan that is based on the provider's assessment of the facility. The control and assessment shall be consistent with the centers for disease control and prevention (CDC) “Guidelines for Preventing the Transmission of Mycobacterium tuberculosis in Health Care Settings, 2005,” MMWR 2005, Volume 54, No. RR-17. The HCF shall retain documentation evidencing compliance with this paragraph and shall furnish such documentation to the director upon request.

(C) Each HCF shall not knowingly permit a staff member to provide services if the staff member:

(1) Has a communicable disease capable of being transmitted during the performance of his or her duties; or
(2) Is under the influence of drugs or alcohol.

(D) Each HCF shall provide each staff member with a written job description delineating his or her responsibilities.

(E) Each HCF shall provide an ongoing training program for its staff. The program shall provide both orientation and continuing training to all staff members. The orientation shall be appropriate to the tasks that each staff member will be expected to perform. Continuing training shall be designed to assure appropriate skill levels are maintained and that staff are informed of changes in techniques, philosophies, goals, and similar matters. The continuing training may include attending and participating in professional meetings and seminars.

(F) All staff shall have appropriate orientation and training regarding the facility's equipment, safety guidelines, practices, and policies.

(G) Each HCF shall evaluate the performance of each staff member at least every twelve months.

(H) Each HCF shall retain staffing schedules, time-worked schedules, on-call schedules, and payroll records for at least two years.

3701-83-09 Service standards for HCFs; policies and procedures.

(A) Each HCF shall assure all staff members provide services in accordance with:

(1) Applicable current and accepted standards of practice and the clinical capabilities of the HCF; and
(2) Applicable state and federal laws and regulations.

(B) Each HCF shall have the ancillary and support services necessary for the provision of the HCF's services.

(C) Each HCF, as part of the quality assessment and performance improvement program required by rule 3701-83-12 of the Administrative Code, shall document and review any complications and adverse events which arise during the provision of the facility's service.

(D) Each HCF shall establish and follow written infection control policies and procedures for the surveillance, control and prevention and reporting of communicable disease organisms by both the contact and airborne routes which shall be consistent with current infection control guidelines issued by the United States centers for disease control. The policies and procedures shall address:

(1) The utilization of protective clothing and equipment;
(2) The storage, maintenance and distribution of sterile supplies and equipment;
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(3) The disposal of biological waste; including blood, body tissue; and fluid in accordance with Ohio law;
(4) Standard precautions/body substance isolation or equivalent; and
(5) Tuberculosis and other airborne diseases.

(E) Each HCF shall maintain and operate equipment in a safe manner and in accordance with the manufacturer's instructions.
(F) Each HCF shall provide the patient or the patient's representative with:
(1) Instruction and education regarding the services to be performed;
(2) Written information about how to obtain appointments and needed services both during and after the HCF's normal hours of operation; and
(3) Verbal and written instructions for post-treatment care and procedures for obtaining emergency care.

(G) Each HCF shall comply with rule 3701-3-03 of the Administrative Code pertaining to reportable disease notification.
(H) Each HCF shall require that each physician practicing in the HCF complies with any provision of the Revised Code related to obtaining informed consent from a patient and the policies and procedures of the HCF.
(I) If an HCF finds that a physician practicing at the HCF does not comply with any provision of the Revised Code related to the obtaining of informed consent from a patient, the HCF shall take reasonable steps to ensure that the physician does not continue the practice at the facility.

3701-83-10 Building and site requirements; disaster and emergency plans.

(A) Each HCF shall:
(1) Have a certificate of use and occupancy, from a local, certified building department or by the department of commerce as meeting applicable requirements of Chapters 3781., 3783., and 3791 of the Revised Code and any rules adopted under them or obtain documentation from the appropriate building authority that the HCF is not regulated by the state building code; and
(2) Comply with the applicable provisions of Chapter 3737 of the Revised Code and the rules adopted under it.
(B) Each HCF shall be maintained in a safe and sanitary manner.
(C) Each HCF shall develop a disaster preparedness plan including evacuation in the event of a fire or other emergency. Each HCF shall review evacuation procedures at least annually and conduct practice drills with staff at least once every six months.
(D) Each HCF shall label, store and dispose of all poisons, hazardous wastes, and flammable materials in a safe manner and in accordance with state and federal laws and regulations.

3701-83-11 Medical records; procedures and requirements; six year minimum.

(A) Each HCF shall maintain a medical record for each patient that documents, in a timely manner and in accordance with acceptable standards of practice, the patient's needs, assessments, and services rendered. Each medical record shall be legible and readily accessible to staff for use in the ordinary course of treatment.
(B) Each HCF shall not disclose individual medical records except as provided by state and federal laws and regulations.
(C) Each HCF shall systematically review the records for conformance with acceptable standards of practice and the requirements of Chapter 3701-83 of the Administrative Code.
(D) Each HCF shall maintain an adequate medical record keeping system and take appropriate measures to protect medical records against theft, loss, destruction, and
(E) Each HCF shall have policies and procedures to ensure the confidentiality of patient medical records.

(F) Each HCF shall maintain medical records as necessary to verify the information and reports required by statute or regulation for at least six years from the date of discharge.

3701-83-12 Quality assessment and improvement program.

(A) Each HCF shall establish a quality assessment and performance improvement program designed to systematically monitor and evaluate the quality of patient care, pursue opportunities to improve patient care, and resolve identified problems.

(B) Each HCF shall develop a written plan that describes the quality assessment and performance improvement program's objectives, organization, scope, and mechanism for overseeing the effectiveness of monitoring, evaluation, improvement and problem-solving activities.

(C) The quality assessment and performance improvement program shall do all of the following:

1. Monitor and evaluate all aspects of care including effectiveness, appropriateness, accessibility, continuity, efficiency, patient outcome, and patient satisfaction;
2. Establish expectations, develop plans, and implement procedures to assess and improve quality of care and resolve identified problems;
3. Establish expectations, develop plans, and implement procedures to assess and improve the health care facility's governance, management, clinical, and support processes;
4. Establish information systems and appropriate data management processes to facilitate the collection, management, and analysis of data needed for quality assessment and performance improvement and to comply with the applicable data collection requirements of Chapter 3701-83 of the Administrative Code;
5. Document and report the status of the quality assessment and performance improvement program to the governing body every twelve months;
6. Document and review all unexpected complications and adverse events, whether serious injury or death, that arise during an operation or procedure; and
7. Hold regular meetings, chaired by the medical director of the HCF or designee, as necessary, but at least within sixty days after a serious injury or death, to review all deaths and serious injuries, and report findings. Any pattern that might indicate a problem shall be investigated and remedied, if necessary.

(D) Each HCF shall implement a program for proactive assessment of high-risk activities related to patient safety and to undertake appropriate improvements.

(E) Each HCF shall report to the director, in a manner and interval prescribed by the director, the data specified in the applicable rules of Chapter 3701-83 of the Administrative Code.

3701-83-13 Complaint documentation minimum standards.

(A) Each HCF shall develop and follow policies and procedures to receive, investigate, and report findings on complaints regarding the quality or appropriateness of services provided by the HCF. The documentation of complaints shall, at a minimum, include the following:

1. The date complaint was received;
2. The identity, if provided, of the complainant;
3. A description of complaint;
4. The identity of persons or facility involved;
5. The findings of the investigation; and
(6) The resolution of the complaint.
    (B) Each HCF shall post the toll free complaint hotline of the department’s complaint unit in a conspicuous place in the HCF.

3701-83-14 Building or safety requirement variances; waivers.

(A) The director may grant a variance or waiver from any building or safety requirement established by Chapter 3701-83 of the Administrative Code, unless the requirement is mandated by statute.
    (B) An HCF seeking a variance or waiver must submit a written request to the director. Such written request must include the following information:
        (1) The specific nature of the request and the rationale for the request;
        (2) The specific building or safety requirement in question, with a reference to the relevant administrative code provision;
        (3) The time period for which the variance or waiver is requested;
        (4) If the request is for a variance, a statement of how the HCF will meet the intent of the requirement in an alternative manner; and
        (5) If the request is for a waiver, a statement regarding why application of the requirement will cause undue hardship to the HCF and why granting the waiver will not jeopardize the health and safety of any patient.
    (C) Upon written request of the HCF the director may grant:
        (1) A variance if the director determines that the requirement has been met in an alternative manner; or
        (2) A waiver if the director determines that the strict application of the license requirement would cause an undue hardship to the HCF and that granting the waiver would not jeopardize the health and safety of any patient.
    (D) The director may stipulate a time period for which a variance or a waiver is to be effective and may establish conditions that the HCF must meet for the variance or waiver to be operative. Such time period may be different than the time period sought by the HCF in the written variance or waiver request.
    (E) The director may establish conditions that the HCF must meet for the variance or waiver to be operative. The director may, in the director's discretion, rescind the waiver or variance at any time upon determining that the HCF is not meeting such conditions.
    (F) The refusal of the director to grant a variance or waiver, in whole or in part, shall be final and shall not be construed as creating any rights to a hearing under Chapter 119 of the Revised Code.
    (G) The granting of a variance or waiver by the director shall not be construed as constituting precedence for the granting of any other variance or waiver. All variance and waiver requests shall be considered on a case-by-case basis.

Ambulatory Surgical Facilities

3701-83-15 Ambulatory Care facilities, anesthesia, assistants; definitions.

For the purposes of rules 3701-83-15 to 3701-83-22 of the Administrative Code, the following definitions shall apply:
    (A) “Ambulatory surgical facility” or “ASF” means a facility whether or not a part of the same organization as a hospital, which is located in a building distinct from another in which inpatient care is provided, and to which any of the following apply:
        (1) Outpatient surgery is routinely performed in the facility and the facility functions separately from a hospital's inpatient surgical service or emergency department, and from the
offices of private physicians, podiatrists, and dentists;

(2) Anesthesia is administered in the facility by an anesthesiologist or certified registered nurse anesthetist and the facility functions separately from a hospital's inpatient surgical service or emergency department, and from the offices of private physicians, podiatrists, and dentists;

(3) The facility applies to be certified by the centers for medicare and medicaid services as an ambulatory surgical center for purposes of reimbursement under Part B of the medicare program, Part B of Title XVIII of the “Social Security Act” 49 Stat. 620 (1935), 42 U.S.C.A. 301, as amended;

(4) The facility applies to be certified by a national accrediting body approved by the centers for medicare and medicaid services for purposes of deemed compliance with the conditions for participating in the medicare program as an ambulatory surgical center;

(5) The facility bills or receives from any third-party payer, governmental health care program, or other person or government entity any ambulatory surgery facility fee that is billed or paid in addition to any fee for professional services; or

(6) The facility is held out to any person or government entity as an ambulatory surgical facility or similar facility by means of signage, advertising, or other promotional efforts.

(B) “Ambulatory surgical facility fee” means a fee for certain overhead costs associated with providing surgical services in an outpatient setting, but does not include any additional payment in excess of a professional fee that is provided to encourage physicians, podiatrists, and dentists to perform certain surgical procedures in their office or their group practice's office rather than a health care facility, if the purpose of the additional fee is to compensate for additional cost incurred in performing office-based surgery. A fee is an ambulatory surgical facility fee only if it directly or indirectly pays for costs associated with any of the following:

(1) Use of operating rooms, procedure rooms, recovery rooms, preparation areas, and waiting rooms and lounges for patients and relatives;

(2) Administrative functions, record keeping, housekeeping, utilities, and rent;

(3) Services provided by nurses, orderlies, technical personnel, and others involved in patient care related to providing surgery.

(C) “Anesthesia” means total or partial loss of sensation, tactile sensibility, or protective reflexes, with or without the loss of consciousness, produced by a pharmacological or non-pharmacological agent or method, or combination thereof.

(D) “Anesthesia qualified dentist” means a dentist who holds a permit of authorization to utilize general anesthesia issued pursuant to rule 4715-5-05 of the Administrative Code.

(E) “Anesthesiologist” means a physician who has completed a residency training program in anesthesiology accredited by the accreditation council of graduate medical education or the American osteopathic association.

(F) “Certified registered nurse anesthetist” or “CRNA” means a registered nurse who is authorized to practice as a certified registered nurse anesthetist under section 4723.43 of the Revised Code and is credentialed and privileged by the HCF to administer anesthetics to patients within his or her scope of practice.

3701-83-16 Governing body of ASF.

(A) As required under paragraph (E) of rule 3701-83-03 of the Administrative Code, each ASF shall have a governing body.

(B) The governing body shall:

(1) At least every twenty-four months review, update, and approve the surgical procedures that may be performed at the facility and maintain an up-to-date listing of these procedures;

(2) Grant or deny clinical (medical-surgical and anesthesia) privileges, in writing and reviewed or re-approved at least every twenty-four months, to physicians and other
appropriately licensed or certified health care professionals based on documented professional peer advice and on recommendations from appropriate professional staff. These actions shall be and based on documented evidence of the following:

(a) Current licensure and certification, if applicable;
(b) Relevant education, training, and experience; and
(c) Competence in performance of the procedures for which privileges are requested, as indicated in part by relevant findings of quality assessment and improvement activities and other reasonable indicators of current competency.

(3) In the case of an ASF owned and operated by a single individual, provide for an external peer review by an unrelated person not otherwise affiliated or associated with the individual. The external peer review shall consist of a quarterly audit of a random sample of surgical cases.

(4) Designate a qualified professional trained in infection control to direct the infection control program required by paragraph (D) of rule 3701-83-09 of the Administrative Code. For the purpose of this rule, a qualified professional trained in infection control means a nurse or physician as defined in rule 3701-83-01 of Administrative Code, who has documentation of completion of training in infection control, including, but not limited to, continuing education units, in-service training, or academic or vocational course completion.

3701-83-17 Admission through discharge.

(A) Each ASF shall only admit patients who do not require planned inpatient care and who shall be kept in the ASF for less than twenty-four hours. The twenty-four hour period begins at the start of the operation or procedure, or the induction of anesthesia, whichever is first. The twenty-four hour period may include an overnight stay if such stay meets all of the conditions set forth in this rule and does not extend the length of time a patient remains in the ASF.

(B) Prior to operation or procedure, each patient shall have a comprehensive medical history and physical exam performed or updated, along with associated pre-procedure studies. The different components of the history and physical may be performed by different health care professionals, consistent with the type of information required and the professionals’ scope of practice, as defined by applicable law. This history and physical exam shall document the pre-operative diagnosis and the procedure to be performed and shall become part of the patient’s medical record prior to surgery.

(C) Documentation, as contained in paragraphs (A)(3), (C)(1), and (C)(7) to (C)(9) of rule 3701-83-21 of the Administrative Code shall be in a patient’s medical record prior to surgery.

(D) Immediately before surgery, the attending physician, podiatrist, or dentist shall examine the patient to evaluate the risks of the procedure to be performed. Each patient shall also be examined by an anesthesiologist, physician, podiatrist, anesthesia qualified dentist, or CRNA, as appropriate, to evaluate the risks of anesthetics and for proper anesthesia recovery before discharge from post anesthesia care.

(E) The attending or other designated physician, podiatrist, or anesthesia qualified dentist shall discharge a patient meeting discharge criteria from the ASF within twenty-four hours of the start of the operation or procedure, or induction of anesthesia, whichever is first, or transfer the patient to a setting appropriate for the patient's needs.

(F) Patients transported to a hospital shall be accompanied by their medical records that are of sufficient content to ensure continuity of care.

(G) Prior to discharge, the ASF shall provide each patient with both verbal and written instructions for post-treatment care and procedures for obtaining emergency care.

(H) The physician, podiatrist, dentist, or a nurse shall ensure that the patient or patient's representative acknowledge, in writing, receipt of the physician's, podiatrist's, or dentist's written discharge instructions.
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(I) Each ASF shall discharge a patient only if accompanied by a responsible person, unless the attending or discharging physician, podiatrist, or anesthesia qualified dentist determines that the patient does not need to be accompanied and documents the circumstances of discharge in the patient's medical record.

3701-83-18 Personnel and staffing requirements; staff records; training program.

(A) Each ASF shall maintain qualified nursing and physician staff, and qualified dental staff, as appropriate for the services provided. Each ASF shall, based on the services provided and the number of patients served, maintain a sufficient number of staff and other personnel and an appropriate schedule of staff time to meet the needs of its patients in a timely manner.

(B) Each ASF shall have a medical director and an administrator as defined in rule 3701-83-01 of the Administrative Code. If the ASF limits its services:

(1) To dental/oral and maxillofacial surgery, a dentist may serve as the medical director; or
(2) To podiatric surgery, a podiatrist may serve as the medical director.

(C) Each ASF shall have a director of nursing who is an RN with experience in surgical and recovery room nursing care. The director of nursing shall be responsible for the management of nursing services.

(D) Each ASF shall only grant privileges to physicians, podiatrists, dentists, and CRNAs:

(1) Whose professional license or certification is maintained in good standing; and
(2) Who meet other guidelines as determined by the governing body.

(E) At all times when patients are receiving treatment or recovering from treatment until they are discharged from post anesthesia care, the ASF shall have present and on duty in the ASF at least one member of the physician staff, podiatry staff, or dental staff, as applicable.

(F) At all times when patients are receiving treatment or recovering from treatment until they are discharged, the ASF shall:

(1) Have at least two nurses present and on duty in the ASF, at least one of whom shall be an RN and at least one of whom is currently certified in advanced cardiac life support who shall be present and on duty in the recovery room when patients are present;
(2) In addition to the requirement of paragraph (F)(1) of this rule, have at least one RN readily available on an on-call basis; and
(3) Have sufficient and qualified additional staff present to attend to the needs of the patients shall be present.

(G) Each ASF shall maintain the following:

(1) An established system of records sufficient for the director to ascertain that all individuals employed at the ASF in a professional capacity meet the standards applicable to that profession, including, but not limited to, possessing a current Ohio license, registration, or other certification required by law; and
(2) Staffing schedules, time-worked schedules, on-call schedules, and payroll records for at least two years.

(H) Each ASF shall provide an ongoing training program for its personnel. The program shall provide both orientation and continuing training to all staff members.

(1) The orientation shall be appropriate to the tasks that each staff member will be expected to perform; and
(2) The continuing training shall be designed to assure appropriate skill levels are maintained and that staff are informed of changes in techniques, philosophies, goals, and similar matters. The continuing training may include attending and participating in professional meetings and seminars.

(I) Each ASF shall require that each physician who practices at the facility complies with any provision of the Revised Code related to the obtaining of informed consent from a patient.
3701-83-19 Service standards and required protocols.

(A) Each ASF shall provide medical services, dental services, nursing services, pharmaceutical services, and anesthesia services. Each service shall be provided in a safe, effective manner that is consistent with the needs of the patient.

(B) Each ASF shall:

(1) Provide adequate space, equipment, and staff for storage and the administration of drugs in compliance with state and federal laws and regulations.

(2) Establish and implement a program for the control and accountability of drug products throughout the facility and maintain a list of medications that are always available.

(C) Each ASF shall:

(1) Ensure that all anesthetics are administered by individuals acting within their licensed scopes of practice.

(2) Maintain an anesthesia record for each patient who receives anesthetics in the facility. This record shall become a part of the patient’s medical record and shall include patient identification data, dosage and duration of anesthesia, and a record of administration of other drugs or therapeutics.

(3) Ensure that, following the administration of general anesthetics, patients are constantly attended by the responsible anesthesiologist, CRNA, anesthesia qualified dentist, physician or podiatrist acting within their scope of practice, or an RN until conscious and in the ambulatory condition normal for him or her.

(D) Each ASF shall respond to medical emergencies including emergency cardiac care that may arise in the provision of services to patients.

(E) Each ASF shall have a written transfer agreement with a hospital for transfer of patients in the event of medical complications, emergency situations, and for other needs as they arise.

(1) A copy of the written transfer agreement shall be filed with the ASF’s application for license renewal in accordance with paragraph (B) of rule 3701-83-04 of the Administrative Code.

(2) A formal agreement is not required in those instances where the licensed ASF is a provider-based entity of a hospital and the ASF policies and procedures to accommodate medical complications, emergency situations, and for other needs as they arise are in place and approved by the governing body of the parent hospital.

(F) Prior to the surgery, the physician, podiatrist, or dentist, shall obtain a statement documenting informed consent, signed by the patient or patient representative, for the performance of the specific surgical procedure or procedures. This statement shall be made part of the patient’s medical record. The ASF shall ensure that informed consents for surgical procedures have been signed.

(G) Each ASF may provide or contract for other services including, but not limited to, laboratory and radiology services.

(H) When a blood supply may be needed for a surgical procedure, the ASF shall:

(1) Have a policy and procedure to obtain blood, blood components, or blood products on a timely basis.

(2) Ensure that blood, blood components or blood products are administered by physicians, anesthesia qualified dentists, or RNs.

3701-83-20 Building and site requirements; equipment; minimum standards.

(A) Each ASF shall have one or more operating rooms or procedure rooms, each of which is designed and equipped so that the types of surgery conducted can be performed in a manner that protects the health and well-being of all individuals in the area. The recovery area
shall be adequately equipped for the proper care of post anesthesia recovery of surgical patients.

(B) Each ASF shall have the following equipment accessible to the operating suite and recovery area:

1. Adequate resuscitation equipment:
   a. ASFs providing surgical procedures under topical and local infiltration blocks with or without oral or intramuscular preoperative sedation shall have: airways, bag mask respirator, oxygen source, suction equipment, and age-appropriate resuscitative drugs;
   b. ASFs providing surgical procedures performed in conjunction with oral, parenteral, or intravenous sedation or under analgesic or dissociative drugs or providing surgical procedures that require general or regional block anesthesia and support of vital bodily functions shall have: airways, endotracheal tubes, laryngoscope, oxygen delivery capability under positive pressure, suction equipment and suitable resuscitative drugs.

2. Appropriate monitoring equipment:
   a. Each ASF shall have size-specific blood pressure apparatus and stethoscopes, electrocardiogram, oscilloscopes and when pediatric patients are treated, size-specific emergency equipment and medications;
   b. ASFs performing surgical procedures in conjunction with oral, parenteral, or intravenous sedation or under analgesic or dissociative drugs, or performing surgical procedures that require general or regional block anesthesia and support of vital bodily functions shall have a defibrillator, pulse oximeter with alarm, and temperature monitor.
   c. ASFs using inhalation anesthesia shall have an anesthesia machine.

3. Each ASF shall have suitable surgical instruments customarily available for the planned surgical procedure in the operating suite.

4. Each ASF shall have in the recovery room, an emergency call system that is connected electronically, electrically, by radio transmission or in a like manner and that effectively alerts staff.

(C) Each ASF shall establish and follow a preventive maintenance program which includes periodic calibration, cleaning and adjustment of all equipment in accordance with manufacturer's instructions. Each ASF using inhalation anesthesia shall develop and follow policies and procedures for monitoring the anesthesia machine which are consistent with the standards recommended by the American society of anesthesiologists.

(D) Each ASF shall have appropriate ventilation and humidity levels in order to minimize the risk of infection and to provide for the safety of the patient.

(E) Each ASF shall have emergency power available in operative, procedure, and recovery areas.

(F) Each ASF shall have separate closed off and distinct areas used as waiting rooms, recovery rooms, treatment rooms, toilet facilities, and storage rooms. The ASF and another entity may not mix functions and operations in a common space during concurrent or overlapping hours of operation. Operating, procedure, and recovery rooms must be used exclusively for surgical procedures.

(G) New construction, alterations or renovations that provide space for operating rooms or procedure rooms may not be used or occupied until authorization for such occupancy has been received by the ASF from the department.

(H) Each ASF shall develop and follow policies and procedures for the storage and use of all medical gases in accordance with the requirements of the national fire protection association (NFPA) 99.

(I) If the ASF uses medications or drugs that may induce malignant hyperthermia, it shall have policies and procedures in place, as well as equipment and medication available, to treat it.

(J) Each ASF shall have appropriate intravenous fluids and administration equipment.
(K) Each ASF shall have sufficient and appropriate stretchers and wheelchairs for the services performed.

3701-83-21 Medical records; minimum standards on content.

Each medical record required by paragraph (A) of rule 3701-83-11 of the Administrative Code shall contain at least the following information as applicable for the surgery to be performed:

(A) Admission data:
   (1) Name, address, date of birth, gender, and race or ethnicity;
   (2) Date and time of admission; and
   (3) Pre-operative diagnosis, which shall be recorded prior to or at the time of admission.

(B) History and physical examination data:
   (1) Personal medical history, including but not limited to allergies, current medications and past adverse drug reactions;
   (2) Family medical history; and
   (3) Physical examination.

(C) Treatment data:
   (1) Physician's, podiatrist's or dentist's orders;
   (2) Physician's, podiatrist's or dentist's notes;
   (3) Physician assistant's notes, if applicable;
   (4) Nurse's notes;
   (5) Medications;
   (6) Temperature, pulse, and respiration;
   (7) Any special examination or report, including but not limited to, x-ray, laboratory, or pathology reports;
   (8) Signed informed consent form;
   (9) Evidence of advanced directives and do-not-resuscitate orders, if applicable;
   (10) Operative record;
   (11) Anesthesia record, if applicable; and
   (12) Consultation record, if applicable.

(D) Discharge data:
   (1) Final diagnosis;
   (2) Procedures and surgeries performed;
   (3) Condition upon discharge;
   (4) Post-treatment care and instructions; and
   (5) Attending physician's, podiatrist's or dentist's signature.

(E) Other information required by law.

3701-83-22 Quality assessment and improvement program data reporting.

As part of the quality assessment and performance improvement program required under paragraph (A) of rule 3701-83-12 of the Administrative Code, each ASF shall collect and maintain the following data on an annual basis and shall report such data to the director upon request:

(A) The total number of patient visits;
(B) The total number of patient transfers to a hospital and the reason why;
(C) The total number of deaths in the ASF; and
(D) The total number of deaths resulting either from the surgery or from surgical complications that occur in the ASF.
Renal Dialysis Facilities

3701-83-23 Dialysis; definitions.

For purposes of rules 3701-83-23 to 3701-83-24 of the Administrative Code the following definitions shall apply:

(A) “Chronic maintenance dialysis” means the regular provision of dialysis for an end stage renal disease patient with any level of patient involvement.

(B) “Dialysis” means a process by which dissolved substances are removed from patient's body by diffusion from one fluid compartment to another across a semipermeable membrane.

(C) “End stage renal disease patient” or “patient” means an individual who is at a stage of renal impairment that appears irreversible and permanent and who requires a regular course of dialysis or renal transplantation to ameliorate uremic symptoms and maintain life.

(D) “Freestanding dialysis center” or “dialysis center” means a facility that provides chronic maintenance dialysis to end stage renal disease patients on an outpatient basis, including the provision of dialysis services in the patient’s place of residence. A freestanding dialysis center does not include the following:

(1) A hospital or other entity that provides dialysis services, other than non-emergent chronic maintenance dialysis, within the same hospital or facility or in another building located on the same property as the hospital or facility, that are reviewed and accredited or certified as part of the hospital's accreditation or certification as required by section 3727.02 of the Revised Code; and

(2) Home dialysis as defined in paragraph (E) of this rule.

(E) “Home dialysis” means either peritoneal dialysis or hemodialysis performed by an appropriately trained patient, with or without minimal assistance, at the patient’s place of residence.

3701-83-23.1 Services standards and required protocols.

(A) Each dialysis center shall:

(1) Develop and follow policies and procedures for the provision of care consistent with national standards of care or guidelines;

(2) Develop and follow protocols for the prevention of disease and infection transmission utilizing standards of care or guidelines for dialysis patients that comply with the regulations for end stage renal disease services contained in 42 C.F.R. 494.30 (October 1, 2009);

(3) Provide services in accordance with the clinical capabilities of the facility;

(4) Develop and follow policies and procedures for the administration of medication;

(5) Develop and follow policies and procedures for the provision of water and dialysate that comply with the regulations for end stage renal disease services contained in 42 C.F.R. 494.40 (October 1, 2009) and are consistent with the association for advancement of medical instrumentation (AAMI) standards, including criteria for the biological and chemical composition of the water;

(6) Develop and follow policies and procedures for the re-use of hemodialyzers that comply with the regulations for end stage renal disease services contained in 42 C.F.R. 494.50 (October 1, 2009) and are consistent with the association for advancement of medical instrumentation (AAMI) standards;

(7) Develop and follow policies and procedures for direct care staff to notify appropriate health care professionals of problems related to the provision of dialysis care;

(8) Develop and follow emergency plans to include patient self disconnect;

(9) Provide each patient with both verbal and written instructions for post treatment care.
and procedures for obtaining emergency care; and

(10) Develop and follow policies and procedures for documenting and responding to adverse events. The policies and procedures shall include the course of action to be taken by staff to respond to adverse events, including patient care and evaluation of equipment, water, or dialysate solution. Each dialysis center shall report to the director all adverse events involving the following:

(a) An event requiring emergency treatment, or hospitalization;
(b) An involuntary discharge of a patient;
(c) Contamination of the water or dialysate;
(d) Development of infection or communicable disease; and
(e) An event having a direct or immediate impact on the health, safety, or security of a patient or staff member.

(B) Each dialysis center shall utilize a coordinated and integrated interdisciplinary team working in conjunction with the patient, to develop and implement a written, individualized, comprehensive patient care plan. The care plan shall:

(1) Be based upon an evaluation of the nature of the patient's illness, the treatment modality prescribed, and an assessment of the patient's needs;
(2) Address the patient's physical, medical, dietary, psychosocial, functional, and rehabilitation needs;
(3) Be reviewed at least semi-annually if the patient is stable and monthly if the patient is not stable.

(C) Each dialysis center shall provide the necessary ancillary and support services to meet the dialysis needs of patients and in accordance with the patients' care plans.

(D) No dialysis center may set up dialysis stations for patient use which exceed the authorized maximum number of licensed dialysis stations.

(E) No dialysis center shall provide dialysis services for hepatitis B positive patients unless the facility has an in-house isolation room, a designated station or area.

(F) Each dialysis center shall provide the patient or the patient's representative in writing the following:

(1) Information regarding the policies, procedures, and mission statement of the dialysis center and the services provided at the facility;
(2) Information concerning the services to be performed;
(3) Information about the complaint policies and procedures required by rule 3701-83-13 of the Administrative Code; and

(4) Information regarding the center's policy on advanced directives and do-not-resuscitate orders, if applicable.

(G) Each dialysis center shall maintain operational records for:

(1) The dialysate solution delivery system;
(2) The reuse of hemodialyzers and bloodlines;
(3) The reprocessing system;
(4) The water treatment system; and

(H) Each dialysis center shall maintain records of water test results and necessary treatment for two years.

(I) Each dialysis center shall maintain an appropriately stocked emergency tray or cart consistent with the types of services being provided.

(J) Each dialysis center shall ensure that all drugs and supplies have not exceeded the expiration date.

(K) Each dialysis center shall develop and follow procedures to respond to medical emergencies that may arise in the provision of services to patients, including emergency cardiac care.
3701-83-23.2 Personnel and staffing requirements.; staff records; ongoing training.

(A) Each dialysis center shall maintain the following:
   (1) An established system of records sufficient for the director to ascertain that all
       individuals employed by the dialysis center who function in a professional capacity meet the
       standards applicable to that profession, including but not limited to, possessing a current Ohio
       license, registration, or certification, if required by law;
   (2) Staffing schedules, time-worked schedules, on-call schedules, and payroll records for
       at least two years; and
   (3) Documentation that the facility has offered the hepatitis B vaccination to staff
       members.

(B) Each dialysis center shall provide an ongoing training program for its personnel. The
    program shall provide orientation, initial training, and continuing training to all staff members.
    (1) The orientation and initial training shall be conducted within thirty days of hire and
        shall be appropriate to the tasks that each staff member will be expected to perform;
    (2) The initial training shall include instruction in the infection control, equipment, and
        dialysate policies and procedures required by rules 3701-83-23.1 and 3701-83-23.4 of the
        Administrative Code; and
    (3) Continuing training shall be designed to assure appropriate skill levels are
        maintained and that staff are informed of changes in techniques, mission, goals, policies and
        procedures including those related to infection control and blood-borne pathogens, and similar
        matters. The continuing training may include attending and participating in professional
        meetings and seminars.

3701-83-23.3 Medical records; minimum standards on content.

Each patient medical record required by paragraph (A) of rule 3701-83-11 of the
Administrative Code shall contain at least the following information:

(A) Patient information including:
   (1) Name, address, date of birth, gender, and race or ethnicity;
   (2) History and physical examination data including allergies, current medications, past
       adverse drug reactions, and family medical history;
   (3) Diagnosis; and
   (4) Dialysis prescriptions.

(B) Treatment data including:
   (1) A written individualized comprehensive patient care plan;
   (2) Progress notes; and
   (3) Treatment notes including dates and times the patient was on or off dialysis, pre-
       dialysis safety checks, vital signs monitoring during dialysis, and notations of adverse reactions.

(C) Medication administration.

(D) Any special examination or report, including x-ray, laboratory, or pathology report.

(E) Signed consent for treatment form.

(F) Documentation indicating that the patient or patient's representative received in
    writing the following:
    (1) Information on complaint policies and grievance procedures;
    (2) Information regarding the center's policy on advanced directives and do-not-
        resuscitate orders, if applicable; and
    (3) Information about the services to be performed.

(G) Documentation indicating that the patient or patient's representative received
    information about:
    (1) Emergency self disconnect; and
(2) Measures to be taken in the event of an at home post-treatment medical emergency.

(H) Discharge data including, condition upon discharge, and post-discharge care and instructions.

(I) When a dialysis patient is transferred to another dialysis center or to a facility for inpatient care, the transferring dialysis center shall send all requested medical records and information to the receiving dialysis center or facility within one day of the transfer.

3701-83-23.4 Infection control and prevention; minimum standards.

(A) In addition to the requirements established in rules 3701-83-09 and 3701-83-23.1 of the Administrative Code, each dialysis center shall develop and follow written policies and procedures for preventing and controlling infections. The policies and procedures shall include, but are not limited to, the following:

(1) The aseptic and isolation techniques to be used;
(2) Use of the isolation room or dedicated station or area, where applicable;
(3) Handling and disposal of biohazardous and potentially infectious waste;
(4) Cleaning and maintenance of equipment;
(5) Cleaning and disinfection of surfaces; and
(6) Use of standard precautions and personal protective equipment.

(B) Each dialysis center shall establish and follow a preventive maintenance program that includes periodic calibration, cleaning and adjustment of all equipment in accordance with manufacturer's instructions.

(C) In addition to the water requirements established in rule 3701-83-23.1 of the Administrative Code, each dialysis center shall:

(1) Culture and conduct water specimen analysis used for dialysis purposes at least every thirty days for bacteria;
(2) Analyze water used for dialysis purposes at least every one hundred and eighty days for chemicals;
(3) Treat water as necessary to maintain a continuous water supply that is biologically and chemically compatible with acceptable dialysis techniques.

(D) Each dialysis center shall conduct routine surveillance of patients and staff for hepatitis B using the most sensitive test methods available.

(1) Each patient must be screened for hepatitis B surface antigen (HBsAG) and hepatitis B surface antibody before admission to the dialysis facility in order to determine their serologic status for surveillance purposes;
(2) New employees must be screened for hepatitis B surface antigen (HBsAG) and hepatitis B surface antibody before or at the time of hire in order to determine their serologic status for surveillance purposes; and
(3) Each dialysis center shall offer the hepatitis B vaccine to all susceptible patients and all staff and document such action in the patient's medical record or the staff member's personnel record.

(E) Each dialysis facility shall investigate and report to the director incidents of infections associated with the provision of dialysis services. Efforts shall be made to determine the origin of any such infection and remedial action shall be taken to protect all non-infected patients and prevent recurrence.

(F) Each dialysis facility shall comply with the reporting requirements established by rule 3701-3-03 and paragraph (A)(10) of rule 3701-83-23.1 of the Administrative Code.

3701-83-24 Quality assessment and improvement system.

(A) Each freestanding dialysis center governing body shall conduct an ongoing,
comprehensive, integrated self-assessment of the quality and appropriateness of care provided by the facility, including:

(1) Adequacy of dialysis;
(2) Vascular access;
(3) Medical injuries and medical error identification;
(4) Infection control;
(5) Nutritional status;
(6) Mineral metabolism and renal bone disease;
(7) Anemia management;
(8) Hemodialysizer reuse program where applicable; and
(9) Patient satisfaction and grievance resolution.

(B) The dialysis center shall designate an individual or individuals to be responsible for the quality assessment and performance improvement program who shall be responsible for the following activities related to the quality of care and services provided by the dialysis center:

(1) Developing and implementing mechanisms for monitoring;
(2) Identifying and resolving issues;
(3) Providing suggestions to the governing body for improvement; and
(4) Reporting program activities and findings to the governing body.

(C) The dialysis center shall use the findings of the quality assessment and performance improvement program to set priorities for performance improvement, correct identified problems, and to revise policies and procedures as necessary.

(D) Identified performance problems that threaten the health or safety of patients shall be immediately corrected.

(E) As part of the quality assessment and performance improvement system required under rule 3701-83-12 of the Administrative Code, each freestanding dialysis center shall provide to the director, upon request, copies of data reports provided to the “renal network” designated by the centers for medicare and medicaid services to include the state of Ohio or any portion of the state of Ohio pursuant to 42 C.F.R. section 405.2112. All patient specific information submitted to the director under this paragraph that identifies a patient shall be maintained in a confidential manner.

Rehabilitation Facilities

3701-83-25 Rehabilitation services; definitions.

For purposes of rules 3701-83-25 to 3701-83-32 of the Administrative Code the following definitions apply:

(A) “Freestanding inpatient rehabilitation facility” or “inpatient rehabilitation facility” means a facility operated for the exclusive purpose of providing specialized rehabilitation services, on an inpatient basis, to persons with functional limitations or chronic disabling conditions who are in a medically stable condition and have the potential to achieve significant improvement in independent functioning. Freestanding inpatient rehabilitation facility does not include the following:

(1) A facility established and operated for the primary purpose of providing rehabilitation treatment services for alcohol or drug abuse;
(2) A general hospital as defined in rule 3701-59-01 of the Administrative Code or other entity that provides rehabilitation services that are reviewed and accredited or certified as part of a general hospital's accreditation or certification as required by section 3727.02 of the Revised Code; or
(3) A nursing home licensed under Chapter 3721 of the Revised Code, a skilled nursing facility that meets the requirements for participation in medicare, or a nursing facility that meets...
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the requirements for participation in medicaid.

(B) “Interdisciplinary team” means a group of individuals representing appropriate licensed disciplines providing an integrated approach to serving the rehabilitation needs specific to a particular patient in an inpatient rehabilitation facility.

(C) “Occupational therapist” means a person licensed to practice occupational therapy pursuant to section 4755.07 of the Revised Code.

(D) “Physical therapist” means a person licensed to practice physical therapy pursuant to section 4755.44 of the Revised Code.

(E) “Psychologist” means a person licensed to practice psychology pursuant to Chapter 4732 of the Revised Code.

(F) “Social worker” means a person licensed to practice social work pursuant to Chapter 4757 of the Revised Code.

(G) “Speech-language pathologist” means a person licensed to practice speech pathology pursuant to Chapter 4753 of the Revised Code.

3701-83-26 Service standard and minimum services – inpatient rehabilitation facilities.

(A) Each inpatient rehabilitation facility shall provide services that meet the needs of its patients in accordance with the patient’s individual plan of care. The facility shall provide the patient or the patient’s representative with:

(1) Information regarding the policies, procedures, and philosophy of the inpatient rehabilitation facility and the services provided at the facility; and

(2) Information concerning the services to be performed.

(B) Each inpatient rehabilitation facility shall:

(1) Develop and follow current care protocols utilizing accepted standards of care;

(2) Provide services in accordance with applicable state and federal laws and regulations; and

(3) Provide services in accordance with the clinical capabilities of the facility.

(C) Each inpatient rehabilitation facility shall utilize a coordinated and integrated, interdisciplinary approach to assess patient needs and to provide treatment and evaluation of physical, psychosocial and cognitive deficits. Each patient shall be provided the services of an interdisciplinary team that:

(1) Is directed by a physician who is board certified in physical medicine and rehabilitation or a specialty appropriate to the services provided or has comparable qualifications and experience, as determined by the medical director; and

(2) Participates in the provision and management of rehabilitation and medical services.

(D) Each inpatient rehabilitation facility shall provide the services identified by the interdisciplinary team for each individual patient, as set forth in the following documents:

(1) The preliminary assessment required by paragraph (C) of rule 3701-83-27 of the Administrative Code;

(2) The comprehensive inpatient rehabilitation evaluation and the treatment plan required by paragraphs (A) and (B) of rule 3701-83-28 of the Administrative Code; and

(3) The discharge plan required by paragraph (E) of rule 3701-83-28 of the Administrative Code.

(E) Each inpatient rehabilitation facility shall respond to medical emergencies that may arise in the provision of services to patients, including emergency cardiac care.

3701-83-27 Admission requirements; preliminary assessments.

(A) Each inpatient rehabilitation facility shall develop written criteria for admission of patients to the facility that includes a description of the programs and services available at the
facility.

(B) Each inpatient rehabilitation facility shall not admit a patient to the facility unless the following conditions are met:

(1) The patient is able to tolerate a minimum of three hours of rehabilitation therapy, five days per week;

(2) The patient is medically stable; and

(3) The patient's prognosis indicates a progressively improved medical condition with the potential for increased independence.

(C) Each inpatient rehabilitation facility shall ensure that a written preliminary assessment of each patient is completed by an interdisciplinary team within forty-eight hours of admission that includes, at a minimum, the following:

(1) An evaluation of the appropriateness of the patient's placement in relation to the services available at the particular facility; and

(2) Identification of the immediate needs of the patient.

3701-83-28 Inpatient rehabilitation evaluation; treatment plan; discharge plan.

(A) Each inpatient rehabilitation facility shall perform a written comprehensive inpatient rehabilitation evaluation for each patient admitted to the facility. The comprehensive inpatient rehabilitation evaluation shall be developed by the interdisciplinary team and include the following:

(1) Purpose and source of the patient's referral;

(2) Summary of the patient's clinical condition;

(3) Functional strengths and limitations of the patient; and

(4) A determination of the patient's need for the following services:
   (a) Medical;
   (b) Nursing;
   (c) Rehabilitation nursing;
   (d) Dietary;
   (e) Occupational therapy;
   (f) Physical therapy;
   (g) Prosthetics and orthotics;
   (h) Psychological assessment and therapy;
   (i) Therapeutic recreation;
   (j) Rehabilitation medicine; and
   (k) Speech-language pathology.

(B) Each inpatient rehabilitation facility shall develop a written treatment plan for each patient admitted to the facility. The treatment plan shall be developed by the interdisciplinary team and shall include findings and services identified in the comprehensive inpatient evaluation completed in accordance with paragraph (A) of this rule, and information regarding the following:

(1) Level of function prior to the disabling condition;

(2) Current functional limitations;

(3) Specific service needs;

(4) A summary of the treatments to be provided;

(5) Supports and adaptations to be provided;

(6) Specific treatment goals and expected outcomes;

(7) Disciplines to be utilized and their respective responsibilities for implementing the treatment plan; and

(8) Anticipated time frames for achieving treatment goals and expected outcomes.

(C) The treatment plan shall be periodically reviewed by the interdisciplinary team as
indicated, but not less than once every seven days. The periodic review of the treatment plan shall be documented in the patient's records and include documentation of, at a minimum, the following:

1. Progress toward achieving defined goals; and
2. Any changes in the treatment plan.

(D) Each inpatient rehabilitation facility shall designate an individual from the patient's interdisciplinary team to be the case manager for each patient who shall be responsible for coordination of the patient's treatment plan.

(E) Each inpatient rehabilitation facility shall develop a written discharge plan for each patient admitted to the facility which is based on the treatment goals and expected outcomes defined in the treatment plan. The discharge plan shall:

1. Identify the expected care setting for the patient after discharge;
2. Be revised periodically based on the patient's progress in achieving the defined goals and any changes in treatment; and
3. Document any referrals provided to the patient.

(F) Each inpatient rehabilitation facility shall complete and initiate implementation of a comprehensive inpatient evaluation, treatment plan, and discharge plan within seventy-two hours of admission.

3701-83-29 Personnel and staffing requirements; staff records; ongoing training.

(A) Each inpatient rehabilitation facility shall provide or arrange for the services of personnel in sufficient number and with appropriate qualifications to meet the rehabilitation and medical needs of the patients being served in the facility. Personnel shall be scheduled in sufficient number:

1. To meet the needs of all patients in a timely manner; and
2. Provide services to each patient as required in rule 3701-83-26 of the Administrative Code.

(B) At a minimum, each inpatient rehabilitation facility shall maintain the following staff:

1. A medical director to be responsible for overseeing and managing medical and rehabilitation services. The medical director shall be a physician who has appropriate experience and training to provide rehabilitation physician services, as demonstrated by at least one of the following:
   a. Certification as a physiatrist by the American board of physical medicine and rehabilitation or the American osteopathic board of rehabilitation medicine;
   b. Formal residency in physical medicine and rehabilitation;
   c. Fellowship in rehabilitation for at least one year; or
   d. At least two years experience in providing inpatient rehabilitation services.
2. A director of nursing to be responsible for managing nursing services. The director of nursing shall be an RN with appropriate experience and training in rehabilitation nursing as demonstrated by the following:
   a. Certification as a rehabilitation nurse by the American rehabilitation nursing certification board; or
   b. At least three years experience in rehabilitation nursing.
3. A sufficient number of nurses, physical therapists, occupational therapists, speech-language pathologists, social workers and psychologists to meet the needs of patients and provide necessary services.

(C) Any licensed professional may be used to meet the needs of patients and provide necessary services consistent with the licensed professional's scope of practice as defined by applicable law.

(D) Each inpatient rehabilitation facility shall maintain the following:
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(1) An established system of records sufficient for the director to ascertain that all individuals employed by the facility who function in a professional capacity meet the standards applicable to that profession, including but not limited to, possessing a current Ohio license, registration, or certification, if required by law.

(2) Staffing schedules, time-worked schedules, on-call schedules, and payroll records for at least two years.

(E) Each inpatient rehabilitation facility shall provide an ongoing training program for its personnel. The program shall provide both orientation and continuing training to all staff members.

(1) The orientation shall be appropriate to the tasks that each staff member will be expected to perform; and

(2) Continuing training shall be designed to assure appropriate skill levels are maintained and that staff are informed of changes in techniques, philosophies, goals, and similar matters. The continuing training may include attending and participating in professional meetings and seminars.

3701-83-30 Building and site requirements; minimum standards.

(A) Each inpatient rehabilitation facility shall have patient bedrooms that, at a minimum, meet the following requirements:

(1) Sufficient open floor space to allow each patient or personnel to easily maneuver a wheelchair, and to allow for the transfer of each patient from the wheelchair to the bed;

(2) Maximum bedroom capacity shall be no more than four patients;

(3) A call system that is connected electrically, electronically, by radio frequency transmission, or in a like manner that:

(a) Provides for independent operation by each patient from the patient's bed; and

(b) Effectively alerts the staff member or members on duty of emergencies or patient needs;

(4) A bed of adjustable height with appropriate supports, which facilitates patient transfer from a wheelchair to the bed, for each patient; and

(5) Appropriate furnishings and adequate storage space designed to meet the special needs of rehabilitation patients for each patient.

(B) Each inpatient rehabilitation facility shall provide the following structural features:

(1) Flooring shall be designed to minimize slipping;

(2) Patient bathrooms shall:

(a) Have sufficient space to allow private use of hand washing, toilet, and bathing or shower facilities by a patient in a wheelchair, with an assisting attendant;

(b) Be equipped with grab bars and appropriate supports so that physically disabled patients may use toilet, hand washing, and bathing or shower facilities; and

(c) Have a call system that is connected electrically, electronically, by radio frequency transmission, or in a like manner that effectively alerts the staff member or members on duty of emergencies or patient needs.

(3) Hand rails on both sides of corridors, ramps, and stairs in areas used by patients;

(4) Doors to be used by patients shall be wide enough to accommodate wheelchairs;

(5) Adequate space designated for group recreation and dining designed to accommodate patients in wheelchairs; and

(6) Adequate and appropriate space for the rehabilitation treatment services provided in the facility that facilitate the treatment goals of the patients served.
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3701-83-31 Equipment and supplies; minimum standards.

(A) Each inpatient rehabilitation facility shall have equipment and supplies of the type and quantity sufficient to meet the needs of individual patients and to provide services in accordance with rule 3701-83-26 of the Administrative Code.

(B) Each inpatient rehabilitation facility shall maintain all equipment and supplies, including equipment and supplies not used for rehabilitation purposes, in a safe and sanitary manner.

(C) Each inpatient rehabilitation facility shall develop, maintain, and implement a preventive maintenance plan for all equipment, designed to assure that the equipment is maintained in a safe manner. The preventive maintenance plan shall include periodic cleaning, adjustment and inspection in accordance with manufacturer's instructions.

3701-83-32 Quality assessment and improvement system.

As part of the quality assessment and performance improvement program as required under rule 3701-83-12 of the Administrative Code, each inpatient rehabilitation facility shall collect and maintain the following data on an annual basis and shall report such data to the director upon request:

(A) The total number of patients admitted to the facility;
(B) The total number of patients discharged from the facility;
(C) The total number of patients transferred to an acute care setting such as, but not limited to, a hospital;
(D) The total number of patients transferred to a long-term care setting such as, but not limited to, a nursing home;
(E) The total number of patients who achieved discharge goals; and
(F) The total number of patients readmitted to the facility for rehabilitation needs based on the same episode.

Birthing Center

3701-83-33 Freestanding birthing facilities, midwives; definitions.

As used in rules 3701-83-33 to 3701-83-42 of the Administrative Code:

(A) “Certified nurse-midwife” or “CNM” means an individual with a certificate to practice nurse-midwifery issued under Chapter 4723 of the Revised Code.

(B) “Director of patient services” means the individual responsible for managing and directing the provision of patient services at the freestanding birthing center.

(C) “Family” means the individual or individuals designated by the expectant mother to participate in the birthing center’s program.

(D) “Freestanding birthing center” or “center” means a facility, or part of a facility, which provides care during pregnancy, delivery, and the immediate postpartum period to the low-risk expectant mother. “Freestanding birthing center” does not include a hospital registered under section 3701.07 of the Revised Code, or an entity that is reviewed as part of a hospital accreditation or certification program.

(E) “Low-risk expectant mother” means an expectant mother that does not exhibit evidence of:

1) Diabetes mellitus or gestational diabetes that is not controlled by diet;

2) Heart disease in which there is any limitation of physical activity and ordinary physical activity does not cause undue fatigue, palpitation, dyspnea, or anginal pain;

3) Renal disease;
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(4) Endocrine disorder, except treated hypothyroidism;
(5) Hematologic disorder;
(6) Severe anemia (hemoglobin less than ten grams/deciliter);
(7) Chronic or gestational hypertension or pre-eclampsia;
(8) Rh factor sensitization or other isoimmunization;
(9) Respiratory disease with significant chance of fetal hypoxia or maternal respiratory distress;
(10) Active herpes;
(11) Prior uterine incisions other than low transverse uterine incisions;
(12) Prematurity (less than thirty-seven weeks gestation);
(13) Human immunodeficiency virus positive;
(14) Known congenital anomalies except for anomalies that do not require services beyond the extent of services the center is authorized by law to provide;
(15) Previous abruption;
(16) Known or suspected drug or alcohol abuse;
(17) Suspected or documented intrauterine growth retardation or fetal macrosomia;
(18) Placental abnormalities;
(19) Multiple births;
(20) Non-vertex presentation; or
(21) Deep venous thrombophlebitis.

3701-83-34 Freestanding birth centers; general provisions.

(A) Freestanding birthing centers are licensed to provide care during pregnancy, birth, and the immediate postpartum period to the low-risk expectant mother and her newborn. Each center shall admit and retain only low-risk expectant mothers anticipating a normal full-term, spontaneous vaginal birth.

(B) Freestanding birthing centers shall consult with the attending physician or the CNM in consultation with the physician prior to providing services to low-risk expectant mothers exhibiting evidence of the following:

1. Previous low transverse cesarean birth;
2. Previous postpartum hemorrhage requiring treatment by transfusion;
3. Epilepsy or seizures controlled by medication;
4. Postmaturity (greater than forty-two weeks gestation);
5. Grand multiparity;
6. No prenatal care, sporadic prenatal care, or prenatal care beginning after the first trimester;
7. Known or suspected drug or alcohol use;
8. Cephalopelvic disproportion; or
9. Other medical conditions, except those listed in paragraph (E) of rule 3701-83-33 of the Administrative Code.

(C) Unless medical intervention or non-routine technology can be safely performed or administered by an attending physician at the freestanding birthing center, each freestanding birthing center shall transfer a patient requiring medical intervention or non-routine technology to a hospital or other appropriate health care setting that can meet the patient's needs. Medical intervention or non-routine technology includes:

1. Anesthetics other than local anesthetics or pudendal;
2. Pharmacological augmentation of labor; or
3. Forceps or vacuum extraction.

(D) If an attending physician at a freestanding birthing center performs or administers any medical intervention or non-routine technology under paragraph (C) of this rule, the
attending physician must remain with the patient throughout active labor and the immediate postpartum period.

(E) Each freestanding birthing center shall provide a home-like environment with adequate space for furnishings, equipment and supplies to provide comfortable accommodations for the number of patients and families served and the personnel providing services.

(F) In addition to the requirements established under paragraph (F) of rule 3701-83-09 of the Administrative Code, each freestanding birthing center shall establish and enforce written policies and procedures for the following:

1. Infection control for patients and families; and
2. Handwashing for patients and families.

3701-83-35 Governing body of birth center.

(A) The governing body of each freestanding birthing center shall include at least one member who is a consumer who is and is not a health care provider.

(B) The governing body shall:

1. Meet regularly to execute responsibilities for the operation of the center and shall maintain minutes of each meeting;
2. Maintain records of the names and addresses of all owners, controlling parties, directors, and officers and shall establish a policy on conflict of interest disclosure;
3. Formulate the mission, goals and long range plans for the center;
4. Adopt bylaws and establish an organizational structure which clearly delineates lines of authority, responsibility, and accountability;
5. Adopt policies and procedures for the orderly development, management, and operation of the center to ensure its compliance with applicable rules and regulations;
6. Appoint the administrator and the director of patient services;
7. Approve the qualifications for the center staff and ensure that all staff have the qualifications required by Chapter 3701-83 of the Administrative Code;
8. Establish the quality assessment and performance improvement program required under rule 3701-83-12 of the Administrative Code;
9. Establish policies and procedures for the handling of all legal matters relating to the operation of the center;
10. Approve all contracts and agreements with individuals or service agencies, such as hospitals, laboratories, emergency transport, consulting specialists, teaching institutions, and organizations conducting research; and
11. Encourage collaboration and networking with community agencies and special interest groups.

3701-83-36 Service standards – freestanding birth centers.

(A) Each freestanding birthing center shall provide services that meet the needs of the center's patients and are in accordance with the patient's plan of care. The center shall provide the patient or the patient's representative:

1. Information regarding the policies, procedures, and philosophy of the center and the services provided at the center;
2. Information concerning the services to be performed, including the process of pregnancy, process of labor, birth and postpartum care of the mother and the newborn;
3. Information about immunizations, vaccines, and state of Ohio newborn screening requirements;
4. Written information about how to obtain appointments and needed services both
during and after normal hours of operation; and
(5) Verbal and written instructions for post-treatment care and procedures for obtaining emergency care.

(B) Each center shall develop and follow current care protocols utilizing nationally recognized and accepted standards of care while maintaining the holistic environment. Each center shall maintain a current listing of the procedures and protocols and shall provide services in accordance with the clinical capabilities of the center.

(C) Each center shall provide intrapartum care that requires minimal intervention and technology including:
- Observation of maternal vital signs;
- Fetal auscultation;
- Nourishment;
- Activities;
- Comfort measures;
- Assessment and evaluation of labor; and
- Interaction with and support of the family.

(D) Each center shall provide postpartum and newborn care that promotes bonding and includes, at a minimum:
- Postpartum care for the mother, including:
  - Observation and evaluation of maternal condition;
  - Education and initiation of newborn feeding;
  - Self-care assessment and education;
  - Ensuring that the center's discharge criteria for the mother are met; and
  - Evaluation of the need for, the provision of, and the administration of immunizations or vaccines and Rh immune globin as necessary.
- Care for the newborn, including:
  - Observation and evaluation of the newborn's condition;
  - Ensuring that the center's discharge criteria for the newborn are met; and
  - Evaluation of the need for, the provision of, and the administration of immunizations, vaccines, and screening as necessary or required.

(E) Each center shall respond to medical emergencies that may arise in the provision of services to patients, including emergency cardiac care.

3701-83-37 Admission; discharge; transfer - freestanding birth centers.

(A) Each freestanding birthing center shall establish policies and procedures for the assessment of expectant mothers to determine:
- If the expectant mother meets the low-risk requirements for admission to the center; and
- If a normal, full term, spontaneous vaginal birth is anticipated.

(B) Each center shall establish and follow admission policies and procedures. The center shall upon admission of a patient:
- Review the patient's health records;
- Observe and document vital signs;
- Observe and document labor progress; and
- Determine whether diagnostic or screening procedures are required.

(C) Each center shall have a written transfer agreement with a hospital, health care provider, or other appropriate health care setting for the transfer of a mother or a newborn in the event of medical complications, emergency situations, or as the need arises.

(D) Each center shall maintain all necessary and appropriate medical equipment and a sufficient staff to provide for the timely transfer and transport to a hospital, health care provider,
or appropriate health care setting.

(E) Each center shall evaluate each expectant mother to determine whether an intrapartum transfer is necessary. The evaluation shall include an assessment of the following:

1. Abnormal progress of labor;
2. Development of maternal complications;
3. Need for cesarean birth; and

(F) Each center shall evaluate each mother and newborn to determine whether a postpartum transfer is necessary including evaluation of the following:

1. Medical complications of the mother; and
2. Medical complications of the newborn.

(G) Each center shall establish and follow discharge criteria utilizing nationally recognized standards. Prior to discharge each center shall identify a primary care provider for both mother and baby. For postpartum stays less than forty-eight hours, each center shall provide or arrange for the examination of the mother and newborn within seventy-two hours after discharge by a licensed health care provider acting within his or her scope of practice.

3701-83-38 Personnel and staffing requirements; staff records; ongoing training.

(A) Each freestanding birthing center shall have an administrator.

(B) Each center shall have a director of patient services who shall be a physician or a CNM who has contracted with a collaborating physician.

(C) Each center shall establish a personnel file for each staff member that shall be retained for two years after the staff member is no longer associated with the center, is maintained in a manner to ensure confidentiality, as provided by law, and contains, at a minimum, the following:

1. Documentation of the qualifications of the staff to provide services;
2. An established system of records sufficient for the director to ascertain that all individuals employed by the center who function in a professional capacity meet the standards applicable to that profession, including but not limited to, possessing a current Ohio license, registration, or certification, if required by law;
3. Documentation of any malpractice insurance carrier, if applicable;
4. Reports of malpractice claims, if applicable;
5. The regular performance evaluations required under paragraph (G) of rule 3701-83-08 of the Administrative Code;
6. Documentation of current certification from the American heart association in cardiac life support or current certification from the American academy of pediatrics in neonatal resuscitation, if applicable; and
7. Documentation of compliance with paragraph (D) of rule 3701-83-08 of the Administrative Code.

(D) Each center shall provide staff access to reference materials and provide continuing education, orientation, and ongoing training that shall be appropriate to the tasks that each staff member will be expected to perform. Training shall be designed to ensure appropriate skill levels are maintained and that staff are informed of changes in techniques, philosophies, goals, and similar matters. Ongoing training may include attending and participating in professional meetings and seminars and may also include:

1. Universal precautions and infection control procedures;
2. Fire, safety and disaster procedures;
3. Licensure requirements;
4. The philosophy of the center; and
5. Procedures for the stabilization of newborns from birth to transport.
(E) Each center shall provide information concerning the philosophy of the center to applicants for employment.

(F) Each center shall provide for the availability of and access to consulting specialists.

(G) Each center shall maintain a sufficient number of staff and schedule staff for availability within the center in number and type to:

1. Meet the demand for services routinely provided by the center;
2. Meet the needs of each patient;
3. Ensure patient safety; and
4. Ensure that no mother in active labor is left unattended.

(H) Each center shall establish and post a schedule for staff and consulting specialists that includes coverage for periods of high demand or emergency.

(I) A staff member who is current in certification from the American heart association in cardiac life support and a second staff member who is current in certification from the American academy of pediatrics in neonatal resuscitation shall be present at each birth.

(J) A physician or CNM shall attend each birth.

(K) A physician shall be available for stabilization and care of ill newborns and mothers.

3701-83-39 Building and site requirements; minimum standards.

(A) Each freestanding birthing center shall provide sufficient space for the number of patients and patient families and staff members to assure privacy for patients and families including:

1. A waiting room;
2. An examination room;
3. A staff area, conference area, or classroom; and
4. A family room with a designated play area for children.

(B) Each center shall have a minimum of two birth rooms. The birth room shall:

1. Be of adequate size and appropriate configuration to provide for the equipment, staff members, supplies and emergency procedures required for the physical and emotional care of the mother, family, and the newborn during birth, labor, and the postpartum period;
2. Have a minimum floor area of one hundred and sixty square feet. The length or width of the room shall have a minimum dimension of eleven feet. The vestibule, toilet and bathing areas and closets will not be considered in determining the square footage;
3. Have doorways and hallways of adequate width and configuration to accommodate the maneuvering of ambulance stretchers and beds;
4. Be located to provide rapid unimpeded access to an exit of the building which can accommodate emergency transportation vehicles and the type and size of emergency equipment utilized for emergency transport; and
5. Have hot and cold running water.

(C) Each center shall provide:

1. Toilet and bathing facilities that include a toilet, sink, bath or shower facilities with appropriately placed grab bars for patients. The toilet and bathing facilities shall be shared by not more than two birth rooms;
2. Toilet and hand washing facilities for families and personnel;
3. Space for coats, boots, and umbrellas in inclement weather;
4. A system of communication between the birth room and other areas of the center that effectively can alert the staff on duty of emergencies or patient needs;
5. Access to an outside telephone line;
6. Handrails in halls, stairwells, and bathrooms;
7. Childproof electrical outlets in public areas;
8. Access to a drinking fountain or potable drinking water with a disposable cup.
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dispenser;

(9) A system to provide emergency lighting; and
(10) A separate area for storing clean and sterile supplies.

(D) Each center shall establish and maintain safety guidelines, practices, and policies which are reviewed at least once every twelve months to ensure a safe environment for patients, families, visitors and staff members. The center shall conduct and maintain records of the following:

(1) Evaluation of the heat, ventilation, emergency lighting, waste disposal, water supply, laundry, and kitchen equipment; and

(2) Evaluation of the physical environment for hazards that may cause injury from falls, electrical shock, poisoning, and burns. Risk factors of hazards include, but are not limited to, unsafe toys, unprotected stairs, and unlocked storage cabinets. The review of the physical environment shall include the exterior of the facility including walkways, parking lots, and outside recreation areas.

(E) Each center may provide laundry services on-site or off-site. Centers that provide laundry services on-site shall provide an area for laundry equipment with counter and storage space. The center shall provide for the separate collection, storage, and disposal of soiled materials. Soiled laundry shall be held in the soiled holding area until deposited in the washer.

(F) Sterile supplies may be prepackaged disposables or processed off-site. If the center sterilizes instruments and supplies on-site, an area for accommodation of sterilizing equipment in a type and number sufficient and appropriate to the patient volume of the center shall be provided.

(G) Each center shall provide an area for families to store and serve light refreshments. The area shall include a sink, counter space, oven or microwave, refrigerator, cooking utensils, disposable tableware or dishwasher, storage space, and a seating area.

(H) Each center shall provide in each birth room, an area for equipment and supplies for newborn care and a separate area for the equipment and supplies for maternal care.

3701-83-40 Equipment; minimum standards.

(A) Each freestanding birthing center shall have a readily accessible and securely stored emergency cart or tray for the newborn, equipped in accordance with national standards of care or guidelines, to carry out the written emergency procedures established by the center.

(B) Each center shall have a readily accessible and securely stored emergency cart or tray for the resuscitation of the mother, equipped in accordance with national standards of care or guidelines, to carry out the written emergency procedures of the center.

(C) Each center shall designate an area for the maternal and newborn emergency equipment and supplies that shall be immediately accessible to any room in which a birth may occur, but out of the direct line of traffic within the facility.

(D) Each center shall develop and implement an equipment preventive maintenance and repair program in accordance with manufacturer’s specifications. The center shall maintain records of equipment performance, maintenance and malfunctions for the lifetime of the equipment’s use at the center and a minimum of three years following the decommissioning or discontinuation of use of any piece of equipment.

3701-83-41 Supplies and medications.

(A) Each freestanding birthing center shall maintain an inventory of supplies and medications in the type and quantity necessary to meet the needs of and care for the number of patients served by the center.

(B) Each center shall establish and follow protocols in accordance with standards
established by the American college of obstetrics and gynecology for the use of medications during labor or at the time of birth.

(C) Each center shall:
(1) Monitor the shelf life of all medications and supplies and dispose of expired items according to industry standards or practices;
(2) Secure, store or dispose of all disposable supplies such as needles and prescription pads appropriately in accordance with state and federal laws;
(3) Maintain controlled drugs in a double-locked secured cabinet and provide refrigeration for biologicals; and
(4) Establish and follow written policies and procedures for accountability of all medications and supplies.

3701-83-42 Quality assessment and improvement program.

(A) As part of the quality assessment and performance improvement program required under rule 3701-83-12 of the Administrative Code, each freestanding birthing center shall evaluate the provision of services to the mothers and newborns who receive care from the center. The evaluation shall, at a minimum, include:
(1) Development and evaluation of risk criteria for determining eligibility for admission to and the continuation of care for a mother and newborn in the birth center program of care;
(2) Documentation and review of complications and adverse events which arise during the provision of the center’s services including complications of pregnancy, labor and the postpartum period;
(3) Review and evaluation of the management of care;
(4) Evaluation of the appropriateness of diagnostic and screening procedures including laboratory studies, sonography, and non-stress tests;
(5) Evaluation of the appropriateness of medications prescribed, dispensed or administered in the center;
(6) Review of all transfers of mothers and newborn to a hospital, health care provider, or other health care setting to determine the appropriateness and quality of each transfer;
(7) Development of discharge criteria for mother and the newborn patients served by the center;
(8) Regular review of medical records including a review for of legibility and completeness;
(9) Annual review of all protocols, policies and procedures relating to maternal and newborn care provided by the center;
(10) Review of the maternal and newborn assessment procedures as they impact on quality of care and cost to the patient;
(11) Review of the provision of emergency services including services listed in paragraph (C) of rule 3701-83-34 of the Administrative Code; and
(12) Evaluation of the center’s compliance with local, state, and federal requirements and national standards of care related to the provision of care to mothers and newborns.

(B) As part of the quality assessment and performance improvement program required under paragraph (A) of rule 3701-83-12 of the Administrative Code, each freestanding birth center shall report to the director:
(1) The total number of women who delivered;
(2) The total number of live births by weight, in grams;
(3) The total number of fetal deaths;
(4) The total number of neonatal deaths;
(5) The total number of maternal deaths;
(6) The total number of emergency cesarean-sections performed including:
(a) The total number of primary cesarean-sections, and
(b) The total number of repeat cesarean-section;
(7) The total number of attempted vaginal births after a previous cesarean-section and
the total number of successful vaginal births after a cesarean-section;
(8) The total number of newborns whose estimated gestational age is less than thirty-seven weeks, and the total number of newborns whose estimated gestational age is greater than forty-two weeks;
(9) The total number of maternal transfers to an obstetric and newborn care service
including:
(a) The total number of transfers prior to delivery, and
(b) The total number of transfers after delivery;
(10) The total number of patients seeking admission and the total number of patients
admitted.

3701-83-56 Definitions - exempt freestanding birthing centers.

As used in rules 3701-83-56 to 3701-83-59 of the Administrative Code:
(A) “Apprentice midwife” means an individual who is currently serving an apprenticeship
under a practicing midwife.
(B) “Certified professional midwife” means an independent practitioner who has met the
standards for certification set by the North American registry of midwives.
(C) “Certified nurse-midwife” or “CNM” has the same meaning as in paragraph (A) of rule
3701-83-33 of the Administrative Code.
(D) “Director of patient services” means the individual who is responsible for managing
and directing the provision of patient services at the exempt center. The director of patient
services may serve as the administrator of the exempt center.
(E) “Doula” means an assistant who provides various forms of non-medical, non-
midwifery and non-clinical physical or emotional support during the pre-natal, childbirth, and
postpartum periods.
(F) “Exempt freestanding birthing center,” “exempt freestanding birth center,” “exempt
birth center,” or “exempt center” means a health care facility that is not required to obtain a
license under section 3702.30 of the Revised Code and paragraph (B) of rule 3701-83-03 of the
Administrative Code.
(G) “Lay midwife” or “traditional midwife” means an individual who has entered the
profession as an apprentice to a practicing midwife rather than a formal school or certification
program.
(H) “Low-risk pregnancy” means an expectant mother that does not exhibit evidence of:
(1) Diabetes mellitus or gestational diabetes that is not controlled by diet;
(2) Heart disease in which there is any limitation of physical activity and ordinary
physical activity does not cause undue fatigue, palpitation, dyspnea or anginal pain;
(3) Renal disease;
(4) Endocrine disorder, except treated by hypothyroidism;
(5) Hematologic disorder;
(6) Severe anemia (hemoglobin less than ten grams per deciliter);
(7) Chronic or gestational hypertension or pre-eclampsia;
(8) RH factor sensitization or other isoimmunization;
(9) Respiratory disease with significant chance of fetal hypoxia or maternal respiratory
distress;
(10) Active herpes;
(11) Prior uterine incisions other than low transverse uterine incisions;
(12) Prematurity as defined as less than thirty-seven weeks gestation;
(13) Human immunodeficiency virus positive;
(14) Known congenital anomalies except for anomalies that do not require services beyond the extent of services the center is authorized by law to provide;
(15) Previous abruption;
(16) Known or suspected drug or alcohol use;
(17) Suspected or documented intrauterine growth retardation or fetal macrosomia;
(18) Placental abnormalities;
(19) Expectation of multiple births;
(20) Non-vertex presentation; and
(21) Deep venous thrombophlebitis.

(I) “Low-risk delivery” means the delivery by a woman not exhibiting evidence of:
   (1) Previous low transverse cesarean birth;
   (2) Previous postpartum hemorrhage requiring treatment by transfusion;
   (3) Epilepsy or seizures controlled by medication;
   (4) Previous postmaturity delivery as defined as greater than forty-two weeks gestation;
   (5) A lack of prenatal care;
   (6) Cephalopelvic disproportion; or
   (7) Other serious or acute medical conditions.

(J) “Medical director” means the physician the exempt center has appointed to provide medical consultation and direction regarding the operations of the center.

(K) “Midwife” means a certified professional midwife, a lay midwife, or a traditional midwife.

(L) “Patient” means an expectant mother, mother, or newborn.

3701-83-57 Patient safety monitoring and evaluation-exempt freestanding birthing centers.

(A) Each exempt freestanding birthing center shall admit, retain, discharge and transfer patients in accordance with the requirements of this rule to assure the safety of its patients.
   (1) Exempt centers may admit, retain, and provide care exclusively to women members of the religious denomination, sect, or group that owns and operates the center who anticipate a low-risk pregnancy, low-risk delivery and normal full-term spontaneous vaginal birth, and to their newborns.
   (2) Prior to admission, each expectant mother shall be assessed by a physician, CNM, or midwife as defined in paragraph (K) of rule 3701-83-56 of the Administrative Code to determine whether she is a low-risk pregnancy and whether a low-risk and full-term, spontaneous vaginal delivery is anticipated.
      (a) Exempt centers shall consult with a physician before admitting or retaining an expectant mother exhibiting signs of having other than a low-risk pregnancy or low-risk and full-term spontaneous vaginal delivery, or an expectant mother who has had no prenatal care.
      (b) If the consulting physician determines that the expectant mother may not have a low risk pregnancy or low risk and full-term spontaneous vaginal delivery, the exempt center shall not admit or retain the expectant mother.
      (c) If the expectant mother presents at the exempt center in actual labor or showing impending labor, and has had no prenatal care, the expectant mother must be transferred to a hospital or other health care facility or evaluated by a physician prior to admission to the exempt center.
   (3) Each exempt center shall have in place an arrangement with a hospital, other appropriate health care setting, or provider for the transfer of a mother or newborn in the event of medical complications, emergency situations or as need arises.
(4) Except as set forth in paragraph (A)(5) of this rule, each exempt center shall transfer the patient to a hospital, other approved health care setting or provider that can meet the needs of the patient if medical intervention or non-routine technology is necessary. Medical intervention or non-routine technology includes:
   (a) Anesthetics other than local anesthetics or pudendal block;
   (b) Pharmacological augmentation of labor; or
   (c) Forceps or vacuum extraction.
(5) An exempt center is not required to transfer a patient requiring medical intervention or non-routine technology if the medical intervention or non-routine technology can be safely and effectively performed by the physician who attends the birth and the attending physician remains with the patient throughout active labor and the immediate postpartum period.

(B) Each exempt freestanding birthing center shall periodically evaluate each patient's health and safety in accordance with the following standards:
   (1) The exempt center shall, upon admission of a patient:
      (a) Review the patient's health history and prenatal care records;
      (b) Observe and document vital signs;
      (c) Observe and document labor progress;
      (d) Consult with a physician when possible or evident risk for delivery is detected; and
      (e) Determine whether further diagnostic or screening procedures at an appropriate health care facility are advisable.
   (2) Each exempt center shall evaluate the expectant mother to determine whether an intrapartum transfer to a hospital or other appropriate health care setting is necessary. The evaluation shall include an assessment for the following:
      (a) Abnormal progress of labor;
      (b) Development of maternal complications;
      (c) Probable need for cesarean birth; and
      (d) Development of fetal complications.
   (3) Each exempt center shall, in consultation with a physician, evaluate the mother and newborn to determine whether a postpartum transfer to a hospital or other appropriate health care setting is necessary including evaluation for the following:
      (a) Medical complications of the mother; and
      (b) Medical complications of the newborn.

(C) Each exempt center shall monitor the provision of services to ensure they are provided in a safe, considerate and timely manner that meets the needs of the exempt center's patients. Each exempt center shall:
   (1) Arrange for and consult with a physician or certified nurse midwife to perform the following activities:
      (a) Periodically review the exempt center's patient care policies and procedures and recommend revisions as may be indicated;
      (b) Oversee the quality of patient care through periodic review of patient care records;
      (c) Periodically review the exempt center's quality and patient safety data; and
      (d) Provide consultation to the exempt center regarding admissions, retentions, transfers, and discharges of patients.
   (2) Practice infection control including observation of all accepted standard precautions and hand washing for staff, patients, and families.
   (3) Provide for the separate storage, security, and disposal of hazardous waste.
   (4) Ensure that no mother in active labor is left unattended and that a midwife, physician, or CNM attends each birth. A doula of the mother's choosing may attend the mother in active labor, but shall be limited to only non-medical, non-midwifery and non-clinical assistance and support.
(5) Timely respond to medical emergencies that may arise in the provision of services to patients.

(6) Provide intrapartum care that requires minimal intervention and technology including:
   (a) Fetal auscultation;
   (b) Nourishment;
   (c) Activities as may be appropriate;
   (d) Comfort measures;
   (e) Assessment and evaluation of labor; and
   (f) Interaction with family and support of the family.

(7) Provide postpartum and newborn care that promotes bonding and meets patients’ needs.

(8) Provide the patient or the patient’s representative:
   (a) Information about recommended immunizations, vaccines, and metabolic screenings for newborns; and
   (b) Instructions for post-treatment care and procedures for obtaining emergency care.
   (c) If so designated by the mother, the patient’s doula may be the representative for the purpose of receiving the information and instructions indicated in this paragraph.

(9) Maintain sufficient equipment, supplies and medicinals to care for its patients. Each exempt center shall:
   (a) Have a readily accessible and securely stored emergency cart or tray equipped to respond to emergency situations involving either the mother or newborn and consistent with the capabilities of the facility staff;
   (b) Monitor the shelf life of all medicinals and supplies maintained by the exempt center for use in the care of services to patients;
   (c) Maintain equipment in good working order; and
   (d) Operate equipment in a safe manner.

(D) Each exempt freestanding birthing center shall establish and maintain a safe and sanitary environment to ensure patient safety. Each exempt center shall:
   (1) Provide, maintain, and periodically evaluate the functional condition of the heating, ventilation, emergency lighting, waste disposal and water supply systems, laundry and kitchen equipment, and handrails in hallways and stairwells;
   (2) Maintain and evaluate the physical environment for hazards that may cause injury from falls, electrical shock, poisoning and burns. Risk factors of hazards include, but are not limited to, unsafe toys in family areas, unprotected stairs and unlocked storage cabinets. The review of the physical environment shall include the exterior of the facility including walkways, parking areas and outside recreation areas;
   (3) Provide and maintain a home-like environment of adequate size and appropriate configuration with sufficient space for furnishings, equipment, and supplies to provide comfortable and safe accommodations for the number of patients and families served and the personnel providing services;
   (4) Provide birth rooms that:
      (a) Are of adequate size and appropriate configuration to provide for the equipment, staff members, supplies, and emergency procedures required for the physical and emotional care of the mother, family, and the newborn during labor, birth and the postpartum period;
      (b) Have doorways and hallways of adequate width and configuration to accommodate maneuvering of ambulance stretchers and beds in emergencies;
      (c) Are located to provide rapid unimpeded access to an exit of the building that will accommodate emergency transportation vehicles and equipment; and
      (d) Have toilet and bathing facilities including toilet, sink, bath or shower facilities with hot and cold running water, and appropriately placed grab bars for patients.
(5) Establish and, when necessary, follow procedures for handling of patients in the event of fire or natural disaster or any other emergency situation requiring the evacuation of patients.

3701-83-58 Quality assessment and performance improvement-exempt freestanding birthing centers. Amish freestanding birth center; quality assessment.

(A) Each exempt center shall monitor and evaluate the provision of direct care services to its patients and shall implement procedures to improve the quality of care and resolve identified problems. The quality assessment shall, at minimum, include:
   (1) The review of all transfers of patients to a hospital or other health care setting; and
   (2) The review of complications and adverse events during the provision of the exempt center’s services.

(B) As part of the quality assessment and performance improvement activities and to assist the director in determining if the exempt center is in compliance with rules 3701-83-57 and 3701-83-58 of the Administrative Code, each exempt freestanding birth center shall report to the director of health, as may be required, but not less frequently than January twentieth of each year, the following information and data in the format and manner prescribed by the director and appendix A to this rule:
   (1) The identification of the administrator or director of patient services of the birth center;
   (2) The identification of the physician(s) providing obstetrical or pediatric consultation and oversight to the exempt birth center staff, and number of patient care-related contacts initiated by staff;
   (3) Staffing of the exempt birth center, including the number of traditional midwives, apprentice midwives, certified professional midwives, and any state-licensed health care professionals;
   (4) How and by whom potential patients are being assessed for risk prior to admission;
   (5) The total number of patients seeking admission and total number admitted;
   (6) The total number of post delivery admissions, the reason for admission, and the length of stay;
   (7) The number of deliveries at the exempt birth center;
   (8) The number of deliveries by a physician, a certified nurse midwife, a certified professional midwife, an apprentice midwife, or a lay midwife;
   (9) Identification of who attended each delivery within the exempt birth center;
   (10) The total number of live births by weight in grams;
   (11) The total number of newborns where estimated gestational age was less than thirty-seven weeks and the total number of newborns where estimated gestational age was greater than forty-two weeks;
   (12) The total number of fetal, neonatal, and maternal deaths;
   (13) The total number of maternal transfers to a hospital obstetric service or other health care setting; whether before or following delivery; the reason for transfer; the date of the transfer; and the name of the receiving entity; and
   (14) The total number of neonate transfers to a hospital newborn service or other health care setting; the reason for the transfer; the date of the transfer; and the name of the receiving entity;

(C) The data submitted under this rule shall be reviewed by the exempt center’s consulting physician prior to submission.
3701-83-59 Compliance - exempt freestanding birthing center. Amish freestanding birth center; ordered compliance.

(A) If the director of health determines that an exempt freestanding birthing center is no longer in compliance with divisions (4) and (5) of section 3702.301 of the Revised Code or rules 3701-83-57 and 3701-83-58 of the Administrative Code, the director may order the facility to come into compliance.
(B) In the order, the director may do any or all of the following:
   (1) Identify which requirement the exempt center is not in compliance with and what actions the center needs to take to come into compliance;
   (2) Require that the exempt center come into compliance within a period specified in the order;
   (3) Require that the exempt center provide the director with a written notice within a time period specified in the order that contains all of the following:
      (a) An attestation that the center has come into compliance;
      (b) The signature of the exempt freestanding birthing center’s administrator or medical director and an attestation that the administrator or medical director, whomever signs the notice, is the center’s authorized representative;
      (c) An attestation that the information contained in the notice and any accompanying documentation are true and accurate;
      (d) Any other information or documentation that the director may require to verify that the center has come into compliance; and
   (e) If the noncompliance pertains to patient care, an attestation that the information or documentation provided has been reviewed by the medical director or the consulting physician.
(C) If the exempt freestanding birthing center fails to comply with the director’s order within the time period specified in the order, the director may issue a second order that requires the center to cease operations until the center obtains a license as a freestanding birthing center under section 3702.30 of the Revised Code.
(D) In determining whether to issue orders under paragraph (C) of this rule, the director may consider any of the following factors:
   (1) The danger of serious physical or life-threatening harm existing or having existed to the patient or patients of the center;
   (2) The nature, duration, gravity, and extent of the identified condition, situation or practice existing or continuing;
   (3) Whether the violation directly relates or related to patient care;
   (4) The center’s history of quality of care data;
   (5) The extent and appropriateness of the actions taken by the center to correct the deficient practice or contributing condition; and
   (6) Whether the administrator, medical director, or other staff of the center materially misrepresented any information provided to the director.

Radiation Therapy Center

3701-83-43 Freestanding radiation therapy center; definitions.

As used in rules 3701-83-43 to 3701-83-50 of the Administrative Code:
(A) “Authorized user” means a physician who meets the definition in rule 3701:1-58-01 of the Administrative Code and is listed as the authorized user on the radioactive materials license issued by the director to the freestanding radiation therapy center.
(B) “Brachytherapy” means a method of radiation therapy in which sources are used to deliver a radiation dose at a distance of up to a few centimeters by surface, intracavitary,
(C) “Dose” or “radiation dose” is a generic term that means absorbed dose, dose equivalent, committed effective dose equivalent, or total effective dose equivalent as defined in rule 3701:1-38-01 of the Administrative Code.

(D) “Freestanding radiation therapy center” means a facility, part of a facility, or any arrangement in which radiation therapy services are transported to various sites, at which radiation therapy is provided to patients. “Freestanding radiation therapy center” does not include the provision of radiation therapy by a hospital registered under section 3701.07 of the Revised Code, or the provision of radiation therapy by an entity that is reviewed as part of a hospital accreditation or certification program.

(E) “Interstitial application” means the use of sealed radioactive sources within special applicators placed in tissue in a predetermined pattern.

(F) “Intracavitary application” means the use of radioactive sources in closed containers placed in body cavities.

(G) “Intraluminal” means within the lumen of a tube or tubular organ, such as a blood vessel.

(H) “Ionizing radiation” means gamma rays and x-rays, alpha and beta particles, high-speed electrons, neutrons, protons, and other atomic or nuclear particles or rays.

(I) “Nuclear medicine physician” means a physician listed as an authorized user on a radioactive materials license issued by the director for that modality as required in Chapter 3701:1-58 of the Administrative Code.

(J) “Radiation oncologist” means a physician who has satisfactorily completed a radiation oncology residency in an accreditation council for graduate medical education or American osteopathic association approved program; and is certified by one of the following:

(1) The American board of radiology or the American osteopathic board of radiology and who has a practice limited to radiation oncology;

(2) The American board of radiology, the American osteopathic board of radiology, or the royal college of physicians and surgeons of Canada in radiation oncology or therapeutic radiology; or

(3) The American board of certification in radiology in radiation oncology.

(K) “Radiologist” means a physician board certified in radiology by the American board of radiology, the American osteopathic board of radiology, or by the royal college of physicians and surgeons of Canada, or who has completed a formal accreditation council for graduate medical education (ACGME) or American osteopathic association approved residency in radiology.


(M) “Simulation” means the mock-up of a patient treatment with radiographic documentation of the treatment portals.


3701-83-44 General service standards.

(A) Each freestanding radiation therapy center shall evaluate the patient and assess tumors.

(1) The evaluation shall be conducted by the radiation oncologist and shall include a medical history, a physical examination, a review of the patient's diagnostic studies and reports,
and, when appropriate, consultation by the radiation oncologist with the referring physician.

(2) The assessment of tumors shall include a definition of tumor location, and the extent and stage of the tumor.

(B) Each freestanding radiation therapy center shall provide services necessary to meet the needs of the patient including:

(1) Consultation;
(2) Treatment planning, including the selection of dose, selection of treatment modality, and selection of treatment technique;
(3) Determination of optimal treatment program and calculation of dose;
(4) Simulation of treatment; and
(5) Clinical treatment management and patient education.

(C) Each freestanding radiation therapy center shall establish policies and implement procedures for the follow-up of patients who are treated with curative intent and patients who are treated with palliative intent by the radiation oncologist.

(1) The radiation oncologist shall establish a post-treatment follow-up plan for each patient.

(2) The follow-up of patients treated with curative intent shall:
   (a) Be for a five year period whenever feasible or practical; and
   (b) Include documentation of the outcome of therapy including the results of treatment such as tumor control or survival, and significant sequelae.

(3) If the center is unable to conduct the follow-up as planned, the center shall document the reason in the patient's medical record.

(D) Radiation therapy shall be provided only upon written order of a radiation oncologist.

Each freestanding radiation therapy center shall communicate with referring physicians regarding the radiation therapy.

(E) Each freestanding radiation therapy center shall comply with the requirements pertaining to the Ohio cancer incidence surveillance system established under sections 3701.261 to 3701.263 of the Revised Code and Chapter 3701-4 of the Administrative Code.

3701-83-45 Personnel requirements and qualifications; staff records.

(A) Each freestanding radiation therapy center shall have an administrator.

(B) Each freestanding radiation therapy center shall have a radiation oncologist, nuclear medicine physician, radiologist, or other authorized user, who meets the qualifications of paragraph (I), (J), or (K) of rule 3701:83-43 of the Administrative Code or rule 3701:1-58-40, 3701:1-58-51 or 3701:1-58-54 of the Administrative Code, as medical director. The medical director, radiation oncologists, radiologists, nuclear medicine physicians, and authorized users shall be qualified by training, experience, and certification to perform the scope of radiation therapy services provided by the facility. The medical director shall:

   (1) Approve specific duties that may be performed by each member of the physics staff as established by the medical physicist under paragraph (E) of this rule; and
   (2) Ensure appropriate coverage of the radiation therapy center by radiation oncologists or other authorized users and staff.

(C) A radiation oncologist, nuclear medicine physician, radiologist, or other authorized user shall be available for direct care and quality review on a daily basis. If the radiation oncologist, nuclear medicine physician, radiologist, or other authorized user is not on-site, the radiation oncologist, nuclear medicine physician, radiologist, or other authorized user shall be accessible by phone, beeper, or other designated mechanism.

(D) Each radiation therapy center shall have a medical physicist or teletherapy physicist who:

   (1) Is certified by the American board of radiology in radiological physics or therapeutic
radiological physics;
(2) Is certified by the American board of medical physics in medical physics with a specialty in radiation oncology physics;
(3) Has a master’s degree or doctorate from an accredited college or university in physics, biophysics, medical physics, radiological physics, nuclear engineering or health physics, and three years of experience in radiation therapy to include performance evaluations, safety checks, and treatment planning; or
(4) Is currently certified by the Ohio department of health as a certified radiation expert in the category of therapeutic and meets the requirements of paragraph (C)(3) of rule 3701:1-66-03 of the Administrative Code.

(E) The medical physicist or teletherapy physicist shall be available for consultation with the radiation oncologist, nuclear medicine physician, radiologist, or other authorized user to provide advice or direction to staff when patient treatments are being planned or patients are being treated. Radiation therapy centers shall have regular on-site physics support during hours of clinical activity. The on-site support shall, at a minimum, be provided on a weekly basis. When a medical physicist or teletherapy physicist is not available on-site, other physics duties shall be established and documented in writing by the medical physicist or teletherapy physicist. The medical physicist shall specify the specific physics duties that shall be performed by each member of the physics staff in accordance with their qualification and competence.

(F) Each freestanding radiation therapy center shall have available a sufficient number of qualified staff for the radiation therapy services provided including individuals licensed as radiation therapy technologists or nuclear medicine technologists under Chapter 4773 of the Revised Code, who are able to supervise and conduct the radiation therapy services as appropriate for the services being offered. The nuclear medicine physician, radiologist, radiation oncologist, or other authorized user and support staff shall be available to initiate urgent treatment with a medically appropriate response time on a twenty-four hour basis.

(G) In addition to the requirements of paragraph (B) of rule 3701-83-08 of the Administrative Code, each freestanding radiation therapy center shall establish personnel files for all individuals who provide radiation therapy services and shall:
(1) Maintain files for each individual which specify the types of procedures or services the individual is permitted to perform; and
(2) Update all files at least every twelve months.

3701-83-46 Treatment standards and protocols.

(A) The radiation oncologist shall establish the doses desired throughout the tumor and set dose limits to critical structures. Treatment deliveries shall meet the specifications of the radiation oncologist.

(B) All treatment applications shall be described in detail and signed by the radiation oncologist. The radiation oncologist shall be notified of any changes that may be necessary in the planned schedule of treatment.

(C) Each freestanding radiation therapy center shall:
(1) Provide or arrange for appropriate radiation treatment localization, simulation and verification;
(2) Provide or arrange for isodose treatment planning with complex analyses generated in appropriate cases;
(3) Provide accurate calculation of doses and dose distribution;
(4) Provide a system for independent checking of initial dose calculations. The check shall be conducted before the third fraction, or before twenty percent of the total dose when the treatment schedule provides less than ten fractions. The independent check includes utilizing another individual or method approved and documented by the medical physicist to verify dose.
calculation.
(5) Conduct ongoing reviews of accumulating doses;
(6) Conduct a chart and port film review weekly;
(7) Accurately chart treatment doses; and
(8) Maintain records of all data used in planning the specific treatment for a patient in the
patient's medical record.
(D) Each freestanding radiation therapy center shall provide devices to aid in positioning
and immobilizing the patient. Normal tissue shields, compensating filters, wedges and other aids
shall be provided as medically appropriate.
(E) Initial port films shall be reviewed by the radiation oncologist prior to the second
treatment and the port films shall be reviewed at least every ten treatments.
(F) Each freestanding radiation therapy center shall establish and maintain procedures
for handling medical emergencies including cardiac care.

3701-83-47 Radiation safety standards; freestanding radiation therapy centers.

(A) Each freestanding radiation therapy center shall maintain and follow written policies
and procedures for the handling of emergencies which may threaten the health and safety of
patients, staff, or the general public.
(B) Each freestanding radiation therapy center shall comply with the applicable
provisions of Chapter 3748 of the Revised Code and the rules adopted pursuant to that chapter.
(C) Each freestanding radiation therapy center shall identify, document, and report to the
department:
(1) Misadministrations in accordance with rule 3701:1-67-12 of the Administrative Code; or

3701-83-48 Equipment; minimum standards.

(A) Each freestanding radiation therapy center shall have the necessary equipment to
provide services with accuracy, precision, and efficiency. Each freestanding radiation therapy
center shall:
(1) Provide, either on-site or by referral, for diagnostic services including computerized
tomography (CT), magnetic resonance imaging (MRI), fluoroscopy, nuclear medicine, and
clinical and surgical pathology; and
(2) Document arrangements for referrals to one or more other radiation therapy sites so
that the patients will have access to a broad spectrum of radiation therapy equipment and a
variety of treatment modalities including at least brachytherapy and a unit of radiation therapy
equipment providing photons of at least ten megavolts (MV) and electron energies to at least
twelve mega electron volts (MeV).
(B) Each freestanding radiation therapy center shall develop and implement a program
to monitor the calibration and measurement of radiation beam characteristics to assure accurate
and reliable delivery of ionizing radiations. Calibration and operation of radiation therapy
equipment shall be in accordance with the radiation requirements specified in rules 3701:1-67-05
(C) Each freestanding radiation therapy center shall develop and implement a preventive
maintenance and repair program for equipment in accordance with manufacturer's
specifications. The center shall maintain records of equipment performance, maintenance and
malfunctions for the lifetime of the equipment's use at the center.
(D) Each freestanding radiation therapy center that operates a linear accelerator, cobalt
radiation therapy unit, or gamma knife shall comply with the applicable provisions of section
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3702.11 of the Revised Code and the rules adopted pursuant to that section.

(E) Each freestanding radiation therapy center shall maintain emergency equipment and medications appropriate for the services provided.

3701-83-49 Medical records; content.

In addition to the requirements of rule 3701-83-11 of the Administrative Code, each freestanding radiation therapy center shall maintain documentation of the following in each patient's medical record:

(A) Confirmation of the presence of malignancy by histopathology, or a statement of benign condition, or other alternative evidence for diagnosis of all cases accepted for radiation;
(B) Documentation of services and radiographic images, including localization films, appropriate to the therapy provided;
(C) Report of the initial evaluation including a definition of the tumor location, and the extent of each cancer as a basis for staging;
(D) The treatment plan including the selection of dose, selection of treatment modality, and selection of treatment technique;
(E) The dosimetry calculations;
(F) The patient's progress and tolerance throughout treatment; and
(G) The completion of treatment with a statement of a follow-up plan.

3701-83-50 Quality assessment and improvement program.

(A) As part of the quality assessment and performance improvement program required under paragraph (A) of rule 3701-83-12 of the Administrative Code, each freestanding radiation therapy center shall report to the director:
(1) The number and type of radiation therapy equipment utilized; and
(2) The type of radiation therapy services provided.
(B) As part of the quality assessment and performance improvement program requirements under paragraph (C) of rule 3701-83-12 of the Administrative Code, each freestanding radiation therapy center shall evaluate the provision of radiation therapy services. The review shall include:
(1) A review of case management and treatment results; and
(2) A review of complications and adverse events which occurred during the provision of the center's services.

Freestanding Diagnostic Imaging Centers

3701-83-51 Definitions; freestanding diagnostic imaging centers.

As used in rules 3701-83-51 to 3701-83-55 of the Administrative Code:
(A) “Authorized user” means a physician who meets the definition of authorized user in rule 3701:1-58-01 of the Administrative Code for the specified modality.
(B) “Chiropractic radiologist” means a chiropractor with:
(1) Diplomat status by the American chiropractic board of radiology; and
(2) CT and MRI credentialing by the American chiropractic board of radiology.
(C) “Computed tomography” or “CT” means the production of a tomogram by the acquisition and computer processing of X-ray transmission data.
(D) “Diagnostic imaging” means the production of images used for medical diagnosis using:
(1) MRI;
(2) PET;
(3) CT;
(5) Fluoroscopy.

“Diagnostic imaging” does not mean the production of images used for medical diagnosis using diagnostic x-ray, mammography, or ultrasound.

(E) “Diagnostic x-ray” means the irradiation of any part of the human body for the purpose of diagnosis or visualization.

(F) “Freestanding diagnostic imaging center” means a facility, or part of a facility, at which diagnostic imaging services are provided. A freestanding diagnostic imaging center does not include the provision of diagnostic imaging by a hospital registered under section 3701.07 of the Revised Code, or the provision of diagnostic imaging by an entity that is reviewed as part of a hospital accreditation or certification program.

(G) “Fluoroscopy” means the use of a fluorescent screen suitably mounted, either separately or in conjunction with a roentgen tube for visualizing and imaging internal structures which uses the injection or ingestion of contrast media for medical diagnosis.

(H) “Magnetic resonance imaging” or “MRI” means the use of an integrated set of machines utilizing radio frequency and magnetic fields to produce images of organs and tissue or spectroscopic quantitative data.

(I) “Mammography” means radiography of the breast.

(J) “Mobile diagnostic imaging center” means any arrangement in which diagnostic imaging services are transported to various sites. A mobile diagnostic imaging center does not include movement within a hospital or movement to a site where the equipment will be located permanently and does not include the provision of diagnostic imaging by an entity that is reviewed as part of a hospital accreditation program.

(K) “Nuclear medicine” means the use of internal radiopharmaceuticals for the diagnosis and treatment of patients.

(L) “Positron emission tomography” or “PET” means a nuclear medicine imaging technique employing a radiotracer radiopharmaceutical with a positron emitting radionuclide to provide functional information such as on blood flow or metabolism.

(M) “Radiologist” means a physician board certified in radiology by the American board of radiology, the American osteopathic board of radiology, or by the royal college of physicians and surgeons of Canada, or who has completed a formal accreditation council for graduate medical education (ACGME) or American osteopathic association approved residency in radiology.

(N) “Nuclear medicine physician” means a physician listed as an authorized user on a radioactive materials license issued by the director for that modality as required in Chapter 3701:1-58 of the Administrative Code.

(O) “Ultrasound” means a diagnostic imaging technique which employs high frequency low energy sound waves for imaging and doppler examinations.

3701-83-52 Personnel and staffing requirements; freestanding diagnostic imaging centers.

(A) Each freestanding or mobile diagnostic imaging center shall have a radiologist, nuclear medicine physician, authorized user, physician acting within their scope of practice, or chiropractic radiologist, as appropriate to the diagnostic imaging services being offered, that has overall responsibility for the diagnostic imaging services being provided by the freestanding or mobile diagnostic imaging center.
(B) Each freestanding or mobile diagnostic imaging center shall have a physician on site when sedation or contrast agents are being administered.

(C) CT freestanding and mobile diagnostic imaging centers shall have available sufficient and qualified personnel as appropriate for the services being offered as follows:

(1) CT services shall be provided only upon the written order of a physician, chiropractor, dentist or podiatrist;

(2) CT image interpretation shall be conducted by:
   (a) A radiologist; or
   (b) A physician or chiropractic radiologist acting within his or her scope of practice who does not meet the requirements of paragraph (N) of rule 3701-83-51 of the Administrative Code who has at least two years cross-sectional imaging and interpretation experience.

(3) A medical physicist with one of the following:
   (a) Certification by the American board of radiology in radiological physics or diagnostic radiological physics;
   (b) Certification by the American board of medical physics in medical physics with a specialty in diagnostic imaging physics;
   (c) Master's degree or doctorate from an accredited college or university in physics, biophysics, medical physics, radiological physics or health physics, or mechanical, electrical or nuclear engineering, or applied mathematics with a minor in physics and three years of experience in evaluating diagnostic radiation-generating equipment and quality assessment and improvement programs; or
   (d) Current certification by the Ohio department of health as a certified radiation expert in the category of diagnostic other than mammography as specified in paragraph (D) of rule 3701:1-66-03 of the Administrative Code.

(4) An individual licensed under Chapter 4773 of the Revised Code as a radiographer.

(D) MRI freestanding and mobile diagnostic imaging centers shall have available sufficient and qualified personnel as appropriate for the services being offered as follows:

(1) MRI services shall be provided only upon the written order of a physician, chiropractor, dentist or podiatrist;

(2) MRI image interpretation shall be conducted by:
   (a) A radiologist; or
   (b) A physician or chiropractic radiologist acting within his or her scope of practice who does not meet the requirements of paragraph (N) of rule 3701-83-51 of the Administrative Code who has at least six months experience or training in cross-sectional body imaging and image evaluation and interpretation.

(3) The monitoring and maintenance of a service and preventive maintenance program implemented in accordance with the manufacturer’s specifications, the equipment management program as required by rule 3701-83-53 of the Administrative Code, and the quality assessment and performance improvement program as required by rules 3701-83-12 and 3701-83-55 of the Administrative Code.

(4) A technologist for preparing and positioning the patient and for obtaining the MRI data in a manner suitable for interpretation. As used in this paragraph, “technologist” means an individual:

   (a) Registered with the American registry of radiologic technologists in the categories of “radiography,” “nuclear medicine technology,” “radiation therapy technology” or “magnetic resonance imaging”;
   (b) Certified by the American registry of magnetic resonance imaging technologists; or
   (c) Registered as a nuclear medicine technologist with the nuclear medicine technology certification board.

(E) PET and nuclear medicine freestanding and mobile diagnostic imaging centers shall have available sufficient and qualified personnel as appropriate for the services being offered as
follows:
(1) PET and nuclear medicine services shall be provided only upon the written order of an authorized user pursuant to rule 3701:1-58 of the Administrative Code;
(2) PET and nuclear medicine image interpretation shall be conducted by one of the following:
   (a) A nuclear medicine physician;
   (b) A radiologist;
   (c) A physician acting within his or her scope of practice who meets the requirements of rule 3701:1-58-36 of the Administrative Code.
   (d) A physician acting within his or her scope of practice who does not meet the requirements of paragraph (M) or (N) of rule 3701-83-51 of the Administrative Code that is supervised by a physician who is qualified pursuant to paragraph (E)(2)(a), (E)(2)(b), or (E)(2)(c) of this rule while the physician is completing a training program that will result in certification as a physician listed in paragraph (E)(2)(a), (E)(2)(b), or (E)(2)(c) of this rule.
(3) An individual licensed under Chapter 4773 of the Revised Code as a nuclear medicine technologist; and
(4) A radiation safety officer who meets the requirements of rule 3701:1-58-18 of the Administrative Code and is listed on the Ohio radioactive materials license.

(F) Fluoroscopy freestanding and mobile diagnostic imaging centers shall have available sufficient and qualified personnel as appropriate for the services being offered as follows:
(1) Fluoroscopy services shall only be provided upon the written order of a physician, dentist, or chiropractor;
(2) Fluoroscopy image interpretation shall be conducted by one of the following:
   (a) A radiologist;
   (b) A physician or chiropractic radiologist acting within his or her scope of practice who does not meet the requirements of paragraph (N) of rule 3701-83-51 of the Administrative Code who has at least six months experience or training in the performance and interpretation of fluoroscopy;
(3) A medical physicist with one of the following:
   (a) Certification by the American board of radiology in radiological physics or diagnostic radiological physics;
   (b) Certification by the American board of medical physics in medical physics with a specialty in diagnostic imaging physics;
   (c) Master's degree or doctorate from an accredited college or university in physics, biophysics, medical physics, radiological physics or health physics, or mechanical, electrical or nuclear engineering, or applied mathematics with a minor in physics and three years of experience in evaluating diagnostic radiation-generating equipment and quality assessment and improvement programs;
   (d) Current certification by the Ohio department of health as a certified radiation expert in the category of diagnostic other than mammography as specified in paragraph (D) of rule 3701:1-66-03 of the Administrative Code; or
(4) An individual licensed under Chapter 4773 of the Revised Code as a radiographer.

(G) In addition to the requirements of paragraph (B) of rule 3701-83-08 of the Administrative Code each freestanding or mobile diagnostic imaging center shall establish personnel files for all individuals who provide diagnostic imaging services and shall:
(1) Maintain files for each individual which specify the types of procedures the individual is permitted to perform; and
(2) At least every twelve months update all files.
(H) For CT and fluoroscopy services, the individual qualified under the requirements of paragraphs (C)(3) and (F)(3) of this rule shall be available for consultation with the radiologist or authorized user responsible for diagnostic imaging services to provide advice and direction, and
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the availability of the medical physicist shall be documented in writing and shall include:

1. Documentation that the individual conducted an on-site survey at least annually of the imaging equipment in accordance with the manufacturer's specifications to evaluate compliance with:
   a. Applicable rules adopted pursuant to Chapter 3748 of the Revised Code;
   b. The equipment management program as required by rule 3701-83-53 of the Administrative Code; and
   c. The quality assessment and improvement program as required by rules 3701-83-12 and 3701-83-55 of the Administrative Code.

2. Establishing written procedures to specify physics duties that shall be performed by each member of the physics staff in accordance with their qualifications and competence, and with the approval of the radiologist or authorized user responsible for diagnostic imaging services, as applicable to the services provided.

   I. For MRI services, an individual shall be available for consultation with the individual specified in paragraph (A) of this rule to provide advice and direction, and the availability of the individual shall be documented in writing and shall include:

   1. Conducting an on-site survey at least annually to evaluate the equipment management program as required by rule 3701-83-53 of the Administrative Code; and

   2. Establishing written procedures to specify service and preventive maintenance duties that shall be performed by each member of the staff in accordance with their qualifications and competence that are approved by the individual specified in paragraph (A) of this rule.


3701-83-53 Service standards and equipment; safety guidelines.

(A) Each freestanding or mobile diagnostic imaging center shall have equipment necessary to provide services with accuracy, precision, and efficiency as evidenced by:

1. All diagnostic imaging equipment shall be certified for clinical use by the United States food and drug administration;

2. All diagnostic imaging equipment specifications and performance shall meet all applicable state and federal requirements; and

3. The development and maintenance of an equipment management program which shall at a minimum:

   a. Maintain a current inventory of all diagnostic imaging equipment utilized by the freestanding or mobile diagnostic imaging center;

   b. Maintain and identify the clinical applications, maintenance requirements, and equipment malfunction history of all diagnostic imaging equipment utilized by the freestanding or mobile diagnostic imaging center;

   c. Assess the clinical and physical risks of all fixed and mobile equipment utilized in the provision of diagnostic imaging services;

   d. Develop and implement procedures for the regular maintenance and testing of equipment in accordance with manufacturer's guidelines; and

   e. Provide appropriate equipment orientation and training programs for personnel who use or maintain the freestanding or mobile diagnostic imaging center's equipment.

(B) Each freestanding or mobile diagnostic imaging center shall identify, document, and report to the department incidents in which equipment utilized by the diagnostic imaging center contributed or may have contributed to patient injury, illness, or death.

(C) Each freestanding or mobile diagnostic imaging center shall establish and maintain
safety guidelines, and practices and policies in accordance with applicable United States nuclear regulatory commission regulations and the applicable provision of Chapter 3748 of the Revised Code and the rules adopted pursuant to that chapter to assure a safe environment for patients, visitors, and personnel.

(D) Safety factors established and maintained by each freestanding or mobile diagnostic imaging center shall also include:

(1) Precautions against electrical and mechanical hazards;

(2) Precautions against the potential interactions of the magnetic field with ferromagnetic objects.

(E) Each freestanding or mobile diagnostic imaging center shall establish and maintain procedures for handling medical emergencies, including emergency cardiac care. Each site at which diagnostic imaging services are provided shall have the equipment, supplies, and personnel necessary to handle clinical emergencies that might occur, including adverse reactions to contrast agents.

(F) Each freestanding or mobile diagnostic imaging center shall have a staff member current in basic life support on duty at the center when patients are there.

3701-83-54 Medical records; content.

(A) In addition to the requirements of rule 3701-83-11 of the Administrative Code, each freestanding or mobile diagnostic imaging center shall maintain a diagnostic imaging radiology report for each patient, which includes the following:

(1) Patient name or identifier;

(2) Name of referring physician, podiatrist, dentist, or chiropractor;

(3) Name of physician or chiropractic radiologist conducting image interpretation;

(4) Name and type of diagnostic image performed and any contrast media used;

(5) Date of image;

(6) Findings;

(7) Factors limiting interpretability of exam;

(8) Pertinent clinical issues; and

(9) Conclusion or diagnosis.

(B) Each freestanding or mobile diagnostic imaging center shall maintain all medical records for a period of six years from the date of service.

(C) A mobile diagnostic imaging center may, by contract with a facility being served, require the facility to maintain such reports and medical records, provided that such reports and medical records are made available to the department for purposes of section 3702.30 of the Revised Code and Chapter 3701-83 of the Administrative Code.

3701-83-55 Quality assessment and improvement program.

(A) As part of the quality assessment and performance improvement program required under paragraph (C) of rule 3701-83-12 of the Administrative Code, each freestanding or mobile diagnostic imaging center shall:

(1) Establish and maintain a clinical image quality control program to monitor and document images repeated due to poor image quality;

(2) Monitor and evaluate the accuracy of image interpretations by:

(a) Establishing a clinical image review program;

(b) Establishing policies and procedures and the semiannual audit of a random, representative sample of total clinical images performed at the center;

(c) Provide for and implement the semiannual audit conducted by a radiologist or by a physician or chiropractor as identified under paragraphs (C)(2), (D)(2), (E)(2), and (F)(2) of rule

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3701-83-52 of the Administrative Code:
(i) Diagnostic imaging centers under the operation of more than one physician or chiropractic radiologist may conduct their own internal semiannual audit of a random sample of clinical images.
(ii) Diagnostic imaging centers operated by a single physician or chiropractic radiologist shall provide for the external semiannual audit of a random sample of clinical images. External audits shall not be conducted by an individual who is associated with, or has a financial interest in the center.
(3) Monitor and evaluate any problems associated with sedation, the administration of contrast agents, and problems identified as part of the semiannual audit of a random sample of clinical images.
(B) As part of the quality assessment and performance improvement program required under paragraph (A) of rule 3701-83-12 of the Administrative Code, each freestanding or mobile diagnostic imaging center shall report to the director:
(1) The number, type, and age, of diagnostic imaging equipment, including magnetic strength when applicable, and whether diagnostic imaging equipment is fixed or mobile;
(2) If diagnostic imaging equipment is mobile, a list of the locations where the service is delivered, including contracted sites for which the service is currently not operational;
(3) The number of procedures performed by CPT code;
(4) The number of repeat procedures taken which were conducted in order to obtain a sufficient image relating to the patient's image order;
(5) The number and type of complications associated with sedation and the administration of contrast agents;
(6) The number of patients who required hospitalization, as a result of a complication, within twenty-four hours of a procedure;
(7) The number of diagnostic procedures performed and the number that revealed negative findings; and
(8) The number of clinical images audited by the center or an external individual, and the number of cases in which there was variance between audited findings and original findings.

Part III. Health Care Services
[Editor’s Note: “Health Care Services” is a term used in Ohio statutes. It refers to hospital-based services.]

3702.11 Safety and quality standards of hospital-based services.

The director of health shall adopt rules establishing safety standards and quality-of-care standards for each of the following:
(A) Solid organ and bone marrow transplantation;
(B) Stem cell harvesting and reinfusion;
(C) Cardiac catheterization;
(D) Open-heart surgery;
(E) Pediatric intensive care;
(F) Operation of linear accelerators;
(G) Operation of cobalt radiation therapy units;
(H) Operation of gamma knives.
3702.14 Requirement to comply.

No person or government entity shall fail to comply with any rule adopted under section 3702.11 of the Revised Code.

3702.15 Director of health shall monitor compliance; reports and audits.

The director of health shall monitor health care providers for compliance with the safety and quality-of-care standards established in the rules adopted under section 3702.11 of the Revised Code. The director may inspect any health care provider as the director determines adequate to monitor compliance. The rules may require health care providers regularly to issue reports and undergo independent audits.

3702.20 Penalties for violating hospital service safety rules.

If the director of health determines that a person has violated section 3702.14 of the Revised Code, the director, after affording the person an opportunity for a hearing conducted in accordance with Chapter 119 of the Revised Code, shall impose a civil penalty of not less than one thousand dollars and not more than two hundred fifty thousand dollars on the person. In addition to the civil penalty, for a second or subsequent violation of section 3702.14 of the Revised Code, or for a first violation that the director determines has caused or poses an imminent threat of serious physical or life-threatening danger, the director, after affording the person an opportunity for a hearing conducted in accordance with Chapter 119 of the Revised Code, may issue an order that the person cease operating the health service. If a person issued such an order continues to operate the health service, the attorney general may apply to the court of common pleas of the county in which the person is located for an order enjoining the person from operating the service. The court shall grant the order on a showing that the person is operating the service.

Civil penalties collected under this section shall be deposited in the general operations fund created by section 3701.83 of the Revised Code and shall be used solely to administer and enforce the rules adopted under section 3702.11 of the Revised Code.

3701-84-01 General definitions.

As used in this chapter:

(A) “Accreditation award letter” means the written survey findings concerning the provider of a health care service, prepared by an entity that the director has determined as having standards and a process for assessing compliance for a particular HCS which equals or exceeds the applicable requirements of Chapter 3701-84 of the Administrative Code, that documents compliance with the entity's standards.

(B) “Administrator” means the person responsible for the overall daily management of the health care service.

(C) “Anesthesiologist” means a physician who has completed a residency training program in anesthesiology accredited by the American council of graduate medical education or the American osteopathic association.

(D) “Bone marrow transplantation service” means the replacement or supplementation of a patient's bone marrow with autologous or allogeneic hematopoietic stem cells when the patient's own bone marrow has been ablated or partially ablated by disease or therapy for the purpose of achieving long-term management of certain hematologic, immunologic, oncologic or genetic conditions, or enzymatic deficiency disease. A bone marrow transplantation service includes a service in stem cell harvesting and reinfusion.
(E) “Autologous/syngeneic bone marrow transplantation” means autologous, peripheral blood stem cell or syngeneic transplants.

(F) “Low-risk allogeneic bone marrow transplantation” means fully matched allogeneic sibling donor transplants without any of the high risk features listed under paragraph (G) of this rule.

(G) “High-risk allogeneic bone marrow transplantation” means unrelated or haploidentical transplants, or matched sibling donor transplants with any of the following features:

1. A primary diagnosis of myelodysplasia;
2. Bone marrow transplant in relapse;
3. Chronic myelogenous leukemia in anything other than in chronic phase;
4. Primary refractory patients; or
5. Patients with eastern cooperative oncology group performance status at time of transplant of greater than or equal to two.

(H) “Chiropractor” means a person licensed under Chapter 4734 of the Revised Code to practice chiropractic care.

(I) “Department” or “director” means the director of health or any official or employee of the department designated by the director of health.

(J) “Health care service” or “HCS” means any of the following:

1. A heart, lung, liver, kidney, pancreas, small bowel, or islet cell transplantation service or all combinations of solid organ transplant services, collectively referred to as a solid organ transplant service;
2. A bone marrow transplant service;
3. A cardiac catheterization service;
4. An open heart surgery service;
5. A pediatric intensive care service;
6. A linear accelerator, cobalt radiation, or gamma knife service;
7. A pediatric cardiac catheterization service;

(K) “Hospital” means an institution required to be registered under section 3701.07 of the Revised Code.

(L) “Licensed practical nurse” or “LPN” means a person licensed under Chapter 4723 of the Revised Code to practice nursing as a licensed practical nurse.

(M) “Medical director” means the physician who is responsible for managing and directing the provision of medical services at the health care service.

(N) “Nurse” means either a licensed practical nurse or a registered nurse.

(O) “Occupational therapist” means a person licensed to practice occupational therapy pursuant to section 4755.07 of the Revised Code.

(P) “Patient” means any individual who receives health care services.

(Q) “Patient representative” means either a person acting on behalf of a patient with the consent of the patient or the patient’s legal guardian.

(R) “Pediatric intensive care unit” or “PICU” or “pediatric intensive care service” means a separate and distinct unit in a hospital where pediatric patients, suffering from critical illness, receive care. “PICU” does not include a neonatal intensive care unit.

(S) “Pharmacist” means a person registered under Chapter 4729 of the Revised Code to practice pharmacy.

(T) “Physical therapist” means a person licensed to practice physical therapy pursuant to section 4755.44 of the Revised Code.

(U) “Physician” means a person who is licensed under Chapter 4731 of the Revised Code to practice medicine and surgery, or osteopathic medicine and surgery.

(V) “Psychologist” means a person licensed to practice psychology pursuant to Chapter
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4732 of the Revised Code.

(W) “Registered dietitian” means a person registered pursuant to Chapter 4759 of the Revised Code to practice dietetics.

(X) “Registered nurse” or “RN” means a person who is licensed under section 4723.09 of the Revised Code to practice as a licensed registered nurse.

(Y) “Certified registered nurse anesthetist” or “CRNA” means an RN who meets the qualifications specified in section 4723.41 of the Revised Code and is credentialed and privileged by the provider of a health care service to administer anesthetics to patients within his or her scope of practice.

(Z) “Social worker” means a person licensed to practice social work pursuant to Chapter 4757 of the Revised Code.

(AA) “Solid organ transplant service” means the transplantation of heart, lung, liver, kidney, pancreas, small bowel, islet cells, excluding autologous islet cell transplantation, and any and all combinations of such transplanted organs.

(BB) “Staff member” or “staff” means the administrator and individuals providing direct care to patients on a full-time, part-time, temporary, contract, or voluntary basis. Staff member or staff does not include volunteers who are family members of a patient.

(CC) “Linear accelerator service” means the structural unit of a health care facility which provides radiation therapy or stereotactic radiosurgery using a linear accelerator.

/DD) “Cobalt service” means the structural unit of a health care facility which provides radiation therapy using a cobalt teletherapy machine.

(EE) “Gamma knife service” means the structural unit of a health care facility which provides stereotactic radiosurgery or stereotactic radiotherapy using a gamma knife.

(FF) “Stereotactic radiosurgery service” means the structural unit of a health care organization which provides stereotactic radiosurgery.

(GG) “Linear accelerator” means a medical linear accelerator which provides a collimated beam of electrons or electronically produced x-rays used for radiation therapy treatment.

(HH) “Cobalt teletherapy machine” means a machine that provides a collimated beam of gamma rays from a sealed cobalt-60 source for the purposes of radiation therapy treatment.

(II) “Gamma knife” means a dedicated device for stereotactic radiosurgery which employs multiple cobalt-60 sealed radiation sources aimed at a single isocenter. The gamma knife may also be used to perform stereotactic radiotherapy.

(JJ) “Stereotactic radiosurgery” means the closed-skull destruction of a precisely defined intracranial target by beam(s) of ionizing radiation in which the total dose is administered during a single treatment session.

(KK) “Stereotactic radiotherapy” means the closed-skull destruction of a precisely defined intracranial target by beam(s) of ionizing radiation in which the total dose of radiation is administered as fractions during multiple treatment sessions.

(LL) “Dose” means energy imparted per unit mass of absorber at a specific site under certain conditions.

(MM) “Radiation therapy service” means the structural unit of a health care organization which provides radiation therapy.

(NN) “Ionizing radiation” means gamma rays and x-rays, alpha and beta particles, high-speed electrons, neutrons, protons, and other atomic or nuclear particles or rays.

(OO) “Radiation oncologist” means a physician who:

(1) Has satisfactorily completed a radiation oncology residency in an accreditation council for graduate medical education or American osteopathic association approved program; or

(2) Is certified in radiology by the American board of radiology or the American osteopathic board of radiology and who has had a practice limited to radiation oncology for the
ten year period prior to May 1, 1996; or

(3) Is certified in radiation oncology or therapeutic radiology by the American board of radiology, the American osteopathic board of radiology, or the royal college of physicians and surgeons of Canada.

(PP) “Radiation therapy” means the use of ionizing radiation, including external beam radiation therapy (teletherapy), or intraoperative radiation therapy and radioactive materials for therapeutic administration as authorized on a radioactive materials license issued by the director pursuant to 3701:1-58 of the Administrative Code in the treatment of human illness.

(QQ) “Simulation” means the mock-up of a patient treatment with radiographic documentation of the treatment portals.

(RR) “Cardiac catheterization” means all anatomic or physiological studies, including electrophysiology procedures, of interventions, both diagnostic and therapeutic, in which the heart or coronary arteries are entered via a systemic vein or artery using a catheter that is manipulated under fluoroscopic visualization. This definition does not include studies of cardiac function performed using flow directed catheters that are positioned without the use of fluoroscopy.

(SS) “Cardiac catheterization service” means the staff, equipment, physical space, and support services required to perform cardiac catheterization and percutaneous coronary interventions.

(TT) “Percutaneous coronary interventions” (PCI”) means the broader group of percutaneous techniques capable of relieving coronary narrowing. Such PCI techniques include rotational atherectomy, directional atherectomy, extraction atherectomy, laser angioplasty, implantation of intracoronary stents and other devices for treating coronary atherosclerosis, including percutaneous transluminal coronary angioplasty.

(UU) “Percutaneous transluminal coronary angioplasty” (“PTCA”) means the inflation of a balloon-tipped catheter at the site of a coronary artery stenosis to attempt to enlarge the diameter of the lumen.

(VV) “Adult open heart surgery service” or “pediatric cardiovascular surgery service” means the combination of staff, equipment, physical space and support services which are used to perform open-heart surgery and other non-invasive cardiovascular surgeries.

(WW) “Pediatric patient” means any patient less than twenty-two years of age, unless otherwise specified in this chapter.

(XX) “Provider of a health care service” means a person or governmental entity who assumes legal liability for purposes of compliance with this chapter.

(YY) For purposes of this chapter, “follow-up inspection” means an inspection, which may include on-site and off-site activities, conducted by the department to determine whether the HCS has corrected a violation or violations cited on a previous inspection and to verify whether the HCS is in compliance with the applicable criteria, standards, and requirements established by section 3702.16 of the Revised Code and Chapter 3701-84 of the Administrative Code.

3701-84-02 Applicability of rules to types of hospital-based services.

(A) All health care services shall comply with rules 3701-84-02 to 3701-84-14 of the Administrative Code. In addition, all:

(1) Solid organ transplant services shall comply with rules 3701-84-16 to 3701-84-21 of the Administrative Code;

(2) Bone marrow transplant services, including stem cell harvesting and reinfusion, shall comply with rules 3701-84-24 to 3701-84-27 of the Administrative Code;

(3) Adult cardiac catheterization services shall comply with rules 3701-84-30 to 3701-84-34.2 of the Administrative Code;
(4) Open heart surgery services shall comply with rules 3701-84-36 to 3701-84-40 of the Administrative Code;
(5) Pediatric intensive care services shall comply with rules 3701-84-61 to 3701-84-65 of the Administrative Code;
(6) Linear accelerator, cobalt, and gamma knife services shall comply with rules 3701-84-67 to 3701-84-73 of the Administrative Code;
(7) Pediatric cardiac catheterization services shall comply with rules 3701-84-75 to 3701-84-79 of the Administrative Code; and
(8) Pediatric cardiovascular surgery services shall comply with rules 3701-84-81 to 3701-84-85 of the Administrative Code.

(B) The director shall review the provisions of Chapter 3701-84 of the Administrative Code periodically, consult with constituent groups and interested parties, and propose changes, as needed, to address technological advances and concerns with current rules.

3701-84-03 General HCS requirements; prohibitions.

(A) No person or agency of state or local government shall operate a HCS that does not comply with the provisions of this chapter of the Administrative Code.
(B) No person or agency of state or local government shall:
(1) Interfere with an inspection or investigation of a HCS by the director or the director’s designee. As used in this paragraph, “interfere” means to obstruct directly or indirectly any individual conducting an authorized inspection or investigation from carrying out their prescribed duties. Interference includes, but is not limited to, harassment, intimidation, and refusal to permit the director or the director's authorized representative upon presentation of official department identification, for the purpose of inspecting or investigating the operation of a HCS, to enter and inspect at any time the building or premises of a HCS, or to enter and inspect records that are kept concerning the operations of the HCS for information pertinent to the legitimate interests of the department.
(2) Materially misrepresent any information provided to the director pursuant to section 3702.16 of the Revised Code and Chapter 3701-84 of the Administrative Code.
(C) Each provider of a HCS shall ensure that the building or structure where it is located is in compliance with all applicable federal, state and local laws and regulations including, but not limited to, building codes.
(D) No provider of a HCS shall permit any person to smoke inside the portion of the structure where the HCS is located. The provider of a HCS shall post a notice in a conspicuous place within the HCS stating that smoking is prohibited inside the HCS.
(E) Nothing in this chapter shall be construed as authorizing individuals to provide services outside their licensed scope of practice.

3701-84-04 Service notification for new or reinitiated HCS.

(A) At least thirty days prior to initiating a new HCS or reactivating a discontinued or temporarily suspended HCS the provider of the HCS shall notify the director in writing, in a manner prescribed by the director, of its intentions to initiate the service. This notice shall contain:
(1) The name, address, and telephone number of the facility where the HCS is located;
(2) The type of HCS which the provider is seeking to initiate including the scope of services to be provided; and
(3) The projected date of initiation.
(B) Prior to initiating a new HCS or reactivating a discontinued or temporarily suspended HCS, the provider of the HCS shall file with the director:
(1) An attestation of compliance, with the applicable provisions of this chapter for the HCS to be initiated or reinstated. The attestation shall be signed by the medical director of the HCS and the authorized representative of the provider of the HCS;

(2) Attestation that to the best of the provider of the HCS's knowledge, the information in the attestation and any accompanying material is true and accurate;

(3) Attestation that the individual, if not the chief executive officer of the entity providing the HCS, is the authorized representative of the provider of the HCS; and

(4) Any other information the director may require regarding the ability to operate the HCS.

(C) The provider of the HCS shall submit a revised attestation within thirty days of the following:

(1) Change in medical director;

(2) Change in authorized representative who previously signed an attestation; or

(3) Change in the provider of the HCS.

(D) The director may request additional information relative to the continuing operation or initiation of a HCS.

(E) At any time, the director may request additional information that the director reasonably determines to be necessary to assess compliance with the applicable criteria, standards, and requirements established by section 3702.16 of the Revised Code and Chapter 3701-84 of the Administrative Code. The provider of the HCS shall submit any additional information requested by the director within thirty days of the director's request. The director may require any additional information requested to be submitted in less than thirty days if patient health or safety is of concern.

(F) If the director determines that the provider of the HCS has failed to demonstrate compliance with the provisions of this chapter, the director may take action under rule 3701-84-05 of the Administrative Code.

(G) At least thirty days prior to a change in the scope of the HCS, the provider of the HCS shall notify the director in writing of its intentions to change the scope of service and the specific changes to be implemented.

(H) Within thirty days of recognizing that the HCS is not in compliance with applicable criteria, standards or requirements established by section 3702.16 of the Revised Code or this chapter of the Administrative Code, the provider of the HCS shall notify the director in writing of:

(1) The criteria, standard or requirement not met;

(2) The reason for failure to meet the criteria, standard or requirement; and

(3) The corrective action that will be taken; and

(4) The time table for meeting the criteria, standard or requirement.

(I) At least thirty days prior to discontinuing a HCS, the provider of the HCS shall notify the director in writing of its intentions to discontinue the service. If the discontinuation is out of the control of the provider of the HCS and the thirty day requirement in this paragraph cannot be met, the written notice shall be given prior to discontinuing the service. The notice shall include the projected date of discontinuance.

3701-84-05 Violations; compliance actions.

(A) If any provider of a HCS fails to comply with section 3702.14 of the Revised Code or Chapter 3701-84 of the Administrative Code, the director shall provide the HCS a reasonable and appropriate amount of time to correct the violation and, in accordance with Chapter 119 of the Revised Code, may:

(1) Impose a civil penalty based on the severity of the violation as follows:

(a) For violations that present an imminent threat of serious physical or life-threatening danger, or an immediate serious threat to the emotional health, safety or security of patients, a
civil penalty of not less than one hundred thousand dollars and not more than two hundred and fifty thousand dollars;

(b) For violations that directly threaten physical or emotional health, safety, or security of patients, a civil penalty of not less than ten thousand dollars and not more than one hundred thousand dollars;

(c) For violations that indirectly threaten or potentially threaten the physical or emotional health, safety, or security of patients, a civil penalty of not less than one thousand dollars and not more than ten thousand dollars; and

(2) Issue an order that the HCS cease operation:

(a) For a second or subsequent violation of section 3701.14 of the Revised Code or Chapter 3701-84 of the Administrative Code; or

(b) For an initial violation that the director has determined to cause or pose an imminent threat of serious physical harm or life-threatening danger.

(B) In determining which of the actions to take under paragraph (A) of this rule, the director may consider the following factors:

(1) The danger of serious physical or life-threatening harm to one or more patients utilizing the health care service;

(2) The nature, duration, gravity, and extent of the violation;

(3) The number, if any, of patients directly affected by the violation;

(4) Whether the violation directly relates to patient care and the extent of the actual or potential harm to patients;

(5) The number of staff involved in the violation;

(6) The actions taken by the provider of the HCS to correct the violation; and

(7) The provider of the HCS's history of compliance.

3701-84-06 Inspections and audits by director; fees.

(A) The director may make announced or unannounced inspections to determine and monitor compliance with section 3702.14 of the Revised Code and the applicable requirements of Chapter 3701-84 of the Administrative Code.

(B) If patient survival or complications of the HCS are outside the industry norm or outside the range of expected values, the director may conduct a review of the HCS or require the provider of the HCS to contract for an independent review of the HCS, to be performed by at least two experts that the director has approved for the situation, to determine the probable cause of the adverse outcomes and make recommendations for improvement.

(1) In determining whether to approve an expert, the director shall consider the individual's knowledge and expertise in the service area and affiliation with the provider of the HCS;

(2) The contract shall require a written report to be submitted to the director by the reviewers within one hundred and twenty days of the director's notice to the HCS of the requirement for a review;

(3) Based on the findings of the review, the director may require the HCS to implement recommendations of the experts; and

(4) The provider of the HCS shall assume all costs of the review. The costs incurred under this paragraph are not subject to or included in the maximum annual fees specified in paragraph (G) of this rule.

(C) Each provider of a HCS shall ensure the director access to its premises, records, including business and medical records, and staff to demonstrate compliance with the requirements established under section 3702.14 of the Revised Code and the applicable requirements of Chapter 3701-84 of the Administrative Code.
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(D) Information obtained by the director pertaining to specific patients is confidential. Information may be released in summary, statistical, or other form which does not disclose the identity of an individual patient. Information may be shared with other state or federal agencies if such information is necessary in carrying out their official duties. An agency or person that receives such patient record information shall protect and preserve patient confidentiality.

(E) The director may conduct an inspection to investigate alleged violations of section 3702.14 of the Revised Code and Chapter 3701-84 of the Administrative Code. The director shall inform the complainant and the HCS of the results of the investigation.

(F) The HCS fee for the inspections conducted by the director pursuant to section 3702.15 of the Revised Code and paragraphs (A) and (E) of this rule shall be, subject to paragraph (G) of this rule, as follows:
   (1) Inspection fee one thousand seven hundred fifty dollars;
   (2) Complaint inspection six hundred fifty dollars;
   (3) Follow-up inspection six hundred fifty dollars; and
   (4) Desk audit or compliance review inspection fee of two hundred fifty dollars.

(G) In charging a provider of a health care service a fee under paragraph (F) of this rule the total fees charged to a provider of a health care service, for services described in section 3702.11 of the Revised Code, shall not exceed five thousand dollars annually.

(H) The director shall provide to each provider of a health care service a statement of the fee charged under paragraph (F) of this rule which itemizes and totals the costs incurred by the department.

(I) The provider of a health care service shall forward the total amount of the fee to the director payable to the “Treasurer, State of Ohio” within fifteen days after receiving a statement of the fee issued under paragraph (H) of this rule.

(J) The director shall deposit HCS fees into the quality monitoring and inspection fund created in the state treasury pursuant to division (A) of section 3702.31 of the Revised Code.

3701-84-07 Patient care policies; minimum standards.

(A) Each provider of a HCS shall develop and follow comprehensive and effective patient care policies that include the following requirements:
   (1) Each patient shall be treated with consideration, respect, and full recognition of dignity and individuality, including privacy in treatment and personal care needs;
   (2) Each patient shall give informed consent and be allowed to refuse or withdraw consent for treatment or give conditional consent for treatment. Written documentation of patient consent shall be maintained in the patient’s medical record;
   (3) Each patient shall have access to his or her medical record, unless access is specifically restricted by the attending physician for medical reasons;
   (4) Each patient's medical and financial records shall be kept confidential; and
   (5) Upon request, each patient shall receive a detailed explanation of charges including an itemized bill for services received.

(B) Each provider of a HCS shall ensure that each patient is informed of the following:
   (1) The diagnosis and treatment alternatives and the risks involved with each;
   (2) The HCS’s policy on advanced directives and, if applicable, do-not-resuscitate orders (DNR); and
   (3) The name of the attending physician or individual supervising the patient’s care and the manner in which that individual may be contacted.
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3701-84-08 Personnel and staffing requirements; records; ongoing training.

(A) Each provider of a HCS shall, based on the services provided and the number of patients served, maintain a sufficient number of qualified staff members and other personnel and an appropriate schedule of staff time to meet the needs of its patients in a timely manner. Each provider of a HCS shall be responsible for the care provided by the staff and personnel of that HCS.

(B) Each provider of a HCS shall utilize personnel to provide services who have appropriate training and qualifications for the services that they provide.

(1) Any staff member who functions in a professional capacity shall meet the standards applicable to that profession, including but not limited to, possessing a current Ohio license, registration, or certification, if required by law, and working within their scope of practice; and

(2) The provider of a HCS shall have an established system of records necessary for the director to ascertain that all individuals employed at the HCF who function in a professional capacity meet the standards applicable to that profession, including, but not limited, possessing a current Ohio license, registration, or other certification, if required by law.

(C) Each provider of a HCS shall have a medical director for the HCS. In lieu of the board certification requirements specified in this chapter, a physician who is board certified by a foreign board and is eligible to take the examination of an American board of medical specialties recognized board or an American osteopathic association board may serve as medical director of an HCS.

(D) The owner, administrator, and the medical director of a HCS shall be competent to perform the applicable job responsibilities and be suitable to own, operate, or direct a HCS.

(E) Each HCS shall develop and follow a tuberculosis control plan that is based on the provider's assessment of the HCS. The control and assessment shall be consistent with the United States centers for disease control and prevention (CDC) “Guidelines for Preventing the Transmission of Mycobacterium tuberculosis in Health Care Settings, 2005,” MMWR 2005, Volume 54, No. RR-17. The HCS shall retain documentation evidencing compliance with this paragraph and shall furnish such documentation to the director upon request.

(F) Each provider of a HCS shall not knowingly permit a staff member to provide services if the staff member:

(1) Has a disease capable of being transmitted during the performance of his or her duties;

(2) Is under the influence of drugs or alcohol; or

(3) After training and orientation by the provider of the HCS, has not demonstrated sufficient knowledge or expertise for the responsibilities of the position.

(G) Each provider of a HCS shall provide each staff member with a written job description delineating his or her responsibilities.

(H) Each provider of a HCS shall provide an ongoing training program for all staff that includes both an orientation and continuing training.

(1) The orientation shall be appropriate to the tasks that each staff member will be expected to perform; and

(2) Continuing training shall be designed to assure appropriate skill levels are maintained and that staff are informed of changes in techniques, philosophies, goals, and similar matters. The continuing training may include attending and participating in professional meetings and seminars and shall include information specific to the appropriate HCS.

(I) All staff shall have appropriate orientation and training regarding the HCS's equipment, safety guidelines, practices, and policies.

(J) Each provider of a HCS shall develop and implement an ongoing process for ensuring the competence of staff members. This process shall include:
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(1) A periodic assessment and re-determination of necessary skill levels identified for the staff member's position; and
(2) At least every thirty-six months, a performance evaluation stating whether each staff member has achieved the skill levels identified for the staff member's position.

(K) Each provider of a HCS shall retain staffing schedules, time-worked schedules, on-call schedules, and payroll records for at least two years.

3701-84-09 Service standards; minimum standards.

(A) Each provider of a HCS shall ensure that all staff members provide services in accordance with:
(1) The patient's plan of care;
(2) The policies and procedures developed by the HCS;
(3) Applicable current and accepted standards of practice and the clinical capabilities of the HCS;
(4) Applicable state and federal laws and regulations; and
(5) The applicable quality of care and safety standards set forth in this chapter.

(B) Each provider of a HCS shall document all medical services performed in the care of the patient in the patient's medical record.

(C) Each provider of a HCS shall provide for the ancillary and support services necessary for the provision of the HCS's services.

(D) Each provider of a HCS shall establish and follow written infection control policies and procedures for the surveillance, control and prevention of communicable disease organisms by both the contact and airborne routes that are consistent with current infection control guidelines issued by the United States centers for disease control and prevention (CDC) and shall facilitate the activities associated with the prevention and spread of communicable infectious diseases. Each HCS shall retain documentation evidencing compliance with this paragraph and furnish such documentation upon request. The policies and procedures shall, at a minimum, address:
(1) The utilization of protective clothing and equipment;
(2) The storage, maintenance and distribution of sterile supplies and equipment;
(3) The disposal of biological waste; including blood, body tissue, and fluid in accordance with Ohio law;
(4) Standard precautions/body substance isolation or equivalent; and
(5) Tuberculosis and other airborne diseases.

(E) Each provider of a HCS shall maintain and operate equipment in a safe manner, in accordance with the manufacturer's instructions, and shall not jeopardize patient health or safety through operation of the equipment.

(F) Each provider of a HCS shall provide the patient or the patient's representative:
(1) Instruction and education regarding the services to be performed;
(2) Written information about how to obtain appointments and needed services, both during and after the HCS's normal hours of operation; and
(3) Verbal and written instructions for post-treatment care and procedures for obtaining emergency care.

3701-84-10 Building and site requirements; minimum standards.

(A) Each provider of a HCS shall ensure that the building or structure where the HCS is located:
(1) Has a certificate of use from a local, certified building department or by the department of commerce as meeting applicable requirements of Chapters 3781., 3783., and 3791 of the Revised Code and any rules adopted under them;
(2) Complies with the Ohio fire code; and
(3) Complies with the applicable provisions of Chapter 3737 of the Revised Code and the rules adopted under it.

(B) Each provider of a HCS shall adopt and follow a disaster preparedness plan, including evacuation in the event of a fire or other emergency. The HCS shall review evacuation procedures at least annually and conduct practice drills with staff at least once every six months.

(C) Each provider of a HCS shall label, store and dispose all poisons, hazardous wastes, and flammable materials in accordance with state and federal laws and regulations and in a safe manner that does not jeopardize patient health or safety.

(D) The minimum space or square footage requirements specified in this chapter are of clear floor space and exclusive of fixed or wall mounted cabinets, desks, and closets that are floor based.

3701-84-11 Medical records; minimum standards.

(A) Each provider of a HCS shall maintain a medical record for each patient that documents, in a timely manner and in accordance with acceptable standards of practice, the patient's needs and assessments, and services rendered. Each medical record shall be legible and readily accessible to staff for use in the ordinary course of treatment.

(B) Each provider of a HCS shall not disclose individual medical records except as authorized by the patient or allowed by state and federal laws and regulations, and the provisions of this chapter.

(C) Each provider of a HCS shall systematically review records for conformance with acceptable standards of practice and the requirements of Chapter 3701-84 of the Administrative Code.

(D) Each provider of a HCS shall maintain an adequate medical record keeping system and take appropriate measures to protect medical records against theft, loss, destruction, and unauthorized use.

(E) Each HCS shall have policies and procedures to ensure the confidentiality of patient medical records.

(F) Each provider of a HCS shall maintain medical records as necessary to verify the information and reports required by statute or regulation for six years from the date of discharge.

3701-84-12 Quality assessment and improvement program.

(A) Each provider of a HCS shall establish a quality assessment and performance improvement program designed to:

(1) Systematically monitor and evaluate the quality of patient care provided;
(2) Pursue opportunities to improve patient care;
(3) Ensure compliance with the applicable quality standards set forth in this chapter; and
(4) Resolve identified problems.

(B) Each provider of a HCS shall develop a written plan for each HCS that describes the quality assessment and performance improvement program's objectives, organization, scope, and mechanism for overseeing the effectiveness of monitoring, evaluation, improvement, and problem-solving activities.

(C) The quality assessment and performance improvement program shall do all of the following:
(1) Monitor and evaluate all aspects of care including effectiveness, appropriateness, accessibility, continuity, efficiency, patient outcome, and patient satisfaction;
(2) Establish expectations, develop plans, and implement procedures to assess and improve the quality of care and resolve identified problems;
(3) Establish expectations, develop plans, and implement procedures to assess and improve the health care service's governance, management, clinical, and support processes;
(4) Establish information systems and appropriate data management processes to facilitate the collection, management, and analysis of data needed for quality improvement;
(5) Internally document and report findings, conclusions, actions taken, and the results of any actions taken to the health care service's management and medical director;
(6) Document and review all unexpected complications and adverse events, being serious injury or death resulting from medical management, which arise during the provision of the service or during the hospital stay; and
(7) Hold regular meetings, chaired by the medical director of the HCS, or designee, as necessary, but at least within sixty days after a death or complication, to review all deaths and complications and to report findings. Any pattern that might indicate a problem shall be investigated and remedied, if necessary.

3701-84-13 Complaints; content, documentation.

(A) Each provider of a HCS shall develop and follow policies and procedures to effectively receive, investigate, and report findings of complaints regarding the quality or appropriateness of services provided by the HCS. The documentation of complaints shall, at a minimum, include the following:
   (1) The date complaint was received;
   (2) The identity, if provided, of the complainant;
   (3) A description of the complaint;
   (4) The identity, if provided, of persons and/or the provider of the HCS involved;
   (5) The findings of the investigation; and
   (6) The resolution of the complaint.
(B) Each provider of a HCS shall post the toll free complaint hotline of the Ohio department of health’s complaint unit in a conspicuous place in the HCS.

3701-84-14 Variances and waivers from this chapter.

(A) In accordance with paragraph (B) of this rule, the director may grant a variance or waiver from any requirement established by Chapter 3701-84 of the Administrative Code.
(B) Upon written request of the provider of a HCS, the director shall grant or deny a variance or waiver by written response within forty-five days of receipt of the request and all information determined necessary by the director to make a decision. In granting a variance or waiver, the director shall stipulate a time period for which the variance or waiver is to be effective and establish conditions that the HCS must meet for the variance or waiver to be operative. The director may grant:
   (1) A variance if the director determines that the requirement has been met in an alternative manner; or
   (2) A waiver if the director determines that the strict application of the requirement would cause an undue hardship to the HCS and that granting the waiver would not jeopardize the health and safety of any patient.
(C) The granting of a variance or waiver is a discretionary act by the director based upon documentation:
(1) In the case of a variance request, as to how the HCS is meeting the intent of the requirement in an alternative manner; and
(2) In the case of a waiver request, as to how the requirement is an undue hardship to the HCS and why the waiver will not jeopardize the health and safety of any patient.
(D) The granting of a variance or waiver by the director shall not be construed as constituting precedent for the granting of any other variance or waiver. All variance and waiver requests shall be considered on a case-by-case basis.
(E) The provider of a HCS whose request for a waiver or variance under this rule is denied may request a reconsideration of the decision by the director.
(1) A request for reconsideration must be received in writing by the director within thirty days of receipt of the director's denial of a waiver or variance request and include information that:
(a) Presents significant, relevant information that was not previously submitted to the director by the provider of the HCS, because it was not available to the provider of the HCS at the time the waiver or variance request was filed; or
(b) Demonstrates that there have been significant changes in factors or circumstances relied upon by the director in reaching the initial decision.
(2) A decision on an appropriately filed request for reconsideration shall be issued within forty-five days of the director's receipt of the request for reconsideration and all information determined necessary by the director to make a decision.
(3) The reconsideration process is an informal procedure not subject to Chapter 119 of the Revised Code. The director's decision on reconsideration is final.
(F) Each new provider of a HCS shall provide the service in compliance with all provisions of Chapter 3701-84 of the Administrative Code, unless a waiver or variance is granted for all provisions not met.

Solid Organ Transplant

3701-84-16 Solid organ transplant service requirements.

(A) The provisions of rules 3701-84-16 to 3701-84-21 of the Administrative Code are applicable to each provider of solid organ transplant services regardless of the date the service was initiated.
(B) Each provider of a solid organ transplant service shall be a registered hospital classified as a general hospital or a children's hospital that meets the following administrative requirements:
(1) Demonstrated institutional commitment to graduate medical education and research programs;
(2) Executed letters of agreement or contracts with an independent organ procurement organization which can provide sufficient numbers of organs to support the applicable volume level specified by rule 3701-84-21 of the Administrative Code;
(3) All kidney transplant services shall be a member of the appropriate end-stage renal disease coordinating council designated for the medicare program under 42 C.F.R. 405.2110 (August 26, 1986);
(4) Cooperates with all extra-renal solid organ transplant services in Ohio relative to the following:
(a) Coordination of solid organ procurement, to be achieved to the extent practicable in cooperation with all established organ procurement organizations in Ohio;
(b) Participation in an effective method for assuring access to solid organ transplantation for the uninsured or financially indigent patient;
(c) Participation in a statewide registry to follow all transplant service patients from the time they receive approval by an inter-institutional patient selection committee until death; and
(d) Participation in a statewide service review process for solid organ transplant services.
(5) Membership in good standing in a statewide consortium of solid organ transplant services which provides the functions listed in paragraph (B)(4) of this rule shall be sufficient to meet the requirements of that rule;
(6) The hospital shall have written patient management policies and protocols for organ transplantation, including:
(a) Detailed plans for the acute and long-term management of each transplant patient by a multidisciplinary care team, including the waiting period, in-hospital phase, and immediate post-discharge period;
(b) Transplant experienced social services available to the patient and the patient's family at all times;
(c) Appropriate and thorough education of the patient;
(d) Liaison with the patient's primary care physician to provide timely notification of changes in the patient's condition; and
(e) If the solid organ transplant service performs living donor transplants, detailed plans for the donor, that include the evaluation, donation, and discharge phases of living organ donation.

3701-84-17 Required personnel and staffing.

(A) Each provider of a solid organ transplant service shall have a medical director that is certified in the appropriate specialty and that actively performs solid organ transplant procedures at the hospital where the HCS is located.
(B) Each provider of a solid organ transplant service shall have on staff:
(1) At least one primary transplant surgeon and at least one primary transplant physician, for each type of organ transplanted, that:
(a) Meet the personnel criteria for transplant surgeons and physicians, which are in effect on the effective date of this rule, as adopted by the national organ procurement and transplantation network, currently the united network for organ sharing; and
(b) Are not dedicated to more than one solid organ transplant service provider unless the solid organ transplant service have credentialed more than one transplant surgeon or transplant physician to provide transplant services for the appropriate type of organ; and
(2) A qualified surgeon with an appropriate level of expertise for the procedure being performed must be present in the operating room at all solid organ transplant surgeries.
(C) Each provider of a solid organ transplant service shall have a transplant surgeon and transplant physician for each type of organ transplanted available on a twenty-four hour a day, seven day a week basis to provide program coverage as follows:
(1) A transplant surgeon shall be readily available to timely facilitate organ acceptance and implantation;
(2) A transplant surgeon or transplant physician shall be available on site within one hour to address urgent patient issues; and
(3) When this coverage is not available, the program shall be temporarily suspended and the provider of the solid organ transplant service shall provide written notice of the temporary suspension of the service and the expected date of the reinstatement of services to the HCS patients and the director. A dated sample of the form letter provided to patients shall be provided to the director in addition to the director's notice. The written notice shall be provided to patients and the director as follows:
(a) For planned temporary suspensions, the notice required in this rule shall be provided
at least five business days prior to the temporary suspension; and

(b) For unexpected temporary suspensions, the notice required in this rule shall be provided within five business days after the temporary suspension.

(D) Each provider of a solid organ transplant service shall ensure that transplant services are delivered by a multidisciplinary team that, at a minimum, includes representatives from the following:

1. Surgical (transplant surgeon);
2. Medical (transplant physician);
3. Nursing;
4. Clinical transplant coordinator;
5. Social services;
6. Nutritional services;
7. Pharmacology; and

(E) Each provider of a solid organ transplant service shall have staff with the expertise needed to manage organ rejection and the problems of immunosuppressed patients.

(F) The following staff, exclusive of the transplant surgeons and physicians, shall meet the criteria set forth in this rule and shall be available at all times to the hospital where the service is located:

1. For extra-renal transplant services, a designated anesthesiologist who:
   a. For heart transplantation, has training in open heart surgery anesthesia;
   b. For lung transplantation, has training in cardiopulmonary anesthesia; or
   c. For liver transplantation, has had an on-site visit to an established liver transplant service and documented experience participating in liver transplant anesthesia or has formal training in liver transplantation anesthesia;
2. A pathologist with training in detecting rejection in the transplanted organ;
3. A nursing team trained in hemodynamic support and immunosuppression management. The training in immunosuppression management shall include training in isolation techniques and infection control methods;
4. A nephrologist on site;
5. An established division or section of infectious disease with physicians who are available for consultation and direct service;
6. A full-time transplant patient coordinator with appropriate experience as a patient coordinator with a transplant service;
7. A psychiatrist and a licensed independent social worker who are available for evaluation and ongoing support of both the patient and family;
8. Available physicians specializing in radiology, respiratory disease, and physical medicine; and

(G) Each provider of a solid organ transplant service shall provide sufficient staff to adequately monitor patients during the post-transplant period.

(H) Each provider of a solid organ transplant service that performs living donor transplantation must identify either an independent living donor advocate or an independent living donor advocate team to ensure protection of the rights of living donors and prospective living donors.
Each provider of a solid organ transplant service shall have available adequate facilities and resources for the transplant service. The following shall be available on-site at all times:

(A) Sufficient operating and recovery room resources;
(B) Intensive care facilities allowing reverse isolation;
(C) A dialysis unit;
(D) Sufficient bed capacity to accommodate at least the minimum volume level specified by rule 3701-84-21 of the Administrative Code for the applicable type of solid organ transplantation;
(E) Clinical laboratory services that include facilities for coagulation monitoring and blood bank resources capable of providing at least twenty units of blood, platelets, and fresh blood products on demand;
(F) Microbiology laboratory experienced in processing the pathogens of opportunistic infection;
(G) Physical therapy services; and
(H) Electron microscopy.

(I) Accessible by gurney at all times:
(1) Angiography;
(2) Cardiac catheterization;
(3) Diagnostic radioisotope scanning;
(4) Endoscopy;
(5) Nuclear medicine;
(6) Routine diagnostic radiology;
(7) Computed tomography;
(8) Bone marrow biopsy;
(9) Diagnostic ultrasound;
(10) Electroencephalography;
(11) Nerve conduction;
(12) Psychometrics;
(13) Pulmonary function; and
(14) Immunofluorescence.

(J) A provider of a solid organ transplant service shall have access to laboratory facilities for histocompatibility testing that are certified by the American society for histocompatibility and immunogenetics at all times.

The provider of a solid organ transplant service shall meet the following safety requirements:

(A) Heart or heart-lung transplantation services shall have an active open-heart surgery service that should be performing the following procedures annually based on the patient population served:
(1) A general heart-lung transplant service, a minimum of two hundred fifty open heart surgery procedures; or
(2) A heart or heart-lung transplantation services that only serves pediatric patients less than twenty-two years of age with an active pediatric open-heart surgery service, a minimum of two hundred pediatric open heart surgery procedures.

(B) Heart-lung transplantation services shall have an active lung transplant service and an active heart transplant service; and

(C) Bowel transplantation services shall have an active liver transplant service.
3701-84-20 Patient selection criteria.

[Editor’s Note: Appendices to this rule can be found at www.odh.ohio.gov/rules/final/finalrules.aspx.]

(A) Each provider of an extra-renal, solid organ transplant service shall participate in a prospective, statewide review process for each patient prior to listing for transplant. The prospective review process shall include a separate review committee for each type of organ. Each review committee shall include at least one transplant physician or transplant surgeon from each program that actively participates in transplantation services for the appropriate organ. An affirmative vote of a majority of the members of the review committee is required in order to list a patient.

(B) Each provider of a solid organ transplant service shall adhere to identical patient selection criteria, including:

(1) For kidney patient selection, end stage renal disease defined as dialysis dependence or pre-dialysis deterioration of renal function as manifested by the following:
   (a) For adult patients, a creatinine clearance less than thirty milliliters/minute for diabetic patients and less than twenty milliliters/minute for all other patients; or
   (b) For pediatric patients over the age of two, evidence of structural or functional kidney abnormalities (abnormal urinalysis, imaging studies, or histology) that persist for at least three months, with or without a decreased glomerular filtration rate (GFR), as defined by a GFR of less than 60 mL/min per 1.73 m2.

(2) For liver, heart, combined heart/lung, pancreas, pancreas islet cell, lung, or small bowel patient selection, the prospective patient selection criteria listed in appendix A to this rule and screening criteria for patients presenting with histories of alcohol or substance dependency as listed in appendix B to this rule.

(3) For heart and lung patient selection, the screening criteria for patients presenting with histories of tobacco use as listed in appendix C to this rule.

(C) If a transplantation service desires to perform a transplant on a patient who does not meet the selection protocols set forth in appendix A to this rule, the facility will need to establish that a thorough review of the case was undertaken to determine that the transplant was appropriate. This review shall, at a minimum, include:

(1) Preparation of a detailed clinical summary of the patient including: a brief medical history, complete laboratory data, a thorough psychological evaluation including the patient's support system, any psychological issues, attitude toward and understanding of the transplant, informed consent, and a justification of the transplant despite failure to meet the selection criteria;

(2) Circulation of the clinical summary to a committee comprised of, at a minimum, the director of health or the director's designee, one experienced transplant physician or transplant surgeon from each organ transplant program who actively participates in transplant services for the appropriate organ, an ethicist or bioethicist, and a lay representative who may be an attorney;

(3) Convening of the committee established in paragraph (C)(2) of this rule to discuss the clinical summary of the patient; and

(4) After sufficient review time, an affirmative vote of a majority of the members of the committee that the transplant is appropriate.

(D) Patients presenting for extra-renal transplantation that have histories of alcohol or substance dependency and do not meet the standard criteria conditions set forth in paragraph (B)(1)(a) or (B)(1)(b) of appendix B to this rule may be evaluated for listing by the chemical disorder committee. The committee shall:

(1) Be comprised of a minimum of one chemical dependency counselor or addiction specialist;
treatment professional from each organ transplant program in Ohio that actively participates in transplant service. Each member must be appropriately credentialed to diagnose substance use disorders either independently or under the clinical supervision of an individual, who reviews and co-signs the diagnosis, and is appropriately credentialed by:
   (a) The Ohio chemical dependency professionals board;
   (b) The Ohio counselor, social worker, and marriage and family therapist board with chemical dependency scope of practice; or
   (c) Is a physician with certification by the American society of addiction medicine or subspecialty certification in addiction psychiatry from the American board of psychiatry and neurology.

   (2) Make an advisory recommendation to the appropriate, organ specific patient selection committee under the prospective statewide review process.

3701-84-21 Volume goals; failing to meet goals.

   (A) Each solid organ transplant service designated as an adult or combined adult/pediatric transplant service performing surgeries in a single hospital or university multi-hospital transplant service, should achieve the following volume goals per year after they have been in existence for two years or more to ensure efficiency and a minimum floor of competency:
      (1) For kidney, fifteen transplants;
      (2) For heart, ten transplants;
      (3) For liver, ten transplants; and
      (4) For lung, ten transplants.
   (B) Volume goals will be considered by the director in conjunction with other indicators of quality, not as the sole indicator of service performance.
   (C) Failure to meet a volume goal for two consecutive years may trigger an extended review of the solid organ transplant service including possible inspections by the director of health. The director may request a statewide consortium of solid organ transplant services to conduct the inspections for solid organ transplant services.
   (D) Solid organ transplant services that are designated as pediatric transplant services are not subject to the volume goals set forth in paragraph (A) of this rule.

Bone Marrow Transplant

3701-84-24 Bone marrow transplant service standard criteria.

   (A) The provisions of rules 3701-84-24 to 3701-84-27 of the Administrative Code are applicable to each provider of bone marrow transplant services regardless of the date service was initiated.
   (B) Each provider of a bone marrow transplantation service shall be a registered hospital classified as a general hospital, a children's hospital or as a specialty hospital that primarily furnishes oncology services that meets all of the following criteria:
      (1) Participates with other hospitals nationally in cancer treatment research, such as national cancer institute sponsored research. The hospital's research activities shall include all of the following:
         (a) Use of uniform patient treatment protocols;
         (b) On-site audits at least every five years by a cancer research organization or another hospital involved in national cancer treatment research; and
         (c) Reporting of patient eligibility and treatment data to the research organization in which the hospital participates.
      (2) Meets the following administrative requirements:
(a) Appropriate patient management plans and protocols, including patient selection criteria, plans for long-term management, protocols to address the prevention of opportunistic infections among bone marrow transplant recipients, and appropriate liaison with the patient's family and primary care physician. The patient management plans and protocols shall be consistent with nationally accepted standards;

(b) Quality assurance standards for the procurement of hematopoietic stem cells including the procurement of bone marrow via a bone marrow harvest, as well as procurement of hematopoietic progenitor cells (stem cells) by the use of leukapheresis or umbilical cord blood collection; and

(c) A procedure for conducting systematic evaluation of clinical outcomes resulting from hematopoietic stem-cell transplantation.

(3) Has a documented agreement to cooperate with all other bone marrow transplantation services in Ohio relative to patient selection that is non-discriminatory as to race, gender, and ability to pay.

(C) Prior to initiating transplantation services, the provider of the bone marrow transplantation service shall specify to the director:

(1) The type of patient population to be served:
   (a) Pediatric patients less than seventeen years of age;
   (b) Patients greater than or equal to seventeen years of age and less than twenty-two years of age; or
   (c) Adult patients twenty-two years of age or older.
A bone marrow transplantation service may serve patients greater than or equal to seventeen years of age and less than twenty-two years of age as a pediatric or an adult patient, whichever best serves the needs of the patient, as determined by the transplant physician and transplant service's medical director;

(2) The type of transplantation service:
   (a) Autologous;
   (b) Allogeneic; or
   (c) Both.

3701-84-25 Personnel and staffing criteria.

Each provider of a bone marrow transplant service shall meet the following staffing criteria:

(A) A medical director responsible for the oversight of the care provided on the unit who actively performs bone marrow transplant services as part of that transplant service and who is:
   (1) Board-certified in hematology, oncology, immunology, or pediatric hematology/oncology or have documented experience in the field of hematopoietic progenitor cell (HPC) transplantation extending over ten years;
   (2) An active physician on staff at the hospital providing involved in direct patient care; and

(3) Has a minimum of one year clinical bone marrow transplantation training at a major transplant center in the United States formally recognized as a bone marrow transplant center by at least one of the following:
   (a) A national cooperative chemotherapy group;
   (b) The national bone marrow donor program; or
   (c) A national institute of health-supported bone marrow transplant research program.

(B) At a minimum, one other primary transplantation physician actively participating in the service.
(C) A nursing team that, in order to ensure adequate continuity of care, is committed to the transplant service on a full-time basis and has the training and skills commensurate with the required tasks performed.

(D) The care of bone marrow transplant patients shall be coordinated by a multidisciplinary team whose members have training and skills commensurate with the required tasks performed.

3701-84-26 Facilities and safety; minimum standards.

(A) The hospital at which the bone marrow transplant service is located shall provide all of the following on site:
   (1) A designated bone marrow transplant unit with a sufficient number of beds to meet the needs of the bone marrow transplant service;
   (2) Active departments or sections in hematology/oncology, immunology and infectious diseases;
   (3) Laboratories;
   (4) Adequate intensive care facilities;
   (5) Protective reverse isolation rooms with appropriate air handling characteristics (i.e., hepa-filtered positive pressure patient rooms);
   (6) Radiologic services including, but not limited to, tomography, computed tomography (CT) scans and/or magnetic resonance imaging (MRI) scans;
   (7) Radionuclide scans and ultrasonography;
   (8) Immunopathology and hepatopathology;
   (9) Histopathology;
   (10) Microbiology laboratory;
   (11) Blood banking services capable of routinely providing irradiated blood products appropriate for cytomegalovirus (CMV) seronegative patients;
   (12) Clinical pharmacology services with a pharmacist familiar with antineoplastic agents;
   (13) Modern radiotherapy capabilities including the ability to provide total body irradiation either on-site or through agreement or contract with another hospital;
   (14) Operating room facilities; and
   (15) Echocardiography or multigated blood-pool imaging (MUGA) scan capability.

(B) The provider of a bone marrow transplant service shall have the following readily available:
   (1) Tissue-typing laboratory;
   (2) Apheresis capability with adequate blood cell component therapy and routine access to a blood irradiator; and
   (3) Facilities to cryopreserve hematopoietic stem cells for transplantation and which additionally may be used to manipulate hematopoietic stem cells ex-vivo.

3701-84-27 Patient selection for transplantation; volume goals.

[Editor’s Note: Appendix A to this rule can be found at www.odh.ohio.gov/rules/final/finalrules.aspx.]

(A) All candidates for bone marrow transplantation shall be subject to prospective patient selection criteria as specified in appendix A to this rule.

(B) If a transplantation service desires to perform a transplant on a patient who does not meet the selection protocols set forth in appendix A to this rule, the service shall undertake a thorough review of the case to determine that the transplant is appropriate. This review shall be
conducted by a bone marrow transplant team comprised of members of the service’s ethics, legal, and medical staff. This review shall, at a minimum, include:

1. Preparation of a detailed clinical summary of the patient that includes:
   a. A brief medical history;
   b. Complete laboratory data related to the diagnosis;
   c. A thorough psychosocial evaluation that includes:
      i. The identification of the patient’s support system, including potential caregivers;
      ii. Identified psychosocial issues;
      iii. Identification of potential barriers and challenges of the transplant; and
      iv. The patient’s attitude toward the transplant and the patient’s understanding of the transplant.
   d. A justification of the transplant despite failure to meet the selection criteria; and
2. After sufficient review time, an affirmative vote of a majority of the members of the team that the transplant is appropriate.

C. Each bone marrow transplantation service should achieve the following volume goals per year to ensure efficiency and a minimum floor of competency:

1. Except as specified in paragraph (C)(2) of this rule, services providing only autologous bone marrow transplantations should perform at least ten per year. From the date a service notifies the director of activation or reactivation of a service, the service should perform at least six transplants in the first twelve months and at least twenty transplants within the first twenty-four months;
2. Services providing only autologous bone marrow transplantation exclusively to patients less than twenty-two years of age should perform at least ten transplants per twenty-four months. From the date this service notifies the director of activation or reactivation of a service, the service should perform at least four transplants in the first twelve months and at least ten transplants within the first twenty-four months;
3. Except as specified in paragraph (C)(4) of this rule, services providing both autologous and allogeneic bone marrow transplantation should perform at least twelve per year with at least six being allogeneic bone marrow transplantations. From the date a service notifies the director of activation or reactivation of a combined autologous and allogeneic service, the service should perform at least eight transplants in the first twelve months and at least twenty-four transplants within the first twenty-four months, of which at least twelve should be allogeneic; and
4. Services providing both autologous and allogeneic bone marrow transplantation exclusively to patients less than twenty-two years of age should perform at least ten transplants per twenty-four months with at least five being allogeneic. From the date this service notifies the director of activation or reactivation of a service, the service should perform at least four transplants in the first twelve months with at least two being allogeneic and at least ten transplants within the first twenty-four months with at least five being allogeneic.

D. Volume goals will be considered by the director in conjunction with other indicators of quality, not as the sole indicator of service performance.

E. Failure to meet a volume goal for two consecutive years may trigger an extended review of the bone marrow transplantation service by the director, including possible inspections.

Adult Cardiac Catheterization

3701-84-30 General adult cardiac catheterization service standards.

[Editor’s Note: Appendix A to this rule can be found at}
Chapter 2. Regulated Healthcare Facilities  
Part III. Health Care Services

www.odh.ohio.gov/rules/final/finalrules.aspx]

(A) The provisions of rules 3701-84-30 to 3701-84-34.2 of the Administrative Code are applicable to each provider of cardiac catheterization services performing procedures on adult patients greater than or equal to twenty-two years of age, regardless of the date service was initiated. An adult cardiac catheterization service may serve a patient greater than or equal to eighteen years of age and less than twenty-two years of age if the patient's attending physician and the adult service's medical director determine that the adult service best serves the needs of the patient.

(B) Each provider of cardiac catheterization services shall:
   (1) Designate in writing to the director the service level classification, as defined in this chapter, it provides or intends to provide;
   (2) Designate in writing to the director the scope of services, including the number of procedure and control rooms, provided within the service level classification;
   (3) Meet the requirements of this chapter for the service level classification designated; and
   (4) Not hold itself out to any person or government entity by means of signage, advertising, or other promotional efforts as having a service level classification for which it is not designated.

(C) Each provider of cardiac catheterization services shall have an established written protocol for the emergency transfer and care of patients who require emergency medical/surgical management during or immediately after cardiac catheterization.

(D) Each provider of cardiac catheterization services shall have immediate access to services for hematology and coagulation disorders; electrocardiography; and diagnostic radiology. Access to clinical pathology, nuclear medicine and nuclear cardiology, doppler-echocardiography, pulmonary function testing, and microbiology must be available within a reasonable amount of time to meet the needs of the service.

(E) Each provider of cardiac catheterization services shall establish and maintain a quality assessment review process, including methodology, for reviewing the quality of cardiac catheterization procedures performed by each physician credentialed to perform such procedures. The review methodology shall, at a minimum, assess the following:
   (1) Appropriateness of cardiac catheterization studies and interventions;
   (2) Technical quality of cardiac catheterization studies;
   (3) Procedure result;
   (4) Rate of therapeutic success; and
   (5) Rate of procedural complications.

(F) Each provider of cardiac catheterization services shall have explicit criteria specifying the number of times a year an appropriately privileged physician shall perform each catheterization procedure in order to retain privileges to perform that procedure. These criteria shall be consistent with current recommendations of recognized professional societies and accrediting bodies.

(G) Each provider of cardiac catheterization services shall conduct an ongoing review of all cases with mortality or significant morbidity within ninety days of the procedure.

(H) Each provider of cardiac catheterization services shall establish and maintain a database to support the review process detailed in paragraph (E) of this rule. The results of analysis and review shall be documented and used to guide periodic random and selected peer reviews of individual physicians with respect to maintaining their credentials to perform specific cardiac catheterization procedures.

(I) Adult cardiac catheterization service shall only be provided in a fully permanent setting within the permanent frame of the building of a registered hospital that is classified as a general hospital or a special hospital-cardiac that primarily furnishes limited services to patients.
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with cardiac conditions. The hospital shall:
   (1) Operate inpatient medical and surgical services in the same building and accessible
by gurney from the cardiac catheterization laboratory;
   (2) Operate an intensive/critical care unit with registered special care beds, that is:
   (a) Reviewed and accredited or certified as such as part of the hospital’s accreditation or
certification program in the same building;
   (b) Accessible by gurney from the cardiac catheterization laboratory; and
   (c) The unit shall provide appropriate equipment and staff to care for coronary patients
and have twenty-four hour monitoring capability.
   (3) Provide a setting in the same building as the adult cardiac catheterization laboratory
in which ambulatory cardiac catheterization patients can be observed for at least two to six
hours after the procedure depending on the access site and the nursing assessment of the
patient; and
   (4) Provide adequate physician coverage to manage post-procedure complications.

(J) For the purpose of rules 3701-84-30 to 3701-84-34.2 of the Administrative Code the
following references are defined and all documents are available at www.acc.org:
   (1) “2012 expert consensus document” means 2012 American college of cardiology
foundation/society for cardiovascular angiography and interventions expert consensus
document on cardiac catheterization laboratory standards update (June 12, 2012);
   (2) “2014 expert consensus document” means the 2014 society for cardiovascular
angiography and interventions/American college of cardiology/American heart association
expert consensus document update on percutaneous coronary intervention without on-site
surgical backup (June 17, 2014);
   (3) “Table 2: support services” means 2012 American college of cardiology
foundation/society for cardiovascular angiography and interventions expert consensus
document on cardiac catheterization laboratory standards update, table 2: optimal
(recommended) on-site support services for invasive cardiac procedures (June 12, 2012).
   (4) “Table 3: facility requirements” means 2014 Society for cardiovascular angiography
and interventions/American college of cardiology/American heart association expert consensus
document update on percutaneous coronary intervention without on-site surgical backup, table
3: facility requirements for percutaneous coronary intervention programs without on-site surgery
(June 17, 2014);
   (5) “Table 4: personnel recommendations” means 2014 society for cardiovascular
angiography and interventions/American college of cardiology/American heart association
expert consensus document update on percutaneous coronary intervention without on-site
surgical backup, table 4: personnel recommendations (June 17, 2014);
   (6) “Table 5: general exclusion criteria” means the 2012 American college of cardiology
foundation/society for cardiovascular angiography and interventions expert consensus
document on cardiac catheterization laboratory standards update, table 5: general exclusion
criteria for invasive cardiac procedures in a setting without cardiothoracic surgery (June 12,
2012);
   (7) “Table 5: recommendations for off-site surgical backup and case selection” means
the 2014 Society for cardiovascular angiography and interventions/American college of
cardiology/American heart association expert consensus document update on percutaneous
coronary intervention without on-site surgical backup, table 5: recommendations for off-site
surgical backup and case selection (June 17, 2014); and
   (8) “Table 6: patient and lesion characteristics” means the 2014 Society for
cardiovascular angiography and interventions/American college of cardiology/American heart
association expert consensus document update on percutaneous coronary intervention without
on-site surgical backup, table 6: patient and lesion characteristics that could be unsuitable for
nonemergency procedures at facilities without an on-site cardiac surgery (June 17, 2014);
(K) For the purpose of rules 3701-84-30 to 3701-84-34.2 of the Administrative Code, major bleeding is defined as:

1. Bleeding event within seventy-two hours;
2. Hemorrhagic stroke;
3. Tamponade;
4. Post-PCI transfusion for patients with a pre-procedure hemoglobin >8 g/dL; or
5. Absolute hemoglobin decrease from pre-PCI to post-PCI of >= 3 g/dL and pre-procedure hemoglobin=<16 g/dL.

3701-84-30.1 Level I cardiac catheterization service standards.

(A) Level I cardiac catheterization service or “level I service” means an adult cardiac catheterization service located in a hospital without an on-site open heart surgery service that provides only diagnostic cardiac catheterization procedures on an organized regular basis.

(B) Level I services shall perform only diagnostic cardiac catheterization procedures to diagnose anatomical and/or physiological problems in the heart. Diagnostic cardiac catheterization procedures include:

1. Intracoronary administration of drugs;
2. Left heart catheterization;
3. Right heart catheterization;
4. Coronary angiography;
5. Basic diagnostic electrophysiology studies not involving transseptal puncture;
6. Intra-aortic balloon pump or, if required for patient stabilization for transfer, placement of percutaneous left ventricular assist device; and
7. Device implantation, including, but not limited to defibrillators.

(C) Each level I service shall implement patient exclusion criteria consistent with the 2012 table 5: general exclusion criteria.

(D) Each level I service shall comply with the personnel and staffing requirements set forth in rule 3701-84-31 of the Administrative Code.

(E) Each level I service shall comply with the facilities, equipment, and supplies requirements set forth in rule 3701-84-32 of the Administrative Code.

(F) Each level I service shall comply with the safety standards set forth in rule 3701-84-33 of the Administrative Code.

(G) Each level I service shall maintain a formal written transfer protocol for emergency medical/surgical management with a registered hospital that provides open heart surgery services, which can be reached expeditiously from the level I service by available emergency vehicle within a reasonable amount of time and that provides the greatest assurance for patient safety. The open heart surgery service that is party to a transfer protocol is referred to as the receiving service. Each protocol shall include, but not be limited to:

1. Provisions addressing indications, contraindications, and other criteria for the emergency transfer of patients in a timely manner;
2. Assurance of the initiation of appropriate medical/surgical management in a timely manner;
3. Assurance that surgical back-up is available for urgent cases at all hours;
4. Specification of mechanisms for continued substantive communication between the services party to the agreement and between their medical directors and physicians;
5. Provisions for a collaborative training program among staff of the services party to the agreement, including the cardiologists from the level I service and the cardiologist/cardiothoracic surgeon from the receiving service;
6. Provisions for the recommendation by the medical director of the receiving service, regarding the cardiac catheterization service’s credentialing criteria; and
(7) Provisions for annual drilling activities to review and test the components of the written transfer protocol. An actual emergent patient transfer consistent with the written transfer protocol within the calendar year meets the requirement for an annual drill.

(H) Major complications and emergency transfers should be reviewed at least once every ninety days by the quality assessment review process required in paragraph (E) of rule 3701-84-30 of the Administrative Code.

(I) Beginning January 1, 2017, each provider of level I services shall submit to the department an annual report for the prior year that meets the following criteria:

1. Maintains patient confidentiality;
2. Shall be filed with the department within one hundred twenty days after the close of the calendar year (April thirtieth); and
3. Include, at a minimum, the following information:
   a. All emergent patient transfers that become necessary during or immediately after cardiac catheterization to the receiving service for interventional medical management;
   b. The number and type of procedures performed;
   c. Post-procedure in-hospital mortality rate;
   d. Vascular access injury requiring surgery or other intervention;
   e. Major bleeding; and
   f. Emergency PCI procedures performed when clinically indicated.

(J) Each level I service shall obtain a signed informed consent form from each patient prior to performance of the diagnostic procedure. The informed consent shall include an acknowledgment by the patient that the diagnostic procedure is being performed in a cardiac catheterization service without an on-site open heart surgery service and an acknowledgment that, if necessary as the result of an adverse event, the patient may be transferred to a receiving service for medical/surgical management.

(K) Nothing in this rule shall prohibit the provision of emergency care, including emergent PCI, when clinically indicated. The service shall notify the department within forty-eight hours of any incident requiring action outside the scope of services authorized to be performed at the level I designation. The notification shall:

1. Maintain patient confidentiality;
2. Indicate when the incident occurred;
3. Describe the nature of the emergency and what actions were taken; and
4. Include the outcome.

3701-84-30.2 Level II cardiac catheterization service standards.

(A) Level II cardiac catheterization service or “level II service” means an adult cardiac catheterization service located in a hospital without an on-site open heart surgery service that provides only diagnostic and authorized therapeutic cardiac catheterization procedures on an organized regular basis.

(B) Each level II service shall operate on an organized, regular, twenty-four hour a day, seven days a week basis to perform primary PCI.

(C) Level II services are prohibited from providing the following procedures:

1. Transcatheter aortic valve replacement (TAVR);
2. Revascularization of chronic total occlusion (CTO);
3. Rotational coronary artherectomy;
4. Alcohol septal ablation;
5. Cardiac biopsy;
6. Mitral valve clip;
7. Transcatheter mitral valve (TMV) repair or replacement;
8. Laser lead extraction;
(9) Atrial septal defect (ASD), patent foramen ovale (PFO), and ventricular septal defect (VSD) closure;
(10) Balloon aortic valvuloplasty;
(11) PCI of last remaining coronary artery;
(12) Left atrial appendage closure;
(13) Ventricular tachycardia ablation;
(14) Atrial fibrillation ablation;
(15) Lead extractions; and
(16) Multivessel PCI in the setting of severe left ventricular dysfunction.

(D) Each provider of a level II service shall have provided at least one year of service performing diagnostic cardiac catheterizations prior to providing notice to the director of their intent to provide level II services. Accelerated designation may be granted to a service on a case-by-case basis by the director and shall not be construed as constituting precedent for the granting of an accelerated designation for any other service provider.

(E) Level II services shall:
(1) Implement patient screening criteria consistent with the 2014 expert consensus document:
   (a) Table 5: recommendations for off-site surgical backup and case selection; and
   (b) Table 6: patient and lesion characteristics.
(2) Ensure that the medical director for the level II service monitors and ensures strict adherence to the patient selection criteria and treatment protocols.

(F) In addition to the general personnel and staffing requirements set forth in rule 3701-84-31 of the Administrative Code, each level II service shall:
(1) Provide nursing and laboratory staff consistent with the 2014 expert consensus document, table 4: personnel recommendations; and
(2) Maintain personnel capable of endotracheal intubation and ventilator management within their scope of practice, both on-site and during transfer of the patient if necessary.

(G) In addition to the general facilities, equipment, and supplies requirements set forth in rule 3701-84-32 of the Administrative Code, each level II service shall have, at a minimum, equipment consistent with the 2014 expert consensus document, table 3: facility requirements.

(H) Each level II service shall comply with the safety standards set forth in rule 3701-84-33 of the Administrative Code.

(I) Each level II service shall maintain a formal written transfer protocol for emergency medical/surgical management with a registered hospital that provides open heart surgery services, which can be reached expeditiously from the level II service by available emergency vehicle within a reasonable amount of time and that provides the greatest assurance for patient safety. The open heart surgery service that is party to a transfer protocol is referred to as the receiving service. Each protocol shall include, but not be limited to:
(1) Provisions addressing indications, contraindications, and other criteria for the emergency transfer of patients in a timely manner;
(2) Assurance of the initiation of appropriate medical/surgical management in a timely manner;
(3) Assurance that surgical back-up is available for urgent cases at all hours;
(4) Specification of mechanisms for continued substantive communication between the services party to the agreement and between their medical directors and physicians;
(5) Provisions for a collaborative training program among staff of the services party to the agreement, including the cardiologists from the level II service and the cardiologist/cardiothoracic surgeon from the receiving service;
(6) Provisions for the recommendation by the medical director of the receiving service, regarding the cardiac catheterization service's credentialing criteria; and
(7) Provisions for annual drilling activities to review and test the components of the...
written transfer protocol. An actual emergent patient transfer consistent with the written transfer protocol within the calendar year meets the requirement for an annual drill.

(J) Each level II service shall maintain a formal written agreement with a ground and/or air ambulance service that can commit to on-site availability within thirty minutes of notification and is capable of advanced cardiac life support and intra-aortic balloon pump transfer of a patient to the hospital party to the written transfer protocol required by paragraph (I) of this rule. Ground and/or air ambulance service agreements should be consistent with the recommendations set forth in the 2014 expert consensus document, table 3: facility requirements.

(K) Major complications and emergency transfers should be reviewed at least once every ninety days by the quality assessment review process required in paragraph (E) of rule 3701-84-30 of the Administrative Code.

(L) Each provider of a level II service shall obtain enrollment and maintain participation in the national cardiovascular data registry/CathPCI registry (NCDR).

(M) Beginning January 1, 2017, each provider of level II services shall submit an annual report to the department based upon the data submitted to the NCDR during the preceding year. At a minimum, the report shall:

1. Maintain patient confidentiality;
2. Be filed with the department within one hundred twenty days after the close of the calendar year (April thirtieth); and
3. Include the following information:
   a. All emergent transfers that became necessary during or immediately after cardiac catheterization to the receiving service for interventional medical management;
   b. The number of procedures performed in the following categories:
      i. Diagnostic;
      ii. Elective PCI; and
      iii. Primary PCI.
   c. PCI in-hospital risk adjusted rate of bleeding (all patients);
   d. PCI in-hospital risk adjusted mortality rate (patients with ST segment elevation myocardial infarction);
   e. PCI in-hospital risk adjusted mortality (ST segment elevation myocardial infarction patients excluded);
   f. As appropriate, the proportion of PCI procedures with post procedure myocardial infarction:
      i. Among hospitals routinely collecting post-PCI biomarkers; or
      ii. Among hospitals who do not routinely collect post-PCI biomarkers;
   g. Composite proportion of PCI patients with death, emergency coronary artery bypass graft, stroke, or repeat target vessel revascularization; and
   h. Median time to immediate PCI for ST segment elevation myocardial infarction patients (in minutes).

(N) Each level II service shall provide notice to the department within thirty days of receipt of their service's NCDR report, for any quarter in which the service falls at or below the twenty-fifth percentile for the specific quality metrics designated in this paragraph. The report shall include a statement for each metric not met, an explanation as to why the service did not meet the metric, and how the service intends to meet the metric in the future. The report shall include the following metrics:

1. PCI in-hospital risk adjusted rate of bleeding (all patients);
2. PCI in-hospital risk adjusted mortality rate (patients with ST segment elevation myocardial infarction);
3. PCI in-hospital risk adjusted mortality (ST segment elevation myocardial infarction patients excluded);
(4) As appropriate, the proportion of PCI procedures with post procedure myocardial infarction:
   (a) Among hospitals routinely collecting post-PCI biomarkers; or
   (b) Among hospitals who do not routinely collect post-PCI biomarkers;

(5) Composite proportion of PCI patients with death, emergency coronary artery bypass graft, stroke, or repeat target vessel revascularization; and

(6) Median time to immediate PCI for ST segment elevation myocardial infarction patients (in minutes).

(O) Each level II service shall obtain an signed informed consent form from each patient prior to performance of any procedure. The informed consent shall include an acknowledgment by the patient that the procedure is being performed in a cardiac catheterization service without an on-site open heart surgery service and an acknowledgment that, if necessary as the result of an adverse event, the patient may be transferred to a receiving service for medical/surgical management.

(P) Nothing in this rule shall prohibit the provision of emergency care, including emergent PCI, when clinically indicated. The service shall notify the department within forty-eight hours of any incident requiring action outside the scope of services authorized to be performed at the level II designation. The notification shall:
   (1) Maintain patient confidentiality;
   (2) Indicate when the incident occurred;
   (3) Describe the nature of the emergency and what actions were taken; and
   (4) Include the outcome.

3701-84-30.3 Level III cardiac catheterization service standards.

(A) Level III cardiac catheterization service or “level III service” means an adult cardiac catheterization service located in a hospital with an on-site open heart surgery service that provides all levels of diagnostic and therapeutic cardiac catheterization procedures.

(B) Each level III service shall operate on an organized, regular, twenty-four hour a day, seven days a week basis to perform primary PCI.

(C) Each provider of a level III service shall have provided at least one year of service performing diagnostic cardiac catheterizations prior to providing notice to the director of their intent to provide level III services. Accelerated designation may be granted to a service on a case-by-case basis by the director and shall not be construed as constituting precedent for the granting of an accelerated designation for any other service provider.

(D) Each level III service shall have the following:
   (1) An on-site adult open heart surgery service available within the same hospital as the cardiac catheterization laboratory and is immediately accessible from the cardiac catheterization laboratory by gurney;
   (2) An experienced cardiovascular surgical team that is readily available in less than sixty minutes on a twenty-four hour a day basis in the event that emergency open heart surgery is required; and
   (3) Support services consistent with the 2012 expert consensus document, table 2: support services.

(E) Each level III service shall comply with the personnel and staffing requirements set forth in rule 3701-84-31 of the Administrative Code.

(F) In addition to the general facilities, equipment, and supplies requirements set forth in rule 3701-84-32 of the Administrative Code, each level III service, shall have:
   (1) One or more surgical suites that are equipped to accommodate thoracic and cardiac surgical procedures requiring cardiopulmonary bypass, with appropriate staff available in less than sixty minutes; and
(2) At a minimum, equipment consistent with the 2014 expert consensus document, table: 3 facility requirements.

(G) Each level III service shall comply with the safety standards set forth in rule 3701-84-33 of the Administrative Code.

(H) Major complications and emergency transfers should be reviewed at least once every ninety days by the quality assessment review process required in paragraph (E) of rule 3701-84-30 of the Administrative Code;

(I) Each provider of a level III service shall obtain enrollment and maintain participation in the national cardiovascular data registry/CathPCI registry (NCDR).

(J) Beginning January 1, 2017, each provider of level III services shall submit an annual report to the department based upon the data submitted to the NCDR during the preceding year. At a minimum, the report shall;

(1) Maintain patient confidentiality;

(2) Be filed with the department within one hundred twenty days after the close of the calendar year (April thirtieth); and

(3) Include the following information:

(a) The number of procedures performed in the following categories:

(i) Diagnostic;

(ii) Elective PCI; and

(iii) Primary PCI.

(b) PCI in-hospital risk adjusted rate of bleeding (all patients);

(c) PCI in-hospital risk adjusted mortality rate (patients with ST segment elevation myocardial infarction);

(d) PCI in-hospital risk adjusted mortality (ST segment elevation myocardial infarction patients excluded);

(e) As appropriate, the proportion of PCI procedures with post procedure myocardial infarction:

(i) Among hospitals routinely collecting post-PCI biomarkers; or

(ii) Among hospitals who do not routinely collect post-PCI biomarkers;

(f) Composite proportion of PCI patients with death, emergency coronary artery bypass graft, stroke, or repeat target vessel revascularization; and

(g) Median time to immediate PCI for ST segment elevation myocardial infarction patients (in minutes).

(K) Each level III service shall provide notice to the department within thirty days of receipt of their service's NCDR report, for any quarter in which the service falls at or below the twenty-fifth percentile for the specific quality metrics designated in this paragraph. The report shall include a statement for each metric not met, an explanation as to why the service did not meet the metric, and how the service intends to meet the metric in the future. The report shall include the following metrics:

(1) PCI in-hospital risk adjusted rate of bleeding (all patients);

(2) PCI in-hospital risk adjusted mortality rate (patients with ST segment elevation myocardial infarction);

(3) PCI in-hospital risk adjusted mortality (ST segment elevation myocardial infarction patients excluded);

(4) As appropriate, the proportion of PCI procedures with post procedure myocardial infarction:

(a) Among hospitals routinely collecting post-PCI biomarkers; or

(b) Among hospitals who do not routinely collect post-PCI biomarkers;

(5) Composite proportion of PCI patients with death, emergency coronary artery bypass graft, stroke, or repeat target vessel revascularization; and

(6) Median time to immediate PCI for ST segment elevation myocardial infarction.
patients (in minutes).

(L) Each level III service provider shall obtain a signed informed consent from each patient prior to the performance of any procedure.

3701-84-31 General personnel/staffing - adult cardiac catheterization service.

(A) The provider of an adult cardiac catheterization service, or “service,” shall designate a medical director.

(B) In addition to the requirements of rule 3701-84-08 of the Administrative Code and any requirements of this rule, the medical director of service shall:

1. Have at least five years catheterization experience and recognized skills in the cardiac catheterization laboratory;
2. Have performed at least five hundred catheterizations;
3. Be an active participant in the operation of the cardiac catheterization laboratory by performing at least fifty cardiac catheterization procedures annually in the cardiac catheterization service where he or she is the medical director; and
4. Be responsible for oversight of quality of care provided in the cardiac catheterization laboratory and be an active participant in the cardiac catheterization laboratory’s quality assessment review process required by paragraph (E) of rule 3701-84-30 of the Administrative Code.

(C) In addition to the requirements of paragraph (B) of this rule, the medical director of a level II or level III service shall:

1. Be board certified in interventional cardiology; and
2. Have at least five years experience in interventional cardiology; or
3. Have performed, as the primary operator, at least five hundred percutaneous coronary interventions.

(D) Each provider of a service shall have at least two licensed physicians credentialed to provide cardiac catheterization services on staff who are knowledgeable of the laboratory’s protocols and equipment by providing cardiac catheterization services at the hospital. Only physicians appropriately credentialed to provide cardiac catheterization services may be the primary operator of a cardiac catheterization procedure.

(E) Each provider of a service shall consider the American college of cardiology/American heart association/American college of physicians task force 2013 update of clinical competence statement on coronary artery interventional procedures in assessing clinical competency. At a minimum, all physicians who perform cardiac catheterization procedures shall:

1. Have training that includes at least one year dedicated to cardiac catheterization procedures;
2. Be a fully-accredited member of the service’s staff; and
3. Participate in the cardiac catheterization laboratory’s quality assurance programs, including peer review.

(F) In addition to requirements contained in paragraph (E) of this rule, physicians performing percutaneous coronary interventions (PCI) who have not performed PCI prior to March 20, 1997 shall have completed a fellowship training program in interventional cardiology.

(G) In addition to the requirements of paragraphs (A), (B), and (D) of this rule and the general personnel requirements of paragraph (B) of rule 3701-84-08 of the Administrative Code, the provider of a service shall have available a sufficient number of qualified staff who are able to supervise and conduct the service including the following:

1. Support staff, all of whom are skilled in cardiac life support, comprised of individuals skilled in the following:
   a. Digital imaging;
(b) Systematic quality control testing;
(c) Patient observation;
(d) Critical care;
(e) Monitoring and recording electrocardiographic and hemodynamic data;
(f) Radiographic and angiographic imaging techniques and safety principles; and
(g) For catheterization laboratories where physiological studies are performed:
   (i) Managing blood samples:
   (ii) Performing blood gas measurements and calculations; and
   (iii) Assisting with indicator dilution studies.

(2) Nursing personnel which may include nurse practitioners, registered nurses, licensed practical nurses, and nursing assistants. Nursing personnel involved in the provision of cardiac catheterization services shall have experience in critical care, and have knowledge of operating room techniques. Nurse practitioners, registered nurses, and licensed practical nurses involved in the provision of cardiac catheterization services shall be advanced cardiac life support certified, have experience in cardiovascular medications and shall have the ability to begin administration of intravenous solutions. Nurse practitioners may assume some of the duties of a physician as permitted by law. However, ultimate responsibility for procedures shall always remain with the physician of record.

(H) Respiratory therapists and critical care staff shall be immediately available at all times to care for patients.

(I) Biomedical, electronic, and radiation safety experts shall be involved in maintaining the equipment utilized by the service.

(J) Staffing requirements of this rule may be met by individuals with equivalent or greater qualifications if the replacement's scope of practice encompasses the duties of the required staff.

3701-84-32 General facilities, equipment, and supplies - adult cardiac catheterization service.

(A) Each provider of an adult cardiac catheterization service, or “service” shall provide adequate, properly designed space to perform cardiac catheterization procedures safely and effectively. The amount of space may vary with the types of procedures performed and the nature of the facility (e.g., interventional versus diagnostic, teaching versus non-teaching).

(B) Each service shall utilize the following:
   (1) Procedure rooms that meet or exceed minimum space requirements established by the equipment manufacturer and are at least four hundred square feet or, if constructed or renovated or cardiac catheterization services initiated after March 20, 1997, at least five hundred square feet. Each procedure room shall have a designated control room;
   (2) Control rooms of at least ninety-six square feet for each procedure room served. Control rooms that are constructed or renovated or cardiac catheterization services initiated after March 20, 1997 shall have at least one hundred and fifty square feet for each procedure room served; and
   (3) Clean utility rooms that can sufficiently and efficiently supply the procedure rooms.

(C) A general radiology room cannot be used as a cardiac catheterization procedure room.

(D) Equipment described in this paragraph may be replaced by newer technology that has equivalent or superior capability as determined by the provider of the service. In assessing these new technologies, consideration should be given to recommendations of recognized professional societies and accrediting bodies (e.g. the American college of cardiology). All services shall, at a minimum have the following equipment:
   (1) High quality x-ray imaging with mutiaxial position capability;
(2) A three-phase, twelve pulse generator with an output of eighty to one hundred kilowatts or a constant potential generator with an output of at least one hundred kilowatts at one hundred kilovolts;  
(3) Multimode or cesium iodide image intensifiers;  
(4) High-quality matched optics;  
(5) Appropriate imaging modality for review and storage of images;  
(6) Digital imaging equipment;  
(7) Carbon-fiber table tops;  
(8) A mechanism for continuous monitoring of a patient's blood pressure and electrocardiogram;  
(9) An adequate supply and variety of catheters, guide wires, and sheaths;  
(10) A crash cart with equipment for ventilatory support;  
(11) A defibrillator;  
(12) A temporary pacemaker; and  
(13) An intra-aortic balloon pump or other percutaneous mechanical circulatory assistance device of superior capability.

(E) The provider of a service shall provide and maintain radiation generating equipment in accordance with applicable state and federal requirements as specified in Chapter 3748 of the Revised Code and the rules adopted thereunder.

3701-84-33 Safety guidelines and standards.

(A) The provider of an adult cardiac catheterization service, or “service,” shall establish and maintain safety guidelines, and practices and policies in accordance with applicable United States nuclear regulatory commission regulations, applicable provisions of Chapter 3748 of the Revised Code, and the rules adopted pursuant to that chapter to assure a safe environment for patients, visitors, and personnel.

(B) The provider of a service shall establish, maintain and follow electrical safety policies that, at a minimum, include:  
(1) A safe primary electrical wiring system;  
(2) Electrical isolation of all equipment attached to a patient;  
(3) Use of an equipotential hardwired grounding system for all equipment; and  
(4) Periodic inspection of the electrical system and measurement of interequipment current leakage.

(C) The provider of a service shall periodically survey all of the equipment utilized by the service and perform preventive maintenance on a schedule that, at a minimum, conforms to manufacturers’ recommendations. Results of surveillance and preventive maintenance activities shall be internally documented.

3701-84-34 Adult cardiac catheterization service performance measures.

[Editor’s Note: Appendix A to this rule can be found at www.odh.ohio.gov/rules/final/finalrules.aspx.]

(A) By the second year of operation:  
(1) Each level I service should perform a minimum of three hundred procedures.  
(2) Each level II or level III service should perform a minimum of three hundred total procedures, including two hundred PCI, consistent with the 2013 American college of cardiology/American heart association/society for cardiovascular angiography and intervention update on the clinical competence statement on coronary artery interventional procedures, available at www.acc.org., and the 2012 expert consensus document.
(B) Volume goals shall be considered by the director in conjunction with other indicators of quality and not as the sole indicator of service performance. However, a level II or level III service that provides less than one hundred fifty PCI procedures per year may be subject to an independent third party review, including individual case review, by a third party approved by the director. The service shall be responsible for:
   (1) Providing a copy of the review to the director; and
   (2) Payment of any fees associated with the independent third party review to the provider of the review.

3701-84-34.1 Inspection and review of adult cardiac catheterization services.

(A) In addition to the inspection and audit requirements set forth in rule 3701-84-06 of the Administrative Code, the director shall conduct an inspection of each adult cardiac catheterization service approximately once every three years.

(B) The number of procedures performed by the service shall be considered by the director in conjunction with other indicators of quality and not as the sole indicator of the service's performance.

(C) Failure to perform the number of procedures established in paragraph (A) of rule 3701-84-34 of the Administrative Code may result in any or all of the following:
   (1) An extended review of the service by the director;
   (2) Mandatory peer review of PCI procedures performed by the service;
   (3) Annual inspections until such time as the service performs the established number of procedures for a period of two consecutive years or the director determines that annual inspection is no longer required; or
   (4) At the discretion of the director, the establishment of a probationary period. If a probationary period is imposed, at a minimum, the service shall be notified of the following:
      (a) The time period for which the probationary period is effective;
      (b) The actions that may be taken by the director for a service's failure to successfully complete the probationary period.

3701-84-34.2 Order to cease operations of an adult cardiac catheterization service.

(A) In accordance with the compliance actions set forth in rule 3701-84-05 of the Administrative Code, the director may issue an order to cease operations to an adult cardiac catheterization service, or service, for the following:
   (1) The director determines, based on clinical criteria including, but not limited to, major complications, the frequency of emergency transfers, and death, that the service poses an imminent threat of serious physical or life-threatening danger to the recipients of cardiac catheterization services;
   (2) Failure of the service to meet designated quality outcome benchmarks, as evidenced by annual reports of the service's national cardiovascular registry/CathPCI registry reports, or the service's annual reportable interventions; or
   (3) Failure of the service to comply with the provisions of this chapter.

(B) The director shall provide a written order to cease operations to the service via certified mail.

(C) An order to cease operations may appealed in accordance with Chapter 119 of the Revised Code. A notice of appeal must be filed with the director not later than thirty days after the notice's date of mailing. If requested by the service, the director shall provide a hearing in accordance with Chapter 119 of the Revised Code.
Chapter 2. Regulated Healthcare Facilities
Part III. Health Care Services

Open Heart Surgery

3701-84-36 Open heart surgery standards.

(A) The provisions of rules 3701-84-36 to 3701-84-40 of the Administrative Code are applicable to each provider of open heart surgery services performing procedures on adult patients greater than or equal to twenty-two years of age, regardless of the date service was initiated. An adult open heart surgery service may serve a patient greater than or equal to eighteen years of age and less than twenty-two years of age if the patient's attending physician and the adult service's medical director determine that the adult service best serves the needs of the patient.

(B) Each provider of an open heart surgery service shall have available at all times and accessible by gurney in the same building, adequate facilities for the open heart surgery service, including but not limited to the following:

1. Cardiac operating rooms;
2. A cardiac surgery intensive care unit;
3. A post-intensive care “step-down” unit; and
4. Cardiac catheterization services.

(C) Each provider of an open heart surgery service shall have the capability, equipment, and personnel to perform emergency open heart procedures on a twenty-four hour a day, seven days a week basis. A cardiovascular surgical team shall be available in less than sixty minutes on a twenty-four hour a day basis.

(D) Each provider of an open heart surgery service shall have access to the following services:

1. Cardiology;
2. Hematology;
3. Nephrology;
4. Pulmonary medicine;
5. Infectious disease;
6. Radiology;
7. Neurology;
8. Emergency care;
9. Electrocardiography;
10. Stress testing;
11. Nuclear medicine;
12. Pathology;
13. Echocardiography;
14. Pulmonary function testing;
15. Cardiac rehabilitation;
16. Pre-admission testing; and
17. Follow-up outpatient nursing referral services.

(E) An open heart surgery service shall only be provided in a fully permanent setting within the permanent frame of the building of a registered hospital that is classified as a general hospital or as a special hospital - cardiac that primarily furnishes limited services to patients with cardiac conditions. The hospital shall be fully equipped to perform the service.

(F) Each provider of an adult open heart surgery service shall obtain and maintain enrollment in the society for thoracic surgeons (STS) adult cardiac surgery database. Adult open heart surgery services in operation as of the effective date of this rule shall obtain enrollment no later than January 1, 2018.

(G) Beginning July 1, 2019, each provider of an adult open heart surgery service shall submit an annual report to the department based upon the data submitted to the STS during the
preceding calendar year. At a minimum, the report shall:

(1) Maintain patient confidentiality;
(2) Include the following information:
(a) The number of open heart procedures performed;
(b) The number of coronary artery bypass grafting (CABG) procedures performed;
(c) In-patient risk adjusted mortality rate for CABG; and
(d) Risk adjusted rate of the following for CABG:
   (i) Prolonged intubation (ventilation);
   (ii) Deep sternal wound infection (mediastinitis);
   (iii) Post-operative renal insufficiency;
   (iv) Surgical re-exploration; and
   (v) Permanent stroke.
(H) Each adult open heart surgery service shall provide notice to the department within thirty days of receipt of their service's STS report for any reporting period in which the service falls at or below the tenth percentile for the national quality forum (NQF) measures for CABG. The report shall include an explanation as to why the service did not meet the measure, and how the service intends to meet the measure in the future. The report shall be based upon the risk adjusted rates for the following:
(1) In-patient mortality rate;
(2) Prolonged intubation (ventilation);
(3) Deep sternal wound infection (mediastinitis);
(4) Post-operative renal insufficiency;
(5) Surgical re-exploration; and
(6) Stroke/cerebrovascular accident.
(I) Each provider of an adult open heart surgery service shall have a written policy requiring the documentation of any internal review of surgeons with a combination of high risk adjusted mortality and low individual surgeon volume.
(J) Each provider of an adult open heart surgery service shall utilize a coordinated and integrated multidisciplinary approach to patient care, including meetings between cardiologists and cardiovascular surgeons as necessary, to address the needs of patients with complex cardiovascular disease.
(K) Each provider of an adult open heart surgery service shall have established criteria that cardiologists and surgeons must utilize for the purposes of patient selection and appropriateness.
(L) Each provider of an adult open heart surgery patient selection and appropriateness criteria:
(1) Shall be consistent with the 2011 American college of cardiology/American heart association (ACC/AHA) guideline update for coronary artery bypass graft surgery, available at www.acc.org; and

3701-84-37 Personnel and staffing; minimum requirements.

(A) The medical director of the adult open heart surgery service shall be board-certified in thoracic surgery. The medical director shall:
(1) Be responsible for oversight of care in the service;
(2) Be credentialed to provide adult open heart surgery services at the hospital where the adult open heart surgery service is located; and
(3) Actively perform open heart procedures at the open heart surgery service where they
are the medical director.

(B) Each provider of an open heart surgery service shall have at least two thoracic surgeons on staff, credentialed to perform open heart procedures at the hospital and actively perform open heart procedures at the hospital. The medical director of the open heart surgery service may be counted as one of the two required thoracic surgeons.

(C) Each provider of an open heart surgery service shall have competent and qualified staff available, including but not limited to:

(1) Surgical assistants to assist the surgeon. A surgical assistant may be a resident, another physician, or a specially trained surgical assistant;

(2) Cardiac anesthesiologists with special training in the anesthetic and supportive requirements of open heart surgery;

(3) Nursing staff that shall include appropriate numbers of scrub nurses or technicians and a circulating nurse based on the needs of the surgeons and the patient. A minimum of two staff, including a circulating nurse and one scrub nurse or technician shall be present for each procedure. Nursing staff shall be trained in cardiac surgical operating room procedures;

(4) A cardiac surgical intensive care unit shall be staffed at the appropriate nurse patient ratio commensurate with the acuity of the patients and the amount of time following surgery that such care is necessary. Cardiac surgical intensive care nurses shall be advanced cardiac life support (ACLS) certified and have specialized training to develop the theoretical knowledge and clinical skills required for the care of cardiac surgical patients; and

(5) A minimum of two perfusionists who are graduates of an accredited cardiovascular perfusion or perfusion technology program or have equivalent training and experience.

(D) In addition to the requirements of paragraph (C) of this rule, an open heart surgery service shall have appropriate staff available, including but not limited to:

(1) Pharmacists;

(2) Dietitians;

(3) Respiratory therapists;

(4) Physical therapists;

(5) Cardiac rehabilitation therapists; and

(6) Social workers.

(E) Staffing requirements of this rule may be met by individuals with equivalent or greater qualifications if the replacement's scope of practice encompasses the duties of the required staff.

3701-84-38 Facilities and equipment; minimum standards.

(A) Operating rooms used for open heart surgery shall have at a minimum four hundred and fifty square feet provided sufficient additional support space is available adjacent to each room for perfusion supplies, set up, and other storage. Operating rooms for open heart surgery constructed or renovated or open heart surgery services initiated after March 1, 1997 shall have at a minimum of six hundred square feet.

(B) Each operating room used for open heart surgery shall have appropriate numbers of oxygen and vacuum outlets and proper operating room lighting. Fiber optic headlights shall be provided.

(C) Equipment and technology described in this paragraph may be replaced by newer technology and equipment with equivalent or superior capability. In assessing this new equipment and technology, consideration should be given to the recommendations of recognized professional societies and accrediting bodies. The provider of an open heart surgery service shall have at least the following:

(1) Two fully operational cardiopulmonary bypass machines equipped with;

(a) A time and temperature module;
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(b) An air bubble and level detector system;
(c) A blender (air and oxygen mixer);
(d) An oxygen analyzer;
(e) A saturation monitor;
(f) Two pressure monitors;
(g) A back up pump head; and
(h) A heater/cooler (one back up).
(2) Appropriate patient monitoring equipment with overhead slave, electrocardiogram, three pressure reading, and cardiac output;
(3) An electrocauter;
(4) A heat exchanger;
(5) Drug infusion equipment;
(6) Transportable monitoring equipment including electrocardiogram, defibrillator, oxygen saturation monitor, and pressure transducer;
(7) An intra-aortic balloon pump or other percutaneous mechanical circulatory assistance device of superior capability;
(8) The availability of a transesophageal echo;
(9) A cardiac pacemaker;
(10) Routine blood gas analysis and chemistry including blood sugar analysis in the operating room;
(11) Defibrillators;
(12) A heating blanket;
(13) An ice bath;
(14) An automated coagulation timer (ACT) machine; and
(15) A cell saver.

(D) Each provider of an open heart surgery service shall ensure that a fully equipped and staffed cardiac surgical intensive care unit that meets the needs of the cardiac surgery patient is available in the building and accessible by gurney from the open heart surgery is performed. The cardiac surgical intensive care unit shall ensure that the number of available intensive care unit beds shall be approximately one-half the number of open heart operations performed per week; however, the beds are not required to be dedicated only to cardiac surgery patients.

(E) The provider of an open heart surgery service shall ensure that a post-intensive care “step-down” unit with telemetry is available in the building and accessible by gurney from where the open heart surgery is performed. The number of “step-down” beds shall be approximately equal to the number of procedures performed per week; however, the beds are not required to be dedicated only to cardiac surgery patients.

3701-84-39 Quality assessment and performance improvement - open heart surgery service.

(A) In addition to the general quality assessment and performance improvement requirements set forth in rule 3701-84-12 of the Administrative Code, each provider of an open heart surgery service shall:
(1) As part of the service’s overall quality assessment and performance improvement process:
   (a) Utilize the quality performance measures outcomes data obtained from the service’s participation in the society for thoracic surgeons national database; and
   (b) Include a periodic review and evaluation of the multidisciplinary meetings required by paragraph (J) of rule 3701-84-36 of the Administrative Code.
(2) Have a regular formal morbidity and mortality conference chaired by the medical
director of the open heart surgery service or the medical director's designee. The morbidity and mortality conferences shall:
   (a) Be held at a minimum once a month or more frequently depending on the need; and
   (b) Review all deaths and complications such as reoperation for bleeding, deep sternal wound infection, stroke, and perioperative myocardial infarction and any patterns that might indicate a problem shall be investigated and remedied if necessary.

(B) Each provider of an open heart surgery service shall maintain a clinical pathway for coronary bypass graft surgery and valve replacements.

3701-84-40 Adult open heart surgery service performance measures.

(A) Each open heart surgery service should meet a volume goal of at least one hundred and fifty open heart procedures per year by the second full year of operation to ensure efficiency and a minimum competency.

(B) Volume goals shall be considered by the director in conjunction with other indicators of quality and not as the sole indicator of service performance.

(C) Failure to meet a volume goal for two consecutive years may trigger an extended review of the open heart surgery service by the director, including possible inspections.

(D) A volume goal of at least twenty five open heart procedures per surgeon per year is recommended and the combination of high risk adjusted mortality and low individual surgeon volume shall trigger a thorough internal review of an individual surgeon by the provider of the open heart surgery service.

(E) Failure to meet the volume goal established in paragraph (A) of this rule may result in any or all of the following:
   (1) An extended review of the service by the director;
   (2) Mandatory peer review of PCI procedures performed by the service;
   (3) Annual inspections until such time as the service performs the established number of procedures for a period of two consecutive years or the director determines that annual inspection is no longer required; or
   (4) At the discretion of the director, the establishment of a probationary period. If a probationary period is imposed, at a minimum, the service shall be notified of the following:
      (a) The time period for which the probationary period is effective;
      (b) The actions that may be taken by the director for a service’s failure to successfully complete the probationary period.

Pediatric Intensive Care Units

3701-84-61 Pediatric intensive care service requirements.

(A) The provisions of rules 3701-84-61 to 3701-84-65 of the Administrative Code are applicable to each provider of a pediatric intensive care service (PICU) services regardless of the date service was initiated.

(B) Each provider of a PICU service shall develop and follow written comprehensive and effective patient care policies and procedures that designate the severity of illnesses that may be treated and the types of care that may be provided in the PICU. The PICU shall operate within the scope of this service plan.

(C) A temporary expansion of PICU services due to seasonal illness or outbreak necessitating an increase in the number of PICU beds does not require notification to the director under the change in the scope of the HCS requirement set forth in paragraph (G) of rule 3701-84-04 of the Administrative Code. Any expansion of PICU services for these purposes shall meet all established requirements for a PICU.
(D) Each provider of a PICU service shall require that the pediatric intensivist or the pediatric intensivist’s designee be available in thirty minutes or less, on a twenty-four hour a day basis.

(E) The following physicians shall be available to the PICU in less than sixty minutes on a twenty-four hour a day, seven days a week basis:

1. An anesthesiologist with demonstrated training and experience in pediatrics;
2. A pediatric surgeon or a general surgeon with demonstrated training and experience in pediatrics;
3. Pediatric subspecialists to include:
   a. A pediatric critical care medicine physician (intensivist);
   b. A cardiologist;
   c. A nephrologist;
   d. A hematologist/oncologist;
   e. A gastroenterologist;
   f. An endocrinologist;
   g. A pulmonologist;
   h. An infectious disease specialist; and
   i. A neurologist;
4. Surgeon subspecialists with demonstrated training and experience in pediatrics, to include:
   a. A neurosurgeon;
   b. An otolaryngologist;
   c. A craniofacial (plastic) surgeon;
   d. An oral surgeon;
   e. An orthopedist; and
   f. A cardiovascular surgeon.
5. A radiologist with demonstrated training and experience in pediatrics;
6. A pathologist with demonstrated training and experience in pediatrics;
7. A psychiatrist or psychologist with demonstrated training and experience in pediatrics.

(F) Each provider of a PICU service shall have access to the following pediatric specialists for consultation and treatment as necessary, either on staff or by arrangement or contract:

1. A neonatologist;
2. An allergist or immunologist; and
3. A geneticist.

(G) Each provider of a PICU service without an on-site pediatric cardiovascular surgery service shall maintain a written transfer agreement for emergency pediatric cardiovascular surgery services with a provider of pediatric cardiovascular surgery services that can be reached expeditiously from the catheterization laboratory or angiography suite, required in paragraph (M)(2) of this rule, by available emergency vehicle in less than sixty minutes on a twenty-four hour a day, seven days a week basis and that provides the greatest assurance for patient safety.

(H) Each provider of a PICU service shall have available at least two operating rooms with the capability, equipment and personnel to perform emergency procedures in less than sixty minutes on a twenty-four hour a day, seven days a week basis.

(I) Each provider of a PICU service shall have access to a blood bank with all blood components available twenty-four hours a day, seven days a week. Unless some unusual antibody is encountered, blood typing and cross matching shall allow for transfusion in less than sixty minutes.

(J) Each provider of the PICU service shall have radiology services available at all times.
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to the PICU to meet the needs of the patient and shall include:

(1) Portable radiology;
(2) Fluoroscopy;
(3) Computerized tomography scanning;
(4) Ultrasonography;
(5) Angiography;
(6) Nuclear scanning; and
(7) Magnetic resonance imaging;

(K) Radiation therapy services shall be available on-site or through contract with another hospital.

(L) Each provider of a PICU service shall have the following clinical laboratory capabilities:

(1) Microspecimen capability and one hour turnaround time for:
   (a) Clotting studies and measurements of complete blood cell count;
   (b) Differential count;
   (c) Platelet count;
   (d) Urinalysis;
   (e) Electrolytes;
   (f) Blood urea nitrogen;
   (g) Creatinine;
   (h) Glucose;
   (i) Calcium;
   (j) Prothrombin time;
   (k) Partial thromboplastin time; and
   (l) Cerebrospinal fluid cell counts;

(2) Blood gas values available within fifteen minutes;

(3) Within three hours, results of:
   (a) Drug screening and levels of serum ammonia;
   (b) Serum and urine osmolarity;
   (c) Phosphorus; and
   (d) Magnesium.

(4) Preparation of gram stains and bacteriological cultures available twenty-four hours a day, seven days a week.

(M) Each provider of a PICU service shall have access to the hospital's pharmacy service and personnel on-site capable of dispensing all necessary medications for pediatric patients of all types and ages, twenty-four hours a day, seven days a week.

(N) Diagnostic cardiac and neurological services shall be available twenty-four hours per day to the provider of a PICU service as needed and technicians with special training in pediatrics should be available to perform the following studies:

(1) Electrocardiograms, two-dimensional and echocardiograms and electroencephalograms;

(2) A catheterization laboratory or angiography suite; and

(3) Doppler ultrasonograph devices and evoked potential monitoring equipment.

(O) Each provider of a PICU service shall timely provide hemodialysis equipment and competent and qualified staff experienced with pediatric patients available twenty-four hours a day, seven days a week.

(P) Each provider of a PICU service shall have an integrated communication system with a local emergency medical transport system.

(Q) Each provider of a PICU service shall have a secondary emergency communication system available twenty-four hours a day, seven days a week into the PICU.

(R) Each provider of a PICU service shall have an internal transportation system and
competent and qualified staff for effective transport.

(S) Each provider of a PICU service shall maintain a communication link to a federal, state, or local poison control center.

(T) A PICU shall only be operated in a fully permanent setting within the permanent frame of the building of a registered hospital that is classified as a general hospital or a children's hospital. The hospital shall be fully equipped to meet the needs of the PICU.

3701-84-62 Personnel and staffing; minimum standards.

(A) Each provider of a PICU service shall have a medical director whose appointment, acceptance and responsibilities shall be in writing and on file in the PICU.

(B) The PICU medical director shall be:

(1) An active service provider in the PICU where he or she is the medical director; and

(2) Be board-certified in one of the following:

(a) Pediatric critical care;

(b) Anesthesiology with practice limited to infants and children and with special qualifications in critical care medicine; or

(c) Pediatric surgery with added qualifications in surgical critical care medicine.

(C) The PICU medical director shall:

(1) Participate in development, review, and implementation of PICU policies;

(2) Participate in budget preparation;

(3) Coordinate staff education;

(4) Maintain a data base and/or vital statistics that describe unit experience and performance;

(5) Supervise resuscitation techniques, including educational component;

(6) Supervise quality control, assessment and improvement activities, including morbidity and mortality reviews;

(7) Coordinate research;

(8) Have the authority to consult on any PICU patient; and

(9) Name qualified designees to fulfill the medical director's duties during absences.

(D) Other individuals may supervise the activities required in paragraph (C) of this rule, but the PICU director shall participate in each.

(E) In addition to the pediatric intensivist required in paragraph (C) of rule 3701-84-61 of the Administrative Code, each provider of a PICU service shall have a licensed physician assigned to the PICU who:

(1) Is available to provide beside care to the patients in the PICU; and

(2) Is skilled in and has the credentials to provide emergency care to critically ill children.

These responsibilities may be shared or delegated to an advanced practice nurse with specialized training in pediatric critical care and credentials and privileges to provide care in the PICU.

(F) Each provider of a PICU service shall have a nurse manager dedicated to the PICU who shall be supervised by the director of pediatric nursing or equivalent. The PICU nurse manager shall have specific training and experience in pediatric critical care. Pediatric critical care registered nurse (CCRN) certification is recommended for the nurse manager, but not required.

(G) The PICU nurse manager shall participate in the following:

(1) Development, review, and implementation of written policies and procedures for the PICU;

(2) Coordination of multidisciplinary staff education;

(3) Quality assurance;

(4) Nurse research;
(5) Budget preparation with the medical director; and
(6) Name qualified designees to fulfill their duties during absences.
These responsibilities may be shared or delegated to advanced practice nurses, but the PICU nurse manager shall maintain overall responsibility for these requirements.

(H) Nursing to patient ratios in the PICU service shall be sufficient to accommodate the acuity level and volume of patients, usually ranging from two nurses to one patient to one nurse to three patients and adjusted as needed.

(I) Required nursing skills for PICU nurses shall include:
(1) Recognition, interpretation and recording of various physiologic variables;
(2) Drug and fluid administration;
(3) Cardio-pulmonary resuscitation (CPR) certification;
(4) Pediatric advanced life support certification (PALS);
(5) Respiratory care techniques including chest physiotherapy, endotracheal suctioning and management, and tracheostomy care;
(6) Preparation and maintenance of patient monitors; and
(7) Psychosocial skills to meet the needs of both patient and family.

(J) Each provider of a PICU service shall provide to nursing staff:
(1) An orientation the the PICU;
(2) A clinical and didactic orientation in pediatric critical care; and
(3) On-going pediatric critical care in-service education.

(K) Each provider of a PICU service shall have respiratory therapy staff assigned to the unit in-house twenty-four hours a day, seven days a week who:
(1) Have clinical experience managing pediatric patients with respiratory failure; and
(2) It is recommended that all respiratory therapy staff have pediatric advanced life support (PALS) training or an equivalent course.

(L) Other PICU staff shall include:
(1) Biomedical technicians (in-house or available within one hour on a twenty-four hours a day, seven day a week basis);
(2) A social worker;
(3) A pharmacist in-house twenty-four hours per day;
(4) A radiology technician;
(5) A registered dietitian;
(6) A physical therapist;
(7) An occupational therapist;
(8) A child life specialist; and
(9) A unit clerk.

(M) As part of a continuing education program, the provider of a PICU service shall:
(1) Have staff participate in regional pediatric critical care education programs; and
(2) Provide regularly scheduled resuscitation practice sessions.

(N) Staffing requirements of this rule may be met by individuals with equivalent or greater qualifications if the replacement's scope of practice encompasses the duties of the required staff.

3701-84-63 Facilities; design and minimum standards.

(A) Each PICU shall have controlled access with no through traffic.
(B) The location of the PICU:
(1) Is recommended to be in close proximity to the physician on-call office.
(2) Shall be in close proximity to a family waiting area; and
(3) Shall be available by gurney to the emergency department, the surgical area, and the recovery area.
(C) Each PICU shall contain the following distinct areas:
(1) Patient isolation rooms;
(2) A clean linen room;
(3) A soiled linen room;
(4) Equipment storage;
(5) Counseling;
(6) A medication station with drug refrigerator and locked narcotic cabinet;
(7) A nourishment station;
(8) Hand washing facilities;
(9) Staff and patient toilets; and
(10) Patient personal effects storage.
(D) All patient rooms shall have:
(1) The capacity to provide patient privacy, such as through the use of walls or curtains;
(2) Easy, rapid access to the head of the bed; and
(3) Adequate electrical outlets, compressed air, oxygen, and vacuum outlets per bed
sufficient in number to supply all necessary equipment.
(E) Each PICU shall have a rapid and reliable system that timely reports and receives
laboratory results.

3701-84-64 Equipment and supplies; minimum requirements.

(A) Appropriate drugs for resuscitation and pediatric advanced life support shall be
present and immediately available for use in the treatment of any patient in the PICU.
(B) The following life-saving, therapeutic and monitoring equipment shall be present or
immediately available in the PICU:
(1) Portable equipment including:
(a) An emergency (“code” or “crash”) cart;
(b) A procedure lamp;
(c) Pediatric sized blood pressure cuffs for systemic arterial pressure determination;
(d) A doppler ultrasound;
(e) An electrocardiograph;
(f) A defibrillator or cardioverter with pediatric paddles;
(g) Thermometers with a range sufficient to identify extremes of hypothermia and
hyperthermia;
(h) Automated blood pressure apparatus;
(i) Transthoracic pacer with pediatric pads;
(j) Devices for accurately measuring body weight;
(k) Cribs and beds with head pressure apparatus;
(l) Infant warmers;
(m) Heating and cooling blankets;
(n) Bilirubin lights;
(o) Temporary pacemakers;
(p) A blood warming apparatus;
(q) A transport monitor;
(r) Infusion pumps with microinfusion capability;
(s) Oxygen tanks for transport and backup;
(t) Suction machines for transport and backup;
(u) Volumetric infusion pumps;
(v) Air-oxygen blenders;
(w) An air compressor;
(x) Gas humidifiers;
(y) Bag-valve mask resuscitators;
(z) An otoscope and ophthalmoscope;
(aa) Isolation carts; and
(bb) A portable electroencephalogram available in the hospital for recordings.
(2) Respiratory equipment appropriate to meet the needs of all patients, including:
(a) Mechanical ventilators suitable for pediatric patients of all sizes;
(b) Pulse oximeters and transcutaneous oxygen monitors;
(c) Carbon dioxide (CO2) monitors;
(d) Inhalation therapy equipment;
(e) Chest physiotherapy and suctioning;
(f) Spirometers; and
(g) Continuous oxygen analyzers with alarms.
(3) Small equipment including:
(a) Tracheal intubation equipment in adequate numbers and type to intubate patients of all ages;
(b) Endotracheal tubes of all pediatric sizes;
(c) Oral/nasal airways;
(d) Flexible bronchoscope;
(e) Suction catheters;
(f) Vascular access equipment; and
(g) Surgical trays for the following;
(i) Vascular cut-downs;
(ii) Open chest procedures;
(iii) Cricothyroidectomy; and
(iv) Tracheostomy;
(h) Intraosseous (IO) needles.
(4) Bedside monitors that shall be capable of providing continuous, sufficient and appropriate monitoring that have visible and audible alarms and are capable of producing a permanent hard copy of the rhythm strip.
(C) Each provider of a PICU service shall have the capability to continuously monitor a patient's:
(1) Electrocardiogram and heart rate;
(2) Respiration;
(3) Temperature;
(4) Systemic arterial pressure;
(5) Oxygen;
(6) Carbon dioxide;
(7) Central venous pressure;
(8) Pulmonary arterial pressure;
(9) Intracranial pressure; and
(10) Four pressures simultaneously.

3701-84-65 Quality assessment and improvement program.

Each PICU shall have a multidisciplinary collaborative quality assessment and performance improvement program. The written quality assessment and performance improvement program plan required under rule 3701-84-12 of the Administrative Code shall, at a minimum, include a review of:
(A) All morbidity and mortality instances;
(B) Utilization;
(C) Medical records;
(D) Discharge criteria and discharge planning; and
(E) Patient safety.

Radiation Therapy and Radiosurgery

3701-84-67 Radiation therapy and radiosurgery service standards.

(A) Each radiation therapy service shall evaluate the patient and assess tumors.
   (1) The evaluation shall be conducted by a radiation oncologist and shall include a
       medical history, a physical examination, a review of the patient's diagnostic studies and reports,
       and, when appropriate, consultation by the radiation oncologist with the referring physician.
       (2) The assessment of tumors shall include a definition of tumor, location, and the extent
           and stage of the tumor.
   (B) Each radiation therapy service shall provide the following as necessary to meet the
       needs of the patient:
       (1) Consultation;
       (2) Treatment planning, including the selection of dose, selection of treatment modality,
           and selection of treatment technique;
       (3) Determination of optimal treatment program and calculation of dose;
       (4) Simulation of treatment; and
       (5) Clinical treatment management and patient education.
   (C) Each stereotactic radiosurgery service shall establish policies and implement
       procedures for the follow-up of patients who are treated with curative intent and patients who
       are treated with palliative intent by the radiation oncologist and/or the neurosurgeon.
       (1) A radiation oncologist and/or a neurosurgeon shall establish a post-treatment follow-
           up plan for each patient.
       (2) Each stereotactic radiosurgery service shall establish policies and procedures to
           provide for the long term follow-up of patients treated with curative intent. The follow-up of
           patients treated with curative intent shall be for a five-year period whenever feasible or practical.
           The follow-up shall include documentation of the outcome of therapy including the results of
           treatment such as tumor control or survival, and significant sequelae.
       (3) If the stereotactic radiosurgery service is unable to conduct the follow up as planned,
           the service shall document the reason in the patient's medical record.
   (D) Radiation therapy shall be provided only upon written order of a radiation oncologist.
   (E) Stereotactic radiosurgery shall be provided only upon written order of a radiation
       oncologist and/or a neurosurgeon. Each stereotactic radiosurgery service shall communicate
       with referring physicians regarding the stereotactic radiosurgery.
   (F) Each radiation therapy service shall comply with the requirements pertaining to the Ohio cancer incidence surveillance system established under sections 3701.261 and 3701.262 of the Revised Code and Chapter 3701-4 of the
       Administrative Code.

3701-84-68 Personnel and staffing; minimum requirements.

(A) Each radiation therapy service shall have an administrator.
   (B) Each stereotactic radiosurgery service and/or each gamma knife service shall have
       as a medical director either a radiation oncologist as defined in rule 3701-84-01 of the
       Administrative Code or a board-certified neurosurgeon certified by the American board of
       neurological surgery.
(C) All radiation therapy services not covered by paragraph (B) of this rule shall have a radiation oncologist as medical director.

(D) The medical director of each radiation therapy and/or stereotactic radiosurgery service shall:

1. Approve the specific clinical duties that may be performed by each member of the physics staff as established by the medical physicist under paragraph (G) of this rule; and
2. Ensure appropriate coverage of the radiation therapy service and/or stereotactic radiosurgery service by radiation oncologists, neurosurgeons, and staff.

3. Ensure that calculation discrepancies identified in rule 3701-84-70 of the Administrative Code are resolved and documented.

(E) A radiation oncologist shall be available for direct care and quality review on a daily basis. If the radiation oncologist is not on-site, the radiation oncologist shall be accessible by phone, pager, or other designated mechanism.

(F) Each radiation therapy service or dedicated stereotactic radiosurgery service shall have a medical physicist who meets the requirements of:

1. Paragraph (D) of rule 3701:1-67-02 of the Administrative Code for radiation therapy using radiation-generating equipment; or

(G) The medical physicist shall be available for consultation with the radiation oncologist or neurosurgeon and provide advice or direction to staff when a patient's treatments are being planned or patients are being treated. Radiation therapy services and stereotactic radiosurgery services shall have regular on-site physics support during hours of clinical activity. The on-site support shall, at a minimum, be provided on a weekly basis. When a medical physicist is not available on-site, other physics duties shall be established and documented in writing by the medical physicist. The medical physicist shall specify the specific physics duties that shall be performed by each member of the physics staff in accordance with their qualification and competence.

(H) Each radiation therapy service shall have available a sufficient number of qualified staff for the radiation therapy services provided, including individuals licensed as a radiation therapist under Chapter 4773 of the Revised Code, who are able to supervise and conduct the radiation therapy services as appropriate for the services being offered. A radiation oncologist and support staff shall be available to initiate urgent treatment with a medically appropriate response time on a twenty-four hour a day, seven days a week basis.

(I) Each stereotactic radiosurgery service shall have available a sufficient number of qualified staff for the stereotactic radiosurgery services provided, including individuals licensed as a radiation therapist under Chapter 4773 of the Revised Code, who are able to supervise and conduct the radiosurgery services as appropriate for the services being offered. A radiation oncologist and/or a neurosurgeon and support staff shall be available to initiate urgent treatment with a medically appropriate response time on a twenty-four hour a day, seven days a week response basis.

(J) In addition to the requirement of paragraph (B) of rule 3701-84-08 of the Administrative Code, each radiation therapy service and radiosurgery service shall establish personnel files for all individuals who provide radiation therapy services and shall maintain files for each individual that specify the types of procedures or services the individual is permitted to perform. All files shall be updated at least every twelve months.

3701-84-69 Facilities and equipment; minimum standards.

(A) Clinical facilities for radiation therapy services and stereotactic radiosurgery services should be designed to accommodate large numbers of outpatients and limited numbers of
inpatients, if applicable.

(B) Ramps, doors, hallways and lavatories shall accommodate wheelchairs and have a holding area for patients on stretchers or beds.

(C) Each radiation therapy service and stereotactic radiosurgery service shall have on-site or accessible:

1. Reception and waiting areas;
2. An adequate number of exam rooms;
3. A physicians’ work room;
4. A secure area for medications;
5. Procedure rooms;
6. A treatment planning area;
7. A physics lab; and
8. A room for fabrication of treatment aids.

(D) Each radiation therapy service shall have the necessary equipment to provide services with accuracy, precision, and efficiency.

1. Each service shall provide for diagnostic services, either on-site or by referral. At a minimum, these services shall include:
   (a) Computerized tomography (CT);
   (b) Magnetic resonance imaging (MRI);
   (c) Fluoroscopy;
   (d) Nuclear medicine; and
   (e) Clinical and surgical pathology.
2. Each radiation therapy service shall document arrangements for referrals to one or more other radiation therapy sites so that the patients will have access to a broad spectrum of radiation therapy equipment and a variety of treatment modalities including, at least, brachytherapy and a unit of radiation therapy equipment providing photons of at least ten megavolts (MV) and electron energies to at least twelve megaelectron volts (MeV).

(E) Each radiation therapy service and/or radiosurgery service shall develop and implement a program to monitor the calibration and radiation beam characteristics to assure accurate and reliable delivery of ionizing radiations. Calibration and operation of radiation therapy equipment shall be in accordance with the applicable requirements in Chapters 3701:1-67 and 3701:1-58 of the Administrative Code.

(F) Gamma knife and stereotactic radiosurgery services shall assess and assure correlation of alignment between imaging and treatment equipment in accordance with current recommended standards for radiosurgery treatment by the American association of physicists in medicine and the American college of medical physics.

(G) Each radiation therapy service shall develop and implement a preventive maintenance and repair program for equipment in accordance with manufacturer’s specifications. The service shall maintain current records of equipment performance, maintenance and malfunctions.

(H) Each radiation therapy service shall maintain emergency equipment and medications appropriate for the services provided.

3701-84-70 Radiation therapy service standards.

(A) For radiation therapy services, the radiation oncologist shall establish the doses desired throughout the tumor and set dose limits to critical structures. The radiation oncologist shall establish the critical structures associated with the tumor treatment site. Treatment deliveries shall meet the specifications of the radiation oncologist.

(B) For stereotactic radiosurgery services, the radiation oncologist and/or the neurosurgeon shall establish the doses desired throughout the tumor or target volume and set
limits of doses to critical structures. The radiation oncologist and/or neurosurgeon shall establish the critical structures associated with the tumor or target volume treatment site. Treatment deliveries shall meet the specifications of the radiation oncologist and/or the neurosurgeon.

(C) For radiation therapy services, all treatment applications shall be described in detail and signed by the radiation oncologist. The radiation oncologist shall be notified of any changes that may be necessary in the planned schedule of treatment.

(D) For stereotactic radiosurgery services, all treatment applications shall be described in detail and signed by the radiation oncologist and/or neurosurgeon. The radiation oncologist and/or neurosurgeon shall be notified of any changes that may be necessary in the planned schedule of treatment.

(E) Each radiation therapy service shall:

1. Provide or arrange for appropriate radiation treatment localization, simulation and verification;
2. Provide or arrange for isodose treatment planning with complex analyses generated in appropriate cases;
3. Provide accurate calculation of doses and dose distribution;
4. Provide a system for independent checking of initial dose calculations. The check shall be conducted before the third fraction, or before twenty per cent of the total dose when the treatment schedule provides less than ten fractions. The independent check includes utilizing another individual or method approved and documented by the medical physicist to verify dose calculations;
5. Conduct ongoing reviews of accumulating doses;
6. Conduct a chart and port film review weekly;
7. Accurately chart treatment doses; and
8. Maintain records of pertinent data used in planning the specific treatment for a patient in the patient's medical record.

(F) Each radiation therapy service shall provide devices to aid in positioning and immobilizing the patient. Normal tissue shields, compensating filters, wedges and other aids shall be provided as medically appropriate.

(G) Initial port films shall be checked by the radiation oncologist prior to the second treatment and the port films shall be rechecked at least every ten treatments.

(H) Each radiation therapy service shall establish and maintain procedures for handling emergency cardiac care.

3701-84-71 Radiation safety standards.

(A) Each radiation therapy service and stereotactic radiosurgery service shall maintain and follow written policies and procedures for the handling of emergencies that may threaten the health and safety of patients, staff, and public.

(B) Each radiation therapy service and stereotactic radiosurgery service shall comply with the applicable provisions of Chapter 3748 of the Revised Code and the rules adopted pursuant to that chapter.

(C) Each radiation therapy service and stereotactic radiosurgery service shall identify, document, and report to the department:

1. Misadministrations of radiation from x-ray therapy equipment in accordance with rule 3701:1-67-12 of the Administrative Code; and
3701-84-72 Quality assessment program.

(A) As part of the quality assessment and performance improvement program requirements under paragraph (C) of rule 3701-84-12 of the Administrative Code, each radiation therapy service shall evaluate the provision of radiation therapy services including:
   (1) A review of case management and treatment results; and
   (2) A review of complications and adverse events that occurred during the provision of the center's services.

(B) The medical director of radiation oncology shall be responsible for the institution and ongoing supervision of the continuing quality assessment and performance improvement program.

3701-84-73 Medical record; content requirements.

In addition to the requirements of rule 3701-84-11 of the Administrative Code, each radiation therapy service and/or stereotactic radiosurgery service shall maintain documentation of the following in each patient's medical record:
   (A) Confirmation of the presence of malignancy by histopathology, a statement of benign condition, or other alternative evidence for diagnosis of all cases accepted for radiation;
   (B) Documentation of services and radiographic images, including localization films, appropriate to the therapy provided;
   (C) Report of the initial evaluation including a definition of the tumor or target type, location, and the extent of each cancer as a basis for staging;
   (D) The treatment plan including the selection of dose, selection of treatment modality, and selection of treatment technique;
   (E) The dosimetry calculations;
   (F) The patient's progress and tolerance; and
   (G) The completion of treatment with statement of a follow-up plan.

Pediatric Cardiac Catheterization

3701-84-75 Pediatric cardiac catheterization service standards.

(A) The provisions of rules 3701-84-75 to 3701-84-79 of the Administrative Code are applicable on the effective date of this rule to each provider of cardiac catheterization services performing procedures on patients less than twenty-two years of age, regardless of the date the service was initiated.

(B) All pediatric cardiac catheterization services shall:
   (1) Have on-site a pediatric cardiovascular surgery service immediately accessible from the pediatric cardiac catheterization laboratory by gurney; and
   (2) Have an experienced pediatric cardiovascular surgical team available in less than sixty minutes on a twenty-four hour a day, seven days a week basis in the event that emergency open heart surgery is required.

(C) Each provider of a pediatric cardiac catheterization services shall have explicit criteria specifying the number of times a year an appropriately privileged physician shall perform each catheterization procedure in order to retain privileges to perform that procedure. These criteria shall be consistent with current recommendations of recognized professional societies and accrediting bodies.

(D) Each provider of a pediatric cardiac catheterization service shall have immediate access to services for:
   (1) Hematology and coagulation disorders;
(2) Electrocardiography;
(3) Diagnostic radiology,
(4) Clinical pathology;
(5) Doppler-electrocardiography;
(6) Pulmonary function testing; and
(7) Microbiology.

(E) Each provider of a pediatric cardiac catheterization service shall have established criteria for patient selection and appropriateness that are specific to each procedure performed in the service.

(F) Each provider of a pediatric cardiac catheterization service shall have a written policy requiring the documentation of any internal review of surgeons with a combination of high risk adjusted mortality and low individual surgeon volume.

(G) Each provider of a pediatric cardiac catheterization service, no later than January 1, 2018, shall enroll and be actively submitting data to the American college of cardiology national cardiovascular data registry (NCDR) “IMPACT” registry for catheterization.

(H) A cardiac catheterization service for pediatric patients shall only be provided in a fully permanent setting within the permanent frame of the building of a registered hospital that is classified as a general hospital, a children's hospital or a special hospital - cardiac, that primarily furnishes limited services to patients with cardiac conditions. The hospital shall:

(1) Operate inpatient pediatric medical and surgical services in the same building that are accessible by gurney from the pediatric cardiac catheterization laboratory;

(2) Operate a pediatric intensive/critical care unit with registered special care beds, that is reviewed and accredited or certified as such as part of the hospital's accreditation or certification program in the same building and accessible by gurney from the pediatric cardiac catheterization laboratory. The unit shall provide appropriate equipment and staff to care for pediatric cardiac patients and have twenty-four hour monitoring capability

(3) Provide a setting in the same building as the pediatric cardiac catheterization laboratory in which ambulatory pediatric cardiac catheterization patients can be observed for at least four hours after the procedure; and

(4) Provide adequate physician coverage to manage postprocedure complications.

3701-84-76 Personnel/staffing.

(A) Each provider of a pediatric cardiac catheterization service shall designate a medical director for the pediatric cardiac catheterization service. The medical director shall:

(1) Possess the experience and leadership qualities that are necessary to manage the laboratory appropriately and to ensure safe and effective delivery of catheterization services to pediatric patients; and

(2) The medical director shall actively perform pediatric cardiac catheterization procedures at the hospital where he or she is the medical director.

(B) The medical director of the pediatric cardiac catheterization service shall be board-certified in pediatric cardiology by the American board of pediatrics or the American osteopathic board of pediatrics.

(C) Each provider of a pediatric cardiac catheterization service shall have at least two licensed physicians credentialed to provide pediatric cardiac catheterization services on staff who are knowledgeable of the laboratory’s protocols and equipment by providing pediatric cardiac catheterization services at the hospital. Only physicians appropriately credentialed to provide pediatric cardiac catheterization services may be the primary operator of a pediatric cardiac catheterization procedure.

(D) At a minimum, all physicians who perform pediatric cardiac catheterization procedures shall be:
(1) A fully-accredited member of the HCS’s staff; and
(2) Shall participate in laboratory quality assurance programs, including peer review.
(E) In addition to the requirements of paragraphs (A) and (C) of this rule, the provider of a pediatric cardiac catheterization service shall have available a sufficient number of qualified staff, who are able to supervise and conduct the cardiac catheterization service and are skilled in pediatric cardiopulmonary resuscitation, including the following, as applicable:
(1) Support staff comprised of individuals skilled in the following:
   (a) Radiographic techniques;
   (b) Digital imaging;
   (c) Systematic quality control testing;
   (d) Patient observation;
   (e) Critical care;
   (f) Monitoring and recording electrocardiographic and hemodynamic data; and
   (g) For catheterization laboratories where physiological studies are performed:
      (i) Managing blood samples;
      (ii) Performing blood gas measurements and calculations; and
      (iii) Assisting with indicator dilution studies.
(2) Nursing personnel in sufficient number and type based on the caseload and types of procedures performed, which may include nurse practitioners, registered nurses, licensed practical nurses, and nursing assistants.
   (a) Nursing personnel involved in the provision of pediatric cardiac catheterization services shall have experience in pediatric critical care and knowledge of operating room techniques;
   (b) Nurse practitioners, registered nurses, and licensed practical nurses involved in the provision of pediatric cardiac catheterization services shall have:
      (i) Knowledge of cardiovascular medications;
      (ii) The ability to begin administration of intravenous solutions and administer drugs;
      (iii) Experience with sterile techniques; and
      (iv) Skills in monitoring vital signs, neurologic status and pain level.
   (c) Nurse practitioners may assume some of the duties of a physician as permitted by law, however, ultimate responsibility for procedures shall always remain with the physician of record.
(F) Respiratory therapists and pediatric critical care staff shall be immediately available to care for pediatric patients.
(G) Biomedical, electronic, and radiation safety experts shall be involved in maintaining the cardiac catheterization laboratory.
(H) Cardiovascular anesthesiologists and perfusion teams shall be immediately available to care for patients.
(I) Staffing requirements of this rule may be met by individuals with equivalent or greater qualifications if the replacement's scope of practice encompasses the duties of the required staff.

3701-84-77 Facilities and equipment; design and minimum requirements.

(A) Each provider of a pediatric cardiac catheterization service shall provide adequate, properly designed space to perform cardiac catheterization procedures safely and effectively. The amount of space may vary with the types of procedures performed and the nature of the facility such as interventional versus diagnostic and teaching versus non-teaching.
(B) Each pediatric cardiac catheterization service shall utilize the following:
   (1) Procedure rooms that meet or exceed minimum space requirements established by the equipment manufacturer and are at least four hundred square feet or, if constructed or
renovated or pediatric cardiac catheterization services initiated after March 1, 1997 at least five hundred square feet; 

(2) Control rooms of at least ninety-six square feet for each procedure room served. Control rooms that are constructed or renovated or pediatric cardiac catheterization services initiated after March 1, 1997 shall have a minimum of one hundred fifty square feet for each procedure room served. Each procedure room shall have an assigned control room; and

(3) Clean utility rooms that can sufficiently and efficiently supply the procedure rooms.

(C) A general radiology room cannot be used as a cardiac catheterization procedure room.

(D) Each provider of a pediatric cardiac catheterization service shall ensure that each laboratory where a cardiac catheterization procedure is conducted is appropriately equipped to provide high quality pediatric imaging, physiological monitoring, and provision of emergency care.

(E) The equipment described in this paragraph may be replaced by newer technology that has equivalent or superior capability as determined by the provider of the pediatric cardiac catheterization service. In assessing these new technologies, consideration should be given to recommendations of recognized professional societies and accrediting bodies (e.g. the American college of cardiology; the American academy of pediatrics). All pediatric cardiac catheterization services shall, at a minimum, have the following equipment:

(1) Biplane imaging equipment with a movable c-arm;
(2) Immediate replay capabilities;
(3) A blood gas analyzer;
(4) A pulse oximeter;
(5) An infant warming device;
(6) Pacing catheters;
(7) An external pacemaker;
(8) A defibrillator;
(9) An emergency cart; and
(10) A comprehensive inventory of pediatric catheters and devices.

(F) Each provider of a pediatric cardiac catheterization service shall provide and maintain radiation generating equipment in accordance with applicable state and federal requirements as specified in Chapter 3748 of the Revised Code and the rules adopted thereunder.

3701-84-78 Safety guidelines.

(A) To assure a safe environment for patients, visitors, and personnel, each provider of a pediatric cardiac catheterization service shall establish and maintain safety guidelines, practices and policies in accordance with applicable United States nuclear regulatory commission regulations, applicable provisions of Chapter 3748 of the Revised Code, and the rules adopted pursuant to that chapter.

(B) Each provider of a pediatric cardiac catheterization service shall establish, maintain, and follow electrical safety policies which at a minimum include:

(1) A safe primary electrical wiring system;
(2) Electrical isolation of all equipment attached to a patient;
(3) Use of an equipotential hardwired grounding system for all equipment; and
(4) Periodic inspection of the electrical system and measurement of interequipment current leakage.

(C) Each provider of a pediatric cardiac catheterization service shall periodically survey all of the equipment utilized by the service and perform preventive maintenance on a schedule.
that, at a minimum, conforms to manufacturers’ recommendations. Results of surveillance and preventive maintenance activities must be internally documented.

3701-84-79 Patient selection criteria; volume goals; failure to meet goals.

(A) Each provider of a pediatric cardiac catheterization service should meet a volume goal of at least one hundred pediatric cardiac catheterization procedures per year consistent with the 2012 American college of cardiology foundation/society for cardiovascular angiography and interventions expert consensus document on cardiac catheterization laboratory standards update available at www.acc.org.

(B) Volume goals shall be considered by the director in conjunction with other indicators of quality and not as the sole indicator of service performance.

(C) Failure to meet a volume goal for two consecutive years may trigger an extended review of the pediatric cardiac catheterization service by the director including possible inspections.

(D) No minimum per physician volume is recommended, however, the combination of high mortality and low volume shall trigger a thorough internal review of an individual physician by the pediatric cardiac catheterization service.

Pediatric Cardiovascular Surgery

3701-84-81 Pediatric cardiovascular surgery standards.

(A) The provisions of rules 3701-84-81 to 3701-84-85 of the Administrative Code are applicable to each provider of pediatric cardiovascular surgery services performing procedures on patients less than twenty-two years of age, regardless of the date service was initiated. Patients between the ages of eighteen and twenty-two years may be served at an adult open heart surgery service, if the patient's attending physician and the adult service's medical director determine that the adult service best serves the needs of the patient.

(B) Each provider of a pediatric cardiovascular surgery service shall have available at all times in the same building as the pediatric cardiovascular surgery service and accessible by gurney, adequate facilities for the pediatric cardiovascular surgery service, including but not limited to:

1. Cardiac operating rooms;
2. Pediatric intensive care facilities appropriate for the recovery of post operative pediatric cardiovascular surgical patients; and
3. A cardiac catheterization service.

(C) Each provider of a pediatric cardiovascular surgery service shall have the capability, equipment, and personnel to perform emergency pediatric open heart procedures on a twenty-four hour a day, seven days a week basis. A pediatric cardiovascular surgical team shall be available and on-site in less than sixty minutes on a twenty-four hour a day, seven days a week basis.

(D) Each provider of a pediatric cardiovascular surgery service shall utilize a coordinated and integrated multidisciplinary approach to patient care, including meetings to determine the appropriate course of treatment for complex patients. Physicians and staff should function as a team and should include adequate numbers of qualified pediatric cardiologists, pediatric cardiovascular surgeons, pediatric cardiovascular anesthesiologists, pediatric intensive care physicians, and/or neonatologists with special expertise in the care of cardiac patients, and additional pediatric specialists required for the overall care of patients.

(E) Each provider of a pediatric cardiovascular surgery service shall have access to the following pediatric services and subspecialties:
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(1) Cardiology, including echocardiogram, doppler echocardiogram and cardiac catheterization;
(2) Hematology;
(3) A general surgeon;
(4) Gastroenterology;
(5) Nephrology;
(6) Pulmonary medicine;
(7) Infectious disease;
(8) Radiology;
(9) Interventional radiology;
(10) Neurology;
(11) Emergency care;
(12) Pathology;
(13) Pulmonary function testing;
(14) Preadmission testing; and
(15) Follow-up outpatient nursing referral.

(F) Each provider of a pediatric cardiovascular surgery service shall have access to the following services either on site or by arrangement with another facility:
(1) Extracorporeal membrane oxygenation (ECMO); and
(2) Ventricular assist device (VAD).

(G) Each provider of a pediatric cardiovascular surgery service, no later than January 1, 2018, shall obtain and maintain enrollment in the society for thoracic surgeons congenital heart surgery database (CHSD).

(H) A pediatric cardiovascular surgery service shall only be provided in a fully permanent setting within the permanent frame of the building of a registered hospital that is classified as a general hospital, a children's hospital or as a special hospital - cardiac, that primarily furnishes limited services to patients with cardiac conditions. The hospital shall be fully equipped to perform the service.

(I) Each provider of a pediatric cardiovascular surgery service shall have established criteria that cardiovascular surgeons, cardiologists, and physicians must utilize for patient selection and appropriateness.

(J) Each provider of a pediatric cardiovascular surgery service shall have a written policy requiring the documentation of any internal review of surgeons with a combination of high risk adjusted mortality and low individual surgeon volume.

3701-84-82 Personnel and staffing requirements.

(A) The medical director of the pediatric cardiovascular surgery service shall be board certified in thoracic surgery. The medical director shall be:
(1) Responsible for oversight and care in the service;
(2) Credentialed to provide pediatric cardiovascular surgery services at the hospital where he or she is the medical director; and
(3) Active in performing pediatric cardiovascular surgery procedures at the hospital where he or she is the medical director.

(B) Each provider of a pediatric cardiovascular surgery service shall have on staff at least two thoracic surgeons who are credentialed to perform and actively perform pediatric cardiovascular surgery procedures at the hospital.

(C) In addition to the requirements of paragraphs (A) and (B) of this rule and the general personnel requirements of paragraph (B) of rule 3701-84-08 of the Administrative Code, each provider of a pediatric cardiovascular surgery service shall have competent and qualified staff available, including but not limited to:
(1) Surgical assistants to assist the surgeon. A surgical assistant may consist of a resident, another physician, or a specially trained surgical assistant;

(2) Anesthesiologists with expertise in the anesthetic and support requirements of pediatric cardiovascular surgery;

(3) Nursing staff which shall include appropriate numbers of scrub nurses or technicians and circulating nurses or technicians. A minimum of one scrub nurse and one circulating nurse or technician alternative as noted, is necessary. Nursing staff shall be trained in pediatric cardiovascular surgical operating room procedures and nurses shall be pediatric advanced life support (PALS) certified;

(4) Pediatric intensive care unit staff who are trained in pediatric advanced life support (PALS) at an appropriate nurse/patient ratio commensurate with the acuity of each individual patient and the amount of time following surgery that such care will be necessary. Pediatric intensive care nurses and physicians shall have specialized training to develop the theoretical knowledge and clinical skills required for the care of pediatric cardiovascular surgical patients;

and

(5) A minimum of two perfusionists. Perfusionists shall be graduates of an accredited cardiovascular perfusion or perfusion technology training program or have equivalent training and experience. The perfusionists shall have training, knowledge, and experience with small body perfusion, extracorporeal membrane oxygenation (ECMO), and ventricular assist devices (VAD) if those services are provided onsite.

(D) In addition to the requirements of paragraph (C) of this rule, each provider of a pediatric cardiovascular surgery service shall have appropriate staff available, including but not limited to pharmacists, dietitians, respiratory therapists, physical therapists and social workers.

(E) Staffing requirements of this rule may be met by individuals with equivalent or greater qualifications if the replacement's scope of practice encompasses the duties of the required staff.

3701-84-83 Facilities and equipment; minimum requirements.

(A) Operating rooms used for pediatric cardiovascular surgery shall have at a minimum four hundred and fifty square feet provided sufficient additional support space is available adjacent to each room for perfusion supplies, set up and other storage. Operating rooms for pediatric cardiovascular surgery constructed or renovated or services initiated after March 1, 1997 shall have at a minimum six hundred square feet.

(B) Each operating room used for pediatric cardiovascular surgery shall have appropriate numbers of oxygen, vacuum and electrical outlets sufficient in number to supply all necessary equipment and proper operating room lighting, including fiber optic headlights.

(C) Each provider of a pediatric cardiovascular surgery service shall have equipment appropriate for the safe performance and care of pediatric cardiovascular surgery patients.

(D) Each provider of a pediatric cardiovascular surgery service shall ensure that a fully equipped and staffed pediatric intensive care unit is available in the building and accessible by gurney from where the pediatric cardiovascular surgery is performed. The number of available pediatric intensive care unit beds shall be approximately one-half the number of pediatric open heart operations performed per week. The physical space of this unit shall meet joint commission, american osteopathic association, or any other national accrediting body approved for deeming authority by the centers for medicare and medicaid services recommended standards, which are in effect on the effective date of this rule, for intensive care unit beds.

(E) The equipment described in this paragraph may be replaced by newer technology that has equivalent or superior capability as determined by the provider of the pediatric cardiac catheterization service. In assessing these new technologies, consideration should be given to recommendations of recognized professional societies and accrediting bodies (e.g. the
American college of cardiology; the American academy of pediatrics). All pediatric cardiovascular surgery services shall, at a minimum, have the following equipment:

1. Immediate replay capabilities;
2. A blood gas analyzer;
3. A pulse oximeter;
4. An infant warming device;
5. Pacing equipment;
6. An external pacemaker;
7. A defibrillator;
8. An emergency cart; and
9. A comprehensive inventory of cannulas and conduits.

**3701-84-84 Patient selection criteria; volume goals.**

(A) Each provider of a pediatric cardiovascular surgery service should meet a volume goal of at least one hundred pediatric procedures per year by the second full year of operation, of which seventy-five are pediatric cardiovascular surgeries, to ensure efficiency and a minimum floor of competency.

(B) Volume goals shall be considered by the director in conjunction with other indicators of quality and not as the sole indicator of service performance.

(C) Failure to meet a volume goal for two consecutive years may trigger an extended review of the pediatric cardiovascular surgery service by the director including possible inspections.

(D) No minimum per surgeon volume is recommended, however, the combination of high risk adjusted mortality and low volume shall trigger a thorough internal review of an individual physician by the provider of the pediatric cardiovascular surgery service.

**3701-84-85 Quality assessment by medical director.**

In addition to the general quality assessment and performance improvement requirements set forth in rule 3701-84-12 of the Administrative Code, each provider of an open heart surgery service shall:

(A) As part of the service's overall quality assessment and performance improvement process:

1. Utilize the quality performance measures outcomes data obtained from the service's participation in the society for thoracic surgeons congenital heart surgery database; and
2. Include a periodic review and evaluation of the multidisciplinary meetings required by paragraph (D) of rule 3701-84-81 of the Administrative Code.

(B) Have a regular formal morbidity and mortality conference chaired by the medical director of the open heart surgery service or the medical director's designee. The morbidity and mortality conferences shall:

1. Be held at a minimum, once a month or more frequently depending on the need; and
2. Review all deaths and complications such as reoperation for bleeding, deep sternal wound infection, stroke, and perioperative myocardial infarction and any patterns that might indicate a problem shall be investigated and remedied if necessary.
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[Editor’s Note: Regulations governing hospices are available at www.odh.ohio.gov/rules/final/finalRules.aspx.]

3712.01 Hospice; definitions.

As used in this chapter:

(A) “Hospice care program” means a coordinated program of home, outpatient, and inpatient care and services that is operated by a person or public agency and that provides the following care and services to hospice patients, including services as indicated below to hospice patients’ families, through a medically directed interdisciplinary team, under interdisciplinary plans of care established pursuant to section 3712.06 of the Revised Code, in order to meet the physical, psychological, social, spiritual, and other special needs that are experienced during the final stages of illness, dying, and bereavement:

(1) Nursing care by or under the supervision of a registered nurse;
(2) Physical, occupational, or speech or language therapy, unless waived by the department of health pursuant to rules adopted under division (A) of section 3712.03 of the Revised Code;
(3) Medical social services by a social worker under the direction of a physician;
(4) Services of a home health aide;
(5) Medical supplies, including drugs and biologicals, and the use of medical appliances;
(6) Physician's services;
(7) Short-term inpatient care, including both palliative and respite care and procedures;
(8) Counseling for hospice patients and hospice patients’ families;
(9) Services of volunteers under the direction of the provider of the hospice care program;
(10) Bereavement services for hospice patients’ families.

“Hospice care program” does not include a pediatric respite care program.

(B) “Hospice patient” means a patient, other than a pediatric respite care patient, who has been diagnosed as terminally ill, has an anticipated life expectancy of six months or less, and has voluntarily requested and is receiving care from a person or public agency licensed under this chapter to provide a hospice care program.

(C) “Hospice patient's family” means a hospice patient’s immediate family members, including a spouse, brother, sister, child, or parent, and any other relative or individual who has significant personal ties to the patient and who is designated as a member of the patient's family by mutual agreement of the patient, the relative or individual, and the patient's interdisciplinary team.

(D) “Interdisciplinary team” means a working unit composed of professional and lay persons that includes at least a physician, a registered nurse, a social worker, a member of the clergy or a counselor, and a volunteer.

(E) “Palliative care” means treatment for a patient with a serious or life-threatening illness directed at controlling pain, relieving other symptoms, and enhancing the quality of life of the patient and the patient's family rather than treatment for the purpose of cure. Nothing in this section shall be interpreted to mean that palliative care can be provided only as a component of a hospice care program or pediatric respite care program.

(F) “Physician” means a person authorized under Chapter 4731 of the Revised Code to practice medicine and surgery or osteopathic medicine and surgery.

(G) “Attending physician” means the physician identified by the hospice patient, pediatric respite care patient, hospice patient's family, or pediatric respite care patient's family as having
primary responsibility for the medical care of the hospice patient or pediatric respite care patient.

(H) “Registered nurse” means a person registered under Chapter 4723 of the Revised Code to practice professional nursing.

(I) “Social worker” means a person licensed under Chapter 4757 of the Revised Code to practice as a social worker or independent social worker.

(J) “Pediatric respite care program” means a program operated by a person or public agency that provides inpatient respite care and related services, including all of the following services, only to pediatric respite care patients and, as indicated below, pediatric respite care patients’ families, in order to meet the physical, psychological, social, spiritual, and other special needs that are experienced during or leading up to the final stages of illness, dying, and bereavement:

(1) Short-term inpatient care, including both palliative and respite care and procedures;
(2) Nursing care by or under the supervision of a registered nurse;
(3) Physician’s services;
(4) Medical social services by a social worker under the direction of a physician;
(5) Medical supplies, including drugs and biologicals, and the use of medical appliances;
(6) Counseling for pediatric respite care patients and pediatric respite care patients’ families;
(7) Bereavement services for respite care patients’ families.

“Pediatric respite care program” does not include a hospice care program.

(K) “Pediatric respite care patient” means a patient, other than a hospice patient, who is less than twenty-seven years of age and to whom all of the following conditions apply:

(1) The patient has been diagnosed with a disease or condition that is life-threatening and is expected to shorten the life expectancy that would have applied to the patient absent the patient's diagnosis, regardless of whether the patient is terminally ill.
(2) The diagnosis described in division (K)(1) of this section occurred while the patient was less than eighteen years of age.
(3) The patient has voluntarily requested and is receiving care from a person or public agency licensed under this chapter to provide a pediatric respite care program.

(L) “Pediatric respite care patient's family” means a pediatric respite care patient's family members, including a spouse, brother, sister, child, or parent, and any other relative or individual who has significant personal ties to the patient and who is designated as a member of the patient’s family by mutual agreement of the patient, the relative or individual, and the patient's interdisciplinary team.

3712.04 Hospice licensure.

(A) Every person or public agency that proposes to provide a hospice care program shall apply to the department of health for a license. Application shall be made on forms prescribed and provided by the department, shall include such information as the department requires, and shall be accompanied by the license fee established by rules of the director of health adopted under division (A) of section 3712.03 of the Revised Code.

The department shall grant a license to the applicant if the applicant is in compliance with this chapter and rules adopted under it.

(B) A license granted under this section shall be valid for three years. Application for renewal of a license shall be made at least ninety days before the expiration of the license in the same manner as for an initial license, except that, if the program provides hospice care and services in a hospice patient’s home, the application for renewal shall include written evidence demonstrating that the applicant is in compliance with section 3712.062 of the Revised Code. The department shall renew the license if the applicant meets the requirements of this chapter and rules adopted under it.
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(C) Subject to Chapter 119 of the Revised Code, the department may suspend or revoke a license if the licensee made any material misrepresentation in the application for the license or no longer meets the requirements of this chapter or rules adopted under it.

(D) A hospital, nursing home, home for the aged, county medical care facility, or other health facility or agency that provides a hospice care program shall be licensed to provide a hospice care program under this section.

(E) A nursing home licensed under Chapter 3721 of the Revised Code that does not hold itself out to be a hospice, does not hold itself out as providing a hospice care program, does not use the term hospice to describe or refer to its activities or facilities, and that does not provide all of the services enumerated in division (A) of section 3712.01 of the Revised Code is not subject to the licensing provisions of this chapter.

3712.05 License required; legal action against unlicensed program.

(A) No person or public agency, other than a person or public agency licensed pursuant to section 3712.04 of the Revised Code, shall hold itself out as providing a hospice care program, or provide a hospice care program, or use the term "hospice" or any term containing "hospice" to describe or refer to a health program, facility, or agency.

A hospital, home providing nursing care, or home health agency that provides services under contract with a person or public agency providing a hospice care program licensed under section 3712.04 of the Revised Code or a terminal care facility for the homeless that has entered into an agreement under section 3712.07 of the Revised Code shall not be considered as providing a hospice care program in violation of this division.

This division does not apply to the activities of regional, state, or national nonprofit organizations of which providers of hospice care programs, individuals interested in hospice care programs, or both, are members and that do not provide or represent that they provide hospice care programs.

As used in this division, "person" does not include a member of an interdisciplinary team, as defined in section 3712.01 of the Revised Code, or any individual who is employed by a person or public agency licensed under section 3712.04 of the Revised Code.

(B) The department of health shall petition the court of common pleas of any county in which a person or public agency, without a license granted under section 3712.04 of the Revised Code, is holding itself out as providing a hospice care program, is providing a hospice care program, or is representing a health program, facility, or agency as a hospice care program, for an order enjoining that person or public agency from conducting those activities without a license. The court has jurisdiction to grant injunctive relief upon a showing that the respondent named in the petition is conducting those activities without a license.

Any person or public agency may request the department to petition the court for injunctive relief under this division, and the department shall do so if it determines that the person or public agency named in the request is violating division (A) of this section.

3712.06 Licensure requirements; contracting-out for service requirements.

Any person or public agency licensed under section 3712.04 of the Revised Code to provide a hospice care program shall:

(A) Provide a planned and continuous hospice care program, the medical components of which shall be under the direction of a physician;

(B) Ensure that care is available twenty-four hours a day and seven days a week;

(C) Establish an interdisciplinary plan of care for each hospice patient and his family
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(1) Is coordinated by one designated individual who shall ensure that all components of the plan of care are addressed and implemented;  
(2) Addresses maintenance of patient-family participation in decision making; and  
(3) Is periodically reviewed by the patient's attending physician and by the patient's interdisciplinary team.  
(D) Have an interdisciplinary team or teams that provide or supervise the provision of care and establish the policies governing the provision of the care;  
(E) Provide bereavement counseling for hospice patients' families;  
(F) Not discontinue care because of a hospice patient's inability to pay for the care;  
(G) Maintain central clinical records on all hospice patients under its care; and  
(H) Provide care in individuals' homes, on an outpatient basis, and on a short-term inpatient basis.

A provider of a hospice care program may arrange for another person or public agency to furnish a component or components of the hospice care program pursuant to a written contract. When a provider of a hospice care program arranges for a hospital, a home providing nursing care, or home health agency to furnish a component or components of the hospice care program to its patient, the care shall be provided by a licensed, certified, or accredited hospital, home providing nursing care, or home health agency pursuant to a written contract under which:  
(1) The provider of a hospice care program furnishes to the contractor a copy of the hospice patient's interdisciplinary plan of care that is established under division (C) of this section and specifies the care that is to be furnished by the contractor;  
(2) The regimen described in the established plan of care is continued while the hospice patient receives care from the contractor, subject to the patient's needs, and with approval of the coordinator of the interdisciplinary team designated pursuant to division (C)(1) of this section;  
(3) All care, treatment, and services furnished by the contractor are entered into the hospice patient's medical record;  
(4) The designated coordinator of the interdisciplinary team ensures conformance with the established plan of care; and  
(5) A copy of the contractor's medical record and discharge summary is retained as part of the hospice patient's medical record.

Any hospital contracting for inpatient care shall be encouraged to offer temporary limited privileges to the hospice patient's attending physician while the hospice patient is receiving inpatient care from the hospital.

3712.07 Terminal care facility for the homeless.

(A) As used in this section, “terminal care facility for the homeless” means a facility that provides accommodations to homeless individuals who are terminally ill.  
(B) A person or public agency licensed under this chapter to provide a hospice care program may enter into an agreement with a terminal care facility for the homeless under which hospice care program services may be provided to individuals residing at the facility, if all of the following apply:  
(1) Each resident of the facility has been diagnosed by a physician as having a terminal condition and an anticipated life expectancy of six months or less;  
(2) No resident of the facility has a relative or other person willing or capable of providing the care necessary to cope with the resident's terminal illness or is financially capable of hiring a person to provide such care;  
(3) Each resident of the facility is under the direct care of a physician;  
(4) No resident of the facility requires the staff of the facility to administer medication by injection;
(5) The facility does not receive any remuneration, directly or indirectly, from the residents;
(6) The facility does not receive any remuneration, directly or indirectly, from the medicaid program or the medicare program;
(7) The facility meets all applicable state and federal health and safety standards, including standards for fire prevention, maintenance of safe and sanitary conditions, and proper preparation and storage of foods.
(C) Hospice care program services may be provided at a terminal care facility for the homeless only by the personnel of the person or public agency that has entered into an agreement with the facility under this section.
(D) A terminal care facility for the homeless that has entered into an agreement under this section may assist its residents with the self-administration of medication if the medication has been prescribed by a physician and is not administered by injection. In the event that a resident has entered the final stages of dying and is no longer mentally alert, the facility may administer medication to that resident if the medication has been prescribed by a physician and is not administered by injection. Determinations of whether an individual has entered the final stages of dying and is no longer mentally alert shall be based on directions from the personnel who provide hospice care program services at the facility.

3712.08 Hospice licensing for nursing home.

The department of health shall not issue a license to conduct a new inpatient hospice care program if the program is to be conducted by a nursing home licensed under Chapter 3721 of the Revised Code.

3701-19-01 Definitions.

As used in this chapter:
(A) “Advanced Practice Nurse” means a registered nurse authorized to practice as a certified nurse specialist, certified registered nurse anesthetist, certified nurse midwife or certified nurse practitioner in accordance with section 4723.41 of the Revised Code;
(B) “Applicant” means a person or public agency that submits an application for a license to provide a hospice care program under rule 3701-19-03 of the Administrative Code.
(C) “Attending physician” means the physician identified by the hospice patient or the hospice patient's family as having primary responsibility for the hospice patient's medical care.
(D) “Dietitian” means an individual licensed under Chapter 4759 of the Revised Code to practice dietetics.
(E) “Director” means the director of health or any official or employee of the department of health designated by the director of health.
(F) “Governing body” means the entity that has ultimate responsibility and authority for the overall operation of a hospice care program, as specified in rule 3701-19-06 of the Administrative Code.
(G) “Home health aide” means an individual who, in accordance with rule 3701-19-16 of the Administrative Code, provides home care services for hospice patients and their families.
(H) “Hospice aide,” for the purpose of this chapter, means a home health aide who has successfully completed a training and competency evaluation program approved by the director under division (A) of section 3721.31 of the Revised Code and Chapter 3701-18 of the Administrative Code, is currently listed in good standing on the state nurse aide registry, and is employed by a hospice care program.
(I) “Hospice care program” or “program” means a coordinated program of home, outpatient, and inpatient care and services that is operated by a person or public agency and
that provides the following care and services to hospice patients, including services as indicated below to hospice patients’ families, through a medically directed interdisciplinary team, under interdisciplinary plans of care established pursuant to section 3712.06 of the Revised Code and rule 3701-19-11 of the Administrative Code, in order to meet the physical, psychological, social, spiritual, and other special needs that are experienced during the final stages of illness, dying, and bereavement:

(1) Nursing care by or under the supervision of a registered nurse;
(2) Physical, occupational, or speech or language therapy, unless waived by the department of health pursuant to paragraph (B) of rule 3701-19-19 of the Administrative Code;
(3) Medical social services by a social worker under the direction of a physician;
(4) Services of a home health aide;
(5) Medical supplies, including drugs and biologicals, and the use of medical appliances;
(6) Physician's services which include medical services provided by a physician or an advanced practice nurse acting within his or her scope of practice, as defined in section 4723.01 of the Revised Code, or a physician assistant acting within his or her scope of practice under the supervision, control, and direction of one or more physicians as defined in section 4730.01 of the Revised Code.
(7) Short-term inpatient care, including both palliative and respite care and procedures;
(8) Counseling for hospice patients and hospice patients’ families;
(9) Services of volunteers under the direction of the provider of the hospice care program;
(10) Bereavement services for hospice patients’ families.

(J) "Hospice patient" or "patient" means a patient who has been diagnosed as terminally ill, has an anticipated life expectancy of six months or less, and has voluntarily requested and is receiving care from a person or public agency licensed under Chapter 3712 of the Revised Code and this chapter to provide a hospice care program.

(K) "Hospice patient's family" or "family" means a hospice patient's immediate family members, including a spouse, brother, sister, child, or parent, and any other relative or individual who has significant personal ties to the patient and who is designated as a member of the patient's family by mutual agreement of the patient, the relative or individual, and the patient's interdisciplinary team.

(L) "Inpatient facility" means a facility that either is operated by or under contract with a hospice care program for the purpose of providing inpatient care to the hospice care program's patients.

(M) “Inpatient hospice facility” means a building or leased unit operated by a hospice care program that is separate and distinct from another licensed or certified facility where the hospice program directly provides accommodations and hospice services for its hospice patients.

(N) “Interdisciplinary plan of care” or “plan of care” means the interdisciplinary plan for care of a hospice patient and his or her family prepared under rule 3701-19-11 of the Administrative Code.

(O) “Interdisciplinary team” means a working unit composed of professional and lay persons that includes at least a physician, a registered nurse, a social worker, a member of the clergy or a counselor, and a volunteer.

(P) “Licensed practical nurse” means a person licensed under Chapter 4723 of the Revised Code to practice nursing as a licensed practical nurse.

(Q) “Nurse” means a registered nurse or licensed practical nurse.
(R) “Palliative care” means treatment for a patient with a serious or life-threatening illness directed at controlling pain, relieving other symptoms, and enhancing the quality of life of the patient and the patient's family rather than treatment for the purpose of cure. Nothing in this section shall be interpreted to mean that palliative care can be provided only as a component of
a hospice care program.

(S) “Person” means an individual, corporation, business trust, estate, trust, partnership, and association.

(T) “Physician” means a person authorized under Chapter 4731 of the Revised Code to practice medicine and surgery or osteopathic medicine and surgery.

(U) “Physician assistant” means a person who holds a certificate of authority to practice as a physician assistant issued under chapter 4730 of the Revised Code.

(V) “Respite care” means hospice care program services provided by the program in a patient's home or in an inpatient facility to give temporary relief to a hospice patient's family or other caregivers when the patient's family or other caregiver needs relief from the daily demands of caring for the patient.

(W) “Registered nurse” means a person registered under Chapter 4723 of the Revised Code to practice professional nursing.

(X) “Social worker” means a person licensed under Chapter 4757 of the Revised Code to practice as a social worker or independent social worker.

(Y) “Staff member” or “staff” means an individual working for a hospice care program including the owner; the administrator; a full-time, part-time or temporary paid employee; or an individual working on contract.

(Z) “Volunteer” means a lay or professional person who offers and provides his or her services to a hospice care program without compensation.

3701-19-06 Governing body; quality assessment and performance improvement.

(A) The overall conduct and operation of the hospice care program, including the quality of care and the provision of services, shall be the full legal responsibility of a clearly defined, organized governing body.

(B) The governing body of a licensed hospice care program may also provide governance for a pediatric respite care program if the programs are dually-licensed and meet all requirements set forth in this rule and Chapter.

(C) The governing body shall:

1. Establish and review policies for the management, operation, and evaluation of the hospice care program, including, but not limited to:
   a. Qualifications of employees and independent contractors; and
   b. Policies and procedures to receive and respond to patient grievances regarding medical treatment, quality of care, the lack of respect for person or property, mistreatment, neglect, verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by any individual furnishing services on behalf of the hospice care program. The policies and procedures developed by the governing body shall, at a minimum, include:
      i. Notification procedures for hospice patients, employees and contracted staff to report alleged violations to the hospice program administration;
      ii. Documentation requirements for reported alleged violations, including time frames for response;
      iii. Reporting procedures for verified violations to the appropriate state licensing authority, local authorities, or both where appropriate; and
      iv. Requirements for timely corrective actions for all verified violations.
2. Arrange for a physician to serve as medical director for the hospice care program who:
   a. Shall be knowledgeable about the psychological, social, and medical aspects of hospice care as the result of training, experience, and interest;
   b. May also serve as the physician representative on an interdisciplinary team or teams.
or as an attending physician; and
(c) Shall designate a physician to act in his or her absence.
(3) Appoint a qualified individual to serve as the director of the hospice care program who shall perform the following duties:
(a) Be responsible for the day-to-day management of the program and for assuring compliance with Chapter 3712 of the Revised Code, Chapter 3701-13, and this chapter of the Administrative Code;
(b) Implement the hospice care program's policies and procedures regarding all activities and services provided by the hospice care program;
(c) Designate an individual to act in his or her absence;
(d) Implement the hospice care program's quality assessment and performance improvement program under paragraph (D) of this rule;
(e) Implement the hospice care program's patient grievance program established under paragraph (C)(1) of this rule.
(f) Implement the drug diversion investigation and reporting program required by section 3712.062 of the Revised Code. The hospice director or the director's designee, must:
(i) Receive reports of suspected drug diversion from hospice staff;
(ii) Within twenty four hours of receipt, investigate reports of suspected drug diversion;
and
(iii) No later than ten days after receipt of a report of suspected drug diversion or upon conclusion of an investigation, report to the law enforcement agency with jurisdiction over the territory in which the hospice patient's home is located the results of the hospice program's investigation when the investigation substantiates that drug diversion has occurred or when the results of the investigation are inconclusive. Nothing in this rule prohibits a hospice care program from reporting the result of any other drug diversion investigation to law enforcement.
(4) Designate a registered nurse that is a member of an interdisciplinary team to coordinate the overall functioning of the team; and
(5) Ensure that all services provided are consistent with accepted standards of practice for hospice care.
(D) Each hospice care program governing body shall ensure that an ongoing, comprehensive, integrated, self-assessment of the quality and appropriateness of care provided by the program, including inpatient care, home care, and care provided under contracts with other persons or public agencies is conducted. The assessment shall include all services that were indicated and provided to the hospice care patients and their families and the patients’ and caregivers' responses or outcomes to those services.
(E) The hospice care program governing body shall ensure the use of the findings of the quality assessment and performance improvement program to correct identified problems and to revise hospice care program policies if necessary.
(F) The hospice care program governing body shall ensure that an evaluation of the hospice care program's quality assessment and performance improvement program is conducted on an annual basis.

3701-19-07 General requirements for hospice care programs after licensure.

(A) Any person or public agency licensed under section 3712.04 of the Revised Code and this chapter to provide a hospice care program shall:
(1) Provide a planned and continuous hospice care program, the medical components of which shall be under the direction of a physician;
(2) Ensure that care is available twenty-four hours a day and seven days a week;
(3) Establish an interdisciplinary plan of care for each hospice patient and the patient's family that:
(a) Is coordinated by one designated individual who shall ensure that all components of the plan of care are addressed and implemented;
(b) Addresses maintenance of patient-family participation in decision making;
(c) Is periodically reviewed by the patient's attending physician and by the patient's interdisciplinary team; and
(d) Provides a list of services that will be provided by or arranged for by the hospice care program.
(4) Have an interdisciplinary team or teams that provide or supervise the provision of care and establish the policies governing the provision of care;
(5) Provide bereavement counseling for hospice patients' families.
(6) Not discontinue care because of a hospice patient's inability to pay for the care;
(7) Maintain central clinical records on all hospice patients under its care.
(8) Provide care in individual's homes, on an outpatient basis, and on a short-term inpatient basis; and
(B) A component or components of the care provided by a hospice care program may be provided under a written contract with another person or public agency, pursuant to rule 3701-19-12 of the Administrative Code
(C) After receiving a license, a hospice care program shall comply with all requirements of Chapter 3712 of the Revised Code and Chapters 3701-13 and 3701-19 of the Administrative Code.
(D) Each licensed hospice care program shall notify the director, in writing, of any of the following:
   (1) Any change in any of the information specified in the license application under paragraphs (C)(1) to (C)(3) of rule 3701-19-03 of the Administrative Code no later than fifteen days after the change;
   (2) Any other change that would render the information submitted in the license application inaccurate at least twenty-one days prior to the effective date of the change; and
   (3) Any intent to cease operation at least sixty days prior to ceasing operation. This notification shall include a plan for assuring continuity of care for the program's patients and their families after the program ceases operation.
(4) Each hospice care program that intends to cease operation shall do the following to assure the continuity of care of hospice program patients and their families by:
   (a) Providing a written notice of the proposed closure of the program, at least sixty days prior to ceasing operation, to each patient or patient's family;
   (b) Developing a written discharge plan to be placed in each patient's record to assist the person or public agency that will be responsible for care of the patient and his or her family after the program ceases operation; and
   (c) Obtaining from each patient or his or her authorized representative a written approval of any transfer to another licensed hospice care program and a written authorization to release pertinent clinical records information to such a program or another person or public agency that will assume responsibility for the patient's and family's care.

3701-19-08 Standards for inpatient hospice facilities.

(A) Each new inpatient hospice facility shall be inspected by the director to determine compliance with provisions of rules 3701-19-01 to 3701-19-24 of the Administrative Code. The new inpatient hospice facility shall not admit patients until the director has determined that the facility is in compliance with the requirements of this chapter of the Administrative Code.
(B) The inpatient hospice facility shall meet all applicable provisions of the Ohio fire code, adopted pursuant to section 3737.82 of the Revised Code.
(C) The building or buildings in which an inpatient hospice facility is located shall comply
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with the applicable provisions of the Ohio building code adopted by the board of building standards pursuant to Chapters 3781., 3783., and 3791 of the Revised Code, and have a certificate of use and occupancy issued by the appropriate building authority.

(D) Each new inpatient hospice facility shall be connected to one of the following dependent upon the location and size of the facility:
   (1) A public sewer system permitted under Chapter 6111 of the Revised Code;
   (2) A small flow on site sewage treatment system permitted by a local health district under Chapter 3718 of the Revised Code; or
   (3) A household sewage treatment system permitted by a local health district under Chapter 3718 of the Revised Code.

(E) Each new inpatient hospice facility shall comply with the following requirements by:
   (1) Maintaining appropriate space providing optimal comfort and privacy for patients and family members designed and equipped for the comfort and privacy of each patient and family members by:
      (a) Providing decor which is homelike in design and function;
      (b) Providing accommodations for family members to remain with the patient;
      (c) Ensuring physical space for private patient and family visiting and allowing patients to receive visitors, including small children, at any hour;
   (2) Maintaining appropriate patient rooms designed and equipped for adequate nursing care, comfort, and privacy of patients. Each room must:
      (a) Be equipped with or conveniently located near toilet and bathing facilities;
      (b) Be at or above grade level;
      (c) Contain an appropriate bed and other appropriate furniture;
      (d) Have closet space providing security and privacy for clothing and personal belongings;
      (e) Contain no more than four beds;
      (f) Measure at least one hundred square feet for a single patient room or eighty square feet for each patient for a multipatient room;
      (g) Be equipped for calling the staff member on duty.
   (3) Maintaining appropriate bathroom facilities and plumbing and provide:
      (a) An adequate supply of hot water at all times for patient use; and
      (b) Plumbing fixtures with control valves that automatically regulate the temperature of the hot water used by patients.
   (4) Each facility shall provide appropriate linens at all times in a quantity for the proper care and comfort of patients. Linens must be handled, stored, processed, and transported in a manner that prevents the spread of infection.
   (5) Each facility shall have provisions for isolating patients with infectious diseases.
   (6) Each facility must provide meal service. A hospice facility providing its own meal service must:
      (a) Obtain an appropriate food service license, unless exempt in accordance with section 3717.42 of the Revised Code, or contracting with another licensed food service provider;
      (b) Serve at least three meals or their equivalent each day at regular times, with not more than fourteen hours between a substantial evening meal and breakfast;
      (c) Procure, store, prepare, distribute and serve all food under sanitary conditions;
      (d) Have a staff member trained or experienced in food management or nutrition who is responsible for:
         (i) Planning menus that meet the nutritional needs of each patient, following the orders of the patient's physician and, to the extent medically possible, the dietary allowances recommended by the national academy of sciences;
         (ii) Supervising the meal preparation and service to ensure that the menu plan is followed;
(7) Each facility must provide pharmaceutical services and must:
   (a) Provide appropriate methods and procedures for dispensing, administering and
disposing of drugs and biologicals;
      (i) The facility is responsible for drugs and biologicals for its patients, whether drugs or
biologicals are obtained from community or institutional pharmacists or stocked by the facility;
      (ii) The facility must ensure that pharmaceutical services are provided in accordance
with accepted professional principles and appropriate federal, state and local laws;
   (b) Employ a pharmacist or have a formal agreement with a licensed pharmacist to
advise the facility on ordering, storage, administration, disposal and recordkeeping of drugs and
biologicals;
   (c) Ensure that orders for medications are given by a physician, physician assistant, or
an advanced practice nurse acting within his or her scope of practice;
      (i) If the medication order is verbal, the physician, physician assistant, or advanced
practice nurse must give it only to a licensed nurse, pharmacist, or another physician; and
      (ii) The individual receiving the order must record and sign it immediately and have the
prescribing physician, physician assistant, or advanced practice nurse sign it in a manner
consistent with good medical practice.

3701-19-09 General requirements for hospice care program personnel.

   (A) Each hospice care program shall utilize personnel that have appropriate training and
qualifications for the services that they provide. Any staff member, including a volunteer, who
functions in a professional capacity shall meet the standards applicable to that profession,
including but not limited to possessing current Ohio licensure, registration, or certification, if
required by law, and practicing within the applicable scope of practice.
   (B) The hospice care program shall provide each staff member, including volunteer and
contracted staff members, with a written job description delineating his or her responsibilities.
The program shall assure that the services provided by staff members, including volunteers and
contracted staff, are provided:
      (1) In accordance with the patients’ plans of care;
      (2) In accordance with the policies and procedures developed by the interdisciplinary
team;
      (3) In accordance with current and accepted standards of practice;
      (4) By staff members who comply with the program's employee health policies;
         (a) The hospice care program shall have written employee health policies which include
the following requirements for any staff, including volunteers, temporary agency employees, or
paid consultants used by the hospice program who has direct patient contact;
      (b) The hospice care program shall have a written plan to ensure the health and safety
of hospice patients that includes policies and procedures regarding screening of staff, including
volunteers, for communicable diseases.
      (c) The hospice care program shall have written policies and procedures regarding
measures taken to prevent staff, including volunteers, with direct hospice patient contact who
have been diagnosed with a communicable disease from transmitting this disease to patients,
care givers or other staff. The policies shall indicate when infected or ill staff must not render
direct patient care; and
      (d) The hospice care program shall document, as applicable, compliance with United
States department of labor’s occupational safety and health administration, United States.
centers for disease control and prevention and applicable Ohio department of health standards
concerning health requirements for staff provision of services in health care settings, including
requirements for maintaining tuberculosis control.
      (5) Documented in the patient’s central clinical record.
(C) Each hospice care program shall ensure that all personnel treat each patient and each patient's property with respect, do not abuse or neglect patients, and do not misappropriate a patient's property.

(D) Each hospice care program shall employ personnel without discrimination on the basis of sex, age, race, creed, national origin, or handicap.

(E) Each hospice care program shall provide both orientation and ongoing training program for its personnel, including volunteers.
   (1) The orientation shall be appropriate to the tasks each member will be expected to perform; and
   (2) The continuing training shall be designed to assure maintenance of appropriate skill levels and ensure that all personnel are informed of changes in techniques, philosophies, and goals of the hospice care program.

(F) Each hospice care program shall evaluate the performance of each staff member regularly.

(G) Except as provided in Chapter 3701-13 of the Administrative Code, no hospice care program shall employ a person who applies on or after January 27, 1997, for a position that involves the provision of direct care to an older adult, if the person:
   (1) Has been convicted of or pleaded guilty to an offense listed in division (C)(1) of section 3712.09 of the Revised Code; or
   (2) Fails to complete the form(s) or provide fingerprint impressions as required by division (B)(3) of section 3712.09 of the Revised Code.

3701-19-10 Medical director.

(A) The medical director of a hospice care program shall be a physician and have overall responsibility for the medical components of the program. The medical director shall be either a paid or contractual staff member or a volunteer.

(B) The duties of the medical director shall include:
   (1) Participating as a member of the interdisciplinary team or teams in the development of individual plans of care or assuring that one or more other qualified physicians participate on the team or teams;
   (2) Reviewing patient medical eligibility for hospice care services;
   (3) Consulting with attending physicians, when appropriate, regarding pain and symptom management;
   (4) Assuring overall continuity of the hospice care program's medical services, including availability of physician services for both routine and emergency situations;
   (5) Acting as liaison between patients' attending physicians and the interdisciplinary team or teams;
   (6) Establishing health policies for employees of the hospice care program; and
   (7) Serving as liaison with community physicians, medical schools, healthcare facilities, and hospitals.

3701-19-11 Interdisciplinary team and interdisciplinary plan of care.

(A) Each hospice care program shall have an interdisciplinary team or teams that provides or supervises the provision of hospice care and services. The registered nurse designated to coordinate each interdisciplinary team shall ensure all of the following for that team:
   (1) There is ongoing assessment of the hospice patient's and family's needs;
   (2) That all components of the plan of care are addressed by the interdisciplinary team; and
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Hospice Care General Provisions

3701-19-12 Contracted services.

(A) A provider of a hospice care program may arrange for another person or public agency to furnish a component or components of the hospice care program pursuant to a written contract in compliance with 42 C.F.R. 418.64 (2008).

(B) Any contract executed under paragraph (A) of this rule, including a contract to which paragraph (C) of this rule applies, shall be legally binding on both parties and shall do all of the following:

(1) Identify the services that may be provided;

(2) Stipulate that services may be provided only with the express authorization of the
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hospice care program;

(3) Describe the manner in which the contracted services are coordinated, supervised, and evaluated by the hospice care program;

(4) Delineate the role or roles of the hospice care program and the contractor in the admission process, patient and family assessment, and the interdisciplinary team reviews;

(5) Stipulate the requirements for documenting that services are furnished in accordance with the contract and the requirements of Chapter 3712 of the Revised Code, Chapter 3701-13 and this chapter of the Administrative Code;

(6) Set forth the qualifications of the personnel providing the services; and

(7) Stipulate that the hospice care program shall provide hospice care orientation and training, in accordance with paragraph (E) of rule 3701-19-09 of the Administrative Code, to the contractor's personnel who provide the care under the contract.

(C) When a provider of a hospice care program arranges for a hospital, a home providing nursing care, or home health agency to furnish a component or components of the hospice care program to its patient, the care shall be provided by a licensed, certified, or accredited hospital, home providing nursing care, or home health agency pursuant to a written contract under which:

(1) The provider of hospice care program furnishes to the contractor a copy of the hospice patient's interdisciplinary plan of care that is established under division (C) of section 3712.06 of the Revised Code and rule 3701-19-11 of the Administrative Code and specifies the care that is to be furnished by the contractor;

(2) The regimen described in the established plan of care is continued while the hospice patient receives care from the contractor, subject to the patient's needs, and with approval of the coordinator of the interdisciplinary team designated pursuant to division (C)(1) of section 3712.06 of the Revised Code and paragraph (A) of rule 3701-19-11 of the Administrative Code;

(3) All care, treatment, and services furnished by the contractor are entered into the hospice patient's medical record;

(4) The designated coordinator of the interdisciplinary team ensures conformance with the established plan of care;

(5) A copy of the contractor's medical record and discharge summary is retained as part of the hospice patient's medical record; and

(6) The contractor complies with the requirements of Chapter 3712 of the Revised Code, and this chapter as applicable to the contracted service.

(D) The hospice care program shall encourage any hospital contracting for inpatient care to offer temporary limited privileges to the hospice patient's attending physician while the hospice patient is receiving inpatient care from the hospital.

(E) The hospice care program shall assure the continuity of patient and family care in the home, outpatient, and inpatient settings.

(F) The hospice care program shall retain professional management responsibility for contracted services and shall ensure that those services are furnished in a safe and effective manner, by persons meeting the qualifications prescribed by Chapter 3701-13 and this chapter of the Administrative Code, and in accordance with the patient's plan of care and the other requirements of this chapter.

(G) The hospice care program shall retain responsibility for payment for services provided by a contractor which are related to the palliation and management of the terminal illness, arranged for by the hospice care program, and included in the patient's plan of care.

(H) The hospice care program may contract with a durable medical equipment supplier, only if that supplier meets the medicare supplier quality and accreditation standards at 42 C.F.R. 424.57 (2011) and, as applicable, the requirements of Chapter 4752 of the Revised Code.
3701-19-13 Volunteer services.

(A) Each hospice care program shall use trained volunteers to assist with the provision of administrative or direct patient care services and shall have trained volunteers available to hospice patients and hospice patients' families as needed. Volunteers shall provide services under the supervision of a designated qualified and experienced hospice staff member.

(B) Each hospice care program shall provide orientation and training to the volunteers it uses that is consistent with acceptable standards of hospice practice. The orientation and training shall include:

1. The hospice care program's goals and services;
2. Confidentiality and the protection of patient and family rights;
3. The volunteer's specific duties and responsibilities and the person or persons to contact if the volunteer needs assistance or instructions regarding the performance of the designated duties and responsibilities;
4. Procedures for responding to medical emergencies or deaths;
5. The physiological and psychological aspects of terminal illness;
6. Family dynamics, coping mechanisms, and psychosocial issues surrounding terminal illness, death, and bereavement;
7. Safety policies and procedures; and
8. General communication skills.

(C) The hospice care program shall document active and ongoing efforts to recruit and retain volunteers.

3701-19-14 Nursing services.

(A) Each hospice care program shall provide nursing care and services by or under the supervision of a registered nurse. The program shall direct and staff nursing services to meet the nursing needs of all of the hospice care program's patients. The program shall specify the patient care responsibilities of nursing personnel.

(B) A registered nurse shall be responsible for the supervision and oversight of all nursing services.

(C) As used in this rule, “supervision” means monitoring and directing the provision of nursing care and services by record review, written or verbal instructions, review of interdisciplinary care plans, or direct observation.

(D) The hospice care program shall ensure that nursing care is available twenty-four hours a day and seven days a week:

1. To provide services to hospice care program patient's; and
2. In each inpatient facility used to provide inpatient care to its patients.

(E) The registered nurse who provides or supervises the provision of nursing services also may serve as the interdisciplinary team coordinator or team member.

3701-19-15 Medical social services.

(A) Each hospice care program shall make medical social services available to each patient and his or her family as needed. Medical social services shall be provided by a social worker under the direction of a physician. For the purposes of this rule, a physician's approval of a patient's interdisciplinary plan of care shall constitute direction.

(B) The medical social service needs of each hospice patient and his or her family shall be considered in conjunction with other services when the interdisciplinary team reviews the patient's and family's status.

(C) Medical social services shall be provided in a timely manner in accordance with
hospice care program's policy.

3701-19-16 Home care services.

(A) Each hospice care program shall provide or make available home care services in the scope and frequency required to meet the needs of the hospice care program's patients and their families. Home care services include assistance with activities of daily living, personal care, ambulation and exercise, household services essential to health care at home, assistance with self-administration of medications, and preparation of meals. The patient and family shall be informed of any limitations on home care services as required by paragraph (E) of rule 3701-19-20 of the Administrative Code.

(B) Home care services shall be provided by home health aides or hospice aides who have been selected on the basis of such factors as a sympathetic attitude toward patients and their families, ability to read, write, and carry out instructions, and maturity and ability to cope with the demands of the job.

(C) The hospice care program shall ensure that home health aides or hospice aides providing home care services have been trained in methods of assisting patients to achieve maximum self-reliance, principles of nutrition and meal preparation, the aging process and emotional problems of illness, procedures for maintaining a clean, healthful, and pleasant environment, changes in a patient's condition that should be reported, the philosophy of hospice care and of the hospice care program, ethics, confidentiality, and recordkeeping.

(D) A registered nurse from the patient's interdisciplinary team shall prepare for each home health aide or hospice aide written instructions for patient care which are consistent with the interdisciplinary plan of care.

(E) The registered nurse responsible for preparing written instructions for home health aides and hospice aides shall make and document a supervisory visit to the patient's residence at least every two weeks when home health aide or hospice aide services are being provided to assess the provision of the home health aide or hospice aide services.

1) The supervisory visit may be made either when the home health aide or hospice aide is present or when the aide is absent; and
2) The purpose of the visit shall be to observe and assist the home health aide or hospice aide, if present; to assess the patient's and family's relationship with the home health aide or hospice aide, and to determine whether the patient's and family's needs and goals are being met; and
3) The supervisory visit may be conducted in conjunction with a visit for other purposes.

3701-19-17 Medical services.

(A) A hospice care patient may identify their own attending physician or may designate the hospice care program medical director to be their attending physician.

(B) Each hospice care program shall provide:

1) Effective palliation and management of terminal illness and related conditions; and
2) Medical services which meet the medical needs of the patient that are not otherwise met by the patient's:

a) Attending physician;
b) A physician assistant, who is acting within his or her scope of practice under the supervision, control, and direction of a physician; or
(c) An advanced practice nurse, who is acting within his or her scope of practice and who is working in collaboration with a physician.

(C) All medical orders for treatment, procedures, tests, and medications shall be signed by: 

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(1) A physician;
(2) A physician assistant, who is acting within his or her scope of practice under the supervision, direction, and control of a physician; or
(3) An advanced practice nurse, who is acting within his or her scope of practice and who is working in collaboration with a physician.

3701-19-18 Counseling and bereavement services.

(A) Each hospice care program shall make available counseling services to the hospice patient and the hospice patient's family. Counseling services shall include dietary, spiritual, bereavement and any other necessary counseling services while the patient is enrolled in the hospice care program. Counseling services shall be provided by a qualified interdisciplinary team member or one or more other qualified individuals, as determined by the hospice care program.

(B) Counseling services shall be organized to meet the needs of the hospice patients and their families.

(1) The hospice care program shall assess the needs of patients and families for spiritual counseling, in accordance with their religious preferences.

(2) The hospice care program shall provide dietary counseling. Dietary counseling shall include use of food and mealtime to promote quality of life for hospice patients and to meet their needs for symptom control. Dietary counseling shall be planned and provided by or under the supervision of a dietitian or, if the program is unable to obtain the services of a dietitian, by a nurse.

(C) The hospice care program shall make reasonable efforts to arrange for visits of clergy and other members of religious organizations in the community to patients who request visits and shall apprise patients of this opportunity.

(D) Each hospice care program shall provide bereavement services, as needed, for hospice patients' families. These services shall be provided for up to one year after the patient's death. Bereavement services shall be provided under the supervision of a designated qualified professional.

(1) The professional designated to supervise bereavement services shall have education or experience or both in providing those services.

(2) Bereavement services shall be based on an assessment of the family's needs and its ability to cope with grief.

(3) The plan of care for bereavement services shall reflect family needs and shall specify the frequency services are to be delivered and the persons furnishing the services.

3701-19-19 Physical therapy, occupational therapy, and speech therapy services.

(A) Each hospice care program shall provide or arrange for the provision of physical therapy, occupational therapy, or speech or language therapy unless the provision of those services is waived by the director pursuant to division (A)(4) of section 3712.03 of the Revised Code and paragraph (B) of this rule. The services shall be adequate in frequency to meet the needs of the hospice patients.

(B) Physical therapy services, occupational therapy services and speech or language therapy services must be offered in a manner consistent with accepted standards of practice for the provision of service to hospice patients.

(C) The director may waive the requirement for providing physical therapy, occupational therapy, or speech or language therapy when the requirement would create a hardship because the therapy is not readily available in the geographic area served by the provider of the hospice care program. A request for a waiver under this paragraph shall be submitted to the director in
writing and shall be accompanied by documentation of the number and location of therapists in
the area served by the program and of the efforts that the program has made to engage those
therapists and to encourage other therapists to serve the area.

(D) Physical therapy shall be provided by a person who is licensed as a physical
therapist under Chapter 4755 of the Revised Code and who meets the requirements under
Chapter 3701-13 of the Administrative Code.

(E) Occupational therapy shall be provided by a person who is licensed as an
occupational therapist under Chapter 4755 of the Revised Code and who meets the
requirements under Chapter 3701-13 of the Administrative Code.

(F) Speech or language therapy shall be provided by a person who is licensed as a
speech pathologist or audiologist under Chapter 4753 of the Revised Code and who meets the
requirements under Chapter 3701-13 of the Administrative Code.

3701-19-20 Admission of patients to the hospice care program.

(A) A hospice care program shall not admit any individual who does not meet the
diagnosis and life expectancy requirements of a hospice patient defined in paragraph (J) of rule
3701-19-01 of the Administrative Code.

(B) A hospice care program shall admit patients, provide care and services, and
discharge or transfer patients without discrimination on the basis of sex, age, race, creed,
national origin, or handicap.

(C) A hospice care program shall require that the patient, or the patient's authorized
representative, sign an informed consent form. This form shall include an acknowledgment by
signature of the patient or patient's representative, that they have been given a full explanation
of the palliative rather than curative nature of hospice care as it relates to the patient's terminal
illness and have been informed that the patient may withdraw consent at any time.

(D) A hospice care program shall permit a hospice patient to withdraw consent for
hospice care at any time.

(E) A hospice care program shall provide a patient or the patient's representative with
information regarding the scope of services provided by the hospice care program, including
any limitations of the hospice care program and charges for the services.

(F) A hospice care program shall distribute a copy of the written policy established under
division (A) of this section 3712.062 of the Revised Code and paragraph (C) of rule 3701-19-21
of the Administrative Code, to the patient and patient's family and discuss the procedures
included in the policy with the patient and patient's family before providing hospice care and
services;

(G) Prior to or within forty-eight hours after admission of each patient, a hospice care
program shall obtain an oral statement from the patient's attending physician, if any, and the
medical director of the hospice care program or the physician member of the interdisciplinary
team certifying that the patient is terminally ill. The program shall obtain written confirmation of
the oral statement after admission. The written certification statement shall be signed by the
patient's attending physician, if any, and the medical director of the hospice care program or the
physician member of the interdisciplinary team.

(1) The program should obtain from each patient's attending physician, if any,
designation of an alternate physician to contact for emergency care of the patient or review of
the patient's plan of care when the attending physician is not available; and

(2) The hospice care program should obtain written confirmation of the oral statement
certifying that the patient is terminally ill within a reasonable period of time after admission,
which is recommended to be not more than twenty-one days or within other acceptable written
standards of practice guidelines.
3701-19-21 Medical supplies, drugs, and biologicals.

(A) Each hospice care program shall arrange for provision of medical supplies, appliances, drugs, and biologicals to hospice patients as needed for the palliation and management of the patient's terminal illness and related conditions. The program shall ensure that drugs and biologicals are available at all times.

(B) Each hospice care program shall ensure that drugs and biologicals are administered only by the following individuals:

   (1) A registered nurse, a licensed practical nurse, or a physician;
   (2) A patient or a family member if approved by the attending physician; or
   (3) Any other individual authorized by the Revised Code to perform this task.

(C) The individuals authorized to administer drugs or biologicals under paragraphs (B)(2) and (B)(3) of this rule and the drugs or biologicals they are authorized to administer shall be specified in the patient's plan of care.

(D) Each hospice care program licensed under this chapter that provides hospice care and services in a hospice patient's home shall establish a written policy establishing procedures to be followed in preventing the diversion of controlled substances containing opioids that are prescribed to its hospice patients. The policy shall include procedures for the disposal of any such drugs prescribed to a hospice patient as part of the patient's interdisciplinary plan of care that are relinquished to the program after the patient's death or that otherwise are no longer needed by the patient. The policy shall require that the disposal be documented by a program employee and conducted in any of the following ways:

   (1) Performed by a program employee and witnessed by the patient or patient's family member;
   (2) Performed by the patient or patient's family member and witnessed by a program employee;
   (3) Performed by a program employee and witnessed by another program employee.

(E) Each hospice care program shall ensure that the patient, patient's representative, and the patient's family receive a copy of the hospice care program's written policies and procedures along with education on the management and disposal of controlled drugs when a controlled substance is ordered, and document such actions in the patient's clinical record.

5160-56-03.3 Hospice services; reporting requirements.

This rule sets forth the requirement for recording the hospice provider span for individuals receiving medicaid hospice care in accordance with Chapter 5160-56 of the Administrative Code, including individuals who may be covered by third-party insurance, such as medicare, for which the hospice seeks reimbursement.

(A) The designated hospice shall report the required enrollment information to the Ohio department of medicaid using the medicaid information technology system (MITS) for the following:

   (1) Individuals in fee-for-service (FFS) medicaid hospice under the designated hospice's care on the effective date of this rule; and
   (2) Individuals in which the hospice seeks to file an original or adjusted claim to ODM for medicaid hospice services rendered under codes T2042 and T2046, including:

      (a) All individuals with FFS claims for routine home care, code T2042, for the dates of service on or after January 1, 2016, whether or not the claim has previously been submitted and paid.
      (b) Individuals in the care of hospice prior to the effective date of this rule, if the provider is submitting an original FFS claim for hospice services other than the services specified in paragraph (A)(2)(a) of this rule.
(c) Individuals in the care of hospice prior to the effective date of this rule, if the provider is submitting an adjusted FFS claim or if ODM must adjust a FFS claim for hospice services other than the services specified in paragraph (A)(2)(a) of this rule.

(B) The designated hospice shall ensure the following information is entered into MITS prior to submitting a claim for reimbursement:

(1) The individual's recipient identification number (also referred to as the medicaid billing number) as shown on the individual's medicaid card;

(2) The date the individual elected hospice;

(3) The begin date and end date of every benefit period recognized under paragraph (D) of rule 5160-56-02 of the Administrative Code. For each benefit period, the designated hospice shall identify the benefit period as either the initial one time ninety-day period, the subsequent one time ninety-day period, or one of the subsequent unlimited sixty-day periods as applicable;

(4) The national provider identifier for the medical doctor who serves on the hospice interdisciplinary group (IDG) for each benefit period;

(5) The national provider identifier for the attending physician or the advanced practice registered nurse for each benefit period;

(6) The oral certification date(s), if applicable;

(7) The written physician certification date(s);

(8) The hospice terminal illness diagnosis code(s);

(a) At least one but not more than three terminal diagnosis codes for the individual;

(b) The effective dates (begin and ending date) that apply to the terminal diagnosis code(s) shall be entered in MITS by the designated hospice;

(9) The county (or counties if more than one) where hospice services were or will be provided during the benefit period;

(10) The national provider identifier of the long term care facility (LTFC) and the corresponding effective date and end date, if the individual resides in a LTCF and provider will be billing for hospice room and board services;

(11) Supporting documentation, as required to be attached to the claim, including:

(a) Copy of the current certification of the terminal illness;

(b) Copy of the individual's election statement;

(12) The date of death, when applicable; and

(13) Any updates or changes to be made to the benefit period as a result of a discharge pursuant to rule 5160-56-03 of the Administrative Code.

(C) The information specified in paragraph (B) of this rule shall be submitted to ODM only through the system in accordance with the requirements of the MITS system.

Part V. Nursing Homes

[Editor's Note: Additional provisions governing nursing homes are available at www.odh.ohio.gov/rules/final/finalrules.aspx.]

3721.01 Defining and classifying facility restrictions.

(A) As used in sections 3721.01 to 3721.09 and 3721.99 of the Revised Code:

(1)(a) “Home” means an institution, residence, or facility that provides, for a period of more than twenty-four hours, whether for a consideration or not, accommodations to three or more unrelated individuals who are dependent upon the services of others, including a nursing home, residential care facility, home for the aging, and a veterans' home operated under Chapter 5907 of the Revised Code.

(b) “Home” also means both of the following:
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(i) Any facility that a person, as defined in section 3702.51 of the Revised Code, proposes for certification as a skilled nursing facility or nursing facility under Title XVIII or XIX of the “Social Security Act,” 49 Stat. 620 (1935), 42 U.S.C.A. 301, as amended, and for which a certificate of need, other than a certificate to recategorize hospital beds as described in section 3702.521 of the Revised Code or division (R)(7)(d) of the version of section 3702.51 of the Revised Code in effect immediately prior to April 20, 1995, has been granted to the person under sections 3702.51 to 3702.62 of the Revised Code after August 5, 1989;

(ii) A county home or district home that is or has been licensed as a residential care facility.

(c) “Home” does not mean any of the following:

(i) Except as provided in division (A)(1)(b) of this section, a public hospital or hospital as defined in section 3701.01 or 5122.01 of the Revised Code;

(ii) A residential facility as defined in section 5119.34 of the Revised Code;

(iii) A residential facility as defined in section 5123.19 of the Revised Code;

(iv) A community addiction services provider as defined in section 5119.01 of the Revised Code;

(v) A facility licensed to provide methadone treatment under section 5119.391 of the Revised Code;

(vi) A facility providing services under contract with the department of developmental disabilities under section 5123.18 of the Revised Code;

(vii) A facility operated by a hospice care program licensed under section 3712.04 of the Revised Code that is used exclusively for care of hospice patients;

(viii) A facility operated by a pediatric respite care program licensed under section 3712.041 of the Revised Code that is used exclusively for care of pediatric respite care patients;

(ix) A facility, infirmary, or other entity that is operated by a religious order, provides care exclusively to members of religious orders who take vows of celibacy and live by virtue of their vows within the orders as if related, and does not participate in the medicare program or the medicaid program if on January 1, 1994, the facility, infirmary, or entity was providing care exclusively to members of the religious order;

(x) A county home or district home that has never been licensed as a residential care facility.

(2) “Unrelated individual” means one who is not related to the owner or operator of a home or to the spouse of the owner or operator as a parent, grandparent, child, grandchild, brother, sister, niece, nephew, aunt, uncle, or as the child of an aunt or uncle.

(3) “Mental impairment” does not mean mental illness, as defined in section 5122.01 of the Revised Code, or developmental disability, as defined in section 5123.01 of the Revised Code.

(4) “Skilled nursing care” means procedures that require technical skills and knowledge beyond those the untrained person possesses and that are commonly employed in providing for the physical, mental, and emotional needs of the ill or otherwise incapacitated. “Skilled nursing care” includes, but is not limited to, the following:

(a) Irrigations, catheterizations, application of dressings, and supervision of special diets;

(b) Objective observation of changes in the patient’s condition as a means of analyzing and determining the nursing care required and the need for further medical diagnosis and treatment;

(c) Special procedures contributing to rehabilitation;

(d) Administration of medication by any method ordered by a physician, such as hypodermically, rectally, or orally, including observation of the patient after receipt of the medication;

(e) Carrying out other treatments prescribed by the physician that involve a similar level of complexity and skill in administration.
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(5)(a) “Personal care services” means services including, but not limited to, the following:
   (i) Assisting residents with activities of daily living;
   (ii) Assisting residents with self-administration of medication, in accordance with rules adopted under section 3721.04 of the Revised Code;
   (iii) Preparing special diets, other than complex therapeutic diets, for residents pursuant to the instructions of a physician or a licensed dietitian, in accordance with rules adopted under section 3721.04 of the Revised Code.

(b) “Personal care services” does not include “skilled nursing care” as defined in division (A)(4) of this section. A facility need not provide more than one of the services listed in division (A)(5)(a) of this section to be considered to be providing personal care services.

(6) “Nursing home” means a home used for the reception and care of individuals who by reason of illness or physical or mental impairment require skilled nursing care and of individuals who require personal care services but not skilled nursing care. A nursing home is licensed to provide personal care services and skilled nursing care.

(7) “Residential care facility” means a home that provides either of the following:
   (a) Accommodations for seventeen or more unrelated individuals and supervision and personal care services for three or more of those individuals who are dependent on the services of others by reason of age or physical or mental impairment;
   (b) Accommodations for three or more unrelated individuals, supervision and personal care services for at least three of those individuals who are dependent on the services of others by reason of age or physical or mental impairment, and, to at least one of those individuals, any of the skilled nursing care authorized by section 3721.011 of the Revised Code.

(8) “Home for the aging” means a home that provides services as a residential care facility and a nursing home, except that the home provides its services only to individuals who are dependent on the services of others by reason of both age and physical or mental impairment.

   The part or unit of a home for the aging that provides services only as a residential care facility is licensed as a residential care facility. The part or unit that may provide skilled nursing care beyond the extent authorized by section 3721.011 of the Revised Code is licensed as a nursing home.

(9) “County home” and “district home” mean a county home or district home operated under Chapter 5155 of the Revised Code.

(B) The director of health may further classify homes. For the purposes of this chapter, any residence, institution, hotel, congregate housing project, or similar facility that meets the definition of a home under this section is such a home regardless of how the facility holds itself out to the public.

(C) For purposes of this chapter, personal care services or skilled nursing care shall be considered to be provided by a facility if they are provided by a person employed by or associated with the facility or by another person pursuant to an agreement to which neither the resident who receives the services nor the resident's sponsor is a party.

(D) Nothing in division (A)(4) of this section shall be construed to permit skilled nursing care to be imposed on an individual who does not require skilled nursing care.

   Nothing in division (A)(5) of this section shall be construed to permit personal care services to be imposed on an individual who is capable of performing the activity in question without assistance.

(E) Division (A)(1)(c)(ix) of this section does not prohibit a facility, infirmary, or other entity described in that division from seeking licensure under sections 3721.01 to 3721.09 of the Revised Code or certification under Title XVIII or XIX of the “Social Security Act.” However, such a facility, infirmary, or entity that applies for licensure or certification must meet the requirements of those sections or titles and the rules adopted under them and obtain a certificate of need from the director of health under section 3702.52 of the Revised Code.
(F) Nothing in this chapter, or rules adopted pursuant to it, shall be construed as authorizing the supervision, regulation, or control of the spiritual care or treatment of residents or patients in any home who rely upon treatment by prayer or spiritual means in accordance with the creed or tenets of any recognized church or religious denomination.

3721.041 Nursing home must post flu vaccine information.

(A) As used in this section:
(1) "Advisory committee" means the advisory committee on immunization practices of the United States centers for disease control and prevention or a successor committee or agency.
(2) "Home" has the same meaning as in section 3721.01 of the Revised Code.
(3) "Physician" means an individual authorized under Chapter 4731 of the Revised Code to practice medicine and surgery or osteopathic medicine and surgery.

(B) (1) Each home shall, on an annual basis, offer to each resident, in accordance with guidelines issued by the advisory committee, vaccination against influenza, unless a physician has determined that vaccination of the resident is medically inappropriate. The vaccine shall be of a form approved by the advisory committee for that calendar year. A resident may refuse vaccination.
(2) Each home shall obtain the influenza vaccine information sheet described in section 3701.138 of the Revised Code and post the sheet in a conspicuous location that is accessible to all residents, employees, and visitors. Not later than the first day of August each year, the home shall determine whether the information sheet it has posted is the most recent version available. If it is not, the home shall replace the information sheet with the updated version. Nothing in this division requires an older adult to be vaccinated against influenza.

Failure to comply with the requirement to post the information sheet shall not be taken into account when any survey or inspection of the home is conducted and shall not be used as the basis for imposing any penalty against the home.

(C) Each home shall offer to each resident, in accordance with guidelines issued by the advisory committee, vaccination against pneumococcal pneumonia, unless the resident has already received such vaccination or a physician has determined that vaccination of the resident is medically inappropriate. Each vaccine shall be of a form approved by the advisory committee for that calendar year. A resident may refuse vaccination.

(D) The director of health may adopt rules under Chapter 119 of the Revised Code as the director considers appropriate to implement this section.

3721.05 Annual license requirements; violations.

No person, firm, partnership, association, or corporation shall:
(A) Operate a home as defined in section 3721.01 of the Revised Code without obtaining a license from the director of health;
(B) Violate any of the conditions or requirements necessary for licensing after the license has been issued;
(C) Operate a home after the license for such has been revoked by the director of health;
(D) Interfere with the inspection of a licensed home by any state or local official when he is performing duties required of him by Chapter 3721 of the Revised Code. All licensed homes shall be open for inspection.
(E) Violate any of the provisions of Chapter 3721 of the Revised Code or any rules and regulations adopted pursuant thereto.
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3721.28 Nurse and nurse aides competency evaluation program.

(A)(1) Each nurse aide used by a long-term care facility on a full-time, temporary, per diem, or other basis on July 1, 1989, shall be provided by the facility a competency evaluation program approved by the director of health under division (A) of section 3721.31 of the Revised Code or conducted by the director under division (C) of that section. Each long-term care facility using a nurse aide on July 1, 1989, shall provide the nurse aide the preparation necessary to complete the competency evaluation program by January 1, 1990.

(2) Each nurse aide used by a long-term care facility on a full-time, temporary, per diem, or other basis on January 1, 1990, who either was not used by the facility on July 1, 1989, or was used by the facility on July 1, 1989, but had not successfully completed a competency evaluation program by January 1, 1990, shall be provided by the facility a competency evaluation program approved by the director under division (A) of section 3721.31 of the Revised Code or conducted by the director under division (C) of that section. Each long-term care facility using a nurse aide described in division (A)(2) of this section shall provide the nurse aide the preparation necessary to complete the competency evaluation program by October 1, 1990, and shall assist the nurse aide in registering for the program.

(B) Effective June 1, 1990, no long-term care facility shall use an individual as a nurse aide for more than four months unless the individual is competent to provide the services the individual is to provide, the facility has received from the nurse aide registry established under section 3721.32 of the Revised Code the information concerning the individual provided through the registry, and one of the following is the case:

(1) The individual was used by a facility as a nurse aide on a full-time, temporary, per diem, or other basis at any time during the period commencing July 1, 1989, and ending January 1, 1990, and successfully completed, not later than October 1, 1990, a competency evaluation program approved by the director under division (A) of section 3721.31 of the Revised Code or conducted by the director under division (C) of that section.

(2) The individual has successfully completed a training and competency evaluation program approved by the director under division (A) of section 3721.31 of the Revised Code or conducted by the director under division (C) of that section and, in addition, if the training and competency evaluation program or the training, instruction, or education the individual completed in meeting the conditions specified in division (F) of this section was conducted by or in a long-term care facility, or if the director pursuant to division (E) of section 3721.31 of the Revised Code so requires, the individual has successfully completed a competency evaluation program conducted by the director.

(3) Prior to July 1, 1989, if the long-term care facility is certified as a skilled nursing facility or a nursing facility under Title XVIII or XIX of the “Social Security Act,” 49 Stat. 620 (1935), 42 U.S.C.A. 301, as amended, or prior to January 1, 1990, if the facility is not so certified, the individual completed a program that the director determines included a competency evaluation component no less stringent than the competency evaluation programs approved by the director under division (A) of section 3721.31 of the Revised Code or conducted by the director under division (C) of that section, and was otherwise comparable to the training and competency evaluation programs being approved by the director under division (A) of that section.

(4) The individual is listed in a nurse aide registry maintained by another state and that state certifies that its program for training and evaluation of competency of nurse aides complies with Titles XVIII and XIX of the “Social Security Act” and regulations adopted thereunder.

(5) Prior to July 1, 1989, the individual was found competent to serve as a nurse aide after the completion of a course of nurse aide training of at least one hundred hours’ duration.

(6) The individual is enrolled in a prelicensure program of nursing education approved by
the board of nursing or by an agency of another state that regulates nursing education, has
provided the long-term care facility with a certificate from the program indicating that the
individual has successfully completed the courses that teach basic nursing skills including
infection control, safety and emergency procedures, and personal care, and has successfully
completed a competency evaluation program conducted by the director under division (C) of
section 3721.31 of the Revised Code.

(7) The individual has the equivalent of twelve months or more of full-time employment in
the preceding five years as a hospital aide or orderly and has successfully completed a
competency evaluation program conducted by the director under division (C) of section 3721.31
of the Revised Code.

(C) Effective June 1, 1990, no long-term care facility shall continue for longer than four
months to use as a nurse aide an individual who previously met the requirements of division (B)
of this section but since most recently doing so has not performed nursing and nursing-related
services for monetary compensation for twenty-four consecutive months, unless the individual
successfully completes additional training and competency evaluation by complying with
divisions (C)(1) and (2) of this section:

(1) Doing one of the following:
(a) Successfully completing a training and competency evaluation program approved by
the director under division (A) of section 3721.31 of the Revised Code or conducted by the
director under division (C) of that section;
(b) Successfully completing a training and competency evaluation program described in
division (B)(4) of this section;
(c) Meeting the requirements specified in division (B)(6) or (7) of this section.

(2) If the training and competency evaluation program completed under division (C)(1)(a)
of this section was conducted by or in a long-term care facility, or if the director pursuant to
division (E) of section 3721.31 of the Revised Code so requires, successfully completing a
competency evaluation program conducted by the director.

(D)(1) The four-month periods provided for in divisions (B) and (C) of this section include
any time, on or after June 1, 1990, that an individual is used as a nurse aide on a full-time,
temporary, per diem, or any other basis by the facility or any other long-term care facility.

(2) During the four-month period provided for in division (B) of this section, during which
a long-term care facility may, subject to division (E) of this section, use as a nurse aide an
individual who does not have the qualifications specified in divisions (B)(1) to (7) of this section,
a facility shall require the individual to comply with divisions (D)(2)(a) and (b) of this section:

(a) Participate in one of the following:
(i) If the individual has successfully completed a training and competency evaluation
program approved by the director under division (A) of section 3721.31 of the Revised Code,
and the program was conducted by or in a long-term care facility, or the director pursuant to
division (E) of section 3721.31 of the Revised Code so requires, a competency evaluation
program conducted by the director;
(ii) If the individual is enrolled in a prelicensure program of nursing education described
in division (B)(6) of this section and has completed or is working toward completion of the
courses described in that division, or the individual has the experience described in division
(B)(7) of this section, a competency evaluation program conducted by the director;
(iii) A training and competency evaluation program approved by the director under
division (A) of section 3721.31 of the Revised Code or conducted by the director under division
(C) of that section.

(b) If the individual participates in or has successfully completed a training and
competency evaluation program under division (D)(2)(a)(iii) of this section that is conducted by
or in a long-term care facility, or the director pursuant to division (E) of section 3721.31 of the
Revised Code so requires, participate in a competency evaluation program conducted by the
director.

(3) During the four-month period provided for in division (C) of this section, during which a long-term care facility may, subject to division (E) of this section, use as a nurse aide an individual who does not have the qualifications specified in divisions (C)(1) and (2) of this section, a facility shall require the individual to comply with divisions (D)(3)(a) and (b) of this section:

(a) Participate in one of the following:
   (i) If the individual has successfully completed a training and competency evaluation program approved by the director, and the program was conducted by or in a long-term care facility, or the director pursuant to division (E) of section 3721.31 of the Revised Code so requires, a competency evaluation program conducted by the director;
   (ii) If the individual is enrolled in a prelicensure program of nursing education described in division (B)(6) of this section and has completed or is working toward completion of the courses described in that division, or the individual has the experience described in division (B)(7) of this section, a competency evaluation program conducted by the director;
   (iii) A training and competency evaluation program approved or conducted by the director.

(b) If the individual participates in or has successfully completed a training and competency evaluation program under division (D)(3)(a)(iii) of this section that is conducted by or in a long-term care facility, or the director pursuant to division (E) of section 3721.31 of the Revised Code so requires, participate in a competency evaluation program conducted by the director.

(E) A long-term care facility shall not permit an individual used by the facility as a nurse aide while participating in a training and competency evaluation program to provide nursing and nursing-related services unless both of the following are the case:

(1) The individual has completed the number of hours of training that must be completed prior to providing services to residents as prescribed by rules that shall be adopted by the director in accordance with Chapter 119 of the Revised Code;

(2) The individual is under the personal supervision of a registered or licensed practical nurse licensed under Chapter 4723 of the Revised Code.

(F) An individual shall be considered to have satisfied the requirement, under division (B)(2) of this section, of having successfully completed a training and competency evaluation program conducted or approved by the director, if the individual meets both of the following conditions:

(1) The individual, as of July 1, 1989, completed at least sixty hours divided between skills training and classroom instruction in the topic areas described in divisions (B)(1) to (8) of section 3721.30 of the Revised Code;

(2) The individual received, as of that date, at least the difference between seventy-five hours and the number of hours actually spent in training and competency evaluation in supervised practical nurse aide training or regular in-service nurse aide education.

(G) The director shall adopt rules in accordance with Chapter 119 of the Revised Code specifying persons, in addition to the director, who may establish competence of nurse aides under division (B)(5) of this section, and establishing criteria for determining whether an individual meets the conditions specified in division (F) of this section.

(H) The rules adopted pursuant to divisions (E)(1) and (G) of this section shall be no less stringent than the requirements, guidelines, and procedures established by the United States secretary of health and human services under sections 1819 and 1919 of the “Social Security Act.”
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3721.32 Nurse aide registry elements; disclosure on request by director.

(A) The director of health shall establish a state nurse aide registry listing all individuals who have done any of the following:
(1) Were used by a long-term care facility as nurse aides on a full-time, temporary, per diem, or other basis at any time during the period commencing July 1, 1989, and ending January 1, 1990, and successfully completed, not later than October 1, 1990, a competency evaluation program approved by the director under division (A) of section 3721.31 of the Revised Code or conducted by the director under division (C) of that section;
(2) Successfully completed a training and competency evaluation program approved by the director under division (A) of section 3721.31 of the Revised Code or met the conditions specified in division (F) of section 3721.28 of the Revised Code, and, if the training and competency evaluation program or the training, instruction, or education the individual completed in meeting the conditions specified in division (F) of section 3721.28 of the Revised Code was conducted in or by a long-term care facility, or if the director so required pursuant to division (E) of section 3721.31 of the Revised Code, has successfully completed a competency evaluation program conducted by the director;
(3) Successfully completed a training and competency evaluation program conducted by the director under division (C) of section 3721.31 of the Revised Code;
(4) Successfully completed, prior to July 1, 1989, a program that the director has determined under division (B)(3) of section 3721.28 of the Revised Code included a competency evaluation component no less stringent than the competency evaluation programs approved or conducted by the director under section 3721.31 of the Revised Code, and was otherwise comparable to the training and competency evaluation program being approved by the director under section 3721.31 of the Revised Code;
(5) Are listed in a nurse aide registry maintained by another state that certifies that its program for training and evaluation of competency of nurse aides complies with Titles XVIII and XIX of the “Social Security Act,” 49 Stat. 620 (1935), 42 U.S.C.A. 301, as amended, or regulations adopted thereunder;
(6) Were found competent, as provided in division (B)(5) of section 3721.28 of the Revised Code, prior to July 1, 1989, after the completion of a course of nurse aide training of at least one hundred hours’ duration;
(7) Are enrolled in a prelicensure program of nursing education approved by the board of nursing or by an agency of another state that regulates nursing education, have provided the long-term care facility with a certificate from the program indicating that the individual has successfully completed the courses that teach basic nursing skills including infection control, safety and emergency procedures, and personal care, and have successfully completed a competency evaluation program conducted by the director under division (A) of section 3721.31 of the Revised Code;
(8) Have the equivalent of twelve months or more of full-time employment in the five years preceding listing in the registry as a hospital aide or orderly and have successfully completed a competency evaluation program conducted by the director under division (C) of section 3721.31 of the Revised Code.

(B) In addition to the list of individuals required by division (A) of this section, the registry shall include both of the following:
(1) The statement required by section 3721.23 of the Revised Code detailing findings by the director under that section regarding alleged abuse, neglect, or exploitation of a resident or misappropriation of resident property;
(2) Any statement provided by an individual under section 3721.23 of the Revised Code disputing the director's findings.

Whenever an inquiry is received as to the information contained in the registry
concerning an individual about whom a statement required by section 3721.23 of the Revised Code is included in the registry, the director shall disclose the statement or a summary of the statement together with any statement provided by the individual under section 3721.23 or a clear and accurate summary of that statement.

(C) The director may by rule specify additional information that must be provided to the registry by long-term care facilities and persons or government agencies conducting approved competency evaluation programs and training and competency evaluation programs.

(D) Information contained in the registry is a public record for the purposes of section 149.43 of the Revised Code, and is subject to inspection and copying under section 1347.08 of the Revised Code.
3727.081 Level II pediatric trauma centers; rules.

(A) Not later than two years after the effective date of this section, the director shall adopt rules that establish standards and procedures for designating hospitals under this section as level II pediatric trauma centers. The rules shall include standards to be followed by a hospital operating as a level II pediatric trauma center under the director's designation and procedures to be used by the director in enforcing those standards. All rules adopted under this division shall be adopted in accordance with Chapter 119 of the Revised Code.

(B) If a hospital has been denied verification as a pediatric trauma center by the American college of surgeons solely because the hospital does not meet that organization's anesthesia and surgical staffing standards, the hospital may submit an application to the director of health to receive the director's designation of the hospital as a level II pediatric trauma center. In a timely manner, the director shall review all applications received, except that the director shall cease reviewing applications on December 31, 2003. Any application pending on that date is void.

(C) Before designating a hospital as a level II pediatric trauma center, the director may conduct an inspection of the hospital. The inspection may be conducted by using a contractor of the department of health with appropriate competence and independence.

(D) The director shall designate a hospital as a level II pediatric trauma center if the hospital has submitted a complete application and the director finds that all of the following apply:

(1) The hospital has established trauma care protocols that ensure a surgeon and anesthesiologist are available from outside the hospital in a timely manner and on short notice.

(2) The hospital's protocols ensure that the surgeon will participate in the early care of a trauma patient.

(3) The hospital has adhered to its protocols and the hospital's performance has met the expected outcomes, as evidenced by data obtained from a review of at least two years of the hospital's trauma care activities.

(4) The care of patients will not be compromised by designating the hospital as a level II pediatric trauma center.

(E) A hospital's designation under this section expires December 31, 2004, unless earlier suspended or revoked by the director or surrendered by the hospital. Any action by the director to suspend or revoke a hospital's designation shall be taken in accordance with Chapter 119 of the Revised Code.

(F) The director of health and any employee or contractor of the department of health shall not make public any information reported to or collected by the department of health under this section or rules adopted under it that identifies or would tend to identify specific patients.

3727.09 Trauma care procedures; trauma patient transfer requirements.

(A) As used in this section and sections 3727.10 and 3727.101 of the Revised Code:

(1) "Trauma," "trauma care," "trauma center," "trauma patient," "pediatric," and "adult"
have the same meanings as in section 4765.01 of the Revised Code.
(2) "Stabilize" and "transfer" have the same meanings as in section 1753.28 of the Revised Code.

(B) On and after November 3, 2002, each hospital in this state that is not a trauma center shall adopt protocols for adult and pediatric trauma care provided in or by that hospital; each hospital in this state that is an adult trauma center and not a level I or level II pediatric trauma center shall adopt protocols for pediatric trauma care provided in or by that hospital; each hospital in this state that is a pediatric trauma center and not a level I and II adult trauma center shall adopt protocols for adult trauma care provided in or by that hospital. In developing its trauma care protocols, each hospital shall consider the guidelines for trauma care established by the American college of surgeons, the American college of emergency physicians, and the American academy of pediatrics. Trauma care protocols shall be written, comply with applicable federal and state laws, and include policies and procedures with respect to all of the following:
   (1) Evaluation of trauma patients, including criteria for prompt identification of trauma patients who require a level of adult or pediatric trauma care that exceeds the hospital's capabilities;
   (2) Emergency treatment and stabilization of trauma patients prior to transfer to an appropriate adult or pediatric trauma center;
   (3) Timely transfer of trauma patients to appropriate adult or pediatric trauma centers based on a patient's medical needs. Trauma patient transfer protocols shall specify all of the following:
      (a) Confirmation of the ability of the receiving trauma center to provide prompt adult or pediatric trauma care appropriate to a patient's medical needs;
      (b) Procedures for selecting an appropriate alternative adult or pediatric trauma center to receive a patient when it is not feasible or safe to transport the patient to a particular trauma center;
      (c) Advance notification and appropriate medical consultation with the trauma center to which a trauma patient is being, or will be, transferred;
      (d) Procedures for selecting an appropriate method of transportation and the hospital responsible for arranging or providing the transportation;
      (e) Confirmation of the ability of the persons and vehicle that will transport a trauma patient to provide appropriate adult or pediatric trauma care;
      (f) Assured communication with, and appropriate medical direction of, the persons transporting a trauma patient to a trauma center;
      (g) Identification and timely transfer of appropriate medical records of the trauma patient being transferred;
      (h) The hospital responsible for care of a patient in transit;
      (i) The responsibilities of the physician attending a patient and, if different, the physician who authorizes a transfer of the patient;
      (j) Procedures for determining, in consultation with an appropriate adult or pediatric trauma center and the persons who will transport a trauma patient, when transportation of the patient to a trauma center may be delayed for either of the following reasons:
         (i) Immediate transfer of the patient is unsafe due to adverse weather or ground conditions.
         (ii) No trauma center is able to provide appropriate adult or pediatric trauma care to the patient without undue delay.
   (4) Peer review and quality assurance procedures for adult and pediatric trauma care provided in or by the hospital.

(C)(1) On and after November 3, 2002, each hospital shall enter into all of the following written agreements unless otherwise provided in division (C)(2) of this section:
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(a) An agreement with one or more adult trauma centers in each level of categorization as a trauma center higher than the hospital that governs the transfer of adult trauma patients from the hospital to those trauma centers;
(b) An agreement with one or more pediatric trauma centers in each level of categorization as a trauma center higher than the hospital that governs the transfer of pediatric trauma patients from the hospital to those trauma centers.

(2) A level I or level II adult trauma center is not required to enter into an adult trauma patient transfer agreement with another hospital. A level I or level II pediatric trauma center is not required to enter into a pediatric trauma patient transfer agreement with another hospital. A hospital is not required to enter into an adult trauma patient transfer agreement with a level III or level IV adult trauma center, or enter into a pediatric trauma patient transfer agreement with a level III or level IV pediatric trauma center, if no trauma center of that type is reasonably available to receive trauma patients transferred from the hospital.

(3) A trauma patient transfer agreement entered into by a hospital under division (C)(1) of this section shall comply with applicable federal and state laws and contain provisions conforming to the requirements for trauma care protocols set forth in division (B) of this section.

(D) A hospital shall make trauma care protocols it adopts under division (B) of this section and trauma patient transfer agreements it adopts under division (C) of this section available for public inspection during normal working hours. A hospital shall furnish a copy of such documents upon request and may charge a reasonable and necessary fee for doing so, provided that upon request it shall furnish a copy of such documents to the director of health free of charge.

(E) A hospital that ceases to operate as an adult or pediatric trauma center under provisional status is not in violation of divisions (B) and (C) of this section during the time it develops different trauma care protocols and enters into different patient transfer agreements pursuant to division (D)(2)(c) of section 3727.101 of the Revised Code.

3727.10 Hospital trauma care prohibitions.

On and after November 3, 2002, no hospital in this state shall knowingly do any of the following:

(A) Represent that it is able to provide adult or pediatric trauma care to a severely injured patient that is inconsistent with its level of categorization as an adult or pediatric trauma center, provided that a hospital that operates an emergency facility may represent that it provides emergency care;

(B) Provide adult or pediatric trauma care to a severely injured patient that is inconsistent with applicable federal laws, state laws, and trauma care protocols and patient transfer agreements the hospital has adopted under section 3727.09 of the Revised Code;

(C) Transfer a severely injured adult or pediatric trauma patient to a hospital that is not a trauma center with an appropriate level of adult or pediatric categorization or otherwise transfer a severely injured adult or pediatric trauma patient in a manner inconsistent with any applicable trauma patient transfer agreement adopted by the hospital under section 3727.09 of the Revised Code.

3727.101 Initial verification, verification at different level and reverification application; operation with provisional status.

(A) If a hospital is seeking initial verification as an adult or pediatric trauma center, verification at a different level, or reverification after having ceased to be verified for one year or longer, the hospital shall submit an application to the American college of surgeons for a consultation visit. If a hospital is seeking reverification after having ceased to be verified for less
than one year, the hospital shall submit an application for either a consultation visit or a reverification visit, except when operating pursuant to division (C)(1)(b) of this section. The hospital shall undergo the visit and obtain a written report of the results of the visit. If the report is not obtained by the date that occurs one year after the application for the visit is submitted, the hospital shall submit a new application.

(B) Not later than one year after obtaining a report under division (A) of this section, a hospital may apply to the American college of surgeons for verification or reverification as an adult or pediatric trauma center if, based on the report, all of the following occur:

(1) The hospital’s chief medical officer and chief executive officer certify in writing to the hospital’s governing board that the hospital is committed and able to provide adult or pediatric trauma care consistent with the level of verification or reverification being sought.

(2) The hospital’s governing board adopts a resolution stating that the hospital is committed and able to provide adult or pediatric trauma care consistent with the level of verification or reverification being sought.

(3) The hospital’s governing board approves a written plan and timetable for obtaining the level of verification or reverification being sought, including provisions for correcting at the earliest practicable date any deficiencies identified in the report obtained pursuant to division (A) of this section.

(C)(1) A hospital may operate as an adult or pediatric trauma center under provisional status, as follows:

(a) On submission of an application under division (B) of this section;

(b) Until it receives the final result of its reverification if the application was submitted within one year before it ceased to be verified.

(2) A hospital operating as an adult or pediatric trauma care center under provisional status is subject to both of the following:

(a) The hospital shall limit its provisional status activities to those activities authorized by the level of verification or reverification being sought.

(b) The hospital shall make a reasonable, good faith effort to comply with all requirements established by the American college of surgeons that must be met for the level of verification or reverification being sought.

(D)(1) A hospital shall cease to operate as an adult or pediatric trauma center under provisional status if any of the following applies:

(a) The application for verification or reverification is denied, suspended, terminated, or withdrawn.

(b) In the case of a hospital seeking initial verification, verification at a different level, or reverification after having ceased to be verified for one year or longer, the hospital has not obtained verification or reverification by the date that occurs eighteen months after commencing to operate under provisional status.

(c) In the case of a hospital seeking reverification after having ceased to be verified for less than one year, the hospital has not obtained reverification by the date that occurs one year after commencing to operate under provisional status.

(2) A hospital that ceases to operate as an adult or pediatric trauma center under provisional status pursuant to division (D)(1) of this section shall do all of the following:

(a) Except as otherwise provided by federal law, at the earliest practicable date transfer to one or more appropriate trauma centers all trauma patients in the hospital to whom the hospital is not permitted to provide trauma care.

(b) Promptly comply with section 3727.10 of the Revised Code according to its current status.

(c) Not later than one hundred eighty days after ceasing to operate under provisional status, comply with section 3727.09 of the Revised Code according to its current status.

(3) A hospital that ceases to operate as an adult or pediatric trauma center under
provisional status may not operate as an adult or pediatric trauma center under provisional status until two years have elapsed since it ceased to operate under that status.

(E) With respect to the availability of documents and other information prepared pursuant to this section, an adult or pediatric trauma center operating under provisional status is subject to both of the following:

1. The trauma center shall make available for public inspection during normal working hours a copy of the certification, resolution, and application prepared pursuant to division (B) of this section. On request, the trauma center shall provide a copy of the documents. A reasonable fee may be charged to cover the necessary expenses incurred in furnishing the copies, except that no fee shall be charged if the copies are being furnished to the director of health.

2. On request, the trauma center shall furnish to the director of health a copy of the report of the consultative or reverification visit obtained from the American college of surgeons pursuant to division (A) of this section and a copy of the plan and timetable approved pursuant to division (B)(3) of this section for obtaining verification or reverification. The documents provided may omit patient-identifying information. Submission of the documents to the director does not waive any privilege or right of confidentiality that otherwise applies to the documents and the information in them.

The documents and the information in them are not public records and shall not be disclosed to any person except employees of the department of health who are expressly authorized by the director of health to examine the copies and information in them. The documents and information in them are not subject to discovery or introduction into evidence in a civil action, except an action brought by the director against the trauma center or a person that authorized, approved, or created the original documents and the information in them.

(F) Notwithstanding any provision of this section regarding the receipt of a report of the results of a consultation visit or reverification visit from the American college of surgeons, if a hospital submitted an application for a consultation visit or reverification visit as an adult or pediatric trauma center on or before May 20, 2002, the hospital may operate as an adult or pediatric trauma center under provisional status. The hospital shall do all of the following:

1. Comply with divisions (B)(1) and (2) of this section as though the report has been received;

2. Approve through its governing board a written plan and timetable for obtaining the level of verification or reverification being sought, including provisions for correcting at the earliest practicable date any deficiencies identified in the exit interview following the consultation or reverification visit and any subsequent report received;

3. Comply with all other provisions of this section applicable to the operation of a trauma center under provisional status, including the requirements of division (D) of this section regarding the ceasing of operation under provisional status.

3727.102 Changes in trauma care status; notice required.

A hospital shall promptly notify in writing the director of health, the emergency medical services division of the department of public safety, and the appropriate regional directors and regional advisory boards appointed under section 4765.05 of the Revised Code if any of the following occurs:

(A) The hospital ceases to be an adult or pediatric trauma center verified by the American college of surgeons.

(B) The hospital changes its level of verification as an adult or pediatric trauma center verified by the American college of surgeons.

(C) The hospital commences to operate as an adult or pediatric trauma center under provisional status pursuant to section 3727.101 of the Revised Code.

(D) The hospital changes the level of verification or reverification it is seeking under its
provisional status.
(E) The hospital ceases to operate under its provisional status.
(F) The hospital receives verification or reverification in place of its provisional status.

Part II. EMS, EMT, Medical Transport

4765.01 Emergency medical services; definitions.

As used in this chapter:
(A) “First responder” means an individual who holds a current, valid certificate issued under section 4765.30 of the Revised Code to practice as a first responder.
(B) “Emergency medical technician-basic” or “EMT-basic” means an individual who holds a current, valid certificate issued under section 4765.30 of the Revised Code to practice as an emergency medical technician-basic.
(C) “Emergency medical technician-intermediate” or “EMT-I” means an individual who holds a current, valid certificate issued under section 4765.30 of the Revised Code to practice as an emergency medical technician-intermediate.
(D) “Emergency medical technician-paramedic” or “paramedic” means an individual who holds a current, valid certificate issued under section 4765.30 of the Revised Code to practice as an emergency medical technician-paramedic.
(E) “Ambulance” means any motor vehicle that is used, or is intended to be used, for the purpose of responding to emergency medical situations, transporting emergency patients, and administering emergency medical service to patients before, during, or after transportation.
(F) “Cardiac monitoring” means a procedure used for the purpose of observing and documenting the rate and rhythm of a patient’s heart by attaching electrical leads from an electrocardiograph monitor to certain points on the patient’s body surface.
(G) “Emergency medical service” means any of the services described in sections 4765.35, 4765.37, 4765.38, and 4765.39 of the Revised Code that are performed by first responders, emergency medical technicians-basic, emergency medical technicians-intermediate, and paramedics. “Emergency medical service” includes such services performed before or during any transport of a patient, including transports between hospitals and transports to and from helicopters.
(H) “Emergency medical service organization” means a public or private organization using first responders, EMTs-basic, EMTs-I, or paramedics, or a combination of first responders, EMTs-basic, EMTs-I, and paramedics, to provide emergency medical services.
(I) “Physician” means an individual who holds a current, valid license issued under Chapter 4731 of the Revised Code authorizing the practice of medicine and surgery or osteopathic medicine and surgery.
(J) “Registered nurse” means an individual who holds a current, valid license issued under Chapter 4723 of the Revised Code authorizing the practice of nursing as a registered nurse.
(K) “Volunteer” means a person who provides services either for no compensation or for compensation that does not exceed the actual expenses incurred in providing the services or in training to provide the services.
(L) “Emergency medical service personnel” means first responders, emergency medical technicians-basic, emergency medical technicians-intermediate, emergency medical technicians-paramedic, and persons who provide medical direction to such persons.
(M) “Hospital” has the same meaning as in section 3727.01 of the Revised Code.
(N) “Trauma” or “traumatic injury” means severe damage to or destruction of tissue that satisfies both of the following conditions:
(1) It creates a significant risk of any of the following:
(a) Loss of life;
(b) Loss of a limb;
(c) Significant, permanent disfigurement;
(d) Significant, permanent disability.
(2) It is caused by any of the following:
(a) Blunt or penetrating injury;
(b) Exposure to electromagnetic, chemical, or radioactive energy;
(c) Drowning, suffocation, or strangulation;
(d) A deficit or excess of heat.
(O) “Trauma victim” or “trauma patient” means a person who has sustained a traumatic injury.
(P) “Trauma care” means the assessment, diagnosis, transportation, treatment, or rehabilitation of a trauma victim by emergency medical service personnel or by a physician, nurse, physician assistant, respiratory therapist, physical therapist, chiropractor, occupational therapist, speech-language pathologist, audiologist, or psychologist licensed to practice as such in this state or another jurisdiction.
(Q) “Trauma center” means all of the following:
(1) Any hospital that is verified by the American college of surgeons as an adult or pediatric trauma center;
(2) Any hospital that is operating as an adult or pediatric trauma center under provisional status pursuant to section 3727.101 of the Revised Code;
(3) Until December 31, 2004, any hospital in this state that is designated by the director of health as a level II pediatric trauma center under section 3727.081 of the Revised Code;
(4) Any hospital in another state that is licensed or designated under the laws of that state as capable of providing specialized trauma care appropriate to the medical needs of the trauma patient.
(R) “Pediatric” means involving a patient who is less than sixteen years of age.
(S) “Adult” means involving a patient who is not a pediatric patient.
(T) “Geriatric” means involving a patient who is at least seventy years old or exhibits significant anatomical or physiological characteristics associated with advanced aging.
(U) “Air medical organization” means an organization that provides emergency medical services, or transports emergency victims, by means of fixed or rotary wing aircraft.
(V) “Emergency care” and “emergency facility” have the same meanings as in section 3727.01 of the Revised Code.
(W) “Stabilize,” except as it is used in division (B) of section 4765.35 of the Revised Code with respect to the manual stabilization of fractures, has the same meaning as in section 1753.28 of the Revised Code.
(X) “Transfer” has the same meaning as in section 1753.28 of the Revised Code.
(Y) “Firefighter” means any member of a fire department as defined in section 742.01 of the Revised Code.
(Z) “Volunteer firefighter” has the same meaning as in section 146.01 of the Revised Code.
(AA) “Part-time paid firefighter” means a person who provides firefighting services on less than a full-time basis, is routinely scheduled to be present on site at a fire station or other designated location for purposes of responding to a fire or other emergency, and receives more than nominal compensation for the provision of firefighting services.
(BB) “Physician assistant” means an individual who holds a valid license to practice as a physician assistant issued under Chapter 4730 of the Revised Code.
4765.04 Emergency medical services; firefighter and fire safety inspector training committee; trauma committee; other committees.

(A) The firefighter and fire safety inspector training committee of the state board of emergency medical, fire, and transportation services is hereby created and shall consist of the members of the board who are chiefs of fire departments, and the members of the board who are emergency medical technicians-basic, emergency medical technicians-intermediate, and emergency medical technicians-paramedic appointed from among persons nominated by the Ohio association of professional fire fighters or the northern Ohio fire fighters and from among persons nominated by the Ohio state firefighter's association. Each member of the committee, except the chairperson, may designate a person with fire experience to serve in that member's place. The members of the committee or their designees shall select a chairperson from among the members or their designees.

The committee may conduct investigations in the course of discharging its duties under this chapter. In the course of an investigation, the committee may issue subpoenas. If a person subpoenaed fails to comply with the subpoena, the committee may authorize its chairperson to apply to the court of common pleas in the county where the person to be subpoenaed resides for an order compelling compliance in the same manner as compliance with a subpoena issued by the court is compelled.

(B) The trauma committee of the state board of emergency medical, fire, and transportation services is hereby created and shall consist of the following members appointed by the director of public safety:

(1) A physician who is certified by the American board of surgery or American osteopathic board of surgery and actively practices general trauma surgery, appointed from among three persons nominated by the Ohio chapter of the American college of surgeons, three persons nominated by the Ohio state medical association, and three persons nominated by the Ohio osteopathic association;

(2) A physician who is certified by the American board of surgery or the American osteopathic board of surgery and actively practices orthopedic trauma surgery, appointed from among three persons nominated by the Ohio orthopedic society and three persons nominated by the Ohio osteopathic association;

(3) A physician who is certified by the American board of neurological surgeons or the American osteopathic board of surgery and actively practices neurosurgery on trauma victims, appointed from among three persons nominated by the Ohio state neurological society and three persons nominated by the Ohio osteopathic association;

(4) A physician who is certified by the American board of surgeons or American osteopathic board of surgeons and actively specializes in treating burn victims, appointed from among three persons nominated by the Ohio chapter of the American college of surgeons and three persons nominated by the Ohio osteopathic association;

(5) A dentist who is certified by the American board of oral and maxillofacial surgery and actively practices oral and maxillofacial surgery, appointed from among three persons nominated by the Ohio dental association;

(6) A physician who is certified by the American board of physical medicine and rehabilitation or American osteopathic board of rehabilitation medicine and actively provides rehabilitative care to trauma victims, appointed from among three persons nominated by the Ohio society of physical medicine and rehabilitation and three persons nominated by the Ohio osteopathic association;

(7) A physician who is certified by the American board of surgery or American osteopathic board of surgery with special qualifications in pediatric surgery and actively practices pediatric trauma surgery, appointed from among three persons nominated by the Ohio
chapter of the American academy of pediatrics and three persons nominated by the Ohio osteopathic association;

(8) A physician who is certified by the American board of emergency medicine or American osteopathic board of emergency medicine, actively practices emergency medicine, and is actively involved in emergency medical services, appointed from among three persons nominated by the Ohio chapter of the American college of emergency physicians and three persons nominated by the Ohio osteopathic association;

(9) A physician who is certified by the American board of pediatrics, American osteopathic board of pediatrics, or American board of emergency medicine, is sub-boarded in pediatric emergency medicine, actively practices pediatric emergency medicine, and is actively involved in emergency medical services, appointed from among three persons nominated by the Ohio chapter of the American college of emergency physicians, three persons nominated by the Ohio chapter of the American academy of pediatrics, and three persons nominated by the Ohio osteopathic association;

(10) A physician who is certified by the American board of surgery, American osteopathic board of surgery, or American board of emergency medicine and is the chief medical officer of an air medical organization, appointed from among three persons nominated by the Ohio association of air medical services;

(11) A coroner or medical examiner appointed from among three people nominated by the Ohio state coroners' association;

(12) A registered nurse who actively practices trauma nursing at an adult or pediatric trauma center, appointed from among three persons nominated by the Ohio association of trauma nurse coordinators;

(13) A registered nurse who actively practices emergency nursing and is actively involved in emergency medical services, appointed from among three persons nominated by the Ohio chapter of the emergency nurses' association;

(14) The chief trauma registrar of an adult or pediatric trauma center, appointed from among three persons nominated by the alliance of Ohio trauma registrars;

(15) The administrator of an adult or pediatric trauma center, appointed from among three persons nominated by OHA: the association for hospitals and health systems, three persons nominated by the Ohio osteopathic association, three persons nominated by the association of Ohio children's hospitals, and three persons nominated by the health forum of Ohio;

(16) The administrator of a hospital that is not a trauma center and actively provides emergency care to adult or pediatric trauma patients, appointed from among three persons nominated by OHA: the association for hospitals and health systems, three persons nominated by the Ohio osteopathic association, three persons nominated by the association of Ohio children's hospitals, and three persons nominated by the health forum of Ohio;

(17) The operator of an ambulance company that actively provides trauma care to emergency patients, appointed from among three persons nominated by the Ohio ambulance association;

(18) The chief of a fire department that actively provides trauma care to emergency patients, appointed from among three persons nominated by the Ohio fire chiefs' association;

(19) An EMT or paramedic who is certified under this chapter and actively provides trauma care to emergency patients, appointed from among three persons nominated by the Ohio association of professional firefighters, three persons nominated by the northern Ohio fire fighters, three persons nominated by the Ohio state firefighters' association, and three persons nominated by the Ohio association of emergency medical services;

(20) A person who actively advocates for trauma victims, appointed from three persons nominated by the Ohio brain injury association and three persons nominated by the governor's council on people with disabilities;
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(21) A physician or nurse who has substantial administrative responsibility for trauma care provided in or by an adult or pediatric trauma center, appointed from among three persons nominated by OHA: the association for hospitals and health systems, three persons nominated by the Ohio osteopathic association, three persons nominated by the association of Ohio children's hospitals, and three persons nominated by the health forum of Ohio;

(22) Three representatives of hospitals that are not trauma centers and actively provide emergency care to trauma patients, appointed from among three persons nominated by OHA: the association for hospitals and health systems, three persons nominated by the Ohio osteopathic association, three persons nominated by the association of Ohio children's hospitals, and three persons nominated by the health forum of Ohio. The representatives may be hospital administrators, physicians, nurses, or other clinical professionals.

Members of the committee shall have substantial experience in the categories they represent, shall be residents of this state, and may be members of the state board of emergency medical, fire, and transportation services. In appointing members of the committee, the director shall attempt to include members representing urban and rural areas, various geographical areas of the state, and various schools of training. The director shall not appoint to the committee more than one member who is employed by or practices at the same hospital, health system, or emergency medical service organization.

The director may refuse to appoint any of the persons nominated by an organization or organizations under this division. In that event, the organization or organizations shall continue to nominate the required number of persons until the director appoints to the committee one or more of the persons nominated by the organization or organizations.

Initial appointments to the committee shall be made by the director not later than ninety days after November 3, 2000. Members of the committee shall serve at the pleasure of the director, except that any member of the committee who ceases to be qualified for the position to which the member was appointed shall cease to be a member of the committee. Vacancies on the committee shall be filled in the same manner as original appointments.

The members of the committee shall serve without compensation but shall be reimbursed for actual and necessary expenses incurred in carrying out duties as members of the committee.

The committee shall select a chairperson and vice-chairperson from among its members. A majority of all members of the committee shall constitute a quorum. No action shall be taken without the concurrence of a majority of all members of the committee. The committee shall meet at the call of the chair, upon written request of five members of the committee, and at the direction of the state board of emergency medical, fire, and transportation services. The committee shall not meet at times or locations that conflict with meetings of the board. The executive director and medical director of the state board of emergency medical, fire, and transportation services may participate in any meeting of the committee and shall do so at the request of the committee.

The committee shall advise and assist the state board of emergency medical, fire, and transportation services in matters related to adult and pediatric trauma care and the establishment and operation of the state trauma registry. In matters relating to the state trauma registry, the board and the committee shall consult with trauma registrars from adult and pediatric trauma centers in the state. The committee may appoint a subcommittee to advise and assist with the trauma registry. The subcommittee may include persons with expertise relevant to the trauma registry who are not members of the board or committee.

(C)(1) The medical transportation committee of the state board of emergency medical, fire, and transportation services is hereby created. The committee shall consist of members appointed by the board in accordance with rules adopted by the board. In appointing members of the committee, the board shall attempt to include members representing urban and rural areas and various geographical areas of the state, and shall ensure the members have
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substantial experience in the transportation of patients, including addressing the unique issues of mobile intensive care and air medical services. The members of the committee shall be residents of this state and may be members of the board. The members of the committee shall serve without compensation but shall be reimbursed for actual and necessary expenses incurred in carrying out duties as members of the committee. The committee shall select a chairperson and vice-chairperson from among its members. A majority of all members of the committee shall constitute a quorum. No action shall be taken without the concurrence of a majority of all members of the committee. The committee shall meet at the call of the chair and at the direction of the board. The committee shall not meet at times or locations that conflict with meetings of the board. The committee shall advise and assist the board in matters related to the licensing of nonemergency medical service, emergency medical service, and air medical service organizations in this state.

(2) There is hereby created the critical care subcommittee of the medical transportation committee. The membership of the subcommittee and the conduct of the subcommittee’s business shall conform to rules adopted by the board. The subcommittee shall advise and assist the committee and board in matters relating to mobile intensive care and air medical service organizations in this state.

(D) The state board of emergency medical, fire, and transportation services may appoint other committees and subcommittees as it considers necessary.

(E) The state board of emergency medical, fire, and transportation services, and any of its committees or subcommittees, may request assistance from any state agency. The board and its committees and subcommittees may permit persons who are not members of those bodies to participate in deliberations of those bodies, but no person who is not a member of the board shall vote on the board and no person who is not a member of a committee created under division (A), (B), or (C) of this section shall vote on that committee.

(F) Sections 101.82 to 101.87 of the Revised Code do not apply to the committees established under divisions (A), (B), and (C) of this section.

4765.06 Emergency incidence reporting system; delivery and frequency of services; trauma registries; confidentiality of information.

(A) The state board of emergency medical, fire, and transportation services shall establish an emergency medical services incidence reporting system for the collection of information regarding the delivery of emergency medical services in this state and the frequency at which the services are provided. All emergency medical service organizations shall submit to the board any information that the board determines is necessary for maintaining the incidence reporting system.

(B) The board shall establish a state trauma registry to be used for the collection of information regarding the care of adult and pediatric trauma victims in this state. The registry shall provide for the reporting of adult and pediatric trauma-related deaths, identification of adult and pediatric trauma patients, monitoring of adult and pediatric trauma patient care data, determination of the total amount of uncompensated adult and pediatric trauma care provided annually by each facility that provides care to trauma victims, and collection of any other information specified by the board. All persons designated by the board shall submit to the board any information it determines is necessary for maintaining the state trauma registry. At the request of the board any state agency possessing information regarding adult or pediatric trauma care shall provide the information to the board. The board shall maintain the state trauma registry in accordance with rules adopted under section 4765.11 of the Revised Code.

Rules relating to the state trauma registry adopted under this section and section 4765.11 of the Revised Code shall not prohibit the operation of other trauma registries and may provide for the reporting of information to the state trauma registry by or through other trauma
registries in a manner consistent with information otherwise reported to the state trauma registry. Other trauma registries may report aggregate information to the state trauma registry, provided the information can be matched to the person that reported it. Information maintained by another trauma registry and reported to the state trauma registry in lieu of being reported directly to the state trauma registry is a public record and shall be maintained, made available to the public, held in confidence, risk adjusted, and not subject to discovery or introduction into evidence in a civil action as provided in section 149.43 of the Revised Code and this section. Any person who provides, maintains, or risk adjusts such information shall comply with this section and rules adopted under it in performing that function and has the same immunities with respect to that function as a person who performs that function with respect to the state trauma registry.

(C) The board and any employee or contractor of the board or the department of public safety shall not make public information it receives under Chapter 4765 of the Revised Code that identifies or would tend to identify a specific recipient of emergency medical services or adult or pediatric trauma care.

(D) Not later than two years after November 3, 2000, the board shall adopt and implement rules under section 4765.11 of the Revised Code that provide written standards and procedures for risk adjustment of information received by the board under Chapter 4765 of the Revised Code. The rules shall be developed in consultation with appropriate medical, hospital, and emergency medical service organizations and may provide for risk adjustment by a contractor of the board. Except as provided in division (G) of this section, before risk adjustment standards and procedures are implemented, no member of the board and no employee or contractor of the board or the department of public safety shall make public information received by the board under Chapter 4765 of the Revised Code that identifies or would tend to identify a specific provider of emergency medical services or adult or pediatric trauma care. Except as provided in division (G) of this section, after risk adjustment standards and procedures are implemented, the board shall make public such information only on a risk adjusted basis.

(E) The board shall adopt rules under section 4765.11 of the Revised Code that specify procedures for ensuring the confidentiality of information that is not to be made public under this section. The rules shall specify the circumstances in which deliberations of the persons performing risk adjustment functions under this section are not open to the public and records of those deliberations are maintained in confidence. Nothing in this section prohibits the board from making public statistical information that does not identify or tend to identify a specific recipient or provider of emergency medical services or adult or pediatric trauma care.

(F) No provider that furnishes information to the board with respect to any patient the provider examined or treated shall, because of this furnishing, be deemed liable in damages to any person or be held to answer for betrayal of a professional confidence in the absence of willful or wanton misconduct. No such information shall be subject to introduction in evidence in any civil action against the provider. No provider that furnishes information to the board shall be liable for the misuse or improper release of the information by the board or any other person. No person who performs risk adjustment functions under this section shall, because of performing such functions, be held liable in a civil action for betrayal of professional confidence or otherwise in the absence of willful or wanton misconduct.

(G) The board may transmit data that identifies or tends to identify a specific provider of emergency medical services care and has not been risk-adjusted from the emergency medical services incident reporting system directly to the national emergency medical services information system, pursuant to a written contract between the board and the federal agency that administers the national emergency medical services information system, which shall ensure to the maximum extent permitted by federal law that such agency shall use such data solely for inclusion in the national emergency medical services information system and shall not disclose such data to the public, through legal discovery, a freedom of information request, or
otherwise, in a manner that identifies or tends to identify a specific provider of emergency medical services care.

4765.12 Trauma victims; guidelines for care; peer review and quality assurance programs required.

(A) Not later than two years after November 3, 2000, the state board of emergency medical, fire, and transportation services shall develop and distribute guidelines for the care of trauma victims by emergency medical service personnel and for the conduct of peer review and quality assurance programs by emergency medical service organizations. The guidelines shall be consistent with the state trauma triage protocols adopted in rules under sections 4765.11 and 4765.40 of the Revised Code and shall place emphasis on the special needs of pediatric and geriatric trauma victims. In developing the guidelines, the board shall consult with entities with interests in trauma and emergency medical services and shall consider any relevant guidelines adopted by national organizations, including the American college of surgeons, American college of emergency physicians, and American academy of pediatrics. The board shall distribute the guidelines, and amendments to the guidelines, to each emergency medical service organization, regional director, regional physician advisory board, certified emergency medical service instructor, and person who regularly provides medical direction to emergency medical service personnel in this state.

(B) Not later than three years after November 3, 2000, each emergency medical service organization in this state shall implement ongoing peer review and quality assurance programs designed to improve the availability and quality of the emergency medical services it provides. The form and content of the programs shall be determined by each emergency medical service organization. In implementing the programs, each emergency medical service organization shall consider how to improve its ability to provide effective trauma care, particularly for pediatric and geriatric trauma victims, and shall take into account the trauma care guidelines developed by the state board of emergency medical, fire, and transportation services under this section.

Information generated solely for use in a peer review or quality assurance program conducted on behalf of an emergency medical service organization is not a public record under section 149.43 of the Revised Code. Such information, and any discussion conducted in the course of a peer review or quality assurance program conducted on behalf of an emergency medical service organization, is not subject to discovery in a civil action and shall not be introduced into evidence in a civil action against the emergency medical service organization on whose behalf the information was generated or the discussion occurred.

No emergency medical service organization on whose behalf a peer review or quality assurance program is conducted, and no person who conducts such a program, because of performing such functions, shall be liable in a civil action for betrayal of professional confidence or otherwise in the absence of willful or wanton misconduct.

4765.35 First responders; services permissible; rules.

(A) A first responder shall perform the emergency medical services described in this section in accordance with this chapter and any rules adopted under it.

(B) A first responder may provide limited emergency medical services to patients until the arrival of an emergency medical technician-basic, emergency medical technician-intermediate, or emergency medical technician-paramedic. In an emergency, a first responder may render emergency medical services such as opening and maintaining an airway, giving mouth to barrier ventilation, chest compressions, electrical interventions with automated defibrillators to support or correct the cardiac function and other methods determined by the board, controlling of hemorrhage, manual stabilization of fractures, bandaging, assisting in
childbirth, and determining triage of trauma victims.

(C) A first responder may perform any other emergency medical services approved pursuant to rules adopted under section 4765.11 of the Revised Code. The board shall determine whether the nature of any such service requires that a first responder receive authorization prior to performing the service.

(D)(1) Except as provided in division (D)(2) of this section, if the board determines under division (C) of this section that a service requires prior authorization, the service shall be performed only pursuant to the written or verbal authorization of a physician or of the cooperating physician advisory board, or pursuant to an authorization transmitted through a direct communication device by a physician, physician assistant designated by a physician, or registered nurse designated by a physician.

(2) If communications fail during an emergency situation or the required response time prohibits communication, a first responder may perform services subject to this division, if, in the judgment of the first responder, the life of the patient is in immediate danger. Services performed under these circumstances shall be performed in accordance with the written protocols for triage of adult and pediatric trauma victims established in rules adopted under sections 4765.11 and 4765.40 of the Revised Code and any applicable protocols adopted by the emergency medical service organization with which the first responder is affiliated.

4765.36 Emergency medical technician services while in hospital.

In a hospital, an emergency medical technician-basic, emergency medical technician-intermediate, or emergency medical technician-paramedic may perform emergency medical services if the services are performed in accordance with both of the following conditions:

(A) Only in the hospital’s emergency department or while moving a patient between the emergency department and another part of the hospital;

(B) Only under the direction and supervision of one of the following:

(1) A physician;

(2) A physician assistant designated by a physician;

(3) A registered nurse designated by a physician.

4765.37 EMT-basic; performance of services.

(A) An emergency medical technician-basic shall perform the emergency medical services described in this section in accordance with this chapter and any rules adopted under it by the state board of emergency medical, fire, and transportation services.

(B) An emergency medical technician-basic may operate, or be responsible for operation of, an ambulance and may provide emergency medical services to patients. In an emergency, an EMT-basic may determine the nature and extent of illness or injury and establish priority for required emergency medical services. An EMT-basic may render emergency medical services such as opening and maintaining an airway, giving positive pressure ventilation, cardiac resuscitation, electrical interventions with automated defibrillators to support or correct the cardiac function and other methods determined by the board, controlling of hemorrhage, treatment of shock, immobilization of fractures, bandaging, assisting in childbirth, management of mentally disturbed patients, initial care of poison and burn patients, and determining triage of adult and pediatric trauma victims. Where patients must in an emergency be extricated from entrapment, an EMT-basic may assess the extent of injury and render all possible emergency medical services and protection to the entrapped patient; provide light rescue services if an ambulance has not been accompanied by a specialized unit; and after extrication, provide additional care in sorting of the injured in accordance with standard emergency procedures.

(C) An EMT-basic may perform any other emergency medical services approved
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pursuant to rules adopted under section 4765.11 of the Revised Code. The board shall determine whether the nature of any such service requires that an EMT-basic receive authorization prior to performing the service.

(D)(1) Except as provided in division (D)(2) of this section, if the board determines under division (C) of this section that a service requires prior authorization, the service shall be performed only pursuant to the written or verbal authorization of a physician or of the cooperating physician advisory board, or pursuant to an authorization transmitted through a direct communication device by a physician, physician assistant designated by a physician, or registered nurse designated by a physician.

(2) If communications fail during an emergency situation or the required response time prohibits communication, an EMT-basic may perform services subject to this division, if, in the judgment of the EMT-basic, the life of the patient is in immediate danger. Services performed under these circumstances shall be performed in accordance with the protocols for triage of adult and pediatric trauma victims established in rules adopted under sections 4765.11 and 4765.40 of the Revised Code and any applicable protocols adopted by the emergency medical service organization with which the EMT-basic is affiliated.

4765.38 EMT-intermediate; performance of services.

(A) An emergency medical technician-intermediate shall perform the emergency medical services described in this section in accordance with this chapter and any rules adopted under it.

(B) An EMT-I may do any of the following:

(1) Establish and maintain an intravenous lifeline that has been approved by a cooperating physician or physician advisory board;
(2) Perform cardiac monitoring;
(3) Perform electrical interventions to support or correct the cardiac function;
(4) Administer epinephrine;
(5) Determine triage of adult and pediatric trauma victims;
(6) Perform any other emergency medical services approved pursuant to rules adopted under section 4765.11 of the Revised Code.

(C)(1) Except as provided in division (C)(2) of this section, the services described in division (B) of this section shall be performed by an EMT-I only pursuant to the written or verbal authorization of a physician or of the cooperating physician advisory board, or pursuant to an authorization transmitted through a direct communication device by a physician, physician assistant designated by a physician, or registered nurse designated by a physician.

(2) If communications fail during an emergency situation or the required response time prohibits communication, an EMT-I may perform any of the services described in division (B) of this section, if, in the judgment of the EMT-I, the life of the patient is in immediate danger. Services performed under these circumstances shall be performed in accordance with the protocols for triage of adult and pediatric trauma victims established in rules adopted under sections 4765.11 and 4765.40 of the Revised Code and any applicable protocols adopted by the emergency medical service organization with which the EMT-I is affiliated.

(D) In addition to, and in the course of, providing emergency medical treatment, an emergency medical technician-intermediate may withdraw blood as provided under sections 1547.11, 4506.17, and 4511.19 of the Revised Code. An emergency medical technician-intermediate shall withdraw blood in accordance with this chapter and any rules adopted under it by the state board of emergency medical, fire, and transportation services.
4765.39 EMT-paramedic; performance of services; emergency situations.

(A) An emergency medical technician-paramedic shall perform the emergency medical services described in this section in accordance with this chapter and any rules adopted under it.

(B) A paramedic may do any of the following:

1. Perform cardiac monitoring;
2. Perform electrical interventions to support or correct the cardiac function;
3. Perform airway procedures;
4. Perform relief of pneumothorax;
5. Administer appropriate drugs and intravenous fluids;
6. Determine triage of adult and pediatric trauma victims;
7. Perform any other emergency medical services, including life support or intensive care techniques, approved pursuant to rules adopted under section 4765.11 of the Revised Code.

(C)(1) Except as provided in division (C)(2) of this section, the services described in division (B) of this section shall be performed by a paramedic only pursuant to the written or verbal authorization of a physician or of the cooperating physician advisory board, or pursuant to an authorization transmitted through a direct communication device by a physician, physician assistant designated by a physician, or registered nurse designated by a physician.

(C)(2) If communications fail during an emergency situation or the required response time prohibits communication, a paramedic may perform any of the services described in division (B) of this section, if, in the paramedic's judgment, the life of the patient is in immediate danger. Services performed under these circumstances shall be performed in accordance with the protocols for triage of adult and pediatric trauma victims established in rules adopted under sections 4765.11 and 4765.40 of the Revised Code and any applicable protocols adopted by the emergency medical service organization with which the paramedic is affiliated.

(D) In addition to, and in the course of, providing emergency medical treatment, an emergency medical technician-paramedic may withdraw blood as provided under sections 1547.11, 4506.17, and 4511.19 of the Revised Code. An emergency medical technician-paramedic shall withdraw blood in accordance with this chapter and any rules adopted under it by the state board of emergency medical, fire, and transportation services.

4765.391 EMS flu vaccine.

(A) The medical director or cooperating physician advisory board of each emergency medical service organization may authorize one or more emergency medical technicians-paramedic within the organization to administer immunizations for influenza to either of the following:

1. A full-time paid firefighter, part-time paid firefighter, or volunteer firefighter;
2. An emergency medical technician-basic, emergency medical technician-intermediate, or paramedic.

(B) The medical director or cooperating physician advisory board of each emergency medical service organization shall establish written protocols and training necessary for a paramedic to administer an immunization for influenza under this section. A paramedic administering an immunization under this section shall do so in accordance with the protocols and training.

(C) For each immunization administered under this section, the paramedic administering the immunization shall, not later than thirty days after the immunization is administered, do either of the following:

1. Provide notice of the immunization administration to the board of health of the city or
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general health district in which the individual receiving the immunization resides or, if there is no
board of health for that district, the authority having the duties of a board of health under section
3709.05 of the Revised Code;
(2) Submit the immunization administration information to the state immunization registry
maintained by the department of health.

4765.40 Trauma victims; state and regional triage protocols.

(A)(1) Not later than two years after November 3, 2000, the state board of emergency
medical, fire, and transportation services shall adopt rules under section 4765.11 of the Revised
Code establishing written protocols for the triage of adult and pediatric trauma victims. The rules
shall define adult and pediatric trauma in a manner that is consistent with section 4765.01 of the
Revised Code, minimizes overtriage and undertriage, and emphasizes the special needs of
pediatric and geriatric trauma patients.
(2) The state triage protocols adopted under division (A) of this section shall require a
trauma victim to be transported directly to an adult or pediatric trauma center that is qualified to
provide appropriate adult or pediatric trauma care, unless one or more of the following
exceptions applies:
(a) It is medically necessary to transport the victim to another hospital for initial
assessment and stabilization before transfer to an adult or pediatric trauma center;
(b) It is unsafe or medically inappropriate to transport the victim directly to an adult or
pediatric trauma center due to adverse weather or ground conditions or excessive transport
time;
(c) Transporting the victim to an adult or pediatric trauma center would cause a shortage
of local emergency medical service resources;
(d) No appropriate adult or pediatric trauma center is able to receive and provide adult or
pediatric trauma care to the trauma victim without undue delay;
(e) Before transport of a patient begins, the patient requests to be taken to a particular
hospital that is not a trauma center or, if the patient is less than eighteen years of age or is not
able to communicate, such a request is made by an adult member of the patient's family or a
legal representative of the patient.

(3)(a) The state triage protocols adopted under division (A) of this section shall require
trauma patients to be transported to an adult or pediatric trauma center that is able to provide
appropriate adult or pediatric trauma care, but shall not require a trauma patient to be
transported to a particular trauma center. The state triage protocols shall establish one or more
procedures for evaluating whether an injury victim requires or would benefit from adult or
pediatric trauma care, which procedures shall be applied by emergency medical service
personnel based on the patient's medical needs. In developing state trauma triage protocols,
the board shall consider relevant model triage rules and shall consult with the commission on
minority health, regional directors, regional physician advisory boards, and appropriate medical,
hospital, and emergency medical service organizations.
(b) Before the joint committee on agency rule review considers state triage protocols for
trauma victims proposed by the state board of emergency medical, fire, and transportation
services, or amendments thereto, the board shall send a copy of the proposal to the Ohio
chapter of the American college of emergency physicians, the Ohio chapter of the American
college of surgeons, the Ohio chapter of the American academy of pediatrics, OHA: the
association for hospitals and health systems, the Ohio osteopathic association, and the
association of Ohio children's hospitals and shall hold a public hearing at which it must consider
the appropriateness of the protocols to minimize overtriage and undertriage of trauma victims.
(c) The board shall provide copies of the state triage protocols, and amendments to the
protocols, to each emergency medical service organization, regional director, regional physician
advisory board, certified emergency medical service instructor, and person who regularly provides medical direction to emergency medical service personnel in the state; to each medical service organization in other jurisdictions that regularly provide emergency medical services in this state; and to others upon request.

(B)(1) The state board of emergency medical, fire, and transportation services shall approve regional protocols for the triage of adult and pediatric trauma victims, and amendments to such protocols, that are submitted to the board as provided in division (B)(2) of this section and provide a level of adult and pediatric trauma care comparable to the state triage protocols adopted under division (A) of this section. The board shall not otherwise approve regional triage protocols for trauma victims. The board shall not approve regional triage protocols for regions that overlap and shall resolve any such disputes by apportioning the overlapping territory among appropriate regions in a manner that best serves the medical needs of the residents of that territory. The trauma committee of the board shall have reasonable opportunity to review and comment on regional triage protocols and amendments to such protocols before the board approves or disapproves them.

(2) Regional protocols for the triage of adult and pediatric trauma victims, and amendments to such protocols, shall be submitted in writing to the state board of emergency medical, fire, and transportation services by the regional physician advisory board or regional director, as appropriate, that serves a majority of the population in the region in which the protocols apply. Prior to submitting regional triage protocols, or an amendment to such protocols, to the state board of emergency medical, fire, and transportation services, a regional physician advisory board or regional director shall consult with each of the following that regularly serves the region in which the protocols apply:

(a) Other regional physician advisory boards and regional directors;
(b) Hospitals that operate an emergency facility;
(c) Adult and pediatric trauma centers;
(d) Professional societies of physicians who specialize in adult or pediatric emergency medicine or adult or pediatric trauma surgery;
(e) Professional societies of nurses who specialize in adult or pediatric emergency nursing or adult or pediatric trauma surgery;
(f) Professional associations or labor organizations of emergency medical service personnel;
(g) Emergency medical service organizations and medical directors of such organizations;
(h) Certified emergency medical service instructors.

(3) Regional protocols for the triage of adult and pediatric trauma victims approved under division (B)(2) of this section shall require patients to be transported to a trauma center that is able to provide an appropriate level of adult or pediatric trauma care; shall not discriminate among trauma centers for reasons not related to a patient's medical needs; shall seek to minimize undertriage and overtriage; may include any of the exceptions in division (A)(2) of this section; and supersede the state triage protocols adopted under division (A) of this section in the region in which the regional protocols apply.

(4) Upon approval of regional protocols for the triage of adult and pediatric trauma victims under division (B)(2) of this section, or an amendment to such protocols, the state board of emergency medical, fire, and transportation services shall provide written notice of the approval and a copy of the protocols or amendment to each entity in the region in which the protocols apply to which the board is required to send a copy of the state triage protocols adopted under division (A) of this section.

(C)(1) The state board of emergency medical, fire, and transportation services shall review the state triage protocols adopted under division (A) of this section at least every three years to determine if they are causing overtriage or undertriage of trauma patients, and shall
modify them as necessary to minimize overtriage and undertriage.

(2) Each regional physician advisory board or regional director that has had regional triage protocols approved under division (B)(2) of this section shall review the protocols at least every three years to determine if they are causing overtriage or undertriage of trauma patients and shall submit an appropriate amendment to the state board, as provided in division (B) of this section, as necessary to minimize overtriage and undertriage. The state board shall approve the amendment if it will reduce overtriage or undertriage while complying with division (B) of this section, and shall not otherwise approve the amendment.

(D) No provider of emergency medical services or person who provides medical direction to emergency medical service personnel in this state shall fail to comply with the state triage protocols adopted under division (A) of this section or applicable regional triage protocols approved under division (B)(2) of this section.

(E) The state board of emergency medical, fire, and transportation services shall adopt rules under section 4765.11 of the Revised Code that provide for enforcement of the state triage protocols adopted under division (A) of this section and regional triage protocols approved under division (B)(2) of this section, and for education regarding those protocols for emergency medical service organizations and personnel, regional directors and regional physician advisory boards, emergency medical service instructors, and persons who regularly provide medical direction to emergency medical service personnel in this state.

4765.43 Ambulance staffing requirement if equipped for emergency medical services.

(A) During each emergency run made by an ambulance that is equipped for emergency medical services, the emergency medical service organization operating the ambulance shall staff the ambulance in accordance with this section.

For purposes of determining the applicable staffing requirements, both of the following apply:

(1) An emergency run consists of components that are distinguished between the period during which the ambulance is traveling to the scene of an emergency and, if applicable, the period during which the ambulance is transporting a patient from the scene of the emergency.

(2) In the case of an emergency medical service organization that utilizes a combination of volunteer and paid first responders, emergency medical service technicians-basic, emergency medical service technicians-intermediate, or emergency medical service technicians-paramedic, the organization is considered to be substantially utilizing volunteers in a particular week when the paid individuals, taken as a whole, are scheduled for a total of not more than one hundred ninety-two hours in that week.

(B) With respect to the driver of an ambulance during an emergency run, both of the following apply:

(1) The driver must be at least eighteen years of age and hold a valid driver's license.

(2) The driver must meet at least one of the following criteria:

(a) Hold a valid certificate issued under section 4765.30 of the Revised Code to practice as a medical first responder, EMT, advanced EMT, or paramedic;

(b) Hold a valid fire training certificate issued pursuant to section 4765.55 of the Revised Code to provide services as a firefighter;

(c) Be employed and in good standing as a sworn sheriff, deputy sheriff, constable, police officer, marshal, deputy marshal, or highway patrol trooper in this state;

(d) Have successfully completed either the emergency vehicle operations course approved by the national highway traffic safety administration or an equivalent course approved by the state board of emergency medical services.

(C) With respect to the component of an emergency run during which the ambulance is traveling to the scene of the emergency, the ambulance shall be staffed by at least one EMT,
advanced EMT, or paramedic. This individual may serve as the driver.

(D) With respect to the component of an emergency run during which a patient is being transported, the ambulance shall be staffed as follows:

(1) If the emergency medical service organization utilizes only paid individuals or utilizes volunteers on a basis that is not considered to be substantially utilizing volunteers, the ambulance shall be staffed by at least two EMTs, advanced EMTs, or paramedics. One of these individuals may serve as the driver.

(2) If the emergency medical service organization is substantially utilizing volunteers or utilizes only volunteers, the ambulance shall be staffed by at least two EMTs, advanced EMTs, or paramedics or by at least one first responder and one EMT, advanced EMT, or paramedic. One of these individuals may serve as the driver, but if the staffing requirement is being met by utilizing a medical first responder, the medical first responder shall serve as the driver.

4765.49 EMTs, related personnel, and agencies; civil immunity.

(A) A first responder, emergency medical technician-basic, emergency medical technician-intermediate, or emergency medical technician-paramedic is not liable in damages in a civil action for injury, death, or loss to person or property resulting from the individual's administration of emergency medical services, unless the services are administered in a manner that constitutes willful or wanton misconduct. A physician, physician assistant designated by a physician, or registered nurse designated by a physician, any of whom is advising or assisting in the emergency medical services by means of any communication device or telemetering system, is not liable in damages in a civil action for injury, death, or loss to person or property resulting from the individual's advisory communication or assistance, unless the advisory communication or assistance is provided in a manner that constitutes willful or wanton misconduct. Medical directors and members of cooperating physician advisory boards of emergency medical service organizations are not liable in damages in a civil action for injury, death, or loss to person or property resulting from their acts or omissions in the performance of their duties, unless the act or omission constitutes willful or wanton misconduct.

(B) A political subdivision, joint ambulance district, joint emergency medical services district, or other public agency, and any officer or employee of a public agency or of a private organization operating under contract or in joint agreement with one or more political subdivisions, that provides emergency medical services, or that enters into a joint agreement or a contract with the state, any political subdivision, joint ambulance district, or joint emergency medical services district for the provision of emergency medical services, is not liable in damages in a civil action for injury, death, or loss to person or property arising out of any actions taken by a first responder, EMT-basic, EMT-I, or paramedic working under the officer's or employee's jurisdiction, or for injury, death, or loss to person or property arising out of any actions of licensed medical personnel advising or assisting the first responder, EMT-basic, EMT-I, or paramedic, unless the services are provided in a manner that constitutes willful or wanton misconduct.

(C) A student who is enrolled in an emergency medical services training program accredited under section 4765.17 of the Revised Code or an emergency medical services continuing education program approved under that section is not liable in damages in a civil action for injury, death, or loss to person or property resulting from either of the following:

(1) The student's administration of emergency medical services or patient care or treatment, if the services, care, or treatment is administered while the student is under the direct supervision and in the immediate presence of an EMT-basic, EMT-I, paramedic, registered nurse, physician assistant, or physician and while the student is receiving clinical training that is required by the program, unless the services, care, or treatment is provided in a manner that constitutes willful or wanton misconduct;
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(2) The student's training as an ambulance driver, unless the driving is done in a manner that constitutes willful or wanton misconduct.

(D) An EMT-basic, EMT-I, paramedic, or other operator, who holds a valid commercial driver's license issued pursuant to Chapter 4506 of the Revised Code or driver's license issued pursuant to Chapter 4507 of the Revised Code and who is employed by an emergency medical service organization that is not owned or operated by a political subdivision as defined in section 2744.01 of the Revised Code, is not liable in damages in a civil action for injury, death, or loss to person or property that is caused by the operation of an ambulance by the EMT-basic, EMT-I, paramedic, or other operator while responding to or completing a call for emergency medical services, unless the operation constitutes willful or wanton misconduct or does not comply with the precautions of section 4511.03 of the Revised Code. An emergency medical service organization is not liable in damages in a civil action for any injury, death, or loss to person or property that is caused by the operation of an ambulance by its employee or agent, if this division grants the employee or agent immunity from civil liability for the injury, death, or loss.

(E) An employee or agent of an emergency medical service organization who receives requests for emergency medical services that are directed to the organization, dispatches first responders, EMTs-basic, EMTs-I, or paramedics in response to those requests, communicates those requests to those employees or agents of the organization who are authorized to dispatch first responders, EMTs-basic, EMTs-I, or paramedics, or performs any combination of these functions for the organization, is not liable in damages in a civil action for injury, death, or loss to person or property resulting from the individual's acts or omissions in the performance of those duties for the organization, unless an act or omission constitutes willful or wanton misconduct.

(F) A person who is performing the functions of a first responder, EMT-basic, EMT-I, or paramedic under the authority of the laws of a state that borders this state and who provides emergency medical services to or transportation of a patient in this state is not liable in damages in a civil action for injury, death, or loss to person or property resulting from the person's administration of emergency medical services, unless the services are administered in a manner that constitutes willful or wanton misconduct. A physician, physician assistant designated by a physician, or registered nurse designated by a physician, any of whom is licensed to practice in the adjoining state and who is advising or assisting in the emergency medical services by means of any communication device or telemetering system, is not liable in damages in a civil action for injury, death, or loss to person or property resulting from the person's advisory communication or assistance, unless the advisory communication or assistance is provided in a manner that constitutes willful or wanton misconduct.

(G) A person certified under section 4765.23 of the Revised Code to teach in an emergency medical services training program or emergency medical services continuing education program, and a person who teaches at the Ohio fire academy established under section 3737.33 of the Revised Code or in a fire service training program described in division (A) of section 4765.55 of the Revised Code, is not liable in damages in a civil action for injury, death, or loss to person or property resulting from the person's acts or omissions in the performance of the person's duties, unless an act or omission constitutes willful or wanton misconduct.

(H) In the accreditation of emergency medical services training programs or approval of emergency medical services continuing education programs, the state board of emergency medical, fire, and transportation services and any person or entity authorized by the board to evaluate applications for accreditation or approval are not liable in damages in a civil action for injury, death, or loss to person or property resulting from their acts or omissions in the performance of their duties, unless an act or omission constitutes willful or wanton misconduct.

(I) A person authorized by an emergency medical service organization to review the performance of first responders, EMTs-basic, EMTs-I, and paramedics or to administer quality assurance programs is not liable in damages in a civil action for injury, death, or loss to person
or property resulting from the person's acts or omissions in the performance of the person's duties, unless an act or omission constitutes willful or wanton misconduct.

4765-15-04 EMT-basic scope of practice.

(A) In addition to the emergency medical services listed in rule 4765-12-04 of the Administrative Code and in accordance with division (B) of section 4765.37 of the Revised Code, an emergency medical technician may perform the following emergency medical services:

1. Endotracheal suctioning through a previously established airway;
2. Endotracheal suctioning through a stoma;
3. Oxygen administration, including the following:
   a. Partial rebreather masks;
   b. Venturi masks.
4. Ventilation management, to include the use of a positive pressure ventilation device, including the following:
   a. Manually triggered ventilators;
   b. Automatic transportation ventilators.
5. Traction splint;
6. Rapid extrication procedures;

(B) In accordance with division (C) of section 4765.37 of the Revised Code, an emergency medical technician may perform the following additional emergency medical services only pursuant to the written or verbal authorization of a physician or of the cooperating physician advisory board, or authorization transmitted through a direct communication device by a physician, physician assistant designated by a physician, or registered nurse designated by a physician, or in accordance with written protocols as specified in division (D) of section 4765.37 of the Revised Code:

1. Pulse oximeter and capnography equipment application and reading;
2. Until January 1, 2013, orotracheal intubation of pulseless and apneic patients only;
3. Dual lumen airway of pulseless and apneic patients only;
4. Oxygen humidifier equipment application and monitoring;
5. Extraglottic airway of pulseless and apneic patients only;
6. Continuous positive airway pressure (CPAP);
7. End tidal carbon dioxide monitoring and detecting;
8. Chest compression assist devices;
9. Administration of aspirin;
10. Pneumatic anti-shock garment;
11. Helmet removal;
12. Glucose monitoring system;
13. Administration of oral glucose;
14. Administration of activated charcoal;
15. Administration of epinephrine auto-injector to a patient suffering from anaphylaxis;
16. Assisted administration of sublingual nitroglycerin, which shall consist of either of the following:
   a. Assisting with patient's prescribed nitroglycerin upon the patient's request and with written protocol;
   b. Assisting with EMS-provided nitroglycerin with verbal medical direction.
17. Assisted administration of aerosolized or nebulized medications, which shall consist of either of the following:
   a. Assisting with a patient's prescribed aerosolized or nebulized medications upon the patient's request and with written protocol;
(b) Assisting with EMS-provided aerosolized or nebulized medications with verbal medical direction.

(18) Pre-hospital advanced life support assistance, to include the setting up of an intravenous administration kit in the presence of an advanced emergency medical technician or paramedic;

(19) Set up and application of a cardiac monitor in the presence of an advanced emergency medical technician or paramedic;

(20) Set up and application of a twelve-lead electrocardiogram, in accordance with written protocols, in either of the following instances:

(a) When the emergency medical technician is assisting an paramedic; or

(b) For the purpose of electronic transmission by the emergency medical technician, provided the following conditions are met:

(i) The emergency medical technician does not interpret the electrocardiogram;

(ii) The emergency medical technician minimizes any delay of patient transport to obtain a twelve-lead electrocardiogram;

(iii) The EMT utilizes the twelve-lead electrocardiogram in conjunction with destination protocols approved by the local medical director.

(21) Any other services approved by the board pursuant to rule 4765-6-01 of the Administrative Code;

(22) Any other services pursuant to a research study approved by the board under rule 4765-6-04 of the Administrative Code and within the parameters established by the board for such study.

(C) A physician or cooperating physician advisory board that serves as the medical director for any EMS organization may limit, but not exceed, the scope of practice for those emergency medical technicians who provide emergency medical services under the auspices of the physician's certificate to practice medicine and surgery, or osteopathic medicine and surgery, issued under Chapter 4731 of the Revised Code.

(D) An emergency medical technician shall not perform emergency medical services within this rule unless the emergency medical technician has received training as part of an initial certification course or through subsequent training approved by the board. If certain emergency medical services, within the emergency medical technician scope of practice, were not included in the training specified in this paragraph, the emergency medical technician must have received training regarding such services approved by the local medical director before performing those services.

4765-16-04 EMT–intermediate scope of practice.

(A) In addition to the emergency medical services listed in rules 4765-12-04 and 4765-15-04 of the Administrative Code, and in accordance with section 4765.38 of the Revised Code, an advanced emergency medical technician may perform the following emergency medical services only pursuant to the written or verbal authorization of a physician or of the cooperating physician advisory board, or authorization transmitted through a direct communication device by a physician, physician assistant designated by physician, or registered nurse designated by a physician, or in accordance with written protocols as specified in division (C) of section 4765.38 of the Revised Code:

(1) Cardiac monitor strip interpretation;

(2) Manual defibrillation;

(3) Obtaining blood specimens;

(4) Subcutaneous or intramuscular administration of epinephrine;

(5) Intravenous access and peripheral initiation;

(6) Intravenous maintenance and fluid administration;
(7) Intraosseous insertion;
(8) Saline lock.

(B) In addition to the emergency medical services described in paragraph (A) of this rule, and in accordance with section 4765.38 of the Revised Code, an advanced emergency medical technician who has completed a training program pursuant to this chapter of the Administrative Code may perform the following emergency medical services only pursuant to the written or verbal authorization of a physician or of the cooperating physician advisory board, or authorization transmitted through a direct communication device by a physician, physician assistant designated by physician, or registered nurse designated by a physician, or in accordance with written protocols as specified in division (C) of section 4765.38 of the Revised Code:

(1) Administration of the following medications:
   (a) Sublingual nitroglycerin;
   (b) Dextrose in water;
   (c) Epinephrine at the concentration of one to one thousand;
   (d) Diphenhydramine;
   (e) Benzodiazepines;
   (f) Bronchodilators;
   (g) Naloxone;
   (h) Glucagon;
   (i) Nitrous oxide;
   (j) Nalbuphine;
   (k) Narcotics or other analgesics for pain relief;
   (l) Lidocaine, for pain relief after intraosseous insertions;
   (m) Any additional drug approved by the board.

(2) Administration of aerosolized or nebulized medications;

(3) Administration of intranasal medications;

(4) Orotracheal intubation of the apneic patient;

(5) Dual lumen airway of the apneic patient;

(6) Extraglottic airway of the apneic patient;

(7) Needle decompression of the chest;

(8) Tracheostomy tube replacement;

(9) Laryngoscopy for removal of airway obstruction;

(10) Set up and application of a twelve-lead electrocardiogram, in accordance with written protocols, in either of the following instances:
   (a) When the advanced emergency medical technician is assisting a paramedic; or
   (b) For the purpose of electronic transmission by the advanced emergency medical technician, provided the following conditions are met:
      (i) The advanced emergency medical technician does not interpret the electrocardiogram;
      (ii) The advanced emergency medical technician minimizes any delay of patient transport while obtaining a twelve-lead electrocardiogram;
      (iii) The advanced emergency medical technician utilizes the twelve-lead electrocardiogram in conjunction with destination protocols approved by the local medical director.

(11) Withdraw blood for the purpose of determining the alcohol, drug, controlled substance, metabolite of a controlled substance, or combination content of the whole blood, blood serum, or blood plasma as provided in division (D) of section 4765.38 of the Revised Code when performed in accordance with the criteria established in rule 4765-6-06 of the Administrative Code and the protocols established by the medical director of the emergency
medical service organization with which the advanced emergency medical technician is affiliated.

(12) Any other services approved by the board pursuant to rule 4765-6-01 of the Administrative Code.

(13) Any other services pursuant to a research study approved by the board under rule 4765-6-04 of the Administrative Code and within the parameters established by the board for such study.

(C) A physician or cooperating physician advisory board that serves as the medical director for any EMS organization may limit, but not exceed, the scope of practice for those advanced emergency medical technicians who provide emergency medical services under the auspices of the physician's certificate to practice medicine and surgery, or osteopathic medicine and surgery, issued under Chapter 4731 of the Revised Code to include the withdrawing of blood for evidence collection.

(D) An advanced emergency medical technician shall not perform emergency medical services within this rule unless the advanced emergency medical technician has received training as part of an initial certification course or through subsequent training approved by the board. If certain emergency medical services, within the advanced emergency medical technician scope of practice, were not included in the training specified in this paragraph, the advanced emergency medical technician must have received training regarding such services approved by the local medical director before performing those services.

### 4765-17-03 EMT–paramedic scope of practice.

(A) In addition to the skills listed in rules 4765-12-04, 4765-15-04 and 4765-16-04 of the Administrative Code, and in accordance with section 4765.39 of the Revised Code, a paramedic may perform the following emergency medical services only pursuant to the written or verbal authorization of a physician or of the cooperating physician advisory board, or authorization transmitted through a direct communication device by a physician, physician assistant designated by a physician, or registered nurse designated by a physician, or in accordance with written protocols as specified in division (C) of section 4765.39 of the Revised Code:

1. Orotracheal intubation;
2. Nasotracheal intubation;
3. Cricothyrotomy (surgical);
4. Cricothyrotomy (needle);
5. Positive end-expiratory pressure;
6. Bilevel positive air pressure;
7. Ventilator management of patients sixteen years of age or older;
8. Chest tube monitoring and management;
9. Central line monitoring;
10. Transcutaneous cardiac pacing;
11. Administration of cardiac medication;
12. Cardioversion;
13. Carotid massage;
14. Twelve-lead electrocardiogram performance and interpretation;
15. Administration of nitroglycerin;
16. Administration of aerosolized or nebulized medication;
17. Placement of nasogastric or orogastric tubes;
18. Administration of cardiac medication;
19. Administration of other medications pursuant to written protocols;
20. Intravenous infusion pump;
21. Blood chemistry analysis;
(22) Thrombolytic therapy initiation and monitoring;
(23) Maintenance of medicated intravenous fluids;
(24) Maintenance of blood administration;
(25) Eye irrigation morgan lens;
(26) Withdraw blood for the purpose of determining the alcohol, drug, controlled substance, metabolite of a controlled substance, or combination content of the whole blood, blood serum, or blood plasma as provided in division (D) of section 4765.39 of the Revised Code when performed in accordance with the criteria established in rule 4765-6-06 of the Administrative Code and the protocols established by the medical director of the emergency medical service organization with which the paramedic is affiliated;
(27) Any other services pursuant to a research study approved by the board under rule 4765-6-04 of the Administrative Code and within the parameters established by the board for such study;
(28) Any other services approved by the board pursuant to rule 4765-6-01 of the Administrative Code.

(B) A physician or cooperating physician advisory board that serves as the medical director for any EMS organization may limit, but not exceed, the scope of practice for those paramedics who provide emergency medical services under the auspices of the physician's certificate to practice medicine and surgery, or osteopathic medicine and surgery, issued under Chapter 4731 of the Revised Code to include the withdrawing of blood for evidence collection.

(C) A paramedic shall not perform emergency medical services within this rule unless the paramedic has received training as part of an initial certification course or through subsequent training approved by the board. If certain emergency medical services, within the paramedic scope of practice, were not included in the training specified in this paragraph, the paramedic must have received training regarding such services approved by the local medical director before performing those services.

4766.01 Medical Transportation Board; definitions.

As used in this chapter:
(A) “Advanced life support” means treatment described in section 4765.39 of the Revised Code that a paramedic is certified to perform.
(B) “Air medical service organization” means an organization that furnishes, conducts, maintains, advertises, promotes, or otherwise engages in providing medical services with a rotorcraft air ambulance or fixed wing air ambulance.
(C) “Air medical transportation” means the transporting of a patient by rotorcraft air ambulance or fixed wing air ambulance with appropriately licensed and certified medical personnel.
(D) “Ambulance” means any motor vehicle that is specifically designed, constructed, or modified and equipped and is intended to be used to provide basic life support, intermediate life support, advanced life support, or mobile intensive care unit services and transportation upon the streets or highways of this state of persons who are seriously ill, injured, wounded, or otherwise incapacitated or helpless. “Ambulance” does not include air medical transportation or a vehicle designed and used solely for the transportation of nonstretcher-bound persons, whether hospitalized or handicapped or whether ambulatory or confined to a wheelchair.
(E) “Ambulette” means a motor vehicle that is specifically designed, constructed, or modified and equipped and is intended to be used for transportation upon the streets or highways of this state of persons who require use of a wheelchair.
(F) “Basic life support” means treatment described in section 4765.37 of the Revised Code that an EMT is certified to perform.
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(G) “Disaster situation” means any condition or situation described by rule of the state board of emergency medical, fire, and transportation services as a mass casualty, major emergency, natural disaster, or national emergency.

(H) “Emergency medical service organization” means an organization that uses EMTs, AEMTs, or paramedics, or a combination of EMTs, AEMTs, and paramedics, to provide medical care to victims of illness or injury. An emergency medical service organization includes, but is not limited to, a commercial ambulance service organization, a hospital, and a funeral home.

(I) “EMT,” “AEMT,” and “paramedic” have the same meanings as in sections 4765.01 and 4765.011 of the Revised Code.

(J) “Fixed wing air ambulance” means a fixed wing aircraft that is specifically designed, constructed, or modified and equipped and is intended to be used as a means of air medical transportation.

(K) “Intermediate life support” means treatment described in section 4765.38 of the Revised Code that an AEMT is certified to perform.

(L) “Major emergency” means any emergency event that cannot be resolved through the use of locally available emergency resources.

(M) “Mass casualty” means an emergency event that results in ten or more persons being injured, incapacitated, made ill, or killed.

(N) “Medical emergency” means an unforeseen event affecting an individual in such a manner that a need for immediate care is created.

(O) “Mobile intensive care unit” means an ambulance used only for maintaining specialized or intensive care treatment and used primarily for interhospital transports of patients whose conditions require care beyond the scope of a paramedic as provided in section 4765.39 of the Revised Code.

(P)(1) “Nonemergency medical service organization” means a person that does both of the following:

(a) Provides services to the public on a regular basis for the purpose of transporting individuals who require the use of a wheelchair or are confined to a wheelchair to receive health care services at health care facilities or health care practitioners’ offices in nonemergency circumstances;

(b) Provides the services for a fee, regardless of whether the fee is paid by the person being transported, a third party payer, as defined in section 3702.51 of the Revised Code, or any other person or government entity.

(2) “Nonemergency medical service organization” does not include a health care facility, as defined in section 1751.01 of the Revised Code, that provides ambulette services only to patients of that facility.

(Q) “Nontransport vehicle” means a motor vehicle operated by a licensed emergency medical service organization not as an ambulance, but as a vehicle for providing services in conjunction with the ambulances operated by the organization or other emergency medical service organizations.

(R) “Patient” means any individual who as a result of illness or injury needs medical attention, whose physical or mental condition is such that there is imminent danger of loss of life or significant health impairment, who may be otherwise incapacitated or helpless as a result of a physical or mental condition, or whose physical condition requires the use of a wheelchair.

(S) “Rotorcraft air ambulance” means a helicopter or other aircraft capable of vertical takeoffs, vertical landings, and hovering that is specifically designed, constructed, or modified and equipped and is intended to be used as a means of air medical transportation.
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4766.03 Ohio medical transportation board to adopt rules.

(A) The state board of emergency medical, fire, and transportation services shall adopt rules, in accordance with Chapter 119 of the Revised Code, implementing the requirements of this chapter. The rules shall include provisions relating to the following:

1. Requirements for an emergency medical service organization to receive a permit for an ambulance or nontransport vehicle;
2. Requirements for an emergency medical service organization to receive a license as a basic life-support, intermediate life-support, advanced life-support, or mobile intensive care unit organization;
3. Requirements for a nonemergency medical service organization to receive a permit for an ambulette vehicle;
4. Requirements for a nonemergency medical service organization to receive a license for an ambulette service;
5. Requirements for an air medical service organization to receive a permit for a rotorcraft air ambulance or fixed wing air ambulance;
6. Requirements for licensure of air medical service organizations;
7. Forms for applications and renewals of licenses and permits;
8. Requirements for record keeping of service responses made by licensed emergency medical service organizations;
9. Fee amounts for licenses and permits, and their renewals;
10. Inspection requirements for licensees' vehicles or aircraft, records, and physical facilities;
11. Fee amounts for inspections of ambulances, ambulettes, rotorcraft air ambulances, fixed wing air ambulances, and nontransport vehicles;
12. Requirements for ambulances and nontransport vehicles used by licensed emergency medical service organizations, for ambulette vehicles used by licensed nonemergency medical service organizations, and for rotorcraft air ambulances or fixed wing air ambulances used by licensed air medical service organizations that specify for each type of vehicle or aircraft the types of equipment that must be carried, the communication systems that must be maintained, and the personnel who must staff the vehicle or aircraft;
13. The level of care each type of emergency medical service organization, nonemergency medical service organization, and air medical service organization is authorized to provide;
14. Eligibility requirements for employment as an ambulette driver, including grounds for disqualification due to the results of a motor vehicle law violation check, chemical test, or criminal records check. The rule may require that an applicant for employment as an ambulette driver provide a set of fingerprints to law enforcement authorities if the applicant comes under final consideration for employment.
15. Any other rules that the board determines necessary for the implementation and enforcement of this chapter.

(B) In the rules for ambulances and nontransport vehicles adopted under division (A)(12) of this section, the board may establish requirements that vary according to whether the emergency medical service organization using the vehicles is licensed as a basic life-support, intermediate life-support, advanced life-support, or mobile intensive care unit organization.

(C) A mobile intensive care unit that is not dually certified to provide advanced life-support and meets the requirements of the rules adopted under this section is not required to carry immobilization equipment, including board splint kits, traction splints, backboards, backboard straps, cervical immobilization devices, cervical collars, stair chairs, folding cots, or other types of immobilization equipment determined by the board to be unnecessary for mobile intensive care units.
A mobile intensive care unit is exempt from the emergency medical technician staffing requirements of section 4765.43 of the Revised Code when it is staffed by at least one physician or registered nurse and another person, designated by a physician, who holds a valid license or certificate to practice in a health care profession, and when at least one of the persons staffing the mobile intensive care unit is a registered nurse whose training meets or exceeds the training required for a paramedic.

4766.17 Air medical service organizations; staffing requirements; medical director’s responsibility.

An air medical service organization licensed under this chapter that uses a rotorcraft or fixed wing air ambulance shall do both of the following:
(A) Use at a minimum a physician who holds a current valid license issued under Chapter 4731 of the Revised Code or registered nurse who holds a current valid license issued under Chapter 4723 of the Revised Code, and a paramedic or one other person, designated by the medical director of the air medical service organization, who holds a current, valid certificate or license to practice a health care profession in this state;
(B) Employ as a medical director an individual who holds a current valid certificate issued under Chapter 4731 of the Revised Code authorizing the practice of medicine and surgery or osteopathic medicine and surgery.

4765-1-02 EMS titles.

(A) In accordance with sections 4765.01 and 4765.011 of the Revised Code, with respect to individuals who receive certificates to practice issued under section 4765.30 of the Revised Code, all of the following shall apply:
(1) A first responder shall be also known as an emergency medical responder or EMR;
(2) An emergency medical technician-basic or EMT-basic shall be also known as an emergency medical technician or EMT, respectively;
(3) An emergency medical technician-intermediate or EMT-intermediate shall be also known as an advanced emergency medical technician or AEMT, respectively;
(4) An emergency medical technician-paramedic or EMT-paramedic shall be also known as a paramedic.
(B) With respect to the provisions set forth in Chapters 4765-1 to 4765-19 of the Administrative Code that refer to the individuals specified in paragraph (A) of this rule, all of the following shall apply:
(1) A reference to a first responder is deemed to be a reference to an emergency medical responder or EMR;
(2) A reference to an emergency medical technician-basic or EMT-basic is deemed to be a reference to an emergency medical technician or EMT, respectively;
(3) A reference to an emergency medical technician intermediate or EMT-intermediate is deemed to be a reference to an advanced emergency medical technician or AEMT.

4765-4-01 Definitions.

(A) “Data systems” means any system established by the state board of emergency medical services for the collection of information regarding the delivery of emergency medical services or trauma care including those established pursuant to section 4765.06 of the Revised Code.
(B) “EMS casualty” means any injury, death, significant exposure to hazardous materials, or significant exposure to biological hazards experienced by EMS personnel, EMS
students, other medical personnel or observers associated with an EMS unit that occur in conjunction with any of the following:

(1) An EMS incident;
(2) Responding to or returning from an EMS incident;
(3) During prehospital internship.

(C) “EMS incident” means any ground or air response to a call for emergency medical services by a public or private emergency medical service organization.

(D) “Emergency care facility” means a hospital emergency department, hospital operating room, hospital labor and delivery department, urgent care facility, or psychiatric urgent care facility.

(E) “EMS care” means the emergency medical care provided by an individual certified to provide emergency medical services under Chapter 4765 of the Revised Code.

(F) “Emergency medical services incident reporting system” or “EMS incident reporting system” means the system established by the state board of emergency medical services pursuant to section 4765.06 of the Revised Code for the collection of information regarding the delivery of emergency medical services in Ohio and the frequency at which the services are provided.

(G) “Glasgow coma scale” or “GCS” is a numeric rating used to assess the severity of neurologic injury.

(H) As used in this chapter, “health care facilities” means any of the following

(1) Hospitals registered under Chapter 3701 of the Revised Code;
(2) Nursing facilities licensed or certified under Chapter 3721 of the Revised Code;
(3) County homes or county nursing homes as defined in section 5155.31 of the Revised Code;
(4) Inpatient rehabilitation facilities as defined in Chapter 3701-83 of the Administrative Code;
(5) Ambulatory surgical facilities as defined in section 3702.30 of the Revised Code;
(l) “Information that identifies or would tend to identify a specific recipient of EMS care or trauma care” shall have the same meaning as “individually identifiable health information”, as defined in Title 45 of the Code of Federal Regulations, subtitle A, section 160.103 (2006) of the health insurance portability and accountability act (HIPAA) of 1996.


(J) As used in HIPAA and in this chapter, “individually identifiable health information” is information that is a subset of health information, including demographic information collected from an individual, and

(1) Is created or received by a health care provider, health plan, employer, or health care clearinghouse; and
(2) Relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and

(a) That identifies the individual; or
(b) With respect to which there is a reasonable basis to believe the information can be used to identify the individual.

(K) “Injury severity score” or “ISS” is a mathematical measure assessing the cumulative effect of injury severity.

(L) “Major Trauma Outcome Study” or “MTOS” is a nationally based research project conducted between 1982 and 1987, which created and validated the TRISS methodology.

(M) “Response to a call for emergency medical service” or “response” means any of the following:

(1) Assessment of or treatment provided to a patient by a person who holds an EMS
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certificate to practice regardless of whether such patient was transported, transport of a patient from a call for EMS to an emergency care facility, or a canceled call;
(2) Transport between emergency care facilities provided by an emergency medical service organization.
(N) “Risk Adjustment” means methodologies applied to a data set in order to identify and control patient variables that are present which may influence patient outcome.
(O) “State trauma registry” means the system established by the state board of emergency medical services pursuant to section 4765.06 of the Revised Code for the collection of information regarding the delivery of trauma care in Ohio and the frequency at which the services are provided.
(P) “Trauma care” has the same meaning as division (P) of section 4765.01 of the Revised Code.
(Q) “Trauma injury severity score” or “TRISS” is a methodology which combines the following variables in order to determine a probability of survival:
(1) Physiologic (systolic blood pressure, respiratory rate, Glasgow coma scale score);
(2) Anatomic injury severity score;
(3) Age (fifty five years or older, or younger than fifty five years);
(4) Trauma type (blunt or penetrating injury).

4765-4-02 Purpose.

(A) The purpose of this chapter is to establish comprehensive reporting standards for data systems by the board. These procedures are adopted to ensure the confidentiality of information as provided in section 4765.06 of the Revised Code.
(B) The board shall use the EMS incident reporting system to collect and analyze data that is necessary to evaluate the delivery of emergency medical services within Ohio. The data collected by the EMS incident reporting system shall be of such a nature as to allow the board to identify and evaluate the following:
(1) Frequency, nature, and duration of responses;
(2) Geographic patterns of responses, including but not limited to areas or regions of the state where improvements are needed in the delivery of emergency medical service;
(3) Needs assessment for the equitable disbursement of funds provided by the EMS grant program established under section 4765.07 of the Revised Code;
(4) Methods by which the delivery of emergency medical services can be maintained and improved, including but not limited to public education on illness and injury prevention, and access to emergency medical services;
(5) Methods by which EMS casualties can be reduced or prevented.
(C) The board shall use the state trauma registry to collect and analyze data that is necessary to evaluate the delivery of trauma care within the state. The data collected by the trauma registry shall be of such a nature as to allow the board to identify and evaluate the following:
(1) Frequency, type, severity, and outcome of trauma injuries;
(2) Criteria used to establish triage protocols;
(3) Geographic patterns of injury, including but not limited to areas or regions of the state where improvements are needed in the delivery of trauma care;
(4) Other factors to consider in recommending, designing, or implementing integrated statewide trauma care delivery system, including but not limited to public education on trauma and injury prevention, access to trauma care, prehospital availability, and cost of trauma care.
4765-4-03 Required reporting.

(A) Pursuant to section 4765.06 of the Revised Code, each emergency medical service organization shall report all EMS incidents to the emergency medical services incident reporting system.

(1) Each EMS organization shall submit data and information as specified by the EMS board. Such data and information shall include, at a minimum, the following:

(a) Identification of the EMS organization;
(b) Time and date of incident;
(c) Location of incident;
(d) Certification level of EMS personnel involved;
(e) Patient demographics;
(f) Information regarding provider assessment;
(g) Information regarding treatment provided;
(h) Transport information.

(2) The board shall grant an exemption from reporting to the EMS incident reporting system in cases of mass casualty incidents and/or natural disasters.

(3) The board may require the reporting of any EMS casualty data to determine methods of reducing or preventing such casualties.

(B) Pursuant to section 4765.06 of the Revised Code health care facilities, state and other public agencies designated by the board that possess information regarding trauma care, and county coroners shall submit data and information to the state trauma registry.

(1) The board shall specify the data and information to be submitted to the state trauma registry by those entities required to do so. Such information shall include, at a minimum, the following:

(a) Type and cause of injury;
(b) Severity of injury;
(c) Patient outcomes;
(d) Patient demographics;
(e) Information regarding treatments provided;
(f) Financial data pertinent to trauma care.

(2) All trauma related deaths shall be reported by the coroner of the county in which the death occurred to the state trauma registry in a manner specified by the board within one hundred-eighty days after the death occurs.

(C) In identifying the information to be provided to the state trauma registry and the EMS incident reporting system under section 4765.06 of the Revised Code and this chapter, the board shall take into consideration the financial and other burdens that these requirements will place on the entities that are required to report.

4765-4-04 Risk adjustment.

(A) The purpose of risk adjustment is to identify and control patient variables that are present which may influence patient outcome.

(B) Methodologies:

(1) TRISS shall be the primary methodology used to risk adjust data in the state trauma registry.

(2) Other methodologies may be used by the board to risk adjust data in the data systems.

(3) The coefficients used to calculate TRISS shall be those derived from the MTOS.

(4) The board may evaluate the possibility of creating Ohio specific coefficients, based upon the Ohio trauma registry data set, to utilize with the TRISS methodology, and when
appropriate, these equations may be utilized. Additionally, the board may evaluate other appropriate data sets for use in developing specific coefficients.

(C) Analysis:
(1) The board shall utilize a variety of acceptable techniques for providing statistical analysis of risk-adjusted data.
(2) The board shall utilize a variety of methodologies to risk adjust by sex, age, or other factors, in order to analyze data in the data systems for specific age groupings, including pediatric and geriatric age groupings.

(D) Risk adjusted outcomes:
(1) Mortality shall be an outcome in the state trauma registry that is risk adjusted. In addition, the board may evaluate the feasibility of risk adjusting other outcomes.

(E) Risk adjustment deliberations:
(1) The department of public safety, division of EMS, may contract with individuals or organizations with specific expertise in risk adjustment and statistical analysis of medical data in order to perform risk adjustment of information received by the board under Chapter 4765 of the Revised Code.

(2) Each person performing risk adjustment of data has a fiduciary duty to maintain the confidentiality of such information. In the event a person performing risk adjustment under this chapter violates this duty, the department of public safety, division of EMS, may terminate such person and employ any other remedies, legal or equitable, available to it.

(3) Each person performing risk adjustment of data shall sign and adhere to a contract with the department of public safety, division of EMS, regarding the confidentiality of such information. In the event a person performing risk adjustment under this chapter violates any terms of this contract, the department of public safety, division of EMS, may terminate such person and employ any other remedies, legal or equitable, available to it.

(4) All meetings in which persons are engaged in performing risk adjustment functions, including deliberations therein, shall not be open to the public.

(5) All records of deliberations of persons performing risk adjustment functions shall be maintained in confidence.

4765-4-05 Protected information.

(A) The information required to be provided to the data systems under section 4765.06 of the Revised Code and this chapter shall be provided and maintained in such a way as to protect against revealing the identity of the recipient of EMS care or trauma care. Any person handling information received for the data systems has a fiduciary duty to maintain the confidentiality of such information and shall sign and adhere to a contract with the department of public safety, division of EMS, regarding the confidentiality of such information. If such person violates this fiduciary duty or violates any terms of the contract, the department of public safety, division of EMS, may terminate such person and employ any other remedies, legal or equitable, available to it. Emergency medical service organizations, health care facilities and other providers shall be identified in the data systems by a code or similar designation other than name.

(B) Information that identifies or would tend to identify a specific EMS casualty or a specific recipient of EMS care or trauma care shall include, but not be limited to, the recipient's social security number, medical record number, EMS incident number and name.

(1) No records provided in response to a public records request shall contain any information that identifies or would tend to identify a specific EMS casualty or a specific recipient of EMS care or trauma care.

(2) No records shall be provided in response to a public records request if the request asks for information sorted by, or if the request contains, information that identifies or would
tend to identify a specific EMS casualty or a specific recipient of EMS care or trauma care.

(3) Prior to the implementation of risk adjustment standards and procedures, no records shall be provided in response to a public records request if the request asks for information sorted by, or if the request contains, information that identifies or would tend to identify a specific provider of EMS care or trauma care. After risk adjustment standards and procedures are implemented, such records may be made public, but only on a risk adjusted basis.

4765-4-06 Submission of data.

(A) Data and information submitted to the data systems shall be transmitted in a format directed by the board.

(B) Data and information submitted to the data systems shall be transmitted using a method directed by the board.

(1) The board shall ensure that the methods used to transmit data protect the security of the data during transmission.

(C) Data and information submitted to and maintained by the data systems shall be in such a format that:

(1) Protects the identity of specific EMS casualties or of specific patients to whom EMS care or trauma care has been rendered;

(2) Identifies specific health care facilities and EMS organizations by a code or similar designation other than name;

(3) Avoids or minimizes duplication of entry.

4765-4-07 Reporting deadlines.

(A) The information required under section 4765.06 of the Revised Code and this chapter shall be reported on a schedule determined by the board and which is available at http://www.ems.ohio.gov.

(B) The board may develop policies for granting extensions to the submission deadlines and which shall be made available at http://www.ems.ohio.gov.

4765-4-08 Failure to report

(A) Any entity that fails to submit data and information to the data systems, as required under section 4765.06 of the Revised Code or this chapter, may be ineligible to participate in the emergency medical services grants program established under section 4765.07 of the Revised Code and as provided in Chapter 4765-5 of the Administrative Code.

(B) Any entity that fails to submit data and information as required in this chapter shall be notified of this failure in writing. The notification shall advise the organization of:

(1) The requirement to report to the appropriate data system pursuant to section 4765.06 of the Revised Code and this chapter.

(2) The consequences of failing to report as provided in paragraph (A) of this rule.

(C) A copy of the notification created pursuant to paragraph (B) of this rule may be delivered to the following individuals as appropriate:

(1) The chief executive officer of the political subdivision for which the EMS organization provides emergency medical services;

(2) The chief executive officer of the private organization under which the EMS organization is established;

(3) The chief executive officer of the health care facility that provides trauma care;

(4) The chairperson of the appropriate regional physician advisory board.
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4765-4-09 Regional reporting.

Any entity, otherwise required to report to the state trauma registry under section 4765.06 of the Revised Code or this chapter, that reports required information to a regional trauma registry need not report individually to the state trauma registry, provided the regional registry reports such information to the state trauma registry in compliance with section 4765.06 of the Revised Code and this chapter. Those entities intending to report through a regional registry shall so notify the board in a manner indicated by the board.

4765-6-06 Withdrawing of blood for evidence collection.

(A) An advanced emergency medical technician or a paramedic may withdraw blood for the purpose of determining the alcohol, drug, controlled substance, metabolite of a controlled substance, or combination content of the whole blood, blood serum, or blood plasma as provided in division (D) of sections 4765.38 and 4765.39 of the Revised Code and in accordance with this rule.

(B) A physician or cooperating physician advisory board that serves as the medical director for any EMS organization may limit the ability of an advanced emergency medical technician and paramedic, who provide emergency medical services under the auspices of the physician's certificate to practice medicine and surgery, or osteopathic medicine and surgery, to withdraw blood for evidence. The withdrawal of blood for evidence collection shall be performed in accordance with protocols and training requirements established by the medical director of the emergency medical service organization with which the advanced emergency medical technician or paramedic is affiliated.

(C) The advanced emergency medical technician or paramedic must have received training approved by the local medical director regarding the withdrawal of blood for evidence collection before performing the withdrawal of blood for evidence.

(D) In the course of providing emergency medical treatment and at the request of a law enforcement officer, an advanced emergency medical technician or paramedic may withdraw blood as provided under sections 1547.11, 4506.17, and 4511.19 of the Revised Code. The advanced emergency medical technician or paramedic shall not respond to the request to withdraw blood for the purpose of evidence collection unless the advanced emergency medical technician or paramedic is also responding to a request for emergency medical treatment and transport of the patient to a health care facility. A clinically competent patient may refuse transport.

(E) The advanced emergency medical technician or paramedic shall not attempt to withdraw blood, if any of the following apply:

(1) In the opinion of the advanced emergency medical technician or paramedic, the physical welfare of the patient, any EMS provider, or any other person would be endangered by the withdrawing of blood;

(2) In the opinion of the advanced emergency medical technician or paramedic, the withdrawing of blood would cause an unreasonable delay in the treatment or transport of the patient or any other person;

(3) Consent of the patient is not obtained by the advanced emergency medical technician or paramedic. Any person who is unconscious, or who otherwise is in a condition rendering the person incapable of refusal, shall be deemed to have consented;

(4) Blood would be withdrawn from a pre-existing central venous access device;

(5) The withdrawing of blood would result in a violation of any rule in this chapter; or

(6) The person is deceased.

(F) The withdrawing of blood shall only be done at the request of a law enforcement officer having reasonable grounds to believe the person was violating section 1547.11, 4506.17
or 4511.19 of the Revised Code. As set forth in section 4511.191 of the Revised Code, the law enforcement officer shall request the person to submit to the withdrawing of blood and shall be responsible for advising the person of the consequences of submitting to, or refusing to submit to, the test.

(G) Blood shall only be collected utilizing the appropriate blood collection kit furnished by the law enforcement officer making the request and in compliance with rule 3701-53-05 of the Administrative Code. The withdrawing of blood must take place under the observation of the law enforcement officer. The blood sample must be immediately provided to the law enforcement officer.

4765-14-01 Trauma triage definitions.

(A) As used in this chapter and section 4765.01 of the Revised Code, “trauma” or “traumatic injury” means severe damage to or destruction of tissue that satisfies both of the following conditions:

1. It creates a significant risk of any of the following:
   a. Loss of life;
   b. Loss of a limb;
   c. Significant, permanent disfigurement;
   d. Significant, permanent disability; and

2. It is caused by any of the following:
   a. Blunt or penetrating injury;
   b. Exposure to electromagnetic, chemical, or radioactive energy;
   c. Drowning, suffocation, or strangulation;
   d. A deficit or excess of heat.

(B) “Evidence of poor perfusion” means physiologic indicators of hemorrhage or decreased cardiovascular function, which may include any of the following symptoms:

1. Weak, distal pulse;
2. Pallor;
3. Cyanosis;
4. Delayed capillary refill;
5. Tachycardia.

(C) “Evidence of respiratory distress or failure” means physiologic indicators of decreased ventilatory function, which may include any of the following symptoms:

1. Stridor;
2. Grunting;
3. Retractions;
4. Cyanosis;
5. Hoarseness;
6. Difficulty speaking.

(D) “Evidence of hemorrhagic shock” means physiologic indicators of blood loss that may include any of the following symptoms:

1. Delayed capillary refill;
2. Cool, pale, diaphoretic skin;
3. Decreased systolic blood pressure with narrowing pulse pressure;
4. Altered level of consciousness.

(E) “Seatbelt sign” means abdominal or thoracic contusions and abrasions resulting from the use of a seatbelt during a motor vehicle collision.

(F) “Signs or symptoms of spinal cord injury” means physiologic indicators that the spinal cord is damaged, including, but not limited to, paralysis, weakness, numbness, or tingling of one or more extremities.
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(G) “Evidence of neurovascular compromise” means physiologic indicators of injury to blood vessels or nerves including, but not limited to, pallor, loss of palpable pulses, paralysis, paraesthesia, or severe pain.

(H) “Body region” means a portion of the trauma victim's body divided into the following areas:

1. Brain;
2. Head, face, and neck;
3. Chest;
4. Abdomen and pelvis;
5. Extremities;

(I) Evidence of traumatic brain injury” means signs of external trauma and physiologic indicators that the brain has suffered an injury caused by external force including, but not limited to:

1. Decrease in level of consciousness from the victim's baseline;
2. Unequal pupils;
3. Blurred vision;
4. Severe or persistent headache;
5. Nausea or vomiting;
6. Change in neurological status.

4765-14-02 Determination of a trauma victim.

Emergency medical service personnel shall use the criteria in this rule, consistent with their certification, to evaluate whether an injured person qualifies as an adult trauma victim, geriatric trauma victim, or pediatric trauma victim, in conjunction with the definition of trauma in section 4765.01 of the Revised Code and this chapter.

(A) An adult trauma victim is a person between the ages of sixteen and sixty-nine years of age inclusive exhibiting one or more of the following physiologic or anatomic conditions:

1. Physiologic conditions
   a. Glasgow coma scale less than or equal to thirteen;
   b. Loss of consciousness greater than five minutes;
   c. Deterioration in level of consciousness at the scene or during transport;
   d. Failure to localize to pain;
   e. Respiratory rate less than ten or greater than twenty-nine;
   f. Need for ventilatory support;
   g. Requires relief of tension pneumothorax;
   h. Pulse greater than one hundred twenty in combination with evidence of hemorrhagic shock;
   i. Systolic blood pressure less than ninety, or absent radial pulse with carotid pulse present;

2. Anatomic conditions
   a. Penetrating trauma to the head, neck, or torso;
   b. Significant, penetrating trauma to extremities proximal to the knee or elbow with evidence of neurovascular compromise;
   c. Injuries to the head, neck, or torso where the following physical findings are present:
      i. Visible crush injury;
      ii. Abdominal tenderness, distention, or seatbelt sign;
      iii. Pelvic fracture;
      iv. Flail chest;
   d. Injuries to the extremities where the following physical findings are present:
(i) Amputations proximal to the wrist or ankle;
(ii) Visible crush injury;
(iii) Fractures of two or more proximal long bones;
(iv) Evidence of neurovascular compromise.
(e) Signs or symptoms of spinal cord injury;
(f) Second degree or third degree burns greater than ten per cent total body surface area, or other significant burns involving the face, feet, hands, genitalia, or airway.
(g) Open skull fracture
(3) Cause of injury
Vehicle telemetry data consistent with a high risk for injury.
(B) A pediatric trauma victim is a person under sixteen years of age exhibiting one or more of the following physiologic or anatomic conditions:
(1) Physiologic conditions
(a) Glasgow coma scale less than or equal to thirteen;
(b) Loss of consciousness greater than five minutes;
(c) Deterioration in level of consciousness at the scene or during transport;
(d) Failure to localize to pain;
(e) Evidence of poor perfusion, or evidence of respiratory distress or failure.
(f) Respiratory rate less than twenty for infants less than one year old.
(2) Anatomic conditions
(a) Penetrating trauma to the head, neck, or torso;
(b) Significant, penetrating trauma to extremities proximal to the knee or elbow with evidence of neurovascular compromise;
(c) Injuries to the head, neck, or torso where the following physical findings are present:
(i) Visible crush injury;
(ii) Abdominal tenderness, distention, or seatbelt sign;
(iii) Pelvic fracture;
(iv) Flail chest;
(d) Injuries to the extremities where the following physical findings are present:
(i) Amputations proximal to the wrist or ankle;
(ii) Visible crush injury:
(iii) Fractures of two or more proximal long bones;
(iv) Evidence of neurovascular compromise.
(e) Signs or symptoms of spinal cord injury;
(f) Second or third degree burns greater than ten per cent total body surface area, or other significant burns involving the face, feet, hands, genitalia, or airway.
(g) Open skull fracture
(3) Cause of injury
Vehicle telemetry data consistent with a high risk for injury.
(C) A geriatric trauma victim is a person seventy years of age or older exhibiting one or more of the following causes of injury or physiologic or anatomic conditions:
(1) Physiologic conditions:
(a) Glasgow coma scale less than or equal to fourteen in a trauma patient with a known or suspected traumatic brain injury;
(b) Glasgow coma score less than or equal to thirteen;
(c) Loss of consciousness greater than five minutes;
(d) Deterioration in level of consciousness at the scene or during transport;
(e) Failure to localize to pain;
(f) Respiratory rate less than ten or greater than twenty-nine;
(g) Need for ventilatory support;
(h) Requires relief of tension pneumothorax;
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(i) Pulse greater than one hundred twenty in combination with evidence of hemorrhagic shock;
(j) Systolic blood pressure less than one-hundred, or absent radial pulse with carotid pulse present.

(2) Anatomic conditions:
(a) Penetrating trauma to the head, neck, or torso;
(b) Significant, penetrating trauma to extremities proximal to the knee or elbow with evidence of neurovascular compromise;
(c) Injuries to the head, neck, or torso where the following physical findings are present:
   (i) Visible crush injury;
   (ii) Abdominal tenderness, distention, or seatbelt sign;
   (iii) Pelvic fracture;
   (iv) Flail chest.
(d) Injuries to the extremities where the following physical findings are present:
   (i) Amputations proximal to the wrist or ankle;
   (ii) Visible crush injury;
   (iii) Fracture of one proximal long bone sustained as a result of a motor vehicle crash;
   (iv) Fractures of two or more proximal long bones;
   (v) Evidence of neurovascular compromise.
(e) Signs or symptoms of spinal cord injury;
(f) Second degree or third degree burns greater than ten per cent total body surface area, or other significant burns involving the face, feet, hands, genitalia, or airway;
(g) Injury sustained in two or more body regions.
(h) Open skull fracture

(3) Cause of injury:
(a) Pedestrian struck by a motor vehicle;
(b) Fall from any height, including standing falls, with evidence of a traumatic brain injury.
(c) Vehicle telemetry data consistent with a high risk for injury.
(D) Emergency medical service personnel shall also consider mechanism of injury and special considerations, as taught in the EMT, advanced EMT or paramedic curriculum, when evaluating whether an injured person qualifies as a trauma victim.

4765-14-03 Enforcement of state or regional trauma triage protocols.

(A) EMS medical directors shall be responsible for enforcing state or regional trauma triage protocols for EMS personnel under their medical direction through a performance improvement or peer review process.
(B) EMS medical directors may request assistance from the RPABs to address issues related to quality improvement and peer review of state or regional trauma triage protocols.
(C) The board shall investigate all complaints regarding violations of state or regional trauma triage protocols consistent with its current procedures for investigations.

4765-14-05 Exceptions to mandatory transport.

(A) Emergency medical service personnel shall transport a trauma victim, as defined in section 4765.01 of the Revised Code and this chapter, directly to an adult or pediatric trauma center that is qualified to provide appropriate adult or pediatric care, unless one or more of the following exceptions apply:
   (1) It is medically necessary to transport the victim to another hospital for initial assessment and stabilization before transfer to an adult or pediatric trauma center;
(2) It is unsafe or medically inappropriate to transport the victim directly to an adult or pediatric trauma center due to adverse weather or ground conditions or excessive transport time;
(3) Transporting the victim to an adult or pediatric trauma center would cause a shortage of local emergency medical service resources;
(4) No appropriate adult or pediatric trauma center is able to receive and provide adult or pediatric trauma care to the trauma victim without undue delay;
(5) Before transport of a patient begins, the patient requests to be taken to a particular hospital that is not a trauma center or, if the patient is less than eighteen years of age or is not able to communicate, such a request is made by an adult member of the patient's family or a legal representative of the patient.

4766-4-01 Mobile intensive care unit; definitions.

[Editor’s Note: The “Comment” portion of the following regulation is part of the official provision.]

[Comment: For dates and availability of material incorporated by reference in this chapter of the Administrative Code, see rule 4766-4-18 of the Administrative Code.]

(A) “Advanced emergency medical technician” or “AEMT” is a person holding a current and valid certificate to practice issued under Chapter 4765 of the Revised Code authorizing the holder to provide medical care as set forth in rule 4765-16-04 of the Administrative Code.

(B) “Board” means the state board of emergency medical, fire, and transportation services within the division of emergency medical services of the department of public safety set forth in section 4765.02 of the Revised Code.

(C) “Division” means the division of emergency medical services within the department of public safety.

(D) “Emergency medical technician” or “EMT” is a person holding a current and valid certificate to practice issued under Chapter 4765 of the Revised Code authorizing the holder to provide medical care as set forth in rule 4765-15-04 of the Administrative Code.

(E) “Headquarters” means the location which a licensee operates, designated by the licensee as the location where the records set forth in this chapter are maintained or readily available.

(F) “Inspection fee” means a fee required to be paid for the inspection of a permitted vehicle.

(G) “License” means a certificate of licensure issued by the board to the service, also known as the licensed mobile intensive care unit.

(H) “Medical director” means an Ohio-licensed physician who meets the requirements as set forth in Chapter 4765 of the Revised Code and rule 4765-3-05 of the Administrative Code.

(I) “Medical transportation organization” or “MTO” has the same meaning as emergency medical service organization as defined in division (H) of section 4766.01 of the Revised Code.

(J) “Mobile intensive care unit” or “MoICU” has the same meaning as mobile intensive care unit as defined in division (O) of section 4766.01 of the Revised Code.

(K) “Neonate” means a newborn beginning at birth and lasting through the twenty-eighth day of life.

(L) “Operate” means to engage in conduct or activity in furtherance of the licensed activity at or from a physical location owned, leased or maintained by the licensee where employees report to work and vehicles or aircraft are stored. Operate also includes the act of receiving a person within Ohio for transportation to a location within Ohio.

(M) “Paramedic” is a person holding a current and valid certificate to practice issued under Chapter 4765 of the Revised Code authorizing the holder to provide medical care as set
forth in rule 4765-17-03 of the Administrative Code.

(N) “Permit” is the authorization to operate issued by the board as set forth in section 4766.07 of the Revised Code for a specific vehicle, known as the “permitted vehicle” and requires the issuance of a decal for the permitted vehicle by the board or its designee.

(O) “Readily available” means produced upon demand by the board or its designee.

(P) “Reinspection fee” means a fee required to conduct an inspection as a result of the issuance of a violation notification by the board, or its designee, to a licensed MoICU or license applicant, regarding a permitted MoICU or a MoICU for which a permit application is pending with the board.

(Q) “Satellite base” means a physical location other than headquarters from which a licensee operates.

(R) “Service number” or “service code” means the number assigned to the MoICU by the board for the purpose of identifying and validating the service or permitted MoICU.

(S) “Temporary vehicle” means a MoICU issued a temporary permit used to replace a permitted MoICU in accordance with rule 4766-4-12 of the Administrative Code that is out of service until the permitted MoICU is returned to service or is replaced. A temporary vehicle may be used for a time period not to exceed sixty days.

(T) “Violation notification” means a written form issued by the board or its designee during an inspection or investigation identifying deficiencies in record keeping requirements, vehicle roadworthiness requirements, or equipment requirements by a service or its vehicle(s).

4766-4-02 Application for initial or renewal licensure.

[Editor’s Note: The “Comment” portion of the following regulation is part of the official provision.]

[Comment: For dates and availability of material incorporated by reference in this chapter of the Administrative Code, see rule 4766-4-18 of the Administrative Code.]

(A) A MTO applying for initial licensure shall file with the board an “Application for Ambulance or Mobile Intensive Care License” form in the English language, and shall submit the completed application to the board:

(1) Accompanied by the appropriate fees as set forth in rule 4766-4-03 of the Administrative Code and;

(2) With all required supporting documentation as set forth in this rule that must be received by the board.

(B) A MTO applying for renewal of a license shall file with the board a “Renewal Application for Ambulance or Mobile Intensive Care License” form in the English language, and shall submit the completed application to the board:

(1) Accompanied by the appropriate fees as set forth in rule 4766-4-03 of the Administrative Code and;

(2) With all required supporting documentation as set forth in this rule that must be received by the board prior to the expiration date of the license.

(C) In addition to the requirements set forth in section 4766.04 of the Revised Code, for each application the MTO applicant shall provide and maintain documentation of:

(1) The name of service, organizational structure and address of applicant to include as follows:

(a) Name;

(b) Identification of organizational structure as a corporation (whether for profit or not-for-profit); limited liability company; partnership; limited liability partnership; government unit; or sole proprietor (individual human);

(c) Tax identification (tax ID) number or employer identification number (EIN);

(d) All other names under which applicant plans to operate while using the same tax ID.
or EIN number. Business organizations with different tax ID or EIN numbers cannot operate under the same license;

(e) Copies of all trade name registrations and fictitious name registrations for all other names under which applicant plans to operate on file with the Ohio secretary of state;

(f) Address of physical location of applicant’s headquarters (no post office box);

(g) Mailing address of applicant;

(2) All medicare provider numbers;

(3) All medicaid provider numbers;

(4) Highest level of service to be provided;

(5) Service areas including county and state;

(6) A list of the names of all officers, directors, and/or owners of the MTO;

(7) The name, contact information, and state of Ohio medical license number of the service’s medical director;

(8) For each satellite base, the MTO shall provide the physical address, city, county, state, and zip code;

(9) The name of the primary contact person(s), business or administrative office telephone number, e-mail address, and if applicable, office fax number;

(10) Year of manufacture, make, model, vehicle identification number, odometer reading, and license plate number (renewal only) of each MoICU or non-transport vehicle to be permitted;

(11) A color photograph of the side of applicant’s vehicle displaying color scheme, insignia, monogram, or other distinguishing characteristic. If multiple color schemes, insignias, monograms, or other distinguishing characteristics are used, a color photograph of each shall accompany application.

(a) Color photographs shall be submitted to the division:

(i) With all initial “Application for Ambulance or Mobile Intensive Care License” forms; and

(ii) Within thirty days of the date a change is made to the vehicle’s color scheme, insignia, monogram, or other distinguishing characteristics.

(b) Digital photographs are preferred.

(12) A current and valid certificate of liability insurance in the name of the applicant, listing the board as a certificate holder with a thirty day cancellation notice as specified in section 4766.06 of the Revised Code:

(a) The actual name on the license application shall appear on the certificate of liability insurance;

(b) Each permitted vehicle with vehicle identification number (VIN) shall be listed on the certificate of liability insurance.

(D) An application that is not completed in the manner as specified on the application or does not include all required documentation shall be deemed incomplete.

(E) An application deemed incomplete shall not be considered and may be returned with the notation to the applicant indicating the reason the application is incomplete.

(F) Failure to provide the required documents within thirty days of the date the initial “Application for Ambulance or Mobile Intensive Care License” form is received by the division may result in the application being deemed incomplete.

(G) A MTO shall submit a completed “Renewal Application for Ambulance or Mobile Intensive Care License” form, appropriate fees, and supporting documentation to the board prior to the expiration of the MTO’s license in order to be considered timely.

(H) The certificate of licensure issued by the board shall indicate the highest level of service that the MTO is authorized to provide.

(I) No applicant or licensed MTO shall submit false, misleading, or deceptive information in order to obtain a license or permit.
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(J) A license is not transferable.

4766-4-03 Fees.

(A) Each MTO shall pay an initial or renewal license fee of one hundred dollars annually.
(B) Each MTO shall pay a permit fee for each MoICU(s) or non-transport vehicle of one hundred dollars annually;
(C) Each MTO shall pay an inspection fee of one hundred dollars per MoICU or non-transport vehicle.
(D) Each MTO shall pay a one hundred dollar reinspection fee for every MoICU or non-transport vehicle that requires reinspection as a result of a violation notification issued by the board or its designee.
(E) Each MTO shall pay a temporary permit fee of one hundred dollars for each temporary permit to be obtained.
(F) Fees shall be submitted with the application.
(G) All fees are nonrefundable.
(H) Each MTO shall pay a re-print fee of five dollars for each vehicle decal that shall be re-printed as a result of the decal being lost, damaged, incorrectly applied, or incorrect vehicle information provided to the division by the service.

4766-4-04 Physical facilities.

[Editor's Note: The “Comment” portion of the following regulation is part of the official provision.]

[Comment: For dates and availability of material incorporated by reference in this chapter of the Administrative Code, see rule 4766-4-18 of the Administrative Code.]

(A) The board or its designee shall conduct initial and renewal inspections of all MTOs pursuant to Chapter 4766 of the Revised Code and rules 4766-4-04 to 4766-4-07 of the Administrative Code to include the following:
   (1) MTO service headquarters;
   (2) MTO service satellite location(s).

(B) A MTO shall not commence operations from its headquarters or satellite base(s) until the MTO has met all requirements set forth in section 4766.04 of the Revised Code and agency 4766 of the Administrative Code including satisfactory inspections of all physical locations.

(C) A MTO shall ensure compliance with the inspection requirements for physical facilities. The inspection requirements for physical facilities of a MTO are as follows:
   (1) The board issued license shall be prominently displayed in a conspicuous location at every licensed facility (renewal inspection only);
   (2) Ohio state board of pharmacy license(s) shall be displayed at each location;
   (3) A written sanitation plan as set forth in Chapter 4766-4 of the Administrative Code shall be on site for each location;
   (4) The physical facilities shall maintain all single use supplies and equipment as set forth in the "MoICU Inspection" form.
   (5) The physical facilities shall be clean and free of debris;
   (6) Crew quarters shall be clean;
   (7) All physical facilities shall be in compliance with state and local building codes;
   (8) Each facility shall be in compliance with state and local fire codes.

(D) The board or its designee may conduct routine unannounced inspections at any location(s) of licensed MTO at any time, including night or weekend inspections to determine compliance with Chapter 4766 of the Revised Code and agency 4766 of the Administrative Code to include, but not limited to, the following:
(1) MTO service headquarters;
(2) MTO service satellite location(s);
(3) MoICU(s) and non-transport vehicle(s).

4766-4-05 Transportation records.

[Editor's Note: The “Comment” portion of the following regulation is part of the official provision.]

[Comment: For dates and availability of material incorporated by reference in this chapter of the Administrative Code, see rule 4766-4-18 of the Administrative Code.]

(A) Each licensed MTO shall maintain or have readily available the following at its headquarters:
(1) Current copy of the organization's operating medical protocol(s) as filed with the Ohio state board of pharmacy;
(2) Verification of the following:
   (a) Completion of emergency vehicle operator course for non-EMS certified personnel as set forth in rule 4766-4-13 of the Administrative Code;
   (b) Certification or license of all personnel;
(3) A current and valid certificate of liability insurance issued by an insurer licensed to do business in Ohio that includes a thirty day notice of cancellation to the board in compliance with the terms set forth in section 4766.06 of the Revised Code listing the board as a certificate holder;
   Each scheduled vehicle must be listed on the certificate or attached on an additional page to the certificate to include the vehicle’s year, make, model and vehicle identification number (VIN). If the certificate indicates “any auto” or “all owned autos,” a list of vehicles does not have to be included or attached.
   (4) Current copy of the MTO’s written policy covering the use of lights and audible warning devices;
   (5) Records or other documents related to patient care or to emergency medical service personnel maintained by the licensed MTO which shall be made available for review by the board or its designee;
   Such records or documents shall be made available in accordance with 45 C.F.R. 164.512;
   (6) Current maintenance records for vehicles as specified in rule 4766-4-09 of the Administrative Code;
   (7) Documentation of compliance with the periodic mechanical safety inspection set forth in rule 4766-4-09 of the Administrative Code;
   (8) Current maintenance records for all equipment used for patient care as specified in rule 4766-4-09 of the Administrative Code;
   (9) Dispatch log;
   (10) Written plan for restocking of supplies or compliance with paragraph (C)(4) of rule 4766-4-04 of the Administrative Code;
   (11) Ohio state board of pharmacy license and addendum;
   (12) DEA registration certificate (as applicable);
   (13) Clinical laboratory improvement amendments (CLIA) waiver (as applicable);

(B) A licensed MTO shall maintain or have readily available the following at each satellite base:
(1) Current copy of the organization's operating medical protocol(s) as filed with the Ohio state board of pharmacy;
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(2) Documentation that meets the requirements as set forth in rule 4766-4-07 of the Administrative Code;

(3) Current copy of the MTO’s written policy covering the use of lights and other warning devices;

(4) Written plan for restocking of supplies or compliance with paragraph (C)(4) of rule 4766-4-04 of the Administrative Code;

(5) Ohio state board of pharmacy license(s) and addendum(s);


(C) Upon licensure, each licensed MTO shall prominently display the original certification of licensure at its headquarters and each satellite base.

(D) Patient records shall be maintained in accordance with this rule.

(1) Each licensed MTO shall maintain accurate records concerning the transportation of each patient for a minimum of seven years;

(2) Each record shall include, at minimum, the following:

(a) Patient’s name;

(b) Patient’s sex;

(c) Patient’s age;

(d) Patient’s date of birth;

(e) Patient’s address;

(f) Location address of incident or pickup;

(g) Patient’s chief complaint;

(h) Patient’s history including:

(i) Current medical condition;

(ii) List of current medications;

(iii) Allergies;

(iv) Vital signs and time assessed:

(a) Blood pressure;

(b) Pulse;

(c) Respiration;

(i) Any responsible guardian;

(j) Advanced directives, if applicable;

(k) Final destination;

(l) Treatment rendered;

(m) The following times:

(i) Time call received;

(ii) Dispatch time;

(iii) Enroute time;

(iv) On-scene time;

(v) Departure from scene time;

(vi) Arrival at destination time;

(n) The names and level of certification or licensure for all EMS providers and other medical personnel;

(o) The names of any non-EMS certified personnel, if applicable.

(3) A copy of the record for each patient shall be provided to the receiving facility, which includes all the information required no later than twenty-four hours from time of dispatch.

4766-4-06 Communication requirements.

(A) All licensed MTO dispatch centers shall be equipped with a base station capable of two-way communications with associated MoICU(s) and non-transport vehicle(s). The base
station shall demonstrate and maintain voice communications with the devices used in the permitted MoICU(s) and non-transport vehicle(s) within the declared service area:
  
  (B) All MoICU(s) and non-transport vehicle(s), permitted as set forth in Chapter 4766 of the Revised Code, shall be equipped, while in use, with a dedicated two-way communications device, which shall have the capability to communicate with the licensed MTO's dispatch center, the receiving medical facility, and with medical control in the licensed MTO's service area.
  
  (C) All MTOs shall maintain a detailed radio/communications log that documents, at a minimum, the following:
      
      (1) Location of call;
      (2) Nature of call;
      (3) Initial dispatch time;
      (4) Enroute time;
      (5) On-scene time;
      (6) Departure from scene time;
      (7) Arrival at destination time;
      
  (D) If a MTO contractually uses another communication center for dispatch purposes, the communication center shall provide written certification of compliance with Chapter 4766 of the Revised Code and agency 4766 of the Administrative Code as applicable.

4766-4-07 Health and safety requirements.

[Editor's Note: The “Comment” portion of the following regulation is part of the official provision.]

  [Comment: For dates and availability of material incorporated by reference in this chapter of the Administrative Code, see rule 4766-4-18 of the Administrative Code.]

  (A) Each licensed MTO shall comply with all occupational safety and health administration-bloodborne pathogens regulations as set forth by 29 C.F.R. 1910.1030.
  
  (B) A licensed MTO shall ensure that sanitation procedures are provided to all personnel in a written document that conforms with current standards as set forth in occupational safety and health administration-bloodborne pathogens protocol.
  
  (C) A licensed MTO shall maintain and follow a written sanitation plan that conforms with the latest bloodborne pathogen standards as written by the occupational safety and health administration. The following documentation shall be maintained for each vehicle:
      
      (1) Sanitation schedule;
      (2) Date the sanitation was completed;
      (3) Documentation of who performed sanitation.
      
  (D) All licensed MTOs shall establish a written policy governing the use of lights and other warning devices pursuant to section 4511.24 of the Revised Code which shall be made available for inspection by the board or its designee.

4766-4-08 Vehicle inspections.

[Editor's Note: The “Comment” portion of the following regulation is part of the official provision.]

  [Comment: For dates and availability of material incorporated by reference in this chapter of the Administrative Code, see rule 4766-4-18 of the Administrative Code.]

  (A) The board or its designee shall inspect all MoICU(s) and non-transport vehicle(s) for roadworthiness and for appropriate equipment using the “MoICU Inspection” form or “Non-transport Vehicle Inspection” form.
(B) A permitted MoICU that is being used as a MoICU shall comply with the requirements of roadworthiness and the requirements set forth in the “MoICU Inspection” form, which shall include carrying the following types of equipment:

1. Isolation equipment;
2. Airway equipment;
3. Onboard definitive care equipment;
4. Bleeding control/burn equipment;
5. Suction equipment;
6. Medical gas and equipment;
7. Adjunct equipment;
8. Intravenous equipment;
9. Neonatal specific equipment; and
10. Immobilization equipment for MoICUs dually certified to provide advanced life support.

(C) A permitted non-transport vehicle that is being used as a non-transport vehicle shall comply with the requirements of roadworthiness and the requirements set forth in the “Non-Transport Vehicle Inspection” form, which shall include carrying specified definitive equipment.

(D) All equipment and supplies shall have current expiration dates where applicable.

(E) Disposable equipment is acceptable where applicable.

(F) All equipment shall be securely stored in each vehicle.

(G) A MTO shall demonstrate proof that each MoICU complies with all specifications set forth in division (C)(2) of section 4766.07 of the Revised Code, by one of the following:

1. Placard/sticker;
2. Certificate issued by the manufacturer;
3. Signed affidavit by the manufacturer certifying compliance with national standards in effect at the time the vehicle was manufactured.

(H) The name of the MTO shall be permanently affixed to each MoICU and non-transport vehicle with letters being a minimum height of three inches on both sides and a minimum height of one and one half inches on the back.

If a MTO is under contract which requires other signage or if the MTO is operating under another name, each vehicle shall have permanently affixed lettering with a minimum height of one and one half inches on the rear and both sides of the vehicle that states:

1. Owned and operated by [MTO's name]; or
2. Operated by [MTO's name]; or
3. Owned by [MTO's name].

(I) All violation notifications issued by the board or its designee shall be corrected.

(J) Each vehicle that receives a violation notification shall be placed out-of-service until:

1. It passes reinspection by the board or its designee; or
2. For seventy-two hour violation notifications, the violation has been corrected and the “Violation Notification” form is signed and returned to the division along with supporting documentation showing the violation has been corrected.

(K) Upon issuance of a vehicle permit, each licensed MTO shall apply the decal on the outside of the right rear window in accordance with division (B)(2) of section 4766.07 of the Revised Code on each MoICU and non-transport vehicle.

The permit shall be unobstructed at all times.

(L) A permit is not transferable.

(M) The board or its designee may conduct routine unannounced inspections at any location of licensed MTO at any time, including night or weekend inspections to determine compliance with Chapter 4766 of the Revised Code and agency 4766 of the Administrative Code to include, but not limited to, MoICU(s) and non-transport vehicle(s).
(N) A permitted MoICU or non-transport vehicle shall maintain compliance with roadworthiness requirements set forth in this rule at any time it is used as an MoICU or non-transport vehicle.

(O) Each permitted vehicle shall be free from dirt, stains, impurities and/or foreign matter in driver's compartment and MoICU patient care compartments.

(P) Permitted MoICUs and non-transport vehicles shall:
(1) Bear license plates issued under section 4503.49 of the Revised Code; or
(2) Comply with residency registration requirements set forth in section 4503.111 of the Revised Code.

4766-4-09 Maintenance documentation.

[Editor's Note: The “Comment” portion of the following regulation is part of the official provision.]

[Comment: For dates and availability of material incorporated by reference in this chapter of the Administrative Code, see rule 4766-4-18 of the Administrative Code.]

(A) MoICU and non-transport vehicles
(1) All licensed MTOs shall ensure performance and maintain documentation of all periodic maintenance and repairs on each permitted vehicle to include:
   (a) Date of service or repair;
   (b) Description of service/repair performed;
   (c) Name of person who performed service/repair and the business name, if applicable.
(2) Licensed MTOs shall subject all permitted MoICU(s) and non-transport vehicle(s) to periodic mechanical safety inspection(s), which shall be documented by the service.
   (a) A periodic mechanical safety inspection shall mean an inspection conducted:
      (i) Prior to a vehicle's initial permit being issued for vehicles with an odometer reading of five thousand miles or more, and;
      (ii) Annually and completed within the six month period prior to the MTO's license expiration date, or;
      (iii) Every twenty thousand miles for a vehicle that has an odometer reading of one hundred fifty thousand miles or more.
   (b) Each mechanical safety inspection shall be conducted by a mechanic with factory training and certification from an original (motor vehicle) equipment manufacturer or equivalent certification for “Emergency Vehicle Technicians” (EVT) or from the “National Institute for Automotive Service Excellence” (ASE).
   (c) Each mechanical safety inspection shall be conducted in addition to the vehicle and equipment inspection by the board or its designee following the procedures adopted in rule 4766-4-08 of the Administrative Code.
(3) Vehicles with failed items found during the mechanical safety inspection shall be removed from service and not placed back into service until items are corrected. Proof of correction(s) shall be maintained by the service with the “Periodic Mechanical Safety Report” form in the vehicle’s maintenance records.
(3) Out of service permitted MoICU(s) or non-transport vehicle(s):
   If a licensed MTO removes a permitted MoICU or non-transport vehicle from service it shall place an “out of service” sign in the permitted MoICU or non-transport vehicle to be visible through the windshield with the following information included on the front of the sign:
   (a) Date permitted MoICU or non-transport vehicle was taken out of service;
   (b) Odometer reading at time permitted MoICU or non-transport vehicle was taken out of service;
   (c) Reason permitted MoICU or non-transport vehicle was taken out of service;
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(d) Printed name and signature of person responsible for taking permitted vehicle out of service;
(e) The words “out of service” utilizing not less than three inch lettering.
(4) If permitted MoICU or non-transport vehicle is at a repair/maintenance shop that is not owned or operated by the licensed MTO for maintenance purposes, no “out of service” sign is required.

(B) Bio-medical equipment/patient care equipment:
(1) A licensed MTO shall ensure performance and maintain documentation of all periodic maintenance and repairs of bio-medical equipment as required by manufacturer and/or food and drug administration including but not limited to the following:
(a) Date of last inspection;
(b) Date of service or repair;
(c) Description of service/repair performed;
(d) Name of person who performed inspection, service, or repair;
(e) Documentation, if any, of inspection, service, or repair performed.
(2) A licensed MTO shall maintain documentation of all periodic maintenance of patient care equipment as required by the original equipment manufacturer, including but not limited to the following:
(a) Date of last inspection;
(b) Date of service or repair;
(c) Description of service/repair performed;
(d) Name of who performed inspection, service, or repair;
(e) Documentation of inspection, service, or repair performed.
(C) MoICU and non-transport vehicle maintenance/repair records and bio-medical maintenance/repair records shall be kept for a period of twelve months after the vehicle/equipment is removed from inventory.

4766-4-11 Use of lights and other warning devices.

(A) Permitted MoICU(s) and non-transport vehicle(s) are considered public safety vehicles pursuant to division (E)(1) of section 4511.01 of the Revised Code.
(B) Permitted MoICU(s) and non-transport vehicle(s), when responding to emergency calls, may use emergency lights and audible warning devices pursuant to section 4511.24 of the Revised Code.
(C) Permitted MoICU(s) and non-transport vehicle(s) shall:
(1) Bear license plates issued under section 4503.49 of the Revised Code; or
(2) Comply with residency registration requirements set forth in section 4503.111 of the Revised Code.
(3) Permitted MoICU(s) and non-transport vehicle(s) owned and operated by a federal, state, county, city, or township or a service that qualifies for gratis license plates from the bureau of motor vehicles are not required to bear ambulance license plates or non-transport vehicle license plates.

4766-4-12 Temporary and disaster operations.

[Editor's Note: The “Comment” portion of the following regulation is part of the official provision.]

[Comment: For dates and availability of material incorporated by reference in this chapter of the Administrative Code, see rule 4766-4-18 of the Administrative Code.]
(A) In the event of a disaster situation when permitted MoICU(s) based in the locality of the disaster situation are incapacitated or insufficient in number to render services needed, a licensed MTO may utilize whatever means necessary to transport and treat patients.

(B) A MoICU or non-transport vehicle that has not been issued a permit by the board may be issued a temporary permit, for a period not to exceed sixty days, if the MoICU or non-transport vehicle is used to replace a permitted MoICU or non-transport vehicle that has been temporarily taken out of service for repair or maintenance or is being permanently replaced. In order to obtain a temporary permit, a MTO shall submit a “Temporary Ambulance / MOICU / Non-transport Vehicle” form to the board containing:

1. Vehicle identification number of the permitted MoICU or non-transport vehicle;
2. Date permitted MoICU or non-transport vehicle was placed out of service;
3. Vehicle identification number of the non-permitted MoICU or non-transport vehicle;
4. Date temporarily permitted MoICU or non-transport vehicle is to be placed in service;
5. Brief description of reason the permitted MoICU or non-transport vehicle was taken out of service.

(C) The licensed MTO shall ensure that the one hundred dollar fee prescribed in paragraph (E) of rule 4766-4-03 of the Administrative Code shall be received by the board within seven days of issuance of a temporary permit.

(D) The MTO shall note the date of return to service of the permitted MoICU or non-transport vehicle on the temporary permit.

(E) The licensed MTO shall return the temporary permit to the board within two days after the permitted MoICU or non-transport vehicle is returned to service.

4766-4-13 Staffing compliance.

[Editor’s Note: The “Comment” portion of the following regulation is part of the official provision.]

[Comment: For dates and availability of material incorporated by reference in this chapter of the Administrative Code, see rule 4766-4-18 of the Administrative Code.]

MoICU transport team shall consist of three personnel: a driver operator and two other healthcare personnel as described herein:

(A) Driver operator means:
1. A person who has successfully completed and passed an emergency vehicle operator course that meets requirements of national highway and traffic safety administration’s “1995 Emergency Vehicle Operators Course (Ambulance): National Standard Curriculum”; or
2. A person who is certified as an Ohio emergency medical technician.

(B) Healthcare personnel means one each of the following:
1. A registered nurse whose training meets or exceeds the training required for a paramedic; and
2. A physician or another person designated by a physician, who holds a valid license or certificate to practice in a health care profession in one of the following areas: paramedic, registered nurse, respiratory therapist, advanced practice nurse, or physician’s assistant.

4766-4-14 Regulations for out of state providers.

The exemption from licensure in division (B) of section 4766.09 of the Revised Code exempts out of state providers receiving a patient in Ohio for transport to a location not within Ohio or when transporting a patient received in another state. An out of state provider that receives a patient in Ohio for transportation to a location in Ohio shall be licensed and is subject to Chapter 4766 of the Revised Code and rules under this chapter and to all applicable fines and sanctions for any violation thereof.
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4766-4-15 Changes to be reported to the board.

[Editor’s Note: The “Comment” portion of the following regulation is part of the official provision.]

[Comment: For dates and availability of material incorporated by reference in this chapter of the Administrative Code, see rule 4766-4-18 of the Administrative Code.]

(A) Each licensed MTO shall give written notification to the board within ten business days of any additions, deletions or changes in:

1. Executive officers or board members;
2. Medical director, including:
   a. Contact information; and
   b. Medical license number;
3. Ownership of a licensed MTO;
4. Tax ID or EIN number;
5. The name of the primary contact person(s), business or administrative office telephone number, email address, and if applicable, office fax number.

(B) Within ten days of the date a permitted MoICU or non-transport vehicle is permanently withdrawn from service, the licensed MTO shall return to the board a “Deletion of Vehicle” form and the decal from the right rear window.

(C) Within ten business days of the date a licensed MTO ceases to operate, it shall return to the board all vehicle decals and the certificate of licensure.

(D) Within ten business days of the date a licensed MTO ceases to operate a satellite base, it shall return to the board the certificate of licensure.

(E) A MTO licensed at the MoICU level may apply at any time to be licensed at a lower level. The application shall be made on a “Change in Level of Service Medical Transportation Organization” form and include the one hundred dollar license fee. The MTO shall also ensure compliance with rules 4766-4-04 and 4766-4-08 of the Administrative Code. A change in level of service does not change the expiration date of the license.

(F) A licensed MTO may apply at any time for change of address of headquarters location. The application shall be made on the “Headquarters Change of Address” form and include the one hundred dollar license fee. The MTO shall also ensure compliance with rules 4766-4-04 of the Administrative Code. A change in headquarters address does not change the expiration date of the license.

4766-4-16 Investigations of alleged offenses.

(A) The division shall investigate all complaints on behalf of the board and in accordance with section 4766.11 of the Revised Code.

(B) After an investigation is completed and based on the findings of such investigation, the board may initiate disciplinary proceedings in accordance with Chapter 119 of the Revised Code and this chapter.

(C) If, based on the findings of an investigation, the board determines that no further action on a complaint is warranted, then the case shall be closed accordingly.

(D) The division shall conduct all investigations and any related proceedings, in such a manner as to protect patient confidentiality and in accordance with section 4765.102 of the Revised Code.

(E) Notwithstanding paragraph (D) of this rule, a patient may consent to have the board release the patient’s name or other identifying information that was collected as part of the division’s investigation. Such consent shall be in writing and signed by the patient in order to be considered proper.
If a patient is less than eighteen years of age, such consent shall be in writing and
signed by the patient's parent, guardian, or legal custodian in order to be considered proper.
(F) No member of the board who participates in an investigation shall participate in any
further adjudication of the case.
(G) No member of the board who participates in an investigation at the local level or is
involved in a case locally, shall participate in any investigation or adjudication of the same case
by the board.

4766-4-18 Incorporations by reference.

Curriculum” can be found at http://www.nhtsa.gov/people/injury/ems/web%20site%20intro.htm.
(B) “29 C.F.R. 1910.1030,” (September 12, 2016), covers exposure to blood or other
potentially infectious materials and can be accessed at the e-CFR Web site main page,
(C) “45 C.F.R. 164.512,” (September 12, 2016), specifies what information can be
shared under the HIPAA laws and can be accessed at the e-CFR Web site main page,
(D) “Application for Ambulance or Mobile Intensive Care License” form or form “EMS
4001” (May, 2016) can be accessed at the division's website at
(E) “Change in Level of Service Medical Transportation Organization” form or form “EMS
4011” (July, 2013) can be accessed at the division's website at
(F) “Deletion of Vehicle” form or form “EMS 4012” (April, 2016) can be accessed at the
(G) “Headquarters Change of Address” form or form “EMS 4004” (April, 2016) can be
accessed at the division's website at http://www.ems.ohio.gov/medical-transportation-
forms.aspx.
(H) “MoICU Inspection” form, or “Mobile Intensive Care Unit Inspection” form, or form
“EMS 4022” (February, 2017) can be accessed at the division's website at
(I) “Non-transport Vehicle Inspection” form or form “EMS 4026” (January, 2017) can be
accessed at the division's website at http://www.ems.ohio.gov/medical-transportation-
forms.aspx.
(J) “Periodic Mechanical Safety Report” form or form “EMS 4039” (May, 2016) can be
accessed at the division's website at http://www.ems.ohio.gov/medical-transportation-
forms.aspx.
(K) “Renewal Application for Ambulance or Mobile Intensive Care License” form or form
“EMS 4040” (May, 2016) can be viewed at the division's website at
(L) “Temporary Ambulance / MOICU / Non-transport Vehicle” form or form “EMS 4009”
(April, 2016) can be accessed at the division's website at http://www.ems.ohio.gov/medical-
transportation-forms.aspx.
(M) “Violation Notification” form or form “EMS 4029” (April, 2015), is issued by the board
to a MTO that is in violation of Chapter 4766 of the Revised Code and agency 4766 of the
Administrative Code and can be viewed at the division's website at
Chapter 4. Minors, Birth and Abortion

Part I. Minors

[Editor’s Note: Additional statutes involving minors and consent are listed elsewhere in this handbook under the applicable topic area.]

2108.31 Blood donation; minors.

Any person seventeen years of age or older may, without consent of the person's parent or guardian, donate blood in a voluntary blood program that is not operated for profit. Any person sixteen years of age but less than seventeen years of age may, with consent of the person's parent or guardian, donate blood in a voluntary blood program that is not operated for profit.

Before obtaining blood donations from students at high schools, joint vocational schools, or technical schools, a blood program shall arrange for the dissemination of written donation information to students to be shared with their parents or guardians. This information shall include a statement that the students will be requested to donate blood.

2151.33 Consent and reimbursement for emergency treatment of minor.

(A) Pending hearing of a complaint filed under section 2151.27 of the Revised Code or a motion filed or made under division (B) of this section and the service of citations, the juvenile court may make any temporary disposition of any child that it considers necessary to protect the best interest of the child and that can be made pursuant to division (B) of this section. Upon the certificate of one or more reputable practicing physicians, the court may summarily provide for emergency medical and surgical treatment that appears to be immediately necessary to preserve the health and well-being of any child concerning whom a complaint or an application for care has been filed, pending the service of a citation upon the child's parents, guardian, or custodian. The court may order the parents, guardian, or custodian, if the court finds the parents, guardian, or custodian able to do so, to reimburse the court for the expense involved in providing the emergency medical or surgical treatment. Any person who disobeys the order for reimbursement may be adjudged in contempt of court and punished accordingly.

If the emergency medical or surgical treatment is furnished to a child who is found at the hearing to be a nonresident of the county in which the court is located and if the expense of the medical or surgical treatment cannot be recovered from the parents, legal guardian, or custodian of the child, the board of county commissioners of the county in which the child has a legal settlement shall reimburse the court for the reasonable cost of the emergency medical or surgical treatment out of its general fund.

(B)(1) After a complaint, petition, writ, or other document initiating a case dealing with an alleged or adjudicated abused, neglected, or dependent child is filed and upon the filing or making of a motion pursuant to division (C) of this section, the court, prior to the final disposition of the case, may issue any of the following temporary orders to protect the best interest of the child:

(a) An order granting temporary custody of the child to a particular party;
(b) An order for the taking of the child into custody pursuant to section 2151.31 of the Revised Code pending the outcome of the adjudicatory and dispositional hearings;
(c) An order granting, limiting, or eliminating parenting time or visitation rights with respect to the child;
(d) An order requiring a party to vacate a residence that will be lawfully occupied by the child;

(e) An order requiring a party to attend an appropriate counseling program that is reasonably available to that party;

(f) Any other order that restrains or otherwise controls the conduct of any party which conduct would not be in the best interest of the child.

(2) Prior to the final disposition of a case subject to division (B)(1) of this section, the court shall do both of the following:

(a) Issue an order pursuant to Chapters 3119. to 3125 of the Revised Code requiring the parents, guardian, or person charged with the child’s support to pay support for the child.

(b) Issue an order requiring the parents, guardian, or person charged with the child’s support to continue to maintain any health insurance coverage for the child that existed at the time of the filing of the complaint, petition, writ, or other document, or to obtain health insurance coverage in accordance with sections 3119.29 to 3119.56 of the Revised Code.

(C)(1) A court may issue an order pursuant to division (B) of this section upon its own motion or if a party files a written motion or makes an oral motion requesting the issuance of the order and stating the reasons for it. Any notice sent by the court as a result of a motion pursuant to this section shall contain a notice that any party to a juvenile proceeding has the right to be represented by counsel and to have appointed counsel if the person is indigent.

(2) If a child is taken into custody pursuant to section 2151.31 of the Revised Code and placed in shelter care, the public children services agency or private child placing agency with which the child is placed in shelter care shall file or make a motion as described in division (C)(1) of this section before the end of the next day immediately after the date on which the child was taken into custody and, at a minimum, shall request an order for temporary custody under division (B)(1)(a) of this section.

(3) A court that issues an order pursuant to division (B)(1)(b) of this section shall comply with section 2151.419 of the Revised Code.

(D) The court may grant an ex parte order upon its own motion or a motion filed or made pursuant to division (C) of this section requesting such an order if it appears to the court that the best interest and the welfare of the child require that the court issue the order immediately. The court, if acting on its own motion, or the person requesting the granting of an ex parte order, to the extent possible, shall give notice of its intent or of the request to the parents, guardian, or custodian of the child who is the subject of the request. If the court issues an ex parte order, the court shall hold a hearing to review the order within seventy-two hours after it is issued or before the end of the next day after the day on which it is issued, whichever occurs first. The court shall give written notice of the hearing to all parties to the action and shall appoint a guardian ad litem for the child prior to the hearing.

The written notice shall be given by all means that are reasonably likely to result in the party receiving actual notice and shall include all of the following:

(1) The date, time, and location of the hearing;

(2) The issues to be addressed at the hearing;

(3) A statement that every party to the hearing has a right to counsel and to court-appointed counsel, if the party is indigent;

(4) The name, telephone number, and address of the person requesting the order;

(5) A copy of the order, except when it is not possible to obtain it because of the exigent circumstances in the case.

If the court does not grant an ex parte order pursuant to a motion filed or made pursuant to division (C) of this section or its own motion, the court shall hold a shelter care hearing on the motion within ten days after the motion is filed. The court shall give notice of the hearing to all affected parties in the same manner as set forth in the Juvenile Rules.

(E) The court, pending the outcome of the adjudicatory and dispositional hearings, shall
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Part I. Minors

Minor's Consent

not issue an order granting temporary custody of a child to a public children services agency or private child placing agency pursuant to this section, unless the court determines and specifically states in the order that the continued residence of the child in the child's current home will be contrary to the child's best interest and welfare and the court complies with section 2151.419 of the Revised Code.

(F) Each public children services agency and private child placing agency that receives temporary custody of a child pursuant to this section shall exercise due diligence to identify and provide notice to all adult grandparents and other adult relatives of the child, including any adult relatives suggested by the parents, within thirty days of the child's removal from the custody of the child's parents, in accordance with 42 U.S.C. 671(a)(29). The agency shall also maintain in the child's case record written documentation that it has placed the child, to the extent that it is consistent with the best interest, welfare, and special needs of the child, in the most family-like setting available and in close proximity to the home of the parents, custodian, or guardian of the child.

(G) For good cause shown, any court order that is issued pursuant to this section may be reviewed by the court at any time upon motion of any party to the action or upon the motion of the court.

(H)(1) Pending the hearing of a complaint filed under section 2151.27 of the Revised Code or a motion filed or made under division (B) of this section and the service of citations, a public children services agency may request that the superintendent of the bureau of criminal identification and investigation conduct a criminal records check with respect to each parent, guardian, custodian, prospective custodian, or prospective placement whose actions resulted in a temporary disposition under division (A) of this section. The public children services agency may request that the superintendent obtain information from the federal bureau of investigation as part of the criminal records check of each parent, guardian, custodian, prospective custodian, or prospective placement.

(2) Each public children services agency authorized by division (H) of this section to request a criminal records check shall do both of the following:

(a) Provide to each parent, guardian, custodian, prospective custodian, or prospective placement for whom a criminal records check is requested a copy of the form prescribed pursuant to division (C)(1) of section 109.572 of the Revised Code and a standard fingerprint impression sheet prescribed pursuant to division (C)(2) of that section and obtain the completed form and impression sheet from the parent, guardian, custodian, prospective custodian, or prospective placement;

(b) Forward the completed form and impression sheet to the superintendent of the bureau of criminal identification and investigation.

(3) A parent, guardian, custodian, prospective custodian, or prospective placement who is given a form and fingerprint impression sheet under division (H)(2)(a) of this section and who fails to complete the form or provide fingerprint impressions may be held in contempt of court.

3109.01 Minors; age of majority.

All persons of the age of eighteen years or more, who are under no legal disability, are capable of contracting and are of full age for all purposes.

3709.241 Minor's consent to diagnosis and treatment of venereal disease.

Notwithstanding any other provision of law, a minor may give consent for the diagnosis or treatment of any venereal disease by a licensed physician. Such consent is not subject to disaffirmance because of minority. The consent of the parent, parents, or guardian of a minor is not required for such diagnosis or treatment. The parent, parents, or guardian of a minor giving
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consent under this section are not liable for payment for any diagnostic or treatment services provided under this section without their consent.

3719.012 Minor’s consent to drug-related treatment.

(A) Notwithstanding any other provision of law, a minor may give consent for the diagnosis or treatment by a physician licensed to practice in this state of any condition which it is reasonable to believe is caused by a drug of abuse, beer, or intoxicating liquor. Such consent shall not be subject to disaffirmance because of minority.

(B) A physician licensed to practice in this state, or any person acting at his direction, who in good faith renders medical or surgical services to a minor giving consent under division (A) of this section, shall not be subject to any civil or criminal liability for assault, battery, or assault and battery.

(C) The parent or legal guardian of a minor giving consent under division (A) of this section is not liable for the payment of any charges made for medical or surgical services rendered such minor, unless the parent or legal guardian has also given consent for the diagnosis or treatment.

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2317.56 Abortion protocols and definitions.

(A) As used in this section:

(1) “Medical emergency” has the same meaning as in section 2919.16 of the Revised Code.

(2) “Medical necessity” means a medical condition of a pregnant woman that, in the reasonable judgment of the physician who is attending the woman, so complicates the pregnancy that it necessitates the immediate performance or induction of an abortion.

(3) “Probable gestational age of the embryo or fetus” means the gestational age that, in the judgment of a physician, is, with reasonable probability, the gestational age of the embryo or fetus at the time that the physician informs a pregnant woman pursuant to division (B)(1)(b) of this section.

(B) Except when there is a medical emergency or medical necessity, an abortion shall be performed or induced only if all of the following conditions are satisfied:

(1) At least twenty-four hours prior to the performance or inducement of the abortion, a physician meets with the pregnant woman in person in an individual, private setting and gives her an adequate opportunity to ask questions about the abortion that will be performed or induced. At this meeting, the physician shall inform the pregnant woman, verbally or, if she is hearing impaired, by other means of communication, of all of the following:

(a) The nature and purpose of the particular abortion procedure to be used and the medical risks associated with that procedure;

(b) The probable gestational age of the embryo or fetus;

(c) The medical risks associated with the pregnant woman carrying the pregnancy to term.

The meeting need not occur at the facility where the abortion is to be performed or induced, and the physician involved in the meeting need not be affiliated with that facility or with the physician who is scheduled to perform or induce the abortion.

(2) At least twenty-four hours prior to the performance or inducement of the abortion, the physician who is to perform or induce the abortion or the physician's agent does each of the following in person, by telephone, by certified mail, return receipt requested, or by regular mail
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evidenced by a certificate of mailing:
   (a) Inform the pregnant woman of the name of the physician who is scheduled to
       perform or induce the abortion;
   (b) Give the pregnant woman copies of the published materials described in division (C)
       of this section;
   (c) Inform the pregnant woman that the materials given pursuant to division (B)(2)(b) of
       this section are published by the state and that they describe the embryo or fetus and list
       agencies that offer alternatives to abortion. The pregnant woman may choose to examine or not
to examine the materials. A physician or an agent of a physician may choose to be
       disassociated from the materials and may choose to comment or not comment on the materials.
   (3) If it has been determined that the unborn human individual the pregnant woman is
       carrying has a detectable heartbeat, the physician who is to perform or induce the abortion shall
       comply with the informed consent requirements in section 2919.192 of the Revised Code in
       addition to complying with the informed consent requirements in divisions (B)(1), (2), (4), and (5)
       of this section.
   (4) Prior to the performance or inducement of the abortion, the pregnant woman signs a
       form consenting to the abortion and certifies both of the following on that form:
       (a) She has received the information and materials described in divisions (B)(1) and (2)
           of this section, and her questions about the abortion that will be performed or induced have
           been answered in a satisfactory manner.
       (b) She consents to the particular abortion voluntarily, knowingly, intelligently, and
           without coercion by any person, and she is not under the influence of any drug of abuse or
           alcohol.
       The form shall contain the name and contact information of the physician who provided
       to the pregnant woman the information described in division (B)(1) of this section.
   (5) Prior to the performance or inducement of the abortion, the physician who is
       scheduled to perform or induce the abortion or the physician's agent receives a copy of the
       pregnant woman's signed form on which she consents to the abortion and that includes the
       certification required by division (B)(4) of this section.
   (C) The department of health shall publish in English and in Spanish, in a typeface large
       enough to be clearly legible, and in an easily comprehensible format, the following materials on
       the department's web site:
       (1) Materials that inform the pregnant woman about family planning information, of
           publicly funded agencies that are available to assist in family planning, and of public and private
           agencies and services that are available to assist her through the pregnancy, upon childbirth,
           and while the child is dependent, including, but not limited to, adoption agencies. The materials
           shall be geographically indexed; include a comprehensive list of the available agencies, a
           description of the services offered by the agencies, and the telephone numbers and addresses
           of the agencies; and inform the pregnant woman about available medical assistance benefits for
           prenatal care, childbirth, and neonatal care and about the support obligations of the father of a
           child who is born alive. The department shall ensure that the materials described in division
           (C)(1) of this section are comprehensive and do not directly or indirectly promote, exclude, or
           discourage the use of any agency or service described in this division.
       (2) Materials that inform the pregnant woman of the probable anatomical and
           physiological characteristics of the zygote, blastocyte, embryo, or fetus at two-week gestational
           increments for the first sixteen weeks of pregnancy and at four-week gestational increments
           from the seventeenth week of pregnancy to full term, including any relevant information
           regarding the time at which the fetus possibly would be viable. The department shall cause
           these materials to be published only after it consults with the Ohio state medical association and
           the Ohio section of the American college of obstetricians and gynecologists relative to the
           probable anatomical and physiological characteristics of a zygote, blastocyte, embryo, or fetus
at the various gestational increments. The materials shall use language that is understandable by the average person who is not medically trained, shall be objective and nonjudgmental, and shall include only accurate scientific information about the zygote, blastocyte, embryo, or fetus at the various gestational increments. If the materials use a pictorial, photographic, or other depiction to provide information regarding the zygote, blastocyte, embryo, or fetus, the materials shall include, in a conspicuous manner, a scale or other explanation that is understandable by the average person and that can be used to determine the actual size of the zygote, blastocyte, embryo, or fetus at a particular gestational increment as contrasted with the depicted size of the zygote, blastocyte, embryo, or fetus at that gestational increment.

(D) Upon the submission of a request to the department of health by any person, hospital, physician, or medical facility for one copy of the materials published in accordance with division (C) of this section, the department shall make the requested copy of the materials available to the person, hospital, physician, or medical facility that requested the copy.

(E) If a medical emergency or medical necessity compels the performance or inducement of an abortion, the physician who will perform or induce the abortion, prior to its performance or inducement if possible, shall inform the pregnant woman of the medical indications supporting the physician's judgment that an immediate abortion is necessary. Any physician who performs or induces an abortion without the prior satisfaction of the conditions specified in division (B) of this section because of a medical emergency or medical necessity shall enter the reasons for the conclusion that a medical emergency or medical necessity exists in the medical record of the pregnant woman.

(F) If the conditions specified in division (B) of this section are satisfied, consent to an abortion shall be presumed to be valid and effective.

(G) The performance or inducement of an abortion without the prior satisfaction of the conditions specified in division (B) of this section does not constitute, and shall not be construed as constituting, a violation of division (A) of section 2919.12 of the Revised Code. The failure of a physician to satisfy the conditions of division (B) of this section prior to performing or inducing an abortion upon a pregnant woman may be the basis of both of the following:

(1) A civil action for compensatory and exemplary damages as described in division (H) of this section;

(2) Disciplinary action under section 4731.22 of the Revised Code.

(H)(1) Subject to divisions (H)(2) and (3) of this section, any physician who performs or induces an abortion with actual knowledge that the conditions specified in division (B) of this section have not been satisfied or with a heedless indifference as to whether those conditions have been satisfied is liable in compensatory and exemplary damages in a civil action to any person, or the representative of the estate of any person, who sustains injury, death, or loss to person or property as a result of the failure to satisfy those conditions. In the civil action, the court additionally may enter any injunctive or other equitable relief that it considers appropriate.

(2) The following shall be affirmative defenses in a civil action authorized by division (H)(1) of this section:

(a) The physician performed or induced the abortion under the circumstances described in division (E) of this section.

(b) The physician made a good faith effort to satisfy the conditions specified in division (B) of this section.

(3) An employer or other principal is not liable in damages in a civil action authorized by division (H)(1) of this section on the basis of the doctrine of respondeat superior unless either of the following applies:

(a) The employer or other principal had actual knowledge or, by the exercise of reasonable diligence, should have known that an employee or agent performed or induced an abortion with actual knowledge that the conditions specified in division (B) of this section had not been satisfied or with a heedless indifference as to whether those conditions had been
satisfied.

(b) The employer or other principal negligently failed to secure the compliance of an employee or agent with division (B) of this section.

(4) Notwithstanding division (E) of section 2919.12 of the Revised Code, the civil action authorized by division (H)(1) of this section shall be the exclusive civil remedy for persons, or the representatives of estates of persons, who allegedly sustain injury, death, or loss to person or property as a result of a failure to satisfy the conditions specified in division (B) of this section.

(I) The department of job and family services shall prepare and conduct a public information program to inform women of all available governmental programs and agencies that provide services or assistance for family planning, prenatal care, child care, or alternatives to abortion.

2317.561 Ultrasound before abortion.

In addition to the requirements in section 2317.56 of the Revised Code, if an obstetric ultrasound examination is performed at any time prior to the performance or inducement of an abortion or the physician performing or inducing the abortion determines that an ultrasound examination will be performed as part of the abortion procedure, the physician shall do both of the following prior to the performance or inducement of the abortion:

(A) Provide the pregnant woman receiving the abortion the opportunity to view the active ultrasound image of the embryo or fetus;
(B) Offer to provide the pregnant woman with a physical picture of the ultrasound image of the embryo or fetus.

The requirements of division (A) of this section shall be performed at no additional charge to the pregnant woman.

2919.11 Abortion; definitions.

As used in the Revised Code, "abortion" means the purposeful termination of a human pregnancy by any person, including the pregnant woman herself, with an intention other than to produce a live birth or to remove a dead fetus or embryo. Abortion is the practice of medicine or surgery for the purposes of section 4731.41 of the Revised Code.

2919.12 Informed consent required; unmarried minors.

(A) No person shall perform or induce an abortion without the informed consent of the pregnant woman.

(B)(1)(a) No person shall knowingly perform or induce an abortion upon a woman who is pregnant, unmarried, under eighteen years of age, and unemancipated unless at least one of the following applies:

(i) Subject to division (B)(2) of this section, the person has given at least twenty-four hours actual notice, in person or by telephone, to one of the woman's parents, her guardian, or her custodian as to the intention to perform or induce the abortion, provided that if the woman has requested, in accordance with division (B)(1)(b) of this section, that notice be given to a specified brother or sister of the woman who is twenty-one years of age or older or to a specified stepparent or grandparent of the woman instead of to one of her parents, her guardian, or her custodian, and if the person is notified by a juvenile court that affidavits of the type described in that division have been filed with that court, the twenty-four hours actual notice described in this division as to the intention to perform or induce the abortion shall be given, in person or by telephone, to the specified brother, sister, stepparent, or grandparent instead of to the parent, guardian, or custodian;
(ii) One of the woman's parents, her guardian, or her custodian has consented in writing to the performance or inducement of the abortion;

(iii) A juvenile court pursuant to section 2151.85 of the Revised Code issues an order authorizing the woman to consent to the abortion without notification of one of her parents, her guardian, or her custodian;

(iv) A juvenile court or a court of appeals, by its inaction, constructively has authorized the woman to consent to the abortion without notification of one of her parents, her guardian, or her custodian under division (B)(1) of section 2151.85 or division (A) of section 2505.073 of the Revised Code.

(b) If a woman who is pregnant, unmarried, under eighteen years of age, and unemancipated desires notification as to a person's intention to perform or induce an abortion on the woman to be given to a specified brother or sister of the woman who is twenty-one years of age or older or to a specified stepparent or grandparent of the woman instead of to one of her parents, her guardian, or her custodian, the person who intends to perform or induce the abortion shall notify the specified brother, sister, stepparent, or grandparent instead of the parent, guardian, or custodian for purposes of division (B)(1)(a)(i) of this section if all of the following apply:

(i) The woman has requested the person to provide the notification to the specified brother, sister, stepparent, or grandparent, clearly has identified the specified brother, sister, stepparent, or grandparent and her relation to that person, and, if the specified relative is a brother or sister, has indicated the age of the brother or sister;

(ii) The woman has executed an affidavit stating that she is in fear of physical, sexual, or severe emotional abuse from the parent, guardian, or custodian who otherwise would be notified under division (B)(1)(a)(i) of this section, and that the fear is based on a pattern of physical, sexual, or severe emotional abuse of her exhibited by that parent, guardian, or custodian, has filed the affidavit with the juvenile court of the county in which the woman has a residence or legal settlement, the juvenile court of any county that borders to any extent the county in which she has a residence or legal settlement, or the juvenile court of the county in which the hospital, clinic, or other facility in which the abortion would be performed or induced is located, and has given the court written notice of the name and address of the person who intends to perform or induce the abortion;

(iii) The specified brother, sister, stepparent, or grandparent has executed an affidavit stating that the woman has reason to fear physical, sexual, or severe emotional abuse from the parent, guardian, or custodian who otherwise would be notified under division (B)(1)(a)(i) of this section, based on a pattern of physical, sexual, or severe emotional abuse of her by that parent, guardian, or custodian, and the woman or the specified brother, sister, stepparent, or grandparent has filed the affidavit with the juvenile court in which the affidavit described in division (B)(1)(b)(ii) of this section was filed;

(iv) The juvenile court in which the affidavits described in divisions (B)(1)(b)(ii) and (iii) of this section were filed has notified the person that both of those affidavits have been filed with the court.

(c) If an affidavit of the type described in division (B)(1)(b)(ii) of this section and an affidavit of the type described in division (B)(1)(b)(iii) of this section are filed with a juvenile court and the court has been provided with written notice of the name and address of the person who intends to perform or induce an abortion upon the woman to whom the affidavits pertain, the court promptly shall notify the person who intends to perform or induce the abortion that the affidavits have been filed. If possible, the notice to the person shall be given in person or by telephone.

(2) If division (B)(1)(a)(ii), (iii), or (iv) of this section does not apply, and if no parent, guardian, or custodian can be reached for purposes of division (B)(1)(a)(i) of this section after a reasonable effort, or if notification is to be given to a specified brother, sister, stepparent, or
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grandparent under that division and the specified brother, sister, stepparent, or grandparent cannot be reached for purposes of that division after a reasonable effort, no person shall perform or induce such an abortion without giving at least forty-eight hours constructive notice to one of the woman's parents, her guardian, or her custodian, by both certified and ordinary mail sent to the last known address of the parent, guardian, or custodian, or if notification for purposes of division (B)(1)(a)(i) of this section is to be given to a specified brother, sister, stepparent, or grandparent, without giving at least forty-eight hours constructive notice to that specified brother, sister, stepparent, or grandparent by both certified and ordinary mail sent to the last known address of that specified brother, sister, stepparent, or grandparent. The forty-eight-hour period under this division begins when the certified mail notice is mailed. If a parent, guardian, or custodian of the woman, or if notification under division (B)(1)(a)(i) of this section is to be given to a specified brother, sister, stepparent, or grandparent, the specified brother, sister, stepparent, or grandparent, is not reached within the forty-eight-hour period, the abortion may proceed even if the certified mail notice is not received.

(3) If a parent, guardian, custodian, or specified brother, sister, stepparent, or grandparent who has been notified in accordance with division (B)(1) or (2) of this section clearly and unequivocally expresses that he or she does not wish to consult with a pregnant woman prior to her abortion, then the abortion may proceed without any further waiting period.

(4) For purposes of prosecutions for a violation of division (B)(1) or (2) of this section, it shall be a rebuttable presumption that a woman who is unmarried and under eighteen years of age is unemancipated.

(C)(1) It is an affirmative defense to a charge under division (B)(1) or (2) of this section that the pregnant woman provided the person who performed or induced the abortion with false, misleading, or incorrect information about her age, marital status, or emancipation, about the age of a brother or sister to whom she requested notice be given as a specified relative instead of to one of her parents, her guardian, or her custodian, or about the last known address of either of her parents, her guardian, her custodian, or a specified brother, sister, stepparent, or grandparent to whom she requested notice be given and the person who performed or induced the abortion did not otherwise have reasonable cause to believe the pregnant woman was under eighteen years of age, unmarried, or unemancipated, to believe that the age of a brother or sister to whom she requested notice be given as a specified relative instead of to one of her parents, her guardian, or her custodian was not twenty-one years of age, or to believe that the last known address of either of her parents, her guardian, her custodian, or a specified brother, sister, stepparent, or grandparent to whom she requested notice be given was incorrect.

(2) It is an affirmative defense to a charge under this section that compliance with the requirements of this section was not possible because an immediate threat of serious risk to the life or physical health of the pregnant woman from the continuation of her pregnancy created an emergency necessitating the immediate performance or induction of an abortion.

(D) Whoever violates this section is guilty of unlawful abortion. A violation of division (A) of this section is a misdemeanor of the first degree on the first offense and a felony of the fourth degree on each subsequent offense. A violation of division (B) of this section is a misdemeanor of the first degree on a first offense and a felony of the fifth degree on each subsequent offense.

(E) Whoever violates this section is liable to the pregnant woman and her parents, guardian, or custodian for civil compensatory and exemplary damages.

(F) As used in this section "unemancipated" means that a woman who is unmarried and under eighteen years of age has not entered the armed services of the United States, has not become employed and self-subsisting, or has not otherwise become independent from the care and control of her parent, guardian, or custodian.
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2919.121 Emancipated minor; performing an unlawful abortion.

(A) For the purpose of this section, a minor shall be considered “emancipated” if the minor has married, entered the armed services of the United States, become employed and self-subsisting, or has otherwise become independent from the care and control of her parent, guardian, or custodian.

(B) No person shall knowingly perform or induce an abortion upon a pregnant minor unless one of the following is the case:

1. The attending physician has secured the informed written consent of the minor and one parent, guardian, or custodian;

2. The minor is emancipated and the attending physician has received her written informed consent;

3. The minor has been authorized to consent to the abortion by a court order issued pursuant to division (C) of this section, and the attending physician has received her informed consent;

4. The court has given its consent in accordance with division (C) of this section and the minor is having the abortion willingly.

(C) The right of a minor to consent to an abortion under division (B)(3) of this section or judicial consent to obtain an abortion under division (B)(4) of this section may be granted by a court order pursuant to the following procedures:

1. The minor or next friend shall make an application to the juvenile court of the county in which the minor has a residence or legal settlement or the juvenile court of any county that borders the county in which she has a residence or legal settlement. The juvenile court shall assist the minor or next friend in preparing the petition and notices required by this section. The minor or next friend shall thereafter file a petition setting forth all of the following: the initials of the minor; her age; the names and addresses of each parent, guardian, custodian, or, if the minor’s parents are deceased and no guardian has been appointed, any other person standing in loco parentis of the minor; that the minor has been fully informed of the risks and consequences of the abortion; that the minor is of sound mind and has sufficient intellectual capacity to consent to the abortion; that the minor has not previously filed a petition under this section concerning the same pregnancy that was denied on the merits; that, if the court does not authorize the minor to consent to the abortion, the court should find that the abortion is in the best interests of the minor and give judicial consent to the abortion; that the court should appoint a guardian ad litem; and if the minor does not have private counsel, that the court should appoint counsel. The petition shall be signed by the minor or the next friend.

2. (a) A hearing on the merits shall be held on the record as soon as possible within five days of filing the petition. If the minor has not retained counsel, the court shall appoint counsel at least twenty-four hours prior to the hearing. The court shall appoint a guardian ad litem to protect the interests of the minor at the hearing. If the guardian ad litem is an attorney admitted to the practice of law in this state, the court may appoint the guardian ad litem to serve as the minor’s counsel. At the hearing, the court shall do all of the following:

(i) Hear evidence relating to the emotional development, maturity, intellect, and understanding of the minor; the nature, possible consequences, and alternatives to the abortion; and any other evidence that the court may find useful in determining whether the minor should be granted the right to consent to the abortion or whether the abortion is in the best interests of the minor;

(ii) Specifically inquire about the minor’s understanding of the possible physical and emotional complications of abortion and how the minor would respond if the minor experienced those complications after the abortion;

(iii) Specifically inquire about the extent to which anyone has instructed the minor on how to answer questions and on what testimony to give at the hearing.
(b) If the minor or her counsel fail to appear for a scheduled hearing, jurisdiction shall remain with the judge who would have presided at the hearing.

(3) If the court finds by clear and convincing evidence that the minor is sufficiently mature and well enough informed to decide intelligently whether to have an abortion, the court shall grant the petition and permit the minor to consent to the abortion.

If the court finds by clear and convincing evidence that the abortion is in the best interests of the minor, the court shall give judicial consent to the abortion, setting forth the grounds for its finding.

If the court does not make either of the findings specified in division (C)(3) of this section, the court shall deny the petition, setting forth the grounds on which the petition is denied.

The court shall issue its order not later than twenty-four hours after the end of the hearing.

(4) No juvenile court shall have jurisdiction to rehear a petition concerning the same pregnancy once a juvenile court has granted or denied the petition.

(5) If the petition is granted, the informed consent of the minor, pursuant to a court order authorizing the minor to consent to the abortion, or judicial consent to the abortion, shall bar an action by the parents, guardian, or custodian of the minor for battery of the minor against any person performing or inducing the abortion. The immunity granted shall only extend to the performance or inducement of the abortion in accordance with this section and to any accompanying services that are performed in a competent manner.

(6) An appeal from an order issued under this section may be taken to the court of appeals by the minor. The record on appeal shall be completed and the appeal perfected within four days from the filing of the notice of appeal. Because the abortion may need to be performed in a timely manner, the supreme court shall, by rule, provide for expedited appellate review of cases appealed under this section.

(7) All proceedings under this section shall be conducted in a confidential manner and shall be given such precedence over other pending matters as will ensure that the court will reach a decision promptly and without delay.

The petition and all other papers and records that pertain to an action commenced under this section shall be kept confidential and are not public records under section 149.43 of the Revised Code.

(8) No filing fee shall be required of or court costs assessed against a person filing a petition under this section or appealing an order issued under this section.

(9) Nothing in division (C) of this section shall constitute a waiver of any testimonial privilege provided under the Revised Code or at common law.

(D) It is an affirmative defense to any civil, criminal, or professional disciplinary claim brought under this section that compliance with the requirements of this section was not possible because an immediate threat of serious risk to the life or physical health of the minor from the continuation of her pregnancy created an emergency necessitating the immediate performance or inducement of an abortion.

(E) Whoever violates division (B) of this section is guilty of unlawful abortion, a misdemeanor of the first degree. If the offender previously has been convicted of or pleaded guilty to a violation of this section, unlawful abortion is a felony of the fourth degree.

(F) Whoever violates division (B) of this section is liable to the pregnant minor and her parents, guardian, or custodian for civil, compensatory, and exemplary damages.

2919.151 Partial birth feticide definitions and protocols.

(A) As used in this section:

(1) "Dilation and evacuation procedure of abortion" does not include the dilation and
extraction procedure of abortion.

(2) "From the body of the mother" means that the portion of the fetus' body in question is beyond the mother's vaginal introitus in a vaginal delivery.

(3) "Partial birth procedure" means the medical procedure that includes all of the following elements in sequence:

(a) Intentional dilation of the cervix of a pregnant woman, usually over a sequence of days;

(b) In a breech presentation, intentional extraction of at least the lower torso to the navel, but not the entire body, of an intact fetus from the body of the mother, or in a cephalic presentation, intentional extraction of at least the complete head, but not the entire body, of an intact fetus from the body of the mother;

(c) Intentional partial evacuation of the intracranial contents of the fetus, which procedure the person performing the procedure knows will cause the death of the fetus, intentional compression of the head of the fetus, which procedure the person performing the procedure knows will cause the death of the fetus, or performance of another intentional act that the person performing the procedure knows will cause the death of the fetus;

(d) Completion of the vaginal delivery of the fetus.

(4) "Partially born" means that the portion of the body of an intact fetus described in division (A)(3)(b) of this section has been intentionally extracted from the body of the mother.

(5) "Serious risk of the substantial and irreversible impairment of a major bodily function" means any medically diagnosed condition that so complicates the pregnancy of the woman as to directly or indirectly cause the substantial and irreversible impairment of a major bodily function.

(6) "Viable" has the same meaning as in section 2901.01 of the Revised Code.

(B) When the fetus that is the subject of the procedure is viable, no person shall knowingly perform a partial birth procedure on a pregnant woman when the procedure is not necessary, in reasonable medical judgment, to preserve the life or health of the mother as a result of the mother's life or health being endangered by a serious risk of the substantial and irreversible impairment of a major bodily function.

(C) When the fetus that is the subject of the procedure is not viable, no person shall knowingly perform a partial birth procedure on a pregnant woman when the procedure is not necessary, in reasonable medical judgment, to preserve the life or health of the mother as a result of the mother's life or health being endangered by a serious risk of the substantial and irreversible impairment of a major bodily function.

(D) Whoever violates division (B) or (C) of this section is guilty of partial birth feticide, a felony of the second degree.

(E) A pregnant woman upon whom a partial birth procedure is performed in violation of division (B) or (C) of this section is not guilty of committing, attempting to commit, complicity in the commission of, or conspiracy in the commission of a violation of those divisions.

(F) This section does not prohibit the suction curettage procedure of abortion, the suction aspiration procedure of abortion, or the dilation and evacuation procedure of abortion.

(G) This section does not apply to any person who performs or attempts to perform a legal abortion if the act that causes the death of the fetus is performed prior to the fetus being partially born even though the death of the fetus occurs after it is partially born.

2919.16 Post-viability abortions; definitions.

As used in sections 2919.16 to 2919.18 of the Revised Code:

(A) “Fertilization” means the fusion of a human spermatozoon with a human ovum.

(B) “Gestational age” or “gestation” means the age of an unborn child as calculated from the first day of the last menstrual period of a pregnant woman.
(C) “Health care facility” means a hospital, clinic, ambulatory surgical treatment center, other center, medical school, office of a physician, infirmary, dispensary, medical training institution, or other institution or location in or at which medical care, treatment, or diagnosis is provided to a person.

(D) “Hospital” has the same meanings as in sections 3701.01, 3727.01, and 5122.01 of the Revised Code.

(E) “Live birth” has the same meaning as in division (A) of section 3705.01 of the Revised Code.

(F) “Medical emergency” means a condition that in the physician's good faith medical judgment, based upon the facts known to the physician at that time, so complicates the woman's pregnancy as to necessitate the immediate performance or induction of an abortion in order to prevent the death of the pregnant woman or to avoid a serious risk of the substantial and irreversible impairment of a major bodily function of the pregnant woman that delay in the performance or induction of the abortion would create.

(G) “Physician” has the same meaning as in section 2305.113 of the Revised Code.

(H) “Pregnant” means the human female reproductive condition, that commences with fertilization, of having a developing fetus.

(I) “Pregnancy” means the condition of being pregnant.

(J) “Premature infant” means a human whose live birth occurs prior to thirty-eight weeks of gestational age.

(K) “Serious risk of the substantial and irreversible impairment of a major bodily function” means any medically diagnosed condition that so complicates the pregnancy of the woman as to directly or indirectly cause the substantial and irreversible impairment of a major bodily function. A medically diagnosed condition that constitutes a “serious risk of the substantial and irreversible impairment of a major bodily function” includes pre-eclampsia, inevitable abortion, and premature rupture of the membranes, may include, but is not limited to, diabetes and multiple sclerosis, and does not include a condition related to the woman's mental health.

(L) “Unborn child” means an individual organism of the species homo sapiens from fertilization until live birth.

(M) “Viable” means the stage of development of a human fetus at which in the determination of a physician, based on the particular facts of a woman's pregnancy that are known to the physician and in light of medical technology and information reasonably available to the physician, there is a realistic possibility of the maintaining and nourishing of a life outside of the womb with or without temporary artificial life-sustaining support.

2919.17 Performing or attempting to perform an abortion after viability.

(A) No person shall purposely perform or induce or attempt to perform or induce an abortion on a pregnant woman when the unborn child is viable.

(B)(1) It is an affirmative defense to a charge under division (A) of this section that the abortion was performed or induced or attempted to be performed or induced by a physician and that the physician determined, in the physician's good faith medical judgment, based on the facts known to the physician at that time, that either of the following applied:

(a) The unborn child was not viable.

(b) The abortion was necessary to prevent the death of the pregnant woman or a serious risk of the substantial and irreversible impairment of a major bodily function of the pregnant woman.

(2) No abortion shall be considered necessary under division (B)(1)(b) of this section on the basis of a claim or diagnosis that the pregnant woman will engage in conduct that would result in the pregnant woman's death or a substantial and irreversible impairment of a major
bodily function of the pregnant woman or based on any reason related to the woman's mental health.

(C) Except when a medical emergency exists that prevents compliance with section 2919.18 of the Revised Code, the affirmative defense set forth in division (B)(1)(a) of this section does not apply unless the physician who performs or induces or attempts to perform or induce the abortion performs the viability testing required by division (A) of section 2919.18 of the Revised Code and certifies in writing, based on the results of the tests performed, that in the physician's good faith medical judgment the unborn child is not viable.

(D) Except when a medical emergency exists that prevents compliance with one or more of the following conditions, the affirmative defense set forth in division (B)(1)(b) of this section does not apply unless the physician who performs or induces or attempts to perform or induce the abortion complies with all of the following conditions:

1. The physician who performs or induces or attempts to perform or induce the abortion certifies in writing that, in the physician's good faith medical judgment, based on the facts known to the physician at that time, the abortion is necessary to prevent the death of the pregnant woman or a serious risk of the substantial and irreversible impairment of a major bodily function of the pregnant woman.

2. Another physician who is not professionally related to the physician who intends to perform or induce the abortion certifies in writing that, in that physician's good faith medical judgment, based on the facts known to that physician at that time, the abortion is necessary to prevent the death of the pregnant woman or a serious risk of the substantial and irreversible impairment of a major bodily function of the pregnant woman.

3. The physician performs or induces or attempts to perform or induce the abortion in a hospital or other health care facility that has appropriate neonatal services for premature infants.

4. The physician who performs or induces or attempts to perform or induce the abortion terminates or attempts to terminate the pregnancy in the manner that provides the best opportunity for the unborn child to survive, unless that physician determines, in the physician's good faith medical judgment, based on the facts known to the physician at that time, that the termination of the pregnancy in that manner poses a greater risk of the death of the pregnant woman or a greater risk of the substantial and irreversible impairment of a major bodily function of the pregnant woman than would other available methods of abortion.

5. The physician certifies in writing the available method or techniques considered and the reasons for choosing the method or technique employed.

6. The physician who performs or induces or attempts to perform or induce the abortion has arranged for the attendance in the same room in which the abortion is to be performed or induced or attempted to be performed or induced at least one other physician who is to take control of, provide immediate medical care for, and take all reasonable steps necessary to preserve the life and health of the unborn child immediately upon the child's complete expulsion or extraction from the pregnant woman.

(E) For purposes of this section, there is a rebuttable presumption that an unborn child of at least twenty-four weeks gestational age is viable.

(F) Whoever violates this section is guilty of terminating or attempting to terminate a human pregnancy after viability, a felony of the fourth degree.

(G) The state medical board shall revoke a physician's license to practice medicine in this state if the physician violates this section.

(H) Any physician who performs or induces an abortion or attempts to perform or induce an abortion with actual knowledge that neither of the affirmative defenses set forth in division (B)(1) of this section applies, or with a heedless indifference as to whether either affirmative defense applies, is liable in a civil action for compensatory and exemplary damages and reasonable attorney's fees to any person, or the representative of the estate of any person, who sustains injury, death, or loss to person or property as the result of the performance or
inducement or the attempted performance or inducement of the abortion. In any action under this division, the court also may award any injunctive or other equitable relief that the court considers appropriate.

(I) A pregnant woman on whom an abortion is performed or induced or attempted to be performed or induced in violation of division (A) of this section is not guilty of violating division (A) of this section or of attempting to commit, conspiring to commit, or complicity in committing a violation of division (A) of this section.

2919.171 Physician to submit report.

(A) A physician who performs or induces or attempts to perform or induce an abortion on a pregnant woman shall submit a report to the department of health in accordance with the forms, rules, and regulations adopted by the department that includes all of the information the physician is required to certify in writing or determine under sections 2919.17 and 2919.18 of the Revised Code:

(B) By September 30 of each year, the department of health shall issue a public report that provides statistics for the previous calendar year compiled from all of the reports covering that calendar year submitted to the department in accordance with this section for each of the items listed in division (A) of this section. The report shall also provide the statistics for each previous calendar year in which a report was filed with the department pursuant to this section, adjusted to reflect any additional information that a physician provides to the department in a late or corrected report. The department shall ensure that none of the information included in the report could reasonably lead to the identification of any pregnant woman upon whom an abortion is performed.

(C)(1) The physician shall submit the report described in division (A) of this section to the department of health within fifteen days after the woman is discharged. If the physician fails to submit the report more than thirty days after that fifteen-day deadline, the physician shall be subject to a late fee of five hundred dollars for each additional thirty-day period or portion of a thirty-day period the report is overdue. A physician who is required to submit to the department of health a report under division (A) of this section and who has not submitted a report or has submitted an incomplete report more than one year following the fifteen-day deadline may, in an action brought by the department of health, be directed by a court of competent jurisdiction to submit a complete report to the department of health within a period of time stated in a court order or be subject to contempt of court.

(2) If a physician fails to comply with the requirements of this section, other than filing a late report with the department of health, or fails to submit a complete report to the department of health in accordance with a court order, the physician is subject to division (B)(44) of section 4731.22 of the Revised Code.

(3) No person shall falsify any report required under this section. Whoever violates this division is guilty of abortion report falsification, a misdemeanor of the first degree.

(D) Within ninety days of October 20, 2011, the department of health shall adopt rules pursuant to section 111.15 of the Revised Code to assist in compliance with this section.

2919.18 Viability tests required; violations.

(A) Except in a medical emergency that prevents compliance with this division, no physician shall perform or induce or attempt to perform or induce an abortion on a pregnant woman after the beginning of the twentieth week of gestation unless, prior to the performance or inducement of the abortion or the attempt to perform or induce the abortion, the physician determines, in the physician's good faith medical judgment, that the unborn child is not viable, and the physician makes that determination after performing a medical examination of the
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pregnant woman and after performing or causing to be performed those tests for assessing gestational age, weight, lung maturity, or other tests that the physician, in that physician's good faith medical judgment, believes are necessary to determine whether an unborn child is viable.

(B) Except in a medical emergency that prevents compliance with this division, no physician shall perform or induce or attempt to perform or induce an abortion on a pregnant woman after the beginning of the twentieth week of gestation without first entering the determination made in division (A) of this section and the associated findings of the medical examination and tests in the medical record of the pregnant woman.

(C) Whoever violates this section is guilty of failure to perform viability testing, a misdemeanor of the fourth degree.

(D) The state medical board shall suspend a physician's license to practice medicine in this state for a period of not less than six months if the physician violates this section.

2919.20 Abortion definitions.

As used in sections 2919.20 to 2919.204 of the Revised Code:

(A) “Fertilization” means the fusion of a human spermatozoon with a human ovum.

(B) “Medical emergency” means a condition that in the physician's reasonable medical judgment, based upon the facts known to the physician at that time, so complicates the woman's pregnancy as to necessitate the immediate performance or inducement of an abortion in order to prevent the death of the pregnant woman or to avoid a serious risk of the substantial and irreversible impairment of a major bodily function of the pregnant woman that delay in the performance or inducement of the abortion would create.

(C) “Pain-capable unborn child” means an unborn child of a probable post-fertilization age of twenty weeks or more.

(D) "Physician" has the same meaning as in section 2305.113 of the Revised Code.

(E) “Post-fertilization age” means the age of the unborn child as calculated from the fusion of a human spermatozoon with a human ovum.

(F) “Probable post-fertilization age” means, in reasonable medical judgment and with reasonable probability, the age of the unborn child, as calculated from fertilization, at the time the abortion is performed or induced or attempted to be performed or induced.

(G) “Reasonable medical judgment” means a medical judgment that would be made by a reasonably prudent physician, knowledgeable about the case and the treatment possibilities with respect to the medical conditions involved.

(H) “Serious risk of the substantial and irreversible impairment of a major bodily function” means any medically diagnosed condition that so complicates the pregnancy of the woman as to directly or indirectly cause the substantial and irreversible impairment of a major bodily function. A medically diagnosed condition that constitutes a “serious risk of the substantial and irreversible impairment of a major bodily function” includes pre-eclampsia, inevitable abortion, and premature rupture of the membranes, but does not include a condition related to the woman's mental health.

(I) “Unborn child” means an individual organism of the species homo sapiens from fertilization until live birth.

2919.201 Twenty week abortion prohibition.

(A) No person shall purposely perform or induce or purposely attempt to perform or induce an abortion on a pregnant woman when the probable post-fertilization age of the unborn child is twenty weeks or greater.

(B)(1) It is an affirmative defense to a charge under division (A) of this section that the abortion was purposely performed or induced or purposely attempted to be performed or
induced by a physician and that the physician determined, in the physician's reasonable medical judgment, based on the facts known to the physician at that time, that either of the following applied:

(a) The probable post-fertilization age of the unborn child was less than twenty weeks.
(b) The abortion was necessary to prevent the death of the pregnant woman or a serious risk of the substantial and irreversible impairment of a major bodily function of the pregnant woman.

(2) No abortion shall be considered necessary under division (B)(1)(b) of this section on the basis of a claim or diagnosis that the pregnant woman will engage in conduct that would result in the pregnant woman's death or a substantial and irreversible impairment of a major bodily function of the pregnant woman or based on any reason related to the woman's mental health.

(C) Except when a medical emergency exists that prevents compliance with section 2919.203 of the Revised Code, the affirmative defense set forth in division (B)(1)(a) of this section does not apply unless the physician who purposely performs or induces or purposely attempts to perform or induce the abortion makes a determination of the probable post-fertilization age of the unborn child as required by division (A) of section 2919.203 of the Revised Code or relied upon such a determination made by another physician and certifies in writing, based on the results of the tests performed, that in the physician's reasonable medical judgment the unborn child's probable post-fertilization age is less than twenty weeks.

(D) Except when a medical emergency exists that prevents compliance with one or more of the following conditions, the affirmative defense set forth in division (B)(1)(b) of this section does not apply unless the physician who purposely performs or induces or purposely attempts to perform or induce the abortion complies with all of the following conditions:

(1) The physician who purposely performs or induces or purposely attempts to perform or induce the abortion certifies in writing that, in the physician's reasonable medical judgment, based on the facts known to the physician at that time, the abortion is necessary to prevent the death of the pregnant woman or a serious risk of the substantial and irreversible impairment of a major bodily function of the pregnant woman.

(2) A different physician not professionally related to the physician described in division (D)(1) of this section certifies in writing that, in that different physician's reasonable medical judgment, based on the facts known to that different physician at that time, the abortion is necessary to prevent the death of the pregnant woman or a serious risk of the substantial and irreversible impairment of a major bodily function of the pregnant woman.

(3) The physician purposely performs or induces or purposely attempts to perform or induce the abortion in a hospital or other health care facility that has appropriate neonatal services for premature infants.

(4) The physician who purposely performs or induces or purposely attempts to perform or induce the abortion terminates or attempts to terminate the pregnancy in the manner that provides the best opportunity for the unborn child to survive, unless that physician determines, in the physician's reasonable medical judgment, based on the facts known to the physician at that time, that the termination of the pregnancy in that manner poses a greater risk of the death of the pregnant woman or a greater risk of the substantial and irreversible impairment of a major bodily function of the pregnant woman than would other available methods of abortion.

(5) The physician certifies in writing the available method or techniques considered and the reasons for choosing the method or technique employed.

(6) The physician who purposely performs or induces or purposely attempts to perform or induce the abortion has arranged for the attendance in the same room in which the abortion is to be performed or induced or attempted to be performed or induced at least one other physician who is to take control of, provide immediate medical care for, and take all reasonable steps necessary to preserve the life and health of the unborn child immediately upon the child's
complete expulsion or extraction from the pregnant woman.

(E) Whoever purposely performs or induces or purposely attempts to perform or induce an abortion in violation of, or without complying with, the requirements of this section is guilty of terminating or attempting to terminate a human pregnancy of a pain-capable unborn child, a felony of the fourth degree.

(F) The state medical board shall revoke a physician's license to practice medicine in this state if the physician violates or fails to comply with this section.

(G) Any physician who purposely performs or induces an abortion or purposely attempts to perform or induce an abortion with actual knowledge that neither of the affirmative defenses set forth in division (B)(1) of this section applies, or with a heedless indifference as to whether either an affirmative defense applies, is liable in a civil action for compensatory and exemplary damages and reasonable attorney's fees to any person, or the representative of the estate of any person, who sustains injury, death, or loss to person or property as the result of the performance or inducement or the attempted performance or inducement of the abortion. In any action under this division, the court also may award any injunctive or other equitable relief that the court considers appropriate.

(H) A pregnant woman on whom an abortion is purposely performed or induced or purposely attempted to be performed or induced in violation of division (A) of this section is not guilty of violating division (A) of this section or of attempting to commit, conspiring to commit, or complicity in committing a violation of division (A) of this section.

2919.202 Abortion reporting by physician.

(A) A physician who performs or induces or attempts to perform or induce an abortion on a pregnant woman shall submit a report to the department of health in accordance with the forms, rules, and regulations adopted by the department that includes all of the information the physician is required to certify in writing or determine under sections 2919.201 and 2919.203 of the Revised Code.

(B) By the thirtieth day of September of each year, the department of health shall issue a public report that provides statistics for the previous calendar year compiled from all of the reports covering that calendar year submitted to the department in accordance with this section for each of the items listed in division (A) of this section. The report shall also provide the statistics for each previous calendar year in which a report was filed with the department pursuant to this section, adjusted to reflect any additional information that a physician provides to the department in a late or corrected report. The department shall ensure that none of the information included in the report could reasonably lead to the identification of any pregnant woman upon whom an abortion is performed.

(C)(1) The physician shall submit the report described in division (A) of this section to the department of health within fifteen days after the woman is discharged. If the physician fails to submit the report more than thirty days after that fifteen-day deadline, the physician shall be subject to a late fee of five hundred dollars for each additional thirty-day period or portion of a thirty-day period the report is overdue. A physician who is required to submit to the department of health a report under division (A) of this section and who has not submitted a report or has submitted an incomplete report more than one year following the last day of the fifteen-day deadline may, in an action brought by the department of health, be directed by a court of competent jurisdiction to submit a complete report to the department of health within a period of time stated in a court order or be subject to contempt of court.

(2) If a physician fails to comply with the requirements of this section, other than filing a late report with the department of health, or fails to submit a complete report to the department of health in accordance with a court order, the physician is subject to division (B)(44) of section 4731.22 of the Revised Code.
(3) No person shall purposely falsify any report required under this section. Whoever purposely violates this division is guilty of pain-capable unborn child abortion report falsification, a misdemeanor of the first degree.

(D) Within ninety days of the effective date of this section, the department of health shall adopt rules pursuant to section 111.15 of the Revised Code to assist in compliance with this section.

2919.203 Twenty week abortion prohibition; medical emergency; misdemeanor.

(A) Except in a medical emergency that prevents compliance with this division, no physician shall purposely perform or induce or purposely attempt to perform or induce an abortion on a pregnant woman after the unborn child reaches the probable post-fertilization age of twenty weeks unless, prior to the performance or inducement of the abortion or the attempt to perform or induce the abortion, the physician determines, in the physician's reasonable medical judgment, the unborn child's probable post-fertilization age. The physician shall make that determination after making inquiries of the pregnant woman and performing any medical examinations or tests of the pregnant woman the physician considers necessary as a reasonably prudent physician, knowledgeable about the case and medical conditions involved, would consider necessary to determine the unborn child's probable post-fertilization age.

(B) Except in a medical emergency that prevents compliance with this division, no physician shall purposely perform or induce or purposely attempt to perform or induce an abortion on a pregnant woman after the unborn child reaches the probable post-fertilization age of twenty weeks without first entering the determination made in division (A) of this section and the associated findings of the medical examination and tests in the medical record of the pregnant woman.

(C) Whoever violates division (A) of this section is guilty of failure to perform probable post-fertilization age testing, a misdemeanor of the fourth degree.

(D) The state medical board shall suspend a physician's license to practice medicine in this state for a period of not less than six months if the physician violates this section.

3701.341 Rules to be implemented by director.

(A) The director of health, pursuant to Chapter 119 and consistent with section 2317.56 of the Revised Code, shall adopt rules relating to abortions and the following subjects:

(1) Post-abortion procedures to protect the health of the pregnant woman;
(2) Pathological reports;
(3) Humane disposition of the product of human conception;
(4) Counseling.

(B) The director of health shall implement the rules and shall apply to the court of common pleas for temporary or permanent injunctions restraining a violation or threatened violation of the rules. This action is an additional remedy not dependent on the adequacy of the remedy at law.

3701.79 Abortion data collecting; reporting; postabortion complications.

(A) As used in this section:

(1) "Abortion" has the same meaning as in section 2919.11 of the Revised Code.
(2) "Abortion report" means a form completed pursuant to division (C) of this section.
(3) "Ambulatory surgical facility" has the same meaning as in section 3702.30 of the Revised Code.
(4) "Department" means the department of health.
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(5) "Hospital" means any building, structure, institution, or place devoted primarily to the maintenance and operation of facilities for the diagnosis, treatment, and medical or surgical care for three or more unrelated individuals suffering from illness, disease, injury, or deformity, and regularly making available at least clinical laboratory services, diagnostic x-ray services, treatment facilities for surgery or obstetrical care, or other definitive medical treatment. "Hospital" does not include a "home" as defined in section 3721.01 of the Revised Code.

(6) "Physician's office" means an office or portion of an office that is used to provide medical or surgical services to the physician's patients. "Physician's office" does not mean an ambulatory surgical facility, a hospital, or a hospital emergency department.

(7) "Postabortion care" means care given after the uterus has been evacuated by abortion.

B) The department shall be responsible for collecting and collating abortion data reported to the department as required by this section.

C) The attending physician shall complete an individual abortion report for each abortion the physician performs upon a woman. The report shall be confidential and shall not contain the woman's name. The report shall include, but is not limited to, all of the following, insofar as the patient makes the data available that is not within the physician's knowledge:

1) Patient number;
2) The name and address of the facility in which the abortion was performed, and whether the facility is a hospital, ambulatory surgical facility, physician's office, or other facility;
3) The date of the abortion;
4) All of the following regarding the woman on whom the abortion was performed:
   a) Zip code of residence;
   b) Age;
   c) Race;
   d) Marital status;
   e) Number of previous pregnancies;
   f) Years of education;
   g) Number of living children;
   h) Number of previously induced abortions;
   i) Date of last induced abortion;
   j) Date of last live birth;
   k) Method of contraception at the time of conception;
   l) Date of the first day of the last menstrual period;
   m) Medical condition at the time of the abortion;
   n) Rh-type;
   o) The number of weeks of gestation at the time of the abortion.
   5) The type of abortion procedure performed;
   6) Complications by type;
   7) Type of procedure performed after the abortion;
   8) Type of family planning recommended;
   9) Type of additional counseling given;
   10) Signature of attending physician.

D) The physician who completed the abortion report under division (C) of this section shall submit the abortion report to the department within fifteen days after the woman is discharged.

E) The appropriate vital records report or certificate shall be made out after the twentieth week of gestation.

F) A copy of the abortion report shall be made part of the medical record of the patient of the facility in which the abortion was performed.

G) Each hospital shall file monthly and annual reports listing the total number of women
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who have undergone a post-twelve-week-gestation abortion and received postabortion care. The annual report shall be filed following the conclusion of the state’s fiscal year. Each report shall be filed within thirty days after the end of the applicable reporting period.

(H) Each case in which a physician treats a post abortion complication shall be reported on a postabortion complication form. The report shall be made upon a form prescribed by the department, shall be signed by the attending physician, and shall be confidential.

(I)(1) Not later than the first day of October of each year, the department shall issue an annual report of the abortion data reported to the department for the previous calendar year as required by this section. The annual report shall include at least the following information:

(a) The total number of induced abortions;
(b) The number of abortions performed on Ohio and out-of-state residents;
(c) The number of abortions performed, sorted by each of the following:
   (i) The age of the woman on whom the abortion was performed, using the following categories: under fifteen years of age, fifteen to nineteen years of age, twenty to twenty-four years of age, twenty-five to twenty-nine years of age, thirty to thirty-four years of age, thirty-five to thirty-nine years of age, forty to forty-four years of age, forty-five years of age or older;
   (ii) The race and Hispanic ethnicity of the woman on whom the abortion was performed;
   (iii) The education level of the woman on whom the abortion was performed, using the following categories or their equivalents: less than ninth grade, ninth through twelfth grade, one or more years of college;
   (iv) The marital status of the woman on whom the abortion was performed;
   (v) The number of living children of the woman on whom the abortion was performed, using the following categories: none, one, or two or more;
   (vi) The number of weeks of gestation of the woman at the time the abortion was performed, using the following categories: less than nine weeks, nine to twelve weeks, thirteen to nineteen weeks, or twenty weeks or more;
   (vii) The county in which the abortion was performed;
   (viii) The type of abortion procedure performed;
   (ix) The number of abortions previously performed on the woman on whom the abortion was performed;
   (x) The type of facility in which the abortion was performed;
   (xi) For Ohio residents, the county of residence of the woman on whom the abortion was performed.

(2) The report also shall indicate the number and type of the abortion complications reported to the department either on the abortion report required under division (C) of this section or the postabortion complication report required under division (H) of this section.

(3) In addition to the annual report required under division (I)(1) of this section, the department shall make available, on request, the number of abortions performed by zip code of residence.

(J) The director of health shall implement this section and shall apply to the court of common pleas for temporary or permanent injunctions restraining a violation or threatened violation of its requirements. This action is an additional remedy not dependent on the adequacy of the remedy at law.

3701.791 Facilities performing abortions must post signage.

(A) As used in this section, “medical emergency” means a condition of a pregnant woman that, in the reasonable judgment of the physician who is attending the woman, creates an immediate threat of serious risk to the life or physical health of the woman from the continuation of the pregnancy necessitating the immediate performance or inducement of an abortion.
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(B) Except as provided in division (D) of this section, an office or facility at which abortions are performed or induced shall post the notice described in division (C) of this section in a conspicuous location in an area of the office or facility that is accessible to all patients, employees, and visitors.

The notice shall be displayed on a poster with dimensions of at least seventeen inches by eleven inches. The first two sentences of the notice shall be printed in at least a forty-four-point typeface and the remaining lines shall be in at least a thirty-point typeface.

(C) The department of health shall publish the following notice on its internet web site in a manner that can be copied and produced in poster form:

“NO ONE CAN FORCE YOU TO HAVE AN ABORTION.

NO ONE--NOT A PARENT, NOT A HUSBAND, NOT A BOYFRIEND--NO ONE.

Under Ohio law, an abortion cannot be legally performed on anyone, regardless of her age, unless she VOLUNTARILY CONSENTS to having the abortion.

Ohio law requires that, before an abortion can legally be performed, the pregnant female must sign a form indicating that she consents to having the abortion “voluntarily” and “WITHOUT COERCION BY ANY PERSON.”

IF SOMEONE IS TRYING TO FORCE YOU TO HAVE AN ABORTION AGAINST YOUR WILL:

DO NOT SIGN THE CONSENT FORM

IF YOU ARE AT AN ABORTION FACILITY, TELL AN EMPLOYEE OF THE FACILITY THAT SOMEONE IS TRYING TO FORCE YOU TO HAVE AN ABORTION.”

(D) Division (B) of this section does not apply to an office or facility at which abortions are performed or induced due only to a medical emergency.

4731.91 Abortion; liability.

(A) No private hospital, private hospital director, or governing board of a private hospital is required to permit an abortion.

(B) No public hospital, public hospital director, or governing board of a public hospital is required to permit an abortion.

(C) Refusal to permit an abortion is not grounds for civil liability nor a basis for disciplinary or other recriminatory action.

(D) No person is required to perform or participate in medical procedures which result in abortion, and refusal to perform or participate in the medical procedures is not grounds for civil liability nor a basis for disciplinary or other recriminatory action.

(E) Whoever violates division (D) of this section is liable in civil damages.

4731.941 Physician protocol for others to furnish naloxone; immunity.

(A)(1) A physician who has established a protocol that meets the requirements of division (C) of this section may authorize one or more other individuals to personally furnish a supply of naloxone pursuant to the protocol to either of the following:

(a) An individual who there is reason to believe is experiencing or at risk of experiencing an opioid-related overdose;
(b) A family member, friend, or other person in a position to assist an individual who there is reason to believe is at risk of experiencing an opioid-related overdose.

(2) An individual authorized under this section to personally furnish naloxone may do so without having examined the individual to whom it may be administered.

(B) An individual authorized by a physician under this section may personally furnish naloxone to an individual described in division (A)(1)(a) or (b) of this section if both of the following conditions are met:

(1) The authorized individual complies with the protocol established by the authorizing physician, including having completed the training required by the protocol.

(2) The authorized individual instructs the individual to whom naloxone is furnished to summon emergency services as soon as practicable either before or after administering naloxone.

(C) A protocol established by a physician for purposes of this section shall be established in writing and include all of the following:

(1) A description of the clinical pharmacology of naloxone;

(2) Precautions and contraindications concerning furnishing naloxone;

(3) Any limitations the physician specifies concerning the individuals to whom naloxone may be furnished;

(4) The naloxone dosage that may be furnished and any variation in the dosage based on circumstances specified in the protocol;

(5) Labeling, storage, record-keeping, and administrative requirements;

(6) Training requirements that must be met before an individual will be authorized to furnish naloxone;

(7) Any instructions or training that the authorized individual must provide to an individual to whom naloxone is furnished.

(D) A physician who in good faith authorizes another individual to personally furnish naloxone in accordance with a protocol established by the physician under this section is not liable for or subject to any of the following for any action or omission of the individual to whom the naloxone is furnished: damages in any civil action, prosecution in any criminal proceeding, or professional disciplinary action.

An individual authorized under this section to personally furnish naloxone who does so in good faith is not liable for or subject to any of the following for any action or omission of the individual to whom the naloxone is furnished: damages in any civil action, prosecution in any criminal proceeding, or professional disciplinary action.

4731.942 Physician naloxone protocol authorization.

A physician may authorize one or more pharmacists and any of the pharmacy interns supervised by the pharmacist or pharmacists to use the protocol developed pursuant to rules adopted under section 4729.44 of the Revised Code for the purpose of dispensing naloxone under section 4729.44 of the Revised Code.

4731.943 Administration of naloxone.

(A) As used in this section, “service entity” has the same meaning as in section 4729.514 of the Revised Code.

(B) A physician who has established a protocol under division (D) of this section may authorize an individual who is an employee, volunteer, or contractor of a service entity to administer naloxone to an individual who is apparently experiencing an opioid-related overdose.

(C) An individual authorized by a physician under this section may administer naloxone to an individual who is apparently experiencing an opioid-related overdose if all of the following
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conditions are met:
(1) The naloxone is obtained from a service entity of which the authorized individual is an employee, volunteer, or contractor.
(2) The authorized individual complies with the protocol established by the authorizing physician.
(3) The authorized individual summons emergency services as soon as practicable either before or after administering the naloxone.
(D) A protocol established by a physician for purposes of this section must be in writing and include all of the following:
   (1) A description of the clinical pharmacology of naloxone;
   (2) Precautions and contraindications concerning the administration of naloxone;
   (3) Any limitations the physician specifies concerning the individuals to whom naloxone may be administered;
   (4) The naloxone dosage that may be administered and any variation in the dosage based on circumstances specified in the protocol;
   (5) Labeling, storage, record-keeping, and administrative requirements;
   (6) Training requirements that must be met before an individual can be authorized to administer naloxone.
(E) A physician who in good faith authorizes an individual to administer naloxone under this section is not liable for or subject to any of the following for any act or omission of the authorized individual: damages in any civil action, prosecution in any criminal proceeding, or professional disciplinary action.
A service entity or an employee, volunteer, or contractor of a service entity is not liable for or subject to any of the following for injury, death, or loss to person or property that allegedly arises from an act or omission associated with procuring, maintaining, accessing, or administering naloxone under this section, unless the act or omission constitutes willful or wanton misconduct: damages in any civil action, prosecution in any criminal proceeding, or professional disciplinary action.
This section does not eliminate, limit, or reduce any other immunity or defense that a service entity or an employee, volunteer, or contractor of a service entity may be entitled to under Chapter 2305 or any other provision of the Revised Code or under the common law of this state.

4731.96 Physician may prescribe epinephrine.

(A) As used in this section, “physician” means an individual authorized under this chapter to practice medicine and surgery, osteopathic medicine and surgery, or podiatric medicine and surgery.
(B)(1) Subject to division (B)(2) of this section, and notwithstanding any provision of this chapter or rule adopted by the state medical board, a physician may do either of the following without having examined an individual to whom epinephrine may be administered:
   (a) Personally furnish a supply of epinephrine autoinjectors for use in accordance with sections 3313.7110, 3313.7111, 3314.143, 3326.28, 3328.29, 3728.03 to 3728.05, and 5101.76 of the Revised Code;
   (b) Issue a prescription for epinephrine autoinjectors for use in accordance with sections 3313.7110, 3313.7111, 3314.143, 3326.28, 3328.29, 3728.03 to 3728.05, and 5101.76 of the Revised Code.
(2) An epinephrine autoinjector personally furnished or prescribed under division (B)(1) of this section must be furnished or prescribed in such a manner that it may be administered only in a manufactured dosage form.
(C) A physician who acts in good faith in accordance with this section is not liable for or
subject to any of the following for any action or omission of an entity to which an epinephrine autoinjector is furnished or a prescription is issued: damages in any civil action, prosecution in any criminal proceeding, or professional disciplinary action.

5101.57 Prohibition against nontherapeutic abortion at any public hospital.

(A) As used in this section:
   (1) "Nontherapeutic abortion" has the same meaning as in section 124.85 of the Revised Code.
   (2) "Political subdivision" means any body corporate and politic that is responsible for governmental activities in a geographic area smaller than the state, except that "political subdivision" does not include either of the following:
      (a) A municipal corporation;
      (b) A county that has adopted a charter under Section 3 of Article X, Ohio Constitution, to the extent that it is exercising the powers of local self-government as provided in that charter and is subject to Section 3 of Article XVIII, Ohio Constitution.
   (3) "Public facility" means any institution, structure, equipment, or physical asset that is owned, leased, or controlled by this state or any agency, institution, instrumentality, or political subdivision thereof. "Public facility" includes any state university, state medical college, health district, joint hospital, or public hospital agency.

(B) No public facility shall be used for the purpose of performing or inducing a nontherapeutic abortion.

3701-47-01 Abortion; definitions.

As used in rules 3701-47-01 to 3701-47-07 of the Ohio Sanitary Code;

(A) "Abortion" means, as defined by section 2919.11 of the Revised Code, the purposeful termination of a human pregnancy by any person, including the pregnant woman herself, with an intention other than to produce a live birth or to remove a dead fetus or embryo. Abortion is the practice of medicine or surgery for the purpose of section 4731.41 of the Revised Code.

(B) "Conceptus" means the product of human conception.

(C) "Department" means the department of health of the state of Ohio.

(D) "Director" means the director of health of the state of Ohio.

(E) "Fetus" means the developing conceptus from fourteen (14) weeks after the first day of the woman's last menstrual period until birth.

(F) "Gestation" means pregnancy.

(G) "Hospital" means any building, structure, institution, or place devoted primarily to the maintenance and operation of facilities for the diagnosis, treatment, and medical or surgical care for three or more non-related individuals, suffering from illness, disease, injury or deformity, and regularly making available at least clinical laboratory services, and diagnostic X-ray services and treatment facilities for surgery or obstetrical care, or other definitive medical treatment. It does not include a "home" as defined in sec. 3721.01 of the Revised Code.

(H) "Pathologist" means a physician licensed to practice in Ohio with special training in the pathology of tissues.

(I) "Post-abortion care" means care given after the uterus has been evacuated by abortion.

3701-47-02 Post-abortion procedures.

In all abortions upon a woman whose conceptus, in the best judgment of the attending
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A fetus as defined in rule 3701-47-01, the physician shall effect compliance with the following:

(A) Immediate post-abortion care shall be provided in a hospital.
(B) Written and oral discharge instructions shall be issued to each woman which shall include, but not be limited to, the following:
   (1) Symptoms of complications to be looked for and recommended response to any such symptoms;
   (2) Activities to be avoided;
   (3) Notification of a 24-hour emergency service;
   (4) Comprehensive birth control information;
   (5) The date for follow-up or return visit after the performance of the abortion, which shall be scheduled as indicated by the condition of the patient and instructions on the importance of a follow-up visit;
   (6) Use of appropriate medications, when indicated;
   (7) Instructions about the care of her body.
(C) Information regarding Rh typing of the patient's blood shall be a part of the patient's medical record. Anti-Rh immune globulin therapy shall be given to all Rh negative patients upon completion of the abortion procedure when medically indicated, except when refused by the patient. If for any reason a patient refuses this therapy, the refusal shall be documented in the clinical record.

3701-47-03 Physician abortion reports.

(A) In addition to the data reported pursuant to division (C) of 3701.79 of the Revised Code, a physician who performs or induces or attempts to perform or induce an abortion on a woman after the beginning of the twentieth week of gestation shall submit a report on a form prescribed by the department of health with the following information:
   (1) Whether the attending physician performed a medical examination of the pregnant woman to determine the gestational age of the unborn child and the viability of the unborn child within forty eight hours before the performance or inducement of the abortion or the attempt to perform or induce the abortion;
   (2) Whether or not, in the attending physician's good faith judgment, the unborn child was viable;
   (3) The type of testing performed to determine gestational age and viability;
   (4) Whether or not a medical emergency existed; and
   (5) For abortions performed for which the physician has indicated under paragraph (A)(2) of this rule that the unborn child is viable;
      (a) Whether, in the attending physician's good faith judgment and based on the facts known to the physician at the time, the abortion was necessary to prevent the death of the pregnant woman or a serious risk of the substantial and irreversible impairment of a major bodily function of the pregnant woman and if a serious risk of the substantial and irreversible impairment of a major bodily function of the pregnant woman exists, the physician must document the specific nature of such risk;
      (b) If the attending physician determined that the abortion was necessary to prevent the death of the pregnant woman or a serious risk of the substantial and irreversible impairment of a major bodily function of the pregnant woman, the name of the physician not professionally related to the attending physician who certified in writing that the abortion was necessary to prevent the death of the pregnant woman or a serious risk of the substantial and irreversible impairment of a major bodily function of the pregnant woman;
      (c) If the attending physician determined that the abortion was necessary to prevent the death of the pregnant woman or a serious risk of the substantial and irreversible impairment of a
major bodily function of the pregnant woman, the method or techniques considered and the reasons for choosing the method or technique employed when performing, inducing or attempting to induce an abortion; and

(d) Whether the abortion was based on a claim or diagnosis that the pregnant woman will engage in conduct that would result in the pregnant woman's death or a substantial and irreversible impairment of a major bodily function of the pregnant woman or on any reason related to the women's mental health.

(B) A physician shall submit the report described in paragraph (A) of this rule to the department of health within fifteen days after the woman is discharged.

(C) A physician who fails to submit the report described in paragraph (A) of this rule more than thirty days after the fifteen-day deadline, shall be subject to a late fee of five hundred dollars for each additional thirty-day period or portion of a thirty-day period the report is overdue.

(D) A physician who is required to submit to the department of health a report under paragraph (A) of this rule and who has not submitted a report or has submitted an incomplete report more than one year following the fifteen-day deadline may, in an action brought by the department of health, be directed by a court of competent jurisdiction to submit a complete report to the department of health within a period of time stated in a court order or be subject to contempt of court.

(E) A physician who fails to comply with the requirements of this rule, other than filing a late report with the department of health, or fails to submit a complete report to the department of health in accordance with a court order is subject to division (B)(41) of section 4731.22 of the Revised Code.

(F) For purposes of this rule, “viable” means the stage of development of a human fetus at which in the determination of a physician, based on the particular facts of a woman's pregnancy that are known to the physician and in light of medical technology and information reasonably available to the physician, there is a realistic possibility of the maintaining and nourishing of a life outside of the womb with or without temporary artificial life-sustaining support.

(G) A physician who, between October 20, 2011 and the effective date of this rule, has performed or induced or attempted to perform or induce an abortion on a woman after the beginning of the twentieth week of gestation shall submit a report to the department of health that includes all of the information the physician is required to certify in writing or determine under sections 2919.17 and 2919.18 of the Revised Code not later than March 1, 2012. A physician may use the forms prescribed by the department of health to submit such reports.

(H) The department of health may require all reports required by section 2919.171 of the Revised Code and this rule to be filed electronically. Until such time as the department of health approves an electronic reporting form, reports shall be submitted on paper forms approved by the department of health.

3701-47-04 Pathological examination.

In the event a physician finds cause to have a pathological examination performed, then he shall order and obtain the same.

3701-47-05 Humane disposition of the product of conception.

(A) The fetus shall be disposed of in a humane manner.

(B) No person shall experiment upon or sell the product of human conception which is aborted. Experiment does not include autopsies pursuant to sections 313.13 and 2108.50 of the Revised Code.
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3701-47-06 Counseling must be provided.

(A) The fact of the availability of both pre-abortion and post-abortion counseling for herself and other persons of her choosing shall be made known by the physician, to each woman who is seeking the abortion of a fetus.

(B) Counseling shall be non-judgmental, regardless of the circumstances of the pregnancy, but shall not be forced upon the woman.

(C) The woman shall be treated in a safe, humane and dignified manner during the counseling period and throughout her stay at the place where the abortion is performed.

Part III. Birth

Umbilical Cord Blood, Paternity and Tests for Pregnant Women

2108.62 Umbilical cords blood donations.

(A) The department of health, on its internet web site, shall make available to health care professionals printable publications that can be downloaded containing standardized, objective information about umbilical cord blood banking that is sufficient to allow a pregnant woman to make an informed decision about whether to participate in an umbilical cord blood banking program. The publications shall include all of the following information:

(1) The medical processes involved in the collection of umbilical cord blood;

(2) The medical risks of umbilical cord blood collection to the mother and the newborn child;

(3) The options available to a mother regarding stem cells contained in the umbilical cord blood after delivery of the mother's newborn child, including:

(a) Having the stem cells discarded;

(b) Donating the stem cells to a public umbilical cord blood bank;

(c) Having the stem cells stored in a private umbilical cord blood bank for use by immediate and extended family members;

(d) Storing the stem cells for use by the family through a family or sibling donor banking program that provides free collection, processing, and storage of the stem cells where there is a medical need.

(4) The current and potential future medical uses, risks, and benefits of umbilical cord blood collection to the mother, newborn child, and biological family;

(5) The current and potential future medical uses, risks, and benefits of umbilical cord blood collection to individuals who are not biologically related to the mother or newborn child;

(6) Any costs that may be incurred by a pregnant woman who chooses to make an umbilical cord blood donation;

(7) The average cost of public and private umbilical cord blood banking.

(B) The department may update the publications prepared pursuant to this section as it considers necessary.

2108.63 Qualified immunity related to umbilical cord blood donations.

A health care professional or health care institution is not liable for damages in a civil action, subject to prosecution in a criminal proceeding, or subject to disciplinary action by the state medical board or board of nursing for acting in good faith pursuant to section 2108.61 of the Revised Code.
3111.30 Acknowledgment of paternity update.

Once an acknowledgment of paternity becomes final, the office of child support shall notify the department of health of the acknowledgment. If the original birth record is inconsistent with the acknowledgment, on receipt of the notice, the department of health shall, in accordance with section 3705.09 of the Revised Code, prepare a new birth record consistent with the acknowledgment and substitute the new record for the original birth record.

3111.31 Paternity affidavit acknowledgegment.

The department of job and family services shall prepare an acknowledgment of paternity affidavit that includes in boldface type at the top of the affidavit the rights and responsibilities of and the due process safeguards afforded to a person who acknowledges that he is the natural father of a child, including that if an alleged father acknowledges a parent and child relationship he assumes the parental duty of support, that both signators waive any right to bring an action pursuant to sections 3111.01 to 3111.18 of the Revised Code or make a request pursuant to section 3111.38 of the Revised Code, other than for purposes of rescinding the acknowledgment pursuant to section 3111.27 of the Revised Code in order to ensure expediency in resolving the question of the existence of a parent and child relationship, that either parent may rescind the acknowledgment pursuant to section 3111.27 of the Revised Code, that an action may be brought pursuant to section 3111.28 of the Revised Code, or a motion may be filed pursuant to section 3119.961 of the Revised Code, to rescind the acknowledgment, and that the natural father has the right to petition a court pursuant to section 2151.23 of the Revised Code. The affidavit shall include all of the following:

(A) Basic instructions for completing the form, including instructions that both the natural father and the mother of the child are required to sign the statement, that they may sign the statement without being in each other's presence, and that the signatures must be notarized;

(B) Blank spaces to enter the full name, social security number, date of birth and address of each parent;

(C) Blank spaces to enter the full name, date of birth, and the residence of the child;

(D) A blank space to enter the name of the hospital or department of health code number assigned to the hospital, for use in situations in which the hospital fills out the form pursuant to section 3727.17 of the Revised Code;

(E) An affirmation by the mother that the information she supplied is true to the best of her knowledge and belief and that she is the natural mother of the child named on the form and assumes the parental duty of support of the child;

(F) An affirmation by the father that the information he supplied is true to the best of his knowledge and belief, that he has received information regarding his legal rights and responsibilities, that he consents to the jurisdiction of the courts of this state, and that he is the natural father of the child named on the form and assumes the parental duty of support of the child;

(G) Signature lines for the mother of the child and the natural father;

(H) Signature lines for the notary public;

(I) An instruction to include or attach any other evidence necessary to complete the new birth record that is required by the department by rule.

3111.32 Pamphlets and toll-free number.

The department of job and family services shall prepare pamphlets that discuss the
benefit of establishing a parent and child relationship, the proper procedure for establishing a parent and child relationship between a father and his child, and a toll-free telephone number that interested persons may call for more information regarding the procedures for establishing a parent and child relationship.

3111.33 Pamphlets and acknowledgment of paternity affidavits.

The department of job and family services shall make available the pamphlets and the acknowledgment of paternity affidavits and statements to the department of health, to each hospital it has a contract with pursuant to section 3727.17 of the Revised Code, and to any individual who requests a pamphlet. The department of job and family services shall make available the affidavit acknowledging paternity to each county child support enforcement agency, the department of health, and any other person or agency that requests copies.

3111.34 Rules for new birth record to be adopted.

The director of job and family services, in consultation with the department of health, shall adopt rules specifying additional evidence necessary to complete a new birth record that is required to be included with an acknowledgment of paternity affidavit.

3111.35 Provision implementation; rules shall be adopted.

The director of job and family services shall adopt rules pursuant to Chapter 119 of the Revised Code to implement sections 3111.20 to 3111.34 of the Revised Code that are consistent with Title IV-D of the “Social Security Act,” 88 Stat. 2351, 42 U.S.C. 651 et seq., as amended.

3701.46 Tests for pregnant women.

In reporting every birth and fetal death, physicians, certified nurse-midwives, and others required to make the reports shall state on the birth or fetal death certificate, as the case may be, whether approved tests for syphilis and gonorrhea have been made in an approved laboratory upon specimens taken from the woman who bore the child for which the certificate is filed, and the approximate date when the specimens were taken. If the tests were not made, the physician, certified nurse-midwife, or other person shall state the reasons why the tests were not made. In no event shall the results of the tests be stated on the birth or fetal death certificate.

3701.48 Syphilis and gonorrhea tests in cases of birth or fetal deaths.

The approved laboratory making the standard tests for syphilis and gonorrhea shall make a report to the physician or health commissioner submitting the specimens. Such laboratory shall forthwith report any reactive syphilis test or positive gonorrhea test to the department of health on forms prescribed and furnished by the director of health.

3701.49 When health commissioner shall test for syphilis and gonorrhea.

If any pregnant woman is attended during the period of gestation by any person authorized to attend pregnant women, other than a licensed physician, but who is not permitted to take test specimens, then such authorized person shall notify immediately the health commissioner of the city or general health district of the residence of such pregnant woman.
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3701.50 Tests for pregnant women; duty of physician; waiver.

Every physician who attends any pregnant woman for conditions relating to pregnancy during the period of gestation shall take specimens of such woman at the time of first examination or within ten days thereof, and shall submit such specimens to an approved laboratory for standard syphilis and gonorrhea tests. If, in the opinion of the physician attending such woman, her condition does not permit the taking of specimens for submission to an approved laboratory, then no specimens shall be taken prior to delivery. If no specimens are taken prior to delivery because of the woman's condition, then such specimens shall be taken as soon after delivery as the physician deems it advisable.

The health commissioner of the city or general health district, wherein any person required to be tested for syphilis and gonorrhea under this section or section 3701.49 of the Revised Code resides, may waive the requirements of such sections if the commissioner is satisfied by written affidavit or other written proof that the tests required are contrary to the tenets or practices of the religious creed of which the person is an adherent, and that the public health and welfare would not be injuriously affected by such waiver.

3727.17 Birth; unmarried mothers; requirement to meet with parents.

Each hospital shall provide a staff person to do all of the following:
(A) Meet with each unmarried mother who gave birth in or en route to the hospital within twenty-four hours after the birth or before the mother is released from the hospital;
(B) Attempt to meet with the father of the unmarried mother's child if possible;
(C) Explain to the unmarried mother and the father, if the father is present, the benefit to the child of establishing a parent and child relationship between the father and the child and the various proper procedures for establishing a parent and child relationship;
(D) Present to the unmarried mother and, if possible, the father, the pamphlet or statement regarding the rights and responsibilities of a natural parent prepared by the department of job and family services pursuant to section 3111.32 of the Revised Code;
(E) Provide the unmarried mother, and if possible the father, all forms and statements necessary to voluntarily establish a parent and child relationship, including the acknowledgment of paternity form prepared by the department of job and family services pursuant to section 3111.31 of the Revised Code;
(F) Upon both the mother's and father's request, help the mother and father complete any specific form or statement necessary to establish a parent and child relationship;
(G) Present to an unmarried mother who is not a recipient of medicaid or a participant in Ohio works first an application for Title IV-D services;
(H) Mail the voluntary acknowledgment of paternity, no later than ten days after it is completed, to the office of child support in the department of job and family services.

Each hospital shall provide a notary public to notarize an acknowledgment of paternity signed by the mother and father. If a hospital knows or determines that a man is presumed under section 3111.03 of the Revised Code to be the father of the child described in this section and that the presumed father is not the man who signed or is attempting to sign an acknowledgment with respect to the child, the hospital shall take no further action with regard to the acknowledgment and shall not mail the acknowledgment pursuant to this section.

A hospital may contract with a person or government entity to fulfill its responsibilities under this section and sections 3111.71 to 3111.74 of the Revised Code. Services provided by
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a hospital under this section or pursuant to a contract under sections 3111.71 and 3111.77 of the Revised Code do not constitute the practice of law. A hospital shall not be subject to criminal or civil liability for any damage or injury alleged to result from services provided pursuant to this section or sections 3111.71 to 3111.74 of the Revised Code unless the hospital acted with malicious purpose, in bad faith, or in a wanton or reckless manner.

5101:12-40-05 Determination of existence/non-existence of father-child relationship.

(A) The following terms and definitions apply throughout division 5101:12 of the Administrative Code:

(1) “Alleged father” means a man who is believed to be or believes himself to be the natural father of a child but a final and enforceable determination of paternity regarding that man and child does not exist.

(2) “Birth record” has the same meaning as in section 3705.01 of the Revised Code.

(3) “Central paternity registry” (CPR) is the birth registry maintained by the office of child support (OCS) in the Ohio department of job and family services (ODJFS) in accordance with section 3111.64 of the Revised Code.

(4) “Determine the existence or non-existence of a father and child relationship” refers to the administrative or judicial process that will determine whether or not a man is the natural father of a child when there is not a final and enforceable determination of paternity.

(5) “Disestablish paternity” means to attempt to overturn or reverse a final and enforceable determination of paternity.

(6) A “final and enforceable determination of paternity” exists when:

(a) In accordance with section 3111.25 of the Revised Code, the mother and father signed a JFS 07038, “Acknowledgment of Paternity Affidavit” (effective or revised effective date as identified in rule 5101:12-1-99 of the Administrative Code) which has been entered into the birth registry, and neither the mother nor the father brought an action under section 3111.27 of the Revised Code within sixty days of the signing to request the JFS 07038 be rescinded;

(b) In accordance with section 3111.49 of the Revised Code, a child support enforcement agency (CSEA) issued a JFS 07774, “CSEA Administrative Order Establishment of Paternity” (effective or revised effective date as identified in rule 5101:12-40-99 of the Administrative Code), or JFS 07771, “CSEA Administrative Order Non-existence of Father and Child Relationship” (effective or revised effective date as identified in rule 5101:12-40-99 of the Administrative Code), and neither the mother, alleged father, nor guardian or legal custodian of the child brought an action under sections 3111.01 to 3111.18 of the Revised Code within thirty days of the issuance of the administrative order to object to the administrative order;

(c) A court issued an order determining that the man is the father of the child, or that the child was born as a product of the marriage, and neither party to the order objected to the order;

(d) In accordance with section 3111.821 of the Revised Code, an administrative child support order was issued or, in accordance with section 2151.232 of the Revised Code, a court support order was issued and neither party to the order raised the issue of the existence or non-existence of a father and child relationship although paternity was presumed pursuant to division (A)(3) of section 3111.03 of the Revised Code and as described in rule 5101:12-40-10 of the Administrative Code;

(e) In accordance with section 3111.95 of the Revised Code, the husband of a married woman consented to artificial insemination; or

(f) Another state or country has established a final and enforceable determination of paternity under the laws of that state or country, regardless of whether the determination of paternity was made pursuant to a voluntary acknowledgment of paternity, an administrative proceeding, or a court proceeding. The CSEA shall give full faith and credit to a final and enforceable determination of paternity made by another state or country.
(7) “Genetic testing” and “genetic tests” mean: tissue or blood tests, including tests that identify the presence or absence of common blood group antigens, the red blood cell antigens, human lymphocyte antigens, serum enzymes, serum proteins, or genetic markers; or deoxyribonucleic acid typing of blood or buccal cell samples. “Genetic test” and “genetic testing” may include the typing and comparison of deoxyribonucleic acid derived from the blood of one individual and buccal cells of another.

(8) “Integrated perinatal health information system” (IPHIS): IPHIS is an electronic system maintained by the Ohio department of health (ODH) that provides the functionality to process and store data for vital statistics purposes.

(a) Individuals with access to IPHIS have the responsibility to maintain the confidentiality of and to safeguard all information contained in a person's case record, whether the information is contained on paper, film, computer, or any other electronic medium in accordance with rule 5101:12-1-20 of the Administrative Code.

(b) In accordance with section 3125.99 of the Revised Code, anyone who discloses information to any person or for any purpose not specifically permitted by rule 5101:12-1-20 of the Administrative Code or its supplemental rules is subject to a fine of up to five hundred dollars or a prison term of up to six months or both.

(B) The following forms are referenced throughout division 5101:12 of the Administrative Code:

(1) JFS 07038, “Acknowledgment of Paternity Affidavit” (effective or revised effective date as identified in rule 5101:12-1-99 of the Administrative Code)- A voluntary affidavit that may be signed by the mother of a child and a man alleging himself to be the natural father of the child.

(2) JFS 04070, “Addendum to the Administrative Order to Modify the Birth Record - Child Surname” (effective or revised effective date as identified in rule 5101:12-40-99 of the Administrative Code) - An addendum that may be signed by the mother of a child and a man alleging himself to be the father indicating an agreement by the parties to change the child's surname, if and only if the alleged father is found to be the natural father. If this agreement is signed by both parties and genetic testing indicates paternity is established it will be incorporated by reference into and become part of the administrative order establishing paternity.

(3) JFS 07774, “CSEA Administrative Order Establishment of Paternity” (effective or revised effective date as identified in rule 5101:12-40-99 of the Administrative Code) - Order indicating through genetic testing that a father and child relationship exists.

(4) JFS 07771, “CSEA Administrative Order Non-Existence of Father and Child Relationship” (effective or revised effective date as identified in rule 5101:12-40-99 of the Administrative Code) - Order indicating through genetic testing that a father and child relationship does not exist.

(5) JFS 07773, “CSEA Administrative Order Paternity Finding Inconclusive” (effective or revised effective date as identified in rule 5101:12-40-99 of the Administrative Code) - Order indicating that a party failed to submit to genetic testing and the results are inconclusive.

(6) JFS 04070-I, “Instructions for Completing the JFS 04070, Addendum to the Administrative Order to Modify the Birth Record - Child Surname” (effective or revised effective date as identified in rule 5101:12-40-99 of the Administrative Code) - Instructions for parents wishing to complete the JFS 04070 to change their child's surname during the administrative paternity process.

(7) JFS 07754, “Notice of Request for Paternity Determination and Order to Appear for Genetic Tests” (effective or revised effective date as identified in rule 5101:12-40-99 of the Administrative Code) - Notice issued to the natural mother, each man presumed to be the father of the child, and each man alleged to be the father of the child ordering that the parties submit to genetic testing.
(8) JFS 07029, “Request for Paternity Determination and Notification to Central Paternity Registry” (effective or revised effective date as identified in rule 5101:12-40-99 of the Administrative Code) - A request that shall be completed by a party that signed a JFS 07038 requesting the CSEA to make an administrative determination of the existence or non-existence of a father and child relationship. The request must be completed no later than sixty days after the date of the last signature on the JFS 07038.

(9) JFS 01716, “Waiver of Service of Notice and Order to Appear for Genetic Testing” (effective or revised effective date as identified in rule 5101:12-40-99 of the Administrative Code) - Waiver to be signed by a presumed father, alleged father or natural mother when the party appears for genetic testing but service of process was not obtained.

(C) In accordance with Chapter 3111 of the Revised Code, the CSEA shall determine the existence or non-existence of a father and child relationship when:

1. The child was born out-of-wedlock and:
   a. The CSEA receives a referral for a child who receives Ohio works first (OWF), Title IV-E foster care maintenance, or medicaid benefits in the same county as the CSEA; or
   b. The CSEA receives a request to determine the existence or non-existence of a father and child relationship, as described in rule 5101:12-40-20 of the Administrative Code, by:
      i. The child’s mother or her personal representative;
      ii. A man alleged or alleging himself to be the father of the child or his personal representative;
      iii. The child or the child’s personal representative; or
      iv. The court pursuant to division (D) of section 3111.381 of the Revised Code.
2. There is a presumption of paternity and:
   a. The CSEA receives a request to determine the existence or non-existence of a father and child relationship, as described in rule 5101:12-40-20 of the Administrative Code, by:
      i. The child’s mother or her personal representative;
      ii. A man alleged or alleging himself to be the father of the child or his personal representative;
   b. Either the mother or the presumed father who are party to a request to establish an administrative support order dispute paternity. The CSEA shall proceed as if a request had been made to determine the existence or non-existence of a father child relationship in accordance with this rule.

(D) In accordance with section 3111.38 of the Revised Code, the CSEA in the county in which the child or the guardian or legal custodian of the child resides shall determine the existence or non-existence of a father and child relationship.

In accordance with section 3111.39 of the Revised Code, when more than one CSEA receives a request to determine the existence or non-existence of a father and child relationship concerning the same child that meets the requirements described in this paragraph, the CSEA that receives the request first shall act on the request. When a CSEA that receives a request is not the appropriate CSEA for the filing of the request, the CSEA shall forward the request to the CSEA in which the child or the guardian or legal custodian of the child resides.

(E) Pursuant to section 3111.381 of the Revised Code, the CSEA shall attempt to determine the existence or non-existence of a father and child relationship through an administrative action and, when the administrative action is unsuccessful, by bringing a court action.

Pursuant to division (E) of section 3111.381 of the Revised Code, if the alleged father of a child is deceased and proceedings for the probate of the estate of the alleged father have been or can be commenced, the court with jurisdiction over the probate proceedings shall retain jurisdiction to determine the existence or non-existence of a father and child relationship between the alleged father and any child without an administrative determination being
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(E) When the CSEA determines the child is subject to an existing final and enforceable determination of paternity as described in paragraph (A)(6) of rule 5101:12-40-05 of the Administrative Code, the CSEA shall inform the parties seeking to notarize the affidavit that the CSEA cannot assist the parties in establishing paternity as a final and enforceable determination of paternity already exists.

(F) The CSEA shall not initiate action to overturn or withdraw a JFS 07038 that has been filed with the CPR when a man presumed to be the father of a child was not the man who signed the JFS 07038. When one of the parties brings an action to rescind the JFS 07038, the CSEA shall proceed as described in rule 5101:12-40-17 of the Administrative Code.

(G) In accordance with section 3111.25 of the Revised Code, a JFS 07038 is final and enforceable without ratification by a court when the JFS 07038 has been filed with the CPR, the information on the JFS 07038 has been entered in the birth registry, and the JFS 07038 has not been rescinded and is not subject to rescission as described in paragraph (C) of rule 5101:12-40-17 of the Administrative Code.

In accordance with section 3111.821 of the Revised Code, a JFS 07038 that has not become final shall be considered final as of the date of the issuance of an administrative support order and neither party to the administrative order raised the issue of the existence or non-existence of a father and child relationship.

(H) When the JFS 07038 becomes final and enforceable, the man who signed the JFS 07038 assumes the parental duty of support.

(I) In accordance with section 3111.30 of the Revised Code, when a JFS 07038 becomes final as described in paragraph (G) of this rule, the CPR shall notify ODH that the JFS 07038 is final and enforceable.

Medically Handicapped Children

[Editor’s Note: Regulations pertaining to medically handicapped children are available at www.odh.ohio.gov/rules/final/finalRules.aspx.]

3701.021 Service protocols.

(A) The director of health shall adopt, in accordance with Chapter 119 of the Revised Code, such rules as are necessary to carry out sections 3701.021 to 3701.0210 of the Revised Code, including, but not limited to, rules to establish the following:

1. Medical and financial eligibility requirements for the program for medically handicapped children;

2. Subject to division (C) of this section, eligibility requirements for providers who provide goods and services for the program for medically handicapped children;

3. Procedures to be followed by the department of health in disqualifying providers for violating requirements adopted under division (A)(2) of this section;

4. Procedures to be used by the department regarding application for diagnostic services under division (B) of section 3701.023 of the Revised Code and payment for those services under division (E) of that section;

5. Standards for the provision of service coordination by the department of health and city and general health districts;

6. Procedures for the department to use to determine the amount to be paid annually by each county for services for medically handicapped children and to allow counties to retain funds under divisions (A)(2) and (3) of section 3701.024 of the Revised Code;

7. Financial eligibility requirements for services for Ohio residents twenty-one years of age or older who have cystic fibrosis;

8. Criteria for payment of approved providers who provide goods and services for medically handicapped children;
(9) Criteria for the department to use in determining whether the payment of health insurance premiums of participants in the program for medically handicapped children is cost-effective;

(10) Procedures for appeal of denials of applications under divisions (A) and (D) of section 3701.023 of the Revised Code, disqualification of providers, and amounts paid for services;

(11) Terms of appointment for members of the medically handicapped children's medical advisory council created in section 3701.025 of the Revised Code;

(12) Eligibility requirements for the hemophilia program, including income and hardship requirements;

(13) If a manufacturer discount program is established under division (J)(1) of section 3701.023 of the Revised Code, procedures for administering the program, including criteria and other requirements for participation in the program by manufacturers of drugs and nutritional formulas.

(B) The department of health shall develop a manual of operational procedures and guidelines for the program for medically handicapped children to implement sections 3701.021 to 3701.0210 of the Revised Code.

(C) A medicaid provider, as defined in section 5164.01 of the Revised Code, is eligible to be a provider of the same goods and services for the program for medically handicapped children that the provider is approved to provide for the medicaid program and the director shall approve such a provider for participation in the program for medically handicapped children.

3701.022 General definitions.

As used in sections 3701.021 to 3701.0210 of the Revised Code:

(A) "Medically handicapped child" means an Ohio resident under twenty-one years of age who suffers primarily from an organic disease, defect, or a congenital or acquired physically handicapping and associated condition that may hinder the achievement of normal growth and development.

(B) "Provider" means a health professional, hospital, medical equipment supplier, and any individual, group, or agency that is approved by the department of health pursuant to division (C) of section 3701.023 of the Revised Code and that provides or intends to provide goods or services to a child who is eligible for the program for medically handicapped children.

(C) "Service coordination" means case management services provided to medically handicapped children that promote effective and efficient organization and utilization of public and private resources and ensure that care rendered is family-centered, community-based, and coordinated.

(D)(1) "Third party" means any person or government entity other than the following:

(a) A medically handicapped child participating in the program for medically handicapped children or the child's parent or guardian;

(b) The department or any program administered by the department, including the "Maternal and Child Health Block Grant," Title V of the "Social Security Act," 95 Stat. 818 (1981), 42 U.S.C.A. 701, as amended;

(c) The "caring program for children" operated by the nonprofit community mutual insurance corporation.

(2) "Third party" includes all of the following:

(a) Any trust established to benefit a medically handicapped child participating in the program or the child's family or guardians, if the trust was established after the date the medically handicapped child applied to participate in the program;

(b) That portion of a trust designated to pay for the medical and ancillary care of a medically handicapped child, if the trust was established on or before the date the medically
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handicapped child applied to participate in the program;
(c) The program awarding reparations to victims of crime established under sections 2743.51 to 2743.72 of the Revised Code.
(E) "Third-party benefits" means any and all benefits paid by a third party to or on behalf of a medically handicapped child participating in the program or the child's parent or guardian for goods or services that are authorized by the department pursuant to division (B) or (D) of section 3701.023 of the Revised Code.
(F) "Hemophilia program" means the hemophilia program the department of health is required to establish and administer under section 3701.029 of the Revised Code.

3701.023 Department of health powers and duties.

(A) The department of health shall review applications for eligibility for the program for medically handicapped children that are submitted to the department by city and general health districts and physician providers approved in accordance with division (C) of this section. The department shall determine whether the applicants meet the medical and financial eligibility requirements established by the director of health pursuant to division (A)(1) of section 3701.021 of the Revised Code, and by the department in the manual of operational procedures and guidelines for the program for medically handicapped children developed pursuant to division (B) of that section. Referrals of potentially eligible children for the program may be submitted to the department on behalf of the child by parents, guardians, public health nurses, or any other interested person. The department of health may designate other agencies to refer applicants to the department of health.

(B) In accordance with the procedures established in rules adopted under division (A)(4) of section 3701.021 of the Revised Code, the department of health shall authorize a provider or providers to provide to any Ohio resident under twenty-one years of age, without charge to the resident or the resident's family and without restriction as to the economic status of the resident or the resident's family, diagnostic services necessary to determine whether the resident has a medically handicapping or potentially medically handicapping condition.

(C) The department of health shall review the applications of health professionals, hospitals, medical equipment suppliers, and other individuals, groups, or agencies that apply to become providers. The department shall enter into a written agreement with each applicant who is determined, pursuant to the requirements set forth in rules adopted under division (A)(2) of section 3701.021 of the Revised Code, to be eligible to be a provider in accordance with the provider agreement required by the medicaid program. No provider shall charge a medically handicapped child or the child's parent or guardian for services authorized by the department under division (B) or (D) of this section.

The department, in accordance with rules adopted under division (A)(3) of section 3701.021 of the Revised Code, may disqualify any provider from further participation in the program for violating any requirement set forth in rules adopted under division (A)(2) of that section. The disqualification shall not take effect until a written notice, specifying the requirement violated and describing the nature of the violation, has been delivered to the provider and the department has afforded the provider an opportunity to appeal the disqualification under division (H) of this section.

(D) The department of health shall evaluate applications from city and general health districts and approved physician providers for authorization to provide treatment services, service coordination, and related goods to children determined to be eligible for the program for medically handicapped children pursuant to division (A) of this section. The department shall authorize necessary treatment services, service coordination, and related goods for each eligible child in accordance with an individual plan of treatment for the child. As an alternative, the department may authorize payment of health insurance premiums on behalf of eligible
children when the department determines, in accordance with criteria set forth in rules adopted under division (A)(9) of section 3701.021 of the Revised Code, that payment of the premiums is cost-effective.

(E) The department of health shall pay, from appropriations to the department, any necessary expenses, including but not limited to, expenses for diagnosis, treatment, service coordination, supportive services, transportation, and accessories and their upkeep, provided to medically handicapped children, provided that the provision of the goods or services is authorized by the department under division (B) or (D) of this section. Money appropriated to the department of health may also be expended for reasonable administrative costs incurred by the program. The department of health also may purchase liability insurance covering the provision of services under the program for medically handicapped children by physicians and other health care professionals.

Payments made to providers by the department of health pursuant to this division for inpatient hospital care, outpatient care, and all other medical assistance furnished to eligible recipients shall be made in accordance with rules adopted by the director of health pursuant to division (A) of section 3701.021 of the Revised Code.

The departments of health and medicaid shall jointly implement procedures to ensure that duplicate payments are not made under the program for medically handicapped children and the medicaid program and to identify and recover duplicate payments.

(F) At the time of applying for participation in the program for medically handicapped children, a medically handicapped child or the child's parent or guardian shall disclose the identity of any third party against whom the child or the child's parent or guardian has or may have a right of recovery for goods and services provided under division (B) or (D) of this section. The department of health shall require a medically handicapped child who receives services from the program or the child's parent or guardian to apply for all third-party benefits for which the child may be eligible and require the child, parent, or guardian to apply all third-party benefits received to the amount determined under division (E) of this section as the amount payable for goods and services authorized under division (B) or (D) of this section. The department is the payer of last resort and shall pay for authorized goods or services, up to the amount determined under division (E) of this section for the authorized goods or services, only to the extent that payment for the authorized goods or services is not made through third-party benefits. When a third party fails to act on an application or claim for benefits by a medically handicapped child or the child's parent or guardian, the department shall pay for the goods or services only after ninety days have elapsed since the date the child, parents, or guardians made an application or claim for all third-party benefits. Third-party benefits received shall be applied to the amount determined under division (E) of this section. Third-party payments for goods and services not authorized under division (B) or (D) of this section shall not be applied to payment amounts determined under division (E) of this section. Payment made by the department shall be considered payment in full of the amount determined under division (E) of this section. Medicaid payments for persons eligible for the medicaid program shall be considered payment in full of the amount determined under division (E) of this section.

(G) The department of health shall administer a program to provide services to Ohio residents who are twenty-one or more years of age who have cystic fibrosis and who meet the eligibility requirements established in rules adopted by the director of health pursuant to division (A)(7) of section 3701.021 of the Revised Code, subject to all provisions of this section, but not subject to section 3701.024 of the Revised Code.

(H) The department of health shall provide for appeals, in accordance with rules adopted under section 3701.021 of the Revised Code, of denials of applications for the program for medically handicapped children under division (A) or (D) of this section, disqualification of providers, or amounts paid under division (E) of this section. Appeals under this division are not subject to Chapter 119 of the Revised Code.
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The department may designate ombudspersons to assist medically handicapped children or their parents or guardians, upon the request of the children, parents, or guardians, in filing appeals under this division and to serve as children's, parents', or guardians' advocates in matters pertaining to the administration of the program for medically handicapped children and eligibility for program services. The ombudspersons shall receive no compensation but shall be reimbursed by the department, in accordance with rules of the office of budget and management, for their actual and necessary travel expenses incurred in the performance of their duties.

(I) The department of health, and city and general health districts providing service coordination pursuant to division (A)(2) of section 3701.024 of the Revised Code, shall provide service coordination in accordance with the standards set forth in the rules adopted under section 3701.021 of the Revised Code, without charge, and without restriction as to economic status.

(J)(1) The department of health may establish a manufacturer discount program under which a manufacturer of a drug or nutritional formula is permitted to enter into an agreement with the department to provide a discount on the price of the drug or nutritional formula distributed to medically handicapped children participating in the program for medically handicapped children. The program shall be administered in accordance with rules adopted under section 3701.021 of the Revised Code.

(2) If a manufacturer enters into an agreement with the department as described in division (J)(1) of this section, the manufacturer and the department may negotiate the amount and terms of the discount.

(3) In lieu of establishing a discount program as described in division (J)(1) of this section, the department and a manufacturer of a drug or nutritional formula may discuss a donation of drugs, nutritional formulas, or money by the manufacturer to the department.

(K) As used in this division “209(b) option” has the same meaning as in section 5166.01 of the Revised Code.

The program for medically handicapped children and the program the department of health administers pursuant to division (G) of this section shall continue to assist individuals who have cystic fibrosis and are enrolled in those programs in qualifying for medicaid under the spenddown process in the same manner it assists such individuals on the effective date of this amendment, regardless of whether the department of medicaid continues to implement the 209(b) option.

Newborn Screening, Hearing and Hearing Impairment

3701.501 Screening newborn infants; advisory council.

(A)(1) Except as provided in division (A)(2) of this section, all newborn children shall be screened for the presence of the genetic, endocrine, and metabolic disorders specified in rules, adopted pursuant to this section.

(2) Division (A)(1) of this section does not apply in either of the following circumstances:

(a) If the parents of the child object to the screening on the grounds that it conflicts with their religious tenets and practices;

(b) With respect to the screening for Krabbe disease described in division (C)(1)(b) of this section, if the parents of the child communicate their decision to forgo the screening.

(B) There is hereby created the newborn screening advisory council to advise the director of health regarding the screening of newborn children for genetic, endocrine, and metabolic disorders. The council shall engage in an ongoing review of the newborn screening requirements established under this section and shall provide recommendations and reports to the director as the director requests and as the council considers necessary. The director may
assign other duties to the council, as the director considers appropriate.

The council shall consist of fourteen members appointed by the director. In making appointments, the director shall select individuals and representatives of entities with interest and expertise in newborn screening, including such individuals and entities as health care professionals, hospitals, children’s hospitals, regional genetic centers, regional sickle cell centers, newborn screening coordinators, and members of the public.

The department of health shall provide meeting space, staff services, and other technical assistance required by the council in carrying out its duties. Members of the council shall serve without compensation, but shall be reimbursed for their actual and necessary expenses incurred in attending meetings of the council or performing assignments for the council.

The council is not subject to sections 101.82 to 101.87 of the Revised Code.

(C)(1)(a) Subject to division (C)(1)(b) of this section, the director of health shall adopt rules in accordance with Chapter 119 of the Revised Code specifying the disorders for which each newborn child must be screened.

(b) In adopting the rules, the director shall specify Krabbe disease as a disorder for which a newborn child who is born on or after July 1, 2016, must be screened. The rules shall limit the screening requirement for Krabbe disease to the process known as “first tier testing,” which is a screening for Krabbe disease that is accomplished by measuring galactocerebrosidase activity using mass spectrometry.

(2) The newborn screening advisory council shall evaluate genetic, metabolic, and endocrine disorders to assist the director in determining which disorders should be included in the screenings required under this section. In determining whether a disorder should be included, the council shall consider all of the following:

(a) The disorder’s incidence, mortality, and morbidity;
(b) Whether the disorder causes disability if diagnosis, treatment, and early intervention are delayed;
(c) The potential for successful treatment of the disorder;
(d) The expected benefits to children and society in relation to the risks and costs associated with screening for the disorder;
(e) Whether a screening for the disorder can be conducted without taking an additional blood sample or specimen.

(3) Based on the considerations specified in division (C)(2) of this section, the council shall make recommendations to the director of health for the adoption of rules under division (C)(1) of this section. The director shall promptly and thoroughly review each recommendation the council submits.

(D) The director shall adopt rules in accordance with Chapter 119 of the Revised Code establishing standards and procedures for the screenings required by this section. The rules shall include standards and procedures for all of the following:

(1) Causing rescreenings to be performed when initial screenings have abnormal results;
(2) Designating the person or persons who will be responsible for causing screenings and rescreenings to be performed;
(3) Giving to the parents of a child notice of the required initial screening and the possibility that rescreenings may be necessary;
(4) Communicating to the parents of a child the results of the child’s screening and any rescreenings that are performed;
(5) Giving notice of the results of an initial screening and any rescreenings to the person who caused the child to be screened or rescreened, or to another person or government entity when the person who caused the child to be screened or rescreened cannot be contacted;
(6) Referring children who receive abnormal screening or rescreening results to providers of follow-up services, including the services made available through funds disbursed under division (F) of this section.
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(E)(1) Except as provided in divisions (E)(2) and (3) of this section, all newborn screenings required by this section shall be performed by the public health laboratory authorized under section 3701.22 of the Revised Code.

(2) If the director determines that the public health laboratory is unable to perform screenings for all of the disorders specified in the rules adopted under division (C) of this section, the director shall select another laboratory to perform the screenings. The director shall select the laboratory by issuing a request for proposals. The director may accept proposals submitted by laboratories located outside this state. At the conclusion of the selection process, the director shall enter into a written contract with the selected laboratory. If the director determines that the laboratory is not complying with the terms of the contract, the director shall immediately terminate the contract and another laboratory shall be selected and contracted with in the same manner.

(3) Any rescreening caused to be performed pursuant to this section may be performed by the public health laboratory or one or more other laboratories designated by the director. Any laboratory the director considers qualified to perform rescreenings may be designated, including a laboratory located outside this state. If more than one laboratory is designated, the person responsible for causing a rescreening to be performed is also responsible for selecting the laboratory to be used.

(F)(1) The director shall adopt rules in accordance with Chapter 119 of the Revised Code establishing a fee that shall be charged and collected in addition to or in conjunction with any laboratory fee that is charged and collected for performing the screenings required by this section. The fee, which shall be not less than fourteen dollars, shall be disbursed as follows:

(a) Not less than ten dollars and twenty-five cents shall be deposited in the state treasury to the credit of the genetics services fund, which is hereby created. Not less than seven dollars and twenty-five cents of each fee credited to the genetics services fund shall be used to defray the costs of the programs authorized by section 3701.502 of the Revised Code. Not less than three dollars from each fee credited to the genetics services fund shall be used to defray costs of phenylketonuria programs.

(b) Not less than three dollars and seventy-five cents shall be deposited into the state treasury to the credit of the sickle cell fund, which is hereby created. Money credited to the sickle cell fund shall be used to defray costs of programs authorized by section 3701.131 of the Revised Code.

(2) In adopting rules under division (F)(1) of this section, the director shall not establish a fee that differs according to whether a screening is performed by the public health laboratory or by another laboratory selected by the director pursuant to division (E)(2) of this section.

3701.504 Statewide hearing screening program.

(A) The department of health shall establish and maintain a statewide hearing screening, tracking, and early intervention program to identify newborn and infant hearing impairment. The department shall also establish appropriate protocols for the treatment and follow-up care of newborns and infants with hearing impairment.

(B) In the case of a child born in a hospital or freestanding birthing center, both of the following apply:

(1) The program shall provide for a hearing screening of the newborn or infant before discharge, unless the newborn or infant is being transferred to another hospital.

(2) If the newborn or infant is transferred to another hospital, the program shall provide for a hearing screening of the newborn or infant when determined to be medically appropriate.

(C) The department of health shall ensure that the program established under this section is incorporated into early intervention activities of the department in compliance with the "Individuals with Disabilities Education Act," 20 U.S.C.A. 1400 et seq.
(D) The department of health may assist hospitals and freestanding birthing centers in acquiring hearing screening equipment by providing information on grant opportunities or loans, and, if funds are available, by mass purchasing equipment or establishing a grant system with department funds.

(E) The department of health shall administer the program established under this section pursuant to rules adopted under section 3701.508 of the Revised Code.

3701.505 Screening required.

(A)(1) Each hospital and each freestanding birthing center shall do all of the following:
   (a) Conduct a hearing screening on each newborn or infant born in the hospital or center unless the newborn or infant is transferred to another hospital;
   (b) Promptly notify the newborn’s or infant’s attending physician of the screening results;
   (c) Notify the department of health of the screening results for each newborn or infant screened.

   (2) A hearing screening conducted under this section shall be conducted under the direction of an audiologist or physician or in collaboration with a physician. Notwithstanding the licensure requirements of Chapter 4753 of the Revised Code, a screening may be conducted by a person who is not licensed under that chapter.

   (3) Each hospital and freestanding birthing center shall take the actions required by divisions (A)(1) and (2) of this section in accordance with the rules adopted under section 3701.508 of the Revised Code. A hospital or freestanding birthing center may commence taking these actions at any time after the effective date of the rules but not later than June 30, 2004, unless an extension is granted. The director may grant an extension to delay for up to one year after June 30, 2004, the requirement of compliance with the rules if the hospital or freestanding birthing center requesting the extension demonstrates justifiable cause for the extension. Justifiable cause may include having ordered but not yet received hearing screening equipment, ongoing efforts to obtain financing for the equipment, or any other cause accepted by the director.

   (B) Any hospital or freestanding birthing center providing a hearing screening in accordance with division (A) of this section shall be reimbursed by the department of health at a rate determined by the director of health if both of the following are the case:
      (1) The screening is performed before the newborn or infant is discharged from the hospital or freestanding birthing center.
      (2) The parent, guardian, or custodian is financially unable to pay for the hearing screening and the hospital or freestanding birthing center is not reimbursed by a third-party payer as determined pursuant to rules adopted under section 3701.508 of the Revised Code.

   (C) A hospital, clinic, or other health care facility at which a hearing evaluation is performed on a newborn or infant shall report the results of the evaluation to the attending physician of the newborn or infant.

3701.506 Department of health; hearing screen information.

The department of health shall prepare and distribute to all hospitals and freestanding birthing centers required to provide hearing screenings under the program established under section 3701.504 of the Revised Code and each board of health, information describing factors or conditions of hearing loss and the effect of such a loss on an infant or child’s language development, and information on the importance of hearing screening, hearing evaluation, early intervention, and follow-up care for newborns and infants. This information shall be updated as the department determines necessary.

Each hospital or freestanding birthing center shall provide the parent, guardian, or
custodian of each newborn or infant born in the hospital or freestanding birthing center with the information prepared by the department pursuant to this section.

Each board of health shall provide the parent, guardian, or custodian of each newborn or infant born in the area served by the board who is not born in a hospital or freestanding birthing center with the information prepared by the department pursuant to this section.

3701.508 Director of Health to adopt hearing screening rules.

(A) The director of health shall adopt rules governing the statewide hearing screening, tracking, and early intervention program established under section 3701.504 of the Revised Code, including rules that do all of the following:

(1) Specify how hospitals and freestanding birthing centers are to comply with the requirements of section 3701.505 of the Revised Code, including methods to be used for hearing screening, except that with regard to the physiologic equipment to be used for hearing screening, the rules may require only that the equipment be capable of giving reliable results and may not specify particular equipment or a particular type of equipment;

(2) Provide that no newborn or infant shall be required to undergo a hearing screening if the parent, guardian, or custodian of the newborn or infant objects on the grounds that the screening conflicts with the parent's, guardian's, or custodian's religious tenets and practices;

(3) Provide for situations in which the parent, guardian, or custodian of a newborn or infant objects to a hearing screening for reasons other than religious tenets and practices;

(4) Specify how the department of health will determine whether a person is financially unable to pay for a hearing screening and define “third-party payer” for the purpose of reimbursement of hearing screening by the department under section 3701.505 of the Revised Code;

(5) Specify an inexpensive and efficient format and procedures for the submission of hearing screening information from hospitals and freestanding birthing centers to the department of health;

(6) Specify a procedure whereby the department may conduct timely reviews of hearing screening information submissions for purposes of quality assurance, training, and disease prevention and control;

(7) Specify any additional information that hospitals and freestanding birthing centers are to provide to the medically handicapped children's medical advisory council's infant hearing screening subcommittee under section 3701.509 of the Revised Code.

(B) In addition to the rules adopted under division (A) of this section, the director shall adopt rules that specify the training that must be completed by persons who will conduct hearing screenings. In adopting these rules, the director shall consider incorporating cost-saving training methods, including computer-assisted learning and on-site training. Neither the rules nor the director of health may establish a minimum educational level for persons conducting hearing screenings.

(C) All rules adopted under this section shall be adopted in accordance with Chapter 119 of the Revised Code and shall be adopted so as to take effect not later than six months after August 1, 2002.

3701.509 Analyzing results; required report.

(A) The department of health shall develop a mechanism to analyze and interpret the hearing screening information to be reported under division (B) of this section. The department shall notify all hospitals and freestanding birthing centers subject to the reporting requirements of the date the department anticipates that the mechanism will be complete. After the mechanism is complete, the department shall notify each hospital and freestanding birthing center...
center subject to the reporting requirement of the date by which the hospital or center must submit its first report.

(B) Subject to division (A) of this section and in accordance with rules adopted by the director of health under section 3701.508 of the Revised Code, each hospital and freestanding birthing center that has conducted a hearing screening required by section 3701.505 of the Revised Code shall provide to the department of health for use by the medically handicapped children's medical advisory council's infant hearing screening subcommittee information specifying all of the following:

1. The number of newborns born in the hospital or freestanding birthing center and the number of newborns and infants not screened because they were transferred to another hospital;
2. The number of newborns and infants referred to the hospital or freestanding birthing center for a hearing screening and the number of those newborns and infants who received a hearing screening;
3. The number of newborns and infants who did not pass the hearing screenings conducted by the hospital or freestanding birthing center;
4. Any other information concerning the program established under section 3701.504 of the Revised Code.

(C) The department of health shall conduct a timely review of the information submitted by hospitals and freestanding birthing centers in accordance with rules adopted by the director under section 3701.508 of the Revised Code.

(D) The infant hearing screening subcommittee, with the support of the department of health, shall compile and summarize the information submitted to the department by hospitals and freestanding birthing centers under division (B) of this section. Beginning with the first year after the mechanism developed under division (A) of this section is complete, the subcommittee shall annually prepare and transmit a report to the director of health, the speaker of the house of representatives, and the president of the senate. The council shall make the report available to the public.

(E) The department and all members of the subcommittee shall maintain the confidentiality of patient-identifying information submitted under division (B) of this section and section 3701.505 of the Revised Code. The information is not a public record under section 149.43 of the Revised Code, except to the extent that the information is used in preparing reports under this section.

Nothing in this division prohibits the department from providing patient-identifying information to other entities as it considers necessary to implement the statewide tracking and early intervention components of the program established under section 3701.504 of the Revised Code. Any entity that receives patient-identifying information from the department shall maintain the confidentiality of the information.

3701.5010 Critical congenital heart defects newborn screening.

(A) As used in this section:
1. “Critical congenital heart defects screening” means the identification of a newborn that may have a critical congenital heart defect, through the use of a physiologic test.
2. “Freestanding birthing center” has the same meaning as in section 3702.141 of the Revised Code.
3. “Hospital,” “maternity unit,” “newborn,” and “physician” have the same meanings as in section 3701.503 of the Revised Code.
4. “Pulse oximetry” means a noninvasive test that estimates the percentage of hemoglobin in blood that is saturated with oxygen.

(B) Except as provided in division (C) of this section, each hospital and each
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freestanding birthing center shall conduct a critical congenital heart defects screening on each newborn born in the hospital or center, unless the newborn is being transferred to another hospital. The screening shall be performed before discharge. If the newborn is transferred to another hospital, that hospital shall conduct the screening when determined to be medically appropriate. The hospital or center shall promptly notify the newborn’s parent, guardian, or custodian and attending physician of the screening results.

(C) A hospital or freestanding birthing center shall not conduct a critical congenital heart defects screening if the newborn's parent objects on the grounds that the screening conflicts with the parent's religious tenets and practices.

(D)(1) The director of health shall adopt rules in accordance with Chapter 119 of the Revised Code establishing standards and procedures for the screening required by this section, including all of the following:

(a) Designating the person or persons responsible for causing the screening to be performed;
(b) Specifying screening equipment and methods;
(c) Identifying when the screening should be performed;
(d) Providing notice of the required screening to the newborn’s parent, guardian, or custodian;
(e) Communicating screening results to the newborn's parent, guardian, or custodian and attending physician;
(f) Reporting screening results to the department of health;
(g) Referring newborns that receive abnormal screening results to providers of follow-up services.

(2) In adopting rules under division (D)(1)(b) of this section, the director shall specify screening equipment and methods that include the use of pulse oximetry or other screening equipment and methods that detect critical congenital heart defects at least as accurately as pulse oximetry. The screening equipment and methods specified shall be consistent with recommendations issued by nationally recognized organizations that advocate on behalf of medical professionals or individuals with cardiovascular conditions.

3701-40-01 Hearing screening for infants and newborns; definitions.

As used in this chapter of the Administrative Code:

(A) “Address,” in the case of an individual, means the individual's residence and, in the case of a government agency, means the office at which the records pertaining to a particular child are maintained.

(B) “Attending physician” means the newborn's or infant's primary care physician who will provide care for the newborn or infant after discharge. If there is no known primary care physician, the physician treating the infant or newborn while the newborn or infant is in the hospital will be deemed the attending physician.

(C) “Audiologist” means an individual authorized under the section 4753.07 of the Revised Code to practice audiology.

(D) “Birth clerk” means an integrated perinatal health information system (IPHIS) user with the ability to enter data to create birth records.

(E) “Board of health” means the board of health of a city or general health district or the authority having the duties of a board of health under section 3709.05 of the Revised Code.

(F) “Certified nurse-midwife” means a registered nurse who holds a valid certificate of authority issued under Chapter 4723 of the Revised Code that authorizes the practice of nursing as a certified nurse-midwife in accordance with section 4723.43 of the Revised Code and rules adopted by the board of nursing.

(G) “Certified nurse practitioner” means a registered nurse who holds a valid certificate
of authority issued under Chapter 4723 of the Revised Code that authorizes the practice of
nursing as a certified nurse practitioner in accordance with section 4723.43 of the Revised Code
and rules adopted by the board of nursing.

(H) “Custodian” means a government agency, or an individual, other than a parent or
guardian, with legal or permanent custody of a child as defined in section 2151.011 of the
Revised Code.

(I) “Department” means the Ohio department of health.

(J) “Diagnostic hearing evaluation” means evaluation through the use of a battery of
pediatric audiology test procedures by an audiologist.

(K) “Director” means the director of health in the state of Ohio or person designated by
the director of health.

(L) “Discharge” means the release of a patient from a hospital or freestanding birthing
center to a non-institutional setting.

(M) “Freestanding birthing center” has the same meaning as the term is defined in
section 3702.51 of the Revised Code.

(N) “Filed” means received by the director.

(O) “Guardian” has the same meaning as the term is defined in section 2111.01 of the
Revised Code.

(P) “Healthcare facility” means any of the following:

(1) A hospital that is registered under section 3701.07 of the Revised Code;

(2) A free standing birthing center as defined in section 3702.51 of the Revised Code; or

(3) A building, office, clinic, or other location in which a physician or an audiologist is
licensed to practice in Ohio and provides hearing evaluations.

(Q) “Hearing clerk” means an integrated perinatal health information systems (IPHIS)
user with the ability to enter data on the hearing screening tab.

(R) “Hearing loss” refers to a permanent loss of hearing in one or both ears in the
frequency region important for speech recognition and comprehension.

(S) “Hearing screening” means the use of a physiologic test in each ear to identify
newborns and infants who may have hearing loss.

(T) “Hospital” means an institution classified and registered as a hospital under section
3701.07 of the Revised Code that has a maternity unit or newborn nursery.

(U) “In collaboration with a physician or audiologist” means a formal arrangement
between the individual conducting the screening and the physician or audiologist responsible for
the oversight of the facility’s hearing screening program. The formal arrangement must provide
that the physician or audiologist is continuously available to communicate with the individual
conducting the screening.

(V) “Infant” means a child who is at least thirty days but less than twenty-four months
old.

(W) “Maternity unit” means any unit or place in a hospital where women are regularly
received and provided care during all or part of the maternity cycle, except that “maternity unit”
does not include an emergency department or similar place dedicated to providing emergency
health care.

(X) “Medical home” means the primary care team led by a physician managing health
care delivery for patients with the goal of maximizing health outcomes.

(Y) “Newborn” means a child who is less than thirty days old.

(Z) “NICU” means neonatal intensive care unit” and is a facility in which a neonatologist
provides primary care for the infant.

(AA) “Non pass result (Refer)” means the newborn did not pass the hearing screening in
the test ear at the time of screening and requires follow up.

(BB) “Nursery” means any area, including an individual patient room, in a hospital or
freestanding birthing center where a newborn or infant is housed prior to being discharged into

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the custody of his or her parent, guardian, or custodian other than for transport to another hospital. Nurseries are divided into three categories:

(1) Level I nursery: a unit that provides basic, well-infant care.
(2) Level II nursery: a unit that provides specialty care by a neonatologist.
(3) Level III nursery: a unit that provides both specialty and subspecialty care including the provision of life support.

(CC) “Parent” means either parent, unless the parents are separated or divorced or their marriage has been dissolved or annulled, in which case “parent” means the parent who is the residential parent and legal custodian.

(DD) “Pass result” means the newborn did pass the hearing screening in the test ear at the time of screening and does not requires follow up; but is likely to demonstrate a low risk for hearing loss.

(EE) “Patient-identifying information” means individually identifiable information relating to the past, present or future physical or mental health or condition of an individual, provision of health care to an individual, or the past, present or future payment for health care provided to an individual.

(FF) “Physician” means an individual authorized under Chapter 4731 of the Revised Code to practice medicine and surgery or osteopathic medicine and surgery.

(GG) “Physiological screening” means a screening method that can detect a response to acoustic stimulation from the cochlea or the brainstem.

(HH) “Provider” means the hospital or freestanding birthing facility that provided a hearing screening under rule 3701-40-02 of the Administrative Code.


(JJ) “Regional infant hearing program” means a regional program that is funded by the Ohio department of health, to provide statewide coverage for follow along and tracking of newborns or infants who do not pass a newborn or infant hearing screening, and provide services for families with newborns, infants and toddlers who are deaf and hard of hearing.

(KK) “Screening methods” means automated otoacoustic emissions screening and automated auditory brainstem evoked response.

(LL) “Third party payer” means any person or agency, government or otherwise, other than the department of health, that provides reimbursement for hearing screenings for newborns and infants.

(MM) “Transfer” means the release of a patient from a hospital or freestanding birthing center to another healthcare facility, which undertakes responsibility for the patient.

3701-40-02 Hearing screening requirements.

(A) Each hospital and each freestanding birthing center shall:
Designate a hearing screening coordinator who is responsible for the coordination of the facility’s hearing screening program. The coordinator shall be an individual with staff privileges at the facility and either:

(1) A physician or audiologist; or
(2) An individual working under the supervision of or in collaboration with a physician or audiologist.

(B) Each hospital and each freestanding birthing center shall develop a written protocol following the recommendations of the joint committee on infant hearing for these criteria:

(1) Conduct hearing screenings on all newborns born, admitted, or transferred into a hospital or free-standing birthing center prior to discharge, or when determined to be medically
appropriate.

(2) Conduct a second hearing screening when the newborn or infant does not pass the first hearing screening in:
   (a) Well baby (level I) nurseries; and
   (b) Special care (level II and III) and NICU nurseries.

(3) Communicate the results of the hearing screening for every newborn or infant to the attending physician, certified nurse-midwife, certified nurse practitioner, primary care physician, or designated medical home to include:
   (a) Results of the hearing screening for each ear;
   (b) Type of hearing screening; and
   (c) Risk factors for hearing loss, if any.

(4) Report the following categories of infants to the attending physician, certified nurse midwife, certified nurse practitioner, primary care physician, or designated medical home within forty-eight hours of discharge for:
   (a) Infants who did not pass a hearing screening; and
   (b) Infants who were discharged from the facility without a hearing screening.

(5) Communicate written results of the newborn or infant's hearing screening to the parent, guardian, or custodian prior to discharge to include:
   (a) Results of the hearing screening for each ear; and
   (b) Type of hearing screening; and
   (c) Risk factors for hearing loss, if any.

(6) Provide the parent, guardian or custodian of a newborn or infant that did not pass the hearing screening or did not receive a hearing screening with the following prior to discharge:
   (a) A referral to audiologist for hearing evaluation; and
   (b) Assistance in scheduling an appointment for hearing evaluation before discharge; and
   (c) Information on the importance of making and keeping an appointment for a hearing evaluation; and
   (d) A list of audiology facilities where newborn hearing screenings and evaluations are conducted within a sixty mile radius of the family's home.

(7) Provide the parent, guardian, or custodian of every newborn with printed information provided by the department as outlined in paragraph (D) of rule 3701-40-10 of the Administrative Code, prior to discharge including obtaining the signature of the parent, guardian, or custodian indicating receipt of the information.

(8) Notify the director of the name and contact information of the individual designated as the hearing screening coordinator, the supervising physician or audiologist, the birth clerk, and the hearing clerk on an annual basis and whenever changes occur.

(9) Report the following categories of infants to the director of ODH, in the manner and format prescribed, within ten days of initial screening, discharge, or transfer:
   (a) Infants who received a hearing screening and the results of the hearing screening;
   (b) Infants who did not receive a hearing screening and the reason(s) not screened;
   (c) Infants whose parents, guardian, or custodian objected to a hearing screening; and
   (d) Infants who were transferred to or from another hospital.

Hospitals and free standing birthing facilities reporting transferred infants shall also report the name of the hospital facility the infant was transferred to or from.

(10) Report to the director, for each infant, the name and address of the primary care physician, the certified nurse-midwife, certified nurse practitioner, or medical home where the parent will take the newborn or infant for follow-up care after discharge.
3701-40-03 Duty of board of health upon notification.

(A) Each board of health registrar, upon notification of the birth of a newborn or infant born in the area served by the board, who is not born in a hospital or freestanding birthing center, shall, within ten business days of the receipt of notification:

(1) Distribute the printed information prepared by the director in accordance with paragraph (D) of rule 3701-40-10 of the Administrative Code, to the parent, guardian, or custodian of every newborn or infant whose birth is registered by the board of health, including
   (a) Information about hearing loss; and
   (b) A list of audiology facilities where newborn hearing screenings and/or evaluations are conducted within a sixty mile radius of the family’s home.
(2) Obtain a signature from the parent, guardian, or custodian of every newborn or infant whose birth is registered at the board of health, using the form prepared by the director, indicating that they have received the printed information and list of audiologists.
(3) If the parent, guardian, or custodian refuses to sign the form, the board of health shall document the refusal to sign the form in the signature space.

(B) Each board of health shall annually report to the director in a format prescribed by the director:

(1) The number of newborns registered;
(2) The number of parents, guardians, or custodians receiving the printed materials and list of audiologists; and
(3) The number of parents, guardians, or custodians who signed that the information was received.

3701-40-04 Objections to screening.

(A) The parent, guardian or custodian of a newborn or infant may object to a hearing screening on the grounds that the hearing screening conflicts with the parent's, guardian's or custodian's religious tenets and practices or for reasons other than religious tenets and practices.

(B) A parent's, guardian's or custodian's refusal to consent to a hearing screening must be documented on a form provided by the director or in a written statement signed by the parent, guardian or custodian. A refusal set forth in a written statement must include all of the following:

(1) The parent, guardian or custodian is fully informed and understands the possible consequences to their child's health resulting from undetected and untreated hearing loss;
(2) The parent, guardian or custodian has received hearing screening information;
(3) The parent, guardian or custodian is objecting on the grounds that the screening conflicts with their religious tenets and practices, or for reasons other than religious tenets and practices; and
(4) The parent, guardian or custodian releases and holds harmless the director, the hospital or freestanding birthing center, the person responsible for conducting the hearing screening, for any injury, illness, and/or consequences which may result from such refusal.

(C) If the parent, guardian, or custodian of a newborn or infant objects to a hearing screening and refuses to sign the form or written statement, the hospital or freestanding birthing center shall document the parent's, guardian's, or custodian's refusal to sign the objection form or statement.

(D) A signed copy of the objection form or written statement shall be sent to the director within ten days of completion.
3701-40-05 Hearing screening personnel; minimum requirements.

(A) A hearing screening conducted under rule 3701-40-02 of the Administrative Code shall be conducted under the direction of an audiologist or physician or in collaboration with an audiologist or physician.

(B) Any individual conducting hearing screenings must complete annual training addressing at a minimum the following topics:

(1) The significance of and rationale for universal newborn hearing screening;
(2) Reasons for a “non-passing” result and the need for further screening and evaluation;
(3) Conveying information to parents, guardians or custodians in a culturally competent manner and in accordance with written materials prepared by the director; and
(4) Usage of hearing screening equipment to include hands-on-training with newborns, competency evaluation, skills demonstration and written testing.

(C) All training of individuals conducted pursuant to this paragraph shall be completed prior to the administration of a hearing screening and on an annual basis thereafter and made available to the director upon request.

3701-40-06 Screening requirements.

(A) Each hospital and freestanding birthing center required to conduct a hearing screening on a newborn or infant shall, before discharge, conduct a hearing screening on each ear of every newborn or infant born in, admitted to or transferred into a hospital or freestanding birthing center through the use of a physiologic test.

(B) The hospital and freestanding birthing center shall conduct a second screening on newborn or infant, if the first screening in either ear was a non-pass.

(C) The second screening shall

(1) Be a physiological test,
(2) Test both ears, and
(3) Be completed prior to discharge.

(D) The hospital or facility shall conduct only two hearing screenings prior to discharge unless there is clearly an equipment error or an error in administering the screening. Only two complete hearing screenings shall be reported to the director.

(E) The equipment used for screening shall be capable of giving reliable results, maintained in good working order, and calibrated annually per manufacturer's guidelines.

(F) The hospital or free standing birthing facility shall have a contingency plan for continued provision of hearing screening when equipment is malfunctioning or awaiting repair or replacement.

3701-40-07 Reimbursement.

(A) The director shall reimburse providers for a maximum of one hearing screening per newborn or infant in accordance with this rule at a rate determined by the director if all the following criteria are met:

(1) The screening is performed before the newborn or infant is discharged by the provider;
(2) The parent, guardian, or custodian certifies with a signed statement that the family
(a) Is financially unable to pay for the screening;
(b) Is not eligible for medicaid; and
(c) Does not have insurance coverage for the screening.
(3) The provider is not reimbursed by a third-party payer.
(B) The provider seeking reimbursement from the director for a hearing screening shall
submit an invoice for reimbursement to the director no later than twelve months after the completion of the screening. The invoice shall contain at least the following information:

1. The name and address of the provider of the screening;
2. The name and Ohio license number of the audiologist performing or supervising the performance of the hearing screening or the name and license number of the physician performing or supervising the hearing screening;
3. The date and nature of service provided and the amount of the charge for this service;
4. The name and date of birth of the newborn or infant screened;
5. The name and address of the newborn's or infant's parent, guardian, or custodian;
6. A written statement signed by the newborn's or infant's parent, guardian, or custodian attesting to an inability to pay for the screening and explaining the circumstances and reasons why the individual is unable to pay;
7. Documentation of compliance with paragraph (D) of this rule; and
8. Signature of the billing agent.

The provider shall:

1. Submit claims for all third-party benefits, including medicaid, for which the newborn or infant may be eligible, which may provide payment for the screening;
2. Make all reasonable efforts to assist the parent, guardian, or custodian of the newborn or infant who was screened to submit claims and appeal denials for third-party benefits; and
3. Provide any information necessary for processing the claims.

Claims for third-party benefits shall have been submitted no less than sixty days before a request for payment is submitted to the director under this rule.

The director shall not make payment for the screening under this rule:

1. If any payment is made by the medicaid program established by Chapter 5111 of the Revised Code; and
2. If the newborn's or infant's parent, guardian, or custodian has applied for medicaid reimbursement; and
   a. The medicaid program has not denied payment for the screening; and
   b. The medicaid administrative appeals process has not been exhausted by the parent, guardian, or custodian.

The director shall review the request for reimbursement and may request any additional information necessary for making a determination regarding reimbursement.

1. The provider shall file any requested information with the director no later than forty-five calendar days after the date on the director's request for additional information.
2. The director shall deny payment if the provider has failed to comply with the requirements established by this rule or if the criteria for payment prescribed by paragraph (B) of this rule have not been met.

Providers reimbursed by the director, medicaid or any third party payers for a hearing screening shall accept the amount paid by the director, medicaid or any third-party payers as payment in full and shall not seek payment from the parent, guardian, or custodian. This paragraph is not intended to prohibit the provider from collecting from the parent, guardian or custodian any applicable copayment or deductible when payment is made by a third party payer.

The director shall send written notification to the provider of

1. A decision to deny reimbursement under this rule; and
2. Procedures for reconsideration.

The provider may submit a written request for reconsideration no later than thirty calendar days after the date on the notice of the proposed action and shall provide:

1. A statement of the reasons why the provider believes that the proposed decision is
incorrect or inappropriate; and
(2) Any written documentation, arguments, or other materials that the provider wishes to submit in defense of the claim.

(J) For the purposes of reconsideration, the director may request from the provider additional relevant records of documentation within forty-five calendar days of receipt of the request for reconsideration or of additional information previously submitted under this paragraph. The provider shall file any requested information with the director no later than forty-five calendar days after the date on the request for additional information.

(K) Within forty-five calendar days after receipt of a request for reconsideration from the provider that complies with paragraph (G) of this rule and of all necessary additional information requested and timely filed under paragraph (H) of this rule, the director shall notify the provider who requested the reconsideration, in writing, of his decision on reconsideration. The director's decision rendered upon reconsideration shall be final.

3701-40-08 Submission results.

(A) Infants that do not pass a hearing screening shall be immediately referred to an audiologist with expertise in evaluating newborns and infants for further examination.

(B) Protocols for hearing evaluation should be consistent with protocols in the recommendations from the joint committee on infant hearing.

(C) Any audiologist that conducts a hearing evaluation of a newborn or infant referred to such provider shall report the diagnostic hearing evaluation results to the director, in the manner and format prescribed by the director, upon confirmation of the infant's hearing status. All diagnostic results shall be reported to the director within seven business days.

3701-40-09 Tracking program.

(A) Patient identifying information, submitted to the department of health under rule 3701-40-02 of the Administrative Code by hospitals, freestanding birthing centers, or boards of health, shall be used by the director to maintain the statewide tracking and early intervention components of the program.

(B) The department of health shall provide patient-identifying information to other entities such as the regional infant hearing programs, help me grow programs, and other programs, bureaus, service providers, state agencies, individuals, or departments as it considers necessary to maintain the statewide tracking and early intervention components of the program established under section 3701.504 of the Revised Code.

(C) The department of health and any entity that receives patient-identifying information from the department shall maintain the confidentiality of the information.

3701-40-10 Information provided by director.

(A) The director shall provide educational programs for personnel conducting and documenting newborn hearing screenings including hearing screening coordinators, screeners, supervising audiologists, supervising physicians, data entry personnel, local boards of health, and any other persons identified as responsible for conducting, documenting, and reporting newborn hearing screening information and diagnostic evaluations.

(B) Educational programs may be provided as computer based learning, self study modules, teleconferences on selected topics, or classroom experiential training at the discretion of the director.

(C) The director shall provide training for personnel including the following:

(1) The significance of universal newborn hearing screening, risk factors for hearing loss,
and the importance of diagnostic follow-up and early intervention for infants with a permanent hearing loss,

(2) Conveying culturally appropriate messages to families about the importance of screening, follow-up for non-pass screening results, early intervention for hearing loss, and developmental milestones for speech and language acquisition,

(3) Documenting and completing paper and electronic records, including quality assurance activities, and

(4) Requirements for reporting hearing screenings, diagnostic evaluation results, and board of health registrations.

(D) The director shall make written materials available to hospitals, birth facilities, and local boards of health as follows:

(1) Culturally appropriate information for parents and caregivers of infants on the importance of hearing screening, hearing evaluation, early intervention, and speech and language acquisition milestones, and

(2) A listing of pediatric audiology facilities and healthcare facilities where hearing screenings and diagnostic hearing evaluations are conducted.

3701-49-01.1 Fees for laboratory services (variable fees).

(A) Unless exempted under paragraph (B) or (C) of rule 3701-49-01 of the Administrative Code, the director of health shall charge and collect a fee for each parameter or group of parameters in the bacteriological, chemical, or radiological analyses of environmental samples or the toxicological analysis of body fluid as set forth in this rule.

(1) Non-potable water samples
(a)

<table>
<thead>
<tr>
<th>Parameter</th>
<th>COST</th>
</tr>
</thead>
<tbody>
<tr>
<td>Radioactivity</td>
<td></td>
</tr>
<tr>
<td>Gross alpha</td>
<td>$ 35.00</td>
</tr>
<tr>
<td>Gross alpha and beta</td>
<td>35.00</td>
</tr>
<tr>
<td>Uranium</td>
<td>100.00</td>
</tr>
<tr>
<td>Iodine 131</td>
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</tr>
<tr>
<td>Strontium 90</td>
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</tr>
<tr>
<td>Tritium</td>
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</tr>
<tr>
<td>Computerized multichannel analyzer (CMA) (72 elements)</td>
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</tr>
<tr>
<td>Gross alpha and beta (milk, soil, sediment, vegetation, etc.)</td>
<td>85.00</td>
</tr>
<tr>
<td>Gamma scan (water)</td>
<td>75.00</td>
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<tr>
<td>Gamma scan (milk)</td>
<td>45.00</td>
</tr>
<tr>
<td>Gamma scan (soil, sediment, vegetation, etc.)</td>
<td>95.00</td>
</tr>
<tr>
<td>Radium 226</td>
<td>150.00</td>
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<tr>
<td>Radium 228</td>
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(2) Hereditary/metabolic diseases

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<tr>
<th>Parameter</th>
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<tbody>
<tr>
<td>Newborn screen</td>
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<tr>
<td>Hemoglobin pattern</td>
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</tr>
</tbody>
</table>

**This fee is in addition to the fee collected pursuant to rule 3701-55-20 of the Administrative Code.

(3) Microbiology testing
(a) General bacteriology unit
### Identification/confirmation

<table>
<thead>
<tr>
<th>Test Description</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stool-positive</td>
<td>$15.00</td>
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<tr>
<td>Stool-negative</td>
<td>$12.00</td>
</tr>
<tr>
<td>Food screen</td>
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</tr>
<tr>
<td>Sero group-salmonella/shigella (and type)</td>
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</tr>
<tr>
<td>Sero group/type salmonella</td>
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</tr>
<tr>
<td>Sero group/hemophilis</td>
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</tr>
<tr>
<td>Sero group/meningitis</td>
<td>$20.00*</td>
</tr>
<tr>
<td>Sero group/lancefield</td>
<td>$20.00*</td>
</tr>
<tr>
<td>FA Bordetella</td>
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</tr>
<tr>
<td>B. pertussis culture</td>
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<tr>
<td>Phage type</td>
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<tr>
<td>Beta hemolytic streptococci</td>
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### (b) Virus isolation unit

<table>
<thead>
<tr>
<th>Test Description</th>
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<tbody>
<tr>
<td>Rabies examination</td>
<td>$30.00</td>
</tr>
<tr>
<td>Stool culture-virus isolation</td>
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</tr>
<tr>
<td>Swab-virus isolation</td>
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</tr>
<tr>
<td>Virocult FA virus isolation (herpes)</td>
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<tr>
<td>Biopsy-virus isolation</td>
<td>$30.00</td>
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<tr>
<td>Spinal fluid-virus isolation</td>
<td>$25.00</td>
</tr>
<tr>
<td>Urine-virus isolation</td>
<td>$25.00</td>
</tr>
<tr>
<td>Viral isolate-confirm/identification</td>
<td>$40.00*</td>
</tr>
<tr>
<td>Chlamydia</td>
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<tr>
<td>HIV EIA</td>
<td>$6.75</td>
</tr>
<tr>
<td>HIV Western Blot</td>
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</tr>
<tr>
<td>Orasure HIV EIA</td>
<td>$5.25</td>
</tr>
<tr>
<td>Orasure HIV Western Blot</td>
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### (c) Special microbiology unit

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<th>Test Description</th>
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<tbody>
<tr>
<td>GC cultures</td>
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</tr>
<tr>
<td>GC smears</td>
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<tr>
<td>Botulism</td>
<td>$40.00</td>
</tr>
<tr>
<td>Legionnaires-cultures</td>
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</tr>
<tr>
<td>Legionnaires-FA</td>
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</tr>
<tr>
<td>Mycoplasma</td>
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</tr>
<tr>
<td>Ureaplasma</td>
<td>$25.00</td>
</tr>
<tr>
<td>Campylobacter/yersinia</td>
<td>$20.00</td>
</tr>
<tr>
<td>Stool-positive</td>
<td>$15.00</td>
</tr>
<tr>
<td>Stool-negative</td>
<td>$12.00</td>
</tr>
</tbody>
</table>

### (d) Mycology/parasitology unit

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<th>Test Description</th>
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<tr>
<td>Smear-parasitology</td>
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<tr>
<td>Stool-parasitology</td>
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</tr>
<tr>
<td>Pinworm</td>
<td>$7.50</td>
</tr>
<tr>
<td>Mycelial identification-mycology</td>
<td>$30.00*</td>
</tr>
<tr>
<td>Yeast identification-mycology</td>
<td>$30.00*</td>
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### Chapter 4. Minors, Birth and Abortion

#### Part III. Birth

<table>
<thead>
<tr>
<th>Test</th>
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<tbody>
<tr>
<td>Nocardia</td>
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</tr>
<tr>
<td>Streptomyces</td>
<td>30.00*</td>
</tr>
<tr>
<td>Sputum-mycology</td>
<td>25.00</td>
</tr>
<tr>
<td>Blood- mycology</td>
<td>20.00</td>
</tr>
<tr>
<td>Spinal fluid- mycology</td>
<td>20.00</td>
</tr>
<tr>
<td>Biopsy- mycology</td>
<td>30.00</td>
</tr>
<tr>
<td>Skin- mycology</td>
<td>20.00</td>
</tr>
<tr>
<td>Nails (whole)- mycology</td>
<td>20.00</td>
</tr>
<tr>
<td>Nails (micronized)- mycology</td>
<td>20.00</td>
</tr>
<tr>
<td>Hair- mycology</td>
<td>20.00</td>
</tr>
<tr>
<td>Environmental samples</td>
<td>25.00/hour</td>
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(e) Serology unit

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<th>Test</th>
<th>Charge</th>
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<tbody>
<tr>
<td>Cryptococcus</td>
<td>$ 30.00</td>
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<tr>
<td>Coccidiomycosis</td>
<td>30.00</td>
</tr>
<tr>
<td>Histo/blastomycosis</td>
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</tr>
<tr>
<td>Histoplasmosis</td>
<td>30.00</td>
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<tr>
<td>Blastomycosis</td>
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<tr>
<td>Aspergilosis</td>
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<tr>
<td>Legionella</td>
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<tr>
<td>Respiratory battery</td>
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<tr>
<td>Para-influenza 1, 2, and 3</td>
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</tr>
<tr>
<td>Adenovirus</td>
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</tr>
<tr>
<td>Respiratory syncytial</td>
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</tr>
<tr>
<td>M. pneumoniae</td>
<td>$ 20.00</td>
</tr>
<tr>
<td>Mumps</td>
<td>15.00</td>
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<tr>
<td>Rubeola</td>
<td>15.00</td>
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<tr>
<td>Varicella</td>
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</tr>
<tr>
<td>Torch battery</td>
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<tr>
<td>Toxoplasmosis</td>
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<tr>
<td>Animal toxoplasmosis-IHA</td>
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<tr>
<td>Rubella</td>
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<tr>
<td>Cytomegalovirus</td>
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<tr>
<td>Herpes simplex</td>
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</tr>
<tr>
<td>Rocky mountain spotted fever</td>
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<tr>
<td>Murine typhus</td>
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</tr>
<tr>
<td>Lyme disease</td>
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<tr>
<td>Q fever</td>
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<tr>
<td>VDRL</td>
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<td>FTA</td>
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<tr>
<td>Chlamydia</td>
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<tr>
<td>Gonorrhea</td>
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(f) Mycobacteriology

<table>
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<tr>
<th>Test</th>
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<tbody>
<tr>
<td>Clinical material- mycobacteriology</td>
<td>$ 20.00</td>
</tr>
<tr>
<td>Smear- mycobacteriology</td>
<td>7.50</td>
</tr>
<tr>
<td>ID- mycobacteriology</td>
<td>27.50*</td>
</tr>
<tr>
<td>Drug sensitivity (mycobac.)</td>
<td>20.00</td>
</tr>
</tbody>
</table>
* exempt for pure cultures

(B) In cases when it is necessary or desirable for the department of health laboratory to perform a test that falls within one of the general categories specified in paragraph (A)(1), (A)(2), or (A)(3) of this rule, but for which no fee has been established by this rule, the director of health may establish and charge a reasonable fee for the test. A fee established under this paragraph shall remain in effect for no longer than one hundred eighty days or until a fee is established by rule of the director, whichever occurs first.

3701-54-01 Definitions.

(A) Critical congenital heart disease (also known as CCHD) means structural heart defects usually associated with hypoxia in the newborn period that could have significant morbidity or mortality early in life with the closing of the ductus arteriosus or other physiologic changes early in life. Seven specific lesions targeted for critical congenital heart disease screening are: hypoplastic left heart syndrome; pulmonary atresia; tetralogy of Fallot; total anomalous pulmonary venous return; transposition of the great arteries; tricuspid atresia and truncus arteriosus.

(B) Critical congenital heart disease screening means the identification of a newborn or infant that may have a critical congenital heart defect, through the use of a physiologic test.

(C) Director means the director of the Ohio department of health or his or her designee.

(D) Freestanding birthing center means a facility other than a hospital perinatal unit providing obstetrical delivery services registered under section 3702.30 of the Revised Code.

(E) Infant means a child who is at least thirty days but less than one year of age.

(F) Hospital has the same meaning as in section 3701.503 of the Revised Code.

(G) Newborn means a child who is less than thirty days old.

(H) For purposes of these rules, “Newborn care nursery” means a distinct portion of a hospital in which inpatient care is provided to infants. It also includes a distinct portion of a children's hospital in which intensive care is provided to infants.

(I) Pulse oximetry means a non-invasive procedure used to measure the oxygen level (or oxygen saturation) in the blood.

3701-54-02 Required screening; facility requirements.

(A) Each newborn or infant shall be screened before discharge, in accordance with procedures set forth in this chapter for the presence of critical congenital heart disease, unless the newborn or infant has had a pediatric echocardiogram or is being discharged home on oxygen.

(B) All hospitals, freestanding birthing centers, and newborn care nurseries that are required by this chapter to conduct critical congenital heart disease screening shall:

1. Designate a CCHD newborn screening coordinator responsible for the coordination, implementation and follow-up procedures for the facility’s CCHD screening;

2. Notify the Ohio department of health genetics section of the name of the individual designated as the CCHD newborn screening coordinator whenever the designated individual changes;

3. Prior to conducting the critical congenital heart disease screening, the person designated in the applicable provision of this rule shall oversee or ensure that each newborn or infant’s parent, legal guardian, or legal custodian, is given notice of the screening to be conducted.

   a. When a birth occurs in a hospital, the hospital shall provide the information;

   b. When a birth occurs in a freestanding birth center, the freestanding birthing center shall provide the information;
Chapter 4. Minors, Birth and Abortion
Part III. Birth

(4) Conduct the critical congenital heart disease screening in accordance with specifications in rule 3701-54-03 of the Administrative Code.

(5) Communicate the results of the critical congenital heart disease screening to the newborn’s or infant’s parent, guardian, or custodian, and attending physician.

(6) Report the results of the newborn’s or infant’s critical congenital heart disease screening to the Ohio department of health through the vital statistics electronic birth certificate system.

(7) Refer newborns or infants that receive abnormal screening results to providers for appropriate pediatric follow-up services. If a newborn is transferred to another hospital before screening can take place, the receiving hospital shall conduct the screening when it is determined to be medically appropriate. Hospitals without access to the Ohio department of health vital statistics electronic birth certificate system shall report screening results to the Ohio department of health on a form provided by the department.

3701-54-03 Critical congenital heart disease screening procedures, equipment.

(A) Each hospital and freestanding birthing center shall conduct a critical congenital heart disease screening using pulse oximetry, prior to discharge, and when the newborn or infant is at least twenty-four hours of age.

(1) If the first pulse oximetry saturation percentage is ninety-five per cent or greater and the difference between the right hand and either foot is three per cent or less, the infant has passed.

(2) If any pulse oximetry saturation percentage is less than ninety per cent in the right hand or either foot, the newborn or infant should receive immediate pediatrician evaluation and/or referral to pediatric cardiology for a pediatric echocardiogram.

(3) If the first pulse oximetry saturation is less than ninety-five per cent in both right hand and either foot or has a difference of greater than three per cent between the right hand and either foot, the pulse oximetry screening should be repeated in approximately one hour.

(4) If the second pulse oximetry reading is less than ninety-five per cent in both right hand and either foot or has a difference of greater than three per cent between the right hand and either foot, the pulse oximetry screening should be repeated again in approximately one hour.

(5) If the third pulse oximetry reading is less than ninety-five per cent in both right hand and either foot or has a difference of greater than three per cent between the right hand and either foot, the newborn or infant should receive immediate pediatrician evaluation and/or referral to pediatric cardiology for a pediatric echocardiogram.

(B) The pulse oximetry screening should be performed with a motion-tolerant pulse oximeter that reports functional oxygen saturation, has been validated in low-perfusion conditions, has been cleared by the food and drug administration for use in newborns, and has a two per cent root-mean-square accuracy.

3701-54-04 Religious exception.

The provisions of this chapter requiring critical congenital heart disease screening of newborns and infants do not apply if the parents, guardian or custodian of the child object thereto on the grounds that such screening conflicts with their religious tenets and practices. Refusal to consent to the critical congenital heart disease screening must be documented in the newborn or infant’s medical record and reported to the director.
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3701-55-01 Newborn screening; definitions.

(A) “Bureau of public health laboratory” means the bureau which is responsible for operating the Ohio department of health laboratory established by section 3701.22 of the Revised Code.

(B) “Certified nurse midwife” means a registered nurse who holds a valid certificate of authority issued under Chapter 4723 of the Revised Code that authorizes the practice of nursing as a certified nurse midwife in accordance with section 4723.43 of the Revised Code and rules adopted by the board of nursing.

(C) “Certified nurse practitioner” means a registered nurse who holds a valid certificate of authority issued under Chapter 4723 of the Revised Code that authorizes the practice of nursing as a certified nurse practitioner in accordance with section 4723.43 of the Revised Code and rules adopted by the board of nursing.

(D) “Clinical nurse specialist” means a registered nurse who holds a valid certificate of authority issued under Chapter 4723 of the Revised Code that authorizes the practice of nursing as a clinical nurse specialist in accordance with section 4723.43 of the Revised Code and rules adopted by the board of nursing.

(E) “Director” means the director of health or his or her designee.

(F) “Freestanding birthing center” means a facility other than a hospital perinatal unit providing obstetrical delivery services registered under section 3702.30 of the Revised Code.

(G) “Health commissioner” means the health commissioner of a general, city or county health district or the individual with the responsibilities of a health commissioner in a city or county health district.

(H) “Hospital” means an institution classified and registered as a hospital under section 3701.07 of the Revised Code that has a maternity unit or newborn nursery.

(I) “Physician” means an individual authorized under Chapter 4731 of the Revised Code to practice medicine and surgery or osteopathic medicine and surgery.

(J) “Bureau for children with medical handicaps” means a health care program in the Ohio department of health established by section 3701.023 of the Revised Code.

(K) “Initial specimen” means the first satisfactory newborn screening blood sample collected on an infant.

(L) “Repeat specimen” means a newborn screening blood sample collected subsequent to a satisfactory initial specimen.

(M) “Unsatisfactory specimen” means a newborn screening blood sample for which testing cannot be performed or interpreted due to errors occurring during the collection, shipping, or testing phase.

3701-55-02 Required screening; facility requirements.

(A) All newborn children shall be screened in accordance with procedures set forth in this chapter for the presence of the following genetic, endocrine, or metabolic disorders:

1. 2-methylbutyryl-CoA dehydrogenase deficiency;
2. 3-hydroxy-3-methylglutaryl-CoA lyase deficiency;
3. 3-ketothiolase deficiency;
4. 3-methylcrotonyl-CoA carboxylase deficiency;
5. Argininemia;
6. Argininosuccinic acidemia;
7. Biotinidase deficiency;
8. Carnitine/acylcarnitine translocase deficiency;
9. Carnitine palmitoyl transferase deficiency type II;
10. Carnitine uptake defect;
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(11) Citrullinemia;
(12) Congenital adrenal hyperplasia;
(13) Congenital hypothyroidism;
(14) Cystic fibrosis;
(15) Galactosemia;
(16) Glutaric acidemia type I;
(17) Glutaric acidemia type II;
(18) Glycogen storage disease type II (Pompe);
(19) Homocystinuria (cystathionine-beta-synthase deficiency);
(20) Hypermethioninemia;
(21) Isobutyryl-CoA dehydrogenase deficiency;
(22) Isovaleric acidemia;
(23) Krabbe disease;
(24) Long chain hydroxyacyl-CoA dehydrogenase deficiency;
(25) Maple syrup urine disease;
(26) Medium chain acyl-CoA dehydrogenase deficiency;
(27) Methylmalonic acidemia;
(28) Mucopolysaccharidosis type 1;
(29) Multiple CoA carboxylase deficiency;
(30) Phenylketonuria;
(31) Propionic acidemia;
(32) Severe combined immune deficiency;
(33) Sickle cell and other hemoglobinopathies;
(34) Trifunctional protein deficiency;
(35) Tyrosinemia type I;
(36) Tyrosinemia type II;
(37) Tyrosinemia type III; and
(38) Very long chain acyl-CoA dehydrogenase deficiency.

(B) All hospitals and freestanding birthing centers that are required by this chapter to cause specimens to be collected for newborn screening for genetic, endocrine, or metabolic disorders shall:

(1) Designate a newborn screening coordinator and physician responsible for the coordination of the facility's newborn screening;
(2) Notify the chief of the Ohio department of health bureau of public laboratories of the name of the individual designated as the newborn screening coordinator on a yearly basis and whenever the designated individual changes; and
(3) Develop a written protocol for tracking newborn screening. The protocol must include a requirement that the name of the physician attending the child after birth or a designee be placed on the specimen slip sent with the initial specimen to the Ohio department of health public health laboratory.

3701-55-03 Public health laboratory responsibilities.

The bureau of public health laboratory shall provide screening for the presence of genetic, endocrine, or metabolic disorders in newborn children. In providing this screening, the bureau shall do all of the following:

(A) Provide instructions for collecting, handling and transporting specimens with specimen collection kits;
(B) Complete each screening within seven business days after receiving the properly collected and submitted specimen;
(C) Transmit the results of the screening performed to the appropriate person, as
specified in rule 3701-55-07 of the Administrative Code, in the manner prescribed by the director;

(D) Keep all newborn screening specimens and the demographic forms associated with each specimen for not less than two years from the date of the bureau's initial receipt of each specimen;

(E) Keep electronic raw test data and any electronic images of reports and/or letters created for each specimen for not less than two years from the date of the bureau's initial receipt of each specimen;

(F) Maintain electronically the screening results, demographic information, and case management information for each properly collected and submitted specimen received by the bureau for not less than twenty one years; and

(G) Provide reports regarding unsatisfactory specimens, disease specific reports and other reports to programs within the department of health, or to entities under grant or contract with the department of health, as prescribed and deemed necessary by the director to carry out the functions and responsibilities of the director and the department of health.

3701-55-04 Notification required.

(A) Prior to collecting the blood specimen for screening, the person designated in the applicable provision of this rule shall give each newborn child’s parent, legal guardian, or legal custodian, notice of the screening to be conducted by providing printed information describing the newborn genetic, endocrine and metabolic screening program.

(1) When a birth occurs in a hospital, the hospital shall provide the information;

(2) When a birth occurs in a freestanding birthing center, the freestanding birthing center shall provide the information;

(3) When a birth occurs outside a hospital or freestanding birthing center, the attending physician, the certified nurse midwife, the certified nurse practitioner or the clinical nurse specialist shall provide the information;

(4) If there is no physician, certified nurse midwife, certified nurse practitioner or clinical nurse specialist in attendance at the time of birth, upon notification of the birth, the health commissioner of the health district in which the birth occurred shall provide the information.

(B) For purposes of screening for krabbe disease, the designated person as listed in paragraph (A) of this rule shall provide information to the parent, legal guardian, or legal custodian of their right to forgo the screening. If the parent, legal guardian, or legal custodian communicates the decision to forgo this screening, the designated person must document and submit this response to the bureau of public health laboratory in a manner prescribed by the director.

(C) The director shall provide the printed information required by this rule to hospitals, freestanding birthing centers, health commissioners, physicians, certified nurse midwives, certified nurse practitioners and clinical nurse specialists.

(D) The director shall conduct educational programs for hospital and freestanding birthing center newborn screening coordinators, physicians, certified nurse midwives, certified nurse practitioners and clinical nurse specialists, nurses, laboratory staff and others involved in the collection and follow-up of newborn screening specimens.

3701-55-05 Initial collection.

(A) The person responsible for causing the initial blood specimen to be collected for screening under this rule shall be as follows:

(1) For births which occur in a hospital or freestanding birthing center, the child’s attending physician, the certified nurse midwife, the certified nurse practitioner or the clinical
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nurse specialist shall cause the initial blood specimen to be collected from each newborn child prior to discharge from the newborn nursery.

(a) For a newborn child who remains in a hospital or a freestanding birthing center for at least twenty-four hours following birth, the blood specimen shall be collected as soon as possible after twenty-four hours of age, but no later than when the child reaches five days of age;

(b) For a newborn child who is discharged to go home from a hospital or freestanding birthing center prior to twenty-four hours of age, the blood specimen shall be collected prior to discharge;

(c) For a newborn child who is transferred to another hospital prior to the collection of the blood specimen, the blood specimen shall be collected at the receiving hospital as soon as possible after twenty-four hours of age, but no later than when the child reaches five days of age.

(2) For births which occur outside a hospital or freestanding birthing center, the attending physician, the certified nurse midwife, the certified nurse practitioner or the clinical nurse specialist shall cause the blood specimen to be collected. The physician, certified nurse midwife, certified nurse practitioner, or clinical nurse specialist shall cause the the blood specimen to be collected as soon as possible after twenty-four hours of age, but no later than when the child reaches five days of age.

(3) For births which occur outside a hospital or freestanding birthing center when no physician, certified nurse midwife, certified nurse practitioner or clinical nurse specialist is in attendance, the health commissioner, shall cause a blood specimen to be collected within five business days after being notified by the local registrar of the birth of a child under this paragraph, but no sooner than when the child reaches twenty-four hours of age.

(B) An initial blood specimen shall be collected prior to a red blood cell transfusion when possible even if the newborn is less than twenty-four hours of age. A specimen collected from a child who has received a transfusion of red blood cells shall be so labeled.

(C) A specimen collected under this rule shall be sent to the bureau of public health laboratory for screening no later than two business days after it is collected.

(D) The person designated by this rule to collect the initial specimen shall cause a repeat specimen to be obtained within five business days after receiving notice from the bureau of public health laboratory that the first specimen is unsatisfactory. Unsatisfactory specimens include, but are not limited to, specimens that are received by the bureau more than fourteen days after they are collected.

(E) If the person responsible for collecting the repeat specimen is unable to locate the newborn child, he or she shall notify the health commissioner of the health district in which the mother, legal guardian, or legal custodian resides. The health commissioner shall make a reasonable effort to locate the child and cause a repeat specimen to be obtained. If the health commissioner is not able to locate the child within the thirty days, he or she may close the file.

3701-55-06 Twenty-four hour required second collection.

(A) If the initial specimen is collected from a child at less than twenty-four hours of age, the child's attending physician, certified nurse midwife, certified nurse practitioner or clinical nurse specialist and the hospital or freestanding birthing center shall make a reasonable effort to cause a repeat blood specimen to be collected from the child in accordance with the provisions of paragraph (B) of this rule.

(B) The repeat blood specimen shall be collected after the child reaches twenty-four hours of age but no later than when the child reaches ten days of age.

(C) A specimen collected under this rule shall be sent to the bureau of public health laboratory for screening no later than two business days after it is collected.
3701-55-07 Initial specimen abnormal.

This rule prescribes the procedures that apply if, upon screening of a specimen, the bureau of public health laboratory determines that the result indicates potential risk for one or more of the screened disorders.

(A) The director shall communicate the results to the following person, as applicable:
(1) If a child was born in a hospital or freestanding birthing center, the director shall communicate the results to the child's attending physician, child's primary medical provider, pediatrician, certified nurse midwife, certified nurse practitioner or clinical nurse specialist. If the director is unable to contact the attending physician, child's primary medical provider, pediatrician, certified nurse midwife, certified nurse practitioner or clinical nurse specialist, the director shall communicate the results to the newborn screening coordinator at the facility where the child was born.
(2) If the child was not born in a hospital or freestanding birthing center, the director shall communicate the results to the person designated in paragraph (A)(2) or (A)(3) of rule 3701-55-05 of the Administrative Code, as applicable.

(B) The person notified of the results by the director under paragraph (A) of this rule shall communicate the results to the child's parent, legal guardian, or legal custodian and shall obtain and submit a repeat blood specimen for screening or diagnostic testing in accordance with the following procedures:
(1) When the result indicates potential risk for a disorder listed in paragraphs (A)(1) to (A)(36) of rule 3701-55-02 of the Administrative Code, a screening or diagnostic test shall be obtained in accordance with paragraph (B)(3) of this rule as soon as possible, but no later than ten days after notification by the director.
(2) When the results are abnormal for a hemoglobin disease or hemoglobin trait, a diagnostic test shall be obtained in accordance with paragraph (B)(3) of this rule before the child reaches two months of age.
(3) Diagnostic specimens obtained under paragraphs (B)(1) and (B)(2) of this rule shall be submitted for testing to a laboratory certified under the Clinical Laboratory Improvement Act, 42 USC 263a as amended January 24, 2004, that reports results with normal pediatric reference ranges. That laboratory shall promptly transmit the results of the diagnostic test to the person who submitted the specimen.

(C) If after ten business days, the person responsible for obtaining and submitting the repeat specimen and/or diagnostic tests under paragraph (B) of this rule is unable to obtain a specimen from a newborn child with an initial screen result of a potential risk despite making a reasonable effort, he or she shall notify the health commissioner of the health district in which the mother, legal guardian, or legal custodian resides.

The health commissioner shall make a reasonable effort to locate the child and cause a second specimen to be obtained. If the health commissioner is not able to locate that child within thirty days, he or she may close the file.

(D) The health commissioner shall submit a report to the director, upon case closure, listing the names and other identifiers of newborns the health commissioner was unable to locate.

3701-55-08 Repeat abnormal screening.

(A) When a repeat screen or diagnostic test is conducted under paragraph (B) of rule 3701-55-07 of the Administrative Code, the person who submitted the specimen shall do the following:
(1) Communicate the results to the child's parent, legal, guardian or legal custodian;
(2) Communicate the results to the director; and
(3) Refer the child for further diagnostic testing, follow-up and management in accordance with the following, as applicable:

(a) A child with abnormal results on the diagnostic test for one or more of the disorders listed in paragraphs (A)(1) to (A)(34) of rule 3701-55-02 of the Administrative Code shall be referred to an appropriate specialist physician who is approved under rule 3701-43-03 of the Administrative Code as a provider for the program for medically handicapped children and is board certified in pediatric endocrinology, medical genetics, or immunology/infectious diseases, or to a cystic fibrosis center approved for the program for medically handicapped children.

(b) A child with abnormal results on the screen for sickle cell disease, Sickle C disease, Sickle Beta Thalassemia, Alpha Thalassemia (major or intermedia), or Beta Thalassemia (major or H disease) shall be referred to a physician who is approved under rule 3701-43-03 of the Administrative Code as a provider for the program for medically handicapped children and is board certified in pediatric hematology.

(c) A child with abnormal results on diagnostic tests for sickle cell and other hemoglobinopathies shall be referred to a state funded Ohio regional sickle cell project for hemoglobin counseling and follow-up.

(B) The physician to whom a child is referred pursuant to paragraph (A) of this rule shall notify the director of results and disposition of the child within thirty days of the referral.

(C) The director may share newborn screening information obtained pursuant to this chapter and from other sources with programs within the department of health and with individuals or entities under grant or contract with the department of health to assist in locating a newborn child, the child's parent, legal guardian, or legal custodian and to otherwise carry out the functions and responsibilities of the director and the department of health.

3701-55-09 Religious exception.

(A) The provisions of this chapter requiring screening of newborn children do not apply if the parents of the child object thereto on the grounds that such screening conflicts with their religious tenets and practices.

(B) Refusal to consent to the newborn screening must be documented on forms provided by the Ohio department of health or must meet the minimum warning requirements set forth on the Ohio department of health forms. A copy of the refusal form or other documentation of parental refusal shall be sent to the Ohio department of health.

3701-55-10 Supplemental studies.

The director may conduct supplemental studies of the initial blood specimen collected pursuant to rule 3701-55-05 of the Administrative Code for the purpose of determining whether additional genetic, endocrine, or metabolic screening is necessary. The results of such supplemental studies will assist in determining whether additional screening can help detect other genetic, endocrine or metabolic disorders that cause disability if undiagnosed and untreated for which a medically accepted treatment is available. No additional blood samples or specimens shall be required to conduct a supplemental study or screening.

(A) Each supplemental screening shall be completed by the bureau of public health laboratory within seven business days after receiving the properly collected and submitted specimen.

(B) If upon supplemental screening of a specimen, the bureau of public health laboratory determines that a result indicates a potential risk for one or more of the supplemental screenings disorders, the director shall communicate the results to the following person, as applicable:

1) If the child was born in a hospital or freestanding birthing center, to the child's
attending physician, certified nurse midwife, certified nurse practitioner, or clinical nurse specialist. If the director is unable to contact the attending physician, certified nurse midwife, certified nurse practitioner, or clinical nurse specialist, the director shall communicate the results to the newborn screening coordinator at the facility where the child was born.

(2) If the child was not born in a hospital or freestanding birthing center, the director shall communicate the results to:
   (a) The attending physician, certified nurse midwife, certified nurse practitioner or the clinical nurse specialist in attendance; or
   (b) The health commissioner of the health district in which the mother, legal guardian, or legal custodian resides, if there was no attending physician, certified nurse midwife, certified nurse practitioner or clinical nurse specialist in attendance. The health commissioner shall make a reasonable effort to locate the child's mother, legal guardian or legal custodian of the child, and to notify the mother, legal guardian or legal custodian of the child of the results of the supplemental screening.

3701-55-20 Fees for genetic services fund; sickle cell fund.

In addition to the laboratory fee authorized by rule 3701-49-01.1 of the Administrative Code, the director of health shall charge and collect a fee of twenty-six dollars and thirty-one cents for performing genetic, endocrine, and metabolic disorder screenings required by section 3701.501 of the Revised Code and this chapter. The fee shall be disbursed as follows:
   (A) Twenty dollars and twenty-six cents shall be deposited in the state treasury to the credit of the genetics services fund. Twelve dollars and twenty-four cents of each fee credited to the genetic services fund shall be used to defray the costs of programs authorized by section 3701.502 of the Revised Code. Four dollars and eighty-seven cents from each fee credited to the genetics services fund shall be used to defray the cost of programs that provide genetic counseling and education to families of newborns with abnormal newborn screening results for cystic fibrosis.
   (B) Six dollars and five cents shall be deposited into the state treasury to the credit of the sickle cell fund. Money credited to the sickle cell fund shall be used to defray costs of programs authorized under section 3701.131 of the Revised Code.

Inflammation of the Eyes of Newborns

3701.51 Inflammation of a newborn’s eyes.

Any inflammation, swelling, or redness in either one or both eyes of any infant, either apart from or together with any unnatural discharge from the eyes of such infant, independent of the nature of the infection, if any, occurring any time within two weeks after the birth of such infant, shall be known as “inflammation of the eyes of the newborn.” Any inflammation of the conjunctiva or cornea, either apart from or together with any unnatural discharge from the eyes, occurring at any time after two weeks after birth, if caused by the gonococcus, shall be known as “gonorrheal ophthalmia.”

3701.52 Newborn eye inflammation; duty to report.

Every physician, surgeon, obstetrician, certified nurse-midwife, nurse, maternity home or hospital of any nature, parent, relative, or any others attendant on any person with inflammation of the eyes, knowing either condition, defined in section 3701.51 of the Revised Code, to exist, within six hours thereafter, shall report such facts, as the department of health shall direct, to the
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health commissioner of the city or general health district within which such person may reside.

3701.55 Use of prophylactic against newborn eye inflammation.

Every physician, certified nurse-midwife, or other person in attendance at childbirth shall, immediately after the birth, use in the eyes of the newborn child some prophylactic against inflammation of the eyes of such child, and shall make a record on the birth certificate of the prophylactic used.

Birth Defects Information System

3705.30 Director of Health to establish birth defects information system.

(A) As used in this section:
(1) “Freestanding birthing center” has the same meaning as in section 3702.141 of the Revised Code.
(2) “Hospital” means a hospital classified under section 3701.07 of the Revised Code as a general hospital or children's hospital.
(3) “Physician” means an individual authorized under Chapter 4731 of the Revised Code to practice medicine and surgery or osteopathic medicine and surgery.

(B) The director of health shall establish and, if funds for this purpose are available, implement a statewide birth defects information system for the collection of information concerning congenital anomalies, stillbirths, and abnormal conditions of newborns.

(C) If the system is implemented under division (B) of this section, all of the following apply:
(1) The director may require each physician, hospital, and freestanding birthing center to report to the system information concerning all patients under five years of age with a primary diagnosis of a congenital anomaly or abnormal condition. The director shall not require a hospital, freestanding birthing center, or physician to report to the system any information that is reported to the director or department of health under another provision of the Revised Code or Administrative Code.
(2) On request, each physician, hospital, and freestanding birthing center shall give the director or authorized employees of the department of health access to the medical records of any patient described in division (C)(1) of this section. The department shall pay the costs of copying any medical records pursuant to this division.
(3) The director may review vital statistics records and shall consider expanding the list of congenital anomalies and abnormal conditions of newborns reported on birth certificates pursuant to section 3705.08 of the Revised Code.

(D) A physician, hospital, or freestanding birthing center that provides information to the system under division (C) of this section shall not be subject to criminal or civil liability for providing the information.

3705.31 System purpose and uses.

If implemented under section 3705.30 of the Revised Code, the birth defects information system may be used for all of the following purposes:
(A) To identify and describe congenital anomalies, stillbirths, and abnormal conditions of newborns;
(B) To detect trends and epidemics in congenital anomalies, stillbirths, and abnormal conditions of newborns;
(C) To quantify morbidity and mortality of congenital anomalies and abnormal conditions.
of newborns;

(D) To stimulate epidemiological research regarding congenital anomalies, stillbirths, and abnormal conditions of newborns;

(E) To identify risk factors for congenital anomalies, stillbirths, and abnormal conditions of newborns;

(F) To facilitate intervention in and prevention of congenital anomalies, stillbirths, and abnormal conditions of newborns;

(G) To facilitate access to treatment for congenital anomalies and abnormal conditions of newborns;

(H) To inform and educate the public about congenital anomalies, stillbirths, and abnormal conditions of newborns.

3705.32 Confidentiality.

(A) Except as provided in this section, records received and information assembled by the birth defects information system pursuant to section 3705.30 of the Revised Code are confidential medical records.

(B)(1) The director of health may use information assembled by the system to notify parents, guardians, and custodians of children with congenital anomalies or abnormal conditions of medical care and other services available for the child and family.

(2) The director may disclose information assembled by the system with the written consent of the parent or legal guardian of the child who is the subject of the information.

(C)(1) Access to information assembled by the system shall be limited to the following persons and government entities:

(a) The director of health;

(b) Authorized employees of the department of health;

(c) Qualified persons or government entities that are engaged in demographic, epidemiological, or similar studies related to health and health care provision.

(2) The director shall give a person or government entity described in division (C)(1)(c) of this section access to the system only if the person or a representative of the person or government entity signs an agreement to maintain the system's confidentiality.

(3) The director shall maintain a record of all persons and government entities given access to the system. The record shall include all of the following information:

(a) The name of the person who authorized access to the system;

(b) The name, title, and organizational affiliation of the person or government entity given access to the system;

(c) The dates the person or government entity was given access to the system;

(d) The specific purpose for which the person or government entity intends to use the information.

(4) The record maintained pursuant to division (C)(3) of this section is a public record, as defined in section 149.43 of the Revised Code.

(5) A person who violates an agreement described in division (C)(2) of this section may be denied further access to confidential information maintained by the director.

(D) The director may disclose information assembled by the system in summary, statistical, or other form that does not identify particular individuals or individual sources of information.

3705.33 Requesting removal of information from system.

As used in this section, “local health department” means a health department operated by the board of health of a city or general health district or the authority having the duties of a
board of health under section 3709.05 of the Revised Code.

A child's parent or legal guardian who wants information concerning the child removed from the birth defects information system shall request from the local health department or the child's physician a form prepared by the director of health. On request, a local health department or physician shall provide the form to the child's parent or legal guardian. The individual providing the form shall discuss with the child's parent or legal guardian the information contained in the system. If the child's parent or legal guardian signs the form, the department or physician shall forward it to the director. On receipt of the signed form, the director shall remove from the system any information that identifies the child.

3701-57-01 Birth defects reporting system; definitions.

As used in this chapter
(A) “Abnormal condition” means any condition established at conception or acquired in utero which results in a morphologic (structural), metabolic (biochemical), functional or behavioral derangement necessitating medical or other intervention.
(B) “Birth defect” means an abnormal condition resulting from an error of metabolism (biochemical), morphogenesis (structural) or both, which is either established at conception or in utero including congenital tumors and birth marks (hamartoneoplasia).
(C) “Birth Defects Information System” or “system” means the collection and maintenance of information regarding abnormal conditions, birth defects and congenital anomalies of fetal deaths and of children from birth to five years of age, and the provision of referral services to families with a child from birth to five years of age with a birth defect. In Ohio, the system is named the “Ohio Connections for Children with Special Needs” or “OCCSN”.
(D) “Congenital anomaly” means an error of morphogenesis (structural) which is either established at conception or acquired during intrauterine life.
(E) “Director” means the director of the Ohio department of health or his or her designee.
(F) “Freestanding birthing center” means any facility in which deliveries routinely occur, regardless of whether the facility is located on the campus of another health care facility, and which is licensed under Chapter 3711 of the Revised Code as level one, two, or three maternity unit or a limited maternity unit.
(G) “Hospital” means a hospital classified under section 3701.07 of the Revised Code as a general hospital or children's hospital.
(H) “Local health department” means a health department operated by the board of health of a city or general health district or the authority having the duties of a board of health under section 3709.05 of the Revised Code.
(I) “Physician” means an individual authorized under Chapter 4731 of the Revised Code to practice medicine and surgery or osteopathic medicine and surgery.
(J) “Referral services” means a formal process to assure that parents or guardians of children with birth defects are informed of medical and support services for which they may be eligible in order to improve health outcomes and/or enhance the quality of their children's lives.
(K) “Stillbirth” or “fetal death” means death of a product of conception of at least twenty weeks of gestation prior to the complete expulsion or extraction from its mother which, after such expulsion or extraction, does not breathe or show any other evidence of life such as beating of the heart, pulsation of the umbilical cord, or definite movement of voluntary muscles.
(L) “Surveillance” means the ongoing systematic collection, analysis, interpretation and dissemination of outcome-specific data for use in the planning, implementation and evaluation of public health practice.
3701-57-02 Reporting requirements.

(A) Each physician, hospital and freestanding birthing center shall report to the birth defects information system information concerning all children from birth to five years of age with any of the following abnormal conditions, birth defects and congenital abnormalities:

(1) Anencephalus;
(2) Spina bifida;
(3) Congenital cataract;
(4) Aniridia;
(5) Truncus arteriosus;
(6) Transposition of great arteries;
(7) Tricuspid atresia;
(8) Tetralogy of Fallot;
(9) Pulmonary atresia;
(10) Congenital stenosis of the aortic valve;
(11) Hypoplastic left heart syndrome;
(12) Coarctation of aorta;
(13) Total anomalous pulmonary venous return;
(14) Choanal atresia;
(15) Cleft palate;
(16) Cleft lip;
(17) Cleft palate with cleft lip;
(18) Esophageal atresia;
(19) Atresia and stenosis of large intestine, rectum and anal canal;
(20) Hirschsprung disease;
(21) Biliary atresia;
(22) Intestinal malrotation and volvulus;
(23) Renal agenesis;
(24) Gastroschisis;
(25) Omphalocele;
(26) Diaphragmatic hernia;
(27) Trisomy 13;
(28) Trisomy 18;
(29) Trisomy 21;
(30) Turner syndrome;
(31) Klinefelter syndrome;
(32) Disorders of sexual development (ambiguous genitalia);
(33) Fetal alcohol syndrome;
(34) Long QT syndrome;
(35) Velo-cardio-facial syndrome (22q11 deletion);
(36) Neurofibromatosis type 1;
(37) Spinal muscular atrophy;
(38) Tuberous sclerosis;
(39) Stickler syndrome, Treacher Collins' syndrome, Pierre Robin syndrome, Goldenhar syndrome; and
(40) Osteogenesis imperfecta.

(B) Each physician, hospital and freestanding birthing center shall report cases as described in paragraph (A) of this rule in an electronic format as prescribed by the director. The report shall contain information regarding the child which includes:

(1) Medical record number;
(2) Child's name;
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(3) Child's county of residence;
(4) Child's address;
(5) Phone number of child's parent or guardian;
(6) Parent/guardian name;
(7) Child's date of birth;
(8) Child's gender;
(9) Child's race;
(10) Child's hispanic ethnicity;
(11) Date of encounter or discharge;
(12) Diagnostic code for the birth defect being reported;
(13) Child's date of death, if applicable;
(14) Mother's maiden name;
(15) Mother's date of birth;
(16) Mother's race;
(17) Mother's hispanic ethnicity;
(18) Reporting hospital Ohio department of health hospital number; and
(19) Date of report.

(C) Each physician, hospital and freestanding birthing center shall report to the Ohio department of health at least quarterly, all new cases from the previous quarter unless the physician, hospital, or freestanding birthing center has evidence that the case has already been reported.

(D) All physicians, hospitals and freestanding birthing centers providing diagnostic or treatment services to individuals with birth defects as specified in paragraph (A) of this rule shall grant to the director, or those representatives authorized in accordance with division (C) of section 3705.32 of the Revised Code, access to records that identify cases of birth defects.

(E) A physician, hospital, or freestanding birthing center is not subject to liability in an action for damages, or other relief for furnishing the information including records, reports, statements, notes, memoranda or other information to the director as required by this rule, or to a qualified person or governmental entity authorized by division (C) of section 3705.32 of the Revised Code.

(F) The director shall establish a form for use by parents and legal guardians who seek to have identifying information regarding their children removed from the birth defects information system. The director shall make the form available to hospitals, local health departments and physicians.

(G) The director shall make available to the state's birth defects information system, the same information listed in paragraph (B) of this rule for newborns diagnosed with disorders on the state's mandated newborn screening panel listed in rule 3701-55-02 of the Administrative Code.

3701-57-03 Referral services.

Ohio department of health birth defects information system staff or appropriate staff from community programs may contact parents and legal guardians of children reported to the birth defects information system to offer referral information for specialty physicians and other agencies and programs such as help me grow early intervention, regional comprehensive genetics centers, public health nurses at local health departments, and the “Children with Medical Handicaps Program” (CMH).

3701-57-04 Confidentiality, research.

(A) Any information, data or reports with respect to a birth defects case that is furnished
to, or obtained by, the birth defects information system or by the director shall be confidential and shall be used for one or more of the following purposes:

(1) For medical research studies including demographic, epidemiologic, teratologic, or similar studies related to health and health care provision;

(2) To inform parents, guardians and custodians of children with birth defects of medical care and other services available for the child and family;

(3) To provide data regarding birth defects in Ohio to the “National Birth Defects Prevention Network”; and

(4) To distribute reports of information as required by section 3705.36 of the Revised Code.

(B) Qualified persons or government entities engaged in demographic, teratologic, epidemiologic or similar studies related to health and health care provision may be given access to confidential information if all the following conditions are met and if the project is approved by the Ohio department of health's institutional review board:

(1) The person requesting to access the data initially meets with the birth defects program administrator or other pertinent Ohio department of health staff to discuss the proposed study concept and programmatic data elements requested.

(2) Following the outcome of paragraph (B)(1) of this rule, the person conducting the study submits a complete application to the Ohio department of health's institutional review board and provides written information about:

(a) The purpose of the study;

(b) The nature of the data to be collected;

(c) How the researcher intends to analyze it;

(d) The records the researcher seeks to review, and;

(e) The safeguards the researcher will take to protect the identity of the patients whose records the researcher will be reviewing.

(C) Based on the results from the meeting and written information submitted to the Ohio department of health's institutional review board under paragraph (B) of this rule, the director shall determine that access to confidential information concerning individuals with birth defects shall be made available to persons engaged in demographic, epidemiologic, teratologic, or similar studies related to health and health care provision if the person or government entity signs an agreement to maintain the confidentiality of the information and the study meets the following standards:

(1) The study had clearly defined goals that pertain to birth defects diagnosis, prevention, treatment or service coordination;

(2) For case control studies, the research design used in the study will involve a sufficiently large sample size that any meaningful difference between cases and controls will be statistically significant. For other projects, the study will provide enough cases for meaningful analysis of the data for identification of potential risk factors and intervention strategies for birth defects treatment and prevention; and

(3) The study will be conducted by researchers who have the ability to analyze and interpret data.

(D) The director may disclose information assembled by the birth defects information system with the written consent of the parent or legal guardian of the child who is the subject of the information.

(E) The director may obtain and merge into the birth defects information system information reported to the Ohio department of health under another provision of the Revised Code or Administrative Code.

(F) Notwithstanding paragraphs (A) and (C) of this rule, the Ohio department of health may release confidential information concerning individuals with birth defects or congenital anomalies to the birth defects information system of another state, if the other state has entered
into a written reciprocal agreement with the Ohio department of health and the agreement provides that the state will comply with the confidentiality provision of this rule and that information identifying a child will not be released to any person without the written consent of the individual's parent or legal guardian.

(G) This rule does not prevent the release of information assembled by the birth defects information system in summary, statistical or other form that does not identify particular individuals or individual sources of information.

Part IV. Abandoned or Shaken Baby

2151.3515 Definitions.

As used in sections 2151.3515 to 2151.3535 of the Revised Code:
(A) “Emergency medical service organization,” “emergency medical technician-basic,” “emergency medical technician-intermediate,” “first responder,” and “paramedic” have the same meanings as in section 4765.01 of the Revised Code.
(B) “Emergency medical service worker” means a first responder, emergency medical technician-basic, emergency medical technician-intermediate, or paramedic.
(C) “Hospital” has the same meaning as in section 3727.01 of the Revised Code.
(D) “Hospital employee” means any of the following persons:
   (1) A physician who has been granted privileges to practice at the hospital;
   (2) A nurse, physician assistant, or nursing assistant employed by the hospital;
   (3) An authorized person employed by the hospital who is acting under the direction of a physician described in division (E)(1) of this section.
   (E) “Law enforcement agency” means an organization or entity made up of peace officers.
   (F) “Nurse” means a person who is licensed under Chapter 4723 of the Revised Code to practice as a registered nurse or licensed practical nurse.
   (G) “Nursing assistant” means a person designated by a hospital as a nurse aide or nursing assistant whose job is to aid nurses, physicians, and physician assistants in the performance of their duties.
   (H) “Peace officer” means a sheriff, deputy sheriff, constable, police officer of a township or joint police district, marshal, deputy marshal, municipal police officer, or a state highway patrol trooper.
   (I) “Physician” means an individual authorized under Chapter 4731 of the Revised Code to practice medicine and surgery, osteopathic medicine and surgery, or podiatric medicine and surgery.
   (J) “Physician assistant” means an individual who holds a current, valid license to practice as a physician assistant issued under Chapter 4730 of the Revised Code.

2151.3516 Delivery of abandoned child by parent or authorized person.

A parent may voluntarily deliver his or her child who is not older than thirty days, without intent to return for the child, to a person specified in section 2151.3517 of the Revised Code or a newborn safety incubator provided by an entity described in that section that meets the requirements of section 2151.3532 of the Revised Code.
2151.3517 Who can accept an abandoned baby.

The following entities or persons, while acting in an official capacity on behalf of any of the entities, shall take possession of a child delivered in accordance with section 2151.3516 of the Revised Code:

(A) A law enforcement agency or a peace officer employed by the agency;
(B) A hospital or a person granted the privilege to practice at, or employed by, the hospital;
(C) An emergency medical service organization or an emergency medical service worker employed by or providing services to the organization.

2151.3518 Duties upon taking possession of abandoned baby.

(A) On taking possession of a child pursuant to section 2151.3517 of the Revised Code, a law enforcement agency, hospital, or emergency medical service organization shall do all the following:

1. Perform any act necessary to protect the child's health or safety;
2. Notify the public children services agency of the county in which the agency, hospital, or organization is located that the child has been taken into possession;
3. If possible, make available to the parent who delivered the child forms developed under section 2151.3534 of the Revised Code that are designed to gather medical information concerning the child and the child's parents;
4. If possible, make available to the parent who delivered the child written materials developed under section 2151.3534 of the Revised Code that describe services available to assist parents and newborns;
5. If the child has suffered a physical or mental wound, injury, disability, or condition of a nature that reasonably indicates abuse or neglect of the child, attempt to identify and pursue the person who delivered the child.

(B) An emergency medical service worker who takes possession of a child shall, in addition to any act performed under division (A)(1) of this section, perform any medical service the worker is authorized to perform that is necessary to protect the physical health or safety of the child.

2151.3519 Action required by children services regarding abandoned baby.

On receipt of a notice given pursuant to section 2151.3518 of the Revised Code that an emergency medical service organization, a law enforcement agency, or hospital has taken possession of a child and in accordance with rules of the department of job and family services, a public children services agency shall do all of the following:

(A) Consider the child to be in need of public care and protective services;
(B) Accept and take emergency temporary custody of the child;
(C) Provide temporary emergency care for the child, without agreement or commitment;
(D) Make an investigation concerning the child;
(E) File a motion with the juvenile court of the county in which the agency is located requesting that the court grant temporary custody of the child to the agency or to a private child placing agency;
(F) Provide any care for the child that the public children services agency considers to be in the best interest of the child, including placing the child in shelter care;
(G) Provide any care and perform any duties that are required of public children services agencies under section 5153.16 of the Revised Code;
(H) Prepare and keep written records of the investigation of the child, of the care and treatment afforded the child, and any other records required by the department of job and family services.

2151.3525 Immunity and abandoned baby.

(A) A parent does not commit a criminal offense under the laws of this state and shall not be subject to criminal prosecution in this state for the act of voluntarily delivering a child under section 2151.3516 of the Revised Code.

(B) A person who delivers or attempts to deliver a child who has suffered any physical or mental wound, injury, disability, or condition of a nature that reasonably indicates abuse or neglect of the child is not immune from civil or criminal liability for abuse or neglect.

(C) A person or entity that takes possession of a child pursuant to section 2151.3517 of the Revised Code or takes emergency temporary custody of and provides temporary emergency care for a child pursuant to section 2151.3519 of the Revised Code is immune from any civil liability that might otherwise be incurred or imposed as a result of these actions, unless the person or entity has acted in bad faith or with malicious purpose. The immunity provided by this division does not apply if the person or entity has immunity from civil liability under section 9.86, 2744.02, or 2744.03 of the Revised Code for the action in question.

(D) A person or entity that takes possession of a child pursuant to section 2151.3517 of the Revised Code or takes emergency temporary custody of and provides temporary emergency care for a child pursuant to section 2151.3519 of the Revised Code is immune from any criminal liability that might otherwise be incurred or imposed as a result of these actions, unless the person or entity has acted in bad faith or with malicious purpose.

(E) Divisions (C) and (D) of this section do not create a new cause of action or substantive legal right against a person or entity, and do not affect any immunities from civil liability or defenses established by another section of the Revised Code or available at common law, to which a person or governmental entity may be entitled under circumstances not covered by this section.

2151.3526 Abandoned baby and parental anonymity.

(A) A parent who voluntarily delivers a child under section 2151.3516 of the Revised Code has the absolute right to remain anonymous. The anonymity of a parent who voluntarily delivers a child does not affect any duty imposed under section 2151.3517 or 2151.3518 of the Revised Code. A parent who voluntarily delivers a child may leave the place at which the parent delivers the child at any time after the delivery of the child.

(B) Notwithstanding division (A) of this section, a parent who delivers or attempts to deliver a child who has suffered any physical or mental wound, injury, disability, or condition of a nature that reasonably indicates abuse or neglect of the child does not have the right to remain anonymous and may be subject to arrest pursuant to Chapter 2935 of the Revised Code.

2151.3528 Abandoned baby and medical forms.

A parent who voluntarily delivers a child under section 2151.3516 of the Revised Code may complete all or any part of the medical information forms made available under division (A)(3) of section 2151.3518 of the Revised Code. The parent may deliver the fully or partially completed forms at the same time as delivering the child or at a later time. The parent is not required to complete all or any part of the forms.
2151.3529 Abandoned baby and refusing medical forms.

A parent who voluntarily delivers a child under section 2151.3516 of the Revised Code may refuse to accept the materials made available under division (A)(4) of section 2151.3518 of the Revised Code.

2151.3530 Abandoned baby and prohibited actions.

(A) No person described in section 2151.3517 of the Revised Code and no other person employed by an entity described in that section shall do the following with respect to a parent who voluntarily delivers a child under that section:

1. Coerce or otherwise try to force the parent into revealing the identity of the child's parents;
2. Pursue or follow the parent after the parent leaves the place at which the child was delivered;
3. Coerce or otherwise try to force the parent not to desert the child;
4. Coerce or otherwise try to force the parent to complete all or any part of the medical information forms made available under division (A)(3) of section 2151.3518 of the Revised Code;
5. Coerce or otherwise try to force the parent to accept the materials made available under division (A)(4) of section 2151.3518 of the Revised Code.

(B) Divisions (A)(1) and (2) of this section do not apply with respect to a person who delivers or attempts to deliver a child who has suffered any physical or mental wound, injury, disability, or condition of a nature that reasonably indicates abuse or neglect of the child.

2151.3532 Newborn safety incubators.

Not later than one hundred eighty days after the effective date of this section, the director of the department of health shall adopt rules in accordance with Chapter 119 of the Revised Code governing newborn safety incubators provided by entities described in section 2151.3517 of the Revised Code. The rules shall provide for all of the following:

(A) Sanitation standards;
(B) Procedures to provide emergency care for a child delivered to an incubator;
(C) Manufacturing and manufacturer standards;
(D) Design and function requirements that include the following:
1. Take into account installation at a law enforcement agency, a hospital, or an emergency medical service organization;
2. Allow a child to be placed anonymously from outside the facility;
3. Lock the incubator after a child is placed in it so that a person outside the facility is unable to access the child;
4. Provide a controlled environment for the care and protection of the child;
5. Provide notification to a centralized location in the facility within thirty seconds of a child being placed in the incubator;
6. Trigger a 9-1-1 call if a facility does not respond within a reasonable amount of time after a child is placed in the facility's incubator.

(E) Operating policies, supervision, and maintenance requirements for an incubator, including requirements that only a peace officer, emergency medical service worker, or hospital employee supervise the incubator and take custody of a child placed in it;

(F) Qualifications for persons to install incubators;
(G) Procedures and forms for the registration of qualified incubator installers;
(H) Costs for registering and regulating incubators and fees to cover those costs;
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(I) Creating and posting signs to be placed near or on incubators to provide information about using them;
(J) Enforcement of and remedies for violations for failure to comply with the requirements governing incubators;
(K) Any other requirement the department considers necessary to ensure the safety and welfare of a child placed in an incubator.

2151.3535 Jobs and family services to distribute forms.

(A) The director of job and family services shall distribute the medical information forms and written materials promulgated under section 2151.3534 of the Revised Code to entities permitted to receive a deserted child, to public children services agencies, and to other public or private agencies that, in the discretion of the director, are best able to disseminate the forms and materials to the persons who are most in need of the forms and materials.

The department of job and family services shall develop an educational plan, in collaboration with the Ohio family and children first cabinet council, for informing at-risk populations who are most likely to voluntarily deliver a child under section 2151.3516 of the Revised Code concerning the provisions of sections 2151.3516 to 2151.3535 of the Revised Code.

(B) If the department of job and family services determines that money in the putative father registry fund created under section 2101.16 of the Revised Code is more than is needed to perform its duties related to the putative father registry, the department may use surplus moneys in the fund for costs related to the distribution of forms and materials pursuant to this section.

3701-86-01 Registration, renewal of registration, annual report of compliance, and voluntary termination of a registration for newborn safety incubator locations.

(A) Prior to utilizing an installed newborn safety incubator, each law enforcement agency, hospital, or emergency medical service organization that has a newborn safety incubator installed at a location shall register with the Ohio department of health. This registration shall include:

(1) A completed “Newborn Safety Incubator - Location” registration form obtained from the Ohio department of health;
(2) An attestation of compliance, signed by the chief operating officer, chief executive officer, or administrator for the location where the newborn safety incubator is installed, affirming compliance with the applicable provisions of this chapter; and
(3) A nonrefundable registration fee of five hundred dollars made payable to the “Treasurer, State of Ohio.”

(B) The registration of a newborn safety incubator shall be valid for a period of three years from the initial date of registration.

(C) Each law enforcement agency, hospital, or emergency medical service organization that has a newborn safety incubator installed at a location shall submit an annual attestation of compliance affirming the location's continuing compliance with the rules set forth in Chapter 3701-86 of the Administrative Code. The form shall be submitted to the Ohio department of health within thirty days of the anniversary of the initial or previous renewal registration date.

(D) Every three years, each law enforcement agency, hospital, or emergency medical service organization that has a registered newborn safety incubator installed shall submit a renewal registration to the Ohio department of health within thirty days of the initial date of registration or the date of previous the previous registration renewal. This renewal registration shall include:
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(1) A completed “Newborn Safety Incubator - Location” registration form obtained from the Ohio department of health;

(2) An attestation of compliance signed by the chief operating officer, chief executive officer, or administrator for the location where the newborn safety incubator is installed, affirming compliance with the applicable provisions of this chapter; and

(3) A nonrefundable registration fee of five hundred dollars made payable to the “Treasurer, State of Ohio.”

(E) The director of the Ohio department of health may, at any time, request additional information that the director determines to be necessary to assess compliance with the applicable criteria, standards, and requirements established by section 2151.3532 of the Revised Code and Chapter 3701-86 of the Administrative Code. The law enforcement agency, hospital, or emergency medical service organization shall submit any additional information requested by the director within thirty days of the director’s request. The director may require any additional information requested to be submitted in less than thirty days if health or safety is of concern.

(F) A law enforcement agency, hospital, or emergency medical service organization that has a newborn safety incubator installed may choose to voluntarily terminate their registration by doing the following:

(1) Removing the newborn safety incubator from use by locking the access portal door and removing all signage for the newborn safety incubator; and

(2) Notifying the Ohio department of health within seven days of removing the newborn safety incubator from use.

3701-86-02 Registration of installers.

(A) Only the following individual’s may register with the Ohio department of health to perform the installation of the access portal door and alarm system components of a newborn safety incubator:

(1) Access portal door installers shall be a county or city licensed general contractor. The licensed general contractor maintains ultimate responsibility for all work performed in the process of the construction of the access portal door by employees and subcontractors.

(2) Access portal door alarm system installers shall be:

(a) A licensed electrical contractor; or

(b) A telecommunications installation professional.

(B) Prior to engaging in the installation of newborn safety incubator access portal door or alarm system, the individual’s authorized in paragraph (A) of this rule, shall register with the department of health. This registration shall include:

(1) A completed “Newborn Safety Incubator - Installer” registration form obtained from the Ohio department of health;

(2) Documentation of occupational license as a general contractor, electrical contractor, or of employment as a telecommunications installation professional; and

(3) A nonrefundable registration fee of two hundred fifty dollars made payable to the “Treasurer, State of Ohio.”

(C) A list of registered installers will be published to the Ohio department of health website.

(D) Registered installers may voluntarily terminate their registration and have their information removed from the list of registered installers by providing written notice to the Ohio department of health.

(E) Any individual who has voluntarily terminated their registration as an installer will be required to complete another registration with the Ohio department of health in accordance with
paragraph (B) of this rule prior to recommencing any action associated with the installation of a newborn safety incubator access portal or alarm system.

**3701-86-03 Location, environment and supervision of a newborn safety incubator.**

(A) In accordance with section 2151.3517 of the Revised Code, newborn safety incubators shall only be installed at locations of the following entities:

(1) Law enforcement agency;
(2) Hospital registered pursuant to section 3701.07 of the Revised Code; or
(3) Emergency medical service organization.

(B) Each location where a newborn safety incubator is installed shall have at least one individual authorized by section 2151.3517 of the Revised Code and outlined in paragraph (F) of this rule present and on duty in the facility at all times, twenty four hours a day, seven days a week to take possession of a surrendered child.

(C) Each location where a newborn safety incubator is installed shall post signage that clearly identifies the newborn safety incubator access portal door and provides both written and pictorial instruction to the surrendering parent to:

(1) Open the access portal door;
(2) Place the infant inside the medical bassinet; and
(3) Close the access portal door to engage the lock.

(D) The newborn safety incubator access portal door shall only be installed:

(1) On an exterior wall of an authorized facility listed in paragraph (A) of this rule that:
   (a) Ensures anonymity of the surrendering parent; and
   (b) Provides access to an area within the interior of the building that provides:
      (i) A climate controlled environment, including temperature control within the range of seventy-one to eighty-one degrees; and
      (ii) Air circulation that is free from pollutants, exhaust, chemical fumes, and smoke.
(2) In a manner that provides unencumbered access from the exterior of the building through the access portal door for the surrender of the child into the medical bassinet:

(E) The placement of the newborn safety incubator access portal door and medical bassinet within the interior of the building shall provide unencumbered access to the medical bassinet for an authorized individual, as outlined in paragraph (F) of this rule, responding to the alarm notification that a child has been surrendered into the newborn safety incubator.

(F) In accordance with section 2151.3517 of the Revised Code, only the following persons, while acting in an official capacity, shall take possession of a child who is thirty days old or younger, from a newborn safety incubator:

(1) A peace officer on behalf of the law enforcement agency that employs the officer;
(2) A hospital employee on behalf of the hospital that has granted the person privilege to practice at the hospital or that employs the person; or
(3) An emergency medical service worker on behalf of the emergency medical service organization that employs the worker or for which the worker provides services.

(G) Upon taking possession of a surrendered child from a newborn safety incubator, the law enforcement agency, hospital, or emergency medical service organization shall act in accordance with the requirements of section 2151.3517 of the Revised Code.

**3701-86-04 Installation of a newborn safety incubator access portal and newborn safety incubator.**

(A) The access portal door to the newborn safety incubator shall be installed by a licensed general contractor registered with the Ohio department of health in accordance with rule 3701-86-02 of the Administrative Code.
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(1) The access portal door shall:
(a) Lock automatically upon closure;
(b) May only be unlocked from the interior of the building;
(c) Trigger a series of alarms that, at a minimum, include:
   (i) An audible alarm triggered to a central location within the facility one minute after the
       opening of the access portal door; and
   (ii) An automatic call to 911 triggered from the alarm system if the alarm is not turned off
       from within the facility one minute of the commencement of the initial alarm.
(2) The access portal door alarm shall only be capable of being turned off from within the
    facility once a response is made to the newborn safety incubator.

(B) The access portal door alarm shall be:
(1) Wired into the existing structure's electrical or telecommunications system.
   (a) If wired into the structure's existing electrical system:
      (i) Be in compliance with the “National Electric Code” and “National Fire Code/National
          Fire Protection Agency” standards, if applicable;
      (ii) Be installed by a licensed electrical contractor registered with the Ohio department of
          health in accordance with rule 3701-86-02 of the Administrative Code; and
      (iii) If the facility has a secondary or back-up power supply, be wired into the secondary
          or back-up power supply to ensure continued operation of the alarm system during outages
          of the structure's primary power supply.
   (b) If wired into the structure's existing telecommunications network, installed by a
      telecommunications installation professional registered with the Ohio department of health in
      accordance with rule 3701-86-02 of the Administrative Code.
(2) Tested following installation to ensure the activation of the audible, 911, and
    disarming components of the system; and
(3) Tested at a minimum of once each quarter to ensure continued functionality.
   (a) Documentation of the required testing shall be maintained onsite by the location as
       long as the newborn safety incubator remains registered at the location; and
   (b) Documentation of the required testing shall be made available to the director upon
       request.

(C) Each newborn safety incubator shall:
(1) Be a medical bassinet in compliance with 21 CFR 880.5145 with the exception of
    bassinet wheels, which must be removed for installation in compliance with paragraph (C)(2) of
    this rule;
(2) Have the supporting frame of the medical bassinet physically anchored to a position
    that aligns the plastic basket or bed portion of the bassinet with the wall directly beneath the
    access portal door and prevents movement of the unit as a whole; and
(3) Provide a safe sleep environment. For the purpose of this rule, a safe sleep
    environment means the medical bassinet includes:
       (a) A firm flat bassinet mattress;
       (b) A bassinet mattress sheet that fits snugly on a mattress and overlaps the mattress so
           it cannot be dislodged by pulling on the corner of the sheet; and
       (c) Is free from any bedding, including pillows, bumpers, and blankets.

3701-86-05 Sanitation of a newborn safety incubator.

(A) The newborn safety incubator shall be checked at a minimum of twice daily for
    debris.
(B) The newborn safety incubator shall be cleaned at least:
   (1) Weekly; and
   (2) After any child surrender.
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(C) The cleaning of the bassinet shall include:
(1) An inspection for breaks in integrity that would impair either cleaning or disinfection/sterilization; and
(2) Sanitization of the basket or bed portion of the bassinet with an EPA-registered hospital disinfectant (e.g., phenolics) using the label's safety precautions and use directions. The surfaces of the bassinet shall be rinsed with water after sanitizing and then dried before being returned to use.
(D) Documentation of the required cleaning and sanitization shall be maintained onsite by the location as long as the newborn safety incubator remains registered at the location. Documentation shall be made available to the director upon request.

3701-86-06 Compliance actions, revocation of registration, and unregistered installation of a newborn safety incubator.

(A) When the director of the Ohio department of health determines that a failure to comply with the rules set forth in Chapter 3701-86 the Administrative Code exists, the entity or individual may be subject to enforcement in accordance with Chapter 119 of the Revised Code as follows:
(1) A fine of five hundred dollars may be imposed for:
(a) Failure of an authorized location to register or renew a registration for a newborn safety incubator as required by paragraph (A) of rule 3701-86-01 of the Administrative Code;
(b) Failure of an authorized location to submit the required annual attestation of compliance as required by paragraph (B) of rule 3701-86-01 of the Administrative Code;
(c) Use of an unregistered installer by an authorized location;
(d) Failure of an installer, as authorized in paragraph (A) of rule 3701-86-02 of the Administrative Code, to register in accordance with paragraph (B) of rule 3701-86-02 of the Administrative Code; or
(e) Failure of an authorized entity or installer to comply with any of the additional requirements set forth in Chapter 3701-86 of the Administrative Code.
(2) Following the imposition of an initial five hundred dollar penalty, a fine of one thousand dollars may be imposed for any continued non-compliance with any of the requirements set forth in Chapter 3701-86 of the Administrative Code.
(3) A fine of five thousand dollars shall be imposed upon any entity or individual for the installation of a newborn safety incubator at an unauthorized location.
(4) The director may revoke the registration of an authorized location or an installer for continued non-compliance with any of the requirements set forth in Chapter 3701-86 of the Administrative Code.
(5) Notwithstanding section 119.06 of the Revised Code, if the director determines that immediate action is necessary to protect the health and safety of infants surrendered to a newborn safety incubator, the director may issue a cease and desist order pursuant to this chapter prior to affording the location or installer the opportunity for a hearing. If the director does so, the director shall issue the order in writing and cause it to be delivered in accordance with section 119.07 of the Revised Code.
(B) The imposition of penalties imposed under this rule may be appealed in accordance with Chapter 119 of the Revised Code.
(C) If the department issues more than one order, any administrative hearing resulting from such orders may be consolidated into one hearing. Consolidation of the hearings does not affect any effective dates prescribed in the orders.
(D) All amounts collected from the imposition of fines under pursuant to this rule, shall be deposited into the state treasury to the credit of the general operations fund created under
section 3701.83 of the Revised Code for use in the administration and enforcement of this chapter.

3701.63 ODH to develop shaken baby syndrome education materials.

(A) As used in this section and sections 3701.64, 3701.66, and 3701.67 of the Revised Code:
(1) “Child day-care center,” “type A family day-care home,” and “licensed type B family day-care home” have the same meanings as in section 5104.01 of the Revised Code.
(2) “Child care facility” means a child day-care center, a type A family day-care home, or a licensed type B family day-care home.
(3) “Foster caregiver” has the same meaning as in section 5103.02 of the Revised Code.
(4) “Freestanding birthing center” has the same meaning as in section 3702.141 of the Revised Code.
(5) “Hospital” means a hospital classified pursuant to rules adopted under section 3701.07 of the Revised Code as a general hospital or children’s hospital and to which either of the following applies:
(a) The hospital has a maternity unit.
(b) The hospital receives care infants who have been transferred to it from other facilities and who have never been discharged to their residences following birth.
(6) “Infant” means a child who is less than one year of age.
(7) “Maternity unit” means the distinct portion of a hospital licensed as a maternity unit under Chapter 3711 of the Revised Code.
(8) “Other person responsible for the infant” includes a foster caregiver.
(9) “Parent” means either parent, unless the parents are separated or divorced or their marriage has been dissolved or annulled, in which case “parent” means the parent who is the residential parent and legal custodian of the child. “Parent” also means a prospective adoptive parent with whom a child is placed.
(10) “Shaken baby syndrome” means signs and symptoms, including, but not limited to, retinal hemorrhages in one or both eyes, subdural hematoma, or brain swelling, resulting from the violent shaking or the shaking and impacting of the head of an infant or small child.

(B) The director of health shall establish the shaken baby syndrome education program by doing all of the following:
(1) Developing educational materials that present readily comprehensible information on shaken baby syndrome;
(2) Making available on the department of health web site in an easily accessible format the educational materials developed under division (B)(1) of this section;
(3) Annually assessing the effectiveness of the shaken baby syndrome education program by doing all of the following:
(a) Evaluating the reports received pursuant to section 5101.135 of the Revised Code;
(b) Reviewing the content of the educational materials to determine if updates or improvements should be made;
(c) Reviewing the manner in which the educational materials are distributed, as described in section 3701.64 of the Revised Code, to determine if modifications to that manner should be made.

(C) In meeting the requirements under division (B) of this section, the director shall develop educational materials that, to the extent possible, minimize administrative or financial burdens on any of the entities or persons listed in section 3701.64 of the Revised Code.
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Part IV. Abandoned or Shaken Baby

3701.64 Shaken baby syndrome materials; immunity.

(A) A copy of the shaken baby syndrome educational materials developed under section 3701.63 of the Revised Code shall be distributed in the following manner:

1. By child birth educators and the staff of obstetricians' offices, to an expectant parent who uses their services;
2. By the staff of pediatric physicians' offices, to any of the following who use their services: an infant's parent, guardian, or other person responsible for the infant;
3. By the staff of a hospital or freestanding birthing center, to an infant's parent, guardian, or other person responsible for the infant, before the child is discharged from the facility to the infant's residence following birth;
4. By the staff of the help me grow program established pursuant to section 3701.61 of the Revised Code, to an infant's parent, guardian, or other person responsible for the infant, during home-visiting services conducted in accordance with that section;
5. By each child care facility operating in this state, to each of its employees;
6. By a public children services agency, when the agency has initial contact with an infant's parent, guardian, or other person responsible for the infant.

(B) An entity or person required to distribute educational materials pursuant to division (A) of this section is not liable for damages in a civil action for injury, death, or loss to person or property that allegedly arises from an act or omission associated with the dissemination of those educational materials unless the act or omission constitutes willful or wanton misconduct.

An entity or person required to distribute educational materials in accordance with division (A) of this section is not subject to criminal prosecution or, to the extent that a person is regulated under Title XLVII of the Revised Code, professional disciplinary action under that title, for an act or omission associated with the dissemination of those educational materials.

This division does not eliminate, limit, or reduce any other immunity or defense that an entity or person may be entitled to under Chapter 2744 of the Revised Code, or any other provision of the Revised Code, or the common law of this state.

3701.66 Infant sleep education.

(A) As used in this section, “sudden unexpected infant death” means the death of an infant that occurs suddenly and unexpectedly, the cause of which is not immediately obvious prior to investigation.

(B) The department of health shall establish the safe sleep education program by doing all of the following:

1. By not later than sixty days after March 19, 2015, developing educational materials that present readily comprehensible information on safe sleeping practices for infants and possible causes of sudden unexpected infant death;
2. Making available on the department's internet web site in an easily accessible format the educational materials developed under division (B)(1) of this section;
3. Providing annual training classes at no cost to individuals who provide safe sleep education to parents and infant caregivers who reside in the urban and rural communities specified under section 3701.142 of the Revised Code, including child care providers as defined in section 2151.011 of the Revised Code, hospital staff and volunteers, local health department staff, social workers, individuals who provide home visiting services, and community health workers;
4. Beginning in 2015, annually assessing the effectiveness of the safe sleep education program by evaluating the reports submitted by child fatality review boards to the department pursuant to section 307.626 of the Revised Code.
(C) In meeting the requirements under division (B) of this section, the department shall
develop educational materials that, to the extent possible, minimize administrative or financial
burdens on any of the entities or persons required by division (D) of this section to distribute the
materials.

(D) A copy of the safe sleep educational materials developed under this section shall be
distributed by entities and persons with and in the same manner as the shaken baby syndrome
educational materials are distributed pursuant to section 3701.64 of the Revised Code.

An entity or person required to distribute the educational materials is not liable for
damages in a civil action for injury, death, or loss to person or property that allegedly arises from
an act or omission associated with the dissemination of those educational materials unless the
act or omission constitutes willful or wanton misconduct.

An entity or person required to distribute the educational materials is not subject to
criminal prosecution or, to the extent that a person is regulated under Title XLVII of the Revised
Code, professional disciplinary action under that title, for an act or omission associated with the
dissemination of those educational materials.

This division does not eliminate, limit, or reduce any other immunity or defense that an
entity or person may be entitled to under Chapter 2744 of the Revised Code, or any other
provision of the Revised Code, or the common law of this state.

(E) Each entity or person that is required to distribute the educational materials and has
infants regularly sleeping at a facility or location under the entity's or person's control shall adopt
an internal infant safe sleep policy. The policy shall specify when and to whom educational
materials on infant safe sleep practices are to be delivered to individuals working or volunteering
at the facility or location and be consistent with the model internal infant safe sleep policy
adopted under division (F) of this section.

(F) The director of health shall adopt a model internal infant safe sleep policy for use by
entities and persons that must comply with division (E) of this section. The policy shall specify
safe infant sleep practices, include images depicting safe infant sleep practices, and specify
sample content for an infant safe sleep education program that entities and persons may use
when conducting new staff orientation programs.

3701.67 Infant safe sleep crib.

(A) As used in this section:
(1) “Contractor” means a person who provides personal services pursuant to a contract.
(2) “Critical access hospital” means a facility designated as a critical access hospital by
the director of health under section 3701.073 of the Revised Code.
(3) “Crib” includes a portable play yard or other suitable sleeping place.
(B) Each hospital and freestanding birthing center shall implement an infant safe sleep
screening procedure. The purpose of the procedure is to determine whether there will be a safe
crib for an infant to sleep in once the infant is discharged from the facility to the infant's
residence following birth. The procedure shall consist of questions that facility staff or volunteers
must ask the infant's parent, guardian, or other person responsible for the infant regarding the
infant's intended sleeping place and environment.

The director of health shall develop questions that facilities may use when implementing
the infant safe sleep screening procedure required by this division. The director may consult
with persons and government entities that have expertise in infant safe sleep practices when
developing the questions.

(C) If, prior to an infant's discharge from a facility to the infant's residence following birth,
a facility other than a critical access hospital or a facility identified under division (D) of this
section determines through the procedure implemented under division (B) of this section that
the infant is unlikely to have a safe crib at the infant's residence, the facility shall make a good
faith effort to arrange for the parent, guardian, or other person responsible for the infant to obtain a safe crib at no charge to that individual. In meeting this requirement, the facility may do any of the following:

(1) Obtain a safe crib with its own resources;
(2) Collaborate with or obtain assistance from persons or government entities that are able to procure a safe crib or provide money to purchase a safe crib;
(3) Refer the parent, guardian, or other person responsible for the infant to a person or government entity described in division (C)(2) of this section to obtain a safe crib free of charge from that source;
(4) If funds are available for the cribs for kids program or a successor program administered by the department of health, refer the parent, guardian, or other person responsible for the infant to a site, designated by the department for purposes of the program, at which a safe crib may be obtained at no charge.

If a safe crib is procured as described in division (C)(1), (2), or (3) of this section, the facility shall ensure that the crib recipient receives safe sleep education and crib assembly instructions from the facility or another source. If a safe crib is procured as described in division (C)(4) of this section, the department of health shall ensure that the cribs for kids program or a successor program administered by the department provides safe sleep education and crib assembly instructions to the recipient.

(D) The director of health shall identify the facilities in this state that are not critical access hospitals and are not served by a site described in division (C)(4) of this section. The director shall identify not less than annually the facilities that meet both criteria and notify those that do so.

(E) When a facility that is a hospital registers with the department of health under section 3701.07 of the Revised Code or a facility that is a freestanding birthing center renews its license in accordance with rules adopted under section 3702.30 of the Revised Code, the facility shall report the following information to the department in a manner the department prescribes:

(1) The number of safe cribs that the facility obtained and distributed by using its own resources as described in division (C)(1) of this section since the last time the facility reported this information to the department;
(2) The number of safe cribs that the facility obtained and distributed by collaborating with or obtaining assistance from another person or government entity as described in division (C)(2) of this section since the last time the facility reported this information to the department;
(3) The number of referrals that the facility made to a person or government entity as described in division (C)(3) of this section since the last time the facility reported this information to the department;
(4) The number of referrals that the facility made to a site designated by the department as described in division (C)(4) of this section since the last time the facility reported this information to the department;
(5) Demographic information specified by the director of health regarding the individuals to whom safe cribs were distributed as described in division (E)(1) or (2) of this section or for whom a referral described in division (E)(3) or (4) of this section was made;
(6) In the case of a critical access hospital or a facility identified under division (D) of this section, demographic information specified by the director of health regarding each parent, guardian, or other person responsible for the infant determined to be unlikely to have a safe crib at the infant's residence pursuant to the procedure implemented under division (B) of this section;
(7) Any other information collected by the facility regarding infant sleep environments and intended infant sleep environments that the director determines to be appropriate.

(F) The director of health shall prepare a written report that summarizes the information collected under division (E) of this section for the preceding twelve months, assesses whether
at-risk families are sufficiently being served by the crib distribution and referral system established by this section, makes suggestions for system improvements, and provides any other information the director considers appropriate for inclusion in the report. On completion, the report shall be submitted to the general assembly with, and in the same manner as, the report that the department of medicaid submits to the general assembly and joint medicaid oversight committee pursuant to section 5162.13 of the Revised Code. A copy of the report also shall be submitted to the governor.

(G) A facility, and any employee, contractor, or volunteer of a facility, that implements an infant safe sleep procedure in accordance with division (B) of this section is not liable for damages in a civil action for injury, death, or loss to person or property that allegedly arises from an act or omission associated with implementation of the procedure, unless the act or omission constitutes willful or wanton misconduct.

A facility, and any employee, contractor, or volunteer of a facility, that implements an infant safe sleep screening procedure in accordance with division (B) of this section is not subject to criminal prosecution or, to the extent that a person is regulated under Title XLVII of the Revised Code, professional disciplinary action under that title, for an act or omission associated with implementation of the procedure.

This division does not eliminate, limit, or reduce any other immunity or defense that a facility, or an employee, contractor, or volunteer of a facility, may be entitled to under Chapter 2744 of the Revised Code, or any other provision of the Revised Code, or the common law of this state.

(H) A facility, and any employee, contractor, or volunteer of a facility, is neither liable for damages in a civil action, nor subject to criminal prosecution, for injury, death, or loss to person or property that allegedly arises from a crib obtained by a parent, guardian, or other person responsible for the infant as a result of any action the facility, employee, contractor, or volunteer takes to comply with division (C) of this section.

The immunity provided by this division does not require compliance with division (D) of section 2305.37 of the Revised Code.

3701.671 ODH crib grant report.

The director of health shall require each recipient of a grant the department of health administers that pertains to safe crib procurement to report annually to the department both of the following:

(A) Demographic information specified by the director of health regarding the individuals to whom safe cribs were distributed;

(B) If known, the extent to which distributed cribs are being used.

3701.69 Down Syndrome information.

(A)(1) The department of health shall create a Down syndrome information sheet that includes all of the following:

(a) A description of Down syndrome, including its causes, effects on development, and potential complications;

(b) Diagnostic tests;

(c) Options for treatment and therapy;

(d) Contact information for local, state, and national organizations that provide Down syndrome educational and support services and programs.

(2) With respect to the medical information included in the information sheet, the department shall include only information that is current and based on medical evidence.
(3) The department shall periodically review and update the information sheet and shall make it available on the department's internet web site.

(B) If a patient under the care of any of the following health care professionals or facilities receives either a test result indicating Down syndrome or a prenatal or postnatal diagnosis of Down syndrome, the health care professional or facility shall provide to the patient or the patient's representative a copy of the information sheet created under division (A) of this section:

(1) A physician authorized under Chapter 4731 of the Revised Code to practice medicine and surgery or osteopathic medicine and surgery;
(2) A certified nurse-midwife who holds a certificate of authority issued under Chapter 4723 of the Revised Code;
(3) A genetic counselor licensed under Chapter 4778 of the Revised Code;
(4) A hospital registered under section 3701.07 of the Revised Code;
(5) A maternity unit, newborn care nursery, or maternity home licensed under Chapter 3711 of the Revised Code;
(6) A freestanding birthing center licensed under section 3702.30 of the Revised Code.
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Autopsy, Coroner, Disposition of Body

9.15 Burial expenses of unclaimed indigent patient.

As used in this section, “legal residence” means a permanent place of abode used or occupied as living quarters at the time of a person's death, including a nursing home, hospital, or other care facility.

When the body of a dead person is found in a township or municipal corporation, and such person was not an inmate of a correctional, benevolent, or charitable institution of this state, and the body is not claimed by any person for private interment or cremation at the person's own expense, or delivered for the purpose of medical or surgical study or dissection in accordance with section 1713.34 of the Revised Code, it shall be disposed of as follows:

(A) If the person was a legal resident of the county, the proper officers of the township or municipal corporation in which the person's body was found shall cause it to be buried or cremated at the expense of the township or municipal corporation in which the person had a legal residence at the time of death.

(B) If the person had a legal residence in any other county of the state at the time of death, the superintendent of the county home of the county in which such body was found shall cause it to be buried or cremated at the expense of the township or municipal corporation in which the person had a legal residence at the time of death.

(C) If the person was an inmate of a correctional institution of the county or a patient or resident of a benevolent institution of the county, the person had no legal residence in the state, or the person's legal residence is unknown, the superintendent shall cause the person to be buried or cremated at the expense of the county.

Such officials shall provide, at the grave of the person or, if the person's cremated remains are buried, at the grave of the person's cremated remains, a metal, stone, or concrete marker on which the person's name and age, if known, and date of death shall be inscribed.

A political subdivision is not relieved of its duty to bury or cremate a person at its expense under this section when the body is claimed by an indigent person. As used in this section, “indigent person” means a person whose income does not exceed one hundred fifty per cent of the federal poverty line, as revised annually by the United States department of health and human services in accordance with section 673(2) of the “Omnibus Budget Reconciliation Act of 1981,” 95 Stat. 511, 42 U.S.C. 9902, as amended, for a family size equal to the size of the person's family.

313.12 Death by criminal or violent means, casualty, suicide, suspicious or unusual manner; report to coroner.

(A) When any person dies as a result of criminal or other violent means, by casualty, by suicide, or in any suspicious or unusual manner, when any person, including a child under two years of age, dies suddenly when in apparent good health, or when any person with a developmental disability dies regardless of the circumstances, the physician called in attendance, or any member of an ambulance service, emergency squad, or law enforcement agency who obtains knowledge thereof arising from the person's duties, shall immediately notify the office of the coroner of the known facts concerning the time, place, manner, and
circumstances of the death, and any other information that is required pursuant to sections 313.01 to 313.22 of the Revised Code. In such cases, if a request is made for cremation, the funeral director called in attendance shall immediately notify the coroner.

(B) As used in this section, “developmental disability” has the same meaning as in section 5123.01 of the Revised Code.

5123.01 Developmental disabilities definition.

[Editor’s Note: This version of the statute is effective until 12/31/2017. The version effective subsequently is included next.]

As used in this chapter:

(A) “Chief medical officer” means the licensed physician appointed by the managing officer of an institution for persons with intellectual disabilities with the approval of the director of developmental disabilities to provide medical treatment for residents of the institution.

(B) “Chief program director” means a person with special training and experience in the diagnosis and management of persons with developmental disabilities, certified according to division (C) of this section in at least one of the designated fields, and appointed by the managing officer of an institution for persons with intellectual disabilities with the approval of the director to provide habilitation and care for residents of the institution.

(C) “Comprehensive evaluation” means a study, including a sequence of observations and examinations, of a person leading to conclusions and recommendations formulated jointly, with dissenting opinions if any, by a group of persons with special training and experience in the diagnosis and management of persons with developmental disabilities, which group shall include individuals who are professionally qualified in the fields of medicine, psychology, and social work, together with such other specialists as the individual case may require.

(D) “Education” means the process of formal training and instruction to facilitate the intellectual and emotional development of residents.

(E) “Habilitation” means the process by which the staff of the institution assists the resident in acquiring and maintaining those life skills that enable the resident to cope more effectively with the demands of the resident's own person and of the resident's environment and in raising the level of the resident's physical, mental, social, and vocational efficiency. Habilitation includes but is not limited to programs of formal, structured education and training.

(F) “Health officer” means any public health physician, public health nurse, or other person authorized or designated by a city or general health district.

(G) “Home and community-based services” means medicaid-funded home and community-based services specified in division (A)(1) of section 5166.20 of the Revised Code provided under the medicaid waiver components the department of developmental disabilities administers pursuant to section 5166.21 of the Revised Code. Except as provided in section 5123.0412 of the Revised Code, home and community-based services provided under the medicaid waiver component known as the transitions developmental disabilities waiver are to be considered to be home and community-based services for the purposes of this chapter, and Chapters 5124 and 5126 of the Revised Code, only to the extent, if any, provided by the contract required by section 5166.21 of the Revised Code regarding the waiver.

(H) “ICF/IID” has the same meaning as in section 5124.01 of the Revised Code.

(I) “Indigent person” means a person who is unable, without substantial financial hardship, to provide for the payment of an attorney and for other necessary expenses of legal representation, including expert testimony.

(J) “Institution” means a public or private facility, or a part of a public or private facility, that is licensed by the appropriate state department and is equipped to provide residential habilitation, care, and treatment for persons with intellectual disabilities.
(K) “Licensed physician” means a person who holds a valid certificate issued under Chapter 4731 of the Revised Code authorizing the person to practice medicine and surgery or osteopathic medicine and surgery, or a medical officer of the government of the United States while in the performance of the officer's official duties.

(L) “Managing officer” means a person who is appointed by the director of developmental disabilities to be in executive control of an institution under the jurisdiction of the department of developmental disabilities.

(M) “Medicaid case management services” means case management services provided to an individual with a developmental disability that the state medicaid plan requires.

(N) “Intellectual disability” means a disability characterized by having significantly subaverage general intellectual functioning existing concurrently with deficiencies in adaptive behavior, manifested during the developmental period.

(O) “Person with an intellectual disability subject to institutionalization by court order” means a person eighteen years of age or older with at least a moderate level of intellectual disability and in relation to whom, because of the person's disability, either of the following conditions exists:

1. The person represents a very substantial risk of physical impairment or injury to self as manifested by evidence that the person is unable to provide for and is not providing for the person’s most basic physical needs and that provision for those needs is not available in the community;

2. The person needs and is susceptible to significant habilitation in an institution.

(P) “Moderate level of intellectual disability” means the condition in which a person, following a comprehensive evaluation, is found to have at least moderate deficits in overall intellectual functioning, as indicated by a full-scale intelligence quotient test score of fifty-five or below, and at least moderate deficits in adaptive behavior, as determined in accordance with the criteria established in the fifth edition of the diagnostic and statistical manual of mental disorders published by the American psychiatric association.

(Q) “Developmental disability” means a severe, chronic disability that is characterized by all of the following:

1. It is attributable to a mental or physical impairment or a combination of mental and physical impairments, other than a mental or physical impairment solely caused by mental illness, as defined in division (A) of section 5122.01 of the Revised Code.

2. It is manifested before age twenty-two.

3. It is likely to continue indefinitely.

4. It results in one of the following:

   a. In the case of a person under three years of age, at least one developmental delay, as defined in rules adopted under section 5123.011 of the Revised Code, or a diagnosed physical or mental condition that has a high probability of resulting in a developmental delay, as defined in those rules;

   b. In the case of a person at least three years of age but under six years of age, at least two developmental delays, as defined in rules adopted under section 5123.011 of the Revised Code;

   c. In the case of a person six years of age or older, a substantial functional limitation in at least three of the following areas of major life activity, as appropriate for the person’s age: self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, and, if the person is at least sixteen years of age, capacity for economic self-sufficiency.

5. It causes the person to need a combination and sequence of special, interdisciplinary, or other type of care, treatment, or provision of services for an extended period of time that is individually planned and coordinated for the person.

“Developmental disability” includes intellectual disability.
(R) “State institution” means an institution that is tax-supported and under the jurisdiction of the department of developmental disabilities.

(S) “Residence” and “legal residence” have the same meaning as “legal settlement,” which is acquired by residing in Ohio for a period of one year without receiving general assistance prior to July 17, 1995, under former Chapter 5113 of the Revised Code, financial assistance under Chapter 5115 of the Revised Code, or assistance from a private agency that maintains records of assistance given. A person having a legal settlement in the state shall be considered as having legal settlement in the assistance area in which the person resides. No adult person coming into this state and having a spouse or minor children residing in another state shall obtain a legal settlement in this state as long as the spouse or minor children are receiving public assistance, care, or support at the expense of the other state or its subdivisions. For the purpose of determining the legal settlement of a person who is living in a public or private institution or in a home subject to licensing by the department of job and family services, the department of mental health and addiction services, or the department of developmental disabilities, the residence of the person shall be considered as though the person were residing in the county in which the person was living prior to the person’s entrance into the institution or home. Settlement once acquired shall continue until a person has been continuously absent from Ohio for a period of one year or has acquired a legal residence in another state. A woman who marries a man with legal settlement in any county immediately acquires the settlement of her husband. The legal settlement of a minor is that of the parents, surviving parent, sole parent, parent who is designated the residential parent and legal custodian by a court, other adult having permanent custody awarded by a court, or guardian of the person of the minor, provided that:

(1) A minor female who marries shall be considered to have the legal settlement of her husband and, in the case of death of her husband or divorce, she shall not thereby lose her legal settlement obtained by the marriage.

(2) A minor male who marries, establishes a home, and who has resided in this state for one year without receiving general assistance prior to July 17, 1995, under former Chapter 5113 of the Revised Code, financial assistance under Chapter 5115 of the Revised Code, or assistance from a private agency that maintains records of assistance given shall be considered to have obtained a legal settlement in this state.

(3) The legal settlement of a child under eighteen years of age who is in the care or custody of a public or private child caring agency shall not change if the legal settlement of the parent changes until after the child has been in the home of the parent for a period of one year.

No person, adult or minor, may establish a legal settlement in this state for the purpose of gaining admission to any state institution.

(T)(1) “Resident” means, subject to division (T)(2) of this section, a person who is admitted either voluntarily or involuntarily to an institution or other facility pursuant to section 2945.39, 2945.40, 2945.401, or 2945.402 of the Revised Code subsequent to a finding of not guilty by reason of insanity or incompetence to stand trial or under this chapter who is under observation or receiving habilitation and care in an institution.

(2) “Resident” does not include a person admitted to an institution or other facility under section 2945.39, 2945.40, 2945.401, or 2945.402 of the Revised Code to the extent that the reference in this chapter to resident, or the context in which the reference occurs, is in conflict with any provision of sections 2945.37 to 2945.402 of the Revised Code.

(U) “Respondent” means the person whose detention, commitment, or continued commitment is being sought in any proceeding under this chapter.

(V) “Working day” and “court day” mean Monday, Tuesday, Wednesday, Thursday, and Friday, except when such day is a legal holiday.

(W) “Prosecutor” means the prosecuting attorney, village solicitor, city director of law, or similar chief legal officer who prosecuted a criminal case in which a person was found not guilty.
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by reason of insanity, who would have had the authority to prosecute a criminal case against a person if the person had not been found incompetent to stand trial, or who prosecuted a case in which a person was found guilty.

(X) “Court” means the probate division of the court of common pleas.

(Y) “Supported living” and “residential services” have the same meanings as in section 5126.01 of the Revised Code.

5123.01 Developmental disabilities definition.

[Editor’s Note: This version of the statute is effective 12/31/2017. The version effective prior to that date is included on the prior pages.]

As used in this chapter:

(A) “Chief medical officer” means the licensed physician appointed by the managing officer of an institution for persons with intellectual disabilities with the approval of the director of developmental disabilities to provide medical treatment for residents of the institution.

(B) “Chief program director” means a person with special training and experience in the diagnosis and management of persons with developmental disabilities, certified according to division (C) of this section in at least one of the designated fields, and appointed by the managing officer of an institution for persons with intellectual disabilities with the approval of the director to provide habilitation and care for residents of the institution.

(C) “Comprehensive evaluation” means a study, including a sequence of observations and examinations, of a person leading to conclusions and recommendations formulated jointly, with dissenting opinions if any, by a group of persons with special training and experience in the diagnosis and management of persons with developmental disabilities, which group shall include individuals who are professionally qualified in the fields of medicine, psychology, and social work, together with such other specialists as the individual case may require.

(D) “Education” means the process of formal training and instruction to facilitate the intellectual and emotional development of residents.

(E) “Habilitation” means the process by which the staff of the institution assists the resident in acquiring and maintaining those life skills that enable the resident to cope more effectively with the demands of the resident's own person and of the resident's environment and in raising the level of the resident's physical, mental, social, and vocational efficiency. Habilitation includes but is not limited to programs of formal, structured education and training.

(F) “Health officer” means any public health physician, public health nurse, or other person authorized or designated by a city or general health district.

(G) “Home and community-based services” means medicaid-funded home and community-based services specified in division (A)(1) of section 5166.20 of the Revised Code provided under the medicaid waiver components the department of developmental disabilities administers pursuant to section 5166.21 of the Revised Code. Except as provided in section 5123.0412 of the Revised Code, home and community-based services provided under the medicaid waiver component known as the transitions developmental disabilities waiver are to be considered to be home and community-based services for the purposes of this chapter, and Chapters 5124 and 5126 of the Revised Code, only to the extent, if any, provided by the contract required by section 5166.21 of the Revised Code regarding the waiver.

(H) “ICF/IID” has the same meaning as in section 5124.01 of the Revised Code.

(I) “Indigent person” means a person who is unable, without substantial financial hardship, to provide for the payment of an attorney and for other necessary expenses of legal representation, including expert testimony.

(J) “Institution” means a public or private facility, or a part of a public or private facility, that is licensed by the appropriate state department and is equipped to provide residential
habilitation, care, and treatment for persons with intellectual disabilities.

(K) “Licensed physician” means a person who holds a valid certificate issued under Chapter 4731 of the Revised Code authorizing the person to practice medicine and surgery or osteopathic medicine and surgery, or a medical officer of the government of the United States while in the performance of the officer’s official duties.

(L) “Managing officer” means a person who is appointed by the director of developmental disabilities to be in executive control of an institution under the jurisdiction of the department of developmental disabilities.

(M) “Medicaid case management services” means case management services provided to an individual with a developmental disability that the state medicaid plan requires.

(N) “Intellectual disability” means a disability characterized by having significantly subaverage general intellectual functioning existing concurrently with deficiencies in adaptive behavior, manifested during the developmental period.

(O) “Person with an intellectual disability subject to institutionalization by court order” means a person eighteen years of age or older with at least a moderate level of intellectual disability and in relation to whom, because of the person’s disability, either of the following conditions exists:

1. The person represents a very substantial risk of physical impairment or injury to self as manifested by evidence that the person is unable to provide for and is not providing for the person’s most basic physical needs and that provision for those needs is not available in the community;

2. The person needs and is susceptible to significant habilitation in an institution.

(P) “Moderate level of intellectual disability” means the condition in which a person, following a comprehensive evaluation, is found to have at least moderate deficits in overall intellectual functioning, as indicated by a full-scale intelligence quotient test score of fifty-five or below, and at least moderate deficits in adaptive behavior, as determined in accordance with the criteria established in the fifth edition of the diagnostic and statistical manual of mental disorders published by the American psychiatric association.

(Q) “Developmental disability” means a severe, chronic disability that is characterized by all of the following:

1. It is attributable to a mental or physical impairment or a combination of mental and physical impairments, other than a mental or physical impairment solely caused by mental illness, as defined in division (A) of section 5122.01 of the Revised Code.

2. It is manifested before age twenty-two.

3. It is likely to continue indefinitely.

4. It results in one of the following:

   a. In the case of a person under three years of age, at least one developmental delay, as defined in rules adopted under section 5123.011 of the Revised Code, or a diagnosed physical or mental condition that has a high probability of resulting in a developmental delay, as defined in those rules;

   b. In the case of a person at least three years of age but under six years of age, at least two developmental delays, as defined in rules adopted under section 5123.011 of the Revised Code;

   c. In the case of a person six years of age or older, a substantial functional limitation in at least three of the following areas of major life activity, as appropriate for the person’s age: self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, and, if the person is at least sixteen years of age, capacity for economic self-sufficiency.

5. It causes the person to need a combination and sequence of special, interdisciplinary, or other type of care, treatment, or provision of services for an extended period of time that is individually planned and coordinated for the person.
“Developmental disability” includes intellectual disability.

(R) “State institution” means an institution that is tax-supported and under the jurisdiction of the department of developmental disabilities.

(S) “Residence” and “legal residence” have the same meaning as “legal settlement,” which is acquired by residing in Ohio for a period of one year without receiving general assistance prior to July 17, 1995, under former Chapter 5113 of the Revised Code, without receiving financial assistance prior to December 31, 2017, under former Chapter 5115 of the Revised Code, or assistance from a private agency that maintains records of assistance given.

A person having a legal settlement in the state shall be considered as having legal settlement in the assistance area in which the person resides. No adult person coming into this state and having a spouse or minor children residing in another state shall obtain a legal settlement in this state as long as the spouse or minor children are receiving public assistance, care, or support at the expense of the other state or its subdivisions. For the purpose of determining the legal settlement of a person who is living in a public or private institution or in a home subject to licensing by the department of job and family services, the department of mental health and addiction services, or the department of developmental disabilities, the residence of the person shall be considered as though the person were residing in the county in which the person was living prior to the person’s entrance into the institution or home. Settlement once acquired shall continue until a person has been continuously absent from Ohio for a period of one year or has acquired a legal residence in another state. A woman who marries a man with legal settlement in any county immediately acquires the settlement of her husband. The legal settlement of a minor is that of the parents, surviving parent, sole parent, parent who is designated the residential parent and legal custodian by a court, other adult having permanent custody awarded by a court, or guardian of the person of the minor, provided that:

(1) A minor female who marries shall be considered to have the legal settlement of her husband and, in the case of death of her husband or divorce, she shall not thereby lose her legal settlement obtained by the marriage.

(2) A minor male who marries, establishes a home, and who has resided in this state for one year without receiving general assistance prior to July 17, 1995, under former Chapter 5113 of the Revised Code or assistance from a private agency that maintains records of assistance given shall be considered to have obtained a legal settlement in this state.

(3) The legal settlement of a child under eighteen years of age who is in the care or custody of a public or private child caring agency shall not change if the legal settlement of the parent changes until after the child has been in the home of the parent for a period of one year.

No person, adult or minor, may establish a legal settlement in this state for the purpose of gaining admission to any state institution.

(T)(1) “Resident” means, subject to division (T)(2) of this section, a person who is admitted either voluntarily or involuntarily to an institution or other facility pursuant to section 2945.39, 2945.40, 2945.401, or 2945.402 of the Revised Code subsequent to a finding of not guilty by reason of insanity or incompetence to stand trial or under this chapter who is under observation or receiving habilitation and care in an institution.

(2) “Resident” does not include a person admitted to an institution or other facility under section 2945.39, 2945.40, 2945.401, or 2945.402 of the Revised Code to the extent that the reference in this chapter to resident, or the context in which the reference occurs, is in conflict with any provision of sections 2945.37 to 2945.402 of the Revised Code.

(U) “Respondent” means the person whose detention, commitment, or continued commitment is being sought in any proceeding under this chapter.

(V) “Working day” and “court day” mean Monday, Tuesday, Wednesday, Thursday, and Friday, except when such day is a legal holiday.

(W) “Prosecutor” means the prosecuting attorney, village solicitor, city director of law, or similar chief legal officer who prosecuted a criminal case in which a person was found not guilty.
by reason of insanity, who would have had the authority to prosecute a criminal case against a
person if the person had not been found incompetent to stand trial, or who prosecuted a case in
which a person was found guilty.

(X) “Court” means the probate division of the court of common pleas.
(Y) “Supported living” and “residential services” have the same meanings as in section
5126.01 of the Revised Code.

1713.34 Possession of an unclaimed or unidentified body.

Superintendents of city hospitals, directors or superintendents of city infirmaries, county
homes, or other charitable institutions, directors or superintendents of workhouses, founded and
supported in whole or in part at public expense, superintendents or managing officers of state
benevolent institutions, boards of township trustees, sheriffs, or coroners, in possession of
bodies not claimed or identified, or which must be buried at the expense of the state, county, or
township, before burial, shall notify the professor of anatomy in a college which by its charter is
empowered to teach anatomy, or the secretary of the board of embalmers and funeral directors
of this state, of the fact that such bodies are being so held. If after a period of thirty-six hours the
body has not been accepted by friends or relatives for burial at their expense, such
superintendent, director, or other officer, on the written application of such professor, or the
secretary of the board of embalmers and funeral directors, shall deliver to such professor or
secretary, for the purpose of medical or surgical study or dissection or for the study of
embalming, the body of any such person who died in any of such institutions from any disease
which is not infectious. The expense of the delivery of the body shall be borne by the parties in
whose keeping the body was placed.

2108.50 Post-mortem examination consent.

(A) Subject to section 2108.521 of the Revised Code, an autopsy or post-mortem
examination may be performed upon the body of a deceased person by a licensed physician or
surgeon if consent has been given by the person who has the right of disposition under section
2108.70 or 2108.81 of the Revised Code.

(B) Consent to an autopsy or post-mortem examination given under this section may be
revoked only by the person executing the consent and in the same manner as required for
execution of consent under this section.

2108.51 Autopsy civil immunity.

Any licensed physician or surgeon who, in good faith and acting in reliance upon an
instrument of consent for an autopsy or post-mortem examination executed under section
2108.50 of the Revised Code and without actual knowledge of revocation of that consent,
performs an autopsy or post-mortem examination is not liable in a civil or criminal action brought
against the licensed physician or surgeon for that act.

2108.70 Disposition of remains.

(A) As used in this section and sections 2108.71 to 2108.90 of the Revised Code:
(1) “Adult” means an individual who is eighteen years of age or older.
(2) “Declarant” means an adult who has executed a written declaration described in
division (B) of this section.
(3) “Representative” means an adult or a group of adults, collectively, to whom a
declarant has assigned the right of disposition.
(4) “Right of disposition” means one or more of the rights described in division (B) of this section that a declarant chooses to assign to a representative in a written declaration executed under that division or all of the rights described in division (B) of this section that are assigned to a person pursuant to section 2108.81 of the Revised Code.

(5) “Successor representative” means an adult or group of adults, collectively, to whom the right of disposition for a declarant has been reassigned because the declarant's representative is disqualified from exercising the right under section 2108.75 of the Revised Code. Each successor representative shall be considered in the order the representative is designated by the declarant.

(B) An adult who is of sound mind may execute at any time a written declaration assigning to a representative one or more of the following rights:

(1) The right to direct the disposition, after death, of the declarant's body or any part of the declarant's body that becomes separated from the body before death. This right includes the right to determine the location, manner, and conditions of the disposition of the declarant's bodily remains.

(2) The right to make arrangements and purchase goods and services for the declarant's funeral. This right includes the right to determine the location, manner, and condition of the declarant's funeral.

(3) The right to make arrangements and purchase goods and services for the declarant's burial, cremation, or other manner of final disposition. This right includes the right to determine the location, manner, and condition of the declarant's burial, cremation, or other manner of final disposition.

(C)(1) Subject to division (C)(2) of this section, a declarant may designate a successor representative.

(2) If a representative is a group of persons and not all of the persons in the group meet at least one criterion to be disqualified from serving as the representative, as described in section 2108.75 of the Revised Code, the persons in the group who are not disqualified shall remain the representative who has the right of disposition.

(D) The assignment or reassignment of a right of disposition to a representative and a successor representative supersedes an assignment of a right of disposition under section 2108.81 of the Revised Code.

2108.81 Disposition and decision-maker priority.

(A) If either of the following is true, division (B) of this section shall apply:

(1) An adult has not executed a written declaration pursuant to sections 2108.70 to 2108.73 of the Revised Code that remains in force at the time of the adult's death.

(2) Each person to whom the right of disposition has been assigned or reassigned pursuant to a written declaration is disqualified from exercising the right as described in section 2108.75 of the Revised Code.

(B) Subject to division (A) of this section and sections 2108.75 and 2108.79 of the Revised Code, the right of disposition is assigned to the following persons, if mentally competent adults who can be located with reasonable effort, in the order of priority stated:

(1) The deceased person's surviving spouse;

(2) The sole surviving child of the deceased person or, if there is more than one surviving child, all of the surviving children, collectively;

(3) The deceased person’s surviving parent or parents;

(4) The deceased person's surviving sibling, whether of the whole or of the half blood or, if there is more than one sibling of the whole or of the half blood, all of the surviving siblings, collectively;

(5) The deceased person's surviving grandparent or grandparents;
(6) The deceased person's surviving grandchild, or if there is more than one surviving grandchild, all of the surviving grandchildren collectively;

(7) The lineal descendants of the deceased person's grandparents, as described in division (l) of section 2105.06 of the Revised Code;

(8) The person who was the deceased person's guardian at the time of the deceased person's death, if a guardian had been appointed;

(9) Any other person willing to assume the right of disposition, including the personal representative of the deceased person's estate or the licensed funeral director with custody of the deceased person's body, after attesting in writing that a good faith effort has been made to locate the persons in divisions (B)(1) to (8) of this section.

(10) If the deceased person was an indigent person or other person the final disposition of whose body is the financial and statutory responsibility of the state or a political subdivision of this state, the public officer or employee responsible for arranging the final disposition of the remains of the deceased person.

5121.53 Burial expenses of unclaimed indigent mental health patient.

The state shall bear the expense of the burial or cremation of an indigent patient who dies in a hospital if the body is not claimed for interment or cremation at the expense of friends or relatives, or is not delivered for anatomical purposes or for the study of embalming in accordance with section 1713.34 of the Revised Code. The managing officer of the hospital shall provide at the grave of the patient or, if the patient's cremated remains are buried, at the grave of the patient's cremated remains, a metal, stone, or concrete marker on which shall be inscribed the name and age of the patient and the date of death.

3701-5-14 Coroner protocols.

(A) The coroner shall investigate the death of and perform an autopsy on any child under two years of age that dies suddenly when in apparent good health unless a court with jurisdiction determines under section 313.131 of the Revised Code that an autopsy is contrary to the religious beliefs of the child. The coroner shall investigate the death and perform the autopsy by conducting the following:

(1) An investigation of the site where the child was found dead and indicating, if the information is available, whether the child was observed to die, when the child was last seen alive, the place of death, the circumstances under which the child was found dead and by whom, the position of the child when found, and the identity of all individuals who attempted to resuscitate the child;

(2) A complete medical history of the child, including, if the information is available, the child's date of birth, birth weight, type of delivery, number of well-baby visits, history of major illness including recent illness and any medical treatment, feeding history, birth mother's prenatal history and history of any drug use, whether any siblings have suddenly died under the age of two while in apparent good health or have died from any other cause;

(3) An external examination of the child including noting the child's state of nutrition and development, examining the nares and choanae, determining the age, race, sex, body length, and body weight of the child, and evaluating the child for evidence of rash, dehydration, anomalies, and injury;

(4) An internal examination including evaluating the epiglottis, larynx, and trachea, and noting the presence or absence of thymic petechiae, pleural petechiae, epicardial petechiae and fluid blood;

(5) A microscopic examination of any of the following that are indicated after conducting paragraphs (A)(1) through (A)(4) of this rule, provided that a specimen is possible to obtain:
(a) One vertical section of the heart including the left atrium and left ventricle;
(b) One section of each lobe of both lungs;
(c) Both kidneys and adrenals;
(d) The ileum including a Peyer’s patch;
(e) The liver and pancreas;
(f) The larynx including the epiglottis;
(g) The brain, including the cortex, basal ganglia, mid-pons, and medulla, each to
include meninges; and
(h) The thymus; and
(6) Any other examination or investigation that is indicated by the facts and
circumstances of the case.

(B) The coroner shall perform the following procedures where indicated by the facts and
circumstances of the case:
(1) A total body x-ray for evidence of repetitive battering;
(2) Biochemical determinations of sodium, potassium, and glucose, using vitreous
humor;
(3) Bacterial cultures of heart blood, spleen, both lungs, stool, cerebrospinal fluid and
larynx;
(4) Viral cultures of the heart, both lungs, one kidney, gastrointestinal tract and brain;
and
(5) A collection for testing of spinal fluid, urine, and gastric contents, five to ten milliliters
of whole blood, and approximately ten grams of the liver. These specimens shall be examined
and the presence and levels of the following shall be determined:
(a) Common agents acting upon the central nervous system;
(b) Salicylates;
(c) Alcohols;
(d) Carbon monoxide; and
(e) Any other agents as appropriate to the case.
(6) Retention of frozen liver, brain, kidney, and lung specimens for a period of at least six
months

(C) The coroner shall report to the Ohio department of health a preliminary diagnosis of
the cause of death of any child under two years of age who died suddenly when in apparent
good health. The preliminary diagnosis shall be reported to the Ohio department of health as
soon as possible, but no later than seventy-two hours after the death of the child and shall be
made either orally, or on a form prescribed by the director of the Ohio department of health
containing the following information:
(1) The child’s name, sex, age, race, date of birth and date of death;
(2) The child’s county of residence and county of death; and
(3) The mother’s and father’s name, age, and address.
If the preliminary diagnosis is orally made to the Ohio department of health, the coroner
shall also report the preliminary diagnosis on the form prescribed by the director and shall
submit the form to the Ohio department of health within fourteen days.

(D) If the child’s parent makes a request for the preliminary results of the autopsy, the
coroner or person designated by him shall give the parent an oral statement of the preliminary
results after they are available.
(E) The coroner shall send written notice of the final results of the investigation and
autopsy, including the final results of examinations, investigations and procedures required in
paragraphs (A) and (B) of this rule, to the Ohio department of health, the health district or
department with jurisdiction in the area in which the child’s parent resides, and, upon a request
of the parent of the child, to the child’s attending physician, within a reasonable time after the
final results are available. The coroner shall send written notice of the final results to a parent
upon written request.

Organ Donation

2108.01 Human Bodies and Parts thereof; definitions.

As used in sections 2108.02 to 2108.35 of the Revised Code:
(A) “Adult” means an individual who is at least eighteen years of age.
(B) “Agent” means an individual who is either of the following:
(1) The principal's attorney in fact under a durable power of attorney for health care;
(2) Expressly authorized to make an anatomical gift on the principal's behalf by any other record signed by the principal.
(C) “Anatomical gift” means a donation of all or part of a human body to take effect after the donor’s death for the purpose of transplantation, therapy, research, or education.
(D) “Decedent” means a deceased individual whose body or part is or may be the source of an anatomical gift. The term includes a stillborn infant and, subject to restrictions imposed by law other than sections 2108.01 to 2108.29 of the Revised Code, a fetus.
(E) “Disinterested witness” means a witness other than a spouse, child, parent, sibling, grandchild, grandparent, or guardian of the individual who makes an anatomical gift, or another adult who exhibited special care and concern for the individual. “Disinterested witness” does not include a person to which an anatomical gift could pass under section 2108.11 of the Revised Code.
(F) “Document of gift” means a donor card or other record used to make an anatomical gift. “Document of gift” includes a statement or symbol on a driver's license or identification card or in the donor registry.
(G) “Donor” means an individual whose body or part is the subject of an anatomical gift.
(H) “Donor registry” means a database that contains records of anatomical gifts and amendments to or revocations of anatomical gifts.
(I) “Driver's license” means a license or permit issued by the registrar of motor vehicles, or a deputy registrar, to operate a vehicle, whether or not conditions are attached to the license or permit and includes a driver's license, commercial driver's license, and a motorcycle operator's license or endorsement.
(J) “Durable power of attorney for health care” means a document created pursuant to sections 1337.11 to 1337.17 of the Revised Code.
(K) “Eye bank” means a person conducting operations in this state that is licensed, accredited, or regulated under federal or state law to engage in the recovery, screening, testing, processing, storage, or distribution of human eyes or portions of human eyes.
(L) “Guardian” means a person appointed by a court to make decisions regarding the support, care, education, health, or welfare of an individual. “Guardian” does not include a guardian ad litem.
(M) “Hospital” means a facility operated as a hospital under the laws of this or any other state or a facility operated as a hospital by the United States, this or any other state, or a subdivision of this or any other state.
(N) “Identification card” means an identification card issued by the registrar of motor vehicles or a deputy registrar.
(O) “Know” means to have actual knowledge.
(P) “Minor” means an individual who is under eighteen years of age.
(Q) “Organ procurement organization” means a person conducting operations in this state that is designated by the secretary of the United States department of health and human services as an organ procurement organization.
(R) “Parent” means a parent whose parental rights have not been terminated.
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(S) “Part” means an organ, an eye, or tissue of a human being. “Part” does not include the whole body.
(T) “Person” means an individual, corporation, business trust, estate, trust, partnership, limited liability company, association, joint venture, public corporation, government or governmental subdivision, agency, or instrumentality, or any other legal or commercial entity.
(U) “Physician” means an individual authorized under Chapter 4731 of the Revised Code to practice medicine and surgery, osteopathic medicine and surgery, or podiatric medicine and surgery, or an individual authorized under the laws of any other state to practice medicine and surgery, osteopathic medicine and surgery, or podiatric medicine and surgery.
(V) “Procurement organization” means an eye bank, organ procurement organization, or tissue bank.
(W) “Prospective donor” means an individual who is dead or near death and has been determined by a procurement organization to have a part that could be medically suitable for transplantation, therapy, research, or education. “Prospective donor” does not include an individual who has made a refusal.
(X) “Reasonably available” means able to be contacted by a procurement organization without undue effort and willing and able to act in a timely manner consistent with existing medical criteria necessary for the making of an anatomical gift.
(Y) “Recipient” means an individual into whose body a decedent's part has been or is intended to be transplanted.
(Z) “Record” means information that is inscribed on a tangible medium or that is stored in an electronic or other medium and is retrievable in perceivable form.
(AA) “Refusal” means a record created under section 2108.07 of the Revised Code that expressly states an intent to bar other persons from making an anatomical gift of an individual's body or part.
(BB) “Sign” means to do either of the following with the present intent to authenticate or adopt a record:
   (1) Execute or adopt a tangible symbol;
   (2) Attach to or logically associate with the record an electronic symbol, sound, or process.
(CC) “Technician” means an individual determined to be qualified to remove or process parts by an appropriate organization that is licensed, accredited, or regulated under federal or state law. “Technician” includes an enucleator and an embalmer licensed pursuant to Chapter 4717 of the Revised Code who has completed a course in eye enucleation and has received a certificate of competency to that effect from a school of medicine recognized by the state medical board or from an eye bank that is a member of the eye bank association of America.
(DD) “Tissue” means a portion of the human body other than an organ or an eye. “Tissue” does not include blood unless the blood is donated for the purpose of research or education.
(EE) “Tissue bank” means a person conducting operations in this state that is licensed, accredited, or regulated under federal or state law to engage in the recovery, screening, testing, processing, storage, or distribution of tissue.
(FF) “Transplant hospital” means a hospital that furnishes organ transplants and other medical and surgical specialty services required for the care of transplant patients.

2108.02 Anatomical gift donees; rights of next of kin.

Sections 2108.01 to 2108.29 of the Revised Code are enacted to adopt the Revised Uniform Anatomical Gift Act (2006), national conference of commissioners on uniform state laws.
2108.03 Who may donate.

Sections 2108.01 to 2108.29 of the Revised Code apply to an anatomical gift or amendment to, revocation of, or refusal to make an anatomical gift, whenever made.

2108.04 Who may donate.

Subject to section 2108.08 of the Revised Code, an anatomical gift of a donor's body or part may be made during the life of the donor for the purpose of transplantation, therapy, research, or education in the manner provided in section 2108.05 of the Revised Code by any of the following:

(A) The donor, if the donor is an adult or if the donor is a minor and either of the following applies:
   (1) The donor is emancipated.
   (2) The donor is authorized to apply for a temporary instruction permit issued under section 4507.05 of the Revised Code because the donor is at least fifteen years and six months of age.

(B) An agent of the donor, unless the durable power of attorney for health care or other record prohibits the agent from making an anatomical gift;

(C) A parent of the donor, if the donor is an unemancipated minor;

(D) The donor's guardian.

2108.05 Manner in which donor may make gift.

(A) A donor may make an anatomical gift by doing any of the following:
   (1) Authorizing a statement or symbol to be imprinted on the donor's driver's license or identification card indicating that the donor has certified a willingness to make an anatomical gift;
   (2) Specifying in the donor's will an intent to make an anatomical gift;
   (3) Specifying an intent to make an anatomical gift in the donor's declaration as described in section 2133.16 of the Revised Code;
   (4) During a terminal illness or injury of the donor, communicating in any manner to a minimum of two adults, at least one of whom is a disinterested witness, that the donor intends to make an anatomical gift;
   (5) Following the procedure in division (B) of this section.

(B) A donor or other person authorized to make an anatomical gift under section 2108.04 of the Revised Code may make a gift by a donor card or other record signed by the donor or other person making the gift or by authorizing that a statement or symbol indicating that the donor has certified a willingness to make an anatomical gift be included in a donor registry. If the donor or other person is physically unable to sign a record, the record may be signed by another individual at the direction of the donor or the other person and shall do both of the following:
   (1) Be witnessed by at least two adults, at least one of whom is a disinterested witness, who have signed at the request of the donor or the other person;
   (2) State that it has been signed and witnessed as provided in division (B)(1) of this section.

(C) Once a donor has authorized a statement or symbol to be imprinted on the donor's driver's license or identification card indicating that the donor has certified a willingness to make an anatomical gift, the donor does not need to recertify the donor's willingness to make an anatomical gift upon renewal of the driver's license or identification card. The authorization shall remain in effect until the donor withdraws that authorization.

(D) Revocation, suspension, expiration, or cancellation of a driver's license or
identification card upon which an anatomical gift is indicated does not invalidate the gift.

(E) An anatomical gift made by will takes effect on the donor's death whether or not the will is probated. Invalidation of the will after the donor's death does not invalidate the gift.

2108.06 Amendment or revocation of organ donation.

(A) Subject to section 2108.08 of the Revised Code, an anatomical gift made under section 2108.04 of the Revised Code may be amended by any of the following means:

(1) By a record signed by the donor or other person authorized to make an anatomical gift under section 2108.04 of the Revised Code;

(2) Subject to division (C) of this section, by a record signed by another individual acting at the direction of the donor or other person authorized to make an anatomical gift under section 2108.04 of the Revised Code if the donor or other person is physically unable to sign;

(3) By a later-executed document of gift that amends a previous anatomical gift or portion of an anatomical gift, either expressly or by inconsistency;

(4) By any form of communication during a terminal illness or injury addressed to at least two adults;

(5) By a parent who is reasonably available, if the donor is an unemancipated minor who has died;

(6) If made in a will, by the manner provided for amendment of wills or by any of the applicable means described in divisions (B)(1) to (5) of this section.

(B) Subject to section 2108.08 of the Revised Code, an anatomical gift made under section 2108.04 of the Revised Code may be revoked by any of the following means:

(1) By a record signed by the donor or other person authorized to make an anatomical gift under section 2108.04 of the Revised Code;

(2) Subject to division (C) of this section, by a record signed by another individual acting at the direction of the donor or other person authorized to make an anatomical gift under section 2108.04 of the Revised Code if the donor or other person is physically unable to sign;

(3) By a later-executed document of gift that revokes a previous anatomical gift or portion of an anatomical gift, either expressly or by inconsistency;

(4) By any form of communication during a terminal illness or injury addressed to at least two adults;

(5) By a parent who is reasonably available, if the donor is an unemancipated minor who has died;

(6) By the destruction or cancellation of the document of gift, or the portion of the document of gift, used to make the gift, with the intent to revoke the gift;

(7) If made in a will, by the manner provided for revocation of wills or by any of the applicable means described in divisions (B)(1) to (6) of this section.

(C) A record signed pursuant to division (A)(2) or (B)(2) of this section shall do both of the following:

(1) Be witnessed by a minimum of two adults who have signed at the request of the donor or other person;

(2) State that it has been signed and witnessed as provided in division (C)(1) of this section.

2108.07 Person may refuse to make organ donation.

(A) An individual may refuse to make an anatomical gift of the individual's body or part by doing any of the following:

(1) Indicating a refusal in a record signed by either of the following:

(a) The individual;
(b) Subject to division (B) of this section, another individual acting at the direction of the individual, if the individual is physically unable to sign.

(2) Indicating a refusal in the individual's will, whether or not the will is admitted to probate or invalidated after the individual's death;

(3) Indicating a refusal by any form of communication made by the individual during the individual's terminal illness or injury addressed to a minimum of two adults.

(B) A record signed pursuant to division (A)(1)(b) of this section shall do both of the following:

(1) Be witnessed by at least two adults who have signed at the request of the individual;

(2) State that it has been signed and witnessed as provided in division (B)(1) of this section.

(C) An individual who has made a refusal may amend or revoke the refusal by doing any of the following:

(1) Amending or revoking the refusal in the manner provided in division (A) of this section for making a refusal;

(2) Subsequently making an anatomical gift pursuant to section 2108.05 of the Revised Code that is inconsistent with the refusal;

(3) Destroying or canceling the record evidencing the refusal, or the portion of the record used to make the refusal, with the intent to revoke the refusal.

(D) Except as provided in division (E) of this section, in the absence of an express, contrary indication by the individual set forth in the refusal, an individual's unrevoked refusal to make an anatomical gift of the individual's body or part bars all other persons from making an anatomical gift of the individual's body or part.

(E) The parent of a deceased unemancipated minor who is reasonably available may revoke a refusal made by the minor.

2108.08 Organ donation cannot be revoked by other party.

(A) Subject to division (F) of this section, in the absence of an express, contrary indication by the donor, a person other than the donor shall be barred from making, amending, or revoking an anatomical gift of a donor's body or part if the donor made an anatomical gift of the donor's body or part under section 2108.05 of the Revised Code or an amendment to an anatomical gift of the donor's body or part under section 2108.06 of the Revised Code.

(B) A donor's revocation of an anatomical gift of the donor's body or part under section 2108.06 of the Revised Code is not a refusal and shall not bar another person specified in section 2108.04 or 2108.09 of the Revised Code from making an anatomical gift of the donor's body or part under section 2108.05 or 2108.10 of the Revised Code.

(C) If a person other than the donor makes an unrevoked anatomical gift of the donor's body or part under section 2108.05 of the Revised Code or an amendment to an anatomical gift of the donor's body or part under section 2108.06 of the Revised Code, another person shall not make, amend, or revoke the gift of the donor's body or part under section 2108.05 or 2108.10 of the Revised Code.

(D) A revocation by a person other than the donor of an anatomical gift of a donor's body or part under section 2108.06 of the Revised Code shall not bar another person from making an anatomical gift of the body or part under section 2108.05 or 2108.10 of the Revised Code.

(E) In the absence of an express, contrary indication by the donor or other person authorized to make an anatomical gift under section 2108.04 of the Revised Code, an anatomical gift of a part is neither a refusal to give another part nor a limitation on the making of an anatomical gift of another part at a later time by the donor or another person.

(F) In the absence of an express, contrary indication by the donor or other person authorized to make an anatomical gift under section 2108.04 of the Revised Code, an
anatomical gift of a part for one or more of the purposes set forth in section 2108.04 of the Revised Code shall not be a limitation on the making of an anatomical gift of the part for any of the other purposes by the donor or other person under section 2108.05 or 2108.10 of the Revised Code.

2108.09 Organ donation of decedent can be made by survivor.

(A) Subject to divisions (B) and (C) of this section, and unless barred by section 2108.07 or 2108.08 of the Revised Code, an anatomical gift of a decedent's body or part for purpose of transplantation, therapy, research, or education may be made in the manner provided for under section 2108.10 of the Revised Code by any member of the following classes of persons who is reasonably available, in the following order of priority:

1. An agent of the decedent at the time of death who could have made an anatomical gift under division (B) of section 2108.04 of the Revised Code immediately before the decedent's death;
2. The decedent's surviving spouse;
3. The decedent's surviving adult children;
4. The decedent's surviving parent or parents;
5. The decedent's surviving adult siblings;
6. The decedent's surviving adult grandchildren;
7. The decedent's surviving grandparent or grandparents;
8. A surviving adult who exhibited special care and concern for the decedent;
9. The persons who were acting as the guardians of the person of the decedent at the time of death;
10. The persons, other than those in divisions (A)(1) to (9) of this section, to whom the right of disposition for the decedent's body has been assigned pursuant to section 2108.70 of the Revised Code or who have the right of disposition for the decedent's body as described in section 2108.81 of the Revised Code.

(B) If there is more than one member of a class listed in division (A)(1), (3), (4), (5), (6), (7), or (9) of this section entitled to make an anatomical gift, an anatomical gift may be made by a single member of the class unless that member or a person to which the gift may pass under section 2108.11 of the Revised Code knows of an objection by another member of the class. If an objection is known, the gift may be made only by a majority of the members of the class who are reasonably available.

(C) A person shall not make an anatomical gift if, at the time of the decedent's death, a person in a prior class under division (A) of this section is reasonably available to make or object to the making of an anatomical gift.

2108.10 Manner in which survivor may make decedent organ donation.

(A) A person authorized to make an anatomical gift under section 2108.09 of the Revised Code may make an anatomical gift by a document of gift signed by the person making the gift or by that person's oral communication that is electronically recorded or is contemporaneously reduced to a record and signed by the individual receiving the oral communication.

(B) Subject to division (C) of this section, an anatomical gift made by a person authorized to make a gift under section 2108.09 of the Revised Code may be amended or revoked orally or in a record by any member of a prior class who is reasonably available. If more than one member of the prior class is reasonably available, the gift made by a person authorized to make a gift under section 2108.09 of the Revised Code may be amended if a majority of the reasonably available members agree to the amendment or revoked if at least half...
of the reasonably available members agree to the revocation.

(C) A revocation under division (B) of this section shall be effective only if the procurement organization, transplant hospital, physician, or technician knows of the revocation, before an incision has been made to remove a part from the donor's body or before invasive procedures have begun to prepare the recipient.

2108.11 Persons to whom a donation may be made.

(A) An anatomical gift may be made to any of the following persons named in the document of gift:

(1) A hospital; an accredited medical school, dental school, college, or university; an organ procurement organization; or another appropriate person, for research or education;

(2) Subject to division (B) of this section, an individual designated by the person making the anatomical gift if the individual is the recipient of the part;

(3) An eye bank or tissue bank.

(B) If an anatomical gift to an individual under division (A)(2) of this section cannot be transplanted into the individual, the part shall pass in accordance with division (G) of this section in the absence of an express, contrary indication by the person making the anatomical gift.

(C) If an anatomical gift of one or more specific parts or of all parts is made in a document of gift that does not name a person described in division (A) of this section but identifies the purpose for which an anatomical gift may be used, the following rules apply:

(1) If the part is an eye and the gift is for the purpose of transplantation or therapy, the gift shall pass to the appropriate eye bank.

(2) If the part is tissue and the gift is for the purpose of transplantation or therapy, the gift shall pass to the appropriate tissue bank.

(3) If the part is an organ and the gift is for the purpose of transplantation or therapy, the gift shall pass to the appropriate organ procurement organization as custodian of the organ.

(4) If the part is an organ, an eye, or tissue and the gift is for the purpose of research or education, the gift shall pass to the appropriate procurement organization.

(D) For the purpose of division (C) of this section, if there is more than one purpose of an anatomical gift set forth in the document of gift but the purposes are not set forth in any priority, the gift shall be used for transplantation or therapy, if suitable. If the gift cannot be used for transplantation or therapy, the gift may be used for research or education.

(E) If an anatomical gift of one or more specific parts is made in a document of gift that does not name a person described in division (A) of this section and does not identify the purpose of the gift, the gift shall be used only for transplantation or therapy, and the gift shall pass in accordance with division (G) of this section.

(F) If a document of gift specifies only a general intent to make an anatomical gift by words such as "donor," "organ donor," or "body donor," or by a symbol or statement of similar import, the gift shall be used only for transplantation or therapy, and the gift shall pass in accordance with division (G) of this section.

(G) For purposes of divisions (B), (E), and (F) of this section, the following rules apply:

(1) If the part is an eye, the gift shall pass to the appropriate eye bank.

(2) If the part is tissue, the gift shall pass to the appropriate tissue bank.

(3) If the part is an organ, the gift shall pass to the appropriate organ procurement organization as custodian of the organ.

(H) An anatomical gift of an organ for transplantation or therapy, other than an anatomical gift under division (A)(2) of this section, shall pass to the organ procurement organization as custodian of the organ.

(I) If an anatomical gift does not pass pursuant to divisions (A) to (H) of this section, or the decedent's body or part is not used for transplantation, therapy, research, or education,
custody of the body or part shall pass to the person to whom the right of disposition for the decedent's body has been assigned pursuant to section 2108.70 of the Revised Code or who has the right of disposition for the decedent's body as described in section 2108.81 of the Revised Code.

(J) A person shall not accept an anatomical gift if the person knows that the gift was not effectively made under section 2108.05 or 2108.10 of the Revised Code, or if the person knows that the decedent made a refusal under section 2108.07 of the Revised Code that was not revoked. For purposes of this division, if a person knows that an anatomical gift was made on a document of gift, the person is deemed to know of any amendment or revocation of the gift or any refusal to make an anatomical gift on the same document of gift.

(K) Except as otherwise provided in division (A)(2) of this section, nothing in sections 2108.01 to 2108.29 of the Revised Code affects the allocation of organs for transplantation or therapy.

2108.12 Search of body for evidence of organ donation.

(A) If any of the following persons, while acting in the course of the person's official duties, finds an individual and reasonably believes that the individual is dead or near death, the person shall make a reasonable search of the body of the individual for a document of gift or other information identifying the individual as a donor or as an individual who made a refusal:

(1) A law enforcement officer as defined in section 2901.01 of the Revised Code;
(2) A member of a fire department as defined in section 4117.01 of the Revised Code;
(3) A first responder, emergency medical technician-basic, emergency medical technician-intermediate, or emergency medical technician-paramedic, as those terms are defined in section 4765.01 of the Revised Code.

(B) If a document of gift or refusal to make an anatomical gift is located by the search required by division (A) of this section, and the individual or deceased individual to whom it relates is taken to a hospital, the person responsible for conducting the search shall send the document of gift or refusal to the hospital.

(C) A person is not subject to criminal or civil liability for failing to discharge the duties imposed by this section but may be subject to any of the following:

(1) Disciplinary action under a collective bargaining agreement, if the person is covered by a collective bargaining agreement entered into under Chapter 4117 of the Revised Code;
(2) Disciplinary action under section 124.34 of the Revised Code, if the person is an officer or employee in the classified service of this state or the counties, civil service townships, cities, city health districts, general health districts, or city school districts of this state;
(3) Disciplinary action by the person's employer.

2108.13 Copy of donation gift or refusal document.

(A) A document of gift need not be delivered during the donor's lifetime to be effective.

(B) On or after an individual's death, a person in possession of a document of gift or a refusal to make an anatomical gift with respect to the individual shall allow examination and copying of the document of gift or refusal by a person authorized to make or object to the making of an anatomical gift with respect to the individual or by a person to which the gift could pass under section 2108.11 of the Revised Code.

2108.14 Hospital shall search for organ donation records.

(A) When a hospital employee or agent refers an individual at or near death to a procurement organization, the organization shall make a reasonable search of the records of
the bureau of motor vehicles and any donor registry that it knows exists for the geographical area in which the individual resides to ascertain whether the individual has made an anatomical gift. The bureau of motor vehicles shall allow the procurement organization reasonable access to its records for purposes of ascertaining whether the individual is a donor.

(B) When a hospital employee or agent refers an individual at or near death to a procurement organization, the organization may conduct any reasonable examination necessary to ensure the medical suitability of a part that is or could be the subject of an anatomical gift for transplantation, therapy, research, or education from a donor or prospective donor. During the examination period, measures necessary to ensure the medical suitability of the part shall not be withdrawn unless the hospital or procurement organization knows that the individual expressed a contrary intent.

(C) Unless prohibited by law other than sections 2108.01 to 2108.29 of the Revised Code, at any time after a donor's death, the person to which a part passes under section 2108.11 of the Revised Code may conduct any reasonable examination necessary to ensure the medical suitability of the body or part for its intended purpose.

(D) Unless prohibited by law other than sections 2108.01 to 2108.29 of the Revised Code, an examination under division (B) or (C) of this section may include an examination of all medical and dental records of the donor or prospective donor.

(E) Upon the death of a minor who was a donor or had signed a refusal, unless a procurement organization knows the minor was emancipated, the procurement organization shall conduct a reasonable search for the parents of the minor and provide the parents with an opportunity to revoke or amend the anatomical gift or revoke the refusal.

(F) Upon referral by a hospital under division (A) of this section, a procurement organization shall make a reasonable search for any person listed in section 2108.09 of the Revised Code having an opportunity to make an anatomical gift on behalf of the prospective donor. If a procurement organization receives information that an anatomical gift to any other person was made, amended, or revoked, it shall promptly advise the other person of all relevant information.

2108.16 Donated parts removal authority.

(A) Except as provided in division (B) of this section, a physician or technician may remove a donated part from the body of a donor that the physician or technician is qualified to remove.

(B) Neither the physician who attends the decedent at death nor the physician who determines the time of the decedent's death shall participate in the procedures for removing or transplanting a part from the decedent.

2108.17 Hospital shall enter into agreement with organ procurement organization.

Each hospital in this state shall enter into agreements or affiliations with procurement organizations for coordination of procurement and use of anatomical gifts.

2108.20 Immunity for good faith action.

(A) A person who acts in accordance with sections 2108.01 to 2108.29 of the Revised Code or with the applicable anatomical gift laws of another state, or attempts in good faith to do so, is not liable for the act in a civil action, criminal prosecution, or administrative proceeding.

(B) Neither the person making the anatomical gift nor the donor's estate is liable for any injury or damage that results from the making or use of the gift.
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2108.21 Relationship to organ donor; descriptions by others.

In determining whether an anatomical gift has been made, amended, or revoked under sections 2108.01 to 2108.29 of the Revised Code, a person may rely upon representations of an individual listed in division (A)(2), (3), (4), (5), (6), (7), or (8) of section 2108.09 of the Revised Code relating to the individual’s relationship to the donor or prospective donor unless the person knows that the representation is untrue.

2108.22 Requirements for valid organ donation.

(A) A document of gift is valid if executed in accordance with any of the following:
   (1) Sections 2108.01 to 2108.29 of the Revised Code;
   (2) The laws of the state or country where it was executed;
   (3) The laws of the state or country where the person making the anatomical gift was domiciled, has a place of residence, or was a resident or national at the time the document of gift was executed.

   (B) If a document of gift is valid under this section, the law of this state shall govern the interpretation of the document of gift.

   (C) A person may presume that a document of gift or amendment of an anatomical gift is valid unless that person knows that it was not validly executed or was revoked.

2108.24 Conflict between organ donation and advance directive.

(A) As used in this section:
   (1) “Advance health-care directive” means a durable power of attorney for health care or a record signed by a prospective donor containing the prospective donor’s direction concerning a health-care decision.
   (2) “Declaration” means a written document executed in accordance with section 2133.02 of the Revised Code.
   (3) “Health care decision” means any decision regarding the health care of the prospective donor.

   (B) If a prospective donor has a declaration or advance health-care directive the terms of which are in conflict with the express or implied terms of a potential anatomical gift with regard to administration of measures necessary to ensure the medical suitability of a part for transplantation or therapy and the prospective donor is capable of resolving the conflict, subject to division (G) of this section, the prospective donor’s attending physician shall confer with the prospective donor to resolve the conflict.

   (C) If a prospective donor has a declaration or advance health-care directive the terms of which are in conflict with the express or implied terms of a potential anatomical gift with regard to administration of measures necessary to ensure the medical suitability of a part for transplantation or therapy and the prospective donor is incapable of resolving the conflict, one of the following shall apply depending on the circumstances:
      (1) If the prospective donor has an agent, the agent shall, subject to division (G) of this section, act for the prospective donor to resolve the conflict.
      (2) If the prospective donor does not have an agent, the individual or class of individuals determined in the following descending order of priority and subject to divisions (D), (E), (F), and (G) of this section shall act for the prospective donor to resolve the conflict:
         (a) The prospective donor’s surviving spouse;
         (b) The prospective donor’s surviving adult children;
         (c) The prospective donor’s surviving parent or parents;
         (d) The prospective donor’s surviving adult siblings;
(e) The prospective donor's surviving adult grandchildren;
(f) The prospective donor's surviving grandparent or grandparents;
(g) A surviving adult who exhibited special care and concern for the prospective donor;
(h) The prospective donor's guardians of the person;
(i) The persons, other than those in divisions (C)(2)(a) to (h) of this section, to whom the prospective donor has assigned the right of disposition for the prospective donor's body pursuant to section 2108.70 of the Revised Code or who have the right of disposition for the prospective donor's body at the time of death as described in section 2108.81 of the Revised Code.

(D) If an appropriate individual entitled to resolve a conflict between the terms of a prospective donor's declaration or advance health-care directive and the express or implied terms of a potential anatomical gift as described in division (C) of this section is not reasonably available to resolve the conflict, is incapacitated, or declines to resolve the conflict, the next priority individual or class of individuals specified in that division is authorized to resolve the conflict.

(E) If at least one individual in a class of individuals entitled to resolve a conflict between the terms of a prospective donor's declaration or advance health-care directive and the express or implied terms of a potential anatomical gift is not reasonably available, is incapacitated, or declines to resolve the conflict, the conflict shall be resolved by the individual or individuals in the class who are reasonably available, not incapacitated, and willing to resolve the conflict.

(F) If individuals in a class of individuals determined in accordance with division (C)(2) of this section disagree on how a conflict between the terms of a prospective donor's declaration or advance health-care directive and the express or implied terms of a potential anatomical gift should be resolved, the opinion of the majority of the individuals who are reasonably available, not incapacitated, and willing to resolve the conflict shall prevail.

(G) A conflict between the terms of a prospective donor's declaration or directive and the express or implied terms of a potential anatomical gift with regard to the administration of measures necessary to ensure the medical suitability of a part for transplantation or therapy shall be resolved as expeditiously as possible. Information relevant to the resolution of the conflict may be obtained from the appropriate procurement organization and any other person authorized to make an anatomical gift for the prospective donor under section 2108.09 of the Revised Code. Before resolution of the conflict, measures necessary to ensure the medical suitability of the part shall not be withheld or withdrawn from the prospective donor unless withholding or withdrawing the measures is necessary for appropriate end-of-life care.

Death

2108.40 Definitions of death and physician immunity.

An individual is dead if the individual has sustained either irreversible cessation of circulatory and respiratory functions or irreversible cessation of all functions of the brain, including the brain stem, as determined in accordance with accepted medical standards. If the respiratory and circulatory functions of a person are being artificially sustained, under accepted medical standards a determination that death has occurred is made by a physician by observing and conducting a test to determine that the irreversible cessation of all functions of the brain has occurred.

A physician who makes a determination of death in accordance with this section and accepted medical standards is not liable for damages in any civil action or subject to prosecution in any criminal proceeding for the physician's acts or the acts of others based on that determination.

Any person who acts in good faith in reliance on a determination of death made by a
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physician in accordance with this section and accepted medical standards is not liable for damages in any civil action or subject to prosecution in any criminal proceeding for the person's actions.

4731-14-01 Pronouncement of death requirements.

(A) Only an individual holding one of the following current certificates or licenses may pronounce a person dead:
(1) A certificate to practice medicine and surgery or osteopathic medicine and surgery issued under section 4731.14 or 4731.29 of the Revised Code;
(2) A training certificate issued under section 4731.291 of the Revised Code;
(3) A clinical research faculty certificate issued under section 4731.293 of the Revised Code;
(4) A special activities certificate issued under section 4731.294 of the Revised Code;
(5) A certificate of authority to practice as a certified nurse practitioner or clinical nurse specialist issued under section 4723.42 of the Revised Code, when the holder acts in compliance with section 4723.36 of the Revised Code;
(6) A license to practice as a registered nurse issued under section 4723.09 of the Revised Code, when the holder acts in compliance with section 4723.36 of the Revised Code.
(7) A license to practice as a physician assistant issued under section 4730.12 of the Revised Code, when the holder acts in compliance with section 4730.12 of the Revised Code;
(8) A certificate of conceded eminence issued under section 4731.297 of the Revised Code;
(9) A certificate to practice podiatric medicine and surgery issued under section 4731.56, 4731.57, or 4731.571 of the Revised Code.

(B) A physician holding a current certificate to practice medicine or surgery or osteopathic medicine and surgery issued under section 4731.14 or 4731.29 of the Revised Code may pronounce a person dead without personally examining the body of the deceased only if a competent observer has recited the facts of the deceased's present medical condition to the physician and the physician is satisfied that death has occurred.

(C) For purposes of this rule a competent observer shall mean one of the following:
(1) A licensed practical nurse holding a current license issued under Chapter 4723 of the Revised Code;
(2) An EMT-Basic holding a current certificate issued under section 4765.30 of the Revised Code;
(3) An EMT-intermediate holding a current certificate issued under section 4765.30 of the Revised Code;
(4) An EMT-paramedic holding a current certificate issued under section 4765.30 of the Revised Code;
(5) A chiropractor holding a current certificate issued under Chapter 4734 of the Revised Code;
(6) An individual authorized to pronounce a person dead under paragraph (A) of this rule;
(7) A coroner's investigator as referenced in section 313.05 of the Revised Code.

Assisted Suicide

3795.01 Assisted suicide; definitions.

As used in sections 3795.01, 3795.02, and 3795.03 of the Revised Code:
(A) “Assist suicide” or “assisting suicide” means knowingly doing either of the following,
with the purpose of helping another person to commit or attempt suicide:

(1) Providing the physical means by which the person commits or attempts to commit suicide;

(2) Participating in a physical act by which the person commits or attempts to commit suicide.

(B) “Certified nurse practitioner,” “certified nurse-midwife,” and “clinical nurse specialist” have the same meanings as in section 4723.01 of the Revised Code.

(C) “CPR” has the same meaning as in section 2133.21 of the Revised Code.

(D) “Health care” means any care, treatment, service, or procedure to maintain, diagnose, or treat a person's physical or mental condition.

(E) “Health care decision” means informed consent, refusal to give informed consent, or withdrawal of informed consent to health care.

(F) “Health care facility” means any of the following:

(1) A hospital;

(2) A hospice care program or pediatric respite care program as defined in section 3712.01 of the Revised Code;

(3) A nursing home;

(4) A home health agency;

(5) An intermediate care facility for individuals with intellectual disabilities.

(G) “Health care personnel” means physicians, nurses, physician assistants, emergency medical technicians-basic, emergency medical technicians-intermediate, emergency medical technicians-paramedic, medical technicians, dietitians, other authorized persons acting under the direction of an attending physician, and administrators of health care facilities.

(H) “Physician” means a person who is authorized under Chapter 4731 of the Revised Code to practice medicine and surgery or osteopathic medicine and surgery.

3795.02 Assisting suicide; injunctions.

(A) Assisting suicide is hereby declared to be against the public policy of the state.

(B) A court of common pleas shall grant an injunction enjoining any action related to assisting suicide if it finds there is reason to believe that the person enjoined is preparing to assist a suicide, is in the course of assisting a suicide, or has assisted a suicide. The injunction shall prohibit the person from assisting any suicide in this state regardless of who is being assisted. The injunction may be granted at the request of any of the following:

(1) A person who has prepared or attempted to commit suicide with the assistance of the person sought to be enjoined;

(2) The guardian, spouse, parent, child, or sibling of a person who is preparing or has prepared to commit, who is attempting or has attempted to commit, or who committed suicide with the assistance of the person sought to be enjoined;

(3) A person entitled to inherit from a person who is preparing or has prepared to commit, who is attempting or has attempted to commit, or who committed suicide with the assistance of the person sought to be enjoined;

(4) A person who has inherited from a person who has prepared or attempted to commit or who committed suicide with the assistance of the person sought to be enjoined;

(5) An individual who is providing or has provided health care to a person who is preparing or has prepared to commit or who is attempting or has attempted to commit suicide with the assistance of the person sought to be enjoined;

(6) An individual who has provided health care to a person who committed suicide with the assistance of the person sought to be enjoined;

(7) A prosecuting attorney;

(8) The attorney general.
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If an injunction is granted, the court may award the party requesting the injunction all reasonable attorney’s fees, which shall be considered damages.

3795.03 Assisted suicide; exceptions.

Nothing in section 3795.01, 3795.02, or 3795.04 of the Revised Code shall do any of the following:
(A) Prohibit or preclude a physician, certified nurse practitioner, certified nurse-midwife, or clinical nurse specialist who carries out the responsibility to provide comfort care to a patient in good faith and while acting within the scope of the physician’s or nurse’s authority from prescribing, dispensing, administering, or causing to be administered any particular medical procedure, treatment, intervention, or other measure to the patient, including, but not limited to, prescribing, personally furnishing, administering, or causing to be administered by judicious titration or in another manner any form of medication, for the purpose of diminishing the patient’s pain or discomfort and not for the purpose of postponing or causing the patient’s death, even though the medical procedure, treatment, intervention, or other measure may appear to hasten or increase the risk of the patient’s death;
(B) Prohibit or preclude health care personnel acting under the direction of a person authorized to prescribe a patient’s treatment and who carry out the responsibility to provide comfort care to the patient in good faith and while acting within the scope of their authority from dispensing, administering, or causing to be administered any particular medical procedure, treatment, intervention, or other measure to the patient, including, but not limited to, personally furnishing, administering, or causing to be administered by judicious titration or in another manner any form of medication, for the purpose of diminishing the patient’s pain or discomfort and not for the purpose of postponing or causing the patient’s death, even though the medical procedure, treatment, intervention, or other measure may appear to hasten or increase the risk of the patient’s death;
(C) Prohibit or affect the use or continuation, or the withholding or withdrawal, of life-sustaining treatment, CPR, or comfort care under Chapter 2133 of the Revised Code;
(D) Prohibit or affect the provision or withholding of health care, life-sustaining treatment, or comfort care to a principal under a durable power of attorney for health care or any other health care decision made by an attorney in fact under sections 1337.11 to 1337.17 of the Revised Code;
(E) Affect or limit the authority of a physician, a health care facility, a person employed by or under contract with a health care facility, or emergency service personnel to provide or withhold health care to a person in accordance with reasonable medical standards applicable in an emergency situation;
(F) Affect or limit the authority of a person to refuse to give informed consent to health care, including through the execution of a durable power of attorney for health care under sections 1337.11 to 1337.17 of the Revised Code, the execution of a declaration under sections 2133.01 to 2133.15 of the Revised Code, or authorizing the withholding or withdrawal of CPR under sections 2133.21 to 2133.26 of the Revised Code.

3795.04 Assisted suicide; prohibitions and penalty.

(A) Except as provided in section 3795.03 of the Revised Code, no person shall knowingly cause another person to commit or attempt to commit suicide by doing either of the following:
(1) Providing the physical means by which the other person commits or attempts to commit suicide;
(2) Participating in a physical act by which the other person commits or attempts to
commit suicide.
  (B) Whoever violates division (A) of this section is guilty of assisting suicide, a felony of the third degree.

Part II. Advance Directives

Durable Power of Attorney

1337.11 Durable power of attorney; definitions.

As used in sections 1337.11 to 1337.17 of the Revised Code:
(A) “Adult” means a person who is eighteen years of age or older.
(B) “Attending physician” means the physician to whom a principal or the family of a principal has assigned primary responsibility for the treatment or care of the principal or, if the responsibility has not been assigned, the physician who has accepted that responsibility.
(C) “Comfort care” means any of the following:
  (1) Nutrition when administered to diminish the pain or discomfort of a principal, but not to postpone death;
  (2) Hydration when administered to diminish the pain or discomfort of a principal, but not to postpone death;
  (3) Any other medical or nursing procedure, treatment, intervention, or other measure that is taken to diminish the pain or discomfort of a principal, but not to postpone death.
(D) “Consulting physician” means a physician who, in conjunction with the attending physician of a principal, makes one or more determinations that are required to be made by the attending physician, or to be made by the attending physician and one other physician, by an applicable provision of sections 1337.11 to 1337.17 of the Revised Code, to a reasonable degree of medical certainty and in accordance with reasonable medical standards.
(E) “Declaration for mental health treatment” has the same meaning as in section 2135.01 of the Revised Code.
(F) “Guardian” means a person appointed by a probate court pursuant to Chapter 2111 of the Revised Code to have the care and management of the person of an incompetent.
(G) “Health care” means any care, treatment, service, or procedure to maintain, diagnose, or treat an individual’s physical or mental condition or physical or mental health.
(H) “Health care decision” means informed consent, refusal to give informed consent, or withdrawal of informed consent to health care.
  (I) “Health care facility” means any of the following:
    (1) A hospital;
    (2) A hospice care program, pediatric respite care program, or other institution that specializes in comfort care of patients in a terminal condition or in a permanently unconscious state;
    (3) A nursing home;
    (4) A home health agency;
    (5) An intermediate care facility for individuals with intellectual disabilities;
    (6) A regulated community mental health organization.
(J) “Health care personnel” means physicians, nurses, physician assistants, emergency medical technicians-basic, emergency medical technicians-intermediate, emergency medical technicians-paramedic, medical technicians, dietitians, other authorized persons acting under the direction of an attending physician, and administrators of health care facilities.
(K) “Home health agency” has the same meaning as in section 3701.881 of the Revised Code.
(L) “Hospice care program” and “pediatric respite care program” have the same
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meanings as in section 3712.01 of the Revised Code.

(M) “Hospital” has the same meanings as in sections 3701.01, 3727.01, and 5122.01 of the Revised Code.

(N) “Hydration” means fluids that are artificially or technologically administered.

(O) “Incompetent” has the same meaning as in section 2111.01 of the Revised Code.

(P) “Intermediate care facility for individuals with intellectual disabilities” has the same meaning as in section 5124.01 of the Revised Code.

(Q) “Life-sustaining treatment” means any medical procedure, treatment, intervention, or other measure that, when administered to a principal, will serve principally to prolong the process of dying.

(R) “Medical claim” has the same meaning as in section 2305.113 of the Revised Code.

(S) “Mental health treatment” has the same meaning as in section 2135.01 of the Revised Code.

(T) “Nursing home” has the same meaning as in section 3721.01 of the Revised Code.

(U) “Nutrition” means sustenance that is artificially or technologically administered.

(V) “Permanently unconscious state” means a state of permanent unconsciousness in a principal that, to a reasonable degree of medical certainty as determined in accordance with reasonable medical standards by the principal’s attending physician and one other physician who has examined the principal, is characterized by both of the following:

(1) Irreversible unawareness of one’s being and environment.

(2) Total loss of cerebral cortical functioning, resulting in the principal having no capacity to experience pain or suffering.

(W) “Person” has the same meaning as in section 1.59 of the Revised Code and additionally includes political subdivisions and governmental agencies, boards, commissions, departments, institutions, offices, and other instrumentalities.

(X) “Physician” means a person who is authorized under Chapter 4731 of the Revised Code to practice medicine and surgery or osteopathic medicine and surgery.

(Y) “Political subdivision” and “state” have the same meanings as in section 2744.01 of the Revised Code.

(Z) “Professional disciplinary action” means action taken by the board or other entity that regulates the professional conduct of health care personnel, including the state medical board and the board of nursing.

(AA) “Regulated community mental health organization” means a residential facility as defined and licensed under section 5119.34 of the Revised Code or a community mental health services provider as defined in section 5122.01 of the Revised Code.

(BB) “Terminal condition” means an irreversible, incurable, and untreatable condition caused by disease, illness, or injury from which, to a reasonable degree of medical certainty as determined in accordance with reasonable medical standards by a principal’s attending physician and one other physician who has examined the principal, both of the following apply:

(1) There can be no recovery.

(2) Death is likely to occur within a relatively short time if life-sustaining treatment is not administered.

(CC) “Tort action” means a civil action for damages for injury, death, or loss to person or property, other than a civil action for damages for a breach of contract or another agreement between persons.

1337.12 Durable power of attorney.

(A)(1) An adult who is of sound mind voluntarily may create a valid durable power of attorney for health care by executing a durable power of attorney, in accordance with section 1337.24 of the Revised Code, that authorizes an attorney in fact as described in division (A)(2)
of this section to make health care decisions for the principal at any time that the attending physician of the principal determines that the principal has lost the capacity to make informed health care decisions for the principal. The durable power of attorney for health care may authorize the attorney in fact, commencing immediately upon the execution of the instrument or at any subsequent time and regardless of whether the principal has lost the capacity to make informed health care decisions, to obtain information concerning the principal's health, including protected health information as defined in 45 C.F.R. 160.103. Except as otherwise provided in divisions (B) to (F) of section 1337.13 of the Revised Code, the authorization may include the right to give informed consent, to refuse to give informed consent, or to withdraw informed consent to any health care that is being or could be provided to the principal. Additionally, to be valid, a durable power of attorney for health care shall satisfy both of the following:

(a) It shall be signed at the end of the instrument by the principal and shall state the date of its execution.
(b) It shall be witnessed in accordance with division (B) of this section or be acknowledged by the principal in accordance with division (C) of this section.

(2) Except as otherwise provided in this division, a durable power of attorney for health care may designate any competent adult as the attorney in fact. The attending physician of the principal and an administrator of any nursing home in which the principal is receiving care shall not be designated as an attorney in fact in, or act as an attorney in fact pursuant to, a durable power of attorney for health care. An employee or agent of the attending physician of the principal and an employee or agent of any health care facility in which the principal is being treated shall not be designated as an attorney in fact in, or act as an attorney in fact pursuant to, a durable power of attorney for health care, except that these limitations do not preclude a principal from designating either type of employee or agent as the principal's attorney in fact if the individual is a competent adult and related to the principal by blood, marriage, or adoption, or if the individual is a competent adult and the principal and the individual are members of the same religious order.

(3) A durable power of attorney for health care shall not expire, unless the principal specifies an expiration date in the instrument. However, when a durable power of attorney contains an expiration date, if the principal lacks the capacity to make informed health care decisions for the principal on the expiration date, the instrument shall continue in effect until the principal regains the capacity to make informed health care decisions for the principal.

(B) If witnessed for purposes of division (A)(1)(b) of this section, a durable power of attorney for health care shall be witnessed by at least two individuals who are adults and who are not ineligible to be witnesses under this division. Any person who is related to the principal by blood, marriage, or adoption, any person who is designated as the attorney in fact or alternate attorney in fact in the instrument, the attending physician of the principal, and the administrator of any nursing home in which the principal is receiving care are ineligible to be witnesses.

The witnessing of a durable power of attorney for health care shall involve the principal signing, or acknowledging the principal's signature, at the end of the instrument in the presence of each witness. Then, each witness shall subscribe the witness's signature after the signature of the principal and, by doing so, attest to the witness's belief that the principal appears to be of sound mind and not under or subject to duress, fraud, or undue influence. The signatures of the principal and the witnesses under this division are not required to appear on the same page of the instrument.

(C) If acknowledged for purposes of division (A)(1)(b) of this section, a durable power of attorney for health care shall be acknowledged before a notary public, who shall make the certification described in section 147.53 of the Revised Code and also shall attest that the principal appears to be of sound mind and not under or subject to duress, fraud, or undue influence.
(D)(1) If a principal has both a valid durable power of attorney for health care and a valid declaration, division (B) of section 2133.03 of the Revised Code applies. If a principal has both a valid durable power of attorney for health care and a DNR identification that is based upon a valid declaration and if the declaration supersedes the durable power of attorney for health care under division (B) of section 2133.03 of the Revised Code, the DNR identification supersedes the durable power of attorney for health care to the extent of any conflict between the two. A valid durable power of attorney for health care supersedes any DNR identification that is based upon a do-not-resuscitate order that a physician issued for the principal which is inconsistent with the durable power of attorney for health care or a valid decision by the attorney in fact under a durable power of attorney.

(2) As used in division (D) of this section:
(a) “Declaration” has the same meaning as in section 2133.01 of the Revised Code.
(b) “Do-not-resuscitate order” and “DNR identification” have the same meanings as in section 2133.21 of the Revised Code.

(E)(1) In a durable power of attorney for health care, a principal may nominate a guardian of the principal's person, estate, or both for consideration by a court if proceedings for the appointment of a guardian for the principal's person, estate, or both are commenced at a later time. The principal may authorize the person nominated as the guardian or the attorney in fact to nominate a successor guardian for consideration by the court. The principal's nomination of a guardian of the principal's person, estate, or both is revoked by the principal's subsequent nomination of a guardian of the principal's person, estate, or both, and, except for good cause shown or disqualification, the court shall make its appointment in accordance with the principal's most recent nomination.

(2) The principal may direct that bond be waived for a person nominated as guardian or successor guardian under division (E)(1) of this section.

(3) A durable power of attorney for health care that contains the nomination of a person to be the guardian of the person, estate, or both of the principal may be filed with the probate court for safekeeping, and the probate court shall designate the nomination as the nomination of a standby guardian.

(4) If a guardian is appointed for the principal, a durable power of attorney for health care is not terminated, and the authority of the attorney in fact continues unless the court, pursuant to its authority under section 2111.50 of the Revised Code, limits, suspends, or terminates the power of attorney after notice to the attorney in fact and upon a finding that the limitation, suspension, or termination is in the best interest of the principal.

1337.13 Attorney in fact health care decision authority.

(A)(1) An attorney in fact under a durable power of attorney for health care shall make health care decisions for the principal only if the instrument substantially complies with section 1337.12 of the Revised Code and specifically authorizes the attorney in fact to make health care decisions for the principal, and only if the attending physician of the principal determines that the principal has lost the capacity to make informed health care decisions for the principal. If authorized in the instrument, the attorney in fact, commencing immediately upon the execution of the instrument or at any subsequent time specified in the instrument and regardless of whether the principal has lost the capacity to make informed health care decisions, may obtain information concerning the principal's health, including protected health information as defined in 45 C.F.R. 160.103. Except as otherwise provided in divisions (B) to (F) of this section and subject to any specific limitations in the instrument, the attorney in fact may make health care decisions for the principal to the same extent as the principal could make those decisions for the principal if the principal had the capacity to do so. Except as otherwise provided in divisions (B) to (F) of this section, in exercising that authority, the attorney in fact shall act consistently with
the desires of the principal or, if the desires of the principal are unknown, shall act in the best interest of the principal.

(2) This section does not affect, and shall not be construed as affecting, any right that the person designated as attorney in fact in a durable power of attorney for health care may have, apart from the instrument, to make or participate in the making of health care decisions on behalf of the principal.

(3) Unless the right is limited in a durable power of attorney for health care, when acting pursuant to the instrument, the attorney in fact has the same right as the principal to receive information about proposed health care, to review health care records, and to consent to the disclosure of health care records.

(B)(1) An attorney in fact under a durable power of attorney for health care does not have authority, on behalf of the principal, to refuse or withdraw informed consent to life-sustaining treatment, unless the principal is in a terminal condition or in a permanently unconscious state and unless the applicable requirements of divisions (B)(2) and (3) of this section are satisfied.

(2) In order for an attorney in fact to refuse or withdraw informed consent to life-sustaining treatment for a principal who is in a permanently unconscious state, the consulting physician associated with the determination that the principal is in the permanently unconscious state shall be a physician who, by virtue of advanced education or training, of a practice limited to particular diseases, illnesses, injuries, therapies, or branches of medicine and surgery or osteopathic medicine and surgery, of certification as a specialist in a particular branch of medicine or surgery or osteopathic medicine and surgery, or of experience acquired in the practice of medicine and surgery or osteopathic medicine and surgery, is qualified to determine whether the principal is in a permanently unconscious state.

(3) In order for an attorney in fact to refuse or withdraw informed consent to life-sustaining treatment for a principal who is in a terminal condition or in a permanently unconscious state, the attending physician of the principal shall determine, in good faith, both of the following:

(a) To a reasonable degree of medical certainty, and in accordance with reasonable medical standards, that there is no reasonable possibility that the principal will regain the capacity to make informed health care decisions for the principal;

(b) That the attorney in fact is competent to make such a decision under division (H) of this section.

(C) Except as otherwise provided in this division, an attorney in fact under a durable power of attorney for health care does not have authority, on behalf of the principal, to refuse or withdraw informed consent to health care necessary to provide comfort care. This division does not preclude, and shall not be construed as precluding, an attorney in fact under a durable power of attorney for health care from refusing or withdrawing informed consent to the provision of nutrition or hydration to the principal if, under the circumstances described in division (E) of this section, the attorney in fact would not be prohibited from refusing or withdrawing informed consent to the provision of nutrition or hydration to the principal.

(D) An attorney in fact under a durable power of attorney for health care does not have authority to refuse or withdraw informed consent to health care for a principal who is pregnant if the refusal or withdrawal of the health care would terminate the pregnancy, unless the pregnancy or the health care would pose a substantial risk to the life of the principal, or unless the principal's attending physician and at least one other physician who has examined the principal determine, to a reasonable degree of medical certainty and in accordance with reasonable medical standards, that the fetus would not be born alive.

(E) An attorney in fact under a durable power of attorney for health care does not have authority to refuse or withdraw informed consent to the provision of nutrition or hydration to the principal, unless the principal is in a terminal condition or in a permanently unconscious state
and unless the following apply:

(1) The principal's attending physician and at least one other physician who has examined the principal determine, to a reasonable degree of medical certainty and in accordance with reasonable medical standards, that nutrition or hydration will not or no longer will serve to provide comfort to, or alleviate pain of, the principal.

(2) If the principal is in a permanently unconscious state, the principal has authorized the attorney in fact to refuse or withdraw informed consent to the provision of nutrition or hydration to the principal if the principal is in a permanently unconscious state by doing both of the following in the durable power of attorney for health care:

(a) Including a statement in capital letters or other conspicuous type, including, but not limited to, a different font, bigger type, or boldface type, that the attorney in fact may refuse or withdraw informed consent to the provision of nutrition or hydration to the principal if the principal is in a permanently unconscious state and if the determination described in division (E)(1) of this section is made, or checking or otherwise marking a box or line that is adjacent to a similar statement on a printed form of a durable power of attorney for health care;

(b) Placing the principal's initials or signature underneath or adjacent to the statement, check, or other mark described in division (E)(2)(a) of this section.

(3) If the principal is in a permanently unconscious state, the principal's attending physician determines, in good faith, that the principal authorized the attorney in fact to refuse or withdraw informed consent to the provision of nutrition or hydration to the principal when the principal is in a permanently unconscious state by complying with the requirements of divisions (E)(2)(a) and (b) of this section.

(4) The principal's attending physician determines, in good faith, that the attorney in fact is competent to make such a decision under division (H) of this section.

(F) An attorney in fact under a durable power of attorney for health care does not have authority to withdraw informed consent to any health care to which the principal previously consented, unless at least one of the following applies:

(1) A change in the physical condition of the principal has significantly decreased the benefit of that health care to the principal.

(2) The health care is not, or is no longer, significantly effective in achieving the purposes for which the principal consented to its use.

(G) An attorney in fact under a durable power of attorney for health care does not have authority to make decisions pertaining to the use or continuation of life-sustaining treatment or the provision of nutrition or hydration to the principal unless the attorney in fact is competent to make those decisions under division (H) of this section.

(H) An attorney in fact is competent to make decisions under division (B), (E), or (G) of this section unless the attorney in fact is subject to a temporary protection order, civil protection order, or any other protection order issued by a court in this state or another state in which the principal is the alleged victim.

1337.14 Durable power of attorney principal revocation.

(A) A principal who creates a valid durable power of attorney for health care may revoke that instrument or the designation of the attorney in fact under it.

The principal may so revoke at any time and in any manner. The revocation shall be effective when the principal expresses an intention to so revoke, except that, if the principal made the principal's attending physician aware of the durable power of attorney for health care, the revocation shall be effective upon its communication to the attending physician by the principal, a witness to the revocation, or other health care personnel to whom the revocation is communicated by such a witness. Absent actual knowledge to the contrary, the attending physician of the principal and other health care personnel who are informed of the revocation of
a durable power of attorney for health care by an alleged witness may rely on the information and act in accordance with the revocation.

(B) Upon the communication as described in division (A) of this section to the attending physician of a principal of the fact that the principal's durable power of attorney for health care has been revoked, the attending physician or other health care personnel acting under the direction of the attending physician shall make the fact a part of the principal's medical record.

(C) Unless the instrument provides otherwise, a valid durable power of attorney for health care revokes a prior, valid durable power of attorney for health care.

(D) Regardless of when the declaration is drafted, the execution of a declaration for mental health treatment does not revoke a valid durable power of attorney for health care. A declaration for mental health treatment executed in accordance with Chapter 2135 of the Revised Code supersedes a valid durable power of attorney for health care with regard to mental health treatment and the designation of a proxy to make decisions regarding mental health treatment.

**1337.15 Immunity of physicians and others.**

(A) Subject to division (H) of this section, an attending physician of a principal is not subject to criminal prosecution or professional disciplinary action and is not liable in damages in a tort or other civil action for actions taken in good faith and in reliance on a health care decision when all of the following are satisfied:

1. The decision is made by an attorney in fact under a durable power of attorney for health care after the attorney in fact receives information sufficient to satisfy the requirements of informed consent or refusal or withdrawal of informed consent, and the attending physician, in good faith, believes that the attorney in fact is authorized to make the decision.

2. The attending physician, in good faith, believes that the decision is consistent with the desires of the principal, or the attorney in fact informs the attending physician that the desires of the principal are unknown and the attending physician, in good faith, believes that the desires of the principal are unknown and that the decision is in the best interest of the principal.

3. The attending physician determines, in good faith, to a reasonable degree of medical certainty, and in accordance with reasonable medical standards, that the principal has lost the capacity to make informed health care decisions for the principal.

4. If the decision is to withhold or withdraw life-sustaining treatment, the attending physician attempts, in good faith, to determine the desires of the principal to the extent that the principal is able to convey them and places a report of the attempt in the health care records of the principal.

5. If the decision is to withhold or withdraw life-sustaining treatment, the attending physician determines, in good faith, to a reasonable degree of medical certainty, and in accordance with reasonable medical standards, that both of the following apply:

   a. The principal is in a terminal condition or in a permanently unconscious state.

   b. There is no reasonable possibility that the principal will regain the capacity to make informed health care decisions for the principal.

6. If the decision pertains to a principal who is pregnant and if the withholding or withdrawal of health care would terminate the pregnancy, the attending physician makes, in good faith, to a reasonable degree of medical certainty, and in accordance with reasonable medical standards, a determination whether or not the pregnancy or health care involved would pose a substantial risk to the life of the principal or a determination whether or not the fetus would be born alive.

7. If the decision pertains to the provision of nutrition or hydration to a principal who is in a terminal condition or in a permanently unconscious state, the attending physician determines,
in good faith, to a reasonable degree of medical certainty, and in accordance with reasonable medical standards, that nutrition or hydration will not or no longer will serve to provide comfort to, or alleviate pain of, the principal.

(8) If the decision pertains to the provision of nutrition or hydration to a principal who is in a permanently unconscious state, the attending physician determines, in good faith, that the principal authorized the attorney in fact to refuse or withdraw informed consent to the provision of nutrition or hydration to the principal when the principal is in a permanently unconscious state by complying with the requirements of divisions (E)(2)(a) and (b) of section 1337.13 of the Revised Code.

(B)(1) Notwithstanding the health care decision of the attorney in fact, subject to division (H) of this section, an attending physician of a principal is not subject to criminal prosecution or professional disciplinary action and is not liable in damages in a tort or other civil action for providing or for failing to withdraw life-sustaining treatment.

(2) Subject to division (H) of this section, an attending physician who is carrying out in good faith and in a manner consistent with divisions (C) and (E) of section 1337.13 of the Revised Code the responsibility to provide comfort care to a principal in a terminal condition or in a permanently unconscious state is not subject to criminal prosecution or professional disciplinary action and is not liable in damages in a tort or other civil action for prescribing, dispensing, administering, or causing to be administered any particular medical procedure, treatment, intervention, or other measure to the principal, including, but not limited to, prescribing, personally furnishing, administering, or causing to be administered by judicious titration or in another manner any form of medication, for the purpose of diminishing the principal's pain or discomfort and not for the purpose of postponing or causing the principal's death, even though the medical procedure, treatment, intervention, or other measure may appear to hasten or increase the risk of the principal's death.

(C) Subject to division (H) of this section, a consulting physician is not subject to criminal prosecution or professional disciplinary action and is not liable in damages in a tort or other civil action as follows:

(1) If the health care decision involved is one other than the health care decision described in division (C)(2), (3), or (4) of this section, the consulting physician made a determination, in good faith, to a reasonable degree of medical certainty, and in accordance with reasonable medical standards, in conjunction with the attending physician of a principal.

(2) If the decision is to withhold or withdraw life-sustaining treatment, the consulting physician determines, in good faith, to a reasonable degree of medical certainty, and in accordance with reasonable medical standards, after examining the principal, that the principal is in a terminal condition or in a permanently unconscious state.

(3) If the health care decision involved pertains to a principal who is pregnant and if the withholding or withdrawal of health care would terminate the pregnancy, the consulting physician makes, in good faith, to a reasonable degree of medical certainty, and in accordance with reasonable medical standards, a determination whether or not the pregnancy or health care involved would pose a substantial risk to the life of the principal or a determination whether or not the fetus would be born alive.

(4) If the decision pertains to the provision of nutrition or hydration to a principal who is in a terminal condition or in a permanently unconscious state, the consulting physician determines, in good faith, to a reasonable degree of medical certainty, and in accordance with reasonable medical standards, that nutrition or hydration will not or no longer will serve to provide comfort to, or alleviate pain of, the principal.

(D) Subject to division (H) of this section, a person is not subject to criminal prosecution or professional disciplinary action and is not liable in damages in a tort or other civil action for actions taken, in good faith, while relying on a durable power of attorney for health care if the person does not have actual knowledge of either of the following facts:
(1) The durable power of attorney has been revoked pursuant to section 1337.14 of the Revised Code.

(2) The durable power of attorney does not substantially comply with sections 1337.11 to 1337.17 of the Revised Code.

(E)(1) Subject to division (H) of this section, a consulting physician, an employee or agent of any health care facility or the attending physician of a principal, and health care personnel acting under the direction of the attending physician of a principal are not subject to criminal prosecution or professional disciplinary action and are not liable in damages in a tort or other civil action for any action described in division (A), (B), (C), or (D) of this section that was undertaken, in good faith, pursuant to the direction of the attending physician of the principal.

(2) Subject to division (H) of this section, health care personnel who are acting under the direction of the principal's attending physician and who carry out the responsibility to provide comfort care to a principal in a terminal condition or in a permanently unconscious state in good faith and in a manner consistent with divisions (C) and (E) of section 1337.13 of the Revised Code are not subject to criminal prosecution or professional disciplinary action and are not liable in damages in a tort or other civil action for dispensing, administering, or causing to be administered any particular medical procedure, treatment, intervention, or other measure to the principal, including, but not limited to, personally furnishing, administering, or causing to be administered by judicious titration or in another manner any form of medication, for the purpose of diminishing the principal's pain or discomfort and not for the purpose of postponing or causing the principal's death, even though the medical procedure, treatment, intervention, or other measure may appear to hasten or increase the risk of the principal's death.

(F) Subject to division (H) of this section, a health care facility is not subject to criminal prosecution or professional disciplinary action and is not liable in damages in a tort or other civil action for any action that properly was undertaken pursuant to division (A), (B), (C), (D), or (E) of this section.

(G) Subject to division (H) of this section, an attorney in fact is not subject to criminal prosecution or professional disciplinary action and is not liable in damages in a tort or other civil action for health care decisions made in good faith while acting pursuant to the attorney in fact's authority under a durable power of attorney for health care.

(H)(1) Sections 1337.11 to 1337.17 of the Revised Code and a durable power of attorney for health care do not affect or limit any potential tort or other civil liability of an attending or consulting physician, an employee or agent of a health care facility or an attending physician, health care personnel acting under the direction of an attending physician, a health care facility, an attorney in fact, or any other person, including, but not limited to, liability associated with a medical claim, that satisfies both of the following:

(a) The liability arises out of a negligent action or omission in connection with the medical diagnosis, care, or treatment of a principal under a durable power of attorney for health care or arises out of any deviation from reasonable medical standards.

(b) The liability is based on the fact that the negligent action or omission, or the deviation, as described in division (H)(1)(a) of this section caused or contributed to the principal under the durable power of attorney for health care having a terminal condition or being in a permanently unconscious state, or otherwise caused or contributed to any injury to or the wrongful death of the principal.

(2) Sections 1337.11 to 1337.17 of the Revised Code and a durable power of attorney for health care do not grant an immunity from criminal or civil liability or from professional disciplinary action to health care personnel for actions that are outside the scope of their authority.
1337.16 Durable power of attorney for healthcare operational provisions.

(A) No physician, health care facility, other health care provider, person authorized to engage in the business of insurance in this state under Title XXXIX of the Revised Code, health insuring corporation, other health care plan, or legal entity that is self-insured and provides benefits to its employees or members shall require an individual to create or refrain from creating a durable power of attorney for health care, or shall require an individual to revoke or refrain from revoking a durable power of attorney for health care, as a condition of being admitted to a health care facility, being provided health care, being insured, or being the recipient of benefits.

(B)(1) Subject to division (B)(2) of this section, an attending physician of a principal or a health care facility in which a principal is confined may refuse to comply or allow compliance with the instructions of an attorney in fact under a durable power of attorney for health care on the basis of a matter of conscience or on another basis. An employee or agent of an attending physician of a principal or of a health care facility in which a principal is confined may refuse to comply with the instructions of an attorney in fact under a durable power of attorney for health care on the basis of a matter of conscience.

(2)(a) An attending physician of a principal who, or health care facility in which a principal is confined that, is not willing or not able to comply or allow compliance with the instructions of an attorney in fact under a durable power of attorney for health care to use or continue, or to withhold or withdraw, health care that were given under division (A) of section 1337.13 of the Revised Code, or with any probate court reevaluation order issued pursuant to division (D)(6) of this section, shall not prevent or attempt to prevent, or unreasonably delay or attempt to unreasonably delay, the transfer of the principal to the care of a physician who, or a health care facility that, is willing and able to so comply or allow compliance.

(b) If the instruction of an attorney in fact under a durable power of attorney for health care that is given under division (A) of section 1337.13 of the Revised Code is to use or continue life-sustaining treatment in connection with a principal who is in a terminal condition or in a permanently unconscious state, the attending physician of the principal who, or the health care facility in which the principal is confined that, is not willing or not able to comply or allow compliance with that instruction shall use or continue the life-sustaining treatment or cause it to be used or continued until a transfer as described in division (B)(2)(a) of this section is made.

(C) Sections 1337.11 to 1337.17 of the Revised Code and a durable power of attorney for health care created under section 1337.12 of the Revised Code do not affect or limit the authority of a physician or a health care facility to provide or not to provide health care to a person in accordance with reasonable medical standards applicable in an emergency situation.

(D)(1) If the attending physician of a principal and one other physician who examines the principal determine that the principal is in a terminal condition or in a permanently unconscious state, if the attending physician additionally determines that the principal has lost the capacity to make informed health care decisions for the principal and that there is no reasonable possibility that the principal will regain the capacity to make informed health care decisions for the principal, and if the attorney in fact under the principal's durable power of attorney for health care makes a health care decision pertaining to the use or continuation, or the withholding or withdrawal, of life-sustaining treatment, the attending physician shall do all of the following:

(a) Record the determinations and health care decision in the principal's medical record;

(b) Make a good faith effort, and use reasonable diligence, to notify the appropriate individual or individuals, in accordance with the following descending order of priority, of the determinations and health care decision:

(i) If any, the guardian of the principal. This division does not permit or require the appointment of a guardian for the principal.
(ii) The principal's spouse;
(iii) The principal's adult children who are available within a reasonable period of time for consultation with the principal's attending physician;
(iv) The principal's parents;
(v) An adult sibling of the principal or, if there is more than one adult sibling, a majority of the principal's adult siblings who are available within a reasonable period of time for such consultation.

(c) Record in the principal's medical record the names of the individual or individuals notified pursuant to division (D)(1)(b) of this section and the manner of notification;
(d) Afford time for the individual or individuals notified pursuant to division (D)(1)(b) of this section to object in the manner described in division (D)(3)(a) of this section.

(2)(a) If, despite making a good faith effort, and despite using reasonable diligence, to notify the appropriate individual or individuals described in division (D)(1)(b) of this section, the attending physician cannot notify the individual or individuals of the determinations and health care decision because the individual or individuals are deceased, cannot be located, or cannot be notified for some other reason, the requirements of divisions (D)(1)(b), (c), and (d) of this section and, except as provided in division (D)(3)(b) of this section, the provisions of divisions (D)(3) to (6) of this section shall not apply in connection with the principal. However, the attending physician shall record in the principal's medical record information pertaining to the reason for the failure to provide the requisite notices and information pertaining to the nature of the good faith effort and reasonable diligence used.

(b) The requirements of divisions (D)(1)(b), (c), and (d) of this section and, except as provided in division (D)(3)(b) of this section, the provisions of divisions (D)(3) to (6) of this section shall not apply in connection with the principal if only one individual would have to be notified pursuant to division (D)(1)(b) of this section and that individual is the attorney in fact under the durable power of attorney for health care. However, the attending physician of the principal shall record in the principal's medical record information indicating that no notice was given pursuant to division (D)(1)(b) of this section because of the provisions of division (D)(2)(b) of this section.

(3)(a) Within forty-eight hours after receipt of a notice pursuant to division (D)(1) of this section, any individual so notified shall advise the attending physician of the principal whether the individual objects on a basis specified in division (D)(4)(c) of this section. If an objection as described in that division is communicated to the attending physician, then, within two business days after the communication, the individual shall file a complaint as described in division (D)(4) of this section in the probate court of the county in which the principal is located. If the individual fails to so file a complaint, the individual's objections as described in division (D)(4)(c) of this section shall be considered to be void.

(b) Within forty-eight hours after the priority individual or any member of a priority class of individuals receives a notice pursuant to division (D)(1) of this section or within forty-eight hours after information pertaining to an unnotified priority individual or unnotified priority class of individuals is recorded in a principal's medical record pursuant to division (D)(2)(a) or (b) of this section, the individual or a majority of the individuals in the next class of individuals that pertains to the principal in the descending order of priority set forth in divisions (D)(1)(b)(i) to (v) of this section shall advise the attending physician of the principal whether the individual or majority object on a basis specified in division (D)(4)(c) of this section. If an objection as described in that division is communicated to the attending physician, then, within two business days after the communication, the objecting individual or majority shall file a complaint as described in division (D)(4) of this section in the probate court of the county in which the principal is located. If the objecting individual or majority fails to file a complaint, the objections as described in division (D)(4)(c) of this section shall be considered to be void.

(4) A complaint of an individual that is filed in accordance with division (D)(3)(a) of this
section or of an individual or majority of individuals that is filed in accordance with division 
(D)(3)(b) of this section shall satisfy all of the following:

(a) Name any health care facility in which the principal is confined;

(b) Name the principal, the principal's attending physician, and the consulting physician 
associated with the determination that the principal is in a terminal condition or in a permanently 
unconscious state;

(c) Indicate whether the plaintiff or plaintiffs object on one or more of the following bases:
   (i) To the attending physician's determination that the principal has lost the capacity to 
      make informed health care decisions for the principal;
   (ii) To the attending physician's determination that there is no reasonable possibility that 
      the principal will regain the capacity to make informed health care decisions for the principal;
   (iii) That, in exercising the attorney in fact's authority, the attorney in fact is not acting 
      consistently with the desires of the principal or, if the desires of the principal are unknown, in the 
      best interest of the principal;
   (iv) That the durable power of attorney for health care has expired or otherwise is no 
      longer effective;
   (v) To the attending physician's and consulting physician's determinations that the 
      principal is in a terminal condition or in a permanently unconscious state;
   (vi) That the attorney in fact's health care decision pertaining to the use or continuation, 
      or the withholding or withdrawal, of life-sustaining treatment is not authorized by the durable 
      power of attorney for health care or is prohibited under section 1337.13 of the Revised Code;
   (vii) That the durable power of attorney for health care was executed when the principal 
      was not of sound mind or was under or subject to duress, fraud, or undue influence;
   (viii) That the durable power of attorney for health care otherwise does not substantially 
      comply with section 1337.12 of the Revised Code.

(d) Request the probate court to issue one or more of the following types of orders:
   (i) An order to the attending physician to reevaluate, in light of the court proceedings, the 
      determination that the principal has lost the capacity to make informed health care decisions for 
      the principal, the determination that the principal is in a terminal condition or in a permanently 
      unconscious state, or the determination that there is no reasonable possibility that the principal 
      will regain the capacity to make informed health care decisions for the principal;
   (ii) An order to the attorney in fact to act consistently with the desires of the principal or, 
      if the desires of the principal are unknown, in the best interest of the principal in exercising the 
      attorney in fact's authority, or to make only health care decisions pertaining to life-sustaining 
      treatment that are authorized by the durable power of attorney for health care and that are not 
      prohibited under section 1337.13 of the Revised Code;
   (iii) An order invalidating the durable power of attorney for health care because it has 
      expired or otherwise is no longer effective, it was executed when the principal was not of sound 
      mind or was under or subject to duress, fraud, or undue influence, or it otherwise does not 
      substantially comply with section 1337.12 of the Revised Code.

(e) Be accompanied by an affidavit of the plaintiff or plaintiffs that includes averments 
relative to whether the plaintiff is an individual or the plaintiffs are individuals as described in 
division (D)(1)(b)(i), (ii), (iii), (iv), or (v) of this section and to the factual basis for the plaintiff's or 
the plaintiffs' objections;

(f) Name any individuals who were notified by the attending physician in accordance with 
division (D)(1)(b) of this section and who are not joining in the complaint as plaintiffs;

(g) Name, in the caption of the complaint, as defendants the attending physician of the 
principal, the attorney in fact under the durable power of attorney for health care, the consulting 
physician associated with the determination that the principal is in a terminal condition or in a 
permanently unconscious state, any health care facility in which the principal is confined, and 
any individuals who were notified by the attending physician in accordance with division
(D)(1)(b) of this section and who are not joining in the complaint as plaintiffs.

(5) Notwithstanding any contrary provision of the Revised Code or of the Rules of Civil Procedure, the state and persons other than an objecting individual as described in division (D)(3)(a) of this section, other than an objecting individual or majority of individuals as described in division (D)(3)(b) of this section, and other than persons described in division (D)(4)(g) of this section are prohibited from commencing a civil action under division (D) of this section and from joining or being joined as parties to an action commenced under division (D) of this section, including joining by way of intervention.

(6)(a) A probate court in which a complaint as described in division (D)(4) of this section is filed within the period specified in division (D)(3)(a) or (b) of this section shall conduct a hearing on the complaint after a copy of it and a notice of the hearing have been served upon the defendants. The clerk of the probate court in which the complaint is filed shall cause the complaint and the notice of the hearing to be so served in accordance with the Rules of Civil Procedure, which service shall be made, if possible, within three days after the filing of the complaint. The hearing shall be conducted at the earliest possible time, but no later than the third business day after such service has been completed. Immediately following the hearing, the court shall enter on its journal its determination whether a requested order will be issued.

(b) If the health care decision of the attorney in fact authorized the use or continuation of life-sustaining treatment and if the plaintiff or plaintiffs requested a reevaluation order to the attending physician of the principal or an order to the attorney in fact as described in division (D)(4)(d)(i) or (ii) of this section, the court shall issue the requested order only if it finds that the plaintiff or plaintiffs have established a factual basis for the objection or objections involved by clear and convincing evidence and, if applicable, to a reasonable degree of medical certainty and in accordance with reasonable medical standards.

(c) If the health care decision of the attorney in fact authorized the withholding or withdrawal of life-sustaining treatment and if the plaintiff or plaintiffs requested a reevaluation order to the attending physician of the principal or an order to the attorney in fact as described in division (D)(4)(d)(i) or (ii) of this section, the court shall issue the requested order only if it finds that the plaintiff or plaintiffs have established a factual basis for the objection or objections involved by preponderance of the evidence and, if applicable, to a reasonable degree of medical certainty and in accordance with reasonable medical standards.

(d) If the plaintiff or plaintiffs requested an invalidation order as described in division (D)(4)(d)(iii) of this section, the court shall issue the order only if it finds that the plaintiff or plaintiffs have established a factual basis for the objection or objections involved by clear and convincing evidence.

(e) If the court issues a reevaluation order to the principal's attending physician pursuant to division (D)(6)(b) or (c) of this section, the attending physician shall make the requisite reevaluation. If, after doing so, the attending physician again determines that the principal has lost the capacity to make informed health care decisions for the principal, that the principal is in a terminal condition or in a permanently unconscious state, or that there is no reasonable possibility that the principal will regain the capacity to make informed health care decisions for the principal, the attending physician shall notify the court in writing of the determination and comply with division (B)(2) of this section.

(E)(1) In connection with the provision of comfort care in a manner consistent with divisions (C) and (E) of section 1337.13 of the Revised Code to a principal who is in a terminal condition or in a permanently unconscious state, nothing in sections 1337.11 to 1337.17 of the Revised Code precludes the attending physician of the principal who carries out the responsibility to provide comfort care to the principal in good faith and while acting within the scope of the attending physician's authority from prescribing, dispensing, administering, or causing to be administered any particular medical procedure, treatment, intervention, or other measure to the principal, including, but not limited to, prescribing, personally furnishing,
administering, or causing to be administered by judicious titration or in another manner any form of medication, for the purpose of diminishing the principal's pain or discomfort and not for the purpose of postponing or causing the principal's death, even though the medical procedure, treatment, intervention, or other measure may appear to hasten or increase the risk of the principal's death. In connection with the provision of comfort care in a manner consistent with divisions (C) and (E) of section 1337.13 of the Revised Code to a principal who is in a terminal condition or in a permanently unconscious state, nothing in sections 1337.11 to 1337.17 of the Revised Code precludes health care personnel acting under the direction of the principal's attending physician who carry out the responsibility to provide comfort care to the principal in good faith and while acting within the scope of their authority from dispensing, administering, or causing to be administered any particular medical procedure, treatment, intervention, or other measure to the principal, including, but not limited to, personally furnishing, administering, or causing to be administered by judicious titration or in another manner any form of medication, for the purpose of diminishing the principal's pain or discomfort and not for the purpose of postponing or causing the principal's death, even though the medical procedure, treatment, intervention, or other measure may appear to hasten or increase the risk of the principal's death.

(2) If, at any time, a priority individual or any member of a priority class of individuals under division (D)(1)(b) of this section or if, at any time, the individual or a majority of the individuals in the next class of individuals that pertains to the principal in the descending order of priority set forth in that division, believes in good faith that both of the following circumstances apply, the priority individual, the member of the priority class of individuals, or the individual or majority of individuals in the next class of individuals that pertains to the principal may commence an action in the probate court of the county in which a principal who is in a terminal condition or permanently unconscious state is located for the issuance of an order mandating the use or continuation of comfort care in connection with the principal in a manner that is consistent with sections 1337.11 to 1337.17 of the Revised Code:

(a) Comfort care is not being used or continued in connection with the principal.

(b) The withholding or withdrawal of the comfort care is contrary to sections 1337.11 to 1337.17 of the Revised Code.

(F) Except as provided in divisions (D) and (E) of this section in connection with principals who are in a terminal condition or in a permanently unconscious state, sections 1337.11 to 1337.17 of the Revised Code do not authorize the commencement of any civil action in a probate court or court of common pleas for the purpose of obtaining an order relative to a health care decision made by an attorney in fact under a durable power of attorney for health care.

(G) A durable power of attorney for health care, or other document, that is similar to a durable power of attorney for health care authorized by sections 1337.11 to 1337.17 of the Revised Code, that is or has been executed under the law of another state prior to, on, or after October 10, 1991, and that substantially complies with that law or with sections 1337.11 to 1337.17 of the Revised Code shall be considered to be valid for purposes of those sections.

1337.17 Printed Form use; notice requirement.

A printed form of durable power of attorney for health care may be sold or otherwise distributed in this state for use by adults who are not advised by an attorney. By use of such a printed form, a principal may authorize an attorney in fact to make health care decisions on the principal's behalf, but the printed form shall not be used as an instrument for granting authority for any other decisions. Any printed form that is sold or otherwise distributed in this state for the purpose described in this section shall include the following notice:
“Notice to Adult Executing This Document

This is an important legal document. Before executing this document, you should know these facts:

This document gives the person you designate (the attorney in fact) the power to make most* health care decisions for you if you lose the capacity to make informed health care decisions for yourself. This power is effective only when your attending physician determines that you have lost the capacity to make informed health care decisions for yourself and, notwithstanding this document, as long as you have the capacity to make informed health care decisions for yourself, you retain the right to make all medical and other health care decisions for yourself.

You may include specific limitations in this document on the authority of the attorney in fact to make health care decisions for you.

Subject to any specific limitations you include in this document, if your attending physician determines that you have lost the capacity to make an informed decision on a health care matter, the attorney in fact generally* will be authorized by this document to make health care decisions for you to the same extent as you could make those decisions yourself, if you had the capacity to do so. The authority of the attorney in fact to make health care decisions for you generally* will include the authority to give informed consent, to refuse to give informed consent, or to withdraw informed consent to any care, treatment, service, or procedure to maintain, diagnose, or treat a physical or mental condition.

However*, even if the attorney in fact has general authority to make health care decisions for you under this document, the attorney in fact never* will be authorized to do any of the following:

1. Refuse or withdraw informed consent to life-sustaining treatment (unless your attending physician and one other physician who examines you determine, to a reasonable degree of medical certainty and in accordance with reasonable medical standards, that either of the following applies:
   a. You are suffering from an irreversible, incurable, and untreatable condition caused by disease, illness, or injury from which (i) there can be no recovery and (ii) your death is likely to occur within a relatively short time if life-sustaining treatment is not administered, and your attending physician additionally determines, to a reasonable degree of medical certainty and in accordance with reasonable medical standards, that there is no reasonable possibility that you will regain the capacity to make informed health care decisions for yourself.
   b. You are in a state of permanent unconsciousness that is characterized by you being irreversibly unaware of yourself and your environment and by a total loss of cerebral cortical functioning, resulting in you having no capacity to experience pain or suffering, and your attending physician additionally determines, to a reasonable degree of medical certainty and in accordance with reasonable medical standards, that there is no reasonable possibility that you will regain the capacity to make informed health care decisions for yourself);

2. Refuse or withdraw informed consent to health care necessary to provide you with comfort care (except that, if the attorney in fact is not prohibited from doing so under (4) below, the attorney in fact could refuse or withdraw informed consent to the provision of nutrition or hydration to you as described under (4) below). (You should understand that comfort care is defined in Ohio law to mean artificially or technologically administered sustenance (nutrition) or fluids (hydration) when administered to diminish your pain or discomfort, not to postpone your death, and any other medical or nursing procedure, treatment, intervention, or other measure that would be taken to diminish your pain or discomfort, not to postpone your death. Consequently, if your attending physician were to determine that a previously described medical or nursing procedure, treatment, intervention, or other measure will not or no longer will serve to provide comfort to you or alleviate your pain, then, subject to (4) below, your attorney in fact
would be authorized to refuse or withdraw informed consent to the procedure, treatment, intervention, or other measure.*);  

(3) Refuse or withdraw informed consent to health care for you if you are pregnant and if the refusal or withdrawal would terminate the pregnancy (unless the pregnancy or health care would pose a substantial risk to your life, or unless your attending physician and at least one other physician who examines you determine, to a reasonable degree of medical certainty and in accordance with reasonable medical standards, that the fetus would not be born alive);  

(4) Refuse or withdraw informed consent to the provision of artificially or technologically administered sustenance (nutrition) or fluids (hydration) to you, unless:  

(a) You are in a terminal condition or in a permanently unconscious state.  

(b) Your attending physician and at least one other physician who has examined you determine, to a reasonable degree of medical certainty and in accordance with reasonable medical standards, that nutrition or hydration will not or no longer will serve to provide comfort to you or alleviate your pain.  

(c) If, but only if, you are in a permanently unconscious state, you authorize the attorney in fact to refuse or withdraw informed consent to the provision of nutrition or hydration to you by doing both of the following in this document:  

(i) Including a statement in capital letters or other conspicuous type, including, but not limited to, a different font, bigger type, or boldface type, that the attorney in fact may refuse or withdraw informed consent to the provision of nutrition or hydration to you if you are in a permanently unconscious state and if the determination that nutrition or hydration will not or no longer will serve to provide comfort to you or alleviate your pain is made, or checking or otherwise marking a box or line (if any) that is adjacent to a similar statement on this document;  

(ii) Placing your initials or signature underneath or adjacent to the statement, check, or other mark previously described.  

(d) Your attending physician determines, in good faith, that you authorized the attorney in fact to refuse or withdraw informed consent to the provision of nutrition or hydration to you if you are in a permanently unconscious state by complying with the requirements of (4)(c)(i) and (ii) above.  

(5) Withdraw informed consent to any health care to which you previously consented, unless a change in your physical condition has significantly decreased the benefit of that health care to you, or unless the health care is not, or is no longer, significantly effective in achieving the purposes for which you consented to its use;  

(6) Provide, refuse, or withdraw informed consent to life-sustaining treatment, or the provision of artificially or technologically administered sustenance (nutrition) or fluids (hydration) to you, if the attorney in fact is subject to a temporary protection order, civil protection order, or any other protection order in this state or another state in which you are the alleged victim.  

Additionally, when exercising authority to make health care decisions for you, the attorney in fact will have to act consistently with your desires or, if your desires are unknown, to act in your best interest. You may express your desires to the attorney in fact by including them in this document or by making them known to the attorney in fact in another manner.  

When acting pursuant to this document, the attorney in fact generally* will have the same rights that you have to receive information about proposed health care, to review health care records, and to consent to the disclosure of health care records. You can limit that right in this document if you so choose.  

Generally, you may designate any competent adult as the attorney in fact under this document. However, you cannot* designate your attending physician or the administrator of any nursing home in which you are receiving care as the attorney in fact under this document. Additionally, you cannot* designate an employee or agent of your attending physician, or an employee or agent of a health care facility at which you are being treated, as the attorney in fact under this document, unless either type of employee or agent is a competent adult and related
to you by blood, marriage, or adoption, or unless either type of employee or agent is a competent adult and you and the employee or agent are members of the same religious order.

This document has no expiration date under Ohio law, but you may choose to specify a date upon which your durable power of attorney for health care generally will expire. However, if you specify an expiration date and then lack the capacity to make informed health care decisions for yourself on that date, the document and the power it grants to your attorney in fact will continue in effect until you regain the capacity to make informed health care decisions for yourself.

You have the right to revoke the designation of the attorney in fact and the right to revoke this entire document at any time and in any manner. Any such revocation generally will be effective when you express your intention to make the revocation. However, if you made your attending physician aware of this document, any such revocation will be effective only when you communicate it to your attending physician, or when a witness to the revocation or other health care personnel to whom the revocation is communicated by such a witness communicate it to your attending physician.

If you execute this document and create a valid durable power of attorney for health care with it, it will revoke any prior, valid durable power of attorney for health care that you created, unless you indicate otherwise in this document.

This document is not valid as a durable power of attorney for health care unless it is acknowledged before a notary public or is signed by at least two adult witnesses who are present when you sign or acknowledge your signature. No person who is related to you by blood, marriage, or adoption may be a witness. The attorney in fact, your attending physician, and the administrator of any nursing home in which you are receiving care also are ineligible to be witnesses.

If there is anything in this document that you do not understand, you should ask your lawyer to explain it to you.”

In the preceding notice, the single words, and the two sentences in the second set of parentheses in paragraph (2), followed by an asterisk and all of paragraph (4) shall appear in the printed form in capital letters or other conspicuous type, including, but not limited to, a different font, bigger type, or boldface type.

**Living Will**

2133.01 Living will; general definitions.

Unless the context otherwise requires, as used in sections 2133.01 to 2133.15 of the Revised Code:

(A) “Adult” means an individual who is eighteen years of age or older.

(B) “Attending physician” means the physician to whom a declarant or other patient, or the family of a declarant or other patient, has assigned primary responsibility for the treatment or care of the declarant or other patient, or, if the responsibility has not been assigned, the physician who has accepted that responsibility.

(C) “Comfort care” means any of the following:

(1) Nutrition when administered to diminish the pain or discomfort of a declarant or other patient, but not to postpone the declarant’s or other patient’s death;

(2) Hydration when administered to diminish the pain or discomfort of a declarant or other patient, but not to postpone the declarant’s or other patient’s death;

(3) Any other medical or nursing procedure, treatment, intervention, or other measure that is taken to diminish the pain or discomfort of a declarant or other patient, but not to postpone the declarant’s or other patient’s death.
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(D) “Consulting physician” means a physician who, in conjunction with the attending physician of a declarant or other patient, makes one or more determinations that are required to be made by the attending physician, or to be made by the attending physician and one other physician, by an applicable provision of this chapter, to a reasonable degree of medical certainty and in accordance with reasonable medical standards.

(E) “Declarant” means any adult who has executed a declaration in accordance with section 2133.02 of the Revised Code.

(F) “Declaration” means a written document executed in accordance with section 2133.02 of the Revised Code.

(G) “Durable power of attorney for health care” means a document created pursuant to sections 1337.11 to 1337.17 of the Revised Code.

(H) “Guardian” means a person appointed by a probate court pursuant to Chapter 2111 of the Revised Code to have the care and management of the person of an incompetent.

(I) “Health care facility” means any of the following:
   (1) A hospital;
   (2) A hospice care program, pediatric respite care program, or other institution that specializes in comfort care of patients in a terminal condition or in a permanently unconscious state;
   (3) A nursing home or residential care facility, as defined in section 3721.01 of the Revised Code;
   (4) A home health agency and any residential facility where a person is receiving care under the direction of a home health agency;
   (5) An intermediate care facility for individuals with intellectual disabilities.

(J) “Health care personnel” means physicians, nurses, physician assistants, emergency medical technicians-basic, emergency medical technicians-intermediate, emergency medical technicians-paramedic, medical technicians, dietitians, other authorized persons acting under the direction of an attending physician, and administrators of health care facilities.

(K) “Home health agency” has the same meaning as in section 3701.881 of the Revised Code.

(L) “Hospice care program” and “pediatric respite care program” have the same meanings as in section 3712.01 of the Revised Code.

(M) “Hospital” has the same meanings as in sections 3701.01, 3727.01, and 5122.01 of the Revised Code.

(N) “Hydration” means fluids that are artificially or technologically administered.

(O) “Incompetent” has the same meaning as in section 2111.01 of the Revised Code.

(P) “Intermediate care facility for the individuals with intellectual disabilities” has the same meaning as in section 5124.01 of the Revised Code.

(Q) “Life-sustaining treatment” means any medical procedure, treatment, intervention, or other measure that, when administered to a qualified patient or other patient, will serve principally to prolong the process of dying.

(R) “Nurse” means a person who is licensed to practice nursing as a registered nurse or to practice practical nursing as a licensed practical nurse pursuant to Chapter 4723 of the Revised Code.

(S) “Nursing home” has the same meaning as in section 3721.01 of the Revised Code.

(T) “Nutrition” means sustenance that is artificially or technologically administered.

(U) “Permanently unconscious state” means a state of permanent unconsciousness in a declarant or other patient that, to a reasonable degree of medical certainty as determined in accordance with reasonable medical standards by the declarant’s or other patient’s attending physician and one other physician who has examined the declarant or other patient, is characterized by both of the following:
   (1) Irreversible unawarness of one’s being and environment.
(2) Total loss of cerebral cortical functioning, resulting in the declarant or other patient having no capacity to experience pain or suffering.

(V) “Person” has the same meaning as in section 1.59 of the Revised Code and additionally includes political subdivisions and governmental agencies, boards, commissions, departments, institutions, offices, and other instrumentalities.

(W) “Physician” means a person who is authorized under Chapter 4731 of the Revised Code to practice medicine and surgery or osteopathic medicine and surgery.

(X) “Political subdivision” and “state” have the same meanings as in section 2744.01 of the Revised Code.

(Y) “Professional disciplinary action” means action taken by the board or other entity that regulates the professional conduct of health care personnel, including the state medical board and the board of nursing.

(Z) “Qualified patient” means an adult who has executed a declaration and has been determined to be in a terminal condition or in a permanently unconscious state.

(AA) “Terminal condition” means an irreversible, incurable, and untreatable condition caused by disease, illness, or injury from which, to a reasonable degree of medical certainty as determined in accordance with reasonable medical standards by a declarant’s or other patient’s attending physician and one other physician who has examined the declarant or other patient, both of the following apply:

(1) There can be no recovery.

(2) Death is likely to occur within a relatively short time if life-sustaining treatment is not administered.

(BB) “Tort action” means a civil action for damages for injury, death, or loss to person or property, other than a civil action for damages for breach of a contract or another agreement between persons.

2133.02 Declarations; requirements; refusing compliance.

(A)(1) An adult who is of sound mind voluntarily may execute at any time a declaration governing the use or continuation, or the withholding or withdrawal, of life-sustaining treatment. The declaration shall be signed at the end by the declarant or by another individual at the direction of the declarant, state the date of its execution, and either be witnessed as described in division (B)(1) of this section or be acknowledged by the declarant in accordance with division (B)(2) of this section. The declaration may include a designation by the declarant of one or more persons who are to be notified by the declarant’s attending physician at any time that life-sustaining treatment would be withheld or withdrawn pursuant to the declaration. The declaration may include a specific authorization for the use or continuation or the withholding or withdrawal of CPR, but the failure to include a specific authorization for the withholding or withdrawal of CPR does not preclude the withholding or withdrawal of CPR in accordance with sections 2133.01 to 2133.15 or sections 2133.21 to 2133.26 of the Revised Code.

(2) Depending upon whether the declarant intends the declaration to apply when the declarant is in a terminal condition, in a permanently unconscious state, or in either a terminal condition or a permanently unconscious state, the declarant’s declaration shall use either or both of the terms “terminal condition” and “permanently unconscious state” and shall define or otherwise explain those terms in a manner that is substantially consistent with the provisions of section 2133.01 of the Revised Code.

(3)(a) If a declarant who has authorized the withholding or withdrawal of life-sustaining treatment intends that the declarant’s attending physician withhold or withdraw nutrition or hydration when the declarant is in a permanently unconscious state and when the nutrition and hydration will not or no longer will serve to provide comfort to the declarant or alleviate the declarant’s pain, then the declarant shall authorize the declarant’s attending physician to
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withhold or withdraw nutrition or hydration when the declarant is in the permanently unconscious state by doing both of the following in the declaration:

(i) Including a statement in capital letters or other conspicuous type, including, but not limited to, a different font, bigger type, or boldface type, that the declarant's attending physician may withhold or withdraw nutrition and hydration if the declarant is in a permanently unconscious state and if the declarant's attending physician and at least one other physician who has examined the declarant determine, to a reasonable degree of medical certainty and in accordance with reasonable medical standards, that nutrition or hydration will not or no longer will serve to provide comfort to the declarant or alleviate the declarant's pain, or checking or otherwise marking a box or line that is adjacent to a similar statement on a printed form of a declaration;

(ii) Placing the declarant's initials or signature underneath or adjacent to the statement, check, or other mark described in division (A)(3)(a)(i) of this section.

(b) Division (A)(3)(a) of this section does not apply to the extent that a declaration authorizes the withholding or withdrawal of life-sustaining treatment when a declarant is in a terminal condition. The provisions of division (E) of section 2133.12 of the Revised Code pertaining to comfort care shall apply to a declarant in a terminal condition.

(B)(1) If witnessed for purposes of division (A) of this section, a declaration shall be witnessed by two individuals as described in this division in whose presence the declarant, or another individual at the direction of the declarant, signed the declaration. The witnesses to a declaration shall be adults who are not related to the declarant by blood, marriage, or adoption, who are not the attending physician of the declarant, and who are not the administrator of any nursing home in which the declarant is receiving care. Each witness shall subscribe the witness' signature after the signature of the declarant or other individual at the direction of the declarant and, by doing so, attest to the witness' belief that the declarant appears to be of sound mind and not under or subject to duress, fraud, or undue influence. The signatures of the declarant or other individual at the direction of the declarant under division (A) of this section and of the witnesses under this division are not required to appear on the same page of the declaration.

(2) If acknowledged for purposes of division (A) of this section, a declaration shall be acknowledged before a notary public, who shall make the certification described in section 147.53 of the Revised Code and also shall attest that the declarant appears to be of sound mind and not under or subject to duress, fraud, or undue influence.

(C) An attending physician, or other health care personnel acting under the direction of an attending physician, who is furnished a copy of a declaration shall make it a part of the declarant's medical record and, when section 2133.05 of the Revised Code is applicable, also shall comply with that section.

(D)(1) Subject to division (D)(2) of this section, an attending physician of a declarant or a health care facility in which a declarant is confined may refuse to comply or allow compliance with the declarant's declaration on the basis of a matter of conscience or on another basis. An employee or agent of an attending physician of a declarant or of a health care facility in which a declarant is confined may refuse to comply with the declarant's declaration on the basis of a matter of conscience.

(2) If an attending physician of a declarant or a health care facility in which a declarant is confined is not willing or not able to comply or allow compliance with the declarant's declaration, the physician or facility promptly shall so advise the declarant and comply with the provisions of section 2133.10 of the Revised Code, or, if the declaration has become operative as described in division (A) of section 2133.03 of the Revised Code, shall comply with the provisions of section 2133.10 of the Revised Code.

(E) As used in this section, "CPR" has the same meaning as in section 2133.21 of the Revised Code.
2133.03 Declarations; when operative; priority of declaration; power of attorney.

(A)(1) A declaration becomes operative when it is communicated to the attending physician of the declarant, the attending physician and one other physician who examines the declarant determine that the declarant is in a terminal condition or in a permanently unconscious state, whichever is addressed in the declaration, the applicable requirements of divisions (A)(2) and (3) of this section are satisfied, and the attending physician determines that the declarant no longer is able to make informed decisions regarding the administration of life-sustaining treatment. When the declaration becomes operative, the attending physician and health care facilities shall act in accordance with its provisions or comply with the provisions of section 2133.10 of the Revised Code.

(2) In order for a declaration to become operative in connection with a declarant who is in a permanently unconscious state, the consulting physician associated with the determination that the declarant is in the permanently unconscious state shall be a physician who, by virtue of advanced education or training, of a practice limited to particular diseases, illnesses, injuries, therapies, or branches of medicine or surgery or osteopathic medicine and surgery, of certification as a specialist in a particular branch of medicine or surgery or osteopathic medicine and surgery, or of experience acquired in the practice of medicine or surgery or osteopathic medicine and surgery, is qualified to determine whether the declarant is in a permanently unconscious state.

(3) In order for a declaration to become operative in connection with a declarant who is in a terminal condition or in a permanently unconscious state, the attending physician of the declarant shall determine, in good faith, to a reasonable degree of medical certainty, and in accordance with reasonable medical standards, that there is no reasonable possibility that the declarant will regain the capacity to make informed decisions regarding the administration of life-sustaining treatment.

(B)(1)(a) A declaration supersedes any general consent to treatment form signed by or on behalf of the declarant prior to, upon, or after the declarant's admission to a health care facility to the extent there is a conflict between the declaration and the form, even if the form is signed after the execution of the declaration. To the extent that the provisions of a declaration and a general consent to treatment form do not conflict, both documents shall govern the use or continuation, or the withholding or withdrawal, of life-sustaining treatment and other medical or nursing procedures, treatments, interventions, or other measures in connection with the declarant. Division (B)(1)(a) of this section does not apply if a declaration is revoked pursuant to section 2133.04 of the Revised Code after the signing of a general consent to treatment form.

(b) A declaration supersedes a DNR identification, as defined in section 2133.21 of the Revised Code, of the declarant or that is based upon a prior inconsistent declaration of the declarant or that is based upon a do-not-resuscitate order, as defined in section 2133.21 of the Revised Code, that a physician has issued for the declarant and that is inconsistent with the declaration.

(2) If a declarant has both a valid durable power of attorney for health care and a valid declaration, the declaration supersedes the durable power of attorney for health care to the extent that the provisions of the documents would conflict if the declarant should be in a terminal condition or in a permanently unconscious state. Division (B)(2) of this section does not apply if the declarant revokes the declaration pursuant to section 2133.04 of the Revised Code.

2133.04 Living will revocation.

(A) A declarant may revoke a declaration at any time and in any manner. The revocation shall be effective when the declarant expresses an intention to revoke the declaration, except that, if the declarant made the declarant's attending physician aware of the declaration, the
revocation shall be effective upon its communication to the attending physician of the declarant by the declarant, a witness to the revocation, or other health care personnel to whom the revocation is communicated by that witness. Absent actual knowledge to the contrary, the attending physician of a declarant and other health care personnel who are informed of the revocation of a declaration by an alleged witness may rely on the information and act in accordance with the revocation.

(B) Upon the communication as described in division (A) of this section to the attending physician of a declarant of the fact that the declaration has been revoked, the attending physician or other health care personnel acting under the direction of the attending physician shall make the fact a part of the declarant's medical record.

(C) Unless a declaration provides otherwise, a declaration is revoked by a subsequent declaration.

2133.05 Duties of physician; notice; objections.

(A) If the attending physician of a declarant and one other physician who examines the declarant determine that the declarant is in a terminal condition or in a permanently unconscious state, whichever is addressed in the declaration, if the attending physician additionally determines that the declarant no longer is able to make informed decisions regarding the administration of life-sustaining treatment for the declarant and that there is no reasonable possibility that the declarant will regain the capacity to make those informed decisions for the declarant, and if the attending physician is aware of the existence of the declarant's declaration, then the attending physician shall do all of the following:

(1) Record the determinations, together with the terms of the declaration or any copy of the declaration acquired as described in division (C) of section 2133.02 of the Revised Code, in the declarant's medical record;

(2)(a) Make a good faith effort, and use reasonable diligence, to notify either of the following:

(i) If the declarant designated in the declarant's declaration one or more persons to be notified at any time that life-sustaining treatment would be withheld or withdrawn pursuant to the declaration, that person or those persons;

(ii) If division (A)(2)(a)(i) of this section is not applicable, the appropriate individual or individuals, in accordance with the following descending order of priority: if any, the guardian of the declarant, but this division does not permit or require, and shall not be construed as permitting or requiring, the appointment of a guardian for the declarant; the declarant's spouse; the declarant's adult children who are available within a reasonable period of time for consultation with the declarant's attending physician; the declarant's parents; or an adult sibling of the declarant or, if there is more than one adult sibling, a majority of the declarant's adult siblings who are available within a reasonable period of time for the consultation.

(b) The attending physician shall record in the declarant's medical record the names of the individual or individuals notified pursuant to division (A)(2)(a) of this section and the manner of notification.

(c) If, despite making a good faith effort, and despite using reasonable diligence, to notify the appropriate individual or individuals described in division (A)(2)(a) of this section, the attending physician cannot notify the individual or individuals of the determinations because the individual or individuals are deceased, cannot be located, or cannot be notified for some other reason, then the requirements of divisions (A)(2)(a) and (b) and (3) of this section and, except as provided in division (B)(1)(b) of this section, the provisions of division (B) of this section shall not apply in connection with the declarant and the declarant's declaration. However, the attending physician shall record in the declarant's medical record information pertaining to the reason for the failure to provide the requisite notices and information pertaining to the nature of
the good faith effort and reasonable diligence used.

(3) Afford time for the individual or individuals notified in accordance with division (A)(2) of this section to object in the manner described in division (B)(1)(a) of this section.

(B)(1)(a) Within forty-eight hours after receipt of a notice pursuant to division (A)(2) of this section, any individual so notified shall advise the attending physician of the declarant whether the individual objects on a basis specified in division (B)(2)(c) of this section. If an objection as described in that division is communicated to the attending physician, then, within two business days after the communication, the individual shall file a complaint as described in division (B)(2) of this section in the probate court of the county in which the declarant is located. If the individual fails to so file a complaint or if the individual would not be competent to decide whether or not to consent to the withholding or withdrawing of life-sustaining treatment for any of the reasons described in division (C)(2) of section 2133.08 of the Revised Code, the individual's objections as described in division (B)(2)(c) of this section shall be considered to be void.

(b) Within forty-eight hours after a person described in division (A)(2)(a)(i) of this section or a priority individual or any member of a priority class of individuals described in division (A)(2)(a)(ii) of this section receives a notice pursuant to division (A)(2) of this section or within forty-eight hours after information pertaining to an unnotified person described in division (A)(2)(a)(i) of this section or an unnotified priority individual or unnotified priority class of individuals described in division (A)(2)(a)(ii) of this section is recorded in a declarant's medical record pursuant to division (A)(2)(c) of this section, either of the following shall advise the attending physician of the declarant whether there is an objection on a basis specified in division (B)(2)(c) of this section:

(i) If a person described in division (A)(2)(a)(i) of this section was notified pursuant to division (A)(2) of this section or was the subject of a recordation under division (A)(2)(c) of this section, then the objection shall be communicated by the individual or a majority of the individuals in either of the first two classes of individuals that pertain to the declarant in the descending order of priority set forth in division (A)(2)(a)(ii) of this section.

(ii) If an individual or individuals in the descending order of priority set forth in division (A)(2)(a)(ii) of this section were notified pursuant to division (A)(2) of this section or were the subject of a recordation under division (A)(2)(c) of this section, then the objection shall be communicated by the individual or a majority of the individuals in the next class of individuals that pertains to the declarant in the descending order of priority set forth in division (A)(2)(a)(ii) of this section.

If an objection as described in division (B)(2)(c) of this section is communicated to the attending physician in accordance with division (B)(1)(b)(i) or (ii) of this section, then, within two business days after the communication, the objecting individual or majority shall file a complaint as described in division (B)(2) of this section in the probate court of the county in which the declarant is located. If the objecting individual or majority fails to file a complaint or if the individual or a member of the majority would not be competent to decide whether or not to consent to the withholding or withdrawing of life-sustaining treatment for any of the reasons described in division (C)(2) of section 2133.08 of the Revised Code, the objections as described in division (B)(2)(c) of this section shall be considered to be void.

(2) A complaint of an individual that is filed in accordance with division (B)(1)(a) of this section or of an individual or majority of individuals that is filed in accordance with division (B)(1)(b) of this section shall satisfy all of the following:

(a) Name any health care facility in which the declarant is confined;

(b) Name the declarant, the declarant's attending physician, and the consulting physician associated with the determination that the declarant is in a terminal condition or in a permanently unconscious state, whichever is addressed in the declaration;

(c) Indicate whether the plaintiff or plaintiffs object on one or more of the following bases:

(i) To the attending physician's and consulting physician's determinations that the
declarant is in a terminal condition or in a permanently unconscious state, whichever is
addressed in the declaration;
   (ii) To the attending physician's determination that the declarant no longer is able to
make informed decisions regarding the administration of life-sustaining treatment;
   (iii) To the attending physician's determination that there is no reasonable possibility that
the declarant will regain the capacity to make informed decisions regarding the administration of
life-sustaining treatment;
   (iv) That the course of action proposed to be undertaken by the attending physician is
not authorized by the declarant's declaration;
   (v) That the declaration was executed when the declarant was not of sound mind or was
under or subject to duress, fraud, or undue influence;
   (vi) That the declaration otherwise does not substantially comply with this chapter.
(d) Request the probate court to issue one of the following types of orders:
   (i) An order to the attending physician to reevaluate, in light of the court proceedings, the
determination that the declarant is in a terminal condition or in a permanently unconscious state,
whichever is addressed in the declaration, the determination that the declarant no longer is able
to make informed decisions regarding the administration of life-sustaining treatment, the
determination that there is no reasonable possibility that the declarant will regain the capacity to
make those informed decisions, or the course of action proposed to be undertaken;
   (ii) An order invalidating the declaration because it was executed when the declarant
was not of sound mind or was under or subject to duress, fraud, or undue influence, or because
it otherwise does not substantially comply with this chapter;
   (e) Be accompanied by an affidavit of the plaintiff or plaintiffs that includes averments
relative to whether the plaintiff is an individual or the plaintiffs are individuals as described in
division (A)(2)(a)(i) or (ii) of this section and to the factual basis for the plaintiff's or the plaintiffs'
objections;
   (f) Name any individuals who were notified by the attending physician in accordance with
division (A)(2)(a) of this section and who are not joining in the complaint as plaintiffs;
   (g) Name, in the caption of the complaint, as defendants the attending physician of the
declarant, the consulting physician associated with the determination that the declarant is in a
terminal condition or in a permanently unconscious state, whichever is addressed in the
declaration, any health care facility in which the declarant is confined, and any individuals who
were notified by the attending physician in accordance with division (A)(2)(a) of this section and
who are not joining in the complaint as plaintiffs.
(3) Notwithstanding any contrary provision of the Revised Code or of the Rules of Civil
Procedure, the state and persons other than an objecting individual as described in division
(B)(1)(a) of this section, other than an objecting individual or majority of individuals as described in
division (B)(2)(b)(i) or (ii) of this section, and other than persons described in division (B)(2)(g)
of this section are prohibited from commencing a civil action under this section and from joining
or being joined as parties to an action commenced under this section, including joining by way
of intervention.
   (4)(a) A probate court in which a complaint as described in division (B)(2) of this section
is filed within the period specified in division (B)(1)(a) or (b) of this section shall conduct a
hearing on the complaint after a copy of the complaint and a notice of the hearing have been
served upon the defendants. The clerk of the probate court in which the complaint is filed shall
cause the complaint and the notice of the hearing to be so served in accordance with the Rules
of Civil Procedure, which service shall be made, if possible, within three days after the filing of
the complaint. The hearing shall be conducted at the earliest possible time, but no later than the
third business day after the service has been completed. Immediately following the hearing, the
court shall enter on its journal its determination whether a requested order will be issued.
   (b) If the declarant's declaration authorized the use or continuation of life-sustaining
treatment should the declarant be in a terminal condition or in a permanently unconscious state and if the plaintiff or plaintiffs requested a reevaluation order to the attending physician of the declarant as described in division (B)(2)(d)(i) of this section, the court shall issue the reevaluation order only if it finds that the plaintiff or plaintiffs have established a factual basis for the objection or objections involved by clear and convincing evidence, to a reasonable degree of medical certainty, and in accordance with reasonable medical standards.

(c) If the declarant's declaration authorized the withholding or withdrawal of life-sustaining treatment should the declarant be in a terminal condition or in a permanently unconscious state and if the plaintiff or plaintiffs requested a reevaluation order to the attending physician of the declarant as described in division (B)(2)(d)(i) of this section, the court shall issue the reevaluation order only if it finds that the plaintiff or plaintiffs have established a factual basis for the objection or objections involved by clear and convincing evidence, to a reasonable degree of medical certainty, and in accordance with reasonable medical standards.

(d) If the plaintiff or plaintiffs requested an invalidation order as described in division (B)(2)(d)(ii) of this section, the court shall issue the order only if it finds that the plaintiff or plaintiffs have established a factual basis for the objection or objections involved by clear and convincing evidence.

(e) If the court issues a reevaluation order to the declarant's attending physician pursuant to division (B)(4)(b) or (c) of this section, then the attending physician shall make the requisite reevaluation. If, after doing so, the attending physician again determines that the declarant is in a terminal condition or in a permanently unconscious state, that the declarant no longer is able to make informed decisions regarding the administration of life-sustaining treatment, that there is no reasonable possibility that the declarant will regain the capacity to make those informed decisions, or that the attending physician would undertake the same proposed course of action, then the attending physician shall notify the court in writing of the determination and comply with the provisions of section 2133.10 of the Revised Code.

2133.06 Patient rights and life-sustaining treatment.

(A) As long as a qualified patient is able to make informed decisions regarding the administration of life-sustaining treatment, the qualified patient may continue to do so.

(B) Life-sustaining treatment shall not be withheld or withdrawn from a declarant pursuant to a declaration if the declarant is pregnant and if the withholding or withdrawal of the treatment would terminate the pregnancy, unless the declarant's attending physician and one other physician who has examined the declarant determine, to a reasonable degree of medical certainty and in accordance with reasonable medical standards, that the fetus would not be born alive.

2133.07 Printed form use.

(A) As used in this section:

(1) “Anatomical gift” has the same meaning as in section 2108.01 of the Revised Code.

(2) “DNR identification” has the same meaning as in section 2133.21 of the Revised Code.

(B) A printed form of a declaration may be sold or otherwise distributed in this state for use by adults who are not advised by an attorney. By use of a printed form of that nature, a declarant may authorize the use or continuation, or the withholding or withdrawal, of life-sustaining treatment should the declarant be in a terminal condition, a permanently unconscious state, or either a terminal condition or a permanently unconscious state, may authorize the withholding or withdrawal of nutrition or hydration should the declarant be in a permanently unconscious state as described in division (A)(3)(a) of section 2133.02 of the Revised Code,
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and may designate one or more persons who are to be notified by the declarant's attending physician at any time that life-sustaining treatment would be withheld or withdrawn pursuant to the declaration. The printed form shall not be used as an instrument for granting any other type of authority or for making any other type of designation, except that the printed form may be used as a DNR identification if the declarant specifies on the form that the declarant wishes to use it as a DNR identification and except as provided in division (C) of this section.

(C) A printed form of a declaration under division (B) of this section shall include, before the signature of the declarant or another individual at the direction of the declarant, statements that conform substantially to the following form:

“ANATOMICAL GIFT (optional)

Upon my death, the following are my directions regarding donation of all or part of my body:

In the hope that I may help others upon my death, I hereby give the following body parts:

_________________________________________
_________________________________________

for any purpose authorized by law: transplantation, therapy, research, or education.

If I do not indicate a desire to donate all or part of my body by filling in the lines above, no presumption is created about my desire to make or refuse to make an anatomical gift.”

(D)(1) A printed form of a declaration under division (B) of this section shall include, as a separate page or as a portion of a page that can be detached from the declaration, a donor registry enrollment form that permits the donor to be included in the donor registry created under section 2108.23 of the Revised Code.

(2) The donor registry enrollment form may be in any form that complies with the requirements of division (B) of section 2108.05 of the Revised Code. On completion, the form shall be forwarded to the bureau of motor vehicles.

2133.08 Consent to withhold or withdraw care.

(A)(1) If written consent to the withholding or withdrawal of life-sustaining treatment, witnessed by two individuals who satisfy the witness eligibility criteria set forth in division (B)(1) of section 2133.02 of the Revised Code, is given by the appropriate individual or individuals as specified in division (B) of this section to the attending physician of a patient who is an adult, and if all of the following apply in connection with the patient, then, subject to section 2133.09 of the Revised Code, the patient’s attending physician may withhold or withdraw the life-sustaining treatment:

(a) The attending physician and one other physician who examines the patient determine, in good faith, to a reasonable degree of medical certainty, and in accordance with reasonable medical standards, that the patient is in a terminal condition or the patient currently is and for at least the immediately preceding twelve months has been in a permanently unconscious state, and the attending physician additionally determines, in good faith, to a reasonable degree of medical certainty, and in accordance with reasonable medical standards, that the patient no longer is able to make informed decisions regarding the administration of life-sustaining treatment and that there is no reasonable possibility that the patient will regain the
capacity to make those informed decisions.

(b) The patient does not have a declaration that addresses the patient's intent should the patient be determined to be in a terminal condition or in a permanently unconscious state, whichever applies, or a durable power of attorney for health care, or has a document that purports to be such a declaration or durable power of attorney for health care but that document is not legally effective.

(c) The consent of the appropriate individual or individuals is given after consultation with the patient's attending physician and after receipt of information from the patient's attending physician or a consulting physician that is sufficient to satisfy the requirements of informed consent.

(d) The appropriate individual or individuals who give a consent are of sound mind and voluntarily give the consent.

(e) If a consent would be given under division (B)(3) of this section, the attending physician made a good faith effort, and used reasonable diligence, to notify the patient's adult children who are available within a reasonable period of time for consultation as described in division (A)(1)(c) of this section.

(2) The consulting physician under division (A)(1)(a) of this section associated with a patient allegedly in a permanently unconscious state shall be a physician who, by virtue of advanced education or training, of a practice limited to particular diseases, illnesses, injuries, therapies, or branches of medicine or surgery or osteopathic medicine and surgery, of certification as a specialist in a particular branch of medicine or surgery or osteopathic medicine and surgery, or of experience acquired in the practice of medicine or surgery or osteopathic medicine and surgery, is qualified to determine whether the patient currently is and for at least the immediately preceding twelve months has been in a permanently unconscious state.

(B) For purposes of division (A) of this section and subject to division (C) of this section, a consent to withhold or withdraw life-sustaining treatment may be given by the appropriate individual or individuals, in accordance with the following descending order of priority:

(1) If any, the guardian of the patient. This division does not permit or require, and shall not be construed as permitting or requiring, the appointment of a guardian for the patient.

(2) The patient's spouse;

(3) An adult child of the patient or, if there is more than one adult child, a majority of the patient's adult children who are available within a reasonable period of time for consultation with the patient's attending physician;

(4) The patient's parents;

(5) An adult sibling of the patient or, if there is more than one adult sibling, a majority of the patient's adult siblings who are available within a reasonable period of time for that consultation;

(6) The nearest adult who is not described in divisions (B)(1) to (5) of this section, who is related to the patient by blood or adoption, and who is available within a reasonable period of time for that consultation.

(C)(1) If an appropriate individual or class of individuals entitled to decide under division (B) of this section whether or not to consent to the withholding or withdrawal of life-sustaining treatment for a patient is not available within a reasonable period of time for the consultation and competent to so decide, or declines to so decide, then the next priority individual or class of individuals specified in that division is authorized to make the decision. However, an equal division in a priority class of individuals under that division does not authorize the next class of individuals specified in that division to make the decision. If an equal division in a priority class of individuals under that division occurs, no written consent to the withholding or withdrawal of life-sustaining treatment from the patient can be given pursuant to this section.

(2)(a) If an appropriate individual entitled to decide under division (B) of this section whether or not to consent to the withholding or withdrawing of life-sustaining treatment for a
patient and that patient are married and are the parties to a pending divorce, dissolution, legal separation, or annulment proceeding, the individual is not competent to so decide, and the next priority individual or class of individuals specified in that division is authorized to make the decision.

(b) If an appropriate individual entitled to decide under division (B) of this section whether or not to consent to the withholding or withdrawing of life-sustaining treatment for a patient is subject to a temporary protection order, civil protection order, or any other protection order issued by a court in this state or another state and the patient is the alleged victim, the individual is not competent to so decide, and the next priority individual or class of individuals specified in that division is authorized to make that decision.

(c) If a member of a class of individuals entitled to decide under division (B) of this section whether or not to consent to the withholding or withdrawal of life-sustaining treatment for a patient is subject to a temporary protection order, civil protection order, or any other protection order issued by a court in this state or another state and the patient is the alleged victim, the member is not competent to so decide, and the other members of the class of individuals are authorized to make the decision.

(d) If an appropriate individual entitled to decide under division (B) of this section whether or not to consent to the withholding or withdrawal of life-sustaining treatment for a patient has been charged with the offense of felonious assault under section 2903.11 of the Revised Code or the offense of aggravated assault under section 2903.12 of the Revised Code against the patient and the serious physical harm or physical harm suffered by the patient as a result of the offense directly caused the patient to be in a terminal condition, the individual is not competent to so decide, and the next priority individual or class of individuals specified in that division is authorized to make the decision.

(e) If a member of a class of individuals entitled to decide under division (B) of this section whether or not to consent to the withholding or withdrawal of life-sustaining treatment for a patient has been charged with the offense of felonious assault under section 2903.11 of the Revised Code or the offense of aggravated assault under section 2903.12 of the Revised Code against the patient and the serious physical harm or physical harm suffered by the patient as a result of the offense directly caused the patient to be in a terminal condition, that member is not competent to so decide, and the other members of the class of individuals are authorized to make the decision.

(D)(1) A decision to consent pursuant to this section to the use or continuation, or the withholding or withdrawal, of life-sustaining treatment for a patient shall be made in good faith.

(2) Except as provided in division (D)(4) of this section, if the patient previously expressed an intention with respect to the use or continuation, or the withholding or withdrawal, of life-sustaining treatment should the patient subsequently be in a terminal condition or in a permanently unconscious state, whichever applies, and no longer able to make informed decisions regarding the administration of life-sustaining treatment, a consent given pursuant to this section shall be valid only if it is consistent with that previously expressed intention.

(3) Except as provided in division (D)(4) of this section, if the patient did not previously express an intention with respect to the use or continuation, or the withholding or withdrawal, of life-sustaining treatment should the patient subsequently be in a terminal condition or in a permanently unconscious state, whichever applies, and no longer able to make informed decisions regarding the administration of life-sustaining treatment, a consent given pursuant to this section shall be valid only if it is consistent with the type of informed consent decision that the patient would have made if the patient previously had expressed an intention with respect to the use or continuation, or the withholding or withdrawal, of life-sustaining treatment should the patient subsequently be in a terminal condition or in a permanently unconscious state, whichever applies, and no longer able to make informed decisions regarding the administration of life-sustaining treatment, as inferred from the lifestyle and character of the patient, and from
any other evidence of the desires of the patient, prior to the patient's becoming no longer able to
make informed decisions regarding the administration of life-sustaining treatment. The Rules of
Evidence shall not be binding for purposes of this division.

(4)(a) The attending physician of the patient, and other health care personnel acting
under the direction of the attending physician, who do not have actual knowledge of a previously
expressed intention as described in division (D)(2) of this section or who do not have actual
knowledge that the patient would have made a different type of informed consent decision under
the circumstances described in division (D)(3) of this section, may rely on a consent given in
accordance with this section unless a probate court decides differently under division (E) of this
section.

(b) The immunity conferred by division (C)(1) of section 2133.11 of the Revised Code is
not forfeited by an individual who gives a consent to the use or continuation, or the withholding
or withdrawal, of life-sustaining treatment for a patient under division (B) of this section if the
individual gives the consent in good faith and without actual knowledge, at the time of giving the
consent, of either a contrary previously expressed intention of the patient, or a previously
expressed intention of the patient, as described in division (D)(2) of this section, that is revealed
to the individual subsequent to the time of giving the consent.

(E)(1) Within forty-eight hours after a priority individual or class of individuals gives a
consent pursuant to this section to the use or continuation, or the withholding or withdrawal, of
life-sustaining treatment and communicates the consent to the patient's attending physician, any
individual described in divisions (B)(1) to (5) of this section, except an individual who is not
competent to give consent under division (C)(2) of this section, who objects to the application of
this section to the patient shall advise the attending physician of the grounds for the objection. If
an objection is so communicated to the attending physician, then, within two business days after
that communication, the objecting individual shall file a complaint against the priority individual
or class of individuals, the patient's attending physician, and the consulting physician associated
with the determination that the patient is in a terminal condition or that the patient currently is
and for at least the immediately preceding twelve months has been in a permanently
unconscious state, in the probate court of the county in which the patient is located for the
issuance of an order reversing the consent of the priority individual or class of individuals. If the
objecting individual fails to so file a complaint, the individual's objections shall be considered to
be void.

A probate court in which a complaint is filed in accordance with this division shall
conduct a hearing on the complaint after a copy of the complaint and a notice of the hearing
have been served upon the defendants. The clerk of the probate court in which the complaint is
filed shall cause the complaint and the notice of the hearing to be so served in accordance with
the Rules of Civil Procedure, which service shall be made, if possible, within three days after the
filing of the complaint. The hearing shall be conducted at the earliest possible time, but no later
than the third business day after the service has been completed. Immediately following the
hearing, the court shall enter on its journal its determination whether the decision of the priority
individual or class of individuals to consent to the use or continuation, or the withholding or
withdrawal, of life-sustaining treatment in connection with the patient will be confirmed or
reversed.

(2) If the decision of the priority individual or class of individuals was to consent to the
use or continuation of life-sustaining treatment in connection with the patient, the court only may
reverse that consent if the objecting individual establishes, by clear and convincing evidence
and, if applicable, to a reasonable degree of medical certainty and in accordance with
reasonable medical standards, one or more of the following:

(a) The patient is able to make informed decisions regarding the administration of life-
sustaining treatment.
(b) The patient has a legally effective declaration that addresses the patient's intent should the patient be determined to be in a terminal condition or in a permanently unconscious state, whichever applies, or a legally effective durable power of attorney for health care.

(c) The decision to use or continue life-sustaining treatment is not consistent with the previously expressed intention of the patient as described in division (D)(2) of this section.

(d) The decision to use or continue life-sustaining treatment is not consistent with the type of informed consent decision that the patient would have made if the patient previously had expressed an intention with respect to the use or continuation, or the withholding or withdrawal, of life-sustaining treatment should the patient subsequently be in a terminal condition or in a permanently unconscious state, whichever applies, and no longer able to make informed decisions regarding the administration of life-sustaining treatment as described in division (D)(3) of this section.

(e) The decision of the priority individual or class of individuals was not made after consultation with the patient's attending physician and after receipt of information from the patient's attending physician or a consulting physician that is sufficient to satisfy the requirements of informed consent.

(f) The priority individual, or any member of the priority class of individuals, who made the decision to use or continue life-sustaining treatment was not of sound mind or did not voluntarily make the decision.

(g) If the decision of a priority class of individuals under division (B)(3) of this section is involved, the patient's attending physician did not make a good faith effort, and use reasonable diligence, to notify the patient's adult children who were available within a reasonable period of time for consultation as described in division (A)(1)(c) of this section.

(h) The decision of the priority individual or class of individuals otherwise was made in a manner that does not comply with this section.

(3) If the decision of the priority individual or class of individuals was to consent to the withholding or withdrawal of life-sustaining treatment in connection with the patient, the court only may reverse that consent if the objecting individual establishes, by a preponderance of the evidence and, if applicable, to a reasonable degree of medical certainty and in accordance with reasonable medical standards, one or more of the following:

(a) The patient is not in a terminal condition, the patient is not in a permanently unconscious state, or the patient has not been in a permanently unconscious state for at least the immediately preceding twelve months.

(b) The patient is able to make informed decisions regarding the administration of life-sustaining treatment.

(c) There is a reasonable possibility that the patient will regain the capacity to make informed decisions regarding the administration of life-sustaining treatment.

(d) The patient has a legally effective declaration that addresses the patient's intent should the patient be determined to be in a terminal condition or in a permanently unconscious state, whichever applies, or a legally effective durable power of attorney for health care.

(e) The decision to withhold or withdraw life-sustaining treatment is not consistent with the previously expressed intention of the patient as described in division (D)(2) of this section.

(f) The decision to withhold or withdraw life-sustaining treatment is not consistent with the type of informed consent decision that the patient would have made if the patient previously had expressed an intention with respect to the use or continuation, or the withholding or withdrawal, of life-sustaining treatment should the patient subsequently be in a terminal condition or in a permanently unconscious state, whichever applies, and no longer able to make informed decisions regarding the administration of life-sustaining treatment as described in division (D)(3) of this section.

(g) The decision of the priority individual or class of individuals was not made after consultation with the patient's attending physician and after receipt of information from the patient's attending physician or a consulting physician that is sufficient to satisfy the requirements of informed consent.
patient's attending physician or a consulting physician that is sufficient to satisfy the requirements of informed consent.

(h) The priority individual, or any member of the priority class of individuals, who made the decision to withhold or withdraw life-sustaining treatment was not of sound mind, was not competent to make the decision under division (C)(2) of this section, or did not voluntarily make the decision.

(i) If the decision of a priority class of individuals under division (B)(3) of this section is involved, the patient's attending physician did not make a good faith effort, and use reasonable diligence, to notify the patient's adult children who were available within a reasonable period of time for consultation as described in division (A)(1)(c) of this section.

(j) The decision of the priority individual or class of individuals otherwise was made in a manner that does not comply with this section.

(4) Notwithstanding any contrary provision of the Revised Code or of the Rules of Civil Procedure, the state and persons other than individuals described in divisions (B)(1) to (5) of this section are prohibited from filing a complaint under division (E) of this section and from joining or being joined as parties to a hearing conducted under division (E) of this section, including joining by way of intervention.

(F) A valid consent given in accordance with this section supersedes any general consent to treatment form signed by or on behalf of the patient prior to, upon, or after the patient's admission to a health care facility to the extent there is a conflict between the consent and the form.

(G) Life-sustaining treatment shall not be withheld or withdrawn from a patient pursuant to a consent given in accordance with this section if the patient is pregnant and if the withholding or withdrawal of the treatment would terminate the pregnancy, unless the patient's attending physician and one other physician who has examined the patient determine, to a reasonable degree of medical certainty and in accordance with reasonable medical standards, that the fetus would not be born alive.

(H) As used in this section, “civil protection order” and “temporary protection order” have the same meanings as in section 2923.124 of the Revised Code.

2133.09 Withholding nutrition or hydration requirements.

(A) The attending physician of a patient who is an adult and who currently is and for at least the immediately preceding twelve months has been in a permanently unconscious state may withhold or withdraw nutrition and hydration in connection with the patient only if all of the following apply:

1. Written consent to the withholding or withdrawal of life-sustaining treatment in connection with the patient has been given by an appropriate individual or individuals in accordance with section 2133.08 of the Revised Code, and divisions (A)(1)(a) to (e) and (2) of that section have been satisfied.

2. A probate court has not reversed the consent to the withholding or withdrawal of life-sustaining treatment in connection with the patient pursuant to division (E) of section 2133.08 of the Revised Code.

3. The attending physician of the patient and one other physician as described in division (A)(2) of section 2133.08 of the Revised Code who examines the patient determine, in good faith, to a reasonable degree of medical certainty, and in accordance with reasonable medical standards, that nutrition and hydration will not or no longer will provide comfort or alleviate pain in connection with the patient.

4. Written consent to the withholding or withdrawal of nutrition and hydration in connection with the patient, witnessed by two individuals who satisfy the witness eligibility criteria set forth in division (B)(1) of section 2133.02 of the Revised Code, is given to the
attending physician of the patient by an appropriate individual or individuals as specified in division (B) of section 2133.08 of the Revised Code.

(5) The written consent to the withholding or withdrawal of the nutrition and hydration in connection with the patient is given in accordance with division (B) of this section.

(6) The probate court of the county in which the patient is located issues an order to withhold or withdraw the nutrition and hydration in connection with the patient pursuant to division (C) of this section.

(B)(1) A decision to consent pursuant to this section to the withholding or withdrawal of nutrition and hydration in connection with a patient shall be made in good faith.

(2) Except as provided in division (B)(4) of this section, if the patient previously expressed an intention with respect to the use or continuation, or the withholding or withdrawal, of nutrition and hydration should the patient subsequently be in a permanently unconscious state and no longer able to make informed decisions regarding the administration of nutrition and hydration, a consent given pursuant to this section shall be valid only if it is consistent with that previously expressed intention.

(3) Except as provided in division (B)(4) of this section, if the patient did not previously express an intention with respect to the use or continuation, or the withholding or withdrawal, of nutrition and hydration should the patient subsequently be in a permanently unconscious state and no longer able to make informed decisions regarding the administration of nutrition and hydration, a consent given pursuant to this section shall be valid only if it is consistent with the type of informed consent decision that the patient would have made if the patient previously had expressed an intention with respect to the use or continuation, or the withholding or withdrawal, of nutrition and hydration should the patient subsequently be in a permanently unconscious state and no longer able to make informed decisions regarding the administration of nutrition and hydration, as inferred from the lifestyle and character of the patient, and from any other evidence of the desires of the patient, prior to the patient’s becoming no longer able to make informed decisions regarding the administration of nutrition and hydration. The Rules of Evidence shall not be binding for purposes of this division.

(4)(a) The attending physician of the patient, and other health care personnel acting under the direction of the attending physician, who do not have actual knowledge of a previously expressed intention as described in division (B)(2) of this section or who do not have actual knowledge that the patient would have made a different type of informed consent decision under the circumstances described in division (B)(3) of this section, may rely on a consent given in accordance with this section unless a probate court decides differently under division (C) of this section.

(b) The immunity conferred by division (C)(2) of section 2133.11 of the Revised Code is not forfeited by an individual who gives a consent to the withholding or withdrawal of nutrition and hydration in connection with a patient under division (A)(4) of this section if the individual gives the consent in good faith and without actual knowledge, at the time of giving the consent, of either a contrary previously expressed intention of the patient, or a previously expressed intention of the patient, as described in division (B)(2) of this section, that is revealed to the individual subsequent to the time of giving the consent.

(C)(1) Prior to the withholding or withdrawal of nutrition and hydration in connection with a patient pursuant to this section, the priority individual or class of individuals that consented to the withholding or withdrawal of the nutrition and hydration shall apply to the probate court of the county in which the patient is located for the issuance of an order that authorizes the attending physician of the patient to commence the withholding or withdrawal of the nutrition and hydration in connection with the patient. Upon the filing of the application, the clerk of the probate court shall schedule a hearing on it and cause a copy of it and a notice of the hearing to be served in accordance with the Rules of Civil Procedure upon the applicant, the attending physician, the consulting physician associated with the determination that nutrition and
hydration will not or no longer will provide comfort or alleviate pain in connection with the patient, and the individuals described in divisions (B)(1) to (5) of section 2133.08 of the Revised Code who are not applicants, which service shall be made, if possible, within three days after the filing of the application. The hearing shall be conducted at the earliest possible time, but no sooner than the thirtieth business day, and no later than the sixtieth business day, after the service has been completed.

At the hearing, any individual described in divisions (B)(1) to (5) of section 2133.08 of the Revised Code who is not an applicant, except an individual who is not competent under division (C)(2) of section 2133.08 of the Revised Code, and who disagrees with the decision of the priority individual or class of individuals to consent to the withholding or withdrawal of nutrition and hydration in connection with the patient shall be permitted to testify and present evidence relative to the use or continuation of nutrition and hydration in connection with the patient. Immediately following the hearing, the court shall enter on its journal its determination whether the requested order will be issued.

(2) The court shall issue an order that authorizes the patient's attending physician to commence the withholding or withdrawal of nutrition and hydration in connection with the patient only if the applicants establish, by clear and convincing evidence, to a reasonable degree of medical certainty, and in accordance with reasonable medical standards, all of the following:

(a) The patient currently is and for at least the immediately preceding twelve months has been in a permanently unconscious state.

(b) The patient no longer is able to make informed decisions regarding the administration of life-sustaining treatment.

(c) There is no reasonable possibility that the patient will regain the capacity to make informed decisions regarding the administration of life-sustaining treatment.

(d) The conditions specified in divisions (A)(1) to (4) of this section have been satisfied.

(e) The decision to withhold or withdraw nutrition and hydration in connection with the patient is consistent with the previously expressed intention of the patient as described in division (B)(2) of this section or is consistent with the type of informed consent decision that the patient would have made if the patient previously had expressed an intention with respect to the use or continuation, or the withholding or withdrawal, of nutrition and hydration should the patient subsequently be in a permanently unconscious state and no longer able to make informed decisions regarding the administration of nutrition and hydration as described in division (B)(3) of this section.

(3) Notwithstanding any contrary provision of the Revised Code or of the Rules of Civil Procedure, the state and persons other than individuals described in division (A)(4) of this section or in divisions (B)(1) to (5) of section 2133.08 of the Revised Code and other than the attending physician and consulting physician associated with the determination that nutrition and hydration will not or no longer will provide comfort or alleviate pain in connection with the patient are prohibited from filing an application under this division and from joining or being joined as parties to a hearing conducted under this division, including joining by way of intervention.

(D) A valid consent given in accordance with this section supersedes any general consent to treatment form signed by or on behalf of the patient prior to, upon, or after the patient's admission to a health care facility to the extent there is a conflict between the consent and the form.

2133.10 Transfer of patient to comply with declaration.

(A) An attending physician who, or a health care facility in which a qualified patient or other patient is confined that, is not willing or is not able to comply or allow compliance with a declaration of a qualified patient, with a consent given in accordance with section 2133.08 or
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2133.09 of the Revised Code, with any probate court order issued pursuant to section 2133.05, 2133.08, or 2133.09 of the Revised Code, or with any other applicable provision of sections 2133.01 to 2133.15 of the Revised Code shall not prevent or attempt to prevent, or unreasonably delay or attempt to unreasonably delay, the transfer of the qualified patient or other patient to the care of a physician who, or a health care facility that, is willing and able to so comply or allow compliance.

(B) If a declaration provides for the use or continuation of life-sustaining treatment should its declarant subsequently be in a terminal condition or in a permanently unconscious state, if a consent decision of a priority individual or class of individuals under section 2133.08 of the Revised Code is to use or continue life-sustaining treatment in connection with a patient described in that section, or if a probate court issues a reevaluation order pursuant to section 2133.05 or 2133.08 of the Revised Code that is intended to result in the use or continuation of life-sustaining treatment in connection with a qualified patient or other patient, then the attending physician of the qualified patient or other patient who, or health care facility in which the qualified patient or other patient is confined that, is not willing or is not able to comply or allow compliance with the declaration, consent decision, or reevaluation order shall use or continue the life-sustaining treatment or cause it to be used or continued until a transfer as described in division (A) of this section is made.

2133.11 Criminal, civil, and professional disciplinary action; immunity.

(A) Subject to division (D) of this section, an attending physician, consulting physician, health care facility, and health care personnel acting under the direction of an attending physician are not subject to criminal prosecution, are not liable in damages in a tort or other civil action, and are not subject to professional disciplinary action for any of the following:

(1) Giving effect to a declaration, if the physician, facility, or personnel gives effect to the declaration in good faith and does not have actual knowledge that the declaration has been revoked or does not substantially comply with this chapter;

(2) Giving effect to a consent under the circumstances described in section 2133.08 of the Revised Code, if the physician, facility, or personnel gives effect to the consent in good faith and does not have actual knowledge that the consent is invalid under that section and if a probate court has not issued an order reversing the consent pursuant to division (E) of that section;

(3) Giving effect to a consent under the circumstances described in section 2133.09 of the Revised Code, if the physician, facility, or personnel gives effect to the consent in good faith and does not have actual knowledge that the consent is invalid under that section and if the appropriate probate court has issued an order authorizing the withholding or withdrawal of nutrition and hydration in connection with the patient in question;

(4) Refusing to or not being able to comply or allow compliance with a declaration of a qualified patient, with a consent given in accordance with section 2133.08 or 2133.09 of the Revised Code, with a probate court order issued pursuant to section 2133.05, 2133.08, or 2133.09 of the Revised Code, or with another applicable provision of this chapter, if the refusal or inability to comply or allow compliance is in good faith, provided that, in the case of an attending physician or health care facility, whichever of the following apply are satisfied:

(a) The attending physician or health care facility does not prevent or attempt to prevent, or unreasonably delay or attempt to unreasonably delay, the transfer of the qualified patient or other patient to the care of a physician who, or a health care facility that, is willing and able to so comply or allow compliance.

(b) If the declaration of the qualified patient provided for the use or continuation of life-sustaining treatment should the declarant subsequently be in a terminal condition or in a permanently unconscious state, if the consent decision of a priority individual or class of
individuals under section 2133.08 of the Revised Code was to use or continue life-sustaining treatment in connection with the patient described in that section, or if the probate court issued a reevaluation order pursuant to section 2133.05 or 2133.08 of the Revised Code that was intended to result in the use or continuation of life-sustaining treatment in connection with the qualified patient or other patient, the attending physician or health care facility used or continued the life-sustaining treatment or caused it to be used or continued until a transfer as described in division (A)(4)(a) of this section was made.

(5) Making determinations other than those described in division (B) of this section, or otherwise acting under this chapter, if the determinations or other actions are made in good faith and in accordance with reasonable medical standards;

(6) Prescribing, dispensing, administering, or causing to be administered any particular medical procedure, treatment, intervention, or other measure to a qualified patient or other patient, including, but not limited to, prescribing, personally furnishing, administering, or causing to be administered by judicious titration or in another manner any form of medication, for the purpose of diminishing the qualified patient's or other patient's pain or discomfort and not for the purpose of postponing or causing the qualified patient's or other patient's death, even though the medical procedure, treatment, intervention, or other measure may appear to hasten or increase the risk of the patient's death, if the attending physician so prescribing, dispensing, administering, or causing to be administered or the health care personnel acting under the direction of the attending physician so dispensing, administering, or causing to be administered are carrying out in good faith the responsibility to provide comfort care described in division (E)(1) of section 2133.12 of the Revised Code.

(B) Subject to division (D) of this section, an attending or consulting physician is not subject to criminal prosecution, is not liable in damages in a tort or other civil action, and is not subject to professional disciplinary action if the physician makes any of the following determinations in good faith, to a reasonable degree of medical certainty, and in accordance with reasonable medical standards:

(1) A determination that a declarant or a patient as described in section 2133.08 of the Revised Code is in a terminal condition;

(2) A determination that a declarant is in a permanently unconscious state;

(3) A determination that a patient as described in section 2133.08 of the Revised Code currently is and for at least the immediately preceding twelve months has been in a permanently unconscious state;

(4) A determination that a declarant or a patient as described in section 2133.08 of the Revised Code no longer is able to make informed decisions regarding the administration of life-sustaining treatment;

(5) A determination that there is no reasonable possibility that a declarant or a patient as described in section 2133.08 of the Revised Code will regain the capacity to make informed decisions regarding the administration of life-sustaining treatment;

(6) A determination that nutrition or hydration will not or no longer will provide comfort or alleviate pain in connection with a patient as described in section 2133.09 of the Revised Code.

(C)(1) Subject to division (D) of this section, an individual who is authorized to give a consent to the use or continuation, or the withholding or withdrawal, of life-sustaining treatment under division (B) of section 2133.08 of the Revised Code and who makes the decision in good faith is not subject to criminal prosecution, is not liable in damages in a tort or other civil action, and is not subject to professional disciplinary action in connection with that decision.

(2) Subject to division (D) of this section, an individual who is authorized to give a consent to the withholding or withdrawal of nutrition and hydration in connection with a patient under division (A)(4) of section 2133.09 of the Revised Code and who gives the consent in good faith is not subject to criminal prosecution, is not liable in damages in a tort or other civil action, and is not subject to professional disciplinary action in connection with that consent.
(D) This section does not grant an immunity from criminal or civil liability or from professional disciplinary action to health care personnel for actions that are outside the scope of their authority.

2133.12 Removal of life-sustaining treatment not suicide or homicide; effect on insurance and annuities; rights unaffected; euthanasia prohibited; providing comfort care.

(A) The death of a qualified patient or other patient resulting from the withholding or withdrawal of life-sustaining treatment in accordance with sections 2133.01 to 2133.15 of the Revised Code does not constitute for any purpose a suicide, aggravated murder, murder, or any other homicide offense.

(B)(1) The execution of a declaration shall not do either of the following:
   (a) Affect the sale, procurement, issuance, or renewal of any policy of life insurance or annuity, notwithstanding any term of a policy or annuity to the contrary;
   (b) Be deemed to modify or invalidate the terms of any policy of life insurance or annuity that is in effect on October 10, 1991.

(2) Notwithstanding any term of a policy of life insurance or annuity to the contrary, the withholding or withdrawal of life-sustaining treatment from an insured, qualified patient or other patient in accordance with sections 2133.01 to 2133.15 of the Revised Code shall not impair or invalidate any policy of life insurance or annuity.

(3) Notwithstanding any term of a policy or plan to the contrary, the use or continuation, or the withholding or withdrawal, of life-sustaining treatment from an insured, qualified patient or other patient in accordance with sections 2133.01 to 2133.15 of the Revised Code shall not impair or invalidate any policy of health insurance or any health care benefit plan.

(4) No physician, health care facility, other health care provider, person authorized to engage in the business of insurance in this state under Title XXXIX of the Revised Code, health insuring corporation, other health care plan, legal entity that is self-insured and provides benefits to its employees or members, or other person shall require any individual to execute or refrain from executing a declaration, or shall require an individual to revoke or refrain from revoking a declaration, as a condition of being insured or of receiving health care benefits or services.

(C)(1) Sections 2133.01 to 2133.15 of the Revised Code do not create any presumption concerning the intention of an individual who has revoked or has not executed a declaration with respect to the use or continuation, or the withholding or withdrawal, of life-sustaining treatment if the individual should be in a terminal condition or in a permanently unconscious state at any time.

(2) Sections 2133.01 to 2133.15 of the Revised Code do not affect the right of a qualified patient or other patient to make informed decisions regarding the use or continuation, or the withholding or withdrawal, of life-sustaining treatment as long as the qualified patient or other patient is able to make those decisions.

(3) Sections 2133.01 to 2133.15 of the Revised Code do not require a physician, other health care personnel, or a health care facility to take action that is contrary to reasonable medical standards.

(4) Sections 2133.01 to 2133.15 of the Revised Code and, if applicable, a declaration do not affect or limit the authority of a physician or a health care facility to provide or not to provide life-sustaining treatment to a person in accordance with reasonable medical standards applicable in an emergency situation.

(D) Nothing in sections 2133.01 to 2133.15 of the Revised Code condones, authorizes, or approves of mercy killing, assisted suicide, or euthanasia.

(E)(1) Sections 2133.01 to 2133.15 of the Revised Code do not affect the responsibility of the attending physician of a qualified patient or other patient, or other health care personnel acting under the direction of the patient's attending physician, to provide comfort care to the
patient. Nothing in sections 2133.01 to 2133.15 of the Revised Code precludes the attending physician of a qualified patient or other patient who carries out the responsibility to provide comfort care to the patient in good faith and while acting within the scope of the attending physician's authority from prescribing, dispensing, administering, or causing to be administered any particular medical procedure, treatment, intervention, or other measure to the patient, including, but not limited to, prescribing, personally furnishing, administering, or causing to be administered by judicious titration or in another manner any form of medication, for the purpose of diminishing the qualified patient's or other patient's pain or discomfort and not for the purpose of postponing or causing the qualified patient's or other patient's death, even though the medical procedure, treatment, intervention, or other measure may appear to hasten or increase the risk of the patient's death. Nothing in sections 2133.01 to 2133.15 of the Revised Code precludes health care personnel acting under the direction of the patient's attending physician who carry out the responsibility to provide comfort care to the patient in good faith and while acting within the scope of their authority from dispensing, administering, or causing to be administered any particular medical procedure, treatment, intervention, or other measure to the patient, including, but not limited to, personally furnishing, administering, or causing to be administered by judicious titration or in another manner any form of medication, for the purpose of diminishing the qualified patient's or other patient's pain or discomfort and not for the purpose of postponing or causing the qualified patient's or other patient's death, even though the medical procedure, treatment, intervention, or other measure may appear to hasten or increase the risk of the patient's death.

(2) (a) If, at any time, a person described in division (A)(2)(a)(i) of section 2133.05 of the Revised Code or the individual or a majority of the individuals in either of the first two classes of individuals that pertain to a declarant in the descending order of priority set forth in division (A)(2)(a)(ii) of section 2133.05 of the Revised Code believes in good faith that both of the following circumstances apply, the person or the individual or majority of individuals in either of the first two classes of individuals may commence an action in the probate court of the county in which a declarant who is in a terminal condition or permanently unconscious state is located for the issuance of an order mandating the use or continuation of comfort care in connection with the declarant in a manner that is consistent with division (E)(1) of this section:

(i) Comfort care is not being used or continued in connection with the declarant.
(ii) The withholding or withdrawal of the comfort care is contrary to division (E)(1) of this section.

(b) If a declarant did not designate in the declarant's declaration a person as described in division (A)(2)(a)(i) of section 2133.05 of the Revised Code and if, at any time, a priority individual or any member of a priority class of individuals under division (A)(2)(a)(ii) of section 2133.05 of the Revised Code or, at any time, the individual or a majority of the individuals in the next class of individuals that pertain to the declarant in the descending order of priority set forth in that division believes in good faith that both of the following circumstances apply, the priority individual, the member of the priority class of individuals, or the individual or majority of individuals in the next class of individuals that pertains to the declarant may commence an action in the probate court of the county in which a declarant who is in a terminal condition or permanently unconscious state is located for the issuance of an order mandating the use or continuation of comfort care in connection with the declarant in a manner that is consistent with division (E)(1) of this section:

(i) Comfort care is not being used or continued in connection with the declarant.
(ii) The withholding or withdrawal of the comfort care is contrary to division (E)(1) of this section.

(c) If, at any time, a priority individual or any member of a priority class of individuals under division (B) of section 2133.08 of the Revised Code or, at any time, the individual or a majority of the individuals in the next class of individuals that pertains to the patient in the
descending order of priority set forth in that division believes in good faith that both of the 
following circumstances apply, the priority individual, the member of the priority class of 
individuals, or the individual or majority of individuals in the next class of individuals that pertains 
to the patient may commence an action in the probate court of the county in which a patient as 
described in division (A) of section 2133.08 of the Revised Code is located for the issuance of 
an order mandating the use or continuation of comfort care in connection with the patient in a 
manner that is consistent with division (E)(1) of this section, unless the individual is not 
competent under division (C)(2) of section 2133.08 of the Revised Code:

(i) Comfort care is not being used or continued in connection with the patient. 
(ii) The withholding or withdrawal of the comfort care is contrary to division (E)(1) of this 
section.

2133.13 Declaration assumed valid.

In the absence of actual knowledge to the contrary and if acting in good faith, an 
attending or consulting physician, other health care personnel, and health care facilities may 
assume that a declaration complies with sections 2133.01 to 2133.15 of the Revised Code and 
is valid.

2133.14 Out-of-state declaration.

A declaration executed under the law of another state in compliance with that law or in 
substantial compliance with sections 2133.01 to 2133.15 of the Revised Code shall be 
considered to be valid for purposes of sections 2133.01 to 2133.15 of the Revised Code.

Do-Not-Resuscitate Order

2133.21 Do-not-resuscitate identification; definitions.

As used in sections 2133.21 to 2133.26 of the Revised Code, unless the context clearly 
requires otherwise:

(A) "Attending physician" means the physician to whom a person, or the family of a 
person, has assigned primary responsibility for the treatment or care of the person or, if the 
person or the person's family has not assigned that responsibility, the physician who has 
accepted that responsibility.

(B) "Declaration," "health care facility," "life-sustaining treatment," "physician," 
"professional disciplinary action," and "tort action" have the same meanings as in section 
2133.01 of the Revised Code.

(C) "DNR identification" means a standardized identification card, form, necklace, or 
bracelet that is of uniform size and design, that has been approved by the department of health 
pursuant to section 2133.25 of the Revised Code, and that signifies either of the following: 
(1) That the person who is named on and possesses the card, form, necklace, or 
bracelet has executed a declaration that authorizes the withholding or withdrawal of CPR and 
that has not been revoked pursuant to section 2133.04 of the Revised Code; 
(2) That the attending physician of the person who is named on and possesses the card, 
form, necklace, or bracelet has issued a current do-not-resuscitate order, in accordance with the 
do-not-resuscitate protocol adopted by the department of health pursuant to section 2133.25 of 
the Revised Code, for that person and has documented the grounds for the order in that 
person's medical record.

(D) "Do-not-resuscitate order" means a directive issued by a physician that identifies a 
person and specifies that CPR should not be administered to the person so identified.
(E) "Do-not-resuscitate protocol" means the standardized method of procedure for the withholding of CPR by physicians, emergency medical service personnel, and health care facilities that is adopted in the rules of the department of health pursuant to section 2133.25 of the Revised Code.

(F) "Emergency medical services personnel" means paid or volunteer firefighters, law enforcement officers, first responders, emergency medical technicians-basic, emergency medical technicians-intermediate, emergency medical technicians-paramedic, medical technicians, or other emergency services personnel acting within the ordinary course of their profession.

(G) "CPR" means cardiopulmonary resuscitation or a component of cardiopulmonary resuscitation, but it does not include clearing a person's airway for a purpose other than as a component of CPR.

2133.211 Authorized actions of qualified nurses.

A person who holds a current, valid license issued under Chapter 4723 of the Revised Code to practice as an advanced practice registered nurse may take any action that may be taken by an attending physician under sections 2133.21 to 2133.26 of the Revised Code and has the immunity provided by section 2133.22 of the Revised Code if the action is taken pursuant to a standard care arrangement with a collaborating physician.

A person who holds a license to practice as a physician assistant issued under Chapter 4730 of the Revised Code may take any action that may be taken by an attending physician under sections 2133.21 to 2133.26 of the Revised Code and has the immunity provided by section 2133.22 of the Revised Code if the action is taken pursuant to a supervision agreement entered into under section 4730.19 of the Revised Code, including, if applicable, the policies of a health care facility in which the physician assistant is practicing.

2133.22 Immunities; CPR.

(A)(1) None of the following are subject to criminal prosecution, to liability in damages in a tort or other civil action for injury, death, or loss to person or property, or to professional disciplinary action arising out of or relating to the withholding or withdrawal of CPR from a person after DNR identification is discovered in the person's possession and reasonable efforts have been made to determine that the person in possession of the DNR identification is the person named on the DNR identification:

(a) A physician who causes the withholding or withdrawal of CPR from the person possessing the DNR identification;
(b) A person who participates under the direction of or with the authorization of a physician in the withholding or withdrawal of CPR from the person possessing the DNR identification;
(c) Any emergency medical services personnel who cause or participate in the withholding or withdrawal of CPR from the person possessing the DNR identification.

(2) None of the following are subject to criminal prosecution, to liability in damages in a tort or other civil action for injury, death, or loss to person or property, or to professional disciplinary action arising out of or relating to the withholding or withdrawal of CPR from a person in a health care facility after DNR identification is discovered in the person's possession and reasonable efforts have been made to determine that the person in possession of the DNR identification is the person named on the DNR identification or a do-not-resuscitate order is issued for the person:

(a) The health care facility or the administrator of the health care facility;
(b) A physician who causes the withholding or withdrawal of CPR from the person
possessing the DNR identification or for whom the do-not-resuscitate order has been issued;
  (c) Any person who works for the health care facility as an employee, contractor, or
  volunteer and who participates under the direction of or with the authorization of a physician in
  the withholding or withdrawal of CPR from the person possessing the DNR identification;
  (d) Any person who works for the health care facility as an employee, contractor, or
  volunteer and who participates under the direction of or with the authorization of a physician in
  the withholding or withdrawal of CPR from the person for whom the do-not-resuscitate order has
  been issued.

  (3) If, after DNR identification is discovered in the possession of a person, the person
  makes an oral or written request to receive CPR, any person who provides CPR pursuant to the
  request, any health care facility in which CPR is provided, and the administrator of any health
  care facility in which CPR is provided are not subject to criminal prosecution as a result of the
  provision of the CPR, are not liable in damages in a tort or other civil action for injury, death, or
  loss to person or property that arises out of or is related to the provision of the CPR, and are not
  subject to professional disciplinary action as a result of the provision of the CPR.
  (B) Divisions (A)(1), (A)(2), and (C) of this section do not apply when CPR is withheld or
  withdrawn from a person who possesses DNR identification or for whom a do-not-resuscitate
  order has been issued unless the withholding or withdrawal is in accordance with the do-not-
  resuscitate protocol.
  (C) Any emergency medical services personnel who comply with a do-not-resuscitate
  order issued by a physician and any individuals who work for a health care facility as
  employees, contractors, or volunteers and who comply with a do-not-resuscitate order issued by
  a physician are not subject to liability in damages in a civil action for injury, death, or loss to
  person or property that arises out of or is related to compliance with the order, are not subject to
  criminal prosecution as a result of compliance with the order, and are not subject to professional
  disciplinary action as a result of compliance with the order.

  In an emergency situation, emergency medical services personnel and emergency
  department personnel are not required to search a person to determine if the person possesses
  DNR identification. If a person possesses DNR identification, if emergency medical services
  personnel or emergency department personnel provide CPR to the person in an emergency
  situation, and if, at that time, the personnel do not know and do not have reasonable cause to
  believe that the person possesses DNR identification, the emergency medical services
  personnel and emergency department personnel are not subject to criminal prosecution as a
  result of the provision of the CPR, are not liable in damages in a tort or other civil action for
  injury, death, or loss to person or property that arises out of or is related to the provision of the
  CPR, and are not subject to professional disciplinary action as a result of the provision of the
  CPR.
  (D) Nothing in sections 2133.21 to 2133.26 of the Revised Code or the do-not-
  resuscitate protocol grants immunity to a physician for issuing a do-not-resuscitate order that is
  contrary to reasonable medical standards or that the physician knows or has reason to know is
  contrary to the wishes of the patient or of a person who is lawfully authorized to make informed
  medical decisions on the patient's behalf.

**2133.23 DNR identification compliance; transfers; notice.**

(A) If emergency medical services personnel, other than physicians, are presented with
DNR identification possessed by a person or are presented with a written do-not-resuscitate
order for a person or if a physician directly issues to emergency medical services personnel,
other than physicians, an oral do-not-resuscitate order for a person, the emergency medical
services personnel shall comply with the do-not-resuscitate protocol for the person. If an oral
do-not-resuscitate order is issued by a physician who is not present at the scene, the
emergency medical services personnel shall verify the physician’s identity.

(B) If a person possesses DNR identification and if the person’s attending physician or the health care facility in which the person is located is unwilling or unable to comply with the do-not-resuscitate protocol for the person, the attending physician or the health care facility shall not prevent or attempt to prevent, or unreasonably delay or attempt to delay, the transfer of the person to a different physician who will follow the protocol or to a different health care facility in which the protocol will be followed.

(C) If a person who possesses DNR identification or for whom a current do-not-resuscitate order has been issued is being transferred from one health care facility to another, before or at the time of the transfer, the transferring health care facility shall notify the receiving health care facility and the persons transporting the person of the existence of the DNR identification or the order. If a current do-not-resuscitate order was issued orally, it shall be reduced to writing before the time of the transfer. The DNR identification or the order shall accompany the person to the receiving health care facility and shall remain in effect unless it is revoked or unless, in the case of a do-not-resuscitate order, the order no longer is current.

2133.25 Withholding CPR regulations.

(A) The department of health, by rule adopted pursuant to Chapter 119 of the Revised Code, shall adopt a standardized method of procedure for the withholding of CPR by physicians, emergency medical services personnel, and health care facilities in accordance with sections 2133.21 to 2133.26 of the Revised Code. The standardized method shall specify criteria for determining when a do-not-resuscitate order issued by a physician is current. The standardized method so adopted shall be the “do-not-resuscitate protocol” for purposes of sections 2133.21 to 2133.26 of the Revised Code. The department also shall approve one or more standard forms of DNR identification to be used throughout this state.

(B) The department of health shall adopt rules in accordance with Chapter 119 of the Revised Code for the administration of sections 2133.21 to 2133.26 of the Revised Code.

(C) The department of health shall appoint an advisory committee to advise the department in the development of rules under this section. The advisory committee shall include, but shall not be limited to, representatives of each of the following organizations:

1. The association for hospitals and health systems (OHA);
2. The Ohio state medical association;
3. The Ohio chapter of the American college of emergency physicians;
4. The Ohio hospice organization;
5. The Ohio council for home care;
6. The Ohio health care association;
7. The Ohio ambulance association;
8. The Ohio medical directors association;
9. The Ohio association of emergency medical services;
10. The bioethics network of Ohio;
11. The Ohio nurses association;
12. The Ohio academy of nursing homes;
13. The Ohio association of professional firefighters;
14. The department of developmental disabilities;
15. The Ohio osteopathic association;
16. The association of Ohio philanthropic homes, housing and services for the aging;
17. The catholic conference of Ohio;
18. The department of aging;
19. The department of mental health and addiction services;
20. The Ohio private residential association;
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(21) The northern Ohio fire fighters association.

3701-62-01 DNR Orders, immunity of medical professionals, revocations; definitions.

As used in this chapter, unless the context clearly requires otherwise:

(A) “Attending physician” means the physician to whom a person, or the family of a person, has assigned primary responsibility for the treatment or care of the person or, if the person or the person’s family has not assigned that responsibility, the physician who has accepted that responsibility.

(B) “Cardiac arrest” means the loss of discernable audible and palpable pulse, with or without the loss of cardiac action/rhythm if on a cardiac monitor, or the sudden abrupt loss of heart function.

(C) “CNP” means a person who holds a certificate of authority to practice as a certified nurse practitioner issued under section 4723.42 of the Revised Code.

(D) “CNS” means a person who holds a certificate of authority to practice as a clinical nurse specialist issued under section 4723.42 of the Revised Code.

(E) “CPR” means cardiopulmonary resuscitation or a component of cardiopulmonary resuscitation, but it does not include clearing a person’s airway for a purpose other than as a component of CPR. “Component of CPR” means any of the following:

1. Administration of chest compressions;
2. Insertion of an artificial airway;
3. Administration of resuscitation drugs;
4. Defibrillation or cardioversion;
5. Provision of respiratory assistance;
6. Initiation of a resuscitative intravenous line; and
7. Initiation of cardiac monitoring.

(F) “Declarant” means any adult who has executed a declaration in accordance with section 2133.02 of the Revised Code.

(G) “Declaration” means a written document executed in accordance with section 2133.02 of the Revised Code.

(H) “Do-not-resuscitate identification” or “DNR identification” means a standardized identification card, form, necklace, or bracelet that has been approved by the department of health pursuant to section 2133.25 of the Revised Code, and that signifies either of the following:

1. That the person who is named on and possesses the card, form, necklace, or bracelet has executed a declaration that authorizes the withholding or withdrawal of CPR and that has not been revoked pursuant to section 2133.04 of the Revised Code; or
2. That the attending physician, or CNP or CNS as provided in rule 3701-62-02 of the Administrative Code, of the person who is named on and possesses the card, form, necklace, or bracelet has issued a current do-not-resuscitate order, in accordance with the do-not-resuscitate protocol adopted by the department of health pursuant to section 2133.25 of the Revised Code, for that person and has documented the grounds for the order in that person’s medical record.

DNR identification that has been approved by the department of health is listed in rule 3701-62-04 of the Administrative Code.

(I) “Do-not-resuscitate order” or “DNR order” means a directive issued by a physician, or by a CNP or CNS as provided in rule 3701-62-02 of the Administrative Code, that identifies a person and specifies that CPR should not be administered to the person so identified. The do-not-resuscitate-order shall be implemented in accordance with the do-not-resuscitate protocol.

(J) “Do-not-resuscitate protocol” or “DNR protocol” means the standardized method of procedure for the withholding of CPR by physicians, CNPs or CNSs as provided in rule 3701-62-02 of the Administrative Code, emergency medical service personnel, and health care
facilities that is adopted in the rules of the department of health pursuant to section 2133.25 of the Revised Code. The do-not-resuscitate protocol is specified in rule 3701-62-05 of the Administrative Code. Treatment other than resuscitative, shall continue to be provided or modified as the individual's condition warrants, in keeping with the individual's treatment plan goals.

(K) “Emergency medical services personnel” means paid or volunteer firefighters, law enforcement officers, first responders, emergency medical technicians-basic, emergency medical technicians-intermediate, emergency medical technicians-paramedic, medical technicians, or other emergency services personnel acting within the ordinary course of their profession.

(L) “Health care facility” means any of the following:
(1) A hospital as defined in section 2108.01, 3701.01, or 5122.01 of the Revised Code;
(2) A hospice care program, as defined in section 3712.01 of the Revised Code, or other institution that specializes in comfort care of patients in a terminal condition or in a permanently unconscious state;
(3) A nursing home or residential care facility, as defined in section 3721.01 of the Revised Code;
(4) A home health agency, as defined in section 3701.881 of the Revised Code, and any residential facility where a person is receiving care under the direction of a home health agency;
(5) An intermediate care facility for the individuals with intellectual disabilities (ICF/IID).

(M) “Life-sustaining treatment” means any medical procedure, treatment, intervention, or other measure that, when administered to a qualified patient or other patient, will serve principally to prolong the process of dying.

(N) “Permanently unconscious state” means a state of permanent unconsciousness in a declarant or other patient that, to a reasonable degree of medical certainty as determined in accordance with reasonable medical standards by the declarant's or other patient's attending physician and one other physician who has examined the declarant or other patient, is characterized by both of the following:
(1) Irreversible unawareness of one's being and environment; and
(2) Total loss of cerebral cortical functioning, resulting in the declarant or other patient having no capacity to experience pain or suffering.

(O) “Physician” means a person who is authorized under Chapter 4731 of the Revised Code to practice medicine and surgery or osteopathic medicine and surgery.

(P) “Physician's assistant” or “PA” means a person who holds a certificate of authority to practice as a physician's assistant issued under Chapter 4730 of the Revised Code.

(Q) “Principal” means a person who has executed a durable power of attorney for health care under sections 1337.11 to 1337.17 of the Revised Code.

(R) “Professional disciplinary action” means action taken by the board or other entity that regulates the professional conduct of health care personnel, including but not limited to the state medical board, the board of nursing, and the state board of emergency medical services.

(S) “Respiratory arrest” means absence of spontaneous respirations or the presence of agonal breathing.

(T) “Standard care arrangement” has the same meaning as defined in division (N) of section 4723.01 of the Revised Code.

(U) “Terminal condition” means an irreversible, incurable, and untreatable condition caused by disease, illness, or injury from which, to a reasonable degree of medical certainty as determined in accordance with reasonable medical standards by a declarant's or other patient's attending physician and one other physician who has examined the declarant or other patient, both of the following apply:
(1) There can be no recovery; and
(2) Death is likely to occur within a relatively short time if life-sustaining treatment is not
administered.

(V) “Tort action” means a civil action for damages for injury, death, or loss to person or property, other than a civil action for damages for breach of a contract or another agreement between persons.

3701-62-02 Certified nurse practitioners and clinical nurse specialists.

(A) A person who holds a certificate of authority to practice as a certified nurse practitioner or clinical nurse specialist issued under section 4723.42 of the Revised Code may take any action that may be taken by an attending physician under sections 2133.21 to 2133.26 of the Revised Code and this chapter and has the immunity provided by section 2133.22 of the Revised Code and rule 3701-62-03 of the Administrative Code if the action is taken pursuant to a standard care arrangement with a collaborating physician.

(B) A person who holds a certificate of authority to practice as a physician's assistant Chapter 4730 of the Revised Code may take any action that may be taken by an attending physician under sections 2133.21 to 2133.26 of the Revised Code and this chapter and has the immunity provided by section 2133.22 of the Revised Code and rule 3701-62-03 of the Administrative Code if the action is taken pursuant to a physician supervisory plan approved pursuant to section 4730.17 of the Revised Code or the policies of a health care facility in which the PA is working.

3701-62-03 Immunities.

(A) Persons with DNR identification.

(1) None of the persons listed in paragraph (A)(2) of this rule are subject to any of the following arising out of or relating to the withholding or withdrawal of CPR from a person after DNR identification is discovered in the person's possession and reasonable efforts have been made to determine that the person in possession of the DNR identification is the person named on the DNR identification:

   (a) Criminal prosecution;
   (b) Liability in damages in a tort or other civil action for injury, death, or loss to person or property; or
   (c) Professional disciplinary action.

(2) The immunity described in paragraph (A)(1) of this rule attaches to the following persons:

   (a) A physician, CNP, CNS, or PA as provided in rule 3701-62-02 of the Administrative Code, who causes the withholding or withdrawal of CPR from the person possessing the DNR identification;
   (b) A person who participates under the direction of or with the authorization of a physician, CNP, CNS, or PA as provided in rule 3701-62-02 of the Administrative Code, in the withholding or withdrawal of CPR from the person possessing the DNR identification; or
   (c) Any emergency medical services personnel who cause or participate in the withholding or withdrawal of CPR from the person possessing the DNR identification.

(3) Paragraph (A) of this rule does not apply when CPR is withheld or withdrawn from a person who possesses DNR identification or for whom a do-not-resuscitate order has been issued unless the withholding or withdrawal is in accordance with the do-not-resuscitate protocol.

(B) Persons in health care facilities.

(1) None of the persons listed in paragraph (B)(2) of this rule are subject to any of the following arising out of or relating to the withholding or withdrawal of CPR from a person in a health care facility after DNR identification is discovered in the person's possession and
reasonable efforts have been made to determine that the person in possession of the DNR identification is the person named on the DNR identification or a do-not-resuscitate order is issued for the person:

(a) Criminal prosecution;
(b) Liability in damages in a tort or other civil action for injury, death, or loss to person or property; or
(c) Professional disciplinary action.

(2) The immunity described in paragraph (B)(1) of this rule attaches to the following persons:

(a) The health care facility or the administrator of the health care facility;
(b) A physician, CNP, CNS, or PA as provided in rule 3701-62-02 of the Administrative Code, who causes the withholding or withdrawal of CPR from the person possessing the DNR identification or for whom the do-not-resuscitate order has been issued;
(c) Any person who works for the health care facility as an employee, contractor, or volunteer and who participates under the direction of or with the authorization of a physician, CNP, CNS, or PA as provided in rule 3701-62-02 of the Administrative Code, in the withholding or withdrawal of CPR from the person possessing the DNR identification; and
(d) Any person who works for the health care facility as an employee, contractor, or volunteer and who participates under the direction of or with the authorization of a physician, CNP, CNS, or PA as provided in rule 3701-62-02 of the Administrative Code, in the withholding or withdrawal of CPR from the person for whom the do-not-resuscitate order has been issued.

(3) Paragraph (B) of this rule does not apply when CPR is withheld or withdrawn from a person who possesses DNR identification or for whom a do-not-resuscitate order has been issued unless the withholding or withdrawal is in accordance with the do-not-resuscitate protocol.

(C) For the purposes of paragraphs (A) and (B) of this rule, information that may be used to determine if the person in possession of DNR identification is the person named on the DNR identification include but are not limited to the following:

(1) Verification of the person's identity by the person or a family member, friend, or caregiver;
(2) Personal knowledge of the person by the emergency medical services personnel, physician, CNP, CNS, or PA as provided in rule 3701-62-02 of the Administrative Code, or person working for a health care facility;
(3) Health care facility identification band;
(4) Driver's license;
(5) Passport; or
(6) Other identification bearing the person's name and photograph.

(D) Request for CPR by person with DNR identification. If, after DNR identification is discovered in the possession of a person, the person makes an oral or written request to receive CPR, any person who provides CPR pursuant to the request, any health care facility in which CPR is provided, and the administrator of any health care facility in which CPR is provided are not subject to any of the following:

(1) Criminal prosecution as a result of the provision of the CPR;
(2) Liability in damages in a tort or other civil action for injury, death, or loss to person or property that arises out of or is related to the provision of the CPR; or
(3) Professional disciplinary action as a result of the provision of the CPR.

(E) Do-not-resuscitate orders.

(1) None of the persons listed in paragraph (E)(2) of this rule who comply with a do-not-resuscitate order issued by a physician, CNP, CNS, or PA as provided in rule 3701-62-02 of the Administrative Code, are subject to any of the following:

(a) Liability in damages in a civil action for injury, death, or loss to person or property that
arises out of or is related to compliance with the order;
   (b) Criminal prosecution as a result of compliance with the order; or
   (c) Professional disciplinary action as a result of compliance with the order.
(2) The immunity described in paragraph (E)(1) of this rule attaches to the following persons:
   (a) Any emergency medical services personnel who comply with a do-not-resuscitate order issued by a physician, CNP, CNS, or PA as provided in rule 3701-62-02 of the Administrative Code; and
   (b) Any individuals who work for a health care facility as employees, contractors, or volunteers and who comply with a do-not-resuscitate order issued by a physician, CNP, CNS, or PA as provided in rule 3701-62-02 of the Administrative Code.
(3) Paragraph (E) of this rule does not apply when CPR is withheld or withdrawn from a person who possesses DNR identification or for whom a do-not-resuscitate order has been issued unless the withholding or withdrawal is in accordance with the do-not-resuscitate protocol.

(F) Emergency situations.
(1) In an emergency situation, emergency medical services personnel and emergency department personnel are not required to search a person to determine if the person possesses DNR identification.
(2) If a person possesses DNR identification, if emergency medical services personnel or emergency department personnel provide CPR to the person in an emergency situation, and if, at that time, the personnel do not know and do not have reasonable cause to believe that the person possesses DNR identification, the emergency medical services personnel and emergency department personnel are not subject to any of the following:
   (a) Criminal prosecution as a result of the provision of the CPR;
   (b) Liability in damages in a tort or other civil action for injury, death, or loss to person or property that arises out of or is related to the provision of the CPR; or
   (c) Professional disciplinary action as a result of the provision of the CPR.
(G) Nothing in sections 2133.21 to 2133.26 of the Revised Code, this rule, or the do-not-resuscitate protocol grants immunity to a physician, or CNP or CNS as provided in rule 3701-62-02 of the Administrative Code, for issuing a do-not-resuscitate order that is contrary to reasonable medical standards or that the physician, CNP, CNS, or PA as provided in rule 3701-62-02 of the Administrative Code, knows or has reason to know is contrary to the wishes of the patient or of a person who is lawfully authorized to make informed medical decisions on the patient's behalf.
(H) Pursuant to paragraphs (B) and (C) of rule 3701-62-13 of the Administrative Code, neither paragraph (G) of this rule nor any other provision of this chapter requires provision of CPR to a person if, in the judgment of the attending physician, or CNP or CNS as provided in rule 3701-62-02 of the Administrative Code, CPR would be futile, or if the person or another person lawfully authorized to make decisions on behalf of the person declines CPR.

3701-62-04 DNR identification.

(A) The following items are approved as DNR identification:
   (1) A do-not-resuscitate order documented on the form depicted in appendix A to this rule. This form may be reproduced as needed;
   (2) Documentation on the form depicted in appendix A to this rule that the person named on the form has executed a declaration that authorizes the withholding or withdrawal of CPR and that has not been revoked pursuant to section 2133.04 of the Revised Code and that the declaration has become operative in accordance with section 2133.03 of the Revised Code;
   (3) A transparent hospital-type bracelet with an insert as depicted in appendix B to this rule.
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(4) A necklace bearing both the logo depicted in appendix C to this rule and the person's name. If the person is a “DNR Comfort Care - Arrest” patient as specified in rule 3701-62-05 of the Administrative Code, the necklace shall include the word “arrest” under the logo;

(5) A bracelet bearing both the logo depicted in appendix C to this rule and the person's name. If the person is a “DNR Comfort Care - Arrest” patient as specified in rule 3701-62-05 of the Administrative Code, the bracelet shall include the word “arrest” under the logo;

(6) A wallet card as depicted in appendix D to this rule. This card may be reproduced as needed; and

(7) A printed form of a declaration sold or otherwise distributed in accordance with section 2133.07 of the Revised Code, if the declarant specifies on the form that the declarant wishes to use it as DNR identification.

(B) A person is eligible to obtain DNR identification if either of the following circumstances exist:

(1) The person has executed a declaration that authorizes the withholding or withdrawal of CPR and that has not been revoked pursuant to section 2133.04 of the Revised Code, and the declaration has become operative in accordance with section 2133.03 of the Revised Code; or

(2) The person's attending physician, CNP, CNS, PA as provided in rule 3701-62-02 of the Administrative Code, has issued a current do-not-resuscitate order, in accordance with the do-not-resuscitate protocol specified in rule 3701-62-05 of the Administrative Code, for that person, and has documented the grounds for the order in that person's medical record. The do-not-resuscitate order itself may be used as DNR identification if it is documented on the form depicted in appendix A to this rule.

(C) A person may obtain DNR identification in the following manner:

(1) In the case of the form specified in paragraphs (A)(1) and (A)(2) of this rule, by obtaining a copy of the form from a physician, CNP, CNS, or health care facility and completing the form in conjunction with the person's attending physician, CNP, CNS, PA as provided in rule 3701-62-02 of the Administrative Code.

(2) In the case of the wallet card specified in paragraph (A)(6) of this rule, by doing both of the following:

(a) Obtaining both the form specified in paragraph (A)(1) of this rule and the wallet card from a physician, CNP, CNS, PA, or health care facility; and

(b) Completing both the form and card in conjunction with the person's attending physician, CNP, CNS, PA as provided in rule 3701-62-02 of the Administrative Code.

(3) In the case of the hospital-type bracelet specified in paragraph (A)(3) of this rule, by doing both of the following:

(a) Obtaining a DNR order from the person's attending physician, CNP, CNS, or PA as provided in rule 3701-62-02 of the Administrative Code; and

(b) Acquiring a bracelet containing a completed insert from a physician, CNP, CNS, PA health care facility, or pharmacy. The physician, CNP, CNS, PA, facility, or pharmacy shall not issue a bracelet to the person unless the person presents a DNR order.

(4) In the case of the necklace specified in paragraph (A)(4) of this rule and the bracelet specified in paragraph (A)(5) of this rule, by doing both of the following:

(a) Obtaining a DNR order from the person's attending physician, CNP, CNS, or PA as provided in rule 3701-62-02 of the Administrative Code; and

(b) Acquiring a necklace or bracelet from a person or government entity that manufactures or distributes it. The order for the necklace or bracelet shall be accompanied by a copy of the DNR order.

(5) In the case of a declaration form specified in paragraph (A)(7) of this rule, by obtaining and completing the form in the manner required by sections 2133.01 to 2133.15 of the
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Revised Code and specifying on the form that the declarant wishes to use it as DNR identification. If the declarant wishes to be a “DNR Comfort Care - Arrest” patient, as specified in rule 3701-62-05 of the Administrative Code, the declarant shall include a statement in the declaration that in the event of a cardiac arrest or a respiratory arrest, the declarant is not to receive CPR.

3701-62-05 DNR protocol.

[Editor’s Note: DNR forms are available at www.odh.ohio.gov/rules/final/finalRules.aspx.]

(A) The appendix to this rule shall constitute the do-not-resuscitate protocol for the state of Ohio.

(B) Under the protocol, a person can be a “DNR Comfort Care” patient or a “DNR Comfort Care - Arrest” patient. For a “DNR Comfort Care” patient, the DNR protocol is activated when a DNR order is issued or when a declaration that includes a directive that the declarant not receive CPR becomes effective under section 2133.03 of the Revised Code. For a “DNR Comfort Care - Arrest” patient, the DNR protocol is activated when the patient experiences cardiac or respiratory arrest.

(C) A “DNR Comfort Care - Arrest” patient is identified by the appropriate indication on the patient’s DNR identification, as specified in rule 3701-62-04 of the Administrative Code, or if the patient does not have DNR identification, by a statement in the DNR order that the event of a cardiac arrest or a respiratory arrest, the patient is not to receive CPR.

3701-62-06 Revocation of DNR identification or DNR order.

(A) A person with DNR identification or a DNR order may revoke his or her DNR status by an oral or written request to receive CPR.

(B) A person with DNR identification may revoke his or her DNR identification by doing any of the following:

1. In the case of a form or wallet card listed in paragraph (A)(1), (A)(2), or (A)(6) of rule 3701-62-04 of the Administrative Code, by destroying the form or wallet card;

2. In the case of a bracelet or necklace, by permanently removing the bracelet or necklace;

3. In the case of a declaration that includes a specification that the declarant wishes to use it as DNR identification, by revoking the declaration in accordance with section 2133.04 of the Revised Code.

(C) The attending physician, CNP, CNS, or PA as provided in rule 3701-62-02 of the Administrative Code, of a person with a DNR order may revoke the DNR order by issuing an order discontinuing the DNR order. If DNR identification was issued on the basis of the DNR order, any revocation of the DNR identification shall be accomplished under paragraph (B) of this rule.

(D) If an attending physician, CNP, CNS, or PA as provided in rule 3701-62-02 of the Administrative Code, issues an order discontinuing a valid DNR order in accordance with paragraph (B) or (C) of this rule, a physician, CNP, CNS, or PA shall ask the patient of the health care facility prior to discharge or transfer whether he or she wishes to make another DNR declaration in accordance with section 2133.02 of the Revised Code.

3701-62-07 EMS personnel and DNR compliance.

(A) If emergency medical services personnel, other than physicians, CNPs, CNSs, or PAs as provided in rule 3701-62-02 of the Administrative Code, are presented with DNR
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identification possessed by a person or are presented with a written do-not-resuscitate order for a person or if a physician, CNP, CNS, or PA as provided in rule 3701-62-02 of the Administrative Code, directly issues to emergency medical services personnel, other than physicians, CNPs, CNSs, PAs as provided in rule 3701-62-02 of the Administrative Code, an oral do-not-resuscitate order for a person, the emergency medical services personnel shall comply with the do-not-resuscitate protocol for the person.

(B) If an oral do-not-resuscitate order is issued by a physician, CNP, CNS, or PA as provided in rule 3701-62-02 of the Administrative Code, who is not present at the scene, the emergency medical services personnel shall verify the physician's, CNP's, CNS's, or PA's identity. Methods of verification include but are not limited to the following:

(1) Personal knowledge of the physician, CNP, CNS, or PA by emergency medical services personnel;
(2) A list of physicians, CNPs, CNSs, and PAs with other identifying information such as addresses; or
(3) A return telephone call to verify information provided.

3701-62-08 Transfer of person to comply with DNR protocol.

If a person possesses DNR identification and if the person's attending physician, CNP, CNS, or PA as provided in rule 3701-62-02 of the Administrative Code, or the health care facility in which the person is located is unwilling or unable to comply with the do-not-resuscitate protocol for the person, the attending physician, CNP, CNS, or PA as provided in rule 3701-62-02 of the Administrative Code, or the health care facility shall not prevent or attempt to prevent, or unreasonably delay or attempt to delay, the transfer of the person to a different physician, CNP, CNS, or PA as provided in rule 3701-62-02 of the Administrative Code, who will follow the protocol or to a different health care facility in which the protocol will be followed.

3701-62-09 DNR order to accompany person.

(A) If a person who possesses DNR identification or for whom a current do-not-resuscitate order has been issued is being transferred from one health care facility to another, before or at the time of the transfer, the transferring health care facility shall notify the receiving health care facility and the persons transporting the person of the existence of the DNR identification or the order.

(B) If a current do-not-resuscitate order was issued orally, it shall be reduced to writing before the time of the transfer. The DNR identification or the order shall accompany the person to the receiving health care facility and shall remain in effect unless it is revoked or unless, in the case of a do-not-resuscitate order, the order no longer is current.

3701-62-10 DNR orders, declarations and durable powers of attorney.

(A) If a principal has both a valid durable power of attorney for health care and a DNR identification that is based upon a valid declaration and if the declaration supersedes the durable power of attorney for health care under division (B) of section 2133.03 of the Revised Code, the DNR identification supersedes the durable power of attorney for health care to the extent of any conflict between the two.

(B) A valid durable power of attorney for health care supersedes any DNR identification that is based upon a do-not-resuscitate order that a physician, CNP, CNS, or PA as provided in rule 3701-62-02 of the Administrative Code, issued for the principal which is inconsistent with the durable power of attorney for health care or a valid decision by the attorney in fact under a durable power of attorney.
(C) A declaration supersedes a DNR identification of the declarant that is based upon a prior, inconsistent declaration of the declarant or that is based upon a do-not-resuscitate order that a physician, CNP, CNS, or PA as provided in rule 3701-62-02 of the Administrative Code, has issued for the declarant and that is inconsistent with the declaration.

3701-62-11 Compliance with DNR protocol not homicide or suicide.

(A) The death of a person resulting from the withholding or withdrawal of CPR for the person pursuant to the do-not-resuscitate protocol and in the circumstances described in section 2133.22 of the Revised Code and rule 3701-62-03 of the Administrative Code or in accordance with division (A) of section 2133.23 of the Revised Code and rule 3701-62-06 of the Administrative Code does not constitute for any purpose a suicide, aggravated murder, murder, or any other homicide.

(B) Nothing in sections 2133.21 to 2133.26 of the Revised Code or this chapter condones, authorizes, or approves of mercy killing, assisted suicide, or euthanasia.

3701-62-12 DNR identification or order and insurance.

(A) If a person possesses DNR identification or if a current do-not-resuscitate order has been issued for a person, the possession or order shall not do either of the following:
   (1) Affect in any manner the sale, procurement, issuance, or renewal of a policy of life insurance or annuity, notwithstanding any term of a policy or annuity to the contrary;
   (2) Be deemed to modify in any manner or invalidate the terms of any policy of life insurance or annuity that is in effect on July 9, 1998.

(B) Notwithstanding any term of a policy of life insurance or annuity to the contrary, the withholding or withdrawal of CPR from a person who is insured or covered under the policy or annuity and who possesses DNR identification or for whom a current do-not-resuscitate order has been issued, in accordance with sections 2133.21 to 2133.26 of the Revised Code and this chapter, shall not impair or invalidate any policy of life insurance or annuity.

(C) Notwithstanding any term of a policy or plan to the contrary, neither of the following shall impair or invalidate any policy of health insurance or other health care benefit plan:
   (1) The withholding or withdrawal, in accordance with sections 2133.21 to 2133.26 of the Revised Code and this chapter, of CPR from a person who is insured or covered under the policy or plan and who possesses DNR identification or for whom a current do-not-resuscitate order has been issued;
   (2) The provision, in accordance with sections 2133.21 to 2133.26 of the Revised Code and this chapter, of CPR to a person of the nature described in paragraph (C)(1) of this rule.

(D) No physician, CNP, CNS, or PA as provided in rule 3701-62-02 of the Administrative Code, health care facility, other health care provider, person authorized to engage in the business of insurance in this state under Title XXXIX of the Revised Code, health insuring corporation, other health care benefit plan, legal entity that is self-insured and provides benefits to its employees or members, or other person shall require an individual to possess DNR identification, or shall require an individual to revoke or refrain from possessing DNR identification, as a condition of being insured or of receiving health care benefits or services.

3701-62-13 Rights preserved.

(A) Sections 2133.21 to 2133.26 of the Revised Code and this chapter do not create any presumption concerning the intent of an individual who does not possess DNR identification with respect to the use, withholding, or withdrawal of CPR.

(B) Sections 2133.21 to 2133.26 of the Revised Code and this chapter do not affect the
right of a person to make informed decisions regarding the use, withholding, or withdrawal of CPR for the person as long as the person is able to make those decisions.

(C) Sections 2133.21 to 2133.26 of the Revised Code and this chapter are in addition to and independent of, and do not limit, impair, or supersede, any right or responsibility that a person has to effect the withholding or withdrawal of life-sustaining treatment to another pursuant to sections 2133.01 to 2133.15 of the Revised Code or in any other lawful manner.

(D) Pursuant to division (A)(1) of section 2133.02 of the Revised Code, a person's declaration may include a specific authorization for the use or continuation or the withholding or withdrawal of CPR, but the failure to include a specific authorization for the withholding or withdrawal of CPR does not preclude the withholding or withdrawal of CPR in accordance with sections 2133.01 to 2133.15 (pertaining to declarations) or sections 2133.21 to 2133.26 of the Revised Code (pertaining to DNR orders and identification).

3701-62-14 Prohibitions; violations.

(A) No physician, CNP, CNS, or PA as provided in rule 3701-62-02 of the Administrative Code, shall purposely prevent or attempt to prevent, or delay or unreasonably attempt to delay, the transfer of a patient in violation of division (B) of section 2133.23 of the Revised Code and rule 3701-62-08 of the Administrative Code.

(B) No person shall purposely conceal, cancel, deface, or obliterate the DNR identification of another person without the consent of the other person.

(C) No person shall purposely falsify or forge a revocation of a declaration that is the basis of the DNR identification of another person or purposely falsify or forge an order of a physician, CNP, CNS, or PA as provided in rule 3701-62-02 of the Administrative Code, that purports to supersede a do-not-resuscitate order issued for another person.

(D) No person shall purposely falsify or forge the DNR identification of another person with the intent to cause the use, withholding, or withdrawal of CPR for the other person.

(E) No person who has personal knowledge that another person has revoked a declaration that is the basis of the other person's DNR identification or personal knowledge that a physician, CNP, CNS, or PA as provided in rule 3701-62-02 of the Administrative Code, has issued an order that supersedes a do-not-resuscitate order that the physician, CNP, CNS, or PA issued for another person shall purposely conceal or withhold that personal knowledge with the intent to cause the use, withholding, or withdrawal of CPR for the other person.

(F) No person shall purposely conceal, cancel, deface, or obliterate a valid DNR order of another person without the consent of the other person.

(G) Pursuant to section 2133.26 of the Revised Code, whoever violates paragraph (A) or (E) of this rule is guilty of a misdemeanor of the third degree. Whoever violates paragraph (B), (C), or (D) of this rule is guilty of a misdemeanor of the first degree.

Part III. Lay Caregivers

3727.70 Lay caregiver.

As used in this section and sections 3727.71 to 3727.79 of the Revised Code:

(A) “Admission” means a patient's admission to a hospital on an inpatient basis by a health care professional specified in division (B)(1) of section 3727.06 of the Revised Code.

(B) “After-care” means assistance provided by a lay caregiver to a patient in the patient's residence after the patient's discharge and includes only the caregiving needs of the patient at the time of discharge.

(C) “Discharge” means the discharge or release of a patient who has been admitted to a
hospital on an inpatient basis from the hospital directly to the patient's residence. “Discharge” does not include the transfer of a patient to another facility or setting.

(D) “Discharging health care professional” means a health care professional who is authorized by division (B)(1) of section 3727.06 of the Revised Code to admit a patient to a hospital and who has assumed responsibility for directing the creation of the patient's discharge plan under section 3727.75 of the Revised Code.

(E) “Guardian” has the same meaning as in section 2133.01 of the Revised Code.

(F) “Lay caregiver” means an adult designated under section 3727.71 of the Revised Code to provide after-care to a patient.

(G) “Lay caregiver designation” means the designation of a lay caregiver for a patient as described in section 3727.71 of the Revised Code.

(H)(1) “Patient's residence” means either of the following:
   (a) The dwelling that a patient or the patient's guardian considers to be the patient's home;
   (b) The dwelling of a relative or other individual who has agreed to temporarily house the patient following discharge and who has communicated this fact to hospital staff.

(2) “Patient's residence” does not include any of the following:
   (a) A hospital;
   (b) A nursing home, residential care facility, county home, or district home, as defined in section 3721.01 of the Revised Code;
   (c) A veterans' home operated under Chapter 5907 of the Revised Code;
   (d) A residential facility, as defined in section 5119.34 of the Revised Code;
   (e) A residential facility, as defined in section 5123.19 of the Revised Code;
   (f) A hospice care program, as defined in section 3712.01 of the Revised Code;
   (g) A freestanding inpatient rehabilitation facility licensed under section 3702.30 of the Revised Code;
   (h) Another facility similar to one specified in this division.

3727.71 Lay caregiver; hospital obligation.

(A) In the case of a patient who is at least fifty-five years of age and not unconscious or otherwise incapacitated at the time of admission, a hospital shall offer the patient or the patient's guardian an opportunity to designate a lay caregiver for the patient. The offer shall be made after the patient's admission and before the patient's discharge.

(B) In the case of a patient who is at least fifty-five years of age and unconscious or otherwise incapacitated at the time of admission, a hospital shall offer the patient or the patient's guardian an opportunity to designate a lay caregiver for the patient. The offer shall be made after the patient regains consciousness or capacity and before the patient's discharge.

3727.72 Lay caregiver; hospital duties.

(A) If a patient or guardian makes a lay caregiver designation, the hospital shall do both of the following:
   (1) To the extent the information is available, record in the patient's medical record the lay caregiver's name, address, telephone number, electronic mail address, and relationship to the patient;
   (2) Request from the patient or guardian consent to disclose the patient's medical information to the lay caregiver in accordance with hospital policy and state and federal law.

(B) If a patient or guardian declines to make a lay caregiver designation, the hospital shall note that decision in the patient's medical record and have no other obligation under sections 3727.71 to 3727.79 of the Revised Code.
3727.73 Lay caregiver; revocation.

A patient or guardian may revoke a lay caregiver designation at any time before the patient's discharge by communicating that intent to hospital staff. After revocation, a new lay caregiver designation may be completed in accordance with section 3727.71 of the Revised Code.

3727.74 Laycaregiver; discharge or transfer notice.

(A) Except as provided in division (B) of this section, a hospital that intends to discharge a patient, or transfer a patient to another hospital or facility, shall notify the patient's lay caregiver of that intent as soon as practicable.

(B) Division (A) of this section does not apply if the patient or guardian has not given the consent described in division (A)(2) of section 3727.72 of the Revised Code.

3727.75 Lay caregiver; hospital discharge plan.

(A) A hospital that intends to discharge a patient shall, as soon as practicable, create a discharge plan in accordance with state and federal law and hospital policy and review that plan with the patient or the patient's guardian. If a lay caregiver designation has been made, the discharging health care professional has determined that the lay caregiver's participation in the review would be appropriate, and the lay caregiver is available within a reasonable amount of time, the hospital shall arrange for the lay caregiver to also participate in the review. The review shall be conducted in accordance with section 3727.76 of the Revised Code.

(B)(1) A discharge plan may include the following information:

(a) A description of the tasks that are necessary to facilitate the patient's transition from the hospital to the patient's residence;

(b) Contact information for the health care providers or providers of community or long-term care services that the hospital and the patient or guardian believe are necessary for successful implementation of the discharge plan.

(2) If a lay caregiver designation has been made and the discharging health care professional has determined that the lay caregiver is to have a role in the discharge plan, the discharge plan may include any of the following:

(a) The lay caregiver's name, address, telephone number, electronic mail address, and relationship to the patient, if available;

(b) A description of all after-care tasks to be performed by the lay caregiver, taking into account the lay caregiver's capability to perform such tasks;

(c) Any other information the hospital believes is necessary for successful implementation of the discharge plan.

(C) A discharging health care professional shall not be subject to criminal prosecution or professional disciplinary action, or be liable in a tort action or other civil action, for an event or occurrence that allegedly arises out of the health care professional's determination that a patient's lay caregiver should or should not participate in the review of the patient's discharge plan.

3727.76 Lay caregiver; discharge plan review.

(A) The review of a discharge plan that has been created under section 3727.75 of the Revised Code shall be conducted in a manner that is culturally sensitive to each individual who participates in the review. In accordance with state and federal law and if appropriate, the hospital shall arrange for an interpreter to be present during the instruction.
(B)(1) The review described in division (A) of this section shall, subject to division (B)(2) of this section, include the following components:

(a) If the discharging health care professional determines that it is appropriate, a live demonstration of each task described in the discharge plan performed by a hospital employee or an individual under contract with the hospital to provide the instruction;
(b) An opportunity for each participant to ask questions and receive responses;
(c) Any other component the hospital believes is necessary to ensure that each participant receives adequate instruction on the tasks described in the discharge plan.

(2) It is the intent of the general assembly that execution of the components in division (B)(1) of this section not unreasonably delay a patient's discharge.

(C) The hospital shall document information concerning the instruction provided under this section in the patient's medical record. The information shall include the date and time the instruction was provided and a description of the instruction content.

3727.77 Lay caregiver designation not required; other.

(A) Sections 3727.70 to 3727.76 of the Revised Code do not require a patient or guardian to make a lay caregiver designation.
(B) A lay caregiver designation does not obligate any individual to perform after-care.
(C) A lay caregiver designation or the absence of one shall not interfere with, delay, or otherwise affect the provision of health care to the patient.

3727.78 Lay caregiver; certain limitations.

It is the intent of the general assembly that sections 3727.70 to 3727.77 of the Revised Code not be construed to do any of the following:
(A) Interfere with the authority of a patient's attorney-in-fact under sections 1337.11 to 1337.17 of the Revised Code or a patient's proxy under sections 2135.01 to 2135.14 of the Revised Code;
(B) Create a right of action against a hospital or an employee, agent, or contractor of the hospital;
(C) Create a liability for a hospital or an employee, agent, or contractor of the hospital;
(D) Limit, impair, or supersede any right or remedy that a person has under any other statute, rule, regulation, or the common law of this state;
(E) Alter the obligations of an insurer under a health insurance policy, contract, or plan.

3727.79 Lay caregiver; ODH to issue rules.

The department of health may adopt rules pursuant to Chapter 119 of the Revised Code as necessary to implement sections 3727.70 to 3727.78 of the Revised Code.
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3705.01 Vital statistics; definitions.

As used in this chapter:

(A) “Live birth” means the complete expulsion or extraction from its mother of a product of human conception that after such expulsion or extraction breathes or shows any other evidence of life such as beating of the heart, pulsation of the umbilical cord, or definite movement of voluntary muscles, whether or not the umbilical cord has been cut or the placenta is attached.

(B)(1) “Fetal death” means death prior to the complete expulsion or extraction from its mother of a product of human conception, irrespective of the duration of pregnancy, which after such expulsion or extraction does not breathe or show any other evidence of life such as beating of the heart, pulsation of the umbilical cord, or definite movement of voluntary muscles.

(2) “Stillborn” means that an infant of at least twenty weeks of gestation suffered a fetal death.

(C) “Dead body” means a human body or part of a human body from the condition of which it reasonably may be concluded that death recently occurred.

(D) “Physician” means a person licensed pursuant to Chapter 4731 of the Revised Code to practice medicine or surgery or osteopathic medicine and surgery.

(E) “Attending physician” means the physician in charge of the patient's care for the illness or condition that resulted in death.

(F) “Institution” means any establishment, public or private, that provides medical, surgical, or diagnostic care or treatment, or domiciliary care, to two or more unrelated individuals, or to persons committed by law.

(G) “Funeral director” has the meaning given in section 4717.01 of the Revised Code.

(H) “State registrar” means the head of the office of vital statistics in the department of health.

(I) “Medical certification” means completion of the medical certification portion of the certificate of death or fetal death as to the cause of death or fetal death.

(J) “Final disposition” means the interment, cremation, removal from the state, donation, or other authorized disposition of a dead body or a fetal death.

(K) “Interment” means the final disposition of the remains of a dead body by burial or entombment.

(L) “Cremation” means the reduction to ashes of a dead body.

(M) “Donation” means gift of a dead body to a research institution or medical school.

(N) “System of vital statistics” means the registration, collection, preservation, amendment, and certification of vital records, the collection of other reports required by this chapter, and activities related thereto.

(O) “Vital records” means certificates or reports of birth, death, fetal death, marriage, divorce, dissolution of marriage, annulment, and data related thereto and other documents maintained as required by statute.

(P) “File” means the presentation of vital records for registration by the office of vital statistics.

(Q) “Registration” means the acceptance by the office of vital statistics and the incorporation of vital records into its official records.

(R) “Birth record” means a birth certificate that has been registered with the office of vital statistics; or, if registered prior to March 16, 1989, with the division of vital statistics; or, if registered prior to the establishment of the division of vital statistics, with the department of
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3705.09 Birth certificates filing requirement.

(A) A birth certificate for each live birth in this state shall be filed in the registration district in which it occurs within ten calendar days after such birth and shall be registered if it has been completed and filed in accordance with this section.

(B) When a birth occurs in or en route to an institution, the person in charge of the institution or a designated representative shall obtain the personal data, prepare the certificate, and complete and certify the facts of birth on the certificate within ten calendar days. The physician or certified nurse-midwife in attendance shall be listed on the birth record.

(C) When a birth occurs outside an institution, the birth certificate shall be prepared and filed by one of the following in the indicated order of priority:

(1) The physician or certified nurse-midwife in attendance at or immediately after the birth;
(2) Any other person in attendance at or immediately after the birth;
(3) The father;
(4) The mother;
(5) The person in charge of the premises where the birth occurred.

(D) Either of the parents of the child or other informant shall attest to the accuracy of the personal data entered on the birth certificate in time to permit the filing of the certificate within the ten days prescribed in this section.

(E) When a birth occurs in a moving conveyance within the United States and the child is first removed from the conveyance in this state, the birth shall be registered in this state and the place where it is first removed shall be considered the place of birth. When a birth occurs on a moving conveyance while in international waters or air space or in a foreign country or its air space and the child is first removed from the conveyance in this state, the birth shall be registered in this state but the record shall show the actual place of birth insofar as can be determined.

(F)(1) If the mother of a child was married at the time of either conception or birth or between conception and birth, the child shall be registered in the surname designated by the mother, and the name of the husband shall be entered on the certificate as the father of the child. The presumption of paternity shall be in accordance with section 3111.03 of the Revised Code.

(2) If the mother was not married at the time of conception or birth or between conception and birth, the child shall be registered by the surname designated by the mother. The name of the father of such child shall also be inserted on the birth certificate if both the mother and the father sign an acknowledgement of paternity affidavit before the birth record has been sent to the local registrar. If the father is not named on the birth certificate pursuant to division (F)(1) or (2) of this section, no other information about the father shall be entered on the record.

(G) When a man is presumed, found, or declared to be the father of a child, according to section 2105.26, sections 3111.01 to 3111.18, former section 3111.21, or sections 3111.38 to 3111.54 of the Revised Code, or the father has acknowledged the child as his child in an acknowledgment of paternity, and the acknowledgment has become final pursuant to section 2151.232, 3111.25, or 3111.821 of the Revised Code, and documentary evidence of such fact is submitted to the department of health in such form as the director may require, a new birth
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record shall be issued by the department which shall have the same overall appearance as the record which would have been issued under this section if a marriage had occurred before the birth of such child. Where handwriting is required to effect such appearance, the department shall supply it. Upon the issuance of such new birth record, the original birth record shall cease to be a public record. Except as provided in division (C) of section 3705.091 of the Revised Code, the original record and any documentary evidence supporting the new registration of birth shall be placed in an envelope which shall be sealed by the department and shall not be open to inspection or copy unless so ordered by a court of competent jurisdiction.

(H) Every birth certificate filed under this section on or after July 1, 1990, shall be accompanied by all social security numbers that have been issued to the parents of the child, unless the division of child support in the department of job and family services, acting in accordance with regulations prescribed under the “Family Support Act of 1988,” 102 Stat. 2353, 42 U.S.C.A. 405, as amended, finds good cause for not requiring that the numbers be furnished with the certificate. The parents’ social security numbers shall not be recorded on the certificate. No social security number obtained under this division shall be used for any purpose other than child support enforcement.

3705.16 Death certificate.

(A) For purposes of this section notwithstanding section 3705.01 of the Revised Code, “fetal death” does not include death of the product of human conception prior to twenty weeks of gestation.

(B) Each death or fetal death that occurs in this state shall be registered with the local registrar of vital statistics of the district in which the death or fetal death occurred, by the funeral director or other person in charge of the final disposition of the remains. The personal and statistical information in the death or fetal death certificate shall be obtained from the best qualified persons or sources available, by the funeral director or other person in charge of the final disposition of the remains. The statement of facts relating to the disposition of the body and information relative to the armed services referred to in section 3705.19 of the Revised Code shall be signed by the funeral director or other person in charge of the final disposition of the remains.

(C) The funeral director or other person in charge of the final disposition of the remains shall present the death or fetal death certificate to the attending physician of the decedent, the coroner, or the medical examiner, as appropriate for certification of the cause of death. If a death or fetal death occurs under any circumstances mentioned in section 313.12 of the Revised Code, the coroner in the county in which the death occurs, or a deputy coroner, medical examiner, or deputy medical examiner serving in an equivalent capacity, shall certify the cause of death unless that death was reported to the coroner, deputy coroner, medical examiner, or deputy medical examiner and that person, after a preliminary examination, declined to assert jurisdiction with respect to the death or fetal death. A physician other than the coroner in the county in which a death or fetal death occurs, or a deputy coroner, medical examiner, or deputy medical examiner serving in an equivalent capacity, may certify only those deaths that occur under natural circumstances.

The medical certificate of death shall be completed and signed by the physician who attended the decedent or by the coroner or medical examiner, as appropriate, within forty-eight hours after the death or fetal death. A coroner or medical examiner may satisfy the requirement of signing a medical certificate showing the cause of death or fetal death as pending either by stamping it with a stamp of the coroner’s or medical examiner’s signature or by signing it in the coroner’s or medical examiner’s own hand, but the coroner or medical examiner shall sign any other medical certificate of death or supplementary medical certification in the coroner’s or medical examiner’s own hand.
(D) Any death certificate registered pursuant to this section shall contain the social security number of the decedent, if available. A social security number obtained under this section is a public record under section 149.43 of the Revised Code.

3705.17 Disposition of body.

The body of a person whose death occurs in this state shall not be interred, deposited in a vault or tomb, cremated, or otherwise disposed of by a funeral director until a burial permit is issued by a local registrar or sub-registrar of vital statistics. No such permit shall be issued by a local registrar or sub-registrar until a satisfactory death, fetal death, or provisional death certificate is filed with the local registrar or sub-registrar. When the medical certification as to the cause of death cannot be provided by the attending physician or coroner prior to burial, for sufficient cause, as determined by rule of the director of health, the funeral director may file a provisional death certificate with the local registrar or sub-registrar for the purpose of securing a burial or burial-transit permit. When the funeral director files a provisional death certificate to secure a burial or burial-transit permit, the funeral director shall file a satisfactory and complete death certificate within five days after the date of death. The director of health, by rule, may provide additional time for filing a satisfactory death certificate. A burial permit authorizing cremation shall not be issued upon the filing of a provisional certificate of death.

When a funeral director or other person obtains a burial permit from a local registrar or sub-registrar, the registrar or sub-registrar shall charge a fee of three dollars for the issuance of the burial permit. Two dollars and fifty cents of each fee collected for a burial permit shall be paid into the state treasury to the credit of the division of real estate in the department of commerce to be used by the division in discharging its duties prescribed in Chapter 4767 of the Revised Code and the Ohio cemetery dispute resolution commission created by section 4767.05 of the Revised Code. A local registrar or sub-registrar shall transmit payments of that portion of the amount of each fee collected under this section to the treasurer of state on a quarterly basis or more frequently, if possible. The director of health, by rule, shall provide for the issuance of a burial permit without the payment of the fee required by this section if the total cost of the burial will be paid by an agency or instrumentality of the United States, the state or a state agency, or a political subdivision of the state.

The director of commerce may by rule adopted in accordance with Chapter 119 of the Revised Code reduce the total amount of the fee required by this section and that portion of the amount of the fee required to be paid to the credit of the division of real estate for the use of the division and the Ohio cemetery dispute resolution commission, if the director determines that the total amount of funds the fee is generating at the amount required by this section exceeds the amount of funds the division of real estate and the commission need to carry out their powers and duties prescribed in Chapter 4767 of the Revised Code.

No person in charge of any premises in which interments or cremations are made shall inter or cremate or otherwise dispose of a body, unless it is accompanied by a burial permit. Each person in charge of a cemetery, crematory, or other place of disposal shall indorse upon a burial permit the date of interment, cremation, or other disposal and shall retain such permits for a period of at least five years. The person in charge shall keep an accurate record of all interments, cremations, or other disposal of dead bodies, made in the premises under the person's charge, stating the name of the deceased person, place of death, date of burial, cremation, or other disposal, and name and address of the funeral director. Such record shall at all times be open to public inspection.

3705.20 Certificate of fetal death.

(A) The fetal death of the product of human conception of at least twenty weeks of
gestation shall be registered on a fetal death certificate.

On application of either parent, the fetal death of the product of human conception prior to twenty weeks of gestation shall be registered on a fetal death certificate, except that the fetal death certificate shall not list the cause of death.

The parent shall include with the application a copy of the statement required by division (B)(1) of section 3727.16 or division (B)(1) of section 4731.82 of the Revised Code. If the father submits the application, he shall also include with it a signed and notarized document from the mother attesting that she voluntarily provided the father with a copy of the statement.

A fetal death certificate for the product of human conception prior to twenty weeks gestation is not proof of a live birth for purposes of federal, state, and local taxes.

(B) The product of human conception of at least twenty weeks of gestation that suffers a fetal death occurring in Ohio shall not be interred, deposited in a vault or tomb, cremated, or otherwise disposed of by a funeral director or other person until a fetal death certificate or provisional death certificate has been filed with and a burial permit is issued by the local registrar of vital statistics of the registration district in which the fetal death occurs, or the body is found.

A burial permit for the product of human conception that suffers a fetal death prior to twenty weeks of gestation shall be issued by the local registrar of vital statistics of the registration district in which the fetal death occurs if either parent files a fetal death certificate with that registrar.

(C)(1) The department of health and the local registrar shall keep a separate record and index record of fetal death certificates.

(2) The personal or statistical information on the fetal death certificate shall be obtained by the funeral director or other person in charge of interment or cremation from the best qualified persons or sources available.

(D) When a burial permit is issued under division (B) of this section for the product of human conception of at least twenty weeks of gestation that suffers a fetal death, the local registrar shall inform the parent or parents listed on the fetal death certificate or provisional death certificate of the option of applying for a certificate that is issued under division (B)(3) of section 3705.23 of the Revised Code.

3727.16 Grieving parents act–hospital duty.

(A) As used in this section, “fetal death” has the same meaning as in section 3705.01 of the Revised Code, except that it does not include either of the following:

(1) The product of human conception of at least twenty weeks of gestation;

(2) The purposeful termination of a pregnancy, as described in section 2919.11 of the Revised Code.

(B) If a woman presents herself at a hospital as a result of a fetal death, the hospital shall provide the woman with all of the following:

(1) A written statement, not longer than one page in length, that confirms that the woman was pregnant and that she subsequently suffered a miscarriage that resulted in a fetal death;

(2) Notice of the right of the woman to apply for a fetal death certificate pursuant to section 3705.20 of the Revised Code;

(3) A short, general description of the hospital’s procedures for disposing of the product of a fetal death.

A hospital or hospital employee may present the notice and description required by divisions (B)(2) and (B)(3) of this section through oral or written means. The hospital or hospital employee shall document in the woman’s medical record that all of the items required by this division were provided to the woman and shall place in the record a copy of the statement required by division (B)(1) of this section.
(C) A hospital or hospital employee is immune from civil or criminal liability or professional disciplinary action with regard to any action taken in good faith compliance with this section.

4731.82 Grieving parents act–physician duty.

(A) As used in this section:
(1) “Fetal death” has the same meaning as in section 3705.01 of the Revised Code, except that it does not include either of the following:
(a) The product of human conception of at least twenty weeks of gestation;
(b) The purposeful termination of a pregnancy, as described in section 2919.11 of the Revised Code.
(2) “Physician” means an individual holding a license issued under this chapter to practice medicine and surgery or osteopathic medicine and surgery.
(B) If a woman in the process of experiencing a fetal death or with the product of human conception as a result of a fetal death presents herself to a physician and is not referred to a hospital, the attending physician shall provide the woman with all of the following:
(1) A written statement, not longer than one page in length, that confirms that the woman was pregnant and that she subsequently suffered a miscarriage that resulted in a fetal death;
(2) Notice of the right of the woman to apply for a fetal death certificate pursuant to section 3705.20 of the Revised Code;
(3) A short, general description of the attending physician's procedures for disposing of the product of a fetal death.

The attending physician may present the notice and description required by divisions (B)(2) and (B)(3) of this section through oral or written means. The physician shall document in the woman's medical record that all of the items required by this division were provided to the woman and shall place in the record a copy of the statement required by division (B)(1) of this section.

(C) A physician is immune from civil or criminal liability or professional disciplinary action with regard to any action taken in good faith compliance with this section.

4765.57 Grieving parents act–EMS disposition of fetal death product.

(A) As used in this section, “fetal death” has the same meaning as in section 3705.01 of the Revised Code.
(B) Emergency medical service personnel shall dispose of the product of a fetal death in the manner set forth for the disposition of fetal remains in the “emergency medical technician-basic: national standard curriculum.”

3701-5-01 Vital statistics; definitions.

As used in this chapter:
(A) “Live birth means the complete expulsion or extraction from its mother of a product of human conception, that after such expulsion or extraction, breathes or shows any other evidence of life such as beating of the heart, pulsation of the umbilical cord, or definite movement of voluntary muscles, whether or not the umbilical cord has been cut or the placenta is attached.
(B) “Fetal death” means death prior to the complete expulsion or extraction from its mother of a product of human conception, of at least twenty weeks of gestation, which, after such expulsion or extraction does not breathe or show any other evidence of life such as breathing of the heart, pulsation of the umbilical cord, or definite movement of voluntary
Chapter 6. Vital Statistics

muscles.

(C) “Dead body” means a human body or part of a human body from the condition of
which it reasonably may be concluded that death occurred.

(D) “Physician” means a person licensed pursuant to Chapter 4731 of the Revised Code
to practice medicine or surgery or osteopathic medicine and surgery.

(E) “Attending physician” means the physician in charge of the patient's care for the
illness or condition that resulted in death.

(F) “Institution” means any establishment, public or private, that provides medical,
surgical, or diagnostic care or treatment, or domiciliary care, to two or more unrelated
individuals, or to persons committed by law.

(G) “Funeral director” means the business or profession of directing or supervising
funerals for profit, the business or profession of preparing dead human bodies for burial by
means other than embalming, the disposition of dead human bodies, the provision or
maintenance of a place for the preparation, the care, or disposition of dead human bodies, the
use in connection with a business of the term “funeral director,” “undertaker,” “mortician,” or any
other term from which can be implied the business of funeral directing, or the holding out to the
public that one is a funeral director or a disposer of dead human bodies.

(H) “Registration district” means a city or county health district created by section
3709.01 of the Revised Code. The director of health may combine two or more primary
registration districts, or may establish any state hospital, or other public institution, as a primary
registration district.

(I) “State registrar” means the head of the bureau of vital statistics in the department of
health.

(J) “Local registrar” means the head of a primary registration district.

(K) “Deputy registrar” means an individual appointed by the local registrar, with the
approval of the director, under section 3705.05, of the Revised Code. In the case of the
absence, illness, or disability of the local registrar, the deputy registrar acts in his or her place.

(L) “Sub-registrar” means a person appointed by a local registrar for the purpose of
approving permits for the disposition of remains, as provided in section 3705.17 of the Revised
Code.

(M) “Final disposition” means the burial, cremation, entombment, removal from the state,
donation, or other authorized disposition of a dead body or a fetus.

(N) “Cremation” means the reduction to ashes of a dead body.

(O) “System of vital statistics means the registration, collection, preservation,
amendment, and certification of vital records, the collection of other reports required by Chapter
3705 of the Revised Code and activities related thereto.

(P) “Vital records” means certificates or reports of birth, death, fetal death, or abstracts of
marriage, divorce, dissolution, and annulment, and data related thereto and other documents
maintained as required by statute.

(Q) “File” means the presentation of vital records to the local registrar.

(R) “Registration” means the acceptance by the bureau of vital statistics and the
incorporation of vital records into its official records.

(S) “Birth record” means a birth certificate that has been registered with the office of vital
statistics; or, if registered prior to the effective date of this section, with the division of vital
statistics; or, if registered prior to the establishment of the division of vital statistics, with the
department of health or a local registrar.

(T) “Certification of birth” means a document issued by the director of health or state
registrar or a local registrar under division (B) of section 3705.23 of the Revised Code.

(U) “Director” means the director of health.

(V) “Physician in attendance” means the physician who was in attendance at or
immediately after the birth of the child or, the physician who is the chief or head of the
department or section of obstetrics in the institution.

(W) “Governmental use only certificate” means a vital record issued to a local, state or federal government agency for use in official government business. The governmental use only certificate will be a plain paper copy issued free of charge and will be marked as a governmental use only certificate. A certified copy of a governmental use only certificate will be issued free of charge upon issuance of a court ordered subpoena for a vital record.

(X) “Stillbirth certificate” means a certificate recognizing the fetal death of an infant at any age of gestation. The director or state registrar shall issue a stillbirth certificate upon receipt of a application signed by either parent. The certificate shall contain the name of the infant, sex of the infant, and date of delivery and place of delivery. The director, state registrar, or local registrar shall charge no fee for the certificate. A certificate recognizing the delivery of a stillborn infant is not proof of a live birth for purposes of federal, state and local taxes.

(Y) “Delayed birth” means any birth that happens in an institution, that is not registered within seven years of date of birth, or is not registered within one year, if the birth occurs out of institution.

3701-5-04 Delayed birth registration.

(A) All birth certificates shall be completed within ten days of birth. All certificates of birth must be presented for filing within twenty-one days of the date of birth with either the local registrar who, at the time the certificate is filed, has jurisdiction over the registration district where the birth occurred, or with the state registrar. If the birth was attended by a physician, the certificate of birth contains the physician’s name and date; or if the birth was not attended by a physician, or was attended by a physician who is deceased, the certificate of birth is supported by an affidavit of an individual, other than one of the child’s parents, who has knowledge that the birth occurred at the time and place indicated on the certificate of birth. An affidavit required by this paragraph shall affirm that the birth occurred at the time and place indicated on the certificate.

(B) A certificate of birth for an institution birth, filed more than one year but not more than seven years after the birth occurred shall be registered if it meets the requirements of paragraph (D) of this rule and if the birth was attended by a physician, the local registrar shall submit the certificate to the bureau of vital statistics with a written request that the bureau search the state files to determine whether an original certificate of birth was filed at the time of birth. The local registrar shall register the certificate of birth if the bureau of vital statistics determines that no original certificate of birth was registered and the state registrar approves the registration.

(C) The birth of any person whose institution birth was not registered within seven years after the birth occurred, or whose birth record has been lost or destroyed, shall be registered upon receipt of an order from a probate court, issued pursuant to section 3705.15 of the Revised Code, ordering registration of the birth.

(D) In addition to the applicable requirements of paragraphs (A) and (B) of this rule, a delayed birth certificate, to be registered, shall meet all of the following requirements:

1) The certificate shall be accompanied by all social security numbers that have been issued to the parents of the child, unless the bureau of child support in the Ohio department of job and family services, acting in accordance with regulations prescribed under the Family Support Act of 1988, 102 Stat. 2353, 42 U.S.C.A. 405, as amended, finds good cause for not requiring that the numbers be furnished with the certificate;

2) The parents’ social security numbers shall not be recorded on the certificate;

3) The local registrar of vital statistics shall transmit the social security numbers to the state bureau of vital statistics in accordance with section 3705.07 of the Revised Code.

(E) No social security number obtained under this section shall be used for any purpose other than child support enforcement.
**3701-5-06 Medical certificate of death.**

The medical certificate of death shall be completed and certified by the attending physician who attended the deceased, or by the coroner, within forty-eight hours after death, unless the results of an autopsy or chemical or biological examination are pending.

**3701-5-07 Death certificate when the cause of death unknown.**

When the results of a coroner's investigation or a medical examination to determine the cause of death are not known within five days from the date of death, the coroner or attending physician, as applicable, shall certify the certificate of death, enter “pending” or “pending - not drug related” in the cause of death portion, and return the certificate to the funeral director or other person in charge of final disposition. The funeral director shall immediately file the certificate of death or fetal death report with the local registrar. If there is no funeral home, the agent shall file the death certificate with the local registrar. When the cause of death has been determined, the coroner or attending physician, as applicable shall complete the supplementary medical certification form prescribed and provided by the director. The coroner or physician shall file the form with the local registrar as an addendum to the previously filed certificate of death no later than six months after the date of death.

**3701-5-16 Birth certificate for birth outside an institution.**

(A) In any case where a birth occurs outside an institution and the birth certificate is filed within one year of the birth, documentation of the following shall be required in order to register an out of institution birth:

(1) Evidence of pregnancy, such as, but not limited to:
   (a) Prenatal or postnatal record, or
   (b) A statement from a physician or other health care provider qualified to determine pregnancy, or
   (c) A home visit by a public health nurse or other health care provider, or
   (d) Other evidence acceptable to the state registrar.

(2) Evidence that the infant was born alive, such as but not limited to:
   (a) A statement from the physician or other health care provider who saw or examined the infant, or
   (b) An observation of the infant during a home visit by a public health nurse, or
   (c) Other evidence acceptable to the state registrar.

(3) If the birth occurred in the mother's residence, evidence of the mother's presence in Ohio on the date of the birth, such as but not limited to:
   (a) A driver's license, or a state issued identification card, which includes the mother's current residence on the face of the license or card, or
   (b) A rent receipt or any type of utility, telephone or other bill that includes the mother's name and address.

(4) If the birth occurred outside of the mother's place of residence and the mother is a resident of this state, such evidence shall consist of:
   (a) An affidavit from the tenant of the premises where the birth occurred that the mother was present on those premises at the time of the birth and;
   (b) Evidence of the affiant's residence;
   (c) Evidence of the mother's residence;
   (d) Any other evidence acceptable to the state registrar.
(B) At the discretion of the state registrar, additional evidence may be required to verify the facts of birth. If the required evidence is not available and the local registrar is not able to verify the facts of birth, the out of institution birth may be filed at the state registrar’s discretion.

(C) An out of institution birth that has not been filed within one year of date of birth, must be filed with the applicable probate court and forwarded to the state bureau of vital statistics for registration.
Chapter 7. Liability, Police, Peer Review, and Health Information Exchange

Part I. Medical and Other Liability

[Editor’s Note: Additional statutes involving liability and immunity are listed elsewhere in this handbook under the applicable topic area.]

9.86 Employee and officer civil liability.

Except for civil actions that arise out of the operation of a motor vehicle and civil actions in which the state is the plaintiff, no officer or employee shall be liable in any civil action that arises under the law of this state for damage or injury caused in the performance of his duties, unless the officer’s or employee’s actions were manifestly outside the scope of his employment or official responsibilities, or unless the officer or employee acted with malicious purpose, in bad faith, or in a wanton or reckless manner.

This section does not eliminate, limit, or reduce any immunity from civil liability that is conferred upon an officer or employee by any other provision of the Revised Code or by case law. This section does not affect the liability of the state in an action filed against the state in the court of claims pursuant to Chapter 2743 of the Revised Code.

2108.30 Human fluids or body parts transactions not sales.

Subject to the prohibition in section 2108.18 of the Revised Code, the procuring, furnishing, donating, processing, distributing, or using of human whole blood, plasma, blood products, blood derivatives, and products, corneas, bones, organs, or other human tissue except hair, for the purpose of injecting, transfusing, or transplanting the fluid or body part in another human body, is considered for all purposes as the rendition of a service by every person participating in the act and not a sale of any such fluid or body part. No warranties of any kind or description are applicable to the act.

2125.01 Wrongful death.

When the death of a person is caused by wrongful act, neglect, or default which would have entitled the party injured to maintain an action and recover damages if death had not ensued, the person who would have been liable if death had not ensued, or the administrator or executor of the estate of such person, as such administrator or executor, shall be liable to an action for damages, notwithstanding the death of the person injured and although the death was caused under circumstances which make it aggravated murder, murder, or manslaughter. When the action is against such administrator or executor, the damages recovered shall be a valid claim against the estate of such deceased person. No action for the wrongful death of a person may be maintained against the owner or lessee of the real property upon which the death occurred if the cause of the death was the violent unprovoked act of a party other than the owner, lessee, or a person under the control of the owner or lessee, unless the acts or omissions of the owner, lessee, or person under the control of the owner or lessee constitute gross negligence.

When death is caused by a wrongful act, neglect, or default in another state or foreign country, for which a right to maintain an action and recover damages is given by a statute of
such other state or foreign country, such right of action may be enforced in this state. Every such action shall be commenced within the time prescribed for the commencement of such actions by the statute of such other state or foreign country.

The same remedy shall apply to any such cause of action now existing and to any such action commenced before January 1, 1932, or attempted to be commenced in proper time and now appearing on the files of any court within this state, and no prior law of this state shall prevent the maintenance of such cause of action.

2305.11 Non-medical torts statute of limitations.

(A) An action for libel, slander, malicious prosecution, or false imprisonment, an action for malpractice other than an action upon a medical, dental, optometric, or chiropractic claim, or an action upon a statute for a penalty or forfeiture shall be commenced within one year after the cause of action accrued, provided that an action by an employee for the payment of unpaid minimum wages, unpaid overtime compensation, or liquidated damages by reason of the nonpayment of minimum wages or overtime compensation shall be commenced within two years after the cause of action accrued.

(B) A civil action for unlawful abortion pursuant to section 2919.12 of the Revised Code, a civil action authorized by division (H) of section 2317.56 of the Revised Code, a civil action pursuant to division (B) of section 2307.52 of the Revised Code for terminating or attempting to terminate a human pregnancy after viability in violation of division (A) of section 2919.17 of the Revised Code, and a civil action for terminating or attempting to terminate a human pregnancy of a pain-capable unborn child in violation of division (E) of section 2919.201 of the Revised Code shall be commenced within one year after the performance or inducement of the abortion or within one year after the attempt to perform or induce the abortion in violation of division (A) of section 2919.17 of the Revised Code or division (E) of section 2919.201 of the Revised Code.

(C) As used in this section, “medical claim,” “dental claim,” “optometric claim,” and “chiropractic claim” have the same meanings as in section 2305.113 of the Revised Code.

2305.113 Time limit for claims.

[Editor’s Note: This version of the statute is effective until 1/21/2018. The version effective subsequently is included next.]

(A) Except as otherwise provided in this section, an action upon a medical, dental, optometric, or chiropractic claim shall be commenced within one year after the cause of action accrued.

(B)(1) If prior to the expiration of the one-year period specified in division (A) of this section, a claimant who allegedly possesses a medical, dental, optometric, or chiropractic claim gives to the person who is the subject of that claim written notice that the claimant is considering bringing an action upon that claim, that action may be commenced against the person notified at any time within one hundred eighty days after the notice is so given.

(2) An insurance company shall not consider the existence or nonexistence of a written notice described in division (B)(1) of this section in setting the liability insurance premium rates that the company may charge the company’s insured person who is notified by that written notice.

(C) Except as to persons within the age of minority or of unsound mind as provided by section 2305.16 of the Revised Code, and except as provided in division (D) of this section, both of the following apply:

(1) No action upon a medical, dental, optometric, or chiropractic claim shall be commenced more than four years after the occurrence of the act or omission constituting the
alleged basis of the medical, dental, optometric, or chiropractic claim.

(2) If an action upon a medical, dental, optometric, or chiropractic claim is not commenced within four years after the occurrence of the act or omission constituting the alleged basis of the medical, dental, optometric, or chiropractic claim, then, any action upon that claim is barred.

(D)(1) If a person making a medical claim, dental claim, optometric claim, or chiropractic claim, in the exercise of reasonable care and diligence, could not have discovered the injury resulting from the act or omission constituting the alleged basis of the claim within three years after the occurrence of the act or omission, but, in the exercise of reasonable care and diligence, discovers the injury resulting from that act or omission before the expiration of the four-year period specified in division (C)(1) of this section, the person may commence an action upon the claim not later than one year after the person discovers the injury resulting from that act or omission.

(2) If the alleged basis of a medical claim, dental claim, optometric claim, or chiropractic claim is the occurrence of an act or omission that involves a foreign object that is left in the body of the person making the claim, the person may commence an action upon the claim not later than one year after the person discovered the foreign object or not later than one year after the person, with reasonable care and diligence, should have discovered the foreign object.

(3) A person who commences an action upon a medical claim, dental claim, optometric claim, or chiropractic claim under the circumstances described in division (D)(1) or (2) of this section has the affirmative burden of proving, by clear and convincing evidence, that the person, with reasonable care and diligence, could not have discovered the injury resulting from the act or omission constituting the alleged basis of the claim within the three-year period described in division (D)(1) of this section or within the one-year period described in division (D)(2) of this section, whichever is applicable.

(E) As used in this section:

(1) “Hospital” includes any person, corporation, association, board, or authority that is responsible for the operation of any hospital licensed or registered in the state, including, but not limited to, those that are owned or operated by the state, political subdivisions, any person, any corporation, or any combination of the state, political subdivisions, persons, and corporations. “Hospital” also includes any person, corporation, association, board, entity, or authority that is responsible for the operation of any clinic that employs a full-time staff of physicians practicing in more than one recognized medical specialty and rendering advice, diagnosis, care, and treatment to individuals. “Hospital” does not include any hospital operated by the government of the United States or any of its branches.

(2) “Physician” means a person who is licensed to practice medicine and surgery or osteopathic medicine and surgery by the state medical board or a person who otherwise is authorized to practice medicine and surgery or osteopathic medicine and surgery in this state.

(3) “Medical claim” means any claim that is asserted in any civil action against a physician, podiatrist, hospital, home, or residential facility, against any employee or agent of a physician, podiatrist, hospital, home, or residential facility, or against a licensed practical nurse, registered nurse, advanced practice registered nurse, physical therapist, physician assistant, emergency medical technician-basic, emergency medical technician-intermediate, or emergency medical technician-paramedic, and that arises out of the medical diagnosis, care, or treatment of any person. “Medical claim” includes the following:

(a) Derivative claims for relief that arise from the plan of care, medical diagnosis, or treatment of a person;

(b) Claims that arise out of the plan of care, medical diagnosis, or treatment of any person and to which either of the following applies:

(i) The claim results from acts or omissions in providing medical care.

(ii) The claim results from the hiring, training, supervision, retention, or termination of
caregivers providing medical diagnosis, care, or treatment.

(c) Claims that arise out of the plan of care, medical diagnosis, or treatment of any person and that are brought under section 3721.17 of the Revised Code;

(d) Claims that arise out of skilled nursing care or personal care services provided in a home pursuant to the plan of care, medical diagnosis, or treatment.

(4) “Podiatrist” means any person who is licensed to practice podiatric medicine and surgery by the state medical board.

(5) “Dentist” means any person who is licensed to practice dentistry by the state dental board.

(6) “Dental claim” means any claim that is asserted in any civil action against a dentist, or against any employee or agent of a dentist, and that arises out of a dental operation or the dental diagnosis, care, or treatment of any person. “Dental claim” includes derivative claims for relief that arise from a dental operation or the dental diagnosis, care, or treatment of a person.

(7) “Derivative claims for relief” include, but are not limited to, claims of a parent, guardian, custodian, or spouse of an individual who was the subject of any medical diagnosis, care, or treatment, dental diagnosis, care, or treatment, dental operation, optometric diagnosis, care, or treatment, or chiropractic diagnosis, care, or treatment, that arise from that diagnosis, care, treatment, or operation, and that seek the recovery of damages for any of the following:

(a) Loss of society, consortium, companionship, care, assistance, attention, protection, advice, guidance, counsel, instruction, training, or education, or any other intangible loss that was sustained by the parent, guardian, custodian, or spouse;
(b) Expenditures of the parent, guardian, custodian, or spouse for medical, dental, optometric, or chiropractic care or treatment, for rehabilitation services, or for other care, treatment, services, products, or accommodations provided to the individual who was the subject of the medical diagnosis, care, or treatment, the dental diagnosis, care, or treatment, the dental operation, the optometric diagnosis, care, or treatment, or the chiropractic diagnosis, care, or treatment.

(8) “Registered nurse” means any person who is licensed to practice nursing as a registered nurse by the board of nursing.

(9) “Chiropractic claim” means any claim that is asserted in any civil action against a chiropractor, or against any employee or agent of a chiropractor, and that arises out of the chiropractic diagnosis, care, or treatment of any person. “Chiropractic claim” includes derivative claims for relief that arise from the chiropractic diagnosis, care, or treatment of a person.

(10) “Chiropractor” means any person who is licensed to practice chiropractic by the state chiropractic board.

(11) “Optometric claim” means any claim that is asserted in any civil action against an optometrist, or against any employee or agent of an optometrist, and that arises out of the optometric diagnosis, care, or treatment of any person. “Optometric claim” includes derivative claims for relief that arise from the optometric diagnosis, care, or treatment of a person.

(12) “Optometrist” means any person licensed to practice optometry by the state board of optometry.

(13) “Physical therapist” means any person who is licensed to practice physical therapy under Chapter 4755 of the Revised Code.

(14) “Home” has the same meaning as in section 3721.10 of the Revised Code.

(15) “Residential facility” means a facility licensed under section 5123.19 of the Revised Code.

(16) “Advanced practice registered nurse” has the same meaning as in section 4723.01 of the Revised Code.

(17) “Licensed practical nurse” means any person who is licensed to practice nursing as a licensed practical nurse by the board of nursing pursuant to Chapter 4723 of the Revised Code.
(18) “Physician assistant” means any person who is licensed as a physician assistant under Chapter 4730 of the Revised Code.

(19) “Emergency medical technician-basic,” “emergency medical technician-intermediate,” and “emergency medical technician-paramedic” means any person who is certified under Chapter 4765 of the Revised Code as an emergency medical technician-basic, emergency medical technician-intermediate, or emergency medical technician-paramedic, whichever is applicable.

(20) “Skilled nursing care” and “personal care services” have the same meanings as in section 3721.01 of the Revised Code.

2305.113 Time limit for claims.

[Editor’s Note: This version of the statute is effective 1/21/2018. The version effective prior to that date is included previously.]

(A) Except as otherwise provided in this section, an action upon a medical, dental, optometric, or chiropractic claim shall be commenced within one year after the cause of action accrued.

(B)(1) If prior to the expiration of the one-year period specified in division (A) of this section, a claimant who allegedly possesses a medical, dental, optometric, or chiropractic claim gives to the person who is the subject of that claim written notice that the claimant is considering bringing an action upon that claim, that action may be commenced against the person notified at any time within one hundred eighty days after the notice is so given.

(2) An insurance company shall not consider the existence or nonexistence of a written notice described in division (B)(1) of this section in setting the liability insurance premium rates that the company may charge the company’s insured person who is notified by that written notice.

(C) Except as to persons within the age of minority or of unsound mind as provided by section 2305.16 of the Revised Code, and except as provided in division (D) of this section, both of the following apply:

(1) No action upon a medical, dental, optometric, or chiropractic claim shall be commenced more than four years after the occurrence of the act or omission constituting the alleged basis of the medical, dental, optometric, or chiropractic claim.

(2) If an action upon a medical, dental, optometric, or chiropractic claim is not commenced within four years after the occurrence of the act or omission constituting the alleged basis of the medical, dental, optometric, or chiropractic claim, then, any action upon that claim is barred.

(D)(1) If a person making a medical claim, dental claim, optometric claim, or chiropractic claim, in the exercise of reasonable care and diligence, could not have discovered the injury resulting from the act or omission constituting the alleged basis of the claim within three years after the occurrence of the act or omission, but, in the exercise of reasonable care and diligence, discovers the injury resulting from that act or omission before the expiration of the four-year period specified in division (C)(1) of this section, the person may commence an action upon the claim not later than one year after the person discovers the injury resulting from that act or omission.

(2) If the alleged basis of a medical claim, dental claim, optometric claim, or chiropractic claim is the occurrence of an act or omission that involves a foreign object that is left in the body of the person making the claim, the person may commence an action upon the claim not later than one year after the person discovered the foreign object or not later than one year after the person, with reasonable care and diligence, should have discovered the foreign object.

(3) A person who commences an action upon a medical claim, dental claim, optometric claim, or chiropractic claim, in the exercise of reasonable care and diligence, could not have discovered the injury resulting from the act or omission constituting the alleged basis of the claim within three years after the occurrence of the act or omission, but, in the exercise of reasonable care and diligence, discovers the injury resulting from that act or omission before the expiration of the four-year period specified in division (C)(1) of this section, the person may commence an action upon the claim not later than one year after the person discovers the injury resulting from that act or omission.
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...
advice, guidance, counsel, instruction, training, or education, or any other intangible loss that was sustained by the parent, guardian, custodian, or spouse;

(b) Expenditures of the parent, guardian, custodian, or spouse for medical, dental, optometric, or chiropractic care or treatment, for rehabilitation services, or for other care, treatment, services, products, or accommodations provided to the individual who was the subject of the medical diagnosis, care, or treatment, the dental diagnosis, care, or treatment, the dental operation, the optometric diagnosis, care, or treatment, or the chiropractic diagnosis, care, or treatment.

(8) “Registered nurse” means any person who is licensed to practice nursing as a registered nurse by the board of nursing.

(9) “Chiropractic claim” means any claim that is asserted in any civil action against a chiropractor, or against any employee or agent of a chiropractor, and that arises out of the chiropractic diagnosis, care, or treatment of any person. “Chiropractic claim” includes derivative claims for relief that arise from the chiropractic diagnosis, care, or treatment of a person.

(10) “Chiropractor” means any person who is licensed to practice chiropractic by the state chiropractic board.

(11) “Optometric claim” means any claim that is asserted in any civil action against an optometrist, or against any employee or agent of an optometrist, and that arises out of the optometric diagnosis, care, or treatment of any person. “Optometric claim” includes derivative claims for relief that arise from the optometric diagnosis, care, or treatment of a person.

(12) “Optometrist” means any person licensed to practice optometry by the state vision professionals board.

(13) “Physical therapist” means any person who is licensed to practice physical therapy under Chapter 4755 of the Revised Code.

(14) “Home” has the same meaning as in section 3721.10 of the Revised Code.

(15) “Residential facility” means a facility licensed under section 5123.19 of the Revised Code.

(16) “Advanced practice registered nurse” has the same meaning as in section 4723.01 of the Revised Code.

(17) “Licensed practical nurse” means any person who is licensed to practice nursing as a licensed practical nurse by the board of nursing pursuant to Chapter 4723 of the Revised Code.

(18) “Physician assistant” means any person who is licensed as a physician assistant under Chapter 4730 of the Revised Code.

(19) “Emergency medical technician-basic,” “emergency medical technician-intermediate,” and “emergency medical technician-paramedic” means any person who is certified under Chapter 4765 of the Revised Code as an emergency medical technician-basic, emergency medical technician-intermediate, or emergency medical technician-paramedic, whichever is applicable.

(20) “Skilled nursing care” and “personal care services” have the same meanings as in section 3721.01 of the Revised Code.

2305.23 Emergency care liability.

No person shall be liable in civil damages for administering emergency care or treatment at the scene of an emergency outside of a hospital, doctor’s office, or other place having proper medical equipment, for acts performed at the scene of such emergency, unless such acts constitute willful or wanton misconduct.

Nothing in this section applies to the administering of such care or treatment where the same is rendered for remuneration, or with the expectation of remuneration, from the recipient of such care or treatment or someone on his behalf. The administering of such care or treatment...
by one as a part of his duties as a paid member of any organization of law enforcement officers or fire fighters does not cause such to be a rendering for remuneration or expectation of remuneration.

2305.231 Immunity for healthcare volunteers in school athletics.

(A) As used in this section:
(1) “Dentist” means a person who is licensed under Chapter 4715 of the Revised Code to practice dentistry.
(2) “Physician” means a person who holds a certificate issued by the state medical board to practice medicine and surgery, osteopathic medicine and surgery, or podiatric medicine and surgery.
(3) “Registered nurse” means a nurse who is licensed as a registered nurse under Chapter 4723 of the Revised Code.
(4) “Therapeutic recreation” means adoptive recreation services to persons with illnesses or disabling conditions in order to do any of the following:
   (a) Restore, remediate, or rehabilitate;
   (b) Improve functioning and independence;
   (c) Reduce or eliminate the effects of illness or disability.
(B) No physician who volunteers the physician's services as a team physician or team podiatrist to a school's athletics program, no dentist who volunteers the dentist's services as a team dentist to a school's athletics program, and no registered nurse who volunteers the registered nurse's services as a team nurse to a school's athletics program is liable in damages in a civil action for administering emergency medical care, emergency dental care, other emergency professional care, or first aid treatment to a participant in an athletic event involving the school, at the scene of the event or while the participant is being transported to a hospital, physician's or dentist's office, or other medical or dental facility, or for acts performed in administering the care or treatment, unless the acts of the physician, dentist, or registered nurse constitute willful or wanton misconduct.
(C)(1) No physician who volunteers the physician's services as a camp physician at a camp that specializes in therapeutic recreation, and no registered nurse who volunteers the registered nurse's services at such a camp, is liable in damages in a civil action for either of the following:
   (a) Administering medical care, or emergency professional care, or first aid treatment to a participant in the camp or while the participant is being transported to a hospital, physician's or dentist's office, or other medical or dental facility;
   (b) Acts performed in administering that care or treatment.
   (2) Division (C)(1) of this section does not apply if the acts of the physician or registered nurse constitute willful or wanton misconduct.
(D) This section does not apply if the administration of emergency medical care, emergency dental care, other emergency professional care, or first aid treatment is rendered for remuneration, or with the expectation of remuneration, from the recipient of the care or treatment or from someone on the recipient's behalf.

2305.234 Volunteer and nonprofit immunity.

(A) As used in this section:
(1) “Chiropractic claim,” “medical claim,” and “optometric claim” have the same meanings as in section 2305.113 of the Revised Code.
(2) “Dental claim” has the same meaning as in section 2305.113 of the Revised Code, except that it does not include any claim arising out of a dental operation or any derivative claim
for relief that arises out of a dental operation.

(3) “Governmental health care program” has the same meaning as in section 4731.65 of the Revised Code.

(4) “Health care facility or location” means a hospital, clinic, ambulatory surgical facility, office of a health care professional or associated group of health care professionals, training institution for health care professionals, a free clinic or other nonprofit shelter or health care facility as those terms are defined in section 3701.071 of the Revised Code, or any other place where medical, dental, or other health-related diagnosis, care, or treatment is provided to a person.

(5) “Health care professional” means any of the following who provide medical, dental, or other health-related diagnosis, care, or treatment:

(a) Physicians authorized under Chapter 4731 of the Revised Code to practice medicine and surgery or osteopathic medicine and surgery;
(b) Advanced practice registered nurses, registered nurses, and licensed practical nurses licensed under Chapter 4723 of the Revised Code;
(c) Physician assistants authorized to practice under Chapter 4730 of the Revised Code;
(d) Dentists and dental hygienists licensed under Chapter 4715 of the Revised Code;
(e) Physical therapists, physical therapist assistants, occupational therapists, occupational therapy assistants, and athletic trainers licensed under Chapter 4755 of the Revised Code;
(f) Chiropractors licensed under Chapter 4734 of the Revised Code;
(g) Optometrists licensed under Chapter 4725 of the Revised Code;
(h) Podiatrists authorized under Chapter 4731 of the Revised Code to practice podiatry;
(i) Dietitians licensed under Chapter 4759 of the Revised Code;
(j) Pharmacists licensed under Chapter 4729 of the Revised Code;
(k) Emergency medical technicians-basic, emergency medical technicians-intermediate, and emergency medical technicians-paramedic, certified under Chapter 4765 of the Revised Code;
(l) Respiratory care professionals licensed under Chapter 4761 of the Revised Code;
(m) Speech-language pathologists and audiologists licensed under Chapter 4753 of the Revised Code;
(n) Licensed professional clinical counselors, licensed professional counselors, independent social workers, social workers, independent marriage and family therapists, and marriage and family therapists, licensed under Chapter 4757 of the Revised Code;
(o) Psychologists licensed under Chapter 4732 of the Revised Code;
(p) Independent chemical dependency counselors-clinical supervisors, independent chemical dependency counselors, chemical dependency counselors III, and chemical dependency counselors II, licensed under Chapter 4758 of the Revised Code, and chemical dependency counselor assistants, prevention consultants, prevention specialists, prevention specialist assistants, and registered applicants, certified under that chapter.

(6) “Health care worker” means a person other than a health care professional who provides medical, dental, or other health-related care or treatment under the direction of a health care professional with the authority to direct that individual's activities, including medical technicians, medical assistants, dental assistants, orderlies, aides, and individuals acting in similar capacities.

(7) “Indigent and uninsured person” means a person who meets both of the following requirements:

(a) Relative to being indigent, the person’s income is not greater than two hundred percent of the federal poverty line, as defined by the United States Office of Management and Budget and revised in accordance with section 673(2) of the “Omnibus Budget Reconciliation Act of 1981,” 95 Stat. 511, 42 U.S.C. 9902, as amended, except in any case in which division
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(A)(7)(b)(iii) of this section includes a person whose income is greater than two hundred percent of the federal poverty line.

(b) Relative to being uninsured, one of the following applies:
   (i) The person is not a policyholder, certificate holder, insured, contract holder, subscriber, enrollee, member, beneficiary, or other covered individual under a health insurance or health care policy, contract, or plan.
   (ii) The person is a policyholder, certificate holder, insured, contract holder, subscriber, enrollee, member, beneficiary, or other covered individual under a health insurance or health care policy, contract, or plan, but the insurer, policy, contract, or plan denies coverage or is the subject of insolvency or bankruptcy proceedings in any jurisdiction.
   (iii) Until June 30, 2019, the person is eligible for the medicaid program or is a medicaid recipient.
   (iv) Except as provided in division (A)(7)(b)(iii) of this section, the person is not eligible for or a recipient, enrollee, or beneficiary of any governmental health care program.

(8) “Nonprofit health care referral organization” means an entity that is not operated for profit and refers patients to, or arranges for the provision of, health-related diagnosis, care, or treatment by a health care professional or health care worker.

(9) “Operation” means any procedure that involves cutting or otherwise infiltrating human tissue by mechanical means, including surgery, laser surgery, ionizing radiation, therapeutic ultrasound, or the removal of intraocular foreign bodies. “Operation” does not include the administration of medication by injection, unless the injection is administered in conjunction with a procedure infiltrating human tissue by mechanical means other than the administration of medicine by injection. “Operation” does not include routine dental restorative procedures, the scaling of teeth, or extractions of teeth that are not impacted.

(10) “Tort action” means a civil action for damages for injury, death, or loss to person or property other than a civil action for damages for a breach of contract or another agreement between persons or government entities.

(11) “Volunteer” means an individual who provides any medical, dental, or other health-care related diagnosis, care, or treatment without the expectation of receiving and without receipt of any compensation or other form of remuneration from an indigent and uninsured person, another person on behalf of an indigent and uninsured person, any health care facility or location, any nonprofit health care referral organization, or any other person or government entity.

(12) “Community control sanction” has the same meaning as in section 2929.01 of the Revised Code.

(13) “Deep sedation” means a drug-induced depression of consciousness during which a patient cannot be easily aroused but responds purposefully following repeated or painful stimulation, a patient's ability to independently maintain ventilatory function may be impaired, a patient may require assistance in maintaining a patent airway and spontaneous ventilation may be inadequate, and cardiovascular function is usually maintained.

(14) “General anesthesia” means a drug-induced loss of consciousness during which a patient is not arousable, even by painful stimulation, the ability to independently maintain ventilatory function is often impaired, a patient often requires assistance in maintaining a patent airway, positive pressure ventilation may be required because of depressed spontaneous ventilation or drug-induced depression of neuromuscular function, and cardiovascular function may be impaired.

(B)(1) Subject to divisions (F) and (G)(3) of this section, a health care professional who is a volunteer and complies with division (B)(2) of this section is not liable in damages to any person or government entity in a tort or other civil action, including an action on a medical, dental, chiropractic, optometric, or other health-related claim, for injury, death, or loss to person or property that allegedly arises from an action or omission of the volunteer in the provision to
an indigent and uninsured person of medical, dental, or other health-related diagnosis, care, or treatment, including the provision of samples of medicine and other medical products, unless the action or omission constitutes willful or wanton misconduct.

(2) To qualify for the immunity described in division (B)(1) of this section, a health care professional shall do all of the following prior to providing diagnosis, care, or treatment:

(a) Determine, in good faith, that the indigent and uninsured person is mentally capable of giving informed consent to the provision of the diagnosis, care, or treatment and is not subject to duress or under undue influence;

(b) Inform the person of the provisions of this section, including notifying the person that, by giving informed consent to the provision of the diagnosis, care, or treatment, the person cannot hold the health care professional liable for damages in a tort or other civil action, including an action on a medical, dental, chiropractic, optometric, or other health-related claim, unless the action or omission of the health care professional constitutes willful or wanton misconduct;

(c) Obtain the informed consent of the person and a written waiver, signed by the person or by another individual on behalf of and in the presence of the person, that states that the person is mentally competent to give informed consent and, without being subject to duress or under undue influence, gives informed consent to the provision of the diagnosis, care, or treatment subject to the provisions of this section. A written waiver under division (B)(2)(c) of this section shall state clearly and in conspicuous type that the person or other individual who signs the waiver is signing it with full knowledge that, by giving informed consent to the provision of the diagnosis, care, or treatment, the person cannot bring a tort or other civil action, including an action on a medical, dental, chiropractic, optometric, or other health-related claim, against the health care professional unless the action or omission of the health care professional constitutes willful or wanton misconduct.

(3) A physician or podiatrist who is not covered by medical malpractice insurance, but complies with division (B)(2) of this section, is not required to comply with division (A) of section 4731.143 of the Revised Code.

(C) Subject to divisions (F) and (G)(3) of this section, health care workers who are volunteers are not liable in damages to any person or government entity in a tort or other civil action, including an action upon a medical, dental, chiropractic, optometric, or other health-related claim, for injury, death, or loss to person or property that allegedly arises from an action or omission of the health care worker in the provision to an indigent and uninsured person of medical, dental, or other health-related diagnosis, care, or treatment, unless the action or omission constitutes willful or wanton misconduct.

(D) Subject to divisions (F) and (G)(3) of this section, a nonprofit health care referral organization is not liable in damages to any person or government entity in a tort or other civil action, including an action on a medical, dental, chiropractic, optometric, or other health-related claim, for injury, death, or loss to person or property that allegedly arises from an action or omission of the nonprofit health care referral organization in referring indigent and uninsured persons to, or arranging for the provision of, medical, dental, or other health-related diagnosis, care, or treatment by a health care professional described in division (B)(1) of this section or a health care worker described in division (C) of this section, unless the action or omission constitutes willful or wanton misconduct.

(E) Subject to divisions (F) and (G)(3) of this section and to the extent that the registration requirements of section 3701.071 of the Revised Code apply, a health care facility or location associated with a health care professional described in division (B)(1) of this section, a health care worker described in division (C) of this section, or a nonprofit health care referral organization described in division (D) of this section is not liable in damages to any person or government entity in a tort or other civil action, including an action on a medical, dental, chiropractic, optometric, or other health-related claim, for injury, death, or loss to person or
property that allegedly arises from an action or omission of the health care professional or worker or nonprofit health care referral organization relative to the medical, dental, or other health-related diagnosis, care, or treatment provided to an indigent and uninsured person on behalf of or at the health care facility or location, unless the action or omission constitutes willful or wanton misconduct.

(F)(1) Except as provided in division (F)(2) of this section, the immunities provided by divisions (B), (C), (D), and (E) of this section are not available to a health care professional, health care worker, nonprofit health care referral organization, or health care facility or location if, at the time of an alleged injury, death, or loss to person or property, the health care professionals or health care workers involved are providing one of the following:

(a) Any medical, dental, or other health-related diagnosis, care, or treatment pursuant to a community service work order entered by a court under division (B) of section 2951.02 of the Revised Code or imposed by a court as a community control sanction;
(b) Performance of an operation to which any one of the following applies:
   (i) The operation requires the administration of deep sedation or general anesthesia.
   (ii) The operation is a procedure that is not typically performed in an office.
   (iii) The individual involved is a health care professional, and the operation is beyond the scope of practice or the education, training, and competence, as applicable, of the health care professional.
(c) Delivery of a baby or any other purposeful termination of a human pregnancy.
(2) Division (F)(1) of this section does not apply when a health care professional or health care worker provides medical, dental, or other health-related diagnosis, care, or treatment that is necessary to preserve the life of a person in a medical emergency.

(G)(1) This section does not create a new cause of action or substantive legal right against a health care professional, health care worker, nonprofit health care referral organization, or health care facility or location.
(2) This section does not affect any immunities from civil liability or defenses established by another section of the Revised Code or available at common law to which a health care professional, health care worker, or nonprofit health care referral organization, or health care facility or location may be entitled in connection with the provision of emergency or other medical, dental, or other health-related diagnosis, care, or treatment.
(3) This section does not grant an immunity from tort or other civil liability to a health care professional, health care worker, or nonprofit health care referral organization, or health care facility or location for actions that are outside the scope of authority of health care professionals or health care workers.

In the case of the diagnosis, care, or treatment of an indigent and uninsured person who is eligible for the medicaid program or is a medicaid recipient, this section grants an immunity from tort or other civil liability only if the person’s diagnosis, care, or treatment is provided in a free clinic, as defined in section 3701.071 of the Revised Code.
(4) This section does not affect any legal responsibility of a health care professional, health care worker, or nonprofit health care referral organization to comply with any applicable law of this state or rule of an agency of this state.
(5) This section does not affect any legal responsibility of a health care facility or location to comply with any applicable law of this state, rule of an agency of this state, or local code, ordinance, or regulation that pertains to or regulates building, housing, air pollution, water pollution, sanitation, health, fire, zoning, or safety.

2305.235 Liability for automated external defibrillators.

(A) As used in this section:
(1) “Automated external defibrillation” means the process of applying a specialized
defibrillator to a person in cardiac arrest, allowing the defibrillator to interpret the cardiac rhythm, and, if appropriate, delivering an electrical shock to the heart to allow it to resume effective electrical activity.

(2) “Physician” has the same meaning as in section 4765.01 of the Revised Code.

(B) Except in the case of willful or wanton misconduct, no physician shall be held liable in civil damages for injury, death, or loss to person or property for providing a prescription for an automated external defibrillator approved for use as a medical device by the United States food and drug administration or consulting with a person regarding the use and maintenance of a defibrillator.

(C) Except in the case of willful or wanton misconduct, no person shall be held liable in civil damages for injury, death, or loss to person or property for doing any of the following:

(1) Providing training in automated external defibrillation and cardiopulmonary resuscitation;
(2) Authorizing, directing, or supervising the installation or placement of an automated external defibrillator;
(3) Designing, managing, or operating a cardiopulmonary resuscitation or automated external defibrillation program;
(4) Acquiring an automated external defibrillator;
(5) Owning, managing, or having responsibility for a premises or location where an automated external defibrillator has been placed.

(D) Except in the case of willful or wanton misconduct or when there is no good faith attempt to activate an emergency medical services system in accordance with section 3701.85 of the Revised Code, no person shall be held liable in civil damages for injury, death, or loss to person or property, or held criminally liable, for performing automated external defibrillation in good faith, regardless of whether the person has obtained appropriate training on how to perform automated external defibrillation or successfully completed a course in cardiopulmonary resuscitation.

2305.44 Disabled person ID search.

(A) A medical practitioner or a trained paramedic, in discharging his duty to a disabled person whom he has undertaken to examine or treat, shall make a reasonable search for an identifying device or identification card and examine them for emergency information.

(B) A cause of action against a medical practitioner or a trained paramedic does not arise from his making a reasonable search of a disabled person to locate an identifying device or identification card, even though the person is not wearing an identifying device or carrying an identification card.

2305.51 Mental health worker’s liability for patient misconduct.

(A)(1) As used in this section:
(a) “Civil Rights” has the same meaning as in section 5122.301 of the Revised Code.
(b) “Mental health client or patient” means an individual who is receiving mental health services from a mental health professional or organization.
(c) “Mental health organization” means an organization that engages one or more mental health professionals to provide mental health services to one or more mental health clients or patients.
(d) “Mental health professional” means an individual who is licensed, certified, or registered under the Revised Code, or otherwise authorized in this state, to provide mental health services for compensation, remuneration, or other personal gain.
(e) “Mental health service” means a service provided to an individual or group of...
individuals involving the application of medical, psychiatric, psychological, professional counseling, social work, marriage and family therapy, or nursing principles or procedures to either of the following:

(i) The assessment, diagnosis, prevention, treatment, or amelioration of mental, emotional, psychiatric, psychological, or psychosocial disorders or diseases, as described in the most recent edition of the diagnostic and statistical manual of mental disorders published by the American psychiatric association;

(ii) The assessment or improvement of mental, emotional, psychiatric, psychological, or psychosocial adjustment or functioning, regardless of whether there is a diagnosable, pre-existing disorder or disease.

(f) “Knowledgeable person” means an individual who has reason to believe that a mental health client or patient has the intent and ability to carry out an explicit threat of inflicting imminent and serious physical harm to or causing the death of a clearly identifiable potential victim or victims and who is either an immediate family member of the client or patient or an individual who otherwise personally knows the client or patient.

(2) For the purpose of this section, in the case of a threat to a readily identifiable structure, “clearly identifiable potential victim” includes any potential occupant of the structure.

(B) A mental health professional or mental health organization may be held liable in damages in a civil action, or may be made subject to disciplinary action by an entity with licensing or other regulatory authority over the professional or organization, for serious physical harm or death resulting from failing to predict, warn of, or take precautions to provide protection from the violent behavior of a mental health client or patient, only if the client or patient or a knowledgeable person has communicated to the professional or organization an explicit threat of inflicting imminent and serious physical harm to or causing the death of one or more clearly identifiable potential victims, the professional or organization has reason to believe that the client or patient has the intent and ability to carry out the threat, and the professional or organization fails to take one or more of the following actions in a timely manner:

(1) Exercise any authority the professional or organization possesses to hospitalize the client or patient on an emergency basis pursuant to section 5122.10 of the Revised Code;

(2) Exercise any authority the professional or organization possesses to have the client or patient involuntarily or voluntarily hospitalized under Chapter 5122 of the Revised Code;

(3) Establish and undertake a documented treatment plan that is reasonably calculated, according to appropriate standards of professional practice, to eliminate the possibility that the client or patient will carry out the threat, and, concurrent with establishing and undertaking the treatment plan, initiate arrangements for a second opinion risk assessment through a management consultation about the treatment plan with, in the case of a mental health organization, the clinical director of the organization, or, in the case of a mental health professional who is not acting as part of a mental health organization, any mental health professional who is licensed to engage in independent practice;

(4) Communicate to a law enforcement agency with jurisdiction in the area where each potential victim resides, where a structure threatened by a mental health client or patient is located, or where the mental health client or patient resides, and if feasible, communicate to each potential victim or a potential victim's parent or guardian if the potential victim is a minor or has been adjudicated incompetent, all of the following information:

(a) The nature of the threat;

(b) The identity of the mental health client or patient making the threat;

(c) The identity of each potential victim of the threat.

(C) All of the following apply when a mental health professional or organization takes one or more of the actions set forth in divisions (B)(1) to (4) of this section:

(1) The mental health professional or organization shall consider each of the alternatives set forth and shall document the reasons for choosing or rejecting each alternative.
(2) The mental health professional or organization may give special consideration to those alternatives which, consistent with public safety, would least abridge the rights of the mental health client or patient established under the Revised Code, including the rights specified in sections 5122.27 to 5122.31 of the Revised Code.

(3) The mental health professional or organization is not required to take an action that, in the exercise of reasonable professional judgment, would physically endanger the professional or organization, increase the danger to a potential victim, or increase the danger to the mental health client or patient.

(4) The mental health professional or organization is not liable in damages in a civil action, and shall not be made subject to disciplinary action by any entity with licensing or other regulatory authority over the professional or organization, for disclosing any confidential information about a mental health client or patient that is disclosed for the purpose of taking any of the actions.

(D) The immunities from civil liability and disciplinary action conferred by this section are in addition to and not in limitation of any immunity conferred on a mental health professional or organization by any other section of the Revised Code or by judicial precedent.

(E) This section does not affect the civil rights of a mental health client or patient under Ohio or federal law.

2307.22 Joint and several; proportionate liability.

(A) Subject to sections 2307.23 and 2307.24 and except as provided in division (B) of section 2307.70, division (B) of section 4507.07, section 4399.02, or another section of the Revised Code that expressly establishes joint and several tort liability for specified persons, joint and several tort liability shall be determined as follows:

(1) In a tort action in which the trier of fact determines that two or more persons proximately caused the same injury or loss to person or property or the same wrongful death and in which the trier of fact determines that more than fifty per cent of the tortious conduct is attributable to one defendant, that defendant shall be jointly and severally liable in tort for all compensatory damages that represent economic loss.

(2) If division (A)(1) of this section is applicable, each defendant who is determined by the trier of fact to be legally responsible for the same injury or loss to person or property or the same wrongful death and to whom fifty per cent or less of the tortious conduct is attributable shall be liable to the plaintiff only for that defendant's proportionate share of the compensatory damages that represent economic loss. The proportionate share of a defendant shall be calculated by multiplying the total amount of the economic damages awarded to the plaintiff by the percentage of tortious conduct as determined pursuant to section 2307.23 of the Revised Code that is attributable to that defendant.

(3) In a tort action in which the trier of fact determines that two or more persons proximately caused the same injury or loss to person or property or the same wrongful death and in which the trier of fact determines that fifty per cent or less of the tortious conduct is attributable to any defendant against whom an intentional tort claim has been alleged and established, that defendant shall be jointly and severally liable in tort for all compensatory damages that represent economic loss.

(4) If division (A)(3) of this section is applicable, each defendant against whom an intentional tort claim has not been alleged and established, who is determined by the trier of fact to be legally responsible for the same injury or loss to person or property or the same wrongful death, and to whom fifty per cent or less of the tortious conduct is attributable shall be liable to the plaintiff only for that defendant's proportionate share of the compensatory damages that represent economic loss. The proportionate share of a defendant shall be calculated by multiplying the total amount of the economic damages awarded to the plaintiff by the percentage
of tortious conduct as determined pursuant to section 2307.23 of the Revised Code that is attributable to that defendant.

(B) Except as otherwise provided in divisions (A)(3) and (4) of this section, in a tort action in which the trier of fact determines that two or more persons proximately caused the same injury or loss to person or property or the same wrongful death and in which the trier of fact determines that fifty per cent or less of the tortious conduct is attributable to each defendant, each defendant shall be liable to the plaintiff only for that defendant's proportionate share of the compensatory damages that represent economic loss. The proportionate share of a defendant shall be calculated by multiplying the total amount of the economic damages awarded to the plaintiff by the percentage of tortious conduct as determined pursuant to section 2307.23 of the Revised Code that is attributable to that defendant.

(C) In a tort action in which the trier of fact determines that two or more persons proximately caused the same injury or loss to person or property or the same wrongful death, each defendant who is determined by the trier of fact to be legally responsible for the same injury or loss to person or property or for the same wrongful death shall be liable to the plaintiff only for that defendant's proportionate share of the compensatory damages that represent non-economic loss. The proportionate share of a defendant shall be calculated by multiplying the total amount of the non-economic damages awarded to the plaintiff by the percentage of tortious conduct as determined pursuant to section 2307.23 of the Revised Code that is attributable to that defendant.

(D) Sections 2307.25 to 2307.29 of the Revised Code shall apply to joint and several tort liability that is described in division (A) of this section.

2315.18 Computing damages; non-medical claims; definitions.

(A) As used in this section and in section 2315.19 of the Revised Code:

(1) "Asbestos claim" has the same meaning as in section 2307.91 of the Revised Code.

(2) "Economic loss" means any of the following types of pecuniary harm:

(a) All wages, salaries, or other compensation lost as a result of an injury or loss to

person or property that is a subject of a tort action;

(b) All expenditures for medical care or treatment, rehabilitation services, or other care,
treatment, services, products, or accommodations as a result of an injury or loss to

person or property that is a subject of a tort action;

(c) Any other expenditures incurred as a result of an injury or loss to person or property

that is a subject of a tort action, other than attorney's fees incurred in connection with that

action.

(3) "Medical claim," "dental claim," "optometric claim," and "chiropractic claim" have the

same meanings as in section 2305.113 of the Revised Code.

(4) "Non-economic loss" means nonpecuniary harm that results from an injury or loss to

person or property that is a subject of a tort action, including, but not limited to, pain and

suffering, loss of society, consortium, companionship, care, assistance, attention, protection,
advice, guidance, counsel, instruction, training, or education, disfigurement, mental anguish,
and any other intangible loss.

(5) "Occurrence" means all claims resulting from or arising out of any one person's

bodily injury.

(6) "Product liability claim" has the same meaning as in section 2307.71 of the Revised

Code.

(7) "Tort action" means a civil action for damages for injury or loss to person or property.
"Tort action" includes a civil action upon a product liability claim or an asbestos claim. "Tort

action" does not include a civil action upon a medical claim, dental claim, optometric claim, or

chiropractic claim or a civil action for damages for a breach of contract or another agreement
between persons.

(8) "Trier of fact" means the jury or, in a nonjury action, the court.

(B) In a tort action to recover damages for injury or loss to person or property, all of the following apply:

(1) There shall not be any limitation on the amount of compensatory damages that represents the economic loss of the person who is awarded the damages in the tort action.

(2) Except as otherwise provided in division (B)(3) of this section, the amount of compensatory damages that represents damages for non-economic loss that is recoverable in a tort action under this section to recover damages for injury or loss to person or property shall not exceed the greater of two hundred fifty thousand dollars or an amount that is equal to three times the economic loss, as determined by the trier of fact, of the plaintiff in that tort action to a maximum of three hundred fifty thousand dollars for each plaintiff in that tort action or a maximum of five hundred thousand dollars for each occurrence that is the basis of that tort action.

(3) There shall not be any limitation on the amount of compensatory damages that represents damages for non-economic loss that is recoverable in a tort action to recover damages for injury or loss to person or property if the non-economic losses of the plaintiff are for either of the following:

(a) Permanent and substantial physical deformity, loss of use of a limb, or loss of a bodily organ system;

(b) Permanent physical functional injury that permanently prevents the injured person from being able to independently care for self and perform life-sustaining activities.

(C) In determining an award of compensatory damages for non-economic loss in a tort action, the trier of fact shall not consider any of the following:

(1) Evidence of a defendant's alleged wrongdoing, misconduct, or guilt;

(2) Evidence of the defendant's wealth or financial resources;

(3) All other evidence that is offered for the purpose of punishing the defendant, rather than offered for a compensatory purpose.

(D) If a trial is conducted in a tort action to recover damages for injury or loss to person or property and a plaintiff prevails in that action, the court in a nonjury trial shall make findings of fact, and the jury in a jury trial shall return a general verdict accompanied by answers to interrogatories, that shall specify all of the following:

(1) The total compensatory damages recoverable by the plaintiff;

(2) The portion of the total compensatory damages that represents damages for economic loss;

(3) The portion of the total compensatory damages that represents damages for non-economic loss.

(E)(1) After the trier of fact in a tort action to recover damages for injury or loss to person or property complies with division (D) of this section, the court shall enter a judgment in favor of the plaintiff for compensatory damages for economic loss in the amount determined pursuant to division (D)(2) of this section, and, subject to division (F)(1) of this section, the court shall enter a judgment in favor of the plaintiff for compensatory damages for non-economic loss. Except as provided in division (B)(3) of this section, in no event shall a judgment for compensatory damages for non-economic loss exceed the maximum recoverable amount that represents damages for non-economic loss as provided in division (B)(2) of this section. Division (B) of this section shall be applied in a jury trial only after the jury has made its factual findings and determination as to the damages.

(2) Prior to the trial in the tort action described in division (D) of this section, any party may seek summary judgment with respect to the nature of the alleged injury or loss to person or property, seeking a determination of the damages as described in division (B)(2) of this section.

(F)(1) A court of common pleas has no jurisdiction to enter judgment on an award of
compensatory damages for non-economic loss in excess of the limits set forth in this section.

(2) If the trier of fact is a jury, the court shall not instruct the jury with respect to the limit on compensatory damages for non-economic loss described in division (B)(2) of this section, and neither counsel for any party nor a witness shall inform the jury or potential jurors of that limit.

(G) With respect to a tort action to which division (B)(2) of this section applies, any excess amount of compensatory damages for non-economic loss that is greater than the applicable amount specified in division (B)(2) of this section shall not be reallocated to any other tortfeasor beyond the amount of compensatory damages that the tortfeasor would otherwise be responsible for under the laws of this state.

(H) This section does not apply to any of the following:

(1) Tort actions that are brought against the state in the court of claims, including, but not limited to, those actions in which a state university or college is a defendant and to which division (B)(3) of section 3345.40 of the Revised Code applies;

(2) Tort actions that are brought against political subdivisions of this state and that are commenced under or are subject to Chapter 2744 of the Revised Code. Division (C) of section 2744.05 of the Revised Code applies to recoverable damages in those actions.

(3) Wrongful death actions brought pursuant to Chapter 2125 of the Revised Code.

(I) If the provisions regarding the limits on compensatory damages for non-economic loss set forth in division (B)(2) of this section have been determined to be unconstitutional, then division (C) of this section and section 2315.19 of the Revised Code shall govern the determination of an award of compensatory damages for non-economic loss in a tort action.

2315.20 Collateral benefits evidence; non-medical claims.

(A) In any tort action, the defendant may introduce evidence of any amount payable as a benefit to the plaintiff as a result of the damages that result from an injury, death, or loss to person or property that is the subject of the claim upon which the action is based, except if the source of collateral benefits has a mandatory self-effectuating federal right of subrogation, a contractual right of subrogation, or a statutory right of subrogation or if the source pays the plaintiff a benefit that is in the form of a life insurance payment or a disability payment. However, evidence of the life insurance payment or disability payment may be introduced if the plaintiff's employer paid for the life insurance or disability policy, and the employer is a defendant in the tort action.

(B) If the defendant elects to introduce evidence described in division (A) of this section, the plaintiff may introduce evidence of any amount that the plaintiff has paid or contributed to secure the plaintiff's right to receive the benefits of which the defendant has introduced evidence.

(C) A source of collateral benefits of which evidence is introduced pursuant to division (A) of this section shall not recover any amount against the plaintiff nor shall it be subrogated to the rights of the plaintiff against a defendant.

(D) As used in this section:

(1) "Tort action" means a civil action for damages for injury, death, or loss to person or property. "Tort action" includes a civil action upon a product liability claim and an asbestos claim. "Tort action" does not include a civil action upon a medical claim, dental claim, optometric claim, or chiropractic claim or a civil action for damages for a breach of contract or another agreement between persons.

(2) "Medical claim," "dental claim," "optometric claim," and "chiropractic claim" have the same meanings as in section 2305.113 of the Revised Code.

(3) "Product liability claim" has the same meaning as in section 2307.71 of the Revised Code.
(4) "Asbestos claim" has the same meaning as in section 2307.91 of the Revised Code.

2315.21 Punitive damages.

(A) As used in this section:

(1) "Tort action" means a civil action for damages for injury or loss to person or property. "Tort action" includes a product liability claim for damages for injury or loss to person or property that is subject to sections 2307.71 to 2307.80 of the Revised Code, but does not include a civil action for damages for a breach of contract or another agreement between persons.

(2) "Trier of fact" means the jury or, in a nonjury action, the court.

(3) "Home" has the same meaning as in section 3721.10 of the Revised Code.

(4) "Employer" includes, but is not limited to, a parent, subsidiary, affiliate, division, or department of the employer. If the employer is an individual, the individual shall be considered an employer under this section only if the subject of the tort action is related to the individual's capacity as an employer.

(5) "Small employer" means an employer who employs not more than one hundred persons on a full-time permanent basis, or, if the employer is classified as being in the manufacturing sector by the North American industrial classification system, "small employer" means an employer who employs not more than five hundred persons on a full-time permanent basis.

(B)(1) In a tort action that is tried to a jury and in which a plaintiff makes a claim for compensatory damages and a claim for punitive or exemplary damages, upon the motion of any party, the trial of the tort action shall be bifurcated as follows:

(a) The initial stage of the trial shall relate only to the presentation of evidence, and a determination by the jury, with respect to whether the plaintiff is entitled to recover compensatory damages for the injury or loss to person or property from the defendant. During this stage, no party to the tort action shall present, and the court shall not permit a party to present, evidence that relates solely to the issue of whether the plaintiff is entitled to recover punitive or exemplary damages for the injury or loss to person or property from the defendant.

(b) If the jury determines in the initial stage of the trial that the plaintiff is entitled to recover compensatory damages for the injury or loss to person or property from the defendant, evidence may be presented in the second stage of the trial, and a determination by that jury shall be made, with respect to whether the plaintiff additionally is entitled to recover punitive or exemplary damages for the injury or loss to person or property from the defendant.

(2) In a tort action that is tried to a jury and in which a plaintiff makes a claim for both compensatory damages and punitive or exemplary damages, the court shall instruct the jury to return, and the jury shall return, a general verdict and, if that verdict is in favor of the plaintiff, answers to an interrogatory that specifies the total compensatory damages recoverable by the plaintiff from each defendant.

(3) In a tort action that is tried to a court and in which a plaintiff makes a claim for both compensatory damages and punitive or exemplary damages, the court shall make its determination with respect to whether the plaintiff is entitled to recover compensatory damages for the injury or loss to person or property from the defendant and, if that determination is in favor of the plaintiff, shall make findings of fact that specify the total compensatory damages recoverable by the plaintiff from the defendant.

(C) Subject to division (E) of this section, punitive or exemplary damages are not recoverable from a defendant in question in a tort action unless both of the following apply:

(1) The actions or omissions of that defendant demonstrate malice or aggravated or egregious fraud, or that defendant as principal or master knowingly authorized, participated in, or ratified actions or omissions of an agent or servant that so demonstrate.

(2) The trier of fact has returned a verdict or has made a determination pursuant to
division (B)(2) or (3) of this section of the total compensatory damages recoverable by the plaintiff from that defendant.

(D)(1) In a tort action, the trier of fact shall determine the liability of any defendant for punitive or exemplary damages and the amount of those damages.

(2) Except as provided in division (D)(6) of this section, all of the following apply regarding any award of punitive or exemplary damages in a tort action:

(a) The court shall not enter judgment for punitive or exemplary damages in excess of two times the amount of the compensatory damages awarded to the plaintiff from that defendant, as determined pursuant to division (B)(2) or (3) of this section.

(b) If the defendant is a small employer or individual, the court shall not enter judgment for punitive or exemplary damages in excess of the lesser of two times the amount of the compensatory damages awarded to the plaintiff from the defendant or ten percent of the employer's or individual's net worth when the tort was committed up to a maximum of three hundred fifty thousand dollars, as determined pursuant to division (B)(2) or (3) of this section.

(c) Any attorneys' fees awarded as a result of a claim for punitive or exemplary damages shall not be considered for purposes of determining the cap on punitive damages.

(3) No award of prejudgment interest under division (C)(1) of section 1343.03 of the Revised Code shall include any prejudgment interest on punitive or exemplary damages found by the trier of fact.

(4) In a tort action, the burden of proof shall be upon a plaintiff in question, by clear and convincing evidence, to establish that the plaintiff is entitled to recover punitive or exemplary damages.

(5)(a) In any tort action, except as provided in division (D)(5)(b) or (6) of this section, punitive or exemplary damages shall not be awarded against a defendant if that defendant files with the court a certified judgment, judgment entries, or other evidence showing that punitive or exemplary damages have already been awarded and have been collected, in any state or federal court, against that defendant based on the same act or course of conduct that is alleged to have caused the injury or loss to person or property for which the plaintiff seeks compensatory damages and that the aggregate of those previous punitive or exemplary damage awards exceeds the maximum amount of punitive or exemplary damages that may be awarded under division (D)(2) of this section against that defendant in the tort action.

(b) Notwithstanding division (D)(5)(a) of this section and except as provided in division (D)(6) of this section, punitive or exemplary damages may be awarded against a defendant in either of the following types of tort actions:

(i) In subsequent tort actions involving the same act or course of conduct for which punitive or exemplary damages have already been awarded, if the court determines by clear and convincing evidence that the plaintiff will offer new and substantial evidence of previously undiscovered, additional behavior of a type described in division (C) of this section on the part of that defendant, other than the injury or loss for which the plaintiff seeks compensatory damages. In that case, the court shall make specific findings of fact in the record to support its conclusion. The court shall reduce the amount of any punitive or exemplary damages otherwise awardable pursuant to this section by the sum of the punitive or exemplary damages awards previously rendered against that defendant in any state or federal court. The court shall not inform the jury about the court's determination and action under division (D)(5)(b)(i) of this section.

(ii) In subsequent tort actions involving the same act or course of conduct for which punitive or exemplary damages have already been awarded, if the court determines by clear and convincing evidence that the total amount of prior punitive or exemplary damages awards was totally insufficient to punish that defendant's behavior of a type described in division (C) of this section and to deter that defendant and others from similar behavior in the future. In that case, the court shall make specific findings of fact in the record to support its conclusion. The court shall reduce the amount of any punitive or exemplary damages otherwise awardable
pursuant to this section by the sum of the punitive or exemplary damages awards previously rendered against that defendant in any state or federal court. The court shall not inform the jury about the court's determination and action under division (D)(5)(b)(ii) of this section.

(6) Division (D)(2) of this section does not apply to a tort action where the alleged injury, death, or loss to person or property resulted from the defendant acting with one or more of the culpable mental states of purposely and knowingly as described in section 2901.22 of the Revised Code and when the defendant has been convicted of or pleaded guilty to a criminal offense that is a felony, that had as an element of the offense one or more of the culpable mental states of purposely and knowingly as described in that section, and that is the basis of the tort action.

(E) This section does not apply to tort actions against the state in the court of claims, including, but not limited to, tort actions against a state university or college that are subject to division (B)(1) of section 3345.40 of the Revised Code, to tort actions against political subdivisions of this state that are commenced under or are subject to Chapter 2744 of the Revised Code, or to the extent that another section of the Revised Code expressly provides any of the following:

(1) Punitive or exemplary damages are recoverable from a defendant in question in a tort action on a basis other than that the actions or omissions of that defendant demonstrate malice or aggravated or egregious fraud or on a basis other than that the defendant in question as principal or master knowingly authorized, participated in, or ratified actions or omissions of an agent or servant that so demonstrate.

(2) Punitive or exemplary damages are recoverable from a defendant in question in a tort action irrespective of whether the plaintiff in question has adduced proof of actual damages.

(3) The burden of proof upon a plaintiff in question to recover punitive or exemplary damages from a defendant in question in a tort action is one other than clear and convincing evidence.

(4) Punitive or exemplary damages are not recoverable from a defendant in question in a tort action.

(F) If the trier of fact is a jury, the court shall not instruct the jury with respect to the limits on punitive or exemplary damages pursuant to division (D) of this section, and neither counsel for any party or a witness shall inform the jury or potential jurors of those limits.

(G) When determining the amount of an award of punitive or exemplary damages against either a home or a residential facility licensed under section 5123.19 of the Revised Code, the trier of fact shall consider all of the following:

(1) The ability of the home or residential facility to pay the award of punitive or exemplary damages based on the home's or residential facility's assets, income, and net worth;

(2) Whether the amount of punitive or exemplary damages is sufficient to deter future tortious conduct;

(3) The financial ability of the home or residential facility, both currently and in the future, to provide accommodations, personal care services, and skilled nursing care.

2317.02 Confidentiality of communications.

The following persons shall not testify in certain respects:

(A)(1) An attorney, concerning a communication made to the attorney by a client in that relation or concerning the attorney's advice to a client, except that the attorney may testify by express consent of the client or, if the client is deceased, by the express consent of the surviving spouse or the executor or administrator of the estate of the deceased client. However, if the client voluntarily reveals the substance of attorney-client communications in a nonprivileged context or is deemed by section 2151.421 of the Revised Code to have waived
any testimonial privilege under this division, the attorney may be compelled to testify on the same subject.

The testimonial privilege established under this division does not apply concerning either of the following:

(a) A communication between a client in a capital case, as defined in section 2901.02 of the Revised Code, and the client's attorney if the communication is relevant to a subsequent ineffective assistance of counsel claim by the client alleging that the attorney did not effectively represent the client in the case;

(b) A communication between a client who has since died and the deceased client's attorney if the communication is relevant to a dispute between parties who claim through that deceased client, regardless of whether the claims are by testate or intestate succession or by inter vivos transaction, and the dispute addresses the competency of the deceased client when the deceased client executed a document that is the basis of the dispute or whether the deceased client was a victim of fraud, undue influence, or duress when the deceased client executed a document that is the basis of the dispute.

(2) An attorney, concerning a communication made to the attorney by a client in that relationship or the attorney's advice to a client, except that if the client is an insurance company, the attorney may be compelled to testify, subject to an in camera inspection by a court, about communications made by the client to the attorney or by the attorney to the client that are related to the attorney's aiding or furthering an ongoing or future commission of bad faith by the client, if the party seeking disclosure of the communications has made a prima-facie showing of bad faith, fraud, or criminal misconduct by the client.

(B)(1) A physician, advanced practice registered nurse, or dentist concerning a communication made to the physician, advanced practice registered nurse, or dentist by a patient in that relation or the advice of a physician, advanced practice registered nurse, or dentist given to a patient, except as otherwise provided in this division, division (B)(2), and division (B)(3) of this section, and except that, if the patient is deemed by section 2151.421 of the Revised Code to have waived any testimonial privilege under this division, the physician or advanced practice registered nurse may be compelled to testify on the same subject.

The testimonial privilege established under this division does not apply, and a physician, advanced practice registered nurse, or dentist may testify or may be compelled to testify, in any of the following circumstances:

(a) In any civil action, in accordance with the discovery provisions of the Rules of Civil Procedure in connection with a civil action, or in connection with a claim under Chapter 4123 of the Revised Code, under any of the following circumstances:

(i) If the patient or the guardian or other legal representative of the patient gives express consent;

(ii) If the patient is deceased, the spouse of the patient or the executor or administrator of the patient's estate gives express consent;

(iii) If a medical claim, dental claim, chiropractic claim, or optometric claim, as defined in section 2305.113 of the Revised Code, an action for wrongful death, any other type of civil action, or a claim under Chapter 4123 of the Revised Code is filed by the patient, the personal representative of the estate of the patient if deceased, or the patient's guardian or other legal representative.

(b) In any civil action concerning court-ordered treatment or services received by a patient, if the court-ordered treatment or services were ordered as part of a case plan journalized under section 2151.412 of the Revised Code or the court-ordered treatment or services are necessary or relevant to dependency, neglect, or abuse or temporary or permanent custody proceedings under Chapter 2151 of the Revised Code.

(c) In any criminal action concerning any test or the results of any test that determines the presence or concentration of alcohol, a drug of abuse, a combination of them, a controlled
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substance, or a metabolite of a controlled substance in the patient's whole blood, blood serum
or plasma, breath, urine, or other bodily substance at any time relevant to the criminal offense in
question.

(d) In any criminal action against a physician, advanced practice registered nurse, or
dentist. In such an action, the testimonial privilege established under this division does not
prohibit the admission into evidence, in accordance with the Rules of Evidence, of a patient's
medical or dental records or other communications between a patient and the physician,
advanced practice registered nurse, or dentist that are related to the action and obtained by
subpoena, search warrant, or other lawful means. A court that permits or compels a physician,
advanced practice registered nurse, or dentist to testify in such an action or permits the
introduction into evidence of patient records or other communications in such an action shall
require that appropriate measures be taken to ensure that the confidentiality of any patient
named or otherwise identified in the records is maintained. Measures to ensure confidentiality
that may be taken by the court include sealing its records or deleting specific information from
its records.

(e)(i) If the communication was between a patient who has since died and the deceased
patient's physician, advanced practice registered nurse, or dentist, the communication is
relevant to a dispute between parties who claim through that deceased patient, regardless of
whether the claims are by testate or intestate succession or by inter vivos transaction, and the
dispute addresses the competency of the deceased patient when the deceased patient
executed a document that is the basis of the dispute or whether the deceased patient was a
victim of fraud, undue influence, or duress when the deceased patient executed a document
that is the basis of the dispute.

(ii) If neither the spouse of a patient nor the executor or administrator of that patient's
estate gives consent under division (B)(1)(a)(ii) of this section, testimony or the disclosure of the
patient's medical records by a physician, advanced practice registered nurse, dentist, or other
health care provider under division (B)(1)(e)(i) of this section is a permitted use or disclosure of
protected health information, as defined in 45 C.F.R. 160.103, and an authorization or
opportunity to be heard shall not be required.

(iii) Division (B)(1)(e)(i) of this section does not require a mental health professional to
disclose psychotherapy notes, as defined in 45 C.F.R. 164.501.

(iv) An interested person who objects to testimony or disclosure under division
(B)(1)(e)(i) of this section may seek a protective order pursuant to Civil Rule 26.

(v) A person to whom protected health information is disclosed under division (B)(1)(e)(i)
of this section shall not use or disclose the protected health information for any purpose other
than the litigation or proceeding for which the information was requested and shall return the
protected health information to the covered entity or destroy the protected health information,
including all copies made, at the conclusion of the litigation or proceeding.

(2)(a) If any law enforcement officer submits a written statement to a health care
provider that states that an official criminal investigation has begun regarding a specified person
or that a criminal action or proceeding has been commenced against a specified person, that
requests the provider to supply to the officer copies of any records the provider possesses that
pertain to any test or the results of any test administered to the specified person to determine
the presence or concentration of alcohol, a drug of abuse, a combination of them, a controlled
substance, or a metabolite of a controlled substance in the person's whole blood, blood serum
or plasma, breath, or urine at any time relevant to the criminal offense in question, and that
conforms to section 2317.022 of the Revised Code, the provider, except to the extent
specifically prohibited by any law of this state or of the United States, shall supply to the officer a
copy of any of the requested records the provider possesses. If the health care provider does
not possess any of the requested records, the provider shall give the officer a written statement
that indicates that the provider does not possess any of the requested records.
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(b) If a health care provider possesses any records of the type described in division (B)(2)(a) of this section regarding the person in question at any time relevant to the criminal offense in question, in lieu of personally testifying as to the results of the test in question, the custodian of the records may submit a certified copy of the records, and, upon its submission, the certified copy is qualified as authentic evidence and may be admitted as evidence in accordance with the Rules of Evidence. Division (A) of section 2317.422 of the Revised Code does not apply to any certified copy of records submitted in accordance with this division. Nothing in this division shall be construed to limit the right of any party to call as a witness the person who administered the test to which the records pertain, the person under whose supervision the test was administered, the custodian of the records, the person who made the records, or the person under whose supervision the records were made.

(3)(a) If the testimonial privilege described in division (B)(1) of this section does not apply as provided in division (B)(1)(a)(iii) of this section, a physician, advanced practice registered nurse, or dentist may be compelled to testify or to submit to discovery under the Rules of Civil Procedure only as to a communication made to the physician, advanced practice registered nurse, or dentist by the patient in question in that relation, or the advice of the physician, advanced practice registered nurse, or dentist given to the patient in question, that related causally or historically to physical or mental injuries that are relevant to issues in the medical claim, dental claim, chiropractic claim, or optometric claim, action for wrongful death, other civil action, or claim under Chapter 4123 of the Revised Code.

(b) If the testimonial privilege described in division (B)(1) of this section does not apply to a physician, advanced practice registered nurse, or dentist as provided in division (B)(1)(c) of this section, the physician, advanced practice registered nurse, or dentist, in lieu of personally testifying as to the results of the test in question, may submit a certified copy of those results, and, upon its submission, the certified copy is qualified as authentic evidence and may be admitted as evidence in accordance with the Rules of Evidence. Division (A) of section 2317.422 of the Revised Code does not apply to any certified copy of results submitted in accordance with this division. Nothing in this division shall be construed to limit the right of any party to call as a witness the person who administered the test to which the records pertain, the person under whose supervision the test was administered, the custodian of the results of the test, the person who compiled the results, or the person under whose supervision the results were compiled.

(4) The testimonial privilege described in division (B)(1) of this section is not waived when a communication is made by a physician or advanced practice registered nurse to a pharmacist or when there is communication between a patient and a pharmacist in furtherance of the physician-patient or advanced practice registered nurse-patient relation.

(5)(a) As used in divisions (B)(1) to (4) of this section, “communication” means acquiring, recording, or transmitting any information, in any manner, concerning any facts, opinions, or statements necessary to enable a physician, advanced practice registered nurse, or dentist to diagnose, treat, prescribe, or act for a patient. A “communication” may include, but is not limited to, any medical or dental, office, or hospital communication such as a record, chart, letter, memorandum, laboratory test and results, x-ray, photograph, financial statement, diagnosis, or prognosis.

(b) As used in division (B)(2) of this section, “health care provider” means a hospital, ambulatory care facility, long-term care facility, pharmacy, emergency facility, or health care practitioner.

(c) As used in division (B)(5)(b) of this section:

(i) “Ambulatory care facility” means a facility that provides medical, diagnostic, or surgical treatment to patients who do not require hospitalization, including a dialysis center, ambulatory surgical facility, cardiac catheterization facility, diagnostic imaging center, extracorporeal shock wave lithotripsy center, home health agency, inpatient hospice, birthing center, radiation therapy center, emergency facility, and an urgent care center. “Ambulatory
health care facility” does not include the private office of a physician, advanced practice registered nurse, or dentist, whether the office is for an individual or group practice.

(ii) “Emergency facility” means a hospital emergency department or any other facility that provides emergency medical services.

(iii) “Health care practitioner” has the same meaning as in section 4769.01 of the Revised Code.

(iv) “Hospital” has the same meaning as in section 3727.01 of the Revised Code.

(v) “Long-term care facility” means a nursing home, residential care facility, or home for the aging, as those terms are defined in section 3721.01 of the Revised Code; a residential facility licensed under section 5119.34 of the Revised Code that provides accommodations, supervision, and personal care services for three to sixteen unrelated adults; a nursing facility, as defined in section 5165.01 of the Revised Code; a skilled nursing facility, as defined in section 5165.01 of the Revised Code; and an intermediate care facility for individuals with intellectual disabilities, as defined in section 5124.01 of the Revised Code.

(vi) “Pharmacy” has the same meaning as in section 4729.01 of the Revised Code.

(d) As used in divisions (B)(1) and (2) of this section, “drug of abuse” has the same meaning as in section 4506.01 of the Revised Code.

(6) Divisions (B)(1), (2), (3), (4), and (5) of this section apply to doctors of medicine, doctors of osteopathic medicine, doctors of podiatry, advanced practice registered nurses, and dentists.

(7) Nothing in divisions (B)(1) to (6) of this section affects, or shall be construed as affecting, the immunity from civil liability conferred by section 307.628 of the Revised Code or the immunity from civil liability conferred by section 2305.33 of the Revised Code upon physicians or advanced practice registered nurses who report an employee's use of a drug of abuse, or a condition of an employee other than one involving the use of a drug of abuse, to the employer of the employee in accordance with division (B) of that section. As used in division (B)(7) of this section, “employee,” “employer,” and “physician” have the same meanings as in section 2305.33 of the Revised Code and “advanced practice registered nurse” has the same meaning as in section 4723.01 of the Revised Code.

(C)(1) A cleric, when the cleric remains accountable to the authority of that cleric's church, denomination, or sect, concerning a confession made, or any information confidentially communicated, to the cleric for a religious counseling purpose in the cleric's professional character. The cleric may testify by express consent of the person making the communication, except when the disclosure of the information is in violation of a sacred trust and except that, if the person voluntarily testifies or is deemed by division (A)(4)(c) of section 2151.421 of the Revised Code to have waived any testimonial privilege under this division, the cleric may be compelled to testify on the same subject except when disclosure of the information is in violation of a sacred trust.

(2) As used in division (C) of this section:

(a) “Cleric” means a member of the clergy, rabbi, priest, Christian Science practitioner, or regularly ordained, accredited, or licensed minister of an established and legally cognizable church, denomination, or sect.

(b) “Sacred trust” means a confession or confidential communication made to a cleric in the cleric's ecclesiastical capacity in the course of discipline enjoined by the church to which the cleric belongs, including, but not limited to, the Catholic Church, if both of the following apply:

(i) The confession or confidential communication was made directly to the cleric.

(ii) The confession or confidential communication was made in the manner and context that places the cleric specifically and strictly under a level of confidentiality that is considered inviolate by canon law or church doctrine.

(D) Husband or wife, concerning any communication made by one to the other, or an act done by either in the presence of the other, during coverture, unless the communication was
made, or act done, in the known presence or hearing of a third person competent to be a witness; and such rule is the same if the marital relation has ceased to exist;

(E) A person who assigns a claim or interest, concerning any matter in respect to which the person would not, if a party, be permitted to testify;

(F) A person who, if a party, would be restricted under section 2317.03 of the Revised Code, when the property or thing is sold or transferred by an executor, administrator, guardian, trustee, heir, devisee, or legatee, shall be restricted in the same manner in any action or proceeding concerning the property or thing.

(G)(1) A school guidance counselor who holds a valid educator license from the state board of education as provided for in section 3319.22 of the Revised Code, a person licensed under Chapter 4757 of the Revised Code as a licensed professional clinical counselor, licensed professional counselor, social worker, independent social worker, marriage and family therapist or independent marriage and family therapist, or registered under Chapter 4757 of the Revised Code as a social work assistant concerning a confidential communication received from a client in that relation or the person’s advice to a client unless any of the following applies:

(a) The communication or advice indicates clear and present danger to the client or other persons. For the purposes of this division, cases in which there are indications of present or past child abuse or neglect of the client constitute a clear and present danger.

(b) The client gives express consent to the testimony.

(c) If the client is deceased, the surviving spouse or the executor or administrator of the estate of the deceased client gives express consent.

(d) The client voluntarily testifies, in which case the school guidance counselor or person licensed or registered under Chapter 4757 of the Revised Code may be compelled to testify on the same subject.

(e) The court in camera determines that the information communicated by the client is not germane to the counselor-client, marriage and family therapist-client, or social worker-client relationship.

(f) A court, in an action brought against a school, its administration, or any of its personnel by the client, rules after an in-camera inspection that the testimony of the school guidance counselor is relevant to that action.

(g) The testimony is sought in a civil action and concerns court-ordered treatment or services received by a patient as part of a case plan journalized under section 2151.412 of the Revised Code or the court-ordered treatment or services are necessary or relevant to dependency, neglect, or abuse or temporary or permanent custody proceedings under Chapter 2151 of the Revised Code.

(2) Nothing in division (G)(1) of this section shall relieve a school guidance counselor or a person licensed or registered under Chapter 4757 of the Revised Code from the requirement to report information concerning child abuse or neglect under section 2151.421 of the Revised Code.

(H) A mediator acting under a mediation order issued under division (A) of section 3109.052 of the Revised Code or otherwise issued in any proceeding for divorce, dissolution, legal separation, annulment, or the allocation of parental rights and responsibilities for the care of children, in any action or proceeding, other than a criminal, delinquency, child abuse, child neglect, or dependent child action or proceeding, that is brought by or against either parent who takes part in mediation in accordance with the order and that pertains to the mediation process, to any information discussed or presented in the mediation process, to the allocation of parental rights and responsibilities for the care of the parents’ children, or to the awarding of parenting time rights in relation to their children;

(I) A communications assistant, acting within the scope of the communication assistant’s authority, when providing telecommunications relay service pursuant to section 4931.06 of the Revised Code or Title II of the “Communications Act of 1934,” 104 Stat. 366 (1990), 47 U.S.C.
225, concerning a communication made through a telecommunications relay service. Nothing in this section shall limit the obligation of a communications assistant to divulge information or testify when mandated by federal law or regulation or pursuant to subpoena in a criminal proceeding.

Nothing in this section shall limit any immunity or privilege granted under federal law or regulation.

(J)(1) A chiropractor in a civil proceeding concerning a communication made to the chiropractor by a patient in that relation or the chiropractor's advice to a patient, except as otherwise provided in this division. The testimonial privilege established under this division does not apply, and a chiropractor may testify or may be compelled to testify, in any civil action, in accordance with the discovery provisions of the Rules of Civil Procedure in connection with a civil action, or in connection with a claim under Chapter 4123 of the Revised Code, under any of the following circumstances:

(a) If the patient or the guardian or other legal representative of the patient gives express consent.

(b) If the patient is deceased, the spouse of the patient or the executor or administrator of the patient's estate gives express consent.

(c) If a medical claim, dental claim, chiropractic claim, or optometric claim, as defined in section 2305.113 of the Revised Code, an action for wrongful death, any other type of civil action, or a claim under Chapter 4123 of the Revised Code is filed by the patient, the personal representative of the estate of the patient if deceased, or the patient's guardian or other legal representative.

(2) If the testimonial privilege described in division (J)(1) of this section does not apply as provided in division (J)(1)(c) of this section, a chiropractor may be compelled to testify or to submit to discovery under the Rules of Civil Procedure only as to a communication made to the chiropractor by the patient in question in that relation, or the chiropractor's advice to the patient in question, that related causally or historically to physical or mental injuries that are relevant to issues in the medical claim, dental claim, chiropractic claim, or optometric claim, action for wrongful death, other civil action, or claim under Chapter 4123 of the Revised Code.

(3) The testimonial privilege established under this division does not apply, and a chiropractor may testify or be compelled to testify, in any criminal action or administrative proceeding.

(4) As used in this division, “communication” means acquiring, recording, or transmitting any information, in any manner, concerning any facts, opinions, or statements necessary to enable a chiropractor to diagnose, treat, or act for a patient. A communication may include, but is not limited to, any chiropractic, office, or hospital communication such as a record, chart, letter, memorandum, laboratory test and results, x-ray, photograph, financial statement, diagnosis, or prognosis.

(K)(1) Except as provided under division (K)(2) of this section, a critical incident stress management team member concerning a communication received from an individual who receives crisis response services from the team member, or the team member's advice to the individual, during a debriefing session.

(2) The testimonial privilege established under division (K)(1) of this section does not apply if any of the following are true:

(a) The communication or advice indicates clear and present danger to the individual who receives crisis response services or to other persons. For purposes of this division, cases in which there are indications of present or past child abuse or neglect of the individual constitute a clear and present danger.

(b) The individual who received crisis response services gives express consent to the testimony.
(c) If the individual who received crisis response services is deceased, the surviving spouse or the executor or administrator of the estate of the deceased individual gives express consent.

(d) The individual who received crisis response services voluntarily testifies, in which case the team member may be compelled to testify on the same subject.

(e) The court in camera determines that the information communicated by the individual who received crisis response services is not germane to the relationship between the individual and the team member.

(f) The communication or advice pertains or is related to any criminal act.

(3) As used in division (K) of this section:

(a) “Crisis response services” means consultation, risk assessment, referral, and on-site crisis intervention services provided by a critical incident stress management team to individuals affected by crisis or disaster.

(b) “Critical incident stress management team member” or “team member” means an individual specially trained to provide crisis response services as a member of an organized community or local crisis response team that holds membership in the Ohio critical incident stress management network.

(c) “Debriefing session” means a session at which crisis response services are rendered by a critical incident stress management team member during or after a crisis or disaster.

(L)(1) Subject to division (L)(2) of this section and except as provided in division (L)(3) of this section, an employee assistance professional, concerning a communication made to the employee assistance professional by a client in the employee assistance professional’s official capacity as an employee assistance professional.

(2) Division (L)(1) of this section applies to an employee assistance professional who meets either or both of the following requirements:

(a) Is certified by the employee assistance certification commission to engage in the employee assistance profession;

(b) Has education, training, and experience in all of the following:

(i) Providing workplace-based services designed to address employer and employee productivity issues;

(ii) Providing assistance to employees and employees’ dependents in identifying and finding the means to resolve personal problems that affect the employees or the employees’ performance;

(iii) Identifying and resolving productivity problems associated with an employee’s concerns about any of the following matters: health, marriage, family, finances, substance abuse or other addiction, workplace, law, and emotional issues;

(iv) Selecting and evaluating available community resources;

(v) Making appropriate referrals;

(vi) Local and national employee assistance agreements;

(vii) Client confidentiality.

(3) Division (L)(1) of this section does not apply to any of the following:

(a) A criminal action or proceeding involving an offense under sections 2903.01 to 2903.06 of the Revised Code if the employee assistance professional’s disclosure or testimony relates directly to the facts or immediate circumstances of the offense;

(b) A communication made by a client to an employee assistance professional that reveals the contemplation or commission of a crime or serious, harmful act;

(c) A communication that is made by a client who is an unemancipated minor or an adult adjudicated to be incompetent and indicates that the client was the victim of a crime or abuse;

(d) A civil proceeding to determine an individual’s mental competency or a criminal action in which a plea of not guilty by reason of insanity is entered;
(e) A civil or criminal malpractice action brought against the employee assistance professional;
(f) When the employee assistance professional has the express consent of the client or, if the client is deceased or disabled, the client's legal representative;
(g) When the testimonial privilege otherwise provided by division (L)(1) of this section is abrogated under law.

2317.421 Presumptive reasonableness of medical bills.

In an action for damages arising from personal injury or wrongful death, a written bill or statement, or any relevant portion thereof, itemized by date, type of service rendered, and charge, shall, if otherwise admissible, be prima-facie evidence of the reasonableness of any charges and fees stated therein for medication and prosthetic devices furnished, or medical, dental, hospital, and funeral services rendered by the person, firm, or corporation issuing such bill or statement, provided, that such bill or statement shall be prima-facie evidence of reasonableness only if the party offering it delivers a copy of it, or the relevant portion thereof, to the attorney of record for each adverse party not less than five days before trial.

2317.422 Qualification of records.

(A) Notwithstanding sections 2317.40 and 2317.41 of the Revised Code but subject to division (B) of this section, the records, or copies or photographs of the records, of a hospital, homes required to be licensed pursuant to section 3721.01 of the Revised Code, and residential facilities licensed pursuant to section 5119.34 of the Revised Code that provides accommodations, supervision, and personal care services for three to sixteen unrelated adults, in lieu of the testimony in open court of their custodian, person who made them, or person under whose supervision they were made, may be qualified as authentic evidence if any such person endorses thereon the person's verified certification identifying such records, giving the mode and time of their preparation, and stating that they were prepared in the usual course of the business of the institution. Such records, copies, or photographs may not be qualified by certification as provided in this section unless the party intending to offer them delivers a copy of them, or of their relevant portions, to the attorney of record for each adverse party not less than five days before trial. Nothing in this section shall be construed to limit the right of any party to call the custodian, person who made such records, or person under whose supervision they were made, as a witness.

(B) Division (A) of this section does not apply to any certified copy of the results of any test given to determine the presence or concentration of alcohol, a drug of abuse, a combination of them, a controlled substance, or a metabolite of a controlled substance in a patient's whole blood, blood serum or plasma, breath, or urine at any time relevant to a criminal offense that is submitted in a criminal action or proceeding in accordance with division (B)(2)(b) or (B)(3)(b) of section 2317.02 of the Revised Code.

2317.43 Statements of sympathy.

(A) In any civil action brought by an alleged victim of an unanticipated outcome of medical care or in any arbitration proceeding related to such a civil action, any and all statements, affirmations, gestures, or conduct expressing apology, sympathy, commiseration, condolence, compassion, or a general sense of benevolence that are made by a health care provider or an employee of a health care provider to the alleged victim, a relative of the alleged victim, or a representative of the alleged victim, and that relate to the discomfort, pain, suffering, injury, or death of the alleged victim as the result of the unanticipated outcome of medical care
are inadmissible as evidence of an admission of liability or as evidence of an admission against interest.

(B) For purposes of this section, unless the context otherwise requires:

(1) "Health care provider" has the same meaning as in division (B)(5) of section 2317.02 of the Revised Code.

(2) "Relative" means a victim's spouse, parent, grandparent, stepfather, stepmother, child, grandchild, brother, sister, half brother, half sister, or spouse's parents. The term includes said relationships that are created as a result of adoption. In addition, "relative" includes any person who has a family-type relationship with a victim.

(3) "Representative" means a legal guardian, attorney, person designated to make decisions on behalf of a patient under a medical power of attorney, or any person recognized in law or custom as a patient's agent.

(4) "Unanticipated outcome" means the outcome of a medical treatment or procedure that differs from an expected result.

2317.54 Informed consent to surgical or medical procedure or course of procedures.

[Editor's Note: This version of the statute is effective until 9/29/2018. The version effective subsequently is included next.]

No hospital, home health agency, ambulatory surgical facility, or provider of a hospice care program or pediatric respite care program shall be held liable for a physician's failure to obtain an informed consent from the physician's patient prior to a surgical or medical procedure or course of procedures, unless the physician is an employee of the hospital, home health agency, ambulatory surgical facility, or provider of a hospice care program or pediatric respite care program.

Written consent to a surgical or medical procedure or course of procedures shall, to the extent that it fulfills all the requirements in divisions (A), (B), and (C) of this section, be presumed to be valid and effective, in the absence of proof by a preponderance of the evidence that the person who sought such consent was not acting in good faith, or that the execution of the consent was induced by fraudulent misrepresentation of material facts, or that the person executing the consent was not able to communicate effectively in spoken and written English or any other language in which the consent is written. Except as herein provided, no evidence shall be admissible to impeach, modify, or limit the authorization for performance of the procedure or procedures set forth in such written consent.

(A) The consent sets forth in general terms the nature and purpose of the procedure or procedures, and what the procedures are expected to accomplish, together with the reasonably known risks, and, except in emergency situations, sets forth the names of the physicians who shall perform the intended surgical procedures.

(B) The person making the consent acknowledges that such disclosure of information has been made and that all questions asked about the procedure or procedures have been answered in a satisfactory manner.

(C) The consent is signed by the patient for whom the procedure is to be performed, or, if the patient for any reason including, but not limited to, competence, minority, or the fact that, at the latest time that the consent is needed, the patient is under the influence of alcohol, hallucinogens, or drugs, lacks legal capacity to consent, by a person who has legal authority to consent on behalf of such patient in such circumstances, including either of the following:

(1) The parent, whether the parent is an adult or a minor, of the parent's minor child;

(2) An adult whom the parent of the minor child has given written authorization to consent to a surgical or medical procedure or course of procedures for the parent's minor child.

Any use of a consent form that fulfills the requirements stated in divisions (A), (B), and
(C) of this section has no effect on the common law rights and liabilities, including the right of a physician to obtain the oral or implied consent of a patient to a medical procedure, that may exist as between physicians and patients on July 28, 1975.

As used in this section the term “hospital” has the same meaning as in section 2305.113 of the Revised Code; “home health agency” has the same meaning as in section 5101.61 of the Revised Code; “ambulatory surgical facility” has the meaning as in division (A) of section 3702.30 of the Revised Code; and “hospice care program” and “pediatric respite care program” have the same meanings as in section 3712.01 of the Revised Code. The provisions of this division apply to hospitals, doctors of medicine, doctors of osteopathic medicine, and doctors of pediatric medicine.

2317.54 Informed consent to surgical or medical procedure or course of procedures.

[Editor’s Note: This version of the statute is effective 9/29/2018. The version effective prior to that date is included previously.]

No hospital, home health agency, ambulatory surgical facility, or provider of a hospice care program or pediatric respite care program shall be held liable for a physician's failure to obtain an informed consent from the physician's patient prior to a surgical or medical procedure or course of procedures, unless the physician is an employee of the hospital, home health agency, ambulatory surgical facility, or provider of a hospice care program or pediatric respite care program.

Written consent to a surgical or medical procedure or course of procedures shall, to the extent that it fulfills all the requirements in divisions (A), (B), and (C) of this section, be presumed to be valid and effective, in the absence of proof by a preponderance of the evidence that the person who sought such consent was not acting in good faith, or that the execution of the consent was induced by fraudulent misrepresentation of material facts, or that the person executing the consent was not able to communicate effectively in spoken and written English or any other language in which the consent is written. Except as herein provided, no evidence shall be admissible to impeach, modify, or limit the authorization for performance of the procedure or procedures set forth in such written consent.

(A) The consent sets forth in general terms the nature and purpose of the procedure or procedures, and what the procedures are expected to accomplish, together with the reasonably known risks, and, except in emergency situations, sets forth the names of the physicians who shall perform the intended surgical procedures.

(B) The person making the consent acknowledges that such disclosure of information has been made and that all questions asked about the procedure or procedures have been answered in a satisfactory manner.

(C) The consent is signed by the patient for whom the procedure is to be performed, or, if the patient for any reason including, but not limited to, competence, minority, or the fact that, at the latest time that the consent is needed, the patient is under the influence of alcohol, hallucinogens, or drugs, lacks legal capacity to consent, by a person who has legal authority to consent on behalf of such patient in such circumstances, including either of the following:

(1) The parent, whether the parent is an adult or a minor, of the parent's minor child;

(2) An adult whom the parent of the minor child has given written authorization to consent to a surgical or medical procedure or course of procedures for the parent's minor child.

Any use of a consent form that fulfills the requirements stated in divisions (A), (B), and (C) of this section has no effect on the common law rights and liabilities, including the right of a physician to obtain the oral or implied consent of a patient to a medical procedure, that may exist as between physicians and patients on July 28, 1975.

As used in this section the term “hospital” has the same meaning as in section 2305.113
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of the Revised Code; “home health agency” has the same meaning as in section 3701.881 of the Revised Code; “ambulatory surgical facility” has the meaning as in division (A) of section 3702.30 of the Revised Code; and “hospice care program” and “pediatric respite care program” have the same meanings as in section 3712.01 of the Revised Code. The provisions of this division apply to hospitals, doctors of medicine, doctors of osteopathic medicine, and doctors of podiatric medicine.

2317.62 Annuities and future damages.

(A) As used in this section:
(1) "Annuity" means an annuity that would be purchased from either of the following types of insurance companies:
(a) An insurance company that the A.M. Best Company, in its most recently published rating guide of life insurance companies, has rated A or better and has rated XII or higher as to financial size or strength;
(b)(i) An insurance company that the superintendent of insurance, under rules adopted pursuant to Chapter 119 of the Revised Code for purposes of implementing this division, determines is licensed to do business in this state and, considering the factors described in division (A)(1)(b)(ii) of this section, is a stable insurance company that issues annuities that are safe and desirable;
(ii) In making determinations as described in division (A)(1)(b)(i) of this section, the superintendent shall be guided by the principle that the trier of fact in a tort action should be presented only with evidence as to the cost of annuities that are safe and desirable for the plaintiffs in such an action who are awarded damages. In making such determinations, the superintendent shall consider the financial condition, general standing, operating results, profitability, leverage, liquidity, amount and soundness of reinsurance, adequacy of reserves, and the management of any insurance company in question and also may consider ratings, grades, and classifications of any nationally recognized rating services of insurance companies and any other factors relevant to the making of such determinations.
(2) "Future damages" means damages that result from an injury or loss to person or property that is a subject of a tort action and that will accrue after the verdict or determination of liability by the trier of fact is rendered in that tort action.
(3) "Tort action" means a civil action for damages for injury or loss to person or property. "Tort action" includes a product liability claim that is subject to sections 2307.71 to 2307.80 of the Revised Code, but does not include a civil action for damages for a breach of contract or another agreement between persons.
(4) "Trier of fact" means the jury or, in a nonjury action, the court.

(B) Consistent with the Rules of Evidence, any party to a tort action may present evidence of the cost of an annuity in connection with any issue of recoverable future damages. If such evidence is presented, then the trier of fact may consider that evidence in determining the future damages suffered by reason of an injury or loss to person or property that is a subject of the tort action. If such evidence is presented, the present value in dollars of any annuity is its cost.

2323.41 Evidence of collateral benefits.

(A) In any civil action upon a medical, dental, optometric, or chiropractic claim, the defendant may introduce evidence of any amount payable as a benefit to the plaintiff as a result of the damages that result from an injury, death, or loss to person or property that is the subject of the claim, except if the source of collateral benefits has a mandatory self-effectuating federal right of subrogation, a contractual right of subrogation, or a statutory right of subrogation.
(B) If the defendant elects to introduce evidence described in division (A) of this section, the plaintiff may introduce evidence of any amount that the plaintiff has paid or contributed to secure the plaintiff's right to receive the benefits of which the defendant has introduced evidence.

(C) A source of collateral benefits of which evidence is introduced pursuant to division (A) of this section shall not recover any amount against the plaintiff nor shall it be subrogated to the rights of the plaintiff against a defendant.

(D) As used in this section, "medical claim," "dental claim," "optometric claim," and "chiropractic claim" have the same meanings as in section 2305.113 of the Revised Code.

### 2323.42 Nonmeritorious claims.

(A) Upon the motion of any defendant in a civil action based upon a medical claim, dental claim, optometric claim, or chiropractic claim, the court shall conduct a hearing regarding the existence or nonexistence of a reasonable good faith basis upon which the particular claim is asserted against the moving defendant. The defendant shall file the motion not earlier than the close of discovery in the action and not later than thirty days after the court or jury renders any verdict or award in the action. After the motion is filed, the plaintiff shall have not less than fourteen days to respond to the motion. Upon good cause shown by the plaintiff, the court shall grant an extension of the time for the plaintiff to respond as necessary to obtain evidence demonstrating the existence of a reasonable good faith basis for the claim.

(B) At the request of any party to the good faith motion described in division (A) of this section, the court shall order the motion to be heard at an oral hearing and shall consider all evidence and arguments submitted by the parties. In determining whether a plaintiff has a reasonable good faith basis upon which to assert the claim in question against the moving defendant, the court shall take into consideration, in addition to the facts of the underlying claim, whether the plaintiff did any of the following:

1. Obtained a reasonably timely review of the merits of the particular claim by a qualified medical, dental, optometric, or chiropractic expert, as appropriate;
2. Reasonably relied upon the results of that review in supporting the assertion of the particular claim;
3. Had an opportunity to conduct a pre-suit investigation or was afforded by the defendant full and timely discovery during litigation;
4. Reasonably relied upon evidence discovered during the course of litigation in support of the assertion of the claim in question;
5. Took appropriate and reasonable steps to timely dismiss any defendant on behalf of whom it was alleged or determined that no reasonable good faith basis existed for continued assertion of the claim in question.

(C) If the court determines that there was no reasonable good faith basis upon which the defendant asserted the claim in question against the moving defendant or that, at some point during the litigation, the plaintiff lacked a good faith basis for continuing to assert that claim, the court shall award all of the following in favor of the moving defendant:

1. All court costs incurred by the moving defendant;
2. Reasonable attorneys' fees incurred by the moving defendant in defense of the claim after the time that the court determines that no reasonable good faith basis existed upon which to assert or continue to assert the claim;
3. Reasonable attorneys' fees incurred in support of the good faith motion.

(D) Prior to filing a good faith motion as described in division (A) of this section, any defendant that intends to file that type of motion shall serve a "notice of demand for dismissal and intention to file a good faith motion." If, within fourteen days of service of that notice, the plaintiff dismisses the defendant from the action, the defendant after the dismissal shall be
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precluded from filing a good faith motion as to any attorneys' fees and other costs subsequent to the dismissal.

(E) As used in this section, "medical claim," "dental claim," "optometric claim," and "chiropractic claim" have the same meanings as in section 2305.113 of the Revised Code.

2323.421 Out-of-state medical experts.

A person licensed in another state to practice medicine, who testifies as an expert witness on behalf of any party in this state in any action against a physician for injury or death, whether in contract or tort, arising out of the provision of or failure to provide health care services, shall be deemed to have a temporary license to practice medicine in this state solely for the purpose of providing such testimony and is subject to the authority of the state medical board and the provisions of Chapter 4731 of the Revised Code. The conclusion of an action against a physician shall not be construed to have any effect on the board's authority to take action against a physician who testifies as an expert witness under this section.

2323.43 Non-economic and economic damage limits; medical claims.

(A) In a civil action upon a medical, dental, optometric, or chiropractic claim to recover damages for injury, death, or loss to person or property, all of the following apply:

(1) There shall not be any limitation on compensatory damages that represent the economic loss of the person who is awarded the damages in the civil action.

(2) Except as otherwise provided in division (A)(3) of this section, the amount of compensatory damages that represents damages for non-economic loss that is recoverable in a civil action under this section to recover damages for injury, death, or loss to person or property shall not exceed the greater of two hundred fifty thousand dollars or an amount that is equal to three times the plaintiff's economic loss, as determined by the trier of fact, to a maximum of three hundred fifty thousand dollars for each plaintiff or a maximum of five hundred thousand dollars for each occurrence.

(3) The amount recoverable for non-economic loss in a civil action under this section may exceed the amount described in division (A)(2) of this section but shall not exceed five hundred thousand dollars for each plaintiff or one million dollars for each occurrence if the non-economic losses of the plaintiff are for either of the following:

(a) Permanent and substantial physical deformity, loss of use of a limb, or loss of a bodily organ system;

(b) Permanent physical functional injury that permanently prevents the injured person from being able to independently care for self and perform life sustaining activities.

(B) If a trial is conducted in a civil action upon a medical, dental, optometric, or chiropractic claim to recover damages for injury, death, or loss to person or property and a plaintiff prevails with respect to that claim, the court in a nonjury trial shall make findings of fact, and the jury in a jury trial shall return a general verdict accompanied by answers to interrogatories, that shall specify all of the following:

(1) The total compensatory damages recoverable by the plaintiff;

(2) The portion of the total compensatory damages that represents damages for economic loss;

(3) The portion of the total compensatory damages that represents damages for non-economic loss.

(C)(1) After the trier of fact in a civil action upon a medical, dental, optometric, or chiropractic claim to recover damages for injury, death, or loss to person or property complies with division (B) of this section, the court shall enter a judgment in favor of the plaintiff for compensatory damages for economic loss in the amount determined pursuant to division (B)(2)
of this section, and, subject to division (D)(1) of this section, the court shall enter a judgment in favor of the plaintiff for compensatory damages for non-economic loss. In no event shall a judgment for compensatory damages for non-economic loss exceed the maximum recoverable amount that represents damages for non-economic loss as provided in divisions (A)(2) and (3) of this section. Division (A) of this section shall be applied in a jury trial only after the jury has made its factual findings and determination as to the damages.

(2) Prior to the trial in the civil action, any party may seek summary judgment with respect to the nature of the alleged injury or loss to person or property, seeking a determination of the damages as described in division (A)(2) or (3) of this section.

(D)(1) A court of common pleas has no jurisdiction to enter judgment on an award of compensatory damages for non-economic loss in excess of the limits set forth in this section.

(2) If the trier of fact is a jury, the court shall not instruct the jury with respect to the limit on compensatory damages for non-economic loss described in divisions (A)(2) and (3) of this section, and neither counsel for any party nor a witness shall inform the jury or potential jurors of that limit.

(E) Any excess amount of compensatory damages for non-economic loss that is greater than the applicable amount specified in division (A)(2) or (3) of this section shall not be reallocated to any other tortfeasor beyond the amount of compensatory damages that that tortfeasor would otherwise be responsible for under the laws of this state.

(F)(1) If pursuant to a contingency fee agreement between an attorney and a plaintiff in a civil action upon a medical claim, dental claim, optometric claim, or chiropractic claim, the amount of the attorney's fees exceed the applicable amount of the limits on compensatory damages for non-economic loss as provided in division (A)(2) or (3) of this section, the attorney shall make an application in the probate court of the county in which the civil action was commenced or in which the settlement was entered. The application shall contain a statement of facts, including the amount to be allocated to the settlement of the claim, the amount of the settlement or judgment that represents the compensatory damages for economic loss and non-economic loss, the relevant provision in the contingency fee agreement, and the dollar amount of the attorney's fees under the contingency fee agreement. The application shall include the proposed distribution of the amount of the judgment or settlement.

(2) The attorney shall give written notice of the hearing and a copy of the application to all interested persons who have not waived notice of the hearing. Notwithstanding the waivers and consents of the interested persons, the probate court shall retain jurisdiction over the settlement, allocation, and distribution of the claim.

(3) The application shall state the arrangements, if any, that have been made with respect to the attorney's fees. The attorney's fees shall be subject to the approval of the probate court.

(G) This section does not apply to any of the following:

(1) Civil actions upon a medical, dental, optometric, or chiropractic claim that are brought against the state in the court of claims, including, but not limited to, those actions in which a state university or college is a defendant and to which division (B)(3) of section 3345.40 of the Revised Code applies;

(2) Civil actions upon a medical, dental, optometric, or chiropractic claim that are brought against political subdivisions of this state and that are commenced under or are subject to Chapter 2744 of the Revised Code. Division (C) of section 2744.05 of the Revised Code applies to recoverable damages in those actions;

(3) Wrongful death actions brought pursuant to Chapter 2125 of the Revised Code.

(H) As used in this section:

(1) "Economic loss" means any of the following types of pecuniary harm:

(a) All wages, salaries, or other compensation lost as a result of an injury, death, or loss to person or property that is a subject of a civil action upon a medical, dental, optometric, or
chiropractic claim;
(b) All expenditures for medical care or treatment, rehabilitation services, or other care, treatment, services, products, or accommodations as a result of an injury, death, or loss to person or property that is a subject of a civil action upon a medical, dental, optometric, or chiropractic claim;
(c) Any other expenditures incurred as a result of an injury, death, or loss to person or property that is a subject of a civil action upon a medical, dental, optometric, or chiropractic claim, other than attorney's fees incurred in connection with that action.
(2) "Medical claim, dental claim," "optometric claim," and "chiropractic claim" have the same meanings as in section 2305.113 of the Revised Code.
(3) "Non-economic loss" means nonpecuniary harm that results from an injury, death, or loss to person or property that is a subject of a civil action upon a medical, dental, optometric, or chiropractic claim, including, but not limited to, pain and suffering, loss of society, consortium, companionship, care, assistance, attention, protection, advice, guidance, counsel, instruction, training, or education, disfigurement, mental anguish, and any other intangible loss.
(4) "Trier of fact" means the jury or, in a nonjury action, the court.

2323.45 Non-involvement affidavit.

(A)(1) A health care provider named as a defendant in a civil action based upon a medical claim is permitted to file a motion with the court for dismissal of the claim accompanied by an affidavit of noninvolvement. The defendant shall notify all parties in writing of the filing of the motion. Prior to ruling on the motion, the court shall allow the parties not less than thirty days from the date that the parties were served with the notice to respond to the motion.

(2) An affidavit of noninvolvement shall set forth, with particularity, the facts that demonstrate that the defendant was misidentified or otherwise not involved individually or through the action of the defendant's agents or employees in the care and treatment of the plaintiff, was not obligated individually or through the defendant's agents or employees to provide for the care and treatment of the plaintiff, and could not have caused the alleged malpractice individually or through the defendant's agents or employees in any way.

(B)(1) The parties shall have the right to challenge the affidavit of noninvolvement by filing a motion and submitting an affidavit with the court that contradicts the assertions of noninvolvement made in the defendant's affidavit of noninvolvement.

(2) If the affidavit of noninvolvement is challenged, any party may request an oral hearing on the motion for dismissal. If requested, the court shall hold a hearing to determine if the defendant was involved, directly or indirectly, in the care and treatment of the plaintiff, or was obligated, directly or indirectly, for the care and treatment of the plaintiff.

(3) The court shall consider all evidence submitted by the parties and the parties' arguments and may dismiss the civil action based upon the defendant's lack of involvement in the elements of the plaintiff's medical claim. The court shall rule on all challenges to the affidavit of noninvolvement within seventy-five days after the filing of the affidavit of noninvolvement.

(4) A court's dismissal of a claim against a defendant pursuant to this section shall be deemed otherwise than upon the merits and without prejudice pursuant to Civil Rule 41.

(C) If the court determines that a health care provider named as a defendant has falsely filed or made false or inaccurate statements in an affidavit of noninvolvement, the court, upon a motion or upon its own initiative, shall immediately reinstate the claim against that defendant, if previously dismissed. Reinstatement of a party pursuant to this division shall not be barred by any statute of limitations defense that was not valid at the time the original affidavit was filed.

(D) In any action in which the defendant is found by the court to have knowingly filed a false or inaccurate affidavit of noninvolvement, the court shall impose upon the person who signed the affidavit or represented the defendant, or both, an appropriate sanction, including,
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but not limited to, an order to pay to other parties to the claim the amount of the reasonable expenses that the parties incurred as a result of the filing of the false or inaccurate affidavit, including reasonable attorney's fees.

(E) In any action in which the court determines that a party falsely objected to a defendant's affidavit of noninvolvement, or knowingly provided an inaccurate statement regarding a defendant's affidavit, the court shall impose upon the party or the party's counsel, or both, an appropriate sanction, including, but not limited to, an order to pay to the other parties to the claim the amount of the reasonable expenses that the parties incurred as a result of the submission of the false objection or inaccurate statement, including reasonable attorney's fees.

(F) As used in this section:
(1) "Health care provider" has the same meaning as in division (B)(5) of section 2317.02 of the Revised Code.
(2) "Medical claim" means any claim that is asserted in any civil action against a health care provider and that arises out of the medical diagnosis, care, or treatment of any person. "Medical claim" includes derivative claims for relief.

2743.18 Determining prejudgment interest.

(A)(1) Prejudgment interest shall be allowed with respect to a civil action on which a judgment or determination is rendered against the state for the same period of time and at the same rate as allowed between private parties to a suit.
(2) The court of claims, in its discretion, may deny prejudgment interest for any period of undue delay between the commencement of the civil action and the entry of a judgment or determination against the state, for which it finds the claimant to have been responsible.

(B)(1) Except as otherwise provided in division (B)(2) of this section, interest shall be allowed on a judgment or determination rendered against the state in a civil action pursuant to this chapter at the same rate that is applicable to judgments rendered against private parties to a suit as specified in section 1343.03 of the Revised Code and for each day between the date of entry of the judgment or the determination pursuant to division (C) of section 2743.10 of the Revised Code and the date of payment of the judgment or determination pursuant to division (C)(3) or (6) of section 2743.19 of the Revised Code, or for sixty days from the date of entry of the judgment or the determination, whichever is less.
(2) If the court of claims renders a judgment pursuant to this chapter against the state in a civil action or the clerk of the court of claims enters an administrative determination under section 2743.10 of the Revised Code against the state in a civil action, the civil action is not based on tortious conduct, and the claimant in the court of claims prevails in any appeal of the judgment or determination, postjudgment interest shall be paid with respect to the judgment or determination rendered against the state at the same rate that is applicable to judgments rendered against private parties to a suit as set forth in section 1343.03 of the Revised Code and for each day between the date of entry of the judgment or determination and the date of payment of the judgment or determination pursuant to division (C)(3) or (6) of section 2743.19 of the Revised Code.

2743.43 Medical experts.

(A) No person shall be deemed competent to give expert testimony on the liability issues in a medical claim, as defined in section 2305.113 of the Revised Code, unless:
(1) Such person is licensed to practice medicine and surgery, osteopathic medicine and surgery, or podiatric medicine and surgery by the state medical board or by the licensing authority of any state;
(2) Such person devotes three-fourths of the person’s professional time to the active
clinical practice of medicine or surgery, osteopathic medicine and surgery, or podiatric medicine and surgery, or to its instruction in an accredited university;

(3) The person practices in the same or a substantially similar specialty as the defendant. The court shall not permit an expert in one medical specialty to testify against a health care provider in another medical specialty unless the expert shows both that the standards of care and practice in the two specialties are similar and that the expert has substantial familiarity between the specialties.

(4) If the person is certified in a specialty, the person must be certified by a board recognized by the American board of medical specialties or the American board of osteopathic specialties in a specialty having acknowledged expertise and training directly related to the particular health care matter at issue.

(B) Nothing in division (A) of this section shall be construed to limit the power of the trial court to adjudge the testimony of any expert witness incompetent on any other ground.

(C) Nothing in division (A) of this section shall be construed to limit the power of the trial court to allow the testimony of any other witness, on a matter unrelated to the liability issues in the medical claim, when that testimony is relevant to the medical claim involved.

4113.71 Immunity for employment recommendations.

(A) As used in this section:

(1) "Employee" means an individual currently or formerly employed by an employer.

(2) "Employer" means the state, any political subdivision of the state, any person employing one or more individuals in this state, and any person directly or indirectly acting in the interest of the state, political subdivision, or such person.

(3) "Political subdivision" and "state" have the same meanings as in section 2744.01 of the Revised Code.

(B) An employer who is requested by an employee or a prospective employer of an employee to disclose to a prospective employer of that employee information pertaining to the job performance of that employee for the employer and who discloses the requested information to the prospective employer is not liable in damages in a civil action to that employee, the prospective employer, or any other person for any harm sustained as a proximate result of making the disclosure or of any information disclosed, unless the plaintiff in a civil action establishes, either or both of the following:

(1) By a preponderance of the evidence that the employer disclosed particular information with the knowledge that it was false, with the deliberate intent to mislead the prospective employer or another person, in bad faith, or with malicious purpose;

(2) By a preponderance of the evidence that the disclosure of particular information by the employer constitutes an unlawful discriminatory practice described in section 4112.02, 4112.021, or 4112.022 of the Revised Code.

(C) If the court finds that the verdict of the jury was in favor of the defendant, the court shall determine whether the lawsuit brought under division (B) of this section constituted frivolous conduct as defined in division (A) of section 2323.51 of the Revised Code, if the court finds by a preponderance of the evidence that the lawsuit constituted frivolous conduct, it may order the plaintiff to pay reasonable attorney's fees and court costs of the defendant.

(D)(1) This section does not create a new cause of action or substantive legal right against an employer.

(2) This section does not affect any immunities from civil liability or defenses established by another section of the Revised Code or available at common law to which an employer may be entitled under circumstances not covered by this section.
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1547.11 Operating water vessel under the influence; immunity for certain persons withdrawing blood

(A) No person shall operate or be in physical control of any vessel underway or shall manipulate any water skis, aquaplane, or similar device on the waters in this state if, at the time of the operation, control, or manipulation, any of the following applies:

(1) The person is under the influence of alcohol, a drug of abuse, or a combination of them.
(2) The person has a concentration of eight-hundredths of one per cent or more by weight of alcohol per unit volume in the person's whole blood.
(3) The person has a concentration of ninety-six-thousandths of one per cent or more by weight per unit volume of alcohol in the person's blood serum or plasma.
(4) The person has a concentration of eleven-hundredths of one gram or more by weight of alcohol per one hundred milliliters of the person's urine.
(5) The person has a concentration of eight-hundredths of one gram or more by weight of alcohol per two hundred ten liters of the person's breath.

(6) Except as provided in division (H) of this section, the person has a concentration of any of the following controlled substances or metabolites of a controlled substance in the person's whole blood, blood serum or plasma, or urine that equals or exceeds any of the following:

(a) The person has a concentration of amphetamine in the person's urine of at least five hundred nanograms of amphetamine per milliliter of the person's urine or has a concentration of amphetamine in the person's whole blood or blood serum or plasma of at least one hundred nanograms of amphetamine per milliliter of the person's whole blood or blood serum or plasma.
(b) The person has a concentration of cocaine in the person's urine of at least one hundred fifty nanograms of cocaine per milliliter of the person's urine or has a concentration of cocaine in the person's whole blood or blood serum or plasma of at least fifty nanograms of cocaine per milliliter of the person's whole blood or blood serum or plasma.
(c) The person has a concentration of cocaine metabolite in the person's urine of at least one hundred fifty nanograms of cocaine metabolite per milliliter of the person's urine or has a concentration of cocaine metabolite in the person's whole blood or blood serum or plasma of at least fifty nanograms of cocaine metabolite per milliliter of the person's whole blood or blood serum or plasma.
(d) The person has a concentration of heroin in the person's urine of at least two thousand nanograms of heroin per milliliter of the person's urine or has a concentration of heroin in the person's whole blood or blood serum or plasma of at least fifty nanograms of heroin per milliliter of the person's whole blood or blood serum or plasma.
(e) The person has a concentration of heroin metabolite (6-monoacetyl morphine) in the person's urine of at least ten nanograms of heroin metabolite (6-monoacetyl morphine) per milliliter of the person's urine or has a concentration of heroin metabolite (6-monoacetyl morphine) in the person's whole blood or blood serum or plasma of at least ten nanograms of heroin metabolite (6-monoacetyl morphine) per milliliter of the person's whole blood or blood serum or plasma.
(f) The person has a concentration of L.S.D. in the person's urine of at least twenty-five nanograms of L.S.D. per milliliter of the person's urine or has a concentration of L.S.D. in the person's whole blood or blood serum or plasma of at least ten nanograms of L.S.D. per milliliter of the person's whole blood or blood serum or plasma.

(g) The person has a concentration of marihuana in the person's urine of at least ten
nanograms of marihuana per milliliter of the person's urine or has a concentration of marihuana in the person's whole blood or blood serum or plasma of at least two nanograms of marihuana per milliliter of the person's whole blood or blood serum or plasma.

(h) The state board of pharmacy has adopted a rule pursuant to section 4729.041 of the Revised Code that specifies the amount of salvia divinorum and the amount of salvinorin A that constitute concentrations of salvia divinorum and salvinorin A in a person's urine, in a person's whole blood, or in a person's blood serum or plasma at or above which the person is impaired for purposes of operating or being in physical control of any vessel underway or manipulating any water skis, aquaplane, or similar device on the waters of this state, the rule is in effect, and the person has a concentration of salvia divinorum or salvinorin A of at least that amount so specified by rule in the person's urine, in the person's whole blood, or in the person's blood serum or plasma.

(i) Either of the following applies:

(i) The person is under the influence of alcohol, a drug of abuse, or a combination of them, and, as measured by gas chromatography mass spectrometry, the person has a concentration of marihuana metabolite in the person's urine of at least fifteen nanograms of marihuana metabolite per milliliter of the person's urine or has a concentration of marihuana metabolite in the person's whole blood or blood serum or plasma of at least five nanograms of marihuana metabolite per milliliter of the person's whole blood or blood serum or plasma.

(ii) As measured by gas chromatography mass spectrometry, the person has a concentration of marihuana metabolite in the person's urine of at least thirty-five nanograms of marihuana metabolite per milliliter of the person's urine or has a concentration of marihuana metabolite in the person's whole blood or blood serum or plasma of at least fifty nanograms of marihuana metabolite per milliliter of the person's whole blood or blood serum or plasma.

(j) The person has a concentration of methamphetamine in the person's urine of at least five hundred nanograms of methamphetamine per milliliter of the person's urine or has a concentration of methamphetamine in the person's whole blood or blood serum or plasma of at least one hundred nanograms of methamphetamine per milliliter of the person's whole blood or blood serum or plasma.

(k) The person has a concentration of phencyclidine in the person's urine of at least twenty-five nanograms of phencyclidine per milliliter of the person's urine or has a concentration of phencyclidine in the person's whole blood or blood serum or plasma of at least ten nanograms of phencyclidine per milliliter of the person's whole blood or blood serum or plasma.

(B) No person under twenty-one years of age shall operate or be in physical control of any vessel underway or shall manipulate any water skis, aquaplane, or similar device on the waters in this state if, at the time of the operation, control, or manipulation, any of the following applies:

(1) The person has a concentration of at least two-hundredths of one per cent, but less than eight-hundredths of one per cent by weight per unit volume of alcohol in the person's whole blood.

(2) The person has a concentration of at least three-hundredths of one per cent but less than ninety-six-thousandths of one per cent by weight per unit volume of alcohol in the person's blood serum or plasma.

(3) The person has a concentration of at least twenty-eight one-thousandths of one gram, but less than eleven-hundredths of one gram by weight of alcohol per one hundred milliliters of the person's urine.

(4) The person has a concentration of at least two-hundredths of one gram, but less than eight-hundredths of one gram by weight of alcohol per two hundred ten liters of the person's breath.

(C) In any proceeding arising out of one incident, a person may be charged with a violation of division (A)(1) and a violation of division (B)(1), (2), (3), or (4) of this section, but the
person shall not be convicted of more than one violation of those divisions.

(D)(1)(a) In any criminal prosecution or juvenile court proceeding for a violation of division (A) or (B) of this section or for an equivalent offense that is watercraft-related, the result of any test of any blood or urine withdrawn and analyzed at any health care provider, as defined in section 2317.02 of the Revised Code, may be admitted with expert testimony to be considered with any other relevant and competent evidence in determining the guilt or innocence of the defendant.

(b) In any criminal prosecution or juvenile court proceeding for a violation of division (A) or (B) of this section or for an equivalent offense that is watercraft-related, the court may admit evidence on the concentration of alcohol, drugs of abuse, controlled substances, metabolites of a controlled substance, or a combination of them in the defendant's or child's whole blood, blood serum or plasma, urine, or breath at the time of the alleged violation as shown by chemical analysis of the substance withdrawn, or specimen taken within three hours of the time of the alleged violation. The three-hour time limit specified in this division regarding the admission of evidence does not extend or affect the two-hour time limit specified in division (C) of section 1547.111 of the Revised Code as the maximum period of time during which a person may consent to a chemical test or tests as described in that section. The court may admit evidence on the concentration of alcohol, drugs of abuse, or a combination of them as described in this division when a person submits to a blood, breath, urine, or other bodily substance test at the request of a law enforcement officer under section 1547.111 of the Revised Code or a blood or urine sample is obtained pursuant to a search warrant. Only a physician, a registered nurse, an emergency medical technician-intermediate, an emergency medical technician-paramedic, or a qualified technician, chemist, or phlebotomist shall withdraw blood for the purpose of determining the alcohol, drug, controlled substance, metabolite of a controlled substance, or combination content of the whole blood, blood serum, or blood plasma. This limitation does not apply to the taking of breath or urine specimens. A person authorized to withdraw blood under this division may refuse to withdraw blood under this division if, in that person's opinion, the physical welfare of the defendant or child would be endangered by withdrawing blood.

The whole blood, blood serum or plasma, urine, or breath withdrawn under division (D)(1)(b) of this section shall be analyzed in accordance with methods approved by the director of health by an individual possessing a valid permit issued by the director pursuant to section 3701.143 of the Revised Code.

(2) In a criminal prosecution or juvenile court proceeding for a violation of division (A) of this section or for an equivalent offense that is watercraft-related, if there was at the time the bodily substance was taken a concentration of less than the applicable concentration of alcohol specified for a violation of division (A)(2), (3), (4), or (5) of this section or less than the applicable concentration of a listed controlled substance or a listed metabolite of a controlled substance specified for a violation of division (A)(6) of this section, that fact may be considered with other competent evidence in determining the guilt or innocence of the defendant or in making an adjudication for the child. This division does not limit or affect a criminal prosecution or juvenile court proceeding for a violation of division (B) of this section or for a violation of a prohibition that is substantially equivalent to that division.

(3) Upon the request of the person who was tested, the results of the chemical test shall be made available to the person or the person's attorney immediately upon completion of the test analysis.

If the chemical test was administered pursuant to division (D)(1)(b) of this section, the person tested may have a physician, a registered nurse, or a qualified technician, chemist, or phlebotomist of the person's own choosing administer a chemical test or tests in addition to any administered at the direction of a law enforcement officer, and shall be so advised. The failure or inability to obtain an additional test by a person shall not preclude the admission of evidence relating to the test or tests taken at the direction of a law enforcement officer.

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(E)(1) In any criminal prosecution or juvenile court proceeding for a violation of division (A) or (B) of this section, of a municipal ordinance relating to operating or being in physical control of any vessel underway or to manipulating any water skis, aquaplane, or similar device on the waters of this state while under the influence of alcohol, a drug of abuse, or a combination of them, or of a municipal ordinance relating to operating or being in physical control of any vessel underway or to manipulating any water skis, aquaplane, or similar device on the waters of this state with a prohibited concentration of alcohol, a controlled substance, or a metabolite of a controlled substance in the whole blood, blood serum or plasma, breath, or urine, if a law enforcement officer has administered a field sobriety test to the operator or person found to be in physical control of the vessel underway involved in the violation or the person manipulating the water skis, aquaplane, or similar device involved in the violation and if it is shown by clear and convincing evidence that the officer administered the test in substantial compliance with the testing standards for reliable, credible, and generally accepted field sobriety tests for vehicles that were in effect at the time the tests were administered, including, but not limited to, any testing standards then in effect that have been set by the national highway traffic safety administration, that by their nature are not clearly inapplicable regarding the operation or physical control of vessels underway or the manipulation of water skis, aquaplanes, or similar devices, all of the following apply:

(a) The officer may testify concerning the results of the field sobriety test so administered.

(b) The prosecution may introduce the results of the field sobriety test so administered as evidence in any proceedings in the criminal prosecution or juvenile court proceeding.

(c) If testimony is presented or evidence is introduced under division (E)(1)(a) or (b) of this section and if the testimony or evidence is admissible under the Rules of Evidence, the court shall admit the testimony or evidence, and the trier of fact shall give it whatever weight the trier of fact considers to be appropriate.

(2) Division (E)(1) of this section does not limit or preclude a court, in its determination of whether the arrest of a person was supported by probable cause or its determination of any other matter in a criminal prosecution or juvenile court proceeding of a type described in that division, from considering evidence or testimony that is not otherwise disallowed by division (E)(1) of this section.

(F)(1) Subject to division (F)(3) of this section, in any criminal prosecution or juvenile court proceeding for a violation of division (A) or (B) of this section or for an equivalent offense that is substantially equivalent to either of those divisions, the court shall admit as prima-facie evidence a laboratory report from any laboratory personnel issued a permit by the department of health authorizing an analysis as described in this division that contains an analysis of the whole blood, blood serum or plasma, breath, urine, or other bodily substance tested and that contains all of the information specified in this division. The laboratory report shall contain all of the following:

(a) The signature, under oath, of any person who performed the analysis;

(b) Any findings as to the identity and quantity of alcohol, a drug of abuse, a controlled substance, a metabolite of a controlled substance, or a combination of them that was found;

(c) A copy of a notarized statement by the laboratory director or a designee of the director that contains the name of each certified analyst or test performer involved with the report, the analyst's or test performer's employment relationship with the laboratory that issued the report, and a notation that performing an analysis of the type involved is part of the analyst's or test performer's regular duties;

(d) An outline of the analyst's or test performer's education, training, and experience in performing the type of analysis involved and a certification that the laboratory satisfies appropriate quality control standards in general and, in this particular analysis, under rules of the department of health.
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(2) Notwithstanding any other provision of law regarding the admission of evidence, a report of the type described in division (F)(1) of this section is not admissible against the defendant or child to whom it pertains in any proceeding, other than a preliminary hearing or a grand jury proceeding, unless the prosecutor has served a copy of the report on the defendant's or child's attorney or, if the defendant or child has no attorney, on the defendant or child.

(3) A report of the type described in division (F)(1) of this section shall not be prima-facie evidence of the contents, identity, or amount of any substance if, within seven days after the defendant or child to whom the report pertains or the defendant's or child's attorney receives a copy of the report, the defendant or child or the defendant's or child's attorney demands the testimony of the person who signed the report. The judge in the case may extend the seven-day time limit in the interest of justice.

(G) Except as otherwise provided in this division, any physician, registered nurse, emergency medical technician-intermediate, emergency medical technician-paramedic, or qualified technician, chemist, or phlebotomist who withdraws blood from a person pursuant to this section or section 1547.111 of the Revised Code, and a hospital, first-aid station, or clinic at which blood is withdrawn from a person pursuant to this section or section 1547.111 of the Revised Code, is immune from criminal and civil liability based upon a claim of assault and battery or any other claim that is not a claim of malpractice, for any act performed in withdrawing blood from the person. The immunity provided in this division also extends to an emergency medical service organization that employs an emergency medical technician-intermediate, an emergency medical technician-paramedic who withdraws blood under this section. The immunity provided in this division is not available to a person who withdraws blood if the person engages in willful or wanton misconduct.

(H) Division (A)(6) of this section does not apply to a person who operates or is in physical control of a vessel underway or manipulates any water skis, aquaplane, or similar device while the person has a concentration of a listed controlled substance or a listed metabolite of a controlled substance in the person's whole blood, blood serum or plasma, or urine that equals or exceeds the amount specified in that division, if both of the following apply:

(1) The person obtained the controlled substance pursuant to a prescription issued by a licensed health professional authorized to prescribe drugs.

(2) The person injected, ingested, or inhaled the controlled substance in accordance with the health professional's directions.

(I) As used in this section and section 1547.111 of the Revised Code:

(1) "Equivalent offense" has the same meaning as in section 4511.181 of the Revised Code.

(2) "National highway traffic safety administration" has the same meaning as in section 4511.19 of the Revised Code.

(3) "Operate" means that a vessel is being used on the waters in this state when the vessel is not securely affixed to a dock or to shore or to any permanent structure to which the vessel has the right to affix or that a vessel is not anchored in a designated anchorage area or boat camping area that is established by the United States coast guard, this state, or a political subdivision and in which the vessel has the right to anchor.

(4) "Controlled substance" and "marihuana" have the same meanings as in section 3719.01 of the Revised Code.

(5) "Cocaine" and "L.S.D." have the same meanings as in section 2925.01 of the Revised Code.

(6) "Equivalent offense that is watercraft-related" means an equivalent offense that is one of the following:

(a) A violation of division (A) or (B) of this section;

(b) A violation of a municipal ordinance prohibiting a person from operating or being in physical control of any vessel underway or from manipulating any water skis, aquaplane, or
similar device on the waters of this state while under the influence of alcohol, a drug of abuse, 
or a combination of them or prohibiting a person from operating or being in physical control of 
any vessel underway or from manipulating any water skis, aquaplane, or similar device on the 
waters of this state with a prohibited concentration of alcohol, a controlled substance, or a 
metabolite of a controlled substance in the whole blood, blood serum or plasma, breath, or 
urine;

(c) A violation of an existing or former municipal ordinance, law of another state, or law 
of the United States that is substantially equivalent to division (A) or (B) of this section;
(d) A violation of a former law of this state that was substantially equivalent to division 
(A) or (B) of this section.
(7) “Emergency medical technician-intermediate” and “emergency medical technician-
paramedic” have the same meanings as in section 4765.01 of the Revised Code.

1547.111 Consent for substance abuse testing implied by operation of water vessel; 
implied consent of dead or unconscious; officer may use reasonable means to ensure 
test.

(A)(1)(a) Any person who operates or is in physical control of a vessel or manipulates 
any water skis, aquaplane, or similar device upon any waters in this state shall be deemed to 
have given consent to a chemical test or tests to determine the alcohol, drug of abuse, 
controlled substance, metabolite of a controlled substance, or combination content of the 
person's whole blood, blood serum or plasma, breath, or urine if arrested for operat 
ing or being 
in physical control of a vessel or manipulating any water skis, aquaplane, or similar device in 
violation of section 1547.11 of the Revised Code or a substantially equivalent municipal 
ordinance.

(b) The test or tests under division (A)(1) of this section shall be administered at the 
request of a law enforcement officer having reasonable grounds to believe the person was 
operating or in physical control of a vessel or manipulating any water skis, aquaplane, or similar device in violation of section 1547.11 of the Revised Code or a substantially equivalent 
municipal ordinance. The law enforcement agency by which the officer is employed shall 
designate which test or tests shall be administered.

(2) Any person who is dead or unconscious or who otherwise is in a condition rendering 
the person incapable of refusal shall be deemed to have consented as provided in division 
(A)(1) of this section, and the test or tests may be administered, subject to sections 313.12 to 
313.16 of the Revised Code.

(B)(1) If a law enforcement officer arrests a person for operating or being in physical 
control of a vessel or manipulating any water skis, aquaplane, or similar device in violation of 
section 1547.11 of the Revised Code or a substantially equivalent municipal ordinance and if 
the person previously has been convicted of or pleaded guilty to two or more violations of 
section 1547.11 of the Revised Code or other equivalent offenses, the law enforcement officer 
shall request the person to submit, and the person shall submit, to a chemical test or tests of the 
person's whole blood, blood serum or plasma, breath, or urine for the purpose of determining 
the alcohol, drug of abuse, controlled substance, metabolite of a controlled substance, or 
combination content of the person's whole blood, blood serum or plasma, breath, or urine. A law 
enforcement officer who makes a request pursuant to this division that a person submit to a 
chemical test or tests is not required to advise the person of the consequences of refusing to 
submit to the test or tests and is not required to give the person the form described in division 
(C) of this section, but the officer shall advise the person at the time of the arrest that if the 
person refuses to take a chemical test the officer may employ whatever reasonable means are 
necessary to ensure that the person submits to a chemical test of the person's whole blood or 
blood serum or plasma. The officer shall also advise the person at the time of the arrest that the
person may have an independent chemical test taken at the person's own expense. The advice shall be in written form prescribed by the chief of the division of parks and watercraft and shall be read to the person. The form shall contain a statement that the form was shown to the person under arrest and read to the person by the arresting officer. The reading of the form shall be witnessed by one or more persons, and the witnesses shall certify to this fact by signing the form. Divisions (A)(1)(b) and (A)(2) of this section apply to the administration of a chemical test or tests pursuant to this division.

(2) If a person refuses to submit to a chemical test upon a request made pursuant to division (B)(1) of this section, the law enforcement officer who made the request may employ whatever reasonable means are necessary to ensure that the person submits to a chemical test of the person's whole blood or blood serum or plasma. A law enforcement officer who acts pursuant to this division to ensure that a person submits to a chemical test of the person's whole blood or blood serum or plasma is immune from criminal and civil liability based upon a claim for assault and battery or any other claim for the acts, unless the officer so acted with malicious purpose, in bad faith, or in a wanton or reckless manner.

(C) Except as provided in division (B) of this section, any person under arrest for violating section 1547.11 of the Revised Code or a substantially equivalent municipal ordinance shall be advised of the consequences of refusing to submit to a chemical test or tests designated as provided in division (A) of this section. The advice shall be in a written form prescribed by the chief of the division of parks and watercraft and shall be read to the person. The form shall contain a statement that the form was shown to the person under arrest and read to the person by the arresting officer. The reading of the form shall be witnessed by one or more persons, and the witnesses shall certify to this fact by signing the form. The person must submit to the chemical test or tests, subsequent to the request of the arresting officer, within two hours of the time of the alleged violation, and if the person does not submit to the test or tests within that two-hour time limit, the failure to submit automatically constitutes a refusal to submit to the test or tests.

(D) Except as provided in division (B) of this section, if a law enforcement officer asks a person under arrest for violating section 1547.11 of the Revised Code or a substantially equivalent municipal ordinance to submit to a chemical test or tests as provided in division (A) of this section, if the arresting officer advises the person of the consequences of the person's refusal as provided in division (C) of this section, and if the person refuses to submit, no chemical test shall be given. Upon receipt of a sworn statement of the officer that the arresting law enforcement officer had reasonable grounds to believe the arrested person violated section 1547.11 of the Revised Code or a substantially equivalent municipal ordinance and that the person refused to submit to the chemical test upon the request of the officer, and upon receipt of the form as provided in division (C) of this section certifying that the arrested person was advised of the consequences of the refusal, the chief of the division of parks and watercraft shall inform the person by written notice that the person is prohibited from operating or being in physical control of a vessel, from manipulating any water skis, aquaplane, or similar device, and from registering any watercraft in accordance with section 1547.54 of the Revised Code, for one year following the date of the alleged violation. The suspension of these operation, physical control, manipulation, and registration privileges shall continue for the entire one-year period, subject to review as provided in this section.

If the person under arrest is the owner of the vessel involved in the alleged violation, the law enforcement officer who arrested the person shall seize the watercraft registration certificate and tags from the vessel involved in the violation and forward them to the chief. The chief shall retain the impounded registration certificate and tags and shall impound all other registration certificates and tags issued to the person in accordance with sections 1547.54 and 1547.57 of the Revised Code, for a period of one year following the date of the alleged violation, subject to review as provided in this section.
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If the arrested person fails to surrender the registration certificate because it is not on the person of the arrested person or in the watercraft, the law enforcement officer who made the arrest shall order the person to surrender it within twenty-four hours to the law enforcement officer or the law enforcement agency that employs the law enforcement officer. If the person fails to do so, the law enforcement officer shall notify the chief of that fact in the statement the officer submits to the chief under this division.

(E) Upon suspending a person's operation, physical control, manipulation, and registration privileges in accordance with division (D) of this section, the chief shall notify the person in writing, at the person's last known address, and inform the person that the person may petition for a hearing in accordance with division (F) of this section. If a person whose operation, physical control, manipulation, and registration privileges have been suspended petitions for a hearing or appeals any adverse decision, the suspension shall begin at the termination of any hearing or appeal unless the hearing or appeal results in a decision favorable to the person.

(F) Any person who has been notified by the chief that the person is prohibited from operating or being in physical control of a vessel or manipulating any water skis, aquaplane, or similar device and from registering any watercraft in accordance with section 1547.54 of the Revised Code, or who has had the registration certificate and tags of the person's watercraft impounded pursuant to division (D) of this section, within twenty days of the notification or impoundment, may file a petition in the municipal court or the county court, or if the person is a minor in juvenile court, with jurisdiction over the place at which the arrest occurred, agreeing to pay the cost of the proceedings and alleging error in the action taken by the chief under division (D) of this section or alleging one or more of the matters within the scope of the hearing as provided in this section, or both. The petitioner shall notify the chief of the filing of the petition and send the chief a copy of the petition.

The scope of the hearing is limited to the issues of whether the law enforcement officer had reasonable grounds to believe the petitioner was operating or in physical control of a vessel or manipulating any water skis, aquaplane, or similar device in violation of section 1547.11 of the Revised Code or a substantially equivalent municipal ordinance, whether the petitioner was placed under arrest, whether the petitioner refused to submit to the chemical test upon request of the officer, and whether the petitioner was advised of the consequences of the petitioner's refusal.

(G)(1) The chief shall furnish the court a copy of the affidavit as provided in division (C) of this section and any other relevant information requested by the court.

(2) In hearing the matter and in determining whether the person has shown error in the decision taken by the chief as provided in division (D) of this section, the court shall decide the issue upon the relevant, competent, and material evidence submitted by the chief or the person whose operation, physical control, manipulation, and registration privileges have been suspended.

In the proceedings, the chief shall be represented by the prosecuting attorney of the county in which the petition is filed if the petition is filed in a county court or juvenile court, except that if the arrest occurred within a city or village within the jurisdiction of the county court in which the petition is filed, the city director of law or village solicitor of that city or village shall represent the chief. If the petition is filed in the municipal court, the chief shall be represented as provided in section 1901.34 of the Revised Code.

(3) If the court finds from the evidence submitted that the person has failed to show error in the action taken by the chief under division (D) of this section or in one or more of the matters within the scope of the hearing as provided in division (F) of this section, or both, the court shall assess the cost of the proceeding against the person and shall uphold the suspension of the operation, physical control, use, and registration privileges provided in division (D) of this section. If the court finds that the person has shown error in the action taken by the chief under
division (D) of this section or in one or more of the matters within the scope of the hearing as provided in division (F) of this section, or both, the cost of the proceedings shall be paid out of the county treasury of the county in which the proceedings were held, the chief shall reinstate the operation, physical control, manipulation, and registration privileges of the person without charge, and the chief shall return the registration certificate and tags, if impounded, without charge.

(4) The court shall give information in writing of any action taken under this section to the chief.

(H) At the end of any period of suspension or impoundment imposed under this section, and upon request of the person whose operation, physical control, use, and registration privileges were suspended or whose registration certificate and tags were impounded, the chief shall reinstate the person's operation, physical control, manipulation, and registration privileges by written notice and return the certificate and tags.

(I) No person who has received written notice from the chief that the person is prohibited from operating or being in physical control of a vessel, from manipulating any water skis, aquaplane, or similar device, and from registering a watercraft, or who has had the registration certificate and tags of the person's watercraft impounded, in accordance with division (D) of this section, shall operate or be in physical control of a vessel or manipulate any water skis, aquaplane, or similar device for a period of one year following the date of the person's alleged violation of section 1547.11 of the Revised Code or the substantially equivalent municipal ordinance.

2317.022 Police request for alcohol blood results.

(A) As used in this section:

(1) "Health care provider" has the same meaning as in section 2317.02 of the Revised Code.

(2) "Drug of abuse" has the same meaning as in section 4506.01 of the Revised Code.

(B) If an official criminal investigation has begun regarding a person or if a criminal action or proceeding is commenced against a person, any law enforcement officer who wishes to obtain from any health care provider a copy of any records the provider possesses that pertain to any test or the result of any test administered to the person to determine the presence or concentration of alcohol, a drug of abuse, or alcohol and a drug of abuse in the person's blood, breath, or urine at any time relevant to the criminal offense in question shall submit to the health care facility a written statement in the following form:

"WRITTEN STATEMENT REQUESTING THE RELEASE OF RECORDS

To: _____________ (insert name of the health care provider in question).

I hereby state that an official criminal investigation has begun regarding, or a criminal action or proceeding has been commenced against .................... (insert the name of the person in question), and that I believe that one or more tests has been administered to that person by this health care provider to determine the presence or concentration of alcohol, a drug of abuse, a combination of them, a controlled substance, or a metabolite of a controlled substance in that person's whole blood, blood serum or plasma, breath, or urine at a time relevant to the criminal offense in question. Therefore, I hereby request that, pursuant to division (B)(2) of section 2317.02 of the Revised Code, this health care provider supply me with copies of any records the provider possesses that pertain to any test or the results of any test administered to the person specified above to determine the presence or concentration of alcohol, a drug of abuse, a combination of them, a controlled substance, or a metabolite of a controlled substance in that
person's whole blood, blood serum or plasma, breath, or urine at any time relevant to the criminal offense in question.

___________________
(Name of officer)

___________________
(Officer's title)

___________________
(Officer's employing agency)

___________________
(Officer's telephone number)

___________________
(Agency's address)

___________________
(Date written statement submitted)"

(C) A health care provider that receives a written statement of the type described in division (B) of this section shall comply with division (B)(2) of section 2317.02 of the Revised Code relative to the written statement.

3715.872 Immunity for drug donation.

(A) As used in this section, "health care professional" means any of the following who provide medical, dental, or other health-related diagnosis, care, or treatment:

1. Individuals authorized under Chapter 4731 of the Revised Code to practice medicine and surgery, osteopathic medicine and surgery, or podiatric medicine and surgery;
2. Registered nurses and licensed practical nurses licensed under Chapter 4723 of the Revised Code;
3. Physician assistants authorized to practice under Chapter 4730 of the Revised Code;
4. Dentists and dental hygienists licensed under Chapter 4715 of the Revised Code;
5. Optometrists licensed under Chapter 4725 of the Revised Code;

(B) For matters related to donating, giving, accepting, or dispensing drugs under the drug repository program, all of the following apply:

1. Any person, including a pharmacy, drug manufacturer, or health care facility, or any government entity that donates or gives drugs to the drug repository program shall not be subject to liability in tort or other civil action for injury, death, or loss to person or property.
(2) A pharmacy, hospital, or nonprofit clinic that accepts or dispenses drugs under the program shall not be subject to liability in tort or other civil action for injury, death, or loss to person or property, unless an action or omission of the pharmacy, hospital, or nonprofit clinic constitutes willful and wanton misconduct.

(3) A health care professional who accepts or dispenses drugs under the program on behalf of a pharmacy, hospital, or nonprofit clinic, and the pharmacy, hospital, or nonprofit clinic that employs or otherwise uses the services of the health care professional, shall not be subject to liability in tort or other civil action for injury, death, or loss to person or property, unless an action or omission of the health care professional, pharmacy, hospital, or nonprofit clinic constitutes willful and wanton misconduct.

(4) The state board of pharmacy and the director of health shall not be subject to liability in tort or other civil action for injury, death, or loss to person or property, unless an action or omission of the board or director constitutes willful and wanton misconduct.

(C) In addition to the immunity granted under division (B)(1) of this section, any person, including a pharmacy, drug manufacturer, or health care facility, and any government entity that donates or gives drugs to the program shall not be subject to criminal prosecution for the donation, giving, acceptance, or dispensing of drugs under the program, unless an action or omission of the person or government entity does not comply with the provisions of this chapter or the rules adopted under it.

(D) In the case of a drug manufacturer, the immunities granted under divisions (B)(1) and (C) of this section apply with respect to any drug manufactured by the drug manufacturer that is donated or given by any person or government entity under the program, including but not limited to liability for failure to transfer or communicate product or consumer information or the expiration date of the drug donated or given.

4511.19 Operating land vehicle under the influence; immunity for certain persons withdrawing blood.

(A)(1) No person shall operate any vehicle, streetcar, or trackless trolley within this state, if, at the time of the operation, any of the following apply:

(a) The person is under the influence of alcohol, a drug of abuse, or a combination of them.

(b) The person has a concentration of eight-hundredths of one per cent or more but less than seventeen-hundredths of one per cent by weight per unit volume of alcohol in the person's whole blood.

(c) The person has a concentration of ninety-six-thousandths of one per cent or more but less than two hundred four-thousandths of one per cent by weight per unit volume of alcohol in the person's blood serum or plasma.

(d) The person has a concentration of eight-hundredths of one gram or more but less than seventeen-hundredths of one gram by weight of alcohol per two hundred ten liters of the person's breath.

(e) The person has a concentration of eleven-hundredths of one gram or more but less than two hundred thirty-eight-thousandths of one gram by weight of alcohol per one hundred milliliters of the person's urine.

(f) The person has a concentration of seventeen-hundredths of one per cent or more by weight per unit volume of alcohol in the person's whole blood.

(g) The person has a concentration of two hundred four-thousandths of one per cent or more by weight per unit volume of alcohol in the person's blood serum or plasma.

(h) The person has a concentration of seventeen-hundredths of one gram or more by weight of alcohol per two hundred ten liters of the person's breath.

(i) The person has a concentration of two hundred thirty-eight-thousandths of one gram
or more by weight of alcohol per one hundred milliliters of the person's urine.

(j) Except as provided in division (K) of this section, the person has a concentration of any of the following controlled substances or metabolites of a controlled substance in the person's whole blood, blood serum or plasma, or urine that equals or exceeds any of the following:

(i) The person has a concentration of amphetamine in the person's urine of at least five hundred nanograms of amphetamine per milliliter of the person's urine or has a concentration of amphetamine in the person's whole blood or blood serum or plasma of at least one hundred nanograms of amphetamine per milliliter of the person's whole blood or blood serum or plasma.

(ii) The person has a concentration of cocaine in the person's urine of at least one hundred fifty nanograms of cocaine per milliliter of the person's urine or has a concentration of cocaine in the person's whole blood or blood serum or plasma of at least fifty nanograms of cocaine per milliliter of the person's whole blood or blood serum or plasma.

(iii) The person has a concentration of cocaine metabolite in the person's urine of at least one hundred fifty nanograms of cocaine metabolite per milliliter of the person's urine or has a concentration of cocaine metabolite in the person's whole blood or blood serum or plasma of at least fifty nanograms of cocaine metabolite per milliliter of the person's whole blood or blood serum or plasma.

(iv) The person has a concentration of heroin in the person's urine of at least two thousand nanograms of heroin per milliliter of the person's urine or has a concentration of heroin in the person's whole blood or blood serum or plasma of at least fifty nanograms of heroin per milliliter of the person's whole blood or blood serum or plasma.

(v) The person has a concentration of heroin metabolite (6-monoacetyl morphine) in the person's urine of at least ten nanograms of heroin metabolite (6-monoacetyl morphine) per milliliter of the person's urine or has a concentration of heroin metabolite (6-monoacetyl morphine) in the person's whole blood or blood serum or plasma of at least ten nanograms of heroin metabolite (6-monoacetyl morphine) per milliliter of the person's whole blood or blood serum or plasma.

(vi) The person has a concentration of L.S.D. in the person's urine of at least twenty-five nanograms of L.S.D. per milliliter of the person's urine or a concentration of L.S.D. in the person's whole blood or blood serum or plasma of at least ten nanograms of L.S.D. per milliliter of the person's whole blood or blood serum or plasma.

(vii) The person has a concentration of marihuana in the person's urine of at least ten nanograms of marihuana per milliliter of the person's urine or has a concentration of marihuana in the person's whole blood or blood serum or plasma of at least two nanograms of marihuana per milliliter of the person's whole blood or blood serum or plasma.

(viii) Either of the following applies:

(I) The person is under the influence of alcohol, a drug of abuse, or a combination of them, and the person has a concentration of marihuana metabolite in the person's urine of at least fifteen nanograms of marihuana metabolite per milliliter of the person's urine or has a concentration of marihuana metabolite in the person's whole blood or blood serum or plasma of at least five nanograms of marihuana metabolite per milliliter of the person's whole blood or blood serum or plasma.

(II) The person has a concentration of marihuana metabolite in the person's urine of at least thirty-five nanograms of marihuana metabolite per milliliter of the person's urine or has a concentration of marihuana metabolite in the person's whole blood or blood serum or plasma of at least fifty nanograms of marihuana metabolite per milliliter of the person's whole blood or blood serum or plasma.

(ix) The person has a concentration of methamphetamine in the person's urine of at least five hundred nanograms of methamphetamine per milliliter of the person's urine or has a concentration of methamphetamine in the person's whole blood or blood serum or plasma of at
least one hundred nanograms of methamphetamine per milliliter of the person's whole blood or blood serum or plasma.

(x) The person has a concentration of phencyclidine in the person's urine of at least twenty-five nanograms of phencyclidine per milliliter of the person's urine or has a concentration of phencyclidine in the person's whole blood or blood serum or plasma of at least ten nanograms of phencyclidine per milliliter of the person's whole blood or blood serum or plasma.

(xi) The state board of pharmacy has adopted a rule pursuant to section 4729.041 of the Revised Code that specifies the amount of salvia divinorum and the amount of salvinorin A that constitute concentrations of salvia divinorum and salvinorin A in a person's urine, in a person's whole blood, or in a person's blood serum or plasma at or above which the person is impaired for purposes of operating any vehicle, streetcar, or trackless trolley within this state, the rule is in effect, and the person has a concentration of salvia divinorum or salvinorin A of at least that amount so specified by rule in the person's urine, in the person's whole blood, or in the person's blood serum or plasma.

(2) No person who, within twenty years of the conduct described in division (A)(2)(a) of this section, previously has been convicted of or pleaded guilty to a violation of division (A)(1) or (B) of this section, or any other equivalent offense shall do both of the following:

(a) Operate any vehicle, streetcar, or trackless trolley within this state while under the influence of alcohol, a drug of abuse, or a combination of them;

(b) Subsequent to being arrested for operating the vehicle, streetcar, or trackless trolley as described in division (A)(2)(a) of this section, being asked by a law enforcement officer to submit to a chemical test or tests under section 4511.191 of the Revised Code, and being advised by the officer in accordance with section 4511.192 of the Revised Code of the consequences of the person's refusal or submission to the test or tests, refuse to submit to the test or tests.

(B) No person under twenty-one years of age shall operate any vehicle, streetcar, or trackless trolley within this state, if, at the time of the operation, any of the following apply:

(1) The person has a concentration of at least two-hundredths of one per cent but less than eight-hundredths of one per cent by weight per unit volume of alcohol in the person's whole blood.

(2) The person has a concentration of at least three-hundredths of one per cent but less than ninety-six-thousandths of one per cent by weight per unit volume of alcohol in the person's blood serum or plasma.

(3) The person has a concentration of at least two-hundredths of one gram but less than eight-hundredths of one gram by weight of alcohol per two hundred ten liters of the person's breath.

(4) The person has a concentration of at least twenty-eight one-thousandths of one gram but less than eleven-hundredths of one gram by weight of alcohol per one hundred milliliters of the person's urine.

(C) In any proceeding arising out of one incident, a person may be charged with a violation of division (A)(1)(a) or (A)(2) and a violation of division (B)(1), (2), or (3) of this section, but the person may not be convicted of more than one violation of these divisions.

(D)(1)(a) In any criminal prosecution or juvenile court proceeding for a violation of division (A)(1)(a) of this section or for an equivalent offense that is vehicle-related, the result of any test of any blood or urine withdrawn and analyzed at any health care provider, as defined in section 2317.02 of the Revised Code, may be admitted with expert testimony to be considered with any other relevant and competent evidence in determining the guilt or innocence of the defendant.

(b) In any criminal prosecution or juvenile court proceeding for a violation of division (A) or (B) of this section or for an equivalent offense that is vehicle-related, the court may admit
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Evidence on the concentration of alcohol, drugs of abuse, controlled substances, metabolites of a controlled substance, or a combination of them in the defendant's whole blood, blood serum or plasma, breath, urine, or other bodily substance at the time of the alleged violation as shown by chemical analysis of the substance withdrawn within three hours of the time of the alleged violation. The three-hour time limit specified in this division regarding the admission of evidence does not extend or affect the two-hour time limit specified in division (A) of section 4511.192 of the Revised Code as the maximum period of time during which a person may consent to a chemical test or tests as described in that section. The court may admit evidence on the concentration of alcohol, drugs of abuse, or a combination of them as described in this division when a person submits to a blood, breath, urine, or other bodily substance test at the request of a law enforcement officer under section 4511.191 of the Revised Code or a blood or urine sample is obtained pursuant to a search warrant. Only a physician, a registered nurse, an emergency medical technician-intermediate, an emergency medical technician-paramedic, or a qualified technician, chemist, or phlebotomist shall withdraw a blood sample for the purpose of determining the alcohol, drug, controlled substance, metabolite of a controlled substance, or combination content of the whole blood, blood serum, or blood plasma. This limitation does not apply to the taking of breath or urine specimens. A person authorized to withdraw blood under this division may refuse to withdraw blood under this division, if in that person's opinion, the physical welfare of the person would be endangered by the withdrawing of blood.

The bodily substance withdrawn under division (D)(1)(b) of this section shall be analyzed in accordance with methods approved by the director of health by an individual possessing a valid permit issued by the director pursuant to section 3701.143 of the Revised Code.

(c) As used in division (D)(1)(b) of this section, "emergency medical technician-intermediate" and "emergency medical technician-paramedic" have the same meanings as in section 4765.01 of the Revised Code.

(2) In a criminal prosecution or juvenile court proceeding for a violation of division (A) of this section or for an equivalent offense that is vehicle-related, if there was at the time the bodily substance was withdrawn a concentration of less than the applicable concentration of alcohol specified in divisions (A)(1)(b), (c), (d), and (e) of this section or less than the applicable concentration of a listed controlled substance or a listed metabolite of a controlled substance specified for a violation of division (A)(1)(j) of this section, that fact may be considered with other competent evidence in determining the guilt or innocence of the defendant. This division does not limit or affect a criminal prosecution or juvenile court proceeding for a violation of division (B) of this section or for an equivalent offense that is substantially equivalent to that division.

(3) Upon the request of the person who was tested, the results of the chemical test shall be made available to the person or the person's attorney, immediately upon the completion of the chemical test analysis.

If the chemical test was obtained pursuant to division (D)(1)(b) of this section, the person tested may have a physician, a registered nurse, or a qualified technician, chemist, or phlebotomist of the person's own choosing administer a chemical test or tests, at the person's expense, in addition to any administered at the request of a law enforcement officer. If the person was under arrest as described in division (A)(5) of section 4511.191 of the Revised Code, the arresting officer shall advise the person at the time of the arrest that the person may have an independent chemical test taken at the person's own expense. If the person was under arrest other than described in division (A)(5) of section 4511.191 of the Revised Code, the form to be read to the person to be tested, as required under section 4511.192 of the Revised Code, shall state that the person may have an independent test performed at the person's expense. The failure or inability to obtain an additional chemical test by a person shall not preclude the admission of evidence relating to the chemical test or tests taken at the request of a law enforcement officer.

(4)(a) As used in divisions (D)(4)(b) and (c) of this section, "national highway traffic

(b) In any criminal prosecution or juvenile court proceeding for a violation of division (A) or (B) of this section, of a municipal ordinance relating to operating a vehicle while under the influence of alcohol, a drug of abuse, or alcohol and a drug of abuse, or of a municipal ordinance relating to operating a vehicle with a prohibited concentration of alcohol, a controlled substance, or a metabolite of a controlled substance in the whole blood, blood serum or plasma, breath, or urine, if a law enforcement officer has administered a field sobriety test to the operator of the vehicle involved in the violation and if it is shown by clear and convincing evidence that the officer administered the test in substantial compliance with the testing standards for any reliable, credible, and generally accepted field sobriety tests that were in effect at the time the tests were administered, including, but not limited to, any testing standards then in effect that were set by the national highway traffic safety administration, all of the following apply:

(i) The officer may testify concerning the results of the field sobriety test so administered.
(ii) The prosecution may introduce the results of the field sobriety test so administered as evidence in any proceedings in the criminal prosecution or juvenile court proceeding.
(iii) If testimony is presented or evidence is introduced under division (D)(4)(b)(i) or (ii) of this section and if the testimony or evidence is admissible under the Rules of Evidence, the court shall admit the testimony or evidence and the trier of fact shall give it whatever weight the trier of fact considers to be appropriate.

(c) Division (D)(4)(b) of this section does not limit or preclude a court, in its determination of whether the arrest of a person was supported by probable cause or its determination of any other matter in a criminal prosecution or juvenile court proceeding of a type described in that division, from considering evidence or testimony that is not otherwise disallowed by division (D)(4)(b) of this section.

(E)(1) Subject to division (E)(3) of this section, in any criminal prosecution or juvenile court proceeding for a violation of division (A)(1)(b), (c), (d), (e), (f), (g), (h), (i), or (j) or (B)(1), (2), (3), or (4) of this section or for an equivalent offense that is substantially equivalent to any of those divisions, a laboratory report from any laboratory personnel issued a permit by the department of health authorizing an analysis as described in this division that contains an analysis of the whole blood, blood serum or plasma, breath, urine, or other bodily substance tested and that contains all of the information specified in this division shall be admitted as prima-facie evidence of the information and statements that the report contains. The laboratory report shall contain all of the following:

(a) The signature, under oath, of any person who performed the analysis;
(b) Any findings as to the identity and quantity of alcohol, a drug of abuse, a controlled substance, a metabolite of a controlled substance, or a combination of them that was found;
(c) A copy of a notarized statement by the laboratory director or a designee of the director that contains the name of each certified analyst or test performer involved with the report, the analyst's or test performer's employment relationship with the laboratory that issued the report, and a notation that performing an analysis of the type involved is part of the analyst's or test performer's regular duties;
(d) An outline of the analyst's or test performer's education, training, and experience in performing the type of analysis involved and a certification that the laboratory satisfies appropriate quality control standards in general and, in this particular analysis, under rules of the department of health.

(2) Notwithstanding any other provision of law regarding the admission of evidence, a report of the type described in division (E)(1) of this section is not admissible against the defendant to whom it pertains in any proceeding, other than a preliminary hearing or a grand
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jury proceeding, unless the prosecutor has served a copy of the report on the defendant's attorney or, if the defendant has no attorney, on the defendant.

(3) A report of the type described in division (E)(1) of this section shall not be prima-facie evidence of the contents, identity, or amount of any substance if, within seven days after the defendant to whom the report pertains or the defendant's attorney receives a copy of the report, the defendant or the defendant's attorney demands the testimony of the person who signed the report. The judge in the case may extend the seven-day time limit in the interest of justice.

(F) Except as otherwise provided in this division, any physician, registered nurse, emergency medical technician-intermediate, emergency medical technician-paramedic, or qualified technician, chemist, or phlebotomist who withdraws blood from a person pursuant to this section or section 4511.191 or 4511.192 of the Revised Code, and any hospital, first-aid station, or clinic at which blood is withdrawn from a person pursuant to this section or section 4511.191 or 4511.192 of the Revised Code, is immune from criminal liability and civil liability based upon a claim of assault and battery or any other claim that is not a claim of malpractice, for any act performed in withdrawing blood from the person. The immunity provided in this division also extends to an emergency medical service organization that employs an emergency medical technician-intermediate or emergency medical technician-paramedic who withdraws blood under this section. The immunity provided in this division is not available to a person who withdraws blood if the person engages in willful or wanton misconduct.

As used in this division, “emergency medical technician-intermediate” and “emergency medical technician-paramedic” have the same meanings as in section 4765.01 of the Revised Code.

(G)(1) Whoever violates any provision of divisions (A)(1)(a) to (i) or (A)(2) of this section is guilty of operating a vehicle under the influence of alcohol, a drug of abuse, or a combination of them. Whoever violates division (A)(1)(j) of this section is guilty of operating a vehicle while under the influence of a listed controlled substance or a listed metabolite of a controlled substance. The court shall sentence the offender for either offense under Chapter 2929 of the Revised Code, except as otherwise authorized or required by divisions (G)(1)(a) to (e) of this section:

(a) Except as otherwise provided in division (G)(1)(b), (c), (d), or (e) of this section, the offender is guilty of a misdemeanor of the first degree, and the court shall sentence the offender to all of the following:

(i) If the sentence is being imposed for a violation of division (A)(1)(a), (b), (c), (d), (e), or (j) of this section, a mandatory jail term of three consecutive days. As used in this division, three consecutive days means seventy-two consecutive hours. The court may sentence an offender to both an intervention program and a jail term. The court may impose a jail term in addition to the three-day mandatory jail term or intervention program. However, in no case shall the cumulative jail term imposed for the offense exceed six months.

The court may suspend the execution of the three-day jail term under this division if the court, in lieu of that suspended term, places the offender under a community control sanction pursuant to section 2929.25 of the Revised Code and requires the offender to attend, for three consecutive days, a drivers' intervention program certified under section 5119.38 of the Revised Code. The court also may suspend the execution of any part of the three-day jail term under this division if it places the offender under a community control sanction pursuant to section 2929.25 of the Revised Code for part of the three days, requires the offender to attend for the suspended part of the term a drivers' intervention program so certified, and sentences the offender to a jail term equal to the remainder of the three consecutive days that the offender does not spend attending the program. The court may require the offender, as a condition of community control and in addition to the required attendance at a drivers' intervention program, to attend and satisfactorily complete any treatment or education programs that comply with the minimum standards adopted pursuant to Chapter 5119 of the Revised Code by the director of mental
health and addiction services that the operators of the drivers' intervention program determine that the offender should attend and to report periodically to the court on the offender's progress in the programs. The court also may impose on the offender any other conditions of community control that it considers necessary.

If the court grants unlimited driving privileges to a first-time offender under section 4510.022 of the Revised Code, all penalties imposed upon the offender by the court under division (G)(1)(a)(i) of this section for the offense apply, except that the court shall suspend any mandatory or additional jail term imposed by the court under division (G)(1)(a)(i) of this section upon granting unlimited driving privileges in accordance with section 4510.022 of the Revised Code.

(ii) If the sentence is being imposed for a violation of division (A)(1)(f), (g), (h), or (i) or division (A)(2) of this section, except as otherwise provided in this division, a mandatory jail term of at least three consecutive days and a requirement that the offender attend, for three consecutive days, a drivers' intervention program that is certified pursuant to section 5119.38 of the Revised Code. As used in this division, three consecutive days means seventy-two consecutive hours. If the court determines that the offender is not conducive to treatment in a drivers' intervention program, if the offender refuses to attend a drivers' intervention program, or if the jail at which the offender is to serve the jail term imposed can provide a driver's intervention program, the court shall sentence the offender to a mandatory jail term of at least six consecutive days.

If the court grants unlimited driving privileges to a first-time offender under section 4510.022 of the Revised Code, all penalties imposed upon the offender by the court under division (G)(1)(a)(ii) of this section for the offense apply, except that the court shall suspend any mandatory or additional jail term imposed by the court under division (G)(1)(a)(ii) of this section upon granting unlimited driving privileges in accordance with section 4510.022 of the Revised Code.

The court may require the offender, under a community control sanction imposed under section 2929.25 of the Revised Code, to attend and satisfactorily complete any treatment or education programs that comply with the minimum standards adopted pursuant to Chapter 5119 of the Revised Code by the director of mental health and addiction services, in addition to the required attendance at drivers' intervention program, that the operators of the drivers' intervention program determine that the offender should attend and to report periodically to the court on the offender's progress in the programs. The court also may impose any other conditions of community control on the offender that it considers necessary.

(iii) In all cases, a fine of not less than three hundred seventy-five and not more than one thousand seventy-five dollars;

(iv) In all cases, a suspension of the offender's driver's or commercial driver's license or permit or nonresident operating privilege for a definite period of one to three years. The court may grant limited driving privileges relative to the suspension under sections 4510.021 and 4510.13 of the Revised Code. The court may grant unlimited driving privileges with an ignition interlock device relative to the suspension and may reduce the period of suspension as authorized under section 4510.022 of the Revised Code.

(b) Except as otherwise provided in division (G)(1)(e) of this section, an offender who, within ten years of the offense, previously has been convicted of or pleaded guilty to one violation of division (A) or (B) of this section or one other equivalent offense is guilty of a misdemeanor of the first degree. The court shall sentence the offender to all of the following:

(i) If the sentence is being imposed for a violation of division (A)(1)(a), (b), (c), (d), (e), or (j) of this section, a mandatory jail term of ten consecutive days. The court shall impose the ten-day mandatory jail term under this division unless, subject to division (G)(3) of this section, it instead imposes a sentence under that division consisting of both a jail term and a term of house arrest with electronic monitoring, with continuous alcohol monitoring, or with both
electronic monitoring and continuous alcohol monitoring. The court may impose a jail term in
addition to the ten-day mandatory jail term. The cumulative jail term imposed for the offense
shall not exceed six months.

In addition to the jail term or the term of house arrest with electronic monitoring or
continuous alcohol monitoring or both types of monitoring and jail term, the court shall require
the offender to be assessed by a community addiction services provider that is authorized by
section 5119.21 of the Revised Code, subject to division (l) of this section, and shall order the
offender to follow the treatment recommendations of the services provider. The purpose of the
assessment is to determine the degree of the offender’s alcohol usage and to determine
whether or not treatment is warranted. Upon the request of the court, the services provider shall
submit the results of the assessment to the court, including all treatment recommendations and
clinical diagnoses related to alcohol use.

(ii) If the sentence is being imposed for a violation of division (A)(1)(f), (g), (h), or (i) or
division (A)(2) of this section, except as otherwise provided in this division, a mandatory jail term
of twenty consecutive days. The court shall impose the twenty-day mandatory jail term under
this division unless, subject to division (G)(3) of this section, it instead imposes a sentence
under that division consisting of both a jail term and a term of house arrest with electronic
monitoring, with continuous alcohol monitoring, or with both electronic monitoring and
continuous alcohol monitoring. The court may impose a jail term in addition to the twenty-day
mandatory jail term. The cumulative jail term imposed for the offense shall not exceed six
months.

In addition to the jail term or the term of house arrest with electronic monitoring or
continuous alcohol monitoring or both types of monitoring and jail term, the court shall require
the offender to be assessed by a community addiction service provider that is authorized by
section 5119.21 of the Revised Code, subject to division (I) of this section, and shall order the
offender to follow the treatment recommendations of the services provider. The purpose of the
assessment is to determine the degree of the offender’s alcohol usage and to determine
whether or not treatment is warranted. Upon the request of the court, the services provider shall
submit the results of the assessment to the court, including all treatment recommendations and
clinical diagnoses related to alcohol use.

(iii) In all cases, notwithstanding the fines set forth in Chapter 2929 of the Revised Code,
a fine of not less than five hundred twenty-five and not more than one thousand six hundred
twenty-five dollars;

(iv) In all cases, a suspension of the offender's driver's license, commercial driver's
license, temporary instruction permit, probationary license, or nonresident operating privilege for
a definite period of one to seven years. The court may grant limited driving privileges relative to
the suspension under sections 4510.021 and 4510.13 of the Revised Code.

(v) In all cases, if the vehicle is registered in the offender's name, immobilization of the
vehicle involved in the offense for ninety days in accordance with section 4503.233 of the
Revised Code and impoundment of the license plates of that vehicle for ninety days.

(c) Except as otherwise provided in division (G)(1)(e) of this section, an offender who,
within ten years of the offense, previously has been convicted of or pleaded guilty to two
violations of division (A) or (B) of this section or other equivalent offenses is guilty of a
misdemeanor. The court shall sentence the offender to all of the following:

(i) If the sentence is being imposed for a violation of division (A)(1)(a), (b), (c), (d), (e), or
(j) of this section, a mandatory jail term of thirty consecutive days. The court shall impose the
thirty-day mandatory jail term under this division unless, subject to division (G)(3) of this section,
it instead imposes a sentence under that division consisting of both a jail term and a term of
house arrest with electronic monitoring, with continuous alcohol monitoring, or with both
electronic monitoring and continuous alcohol monitoring. The court may impose a jail term in
addition to the thirty-day mandatory jail term. Notwithstanding the jail terms set forth in sections
2929.21 to 2929.28 of the Revised Code, the additional jail term shall not exceed one year, and the cumulative jail term imposed for the offense shall not exceed one year.

(ii) If the sentence is being imposed for a violation of division (A)(1)(f), (g), (h), or (i) or division (A)(2) of this section, a mandatory jail term of sixty consecutive days. The court shall impose the sixty-day mandatory jail term under this division unless, subject to division (G)(3) of this section, it instead imposes a sentence under that division consisting of both a jail term and a term of house arrest with electronic monitoring, with continuous alcohol monitoring, or with both electronic monitoring and continuous alcohol monitoring. The court may impose a jail term in addition to the sixty-day mandatory jail term. Notwithstanding the jail terms set forth in sections 2929.21 to 2929.28 of the Revised Code, the additional jail term shall not exceed one year, and the cumulative jail term imposed for the offense shall not exceed one year.

(iii) In all cases, notwithstanding the fines set forth in Chapter 2929 of the Revised Code, a fine of not less than eight hundred fifty and not more than two thousand seven hundred fifty dollars;

(iv) In all cases, a suspension of the offender’s driver’s license, commercial driver’s license, temporary instruction permit, probationary license, or nonresident operating privilege for a definite period of two to twelve years. The court may grant limited driving privileges relative to the suspension under sections 4510.021 and 4510.13 of the Revised Code.

(v) In all cases, if the vehicle is registered in the offender’s name, criminal forfeiture of the vehicle involved in the offense in accordance with section 4503.234 of the Revised Code. Division (G)(6) of this section applies regarding any vehicle that is subject to an order of criminal forfeiture under this division.

(vi) In all cases, the court shall order the offender to participate with a community addiction services provider authorized by section 5119.21 of the Revised Code, subject to division (I) of this section, and shall order the offender to follow the treatment recommendations of the services provider. The operator of the services provider shall determine and assess the degree of the offender’s alcohol dependency and shall make recommendations for treatment. Upon the request of the court, the services provider shall submit the results of the assessment to the court, including all treatment recommendations and clinical diagnoses related to alcohol use.

(d) Except as otherwise provided in division (G)(1)(e) of this section, an offender who, within ten years of the offense, previously has been convicted of or pleaded guilty to three or four violations of division (A) or (B) of this section or other equivalent offenses or an offender who, within twenty years of the offense, previously has been convicted of or pleaded guilty to five or more violations of that nature is guilty of a felony of the fourth degree. The court shall sentence the offender to all of the following:

(i) If the sentence is being imposed for a violation of division (A)(1)(a), (b), (c), (d), (e), or (j) of this section, a mandatory prison term of one, two, three, four, or five years as required by and in accordance with division (G)(2) of section 2929.13 of the Revised Code if the offender also is convicted of or also pleads guilty to a specification of the type described in section 2941.1413 of the Revised Code or, in the discretion of the court, either a mandatory term of local incarceration of sixty consecutive days in accordance with division (G)(1) of section 2929.13 of the Revised Code or a mandatory prison term of sixty consecutive days in accordance with division (G)(2) of that section if the offender is not convicted of and does not plead guilty to a specification of that type. If the court imposes a mandatory term of local incarceration, it may impose a jail term in addition to the sixty-day mandatory term, the cumulative total of the mandatory term and the jail term for the offense shall not exceed one year, and, except as provided in division (A)(1) of section 2929.13 of the Revised Code, no prison term is authorized for the offense. If the court imposes a mandatory prison term, notwithstanding division (A)(4) of section 2929.14 of the Revised Code, it also may sentence the offender to a definite prison term that shall be not less than six months and not more than thirty
months and the prison terms shall be imposed as described in division (G)(2) of section 2929.13 of the Revised Code. If the court imposes a mandatory prison term or mandatory prison term and additional prison term, in addition to the term or terms so imposed, the court also may sentence the offender to a community control sanction for the offense, but the offender shall serve all of the prison terms so imposed prior to serving the community control sanction.

(ii) If the sentence is being imposed for a violation of division (A)(1)(f), (g), (h), or (i) or division (A)(2) of this section, a mandatory prison term of one, two, three, four, or five years as required by and in accordance with division (G)(2) of section 2929.13 of the Revised Code if the offender also is convicted of or also pleads guilty to a specification of the type described in section 2941.1413 of the Revised Code or, in the discretion of the court, either a mandatory term of local incarceration of one hundred twenty consecutive days in accordance with division (G)(1) of section 2929.13 of the Revised Code or a mandatory prison term of one hundred twenty consecutive days in accordance with division (G)(2) of that section if the offender is not convicted of and does not plead guilty to a specification of that type. If the court imposes a mandatory term of local incarceration, it may impose a jail term in addition to the one hundred twenty-day mandatory term, the cumulative total of the mandatory term and the jail term for the offense shall not exceed one year, and, except as provided in division (A)(1) of section 2929.13 of the Revised Code, no prison term is authorized for the offense. If the court imposes a mandatory prison term, notwithstanding division (A)(4) of section 2929.14 of the Revised Code, it also may sentence the offender to a definite prison term that shall be not less than six months and not more than thirty months and the prison terms shall be imposed as described in division (G)(2) of section 2929.13 of the Revised Code. If the court imposes a mandatory prison term or mandatory prison term and additional prison term, in addition to the term or terms so imposed, the court also may sentence the offender to a community control sanction for the offense, but the offender shall serve all of the prison terms so imposed prior to serving the community control sanction.

(iii) In all cases, notwithstanding section 2929.18 of the Revised Code, a fine of not less than one thousand three hundred fifty nor more than ten thousand five hundred dollars;

(iv) In all cases, a class two license suspension of the offender's driver's license, commercial driver's license, temporary instruction permit, probationary license, or nonresident operating privilege from the range specified in division (A)(2) of section 4510.02 of the Revised Code. The court may grant limited driving privileges relative to the suspension under sections 4510.021 and 4510.13 of the Revised Code.

(v) In all cases, if the vehicle is registered in the offender's name, criminal forfeiture of the vehicle involved in the offense in accordance with section 4503.234 of the Revised Code. Division (G)(6) of this section applies regarding any vehicle that is subject to an order of criminal forfeiture under this division.

(vi) In all cases, the court shall order the offender to participate with a community addiction services provider authorized by section 5119.21 of the Revised Code, subject to division (I) of this section, and shall order the offender to follow the treatment recommendations of the services provider. The operator of the services provider shall determine and assess the degree of the offender's alcohol dependency and shall make recommendations for treatment. Upon the request of the court, the services provider shall submit the results of the assessment to the court, including all treatment recommendations and clinical diagnoses related to alcohol use.

(vii) In all cases, if the court sentences the offender to a mandatory term of local incarceration, in addition to the mandatory term, the court, pursuant to section 2929.17 of the Revised Code, may impose a term of house arrest with electronic monitoring. The term shall not commence until after the offender has served the mandatory term of local incarceration.

(e) An offender who previously has been convicted of or pleaded guilty to a violation of division (A) of this section that was a felony, regardless of when the violation and the conviction
or guilty plea occurred, is guilty of a felony of the third degree. The court shall sentence the
offender to all of the following:

(i) If the offender is being sentenced for a violation of division (A)(1)(a), (b), (c), (d), (e),
or (j) of this section, a mandatory prison term of one, two, three, four, or five years as required
by and in accordance with division (G)(2) of section 2929.13 of the Revised Code if the offender
also is convicted of or also pleads guilty to a specification of the type described in section
2941.1413 of the Revised Code or a mandatory prison term of sixty consecutive days in
accordance with division (G)(2) of section 2929.13 of the Revised Code if the offender is not
convicted of and does not plead guilty to a specification of that type. The court may impose a
prison term in addition to the mandatory prison term. The cumulative total of a sixty-day
mandatory prison term and the additional prison term for the offense shall not exceed five years.
In addition to the mandatory prison term or mandatory prison term and additional prison term
the court imposes, the court also may sentence the offender to a community control sanction for
the offense, but the offender shall serve all of the prison terms so imposed prior to serving the
community control sanction.

(ii) If the sentence is being imposed for a viola-
tion of division (A)(1)(f), (g), (h), or (i) or
division (A)(2) of this section, a mandatory prison term of one, two, three, four, or five years as
required by and in accordance with division (G)(2) of section 2929.13 of the Revised Code if the
offender also is convicted of or also pleads guilty to a specification of the type described in
section 2941.1413 of the Revised Code or a mandatory prison term of one hundred twenty
consecutive days in accordance with division (G)(2) of section 2929.13 of the Revised Code if
the offender is not convicted of and does not plead guilty to a specification of that type. The
court may impose a prison term in addition to the mandatory prison term. The cumulative total of
a one hundred twenty-day mandatory prison term and the additional prison term for the offense
shall not exceed five years. In addition to the mandatory prison term or mandatory prison term
and additional prison term the court imposes, the court also may sentence the offender to a
community control sanction for the offense, but the offender shall serve all of the prison terms
so imposed prior to serving the community control sanction.

(iii) In all cases, notwithstanding section 2929.18 of the Revised Code, a fine of not less
than one thousand three hundred fifty nor more than ten thousand five hundred dollars;

(iv) In all cases, a class two license suspension of the offender’s driver’s license,
commercial driver’s license, temporary instruction permit, probationary license, or nonresident
operating privilege from the range specified in division (A)(2) of section 4510.02 of the Revised
Code. The court may grant limited driving privileges relative to the suspension under sections
4510.021 and 4510.13 of the Revised Code.

(v) In all cases, if the vehicle is registered in the offender’s name, criminal forfeiture of
the vehicle involved in the offense in accordance with section 4503.234 of the Revised Code.
Division (G)(6) of this section applies regarding any vehicle that is subject to an order of criminal
forfeiture under this division.

(vi) In all cases, the court shall order the offender to participate with a community
addiction services provider authorized by section 5119.21 of the Revised Code, subject to
division (I) of this section, and shall order the offender to follow the treatment recommendations
of the services provider. The operator of the services provider shall determine and assess the
degree of the offender’s alcohol dependency and shall make recommendations for treatment.
Upon the request of the court, the services provider shall submit the results of the assessment
to the court, including all treatment recommendations and clinical diagnoses related to alcohol
use.

(2) An offender who is convicted of or pleads guilty to a violation of division (A) of this
section and who subsequently seeks reinstatement of the driver’s or occupational driver’s
license or permit or nonresident operating privilege suspended under this section as a result of
the conviction or guilty plea shall pay a reinstatement fee as provided in division (F)(2) of
section 4511.191 of the Revised Code.

(3) If an offender is sentenced to a jail term under division (G)(1)(b)(i) or (ii) or (G)(1)(c)(i) or (ii) of this section and if, within sixty days of sentencing of the offender, the court issues a written finding on the record that, due to the unavailability of space at the jail where the offender is required to serve the term, the offender will not be able to begin serving that term within the sixty-day period following the date of sentencing, the court may impose an alternative sentence under this division that includes a term of house arrest with electronic monitoring, with continuous alcohol monitoring, or with both electronic monitoring and continuous alcohol monitoring.

As an alternative to a mandatory jail term of ten consecutive days required by division (G)(1)(b)(i) of this section, the court, under this division, may sentence the offender to five consecutive days in jail and not less than eighteen consecutive days of house arrest with electronic monitoring, with continuous alcohol monitoring, or with both electronic monitoring and continuous alcohol monitoring. The cumulative total of the five consecutive days in jail and the period of house arrest with electronic monitoring, continuous alcohol monitoring, or both types of monitoring shall not exceed six months. The five consecutive days in jail do not have to be served prior to or consecutively to the period of house arrest.

As an alternative to the mandatory jail term of twenty consecutive days required by division (G)(1)(b)(ii) of this section, the court, under this division, may sentence the offender to ten consecutive days in jail and not less than thirty-six consecutive days of house arrest with electronic monitoring, with continuous alcohol monitoring, or with both electronic monitoring and continuous alcohol monitoring. The cumulative total of the ten consecutive days in jail and the period of house arrest with electronic monitoring, continuous alcohol monitoring, or both types of monitoring shall not exceed six months. The ten consecutive days in jail do not have to be served prior to or consecutively to the period of house arrest.

As an alternative to a mandatory jail term of thirty consecutive days required by division (G)(1)(c)(i) of this section, the court, under this division, may sentence the offender to fifteen consecutive days in jail and not less than fifty-five consecutive days of house arrest with electronic monitoring, with continuous alcohol monitoring, or with both electronic monitoring and continuous alcohol monitoring. The cumulative total of the fifteen consecutive days in jail and the period of house arrest with electronic monitoring, continuous alcohol monitoring, or both types of monitoring shall not exceed one year. The fifteen consecutive days in jail do not have to be served prior to or consecutively to the period of house arrest.

As an alternative to the mandatory jail term of sixty consecutive days required by division (G)(1)(c)(ii) of this section, the court, under this division, may sentence the offender to thirty consecutive days in jail and not less than one hundred ten consecutive days of house arrest with electronic monitoring, with continuous alcohol monitoring, or with both electronic monitoring and continuous alcohol monitoring. The cumulative total of the thirty consecutive days in jail and the period of house arrest with electronic monitoring, continuous alcohol monitoring, or both types of monitoring shall not exceed one year. The thirty consecutive days in jail do not have to be served prior to or consecutively to the period of house arrest.

(4) If an offender’s driver’s or occupational driver’s license or permit or nonresident operating privilege is suspended under division (G) of this section and if section 4510.13 of the Revised Code permits the court to grant limited driving privileges, the court may grant the limited driving privileges in accordance with that section. If division (A)(7) of that section requires that the court impose as a condition of the privileges that the offender must display on the vehicle that is driven subject to the privileges restricted license plates that are issued under section 4503.231 of the Revised Code, except as provided in division (B) of that section, the court shall impose that condition as one of the conditions of the limited driving privileges granted to the offender, except as provided in division (B) of section 4503.231 of the Revised Code.

(5) Fines imposed under this section for a violation of division (A) of this section shall be
distributed as follows:

(a) Twenty-five dollars of the fine imposed under division (G)(1)(a)(iii), thirty-five dollars of the fine imposed under division (G)(1)(b)(iii), one hundred twenty-three dollars of the fine imposed under division (G)(1)(c)(iii), and two hundred ten dollars of the fine imposed under division (G)(1)(d)(iii) or (e)(iii) of this section shall be paid to an enforcement and education fund established by the legislative authority of the law enforcement agency in this state that primarily was responsible for the arrest of the offender, as determined by the court that imposes the fine. The agency shall use this share to pay only those costs it incurs in enforcing this section or a municipal OVI ordinance and in informing the public of the laws governing the operation of a vehicle while under the influence of alcohol, the dangers of the operation of a vehicle under the influence of alcohol, and other information relating to the operation of a vehicle under the influence of alcohol and the consumption of alcoholic beverages.

(b) Fifty dollars of the fine imposed under division (G)(1)(a)(iii) of this section shall be paid to the political subdivision that pays the cost of housing the offender during the offender's term of incarceration. If the offender is being sentenced for a violation of division (A)(1)(a), (b), (c), (d), (e), or (j) of this section and was confined as a result of the offense prior to being sentenced for the offense but is not sentenced to a term of incarceration, the fifty dollars shall be paid to the political subdivision that paid the cost of housing the offender during that period of confinement. The political subdivision shall use the share under this division to pay or reimburse incarceration or treatment costs it incurs in housing or providing drug and alcohol treatment to persons who violate this section or a municipal OVI ordinance, costs for any immobilizing or disabling device used on the offender's vehicle, and costs of electronic house arrest equipment needed for persons who violate this section.

(c) Twenty-five dollars of the fine imposed under division (G)(1)(a)(iii) and fifty dollars of the fine imposed under division (G)(1)(b)(iii) of this section shall be deposited into the county or municipal indigent drivers' alcohol treatment fund under the control of that court, as created by the county or municipal corporation under division (F) of section 4511.191 of the Revised Code.

(d) One hundred fifteen dollars of the fine imposed under division (G)(1)(a)(iii), one hundred twenty-five dollars of the fine imposed under division (G)(1)(b)(iii), two hundred fifty dollars of the fine imposed under division (G)(1)(d)(iii), and five hundred dollars of the fine imposed under
division (G)(1)(d)(iii) or (e)(iii) of this section shall be transmitted to the treasurer of state for deposit into the indigent defense support fund established under section 120.08 of the Revised Code.

(g) The balance of the fine imposed under division (G)(1)(a)(iii), (b)(iii), (c)(iii), (d)(iii), or (e)(iii) of this section shall be disbursed as otherwise provided by law.

(6) If title to a motor vehicle that is subject to an order of criminal forfeiture under division (G)(1)(c), (d), or (e) of this section is assigned or transferred and division (B)(2) or (3) of section 4503.234 of the Revised Code applies, in addition to or independent of any other penalty established by law, the court may fine the offender the value of the vehicle as determined by publications of the national automobile dealers association. The proceeds of any fine so imposed shall be distributed in accordance with division (C)(2) of that section.

(7) In all cases in which an offender is sentenced under division (G) of this section, the offender shall provide the court with proof of financial responsibility as defined in section 4509.01 of the Revised Code. If the offender fails to provide that proof of financial responsibility, the court, in addition to any other penalties provided by law, may order restitution pursuant to section 2929.18 or 2929.28 of the Revised Code in an amount not exceeding five thousand dollars for any economic loss arising from an accident or collision that was the direct and proximate result of the offender's operation of the vehicle before, during, or after committing the offense for which the offender is sentenced under division (G) of this section.

(8) A court may order an offender to reimburse a law enforcement agency for any costs incurred by the agency with respect to a chemical test or tests administered to the offender if all of the following apply:

(a) The offender is convicted of or pleads guilty to a violation of division (A) of this section.

(b) The test or tests were of the offender's whole blood, blood serum or plasma, or urine.

(c) The test or tests indicated that the offender had a prohibited concentration of a controlled substance or a metabolite of a controlled substance in the offender's whole blood, blood serum or plasma, or urine at the time of the offense.

(9) As used in division (G) of this section, “electronic monitoring,” “mandatory prison term,” and “mandatory term of local incarceration” have the same meanings as in section 2929.01 of the Revised Code.

(H) Whoever violates division (B) of this section is guilty of operating a vehicle after underage alcohol consumption and shall be punished as follows:

(1) Except as otherwise provided in division (H)(2) of this section, the offender is guilty of a misdemeanor of the fourth degree. In addition to any other sanction imposed for the offense, the court shall impose a class six suspension of the offender’s driver’s license, commercial driver’s license, temporary instruction permit, probationary license, or nonresident operating privilege from the range specified in division (A)(6) of section 4510.02 of the Revised Code. The court may grant limited driving privileges relative to the suspension under sections 4510.021 and 4510.13 of the Revised Code. The court may grant unlimited driving privileges with an ignition interlock device relative to the suspension and may reduce the period of suspension as authorized under section 4510.022 of the Revised Code. If the court grants unlimited driving privileges under section 4510.022 of the Revised Code, the court shall suspend any jail term imposed under division (H)(1) of this section as required under that section.

(2) If, within one year of the offense, the offender previously has been convicted of or pleaded guilty to one or more violations of division (A) or (B) of this section or other equivalent offenses, the offender is guilty of a misdemeanor of the third degree. In addition to any other sanction imposed for the offense, the court shall impose a class four suspension of the offender’s driver’s license, commercial driver’s license, temporary instruction permit, probationary license, or nonresident operating privilege from the range specified in division (A)(4) of section 4510.02 of the Revised Code. The court may grant limited driving privileges
relative to the suspension under sections 4510.021 and 4510.13 of the Revised Code.

(3) If the offender also is convicted of or also pleads guilty to a specification of the type
described in section 2941.1416 of the Revised Code and if the court imposes a jail term for the
violation of division (B) of this section, the court shall impose upon the offender an additional
definite jail term pursuant to division (E) of section 2929.24 of the Revised Code.

(4) The offender shall provide the court with proof of financial responsibility as defined in
section 4509.01 of the Revised Code. If the offender fails to provide that proof of financial
responsibility, then, in addition to any other penalties provided by law, the court may order
restitution pursuant to section 2929.28 of the Revised Code in an amount not exceeding five
thousand dollars for any economic loss arising from an accident or collision that was the direct
and proximate result of the offender's operation of the vehicle before, during, or after committing
the violation of division (B) of this section.

(I)(1) No court shall sentence an offender to an alcohol treatment program under this
section unless the treatment program complies with the minimum standards for alcohol
treatment programs adopted under Chapter 5119 of the Revised Code by the director of mental
health and addiction services.

(2) An offender who stays in a drivers' intervention program or in an alcohol treatment
program under an order issued under this section shall pay the cost of the stay in the program.
However, if the court determines that an offender who stays in an alcohol treatment program
under an order issued under this section is unable to pay the cost of the stay in the program, the
court may order that the cost be paid from the court's indigent drivers' alcohol treatment fund.

(J) If a person whose driver's or commercial driver's license or permit or nonresident
operating privilege is suspended under this section files an appeal regarding any aspect of the
person's trial or sentence, the appeal itself does not stay the operation of the suspension.

(K) Division (A)(1)(j) of this section does not apply to a person who operates a vehicle,
streetcar, or trackless trolley while the person has a concentration of a listed controlled
substance or a listed metabolite of a controlled substance in the person's whole blood, blood
serum or plasma, or urine that equals or exceeds the amount specified in that division, if both of
the following apply:

(1) The person obtained the controlled substance pursuant to a prescription issued by a
licensed health professional authorized to prescribe drugs.

(2) The person injected, ingested, or inhaled the controlled substance in accordance with
the health professional's directions.

(L) The prohibited concentrations of a controlled substance or a metabolite of a
controlled substance listed in division (A)(1)(j) of this section also apply in a prosecution of a
violation of division (D) of section 2923.16 of the Revised Code in the same manner as if the
offender is being prosecuted for a prohibited concentration of alcohol.

(M) All terms defined in section 4510.01 of the Revised Code apply to this section. If the
meaning of a term defined in section 4510.01 of the Revised Code conflicts with the meaning of
the same term as defined in section 4501.01 or 4511.01 of the Revised Code, the term as
defined in section 4510.01 of the Revised Code applies to this section.

(N)(1) The Ohio Traffic Rules in effect on January 1, 2004, as adopted by the supreme
court under authority of section 2937.46 of the Revised Code, do not apply to felony violations
of this section. Subject to division (N)(2) of this section, the Rules of Criminal Procedure apply to
felony violations of this section.

(2) If, on or after January 1, 2004, the supreme court modifies the Ohio Traffic Rules to
provide procedures to govern felony violations of this section, the modified rules shall apply to
felony violations of this section.
4511.191 Consent for substance abuse testing implied by operation of land vehicle; implied consent of dead or unconscious; officer may use reasonable means to ensure test.

(A)(1) As used in this section:
   (a) "Physical control" has the same meaning as in section 4511.194 of the Revised Code.
   (b) "Alcohol monitoring device" means any device that provides for continuous alcohol monitoring, any ignition interlock device, any immobilizing or disabling device other than an ignition interlock device that is constantly available to monitor the concentration of alcohol in a person's system, or any other device that provides for the automatic testing and periodic reporting of alcohol consumption by a person and that a court orders a person to use as a sanction imposed as a result of the person's conviction of or plea of guilty to an offense.
   (c) "Community addiction services provider" has the same meaning as in section 5119.01 of the Revised Code.

(2) Any person who operates a vehicle, streetcar, or trackless trolley upon a highway or any public or private property used by the public for vehicular travel or parking within this state or who is in physical control of a vehicle, streetcar, or trackless trolley shall be deemed to have given consent to a chemical test or tests of the person's whole blood, blood serum or plasma, breath, or urine to determine the alcohol, drug of abuse, controlled substance, metabolite of a controlled substance, or combination content of the person's whole blood, blood serum or plasma, breath, or urine if arrested for a violation of division (A) or (B) of section 4511.19 of the Revised Code, section 4511.194 of the Revised Code or a substantially equivalent municipal ordinance, or a municipal OVI ordinance.

(3) The chemical test or tests under division (A)(2) of this section shall be administered at the request of a law enforcement officer having reasonable grounds to believe the person was operating or in physical control of a vehicle, streetcar, or trackless trolley in violation of a division, section, or ordinance identified in division (A)(2) of this section. The law enforcement agency by which the officer is employed shall designate which of the tests shall be administered.

(4) Any person who is dead or unconscious, or who otherwise is in a condition rendering the person incapable of refusal, shall be deemed to have consented as provided in division (A)(2) of this section, and the test or tests may be administered, subject to sections 313.12 to 313.16 of the Revised Code.

(5)(a) If a law enforcement officer arrests a person for a violation of division (A) or (B) of section 4511.19 of the Revised Code, section 4511.194 of the Revised Code or a substantially equivalent municipal ordinance, or a municipal OVI ordinance and if the person if convicted would be required to be sentenced under division (G)(1)(c), (d), or (e) of section 4511.19 of the Revised Code, the law enforcement officer shall request the person to submit, and the person shall submit, to a chemical test or tests of the person's whole blood, blood serum or plasma, breath, or urine for the purpose of determining the alcohol, drug of abuse, controlled substance, metabolite of a controlled substance, or combination content of the person's whole blood, blood serum or plasma, breath, or urine. A law enforcement officer who makes a request pursuant to this division that a person submit to a chemical test or tests is not required to advise the person of the consequences of submitting to, or refusing to submit to, the test or tests and is not required to give the person the form described in division (B) of section 4511.192 of the Revised Code, but the officer shall advise the person at the time of the arrest that if the person refuses to take a chemical test the officer may employ whatever reasonable means are necessary to ensure that the person submits to a chemical test of the person's whole blood or blood serum or plasma. The officer shall also advise the person at the time of the arrest that the person may have an independent chemical test taken at the person's own expense. Divisions (A)(3) and (4)
(b) If a person refuses to submit to a chemical test upon a request made pursuant to
division (A)(5)(a) of this section, the law enforcement officer who made the request may employ
whatever reasonable means are necessary to ensure that the person submits to a chemical test
of the person's whole blood or blood serum or plasma. A law enforcement officer who acts
pursuant to this division to ensure that a person submits to a chemical test of the person's whole
blood or blood serum or plasma is immune from criminal and civil liability based upon a claim for
assault and battery or any other claim for the acts, unless the officer so acted with malicious
purpose, in bad faith, or in a wanton or reckless manner.

(B)(1) Upon receipt of the sworn report of a law enforcement officer who arrested a
person for a violation of division (A) or (B) of section 4511.19 of the Revised Code, section
4511.194 of the Revised Code or a substantially equivalent municipal ordinance, or a municipal
OVI ordinance that was completed and sent to the registrar of motor vehicles and a court
pursuant to section 4511.192 of the Revised Code in regard to a person who refused to take the
designated chemical test, the registrar shall enter into the registrar's records the fact that the
person's driver's or commercial driver's license or permit or nonresident operating privilege was
suspended by the arresting officer under this division and that section and the period of the
suspension, as determined under this section. The suspension shall be subject to appeal as
provided in section 4511.197 of the Revised Code. The suspension shall be for whichever of the
following periods applies:

(a) Except when division (B)(1)(b), (c), or (d) of this section applies and specifies a
different class or length of suspension, the suspension shall be a class C suspension for the
period of time specified in division (B)(3) of section 4510.02 of the Revised Code.

(b) If the arrested person, within ten years of the date on which the person refused the
request to consent to the chemical test, had refused one previous request to consent to a
chemical test or had been convicted of or pleaded guilty to one violation of division (A) or (B) of
section 4511.19 of the Revised Code or one other equivalent offense, the suspension shall be a
class B suspension imposed for the period of time specified in division (B)(2) of section 4510.02
of the Revised Code.

(c) If the arrested person, within ten years of the date on which the person refused the
request to consent to the chemical test, had refused two previous requests to consent to a
chemical test, had been convicted of or pleaded guilty to two violations of division (A) or (B) of
section 4511.19 of the Revised Code or other equivalent offenses, or had refused one previous
request to consent to a chemical test and also had been convicted of or pleaded guilty to one
violation of division (A) or (B) of section 4511.19 of the Revised Code or other equivalent
offenses, which violation or offense arose from an incident other than the incident that led to the
refusal, the suspension shall be a class A suspension imposed for the period of time specified in
division (B)(1) of section 4510.02 of the Revised Code.

(d) If the arrested person, within ten years of the date on which the person refused the
request to consent to the chemical test, had refused three or more previous requests to consent
to a chemical test, had been convicted of or pleaded guilty to three or more violations of division
(A) or (B) of section 4511.19 of the Revised Code or other equivalent offenses, or had refused a
number of previous requests to consent to a chemical test and also had been convicted of or
pleaded guilty to a number of violations of division (A) or (B) of section 4511.19 of the Revised
Code or other equivalent offenses that cumulatively total three or more such refusals,
convictions, and guilty pleas, the suspension shall be for five years.

(2) The registrar shall terminate a suspension of the driver's or commercial driver's
license or permit of a resident or of the operating privilege of a nonresident, or a denial of a
driver's or commercial driver's license or permit, imposed pursuant to division (B)(1) of this
section upon receipt of notice that the person has entered a plea of guilty to, or that the person
has been convicted after entering a plea of no contest to, operating a vehicle in violation of
section 4511.19 of the Revised Code or in violation of a municipal OVI ordinance, if the offense for which the conviction is had or the plea is entered arose from the same incident that led to the suspension or denial.

The registrar shall credit against any judicial suspension of a person's driver's or commercial driver's license or permit or nonresident operating privilege imposed pursuant to section 4511.19 of the Revised Code, or pursuant to section 4510.07 of the Revised Code for a violation of a municipal OVI ordinance, any time during which the person serves a related suspension imposed pursuant to division (B)(1) of this section.

(C)(1) Upon receipt of the sworn report of the law enforcement officer who arrested a person for a violation of division (A) or (B) of section 4511.19 of the Revised Code or a municipal OVI ordinance that was completed and sent to the registrar and a court pursuant to section 4511.192 of the Revised Code in regard to a person whose test results indicate that the person's whole blood, blood serum or plasma, breath, or urine contained at least the concentration of alcohol specified in division (A)(1)(b), (c), (d), or (e) of section 4511.19 of the Revised Code or at least the concentration of a listed controlled substance or a listed metabolite of a controlled substance specified in division (A)(1)(j) of section 4511.19 of the Revised Code, the registrar shall enter into the registrar's records the fact that the person's driver's or commercial driver's license or permit or nonresident operating privilege was suspended by the arresting officer under this division and section 4511.192 of the Revised Code and the period of the suspension, as determined under divisions (C)(1)(a) to (d) of this section. The suspension shall be subject to appeal as provided in section 4511.197 of the Revised Code. The suspension described in this division does not apply to, and shall not be imposed upon, a person arrested for a violation of section 4511.194 of the Revised Code or a substantially equivalent municipal ordinance who submits to a designated chemical test. The suspension shall be for whichever of the following periods applies:

(a) Except when division (C)(1)(b), (c), or (d) of this section applies and specifies a different period, the suspension shall be a class E suspension imposed for the period of time specified in division (B)(5) of section 4510.02 of the Revised Code.

(b) The suspension shall be a class C suspension for the period of time specified in division (B)(3) of section 4510.02 of the Revised Code if the person has been convicted of or pleaded guilty to, within ten years of the date the test was conducted, one violation of division (A) or (B) of section 4511.19 of the Revised Code or one other equivalent offense.

(c) If, within ten years of the date the test was conducted, the person has been convicted of or pleaded guilty to two violations of a statute or ordinance described in division (C)(1)(b) of this section, the suspension shall be a class B suspension imposed for the period of time specified in division (B)(2) of section 4510.02 of the Revised Code.

(d) If, within ten years of the date the test was conducted, the person has been convicted of or pleaded guilty to more than two violations of a statute or ordinance described in division (C)(1)(b) of this section, the suspension shall be a class A suspension imposed for the period of time specified in division (B)(1) of section 4510.02 of the Revised Code.

(2) The registrar shall terminate a suspension of the driver's or commercial driver's license or permit of a resident or of the operating privilege of a nonresident, or a denial of a driver's or commercial driver's license or permit, imposed pursuant to division (C)(1) of this section upon receipt of notice that the person has entered a plea of guilty to, or that the person has been convicted after entering a plea of no contest to, operating a vehicle in violation of section 4511.19 of the Revised Code or in violation of a municipal OVI ordinance, if the offense for which the conviction is had or the plea is entered arose from the same incident that led to the suspension or denial.

The registrar shall credit against any judicial suspension of a person's driver's or commercial driver's license or permit or nonresident operating privilege imposed pursuant to section 4511.19 of the Revised Code, or pursuant to section 4510.07 of the Revised Code for a
violation of a municipal OVI ordinance, any time during which the person serves a related suspension imposed pursuant to division (C)(1) of this section.

(D)(1) A suspension of a person's driver's or commercial driver's license or permit or nonresident operating privilege under this section for the time described in division (B) or (C) of this section is effective immediately from the time at which the arresting officer serves the notice of suspension upon the arrested person. Any subsequent finding that the person is not guilty of the charge that resulted in the person being requested to take the chemical test or tests under division (A) of this section does not affect the suspension.

(2) If a person is arrested for operating a vehicle, streetcar, or trackless trolley in violation of division (A) or (B) of section 4511.19 of the Revised Code or a municipal OVI ordinance, or for being in physical control of a vehicle, streetcar, or trackless trolley in violation of section 4511.194 of the Revised Code or a substantially equivalent municipal ordinance, regardless of whether the person's driver's or commercial driver's license or permit or nonresident operating privilege is or is not suspended under division (B) or (C) of this section or Chapter 4510 of the Revised Code, the person's initial appearance on the charge resulting from the arrest shall be held within five days of the person's arrest or the issuance of the citation to the person, subject to any continuance granted by the court pursuant to section 4511.197 of the Revised Code regarding the issues specified in that division.

(E) When it finally has been determined under the procedures of this section and sections 4511.192 to 4511.197 of the Revised Code that a nonresident's privilege to operate a vehicle within this state has been suspended, the registrar shall give information in writing of the action taken to the motor vehicle administrator of the state of the person's residence and of any state in which the person has a license.

(F) At the end of a suspension period under this section, under section 4511.194, section 4511.196, or division (G) of section 4511.19 of the Revised Code, or under section 4510.07 of the Revised Code for a violation of a municipal OVI ordinance and upon the request of the person whose driver's or commercial driver's license or permit was suspended and who is not otherwise subject to suspension, cancellation, or disqualification, the registrar shall return the driver's or commercial driver's license or permit to the person upon the occurrence of all of the conditions specified in divisions (F)(1) and (2) of this section:

(1) A showing that the person has proof of financial responsibility, a policy of liability insurance in effect that meets the minimum standards set forth in section 4509.51 of the Revised Code, or proof, to the satisfaction of the registrar, that the person is able to respond in damages in an amount at least equal to the minimum amounts specified in section 4509.51 of the Revised Code.

(2) Subject to the limitation contained in division (F)(3) of this section, payment by the person to the registrar or an eligible deputy registrar of a license reinstatement fee of four hundred seventy-five dollars, which fee shall be deposited in the state treasury and credited as follows:

(a) One hundred twelve dollars and fifty cents shall be credited to the statewide treatment and prevention fund created by section 4301.30 of the Revised Code. Money credited to the fund under this section shall be used for purposes identified under section 5119.22 of the Revised Code.

(b) Seventy-five dollars shall be credited to the reparations fund created by section 2743.191 of the Revised Code.

(c) Thirty-seven dollars and fifty cents shall be credited to the indigent drivers alcohol treatment fund, which is hereby established in the state treasury. The department of mental health and addiction services shall distribute the moneys in that fund to the county indigent drivers alcohol treatment funds, the county juvenile indigent drivers alcohol treatment funds, and the municipal indigent drivers alcohol treatment funds that are required to be established by counties and municipal corporations pursuant to division (H) of this section to be used only as
provided in division (H)(3) of this section. Moneys in the fund that are not distributed to a county indigent drivers alcohol treatment fund, a county juvenile indigent drivers alcohol treatment fund, or a municipal indigent drivers alcohol treatment fund under division (H) of this section because the director of mental health and addiction services does not have the information necessary to identify the county or municipal corporation where the offender or juvenile offender was arrested may be transferred by the director of budget and management to the statewide treatment and prevention fund created by section 4301.30 of the Revised Code, upon certification of the amount by the director of mental health and addiction services.

(d) Seventy-five dollars shall be credited to the opportunities for Ohioans with disabilities agency established by section 3304.15 of the Revised Code, to the services for rehabilitation fund, which is hereby established. The fund shall be used to match available federal matching funds where appropriate, and for any other purpose or program of the agency to rehabilitate persons with disabilities to help them become employed and independent.

(e) Seventy-five dollars shall be deposited into the state treasury and credited to the drug abuse resistance education programs fund, which is hereby established, to be used by the attorney general for the purposes specified in division (F)(4) of this section.

(f) Thirty dollars shall be credited to the public safety--highway purposes fund created by section 4501.06 of the Revised Code.

(g) Twenty dollars shall be credited to the trauma and emergency medical services fund created by section 4513.263 of the Revised Code.

(h) Fifty dollars shall be credited to the indigent drivers interlock and alcohol monitoring fund, which is hereby established in the state treasury. Moneys in the fund shall be distributed by the department of public safety to the county indigent drivers interlock and alcohol monitoring funds, the county juvenile indigent drivers interlock and alcohol monitoring funds, and the municipal indigent drivers interlock and alcohol monitoring funds that are required to be established by counties and municipal corporations pursuant to this section, and shall be used only to pay the cost of an immobilizing or disabling device, including a certified ignition interlock device, or an alcohol monitoring device used by an offender or juvenile offender who is ordered to use the device by a county, juvenile, or municipal court judge and who is determined by the county, juvenile, or municipal court judge not to have the means to pay for the person's use of the device.

(3) If a person's driver's or commercial driver's license or permit is suspended under this section, under section 4511.196 or division (G) of section 4511.19 of the Revised Code, under section 4510.07 of the Revised Code for a violation of a municipal OVI ordinance or under any combination of the suspensions described in division (F)(3) of this section, and if the suspensions arise from a single incident or a single set of facts and circumstances, the person is liable for payment of, and shall be required to pay to the registrar or an eligible deputy registrar, only one reinstatement fee of four hundred seventy-five dollars. The reinstatement fee shall be distributed by the bureau in accordance with division (F)(2) of this section.

(4) The attorney general shall use amounts in the drug abuse resistance education programs fund to award grants to law enforcement agencies to establish and implement drug abuse resistance education programs in public schools. Grants awarded to a law enforcement agency under this section shall be used by the agency to pay for not more than fifty per cent of the amount of the salaries of law enforcement officers who conduct drug abuse resistance education programs in public schools. The attorney general shall not use more than six per cent of the amounts the attorney general's office receives under division (F)(2)(e) of this section to pay the costs it incurs in administering the grant program established by division (F)(2)(e) of this section and in providing training and materials relating to drug abuse resistance education programs.

The attorney general shall report to the governor and the general assembly each fiscal year on the progress made in establishing and implementing drug abuse resistance education
programs. These reports shall include an evaluation of the effectiveness of these programs.

(5) In addition to the reinstatement fee under this section, if the person pays the reinstatement fee to a deputy registrar, the deputy registrar shall collect a service fee of ten dollars to compensate the deputy registrar for services performed under this section. The deputy registrar shall retain eight dollars of the service fee and shall transmit the reinstatement fee, plus two dollars of the service fee, to the registrar in the manner the registrar shall determine.

(G) Suspension of a commercial driver's license under division (B) or (C) of this section shall be concurrent with any period of disqualification under section 3123.611 or 4506.16 of the Revised Code or any period of suspension under section 3123.58 of the Revised Code. No person who is disqualified for life from holding a commercial driver's license under section 4506.16 of the Revised Code shall be issued a driver's license under Chapter 4507 of the Revised Code during the period for which the commercial driver's license was suspended under division (B) or (C) of this section. No person whose commercial driver's license is suspended under division (B) or (C) of this section shall be issued a driver's license under Chapter 4507 of the Revised Code during the period of the suspension.

(H)(1) Each county shall establish an indigent drivers alcohol treatment fund and a juvenile indigent drivers alcohol treatment fund. Each municipal corporation in which there is a municipal court shall establish an indigent drivers alcohol treatment fund. All revenue that the general assembly appropriates to the indigent drivers alcohol treatment fund for transfer to a county indigent drivers alcohol treatment fund, a county juvenile indigent drivers alcohol treatment fund, or a municipal indigent drivers alcohol treatment fund, all portions of fees that are paid under division (F) of this section and that are credited under that division to the indigent drivers alcohol treatment fund in the state treasury for a county indigent drivers alcohol treatment fund, a county juvenile indigent drivers alcohol treatment fund, or a municipal indigent drivers alcohol treatment fund, all portions of additional costs imposed under section 2949.094 of the Revised Code that are specified for deposit into a county, county juvenile, or municipal indigent drivers alcohol treatment fund by that section, and all portions of fines that are specified for deposit into a county or municipal indigent drivers alcohol treatment fund by section 4511.193 of the Revised Code shall be deposited into that county indigent drivers alcohol treatment fund, county juvenile indigent drivers alcohol treatment fund, or municipal indigent drivers alcohol treatment fund. The portions of the fees paid under division (F) of this section that are to be so deposited shall be determined in accordance with division (H)(2) of this section. Additionally, all portions of fines that are paid for a violation of section 4511.19 or any prohibition contained in Chapter 4510 of the Revised Code to be deposited into a county indigent drivers alcohol treatment fund or municipal indigent drivers alcohol treatment fund shall be deposited into the appropriate fund in accordance with the applicable division of the section or provision.

(2) That portion of the license reinstatement fee that is paid under division (F) of this section and that is credited under that division to the indigent drivers alcohol treatment fund shall be deposited into a county indigent drivers alcohol treatment fund, a county juvenile indigent drivers alcohol treatment fund, or a municipal indigent drivers alcohol treatment fund as follows:

(a) Regarding a suspension imposed under this section, that portion of the fee shall be deposited as follows:

(i) If the fee is paid by a person who was charged in a county court with the violation that resulted in the suspension or in the imposition of the court costs, the portion shall be deposited into the county indigent drivers alcohol treatment fund under the control of that court;

(ii) If the fee is paid by a person who was charged in a juvenile court with the violation that resulted in the suspension or in the imposition of the court costs, the portion shall be
deposited into the county juvenile indigent drivers alcohol treatment fund established in the county served by the court;

(iii) If the fee is paid by a person who was charged in a municipal court with the violation that resulted in the suspension or in the imposition of the court costs, the portion shall be deposited into the municipal indigent drivers alcohol treatment fund under the control of that court.

(b) Regarding a suspension imposed under section 4511.19 of the Revised Code or under section 4510.07 of the Revised Code for a violation of a municipal OVI ordinance, that portion of the fee shall be deposited as follows:

(i) If the fee is paid by a person whose license or permit was suspended by a county court, the portion shall be deposited into the county indigent drivers alcohol treatment fund under the control of that court;

(ii) If the fee is paid by a person whose license or permit was suspended by a municipal court, the portion shall be deposited into the municipal indigent drivers alcohol treatment fund under the control of that court.

(3) (a) As used in division (H)(3) of this section, “indigent person” means a person who is convicted of a violation of division (A) or (B) of section 4511.19 of the Revised Code or a substantially similar municipal ordinance or found to be a juvenile traffic offender by reason of a violation of division (A) or (B) of section 4511.19 of the Revised Code or a substantially similar municipal ordinance, who is ordered by the court to attend an alcohol and drug addiction treatment program, and who is determined by the court under division (H)(5) of this section to be unable to pay the cost of the assessment or the cost of attendance at the treatment program.

(b) A county, juvenile, or municipal court judge, by order, may make expenditures from a county indigent drivers alcohol treatment fund, a county juvenile indigent drivers alcohol treatment fund, or a municipal indigent drivers alcohol treatment fund with respect to an indigent person for any of the following:

(i) To pay the cost of an assessment that is conducted by an appropriately licensed clinician at either a driver intervention program that is certified under section 5119.38 of the Revised Code or at a community addiction services provider whose alcohol and drug addiction services are certified under section 5119.36 of the Revised Code;

(ii) To pay the cost of alcohol addiction services, drug addiction services, or integrated alcohol and drug addiction services at a community addiction services provider whose alcohol and drug addiction services are certified under section 5119.36 of the Revised Code;

(iii) To pay the cost of transportation to attend an assessment as provided under division (H)(3)(b)(i) of this section or addiction services as provided under division (H)(3)(b)(ii) of this section.

The alcohol and drug addiction services board or the board of alcohol, drug addiction, and mental health services established pursuant to section 340.02 or 340.021 of the Revised Code and serving the alcohol, drug addiction, and mental health service district in which the court is located shall administer the indigent drivers alcohol treatment program of the court.

When a court orders an offender or juvenile traffic offender to obtain an assessment or attend an alcohol and drug addiction treatment program, the board shall determine which program is suitable to meet the needs of the offender or juvenile traffic offender, and when a suitable program is located and space is available at the program, the offender or juvenile traffic offender shall attend the program designated by the board. A reasonable amount not to exceed five per cent of the amounts credited to and deposited into the county indigent drivers alcohol treatment fund, the county juvenile indigent drivers alcohol treatment fund, or the municipal indigent drivers alcohol treatment fund serving every court whose program is administered by that board shall be paid to the board to cover the costs it incurs in administering those indigent drivers alcohol treatment programs.

(c) Upon exhaustion of moneys in the indigent drivers interlock and alcohol monitoring
fund for the use of an alcohol monitoring device, a county, juvenile, or municipal court judge may use moneys in the county indigent drivers alcohol treatment fund, county juvenile indigent drivers alcohol treatment fund, or municipal indigent drivers alcohol treatment fund in either of the following manners:

(i) If the source of the moneys was an appropriation of the general assembly, a portion of a fee that was paid under division (F) of this section, a portion of a fine that was specified for deposit into the fund by section 4511.193 of the Revised Code, or a portion of a fine that was paid for a violation of section 4511.19 of the Revised Code or of a provision contained in Chapter 4510 of the Revised Code that was required to be deposited into the fund, to pay for the continued use of an alcohol monitoring device by an offender or juvenile traffic offender, in conjunction with a treatment program approved by the department of mental health and addiction services, when such use is determined clinically necessary by the treatment program and when the court determines that the offender or juvenile traffic offender is unable to pay all or part of the daily monitoring or cost of the device;

(ii) If the source of the moneys was a portion of an additional court cost imposed under section 2949.094 of the Revised Code, to pay for the continued use of an alcohol monitoring device by an offender or juvenile traffic offender when the court determines that the offender or juvenile traffic offender is unable to pay all or part of the daily monitoring or cost of the device. The moneys may be used for a device as described in this division if the use of the device is in conjunction with a treatment program approved by the department of mental health and addiction services, when the use of the device is determined clinically necessary by the treatment program, but the use of a device is not required to be in conjunction with a treatment program approved by the department in order for the moneys to be used for the device as described in this division.

(4) If a county, juvenile, or municipal court determines, in consultation with the alcohol and drug addiction services board or the board of alcohol, drug addiction, and mental health services established pursuant to section 340.02 or 340.021 of the Revised Code and serving the alcohol, drug addiction, and mental health district in which the court is located, that the funds in the county indigent drivers alcohol treatment fund, the county juvenile indigent drivers alcohol treatment fund, or the municipal indigent drivers alcohol treatment fund under the control of the court are more than sufficient to satisfy the purpose for which the fund was established, as specified in divisions (H)(1) to (3) of this section, the court may declare a surplus in the fund. If the court declares a surplus in the fund, the court may take any of the following actions with regard to the amount of the surplus in the fund:

(a) Expend any of the surplus amount for alcohol and drug abuse assessment and treatment, and for the cost of transportation related to assessment and treatment, of persons who are charged in the court with committing a criminal offense or with being a delinquent child or juvenile traffic offender and in relation to whom both of the following apply:

(i) The court determines that substance abuse was a contributing factor leading to the criminal or delinquent activity or the juvenile traffic offense with which the person is charged.

(ii) The court determines that the person is unable to pay the cost of the alcohol and drug abuse assessment and treatment for which the surplus money will be used.

(b) Expend any of the surplus amount to pay all or part of the cost of purchasing alcohol monitoring devices to be used in conjunction with division (H)(3)(c) of this section, upon exhaustion of moneys in the indigent drivers interlock and alcohol monitoring fund for the use of an alcohol monitoring device.

(c) Transfer to another court in the same county any of the surplus amount to be utilized in a manner consistent with division (H)(3) of this section. If surplus funds are transferred to another court, the court that transfers the funds shall notify the alcohol and drug addiction services board or the board of alcohol, drug addiction, and mental health services that serves the alcohol, drug addiction, and mental health service district in which that court is located.
(d) Transfer to the alcohol and drug addiction services board or the board of alcohol, drug addiction, and mental health services that serves the alcohol, drug addiction, and mental health service district in which the court is located any of the surplus amount to be utilized in a manner consistent with division (H)(3) of this section or for board contracted recovery support services.

(5) In order to determine if an offender does not have the means to pay for the offender's attendance at an alcohol and drug addiction treatment program for purposes of division (H)(3) of this section or if an alleged offender or delinquent child is unable to pay the costs specified in division (H)(4) of this section, the court shall use the indigent client eligibility guidelines and the standards of indigency established by the state public defender to make the determination.

(6) The court shall identify and refer any community addiction services provider that intends to provide alcohol and drug addiction services and has not had its alcohol and drug addiction services certified under section 5119.36 of the Revised Code and that is interested in receiving amounts from the surplus in the fund declared under division (H)(4) of this section to the department of mental health and addiction services in order for the community addiction services provider to have its alcohol and drug addiction services certified by the department. The department shall keep a record of applicant referrals received pursuant to this division and shall submit a report on the referrals each year to the general assembly. If a community addiction services provider interested in having its alcohol and drug addiction services certified makes an application pursuant to section 5119.36 of the Revised Code, the community addiction services provider is eligible to receive surplus funds as long as the application is pending with the department. The department of mental health and addiction services must offer technical assistance to the applicant. If the interested community addiction services provider withdraws the certification application, the department must notify the court, and the court shall not provide the interested community addiction services provider with any further surplus funds.

(7)(a) Each alcohol and drug addiction services board and board of alcohol, drug addiction, and mental health services established pursuant to section 340.02 or 340.021 of the Revised Code shall submit to the department of mental health and addiction services an annual report for each indigent drivers alcohol treatment fund in that board's area.

(b) The report, which shall be submitted not later than sixty days after the end of the state fiscal year, shall provide the total payment that was made from the fund, including the number of indigent consumers that received treatment services and the number of indigent consumers that received an alcohol monitoring device. The report shall identify the treatment program and expenditure for an alcohol monitoring device for which that payment was made. The report shall include the fiscal year balance of each indigent drivers alcohol treatment fund located in that board's area. In the event that a surplus is declared in the fund pursuant to division (H)(4) of this section, the report also shall provide the total payment that was made from the surplus moneys and identify the authorized purpose for which that payment was made.

(c) If a board is unable to obtain adequate information to develop the report to submit to the department for a particular indigent drivers alcohol treatment fund, the board shall submit a report detailing the effort made in obtaining the information.

(I)(1) Each county shall establish an indigent drivers interlock and alcohol monitoring fund and a juvenile indigent drivers interlock and alcohol treatment fund. Each municipal corporation in which there is a municipal court shall establish an indigent drivers interlock and alcohol monitoring fund. All revenue that the general assembly appropriates to the indigent drivers interlock and alcohol monitoring fund for transfer to a county indigent drivers interlock and alcohol monitoring fund, a county juvenile indigent drivers interlock and alcohol monitoring fund, or a municipal indigent drivers interlock and alcohol monitoring fund, all portions of license reinstatement fees that are paid under division (F)(2) of this section and that are credited under that division to the indigent drivers interlock and alcohol monitoring fund in the state treasury, and all portions of fines that are paid under division (G) of section 4511.19 of the Revised Code
and that are credited by division (G)(5)(e) of that section to the indigent drivers interlock and alcohol monitoring fund in the state treasury shall be deposited in the appropriate fund in accordance with division (I)(2) of this section.

(2) That portion of the license reinstatement fee that is paid under division (F) of this section and that portion of the fine paid under division (G) of section 4511.19 of the Revised Code and that is credited under either division to the indigent drivers interlock and alcohol monitoring fund shall be deposited into a county indigent drivers interlock and alcohol monitoring fund, a county juvenile indigent drivers interlock and alcohol monitoring fund, or a municipal indigent drivers interlock and alcohol monitoring fund as follows:

(a) If the fee or fine is paid by a person who was charged in a county court with the violation that resulted in the suspension or fine, the portion shall be deposited into the county indigent drivers interlock and alcohol monitoring fund under the control of that court.

(b) If the fee or fine is paid by a person who was charged in a juvenile court with the violation that resulted in the suspension or fine, the portion shall be deposited into the county juvenile indigent drivers interlock and alcohol monitoring fund established in the county served by the court.

(c) If the fee or fine is paid by a person who was charged in a municipal court with the violation that resulted in the suspension, the portion shall be deposited into the municipal indigent drivers interlock and alcohol monitoring fund under the control of that court.

(3) If a county, juvenile, or municipal court determines that the funds in the county indigent drivers interlock and alcohol monitoring fund, the county juvenile indigent drivers interlock and alcohol monitoring fund, or the municipal indigent drivers interlock and alcohol monitoring fund under the control of that court are more than sufficient to satisfy the purpose for which the fund was established as specified in division (F)(2)(h) of this section, the court may declare a surplus in the fund. The court then may order the transfer of a specified amount into the county indigent drivers alcohol treatment fund, the county juvenile indigent drivers alcohol treatment fund, or the municipal indigent drivers alcohol treatment fund under the control of that court to be utilized in accordance with division (H) of this section.

Part III. Peer Review and Immunity

2305.24 Confidentiality.

Any information, data, reports, or records made available to a quality assurance committee or utilization committee of a hospital or long-term care facility or of any not-for-profit health care corporation that is a member of the hospital or long-term care facility or of which the hospital or long-term care facility is a member are confidential and shall be used by the committee and the committee members only in the exercise of the proper functions of the committee. Any information, data, reports, or records made available to a utilization committee of a state or local medical society composed of doctors of medicine or doctors of osteopathic medicine are confidential and shall be used by the committee and the committee members only in the exercise of the proper functions of the committee. A right of action similar to that a patient may have against an attending physician for misuse of information, data, reports, or records arising out of the physician-patient relationship shall accrue against a member of a quality assurance committee or utilization committee for misuse of any information, data, reports, or records furnished to the committee by an attending physician. No physician, institution, hospital, or long-term care facility furnishing information, data, reports, or records to a committee with respect to any patient examined or treated by the physician or confined in the institution, hospital, or long-term care facility shall, by reason of the furnishing, be deemed liable in damages to any person, or be held to answer for betrayal of a professional confidence within
the meaning and intent of section 4731.22 of the Revised Code. Information, data, or reports furnished to a utilization committee of a state or local medical society shall contain no name of any person involved therein.

Any information, data, reports, or records made available to a quality assurance committee of the bureau of workers' compensation or the industrial commission that is responsible for reviewing the professional qualifications and the performance of providers conducting medical examinations or file reviews for the bureau or the commission are confidential and shall be used by the committee and the committee members only in the exercise of the proper functions of the committee.

As used in this section, “utilization committee” is the committee established to administer a utilization review plan of a hospital, of a not-for-profit health care corporation which is a member of the hospital or of which the hospital is a member, or of a skilled nursing facility as provided in the “Health Insurance for the Aged Act,” 79 Stat. 313 (1965), 42 U.S.C. 1395x(k).

2305.25 Peer review committees; definitions.

As used in this section and sections 2305.251 to 2305.253 of the Revised Code:

(A)(1) “Health care entity” means an entity, whether acting on its own behalf or on behalf of or in affiliation with other health care entities, that conducts as part of its regular business activities professional credentialing or quality review activities involving the competence of, professional conduct of, or quality of care provided by health care providers, including both individuals who provide health care and entities that provide health care.

(2) “Health care entity” includes any entity described in division (A)(1) of this section, regardless of whether it is a government entity; for-profit or nonprofit corporation; limited liability company; partnership; professional corporation; state or local society composed of physicians, dentists, optometrists, psychologists, or pharmacists; accountable care organization; other health care organization; or combination of any of the foregoing entities.

(B) “Health insuring corporation” means an entity that holds a certificate of authority under Chapter 1751 of the Revised Code. “Health insuring corporation” includes wholly owned subsidiaries of a health insuring corporation.

(C) “Hospital” means any of the following:

(1) An institution that has been registered or licensed by the department of health as a hospital;

(2) An entity, other than an insurance company authorized to do business in this state, that owns, controls, or is affiliated with an institution that has been registered or licensed by the department of health as a hospital;

(3) A group of hospitals that are owned, sponsored, or managed by a single entity.

(D) “Incident report or risk management report” means a report of an incident involving injury or potential injury to a patient as a result of patient care provided by health care providers, including both individuals who provide health care and entities that provide health care, that is prepared by or for the use of a peer review committee of a health care entity and is within the scope of the functions of that committee.

(E)(1) “Peer review committee” means a utilization review committee, quality assessment committee, performance improvement committee, tissue committee, credentialing committee, or other committee that does either of the following:

(a) Conducts professional credentialing or quality review activities involving the competence of, professional conduct of, or quality of care provided by health care providers, including both individuals who provide health care and entities that provide health care;

(b) Conducts any other attendant hearing process initiated as a result of a peer review committee’s recommendations or actions.

(2) “Peer review committee” includes all of the following:
(a) A peer review committee of a hospital or long-term care facility or a peer review committee of a nonprofit health care corporation that is a member of the hospital or long-term care facility or of which the hospital or facility is a member;
(b) A peer review committee of a community mental health center;
(c) A board or committee of a hospital, a long-term care facility, or other health care entity when reviewing professional qualifications or activities of health care providers, including both individuals who provide health care and entities that provide health care;
(d) A peer review committee, professional standards review committee, or arbitration committee of a state or local society composed of members who are in active practice as physicians, dentists, optometrists, psychologists, or pharmacists;
(e) A peer review committee of a health insuring corporation that has at least a two-thirds majority of member physicians in active practice and that conducts professional credentialing and quality review activities involving the competence or professional conduct of health care providers that adversely affects or could adversely affect the health or welfare of any patient;
(f) A peer review committee of a health insuring corporation that has at least a two-thirds majority of member physicians in active practice and that conducts professional credentialing and quality review activities involving the competence or professional conduct of a health care facility that has contracted with the health insuring corporation to provide health care services to enrollees, which conduct adversely affects, or could adversely affect, the health or welfare of any patient;
(g) A peer review committee of a sickness and accident insurer that has at least a two-thirds majority of physicians in active practice and that conducts professional credentialing and quality review activities involving the competence or professional conduct of health care providers that adversely affects or could adversely affect the health or welfare of any patient;
(h) A peer review committee of a sickness and accident insurer that has at least a two-thirds majority of physicians in active practice and that conducts professional credentialing and quality review activities involving the competence or professional conduct of a health care facility that has contracted with the insurer to provide health care services to insureds, which conduct adversely affects, or could adversely affect, the health or welfare of any patient;
(i) A peer review committee of any insurer authorized under Title XXXIX of the Revised Code to do the business of medical professional liability insurance in this state that conducts professional quality review activities involving the competence or professional conduct of health care providers that adversely affects or could affect the health or welfare of any patient;
(j) A peer review committee of the bureau of workers' compensation or the industrial commission that is responsible for reviewing the professional qualifications and the performance of providers certified by the bureau to participate in the health partnership program or of providers conducting medical examinations or file reviews for the bureau or the commission;
(k) Any other peer review committee of a health care entity.

(F) "Physician" means an individual authorized to practice medicine and surgery, osteopathic medicine and surgery, or podiatric medicine and surgery.
(G) "Sickness and accident insurer" means an entity authorized under Title XXXIX of the Revised Code to do the business of sickness and accident insurance in this state.
(H) "Tort action" means a civil action for damages for injury, death, or loss to a patient of a health care entity. "Tort action" includes a product liability claim, as defined in section 2307.71 of the Revised Code, and an asbestos claim, as defined in section 2307.91 of the Revised Code, but does not include a civil action for a breach of contract or another agreement between persons.
(I) "Accountable care organization" means such an organization as defined in 42 C.F.R. 425.20.
Chapter 7. Liability, Police, Peer Review, and Health Information Exchange
Part III. Peer Review and Immunity

2305.251 Immunity; presumption of no negligence in credentialing.

(A) No health care entity shall be liable in damages to any person for any acts, omissions, decisions, or other conduct within the scope of the functions of a peer review committee of the health care entity. No individual who is a member of or works for or on behalf of a peer review committee of a health care entity shall be liable in damages to any person for any acts, omissions, decisions, or other conduct within the scope of the functions of the peer review committee.

(B)(1) A hospital shall be presumed to not be negligent in the credentialing of an individual who has, or has applied for, staff membership or professional privileges at the hospital pursuant to section 3701.351 of the Revised Code, and a health insuring corporation or sickness and accident insurer shall be presumed to not be negligent in the credentialing of an individual who is, or has applied to be, a participating provider with the health insuring corporation or sickness and accident insurer, if the hospital, health insuring corporation, or sickness and accident insurer proves by a preponderance of the evidence that, at the time of the alleged negligent credentialing of the individual, the hospital, health insuring corporation, or sickness and accident insurer was accredited by one of the following:

(a) The joint commission on accreditation of healthcare organizations;
(b) The American osteopathic association;
(c) The national committee for quality assurance;
(d) The utilization review accreditation commission.

(2) The presumption that a hospital, health insuring corporation, or sickness and accident insurer is not negligent as provided in division (B)(1) of this section may be rebutted only by proof, by a preponderance of the evidence, of any of the following:

(a) The credentialing and review requirements of the accrediting organization did not apply to the hospital, health insuring corporation, sickness and accident insurer, the individual, or the type of professional care that is the basis of the claim against the hospital, health insuring corporation, or sickness and accident insurer.
(b) The hospital, health insuring corporation, or sickness and accident insurer failed to comply with all material credentialing and review requirements of the accrediting organization that applied to the individual.
(c) The hospital, health insuring corporation, or sickness and accident insurer, through its medical staff executive committee or its governing body and sufficiently in advance to take appropriate action, knew that a previously competent individual had developed a pattern of incompetence or otherwise inappropriate behavior, either of which indicated that the individual's staff membership, professional privileges, or participation as a provider should have been limited or terminated prior to the individual's provision of professional care to the plaintiff.
(d) The hospital, health insuring corporation, or sickness and accident insurer, through its medical staff executive committee or its governing body and sufficiently in advance to take appropriate action, knew that a previously competent individual would provide fraudulent medical treatment but failed to limit or terminate the individual's staff membership, professional privileges, or participation as a provider prior to the individual's provision of professional care to the plaintiff.

(3) If the plaintiff fails to rebut the presumption provided in division (B)(1) of this section, upon the motion of the hospital, health insuring corporation, or sickness and accident insurer, the court shall enter judgment in favor of the hospital, health insuring corporation, or sickness and accident insurer on the claim of negligent credentialing.

(C) Nothing in this section otherwise shall relieve any individual or health care entity from liability arising from treatment of an individual. Nothing in this section shall be construed as creating an exception to section 2305.252 of the Revised Code.

(D) No person who provides information under this section without malice and in the
reasonable belief that the information is warranted by the facts known to the person shall be subject to suit for civil damages as a result of providing the information.

2305.252 Peer review committee confidentiality.

(A) Proceedings and records within the scope of a peer review committee of a health care entity shall be held in confidence and shall not be subject to discovery or introduction in evidence in any civil action against a health care entity or health care provider, including both individuals who provide health care and entities that provide health care, arising out of matters that are the subject of evaluation and review by the peer review committee. No individual who attends a meeting of a peer review committee, serves as a member of a peer review committee, works for or on behalf of a peer review committee, or provides information to a peer review committee shall be permitted or required to testify in any civil action as to any evidence or other matters produced or presented during the proceedings of the peer review committee or as to any finding, recommendation, evaluation, opinion, or other action of the committee or a member thereof.

Information, documents, or records otherwise available from original sources are not to be construed as being unavailable for discovery or for use in any civil action merely because they were produced or presented during proceedings of a peer review committee, but the information, documents, or records are available only from the original sources and cannot be obtained from the peer review committee's proceedings or records.

The release of any information, documents, or records that were produced or presented during proceedings of a peer review committee or created to document the proceedings does not affect the confidentiality of any other information, documents, or records produced or presented during those proceedings or created to document them. Only the information, documents, or records actually released cease to be privileged under this section.

Nothing in this section precludes health care entities from sharing information, documents, or records that were produced or presented during proceedings of a peer review committee or created to document them as long as the information, documents, or records are used only for peer review purposes.

An individual who testifies before a peer review committee, serves as a representative of a peer review committee, serves as a member of a peer review committee, works for or on behalf of a peer review committee, or provides information to a peer review committee shall not be prevented from testifying as to matters within the individual's knowledge, but the individual cannot be asked about the individual's testimony before the peer review committee, information the individual provided to the peer review committee, or any opinion the individual formed as a result of the peer review committee's activities.

An order by a court to produce for discovery or for use at trial the proceedings or records described in this section is a final order.

(B) Division (A) of this section applies to a peer review committee of the bureau of workers' compensation that is responsible for reviewing the professional qualifications and the performance of providers certified by the bureau to participate in the health partnership program created under sections 4121.44 and 4121.441 of the Revised Code, except that the proceedings and records within the scope of the peer review committee are subject to discovery or court subpoena and may be admitted into evidence in any criminal action or administrative or civil action initiated, prosecuted, or adjudicated by the bureau involving an alleged violation of applicable statutes or administrative rules. The bureau may share proceedings and records within the scope of the peer review committee, including claimant records and claim file information, with law enforcement agencies, licensing boards, and other governmental agencies that are prosecuting, adjudicating, or investigating alleged violations of applicable statutes or administrative rules. If the bureau shares proceedings or records with a law enforcement
agency, licensing board, or another governmental agency pursuant to this division, that sharing does not affect the confidentiality of the record. Recipients of claimant records and claim file information provided by the bureau pursuant to this division shall take appropriate measures to maintain the confidentiality of the information.

2305.253 Confidentiality; incident report.

(A) Notwithstanding any contrary provision of section 149.43, 1751.21, 2305.24, 2305.25, 2305.251, 2305.252, or 2305.28 of the Revised Code, an incident report or risk management report and the contents of an incident report or risk management report are not subject to discovery in, and are not admissible in evidence in the trial of, a tort action. An individual who prepares or has knowledge of the contents of an incident report or risk management report shall not testify and shall not be required to testify in a tort action as to the contents of the report.

(B)(1) Except as specified in division (A) of this section, this section does not affect any provision of section 149.43, 1751.21, 2305.24, 2305.25, 2305.251, 2305.252, or 2305.28 of the Revised Code that describes, imposes, or confers any of the following:

(a) An immunity from tort or other civil liability;
(b) A forfeiture of an immunity from tort or other civil liability;
(c) A requirement of confidentiality;
(d) A limitation on the use of information, data, reports, or records;
(e) Tort or other civil liability;
(f) A limitation on discovery of matter, introduction into evidence of matter, or testimony pertaining to matter in a tort or other civil action.

(2) Divisions (A) and (B)(1) of this section do not prohibit or limit the discovery or admissibility of testimony or evidence relating to patient care that is within an individual’s personal knowledge.

(3) Divisions (A) and (B)(1) and (2) of this section do not affect a privileged communication between an attorney and the attorney’s client as described in section 2317.02 of the Revised Code.

2305.28 Committee, nonprofit and professional association immunity.

(A) As used in this section, “counseling and assistance committee” means a committee of a professional organization whose purpose is to render counseling and assistance to members of the profession whose personal or professional lives are or reasonably appear to be impaired by reason of substance abuse, chemical dependency, or mental illness.

(B) No member or employee of a peer review committee, professional standards review committee, or counseling and assistance committee of a state or local professional organization composed of doctors of chiropractic, doctors of veterinary medicine, attorneys at law, real estate brokers, architects, professional engineers, certified public accountants, public accountants, or registered nurses is liable to any person for any action taken or recommendation made within the scope of the functions of the committee, if the committee member or employee acts without malice and in the reasonable belief that the action or recommendation is warranted by the facts known to him after reasonable effort to obtain the facts of the matter as to which the action is taken or recommendation is made.

(C) Division (B) of this section also shall apply to any member or employee of a nonprofit corporation that is engaged in performing the functions of a peer review committee, professional standards review committee, or counseling and assistance committee of a state or local professional organization composed of doctors of chiropractic, doctors of veterinary medicine, attorneys at law, real estate brokers, architects, professional engineers, certified public
accountants, public accountants, or registered nurses.  

(D) No person who provides information to a peer review committee, professional standards review committee, or counseling and assistance committee of a state or local professional organization as described in division (B) of this section, to a nonprofit corporation as described in division (C) of this section, or to a member or employee of such a peer review committee, professional standards review committee, counseling and assistance committee, or nonprofit corporation, without malice and in the reasonable belief that the information is warranted by the facts known to him is liable in damages in a civil action as a result of providing that information.

Part IV. Medical Records and Health Information Exchange

173.20 Access to records; employee designations; legal powers.

(A) If consent is given and unless otherwise prohibited by law, a representative of the office of the state long-term care ombudsman program shall have access to any records, including medical records, of a resident or a recipient that are reasonably necessary for investigation of a complaint. Consent may be given in any of the following ways:

1. In writing by the resident or recipient;
2. Orally by the resident or recipient, witnessed in writing at the time it is given by one other person;
3. In writing by the guardian of the resident or recipient;
4. In writing by the attorney in fact of the resident or recipient, if the resident or recipient has authorized the attorney in fact to give such consent;
5. In writing by the executor or administrator of the estate of a deceased resident or recipient.

(B) If consent to access to records is not refused by a resident or recipient or the resident's or recipient's legal representative but cannot be obtained and any of the following circumstances exist, a representative of the office of the state long-term care ombudsman program, on approval of the state long-term care ombudsman, may inspect the records of a resident or a recipient, including medical records, that are reasonably necessary for investigation of a complaint:

1. The resident or recipient is unable to express written or oral consent and there is no guardian or attorney in fact;
2. There is a guardian or attorney in fact, but the guardian or attorney in fact cannot be contacted within three working days;
3. There is a guardianship or durable power of attorney, but its existence is unknown by the long-term care provider and the representative of the office at the time of the investigation;
4. There is no executor or administrator of the estate of a deceased resident or recipient.

(C) If a representative of the office of the state long-term care ombudsman program has been refused access to records by a guardian or attorney in fact, but has reasonable cause to believe that the guardian or attorney in fact is not acting in the best interests of the resident or recipient, the representative may, on approval of the state long-term care ombudsman, inspect the records of the resident or recipient, including medical records, that are reasonably necessary for investigation of a complaint.

(D) A representative of the office of the state long-term care ombudsman program shall have access to any records of a long-term care provider reasonably necessary to an investigation conducted under this section, including but not limited to: incident reports, dietary records, policies and procedures of a facility required to be maintained under section 5165.06 of
the Revised Code, admission agreements, staffing schedules, any document depicting the actual staffing pattern of the provider, any financial records that are matters of public record, resident council and grievance committee minutes, and any waiting list maintained by a facility in accordance with section 5165.08 of the Revised Code, or any similar records or lists maintained by a provider of community-based long-term care services. Pursuant to division (E) of this section, a representative shall be permitted to make or obtain copies of any of these records after giving the long-term care provider twenty-four hours' notice. A long-term care provider may impose a charge for providing copies of records under this division that does not exceed the actual and necessary expense of making the copies.

(E) Each long-term care provider shall designate one or more of its employees to be responsible for releasing records for copying to representatives of the office of the state long-term care ombudsman program who request permission to make or obtain copies of records specified in division (D) of this section. In the event that a designated employee is not available when a representative of the office makes the request, the long-term care provider shall designate another employee to release the records for copying.

(F) A long-term care provider or any employee of such a provider is immune from civil or criminal liability or action taken pursuant to a professional disciplinary procedure for the release or disclosure of records to a representative of the office pursuant to this section.

(G) A state or local government agency or entity with records relevant to a complaint or investigation being conducted by a representative of the office shall provide the representative access to the records.

(H) The state ombudsman, with the approval of the director of aging, may issue a subpoena to compel any person the ombudsman reasonably believes may be able to provide information to appear before the ombudsman or the ombudsman's designee and give sworn testimony and to produce documents, books, records, papers, or other evidence the state ombudsman believes is relevant to the investigation. On the refusal of a witness to be sworn or to answer any question put to the witness, or if a person disobeys a subpoena, the ombudsman shall apply to the Franklin county court of common pleas for a contempt order, as in the case of disobedience of the requirements of a subpoena issued from the court, or a refusal to testify in the court.

(I) The state ombudsman may petition the court of common pleas in the county in which a long-term care facility is located to issue an injunction against any long-term care facility in violation of sections 3721.10 to 3721.17 of the Revised Code.

(J) To the extent permitted by federal law, a representative of the office may report to an appropriate authority any suspected violation of state law discovered during the course of an advocacy visit or investigation.

(K) The department of aging shall adopt rules in accordance with Chapter 119 of the Revised Code for referral by the state ombudsman and regional long-term care ombudsman programs of complaints to other public agencies or entities. A public agency or entity to which a complaint is referred shall keep the state ombudsman or regional program handling the complaint advised and notified in writing in a timely manner of the disposition of the complaint to the extent permitted by law.

3701.74 Patient or representative’s access to medical records; timing.

(A) As used in this section and section 3701.741 of the Revised Code:

1. “Ambulatory care facility” means a facility that provides medical, diagnostic, or surgical treatment to patients who do not require hospitalization, including a dialysis center, ambulatory surgical facility, cardiac catheterization facility, diagnostic imaging center, extracorporeal shock wave lithotripsy center, home health agency, inpatient hospice, birthing center, radiation therapy center, emergency facility, and an urgent care center. “Ambulatory
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"care facility" does not include the private office of a physician or dentist, whether the office is for an individual or group practice.

(2) "Chiropractor" means an individual licensed under Chapter 4734 of the Revised Code to practice chiropractic.

(3) "Emergency facility" means a hospital emergency department or any other facility that provides emergency medical services.

(4) "Health care practitioner" means all of the following:
   (a) A dentist or dental hygienist licensed under Chapter 4715 of the Revised Code;
   (b) A registered or licensed practical nurse licensed under Chapter 4723 of the Revised Code;
   (c) An optometrist licensed under Chapter 4725 of the Revised Code;
   (d) A dispensing optician, spectacle dispensing optician, contact lens dispensing optician, or spectacle-contact lens dispensing optician licensed under Chapter 4725 of the Revised Code;
   (e) A pharmacist licensed under Chapter 4729 of the Revised Code;
   (f) A physician;
   (g) A physician assistant authorized under Chapter 4730 of the Revised Code to practice as a physician assistant;
   (h) A practitioner of a limited branch of medicine issued a certificate under Chapter 4731 of the Revised Code;
   (i) A psychologist licensed under Chapter 4732 of the Revised Code;
   (j) A chiropractor;
   (k) A hearing aid dealer or fitter licensed under Chapter 4747 of the Revised Code;
   (l) A speech-language pathologist or audiologist licensed under Chapter 4753 of the Revised Code;
   (m) An occupational therapist or occupational therapy assistant licensed under Chapter 4755 of the Revised Code;
   (n) A physical therapist or physical therapy assistant licensed under Chapter 4755 of the Revised Code;
   (o) A licensed professional clinical counselor, licensed professional counselor, social worker, independent social worker, independent marriage and family therapist, or marriage and family therapist licensed, or a social work assistant registered, under Chapter 4757 of the Revised Code;
   (p) A dietitian licensed under Chapter 4759 of the Revised Code;
   (q) A respiratory care professional licensed under Chapter 4761 of the Revised Code;
   (r) An emergency medical technician-basic, emergency medical technician-intermediate, or emergency medical technician-paramedic certified under Chapter 4765 of the Revised Code.

(5) "Health care provider" means a hospital, ambulatory care facility, long-term care facility, pharmacy, emergency facility, or health care practitioner.

(6) "Hospital" has the same meaning as in section 3727.01 of the Revised Code.

(7) "Long-term care facility" means a nursing home, residential care facility, or home for the aging, as those terms are defined in section 3721.01 of the Revised Code; a residential facility licensed under section 5119.34 of the Revised Code that provides accommodations, supervision, and personal care services for three to sixteen unrelated adults; a nursing facility, as defined in section 5165.01 of the Revised Code; a skilled nursing facility, as defined in section 5165.01 of the Revised Code; and an intermediate care facility for individuals with intellectual disabilities, as defined in section 5124.01 of the Revised Code.

(8) "Medical record" means data in any form that pertains to a patient's medical history, diagnosis, prognosis, or medical condition and that is generated and maintained by a health care provider in the process of the patient's health care treatment.

(9) "Medical records company" means a person who stores, locates, or copies medical
records for a health care provider, or is compensated for doing so by a health care provider, and charges a fee for providing medical records to a patient or patient's representative.

(10) “Patient” means either of the following:
   (a) An individual who received health care treatment from a health care provider;
   (b) A guardian, as defined in section 1337.11 of the Revised Code, of an individual described in division (A)(10)(a) of this section.

(11) “Patient's personal representative” means a minor patient's parent or other person acting in loco parentis, a court-appointed guardian, or a person with durable power of attorney for health care for a patient, the executor or administrator of the patient's estate, or the person responsible for the patient's estate if it is not to be probated. “Patient's personal representative” does not include an insurer authorized under Title XXXIX of the Revised Code to do the business of sickness and accident insurance in this state, a health insuring corporation holding a certificate of authority under Chapter 1751 of the Revised Code, or any other person not named in this division.

(12) “Pharmacy” has the same meaning as in section 4729.01 of the Revised Code.

(13) “Physician” means a person authorized under Chapter 4731 of the Revised Code to practice medicine and surgery, osteopathic medicine and surgery, or podiatric medicine and surgery.

(14) “Authorized person” means a person to whom a patient has given written authorization to act on the patient's behalf regarding the patient's medical record.

(B) A patient, a patient's personal representative, or an authorized person who wishes to examine or obtain a copy of part or all of a medical record shall submit to the health care provider a written request signed by the patient, personal representative, or authorized person dated not more than one year before the date on which it is submitted. The request shall indicate whether the copy is to be sent to the requestor, physician or chiropractor, or held for the requestor at the office of the health care provider. Within a reasonable time after receiving a request that meets the requirements of this division and includes sufficient information to identify the record requested, a health care provider that has the patient's medical records shall permit the patient to examine the record during regular business hours without charge or, on request, shall provide a copy of the record in accordance with section 3701.741 of the Revised Code, except that if a physician, psychologist, licensed professional clinical counselor, licensed professional counselor, independent social worker, social worker, independent marriage and family therapist, marriage and family therapist, or chiropractor who has treated the patient determines for clearly stated treatment reasons that disclosure of the requested record is likely to have an adverse effect on the patient, the health care provider shall provide the record to a physician, psychologist, licensed professional clinical counselor, licensed professional counselor, independent social worker, social worker, independent marriage and family therapist, marriage and family therapist, or chiropractor designated by the patient. The health care provider shall take reasonable steps to establish the identity of the person making the request to examine or obtain a copy of the patient's record.

(C) If a health care provider fails to furnish a medical record as required by division (B) of this section, the patient, personal representative, or authorized person who requested the record may bring a civil action to enforce the patient's right of access to the record.

(D)(1) This section does not apply to medical records whose release is covered by section 173.20 or 3721.13 of the Revised Code, by Chapter 1347., 5119., or 5122 of the Revised Code, by 42 C.F.R. part 2, “Confidentiality of Alcohol and Drug Abuse Patient Records,” or by 42 C.F.R. 483.10.

(2) Nothing in this section is intended to supersede the confidentiality provisions of sections 2305.24, 2305.25, 2305.251, and 2305.252 of the Revised Code.
3701.741 Medical record copying fees.

(A) Each health care provider and medical records company shall provide copies of medical records in accordance with this section.

(B) Except as provided in divisions (C) and (E) of this section, a health care provider or medical records company that receives a request for a copy of a patient's medical record shall charge not more than the amounts set forth in this section.

(1) If the request is made by the patient or the patient's personal representative, total costs for copies and all services related to those copies shall not exceed the sum of the following:

(a) Except as provided in division (B)(1)(b) of this section, with respect to data recorded on paper or electronically, the following amounts adjusted in accordance with section 3701.742 of the Revised Code:
   (i) Two dollars and seventy-four cents per page for the first ten pages;
   (ii) Fifty-seven cents per page for pages eleven through fifty;
   (iii) Twenty-three cents per page for pages fifty-one and higher;

(b) With respect to data resulting from an x-ray, magnetic resonance imaging (MRI), or computed axial tomography (CAT) scan and recorded on paper or film, one dollar and eighty-seven cents per page;

(c) The actual cost of any related postage incurred by the health care provider or medical records company.

(2) If the request is made other than by the patient or the patient's personal representative, total costs for copies and all services related to those copies shall not exceed the sum of the following:

(a) An initial fee of sixteen dollars and eighty-four cents adjusted in accordance with section 3701.742 of the Revised Code, which shall compensate for the records search;

(b) Except as provided in division (B)(2)(c) of this section, with respect to data recorded on paper or electronically, the following amounts adjusted in accordance with section 3701.742 of the Revised Code:
   (i) One dollar and eleven cents per page for the first ten pages;
   (ii) Fifty-seven cents per page for pages eleven through fifty;
   (iii) Twenty-three cents per page for pages fifty-one and higher.

(c) With respect to data resulting from an x-ray, magnetic resonance imaging (MRI), or computed axial tomography (CAT) scan and recorded on paper or film, one dollar and eighty-seven cents per page;

(d) The actual cost of any related postage incurred by the health care provider or medical records company.

(C)(1) On request, a health care provider or medical records company shall provide one copy of the patient's medical record and one copy of any records regarding treatment performed subsequent to the original request, not including copies of records already provided, without charge to the following:

(a) The bureau of workers' compensation, in accordance with Chapters 4121 and 4123 of the Revised Code and the rules adopted under those chapters;

(b) The industrial commission, in accordance with Chapters 4121 and 4123 of the Revised Code and the rules adopted under those chapters;

(c) The department of medicaid or a county department of job and family services, in accordance with Chapters 5160., 5161., 5162., 5163., 5164., 5165., 5166., and 5167 of the Revised Code and the rules adopted under those chapters;

(d) The attorney general, in accordance with sections 2743.51 to 2743.72 of the Revised Code and any rules that may be adopted under those sections;
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(e) A patient, patient's personal representative, or authorized person if the medical record is necessary to support a claim under Title II or Title XVI of the “Social Security Act,” 49 Stat. 620 (1935), 42 U.S.C.A. 401 and 1381, as amended, and the request is accompanied by documentation that a claim has been filed.

(2) Nothing in division (C)(1) of this section requires a health care provider or medical records company to provide a copy without charge to any person or entity not listed in division (C)(1) of this section.

(D) Division (C) of this section shall not be construed to supersede any rule of the bureau of workers' compensation, the industrial commission, or the department of medicaid.

(E) A health care provider or medical records company may enter into a contract with either of the following for the copying of medical records at a fee other than as provided in division (B) of this section:

(1) A patient, a patient's personal representative, or an authorized person;

(2) An insurer authorized under Title XXXIX of the Revised Code to do the business of sickness and accident insurance in this state or health insuring corporations holding a certificate of authority under Chapter 1751 of the Revised Code.

(F) This section does not apply to medical records the copying of which is covered by section 173.20 of the Revised Code or by 42 C.F.R. 483.10.

3701.742 Adjustment of fees for medical records based on Consumer Price Index.

The amounts specified in division (B) of section 3701.741 of the Revised Code shall be adjusted annually in accordance with this section. These amounts plus any amounts previously computed by annual adjustments made under this section shall be increased or decreased by the average percentage of increase or decrease in the consumer price index for all urban consumers (United States city average, all items), prepared by the United States department of labor, bureau of labor statistics, for the immediately preceding calendar year over the calendar year immediately preceding that year, as reported by the bureau. The director of health shall make this determination and adjust the amounts accordingly. The director shall make a list of the adjusted amounts available to the public on the internet web site maintained by the department of health.

3701.75 Electronic signature system requirements.

(A) As used in this section:

(1) "Electronic record" means a record communicated, received, or stored by electronic, magnetic, optical, or similar means for storage in an information system or transmission from one information system to another. "Electronic record" includes a record that is communicated, received, or stored by electronic data interchange, electronic mail, facsimile, telex, or similar methods of communication.

(2) "Electronic signature" means any of the following attached to or associated with an electronic record by an individual to authenticate the record:

(a) A code consisting of a combination of letters, numbers, characters, or symbols that is adopted or executed by an individual as that individual's electronic signature;

(b) A computer-generated signature code created for an individual;

(c) An electronic image of an individual's handwritten signature created by using a pen computer.

(3) "Health care record" means any document or combination of documents pertaining to a patient's medical history, diagnosis, prognosis, or medical condition that is generated and maintained in the process of the patient's treatment.

(B) All notes, orders, and observations entered into a health care record, including any
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interpretive reports of diagnostic tests or specific treatments, such as radiologic or electrocardiographic reports, operative reports, reports of pathologic examination of tissue, and similar reports, shall be authenticated by the individual who made or authorized the entry. An entry into a health care record may be authenticated by executing handwritten signatures or handwritten initials directly on the entry. An entry that is an electronic record may be authenticated by an electronic signature if all of the following apply:

1. The entity responsible for creating and maintaining the health care record adopts a policy that permits the use of electronic signatures on electronic records.
2. The entity’s electronic signature system utilizes either a two-level access control mechanism that assigns a unique identifier to each user or a biometric access control device.
3. The entity takes steps to safeguard against unauthorized access to the system and forgery of electronic signatures.
4. The system includes a process to verify that the individual affixing the electronic signature has reviewed the contents of the entry and determined that the entry contains what that individual intended.
5. The policy adopted by the entity pursuant to division (B)(1) of this section prescribes all of the following:
   a. A procedure by which each user of the system must certify in writing that the user will follow the confidentiality and security policies maintained by the entity for the system;
   b. Penalties for misusing the system;
   c. Training for all users of the system that includes an explanation of the appropriate use of the system and the consequences for not complying with the entity’s confidentiality and security policies.

3798.01 Health information exchange; definitions.

As used in this chapter:

A. “Administrative safeguards,” “physical safeguards,” and “technical safeguards” have the same meanings as in 45 C.F.R. 164.304.
B. “Approved health information exchange” means a health information exchange that has been approved or reapproved by the medicaid director pursuant to the approval or reapproval process, as applicable, the director establishes in rules adopted under division (A) of section 3798.15 of the Revised Code or that has been certified by the office of the national coordinator for health information technology in the United States department of health and human services.
C. “Covered entity,” “disclosure,” “health care provider,” “health information,” “individually identifiable health information,” “protected health information,” and “use” have the same meanings as in 45 C.F.R. 160.103.
D. “Designated record set” has the same meaning as in 45 C.F.R. 164.501.
E. “Direct exchange” means the activity of electronic transmission of health information through a direct connection between the electronic record systems of health care providers without the use of a health information exchange.
F. “Health care component” and “hybrid entity” have the same meanings as in 45 C.F.R. 164.103.
G. “Health information exchange” means any person or governmental entity that provides in this state a technical infrastructure to connect computer systems or other electronic devices used by covered entities to facilitate the secure transmission of health information.
H. “Health information exchange” excludes health care providers engaged in direct exchange, including direct exchange through the use of a health information service provider.
I. “HIPAA privacy rule” means the standards for privacy of individually identifiable health information in 45 C.F.R. part 160 and in 45 C.F.R. part 164, subparts A and E.
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(I) “Interoperability” means the capacity of two or more information systems to exchange information in an accurate, effective, secure, and consistent manner.

(J) “Minor” means an unemancipated person under eighteen years of age or a mentally or physically disabled person under twenty-one years of age who meets criteria specified in rules adopted by the medicaid director under section 3798.13 of the Revised Code.

(K) “More stringent” has the same meaning as in 45 C.F.R. 160.202.

(L) “Office of health transformation” means the office of health transformation created by executive order 2011-02K or a successor governmental entity responsible for health system oversight in this state.

(M) “Personal representative” means a person who has authority under applicable law to make decisions related to health care on behalf of an adult or emancipated minor, or the parent, legal guardian, or other person acting in loco parentis who is authorized under law to make health care decisions on behalf of an unemancipated minor. “Personal representative” does not include the parent or legal guardian of, or another person acting in loco parentis to, a minor who consents to the minor’s own receipt of health care or a minor who makes medical decisions on the minor’s own behalf pursuant to law, court approval, or because the minor’s parent, legal guardian, or other person acting in loco parentis has assented to an agreement of confidentiality between the provider and the minor.

(N) “Political subdivision” means a municipal corporation, township, county, school district, or other body corporate and politic responsible for governmental activities in a geographic area smaller than that of the state.

(O) “State agency” means any one or more of the following:
(1) The department of administrative services;
(2) The department of aging;
(3) The department of mental health and addiction services;
(4) The department of developmental disabilities;
(5) The department of education;
(6) The department of health;
(7) The department of insurance;
(8) The department of job and family services;
(9) The department of medicaid;
(10) The department of rehabilitation and correction;
(11) The department of youth services;
(12) The bureau of workers’ compensation;
(13) The opportunities for Ohioans with disabilities agency;
(14) The office of the attorney general;
(15) A health care licensing board created under Title XLVII of the Revised Code that possesses individually identifiable health information.

3798.02 HIPAA privacy rule is Ohio law.

It is the intent of the general assembly in enacting this chapter to make the laws of this state governing the use and disclosure of protected health information by covered entities consistent with, but generally not more stringent than, the HIPAA privacy rule for the purpose of eliminating barriers to the adoption and use of electronic health records and health information exchanges. Therefore, it is also the general assembly’s intent in enacting this chapter to supersede any judicial or administrative ruling issued in this state that is inconsistent with the provisions of this chapter.
3798.03 Covered entity’s duty.

(A) Subject to division (B) of this section, a covered entity shall do both of the following:
(1) If an individual’s protected health information is maintained by the covered entity in a designated record set, provide the individual or the individual’s personal representative with access to that information in a manner consistent with 45 C.F.R. 164.524;
(2) Implement and maintain appropriate administrative, technical, and physical safeguards to protect the privacy of protected health information in a manner consistent with 45 C.F.R. 164.530(c).

(B) If a covered entity is a hybrid entity, this section applies only to the health care component of the covered entity.

3798.06 Covered entity prohibitions.

Except in the circumstances described in division (A) of section 3798.04 of the Revised Code when a covered entity is permitted to disclose protected health information without an authorization that is valid under 45 C.F.R. 164.508, a covered entity shall not disclose protected health information to a health information exchange without an authorization described in division (A) of section 3798.04 of the Revised Code unless all of the following are true:
(A) The disclosure is to an approved health information exchange.
(B) The covered entity is a party to a valid participation agreement with the approved health information exchange that meets the requirements of rules adopted under section 3798.16 of the Revised Code.
(C) The disclosure is consistent with all procedures established by the approved health information exchange.
(D) Prior to the disclosure, the covered entity furnishes to the individual or individual’s personal representative a written notice that complies with rules adopted under division (A)(3) of section 3798.16 of the Revised Code.

3798.07 Protected health information disclosed to health information exchange.

(A) In addition to a covered entity generally being subject to the conditions specified in divisions (A) to (D) of section 3798.06 of the Revised Code when the covered entity discloses protected health information to a health information exchange without a valid authorization, the covered entity shall also be subject to the following conditions when it discloses protected health information to a health information exchange:
(1) The covered entity shall restrict disclosure consistent with all applicable federal laws governing the disclosure;
(2) If the protected health information concerns a minor, the covered entity shall restrict disclosure in a manner that complies with laws of this state pertaining to the circumstances under which a minor may consent to the minor’s own receipt of health care or make medical decisions on the minor’s own behalf, including sections 2907.29, 3709.241, 3719.012, 5120.172, 5122.04, and 5126.043 of the Revised Code unless the minor authorizes the disclosure.
(3) The covered entity shall restrict disclosure in a manner that is consistent with a written request from the individual or the individual’s personal representative to restrict disclosure of all of the individual’s protected health information.
(4) The covered entity shall restrict disclosure in a manner that is consistent with a written request from the individual or the individual’s personal representative concerning specific categories of protected health information to the extent that rules adopted pursuant to section 3798.16 of the Revised Code require the covered entity to comply with such a request.
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(B) The conditions in division (A) of this section on a covered entity’s disclosure of protected health information to a health information exchange do not render unenforceable or restrict in any manner any of the following:

(1) A provision of the Revised Code that on the effective date of this section requires a person or governmental entity to disclose protected health information to a state agency, political subdivision, or other governmental entity;

(2) The confidential status of proceedings and records within the scope of a peer review committee of a health care entity as described in section 2305.252 of the Revised Code;

(3) The confidential status of quality assurance program activities and quality assurance records as described in section 5122.32 of the Revised Code;

(4) The testimonial privilege established by division (B) of section 2317.02 of the Revised Code;

(5) Any of the following items that govern the confidentiality, privacy, security, or privileged status of protected health information in the possession or custody of an agency as defined in section 111.15 of the Revised Code; govern the process for obtaining from a patient consent to the provision of health care or consent for participation in medical or other scientific research; govern the process for determining whether an adult has a physical or mental impairment or an adult's capacity to make health care decisions for purposes of Chapter 5126 of the Revised Code; or govern the process for determining whether a minor has been emancipated:

(a) A section of the Revised Code that is not in this chapter;
(b) A rule as defined in section 119.01 of the Revised Code;
(c) An internal management rule as defined in section 111.15 of the Revised Code;
(d) Guidance issued by an agency as defined in section 111.15 of the Revised Code;
(e) Orders or regulations of a board of health of a city health district made under section 3709.20 of the Revised Code;
(f) Orders or regulations of a board of health of a general health district made under section 3709.21 of the Revised Code;
(g) An ordinance or resolution adopted by a political subdivision;
(h) A professional code of ethics;
(i) When a minor is authorized to consent to the minor's own receipt of health care or make medical decisions on the minor's own behalf, including the circumstances described in sections 2907.29, 3709.241, 3719.012, 5120.172, 5122.04, and 5126.043 of the Revised Code.

3798.08 Health information exchange; limited immunity.

(A) A covered entity that accesses protected health information from or through an approved health information exchange or discloses protected health information to an approved health information exchange in a manner that complies with section 3798.07 of the Revised Code and is not in violation of section 3798.04 or 3798.06 of the Revised Code is not liable in a civil action and is not subject to criminal prosecution or professional disciplinary action arising out of or relating to the access or disclosure.

(B) An approved health information exchange is not liable in a civil action and not subject to criminal prosecution arising out of or relating to either of the following:

(1) A covered entity's having accessed protected health information from or through an approved health information exchange;

(2) A covered entity's disclosure of protected health information to the approved health information exchange if the disclosure complies with section 3798.07 of the Revised Code and is not in violation of section 3798.04 or 3798.06 of the Revised Code.
4113.23 Employer obtains medical records on employee; availability to employee; exception; penalty.

(A) No employer or physician, other health care professional, hospital, or laboratory that contracts with the employer to provide medical information pertaining to employees shall refuse upon written request of an employee to furnish to the employee or former employee or their designated representative a copy of any medical report pertaining to the employee. The requirements of this section extend to any medical report arising out of any physical examination by a physician or other health care professional and any hospital or laboratory tests which examinations or tests are required by the employer as a condition of employment or arising out of any injury or disease related to the employee’s employment. However, if a physician concludes that presentation of all or any part of an employee’s medical record directly to the employee will result in serious medical harm to the employee, he shall so indicate on the medical record, in which case a copy thereof shall be given to a physician designated in writing by the employee.

(B) The employer may require the employee to pay the cost of furnishing copies of the medical reports described in division (A) of this section but in no case shall the employer charge more than twenty-five cents for each page of a report.

(C) As used in this section, “employer” has the same meaning as contained in the definition of that term found in section 4123.01 of the Revised Code.

(D) Any employer who refuses to furnish the reports to which an employee is entitled is guilty of a minor misdemeanor for each violation. The bureau of workers' compensation shall enforce this section.
Chapter 8. Mental Health

Part I. Mental Health Advance Directive

2135.01 Mental health advance directive; definitions.

As used in sections 2135.01 to 2135.14 of the Revised Code:
(A) "Adult" means a person who is eighteen years of age or older.
(B) "Capacity to consent to mental health treatment decisions" means the functional
ability to understand information about the risks of, benefits of, and alternatives to the proposed
mental health treatment, to rationally use that information, to appreciate how that information
applies to the declarant, and to express a choice about the proposed treatment.
(C) "Declarant" means an adult who has executed a declaration for mental health
treatment in accordance with this chapter.
(D) "Declaration for mental health treatment" or "declaration" means a written document
declaring preferences or instructions regarding mental health treatment executed in accordance
with this chapter.
(E) "Designated physician" means the physician the declarant has named in a
declaration for mental health treatment and has assigned the primary responsibility for the
declarant's mental health treatment or, if the declarant has not so named a physician, the
physician who has accepted that responsibility.
(F) "Guardian" means a person appointed by a probate court pursuant to Chapter 2111
of the Revised Code to have the care and management of the person of an incompetent.
(G) "Health care" means any care, treatment, service, or procedure to maintain,
diagnose, or treat an individual's physical or mental condition or physical or mental health.
(H) "Health care facility" has the same meaning as in section 1337.11 of the Revised
Code.
(I) "Incompetent" has the same meaning as in section 2111.01 of the Revised Code.
(J) "Informed consent" means consent voluntarily given by a person after a sufficient
explanation and disclosure of the subject matter involved to enable that person to have a
general understanding of the nature, purpose, and goal of the treatment or procedures,
including the substantial risks and hazards inherent in the proposed treatment or procedures
and any alternative treatment or procedures, and to make a knowing health care decision
without coercion or undue influence.
(K) "Medical record" means any document or combination of documents that pertains to
a declarant's medical history, diagnosis, prognosis, or medical condition and that is generated
and maintained in the process of the declarant's health care.
(L) "Mental health treatment" means any care, treatment, service, or procedure to
maintain, diagnose, or treat an individual's mental condition or mental health, including, but not
limited to, electroconvulsive or other convulsive treatment, treatment of mental illness with
medication, and admission to and retention in a health care facility.
(M) "Mental health treatment decision" means informed consent, refusal to give informed
consent, or withdrawal of informed consent to mental health treatment.
(N) "Mental health treatment provider" means physicians, physician assistants,
psychologists, licensed independent social workers, licensed professional clinical counselors,
and psychiatric nurses.
(O) "Physician" means a person who is authorized under Chapter 4731 of the Revised
Code to practice medicine and surgery or osteopathic medicine and surgery.
(P) "Professional disciplinary action" means action taken by the board or other entity that
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regulates the professional conduct of health care personnel, including, but not limited to, the state medical board, the state board of psychology, and the state board of nursing.

(Q) "Proxy" means an adult designated to make mental health treatment decisions for a declarant under a valid declaration for mental health treatment.

(S) "Psychiatrist" has the same meaning as in section 5122.01 of the Revised Code.

(T) "Psychologist" has the same meaning as in section 4732.01 of the Revised Code.

(U) "Registered nurse" has the same meaning as in section 4723.01 of the Revised Code.

(V) "Tort action" means a civil action for damages for injury, death, or loss to person or property, other than a civil action for damages for a breach of contract or another agreement between persons.

2135.02 Mental health treatment declaration.

(A) An adult who has the capacity to consent to mental health treatment decisions voluntarily may execute at any time a declaration governing the use or continuation, or the withholding or withdrawal, of mental health treatment. The declaration shall be signed at the end by the declarant, state the date of its execution, and either be witnessed or be acknowledged in accordance with section 2135.06 of the Revised Code. The declaration may include a designation by the declarant of a person to act as a proxy to make decisions regarding mental health treatment pursuant to the declaration, and, if the declaration includes a designation of a proxy, the declaration shall be signed at the end by the designated proxy. The declarant may also specifically designate in the declaration an alternate proxy to act in that role if the original proxy is unable or unwilling to act at any time, and, if the declaration includes a designation of an alternate proxy, the declaration shall be signed at the end by the designated alternate proxy. The declarant may name in the declaration a physician and assign the physician the primary responsibility for the declarant's mental health treatment. The declaration may include a specific authorization for the use or continuation, or the withholding or withdrawal, of mental health treatment.

(B) A mental health treatment provider or a health care facility providing services to a declarant shall continue to obtain the declarant's informed consent to all mental health treatment decisions if the declarant has the capacity to consent to mental health treatment decisions.

2135.03 Declaration validity and revocation.

(A) Except as otherwise provided in this division and subject to division (C) of this section, a declaration for mental health treatment remains valid and effective for three years after its execution unless it is properly revoked. A declaration for mental health treatment may become operative as provided in section 2135.04 of the Revised Code. If the declaration becomes operative, the authority of a proxy named in the declaration continues in effect as long as the declaration designating the proxy is in effect or until the proxy has withdrawn. If a declaration for mental health treatment has become operative and is in effect at the expiration of three years after its execution, the declaration remains effective until the declarant has the capacity to consent to mental health treatment decisions. If a declaration for mental health treatment has not become operative at the expiration of three years after its execution, the declaration may be renewed as provided in division (C)(1) of this section or remains effective as provided in division (C)(2) of this section.

(B) A valid declaration may be revoked in accordance with section 2135.09 of the Revised Code or renewed in accordance with division (C) (1) of this section, but it shall not otherwise be altered or amended after it has been executed. A properly executed declaration is not revoked or invalidated by an alteration of or amendment to the declaration. Any alteration of
or amendment to the declaration is not a part of the declaration.

(C)(1) A declarant may renew a declaration once, extending the validity of the document for an additional three-year period from the date of the renewal, by repeating the procedures set forth in section 2135.06 of the Revised Code, if the declarant has included in the declaration a specific authorization for the use or continuation, or the withholding or withdrawal, of mental health treatment, and the declarant makes no change with respect to that authorization. A declarant shall not make any changes to any term or provision of the declaration when renewing under division (C)(1) of this section.

(2) A declaration for mental health treatment that has not become operative at the expiration of three years after its execution remains effective if both of the following apply:
   (a) The declaration designates a proxy or an alternate proxy.
   (b) The declarant does not include in the declaration a specific authorization for the use or continuation, or the withholding or withdrawal, of mental health treatment.

2135.04 Effect and operation of declaration.

(A) A declaration becomes operative when both of the following apply:
   (1) The declaration is communicated to a mental health treatment provider of the declarant.
   (2) The designated physician or a psychiatrist, and one other mental health treatment provider, who examine the declarant determine that the declarant does not have the capacity to consent to mental health treatment decisions. At least one of the two persons who make this determination shall not currently be involved in the declarant's treatment at the time of the determination. If a designated physician is named in the declaration and is not one of the two persons who make this determination, then the psychiatrist who makes the determination in lieu of the designated physician shall make a good faith effort to consult with the designated physician as soon as practicable.

(B) A mental health treatment provider for a declarant or a health care facility providing services to a declarant shall make a declaration part of the declarant's medical record and shall note in that record when the declaration is operative.

(C) A mental health treatment provider for a declarant or a health care facility providing services to a declarant shall act in accordance with an operative declaration of the declarant consistent with reasonable medical practice, the availability of treatments requested, and applicable law. The mental health treatment provider or the health care facility shall continue to act in accordance with an operative declaration until the declarant has the capacity to consent to mental health treatment decisions.

(D) An operative declaration of a declarant supersedes any general consent to treatment form signed by the declarant prior to, upon, or after the declarant’s admission to a health care facility to the extent there is a conflict between the declaration and the form, even if the declarant signs the form after the execution of the declaration. To the extent that the provisions of a declarant’s declaration and a general consent to treatment form signed by the declarant do not conflict, both documents shall govern the use or continuation, or the withholding or withdrawal, of mental health treatment for the declarant. This division does not apply if a declarant revokes a declaration after the declarant signs a general consent to treatment form.

2135.05 Proxies.

(A) A declaration may designate an adult to act as a proxy to make decisions about the mental health treatment of the declarant and may designate an adult as an alternate proxy as described in section 2135.02 of the Revised Code. A proxy designated to make decisions about mental health treatment may make decisions about mental health treatment on behalf of the
declarant only when the declaration has become operative. The decisions of the proxy regarding the mental health treatment of the declarant must be consistent with desires the declarant has expressed in the declaration.

(B) The following persons may not serve as a proxy for a declarant:
1. The declarant's mental health treatment provider, or an employee of the declarant's mental health treatment provider;
2. The owner, operator, or employee of a health care facility in which the declarant is a patient receiving its services or a resident.

(C) Divisions (B)(1) and (2) of this section do not apply if the declarant and proxy are related by blood, marriage, or adoption.

(D) A proxy may withdraw from a declaration prior to the declaration becoming operative by giving notice to the declarant. If the declaration is operative, a proxy may withdraw by giving written notice to the declarant's mental health treatment provider or the health care facility providing services to the declarant. The mental health treatment provider or the health care facility shall note the withdrawal of a proxy as part of the declarant's medical record.

2135.06 Declaration requirements.

(A) A declaration for mental health treatment is valid only if it is signed by the declarant, states the date of its execution, and is either witnessed by two adults or acknowledged before a notary public.

If a proxy, or a proxy and an alternate proxy, have been designated in the declaration, then each proxy also shall sign the declaration, and the signature of each proxy shall be either witnessed by two adults or acknowledged before a notary public, except that, notwithstanding these requirements, both of the following apply:
1. No declaration shall be invalid or be held invalid because a proxy has not signed the declaration.
2. If a proxy has not signed the declaration, or if the signature of a proxy named in a valid declaration is not either witnessed by two adults or acknowledged before a notary public, then the designation of the proxy is invalid, but the declaration is not invalid because of the absence of a witnessed or acknowledged signature of a proxy.

(B) If witnessed for purposes of this section, a declaration shall be witnessed by two individuals as described in this division in whose presence the declarant and each designated proxy signs the declaration. Each witness shall subscribe the witness' signature after the signature of the declarant and, by doing so, attest to the witness' belief that the declarant appears to be of sound mind and not under or subject to duress, fraud, or undue influence. The signatures of the declarant and any proxy under this section and of the witnesses under this division are not required to appear on the same page of the declaration.

(C) If acknowledged for purposes of this section, a declaration shall be acknowledged before a notary public, who shall make the certification described in section 147.53 of the Revised Code and also shall attest that the declarant and each designated proxy appear to be of sound mind and not under or subject to duress, fraud, or undue influence.

(D) The following may not serve as a witness to the signing of a declarant's declaration:
1. The declarant's mental health treatment provider or a relative or employee of the declarant's mental health treatment provider;
2. The owner, the operator, or a relative or employee of an owner or operator of a health care facility in which the declarant is a patient receiving its services or a resident;
3. A person related to the declarant by blood, marriage, or adoption;
4. A person named as a proxy in the declarant's declaration.
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2135.07 Refusal to comply with declaration.

(A) If a mental health treatment provider of a declarant or a health care facility providing services to a declarant is unwilling at any time to comply with the declarant’s declaration, the mental health treatment provider or health care facility promptly shall notify the declarant and any proxy and document the notification in the declarant's medical record. The mental health treatment provider or health care facility that is unwilling to comply with the declarant's declaration shall not prevent or attempt to prevent, or unreasonably delay or attempt to unreasonably delay, the transfer of the declarant to the care of a mental health treatment provider or a health care facility that is willing and able to comply or allow compliance with the declarant's declaration.

(B) The mental health treatment provider of a declarant or a health care facility providing services to a declarant may subject the declarant to treatment in a manner contrary to the declarant's expressed wishes only if either of the following applies:

1. The declarant has been committed as a patient under Chapter 2945 or 5122 of the Revised Code, and, if the court knows of the declaration, the committing court acknowledges the existence of the declaration and specifically orders treatment in a manner contrary to the declaration.

2. An emergency situation endangers the life or health of the declarant or others.

2135.08 Proxy's liability.

(A) The proxy under a declaration is not, as a result of acting in that capacity, personally liable for the cost of treatment provided to the declarant. Except to the extent the right is limited by the declaration or any federal law, a proxy has the same right as the declarant to receive information regarding the proposed mental health treatment of the declarant and to receive, review, and consent to disclosure of the declarant's medical records relating to that treatment. This right of access does not waive any evidentiary privilege.

(B) In exercising authority under a declaration, the proxy has a duty to act consistently with the desires of the declarant as expressed in the declaration. If the declarant's desires are not expressed in the declaration, the proxy has a duty to act in what the proxy in good faith believes to be the best interests of the declarant.

(C) A proxy is not subject to criminal prosecution, tort or other civil liability for injury, death, or loss to person or property, or professional disciplinary action for an action taken in good faith under a declaration for mental health treatment.

2135.09 Declaration revocation.

(A) A declarant may revoke a declaration at any time the declarant has the capacity to consent to mental health treatment decisions. Any revocation of a declaration by a declarant shall be in writing, signed by the declarant, and dated. The revocation shall be effective upon its communication to the mental health treatment provider of the declarant or the health care facility providing services to the declarant. If the declaration is operative, then the declarant may revoke the declaration after a designated physician or a psychiatrist, and one other mental health treatment provider, who examine the declarant determine that the declarant has the capacity to consent to mental health treatment decisions.

(B) Upon the declarant's revocation of a declaration, the mental health treatment provider or the health care facility shall make the revocation a part of the declarant's medical record.

(C) A valid declaration for mental health treatment revokes a prior, valid declaration for mental health treatment.
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(D) The probate judge of the county in which the declarant is located may revoke a declaration if the judge appoints a guardian for the declarant and specifically orders the revocation of the declaration.

2135.10 Care provider liability and immunity.

A mental health treatment provider of a declarant, a health care facility providing services to a declarant, or other authorized persons acting under the direction of either a mental health treatment provider of a declarant or a health care facility providing services to a declarant who administer or do not administer mental health treatment according to and in good faith reliance upon the validity of the declarant's declaration are not subject to criminal prosecution, are not liable in tort or other civil damages for injury, death, or loss to person or property, and are not subject to professional disciplinary action resulting from a subsequent finding of a declaration's invalidity.

2135.11 Prohibition on mandatory execution and restraint.

No person shall require an individual to execute or to refrain from executing a declaration as a criterion for insurance, as a condition for receiving mental health treatment or health care, or as a condition of admission to or discharge from a health care facility.

2135.12 Priority and scope of declaration.

(A) A declaration executed in accordance with this chapter shall not supersede a valid declaration governing the use or continuation, or the withholding or withdrawal, of life-sustaining treatment executed under Chapter 2133 of the Revised Code.

(B) A declaration executed in accordance with this chapter does not revoke a valid durable power of attorney for health care created under Chapter 1337 of the Revised Code, but a declaration so executed shall supersede the designation of an attorney in fact made in a valid health care power of attorney under Chapter 1337 of the Revised Code with respect to the mental health treatment of the declarant. The designation of an attorney in fact in a valid health care power of attorney under Chapter 1337 of the Revised Code shall remain effective in all other respects.

2135.13 Opposing decisions; physician may petition.

(A) A person who opposes any decision arising under this chapter may make an application opposing the decision to the probate division of the court of common pleas of the county in which the declarant is located or in which the declaration was either witnessed or acknowledged as described in this chapter.

(B) If a declarant has not named any proxies in the declaration, or if all the named proxies have withdrawn or are unable or unwilling to act at a time when the declaration has become operative, then the physician who has the primary responsibility for treating the declarant may petition the probate division of the court of common pleas of the county in which the declarant is located to appoint a person to act as a proxy. If the judge of the probate division of the court of common pleas finds it to be in the best interest of the declarant, then the court shall appoint a person to serve as a proxy for the declarant while the declaration is effective. The person so appointed shall be a person who is eligible to serve as a proxy as determined under section 2135.05 of the Revised Code.
2135.14 Printed form use.

A printed form of a declaration may be sold or otherwise distributed in this state for use by adults who are not advised by an attorney. By use of a printed form of that nature, a declarant may consent or refuse to consent to mental health treatment and may designate a proxy to make mental health treatment decisions in accordance with this chapter. The printed form shall not be used as an instrument for granting any other type of authority or for making any other type of designation, including those declarations that may be made under Chapter 2133 of the Revised Code or designations made under Chapter 1337 of the Revised Code.

Part II. Voluntary and Involuntary Hospitalization

5122.01 Definitions governing mental health statutes.

As used in this chapter and Chapter 5119 of the Revised Code:
(A) “Mental illness” means a substantial disorder of thought, mood, perception, orientation, or memory that grossly impairs judgment, behavior, capacity to recognize reality, or ability to meet the ordinary demands of life.
(B) “Mentally ill person subject to court order” means a mentally ill person who, because of the person's illness:
   (1) Represents a substantial risk of physical harm to self as manifested by evidence of threats of, or attempts at, suicide or serious self-inflicted bodily harm;
   (2) Represents a substantial risk of physical harm to others as manifested by evidence of recent homicidal or other violent behavior, evidence of recent threats that place another in reasonable fear of violent behavior and serious physical harm, or other evidence of present dangerousness;
   (3) Represents a substantial and immediate risk of serious physical impairment or injury to self as manifested by evidence that the person is unable to provide for and is not providing for the person's basic physical needs because of the person's mental illness and that appropriate provision for those needs cannot be made immediately available in the community;
   (4) Would benefit from treatment for the person's mental illness and is in need of such treatment as manifested by evidence of behavior that creates a grave and imminent risk to substantial rights of others or the person;
   (5)(a) Would benefit from treatment as manifested by evidence of behavior that indicates all of the following:
      (i) The person is unlikely to survive safely in the community without supervision, based on a clinical determination.
      (ii) The person has a history of lack of compliance with treatment for mental illness and one of the following applies:
         (I) At least twice within the thirty-six months prior to the filing of an affidavit seeking court-ordered treatment of the person under section 5122.111 of the Revised Code, the lack of compliance has been a significant factor in necessitating hospitalization in a hospital or receipt of services in a forensic or other mental health unit of a correctional facility, provided that the thirty-six-month period shall be extended by the length of any hospitalization or incarceration of the person that occurred within the thirty-six-month period.
         (II) Within the forty-eight months prior to the filing of an affidavit seeking court-ordered treatment of the person under section 5122.111 of the Revised Code, the lack of compliance resulted in one or more acts of serious violent behavior toward self or others or threats of, or attempts at, serious physical harm to self or others, provided that the forty-eight-month period
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shall be extended by the length of any hospitalization or incarceration of the person that occurred within the forty-eight-month period.

(iii) The person, as a result of the person's mental illness, is unlikely to voluntarily participate in necessary treatment.

(iv) In view of the person's treatment history and current behavior, the person is in need of treatment in order to prevent a relapse or deterioration that would be likely to result in substantial risk of serious harm to the person or others.

(b) An individual who meets only the criteria described in division (B)(5)(a) of this section is not subject to hospitalization.

(C)(1) “Patient” means, subject to division (C)(2) of this section, a person who is admitted either voluntarily or involuntarily to a hospital or other place under section 2945.39, 2945.40, 2945.401, or 2945.402 of the Revised Code subsequent to a finding of not guilty by reason of insanity or incompetence to stand trial or under this chapter, who is under observation or receiving treatment in such place.

(2) “Patient” does not include a person admitted to a hospital or other place under section 2945.39, 2945.40, 2945.401, or 2945.402 of the Revised Code to the extent that the reference in this chapter to patient, or the context in which the reference occurs, is in conflict with any provision of sections 2945.37 to 2945.402 of the Revised Code.

(D) “Licensed physician” means a person licensed under the laws of this state to practice medicine or a medical officer of the government of the United States while in this state in the performance of the person's official duties.

(E) “Psychiatrist” means a licensed physician who has satisfactorily completed a residency training program in psychiatry, as approved by the residency review committee of the American medical association, the committee on post-graduate education of the American osteopathic association, or the American osteopathic board of neurology and psychiatry, or who on July 1, 1989, has been recognized as a psychiatrist by the Ohio state medical association or the Ohio osteopathic association on the basis of formal training and five or more years of medical practice limited to psychiatry.

(F) “Hospital” means a hospital or inpatient unit licensed by the department of mental health and addiction services under section 5119.33 of the Revised Code, and any institution, hospital, or other place established, controlled, or supervised by the department under Chapter 5119 of the Revised Code.

(G) “Public hospital” means a facility that is tax-supported and under the jurisdiction of the department of mental health and addiction services.

(H) “Community mental health services provider” means an agency, association, corporation, individual, or program that provides community mental health services that are certified by the director of mental health and addiction services under section 5119.36 of the Revised Code.

(I) “Licensed clinical psychologist” means a person who holds a current valid psychologist license issued under section 4732.12 of the Revised Code, and in addition, meets the educational requirements set forth in division (B) of section 4732.10 of the Revised Code and has a minimum of two years' full-time professional experience, or the equivalent as determined by rule of the state board of psychology, at least one year of which shall be a predoctoral internship, in clinical psychological work in a public or private hospital or clinic or in private practice, diagnosing and treating problems of mental illness or intellectual disability under the supervision of a psychologist who is licensed or who holds a diploma issued by the American board of professional psychology, or whose qualifications are substantially similar to those required for licensure by the state board of psychology when the supervision has occurred prior to enactment of laws governing the practice of psychology.
(J) “Health officer” means any public health physician; public health nurse; or other person authorized or designated by a city or general health district or a board of alcohol, drug addiction, and mental health services to perform the duties of a health officer under this chapter.

(K) “Chief clinical officer” means the medical director of a hospital, community mental health services provider, or board of alcohol, drug addiction, and mental health services, or, if there is no medical director, the licensed physician responsible for the treatment provided by a hospital or community mental health services provider. The chief clinical officer may delegate to the attending physician responsible for a patient’s care the duties imposed on the chief clinical officer by this chapter. Within a community mental health services provider, the chief clinical officer shall be designated by the governing body of the services provider and shall be a licensed physician or licensed clinical psychologist who supervises diagnostic and treatment services. A licensed physician or licensed clinical psychologist designated by the chief clinical officer may perform the duties and accept the responsibilities of the chief clinical officer in the chief clinical officer's absence.

(L) “Working day” or “court day” means Monday, Tuesday, Wednesday, Thursday, and Friday, except when such day is a holiday.

(M) “Indigent” means unable without deprivation of satisfaction of basic needs to provide for the payment of an attorney and other necessary expenses of legal representation, including expert testimony.

(N) “Respondent” means the person whose detention, commitment, hospitalization, continued hospitalization or commitment, or discharge is being sought in any proceeding under this chapter.

(O) “Ohio protection and advocacy system” has the same meaning as in section 5123.60 of the Revised Code.

(P) “Independent expert evaluation” means an evaluation conducted by a licensed clinical psychologist, psychiatrist, or licensed physician who has been selected by the respondent or the respondent's counsel and who consents to conducting the evaluation.

(Q) “Court” means the probate division of the court of common pleas.

(R) “Expunge” means:
   (1) The removal and destruction of court files and records, originals and copies, and the deletion of all index references;
   (2) The reporting to the person of the nature and extent of any information about the person transmitted to any other person by the court;
   (3) Otherwise insuring that any examination of court files and records in question shall show no record whatever with respect to the person;
   (4) That all rights and privileges are restored, and that the person, the court, and any other person may properly reply that no such record exists, as to any matter expunged.

(S) “Residence” means a person’s physical presence in a county with intent to remain there, except that:
   (1) If a person is receiving a mental health service at a facility that includes nighttime sleeping accommodations, residence means that county in which the person maintained the person’s primary place of residence at the time the person entered the facility;
   (2) If a person is committed pursuant to section 2945.38, 2945.39, 2945.40, 2945.401, or 2945.402 of the Revised Code, residence means the county where the criminal charges were filed.

When the residence of a person is disputed, the matter of residence shall be referred to the department of mental health and addiction services for investigation and determination. Residence shall not be a basis for a board’s denying services to any person present in the board’s service district, and the board shall provide services for a person whose residence is in dispute while residence is being determined and for a person in an emergency situation.
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(T) “Admission” to a hospital or other place means that a patient is accepted for and stays at least one night at the hospital or other place.

(U) “Prosecutor” means the prosecuting attorney, village solicitor, city director of law, or similar chief legal officer who prosecuted a criminal case in which a person was found not guilty by reason of insanity, who would have had the authority to prosecute a criminal case against a person if the person had not been found incompetent to stand trial, or who prosecuted a case in which a person was found guilty.

(V)(1) “Treatment plan” means a written statement of reasonable objectives and goals for an individual established by the treatment team, with specific criteria to evaluate progress towards achieving those objectives.

(2) The active participation of the patient in establishing the objectives and goals shall be documented. The treatment plan shall be based on patient needs and include services to be provided to the patient while the patient is hospitalized, after the patient is discharged, or in an outpatient setting. The treatment plan shall address services to be provided. In the establishment of the treatment plan, consideration should be given to the availability of services, which may include but are not limited to all of the following:

(a) Community psychiatric supportive treatment;

(b) Assertive community treatment;

(c) Medications;

(d) Individual or group therapy;

(e) Peer support services;

(f) Financial services;

(g) Housing or supervised living services;

(h) Alcohol or substance abuse treatment;

(i) Any other services prescribed to treat the patient’s mental illness and to either assist the patient in living and functioning in the community or to help prevent a relapse or a deterioration of the patient’s current condition.

(3) If the person subject to the treatment plan has executed an advanced directive for mental health treatment, the treatment team shall consider any directions included in such advanced directive in developing the treatment plan.

(W) “Community control sanction” has the same meaning as in section 2929.01 of the Revised Code.

(X) “Post-release control sanction” has the same meaning as in section 2967.01 of the Revised Code.

(Y) “Local correctional facility” has the same meaning as in section 2903.13 of the Revised Code.

5122.011 Applicability of and conflicts between provisions; insanity.

The provisions of this chapter regarding hospitalization apply to a person who is found incompetent to stand trial or not guilty by reason of insanity and is committed pursuant to section 2945.39, 2945.40, 2945.401, or 2945.402 of the Revised Code to the extent that the provisions are not in conflict with any provision of sections 2945.37 to 2945.402 of the Revised Code. If a provision of this chapter is in conflict with a provision in sections 2945.37 to 2945.402 of the Revised Code regarding a person who has been so committed, the provision in sections 2945.37 to 2945.402 of the Revised Code shall control regarding that person.

5122.02 Admission of patients.

(A) Except as provided in division (D) of this section, any person who is eighteen years of age or older and who is, appears to be, or believes self to be mentally ill may make written
application for voluntary admission to the chief medical officer of a hospital.

(B) Except as provided in division (D) of this section, the application also may be made on behalf of a minor by a parent, a guardian of the person, or the person with custody of the minor, and on behalf of an adult incompetent person by the guardian or the person with custody of the incompetent person.

Any person whose admission is applied for under division (A) or (B) of this section may be admitted for observation, diagnosis, care, or treatment, in any hospital unless the chief clinical officer finds that hospitalization is inappropriate, and except that, in the case of a public hospital, no person shall be admitted without the authorization of the board of the person’s county of residence.

(C) If a minor or person adjudicated incompetent due to mental illness whose voluntary admission is applied for under division (B) of this section is admitted, the court shall determine, upon petition by private or otherwise appointed counsel, a relative, or one acting as next friend, whether the admission or continued hospitalization is in the best interest of the minor or incompetent.

The chief clinical officer shall discharge any voluntary patient who has recovered or whose hospitalization the officer determines to be no longer advisable and may discharge any voluntary patient who refuses to accept treatment consistent with the written treatment plan required by section 5122.27 of the Revised Code.

(D) A person who is found incompetent to stand trial or not guilty by reason of insanity and who is committed pursuant to section 2945.39, 2945.40, 2945.401, or 2945.402 of the Revised Code shall not voluntarily admit the person or be voluntarily admitted to a hospital pursuant to this section until after the final termination of the commitment, as described in division (J) of section 2945.401 of the Revised Code.

5122.03 Voluntary patient’s right to request release.

A patient admitted under section 5122.02 of the Revised Code who requests release in writing, or whose release is requested in writing by the patient’s counsel, legal guardian, parent, spouse, or adult next of kin shall be released forthwith, except that when:

(A) The patient was admitted on the patient’s own application and the request for release is made by a person other than the patient, release may be conditional upon the agreement of the patient; or

(B) The chief clinical officer of the hospital, within three court days from the receipt of the request for release, files or causes to be filed with the court of the county where the patient is hospitalized or of the county where the patient is a resident, an affidavit under section 5122.11 of the Revised Code. Release may be postponed until the hearing held under section 5122.141 of the Revised Code. A telephone communication within three court days from the receipt of the request for release from the chief clinical officer to the court, indicating that the required affidavit has been mailed, is sufficient compliance with the time limit for filing such affidavit.

Unless the patient is released within three days from the receipt of the request by the chief clinical officer, the request shall serve as a request for an initial hearing under section 5122.141 of the Revised Code. If the court finds that the patient is a mentally ill person subject to court order, all provisions of this chapter with respect to involuntary hospitalization apply to such person.

Judicial proceedings for hospitalization shall not be commenced with respect to a voluntary patient except pursuant to this section.

Sections 5121.30 to 5121.56 of the Revised Code apply to persons received in a hospital operated by the department of mental health and addiction services on a voluntary application.

The chief clinical officer of the hospital shall provide reasonable means and
arrangements for informing patients of their rights to release as provided in this section and for assisting them in making and presenting requests for release or for a hearing under section 5122.141 of the Revised Code.

Before a patient is released from a public hospital, the chief clinical officer shall, when possible, notify the board of the patient's county of residence of the patient's pending release after the chief clinical officer has informed the patient that the board will be so notified.

5122.04 Minors receiving outpatient mental health services.

(A) Upon the request of a minor fourteen years of age or older, a mental health professional may provide outpatient mental health services, excluding the use of medication, without the consent or knowledge of the minor's parent or guardian. Except as otherwise provided in this section, the minor's parent or guardian shall not be informed of the services without the minor's consent unless the mental health professional treating the minor determines that there is a compelling need for disclosure based on a substantial probability of harm to the minor or to other persons, and if the minor is notified of the mental health professional's intent to inform the minor's parent, or guardian.

(B) Services provided to a minor pursuant to this section shall be limited to not more than six sessions or thirty days of services whichever occurs sooner. After the sixth session or thirty days of services the mental health professional shall terminate the services or, with the consent of the minor, notify the parent, or guardian, to obtain consent to provide further outpatient services.

(C) The minor's parent or guardian shall not be liable for the costs of services which are received by a minor under division (A).

(D) Nothing in this section relieves a mental health professional from the obligations of section 2151.421 of the Revised Code.

(E) As used in this section, "Mental health professional" has the same meaning as in section 340.02 of the Revised Code.

5122.05 Involuntary admission.

(A) The chief clinical officer of a hospital may, and the chief clinical officer of a public hospital in all cases of psychiatric medical emergencies, shall receive for observation, diagnosis, care, and treatment any person whose admission is applied for under any of the following procedures:

1. Emergency procedure, as provided in section 5122.10 of the Revised Code;

Upon application for such admission, the chief clinical officer of a hospital immediately shall notify the board of the patient's county of residence. To assist the hospital in determining whether the patient is subject to involuntary hospitalization and whether alternative services are available, the board or an agency the board designates promptly shall assess the patient unless the board or agency already has performed such assessment, or unless the commitment is pursuant to section 2945.38, 2945.39, 2945.40, 2945.401, or 2945.402 of the Revised Code.

(B) No person who is being treated by spiritual means through prayer alone, in accordance with a recognized religious method of healing, may be involuntarily committed unless the court has determined that the person represents a substantial risk of impairment or injury to self or others;

(C) Any person who is involuntarily detained in a hospital or otherwise is in custody under this chapter, immediately upon being taken into custody, shall be informed and provided with a written statement that the person may do any of the following:
(1) Immediately make a reasonable number of telephone calls or use other reasonable means to contact an attorney, a licensed physician, or a licensed clinical psychologist, to contact any other person or persons to secure representation by counsel, or to obtain medical or psychological assistance, and be provided assistance in making calls if the assistance is needed and requested;

(2) Retain counsel and have independent expert evaluation of the person's mental condition and, if the person is unable to obtain an attorney or independent expert evaluation, be represented by court-appointed counsel or have independent expert evaluation of the person's mental condition, or both, at public expense if the person is indigent;

(3) Have a hearing to determine whether or not the person is a mentally ill person subject to court order.

5122.09 Release prior to initial hearing; court record expunged.

If a person taken into custody under section 5122.10 or 5122.11 of the Revised Code is released from custody before having an initial hearing, a court that has made a file or record relating to the person during this period shall expunge it.

5122.10 Emergency mental health admission.

Any psychiatrist, licensed clinical psychologist, licensed physician, health officer, parole officer, police officer, or sheriff may take a person into custody, or the chief of the adult parole authority or a parole or probation officer with the approval of the chief of the authority may take a parolee, an offender under a community control sanction or a post-release control sanction, or an offender under transitional control into custody and may immediately transport the parolee, offender on community control or post-release control, or offender under transitional control to a hospital or, notwithstanding section 5119.33 of the Revised Code, to a general hospital not licensed by the department of mental health and addiction services where the parolee, offender on community control or post-release control, or offender under transitional control may be held for the period prescribed in this section, if the psychiatrist, licensed clinical psychologist, licensed physician, health officer, parole officer, police officer, or sheriff has reason to believe that the person is a mentally ill person subject to court order under division (B) of section 5122.01 of the Revised Code, and represents a substantial risk of physical harm to self or others if allowed to remain at liberty pending examination.

A written statement shall be given to such hospital by the transporting psychiatrist, licensed clinical psychologist, licensed physician, health officer, parole officer, police officer, chief of the adult parole authority, parole or probation officer, or sheriff stating the circumstances under which such person was taken into custody and the reasons for the psychiatrist's, licensed clinical psychologist's, licensed physician's, health officer's, parole officer's, police officer's, chief of the adult parole authority's, parole or probation officer's, or sheriff's belief. This statement shall be made available to the respondent or the respondent's attorney upon request of either.

Every reasonable and appropriate effort shall be made to take persons into custody in the least conspicuous manner possible. A person taking the respondent into custody pursuant to this section shall explain to the respondent: the name and professional designation and affiliation of the person taking the respondent into custody; that the custody-taking is not a criminal arrest; and that the person is being taken for examination by mental health professionals at a specified mental health facility identified by name.

If a person taken into custody under this section is transported to a general hospital, the general hospital may admit the person, or provide care and treatment for the person, or both, notwithstanding section 5119.33 of the Revised Code, but by the end of twenty-four hours after...
arrival at the general hospital, the person shall be transferred to a hospital as defined in section 5122.01 of the Revised Code.

A person transported or transferred to a hospital or community mental health services provider under this section shall be examined by the staff of the hospital or services provider within twenty-four hours after arrival at the hospital or services provider. If to conduct the examination requires that the person remain overnight, the hospital or services provider shall admit the person in an unclassified status until making a disposition under this section. After the examination, if the chief clinical officer of the hospital or services provider believes that the person is not a mentally ill person subject to court order, the chief clinical officer shall release or discharge the person immediately unless a court has issued a temporary order of detention applicable to the person under section 5122.11 of the Revised Code. After the examination, if the chief clinical officer believes that the person is a mentally ill person subject to court order, the chief clinical officer may detain the person for not more than three court days following the day of the examination and during such period admit the person as a voluntary patient under section 5122.02 of the Revised Code or file an affidavit under section 5122.11 of the Revised Code. If neither action is taken and a court has not otherwise issued a temporary order of detention applicable to the person under section 5122.11 of the Revised Code, the chief clinical officer shall discharge the person at the end of the three-day period unless the person has been sentenced to the department of rehabilitation and correction and has not been released from the person's sentence, in which case the person shall be returned to that department.

5122.11 Hospitalization by affidavit.

Proceedings for a mentally ill person subject to court order pursuant to sections 5122.11 to 5122.15 of the Revised Code shall be commenced by the filing of an affidavit in the manner prescribed by the department of mental health and addiction services and in a form prescribed in section 5122.111 of the Revised Code, by any person or persons with the probate court, either on reliable information or actual knowledge, whichever is determined to be proper by the court. This section does not apply to the hospitalization of a person pursuant to section 2945.39, 2945.40, 2945.401, or 2945.402 of the Revised Code.

The affidavit shall contain an allegation setting forth the specific category or categories under division (B) of section 5122.01 of the Revised Code upon which the jurisdiction of the court is based and a statement of alleged facts sufficient to indicate probable cause to believe that the person is a mentally ill person subject to court order. The affidavit may be accompanied, or the court may require that the affidavit be accompanied, by a certificate of a psychiatrist, or a certificate signed by a licensed clinical psychologist and a certificate signed by a licensed physician stating that the person who issued the certificate has examined the person and is of the opinion that the person is a mentally ill person subject to court order, or shall be accompanied by a written statement by the applicant, under oath, that the person has refused to submit to an examination by a psychiatrist, or by a licensed clinical psychologist and licensed physician.

Upon receipt of the affidavit, if a judge of the court or a referee who is an attorney at law appointed by the court has probable cause to believe that the person named in the affidavit is a mentally ill person subject to court order, the judge or referee may issue a temporary order of detention ordering any health or police officer or sheriff to take into custody and transport the person to a hospital or other place designated in section 5122.17 of the Revised Code, or may set the matter for further hearing. If a temporary order of detention is issued and the person is transported to a hospital or other designated place, the court that issued the order shall retain jurisdiction over the case as it relates to the person's outpatient treatment, notwithstanding that the hospital or other designated place to which the person is transported is outside the territorial jurisdiction of the court.
The person may be observed and treated until the hearing provided for in section 5122.141 of the Revised Code. If no such hearing is held, the person may be observed and treated until the hearing provided for in section 5122.15 of the Revised Code.

5122.111 Court-ordered treatment affidavit of mental illness.

To initiate proceedings for court-ordered treatment of a person under section 5122.11 of the Revised Code, a person or persons shall file an affidavit with the probate court that is identical in form and content to the following:

AFFIDAVIT OF MENTAL ILLNESS
The State of Ohio

............... County, ss.
............... Court

the undersigned, residing
at

............... says, that he/she has information to believe or has actual knowledge
that

(Please specify specific category(ies) below with an X.)
[ ] Represents a substantial risk of physical harm to self as manifested by evidence of threats of, or attempts at, suicide or serious self-inflicted bodily harm;
[ ] Represents a substantial risk of physical harm to others as manifested by evidence of recent homicidal or other violent behavior or evidence of recent threats that place another in reasonable fear of violent behavior and serious physical harm or other evidence of present dangerousness;
[ ] Represents a substantial and immediate risk of serious physical impairment or injury to self as manifested by evidence of being unable to provide for and of not providing for basic physical needs because of mental illness and that appropriate provision for such needs cannot be made immediately available in the community;
[ ] Would benefit from treatment for mental illness and is in need of such treatment as manifested by evidence of behavior that creates a grave and imminent risk to substantial rights of others or the person; or
[ ] Would benefit from treatment as manifested by evidence of behavior that indicates all of the following:
   (a) The person is unlikely to survive safely in the community without supervision, based on a clinical determination.
   (b) The person has a history of lack of compliance with treatment for mental illness and one of the following applies:
      (i) At least twice within the thirty-six months prior to the filing of an affidavit seeking court-ordered treatment of the person under section 5122.111 of the Revised Code, the lack of compliance has been a significant factor in necessitating hospitalization in a hospital or receipt of services in a forensic or other mental health unit of a correctional facility, provided that the thirty-six-month period shall be extended by the length of any hospitalization or incarceration of the person that occurred within the thirty-six-month period.
      (ii) Within the forty-eight months prior to the filing of an affidavit seeking court-ordered treatment of the person under section 5122.111 of the Revised Code, the lack of compliance resulted in one or more acts of serious violent behavior toward self or others or threats of, or attempts at, serious physical harm to self or others, provided that the forty-eight-month period...
shall be extended by the length of any hospitalization or incarceration of the person that occurred within the forty-eight-month period.

(c) The person, as a result of mental illness, is unlikely to voluntarily participate in necessary treatment.

(d) In view of the person’s treatment history and current behavior, the person is in need of treatment in order to prevent a relapse or deterioration that would be likely to result in substantial risk of serious harm to the person or others.

(Name of the party filing the affidavit) further says that the facts supporting this belief are as follows:

These facts being sufficient to indicate probable cause that the above said person is a mentally ill person subject to court order.

Name of Patient’s Last Physician or Licensed Clinical Psychologist

Address of Patient’s Last Physician or Licensed Clinical Psychologist

The name and address of respondent’s legal guardian, spouse, and adult next of kin are:

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The following constitutes additional information that may be necessary for the purpose of determining residence:

Dated this .......... day of .........., 20...

Signature of the party filing the affidavit

Sworn to before me and signed in my presence on the day and year above dated.
Chapter 8. Mental Health
Part II. Voluntary and Involuntary Hospitalization

WAIVER

I, the undersigned party filing the affidavit hereby waive the issuing and service of notice of the hearing on said affidavit, and voluntarily enter my appearance herein.

Dated this .......... day of .............., 20...

........................................
Signature of the party filing the affidavit

5122.12 Hearing notice.

After receipt of the affidavit required by section 5122.11 of the Revised Code, the court shall cause written notice by mail or otherwise of any hearing as the court directs to be given to the following persons:

(A) The respondent;
(B) The respondent's legal guardian, if any, the respondent's spouse, if any, and the respondent's parents, if the respondent is a minor, if these persons' addresses are known to the court or can be obtained through exercise of reasonable diligence;
(C) The person who filed the affidavit;
(D) Any one person designated by the respondent; but if the respondent does not make a selection, the notice shall be sent to the adult next of kin other than the person who filed the affidavit if that person's address is known to the court or can be obtained through exercise of reasonable diligence;
(E) The respondent's counsel;
(F) The director, chief clinical officer, or the respective designee of the hospital, board, community mental health services provider, or facility to which the person has been committed;
(G) The board of alcohol, drug addiction, and mental health services serving the respondent's county of residence or a services provider the board designates.

Any person entitled to notice under this section, with the exception of the respondent, may waive the notice.

A copy of the affidavit and temporary order of detention shall be served with the notice to the parties and to respondent's counsel, if counsel has been appointed or retained.

5122.13 Court investigation; temporary detention order.

Within two business days after receipt of the affidavit required by section 5122.11 of the Revised Code, the probate court shall refer the affidavit to the board of alcohol, drug addiction, and mental health services or community mental health services provider the board designates to assist the court in determining whether the respondent is subject to court-ordered treatment and whether alternatives to hospitalization are available, unless the services provider or board has already performed such screening. The board or services provider shall review the allegations of the affidavit and other information relating to whether or not the person named in the affidavit or statement is a mentally ill person subject to court order, and the availability of appropriate treatment alternatives.

The person who conducts the investigation shall promptly make a report to the court, in writing, in open court or in chambers, as directed by the court and a full record of the report shall be made by the court. The report is not admissible as evidence for the purpose of establishing whether or not the respondent is a mentally ill person subject to court order, but shall be considered by the court in its determination of an appropriate placement for any person after
that person is found to be a mentally ill person subject to court order.

The court, prior to the hearing under section 5122.141 of the Revised Code, shall release a copy of the investigative report to the respondent's counsel.

Nothing in this section precludes a judge or referee from issuing a temporary order of detention pursuant to section 5122.11 of the Revised Code.

5122.14 Admission by affidavit; required medical examination.

Immediately after acceptance of an affidavit required under section 5122.11 of the Revised Code, the court may appoint a psychiatrist, or a licensed clinical psychologist and a licensed physician to examine the respondent, and at the first hearing held pursuant to section 5122.141 of the Revised Code, such psychiatrist, or licensed clinical psychologist and licensed physician, shall report to the court his findings as to the mental condition of respondent, and his need for custody, care, or treatment in a mental hospital. The court may accept as evidence the written report of a psychiatrist, or the written report of a licensed clinical psychologist and a licensed physician, designated by the board of alcohol, drug addiction, and mental health services as the report and findings referred to in this section.

The examination, if possible, shall be held at a hospital or other medical facility, at the home of the respondent, or at any other suitable place least likely to have a harmful effect on the respondent's health.

The court shall prior to a hearing under section 5122.141 or 5122.15 of the Revised Code release a copy of the report to the respondent's counsel.

5122.141 Determination of mental illness; hearing.

(A) A respondent who is involuntarily placed in a hospital or other place as designated in section 5122.10 or 5122.17 of the Revised Code, or with respect to whom proceedings have been instituted under section 5122.11 of the Revised Code, shall be afforded a hearing to determine whether or not the respondent is a mentally ill person subject to court order. The hearing shall be conducted pursuant to section 5122.15 of the Revised Code, and the respondent shall have the right to counsel as provided in that section.

(B) The hearing shall be conducted within five court days from the day on which the respondent is detained or an affidavit is filed, whichever occurs first, in a physical setting not likely to have a harmful effect on the respondent, and may be conducted in a hospital in or out of the county. On the motion of the respondent, the respondent's counsel, the chief clinical officer, or on its own motion, and for good cause shown, the court may order a continuance of the hearing. The continuance may be for no more than ten days from the day on which the respondent is detained or on which an affidavit is filed, whichever occurs first. Failure to conduct the hearing within this time shall effect an immediate discharge of the respondent. If the proceedings are not reinstituted within thirty days, all records of the proceedings shall be expunged.

(C) If the court does not find that the respondent is a mentally ill person subject to court order, it shall order the respondent's immediate discharge, and shall expunge all record of the proceedings during this period.

(D) If the court finds that the respondent is a mentally ill person subject to court order, the court may issue an interim order of detention ordering any health or police officer or sheriff to take into custody and transport such person to a hospital or other place designated in section 5122.17 of the Revised Code, where the respondent may be observed and treated.

(E) A respondent or a respondent's counsel, after obtaining the consent of the respondent, may waive the hearing provided for in this section. In such case, unless the person has been discharged, a mandatory full hearing shall be held by the thirtieth day after the original
involuntary detention of the respondent. Failure to conduct the mandatory full hearing within this time limit shall result in the immediate discharge of the respondent.

(F) Where possible, the initial hearing shall be held before the respondent is taken into custody.

5122.15 Full hearing; respondent’s rights.

(A) Full hearings shall be conducted in a manner consistent with this chapter and with due process of law. The hearings shall be conducted by a judge of the probate court or a referee designated by a judge of the probate court and may be conducted in or out of the county in which the respondent is held. Any referee designated under this division shall be an attorney.

(1) With the consent of the respondent, the following shall be made available to counsel for the respondent:

(a) All relevant documents, information, and evidence in the custody or control of the state or prosecutor;

(b) All relevant documents, information, and evidence in the custody or control of the hospital in which the respondent currently is held, or in which the respondent has been held pursuant to this chapter;

(c) All relevant documents, information, and evidence in the custody or control of any hospital, facility, or person not included in division (A)(1)(a) or (b) of this section.

(2) The respondent has the right to attend the hearing and to be represented by counsel of the respondent's choice. The right to attend the hearing may be waived only by the respondent or counsel for the respondent after consultation with the respondent.

(3) If the respondent is not represented by counsel, is absent from the hearing, and has not validly waived the right to counsel, the court shall appoint counsel immediately to represent the respondent at the hearing, reserving the right to tax costs of appointed counsel to the respondent, unless it is shown that the respondent is indigent. If the court appoints counsel, or if the court determines that the evidence relevant to the respondent's absence does not justify the absence, the court shall continue the case.

(4) The respondent shall be informed that the respondent may retain counsel and have independent expert evaluation. If the respondent is unable to obtain an attorney, the respondent shall be represented by court-appointed counsel. If the respondent is indigent, court-appointed counsel and independent expert evaluation shall be provided as an expense under section 5122.43 of the Revised Code.

(5) The hearing shall be closed to the public, unless counsel for the respondent, with the permission of the respondent, requests that the hearing be open to the public.

(6) If the hearing is closed to the public, the court, for good cause shown, may admit persons who have a legitimate interest in the proceedings. If the respondent, the respondent's counsel, or the designee of the director or of the chief clinical officer objects to the admission of any person, the court shall hear the objection and any opposing argument and shall rule upon the admission of the person to the hearing.

(7) The affiant under section 5122.11 of the Revised Code shall be subject to subpoena by either party.

(8) The court shall examine the sufficiency of all documents filed and shall inform the respondent, if present, and the respondent's counsel of the nature and content of the documents and the reason for which the respondent is being detained, or for which the respondent's placement is being sought.

(9) The court shall receive only reliable, competent, and material evidence.

(10) Unless proceedings are initiated pursuant to section 5120.17 or 5139.08 of the Revised Code, an attorney that the board designates shall present the case demonstrating that the respondent is a mentally ill person subject to court order. The attorney shall offer evidence
of the diagnosis, prognosis, record of treatment, if any, and less restrictive treatment plans, if any. In proceedings pursuant to section 5120.17 or 5139.08 of the Revised Code, the attorney general shall designate an attorney who shall present the case demonstrating that the respondent is a mentally ill person subject to court order. The attorney shall offer evidence of the diagnosis, prognosis, record of treatment, if any, and less restrictive treatment plans, if any.

(11) The respondent or the respondent's counsel has the right to subpoena witnesses and documents and to examine and cross-examine witnesses.

(12) The respondent has the right, but shall not be compelled, to testify, and shall be so advised by the court.

(13) On motion of the respondent or the respondent's counsel for good cause shown, or on the court's own motion, the court may order a continuance of the hearing.

(14) If the respondent is represented by counsel and the respondent's counsel requests a transcript and record, or if the respondent is not represented by counsel, the court shall make and maintain a full transcript and record of the proceeding. If the respondent is indigent and the transcript and record is made, a copy shall be provided to the respondent upon request and be treated as an expense under section 5122.43 of the Revised Code.

(15) To the extent not inconsistent with this chapter, the Rules of Civil Procedure are applicable.

(B) Unless, upon completion of the hearing the court finds by clear and convincing evidence that the respondent is a mentally ill person subject to court order, it shall order the respondent's discharge immediately.

(C) If, upon completion of the hearing, the court finds by clear and convincing evidence that the respondent is a mentally ill person subject to court order, the court shall order the respondent for a period not to exceed ninety days to any of the following:

1. A hospital operated by the department of mental health and addiction services if the respondent is committed pursuant to section 5139.08 of the Revised Code;
2. A nonpublic hospital;
3. The veterans' administration or other agency of the United States government;
4. A board of alcohol, drug addiction, and mental health services or services provider the board designates;
5. Receive private psychiatric or psychological care and treatment;
6. Any other suitable facility or person consistent with the diagnosis, prognosis, and treatment needs of the respondent. A jail or other local correctional facility is not a suitable facility.

(D) Any order made pursuant to division (C)(2), (3), (5), or (6) of this section shall be conditioned upon the receipt by the court of consent by the hospital, facility, agency, or person to accept the respondent and may include a requirement that a person or entity described in division (C)(2), (3), (5), or (6) of this section inform the board of alcohol, drug addiction, and mental health services or community mental health services provider the board designates about the progress of the respondent with the treatment plan.

(E) In determining the entity or person to which the respondent is to be committed under division (C) of this section, the court shall consider the diagnosis, prognosis, preferences of the respondent and the projected treatment plan for the respondent and shall order the implementation of the least restrictive alternative available and consistent with treatment goals. If the court determines that the least restrictive alternative available that is consistent with treatment goals is inpatient hospitalization, the court's order shall so state.

(F) During the ninety-day period the entity or person shall examine and treat the respondent. If the respondent is receiving treatment in an outpatient setting, or receives treatment in an outpatient setting during a subsequent period of continued commitment under division (H) of this section, the entity or person to whom the respondent is committed shall determine the appropriate outpatient treatment for the respondent. If, at any time prior to the
expiration of the ninety-day period, it is determined by the entity or person that the respondent's treatment needs could be equally well met in an available and appropriate less restrictive setting, both of the following apply:

1. The respondent shall be released from the care of the entity or person immediately and shall be referred to the court together with a report of the findings and recommendations of the entity or person;

2. The entity or person shall notify the respondent's counsel or the attorney designated by a board of alcohol, drug addiction, and mental health services or, if the respondent was committed to a board or a services provider designated by the board, it shall place the respondent in the least restrictive setting available consistent with treatment goals and notify the court and the respondent's counsel of the placement.

The court shall dismiss the case or order placement in the least restrictive setting.

(G)(1) Except as provided in division (G)(2) of this section, any person for whom proceedings for treatment have been commenced pursuant to section 5122.11 of the Revised Code, may apply at any time for voluntary admission or treatment to the entity or person to which the person was committed. Upon admission as a voluntary patient the chief clinical officer of the entity or the person immediately shall notify the court, the patient's counsel, and the attorney designated by the board, if the attorney has entered the proceedings, in writing of that fact, and, upon receipt of the notice, the court shall dismiss the case.

(G)(2) A person who is found incompetent to stand trial or not guilty by reason of insanity and who is committed pursuant to section 2945.39, 2945.40, 2945.401, or 2945.402 of the Revised Code shall not voluntarily commit the person pursuant to this section until after the final termination of the commitment, as described in division (J) of section 2945.401 of the Revised Code.

(H) If, at the end of the first ninety-day period or any subsequent period of continued commitment, there has been no disposition of the case, either by discharge or voluntary admission or treatment, the entity or person shall discharge the patient immediately, unless at least ten days before the expiration of the period the attorney the board designates or the prosecutor files with the court an application for continued commitment. The application of the attorney or the prosecutor shall include a written report containing the diagnosis, prognosis, past treatment, a list of alternative treatment settings and plans, and identification of the treatment setting that is the least restrictive consistent with treatment needs. The attorney the board designates or the prosecutor shall file the written report at least three days prior to the full hearing. A copy of the application and written report shall be provided to the respondent's counsel immediately.

The court shall hold a full hearing on applications for continued commitment at the expiration of the first ninety-day period and at least every two years after the expiration of the first ninety-day period.

Hearings following any application for continued commitment are mandatory and may not be waived.

For a respondent who is ordered to receive treatment in an outpatient setting, if at any time after the first ninety-day period the entity or person to whom the respondent was ordered determines that the respondent has demonstrated voluntary consent for treatment, that entity or person shall immediately notify the respondent, the respondent's counsel, the attorney designated by the board, and the court. The entity or person shall submit to the court a report of the findings and recommendations. The court may dismiss the case upon review of the facts.

Upon request of a person who is involuntarily committed under this section, or the person's counsel, that is made more than one hundred eighty days after the person's last full hearing, mandatory or requested, the court shall hold a full hearing on the person's continued commitment. Upon the application of a person involuntarily committed under this section, supported by an affidavit of a psychiatrist or licensed clinical psychologist, alleging that the
person no longer is a mentally ill person subject to court order, the court for good cause shown may hold a full hearing on the person's continued commitment prior to the expiration of one hundred eighty days after the person's last full hearing. Section 5122.12 of the Revised Code applies to all hearings on continued commitment.

If the court, after a hearing for continued commitment finds by clear and convincing evidence that the respondent is a mentally ill person subject to court order, the court may order continued commitment at places or to persons specified in division (C) of this section.

(I) Unless the admission is pursuant to section 5120.17 or 5139.08 of the Revised Code, the chief clinical officer of the entity admitting a respondent pursuant to a judicial proceeding, within ten working days of the admission, shall make a report of the admission to the board of alcohol, drug addiction, and mental health services serving the respondent's county of residence.

(J) A referee appointed by the court may make all orders that a judge may make under this section and sections 5122.11 and 5122.141 of the Revised Code, except an order of contempt of court. The orders of a referee take effect immediately. Within fourteen days of the making of an order by a referee, a party may file written objections to the order with the court. The filed objections shall be considered a motion, shall be specific, and shall state their grounds with particularity. Within ten days of the filing of the objections, a judge of the court shall hold a hearing on the objections and may hear and consider any testimony or other evidence relating to the respondent's mental condition. At the conclusion of the hearing, the judge may ratify, rescind, or modify the referee's order.

(K) An order of the court under division (C), (H), or (J) of this section is a final order.

(L) Before a board, or a services provider the board designates, may place an unconsenting respondent in an inpatient setting from a less restrictive placement, the board or services provider shall do all of the following:

(1) Determine that the respondent is in immediate need of treatment in an inpatient setting because the respondent represents a substantial risk of physical harm to the respondent or others if allowed to remain in a less restrictive setting;

(2) On the day of placement in the inpatient setting or on the next court day, file with the court a motion for transfer to an inpatient setting or communicate to the court by telephone that the required motion has been mailed;

(3) Ensure that every reasonable and appropriate effort is made to take the respondent to the inpatient setting in the least conspicuous manner possible;

(4) Immediately notify the board's designated attorney and the respondent's attorney. At the respondent's request, the court shall hold a hearing on the motion and make a determination pursuant to division (E) of this section within five days of the placement.

(M) Before a board, or a services provider the board designates, may move a respondent from one residential placement to another, the board or services provider shall consult with the respondent about the placement. If the respondent objects to the placement, the proposed placement and the need for it shall be reviewed by a qualified mental health professional who otherwise is not involved in the treatment of the respondent.

(N) The entity or person to whom the respondent was ordered for treatment in an outpatient setting may submit a report to the court indicating that the respondent has either failed to comply with the treatment plan or begun to demonstrate signs of decompensation that may be grounds for hospitalization. On receipt of the report, the court shall promptly schedule a hearing to review the case. The court shall conduct the hearing in a manner consistent with this chapter and due process of law. The board shall receive notice of the hearing and the board and entity or person treating the respondent shall submit a report to the court with a plan for appropriate alternative treatment, if any, or recommend that the court discontinue the court-ordered treatment. The court shall consider available and appropriate alternative placements but shall not impose criminal sanctions that result in confinement in a jail or other local.
correctional facility based on the respondent's failure to comply with the treatment plan. The
court may not order the respondent to a more restrictive placement unless the criteria specified
in division (L) of this section are met and may not order the respondent to an inpatient setting
unless the court determines by clear and convincing evidence presented by the board that the
respondent meets the criteria specified in divisions (A) and (B)(1), (2), (3), or (4) of section
5122.01 of the Revised Code.

5122.16 Federal facility hospitalization.

If a person, ordered to be hospitalized pursuant to section 5122.15 of the Revised Code,
is eligible for hospital care or treatment by the veterans’ administration or other agency of the
United States government, such hospitalization may be ordered to those facilities provided by
section 5905.02 of the Revised Code.

5122.17 Temporary detention in medical facility.

Pending removal to a hospital, a person taken into custody or ordered to be hospitalized
pursuant to this chapter may be detained for not more than forty-eight hours in a licensed rest or
nursing home, a licensed or unlicensed hospital, a community mental health services provider,
or a county home, but the person shall not be detained in a nonmedical facility used for
detention of persons charged with or convicted of penal offenses unless the court finds that a
less restrictive alternative cannot be made available.

5122.18 Hospitalization; notice.

Whenever a person has been involuntarily detained at or admitted to a hospital,
community mental health services provider, or other facility at the request of anyone other than
the person's legal guardian, spouse, or next of kin under this chapter, the chief clinical officer of
the hospital, services provider, or other facility in which the person is temporarily detained under
section 5122.17 of the Revised Code shall immediately notify the person's legal guardian,
spouse or next of kin, and counsel, if these persons can be ascertained through exercise of
reasonable diligence. If a person voluntarily remains at or is admitted to a hospital, services
provider, or other facility, such notification shall not be given without the person's consent. The
chief clinical officer of the hospital, services provider, or other facility shall inform a person
voluntarily remaining at or admitted to a hospital, services provider, or other facility that the
person may authorize such notification.

5122.19 Medical examination required.

Every person transported to a hospital or community mental health services provider
pursuant to sections 5122.11 to 5122.16 of the Revised Code, shall be examined by the staff of
the hospital or services provider as soon as practicable after arrival at the hospital or services
provider. Such an examination shall be held within twenty-four hours after the time of arrival,
and if the chief clinical officer fails after such an examination to certify that in the chief clinical
officer's opinion the person is a mentally ill person subject to court order, the person shall be
immediately released.

5122.20 Transferring patients involuntarily committed.

The director of mental health and addiction services or the director's designee may
transfer, or authorize the transfer of, an involuntary patient, or a consenting voluntary patient
hospitized pursuant to section 5122.02 or sections 5122.11 to 5122.15 of the Revised Code, from one public hospital to another, or to a hospital, community mental health services provider, or other facility offering treatment or other services for mental illness, if the medical director of the department of mental health and addiction services determines that it would be consistent with the medical needs of the patient to do so. If such a transfer is made to a private facility, the transfer shall be conditioned upon the consent of the facility.

Before an involuntary patient may be transferred to a more restrictive setting, the chief clinical officer shall file a motion with the court requesting the court to amend its order of placement issued under section 5122.15 of the Revised Code. At the patient's request, the court shall hold a hearing on the motion at which the patient has the same rights as at a full hearing under section 5122.15 of the Revised Code. The hearing shall be held within ten days after the date on which the respondent was transferred to the more restrictive setting or on which the motion was filed, whichever is earlier. On the motion of the respondent, the respondent's counsel, or the chief clinical officer, or on its own motion, and for good cause shown, the court may order a continuance of the hearing for up to ten days.

Whenever an involuntary patient is transferred, written notice of the transfer shall be given to the patient's legal guardian, parents, spouse, and counsel, or, if none is known, to the patient's nearest known relative or friend. If the patient is a minor, the department, before making such a transfer, shall make a minute of the order for the transfer and the reason for it upon its record and shall send a certified copy at least seven days prior to the transfer to the person shown by its record to have had the care or custody of the minor immediately prior to the minor's commitment. Whenever a consenting voluntary patient is transferred, the notification shall be given only at the patient's request. The chief clinical officer shall advise a voluntary patient who is being transferred that the patient may decide if the notification shall be given. In all such transfers, due consideration shall be given to the wishes of the patient, and the relationship of the patient to the patient's family, legal guardian, or friends, so as to maintain the relationship and encourage visits beneficial to the patient.

When a voluntary patient whose medical or psychological needs are found by the chief clinical officer to warrant a transfer refuses to be transferred to an alternate facility, the chief clinical officer may file an affidavit for a hearing under section 5122.11 of the Revised Code.

5122.21 Discharge of involuntary mental health inpatients.

(A) The chief clinical officer shall as frequently as practicable, and at least once every thirty days, examine or cause to be examined every patient, and, whenever the chief clinical officer determines that the conditions justifying involuntary hospitalization or commitment no longer obtain, shall discharge the patient not under indictment or conviction for crime and immediately make a report of the discharge to the department of mental health and addiction services. The chief clinical officer may discharge a patient who is under an indictment, a sentence of imprisonment, a community control sanction, or a post-release control sanction or on parole ten days after written notice of intent to discharge the patient has been given by personal service or certified mail, return receipt requested, to the court having criminal jurisdiction over the patient. Except when the patient was found not guilty by reason of insanity and the defendant's commitment is pursuant to section 2945.40 of the Revised Code, the chief clinical officer has final authority to discharge a patient who is under an indictment, a sentence of imprisonment, a community control sanction, or a post-release control sanction or on parole.

(B) After a finding pursuant to section 5122.15 of the Revised Code that a person is a mentally ill person subject to court order, the chief clinical officer of the hospital or community mental health services provider to which the person is ordered or to which the person is transferred under section 5122.20 of the Revised Code, may grant a discharge without the consent or authorization of any court.
Upon discharge, the chief clinical officer shall notify the court that caused the judicial hospitalization of the discharge from the hospital.

5122.22 Trial visit releases.

When the chief clinical officer of a hospital considers it in the best interest of a patient, the officer may permit the patient to leave the hospital on a trial visit. The trial visit shall be for the period of time the chief clinical officer determines, but shall not exceed ninety days, unless extended for subsequent periods not to exceed ninety days after evaluation of the patient’s condition.

The chief clinical officer, upon releasing a patient on trial visit, may impose requirements and conditions in relation to the patient while the patient is absent from the hospital that are consistent with the treatment plan.

The chief clinical officer of the hospital from which the patient is released on trial visit may at any time revoke the trial visit if there is reason to believe that it is in the best interests of the patient to be returned to the hospital.

If the revocation of the trial visit is not voluntarily complied with, the chief clinical officer, within five days, shall authorize any health or police officer or sheriff to take the patient into custody and transport the patient to the hospital.

At the completion of the trial visit, the chief clinical officer shall take whatever measures are necessary to enable the patient to return to the hospital.

If an involuntarily committed patient has successfully completed one year of continuous trial visit, the chief clinical officer shall discharge the patient subject to any applicable notice requirements of section 5122.21 of the Revised Code.

5122.23 Report of vital statistics to department.

The chief clinical officer of a public hospital shall immediately report to the department of mental health and addiction services and the board of alcohol, drug addiction, and mental health services serving the patient’s county of residence the removal, death, escape, discharge, or trial visit of any patient hospitalized under section 5122.15 of the Revised Code, or the return of such an escaped or visiting patient to the department, the probate judge of the county from which such patient was hospitalized, and the probate judge of the county of residence of such patient. In case of death, the chief clinical officer also shall notify one or more of the nearest relatives of the deceased patient, if known to the chief clinical officer, by letter, telegram, or telephone. If the place of residence of such relative is unknown to the chief clinical officer, immediately upon receiving notification the probate judge shall in the speediest manner possible notify such relatives, if known to the probate judge.

The chief clinical officer of a public hospital, upon the request of the probate judge of the county from which a patient was hospitalized or the probate judge of the county of residence of such a patient, shall make a report to the judge of the condition of any patient under the care, treatment, custody, or control of the chief clinical officer.

5122.231 Hospitalization; alcohol, drug addiction, and mental health services.

Any person who has been hospitalized or committed under this chapter may, at any time, apply to the board of alcohol, drug addiction, and mental health services serving his county of residence for services listed in section 340.09 of the Revised Code.
5122.25 Hospitalization; rehearings.

Upon the request of a hospital, person, board, community mental health services provider, or facility who has custody of a patient hospitalized pursuant to section 5122.15 of the Revised Code, or on the order of the court, such patient may be called for a rehearing at such place within the county of the patient's residence or the county where such patient is hospitalized as the court designates. The hearing shall be conducted pursuant to section 5122.15 of the Revised Code.

5122.26 Unauthorized absence; escape.

(A) If a patient is absent without leave, on a verbal or written order issued within five days of the time of the unauthorized absence by the department of mental health and addiction services, the chief clinical officer of the hospital from which the patient is absent without leave, or the court of either the county from which the patient was committed or in which the patient is found, any health or police officer or sheriff may take the patient into custody and transport the patient to the hospital in which the patient was hospitalized or to a place that is designated in the order. The officer immediately shall report such fact to the entity that issued the order.

The chief clinical officer of a hospital may discharge a patient who is under an indictment, a sentence of imprisonment, a community control sanction, or a post-release control sanction or on parole and who has been absent without leave for more than thirty days but shall give written notice of the discharge to the court with criminal jurisdiction over the patient. The chief clinical officer of a hospital may discharge any other patient who has been absent without leave for more than fourteen days.

The chief clinical officer shall take all proper measures for the apprehension of an escaped patient. The expense of the return of an escaped patient shall be borne by the hospital where the patient is hospitalized.

(B)(1) Subject to division (B)(2) of this section, no patient hospitalized under Chapter 5122 of the Revised Code whose absence without leave was caused or contributed to by the patient's mental illness shall be subject to a charge of escape.

(2) Division (B)(1) of this section does not apply to any person who was hospitalized, institutionalized, or confined in a facility under an order made pursuant to or under authority of section 2945.37, 2945.371, 2945.38, 2945.39, 2945.40, 2945.401, or 2945.402 of the Revised Code and who escapes from the facility, from confinement in a vehicle for transportation to or from the facility, or from supervision by an employee of the facility that is incidental to hospitalization, institutionalization, or confinement in the facility and that occurs outside the facility, in violation of section 2921.34 of the Revised Code.

5122.27 Chief clinical officer to assure standards of care; required treatment unavailable.

The chief clinical officer of the hospital or the chief clinical officer's designee shall assure that all patients hospitalized or committed pursuant to this chapter shall:

(A) Receive, within twenty days of their admission sufficient professional care to assure that an evaluation of current status, differential diagnosis, probable prognosis, and description of the current treatment plan is stated on the official chart;

(B) Have a written treatment plan consistent with the evaluation, diagnosis, prognosis, and goals which shall be provided, upon request of the patient or patient's counsel, to the patient's counsel and to any private physician or licensed clinical psychologist designated by the patient or the patient's counsel or to the Ohio protection and advocacy system;

(C) Receive treatment consistent with the treatment plan. The department of mental health and addiction services shall set standards for treatment provided to such patients,
consistent wherever possible with standards set by the joint commission.

(D) Receive periodic reevaluations of the treatment plan by the professional staff at intervals not to exceed ninety days;

(E) Be provided with adequate medical treatment for physical disease or injury;

(F) Receive humane care and treatment, including without limitation, the following:

1. The least restrictive environment consistent with the treatment plan;
2. The necessary facilities and personnel required by the treatment plan;
3. A humane psychological and physical environment;
4. The right to obtain current information concerning the patient’s treatment program and expectations in terms that the patient can reasonably understand;
5. Participation in programs designed to afford the patient substantial opportunity to acquire skills to facilitate return to the community or to terminate an involuntary commitment;
6. The right to be free from unnecessary or excessive medication;
7. Freedom from restraints or isolation unless it is stated in a written order by the chief clinical officer or the chief clinical officer’s designee, or the patient’s individual physician or psychologist in a private or general hospital.

If the chief clinical officer of the hospital is unable to provide the treatment required by divisions (C), (E), and (F) of this section for any patient hospitalized pursuant to Chapter 5122 of the Revised Code, the chief clinical officer shall immediately notify the patient, the court, the Ohio protection and advocacy system, the director of mental health and addiction services, and the patient's counsel and legal guardian, if known. If within ten days after receipt of such notification by the director, the director is unable to effect a transfer of the patient, pursuant to section 5122.20 of the Revised Code, to a hospital, community mental health services provider, or other medical facility where treatment is available, or has not received an order of the court to the contrary, the involuntary commitment of any patient hospitalized pursuant to Chapter 5122 of the Revised Code and defined as a mentally ill person subject to court order under division (B)(4) of section 5122.01 of the Revised Code shall automatically be terminated.

5122.271 Consent required for certain treatments; medical emergency protocols.

(A) Except as provided in divisions (C), (D), and (E) of this section, the chief clinical officer or, in a nonpublic hospital, the attending physician responsible for a patient's care shall provide all information, including expected physical and medical consequences, necessary to enable any patient of a hospital for the mentally ill to give a fully informed, intelligent, and knowing consent, the opportunity to consult with independent specialists and counsel, and the right to refuse consent for any of the following:

1. Surgery;
2. Convulsive therapy;
3. Major aversive interventions;
4. Sterilizations;
5. Any unusually hazardous treatment procedures;

(B) No patient shall be subjected to any of the procedures listed in divisions (A)(4) to (6) of this section until both the patient's informed, intelligent, and knowing consent and the approval of the court have been obtained, except that court approval is not required for a legally competent and voluntary patient in a nonpublic hospital.

(C) If, after providing the information required under division (A) of this section to the patient, the chief clinical officer or attending physician concludes that a patient is physically or mentally unable to receive the information required for surgery under division (A)(1) of this section, or has been adjudicated incompetent, the information may be provided to the patient's natural or court-appointed guardian, who may give an informed, intelligent, and knowing written
If a patient is physically or mentally unable to receive the information required for surgery under division (A)(1) of this section and has no guardian, the information, the recommendation of the chief clinical officer, and the concurring judgment of a licensed physician who is not a full-time employee of the state may be provided to the court in the county in which the hospital is located, which may approve the surgery. Before approving the surgery, the court shall notify the Ohio protection and advocacy system created by section 5123.60 of the Revised Code, and shall notify the patient of the rights to consult with counsel, to have counsel appointed by the court if the patient is indigent, and to contest the recommendation of the chief clinical officer.

(D) If, in a medical emergency, and after providing the information required under division (A) of this section to the patient, it is the judgment of one licensed physician that delay in obtaining surgery would create a grave danger to the health of the patient, it may be administered without the consent of the patient or the patient's guardian if the necessary information is provided to the patient's spouse or next of kin to enable that person to give informed, intelligent, and knowing written consent. If no spouse or next of kin can reasonably be contacted, or if the spouse or next of kin is contacted, but refuses to consent, the surgery may be performed upon the written authorization of the chief clinical officer or, in a nonpublic hospital, upon the written authorization of the attending physician responsible for the patient's care, and after the approval of the court has been obtained. However, if delay in obtaining court approval would create a grave danger to the life of the patient, the chief clinical officer or, in a nonpublic hospital, the attending physician responsible for the patient's care may authorize surgery, in writing, without court approval. If the surgery is authorized without court approval, the chief clinical officer or the attending physician who made the authorization and the physician who performed the surgery shall each execute an affidavit describing the circumstances constituting the emergency and warranting the surgery and the circumstances warranting their not obtaining prior court approval. The affidavit shall be filed with the court with which the request for prior approval would have been filed within five court days after the surgery, and a copy of the affidavit shall be placed in the patient's file and be given to the guardian, spouse, or next of kin of the patient, to the hospital at which the surgery was performed, and to the Ohio protection and advocacy system as defined in section 5123.60 of the Revised Code.

(E) Major aversive interventions shall not be used unless a patient continues to engage in behavior destructive to self or others after other forms of therapy have been attempted. Major aversive interventions may be applied if approved by the director of mental health and addiction services. Major aversive interventions shall not be applied to a voluntary patient without the informed, intelligent, and knowing written consent of the patient or the patient's guardian.

(F) Unless there is substantial risk of physical harm to self or others, or other than under division (D) of this section, this chapter does not authorize any form of compulsory medical, psychological, or psychiatric treatment of any patient who is being treated by spiritual means through prayer alone in accordance with a recognized religious method of healing without specific court authorization.

(G) For purposes of this section, “convulsive therapy” does not include defibrillation.

5122.29 Patients’ rights.

All patients hospitalized or committed pursuant to this chapter have the following rights:

(A) The right to a written list of all rights enumerated in this chapter, to that person, that person's legal guardian, and that person's counsel. If the person is unable to read, the list shall be read and explained to the person.

(B) The right at all times to be treated with consideration and respect for the patient's privacy and dignity, including without limitation, the following:

(1) At the time a person is taken into custody for diagnosis, detention, or treatment under
Chapter 5122 of the Revised Code, the person taking that person into custody shall take reasonable precautions to preserve and safeguard the personal property in the possession of or on the premises occupied by that person;

(2) A person who is committed, voluntarily or involuntarily, shall be given reasonable protection from assault or battery by any other person.

(C) The right to communicate freely with and be visited at reasonable times by the patient's private counsel or personnel of the Ohio protection and advocacy system and, unless prior court restriction has been obtained, to communicate freely with and be visited at reasonable times by the patient's personal physician or psychologist.

(D) The right to communicate freely with others, unless specifically restricted in the patient's treatment plan for clear treatment reasons, including without limitation the following:

(1) To receive visitors at reasonable times;
(2) To have reasonable access to telephones to make and receive confidential calls, including a reasonable number of free calls if unable to pay for them and assistance in calling if requested and needed.

(E) The right to have ready access to letter writing materials, including a reasonable number of stamps without cost if unable to pay for them, and to mail and receive unopened correspondence and assistance in writing if requested and needed.

(F) The right to the following personal privileges consistent with health and safety:

(1) To wear the patient's own clothes and maintain the patient's own personal effects;
(2) To be provided an adequate allowance for or allotment of neat, clean, and seasonable clothing if unable to provide the patient's own;
(3) To maintain the patient's personal appearance according to the patient's own personal taste, including head and body hair;
(4) To keep and use personal possessions, including toilet articles;
(5) To have access to individual storage space for the patient's private use;
(6) To keep and spend a reasonable sum of the patient's own money for expenses and small purchases;
(7) To receive and possess reading materials without censorship, except when the materials create a clear and present danger to the safety of persons in the facility.

(G) The right to reasonable privacy, including both periods of privacy and places of privacy.

(H) The right to free exercise of religious worship within the facility, including a right to services and sacred texts that are within the reasonable capacity of the facility to supply, provided that no patient shall be coerced into engaging in any religious activities.

(I) The right to social interaction with members of either sex, subject to adequate supervision, unless such social interaction is specifically withheld under a patient's written treatment plan for clear treatment reasons.

As used in this section, “clear treatment reasons” means that permitting the patient to communicate freely with others will present a substantial risk of physical harm to the patient or others or will substantially preclude effective treatment of the patient. If a right provided under this section is restricted or withheld for clear treatment reasons, the patient's written treatment plan shall specify the treatment designed to eliminate the restriction or withholding of the right at the earliest possible time.

5122.30 Patients’ rights; habeas corpus.

Any person detained pursuant to this chapter or section 2945.39, 2945.40, 2945.401, or 2945.402 of the Revised Code shall be entitled to the writ of habeas corpus upon proper petition by self or by a friend to any court generally empowered to issue the writ of habeas corpus in the county in which the person is detained.
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No person may bring a petition for a writ of habeas corpus that alleges that a person involuntarily detained pursuant to this chapter no longer is a mentally ill person subject to court order unless the person shows that the release procedures of division (H) of section 5122.15 of the Revised Code are inadequate or unavailable.

5122.301 Rights of patients preserved.

No person shall be deprived of any public or private employment solely because of having been admitted to a hospital or otherwise receiving services, voluntarily or involuntarily, for a mental illness or other mental disability.

Any person admitted to a hospital or otherwise taken into custody, voluntarily or involuntarily, under this chapter retains all civil rights not specifically denied in the Revised Code or removed by an adjudication of incompetence following a judicial proceeding other than a proceeding under sections 5122.11 to 5122.15 of the Revised Code.

As used in this section, "civil rights" includes, without limitation, the rights to contract, hold a professional, occupational, or motor vehicle driver's or commercial driver's license, marry or obtain a divorce, annulment, or dissolution of marriage, make a will, vote, and sue and be sued.

5122.31 Information disclosure.

(A) All certificates, applications, records, and reports made for the purpose of this chapter and sections 2945.38, 2945.39, 2945.40, 2945.401, and 2945.402 of the Revised Code, other than court journal entries or court docket entries, and directly or indirectly identifying a patient or former patient or person whose hospitalization or commitment has been sought under this chapter, shall be kept confidential and shall not be disclosed by any person except:

(1) If the person identified, or the person's legal guardian, if any, or if the person is a minor, the person's parent or legal guardian, consents, and if the disclosure is in the best interests of the person, as may be determined by the court for judicial records and by the chief clinical officer for medical records;

(2) When disclosure is provided for in this chapter or Chapters 340 or 5119 of the Revised Code or in accordance with other provisions of state or federal law authorizing such disclosure;

(3) That hospitals, boards of alcohol, drug addiction, and mental health services, and community mental health services providers may release necessary medical information to insurers and other third-party payers, including government entities responsible for processing and authorizing payment, to obtain payment for goods and services furnished to the patient;

(4) Pursuant to a court order signed by a judge;

(5) That a patient shall be granted access to the patient's own psychiatric and medical records, unless access specifically is restricted in a patient's treatment plan for clear treatment reasons;

(6) That hospitals and other institutions and facilities within the department of mental health and addiction services may exchange psychiatric records and other pertinent information with other hospitals, institutions, and facilities of the department, and with community mental health services providers and boards of alcohol, drug addiction, and mental health services with which the department has a current agreement for patient care or services. Records and information that may be released pursuant to this division shall be limited to medication history, physical health status and history, financial status, summary of course of treatment in the hospital, summary of treatment needs, and a discharge summary, if any.

(7) That hospitals within the department and other institutions and facilities within the department may exchange psychiatric records and other pertinent information with payers and
other providers of treatment, health services, and recovery supports if the purpose of the exchange is to facilitate continuity of care for a patient or for the emergency treatment of an individual;

(8) That a patient's family member who is involved in the provision, planning, and monitoring of services to the patient may receive medication information, a summary of the patient's diagnosis and prognosis, and a list of the services and personnel available to assist the patient and the patient's family, if the patient's treating physician determines that the disclosure would be in the best interests of the patient. No such disclosure shall be made unless the patient is notified first and receives the information and does not object to the disclosure.

(9) That community mental health services providers may exchange psychiatric records and certain other information with the board of alcohol, drug addiction, and mental health services and other services providers in order to provide services to a person involuntarily committed to a board. Release of records under this division shall be limited to medication history, physical health status and history, financial status, summary of course of treatment, summary of treatment needs, and discharge summary, if any.

(10) That information may be disclosed to the executor or the administrator of an estate of a deceased patient when the information is necessary to administer the estate;

(11) That records in the possession of the Ohio history connection may be released to the closest living relative of a deceased patient upon request of that relative;

(12) That records pertaining to the patient's diagnosis, course of treatment, treatment needs, and prognosis shall be disclosed and released to the appropriate prosecuting attorney if the patient was committed pursuant to section 2945.38, 2945.39, 2945.40, 2945.401, or 2945.402 of the Revised Code, or to the attorney designated by the board for proceedings pursuant to involuntary commitment under this chapter.

(13) That the department of mental health and addiction services may exchange psychiatric hospitalization records, other mental health treatment records, and other pertinent information with the department of rehabilitation and correction and with the department of youth services to ensure continuity of care for inmates or offenders who are receiving mental health services in an institution of the department of rehabilitation and correction or the department of youth services and may exchange psychiatric hospitalization records, other mental health treatment records, and other pertinent information with boards of alcohol, drug addiction, and mental health services and community mental health services providers to ensure continuity of care for inmates or offenders who are receiving mental health services in an institution and are scheduled for release within six months. The release of records under this division is limited to records regarding an inmate's or offender's medication history, physical health status and history, summary of course of treatment, summary of treatment needs, and a discharge summary, if any;

(14) That records and reports relating to a person who has been deceased for fifty years or more are no longer considered confidential.

(B) Before records are disclosed pursuant to divisions (A)(3), (6), and (9) of this section, the custodian of the records shall attempt to obtain the patient's consent for the disclosure. No person shall reveal the contents of a medical record of a patient except as authorized by law.

(C) The managing officer of a hospital who releases necessary medical information under division (A)(3) of this section to allow an insurance carrier or other third party payor to comply with section 5121.43 of the Revised Code shall neither be subject to criminal nor civil liability.

5122.311 Mentally ill or involuntary person's admission; notice.

(A) Notwithstanding any provision of the Revised Code to the contrary, if, on or after April 8, 2004, an individual is found by a court to be a mentally ill person subject to court order...
or becomes an involuntary patient other than one who is a patient only for purposes of observation, the probate judge who made the adjudication or the chief clinical officer of the hospital, community mental health services provider, or facility in which the person is an involuntary patient shall notify the office of the attorney general, on the form described in division (C) of this section, of the identity of the individual. The notification shall be transmitted by the judge or the chief clinical officer not later than seven days after the adjudication or commitment.

(B) The office of the attorney general shall compile and maintain the notices it receives under division (A) of this section and the notices shall be used for the purpose of conducting incompetency records checks pursuant to section 311.41 of the Revised Code. The notices and the information they contain are confidential, except as provided in this division, and are not public records.

(C) The attorney general, by rule adopted under Chapter 119 of the Revised Code, shall prescribe and make available to all probate judges and all chief clinical officers a form to be used by them for the purpose of making the notifications required by division (A) of this section.

5122.32 Quality assurance program records; confidentiality.

(A) As used in this section:

(1) “Quality assurance committee” means a committee that is appointed in the central office of the department of mental health and addiction services by the director of mental health and addiction services, a committee of a hospital or community setting program, or a duly authorized subcommittee of a committee of that nature and that is designated to carry out quality assurance program activities.

(2) “Quality assurance program” means a comprehensive program within the department of mental health and addiction services to systematically review and improve the quality of medical and mental health services within the department and its hospitals and community setting programs, the safety and security of persons receiving or administering medical and mental health services within the department and its hospitals and community setting programs, and the efficiency and effectiveness of the utilization of staff and resources in the delivery of medical and mental health services within the department and its hospitals and community setting programs. “Quality assurance program” includes the central office quality assurance committees, morbidity and mortality review committees, quality assurance programs of community setting programs, quality assurance committees of hospitals operated by the department of mental health and addiction services, and the office of licensure and certification of the department.

(3) “Quality assurance program activities” include collecting or compiling information and reports required by a quality assurance committee, receiving, reviewing, or implementing the recommendations made by a quality assurance committee, and credentialing, privileging, infection control, tissue review, peer review, utilization review including access to patient care records, patient care assessment records, and medical and mental health records, medical and mental health resource management, mortality and morbidity review, and identification and prevention of medical or mental health incidents and risks, whether performed by a quality assurance committee or by persons who are directed by a quality assurance committee.

(4) “Quality assurance records” means the proceedings, discussion, records, findings, recommendations, evaluations, opinions, minutes, reports, and other documents or actions that emanate from quality assurance committees, quality assurance programs, or quality assurance program activities. “Quality assurance records” does not include aggregate statistical information that does not disclose the identity of persons receiving or providing medical or mental health services in department of mental health and addiction services hospitals or community setting programs.
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(B)(1) Except as provided in division (E) of this section, quality assurance records are confidential and are not public records under section 149.43 of the Revised Code, and shall be used only in the course of the proper functions of a quality assurance program.

(2) Except as provided in division (E) of this section, no person who possesses or has access to quality assurance records and who knows that the records are quality assurance records shall willfully disclose the contents of the records to any person or entity.

(C)(1) Except as provided in division (E) of this section, no quality assurance record shall be subject to discovery, and is not admissible in evidence, in any judicial or administrative proceeding.

(2) Except as provided in division (E) of this section, no member of a quality assurance committee or a person who is performing a function that is part of a quality assurance program shall be permitted or required to testify in a judicial or administrative proceeding with respect to quality assurance records or with respect to any finding, recommendation, evaluation, opinion, or other action taken by the committee, member, or person.

(3) Information, documents, or records otherwise available from original sources are not to be construed as being unavailable for discovery or admission in evidence in a judicial or administrative proceeding merely because they were presented to a quality assurance committee. No person testifying before a quality assurance committee or person who is a member of a quality assurance committee shall be prevented from testifying as to matters within the person's knowledge, but the witness cannot be asked about the witness' testimony before the quality assurance committee or about an opinion formed by the person as a result of the quality assurance committee proceedings.

(D)(1) A person who, without malice and in the reasonable belief that the information is warranted by the facts known to the person, provides information to a person engaged in quality assurance program activities is not liable for damages in a civil action for injury, death, or loss to person or property to any person as a result of providing the information.

(2) A member of a quality assurance committee, a person engaged in quality assurance program activities, and an employee of the department of mental health and addiction services shall not be liable in damages in a civil action for injury, death, or loss to person or property to any person for any acts, omissions, decisions, or other conduct within the scope of the functions of the quality assurance program.

(3) Nothing in this section shall relieve any institution or individual from liability arising from the treatment of a patient.

(E) Quality assurance records may be disclosed, and testimony may be provided concerning quality assurance records, only to the following persons or entities:

(1) Persons who are employed or retained by the department of mental health and addiction services and who have authority to evaluate or implement the recommendations of a state-operated hospital, community setting program, or central office quality assurance committee;

(2) Public or private agencies or organizations if needed to perform a licensing or accreditation function related to department of mental health and addiction services hospitals or community setting programs, or to perform monitoring of a hospital or program of that nature as required by law.

(F) A disclosure of quality assurance records pursuant to division (E) of this section does not otherwise waive the confidential and privileged status of the disclosed quality assurance records.

(G) Nothing in this section shall limit the access of the Ohio protection and advocacy system to records or personnel as required under section 5123.601 of the Revised Code. Nothing in this section shall limit the admissibility of documentary or testimonial evidence in an action brought by the Ohio protection and advocacy system in its own name or on behalf of a client.
5122.33 Department of mental health powers.

The department of mental health and addiction services may prescribe the form of applications, reports, records, and medical certificates provided for under this chapter, and the information required to be contained therein; require reports from the chief clinical officer of any public hospital relating to the admission, examination, diagnosis, release, or discharge of any patient; visit each such hospital regularly to review the admission procedures of all new patients admitted between visits; investigate by personal visit complaints made by any patient or by any person on behalf of a patient; and adopt such rules as are reasonably necessary to effectuate the provisions of this chapter.

5122.34 Liability of participants.

(A) Persons, including, but not limited to, boards of alcohol, drug addiction, and mental health services and community mental health services providers, acting in good faith, either upon actual knowledge or information thought by them to be reliable, who procedurally or physically assist in the hospitalization or discharge, determination of appropriate placement, court-ordered treatment, or in judicial proceedings of a person under this chapter, do not come within any criminal provisions, and are free from any liability to the person hospitalized or receiving court-ordered treatment or to any other person.

(B) Regardless of whether any affirmative action has been taken under this chapter with respect to a mental health client or patient and except as otherwise provided in section 2305.51 of the Revised Code, no person shall be liable for any harm that results to any other person as a result of failing to disclose any confidential information about the mental health client or patient, or failing to otherwise attempt to protect such other person from harm by such client or patient.

(C) This section applies to expert witnesses who testify at hearings under this chapter.

(D) The immunity from liability conferred by this section is in addition to and not in limitation of any immunity conferred by any other section of the Revised Code or by judicial precedent.

5122.35 Probate court's jurisdiction.

(A) In a case in which the jurisdiction of a court has not been specifically given or the procedure provided for, the court in the county in which a person alleged to be mentally ill is found shall have full, complete, and general jurisdiction to make disposition of such person in accordance with the procedure prescribed by Chapter 5122 of the Revised Code.

(B) When an affidavit is filed in the court as provided in section 5122.11 of the Revised Code, and the person alleged to be mentally ill is detained in a hospital located in another county, the court of the county in which such hospital is located shall, upon the request of the court receiving the affidavit, hold a hearing and make disposition of such person in accordance with Chapter 5122 of the Revised Code.

5122.38 Competency adjudication.

Each individual now or formerly hospitalized pursuant to this chapter or former Chapter 5123 of the Revised Code, is entitled to an adjudication of competency or incompetency or termination of guardianship upon written request by any such individual, his guardian, or the chief clinical officer to the probate court. The court, on its own motion, may initiate such a hearing.

Upon filing of such application, or on the court's own motion, notice of the purpose, time, and place of the hearing shall be given to the person upon whose affidavit such adjudication
was made, to the guardian of the applicant, and to his spouse at his residence, if such address is known.

Upon hearing, if it is proven that such applicant is competent, the court shall so find and enter the finding on its journal. The adjudicating court shall send a transcript of the adjudication to the county of the patient's residence.

5122.39 Mentally ill minors; guardianship.

(A) Mentally ill minors shall remain under the natural guardianship of their parents, notwithstanding hospitalization pursuant to this chapter, unless parental rights have been terminated pursuant to a court finding that the minor is neglected or dependent. Where a mentally ill minor is found to be dependent or neglected, the public children's services agency in the county of residence has final guardianship authority and responsibility.

(B) In no case shall the guardianship of a mentally ill person be assigned to the chief medical officer or any staff member of a hospital, board, or provider from which the person is receiving mental health services.

5122.41 Patient's possessions at time of hospitalization; special guardian.

The court, upon making an order hospitalizing a person under this chapter, shall immediately transmit to the chief clinical officer of the hospital, copies, under his official seal, of court papers in the case, including the certificate of the medical witnesses and of his findings in the case.

Upon hospitalization, the chief clinical officer of the hospital to which the patient is admitted shall take possession of all money and other valuables that may be upon the person of the patient, and shall within ten days file a list thereof with the probate judge of the county of which the patient is a resident. If the amount of money is fifty dollars or less it shall be retained and expended by the chief clinical officer of the hospital for the benefit of the patient. Unless a guardian of the estate of the patient has already been appointed, the probate judge may, upon his own motion and without notice, appoint a special guardian of the estate of the patient. Any special guardian, before being appointed, shall file a bond approved by the probate judge in the same amount as is required by section 2109.04 of the Revised Code. A special guardian as provided for in this section, and while acting as such, shall be governed by all laws applicable to guardians of the estates of either minors or incompetents. The special guardian shall be allowed such compensation for his services as the court thinks reasonable, provided he forthwith performs all the duties incumbent upon him.

5122.42 Rules of construction; preservation of rights.

Nothing in this chapter limits any rights, privileges, or immunities under the constitution, and laws of the United States or this state.

5122.43 Costs and expenses of proceedings.

(A) Costs, fees, and expenses of all proceedings held under this chapter shall be paid as follows:

(1) To police and health officers, other than sheriffs or their deputies, the same fees allowed to constables, to be paid upon the approval of the probate judge;

(2) To sheriffs or their deputies, the same fees allowed for similar services in the court of common pleas;

(3) To physicians or licensed clinical psychologists acting as expert witnesses and to
other expert witnesses designated by the court, an amount determined by the court;
(4) To other witnesses, the same fees and mileage as for attendance at the court of common pleas, to be paid upon the approval of the probate judge;
(5) To a person, other than the sheriff or the sheriff's deputies, for taking a mentally ill person to a hospital or removing a mentally ill person from a hospital, the actual necessary expenses incurred, specifically itemized, and approved by the probate judge;
(6) To assistants who convey mentally ill persons to the hospital when authorized by the probate judge, a fee set by the probate court, provided the assistants are not drawing a salary from the state or any political subdivision of the state, and their actual necessary expenses incurred, provided that the expenses are specifically itemized and approved by the probate judge;
(7) To an attorney appointed by the probate division for an indigent who allegedly is a mentally ill person pursuant to any section of this chapter or a person suffering from alcohol and other drug abuse and who may be ordered under sections 5119.91 to 5119.98 of the Revised Code to undergo treatment, the fees that are determined by the probate division. When those indigent persons are before the court, all filing and recording fees shall be waived.
(8) To a referee who is appointed to conduct proceedings under this chapter that involve a respondent whose domicile is or, before the respondent's hospitalization, was not the county in which the proceedings are held, compensation as fixed by the probate division, but not more than the compensation paid for similar proceedings for respondents whose domicile is in the county in which the proceedings are held;
(9) To a court reporter appointed to make a transcript of proceedings under this chapter, the compensation and fees allowed in other cases under section 2101.08 of the Revised Code.

(B) A county shall pay for the costs, fees, and expenses described in division (A) of this section with money appropriated pursuant to section 2101.11 of the Revised Code. A county may seek reimbursement from the department of mental health and addiction services by submitting a request and certification by the county auditor of the costs, fees, and expenses to the department within two months of the date the costs, fees, and expenses are incurred by the county.

Each fiscal year, based on past allocations, historical utilization, and other factors the department considers appropriate, the department shall allocate for each county an amount for reimbursements under this section. The total of all the allocations shall equal the amount appropriated for the fiscal year to the department specifically for the purposes of this section.

On receipt, the department shall review each request for reimbursement and prepare a voucher for the amount of the costs, fees, and expenses incurred by the county, provided that the total amount of money paid to all counties in each fiscal year shall not exceed the total amount of moneys specifically appropriated to the department for these purposes.

The department's total reimbursement to each county shall be the lesser of the full amount requested or the amount allocated for the county under this division. In addition, the department shall distribute any surplus remaining from the money appropriated for the fiscal year to the department for the purposes of this section as follows to counties whose full requests exceed their allocations:
(1) If the surplus is sufficient to reimburse such counties the full amount of their requests, each such county shall receive the full amount of its request;
(2) If the surplus is insufficient, each such county shall receive a percentage of the surplus determined by dividing the difference between the county's full request and its allocation by the difference between the total of the full requests of all such counties and the total of the amounts allocated for all such counties.

The department may adopt rules in accordance with Chapter 119 of the Revised Code to implement the payment of costs, fees, and expenses under this section.
5122.99 Violations of confidentiality of quality assurance records.

A person who violates division (B)(2) of section 5122.32 of the Revised Code shall be fined not more than two thousand five hundred dollars on a first offense and not more than twenty thousand dollars on a subsequent offense.

5122-27-06 Release of information.

(A) Each request for information regarding a current or previous client shall be accompanied by an authorization for release of information, except as specified in sections 5119.27, 5119.28, and 5122.31 of the Revised Code.

(B) The authorization for release of information shall include, but not be limited to, the following:

(1) The full name of the client.
(2) Date of birth of the client.
(3) The specific information to be disclosed.
(4) The name of the person or entity disclosing the information.
(5) The name of the person or entity receiving the information.
(6) The date, event, or condition upon which the authorization shall expire.
(7) Statement that the consent is subject to revocation at any time except to the extent the provider or person who is to make the disclosure has already acted in reliance on it.
(8) The dated signature of the client or, as appropriate, a legally authorized agent and the agent's relationship to the client.
(9) For clients receiving addiction services treatment, the following statement: “This information has been disclosed to you from records protected by federal confidentiality rules. The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R. part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The federal rules restrict any use of information to criminally investigate or prosecute any alcohol or drug abuse client.”

(C) If the client is a minor, the release of information shall either:

(1) Be signed by the client's parent or legal guardian;
(2) In the case of providers who are certified to provide AoD treatment services, be signed by the client and the client's parent or legal guardian; or,
(3) In the case of providers who are certified to provide AoD treatment services and minor client's providing consent to treatment pursuant to section 3719.012 of the Revised Code, the client shall sign the release of information.

(D) In the case of providers who are certified to provide AoD treatment services, when providing services to clients who are minors but who are not providing consent pursuant to section 3719.012 of the Revised code; the provider must either obtain the client's authorization to contact the client's parent or legal guardian or find the minor lacks in capacity to make a rational choice in accordance with 42 C.F.R. part 2.14(c)(2).

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5119.23 Department of mental health and addiction services; reimbursement.

(A) The department of mental health and addiction services shall establish a methodology for allocating to boards of alcohol, drug addiction, and mental health services the
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funds appropriated by the general assembly to the department for the purpose of the community-based continuum of care that each board establishes under section 340.032 of the Revised Code. The department shall establish the methodology after notifying and consulting with relevant constituencies as required by division (A)(10) of section 5119.21 of the Revised Code. The methodology may provide for the funds to be allocated to boards on a district or multi-district basis.

(B) Subject to section 5119.25 of the Revised Code, and to required submissions and approvals under sections 340.08 and 5119.22 of the Revised Code, the department shall allocate the funds to the boards in a manner consistent with the methodology, this section, other state and federal laws, rules, and regulations.

(C) In consultation with boards, community addiction services providers, community mental health services providers, and persons receiving addiction services, mental health services, and recovery supports, the department shall establish guidelines for the use of funds allocated under this section.

5119.311 Department of Mental Health and Addiction Services powers.

The department of mental health and addiction services may examine into, with or without expert assistance, the question of the mental and physical condition of any person committed to or involuntarily confined in any hospital for the mentally ill, or restrained of liberty at any place within this state by reason of alleged mental illness and may order and compel the discharge of any such person who is not a mentally ill person subject to court order as defined in division (B) of section 5122.01 of the Revised Code and direct what disposition shall be made of the person. The order of discharge shall be signed by the director of mental health and addiction services. Upon receipt of such order by the superintendent or other person in charge of the building in which the person named in such order is confined, such person shall forthwith be discharged or otherwise disposed of according to the terms of said order, and any further or other detention of such person is unlawful. No such order shall be made in favor of any person committed and held for trial on a criminal charge, in confinement by an order of a judge or court made in a criminal proceeding, or in any case unless notice is given to the superintendent or other person having charge of the building in which the alleged mentally ill person is detained, and a reasonable opportunity is allowed the person in charge to justify further detention of the person confined.

5119.331 Injunctions against unlicensed hospitals providing treatment or care.

If the department of mental health and addiction services determines that a hospital not licensed by the department is receiving for care or treatment any person who is or appears to be mentally ill, the department may request in writing that the attorney general petition the court of common pleas in the county where the hospital is located to enjoin the hospital from continued operation in violation of section 5119.33 of the Revised Code.

5119.333 License required to treat mentally ill.

No person shall keep or maintain a hospital for the care or treatment of mentally ill persons unless it is licensed by the department of mental health and addiction services, as provided by section 5119.33 of the Revised Code.

5122-14-01 Department of mental health and related definitions.

(A) The provisions of Chapter 5122-14 of the Administrative Code are applicable to each
inpatient psychiatric service provider licensed pursuant to section 5119.33 of the Revised Code by the department of mental health and addiction services.

(B) The following definitions shall apply to Chapter 5122-14 of the Administrative Code:

(1) “Abuse” means any act or absence of action caused by an employee inconsistent with rights which results or could result in physical injury to a patient; any act which constitutes sexual activity, as defined under Chapter 2907 of the Revised Code, when such activity would constitute an offense against a patient under that Chapter; insulting or coarse language or gestures directed toward a patient which subjects the patient to humiliation or degradation; or depriving a patient of real or personal property by fraudulent or illegal means. For children, in addition to the above, the definition of abuse is the same as in section 2151.031 of the Revised Code.

(2) “Admission” means acceptance by the inpatient psychiatric service provider of a person with the intent of providing at least twenty-four hours continuous care and treatment to that person.

(3) “Advance directives” means a legal document an adult can use to direct in advance the decisions about their mental or physical health treatment, if in the future they lack the capacity to make their own health care decisions.

(4) “Certified nurse practitioner” means a registered nurse who holds a current, valid certificate of authority issued by the Ohio board of nursing that authorizes the practice of nursing as a nurse practitioner in accordance with Chapter 4723 of the Revised Code.

(5) “Chemical restraint” means any medication that alters the functioning of the central nervous system in a manner that limits physical and cognitive functioning to the degree that the patient cannot attain the patient’s highest practicable physical, mental, and psychosocial well-being.

(6) “Child and adolescent psychiatrist” means a psychiatrist who is certified in child and adolescent psychiatry by the American board of psychiatry and neurology or has successfully completed training in a child and adolescent psychiatry program approved by the residency review committee of the accreditation council for graduate medical education of the American medical association. A child and adolescent psychiatrist is also a psychiatrist as defined in this rule.

(7) “Clear treatment reasons” means that a patient would present a substantial risk of physical harm to themselves or others, or that effective treatment of the patient would be substantially precluded.

(8) “Clinical nurse specialist” means a registered nurse who holds a current, valid certificate of authority issued by the Ohio board of nursing that authorizes the practice of nursing as a clinical nurse specialist in accordance with Chapter 4723 of the Revised Code.

(9) “Clinical privileges” means authorization granted to a practitioner to provide specific health care services in the organization within well-defined limits, based on the following factors, as applicable: license, certification, registration, education, training, experience, competence, health status, and judgment.

(10) “CMS” means the centers for medicare and medicaid services, a federal agency within the U.S. department of health and human services.

(11) “Community addiction services provider” means an agency, association, corporation, individual, or program that provides alcohol, drug addiction, or gambling addiction services that are certified by the department of mental health and addiction services under section 5119.36 of the Revised Code.

(12) “Community mental health services provider” means an agency, association, corporation, individual, or program that provides mental health services that are certified by the department of mental health and addiction services under section 5119.36 of the Revised Code.

(13) “Counselor” means an individual who is licensed as a professional counselor or a professional clinical counselor according to Chapter 4757 of the Revised Code.


(14) “Cultural sensitivity” means an awareness, understanding, and responsiveness to the beliefs, values, customs, and institutions (family, religious, etc.) of a group of people, particularly those of a race or ethnic group different from one's own, or those identified cultures of persons with specific disabilities such as deafness.

(15) “Culturally relevant” means incorporating awareness, understanding, and responsiveness to the beliefs, values, customs, and institutions (family, religious, etc.) and ethnic heritage of individuals or those identified cultures of persons with specific disabilities such as deafness, into training, treatment, and services designed to impact upon, or meet the needs of individuals or groups.

(16) “Department” means the Ohio department of mental health and addiction services.

(17) “Det norske veritas (DNV) healthcare, inc.” means the organization, a division of det norske veritas, which operates the national integrated accreditation for healthcare organizations program.

(18) “Developmental disability” means physical, neurological, developmental, or accidental disabilities that seriously impair health, mobility, or functioning. The disability may be congenital or acquired. Included are persons with epilepsy, autism, narcolepsy, tourette's disorder, spina bifida, head injuries, learning disabilities, and others who have chronic or lifelong conditions and impairments and are at considerable risk for mental health problems.

(19) “Director” means the director of the Ohio department of mental health and addiction services.

(20) “Dietitian” means an individual who is licensed as a dietitian according to Chapter 4759 of the Revised Code.

(21) “Emergency” means an impending or crisis situation that creates circumstances demanding immediate action.

(22) “Expressive therapist” means an individual who provides treatment intervention through the use of such activities as art, music, dance; who is certified or registered by the national expressive therapist association, certification board for music therapists, American arts therapy association, American dance therapy association, or is licensed, certified or registered by another recognized state or national body to practice expressive therapy.

(23) “Family members” means persons related by family to a patient.

(24) “Grievance” means a written record of a patient's, family member's, or significant other's dissatisfaction with mental health services, initiated by the patient, family member, significant other, patient rights advocate, or other interested person or agency.

(25) “Guardian” means any person, association, or corporation appointed by the probate court to have responsibility for the care and management of a minor or a person declared incompetent in accordance with Chapter 2111 of the Revised Code.

(26) “HFAP” means the healthcare facilities accreditation program, a program of the American osteopathic association (AOA).

(27) “Hospital” means the same as inpatient psychiatric service provider.

(28) “Incident” means any event that poses a danger to the health and safety of patients, staff, or visitors of the hospital, and is not consistent with routine care of persons served or routine operation of the hospital.

(29) “Informed consent” means the voluntary, knowing, reasoned choice of a person, or, as appropriate, the person's legal guardian to a proposed treatment or procedure.

(30) “Inpatient psychiatric service provider” means a psychiatric hospital, or psychiatric inpatient unit administered by a general hospital, community mental health service provider, or other facility, that provides inpatient psychiatric services.

(31) “Involuntary” means against an individual's will or without having been provided informed consent.

(32) “Joint commission” (TJC) means the joint commission, formerly known as the joint commission on accreditation of healthcare organizations (JCAHO).
(33) “License” means the department's written approval and authorization for an inpatient psychiatric service provider to receive persons with a mental disorder for care and treatment.

(34) “Licensed practical nurse” means an individual who is licensed as a practical nurse according to Chapter 4723 of the Revised Code.

(35) “Medical record” means the account of a patient's hospitalization, compiled by health care professionals, including but not limited to a patient's history, present illness, findings on examination, details of care, services and treatment, and progress notes.

(36) “Medication” means therapeutic drugs (or agents or compounds) that require a prescription or order by an appropriately licensed independent practitioner.

(37) “Mental retardation” now designated as developmental disability (DD), means having significantly sub-average general intellectual functioning existing concurrently with deficiencies in adaptive behavior. The assessed level of retardation is based on I.Q. scores moderated by adaptive behavior testing or an assessment of the individual's actual functioning in daily life activities.

(38) “Neglect” means a purposeful or negligent disregard of duty imposed on an employee or staff member by statute, rule, or professional standard and owed to a patient by that employee or staff member.

(39) “Nursing staff” means clinical nurse specialists, nurse practitioners, registered nurses, licensed practical nurses, nursing assistants, and other nursing personnel who perform patient care.

(40) “Occupational therapist” means an individual who is licensed as an occupational therapist according to Chapter 4755 of the Revised Code.

(41) “Occupational therapy assistant” means an individual who is licensed as an occupational therapy assistant according to Chapter 4755 of the Revised Code.

(42) “Patient” means a person admitted to a hospital or inpatient unit either voluntarily or involuntarily who is under observation or receiving treatment, or is receiving any other mental health services by the inpatient psychiatric service provider.

(43) “Patient rights specialist” means that person(s), designated by each inpatient psychiatric service provider to safeguard patient rights and to assist patients in exercising their rights, including the rights in this chapter and in Chapter 5122 of the Revised Code.

(44) “Physician” means a person licensed by the state medical board according to Chapter 4731 of the Revised Code to practice medicine, or a medical officer of the government of the United States while in this state in the performance of his/her official duties.

(45) “Prone Restraint” means all items or measures used to limit or control the movement or normal functioning of any portion or all of an individual's body while the individual is in a face-down positions. Prone restraint may include either physical (also known as manual), or mechanical restraint.

(46) “Psychiatric intensive care” means a program, within a defined secure physical space, normally including patient lounge and sleeping room space, utilized to provide a more intense form of care for those patients requiring closer observation, decreased environmental stimulation, or a more intensive staff to patient ratio.

(47) “Psychiatrist” means a licensed physician who has satisfactorily completed a residency training program in psychiatry as approved by the residency review committee of the accreditation council for graduate medical education of the American medical association; or the committee on postgraduate education of the American osteopathic board of neurology and psychiatry, or who has been recognized as of July 1, 1989, as a psychiatrist by the Ohio state medical association or the Ohio osteopathic association, on the basis of formal training and five or more years of medical practice limited to psychiatry.

(48) “Psychiatrist with clinical privileges in adolescent psychiatry” means a psychiatrist who is qualified through training and experience specific to the needs of adolescent age.
patients, and who has specific hospital clinical privileges to provide treatment to adolescent age patients.

(49) “Psychiatrist with clinical privileges in geriatric psychiatry” means a psychiatrist who is qualified through the American board of psychiatry and neurology or through other documented training or experience specific to the needs of geriatric age patients, and who has specific hospital clinical privileges to provide treatment to geriatric age patients.

(50) “Psychologist” means an individual who holds a current license under Chapter 4732 of the Revised Code which authorizes the practice of psychology.

(51) “Psychotropic medication” means that group of medications which has a specific and intended effect on central nervous system functions and which is ordinarily used to alter disorders of thought, perception, mood, or behavior.

(52) “Recovery” means a personal process of overcoming the negative impact of a psychiatric disability despite its continued presence.

(53) “Recreational therapist” means an individual who is registered by the Ohio recreational therapy registration board or certified by the national council for therapeutic recreation certification; or is licensed, certified or registered by another recognized state or national body to practice recreational therapy.

(54) “Registered nurse (R.N.)” means an individual who is licensed as a registered nurse according to Chapter 4723 of the Revised Code.

(55) “Rehabilitation therapist” means either an occupational therapist, an occupational therapy assistant, a recreational therapist, or an expressive therapist as defined in this rule. Such individuals shall comply with current, applicable scope of practice and supervisory requirements as identified by their appropriate licensing, certifying or registering bodies.

(56) “Rehabilitation therapy services” means structured activities designed to help a patient develop or maintain functional living skills including physical, social and creative skills through participation in activities of daily living, vocational, recreational, social, expressive, or other activities designed to promote patient recovery, resiliency and independence in both the hospital and community setting.

(57) “Reportable incident” means an incident that must be submitted to the department, including incidents that must then be forwarded by the department to disability rights Ohio pursuant to section 5123.604 of the Revised Code. As referenced in division (E) of section 5119.36 of the Revised Code, “major unusual incident” has the same meaning as “reportable incident”.

(58) “Resiliency” means the personal and community qualities that enable individuals to rebound from adversity, trauma, tragedy, threats, or other stresses - and to go on with life with a sense of mastery, competence and hope.

(59) “Restraint” means any manual method, physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a patient to move his or her arms, legs, body, or head freely.

(60) “Seclusion” means the involuntary confinement of a patient alone in a room where the patient is physically prevented from leaving.

(61) “Significant other” means individuals who are significant and important to the well-being of the patient, as identified by the patient.

(62) “Social worker,” means an individual who is licensed as an independent social worker or as a social worker according to Chapter 4757 of the Revised Code.

(63) “Transitional hold” means a brief physical (also known as manual) restraint of an individual face-down for the purpose of effectively gaining physical control of an individual in order to prevent harm to self and others, or for the purpose of transport, i.e. carrying a individual to another location within the facility.

(64) “Treatment plan” means a written statement of goals and objectives for a patient with corresponding treatment interventions and services.
(65) “Variance” means permission granted by the director or designee in writing to an inpatient psychiatric service provider to change the conditions or specific requirements of a rule.

(66) “Waiver” means permission granted by the director or designee in writing to an inpatient psychiatric service provider to be exempted from the conditions of specific requirements of a rule.

5122-14-02 Accreditation requirements.

(A) Each inpatient psychiatric service provider licensed by the department shall be accredited under a hospital accreditation program by either the joint commission (TJC) healthcare facilities accreditation program (HFAP) or DNV healthcare inc (DNV).

(B) Proof of such accreditation shall be submitted by the inpatient psychiatric service provider as indicated in paragraphs (A)(1)(h) and (B)(7) of rule 5122-14-03 of the Administrative Code.

5122-14-03 Licensure procedures.

(A) An inpatient psychiatric service provider wishing to establish inpatient services for the first time for persons with mental disorders shall, prior to occupancy and provision of services, make application for full licensure to the department.

(1) The application shall consist of, at minimum:

(a) Completed application form;

(b) Approved building inspection or certificate of occupancy report;

(c) Approved fire inspection report;

(d) Non-refundable annual licensure fee;

(e) Reduced line drawing showing location and function of all patient and staff areas including the floor and social space square footage;

(f) Comprehensive plan of service;

(g) Proof of psychiatric bed registration as reported annually to the Ohio department of health, as applicable;

(h) Verification of current TJC, HFAP, or DNV accreditation as demonstrated by the submission of a copy of the most recent letter of accreditation;

(i) Completed self-survey checklist; and

(j) Statement of the number of licensed beds designated for treatment of persons less than eighteen years of age, and the number of licensed beds designated for treatment of persons eighteen years of age and older. The sum of beds designated for treatment of persons less than eighteen years of age and beds designated for treatment of persons eighteen years and older shall equal the total number of licensed beds for the inpatient psychiatric service provider.

(2) The proposed inpatient psychiatric service provider shall be subject to an on-site inspection by a designee of the department prior to occupancy to determine if the inpatient psychiatric service provider is in compliance with this chapter.

(3) An interim license not to exceed ninety days may be issued to the inpatient psychiatric service provider upon completion and departmental approval of the requirements stated in paragraphs (A)(1) to (A)(2) of this rule.

(4) Prior to expiration of the interim license, the department may issue a full license based on review and approval by the department of:

(a) Implementation of policies and procedures; and

(b) Documentation of being in compliance with licensure rules in this chapter.

(B) For an inpatient psychiatric service provider holding a current license, annual renewal of full licensure shall be based on receipt and approval by the department of:
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(1) Completed application form which assures that the private inpatient psychiatric service provider remains in compliance with licensure rules in this chapter;
(2) All substantial changes in written policies and procedures specific to inpatient psychiatric service provider treatment and licensure rules in this chapter to be submitted to the department when the inpatient psychiatric service provider does not receive an on-site survey;
(3) Approved fire inspection report, dated within one year of licensure renewal date;
(4) Approved building inspection report, if renovations or major changes in the building have been made, or a major change has been made in the use of space;
(5) Non-refundable annual licensure fee;
(6) Statement of the number of licensed beds designated for treatment of persons less than eighteen years of age, and the number of licensed beds dedicated for treatment of persons eighteen years of age and older. The sum of beds designated for treatment of persons less than eighteen years of age and beds designated for treatment of persons eighteen years and older shall equal the total number of licensed beds for the inpatient psychiatric service provider;
(7) Verification of current TJC, HFAP, or DNV accreditation as demonstrated by the submission of a copy of the most recent letter of accreditation; and
(8) A thirty-day notice shall be given whenever possible by the department to the inpatient psychiatric service provider prior to the expiration of the annual license.

(C) Renewal of full licensure shall require an on-site survey of the inpatient psychiatric service provider every three years, or as determined by the department, to be conducted by a designee of the department to assure compliance with licensure rules in this chapter. A thirty-day notice shall be given whenever possible by the department to the inpatient psychiatric service provider prior to such a survey.

(D) The department shall provide to an inpatient psychiatric service provider a written communication identifying any deficiencies or non-compliance with licensure rules in this chapter subsequent to an on-site survey, or whenever the inpatient psychiatric service provider is found to be in non-compliance with such rules.

(1) If deficiencies or non-compliance with such rules are present, the inpatient psychiatric service provider shall submit documentation of its corrective actions as specified by the department in its written report.
(2) When the deficiencies have been corrected, or a plan to do so has been received and granted approval by the department, the department may then issue a full or probationary license. The existing license shall remain in effect until the department grants a full, probationary or interim license, or rescinds the license in accordance with provisions of Chapter 119 of the Revised Code.

(3) The inpatient psychiatric service provider shall fully implement its plan of correction within the timeframes specified by the department.

(E) A license shall be issued to a specific inpatient psychiatric service provider for a specified total maximum daily census expressed as licensed beds, and may not be transferred, modified, or changed without prior approval from the department.

(1) Licensed beds shall be registered annually with the Ohio department of health, pursuant to section 3701.07 of the Revised Code.
(2) Any change in the location or the total number of licensed beds shall require prior approval from the department.
(3) The number of licensed beds shall refer to the actual number of set up and staffed beds available for immediate patient occupancy, or which can be made available for patient occupancy within twenty-four hours.

(a) If an inpatient psychiatric service provider has temporarily designated patient bed space for other purposes to best meet space allocation needs, or if beds have been unavailable for occupancy due to renovation of the psychiatric hospital's or inpatient unit(s)' physical facilities, these beds once available for patient occupancy may be licensed upon application by
the inpatient psychiatric service provider to the department.

(b) The total number of licensed beds shall not exceed the number of beds registered with the department of health pursuant to section 3701.07 of the Revised Code.

(4) If an inpatient psychiatric service provider wishes to cease provision of inpatient services, it shall notify the department in writing so that its license can be terminated. The inpatient psychiatric service provider shall also notify the department of health, as applicable.

(F) An inpatient psychiatric service provider may be visited at any time by a designee of the department to determine compliance with rules in this chapter.

5122-14-04 Three classifications of licenses; age categories authorization.

(A) Licenses shall be classified as follows:

(1) A probationary license, which shall expire within one hundred twenty days of the date of issuance, to be used when:
   (a) Serious deficiencies are found during the department's on-site survey of an inpatient psychiatric service provider; or
   (b) An inpatient psychiatric service provider's documented corrective action is not approved by the department.

(2) An interim license, which shall expire within ninety days after the date of issuance, to be used for emergency licensure purposes or administrative reasons as determined by the department.

   An inpatient psychiatric service provider applying for its first license, and who has preliminary, interim, or similar accreditation shall be issued an interim license until it obtains full accreditation from either TJC, HFAP, or DNV.

(C) Licenses shall specify authorization to admit either one or both age categories of patients based upon the provision of age appropriate diagnostic and treatment services. The child/adolescent category shall apply to all persons less than eighteen years of age upon admission. The adult category shall apply to all persons eighteen years of age and older upon admission.

   (1) Persons less than eighteen years of age shall be admitted only to authorized child/adolescent designated beds;
   (2) Persons eighteen years of age and older shall be admitted only to authorized adult designated beds.

   (3) The following will be the only exceptions permitted for not admitting a patient to an age appropriate bed. All exceptions shall be based on clinical needs specific to each patient, or the unavailability of age appropriate designated beds. For all exceptions there shall be documentation in the patient's medical record of the reasons for the exception, and ongoing concurrent utilization review. The inpatient service provider shall maintain a log which shall contain the reason for admission, length of stay, referral arrangements, and reason for the exception. The department shall review the log annually.

(a) For child/adolescent admissions to adult beds due to the unavailability of child/adolescent beds, the concurrent utilization review shall include documentation indicating all efforts made to seek appropriate resources and linkages with child/adolescent providers for consultation including treatment planning and after hospitalization care.

   (b) The inpatient psychiatric service provider shall inform the parent or legal guardian of the reasons for the decision to admit a child/adolescent to an adult designated bed and also provide information about all available child/adolescent designated beds.

   (c) When the admission is an emergency and all child/adolescent designated beds are
unavailable, a person less than eighteen years of age upon admission may be admitted to an adult designated bed.

(i) A sixteen or seventeen-year-old patient may remain in an adult designated bed for up to seventy-two hours, and if all child/adolescent beds remain unavailable, the admission may be extended for an additional seventy-two hours. If the admission is extended beyond the first seventy-two hours, an assessment as required in accordance with paragraph (E)(2)(g) of rule 5122-14-13 of the Administrative Code shall be conducted, and rehabilitation therapy services and family therapy/interventions shall be available in accordance with paragraphs (K)(3) to (K)(4) of rule 5122-14-12 of the Administrative Code.

(ii) A fifteen-year-old or younger patient may remain in an adult designated bed for a maximum of forty-eight hours if all child/adolescent beds remain unavailable.

(d) A seventeen-year-old person may be electively admitted and treated in an adult designated bed if the person is functioning as an adult in such areas as employment (with limited or no school involvement), family, or marriage, or if the diagnosis or problem is such that treatment is warranted in an adult designated bed, providing that such treatment best meets the patient's needs.

(e) An eighteen through twenty-one year old patient may be admitted to a child/adolescent designated bed based on developmental or other clinical needs specific to the patient.

(4) Licensure authorization to admit persons less than eighteen years of age shall require diagnostic and treatment services to meet the needs of these patients in accordance with rules 5122-14-12 and 5122-14-14 of the Administrative Code.

5122-14-05 Termination of license criteria and procedures.

(A) The inpatient psychiatric service provider's existing license shall remain in effect until the department grants a full, probationary, or interim license or rescinds the license in accordance with provisions of Chapter 119 of the Revised Code.

(B) The department may refuse to grant or renew, or revoke, a full, probationary, or interim license, in accordance with Chapter 119 of the Revised Code if:

(1) An inpatient psychiatric service provider is found to be in non-compliance with any or all of rules in this chapter and a plan of correction is requested of the inpatient psychiatric service provider by the department and is either not received within the time period specified by the department, is not granted approval by the department, or is not implemented by the inpatient psychiatric service provider;

(2) An inpatient psychiatric service provider's submitted application materials are not approved by the department;

(3) An inpatient psychiatric service provider ceases provision of inpatient services;

(4) An inpatient psychiatric service provider presents or submits false or misleading information as part of a license application, renewal, or investigation;

(5) An inpatient psychiatric service provider has been cited for a pattern of serious noncompliance or repeated violations of statutes or rules during the period of current or previous licenses;

(6) An inpatient psychiatric service provider does not apply for licensure renewal at least thirty days prior to the expiration date of the license; or,

(7) The applicant, operator, manager, or owner is or has been the owner or manager of an inpatient psychiatric service provider that has had a previous license to operate revoked or denied renewal for any reason other than nonpayment of the license fee unless:

(a) A minimum period of twenty-four months has passed from the date of the director's order revoking or denying renewal of the inpatient psychiatric service provider's previous license; and
(b) The licensure revocation or non-renewal was not due to any act or omission that violated the patient's right to be free from abuse, neglect, or exploitation.

(C) Notice of the department's intent to deny or revoke a license shall be provided to the inpatient psychiatric service provider in accordance with section 119.07 of the Revised Code. An opportunity for a hearing shall be afforded the inpatient psychiatric service provider in accordance with Chapter 119 of the Revised Code.

(D) The submission of incomplete materials for the application shall be considered a failure to submit an application for licensure, and the non-issuance of an initial license or a renewal license due to an incomplete application shall not be considered the denial or revocation of a license.

(E) In proceedings initiated to deny, refuse to renew, or revoke licenses, the department may deny, refuse to renew, or revoke a license regardless of whether some or all of the deficiencies that prompted the proceedings have been corrected at the time of the hearing.

5122-14-06 Waivers and variances.

(A) An inpatient psychiatric service provider may submit a dated, written request to the department for a waiver or variance. The written request must clearly state the licensure rule of the waiver/variance request, the rationale and need for the requested waiver or variance, and the consequence of not receiving approval of the request.

(B) Upon receipt of a written request for a waiver or variance that provides a clear and valid statement of need, the department in its discretion may grant a waiver or variance for a period of time determined by the department but that shall not exceed the expiration date of the current license.

(C) The department shall acknowledge and respond to the waiver/variance request within thirty days of receipt by the department.

5122-14-07 Display of license.

(A) The current license shall be displayed by the inpatient psychiatric service provider in a conspicuous place which is readily accessible to the patients and the public.

(B) The license shall remain the property of the department, and revoked or terminated licenses shall be returned to the department.

5122-14-08 Fees.

(A) The purpose of this rule is to state the fees for various classifications of license.

(B) The provisions of this rule are applicable to each inpatient psychiatric service provider licensed by the department.

(C) Definitions applying to this rule are those appearing in rule 5122-14-01 of the Administrative Code.

(D) Inpatient psychiatric service provider(s) shall pay an annual fee with each application for full licensure or full licensure renewal according to the following schedule:

<table>
<thead>
<tr>
<th>Psychiatric bed capacity</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>25 or less persons</td>
<td>$750</td>
</tr>
<tr>
<td>26-50 persons</td>
<td>$1350</td>
</tr>
<tr>
<td>51-75 persons</td>
<td>$1650</td>
</tr>
<tr>
<td>76-100 persons</td>
<td>$1950</td>
</tr>
<tr>
<td>Over 100 persons</td>
<td>$2250</td>
</tr>
</tbody>
</table>
(E) Fees for probationary and interim licenses or re-issuance of a license due to a change in the number of licensed beds may be assessed and shall be prorated based on the annual fee.

5122-14-10 Safety policies; facility requirements.

(A) Each inpatient psychiatric service provider shall comply with all applicable TJC, HFAP, or DNV requirements; or federal, state, and local laws and regulations, regarding patient care, safety, sanitation, and fire protection.

(1) A building inspection shall be made upon application for an initial license, repeated whenever renovations or changes in the building are made that would affect either the maximum number of licensed patient beds or substantially change the services provided by the inpatient psychiatric service provider, or whenever the department deems necessary.

(2) If an inpatient psychiatric service provider occupies part of a building, the entire building shall be inspected except where there is a fire wall or other fire resistant separation between the part of the building to be licensed and the rest of the building. If this fire separation does not exist the total building shall be used to determine safety for inspection purposes only.

(3) A building inspection shall be performed by a local certified building inspector or, where none is available, by the chief of the division of factory and building inspection of the Ohio department of industrial relations.

(4) The inpatient psychiatric service provider shall be inspected annually by a certified fire authority or, where none is available, by the division of state fire marshal of the Ohio department of commerce. Copies of annual inspections shall be maintained by the inpatient psychiatric service provider for a period of at least three years or until the next on-site licensure survey.

(5) The inpatient psychiatric service provider's food service shall be inspected annually by the authorized local municipal county health department. Copies of annual inspections shall be maintained by the inpatient psychiatric service provider for a period of at least three years or until the next on-site licensure survey.

(6) If the inpatient psychiatric service provider's water supply and sewage disposal is not part of a municipal system, it shall comply with applicable state or local regulations, rules, codes, or ordinances.

(B) Each inpatient psychiatric service provider shall provide an environment that is clean, safe, aesthetic, and therapeutic. Appropriate space, equipment, and facilities shall be available to provide services.

(1) If smoking is permitted, a separate enclosed area shall be used for smoking;

(2) Each patient's sleeping room shall have a:
   (a) Window, with an operable covering for privacy, that has a view to the outdoors;
   (b) Minimum of one hundred net square feet of usable floor space per bed for single occupancy, and a minimum of eighty net square feet of usable floor space per bed for multi-occupancy;
   (c) Minimum of a bed, chair, storage for personal belongings, and other therapeutic furnishings as appropriate; and
   (d) Degree of privacy from other patients if there is more than one bed in the room.

(3) Child/adolescent patients shall not share the same sleeping room with adult patients.

(4) For all patients, a safe and secure storage area for personal belongings accessible to the patient shall be provided. Personal belongings that may pose safety issues for patients may be placed in a safe and secure storage area accessible to patients through a request of staff.

(5) Each inpatient psychiatric service provider shall provide common patient areas that adequately meet patient needs and program requirements.
(a) There shall be a minimum of eighty total square feet of usable social space per licensed bed to include:
   (i) Patient lounge area totaling at least thirty square feet per licensed bed, including separate smoking and non-smoking areas if smoking is permitted in the lounge area;
   (ii) Patient activity area totaling at least thirty square feet per licensed bed which may include indoor recreation areas;
   (iii) Dining room facilities to meet patient needs;
   (iv) Patient kitchen area to include a sink, a refrigerator, and cooking facilities as appropriate to patient need; and
   (v) Patient laundry area.

(6) Patient lounge, activity, and dining areas may be shared spaces as appropriate to patient need. Child/adolescent patients shall be provided the use of a patient lounge area appropriate for their use separate from adult use of patient lounge areas.

(7) There shall be private areas to include:
   (a) Private area for visitation from family members, significant others, or other persons;
   (b) Private area for telephone use;
   (c) Group therapy area as appropriate to patient need; and
   (d) Private areas to include places and times for personal privacy.

(8) Each inpatient psychiatric service provider shall provide an environment that is accessible to persons with disabilities and make reasonable accommodations in accordance with all applicable federal, state and local laws and regulations.

(9) Each inpatient psychiatric service provider shall develop policies and procedures regarding services designed to assist deaf/hard of hearing persons as well as persons for whom English is not the primary language.

(a) Services shall be provided at such a level so that the patient and patient's family or significant others are not denied the benefits of participation in the inpatient psychiatric service provider's treatment program. Services shall comply with all applicable state, federal and HIPAA guidelines regarding the maintenance of patient confidentiality. As applicable, such services shall consist of but may not be limited to availability of:
   (i) Qualified interpreters with demonstrated ability or certification;
   (ii) Telecommunication devices for the deaf or hard of hearing; and
   (iii) Television closed caption capability.

(b) Such services shall be available to patients and their family members or significant others who are receiving services. Specifically for emergency services, the inpatient psychiatric service provider shall have policies and procedures that address the need for immediate accessibility to qualified interpreters, telecommunication devices for the deaf/hard of hearing, and/or other assistance with communication.

(c) Direct care staff and treatment team members shall be trained in issues relating to barriers to traditional verbal/English communication.

(d) Services to assist patients and families of patients or significant others shall be available at no charge to the patient, family or significant others.

(10) Each inpatient psychiatric service provider shall implement a falls prevention program that is monitored through its quality improvement process.

(C) Each inpatient psychiatric service provider shall have a sufficient number of professional, administrative, and support staff to meet both census needs and patient needs.

(1) Staffing for all services shall reflect the volume of patients, patient acuity, and the level of intensity of the services provided to ensure that desired outcomes of care are achieved and negative outcomes are avoided.

(2) Staffing of any organized patient activity (e.g., rehabilitation therapy services or nursing services provided to groups of patients), shall be sufficient to ensure safety and may be dependent on the type, duration and location of the activity and the immediate accessibility of
other staff.

(3) For nursing services:
   (a) A 1:4 minimum nursing staff-to-patient ratio shall be maintained as an overall average in any four week period with the exception of night hours when patients are sleeping.
   (b) For reasons of safety at least two staff shall be present at all times.
   (c) A registered nurse must be on site twenty-four hours each day, seven days a week.
   (d) A registered nurse must be available for direct patient care when needed.
   (D) Each inpatient psychiatric service provider shall meet all applicable medicare conditions of participation, TJC, HFAP, or DNV standards for seclusion and restraint in addition to the following:
      (1) The following shall not be used under any circumstances:
         (a) Behavior management interventions that employ unpleasant or aversive stimuli such as: the contingent loss of the regular meal, the contingent loss of bed, and the contingent use of unpleasant substances or stimuli such as bitter tastes, bad smells, splashing with cold water, and loud, annoying noises;
         (b) Any technique that obstructs the airway or impairs breathing;
         (c) Any technique that obstructs vision;
         (d) Any technique that restricts the individual's ability to communicate;
         (e) Any technique that causes an individual to be retraumatized based on an individual's history of traumatic experiences;
         (f) Weapons and law enforcement restraint devices, as defined by CMS in appendix A of its interpretive guidelines to 42 C.F.R. 482.13(f) and found in manual publication No. 100-7, "Medicare State Operations", November 20, 2015 revision, used by any hospital staff or hospital-employed security or law enforcement personnel, as a means of subduing a patient to place that patient in patient restraint/seclusion; and
         (g) Chemical restraint.
      (2) Position in physical or mechanical restraint.
         (a) An individual shall be placed in a position that allows airway access and does not compromise respiration.
            (i) The use of prone restraint is prohibited.
            (ii) A transitional hold shall be limited to the minimum amount of time necessary to safely bring the person under control, at which time staff shall either terminate the transitional hold, and begin the post-restraint process required by this rule, or, if the individual cannot safely be released from the transitional hold, re-position the individual into an alternate restraint position.
               The use of transitional hold shall not be utilized with mechanical restraint.
            (b) The use of transitional hold shall be subject to the following requirements:
               (i) Applied only by staff who have current training on the safe use of transitional hold, including how to recognize and respond to signs of distress in the individual.
               (ii) The weight of the staff shall be placed to the side, rather than on top of the individual. No transitional hold shall allow staff to straddle or bear weight on the individual's torso while applying the restraint, i.e. no downward pressure may be applied that may compromise the individual's ability to breathe.
               (iii) No transitional hold shall allow the individual's hands or arms to be under or behind his/her head or body. The arms must be at the individual's side.
               (iv) No soft device, such as a pillow, blanket or other item, shall be used to cushion the client's head, since such a device may restrict the individual's ability to breathe.
               (v) All staff involved in the procedure must constantly observe the individual's respiration, coloring, and other signs of distress, listen for the individual's complaints of breathing problems, and immediately respond to assure safety.
               (vi) After conclusion of the transitional hold, the hospital shall monitor and document the condition of the individual at least every fifteen minutes, for two hours. The inability to complete
the fifteen minute monitoring and rational shall be documented.

(3) The inpatient psychiatric service provider shall identify, educate and approve staff members to use seclusion or restraint. Competency of staff in the use and documentation of seclusion or restraint methods shall be routinely evaluated. The results of evaluations shall be maintained by the inpatient psychiatric service provider for a minimum of three years for each staff member identified.

Staff shall have appropriate training prior to utilizing seclusion or restraint, and, at a minimum, annually thereafter. The exception to annual training is a first aid or CPR training/certification program of a nationally recognized certifying body, e.g. the american red cross or american heart association, when that certifying body establishes a longer time frame for certification and renewal.

(a) Staff shall be trained in and demonstrate competency in the safe application of all seclusion or restraint interventions he or she is authorized to perform, including specific training in utilization of transitional holds, if applicable;

(b) Staff shall be trained in and demonstrate competency in choosing the least restrictive intervention based on an individualized assessment of the patient's behavioral and/or medical status or condition;

(c) Staff shall be trained in and demonstrate competency in recognizing and responding to signs of physical distress in clients who are being secluded or restrained;

(d) Staff shall be trained and certified in first aid and CPR;

(e) Staff shall be trained in and demonstrate competency in recognizing and responding to signs of physical distress in clients who are being secluded or restrained;

(f) Staff authorized to take vital signs and blood pressure shall be trained in and demonstrate competency in taking them and understanding their relevance to physical safety and distress;

(g) Staff shall be trained in and demonstrate competency in assessing circulation, range of motion, nutrition, hydration, hygiene, and toileting needs; and

(h) Staff shall be trained in and demonstrate competency in helping a client regain control to meet behavioral criteria to discontinue seclusion or restraint.

(4) The presence of advance directives or client preferences addressing the use of seclusion or restraint shall be determined and considered, and documented in the medical record. If the inpatient psychiatric service provider will be unable to utilize seclusion or restraint in a manner in accordance with the patient's directives or preferences, the provider shall notify the patient, including the rationale, and document such in the ICR.

(5) In each patient's medical record, upon admission and upon any relevant changes in the patient's condition, any perceived medical or psychiatric contraindications for the possible use of seclusion or restraint shall be documented. The specific contra-indication shall be described and shall take into account the following which may place the patient at greater risk for such use:

(a) Gender;

(b) Age;

(c) Developmental issues;

(d) Culture, race, ethnicity, and primary language;

(e) History of physical, sexual abuse, or psychological trauma;

(f) Medical and other conditions that might compromise physical well-being, e.g., asthma, epilepsy, obesity, lung and heart conditions, an existing broken bone, pregnancy, and drug/alcohol use; and

(g) Physical disabilities.

(6) Orders shall be written only by an individual with specific clinical privileges/authorization granted by the inpatient psychiatric service provider to order seclusion and restraint, and who is a:
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(a) Psychiatrist or other physician; or  
(b) Physician's assistant, certified nurse practitioner or clinical nurse specialist authorized in accordance with his or her scope of practice and as permitted by applicable law or regulation.

(c) Countersignatures to telephone orders for seclusion and/or restraint shall be signed within twenty four hours by an individual with specific clinical privileges/authorization granted by the hospital to order seclusion and restraint, and who is a psychiatrist or other physician, physician's assistant, certified nurse practitioner, or clinical nurse specialist

(7) Following the conclusion of each incident of seclusion or restraint, the patient and staff shall participate in a debriefing.

(a) The debriefing shall occur within twenty-four hours of the incident unless the client refuses, is unavailable, or there is a documented clinical contraindication.

(b) The following shall be invited to participate unless such participation is clinically contraindicated and the rationale is documented in the clinical record:

(i) For a child/adolescent client, the family, or custodian or guardian, or
(ii) For an adult client, the client's family or significant other when the client has given consent, or an adult client's guardian, if applicable.

(8) As part of the inpatient psychiatric service provider's performance improvement process, a periodic review and analysis of the use of seclusion and restraint shall be performed.

(9) The inpatient psychiatric service provider shall maintain an ongoing log of its seclusion and restraint utilization for departmental review. A log shall be maintained for department review of each incident of mechanical restraint, seclusion, and physical restraint, and for time-out exceeding sixty minutes per episode. The log shall include, at minimum, the following information.

(a) The person's name or other identifier;
(b) The date, time and type of method utilized, i.e., seclusion, physical or mechanical restraint, or time-out. The log of physical and mechanical restraint shall also describe the type of intervention as follows:

(i) For mechanical restraint, the type of mechanical restraint device used;
(ii) For physical restraint, the type of hold or holds as follows:
(a) Transitional hold, and/or
(b) Physical restraint; and
(c) The duration of the method or methods.

If both transitional hold and physical restraint are utilized during a single episode of restraint, the duration in each shall be included on the log. For example, a physical restraint that begins with a one minute transitional hold, followed by a three minute physical restraint shall be logged as one restraint, indicating the length of time in each restraint type.

(10) Plan to reduce seclusion and restraint.

(a) A inpatient psychiatric service provider which utilizes seclusion or restraint shall develop a plan designed to reduce its use. The plan shall include attention to the following strategies:

(i) Identification of the role of leadership;
(ii) Use of data to inform practice;
(iii) Workforce development;
(iv) Identification and implementation of prevention strategies;
(v) Identification of the role of clients (including children), families, and external advocates; and
(vi) Utilization of the post seclusion or restraint debriefing process.

(b) A written status report shall be prepared annually, and reviewed by leadership.

(E) Pursuant to rule 5122-14-14 of the Administrative Code, the hospital shall notify the department of each:
(1) Instance of physical injury to a patient that is restraint-related, e.g., injuries incurred when being placed in seclusion and/or restraint or while in seclusion or restraint, with the exception of injury that is self-inflicted, i.e., a patient banging his/her own head;
(2) Death that occurs while a person is restrained or in seclusion;
(3) Death occurring within twenty-four hours after the person has been removed from restraint or seclusion, and
(4) Death where it is reasonable to assume that a person’s death may be related to or is a result of such seclusion or restraint.

(F) Staff actions commonly known as therapeutic, supportive or directional touch, utilized to direct an individual to another area without the use of force and which do not restrict an individual’s freedom of movement, are not considered restraint and are not subject to the provisions of paragraph (D) of this rule.

5122-14-11 Patient rights policies.

(A) In addition to the definitions appearing in rule 5122-14-01 of the Administrative Code, the following definitions apply to this rule:
(1) “Client rights specialist” means the individual designated by the inpatient psychiatric service provider with responsibility for assuring compliance with the patient rights and grievance procedure rule.
(2) “Grievance” means a written complaint initiated either verbally or in writing by a patient or by any other person or agency on behalf of a patient regarding denial or abuse of any patient’s rights.
(3) “Reasonable” means a standard for what is fair and appropriate under usual and ordinary circumstances.
(4) “Services” means the complete array of professional interventions designed to help a person achieve improvements in mental health such as counseling, individual or group therapy, education, community psychiatric supportive treatment, assessment, diagnosis, treatment planning and goal setting, clinical review, psychopharmacology, discharge planning, professionally-led support, etc.

(B) Each patient shall have the following rights, as well as the additional rights listed in paragraph (C) of this rule:
(1) Each person who accesses mental health services is informed of these rights:
(a) The right to be informed within twenty-four hours of admission of the rights described in this rule, and to request a written copy of these rights;
(b) The right to receive information in language and terms appropriate for the patient’s understanding; and
(c) The right to request to speak to a financial counselor.
(2) Services are appropriate and respectful of personal liberty:
(a) The right to be treated in a safe treatment environment, with respect for personal dignity, autonomy and privacy, in accordance with existing federal, state and local laws and regulations;
(b) The right to receive humane services;
(c) The right to participate in any appropriate and available service that is consistent with an individual service/treatment plan, regardless of the refusal of any other service, unless that service is a necessity for clear treatment reasons and requires the person’s participation;
(d) The right to reasonable assistance, in the least restrictive setting; and
(e) The right to reasonable protection from physical, sexual, or emotional abuse or harassment.
(3) Development of service/treatment plans:
(a) The right to a current individualized treatment plan (ITP) that addresses the needs
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and responsibilities of an individual that specifies the provision of appropriate and adequate services, as available, either directly or by referral; and
(b) The right to actively participate in periodic ITP reviews with the staff including services necessary upon discharge.
(4) Declining or consenting to services:
The right to give full informed consent to services prior to commencement and the right to decline services absent an emergency.
(5) Restraint or seclusion.
The right to be free from restraint or seclusion unless there is imminent risk of physical harm to self or others.
(6) Privacy:
(a) The right to reasonable privacy and freedom from excessive intrusion by visitors, guests and non-hospital surveyors, contractors, construction crews or others; and
(b) The right to be advised of and refuse observation by techniques such as one-way vision mirrors, tape recorders, televisions, movies, or photographs, or other audio and visual recording technology. This right does not prohibit a hospital from using closed-circuit monitoring to observe seclusion rooms or common areas, but closed circuit monitoring shall not be utilized in patient bedrooms and bathrooms.
(7) Confidentiality:
(a) The right to confidentiality unless a release or exchange of information is authorized and the right to request to restrict treatment information being shared; and
(b) The right to be informed of the circumstances under which the hospital is authorized or intends to release, or has released, confidential information without written consent for the purposes of continuity of care as permitted by division (A)(7) of section 5122.31 of the Revised Code.
(8) Grievances:
The right to have the grievance procedure explained orally and in writing; the right to file a grievance with assistance if requested; and the right to have a grievance reviewed through the grievance process, including the right to appeal a decision.
(9) Non-discrimination:
The right to receive services and participate in activities free of discrimination on the basis of race, ethnicity, age, color, religion, gender, national origin, sexual orientation, physical or mental handicap, developmental disability, genetic information, human immunodeficiency virus status, or in any manner prohibited by local, state or federal laws.
(10) No reprisal for exercising rights:
The right to exercise rights without reprisal in any form including the ability to continue services with uncompromised access. No right extends so far as to supersede health and safety considerations.
(11) Outside opinions:
The right to have the opportunity to consult with independent specialists or legal counsel, at one's own expense.
(12) No conflicts of interest:
No inpatient psychiatric service provider employee may be a person's guardian or representative if the person is currently receiving services from said provider.
(13) The right to have access to one's own psychiatric, medical or other treatment records, unless access to particular identified items of information is specifically restricted for that individual patient for clear treatment reasons in the patient's treatment plan. If access is restricted, the treatment plan shall also include a goal to remove the restriction.
(14) The right to be informed in advance of the reason(s) for discontinuance of service provision, and to be involved in planning for the consequences of that event.
(15) The right to receive an explanation of the reasons for denial of service.
In addition to the rights listed in paragraph (D) of this rule, each consumer residing in an inpatient psychiatric hospital shall have the following sixteen rights:

1. Each consumer of mental health services are informed of these rights:
   a. The right to receive humane services in a comfortable, welcoming, stable and supportive environment; and
   b. The right to retain personal property and possessions, including a reasonable sum of money, consistent with the person's health, safety, service/treatment plan and developmental age.

2. Development of service/treatment plans:
   The right to formulate advance directives, submit them to hospital staff, and rely on practitioners to follow them when within the parameters of the law.

3. Labor of patients:
   The right to not be compelled to perform labor which involves the operation, support, or maintenance of the hospital or for which the hospital is under contract with an outside organization. Privileges or release from the hospital shall not be conditional upon the performance of such labor.

4. Declining or consenting to services:
   a. The right to consent to or refuse the provision of any individual personal care activity and/or mental health services/treatment interventions; and
   b. The right, when on voluntary admission status, to decline medication, unless there is imminent risk of physical harm to self or others; or
   c. The right when hospitalized by order of a probate or criminal court to decline medication unless there is imminent risk of harm to self or others, or through an order by the committing court, except that involuntary medication is not permitted, unless there is imminent risk of harm to self or others, for persons admitted for a competency evaluation under division (G)(3) of section 2945.371 of the Revised Code or admitted for sanity evaluation under division (G)(4) of section 2945.371 of the Revised Code. The inpatient psychiatric service provider shall provide the opportunity for informed consent.

5. Privacy, dignity, free exercise of worship and social interaction:
   The right to enjoy freedom of thought, conscience, and religion; including religious worship within the hospital, and services or sacred texts that are within the reasonable capacity of the hospital to supply, provided that no patient shall be coerced into engaging in any religious activities.

6. Private conversation, and access to phone, mail and visitors:
   a. The right to communicate freely with and be visited at reasonable times by private counsel or personnel of the legal rights service and, unless prior court restriction has been obtained, to communicate freely with and be visited at reasonable times by a personal physician or psychologist;
   b. The right to communicate freely with others, unless specifically restricted in the patient's service/treatment plan for reasons that advance the person's goals, including, without limitation, the following:
      i. The right of an adult to reasonable privacy and freedom to meet with visitors, guests, or surveyors, and make and/or receive phone calls; or the right of a minor to meet with inspectors, and the right to communicate with family, guardian, custodian, friends and significant others outside the hospital in accordance with the minor's individualized service/treatment plan;
      ii. The right to have reasonable access to telephones to make and receive confidential calls, including a reasonable number of free calls if unable to pay for them and assistance in calling if requested and needed. The right of a minor to make phone calls shall be in accordance with the minor's individualized service/treatment plan; and
   c. The right to have ready access to letter-writing materials, including a reasonable number of stamps without cost if unable to pay for them, and to mail and receive unopened
correspondence and assistance in writing if requested and needed subject to the hospital's rules regarding contraband. The right of a minor to send or receive mail shall also be subject to directives from the parent or legal custodian when such directives do not conflict with federal postal regulations.

(7) Notification to family or physician:
   The right to have a physician, family member or representative of the person's choice notified promptly upon admission to a hospital.

(D) Each inpatient psychiatric service provider shall provide a patient rights advocate to safeguard patient rights. The client rights specialist or a designee shall:
   
   (1) Be appropriately trained and knowledgeable in the fundamental human, civil, constitutional and statutory rights of psychiatric patients including the role of the Ohio protection and advocacy system (disability rights Ohio);
   
   (2) Ensure that the patient, and as appropriate, the patient's family members, significant others, and the patient's legal guardian, are informed about patient rights, in understandable terms, upon admission, and throughout the hospital stay. Treatment staff shall also work with patient to assist them in understanding and exercising patient rights. For any person who is involuntarily detained, the inpatient psychiatric service provider shall, immediately upon being taken into custody, inform the person orally and in writing of their rights described in division (C) of section 5122.05 of the Revised Code;
   
   (3) Be accessible in person during normal business hours, and during evenings, weekends, and holidays as needed for advocacy issues. The name, title, location, hours of availability, and telephone number of the client rights specialist along with a copy of the client rights and grievance procedure as set forth in this rule shall be posted in an area available to the patient, and made available to the patient's legal guardian if any, and the patient's family and significant others, upon request at all times;
   
   (4) Assist and support patients, their family members, and significant others in exercising their legal rights and representing themselves in resolving complaints. This shall include providing copies of the inpatient psychiatric service provider's policies and procedures relevant to patient rights and grievances upon request, and assistance with the grievance procedure. This shall also include assistance in obtaining services of the Ohio protection and advocacy system (disability rights Ohio) in accordance with sections 5123.60 to 5123.601 of the Revised Code, and assistance in obtaining access to or services of outside agencies or resources upon request;
   
   (5) Not be a member of the patient's treatment team and not have clinical management or care responsibility for the patient for whom he or she is acting as the patient rights advocate; and
   
   (6) Maintain a log available for department review of patient grievances, including all allegations of denial of patient rights as identified by patients, family members of patients, significant others or other persons.
   
(E) Each inpatient psychiatric service provider shall ensure that its staff members are knowledgeable about patient rights and referral of patients to the patient rights advocate.

(F) Each inpatient psychiatric service provider shall ensure that patients and families of patients participate in an advisory capacity related to programming and relevant policies and procedures.

(G) Each inpatient psychiatric service provider shall ensure that patient and family education is an interdisciplinary and coordinated process, as appropriate to the patient's treatment plan, consistent with patient confidentiality and documented in the medical record. Education shall incorporate appropriate members of the treatment team, types of materials, methods of teaching, community educational resources, and special devices, interpreters, or other aids to meet specialized needs.

(H) Each inpatient psychiatric service provider shall obtain the informed consent of a
patient or when appropriate, a guardian, for all prescribed medications that have been ordered, except in an emergency, and for those medical interventions as referenced in and in accordance with division (A) of section 5122.271 of the Revised Code.

(1) Each inpatient psychiatric service provider shall ensure that the patient and legal guardian, when legally appropriate, receives written and/or oral information in a language and format that may be standardized and that is understandable to the person receiving it.

(a) Information shall include the anticipated benefits and side effects of the intervention, including the anticipated results of not receiving the intervention, and of alternatives to the intervention.

(b) Persons served shall be given the opportunity to ask questions, seek additional information and provide input before the intervention or medication is administered/dispensed.

(c) Documentation shall be kept in the patient's medical record regarding the patient's participation in this process, including the patient's response, objections, and decisions regarding the medication or medical intervention. Such documentation may be accomplished through a notation from an appropriate professional staff person, signature of the patient or guardian, or other mechanism.

(2) For purposes of informed consent specific to medication, each psychiatric inpatient service provider shall ensure that the patient and parent or legal guardian when legally appropriate receives written and/or oral information from a physician, registered nurse, or registered pharmacist.

5122-14-12 Service requirements.

(A) Each inpatient psychiatric service provider shall have a written comprehensive plan of service which shall be reviewed annually and revised if necessary.

(B) The comprehensive plan of service shall include:

(1) Description of services provided;

(2) Description of any affiliation or agreements with other agencies or entities;

(3) Description of the population served including age groups and other relevant characteristics of the patient populations;

(4) Criteria for admission, continued stay, and discharge; and

(5) Description of how patients and family members of patients shall participate in an advisory role to the inpatient service.

(C) Criteria for admission shall:

(1) Limit admissions to those persons whose principal diagnosis and focus of treatment upon admission is a mental disorder according to the latest edition of the American psychiatric association's diagnostic and statistical manual of mental disorders (DSM), but excluding admissions to those persons whose principal diagnosis and focus of treatment is a substance abuse disorder, detoxification for substance abuse, a chronic dementing organic mental disorder, or mental retardation. This does not preclude admissions for which the above named excluded diagnoses may be a secondary diagnosis;

(a) To support best clinical practice of concurrent integrated treatment for persons with co-occurring of mental illness and substance abuse, an inpatient psychiatric service provider may co-locate both psychiatric and substance abuse and/or detox registered beds in the same physical area, and may use staff who are cross-trained in both treatment disciplines to provide integrated services.

(b) The total number of psychiatric beds and the total number of detox (med/surg) beds and/or substance abuse beds must remain as registered with the Ohio department of health.

(c) Patients shall be admitted to the appropriate registered bed based upon their principal diagnosis and focus of treatment. However, this would not preclude integrated concurrent treatment for a co-occurring disorder.
(2) Include any applicable age limits, diagnostic categories, and other criteria necessary to ensure that each admission is the least restrictive alternative available and consistent with each patient's treatment needs;

(3) Specify procedures and timelines for responding to an application for voluntary admission; and

(4) Assure that the inpatient psychiatric service provider will accept patients on a civil commitment and that it has the clinical competence to treat these patients:

(a) Utilizing the same criteria applied to voluntary patients, and

(b) According to admission criteria applied to voluntary patients.

The inpatient psychiatric service provider shall assure that it will provide such patients access to its full range of available services.

(D) Discharge criteria shall include but not be limited to achievement of treatment goals, or that the patient must be transferred to a more appropriate treatment facility. A civilly committed patient shall be discharged when the patient no longer meets the criteria for civil commitment, however such patients shall have the right to apply for voluntary admission status at any time pursuant to division (G) of section 5122.15 of the Revised Code.

(E) The primary function of each inpatient psychiatric service provider shall be to provide diagnostic and treatment services for persons with a primary diagnosis of mental illness. Such services shall be culturally relevant and sensitive and shall take into consideration any relevant patient history of trauma and/or abuse.

(F) Clinical services shall be provided by an interdisciplinary treatment team working together.

(1) All members of the treatment team who have specific treatment responsibilities shall have either appropriate clinical privileges and be qualified by training or experience and demonstrated competence, or shall be supervised by a clinically privileged practitioner.

(2) Each inpatient psychiatric service provider shall specify in policy and procedures the roles and responsibilities of team members in identifying and meeting the clinical needs of patients in relationship to its goals and programs.

(3) Each inpatient psychiatric service provider shall assure and provide for the staffing of team members to meet the clinical needs of each patient as identified in the patient's treatment plan.

(G) Each professional discipline shall:

(1) Identify special skills required to render specific patient care and treatment services.

(2) Participate in the development of criteria for qualifications of its staff members, which shall include education, experience, and licensure or certification requirements.

(H) Each inpatient psychiatric service provider shall provide or make provision for the following services in order to promote recovery and meet the comprehensive needs of each patient. Such services may be provided by any qualified individual, unless otherwise specified in these rules and/or regulated by professional licensure and scope of practice:

(1) Medical services, including dental, to meet the comprehensive physical and psychiatric treatment needs of each patient as identified in the patient's treatment plan;

(2) Dietetic services shall include availability of a licensed dietitian;

(3) Emergency services shall be available and accessible through a written plan for psychiatric emergencies for both persons receiving inpatient treatment from the inpatient psychiatric service provider and for any persons presenting themselves as in need of and requesting emergency treatment;

(a) If the inpatient psychiatric service provider maintains an emergency room or emergency service, it will not refuse emergency care to individuals presenting with potentially life or health-threatening psychiatric situations.

(b) If the inpatient psychiatric service provider does not maintain an emergency room or emergency service, it shall provide emergency care on site until an individual presenting with a
potentially life or health-threatening psychiatric situation is transferred to a more appropriate
provider.

(4) Medical services shall;
(a) Be under the direction of a psychiatrist.
(b) Include availability of twenty-four hour, seven day a week consultation of a
psychiatrist, either in person or by telephone;
(5) Nursing services shall be under the direction or supervision of a full time registered
nurse who has a bachelor's or master's degree in nursing and four years psychiatric nursing
experience. It is preferred, but not required, that the individual holds voluntary certification in
psychiatric and mental health nursing by the American nurses credentialing association. This
requirement shall apply to those individuals hired into this position after January 1, 2000
Psychiatric nursing experience is the treatment and care of persons whose principal diagnosis
and focus of treatment is a psychiatric disorder, the experience can include working as a staff
nurse on a psychiatric inpatient unit or in an outpatient setting with individuals who have a
primary psychiatric diagnosis. It is not caring for individuals in a nursing home, whose principal
or primary diagnosis is often a chronic dementing organic mental disorder;
(6) Pastoral services shall be offered by inpatient psychiatric service provider clergy or
the provider shall arrange for pastoral services from family or community clergy;
(7) Patient education services shall be readily accessible at all reasonable hours and
include current reading and resource materials for education and leisure to meet the needs of
the patients;
(8) Pharmaceutical services shall:
(a) Be under the direction of a qualified registered pharmacist with a current license.
(b) Operate in accordance with Chapters 3715., 3719., and 4729 of the Revised Code
regarding operation of pharmacies, storage, and dispensing of drugs;
(9) Physical rehabilitation services shall be under the direction of qualified staff;
(10) Psychological services shall be under the direction of a licensed psychologist;
(11) Psycho-social services shall be:
(a) Provided by qualified staff;
(b) Staffed by at least one person who is licensed either as a professional counselor,
professional clinical counselor, independent social worker, or a social worker; and
(c) Provided during the day, and available evenings, weekends, and holidays as needed.
(12) Rehabilitation therapy services shall be:
(a) Provided by qualified staff;
(b) Staffed by at least one rehabilitation therapist as defined in rule 5122-14-01 of the
Administrative Code;
(c) Provided during the day, and available evenings, weekends, and holidays as needed;
(d) Provided by rehabilitation therapy staff with diverse skills to meet the needs of all
patients; and
(13) Substance abuse diagnostic and treatment services for all patients who have a
secondary problem of substance abuse shall be provided by a certified chemical dependency
counselor in accordance with Chapter 5119 of the Revised Code, or by other individuals
licensed to provide diagnostic or substance abuse treatment services.
(I) Each inpatient psychiatric service provider shall develop special programs to include
but not be limited to the following groups whenever the annual average daily census for that
group is six or more patients:
(1) Adults age sixty-five and older; ;
(2) Patients with a secondary diagnosis of substance use disorder; and
(3) Patients with a secondary diagnosis of developmental disability or pervasive
developmental disorder.
(J) Written policies and procedures, and program descriptions shall document that
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patient needs, based on at least age and diagnosis, will be met for all patient groups in paragraph (i) of this rule.

(1) Inpatient psychiatric service providers that provide services for adults sixty-five years of age and older shall develop written policies and procedures regarding services to meet the special needs of such patients. These needs shall include vision, hearing, dietary, physical, cognitive, functional living skills and psychiatric needs, and the needs of the patients' family members. Special attention shall be given to problems associated with utilization of medication including polypharmacy. Diagnostic and treatment services shall be provided by a psychiatrist with clinical privileges in geriatric psychiatry. Consultation with an occupational therapist or an occupational therapy assistant in collaboration with an occupational therapist shall be available as appropriate to each patient's needs.

(2) Services for patients who have a secondary problem of substance abuse shall include specialized diagnostic assessments, group and/or individual therapy, education, linkage to self help groups and referrals for post discharge substance abuse treatment if appropriate.

(3) Inpatient psychiatric service providers that provide services for patients with a secondary diagnosis of mental retardation or developmental disability shall adhere to treatment standards in accordance with Chapters 5122 and 5123 of the Revised Code or equivalent standards and as appropriate to the psychiatric services provided.

(K) Inpatient psychiatric service providers authorized to serve children and adolescents shall provide for the educational, recreational, developmental, social and functional needs of these patients and for the treatment needs of these patients' families.

(1) For all children twelve years of age and less, diagnostic and treatment services shall be provided by a child and adolescent psychiatrist, or by a psychiatrist in consultation with a child and adolescent psychiatrist within seventy-two hours of admission.

(2) For all children thirteen through seventeen years of age, diagnostic and treatment services shall be provided by a child and adolescent psychiatrist, a psychiatrist with clinical privileges in adolescent psychiatry, or by a psychiatrist in consultation with a child and adolescent psychiatrist within seventy-two hours of admission.

(3) Each inpatient psychiatric service provider shall provide rehabilitation therapy services including at least five hours per week per patient of active physical activities, as appropriate to patient need and indicated on the patient's treatment plan.

(4) Each inpatient psychiatric service provider shall provide a minimum of two hours per week per patient of family therapy or other family interventions as appropriate to patient need and indicated on the patient's treatment plan.

(5) Each inpatient psychiatric service provider shall provide services to assist the patient in maintaining his/her educational and intellectual development at least five hours per week, consistent with the patient's treatment plan.

(a) If the admission is longer than ten days, the inpatient psychiatric service provider shall, with the consent of the parent/adult student, notify the school district where the provider is located, of the need for services, and shall provide appropriate physical space so that the patient can access or continue individualized education plan IEP services provided by the school district.

(b) If educational needs and/or eligibility for special education services under Chapter 3323 of the Revised Code are identified during the admission, the inpatient psychiatric service provider shall communicate this to the patient's home school, upon parent or guardian request with appropriate consent.

(L) If a psychiatric intensive care unit is provided the following additional standards shall be met:

(1) The psychiatric intensive care unit shall be directed and staffed according to the special needs of its patients;

(2) Written policies and procedures shall describe criteria for the use of psychiatric
intensive care, and any special procedures used; and

(3) Psychiatric intensive care units shall be designed and equipped to facilitate safe and
effective care of patients.

(M) Inpatient psychiatric service providers that accept individuals into an observation or
treatment status for periods of less than twenty-four hours shall develop policies and procedures
regarding the following:

(1) Conditions under which individuals are accepted and released;
(2) Provision of patient rights information; and
(3) Provision for after hospitalization care.

(N) Prior to or within twenty-four hours of admission of each patient, appropriate
community resources and needs relative to the patient's treatment shall be identified, which may
include professionals who have rendered prior treatment, referral sources, court, school,
employer, religious affiliation, community psychiatric supportive treatment services, and
discharge planning.

(O) All identified community resources shall, when appropriate to patient need and with
permission of the patient, be contacted to participate in treatment planning for discharge. Such
efforts and involvement shall be documented in the medical record.

(P) If a patient is likely to be referred to a community mental health agency upon
discharge, the inpatient psychiatric service provider with permission from the patient shall invite
participation by the community psychiatric supportive treatment providers from the local
community mental health agencies in team meetings and planning for discharge.

(Q) The inpatient psychiatric service provider shall make arrangements for each patient
for post discharge services as specified in the patient's treatment plan.

(1) Each inpatient psychiatric service provider shall provide an appropriate discharge
plan for patients, or the inpatient psychiatric service provider shall arrange for each of these
patients, as necessary, to receive mental health services from other mental health providers,
consistent with patient choice and acceptance.

(a) The inpatient psychiatric service provider shall provide interim post discharge
services for up to two weeks post discharge, unless the post discharge provider assumes
responsibility for the provision of mental health services prior to the end of the interim two-week
period. This shall include an appointment for medication management as needed. Such interim
post discharge services shall include a crisis management plan, which may include a
mechanism to contact a physician, interim medication management, referral to or provision of a
support group or individual supportive services, or a mechanism to contact an emergency
services provider.

(b) The inpatient psychiatric service provider shall determine, in collaboration with the
patient and post discharge provider, that the post discharge provider has the appropriate
services the patient has been identified as needing, to include the provision of in-depth patient
education regarding the nature and management of the patient's illness/disorder.

(2) As part of discharge planning, the inpatient psychiatric service provider shall make all
reasonable efforts prior to discharge to ensure that the patient has a specified appointment, as
appropriate, with a mental health service provider(s), upon discharge whenever possible and no
later than two weeks post discharge if it has been concluded that these services are required
within two weeks.

(3) For children/adolescents, each inpatient psychiatric service provider shall make
provision for coordination of psycho-educational treatment and recommended aftercare with the
patient's local school and any existing individualized education plan from the patient's local
school.

(4) The clinical treatment team shall develop a discharge plan with active participation by
the patient. The parent, guardian, or family shall also participate, where appropriate, according
to the treatment plan and with permission of the patient as needed. If the patient is a minor in
the custody of an agency, that agency shall participate in the development of the discharge plan.

(5) A copy of the relevant portions of the post discharge plan shall be given to the patient, or as appropriate, the patient's guardian, and shall be made available, with the patient's permission, to the person or agency that will assume primary responsibility for implementation of the discharge plan.

(R) When utilization patterns indicate problems or opportunities for improvement in the larger community system in which the inpatient psychiatric service provider is located, the inpatient psychiatric service provider shall discuss these issues with the relevant community mental health board(s), and such discussions shall be documented.

5122-14-13 Medical records.

(A) Each inpatient psychiatric service provider shall maintain a complete medical record for each individual patient.

(B) Necessary components of the medical record shall include to the extent possible, but not be limited to, the following:

(1) Patient demographic information, including indication of legal status as a voluntary or involuntary patient;

(2) All legal documents, including, as appropriate, an application for voluntary admission signed and dated by the patient, written requests for release pursuant to section 5122.03 of the Revised Code, and all legal documents pertaining to civil commitment and guardianship.

For patients with a guardian, the inpatient psychiatric service provider shall make effort to obtain all needed consent forms signed and dated by the guardian. If the guardian is unable to provide written consent, the provider may obtain and document verbal consent of the guardian as long as two individuals document, in writing, that each witnessed the guardian provide the verbal consent.

(3) The reason for admission including presenting problem(s), precipitating factors, and initial diagnosis;

(4) Previous hospitalizations;

(5) Reports of all patient assessments and examinations;

(6) An individualized treatment plan which shall include criteria for discharge and which shall meet requirements of section 5122.27 of the Revised Code;

(7) All medical orders;

(8) Documentation of the patient's progress, and other significant patient events which could impact on treatment;

(9) Appropriate, complete, signed and dated consents for treatment, and for release of confidential information;

(10) A discharge summary completed within thirty days after discharge and signed by the attending or treating physician; and

(11) A post discharge plan.

(C) All entries in the medical record shall be dated, signed, and legible.

(D) Each inpatient psychiatric service provider shall be responsible for conducting a complete assessment of each patient including a consideration of the patient's strengths and patient's needs, and types of services to meet those needs in the least restrictive environment consistent with treatment needs.

(1) The assessments shall include as appropriate to patient need: physical, laboratory, emotional, behavioral, social, recreational, cognitive, functional living skills, educational, legal, vocational, nutritional, cultural, religious, income support, housing needs, and other community support and discharge planning needs.

(2) Each inpatient psychiatric service provider shall define in writing the scope of
assessments to be performed by each clinical discipline not otherwise specified in this chapter, consistent with the discipline's scope of practice, state licensure laws, applicable regulations, certification, or registration.

(E) Written assessments of each patient shall be provided and dated by the respective interdisciplinary team members as soon as possible after admission and prior to the development of the treatment plan which is required within twenty-four hours of admission unless otherwise specified in this rule.

(1) For new admissions if assessments are available from prior evaluations and/or admissions within the past six months, each assessment shall be reviewed, revised as necessary, dated, and signed by a member of the respective discipline as soon as possible after admission and prior to the development of the treatment plan.

(2) The following required patient assessments shall be completed within twenty-four hours of a patient's admission:

(a) A physician shall be responsible for a medical history and physical examination. If the patient's condition does not permit completion of the examination each part of the examination shall be completed as soon as the patient's condition permits it. If a physician was responsible for the completion of a medical history and physical examination within thirty days of the current course of treatment and the patient's condition remains consistent with the results of that examination, a signed copy of this history and examination may suffice. The medical history and physical examination may be conducted by a physician's assistant, certified nurse practitioner or clinical nurse specialist authorized in accordance with his or her scope of practice and as permitted by applicable law or regulation.

   (i) The history and physical examination shall include a basic neurological examination that includes an examination of the cranial nerves, sensory and motor functions, coordination, and deep tendon reflexes.

   (ii) If the patient is a child, adolescent, or person with mental retardation/developmental disabilities, the history and physical examination shall include evaluations of motor development and functioning, sensorimotor functioning, speech, hearing and language functioning, visual functioning, immunization status, and oral health and oral hygiene;

(b) A psychiatrist, or a physician with specific clinical privileges to conduct such an examination shall be responsible for a psychiatric examination including a mental status examination. The psychiatric examination may be conducted by a physician's assistant, certified nurse practitioner or clinical nurse specialist authorized in accordance with his or her scope of practice and as permitted by applicable law or regulation;

(c) A registered nurse shall be responsible for completing an assessment of each patient's nursing care needs. As part of the nursing assessment, the R.N. shall conduct a screening of each patient's nutritional status unless otherwise assessed by a registered dietitian;

(d) An assessment for functional and rehabilitation needs which may include activities of daily living; community living skills; social, leisure and vocational skills; self care and self control abilities; physical/sensori-motor capabilities, speech, language, oral, and pharyngeal sensor-motor competencies and auditory and vestibular competencies;

(e) An emotional and behavioral assessment which includes at least a history of emotional, behavioral, substance-abuse problems or treatment and physical or sexual abuse history;

(f) A psycho-social assessment which shall include the following information about the patient, as appropriate:

   (i) Environment and home;
   (ii) Leisure and recreation;
   (iii) Work history;
   (iv) Spirituality;
(v) Childhood history;
(vi) Military service history;
(vii) Financial status;
(viii) Usual social, peer-group, and environmental setting;
(ix) Sexual orientation; and
(x) Family circumstances, including the constellation of the family group, the current living situation, and social, ethnic, cultural, emotional, and health factors. The psychosocial assessment includes determining the need and extent for family participation;

(g) In programs serving children and adolescents, an assessment shall be performed which includes the following:
(i) The impact of the child's/adolescent's condition on the family and the family's impact on the child/adolescent;
(ii) The child/adolescent's legal custody status, when applicable;
(iii) The child/adolescent's growth and development, including physical, emotional, cognitive, educational, nutritional, and social development;
(iv) The child/individual's play and daily activities needs; and
(v) The family's or guardian's expectations for and involvement in the child/adolescent's assessment, initial treatment, and continuing care.

(F) Each patient shall have a written individualized treatment plan that is responsive and timely to the treatment needs of the patient based on information provided by the patient and the patient's family and assessments by the clinical treatment team. The initial treatment plan and subsequent revisions shall be developed with the active participation of the patient, and through collaborative efforts of the clinical team. As appropriate and with patient consent, family members and significant others shall also participate. Such patient, family, and clinical treatment team collaboration shall be documented on the treatment plan. A patient's inability or refusal to participate in treatment planning and the patient's reasons for such shall also be documented on the treatment plan. The patient, and as appropriate parent or guardian, shall have the right to be informed of changes on the treatment plan including a change in assignment of the primary therapist or attending physician.

(1) The initial treatment plan shall be developed with the active participation of the patient and implemented within twenty-four hours of admission through collaborative efforts by the interdisciplinary clinical treatment team.

(2) The initial treatment plan and any subsequent revisions to the plan shall:
(a) Reflect the patient's clinical needs, condition, functional strengths, and limitations.
(i) The patient's perceptions of his/her needs are documented, as are the families' perceptions when appropriate and available.
(ii) Justification is documented when identified needs are not addressed;
(b) Specify goals for achieving emotional and/or physical health as well as maximum growth and adaptive capabilities.
(i) Treatment plan goals are based on assessments of the patient and, as appropriate, the family.
(ii) Treatment plan goals are linked to living, learning, and work activities.
(iii) Treatment goals identified by the patient and actions the patient agrees to or requests to take, and the patient's involvement in and expressed concerns about the treatment plan are documented;
(c) Specify intermediate steps toward those goals in measurable terms;
(d) Specify target dates or time-frames for completion of goals and steps;
(e) Specify services and interventions to be provided to achieve patient goals, and to indicate the staff person(s) and/or discipline responsible for provision of service(s);
(f) Specify frequency of services; and
(g) Specify criteria for discharge.
(3) The initial treatment plan shall be reviewed, updated and/or revised within seventy-two hours of a patient's admission. All subsequent updates to the plan shall occur at least every seven days for the first month of hospitalization, at least monthly thereafter, and as appropriate to patient needs.

(G) The discharge summary completed within thirty days after discharge shall include:

1. Assessment of the patient's condition on admission;
2. Assessment of the patient's condition upon discharge and reason for discharge;
3. Description of diagnostic and treatment services received by the patient, with reference to interventions identified on the treatment plan, and the patient's response;
4. All recommendations made to the patient;
5. Medications prescribed upon discharge; and
6. Initial and final diagnosis, both physical and psychiatric, according to the American psychiatric association's latest edition of the diagnostic and statistical manual of mental disorders (DSM), which shall be recorded in full without the use of either symbols or abbreviations.

(H) A discharge plan shall be developed with each patient and shall:

1. State all appropriate recommendations and specific plans to include but not be limited to psychiatric, medical, case management, housing, vocational, financial, educational needs, other community support needs, and community resources available to meet these needs;
2. Identify specific resources and state recommendations for continued, ongoing patient and family education regarding the nature and management of the patient's illness/disorder;
3. Specify persons or agencies responsible for each recommended intervention or service;
4. Specify the time-frame for initiation of each recommended intervention or service;
5. Specify a crisis management plan as described in paragraph (Q)(1)(a) of rule 5122-14-12 of the Administrative Code; and
6. Be signed and dated by the patient, or as appropriate parent or guardian, and by each member(s) of the clinical treatment team responsible for reviewing the plan with the patient. A patient's inability or refusal to sign or participate in discharge planning and the patient's reasons for such shall be documented on the plan.

(I) The patient's treatment plan and medical record shall be available to the patient and family members according to section 5122.31 of the Revised Code.

(J) The inpatient psychiatric service provider shall have written policies and procedures regarding the release of information and confidentiality of oral or written patient information, in compliance with section 5122.31 of the Revised Code.

5122-14-14 Incident notification and risk management.

(A) This rule establishes standards to ensure the prompt and accurate notification of certain prescribed incidents. It also requires the agency to review and analyze all incidents so that it might identify and implement corrective measures designed to prevent recurrence and manage risk.

(B) Definitions

1. “Incident” means an event that poses a danger to the health and safety of patients and/or staff and visitors of the hospital, and is not consistent with routine care of persons served or routine operation of the hospital.

2. “Reportable incident” means an incident that must be submitted to the department, including incidents that must then be forwarded by the department to disability rights Ohio. As referenced in division (E) of section 5119.36 of the Revised Code, “major unusual incident” has the same meaning as “reportable incident.”
(3) “Six month reportable incident” means an incident type of which limited information must be reported to the department. A six month reportable incident is not the same as a reportable incident.

(4) “Six month incident data report” means a data report which must be submitted to the department.

(C) The inpatient psychiatric service provider shall develop an incident reporting system to include a mechanism for the review and analysis of all reportable incidents such that clinical and administrative activities are undertaken to identify, evaluate, and reduce risk to patients, staff, and visitors. The inpatient psychiatric service provider shall identify in policy other incidents to be reviewed and analyzed.

(1) An incident report shall be submitted in written form to the inpatient psychiatric service provider's chief executive officer or designee within twenty-four hours of discovery of the incident.

(2) As part of the inpatient psychiatric service provider's performance improvement process, a periodic review and analysis of reportable incidents, and other incidents as defined in policy, shall be performed.

(3) The inpatient psychiatric service provider shall maintain an ongoing log of its reportable incidents for departmental review.

(D) Any person who has knowledge of any instance of abuse or neglect, or alleged or suspected abuse or neglect, or of an alleged crime which would constitute a felony, of:

(1) Any child or adolescent, shall immediately notify any alleged or suspected abuse or neglect to the county children's services board, the designated child protective agency, or law enforcement authorities, in accordance with section 2151.421 of the Revised Code, or of an alleged crime against a child or adolescent which would constitute a felony, including a crime allegedly committed by another child or adolescent which would constitute a felony if committed by an adult, shall immediately notify law enforcement authorities.

(2) An elderly person, shall immediately notify the appropriate law enforcement and county department of jobs and family services authorities in accordance with section 5101.61 of the Revised Code.

(E) Each inpatient psychiatric service provider shall submit reportable incidents and six month reportable incidents as defined by and according to the schedule included in appendix A to the rule.

(F) Each reportable incident shall be documented on form “DMH-LIC-013” as required by the department, and shall be forwarded to the department within twenty-four hours of its discovery, exclusive of weekends and holidays. Form “DMH-LIC-013” shall include identifying information about the inpatient psychiatric service provider, date, time and type of incident, and client information that has been de-identified pursuant to the HIPAA privacy regulations, [45 C.F.R.164.514(b)(2)].

(1) The inpatient psychiatric service provider shall file only one incident form per event occurrence and identify each incident report category, if more than one, and include information regarding all involved patients, staff, and visitors.

(2) The inpatient psychiatric service provider shall notify the patient's parent, guardian or custodian, if applicable, within twenty-four hours of discovery of a reportable incident, and document such notification.

(a) Notification may be made by phone, mailing, faxing or e-mailing a copy of the incident form, or other means according to inpatient psychiatric service provider policy and procedures.

(b) When notification does not include sending a copy of the incident form, the inpatient psychiatric service provider must inform the parent, guardian or custodian, of his/her right to receive a copy, and forward a copy within twenty-four hours of receiving a request for a copy. The inpatient psychiatric service provider shall document compliance with the provisions of this
paragraph.

(G) Each inpatient psychiatric service provider shall submit a six month incident data report to the department utilizing the form that is in appendix B to this rule.

The six month data report must be submitted according to the following schedule:

1. The six month data report for the period of January first to June thirtieth of each year shall be submitted no later than July thirty-first of the same year; and
2. The six month data report for the period of July first to December thirty-first of each year shall be submitted no later than January thirty-first of the following year.

(H) The department may initiate follow-up and further investigation of a reportable incident and six month reportable incidents, as deemed necessary and appropriate, or may request such follow-up and investigation by the inpatient psychiatric service provider, and/or regulatory or enforcement authority.
Chapter 9. Crime, Records Check, False Claims and Fraud

Part I. Crime

[Editor’s Note: Additional statutes involving crime and penalties are listed elsewhere in this handbook under the applicable topic area.]

109:7-1-01 Sexual assault examination protocol.

(A) When conducting a medical examination of a victim of an offense under any provision of sections 2907.02 to 2907.06 of the Revised Code for the purpose of gathering physical evidence for a possible prosecution, a hospital, children's advocacy center, or other emergency medical facility shall follow the protocol designated in this rule and shall only use a sexual assault evidence collection kit that meets that protocol in order to qualify for payment from the reparations fund established pursuant section 2743.191 of the Revised Code. The protocol shall be as follows:

(1) For victims other than children, the hospital or other emergency medical facility shall follow the protocol adopted by the Ohio department of health.

(2) For victims who are children, the hospital, children's advocacy center, or other emergency medical facility shall follow the protocol adopted by the committee on child abuse and neglect of the Ohio chapter of the American academy of pediatrics.

(B) When a hospital, children's advocacy center, or other emergency medical facility provides an HIV post-exposure prophylaxis treatment as part of the examination under this section it shall be administered in accordance with the centers for disease control and prevention’s “Updated Guidelines for Antiretroviral Postexposure Prophylaxis After Sexual, Injection Drug Use, or Other Nonoccupational Exposure to HIV.”

109:7-1-02 Sexual assault examination payment amount.

A hospital, children's advocacy center, or other emergency medical facility shall accept a flat fee payment of:

(A) Six hundred thirty-two dollars as payment in full for any cost incurred in conducting a medical examination and test of a victim of an offense under any provision of sections 2907.02 to 2907.06 of the Revised Code for the purpose of gathering physical evidence for a possible prosecution of a person, including the cost of any antibiotics administered as part of the examination.

(B) A hospital, children's advocacy center, or other emergency medical facility shall accept payment of the actual amount billed; not to exceed twenty-five hundred dollars, as payment in full for any cost incurred in administration of HIV post-exposure prophylaxis protocol in rule 109:7-1-01 of the Administrative Code.

(C) The attorney general may increase either payment amount for inflation by a reasonable percentage according to the consumer price index (all urban consumers, all items) prepared by the bureau of labor statistics of the United States department of labor.

2151.421 Abuse or neglect of child.

(A)(1)(a) No person described in division (A)(1)(b) of this section who is acting in an official or professional capacity and knows, or has reasonable cause to suspect based on facts that would cause a reasonable person in a similar position to suspect, that a child under...
eighteen years of age, or a person under twenty-one years of age with a developmental disability or physical impairment, has suffered or faces a threat of suffering any physical or mental wound, injury, disability, or condition of a nature that reasonably indicates abuse or neglect of the child shall fail to immediately report that knowledge or reasonable cause to suspect to the entity or persons specified in this division. Except as provided in section 5120.173 of the Revised Code, the person making the report shall make it to the public children services agency or a municipal or county peace officer in the county in which the child resides or in which the abuse or neglect is occurring or has occurred. In the circumstances described in section 5120.173 of the Revised Code, the person making the report shall make it to the entity specified in that section.

(b) Division (A)(1) of this section applies to any person who is an attorney; health care professional; practitioner of a limited branch of medicine as specified in section 4731.15 of the Revised Code; independent marriage and family therapist or marriage and family therapist; coroner; administrator or employee of a child day-care center; administrator or employee of a residential camp, child day camp, or private, nonprofit therapeutic wilderness camp; administrator or employee of a certified child care agency or other public or private children services agency; school teacher; school employee; school authority; agent of a county humane society; person, other than a cleric, rendering spiritual treatment through prayer in accordance with the tenets of a well-recognized religion; employee of a county department of job and family services who is a professional and who works with children and families; superintendent or regional administrator employed by the department of youth services; superintendent, board member, or employee of a county board of developmental disabilities; investigative agent contracted with by a county board of developmental disabilities; employee of the department of developmental disabilities; employee of a facility or home that provides respite care in accordance with section 5123.171 of the Revised Code; employee of an entity that provides homemaker services; a person performing the duties of an assessor pursuant to Chapter 3107 or 5103 of the Revised Code; third party employed by a public children services agency to assist in providing child or family related services; court appointed special advocate; or guardian ad litem.

(c) If two or more health care professionals, after providing health care services to a child, determine or suspect that the child has been or is being abused or neglected, the health care professionals may designate one of the health care professionals to report the abuse or neglect. A single report made under this division shall meet the reporting requirements of division (A)(1) of this section.

(2) Except as provided in division (A)(3) of this section, an attorney or a physician is not required to make a report pursuant to division (A)(1) of this section concerning any communication the attorney or physician receives from a client or patient in an attorney-client or physician-patient relationship, if, in accordance with division (A) or (B) of section 2317.02 of the Revised Code, the attorney or physician could not testify with respect to that communication in a civil or criminal proceeding.

(3) The client or patient in an attorney-client or physician-patient relationship described in division (A)(2) of this section is deemed to have waived any testimonial privilege under division (A) or (B) of section 2317.02 of the Revised Code with respect to any communication the attorney or physician receives from the client or patient in that attorney-client or physician-patient relationship, and the attorney or physician shall make a report pursuant to division (A)(1) of this section with respect to that communication, if all of the following apply:

(a) The client or patient, at the time of the communication, is a child under eighteen years of age or is a person under twenty-one years of age with a developmental disability or physical impairment.

(b) The attorney or physician knows, or has reasonable cause to suspect based on facts that would cause a reasonable person in similar position to suspect that the client or patient has
suffered or faces a threat of suffering any physical or mental wound, injury, disability, or condition of a nature that reasonably indicates abuse or neglect of the client or patient.

(c) The abuse or neglect does not arise out of the client's or patient's attempt to have an abortion without the notification of her parents, guardian, or custodian in accordance with section 2151.85 of the Revised Code.

(4)(a) No cleric and no person, other than a volunteer, designated by any church, religious society, or faith acting as a leader, official, or delegate on behalf of the church, religious society, or faith who is acting in an official or professional capacity, who knows, or has reasonable cause to believe based on facts that would cause a reasonable person in a similar position to believe, that a child under eighteen years of age, or a person under twenty-one years of age with a developmental disability or physical impairment, has suffered or faces a threat of suffering any physical or mental wound, injury, disability, or condition of a nature that reasonably indicates abuse or neglect of the child, and who knows, or has reasonable cause to believe based on facts that would cause a reasonable person in a similar position to believe, that another cleric or another person, other than a volunteer, designated by a church, religious society, or faith caused, or poses the threat of causing, the wound, injury, disability, or condition that reasonably indicates abuse or neglect shall fail to immediately report that knowledge or reasonable cause to believe to the entity or persons specified in this division. Except as provided in section 5120.173 of the Revised Code, the person making the report shall make it to the public children services agency or a municipal or county peace officer in the county in which the child resides or in which the abuse or neglect is occurring or has occurred. In the circumstances described in section 5120.173 of the Revised Code, the person making the report shall make it to the entity specified in that section.

(b) Except as provided in division (A)(4)(c) of this section, a cleric is not required to make a report pursuant to division (A)(4)(a) of this section concerning any communication the cleric receives from a penitent in a cleric-penitent relationship, if, in accordance with division (C) of section 2317.02 of the Revised Code, the cleric could not testify with respect to that communication in a civil or criminal proceeding.

(c) The penitent in a cleric-penitent relationship described in division (A)(4)(b) of this section is deemed to have waived any testimonial privilege under division (C) of section 2317.02 of the Revised Code with respect to any communication the cleric receives from the penitent in that cleric-penitent relationship, and the cleric shall make a report pursuant to division (A)(4)(a) of this section with respect to that communication, if all of the following apply:

(i) The penitent, at the time of the communication, is a child under eighteen years of age or is a person under twenty-one years of age with a developmental disability or physical impairment.

(ii) The cleric knows, or has reasonable cause to believe based on facts that would cause a reasonable person in a similar position to believe, as a result of the communication or any observations made during that communication, the penitent has suffered or faces a threat of suffering any physical or mental wound, injury, disability, or condition of a nature that reasonably indicates abuse or neglect of the penitent.

(iii) The abuse or neglect does not arise out of the penitent's attempt to have an abortion performed upon a child under eighteen years of age or upon a person under twenty-one years of age with a developmental disability or physical impairment without the notification of her parents, guardian, or custodian in accordance with section 2151.85 of the Revised Code.

(d) Divisions (A)(4)(a) and (c) of this section do not apply in a cleric-penitent relationship when the disclosure of any communication the cleric receives from the penitent is in violation of the sacred trust.

(e) As used in divisions (A)(1) and (4) of this section, “cleric” and “sacred trust” have the same meanings as in section 2317.02 of the Revised Code.
(B) Anyone who knows, or has reasonable cause to suspect based on facts that would cause a reasonable person in similar circumstances to suspect, that a child under eighteen years of age, or a person under twenty-one years of age with a developmental disability or physical impairment, has suffered or faces a threat of suffering any physical or mental wound, injury, disability, or other condition of a nature that reasonably indicates abuse or neglect of the child may report or cause reports to be made of that knowledge or reasonable cause to suspect to the entity or persons specified in this division. Except as provided in section 5120.173 of the Revised Code, a person making a report or causing a report to be made under this division shall make it or cause it to be made to the public children services agency or to a municipal or county peace officer. In the circumstances described in section 5120.173 of the Revised Code, a person making a report or causing a report to be made under this division shall make it or cause it to be made to the entity specified in that section.

(C) Any report made pursuant to division (A) or (B) of this section shall be made forthwith either by telephone or in person and shall be followed by a written report, if requested by the receiving agency or officer. The written report shall contain:

1. The names and addresses of the child and the child's parents or the person or persons having custody of the child, if known;
2. The child's age and the nature and extent of the child's injuries, abuse, or neglect that is known or reasonably suspected or believed, as applicable, to have occurred or of the threat of injury, abuse, or neglect that is known or reasonably suspected or believed, as applicable, to exist, including any evidence of previous injuries, abuse, or neglect;
3. Any other information, including, but not limited to, results and reports of any medical examinations, tests, or procedures performed under division (D) of this section, that might be helpful in establishing the cause of the injury, abuse, or neglect that is known or reasonably suspected or believed, as applicable, to have occurred or of the threat of injury, abuse, or neglect that is known or reasonably suspected or believed, as applicable, to exist.

(D)(1) Any person, who is required by division (A) of this section to report child abuse or child neglect that is known or reasonably suspected or believed to have occurred, may take or cause to be taken color photographs of areas of trauma visible on a child and, if medically necessary for the purpose of diagnosing or treating injuries that are suspected to have occurred as a result of child abuse or child neglect, perform or cause to be performed radiological examinations and any other medical examinations of, and tests or procedures on, the child.

2. The results and any available reports of examinations, tests, or procedures made under division (D)(1) of this section shall be included in a report made pursuant to division (A) of this section. Any additional reports of examinations, tests, or procedures that become available shall be provided to the public children services agency, upon request.

3. If a health care professional provides health care services in a hospital, children's advocacy center, or emergency medical facility to a child about whom a report has been made under division (A) of this section, the health care professional may take any steps that are reasonably necessary for the release or discharge of the child to an appropriate environment. Before the child's release or discharge, the health care professional may obtain information, or consider information obtained, from other entities or individuals that have knowledge about the child. Nothing in division (D)(3) of this section shall be construed to alter the responsibilities of any person under sections 2151.27 and 2151.31 of the Revised Code.

4. A health care professional may conduct medical examinations, tests, or procedures on the siblings of a child about whom a report has been made under division (A) of this section and on other children who reside in the same home as the child, if the professional determines that the examinations, tests, or procedures are medically necessary to diagnose or treat the siblings or other children in order to determine whether reports under division (A) of this section are warranted with respect to such siblings or other children. The results of the examinations, tests, or procedures on the siblings and other children may be included in a report made
Chapter 9. Crime, Records Check, False Claims and Fraud
Part I. Crime

Crime - General Provisions

(5) Medical examinations, tests, or procedures conducted under divisions (D)(1) and (4) of this section and decisions regarding the release or discharge of a child under division (D)(3) of this section do not constitute a law enforcement investigation or activity.

(E)(1) When a municipal or county peace officer receives a report concerning the possible abuse or neglect of a child or the possible threat of abuse or neglect of a child, upon receipt of the report, the municipal or county peace officer who receives the report shall refer the report to the appropriate public children services agency.

(2) When a public children services agency receives a report pursuant to this division or division (A) or (B) of this section, upon receipt of the report, the public children services agency shall do both of the following:
   a. Comply with section 2151.422 of the Revised Code;
   b. If the county served by the agency is also served by a children's advocacy center and the report alleges sexual abuse of a child or another type of abuse of a child that is specified in the memorandum of understanding that creates the center as being within the center's jurisdiction, comply regarding the report with the protocol and procedures for referrals and investigations, with the coordinating activities, and with the authority or responsibility for performing or providing functions, activities, and services stipulated in the interagency agreement entered into under section 2151.428 of the Revised Code relative to that center.

(F) No township, municipal, or county peace officer shall remove a child about whom a report is made pursuant to this section from the child's parents, stepparents, or guardian or any other persons having custody of the child without consultation with the public children services agency, unless, in the judgment of the officer, and, if the report was made by physician, the physician, immediate removal is considered essential to protect the child from further abuse or neglect. The agency that must be consulted shall be the agency conducting the investigation of the report as determined pursuant to section 2151.422 of the Revised Code.

(G)(1) Except as provided in section 2151.422 of the Revised Code or in an interagency agreement entered into under section 2151.428 of the Revised Code that applies to the particular report, the public children services agency shall investigate, within twenty-four hours, each report of child abuse or child neglect that is known or reasonably suspected or believed to have occurred and of a threat of child abuse or child neglect that is known or reasonably suspected or believed to exist that is referred to it under this section to determine the circumstances surrounding the injuries, abuse, or neglect or the threat of injury, abuse, or neglect, the cause of the injuries, abuse, neglect, or threat, and the person or persons responsible. The investigation shall be made in cooperation with the law enforcement agency and in accordance with the memorandum of understanding prepared under division (K) of this section. A representative of the public children services agency shall, at the time of initial contact with the person subject to the investigation, inform the person of the specific complaints or allegations made against the person. The information shall be given in a manner that is consistent with division (I)(1) of this section and protects the rights of the person making the report under this section.

A failure to make the investigation in accordance with the memorandum is not grounds for, and shall not result in, the dismissal of any charges or complaint arising from the report or the suppression of any evidence obtained as a result of the report and does not give, and shall not be construed as giving, any rights or any grounds for appeal or post-conviction relief to any person. The public children services agency shall report each case to the uniform statewide automated child welfare information system that the department of job and family services shall maintain in accordance with section 5101.13 of the Revised Code. The public children services agency shall submit a report of its investigation, in writing, to the law enforcement agency.

(2) The public children services agency shall make any recommendations to the county
prosecuting attorney or city director of law that it considers necessary to protect any children that are brought to its attention.

(H)(1)(a) Except as provided in divisions (H)(1)(b) and (I)(3) of this section, any person, health care professional, hospital, institution, school, health department, or agency shall be immune from any civil or criminal liability for injury, death, or loss to person or property that otherwise might be incurred or imposed as a result of any of the following:

(i) Participating in the making of reports pursuant to division (A) of this section or in the making of reports in good faith, pursuant to division (B) of this section;

(ii) Participating in medical examinations, tests, or procedures under division (D) of this section;

(iii) Providing information used in a report made pursuant to division (A) of this section or providing information in good faith used in a report made pursuant to division (B) of this section;

(iv) Participating in a judicial proceeding resulting from a report made pursuant to division (A) of this section or participating in good faith in a proceeding resulting from a report made pursuant to division (B) of this section.

(b) Immunity under division (H)(1)(a)(ii) of this section shall not apply when a health care provider has deviated from the standard of care applicable to the provider's profession.

(c) Notwithstanding section 4731.22 of the Revised Code, the physician-patient privilege shall not be a ground for excluding evidence regarding a child's injuries, abuse, or neglect, or the cause of the injuries, abuse, or neglect in any judicial proceeding resulting from a report submitted pursuant to this section.

(2) In any civil or criminal action or proceeding in which it is alleged and proved that participation in the making of a report under this section was not in good faith or participation in a judicial proceeding resulting from a report made under this section was not in good faith, the court shall award the prevailing party reasonable attorney's fees and costs and, if a civil action or proceeding is voluntarily dismissed, may award reasonable attorney's fees and costs to the party against whom the civil action or proceeding is brought.

(I)(1) Except as provided in divisions (I)(4) and (O) of this section, a report made under this section is confidential. The information provided in a report made pursuant to this section and the name of the person who made the report shall not be released for use, and shall not be used, as evidence in any civil action or proceeding brought against the person who made the report. Nothing in this division shall preclude the use of reports of other incidents of known or suspected abuse or neglect in a criminal action or proceeding brought pursuant to division (N) of this section against a person who is alleged to have violated division (A)(1) of this section, provided that any information in a report that would identify the child who is the subject of the report or the maker of the report, if the maker of the report is not the defendant or an agent or employee of the defendant, has been redacted. In a criminal proceeding, the report is admissible in evidence in accordance with the Rules of Evidence and is subject to discovery in accordance with the Rules of Criminal Procedure.

(I)(2)(a) Except as provided in division (I)(2)(b) of this section, no person shall permit or encourage the unauthorized dissemination of the contents of any report made under this section.

(b) A health care professional that obtains the same information contained in a report made under this section from a source other than the report may disseminate the information, if its dissemination is otherwise permitted by law.

(3) A person who knowingly makes or causes another person to make a false report under division (B) of this section that alleges that any person has committed an act or omission that resulted in a child being an abused child or a neglected child is guilty of a violation of section 2921.14 of the Revised Code.

(4) If a report is made pursuant to division (A) or (B) of this section and the child who is the subject of the report dies for any reason at any time after the report is made, but before the...
child attains eighteen years of age, the public children services agency or municipal or county peace officer to which the report was made or referred, on the request of the child fatality review board or the director of health pursuant to guidelines established under section 3701.70 of the Revised Code, shall submit a summary sheet of information providing a summary of the report to the review board of the county in which the deceased child resided at the time of death or to the director. On the request of the review board or director, the agency or peace officer may, at its discretion, make the report available to the review board or director. If the county served by the public children services agency is also served by a children's advocacy center and the report of alleged sexual abuse of a child or another type of abuse of a child is specified in the memorandum of understanding that creates the center as being within the center's jurisdiction, the agency or center shall perform the duties and functions specified in this division in accordance with the interagency agreement entered into under section 2151.428 of the Revised Code relative to that advocacy center.

(5) A public children services agency shall advise a person alleged to have inflicted abuse or neglect on a child who is the subject of a report made pursuant to this section, including a report alleging sexual abuse of a child or another type of abuse of a child referred to a children's advocacy center pursuant to an interagency agreement entered into under section 2151.428 of the Revised Code, in writing of the disposition of the investigation. The agency shall not provide to the person any information that identifies the person who made the report, statements of witnesses, or police or other investigative reports.

(J) Any report that is required by this section, other than a report that is made to the state highway patrol as described in section 5120.173 of the Revised Code, shall result in protective services and emergency supportive services being made available by the public children services agency on behalf of the children about whom the report is made, in an effort to prevent further neglect or abuse, to enhance their welfare, and, whenever possible, to preserve the family unit intact. The agency required to provide the services shall be the agency conducting the investigation of the report pursuant to section 2151.422 of the Revised Code.

(K)(1) Each public children services agency shall prepare a memorandum of understanding that is signed by all of the following:

(a) If there is only one juvenile judge in the county, the juvenile judge of the county or the juvenile judge's representative;
(b) If there is more than one juvenile judge in the county, a juvenile judge or the juvenile judges' representative selected by the juvenile judges or, if they are unable to do so for any reason, the juvenile judge who is senior in point of service or the senior juvenile judge's representative;
(c) The county peace officer;
(d) All chief municipal peace officers within the county;
(e) Other law enforcement officers handling child abuse and neglect cases in the county;
(f) The prosecuting attorney of the county;
(g) If the public children services agency is not the county department of job and family services, the county department of job and family services;
(h) The county humane society;
(i) If the public children services agency participated in the execution of a memorandum of understanding under section 2151.426 of the Revised Code establishing a children's advocacy center, each participating member of the children's advocacy center established by the memorandum.

(2) A memorandum of understanding shall set forth the normal operating procedure to be employed by all concerned officials in the execution of their respective responsibilities under this section and division (C) of section 2919.21, division (B)(1) of section 2919.22, division (B) of section 2919.23, and section 2919.24 of the Revised Code and shall have as two of its primary goals the elimination of all unnecessary interviews of children who are the subject of reports
made pursuant to division (A) or (B) of this section and, when feasible, providing for only one
interview of a child who is the subject of any report made pursuant to division (A) or (B) of
this section. A failure to follow the procedure set forth in the memorandum by the concerned officials
is not grounds for, and shall not result in, the dismissal of any charges or complaint arising from
any reported case of abuse or neglect or the suppression of any evidence obtained as a result
of any reported child abuse or child neglect and does not give, and shall not be construed as
giving, any rights or any grounds for appeal or post-conviction relief to any person.

(3) A memorandum of understanding shall include all of the following:
(a) The roles and responsibilities for handling emergency and nonemergency cases of
abuse and neglect;
(b) Standards and procedures to be used in handling and coordinating investigations of
reported cases of child abuse and reported cases of child neglect, methods to be used in
interviewing the child who is the subject of the report and who allegedly was abused or
neglected, and standards and procedures addressing the categories of persons who may
interview the child who is the subject of the report and who allegedly was abused or neglected.

(4) If a public children services agency participated in the execution of a memorandum of
understanding under section 2151.426 of the Revised Code establishing a children's advocacy
center, the agency shall incorporate the contents of that memorandum in the memorandum
prepared pursuant to this section.

(5) The clerk of the court of common pleas in the county may sign the memorandum of
understanding prepared under division (K)(1) of this section. If the clerk signs the memorandum
of understanding, the clerk shall execute all relevant responsibilities as required of officials
specified in the memorandum.

(L)(1) Except as provided in division (L)(4) or (5) of this section, a person who is required
to make a report pursuant to division (A) of this section may make a reasonable number of
requests of the public children services agency that receives or is referred the report, or of the
children's advocacy center that is referred the report if the report is referred to a children's
advocacy center pursuant to an interagency agreement entered into under section 2151.428 of
the Revised Code, to be provided with the following information:
(a) Whether the agency or center has initiated an investigation of the report;
(b) Whether the agency or center is continuing to investigate the report;
(c) Whether the agency or center is otherwise involved with the child who is the subject
of the report;
(d) The general status of the health and safety of the child who is the subject of the
report;
(e) Whether the report has resulted in the filing of a complaint in juvenile court or of
criminal charges in another court.

(2) A person may request the information specified in division (L)(1) of this section only
if, at the time the report is made, the person's name, address, and telephone number are
provided to the person who receives the report.

When a municipal or county peace officer or employee of a public children services
agency receives a report pursuant to division (A) or (B) of this section the recipient of the report
shall inform the person of the right to request the information described in division (L)(1) of this
section. The recipient of the report shall include in the initial child abuse or child neglect report
that the person making the report was so informed and, if provided at the time of the making of
the report, shall include the person's name, address, and telephone number in the report.

Each request is subject to verification of the identity of the person making the report. If
that person's identity is verified, the agency shall provide the person with the information
described in division (L)(1) of this section a reasonable number of times, except that the agency
shall not disclose any confidential information regarding the child who is the subject of the report
other than the information described in those divisions.
(3) A request made pursuant to division (L)(1) of this section is not a substitute for any report required to be made pursuant to division (A) of this section.

(4) If an agency other than the agency that received or was referred the report is conducting the investigation of the report pursuant to section 2151.422 of the Revised Code, the agency conducting the investigation shall comply with the requirements of division (L) of this section.

(5) A health care professional who made a report under division (A) of this section, or on whose behalf such a report was made as provided in division (A)(1)(c) of this section, may authorize a person to obtain the information described in division (L)(1) of this section if the person requesting the information is associated with or acting on behalf of the health care professional who provided health care services to the child about whom the report was made.

(M) The director of job and family services shall adopt rules in accordance with Chapter 119 of the Revised Code to implement this section. The department of job and family services may enter into a plan of cooperation with any other governmental entity to aid in ensuring that children are protected from abuse and neglect. The department shall make recommendations to the attorney general that the department determines are necessary to protect children from child abuse and child neglect.

(N) Whoever violates division (A) of this section is liable for compensatory and exemplary damages to the child who would have been the subject of the report that was not made. A person who brings a civil action or proceeding pursuant to this division against a person who is alleged to have violated division (A)(1) of this section may use in the action or proceeding reports of other incidents of known or suspected abuse or neglect, provided that any information in a report that would identify the child who is the subject of the report or the maker of the report, if the maker is not the defendant or an agent or employee of the defendant, has been redacted.

(O)(1) As used in this division:

(a) “Out-of-home care” includes a nonchartered nonpublic school if the alleged child abuse or child neglect, or alleged threat of child abuse or child neglect, described in a report received by a public children services agency allegedly occurred in or involved the nonchartered nonpublic school and the alleged perpetrator named in the report holds a certificate, permit, or license issued by the state board of education under section 3301.071 or Chapter 3319 of the Revised Code.

(b) “Administrator, director, or other chief administrative officer” means the superintendent of the school district if the out-of-home care entity subject to a report made pursuant to this section is a school operated by the district.

(2) No later than the end of the day following the day on which a public children services agency receives a report of alleged child abuse or child neglect, or a report of an alleged threat of child abuse or child neglect, that allegedly occurred in or involved an out-of-home care entity, the agency shall provide written notice of the allegations contained in and the person named as the alleged perpetrator in the report to the administrator, director, or other chief administrative officer of the out-of-home care entity that is the subject of the report unless the administrator, director, or other chief administrative officer is named as an alleged perpetrator in the report. If the administrator, director, or other chief administrative officer of an out-of-home care entity is named as an alleged perpetrator in a report of alleged child abuse or child neglect, or a report of an alleged threat of child abuse or child neglect, that allegedly occurred in or involved the out-of-home care entity, the agency shall provide the written notice to the owner or governing board of the out-of-home care entity that is the subject of the report. The agency shall not provide witness statements or police or other investigative reports.

(3) No later than three days after the day on which a public children services agency that conducted the investigation as determined pursuant to section 2151.422 of the Revised Code makes a disposition of an investigation involving a report of alleged child abuse or child neglect,
or a report of an alleged threat of child abuse or child neglect, that allegedly occurred in or involved an out-of-home care entity, the agency shall send written notice of the disposition of the investigation to the administrator, director, or other chief administrative officer and the owner or governing board of the out-of-home care entity. The agency shall not provide witness statements or police or other investigative reports.

(P) As used in this section:

(1) “Children's advocacy center” and “sexual abuse of a child” have the same meanings as in section 2151.425 of the Revised Code.

(2) “Health care professional” means an individual who provides health-related services including a physician, hospital intern or resident, dentist, podiatrist, registered nurse, licensed practical nurse, visiting nurse, licensed psychologist, speech pathologist, audiologist, person engaged in social work or the practice of professional counseling, and employee of a home health agency. “Health care professional” does not include a practitioner of a limited branch of medicine as specified in section 4731.15 of the Revised Code, licensed school psychologist, independent marriage and family therapist or marriage and family therapist, or coroner.

(3) “Investigation” means the public children services agency's response to an accepted report of child abuse or neglect through either an alternative response or a traditional response.

2903.13 Assault including against hospital staff member.

(A) No person shall knowingly cause or attempt to cause physical harm to another or to another's unborn.

(B) No person shall recklessly cause serious physical harm to another or to another's unborn.

(C)(1) Whoever violates this section is guilty of assault, and the court shall sentence the offender as provided in this division and divisions (C)(1), (2), (3), (4), (5), (6), (7), (8), (9), and (10) of this section. Except as otherwise provided in division (C)(2), (3), (4), (5), (6), (7), (8), or (9) of this section, assault is a misdemeanor of the first degree.

(2) Except as otherwise provided in this division, if the offense is committed by a caretaker against a functionally impaired person under the caretaker's care, assault is a felony of the fourth degree. If the offense is committed by a caretaker against a functionally impaired person under the caretaker's care, if the offender previously has been convicted of or pleaded guilty to a violation of this section or section 2903.11 or 2903.16 of the Revised Code, and if in relation to the previous conviction the offender was a caretaker and the victim was a functionally impaired person under the offender's care, assault is a felony of the third degree.

(3) If the offense occurs in or on the grounds of a state correctional institution or an institution of the department of youth services, the victim of the offense is an employee of the department of rehabilitation and correction or the department of youth services, and the offense is committed by a person incarcerated in the state correctional institution or by a person institutionalized in the department of youth services institution pursuant to a commitment to the department of youth services, assault is a felony of the third degree.

(4) If the offense is committed in any of the following circumstances, assault is a felony of the fifth degree:

(a) The offense occurs in or on the grounds of a local correctional facility, the victim of the offense is an employee of the local correctional facility or a probation department or is on the premises of the facility for business purposes or as a visitor, and the offense is committed by a person who is under custody in the facility subsequent to the person’s arrest for any crime or delinquent act, subsequent to the person’s being charged with or convicted of any crime, or subsequent to the person’s being alleged to be or adjudicated a delinquent child.

(b) The offense occurs off the grounds of a state correctional institution and off the grounds of an institution of the department of youth services, the victim of the offense is an
employee of the department of rehabilitation and correction, the department of youth services, or a probation department, the offense occurs during the employee's official work hours and while the employee is engaged in official work responsibilities, and the offense is committed by a person incarcerated in a state correctional institution or institutionalized in the department of youth services who temporarily is outside of the institution for any purpose, by a parolee, by an offender under transitional control, under a community control sanction, or on an escorted visit, by a person under post-release control, or by an offender under any other type of supervision by a government agency.

(c) The offense occurs off the grounds of a local correctional facility, the victim of the offense is an employee of the local correctional facility or a probation department, the offense occurs during the employee's official work hours and while the employee is engaged in official work responsibilities, and the offense is committed by a person who is under custody in the facility subsequent to the person's arrest for any crime or delinquent act, subsequent to the person being charged with or convicted of any crime, subsequent to the person being alleged to be or adjudicated a delinquent child and who temporarily is outside of the facility for any purpose or by a parolee, by an offender under transitional control, under a community control sanction, or on an escorted visit, by a person under post-release control, or by an offender under any other type of supervision by a government agency.

(d) The victim of the offense is a school teacher or administrator or a school bus operator, and the offense occurs in a school, on school premises, in a school building, on a school bus, or while the victim is outside of school premises or a school bus and is engaged in duties or official responsibilities associated with the victim's employment or position as a school teacher or administrator or a school bus operator, including, but not limited to, driving, accompanying, or chaperoning students at or on class or field trips, athletic events, or other school extracurricular activities or functions outside of school premises.

(e) If the victim of the offense is a peace officer or an investigator of the bureau of criminal identification and investigation, a firefighter, or a person performing emergency medical service, while in the performance of their official duties, assault is a felony of the fourth degree.

(f) If the victim of the offense is a peace officer or an investigator of the bureau of criminal identification and investigation and if the victim suffered serious physical harm as a result of the commission of the offense, assault is a felony of the fourth degree, and the court, pursuant to division (F) of section 2929.13 of the Revised Code, shall impose as a mandatory prison term one of the prison terms prescribed for a felony of the fourth degree that is at least twelve months in duration.

(g) If the victim of the offense is an officer or employee of a public children services agency or a private child placing agency and the offense relates to the officer's or employee's performance or anticipated performance of official responsibilities or duties, assault is either a felony of the fifth degree or, if the offender previously has been convicted of or pleaded guilty to an offense of violence, the victim of that prior offense was an officer or employee of a public children services agency or private child placing agency, and that prior offense related to the officer's or employee's performance or anticipated performance of official responsibilities or duties, a felony of the fourth degree.

(h) If the victim of the offense is a health care professional of a hospital, a health care worker of a hospital, or a security officer of a hospital whom the offender knows or has reasonable cause to know is a health care professional of a hospital, a health care worker of a hospital, or a security officer of a hospital, if the victim is engaged in the performance of the victim's duties, and if the hospital offers de-escalation or crisis intervention training for such professionals, workers, or officers, assault is one of the following:

(a) Except as otherwise provided in division (C)(8)(b) of this section, assault committed in the specified circumstances is a misdemeanor of the first degree. Notwithstanding the fine specified in division (A)(2)(b) of section 2929.28 of the Revised Code for a misdemeanor of the
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first degree, in sentencing the offender under this division and if the court decides to impose a fine, the court may impose upon the offender a fine of not more than five thousand dollars.

(b) If the offender previously has been convicted of or pleaded guilty to one or more assault or homicide offenses committed against hospital personnel, assault committed in the specified circumstances is a felony of the fifth degree.

(9) If the victim of the offense is a judge, magistrate, prosecutor, or court official or employee whom the offender knows or has reasonable cause to know is a judge, magistrate, prosecutor, or court official or employee, and if the victim is engaged in the performance of the victim's duties, assault is one of the following:

(a) Except as otherwise provided in division (C)(8)(b) of this section, assault committed in the specified circumstances is a misdemeanor of the first degree. In sentencing the offender under this division, if the court decides to impose a fine, notwithstanding the fine specified in division (A)(2)(b) of section 2929.28 of the Revised Code for a misdemeanor of the first degree, the court may impose upon the offender a fine of not more than five thousand dollars.

(b) If the offender previously has been convicted of or pleaded guilty to one or more assault or homicide offenses committed against justice system personnel, assault committed in the specified circumstances is a felony of the fifth degree.

(10) If an offender who is convicted of or pleads guilty to assault when it is a misdemeanor also is convicted of or pleads guilty to a specification as described in section 2941.1423 of the Revised Code that was included in the indictment, count in the indictment, or information charging the offense, the court shall sentence the offender to a mandatory jail term as provided in division (G) of section 2929.24 of the Revised Code.

If an offender who is convicted of or pleads guilty to assault when it is a felony also is convicted of or pleads guilty to a specification as described in section 2941.1423 of the Revised Code that was included in the indictment, count in the indictment, or information charging the offense, except as otherwise provided in division (C)(6) of this section, the court shall sentence the offender to a mandatory prison term as provided in division (B)(8) of section 2929.14 of the Revised Code.

(D) As used in this section:

(1) "Peace officer" has the same meaning as in section 2935.01 of the Revised Code.

(2) "Firefighter" has the same meaning as in section 3937.41 of the Revised Code.

(3) "Emergency medical service" has the same meaning as in section 4765.01 of the Revised Code.

(4) "Local correctional facility" means a county, multicounty, municipal, municipal-county, or multicounty-municipal jail or workhouse, a minimum security jail established under section 341.23 or 753.21 of the Revised Code, or another county, multicounty, municipal, municipal-county, or multicounty-municipal facility used for the custody of persons arrested for any crime or delinquent act, persons charged with or convicted of any crime, or persons alleged to be or adjudicated a delinquent child.

(5) "Employee of a local correctional facility" means a person who is an employee of the political subdivision or of one or more of the affiliated political subdivisions that operates the local correctional facility and who operates or assists in the operation of the facility.

(6) "School teacher or administrator" means either of the following:

(a) A person who is employed in the public schools of the state under a contract described in section 3311.77 or 3319.08 of the Revised Code in a position in which the person is required to have a certificate issued pursuant to sections 3319.22 to 3319.311 of the Revised Code.

(b) A person who is employed by a nonpublic school for which the state board of education prescribes minimum standards under section 3301.07 of the Revised Code and who is certificated in accordance with section 3301.071 of the Revised Code.

(7) "Community control sanction" has the same meaning as in section 2929.01 of the Revised Code.
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(8) “Escorted visit” means an escorted visit granted under section 2967.27 of the Revised Code.

(9) “Post-release control” and “transitional control” have the same meanings as in section 2967.01 of the Revised Code.

(10) “Investigator of the bureau of criminal identification and investigation” has the same meaning as in section 2903.11 of the Revised Code.

(11) “Health care professional” and “health care worker” have the same meanings as in section 2305.234 of the Revised Code.

(12) “Assault or homicide offense committed against hospital personnel” means a violation of this section or of section 2903.01, 2903.02, 2903.03, 2903.04, 2903.041, 2903.11, 2903.12, or 2903.14 of the Revised Code committed in circumstances in which all of the following apply:

(a) The victim of the offense was a health care professional of a hospital, a health care worker of a hospital, or a security officer of a hospital.

(b) The offender knew or had reasonable cause to know that the victim was a health care professional of a hospital, a health care worker of a hospital, or a security officer of a hospital.

(c) The victim was engaged in the performance of the victim’s duties.

(d) The hospital offered de-escalation or crisis intervention training for such professionals, workers, or officers.

(13) “De-escalation or crisis intervention training” means de-escalation or crisis intervention training for health care professionals of a hospital, health care workers of a hospital, and security officers of a hospital to facilitate interaction with patients, members of a patient's family, and visitors, including those with mental impairments.

(14) “Assault or homicide offense committed against justice system personnel” means a violation of this section or of section 2903.01, 2903.02, 2903.03, 2903.04, 2903.041, 2903.11, 2903.12, or 2903.14 of the Revised Code committed in circumstances in which the victim of the offense was a judge, magistrate, prosecutor, or court official or employee whom the offender knew or had reasonable cause to know was a judge, magistrate, prosecutor, or court official or employee, and the victim was engaged in the performance of the victim’s duties.

(15) “Court official or employee” means any official or employee of a court created under the constitution or statutes of this state or of a United States court located in this state.

(16) “Judge” means a judge of a court created under the constitution or statutes of this state or of a United States court located in this state.

(17) “Magistrate” means an individual who is appointed by a court of record of this state and who has the powers and may perform the functions specified in Civil Rule 53, Criminal Rule 19, or Juvenile Rule 40, or an individual who is appointed by a United States court located in this state who has similar powers and functions.

(18) “Prosecutor” has the same meaning as in section 2935.01 of the Revised Code.

(19)(a) “Hospital” means, subject to division (D)(19)(b) of this section, an institution classified as a hospital under section 3701.01 of the Revised Code which is provided to patients diagnostic, medical, surgical, obstetrical, psychiatric, or rehabilitation care or a hospital operated by a health maintenance organization.

(b) “Hospital” does not include any of the following:

(i) A facility licensed under Chapter 3721 of the Revised Code, a health care facility operated by the department of mental health or the department of developmental disabilities, a health maintenance organization that does not operate a hospital, or the office of any private, licensed health care professional, whether organized for individual or group practice;

(ii) An institution for the sick that is operated exclusively for patients who use spiritual means for healing and for whom the acceptance of medical care is inconsistent with their
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religious beliefs, accredited by a national accrediting organization, exempt from federal income taxation under section 501 of the “Internal Revenue Code of 1986,” 100 Stat. 2085, 26 U.S.C. 1, as amended, and providing twenty-four-hour nursing care pursuant to the exemption in division (E) of section 4723.32 of the Revised Code from the licensing requirements of Chapter 4723 of the Revised Code.

(20) “Health maintenance organization” has the same meaning as in section 3727.01 of the Revised Code.

2903.33 Patient abuse; definitions.

As used in sections 2903.33 to 2903.36 of the Revised Code:

(A) “Care facility” means any of the following:
(1) Any “home” as defined in section 3721.10 of the Revised Code;
(2) Any “residential facility” as defined in section 5123.19 of the Revised Code;
(3) Any institution or facility operated or provided by the department of mental health and addiction services or by the department of developmental disabilities pursuant to sections 5119.14 and 5123.03 of the Revised Code;
(4) Any “residential facility” as defined in section 5119.34 of the Revised Code;
(5) Any unit of any hospital, as defined in section 3701.01 of the Revised Code, that provides the same services as a nursing home, as defined in section 3721.01 of the Revised Code;
(6) Any institution, residence, or facility that provides, for a period of more than twenty-four hours, whether for a consideration or not, accommodations to one individual or two unrelated individuals who are dependent upon the services of others.

(B) “Abuse” means knowingly causing physical harm or recklessly causing serious physical harm to a person by physical contact with the person or by the inappropriate use of a physical or chemical restraint, medication, or isolation on the person.

(C)(1) “Gross neglect” means knowingly failing to provide a person with any treatment, care, goods, or service that is necessary to maintain the health or safety of the person when the failure results in physical harm or serious physical harm to the person.
(2) “Neglect” means recklessly failing to provide a person with any treatment, care, goods, or service that is necessary to maintain the health or safety of the person when the failure results in serious physical harm to the person.

(D) “Inappropriate use of a physical or chemical restraint, medication, or isolation” means the use of physical or chemical restraint, medication, or isolation as punishment, for staff convenience, excessively, as a substitute for treatment, or in quantities that preclude habilitation and treatment.

2903.34 Abuse or neglect of a patient.

(A) No person who owns, operates, or administers, or who is an agent or employee of, a care facility shall do any of the following:
(1) Commit abuse against a resident or patient of the facility;
(2) Commit gross neglect against a resident or patient of the facility;
(3) Commit neglect against a resident or patient of the facility.

(B)(1) A person who relies upon treatment by spiritual means through prayer alone, in accordance with the tenets of a recognized religious denomination, shall not be considered neglected under division (A)(3) of this section for that reason alone.
(2) It is an affirmative defense to a charge of gross neglect or neglect under this section that the actor’s conduct was committed in good faith solely because the actor was ordered to commit the conduct by a person with supervisory authority over the actor.
(C) Whoever violates division (A)(1) of this section is guilty of patient abuse, a felony of the fourth degree. If the offender previously has been convicted of, or pleaded guilty to, any violation of this section, patient abuse is a felony of the third degree.

(D) Whoever violates division (A)(2) of this section is guilty of gross patient neglect, a misdemeanor of the first degree. If the offender previously has been convicted of, or pleaded guilty to, any violation of this section, gross patient neglect is a felony of the fifth degree.

(E) Whoever violates division (A)(3) of this section is guilty of patient neglect, a misdemeanor of the second degree. If the offender previously has been convicted of or pleaded guilty to any violation of this section, patient neglect is a felony of the fifth degree.

2903.341 Patient endangerment; defenses.

(A) As used in this section:

(1) “Developmental disabilities caretaker” means any developmental disabilities employee or any person who assumes the duty to provide for the care and protection of a person with a developmental disability on a voluntary basis, by contract, through receipt of payment for care and protection, as a result of a family relationship, or by order of a court of competent jurisdiction. “Developmental disabilities caretaker” includes a person who is an employee of a care facility and a person who is an employee of an entity under contract with a provider. “Developmental disabilities caretaker” does not include a person who owns, operates, or administers a care facility or who is an agent of a care facility unless that person also personally provides care to a person with a developmental disability.

(2) Developmental disabilities employee” has the same meaning as in section 5123.50 of the Revised Code.

(3) “Developmental disability” has the same meaning as in section 5123.01 of the Revised Code.

(B) No developmental disabilities caretaker shall create a substantial risk to the health or safety of a person with a developmental disability. A developmental disabilities caretaker does not create a substantial risk to the health or safety of a person with a developmental disability under this division when the developmental disabilities caretaker treats a physical or mental illness or defect of the person with a developmental disability by spiritual means through prayer alone, in accordance with the tenets of a recognized religious body.

(C) No person who owns, operates, or administers a care facility or who is an agent of a care facility shall condone, or knowingly permit, any conduct by a developmental disabilities caretaker who is employed by or under the control of the owner, operator, administrator, or agent that is in violation of division (B) of this section and that involves a person with a developmental disability who is under the care of the owner, operator, administrator, or agent. A person who relies upon treatment by spiritual means through prayer alone, in accordance with the tenets of a recognized religious denomination, shall not be considered endangered under this division for that reason alone.

(D)(1) It is an affirmative defense to a charge of a violation of division (B) or (C) of this section that the actor’s conduct was committed in good faith solely because the actor was ordered to commit the conduct by a person to whom one of the following applies:

(a) The person has supervisory authority over the actor.

(b) The person has authority over the actor’s conduct pursuant to a contract for the provision of services.

(2) It is an affirmative defense to a charge of a violation of division (C) of this section that the person who owns, operates, or administers a care facility or who is an agent of a care facility and who is charged with the violation is following the individual service plan for the involved person with a developmental disability or that the admission, discharge, and transfer rule set forth in the Administrative Code is being followed.
(3) It is an affirmative defense to a charge of a violation of division (C) of this section that
the actor did not have readily available a means to prevent either the harm to the person with a
developmental disability or the death of such a person and the actor took reasonable steps to
summon aid.

(E)(1) Except as provided in division (E)(2) or (E)(3) of this section, whoever violates
division (B) or (C) of this section is guilty of patient endangerment, a misdemeanor of the first
degree.

(2) If the offender previously has been convicted of, or pleaded guilty to, a violation of
this section, patient endangerment is a felony of the fourth degree.

(3) If the violation results in serious physical harm to the person with a developmental
disability, patient endangerment is a felony of the third degree.

2907.28 Victim or accused’s medical exam.

(A) Any cost incurred by a hospital or emergency medical facility in conducting a medical
examination of a victim of an offense under any provision of sections 2907.02 to 2907.06 of the
Revised Code for the purpose of gathering physical evidence for a possible prosecution,
including the cost of any antibiotics administered as part of the examination and the cost of HIV
post-exposure prophylaxis provided as part of the examination, shall be paid out of the
reparations fund established pursuant to section 2743.191 of the Revised Code, subject to the
following conditions:

(1) The hospital or emergency facility shall follow a protocol for conducting such medical
examinations that is identified by the attorney general in rule adopted in accordance with
Chapter 119 of the Revised Code.

(2) The hospital or emergency facility shall submit requests for payment to the attorney
general on a monthly basis, through a procedure determined by the attorney general and on
forms approved by the attorney general. The requests shall identify the number of sexual
assault examinations performed and the number of sexual assault examinations in which HIV
post-exposure prophylaxis was provided and shall verify that all required protocols were met for
each examination form submitted for payment in the request.

(3) The attorney general shall review all requests for payment that are submitted under
division (A)(2) of this section and shall submit for payment as described in division (A)(5) of this
section all requests that meet the requirements of this section.

(4)(a) The hospital or emergency facility shall accept a flat fee payment for conducting
each examination in the amount determined by the attorney general pursuant to Chapter 119 of
the Revised Code as payment in full for any cost incurred in conducting a medical examination
and test of a victim of an offense under any provision of sections 2907.02 to 2907.06 of the
Revised Code for the purpose of gathering physical evidence for a possible prosecution of a
person, other than the cost of providing HIV post-exposure prophylaxis. The attorney general
shall determine a flat fee payment amount to be paid under this division that is reasonable.

(b) The hospital or emergency facility shall accept a flat fee payment for providing HIV
post-exposure prophylaxis in the amount determined by the attorney general pursuant to
Chapter 119 of the Revised Code as payment in full for any cost incurred in providing HIV post-
exposure prophylaxis while conducting a medical examination and test of a victim of an offense
under any provision of sections 2907.02 to 2907.06 of the Revised Code for the purpose of
gathering physical evidence for a possible prosecution of a person. The attorney general shall
determine a reasonable flat fee payment amount to be paid under this division.

(5) In approving a payment under this section, the attorney general shall order the
payment against the state. The payment shall be accomplished only through the following
procedure, and the procedure may be enforced through a mandamus action and a writ of
mandamus directed to the appropriate official:
(a) The attorney general shall provide for payment in the amount set forth in the order.
(b) The expense of the payment of the amount described in this section shall be charged
against all available unencumbered moneys in the reparations fund.
(B) No costs incurred by a hospital or emergency facility in conducting a medical
examination and test of any victim of an offense under any provision of sections 2907.02 to
2907.06 of the Revised Code for the purpose of gathering physical evidence for a possible
prosecution of a person shall be billed or charged directly or indirectly to the victim or the
victim's insurer.
(C) Any cost incurred by a hospital or emergency medical facility in conducting a medical
examination and test of any person who is charged with a violation of division (B) of section
2903.11 or of section 2907.02, 2907.03, 2907.04, 2907.05, 2907.12, 2907.24, 2907.241, or
2907.25 of the Revised Code, with a violation of a municipal ordinance that is substantially
equivalent to that division or any of those sections, or with a violation of a statute or municipal
ordinance under which by force or threat of force the accused compelled the victim to engage in
sexual activity, pursuant to division (B) of section 2907.27 of the Revised Code, shall be
charged to and paid by the accused who undergoes the examination and test, unless the court
determines that the accused is unable to pay, in which case the cost shall be charged to and
paid by the county if the offense allegedly was committed within an unincorporated area. If
separate counts of an alleged offense or alleged separate offenses under division (B) of section
2903.11 or section 2907.02, 2907.03, 2907.04, 2907.05, 2907.12, 2907.24, 2907.241, or
2907.25 of the Revised Code, under a municipal ordinance that is substantially equivalent to
that division or any of those sections, or under a statute or municipal ordinance in violation of
which by force or threat of force the accused compelled the victim to engage in sexual activity
took place in more than one municipal corporation or more than one unincorporated area, or
both, the local governments shall share the cost of the examination and test. If a hospital or
other emergency medical facility has submitted charges for the cost of a medical examination
and test to an accused and has been unable to collect payment for the charges after making
good faith attempts to collect for a period of six months or more, the cost shall be charged to
and paid by the appropriate municipal corporation or county as specified in division (C) of this
section.
(D) As used in this section:
(1) “AIDS” and “HIV” have the same meanings as in section 3701.24 of the Revised
Code.
(2) “HIV post-exposure prophylaxis” means the administration of medicines to prevent
AIDS or HIV infection following exposure to HIV.

2907.29 Victim's emergency medical services.

Every hospital of this state that offers organized emergency services shall provide that a
physician, a physician assistant, a clinical nurse specialist, a certified nurse practitioner, or a
certified nurse-midwife is available on call twenty-four hours each day for the examination of
persons reported to any law enforcement agency to be victims of sexual offenses cognizable as
violations of any provision of sections 2907.02 to 2907.06 of the Revised Code. The physician,
physician assistant, clinical nurse specialist, certified nurse practitioner, or certified nurse-
midwife, upon the request of any peace officer or prosecuting attorney and with the consent of
the reported victim or upon the request of the reported victim, shall examine the person for the
purposes of gathering physical evidence and shall complete any written documentation of the
physical examination. The director of health shall establish procedures for gathering evidence
under this section.

Each reported victim shall be informed of available venereal disease, pregnancy,
medical, and psychiatric services.

Notwithstanding any other provision of law, a minor may consent to examination under this section. The consent is not subject to disaffirmance because of minority, and consent of the parent, parents, or guardian of the minor is not required for an examination under this section. However, the hospital shall give written notice to the parent, parents, or guardian of a minor that an examination under this section has taken place. The parent, parents, or guardian of a minor giving consent under this section are not liable for payment for any services provided under this section without their consent.

2907.30 Interview by peace officer with crisis training.

(A) A victim of a sexual offense cognizable as a violation of section 2907.02 of the Revised Code who is interviewed by a law enforcement agency shall be interviewed by a peace officer employed by the agency who has had crisis intervention training, if any of the peace officers employed by the agency who have had crisis intervention training is reasonably available.

(B) When a person is charged with a violation of section 2907.02, 2907.03, 2907.04, 2907.05, or 2907.06 of the Revised Code and the law enforcement agency that arrested the person or a court discovers that the person arrested or a person whom the person arrested caused to engage in sexual activity has a communicable disease, the law enforcement agency that arrested the person or the court immediately shall notify the victim of the nature of the disease.

(C) As used in this section, "crisis intervention training" has the same meaning as in section 109.71 of the Revised Code.

2921.22 Reporting requirement for felony, gunshot, stabbing, burn injuries and suspected domestic violence.

(A)(1) Except as provided in division (A)(2) of this section, no person, knowing that a felony has been or is being committed, shall knowingly fail to report such information to law enforcement authorities.

(2) No person, knowing that a violation of division (B) of section 2913.04 of the Revised Code has been, or is being committed or that the person has received information derived from such a violation, shall knowingly fail to report the violation to law enforcement authorities.

(B) Except for conditions that are within the scope of division (E) of this section, no person giving aid to a sick or injured person shall negligently fail to report to law enforcement authorities any gunshot or stab wound treated or observed by the person, or any serious physical harm to persons that the person knows or has reasonable cause to believe resulted from an offense of violence.

(C) No person who discovers the body or acquires the first knowledge of the death of a person shall fail to report the death immediately to a physician or advanced practice registered nurse whom the person knows to be treating the deceased for a condition from which death at such time would not be unexpected, or to a law enforcement officer, an ambulance service, an emergency squad, or the coroner in a political subdivision in which the body is discovered, the death is believed to have occurred, or knowledge concerning the death is obtained. For purposes of this division, "advanced practice registered nurse" does not include a certified registered nurse anesthetist.

(D) No person shall fail to provide upon request of the person to whom a report required by division (C) of this section was made, or to any law enforcement officer who has reasonable cause to assert the authority to investigate the circumstances surrounding the death, any facts within the person's knowledge that may have a bearing on the investigation of the death.
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(E)(1) As used in this division, “burn injury” means any of the following:
(a) Second or third degree burns;
(b) Any burns to the upper respiratory tract or laryngeal edema due to the inhalation of superheated air;
(c) Any burn injury or wound that may result in death;
(d) Any physical harm to persons caused by or as the result of the use of fireworks, novelties and trick noisemakers, and wire sparklers, as each is defined by section 3743.01 of the Revised Code.

(2) No physician, nurse, physician assistant, or limited practitioner who, outside a hospital, sanitarium, or other medical facility, attends or treats a person who has sustained a burn injury that is inflicted by an explosion or other incendiary device or that shows evidence of having been inflicted in a violent, malicious, or criminal manner shall fail to report the burn injury immediately to the local arson, or fire and explosion investigation, bureau, if there is a bureau of this type in the jurisdiction in which the person is attended or treated, or otherwise to local law enforcement authorities.

(3) No manager, superintendent, or other person in charge of a hospital, sanitarium, or other medical facility in which a person is attended or treated for any burn injury that is inflicted by an explosion or other incendiary device or that shows evidence of having been inflicted in a violent, malicious, or criminal manner shall fail to report the burn injury immediately to the local arson, or fire and explosion investigation, bureau, if there is a bureau of this type in the jurisdiction in which the person is attended or treated, or otherwise to local law enforcement authorities.

(4) No person who is required to report any burn injury under division (E)(2) or (3) of this section shall fail to file, within three working days after attending or treating the victim, a written report of the burn injury with the office of the state fire marshal. The report shall comply with the uniform standard developed by the state fire marshal pursuant to division (A)(15) of section 3737.22 of the Revised Code.

(5) Anyone participating in the making of reports under division (E) of this section or anyone participating in a judicial proceeding resulting from the reports is immune from any civil or criminal liability that otherwise might be incurred or imposed as a result of such actions. Notwithstanding section 4731.22 of the Revised Code, the physician-patient relationship or advanced practice registered nurse-patient relationship is not a ground for excluding evidence regarding a person's burn injury or the cause of the burn injury in any judicial proceeding resulting from a report submitted under division (E) of this section.

(F)(1) Any doctor of medicine or osteopathic medicine, hospital intern or resident, nurse, psychologist, social worker, independent social worker, social work assistant, licensed professional clinical counselor, licensed professional counselor, independent marriage and family therapist, or marriage and family therapist who knows or has reasonable cause to believe that a patient or client has been the victim of domestic violence, as defined in section 3113.31 of the Revised Code, shall note that knowledge or belief and the basis for it in the patient's or client's records.

(2) Notwithstanding section 4731.22 of the Revised Code, the physician-patient privilege or advanced practice registered nurse-patient privilege shall not be a ground for excluding any information regarding the report containing the knowledge or belief noted under division (F)(1) of this section, and the information may be admitted as evidence in accordance with the Rules of Evidence.

(G) Divisions (A) and (D) of this section do not require disclosure of information, when any of the following applies:
(1) The information is privileged by reason of the relationship between attorney and client; physician and patient; advanced practice registered nurse and patient; licensed psychologist or licensed school psychologist and client; licensed professional clinical counselor,
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licensed professional counselor, independent social worker, social worker, independent marriage and family therapist, or marriage and family therapist and client; member of the clergy, rabbi, minister, or priest and any person communicating information confidentially to the member of the clergy, rabbi, minister, or priest for a religious counseling purpose of a professional character; husband and wife; or a communications assistant and those who are a party to a telecommunications relay service call.

(2) The information would tend to incriminate a member of the actor's immediate family.

(3) Disclosure of the information would amount to revealing a news source, privileged under section 2739.04 or 2739.12 of the Revised Code.

(4) Disclosure of the information would amount to disclosure by a member of the ordained clergy of an organized religious body of a confidential communication made to that member of the clergy in that member's capacity as a member of the clergy by a person seeking the aid or counsel of that member of the clergy.

(5) Disclosure would amount to revealing information acquired by the actor in the course of the actor’s duties in connection with a bona fide program of treatment or services for drug dependent persons or persons in danger of drug dependence, which program is maintained or conducted by a hospital, clinic, person, agency, or community addiction services provider whose alcohol and drug addiction services are certified pursuant to section 5119.36 of the Revised Code.

(6) Disclosure would amount to revealing information acquired by the actor in the course of the actor’s duties in connection with a bona fide program for providing counseling services to victims of crimes that are violations of section 2907.02 or 2907.05 of the Revised Code or to victims of felonious sexual penetration in violation of former section 2907.12 of the Revised Code. As used in this division, “counseling services” include services provided in an informal setting by a person who, by education or experience, is competent to provide those services.

(H) No disclosure of information pursuant to this section gives rise to any liability or recrimination for a breach of privilege or confidence.

(I) Whoever violates division (A) or (B) of this section is guilty of failure to report a crime. Violation of division (A)(1) of this section is a misdemeanor of the fourth degree. Violation of division (A)(2) or (B) of this section is a misdemeanor of the second degree.

(J) Whoever violates division (C) or (D) of this section is guilty of failure to report knowledge of a death, a misdemeanor of the fourth degree.

(K)(1) Whoever negligently violates division (E) of this section is guilty of a minor misdemeanor.

(2) Whoever knowingly violates division (E) of this section is guilty of a misdemeanor of the second degree.

(L) As used in this section, “nurse” includes an advanced practice registered nurse, registered nurse, and licensed practical nurse.

2927.01 Human corpse abuse.

(A) No person, except as authorized by law, shall treat a human corpse in a way that the person knows would outrage reasonable family sensibilities.

(B) No person, except as authorized by law, shall treat a human corpse in a way that would outrage reasonable community sensibilities.

(C) Whoever violates division (A) of this section is guilty of abuse of a corpse, a misdemeanor of the second degree. Whoever violates division (B) of this section is guilty of gross abuse of a corpse, a felony of the fifth degree.
**3721.22 Abuse of patient; duty to report; immunity.**

(A)(1) No person identified in division (P)(1) to (12), (14), or (15) of section 3721.21 of the Revised Code who knows or suspects that a resident has been abused, neglected, or exploited, or that a resident's property has been misappropriated, by any individual used by a long-term care facility or residential care facility to provide services to residents, shall fail to report that knowledge or suspicion to the facility.

(2) No nursing home administrator licensed or temporarily licensed under Chapter 4751 of the Revised Code, and no administrator of a residential care facility, who knows or suspects that a resident has been abused, neglected, or exploited, or that a resident's property has been misappropriated, by any individual used by a long-term care facility or residential care facility to provide services to residents, shall fail to report that knowledge or suspicion to the director of health.

(B) Any person, including a resident, who knows or suspects that a resident has been abused, neglected, or exploited, or that a resident's property has been misappropriated, by any individual used by a long-term care facility or residential care facility to provide services to residents, may report that knowledge or suspicion to the director of health.

(C) Any person who in good faith reports suspected abuse, neglect, exploitation, or misappropriation to a facility or the director of health, provides information during an investigation of suspected abuse, neglect, exploitation, or misappropriation conducted by the director, or participates in a hearing conducted under section 3721.23 of the Revised Code is not subject to criminal prosecution, liable in damages in a tort or other civil action, or subject to professional disciplinary action because of injury or loss to person or property allegedly arising from the making of the report, provision of information, or participation in the hearing.

(D) If the director has reason to believe that a violation of division (A) of this section has occurred, the director may report the suspected violation to the appropriate professional licensing authority and to the attorney general, county prosecutor, or other appropriate law enforcement official.

(E) No person shall knowingly make a false allegation of abuse, neglect, or exploitation of a resident or misappropriation of a resident's property, or knowingly swear or affirm the truth of a false allegation, when the allegation is made for the purpose of incriminating another.

**3727.08 Domestic violence; hospital protocols.**

Not later than ninety days after the effective date of this section, every hospital shall adopt protocols providing for conducting an interview with the patient, for conducting one or more interviews, separate and apart from the interview with the patient, with any family or household member present, and for creating whenever possible a photographic record of the patient's injuries, in situations in which a doctor of medicine or osteopathic medicine, hospital intern or resident, or registered, advanced practice registered, or licensed practical nurse knows or has reasonable cause to believe that the patient has been the victim of domestic violence, as defined in section 3113.31 of the Revised Code.

**3727.18 Hospital may post warning notice regarding assaults against staff.**

(A) Any hospital may post the notice described in division (B) of this section in accordance with this division. A hospital that decides to post the notice shall consider posting it in a conspicuous location in all of the following areas:

(1) Major waiting room areas, including the waiting room areas of the emergency department, the labor and delivery department, the surgical department or unit, and the intensive care unit;
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(2) The main entrance to the hospital;
(3) Any other area that the hospital determines to be appropriate.
(B) A notice posted pursuant to division (A) of this section shall include, at a minimum, all of the following statements and information:

"WE WILL NOT TOLERATE
any form of threatening or
aggressive behavior
toward our staff.
Assaults against our staff might
result in a felony conviction.
All staff have the right to carry out
their work without fearing for their safety."

4113.52 Ohio whistleblower protections; retaliation.

(A)(1)(a) If an employee becomes aware in the course of the employee's employment of a violation of any state or federal statute or any ordinance or regulation of a political subdivision that the employee's employer has authority to correct, and the employee reasonably believes that the violation is a criminal offense that is likely to cause an imminent risk of physical harm to persons or a hazard to public health or safety, a felony, or an improper solicitation for a contribution, the employee orally shall notify the employee's supervisor or other responsible officer of the employee's employer of the violation and subsequently shall file with that supervisor or officer a written report that provides sufficient detail to identify and describe the violation. If the employer does not correct the violation or make a reasonable and good faith effort to correct the violation within twenty-four hours after the oral notification or the receipt of the report, whichever is earlier, the employer may file a written report that provides sufficient detail to identify and describe the violation with the prosecuting authority of the county or municipal corporation where the violation occurred, with a peace officer, with the inspector general if the violation is within the inspector general's jurisdiction, or with any other appropriate public official or agency that has regulatory authority over the employer and the industry, trade, or business in which the employer is engaged.

(b) If an employee makes a report under division (A)(1)(a) of this section, the employer, within twenty-four hours after the oral notification was made or the report was received or by the close of business on the next regular business day following the day on which the oral notification was made or the report was received, whichever is later, shall notify the employee, in writing, of any effort of the employer to correct the alleged violation or hazard or of the absence of the alleged violation or hazard.

(2) If an employee becomes aware in the course of the employee's employment of a violation of chapter 3704, 3734, 6109, or 6111 of the Revised Code that is a criminal offense, the employee directly may notify, either orally or in writing, any appropriate public official or agency that has regulatory authority over the employer and the industry, trade, or business in which the employer is engaged.

(3) If an employee becomes aware in the course of the employee's employment of a violation by a fellow employee of any state or federal statute, any ordinance or regulation of a political subdivision, or any work rule or company policy of the employee's employer and the employee reasonably believes that the violation is a criminal offense that is likely to cause an imminent risk of physical harm to persons or a hazard to public health or safety, a felony, or an improper solicitation for a contribution, the employee orally shall notify the employee's supervisor or other responsible officer of the employee's employer of the violation and
subsequently shall file with that supervisor or officer a written report that provides sufficient detail to identify and describe the violation.

(B) Except as otherwise provided in division (C) of this section, no employer shall take any disciplinary or retaliatory action against an employee for making any report authorized by division (A)(1) or (2) of this section, or as a result of the employee's having made any inquiry or taken any other action to ensure the accuracy of any information reported under either such division. No employer shall take any disciplinary or retaliatory action against an employee for making any report authorized by division (A)(3) of this section if the employee made a reasonable and good faith effort to determine the accuracy of any information so reported, or as a result of the employee's having made any inquiry or taken any other action to ensure the accuracy of any information reported under that division. For purposes of this division, disciplinary or retaliatory action by the employer includes, without limitation, doing any of the following:

(1) Removing or suspending the employee from employment;
(2) Withholding from the employee salary increases or employee benefits to which the employee is otherwise entitled;
(3) Transferring or reassigning the employee;
(4) Denying the employee a promotion that otherwise would have been received;
(5) Reducing the employee in pay or position.

(C) An employee shall make a reasonable and good faith effort to determine the accuracy of any information reported under division (A)(1) or (2) of this section. If the employee who makes a report under either division fails to make such an effort, the employee may be subject to disciplinary action by the employee's employer, including suspension or removal, for reporting information without a reasonable basis to do so under division (A)(1) or (2) of this section.

(D) If an employer takes any disciplinary or retaliatory action against an employee as a result of the employee's having filed a report under division (A) of this section, the employee may bring a civil action for appropriate injunctive relief or for the remedies set forth in division (E) of this section, or both, within one hundred eighty days after the date the disciplinary or retaliatory action was taken, in a court of common pleas in accordance with the Rules of Civil Procedure. A civil action under this division is not available to an employee as a remedy for any disciplinary or retaliatory action taken by an appointing authority against the employee as a result of the employee's having filed a report under division (A) of section 124.341 of the Revised Code.

(E) The court, in rendering a judgment for the employee in an action brought pursuant to division (D) of this section, may order, as it determines appropriate, reinstatement of the employee to the same position that the employee held at the time of the disciplinary or retaliatory action and at the same site of employment or to a comparable position at that site, the payment of back wages, full reinstatement of fringe benefits and seniority rights, or any combination of these remedies. The court also may award the prevailing party all or a portion of the costs of litigation and, if the employee who brought the action prevails in the action, may award the prevailing employee reasonable attorney's fees, witness fees, and fees for experts who testify at trial, in an amount the court determines appropriate. If the court determines that an employer deliberately has violated division (B) of this section, the court, in making an award of back pay, may include interest at the rate specified in section 1343.03 of the Revised Code.

(F) Any report filed with the inspector general under this section shall be filed as a complaint in accordance with section 121.46 of the Revised Code.

(G) As used in this section:

(1) "Contribution" has the same meaning as in section 3517.01 of the Revised Code.
(2) "Improper solicitation for a contribution" means a solicitation for a contribution that satisfies all of the following:
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(a) The solicitation violates division (B), (C), or (D) of section 3517.092 of the Revised Code;
(b) The solicitation is made in person by a public official or by an employee who has a supervisory role within the public office;
(c) The public official or employee knowingly made the solicitation, and the solicitation violates division (B), (C), or (D) of section 3517.092 of the Revised Code;
(d) The employee reporting the solicitation is an employee of the same public office as the public official or the employee with the supervisory role who is making the solicitation.

4973.17 Commission of hospital police.

(A)(1) Upon the application of any bank; savings and loan association; savings bank; credit union; or association of banks, savings and loan associations, savings banks, or credit unions in this state, the secretary of state may appoint and commission any persons that the bank; savings and loan association; savings bank; credit union; or association of banks, savings and loan associations, savings banks, or credit unions designates, or as many of those persons as the secretary of state considers proper, to act as police officers for and on the premises of that bank; savings and loan association; savings bank; credit union; or association of banks, savings and loan associations, savings banks, or credit unions; or elsewhere, when directly in the discharge of their duties. Police officers so appointed shall be citizens of this state and of good character. Police officers so appointed who start to perform their duties on or after April 14, 2006, shall successfully complete a training program approved by the Ohio peace officer training commission described in section 109.71 of the Revised Code and be certified by the commission within six months after starting to perform their duties. Police officers so appointed shall hold office for three years, unless, for good cause shown, their commission is revoked by the secretary of state, or by the bank; savings and loan association; savings bank; credit union; or association of banks, savings and loan associations, savings banks, or credit unions, as provided by law.

(2) Persons commissioned as police officers pursuant to division (A) of this section prior to April 14, 2006, who have not successfully completed a training program approved by the Ohio peace officer training commission, and who have not been certified by the commission, may be reappointed and re-commissioned by the secretary of state only during the person's continuous employment as a police officer by the institution for which the person was employed on April 14, 2006, or by a successor institution to the institution for which the person was employed on April 14, 2006. The secretary of state shall note on such appointments and commissions that the person is not a peace officer as defined in section 109.71 of the Revised Code.

(3) For the exclusive purpose of assigning break in service update training as prescribed in rule 109:2-1-12 (D) of the Administrative Code, a police officer appointed under division (A) of this section, who began performing police officer duties on or before April 14, 2006, shall be credited as holding a valid peace officer appointment retroactive to the date on which the officer began performing these duties.

(B) Upon the application of a company owning or using a railroad in this state and subject to section 4973.171 of the Revised Code, the secretary of state may appoint and commission any persons that the railroad company designates, or as many of those persons as the secretary of state considers proper, to act as police officers for and on the premises of the railroad company, its affiliates or subsidiaries, or elsewhere, when directly in the discharge of their duties. Police officers so appointed, within the time set by the Ohio peace officer training commission, shall successfully complete a commission approved training program and be certified by the commission. They shall hold office for three years, unless, for good cause shown, their commission is revoked by the secretary of state, or railroad company, as provided
Any person holding a similar commission in another state may be commissioned and may hold office in this state without completing the approved training program required by this division provided that the person has completed a substantially equivalent training program in the other state. The Ohio peace officer training commission shall determine whether a training program in another state meets the requirements of this division.

(C) Upon the application of any company under contract with the United States atomic energy commission for the construction or operation of a plant at a site owned by the commission, the secretary of state may appoint and commission persons the company designates, not to exceed one hundred fifty, to act as police officers for the company at the plant or site owned by the commission. Police officers so appointed shall be citizens of this state and of good character. They shall hold office for three years, unless, for good cause shown, their commission is revoked by the secretary of state or by the company, as provided by law.

(D)(1) Upon the application of any hospital that is operated by a public hospital agency or a nonprofit hospital agency and that employs and maintains its own proprietary police department or security department and subject to section 4973.171 of the Revised Code, the secretary of state may appoint and commission any persons that the hospital designates, or as many of those persons as the secretary of state considers proper, to act as police officers for the hospital. No person who is appointed as a police officer under this division shall engage in any duties or activities as a police officer for the hospital or any affiliate or subsidiary of the hospital unless all of the following apply:

(a) The chief of police of the municipal corporation in which the hospital is located or, if the hospital is located in the unincorporated area of a county, the sheriff of that county has granted approval to the hospital to permit persons appointed as police officers under this division to engage in those duties and activities. The approval required by this division is general in nature and is intended to cover in the aggregate all persons appointed as police officers for the hospital under this division; a separate approval is not required for each appointee on an individual basis.

(b) Subsequent to the grant of approval described in division (D)(1)(a) of this section, the hospital has entered into a written agreement with the chief of police of the municipal corporation in which the hospital is located or, if the hospital is located in the unincorporated area of a county, with the sheriff of that county, that sets forth the standards and criteria to govern the interaction and cooperation between persons appointed as police officers for the hospital under this division and law enforcement officers serving the agency represented by the chief of police or sheriff who signed the agreement in areas of their concurrent jurisdiction. The written agreement shall be signed by the appointing authority of the hospital and by the chief of police or sheriff. The standards and criteria may include, but are not limited to, provisions governing the reporting of offenses discovered by hospital police officers to the agency represented by the chief of police or sheriff, provisions governing investigatory responsibilities relative to offenses committed on hospital property, and provisions governing the processing and confinement of persons arrested for offenses committed on hospital property. The agreement required by this division is intended to apply in the aggregate to all persons appointed as police officers for the hospital under this division; a separate agreement is not required for each appointee on an individual basis.

(c) The person has successfully completed a training program approved by the Ohio peace officer training commission and has been certified by the commission. A person appointed as a police officer under this division may attend a training program approved by the commission and be certified by the commission regardless of whether the appropriate chief of police or sheriff has granted the approval described in division (D)(1)(a) of this section and regardless of whether the hospital has entered into the written agreement described in division (D)(1)(b) of this section with the appropriate chief of police or sheriff.
(2)(a) A person who is appointed as a police officer under division (D)(1) of this section is entitled, upon the grant of approval described in division (D)(1)(a) of this section and upon the person's and the hospital's compliance with the requirements of divisions (D)(1)(b) and (c) of this section, to act as a police officer for the hospital on the premises of the hospital and of its affiliates and subsidiaries that are within the territory of the municipal corporation served by the chief of police or the unincorporated area of the county served by the sheriff who signed the written agreement described in division (D)(1)(b) of this section, whichever is applicable, and anywhere else within the territory of that municipal corporation or within the unincorporated area of that county. The authority to act as a police officer as described in this division is granted only if the person, when engaging in that activity, is directly in the discharge of the person's duties as a police officer for the hospital. The authority to act as a police officer as described in this division shall be exercised in accordance with the standards and criteria set forth in the written agreement described in division (D)(1)(b) of this section.

(b) Additionally, a person appointed as a police officer under division (D)(1) of this section is entitled, upon the grant of approval described in division (D)(1)(a) of this section and upon the person's and the hospital's compliance with the requirements of divisions (D)(1)(b) and (c) of this section, to act as a police officer elsewhere, within the territory of a municipal corporation or within the unincorporated area of a county, if the chief of police of that municipal corporation or the sheriff of that county, respectively, has granted approval for that activity to the hospital, police department, or security department served by the person as a police officer and if the person, when engaging in that activity, is directly in the discharge of the person's duties as a police officer for the hospital. The approval described in this division may be general in nature or may be limited in scope, duration, or applicability, as determined by the chief of police or sheriff granting the approval.

(3) Police officers appointed under division (D)(1) of this section shall hold office for three years, unless, for good cause shown, their commission is revoked by the secretary of state or by the hospital, as provided by law. As used in divisions (D)(1) to (3) of this section, “public hospital agency” and “nonprofit hospital agency” have the same meanings as in section 140.01 of the Revised Code.

(E)(1) Upon the application of any owner or operator of an amusement park that has an average yearly attendance in excess of six hundred thousand guests and that employs and maintains its own proprietary police department or security department and subject to section 4973.171 of the Revised Code, any judge of the municipal court or county court that has territorial jurisdiction over the amusement park may appoint and commission any persons that the owner or operator designates, or as many of those persons as the judge considers proper, to act as police officers for the amusement park. If the amusement park is located in more than one county, any judge of the municipal court or county court of any of those counties may make the appointments and commissions as described in this division. No person who is appointed as a police officer under this division shall engage in any duties or activities as a police officer for the amusement park or any affiliate or subsidiary of the owner or operator of the amusement park unless all of the following apply:

(a) The appropriate chief or chiefs of police of the political subdivision or subdivisions in which the amusement park is located as specified in this division have granted approval to the owner or operator of the amusement park to permit persons appointed as police officers under this division to engage in those duties and activities. If the amusement park is located in a single municipal corporation or a single township, the chief of police of that municipal corporation or township is the appropriate chief of police for the grant of approval under this division. If the amusement park is located in two or more townships, two or more municipal corporations, or one or more townships and one or more municipal corporations, the chiefs of police of all of the affected townships and municipal corporations are the appropriate chiefs of police for the grant of approval under this division. If the approval under this division, and the approval must be jointly granted by all of those chiefs of
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police. The approval required by this division is general in nature and is intended to cover in the aggregate all persons appointed as police officers for the amusement park under this division. A separate approval is not required for each appointee on an individual basis.

(b) Subsequent to the grant of approval described in division (E)(1)(a) of this section, the owner or operator has entered into a written agreement with the appropriate chief or chiefs of police of the political subdivision or subdivisions in which the amusement park is located as specified in this division and has provided the sheriff of the county in which the political subdivision or subdivisions are located with a copy of the agreement. If the amusement park is located in a single municipal corporation or a single township, the chief of police of that municipal corporation or township is the appropriate chief of police for entering into the written agreement under this division. If the amusement park is located in two or more townships, two or more municipal corporations, or one or more townships and one or more municipal corporations, the chiefs of police of all of the affected townships and municipal corporations are the appropriate chiefs of police for entering into the written agreement under this division, and the written agreement must be jointly entered into by all of those chiefs of police. The written agreement between the owner or operator and the chief or chiefs of police shall address the scope of activities, the duration of the agreement, and mutual aid arrangements and shall set forth the standards and criteria to govern the interaction and cooperation between persons appointed as police officers for the amusement park under this division and law enforcement officers serving the agency represented by the chief of police who signed the agreement. The written agreement shall be signed by the owner or operator and by the chief or chiefs of police who enter into it. The standards and criteria may include, but are not limited to, provisions governing the reporting of offenses discovered by the amusement park's police officers to the agency represented by the chief of police of the municipal corporation or township in which the offense occurred, provisions governing investigatory responsibilities relative to offenses committed on amusement park property, and provisions governing the processing and confinement of persons arrested for offenses committed on amusement park property. The agreement required by this division is intended to apply in the aggregate to all persons appointed as police officers for the amusement park under this division. A separate agreement is not required for each appointee on an individual basis.

(c) The person has successfully completed a training program approved by the Ohio peace officer training commission and has been certified by the commission. A person appointed as a police officer under this division may attend a training program approved by the commission and be certified by the commission regardless of whether the appropriate chief of police has granted the approval described in division (E)(1)(a) of this section and regardless of whether the owner or operator of the amusement park has entered into the written agreement described in division (E)(1)(b) of this section with the appropriate chief of police.

(2)(a) A person who is appointed as a police officer under division (E)(1) of this section is entitled, upon the grant of approval described in section (E)(1)(a) of this section and upon the person's and the owner or operator's compliance with the requirements of division (E)(1)(b) and (c) of this section, to act as a police officer for the amusement park and its affiliates and subsidiaries that are within the territory of the political subdivision or subdivisions served by the chief of police, or respective chiefs of police, who signed the written agreement described in division (E)(1)(b) of this section, and upon any contiguous real property of the amusement park that is covered by the written agreement, whether within or adjacent to the political subdivision or subdivisions. The authority to act as a police officer as described in this division is granted only if the person, when engaging in that activity, is directly in the discharge of the person's duties as a police officer for the amusement park. The authority to act as a police officer as described in this division shall be exercised in accordance with the standards and criteria set forth in the written agreement described in division (E)(1)(b) of this section.

(b) In addition to the authority granted under division (E)(2)(a) of this section, a person
appointed as a police officer under division (E)(1) of this section is entitled, upon the grant of approval described in division (E)(1)(a) of this section and upon the person's and the owner or operator's compliance with the requirements of divisions (E)(1)(b) and (c) of this section, to act as a police officer elsewhere within the territory of a municipal corporation or township if the chief of police of that municipal corporation or township has granted approval for that activity to the owner or operator served by the person as a police officer and if the person, when engaging in that activity, is directly in the discharge of the person's duties as a police officer for the amusement park. The approval described in this division may be general in nature or may be limited in scope, duration, or applicability, as determined by the chief of police granting the approval.

(3) Police officers appointed under division (E)(1) of this section shall hold office for five years, unless, for good cause shown, their commission is revoked by the appointing judge or the judge's successor or by the owner or operator, as provided by law.

(F) A fee of fifteen dollars for each commission applied for under this section shall be paid at the time the application is made, and this amount shall be returned if for any reason a commission is not issued.

5101.60 Definition of older adult; abuse.

[Editor's Note: This version of the statute is effective until 9/29/2018. The version in effect subsequently is included next.]

As used in sections 5101.60 to 5101.71 of the Revised Code:

(A) “Abuse” means the infliction upon an adult by self or others of injury, unreasonable confinement, intimidation, or cruel punishment with resulting physical harm, pain, or mental anguish.

(B) “Adult” means any person sixty years of age or older within this state who is handicapped by the infirmities of aging or who has a physical or mental impairment which prevents the person from providing for the person's own care or protection, and who resides in an independent living arrangement. An “independent living arrangement” is a domicile of a person's own choosing, including, but not limited to, a private home, apartment, trailer, or rooming house. An “independent living arrangement” includes a residential facility licensed under section 5119.34 of the Revised Code that provides accommodations, supervision, and personal care services for three to sixteen unrelated adults, but does not include other institutions or facilities licensed by the state or facilities in which a person resides as a result of voluntary, civil, or criminal commitment.

(C) “Caretaker” means the person assuming the responsibility for the care of an adult on a voluntary basis, by contract, through receipt of payment for care, as a result of a family relationship, or by order of a court of competent jurisdiction.

(D) “Court” means the probate court in the county where an adult resides.

(E) “Emergency” means that the adult is living in conditions which present a substantial risk of immediate and irreparable physical harm or death to self or any other person.

(F) “Emergency services” means protective services furnished to an adult in an emergency.

(G) “Exploitation” means the unlawful or improper act of a caretaker using an adult or an adult's resources for monetary or personal benefit, profit, or gain when the caretaker obtained or exerted control over the adult or the adult's resources in any of the following ways:

(1) Without the adult's consent or the consent of the person authorized to give consent on the adult's behalf;

(2) Beyond the scope of the express or implied consent of the adult or the person authorized to give consent on the adult's behalf;
(3) By deception;
(4) By threat;
(5) By intimidation.
(H) “In need of protective services” means an adult known or suspected to be suffering from abuse, neglect, or exploitation to an extent that either life is endangered or physical harm, mental anguish, or mental illness results or is likely to result.
(I) “Incapacitated person” means a person who is impaired for any reason to the extent that the person lacks sufficient understanding or capacity to make and carry out reasonable decisions concerning the person's self or resources, with or without the assistance of a caretaker. Refusal to consent to the provision of services shall not be the sole determinative that the person is incapacitated. “Reasonable decisions” are decisions made in daily living which facilitate the provision of food, shelter, clothing, and health care necessary for life support.
(J) “Mental illness” means a substantial disorder of thought, mood, perception, orientation, or memory that grossly impairs judgment, behavior, capacity to recognize reality, or ability to meet the ordinary demands of life.
(K) “Neglect” means the failure of an adult to provide for self the goods or services necessary to avoid physical harm, mental anguish, or mental illness or the failure of a caretaker to provide such goods or services.
(L) “Peace officer” means a peace officer as defined in section 2935.01 of the Revised Code.
(M) “Physical harm” means bodily pain, injury, impairment, or disease suffered by an adult.
(N) “Protective services” means services provided by the county department of job and family services or its designated agency to an adult who has been determined by evaluation to require such services for the prevention, correction, or discontinuance of an act of as well as conditions resulting from abuse, neglect, or exploitation. Protective services may include, but are not limited to, case work services, medical care, mental health services, legal services, fiscal management, home health care, homemaker services, housing-related services, guardianship services, and placement services as well as the provision of such commodities as food, clothing, and shelter.
(O) “Working day” means Monday, Tuesday, Wednesday, Thursday, and Friday, except when such day is a holiday as defined in section 1.14 of the Revised Code.

5101.60 Definition of older adult; abuse.

[Editor’s Note: This version of the statute is effective until 9/29/2018. The version in effect subsequently is included next.]

As used in sections 5101.60 to 5101.73 of the Revised Code:
(A) “Abandonment” means desertion of an adult by a caretaker without having made provision for transfer of the adult's care.
(B) “Abuse” means the infliction upon an adult by self or others of injury, unreasonable confinement, intimidation, or cruel punishment with resulting physical harm, pain, or mental anguish.
(C) “Adult” means any person sixty years of age or older within this state who is handicapped by the infirmities of aging or who has a physical or mental impairment which prevents the person from providing for the person's own care or protection, and who resides in an independent living arrangement.
(D) “Area agency on aging” means a public or private nonprofit entity designated under section 173.011 of the Revised Code to administer programs on behalf of the department of aging.
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(E) “Caretaker” means the person assuming the primary responsibility for the care of an adult by any of the following means:
(1) On a voluntary basis;
(2) By contract;
(3) Through receipt of payment for care;
(4) As a result of a family relationship;
(5) By order of a court of competent jurisdiction.
(F) “Community mental health agency” means any agency, program, or facility with which a board of alcohol, drug addiction, and mental health services contracts to provide the mental health services listed in section 340.99 of the Revised Code.
(G) “Court” means the probate court in the county where an adult resides.
(H) “Emergency” means that the adult is living in conditions which present a substantial risk of immediate and irreparable physical harm or death to self or any other person.
(I) “Emergency services” means protective services furnished to an adult in an emergency.
(J) “Exploitation” means the unlawful or improper act of a person using, in one or more transactions, an adult or an adult’s resources for monetary or personal benefit, profit, or gain when the person obtained or exerted control over the adult or the adult’s resources in any of the following ways:
(1) Without the adult’s consent or the consent of the person authorized to give consent on the adult’s behalf;
(2) Beyond the scope of the express or implied consent of the adult or the person authorized to give consent on the adult’s behalf;
(3) By deception;
(4) By threat;
(5) By intimidation.
(K) “In need of protective services” means an adult known or suspected to be suffering from abuse, neglect, or exploitation to an extent that either life is endangered or physical harm, mental anguish, or mental illness results or is likely to result.
(L) “Incapacitated person” means a person who is impaired for any reason to the extent that the person lacks sufficient understanding or capacity to make and carry out reasonable decisions concerning the person’s self or resources, with or without the assistance of a caretaker. Refusal to consent to the provision of services shall not be the sole determinative that the person is incapacitated.
(M) “Independent living arrangement” means a domicile of a person’s own choosing, including, but not limited to, a private home, apartment, trailer, or rooming house. “Independent living arrangement” includes a residential facility licensed under section 5119.22 of the Revised Code that provides accommodations, supervision, and personal care services for three to sixteen unrelated adults, but does not include any other institution or facility licensed by the state or a facility in which a person resides as a result of voluntary, civil, or criminal commitment.
(N) “Mental illness” means a substantial disorder of thought, mood, perception, orientation, or memory that grossly impairs judgment, behavior, capacity to recognize reality, or ability to meet the ordinary demands of life.
(O) “Neglect” means any of the following:
(1) Failure of an adult to provide for self the goods or services necessary to avoid physical harm, mental anguish, or mental illness;
(2) Failure of a caretaker to provide such goods or services;
(3) Abandonment.
(P) “Outpatient health facility” means a facility where medical care and preventive, diagnostic, therapeutic, rehabilitative, or palliative items or services are provided to outpatients by or under the direction of a physician or dentist.
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(P) “Peace officer” means a peace officer as defined in section 2935.01 of the Revised Code.

(R) “Physical harm” means bodily pain, injury, impairment, or disease suffered by an adult.

(S) “Protective services” means services provided by the county department of job and family services or its designated agency to an adult who has been determined by evaluation to require such services for the prevention, correction, or discontinuance of an act of as well as conditions resulting from abuse, neglect, or exploitation. Protective services may include, but are not limited to, case work services, medical care, mental health services, legal services, fiscal management, home health care, homemaker services, housing-related services, guardianship services, and placement services as well as the provision of such commodities as food, clothing, and shelter.

(T) “Reasonable decisions” means decisions made in daily living that facilitate the provision of food, shelter, clothing, and health care necessary for life support.

(U) “Senior service provider” means a person who provides care or specialized services to an adult, except that it does not include the state long-term care ombudsman or a regional long-term care ombudsman.

(V) “Working day” means Monday, Tuesday, Wednesday, Thursday, and Friday, except when such day is a holiday as defined in section 1.14 of the Revised Code.

5101.61 Reporting suspected abuse or neglect of adult.

[Editor’s Note: This version of the statute is effective until 9/29/2018.]

(A) As used in this section:

(1) “Senior service provider” means any person who provides care or services to a person who is an adult as defined in division (B) of section 5101.60 of the Revised Code.

(2) “Ambulatory health facility” means a nonprofit, public or proprietary freestanding organization or a unit of such an agency or organization that:

(a) Provides preventive, diagnostic, therapeutic, rehabilitative, or palliative items or services furnished to an outpatient or ambulatory patient, by or under the direction of a physician or dentist in a facility which is not a part of a hospital, but which is organized and operated to provide medical care to outpatients;

(b) Has health and medical care policies which are developed with the advice of, and with the provision of review of such policies, an advisory committee of professional personnel, including one or more physicians, one or more dentists, if dental care is provided, and one or more registered nurses;

(c) Has a medical director, a dental director, if dental care is provided, and a nursing director responsible for the execution of such policies, and has physicians, dentists, nursing, and ancillary staff appropriate to the scope of services provided;

(d) Requires that the health care and medical care of every patient be under the supervision of a physician, provides for medical care in a case of emergency, has in effect a written agreement with one or more hospitals and other centers or clinics, and has an established patient referral system to other resources, and a utilization review plan and program;

(e) Maintains clinical records on all patients;

(f) Provides nursing services and other therapeutic services in accordance with programs and policies, with such services supervised by a registered professional nurse, and has a registered professional nurse on duty at all times of clinical operations;

(g) Provides approved methods and procedures for the dispensing and administration of drugs and biologicals;
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(h) Has established an accounting and record keeping system to determine reasonable and allowable costs;

(i) “Ambulatory health facilities” also includes an alcoholism treatment facility approved by the joint commission on accreditation of healthcare organizations as an alcoholism treatment facility or certified by the department of mental health and addiction services, and such facility shall comply with other provisions of this division not inconsistent with such accreditation or certification.

(3) “Community mental health facility” means a facility which provides community mental health services and is included in the comprehensive mental health plan for the alcohol, drug addiction, and mental health service district in which it is located.

(4) “Community mental health service” means services, other than inpatient services, provided by a community mental health facility.

(5) “Home health agency” means an institution or a distinct part of an institution operated in this state which:

(a) Is primarily engaged in providing home health services;

(b) Has home health policies which are established by a group of professional personnel, including one or more duly licensed doctors of medicine or osteopathy and one or more registered professional nurses, to govern the home health services it provides and which includes a requirement that every patient must be under the care of a duly licensed doctor of medicine or osteopathy;

(c) Is under the supervision of a duly licensed doctor of medicine or doctor of osteopathy or a registered professional nurse who is responsible for the execution of such home health policies;

(d) Maintains comprehensive records on all patients;

(e) Is operated by the state, a political subdivision, or an agency of either, or is operated not for profit in this state and is licensed or registered, if required, pursuant to law by the appropriate department of the state, county, or municipality in which it furnishes services; or is operated for profit in this state, meets all the requirements specified in divisions (A)(5)(a) to (d) of this section, and is certified under Title XVIII of the “Social Security Act,” 49 Stat. 620 (1935), 42 U.S.C. 301, as amended.

(6) “Home health service” means the following items and services, provided, except as provided in division (A)(6)(g) of this section, on a visiting basis in a place of residence used as the patient’s home:

(a) Nursing care provided by or under the supervision of a registered professional nurse;

(b) Physical, occupational, or speech therapy ordered by the patient’s attending physician;

(c) Medical social services performed by or under the supervision of a qualified medical or psychiatric social worker and under the direction of the patient’s attending physician;

(d) Personal health care of the patient performed by aides in accordance with the orders of a doctor of medicine or osteopathy and under the supervision of a registered professional nurse;

(e) Medical supplies and the use of medical appliances;

(f) Medical services of interns and residents-in-training under an approved teaching program of a nonprofit hospital and under the direction and supervision of the patient’s attending physician;

(g) Any of the foregoing items and services which:

(i) Are provided on an outpatient basis under arrangements made by the home health agency at a hospital or skilled nursing facility;

(ii) Involve the use of equipment of such a nature that the items and services cannot readily be made available to the patient in the patient’s place of residence, or which are furnished at the hospital or skilled nursing facility while the patient is there to receive any item or...
service involving the use of such equipment.

(7) “Representative of the office of the state long-term care program” has the same meaning as in section 173.14 of the Revised Code.

Any attorney, physician, osteopath, podiatrist, chiropractor, dentist, psychologist, any employee of a hospital as defined in section 3701.01 of the Revised Code, any nurse licensed under Chapter 4723 of the Revised Code, any employee of an ambulatory health facility, any employee of a home health agency, any employee of a residential facility licensed under section 5119.34 of the Revised Code that provides accommodations, supervision, and personal care services for three to sixteen unrelated adults, any employee of a nursing home, residential care facility, or home for the aging, as defined in section 3721.01 of the Revised Code, any employee of a nursing home, residential care facility, or home for the aging, as defined in section 3721.01 of the Revised Code, any senior service provider other than a representative of the office of the state long-term care program, any peace officer, coroner, member of the clergy, any employee of a community mental health facility, and any person engaged in professional counseling, social work, or marriage and family therapy having reasonable cause to believe that an adult is being abused, neglected, or exploited, or is in a condition which is the result of abuse, neglect, or exploitation shall immediately report such belief to the county department of job and family services.

This section does not apply to employees of any hospital or public hospital as defined in section 5122.01 of the Revised Code.

(B) Any person having reasonable cause to believe that an adult has suffered abuse, neglect, or exploitation may report, or cause reports to be made of such belief to the department.

This division applies to a representative of the office of the state long-term care program only to the extent permitted by federal law.

(C) The reports made under this section shall be made orally or in writing except that oral reports shall be followed by a written report if a written report is requested by the department. Written reports shall include:

(1) The name, address, and approximate age of the adult who is the subject of the report;
(2) The name and address of the individual responsible for the adult's care, if any individual is, and if the individual is known;
(3) The nature and extent of the alleged abuse, neglect, or exploitation of the adult;
(4) The basis of the reporter's belief that the adult has been abused, neglected, or exploited.

(D) Any person with reasonable cause to believe that an adult is suffering abuse, neglect, or exploitation who makes a report pursuant to this section or who testifies in any administrative or judicial proceeding arising from such a report, or any employee of the state or any of its subdivisions who is discharging responsibilities under section 5101.62 of the Revised Code shall be immune from civil or criminal liability on account of such investigation, report, or testimony, except liability for perjury, unless the person has acted in bad faith or with malicious purpose.

(E) No employer or any other person with the authority to do so shall discharge, demote, transfer, prepare a negative work performance evaluation, or reduce benefits, pay, or work privileges, or take any other action detrimental to an employee or in any way retaliate against an employee as a result of the employee's having filed a report under this section.

(F) The written or oral report provided for in this section and the investigatory report provided for in section 5101.62 of the Revised Code are confidential and are not public records, as defined in section 149.43 of the Revised Code. In accordance with rules adopted by the department of job and family services, information contained in the report shall upon request be made available to the adult who is the subject of the report and to legal counsel for the adult.

(G) The county department of job and family services shall be available to receive the written or oral report provided for in this section twenty-four hours a day and seven days a
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week.

5123.61 Abuse or neglect of developmentally disabled.

[Editor’s Note: This version of the statute is effective until 9/29/2018. The version effective subsequently is included next.]

(A) As used in this section:
(1) “Law enforcement agency” means the state highway patrol, the police department of a municipal corporation, or a county sheriff.
(2) “Abuse” has the same meaning as in section 5123.50 of the Revised Code, except that it includes a misappropriation, as defined in that section.
(3) “Neglect” has the same meaning as in section 5123.50 of the Revised Code.

(B) The department of developmental disabilities shall establish a registry office for the purpose of maintaining reports of abuse, neglect, and other major unusual incidents made to the department under this section and reports received from county boards of developmental disabilities under section 5126.31 of the Revised Code. The department shall establish committees to review reports of abuse, neglect, and other major unusual incidents.

(C)(1) Any person listed in division (C)(2) of this section, having reason to believe that an individual with a developmental disability has suffered or faces a substantial risk of suffering any wound, injury, disability, or condition of such a nature as to reasonably indicate abuse or neglect of that individual, shall immediately report or cause reports to be made of such information to the entity specified in this division. Except as provided in section 5120.173 of the Revised Code or as otherwise provided in this division, the person making the report shall make it to a law enforcement agency or to the county board of developmental disabilities. If the report concerns a resident of a facility operated by the department of developmental disabilities the report shall be made either to a law enforcement agency or to the department. If the report concerns any act or omission of an employee of a county board of developmental disabilities, the report immediately shall be made to the department and to the county board.

(2) All of the following persons are required to make a report under division (C)(1) of this section:
(a) Any physician, including a hospital intern or resident, any dentist, podiatrist, chiropractor, practitioner of a limited branch of medicine as specified in section 4731.15 of the Revised Code, hospital administrator or employee of a hospital, nurse licensed under Chapter 4723 of the Revised Code, employee of an ambulatory health facility as defined in section 5101.61 of the Revised Code, employee of a home health agency, employee of a residential facility licensed under section 5119.34 of the Revised Code that provides accommodations, supervision, and personal care services for three to sixteen unrelated adults, or employee of a community mental health facility;
(b) Any school teacher or school authority, licensed professional clinical counselor, licensed professional counselor, independent social worker, social worker, independent marriage and family therapist, marriage and family therapist, psychologist, attorney, peace officer, coroner, or residents’ rights advocate as defined in section 3721.10 of the Revised Code;
(c) A superintendent, board member, or employee of a county board of developmental disabilities; an administrator, board member, or employee of a residential facility licensed under section 5123.19 of the Revised Code; an administrator, board member, or employee of any other public or private provider of services to an individual with a developmental disability, or any developmental disabilities employee, as defined in section 5123.50 of the Revised Code;
(d) A member of a citizen's advisory council established at an institution or branch institution of the department of developmental disabilities under section 5123.092 of the Revised Code;

(e) A member of the clergy who is employed in a position that includes providing specialized services to an individual with a developmental disability, while acting in an official or professional capacity in that position, or a person who is employed in a position that includes providing specialized services to an individual with a developmental disability and who, while acting in an official or professional capacity, renders spiritual treatment through prayer in accordance with the tenets of an organized religion.

(3)(a) The reporting requirements of this division do not apply to employees of the Ohio protection and advocacy system.

(b) An attorney or physician is not required to make a report pursuant to division (C)(1) of this section concerning any communication the attorney or physician receives from a client or patient in an attorney-client or physician-patient relationship, if, in accordance with division (A) or (B) of section 2317.02 of the Revised Code, the attorney or physician could not testify with respect to that communication in a civil or criminal proceeding, except that the client or patient is deemed to have waived any testimonial privilege under division (A) or (B) of section 2317.02 of the Revised Code with respect to that communication and the attorney or physician shall make a report pursuant to division (C)(1) of this section, if both of the following apply:

(i) The client or patient, at the time of the communication, is an individual with a developmental disability.

(ii) The attorney or physician knows or suspects, as a result of the communication or any observations made during that communication, that the client or patient has suffered or faces a substantial risk of suffering any wound, injury, disability, or condition of a nature that reasonably indicates abuse or neglect of the client or patient.

(4) Any person who fails to make a report required under division (C) of this section and who is a developmental disabilities employee, as defined in section 5123.50 of the Revised Code, shall be eligible to be included in the registry regarding misappropriation, abuse, neglect, or other specified misconduct by developmental disabilities employees established under section 5123.52 of the Revised Code.

D The reports required under division (C) of this section shall be made forthwith by telephone or in person and shall be followed by a written report. The reports shall contain the following:

(1) The names and addresses of the individual with a developmental disability and the individual's custodian, if known;

(2) The age of the individual with a developmental disability;

(3) Any other information that would assist in the investigation of the report.

(E) When a physician performing services as a member of the staff of a hospital or similar institution has reason to believe that an individual with a developmental disability has suffered injury, abuse, or physical neglect, the physician shall notify the person in charge of the institution or that person's designated delegate, who shall make the necessary reports.

(F) Any person having reasonable cause to believe that an individual with a developmental disability has suffered or faces a substantial risk of suffering abuse or neglect may report or cause a report to be made of that belief to the entity specified in this division. Except as provided in section 5120.173 of the Revised Code or as otherwise provided in this division, the person making the report shall make it to a law enforcement agency or the county board of developmental disabilities. If the individual is a resident of a facility operated by the department of developmental disabilities, the report shall be made to a law enforcement agency or to the department. If the report concerns any act or omission of an employee of a county board of developmental disabilities, the report immediately shall be made to the department and to the county board.
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(G)(1) Upon the receipt of a report concerning the possible abuse or neglect of an individual with a developmental disability, the law enforcement agency shall inform the county board of developmental disabilities or, if the individual is a resident of a facility operated by the department of developmental disabilities, the department.
(2) On receipt of a report under this section that includes an allegation of action or inaction that may constitute a crime under federal law or the law of this state, the department of developmental disabilities shall notify the law enforcement agency.
(3) When a county board of developmental disabilities receives a report under this section that includes an allegation of action or inaction that may constitute a crime under federal law or the law of this state, the superintendent of the board or an individual the superintendent designates under division (H) of this section shall notify the law enforcement agency. The superintendent or individual shall notify the department of developmental disabilities when it receives any report under this section.
(4) When a county board of developmental disabilities receives a report under this section and believes that the degree of risk to the person is such that the report is an emergency, the superintendent of the board or an employee of the board the superintendent designates shall attempt a face-to-face contact with the individual with a developmental disability who allegedly is the victim within one hour of the board's receipt of the report.
(H) The superintendent of the board may designate an individual to be responsible for notifying the law enforcement agency and the department when the county board receives a report under this section.
(I) An adult with a developmental disability about whom a report is made may be removed from the adult's place of residence only by law enforcement officers who consider that the adult's immediate removal is essential to protect the adult from further injury or abuse or in accordance with the order of a court made pursuant to section 5126.33 of the Revised Code.
(J) A law enforcement agency shall investigate each report of abuse or neglect it receives under this section. In addition, the department, in cooperation with law enforcement officials, shall investigate each report regarding a resident of a facility operated by the department to determine the circumstances surrounding the injury, the cause of the injury, and the person responsible. The investigation shall be in accordance with the memorandum of understanding prepared under section 5126.058 of the Revised Code. The department shall determine, with the registry office which shall be maintained by the department, whether prior reports have been made concerning an adult with a developmental disability or other principals in the case. If the department finds that the report involves action or inaction that may constitute a crime under federal law or the law of this state, it shall submit a report of its investigation, in writing, to the law enforcement agency. If the individual with a developmental disability is an adult, with the consent of the adult, the department shall provide such protective services as are necessary to protect the adult. The law enforcement agency shall make a written report of its findings to the department.
If the individual with a developmental disability is an adult and is not a resident of a facility operated by the department, the county board of developmental disabilities shall review the report of abuse or neglect in accordance with sections 5126.30 to 5126.33 of the Revised Code and the law enforcement agency shall make the written report of its findings to the county board.
(K) Any person or any hospital, institution, school, health department, or agency participating in the making of reports pursuant to this section, any person participating as a witness in an administrative or judicial proceeding resulting from the reports, or any person or governmental entity that discharges responsibilities under sections 5126.31 to 5126.33 of the Revised Code shall be immune from any civil or criminal liability that might otherwise be incurred or imposed as a result of such actions except liability for perjury, unless the person or governmental entity has acted in bad faith or with malicious purpose.
(L) No employer or any person with the authority to do so shall discharge, demote, transfer, prepare a negative work performance evaluation, reduce pay or benefits, terminate work privileges, or take any other action detrimental to an employee or retaliate against an employee as a result of the employee’s having made a report under this section. This division does not preclude an employer or person with authority from taking action with regard to an employee who has made a report under this section if there is another reasonable basis for the action.

(M) Reports made under this section are not public records as defined in section 149.43 of the Revised Code. Information contained in the reports on request shall be made available to the individual who is the subject of the report, to the individual’s legal counsel, and to agencies authorized to receive information in the report by the department or by a county board of developmental disabilities.

(N) Notwithstanding section 4731.22 of the Revised Code, the physician-patient privilege shall not be a ground for excluding evidence regarding the injuries or physical neglect of an individual with a developmental disability or the cause thereof in any judicial proceeding resulting from a report submitted pursuant to this section.

5123.61 Abuse or neglect of developmentally disabled.

[Editor’s Note: This version of the statute is effective until 9/29/2018. The version effective subsequently is included next.]

(A) As used in this section:

(1) “Law enforcement agency” means the state highway patrol, the police department of a municipal corporation, or a county sheriff.

(2) “Abuse” has the same meaning as in section 5123.50 of the Revised Code, except that it includes a misappropriation, as defined in that section.

(3) “Neglect” has the same meaning as in section 5123.50 of the Revised Code.

(B) The department of developmental disabilities shall establish a registry office for the purpose of maintaining reports of abuse, neglect, and other major unusual incidents made to the department under this section and reports received from county boards of developmental disabilities under section 5126.31 of the Revised Code. The department shall establish committees to review reports of abuse, neglect, and other major unusual incidents.

(C)(1) Any person listed in division (C)(2) of this section, having reason to believe that an individual with a developmental disability has suffered or faces a substantial risk of suffering any wound, injury, disability, or condition of such a nature as to reasonably indicate abuse or neglect of that individual, shall immediately report or cause reports to be made of such information to the entity specified in this division. Except as provided in section 5120.173 of the Revised Code or as otherwise provided in this division, the person making the report shall make it to a law enforcement agency or to the county board of developmental disabilities. If the report concerns a resident of a facility operated by the department of developmental disabilities the report shall be made either to a law enforcement agency or to the department. If the report concerns any act or omission of an employee of a county board of developmental disabilities, the report immediately shall be made to the department and to the county board.

(2) All of the following persons are required to make a report under division (C)(1) of this section:

(a) Any physician, including a hospital intern or resident, any dentist, podiatrist, chiropractor, practitioner of a limited branch of medicine as specified in section 4731.15 of the Revised Code, hospital administrator or employee of a hospital, nurse licensed under Chapter 4723 of the Revised Code, employee of an outpatient health facility as defined in section 5101.60 of the Revised Code, employee of a home health agency, employee of a residential
facility licensed under section 5119.34 of the Revised Code that provides accommodations, supervision, and personal care services for three to sixteen unrelated adults, or employee of a community mental health facility;

(b) Any school teacher or school authority, licensed professional clinical counselor, licensed professional counselor, independent social worker, social worker, independent marriage and family therapist, marriage and family therapist, psychologist, attorney, peace officer, coroner, or residents' rights advocate as defined in section 3721.10 of the Revised Code;

(c) A superintendent, board member, or employee of a county board of developmental disabilities; an administrator, board member, or employee of a residential facility licensed under section 5123.19 of the Revised Code; an administrator, board member, or employee of any other public or private provider of services to an individual with a developmental disability, or any developmental disabilities employee, as defined in section 5123.50 of the Revised Code;

(d) A member of a citizen's advisory council established at an institution or branch institution of the department of developmental disabilities under section 5123.092 of the Revised Code;

(e) A member of the clergy who is employed in a position that includes providing specialized services to an individual with a developmental disability, while acting in an official or professional capacity in that position, or a person who is employed in a position that includes providing specialized services to an individual with a developmental disability and who, while acting in an official or professional capacity, renders spiritual treatment through prayer in accordance with the tenets of an organized religion.

(3)(a) The reporting requirements of this division do not apply to employees of the Ohio protection and advocacy system.

(b) An attorney or physician is not required to make a report pursuant to division (C)(1) of this section concerning any communication the attorney or physician receives from a client or patient in an attorney-client or physician-patient relationship, if, in accordance with division (A) or (B) of section 2317.02 of the Revised Code, the attorney or physician could not testify with respect to that communication in a civil or criminal proceeding, except that the client or patient is deemed to have waived any testimonial privilege under division (A) or (B) of section 2317.02 of the Revised Code with respect to that communication and the attorney or physician shall make a report pursuant to division (C)(1) of this section, if both of the following apply:

(i) The client or patient, at the time of the communication, is an individual with a developmental disability.

(ii) The attorney or physician knows or suspects, as a result of the communication or any observations made during that communication, that the client or patient has suffered or faces a substantial risk of suffering any wound, injury, disability, or condition of a nature that reasonably indicates abuse or neglect of the client or patient.

(4) Any person who fails to make a report required under division (C) of this section and who is a developmental disabilities employee, as defined in section 5123.50 of the Revised Code, shall be eligible to be included in the registry regarding misappropriation, abuse, neglect, or other specified misconduct by developmental disabilities employees established under section 5123.52 of the Revised Code.

(D) The reports required under division (C) of this section shall be made forthwith by telephone or in person and shall be followed by a written report. The reports shall contain the following:

(1) The names and addresses of the individual with a developmental disability and the individual's custodian, if known;

(2) The age of the individual with a developmental disability;

(3) Any other information that would assist in the investigation of the report.
(E) When a physician performing services as a member of the staff of a hospital or similar institution has reason to believe that an individual with a developmental disability has suffered injury, abuse, or physical neglect, the physician shall notify the person in charge of the institution or that person's designated delegate, who shall make the necessary reports.

(F) Any person having reasonable cause to believe that an individual with a developmental disability has suffered or faces a substantial risk of suffering abuse or neglect may report or cause a report to be made of that belief to the entity specified in this division. Except as provided in section 5120.173 of the Revised Code or as otherwise provided in this division, the person making the report shall make it to a law enforcement agency or the county board of developmental disabilities. If the individual is a resident of a facility operated by the department of developmental disabilities, the report shall be made to a law enforcement agency or to the department. If the report concerns any act or omission of an employee of a county board of developmental disabilities, the report immediately shall be made to the department and to the county board.

(G)(1) Upon the receipt of a report concerning the possible abuse or neglect of an individual with a developmental disability, the law enforcement agency shall inform the county board of developmental disabilities or, if the individual is a resident of a facility operated by the department of developmental disabilities, the department.

(2) On receipt of a report under this section that includes an allegation of action or inaction that may constitute a crime under federal law or the law of this state, the department of developmental disabilities shall notify the law enforcement agency.

(3) When a county board of developmental disabilities receives a report under this section that includes an allegation of action or inaction that may constitute a crime under federal law or the law of this state, the superintendent of the board or an individual the superintendent designates under division (H) of this section shall notify the law enforcement agency. The superintendent or individual shall notify the department of developmental disabilities when it receives any report under this section.

(4) When a county board of developmental disabilities receives a report under this section and believes that the degree of risk to the person is such that the report is an emergency, the superintendent of the board or an employee of the board the superintendent designates shall attempt a face-to-face contact with the individual with a developmental disability who allegedly is the victim within one hour of the board's receipt of the report.

(H) The superintendent of the board may designate an individual to be responsible for notifying the law enforcement agency and the department when the county board receives a report under this section.

(I) An adult with a developmental disability about whom a report is made may be removed from the adult's place of residence only by law enforcement officers who consider that the adult's immediate removal is essential to protect the adult from further injury or abuse or in accordance with the order of a court made pursuant to section 5126.33 of the Revised Code.

(J) A law enforcement agency shall investigate each report of abuse or neglect it receives under this section. In addition, the department, in cooperation with law enforcement officials, shall investigate each report regarding a resident of a facility operated by the department to determine the circumstances surrounding the injury, the cause of the injury, and the person responsible. The investigation shall be in accordance with the memorandum of understanding prepared under section 5126.058 of the Revised Code. The department shall determine, with the registry office which shall be maintained by the department, whether prior reports have been made concerning an adult with a developmental disability or other principals in the case. If the department finds that the report involves action or inaction that may constitute a crime under federal law or the law of this state, it shall submit a report of its investigation, in writing, to the law enforcement agency. If the individual with a developmental disability is an adult, with the consent of the adult, the department shall provide such protective services as are
necessary to protect the adult. The law enforcement agency shall make a written report of its findings to the department.

If the individual with a developmental disability is an adult and is not a resident of a facility operated by the department, the county board of developmental disabilities shall review the report of abuse or neglect in accordance with sections 5126.30 to 5126.33 of the Revised Code and the law enforcement agency shall make the written report of its findings to the county board.

(K) Any person or any hospital, institution, school, health department, or agency participating in the making of reports pursuant to this section, any person participating as a witness in an administrative or judicial proceeding resulting from the reports, or any person or governmental entity that discharges responsibilities under sections 5126.31 to 5126.33 of the Revised Code shall be immune from any civil or criminal liability that might otherwise be incurred or imposed as a result of such actions except liability for perjury, unless the person or governmental entity has acted in bad faith or with malicious purpose.

(L) No employer or any person with the authority to do so shall discharge, demote, transfer, prepare a negative work performance evaluation, reduce pay or benefits, terminate work privileges, or take any other action detrimental to an employee or retaliate against an employee as a result of the employee's having made a report under this section. This division does not preclude an employer or person with authority from taking action with regard to an employee who has made a report under this section if there is another reasonable basis for the action.

(M) Reports made under this section are not public records as defined in section 149.43 of the Revised Code. Information contained in the reports on request shall be made available to the individual who is the subject of the report, to the individual's legal counsel, and to agencies authorized to receive information in the report by the department or by a county board of developmental disabilities.

(N) Notwithstanding section 4731.22 of the Revised Code, the physician-patient privilege shall not be a ground for excluding evidence regarding the injuries or physical neglect of an individual with a developmental disability or the cause thereof in any judicial proceeding resulting from a report submitted pursuant to this section.

3701-64-02 Abuse and neglect of nursing home resident

(A) The director of health shall receive, review, and investigate allegations of abuse or neglect of a resident or misappropriation of the property of a resident by any individual used by a long-term care facility or a residential care facility to provide services to residents.

(B) Allegations of abuse, neglect, or misappropriation may be presented orally or in writing. Oral and written allegations may be made to the Ohio department of health's office of health assurance and licensing.

(C) Allegations shall be investigated by appropriately qualified individuals, as determined by the director. No long-term care facility or a residential care facility shall do any of the following in the course of an investigation by the director under this rule:

(1) Refuse to permit the director to enter the facility;
(2) Refuse to permit the director to interview employees or other personnel used by the facility, residents, or families of residents;
(3) Refuse to permit the director to review any record, medical or otherwise, kept by the facility; or
(4) Otherwise hinder the director's investigation of an allegation of abuse, neglect of a resident, or misappropriation of property of a resident.

(D) If, after investigation, the director determines that there is a reasonable basis for an allegation, the director shall provide written notice to the accused in accordance with
paragraphs (E) and (F) of this rule. The director also shall send a copy of the notice to any long-
term care facility or a residential care facility that the director knows currently is using the
accused to provide services.

(E) The written notice shall include all of the following items:
(1) A statement of the nature of the allegation;
(2) A statement advising the accused of his or her right to a hearing on the allegation
and of the manner in which and time within which a hearing may be requested;
(3) An explanation that the director will report any finding that the accused abused or
neglected a resident or misappropriated a resident's property to the following entity, as
applicable:
   (a) The nurse aide registry established under section 3721.32 of the Revised Code, if
   the accused is a nurse aide or otherwise not a licensed health professional;
   (b) The appropriate licensure authority, if the accused is a licensed health professional;
   and
   (c) Any other entity that holds authority or association with the accused.
   (4) A warning that if the accused fails to submit a written request for a hearing within
   thirty days after he or she receives or was deemed to have received the notice, the director may
do both of the following:
   (a) Make a finding adverse to the accused; and
   (b) Pursuant to rule 3701-64-05 of the Administrative Code, report the finding to the
   nurse aide registry, the appropriate licensure authority, or other relevant entity that would benefit
   from the notice, whichever is applicable, the long-term care facility or a residential care facility
   where the incident occurred, any other long-term care facility or a residential care facility known
   by the director to be using the accused to provide services to residents at the time of his or her
   finding, and the appropriate law enforcement official.

(F) The director first shall provide the written notice to the accused by certified mail,
return receipt requested, or by sending it by personal delivery to the accused's last known
address.

(1) If a certified mail notice is returned because the party fails to claim the notice, the
director then may send the notice to the accused's last known address by ordinary mail. The
notice shall be deemed complete when the certificate of mailing is obtained unless the notice is
returned showing failure of delivery.

(2) If any notice sent by certified or ordinary mail is returned for failure of delivery, the
director shall publish notice to the department's website. The notice shall be published for
twenty one days, shall summarize the information required by paragraph (E) of this rule, and
shall refer the accused to the Ohio department of health's office of health assurance and
licensing for additional information. When notice is given by publication, a proof of publication
affidavit, with a copy of the notice set forth in the affidavit, shall be mailed by ordinary mail to the
party at the party's last known address and the notice shall be deemed received as of the
twenty first day of publication. An employee or agent of the agency may make personal delivery
of the notice upon a party at any time.

Refusal of delivery by personal service or by mail is not failure of delivery and service is
deemed to be complete. Failure of delivery occurs only when a mailed notice is returned by the
postal authorities marked undeliverable, address or addressee unknown, or forwarding address
unknown or expired.
109.572 Checking criminal records.

[Editor’s Note: This version of the statute is effective until 1/1/2018. The versions effective subsequently are included in the following pages.]

(A)(1) Upon receipt of a request pursuant to section 121.08, 3301.32, 3301.541, or 3319.39 of the Revised Code, a completed form prescribed pursuant to division (C)(1) of this section, and a set of fingerprint impressions obtained in the manner described in division (C)(2) of this section, the superintendent of the bureau of criminal identification and investigation shall conduct a criminal records check in the manner described in division (B) of this section to determine whether any information exists that indicates that the person who is the subject of the request previously has been convicted of or pleaded guilty to any of the following:

(a) A violation of section 2903.01, 2903.02, 2903.03, 2903.11, 2903.12, 2903.13, 2903.16, 2903.21, 2903.34, 2905.01, 2905.02, 2905.05, 2907.02, 2907.03, 2907.04, 2907.05, 2907.06, 2907.07, 2907.08, 2907.09, 2907.21, 2907.22, 2907.23, 2907.25, 2907.31, 2907.32, 2907.321, 2907.322, 2907.323, 2911.01, 2911.02, 2911.11, 2911.12, 2919.12, 2919.22, 2919.24, 2919.25, 2923.12, 2923.13, 2923.161, 2925.02, 2925.03, 2925.04, 2925.05, 2925.06, or 3716.11 of the Revised Code, felonious sexual penetration in violation of former section 2907.12 of the Revised Code, a violation of section 2905.04 of the Revised Code as it existed prior to July 1, 1996, a violation of section 2919.23 of the Revised Code that would have been a violation of section 2905.04 of the Revised Code as it existed prior to July 1, 1996, had the violation been committed prior to that date, or a violation of section 2925.11 of the Revised Code that is not a minor drug possession offense;

(b) A violation of an existing or former law of this state, any other state, or the United States that is substantially equivalent to any of the offenses listed in division (A)(1)(a) of this section;

(c) If the request is made pursuant to section 3319.39 of the Revised Code for an applicant who is a teacher, any offense specified in section 3319.31 of the Revised Code.

(2) On receipt of a request pursuant to section 3712.09 or 3721.121 of the Revised Code, a completed form prescribed pursuant to division (C)(1) of this section, and a set of fingerprint impressions obtained in the manner described in division (C)(2) of this section, the superintendent of the bureau of criminal identification and investigation shall conduct a criminal records check with respect to any person who has applied for employment in a position for which a criminal records check is required by those sections. The superintendent shall conduct the criminal records check in the manner described in division (B) of this section to determine whether any information exists that indicates that the person who is the subject of the request previously has been convicted of or pleaded guilty to any of the following:

(a) A violation of section 2903.01, 2903.02, 2903.03, 2903.11, 2903.12, 2903.13, 2903.16, 2903.21, 2903.34, 2905.01, 2905.02, 2905.05, 2907.02, 2907.03, 2907.04, 2907.05, 2907.06, 2907.07, 2907.09, 2907.11, 2907.12, 2907.15, 2907.21, 2907.22, 2907.23, 2907.25, 2907.31, 2907.32, 2907.321, 2907.322, 2907.323, 2911.01, 2911.02, 2911.11, 2911.12, 2919.12, 2919.22, 2919.23, 2919.24, 2923.12, 2923.13, 2923.161, 2925.02, 2925.03, 2925.04, 2925.05, 2925.06, or 3716.11 of the Revised Code;

(b) An existing or former law of this state, any other state, or the United States that is substantially equivalent to any of the offenses listed in division (A)(2)(a) of this section.

(3) On receipt of a request pursuant to section 173.27, 173.38, 173.381, 3701.881, 5164.34, 5164.341, 5164.342, 5123.081, or 5123.169 of the Revised Code, a completed form
prescribed pursuant to division (C)(1) of this section, and a set of fingerprint impressions
obtained in the manner described in division (C)(2) of this section, the superintendent of the
bureau of criminal identification and investigation shall conduct a criminal records check of the
person for whom the request is made. The superintendent shall conduct the criminal records
check in the manner described in division (B) of this section to determine whether any
information exists that indicates that the person who is the subject of the request previously has
been convicted of, has pleaded guilty to, or (except in the case of a request pursuant to section
5164.34, 5164.341, or 5164.342 of the Revised Code) has been found eligible for intervention in
lieu of conviction for any of the following, regardless of the date of the conviction, the date
of entry of the guilty plea, or (except in the case of a request pursuant to section 5164.34,
5164.341, or 5164.342 of the Revised Code) the date the person was found eligible for
intervention in lieu of conviction:

(a) A violation of section 959.13, 959.131, 2903.01, 2903.02, 2903.03, 2903.04,
2903.041, 2903.11, 2903.12, 2903.13, 2903.15, 2903.16, 2903.21, 2903.22, 2903.34,
2903.341, 2905.01, 2905.02, 2905.05, 2905.11, 2905.12, 2905.32, 2905.33, 2907.02, 2907.03,
2907.04, 2907.05, 2907.06, 2907.07, 2907.08, 2907.09, 2907.21, 2907.22, 2907.23, 2907.24,
2907.25, 2907.31, 2907.32, 2907.321, 2907.322, 2907.323, 2907.33, 2909.02, 2909.03,
2909.04, 2909.22, 2909.23, 2909.24, 2911.01, 2911.02, 2911.11, 2911.12, 2911.13, 2913.02,
2913.03, 2913.04, 2913.05, 2913.11, 2913.21, 2913.31, 2913.32, 2913.40, 2913.41, 2913.42,
2913.43, 2913.44, 2913.441, 2913.45, 2913.46, 2913.47, 2913.48, 2913.49, 2913.51, 2917.01,
2917.02, 2917.03, 2917.31, 2919.12, 2919.121, 2919.123, 2919.22, 2919.23, 2919.24, 2919.25,
2921.03, 2921.11, 2921.12, 2921.13, 2921.21, 2921.24, 2921.32, 2921.321, 2921.34, 2921.35,
2921.36, 2921.51, 2923.12, 2923.122, 2923.123, 2923.13, 2923.161, 2923.162, 2923.21,
2923.32, 2923.42, 2925.02, 2925.03, 2925.04, 2925.041, 2925.05, 2925.06, 2925.09, 2925.11,
2925.13, 2925.14, 2925.141, 2925.22, 2925.23, 2925.24, 2925.36, 2925.55, 2925.56, 2927.12,
or 3716.11 of the Revised Code;

(b) Felonious sexual penetration in violation of former section 2907.12 of the Revised
Code;

(c) A violation of section 2905.04 of the Revised Code as it existed prior to July 1, 1996;

(d) A violation of section 2923.01, 2923.02, or 2923.03 of the Revised Code when the
underlying offense that is the object of the conspiracy, attempt, or complicity is one of the
offenses listed in divisions (A)(3)(a) to (c) of this section;

(e) A violation of an existing or former municipal ordinance or law of this state, any other
state, or the United States that is substantially equivalent to any of the offenses listed in
divisions (A)(3)(a) to (d) of this section.

(4) On receipt of a request pursuant to section 2151.86 of the Revised Code, a
completed form prescribed pursuant to division (C)(1) of this section, and a set of fingerprint
impressions obtained in the manner described in division (C)(2) of this section, the
superintendent of the bureau of criminal identification and investigation shall conduct a criminal
records check in the manner described in division (B) of this section to determine whether any
information exists that indicates that the person who is the subject of the request previously has
been convicted of or pleaded guilty to any of the following:

(a) A violation of section 959.13, 2903.01, 2903.02, 2903.03, 2903.11,
2903.12, 2903.13, 2903.15, 2903.16, 2903.21, 2903.22, 2903.34, 2905.01, 2905.02,
2905.05, 2907.02, 2907.03, 2907.04, 2907.05, 2907.06, 2907.07, 2907.08, 2907.09, 2907.21,
2907.22, 2907.23, 2907.25, 2907.31, 2907.32, 2907.321, 2907.322, 2907.323, 2909.02,
2909.03, 2909.22, 2909.23, 2909.24, 2911.01, 2911.02, 2911.11, 2911.12, 2913.49, 2917.01,
2917.02, 2917.03, 2917.31, 2919.12, 2919.121, 2919.123, 2919.22, 2919.23, 2919.24, 2919.25,
2921.03, 2921.11, 2921.12, 2921.13, 2921.21, 2921.24, 2921.32, 2921.321, 2921.34, 2921.35,
2921.36, 2921.51, 2923.12, 2923.122, 2923.123, 2923.13, 2923.161, 2923.162, 2923.21,
2923.32, 2923.42, 2925.02, 2925.03, 2925.04, 2925.041, 2925.05, 2925.06, 2925.09, 2925.11,
2925.13, 2925.14, 2925.141, 2925.22, 2925.23, 2925.24, 2925.36, 2925.55, 2925.56, 2927.12,
or 3716.11 of the Revised Code, a violation of section 2905.04 of the Revised Code as it
existed prior to July 1, 1996, a violation of section 2919.23 of the Revised Code that would have been a violation of section 2905.04 of the Revised Code as it
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existed prior to July 1, 1996, had the violation been committed prior to that date, a violation of section 2925.11 of the Revised Code that is not a minor drug possession offense, two or more OVI or OUVAC violations committed within the three years immediately preceding the submission of the application or petition that is the basis of the request, or felonious sexual penetration in violation of former section 2907.12 of the Revised Code;

(b) A violation of an existing or former law of this state, any other state, or the United States that is substantially equivalent to any of the offenses listed in division (A)(4)(a) of this section.

(5) Upon receipt of a request pursuant to section 5104.013 of the Revised Code, a completed form prescribed pursuant to division (C)(1) of this section, and a set of fingerprint impressions obtained in the manner described in division (C)(2) of this section, the superintendent of the bureau of criminal identification and investigation shall conduct a criminal records check in the manner described in division (B) of this section to determine whether any information exists that indicates that the person who is the subject of the request has been convicted of or pleaded guilty to any of the following:

(a) A violation of section 2151.421, 2903.01, 2903.02, 2903.03, 2903.04, 2903.11, 2903.12, 2903.13, 2903.16, 2903.21, 2903.22, 2903.34, 2905.01, 2905.02, 2905.05, 2905.11, 2905.32, 2907.02, 2907.03, 2907.04, 2907.05, 2907.06, 2907.07, 2907.08, 2907.09, 2907.19, 2907.21, 2907.22, 2907.23, 2907.24, 2907.25, 2907.26, 2907.31, 2907.32, 2907.321, 2907.322, 2907.323, 2909.02, 2909.03, 2909.04, 2909.05, 2911.01, 2911.02, 2911.11, 2911.12, 2913.02, 2913.03, 2913.04, 2913.041, 2913.05, 2913.06, 2913.11, 2913.12, 2913.13, 2913.32, 2913.33, 2913.34, 2913.40, 2913.41, 2913.42, 2913.43, 2913.44, 2913.441, 2913.45, 2913.46, 2913.47, 2913.48, 2913.49, 2917.01, 2917.02, 2917.03, 2917.31, 2919.12, 2919.22, 2919.224, 2919.225, 2919.24, 2919.25, 2921.03, 2921.11, 2921.12, 2921.13, 2921.14, 2921.34, 2921.35, 2923.01, 2923.12, 2923.13, 2923.161, 2925.02, 2925.03, 2925.04, 2925.05, 2925.06, or 3716.11 of the Revised Code, felonious sexual penetration in violation of former section 2907.12 of the Revised Code, a violation of section 2905.04 of the Revised Code as it existed prior to July 1, 1996, a violation of section 2905.04 of the Revised Code that would have been a violation of section 2905.04 of the Revised Code as it existed prior to July 1, 1996, had the violation been committed prior to that date, a violation of section 2925.11 of the Revised Code that is not a minor drug possession offense, a violation of section 2923.02 or 2923.03 of the Revised Code that relates to a crime specified in this division, or a second violation of section 4511.19 of the Revised Code within five years of the date of application for licensure or certification.

(b) A violation of an existing or former law of this state, any other state, or the United States that is substantially equivalent to any of the offenses or violations described in division (A)(5)(a) of this section.

(6) Upon receipt of a request pursuant to section 5153.111 of the Revised Code, a completed form prescribed pursuant to division (C)(1) of this section, and a set of fingerprint impressions obtained in the manner described in division (C)(2) of this section, the superintendent of the bureau of criminal identification and investigation shall conduct a criminal records check in the manner described in division (B) of this section to determine whether any information exists that indicates that the person who is the subject of the request previously has been convicted of or pleaded guilty to any of the following:

(a) A violation of section 2903.01, 2903.02, 2903.03, 2903.04, 2903.11, 2903.12, 2903.13, 2903.16, 2903.21, 2903.34, 2905.01, 2905.02, 2905.05, 2905.11, 2905.32, 2907.05, 2907.06, 2907.07, 2907.08, 2907.09, 2907.19, 2907.21, 2907.22, 2907.23, 2907.24, 2907.25, 2907.26, 2907.31, 2907.32, 2907.321, 2907.322, 2907.323, 2909.04, 2909.05, 2911.01, 2911.02, 2911.11, 2911.12, 2913.02, 2913.03, 2913.04, 2913.041, 2913.05, 2913.06, 2913.11, 2913.12, 2913.13, 2913.32, 2913.33, 2913.34, 2913.40, 2913.41, 2913.42, 2913.43, 2913.44, 2913.441, 2913.45, 2913.46, 2913.47, 2913.48, 2913.49, 2917.01, 2917.02, 2917.03, 2917.31, 2919.12, 2919.22, 2919.224, 2919.225, 2919.24, 2919.25, 2921.03, 2921.11, 2921.12, 2921.13, 2921.14, 2921.24, 2921.25, 2923.01, 2923.12, 2923.13, 2923.161, 2925.02, 2925.03, 2925.04, 2925.05, 2925.06, or 3716.11 of the Revised Code, felonious sexual penetration in violation of former section 2907.12 of the Revised Code, a violation of section 2905.04 of the Revised Code as it existed prior to July 1, 1996, a violation of section 2907.12 of the Revised Code as it existed prior to July 1, 1996, a violation of section 2919.23 of the Revised Code that would have been a violation of section 2905.04 of the Revised Code as it existed prior to July 1, 1996, had the violation been committed prior to that date, a violation of section 2925.11 of the Revised Code that is not a minor drug possession offense, a violation of section 2923.02 or 2923.03 of the Revised Code that relates to a crime specified in this division, or a second violation of section 4511.19 of the Revised Code within five years of the date of application for licensure or certification.
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(7) On receipt of a request for a criminal records check from an individual pursuant to section 4749.03 or 4749.06 of the Revised Code, accompanied by a completed copy of the form prescribed in division (C)(1) of this section and a set of fingerprint impressions obtained in a manner described in division (C)(2) of this section, the superintendent of the bureau of criminal identification and investigation shall conduct a criminal records check in the manner described in division (B) of this section to determine whether any information exists indicating that the person who is the subject of the request has been convicted of or pleaded guilty to a felony in this state or in any other state. If the individual indicates that a firearm will be carried in the course of business, the superintendent shall require information from the federal bureau of investigation as described in division (B)(2) of this section. Subject to division (F) of this section, the superintendent shall report the findings of the criminal records check and any information the federal bureau of investigation provides to the director of public safety.

(8) On receipt of a request pursuant to section 1321.37, 1321.53, 1321.531, 1322.03, 1322.031, or 4763.05 of the Revised Code, a completed form prescribed pursuant to division (C)(1) of this section, and a set of fingerprint impressions obtained in the manner described in division (C)(2) of this section, the superintendent of the bureau of criminal identification and investigation shall conduct a criminal records check with respect to any person who has applied for a license, permit, or certification from the department of commerce or a division in the department. The superintendent shall conduct the criminal records check in the manner described in division (B) of this section to determine whether any information exists that indicates that the person who is the subject of the request previously has been convicted of or pleaded guilty to any of the following: a violation of section 2913.02, 2913.11, 2913.31, 2913.51, or 2925.03 of the Revised Code; any other criminal offense involving theft, receiving stolen property, embezzlement, forgery, fraud, passing bad checks, money laundering, or drug trafficking, or any criminal offense involving money or securities, as set forth in Chapters 2909., 2911., 2913., 2915., 2921., 2923., and 2925 of the Revised Code; or any existing or former law of this state, any other state, or the United States that is substantially equivalent to those offenses.

(9) On receipt of a request for a criminal records check from the treasurer of state under section 113.041 of the Revised Code or from an individual under section 4701.08, 4715.101, 4717.061, 4725.121, 4725.501, 4729.071, 4730.101, 4730.14, 4730.28, 4731.081, 4731.15, 4731.171, 4731.222, 4731.281, 4731.296, 4731.531, 4732.091, 4734.202, 4740.061, 4741.10, 4755.70, 4757.101, 4759.061, 4760.032, 4760.06, 4761.051, 4762.031, 4762.06, 4774.031, 4774.06, 4776.021, 4778.04, 4778.07, 4779.091, or 4783.04 of the Revised Code, accompanied by a completed form prescribed under division (C)(1) of this section and a set of fingerprint impressions obtained in the manner described in division (C)(2) of this section, the superintendent of the bureau of criminal identification and investigation shall conduct a criminal records check in the manner described in division (B) of this section to determine whether any information exists that indicates that the person who is the subject of the request has been convicted of or pleaded guilty to any criminal offense in this state or any other state. Subject to division (F) of this section, the superintendent shall send the results of a check requested under section 113.041 of the Revised Code to the treasurer of state and shall send the results of a check requested under any of the other listed sections to the licensing board specified by the individual in the request.
(10) On receipt of a request pursuant to section 1121.23, 1155.03, 1163.05, 1315.141, 1733.47, or 1761.26 of the Revised Code, a completed form prescribed pursuant to division (C)(1) of this section, and a set of fingerprint impressions obtained in the manner described in division (C)(2) of this section, the superintendent of the bureau of criminal identification and investigation shall conduct a criminal records check in the manner described in division (B) of this section to determine whether any information exists that indicates that the person who is the subject of the request previously has been convicted of or pleaded guilty to any criminal offense under any existing or former law of this state, any other state, or the United States.

(11) On receipt of a request for a criminal records check from an appointing or licensing authority under section 3772.07 of the Revised Code, a completed form prescribed under division (C)(1) of this section, and a set of fingerprint impressions obtained in the manner prescribed in division (C)(2) of this section, the superintendent of the bureau of criminal identification and investigation shall conduct a criminal records check in the manner described in division (B) of this section to determine whether any information exists that indicates that the person who is the subject of the request previously has been convicted of or pleaded guilty or no contest to any offense under any existing or former law of this state, any other state, or the United States that is a disqualifying offense as defined in section 3772.07 of the Revised Code or substantially equivalent to such an offense.

(12) On receipt of a request pursuant to section 2151.33 or 2151.412 of the Revised Code, a completed form prescribed pursuant to division (C)(1) of this section, and a set of fingerprint impressions obtained in the manner described in division (C)(2) of this section, the superintendent of the bureau of criminal identification and investigation shall conduct a criminal records check with respect to any person for whom a criminal records check is required under that section. The superintendent shall conduct the criminal records check in the manner described in division (B) of this section to determine whether any information exists that indicates that the person who is the subject of the request previously has been convicted of or pleaded guilty to any of the following:

(a) A violation of section 2903.01, 2903.02, 2903.03, 2903.04, 2903.11, 2903.12, 2903.13, 2903.16, 2903.21, 2903.34, 2905.01, 2905.02, 2905.11, 2905.12, 2907.02, 2907.03, 2907.05, 2907.06, 2907.07, 2907.08, 2907.09, 2907.12, 2907.25, 2907.31, 2907.32, 2907.321, 2907.322, 2907.323, 2911.01, 2911.02, 2911.11, 2911.12, 2911.13, 2913.02, 2913.03, 2913.04, 2913.11, 2913.21, 2913.31, 2913.40, 2913.43, 2913.47, 2913.51, 2919.25, 2921.36, 2923.12, 2923.13, 2923.161, 2925.02, 2925.03, 2925.11, 2925.13, 2925.22, 2925.23, or 3716.11 of the Revised Code;

(b) An existing or former law of this state, any other state, or the United States that is substantially equivalent to any of the offenses listed in division (A)(12)(a) of this section.

(13) On receipt of a request pursuant to section 3796.12 of the Revised Code, a completed form prescribed pursuant to division (C)(1) of this section, and a set of fingerprint impressions obtained in a manner described in division (C)(2) of this section, the superintendent of the bureau of criminal identification and investigation shall conduct a criminal records check in the manner described in division (B) of this section to determine whether any information exists that indicates that the person who is the subject of the request previously has been convicted of or pleaded guilty to any of the following:

(a) A disqualifying offense as specified in rules adopted under division (B)(2)(b) of section 3796.03 of the Revised Code if the person who is the subject of the request is an administrator or other person responsible for the daily operation of, or an owner or prospective owner, officer or prospective officer, or board member or prospective board member of, an entity seeking a license from the department of commerce under Chapter 3796 of the Revised Code;

(b) A disqualifying offense as specified in rules adopted under division (B)(2)(b) of section 3796.04 of the Revised Code if the person who is the subject of the request is an
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administrator or other person responsible for the daily operation of, or an owner or prospective owner, officer or prospective officer, or board member or prospective board member of, an entity seeking a license from the state board of pharmacy under Chapter 3796 of the Revised Code.

(14) On receipt of a request required by section 3796.13 of the Revised Code, a completed form prescribed pursuant to division (C)(1) of this section, and a set of fingerprint impressions obtained in a manner described in division (C)(2) of this section, the superintendent of the bureau of criminal identification and investigation shall conduct a criminal records check in the manner described in division (B) of this section to determine whether any information exists that indicates that the person who is the subject of the request previously has been convicted of or pleaded guilty to the following:

(a) A disqualifying offense as specified in rules adopted under division (B)(8)(a) of section 3796.03 of the Revised Code if the person who is the subject of the request is seeking employment with an entity licensed by the department of commerce under Chapter 3796 of the Revised Code;

(b) A disqualifying offense as specified in rules adopted under division (B)(14)(a) of section 3796.04 of the Revised Code if the person who is the subject of the request is seeking employment with an entity licensed by the state board of pharmacy under Chapter 3796 of the Revised Code.

(B) Subject to division (F) of this section, the superintendent shall conduct any criminal records check to be conducted under this section as follows:

(1) The superintendent shall review or cause to be reviewed any relevant information gathered and compiled by the bureau under division (A) of section 109.57 of the Revised Code that relates to the person who is the subject of the criminal records check, including, if the criminal records check was requested under section 113.041, 121.08, 173.27, 173.38, 173.381, 1121.23, 1155.03, 1163.05, 1315.141, 1321.37, 1321.53, 1321.531, 1322.03, 1322.031, 1733.47, 1761.26, 2151.86, 3301.32, 3301.541, 3319.39, 3701.881, 3712.09, 3721.121, 3772.07, 3796.12, 3796.13, 4749.03, 4749.06, 4763.05, 5104.013, 5164.34, 5164.341, 5164.342, 5123.081, 5123.169, or 5153.111 of the Revised Code, any relevant information contained in records that have been sealed under section 2953.32 of the Revised Code;

(2) If the request received by the superintendent asks for information from the federal bureau of investigation, the superintendent shall request from the federal bureau of investigation any information it has with respect to the person who is the subject of the criminal records check, including fingerprint-based checks of national crime information databases as described in 42 U.S.C. 671 if the request is made pursuant to section 2151.86 or 5104.013 of the Revised Code or if any other Revised Code section requires fingerprint-based checks of that nature, and shall review or cause to be reviewed any information the superintendent receives from that bureau. If a request under section 3319.39 of the Revised Code asks only for information from the federal bureau of investigation, the superintendent shall not conduct the review prescribed by division (B)(1) of this section.

(3) The superintendent or the superintendent’s designee may request criminal history records from other states or the federal government pursuant to the national crime prevention and privacy compact set forth in section 109.571 of the Revised Code.

(4) The superintendent shall include in the results of the criminal records check a list or description of the offenses listed or described in division (A)(1), (2), (3), (4), (5), (6), (7), (8), (9), (10), (11), (12), (13), or (14) of this section, whichever division requires the superintendent to conduct the criminal records check. The superintendent shall exclude from the results any information the dissemination of which is prohibited by federal law.

(5) The superintendent shall send the results of the criminal records check to the person to whom it is to be sent not later than the following number of days after the date the superintendent receives the request for the criminal records check, the completed form
prescribed under division (C)(1) of this section, and the set of fingerprint impressions obtained in
the manner described in division (C)(2) of this section:

(a) If the superintendent is required by division (A) of this section (other than division
(A)(3) of this section) to conduct the criminal records check, thirty;

(b) If the superintendent is required by division (A)(3) of this section to conduct the
criminal records check, sixty.

(C)(1) The superintendent shall prescribe a form to obtain the information necessary to
conduct a criminal records check from any person for whom a criminal records check is to be
conducted under this section. The form that the superintendent prescribes pursuant to this
division may be in a tangible format, in an electronic format, or in both tangible and electronic
formats.

(2) The superintendent shall prescribe standard impression sheets to obtain the
fingerprint impressions of any person for whom a criminal records check is to be conducted
under this section. Any person for whom a records check is to be conducted under this section
shall obtain the fingerprint impressions at a county sheriff's office, municipal police department,
or any other entity with the ability to make fingerprint impressions on the standard impression
sheets prescribed by the superintendent. The office, department, or entity may charge the
person a reasonable fee for making the impressions. The standard impression sheets the
superintendent prescribes pursuant to this division may be in a tangible format, in an electronic
format, or in both tangible and electronic formats.

(3) Subject to division (D) of this section, the superintendent shall prescribe and charge
a reasonable fee for providing a criminal records check under this section. The person
requesting the criminal records check shall pay the fee prescribed pursuant to this division. In
the case of a request under section 1121.23, 1155.03, 1163.05, 1315.141, 1733.47, 1761.26,
2151.33, 2151.412, or 5164.34 of the Revised Code, the fee shall be paid in the manner
specified in that section.

(4) The superintendent of the bureau of criminal identification and investigation may
prescribe methods of forwarding fingerprint impressions and information necessary to conduct a
criminal records check, which methods shall include, but not be limited to, an electronic method.

(D) The results of a criminal records check conducted under this section, other than a
criminal records check specified in division (A)(7) of this section, are valid for the person who is
the subject of the criminal records check for a period of one year from the date upon which the
superintendent completes the criminal records check. If during that period the superintendent
receives another request for a criminal records check to be conducted under this section for that
person, the superintendent shall provide the results from the previous criminal records check of
the person at a lower fee than the fee prescribed for the initial criminal records check.

(E) When the superintendent receives a request for information from a registered private
provider, the superintendent shall proceed as if the request was received from a school district
board of education under section 3319.39 of the Revised Code. The superintendent shall apply
division (A)(1)(c) of this section to any such request for an applicant who is a teacher.

(F)(1) Subject to division (F)(2) of this section, all information regarding the results of a
criminal records check conducted under this section that the superintendent reports or sends
under division (A)(7) or (9) of this section to the director of public safety, the treasurer of state,
or the person, board, or entity that made the request for the criminal records check shall relate
to the conviction of the subject person, or the subject person's plea of guilty to, a criminal
offense.

(2) Division (F)(1) of this section does not limit, restrict, or preclude the superintendent's
release of information that relates to the arrest of a person who is eighteen years of age or
older, to an adjudication of a child as a delinquent child, or to a criminal conviction of a person
under eighteen years of age in circumstances in which a release of that nature is authorized.
under division (E)(2), (3), or (4) of section 109.57 of the Revised Code pursuant to a rule adopted under division (E)(1) of that section.

(G) As used in this section:

(1) “Criminal records check” means any criminal records check conducted by the superintendent of the bureau of criminal identification and investigation in accordance with division (B) of this section.

(2) “Minor drug possession offense” has the same meaning as in section 2925.01 of the Revised Code.

(3) “OVI or OVUAC violation” means a violation of section 4511.19 of the Revised Code or a violation of an existing or former law of this state, any other state, or the United States that is substantially equivalent to section 4511.19 of the Revised Code.

(4) “Registered private provider” means a nonpublic school or entity registered with the superintendent of public instruction under section 3310.41 of the Revised Code to participate in the autism scholarship program or section 3310.58 of the Revised Code to participate in the Jon Peterson special needs scholarship program.

109.572 Checking criminal records.

[Editor’s Note: This version of the statute is effective 1/1/2018 until 1/21/2018. The version effective subsequently is included next. The version in effect prior to those dates is included previously.]

(A)(1) Upon receipt of a request pursuant to section 121.08, 3301.32, 3301.541, or 3319.39 of the Revised Code, a completed form prescribed pursuant to division (C)(1) of this section, and a set of fingerprint impressions obtained in the manner described in division (C)(2) of this section, the superintendent of the bureau of criminal identification and investigation shall conduct a criminal records check in the manner described in division (B) of this section to determine whether any information exists that indicates that the person who is the subject of the request previously has been convicted of or pleaded guilty to any of the following:

(a) A violation of section 2903.01, 2903.02, 2903.03, 2903.04, 2903.11, 2903.12, 2903.13, 2903.16, 2903.21, 2903.34, 2905.01, 2905.02, 2905.05, 2907.02, 2907.03, 2907.04, 2907.05, 2907.06, 2907.07, 2907.08, 2907.09, 2907.21, 2907.22, 2907.23, 2907.25, 2907.31, 2907.32, 2907.321, 2907.322, 2907.323, 2911.01, 2911.02, 2911.11, 2911.12, 2919.12, 2919.22, 2919.24, 2919.25, 2923.12, 2923.13, 2923.161, 2925.02, 2925.03, 2925.04, 2925.05, 2925.06, or 3716.11 of the Revised Code, felonious sexual penetration in violation of former section 2907.12 of the Revised Code, a violation of section 2905.04 of the Revised Code as it existed prior to July 1, 1996, a violation of section 2919.23 of the Revised Code that would have been a violation of section 2905.04 of the Revised Code as it existed prior to July 1, 1996, had the violation been committed prior to that date, or a violation of section 2925.11 of the Revised Code that is not a minor drug possession offense;

(b) A violation of an existing or former law of this state, any other state, or the United States that is substantially equivalent to any of the offenses listed in division (A)(1)(a) of this section;

(c) If the request is made pursuant to section 3319.39 of the Revised Code for an applicant who is a teacher, any offense specified in section 3319.31 of the Revised Code.

(2) On receipt of a request pursuant to section 3712.09 or 3721.121 of the Revised Code, a completed form prescribed pursuant to division (C)(1) of this section, and a set of fingerprint impressions obtained in the manner described in division (C)(2) of this section, the superintendent of the bureau of criminal identification and investigation shall conduct a criminal records check with respect to any person who has applied for employment in a position for which a criminal records check is required by those sections. The superintendent shall conduct
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the criminal records check in the manner described in division (B) of this section to determine whether any information exists that indicates that the person who is the subject of the request previously has been convicted of or pleaded guilty to any of the following:

(a) A violation of section 2903.01, 2903.02, 2903.03, 2903.04, 2903.11, 2903.12, 2903.13, 2903.16, 2903.21, 2903.34, 2905.01, 2905.02, 2905.11, 2905.12, 2907.02, 2907.03, 2907.05, 2907.06, 2907.07, 2907.08, 2907.09, 2907.12, 2907.25, 2907.31, 2907.32, 2907.322, 2907.323, 2911.01, 2911.02, 2911.11, 2911.12, 2911.13, 2913.02, 2913.03, 2913.04, 2913.11, 2913.21, 2913.31, 2913.40, 2913.43, 2913.47, 2913.51, 2919.25, 2921.36, 2923.12, 2923.13, 2923.161, 2925.02, 2925.03, 2925.11, 2925.13, 2925.22, 2925.23, or 3716.11 of the Revised Code;

(b) An existing or former law of this state, any other state, or the United States that is substantially equivalent to any of the offenses listed in division (A)(2)(a) of this section.

(3) On receipt of a request pursuant to section 173.27, 173.38, 173.381, 3701.881, 5164.34, 5164.341, 5164.342, 5123.081, or 5123.169 of the Revised Code, a completed form prescribed pursuant to division (C)(1) of this section, and a set of fingerprint impressions obtained in the manner described in division (C)(2) of this section, the superintendent of the bureau of criminal identification and investigation shall conduct a criminal records check of the person for whom the request is made. The superintendent shall conduct the criminal records check in the manner described in division (B) of this section to determine whether any information exists that indicates that the person who is the subject of the request previously has been convicted of, has pleaded guilty to, or (except in the case of a request pursuant to section 5164.34, 5164.341, or 5164.342 of the Revised Code) has been found eligible for intervention in lieu of conviction for any of the following, regardless of the date of the conviction, the date of entry of the guilty plea, or (except in the case of a request pursuant to section 5164.34, 5164.341, or 5164.342 of the Revised Code) the date the person was found eligible for intervention in lieu of conviction:

(a) A violation of section 959.13, 959.131, 2903.01, 2903.02, 2903.03, 2903.04, 2903.041, 2903.11, 2903.12, 2903.13, 2903.15, 2903.16, 2903.21, 2903.211, 2903.22, 2903.34, 2903.341, 2905.01, 2905.02, 2905.05, 2905.11, 2905.12, 2905.32, 2905.33, 2907.02, 2907.03, 2907.04, 2907.05, 2907.06, 2907.07, 2907.08, 2907.09, 2907.21, 2907.22, 2907.23, 2907.24, 2907.25, 2907.31, 2907.32, 2907.321, 2907.322, 2907.323, 2907.33, 2909.02, 2909.03, 2909.04, 2909.22, 2909.23, 2909.24, 2911.01, 2911.02, 2911.11, 2911.12, 2911.13, 2913.02, 2913.03, 2913.04, 2913.05, 2913.11, 2913.21, 2913.31, 2913.32, 2913.40, 2913.41, 2913.42, 2913.43, 2913.44, 2913.441, 2913.45, 2913.46, 2913.47, 2913.48, 2913.49, 2913.51, 2917.01, 2917.02, 2917.03, 2917.31, 2919.12, 2919.121, 2919.123, 2919.22, 2919.23, 2919.24, 2919.25, 2921.03, 2921.11, 2921.12, 2921.13, 2921.21, 2921.24, 2921.32, 2921.321, 2921.34, 2921.35, 2921.36, 2921.51, 2923.12, 2923.122, 2923.123, 2923.13, 2923.161, 2923.162, 2923.21, 2923.32, 2923.42, 2925.02, 2925.03, 2925.04, 2925.041, 2925.05, 2925.06, 2925.09, 2925.11, 2925.13, 2925.14, 2925.141, 2925.22, 2925.23, 2925.24, 2925.36, 2925.55, 2925.56, 2927.12, or 3716.11 of the Revised Code;

(b) Felonious sexual penetration in violation of former section 2907.12 of the Revised Code;

(c) A violation of section 2905.04 of the Revised Code as it existed prior to July 1, 1996;
(d) A violation of section 2923.01, 2923.02, or 2923.03 of the Revised Code when the underlying offense that is the object of the conspiracy, attempt, or complicity is one of the offenses listed in divisions (A)(3)(a) to (c) of this section;
(e) A violation of an existing or former municipal ordinance or law of this state, any other state, or the United States that is substantially equivalent to any of the offenses listed in divisions (A)(3)(a) to (d) of this section.

(4) On receipt of a request pursuant to section 2151.86 of the Revised Code, a completed form prescribed pursuant to division (C)(1) of this section, and a set of fingerprint
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impressions obtained in the manner described in division (C)(2) of this section, the superintendent of the bureau of criminal identification and investigation shall conduct a criminal records check in the manner described in division (B) of this section to determine whether any information exists that indicates that the person who is the subject of the request previously has been convicted of or pleaded guilty to any of the following:

(a) A violation of section 959.13, 2903.01, 2903.02, 2903.03, 2903.04, 2903.11, 2903.12, 2903.13, 2903.15, 2903.16, 2903.21, 2903.211, 2903.22, 2903.34, 2905.01, 2905.02, 2905.05, 2907.02, 2907.03, 2907.04, 2907.05, 2907.06, 2907.07, 2907.08, 2907.09, 2907.21, 2907.22, 2907.23, 2907.25, 2907.31, 2907.32, 2907.321, 2907.322, 2907.323, 2909.02, 2909.03, 2909.22, 2909.23, 2909.24, 2911.01, 2911.02, 2911.11, 2911.12, 2913.49, 2917.01, 2917.02, 2919.12, 2919.22, 2919.24, 2919.25, 2923.12, 2923.13, 2923.161, 2925.02, 2925.03, 2925.04, 2925.05, 2925.06, 2927.12, or 3716.11 of the Revised Code, a violation of section 2905.04 of the Revised Code as it existed prior to July 1, 1996, a violation of section 2919.23 of the Revised Code that would have been a violation of section 2905.04 of the Revised Code as it existed prior to July 1, 1996, had the violation been committed prior to that date, a violation of section 2925.11 of the Revised Code that is not a minor drug possession offense, two or more OVI or OVUAC violations committed within the three years immediately preceding the submission of the application or petition that is the basis of the request, or felonious sexual penetration in violation of former section 2907.12 of the Revised Code;

(b) A violation of an existing or former law of this state, any other state, or the United States that is substantially equivalent to any of the offenses listed in division (A)(5)(a) of this section.

(5) Upon receipt of a request pursuant to section 5104.013 of the Revised Code, a completed form prescribed pursuant to division (C)(1) of this section, and a set of fingerprint impressions obtained in the manner described in division (C)(2) of this section, the superintendent of the bureau of criminal identification and investigation shall conduct a criminal records check in the manner described in division (B) of this section to determine whether any information exists that indicates that the person who is the subject of the request has been convicted of or pleaded guilty to any of the following:

(a) A violation of section 2903.01, 2903.02, 2903.03, 2903.04, 2903.05, 2903.11, 2903.12, 2903.13, 2903.15, 2903.16, 2903.21, 2903.211, 2903.22, 2903.34, 2905.01, 2905.02, 2905.05, 2905.06, 2905.07, 2905.08, 2905.09, 2907.02, 2907.03, 2907.04, 2907.05, 2907.06, 2907.07, 2907.08, 2907.09, 2907.11, 2907.12, 2907.21, 2907.22, 2907.23, 2907.25, 2907.31, 2907.32, 2907.321, 2907.322, 2907.323, 2909.02, 2909.03, 2909.22, 2909.23, 2909.24, 2911.01, 2911.02, 2911.11, 2911.12, 2913.49, 2917.01, 2917.02, 2919.12, 2919.22, 2919.24, 2919.25, 2923.12, 2923.13, 2923.161, 2925.02, 2925.03, 2925.04, 2925.05, 2925.06, 2927.12, or 3716.11 of the Revised Code, a violation of section 2905.04 of the Revised Code as it existed prior to July 1, 1996, a violation of section 2919.23 of the Revised Code that would have been a violation of section 2905.04 of the Revised Code as it existed prior to July 1, 1996, had the violation been committed prior to that date, a violation of section 2925.11 of the Revised Code that is not a minor drug possession offense, two or more OVI or OVUAC violations committed within the three years immediately preceding the submission of the application or petition that is the basis of the request, or felonious sexual penetration in violation of former section 2907.12 of the Revised Code;

(b) A violation of an existing or former law of this state, any other state, or the United States that is substantially equivalent to any of the offenses listed in division (A)(5)(a) of this section.
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(6) Upon receipt of a request pursuant to section 5153.111 of the Revised Code, a completed form prescribed pursuant to division (C)(1) of this section, and a set of fingerprint impressions obtained in the manner described in division (C)(2) of this section, the superintendent of the bureau of criminal identification and investigation shall conduct a criminal records check in the manner described in division (B) of this section to determine whether any information exists that indicates that the person who is the subject of the request previously has been convicted of or pleaded guilty to any of the following:

(a) A violation of section 2903.01, 2903.02, 2903.03, 2903.04, 2903.11, 2903.12, 2903.13, 2903.16, 2903.21, 2903.34, 2905.01, 2905.02, 2905.05, 2907.02, 2907.03, 2907.04, 2907.05, 2907.06, 2907.07, 2907.08, 2907.09, 2907.21, 2907.22, 2907.23, 2907.25, 2907.31, 2907.32, 2907.321, 2907.322, 2907.323, 2909.02, 2909.03, 2911.01, 2911.02, 2911.11, 2911.12, 2919.12, 2919.22, 2919.24, 2919.25, 2923.12, 2923.13, 2923.161, 2925.02, 2925.03, 2925.04, 2925.05, 2925.06, or 3716.11 of the Revised Code, felonious sexual penetration in violation of former section 2907.12 of the Revised Code, a violation of section 2905.04 of the Revised Code as it existed prior to July 1, 1996, a violation of section 2919.23 of the Revised Code that would have been a violation of section 2905.04 of the Revised Code as it existed prior to July 1, 1996, had the violation been committed prior to that date, or a violation of section 2925.11 of the Revised Code that is not a minor drug possession offense;

(b) A violation of an existing or former law of this state, any other state, or the United States that is substantially equivalent to any of the offenses listed in division (A)(6)(a) of this section.

(7) On receipt of a request for a criminal records check from an individual pursuant to section 4749.03 or 4749.06 of the Revised Code, accompanied by a completed copy of the form prescribed in division (C)(1) of this section and a set of fingerprint impressions obtained in a manner described in division (C)(2) of this section, the superintendent of the bureau of criminal identification and investigation shall conduct a criminal records check in the manner described in division (B) of this section to determine whether any information exists indicating that the person who is the subject of the request has been convicted of or pleaded guilty to a felony in this state or in any other state. If the individual indicates that a firearm will be carried in the course of business, the superintendent shall require information from the federal bureau of investigation as described in division (B)(2) of this section. Subject to division (F) of this section, the superintendent shall report the findings of the criminal records check and any information the federal bureau of investigation provides to the director of public safety.

(8) On receipt of a request pursuant to section 1321.37, 1321.53, 1321.531, 1322.03, 1322.031, or 4763.05 of the Revised Code, a completed form prescribed pursuant to division (C)(1) of this section, and a set of fingerprint impressions obtained in the manner described in division (C)(2) of this section, the superintendent of the bureau of criminal identification and investigation shall conduct a criminal records check with respect to any person who has applied for a license, permit, or certification from the department of commerce or a division in the department. The superintendent shall conduct the criminal records check in the manner described in division (B) of this section to determine whether any information exists that indicates that the person who is the subject of the request previously has been convicted of or pleaded guilty to any of the following: a violation of section 2913.02, 2913.11, 2913.31, 2913.51, or 2925.03 of the Revised Code; any other criminal offense involving theft, receiving stolen property, embezzlement, forgery, fraud, passing bad checks, money laundering, or drug trafficking, or any criminal offense involving money or securities, as set forth in Chapters 2909., 2911., 2913., 2915., 2921., 2923., and 2925 of the Revised Code; or any existing or former law of this state, any other state, or the United States that is substantially equivalent to those offenses.

(9) On receipt of a request for a criminal records check from the treasurer of state under section 113.041 of the Revised Code or from an individual under section 4701.08, 4715.101,
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4717.061, 4725.121, 4725.501, 4729.071, 4730.101, 4730.14, 4730.28, 4731.081, 4731.15, 4731.171, 4731.222, 4731.281, 4731.296, 4731.531, 4732.091, 4734.202, 4740.061, 4741.10, 4755.70, 4757.101, 4759.061, 4760.032, 4760.06, 4761.051, 4762.031, 4762.06, 4774.031, 4774.06, 4776.021, 4778.04, 4778.07, 4779.091, or 4783.04 of the Revised Code, accompanied by a completed form prescribed under division (C)(1) of this section and a set of fingerprint impressions obtained in the manner described in division (C)(2) of this section, the superintendent of the bureau of criminal identification and investigation shall conduct a criminal records check in the manner described in division (B) of this section to determine whether any information exists that indicates that the person who is the subject of the request has been convicted of or pleaded guilty to any criminal offense in this state or any other state. Subject to division (F) of this section, the superintendent shall send the results of a check requested under section 113.041 of the Revised Code to the treasurer of state and shall send the results of a check requested under any of the other listed sections to the licensing board specified by the individual in the request.

(10) On receipt of a request pursuant to section 1121.23, 1315.141, 1733.47, or 1761.26 of the Revised Code, a completed form prescribed pursuant to division (C)(1) of this section, and a set of fingerprint impressions obtained in the manner described in division (C)(2) of this section, the superintendent of the bureau of criminal identification and investigation shall conduct a criminal records check in the manner described in division (B) of this section to determine whether any information exists that indicates that the person who is the subject of the request previously has been convicted of or pleaded guilty to any criminal offense under any existing or former law of this state, any other state, or the United States.

(11) On receipt of a request for a criminal records check from an appointing or licensing authority under section 3772.07 of the Revised Code, a completed form prescribed under division (C)(1) of this section, and a set of fingerprint impressions obtained in the manner prescribed in division (C)(2) of this section, the superintendent of the bureau of criminal identification and investigation shall conduct a criminal records check in the manner described in division (B) of this section to determine whether any information exists that indicates that the person who is the subject of the request previously has been convicted of or pleaded guilty or no contest to any offense under any existing or former law of this state, any other state, or the United States that is a disqualifying offense as defined in section 3772.07 of the Revised Code or substantially equivalent to such an offense.

(12) On receipt of a request pursuant to section 2151.33 or 2151.412 of the Revised Code, a completed form prescribed pursuant to division (C)(1) of this section, and a set of fingerprint impressions obtained in the manner described in division (C)(2) of this section, the superintendent of the bureau of criminal identification and investigation shall conduct a criminal records check with respect to any person for whom a criminal records check is required under that section. The superintendent shall conduct the criminal records check in the manner described in division (B) of this section to determine whether any information exists that indicates that the person who is the subject of the request previously has been convicted of or pleaded guilty to any of the following:

(a) A violation of section 2903.01, 2903.02, 2903.03, 2903.04, 2903.11, 2903.12, 2903.13, 2903.16, 2903.21, 2903.34, 2905.01, 2905.02, 2905.11, 2905.12, 2907.02, 2907.03, 2907.05, 2907.06, 2907.07, 2907.08, 2907.09, 2907.12, 2907.25, 2907.31, 2907.32, 2907.321, 2907.322, 2907.323, 2911.01, 2911.02, 2911.11, 2911.12, 2911.13, 2913.02, 2913.03, 2913.04, 2913.11, 2913.21, 2913.31, 2913.40, 2913.43, 2913.47, 2913.51, 2919.25, 2921.36, 2923.12, 2923.13, 2923.161, 2925.02, 2925.03, 2925.11, 2925.13, 2925.22, 2925.23, or 3716.11 of the Revised Code;

(b) An existing or former law of this state, any other state, or the United States that is substantially equivalent to any of the offenses listed in division (A)(12)(a) of this section.
(13) On receipt of a request pursuant to section 3796.12 of the Revised Code, a completed form prescribed pursuant to division (C)(1) of this section, and a set of fingerprint impressions obtained in a manner described in division (C)(2) of this section, the superintendent of the bureau of criminal identification and investigation shall conduct a criminal records check in the manner described in division (B) of this section to determine whether any information exists that indicates that the person who is the subject of the request previously has been convicted of or pleaded guilty to the following:

(a) A disqualifying offense as specified in rules adopted under division (B)(2)(b) of section 3796.03 of the Revised Code if the person who is the subject of the request is an administrator or other person responsible for the daily operation of, or an owner or prospective owner, officer or prospective officer, or board member or prospective board member of, an entity seeking a license from the department of commerce under Chapter 3796 of the Revised Code;

(b) A disqualifying offense as specified in rules adopted under division (B)(2)(b) of section 3796.04 of the Revised Code if the person who is the subject of the request is an administrator or other person responsible for the daily operation of, or an owner or prospective owner, officer or prospective officer, or board member or prospective board member of, an entity seeking a license from the state board of pharmacy under Chapter 3796 of the Revised Code.

(14) On receipt of a request required by section 3796.13 of the Revised Code, a completed form prescribed pursuant to division (C)(1) of this section, and a set of fingerprint impressions obtained in a manner described in division (C)(2) of this section, the superintendent of the bureau of criminal identification and investigation shall conduct a criminal records check in the manner described in division (B) of this section to determine whether any information exists that indicates that the person who is the subject of the request previously has been convicted of or pleaded guilty to the following:

(a) A disqualifying offense as specified in rules adopted under division (B)(8)(a) of section 3796.03 of the Revised Code if the person who is the subject of the request is seeking employment with an entity licensed by the department of commerce under Chapter 3796 of the Revised Code;

(b) A disqualifying offense as specified in rules adopted under division (B)(14)(a) of section 3796.04 of the Revised Code if the person who is the subject of the request is seeking employment with an entity licensed by the state board of pharmacy under Chapter 3796 of the Revised Code.

(B) Subject to division (F) of this section, the superintendent shall conduct any criminal records check to be conducted under this section as follows:

(1) The superintendent shall review or cause to be reviewed any relevant information gathered and compiled by the bureau under division (A) of section 109.57 of the Revised Code that relates to the person who is the subject of the criminal records check, including, if the criminal records check was requested under section 113.041, 121.08, 173.27, 173.38, 173.381, 1121.23, 1315.141, 1321.37, 1321.53, 1321.531, 1322.03, 1322.031, 1733.47, 1761.26, 2151.86, 3301.32, 3301.541, 3319.39, 3701.881, 3712.09, 3721.121, 3772.07, 3796.12, 3796.13, 4749.03, 4749.06, 4763.05, 5104.013, 5164.34, 5164.341, 5164.342, 5123.081, 5123.169, or 5153.111 of the Revised Code, any relevant information contained in records that have been sealed under section 2953.32 of the Revised Code;

(2) If the request received by the superintendent asks for information from the federal bureau of investigation, the superintendent shall request from the federal bureau of investigation any information it has with respect to the person who is the subject of the criminal records check, including fingerprint-based checks of national crime information databases as described in 42 U.S.C. 671 if the request is made pursuant to section 2151.86 or 5104.013 of the Revised Code or if any other Revised Code section requires fingerprint-based checks of that nature, and

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shall review or cause to be reviewed any information the superintendent receives from that bureau. If a request under section 3319.39 of the Revised Code asks only for information from the federal bureau of investigation, the superintendent shall not conduct the review prescribed by division (B)(1) of this section.

(3) The superintendent or the superintendent's designee may request criminal history records from other states or the federal government pursuant to the national crime prevention and privacy compact set forth in section 109.571 of the Revised Code.

(4) The superintendent shall include in the results of the criminal records check a list or description of the offenses listed or described in division (A)(1), (2), (3), (4), (5), (6), (7), (8), (9), (10), (11), (12), (13), or (14) of this section, whichever division requires the superintendent to conduct the criminal records check. The superintendent shall exclude from the results any information the dissemination of which is prohibited by federal law.

(5) The superintendent shall send the results of the criminal records check to the person to whom it is to be sent not later than the following number of days after the date the superintendent receives the request for the criminal records check, the completed form prescribed under division (C)(1) of this section, and the set of fingerprint impressions obtained in the manner described in division (C)(2) of this section:
   (a) If the superintendent is required by division (A) of this section (other than division (A)(3) of this section) to conduct the criminal records check, thirty;
   (b) If the superintendent is required by division (A)(3) of this section to conduct the criminal records check, sixty.

(C)(1) The superintendent shall prescribe a form to obtain the information necessary to conduct a criminal records check from any person for whom a criminal records check is to be conducted under this section. The form that the superintendent prescribes pursuant to this division may be in a tangible format, in an electronic format, or in both tangible and electronic formats.

(2) The superintendent shall prescribe standard impression sheets to obtain the fingerprint impressions of any person for whom a records check is to be conducted under this section. Any person for whom a records check is to be conducted under this section shall obtain the fingerprint impressions at a county sheriff's office, municipal police department, or any other entity with the ability to make fingerprint impressions on the standard impression sheets prescribed by the superintendent. The office, department, or entity may charge the person a reasonable fee for making the impressions. The standard impression sheets the superintendent prescribes pursuant to this division may be in a tangible format, in an electronic format, or in both tangible and electronic formats.

(3) Subject to division (D) of this section, the superintendent shall prescribe and charge a reasonable fee for providing a criminal records check under this section. The person requesting the criminal records check shall pay the fee prescribed pursuant to this division. In the case of a request under section 1121.23, 1155.03, 1163.05, 1315.141, 1733.47, 1761.26, 2151.33, 2151.412, or 5164.34 of the Revised Code, the fee shall be paid in the manner specified in that section.

(4) The superintendent of the bureau of criminal identification and investigation may prescribe methods of forwarding fingerprint impressions and information necessary to conduct a criminal records check, which methods shall include, but not be limited to, an electronic method.

(D) The results of a criminal records check conducted under this section, other than a criminal records check specified in division (A)(7) of this section, are valid for the person who is the subject of the criminal records check for a period of one year from the date upon which the superintendent completes the criminal records check. If during that period the superintendent receives another request for a criminal records check to be conducted under this section for that person, the superintendent shall provide the results from the previous criminal records check of the person at a lower fee than the fee prescribed for the initial criminal records check.
(E) When the superintendent receives a request for information from a registered private provider, the superintendent shall proceed as if the request was received from a school district board of education under section 3319.39 of the Revised Code. The superintendent shall apply division (A)(1)(c) of this section to any such request for an applicant who is a teacher.

(F)(1) Subject to division (F)(2) of this section, all information regarding the results of a criminal records check conducted under this section that the superintendent reports or sends under division (A)(7) or (9) of this section to the director of public safety, the treasurer of state, or the person, board, or entity that made the request for the criminal records check shall relate to the conviction of the subject person, or the subject person's plea of guilty to, a criminal offense.

(2) Division (F)(1) of this section does not limit, restrict, or preclude the superintendent's release of information that relates to the arrest of a person who is eighteen years of age or older, to an adjudication of a child as a delinquent child, or to a criminal conviction of a person under eighteen years of age in circumstances in which a release of that nature is authorized under division (E)(2), (3), or (4) of section 109.57 of the Revised Code pursuant to a rule adopted under division (E)(1) of that section.

(G) As used in this section:
(1) “Criminal records check” means any criminal records check conducted by the superintendent of the bureau of criminal identification and investigation in accordance with division (B) of this section.

(2) “Minor drug possession offense” has the same meaning as in section 2925.01 of the Revised Code.

(3) “OVI or OVUAC violation” means a violation of section 4511.19 of the Revised Code or a violation of an existing or former law of this state, any other state, or the United States that is substantially equivalent to section 4511.19 of the Revised Code.

(4) “Registered private provider” means a nonpublic school or entity registered with the superintendent of public instruction under section 3310.41 of the Revised Code to participate in the autism scholarship program or section 3310.58 of the Revised Code to participate in the Jon Peterson special needs scholarship program.

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[Editor's Note: This version of the statute is effective 1/21/2018. The versions in effect previously are included in the prior pages.]

(A)(1) Upon receipt of a request pursuant to section 121.08, 3301.32, 3301.541, or 3319.39 of the Revised Code, a completed form prescribed pursuant to division (C)(1) of this section, and a set of fingerprint impressions obtained in the manner described in division (G)(2) of this section, the superintendent of the bureau of criminal identification and investigation shall conduct a criminal records check in the manner described in division (D) of this section to determine whether any information exists that indicates that the person who is the subject of the request previously has been convicted of or pleaded guilty to any of the following:

(a) A violation of section 2903.01, 2903.02, 2903.03, 2903.04, 2903.11, 2903.12, 2903.13, 2903.16, 2903.21, 2903.34, 2905.01, 2905.02, 2905.05, 2907.02, 2907.03, 2907.04, 2907.05, 2907.06, 2907.07, 2907.08, 2907.09, 2907.21, 2907.22, 2907.23, 2907.25, 2907.31, 2907.32, 2907.321, 2907.322, 2907.323, 2911.01, 2911.02, 2911.11, 2911.12, 2919.12, 2919.19, 2919.24, 2919.25, 2923.12, 2923.13, 2923.161, 2925.02, 2925.03, 2925.04, 2925.05, 2925.06, or 3716.11 of the Revised Code, felonious sexual penetration in violation of former section 2907.12 of the Revised Code, a violation of section 2905.04 of the Revised Code as it existed prior to July 1, 1996, a violation of section 2919.23 of the Revised Code that would have been a violation of section 2905.04 of the Revised Code as it existed prior to July 1, 1996, had
the violation been committed prior to that date, or a violation of section 2925.11 of the Revised Code that is not a minor drug possession offense;

(b) A violation of an existing or former law of this state, any other state, or the United States that is substantially equivalent to any of the offenses listed in division (A)(1)(a) of this section;

(c) If the request is made pursuant to section 3319.39 of the Revised Code for an applicant who is a teacher, any offense specified in section 3319.31 of the Revised Code.

(2) On receipt of a request pursuant to section 3712.09 or 3721.121 of the Revised Code, a completed form prescribed pursuant to division (C)(1) of this section, and a set of fingerprint impressions obtained in the manner described in division (C)(2) of this section, the superintendent of the bureau of criminal identification and investigation shall conduct a criminal records check with respect to any person who has applied for employment in a position for which a criminal records check is required by those sections. The superintendent shall conduct the criminal records check in the manner described in division (B) of this section to determine whether any information exists that indicates that the person who is the subject of the request previously has been convicted of or pleaded guilty to any of the following:

(a) A violation of section 2903.01, 2903.02, 2903.03, 2903.04, 2903.11, 2903.12, 2903.13, 2903.16, 2903.21, 2903.34, 2905.01, 2905.02, 2905.11, 2905.12, 2907.02, 2907.03, 2907.05, 2907.06, 2907.07, 2907.08, 2907.09, 2907.12, 2907.25, 2907.31, 2907.32, 2907.321, 2907.322, 2907.323, 2911.01, 2911.02, 2911.11, 2911.12, 2911.13, 2913.02, 2913.03, 2913.04, 2913.11, 2913.21, 2913.31, 2913.40, 2913.43, 2913.47, 2913.51, 2919.25, 2921.36, 2923.12, 2923.13, 2923.161, 2925.02, 2925.03, 2925.11, 2925.13, 2925.22, 2925.23, or 3716.11 of the Revised Code;

(b) An existing or former law of this state, any other state, or the United States that is substantially equivalent to any of the offenses listed in division (A)(2)(a) of this section.

(3) On receipt of a request pursuant to section 173.27, 173.38, 173.381, 3701.881, 5164.34, 5164.341, 5164.342, 5123.081, or 5123.169 of the Revised Code, a completed form prescribed pursuant to division (C)(1) of this section, and a set of fingerprint impressions obtained in the manner described in division (C)(2) of this section, the superintendent of the bureau of criminal identification and investigation shall conduct a criminal records check of the person for whom the request is made. The superintendent shall conduct the criminal records check in the manner described in division (B) of this section to determine whether any information exists that indicates that the person who is the subject of the request previously has been convicted of, has pleaded guilty to, or (except in the case of a request pursuant to section 5164.34, 5164.341, or 5164.342 of the Revised Code) has been found eligible for intervention in lieu of conviction for any of the following, regardless of the date of the conviction, the date of entry of the guilty plea, or (except in the case of a request pursuant to section 5164.34, 5164.341, or 5164.342 of the Revised Code) the date the person was found eligible for intervention in lieu of conviction:

(a) A violation of section 959.13, 959.131, 2903.01, 2903.02, 2903.03, 2903.04, 2903.041, 2903.11, 2903.12, 2903.13, 2903.15, 2903.16, 2903.21, 2903.22, 2903.34, 2903.341, 2905.01, 2905.02, 2905.05, 2905.11, 2905.12, 2905.13, 2907.02, 2907.03, 2907.04, 2907.05, 2907.06, 2907.07, 2907.08, 2907.09, 2907.11, 2907.21, 2907.22, 2907.23, 2907.24, 2907.25, 2907.31, 2907.32, 2907.321, 2907.322, 2907.323, 2907.324, 2907.325, 2907.33, 2909.02, 2909.03, 2909.04, 2909.22, 2909.23, 2909.24, 2911.01, 2911.02, 2911.11, 2911.12, 2913.02, 2913.03, 2913.04, 2913.05, 2913.11, 2913.21, 2913.31, 2913.32, 2913.40, 2913.41, 2913.42, 2913.43, 2913.44, 2913.45, 2913.46, 2913.47, 2913.48, 2913.49, 2913.51, 2913.52, 2917.01, 2917.02, 2917.03, 2917.31, 2919.12, 2919.121, 2919.122, 2919.123, 2919.22, 2919.23, 2919.24, 2919.25, 2921.03, 2921.11, 2921.12, 2921.13, 2921.21, 2921.24, 2921.32, 2921.321, 2921.34, 2921.35, 2921.36, 2921.51, 2923.12, 2923.122, 2923.123, 2923.13, 2923.161, 2923.162, 2923.21, 2923.32, 2923.42, 2925.02, 2925.03, 2925.04, 2925.05, 2925.06, 2925.09, 2925.11,
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2925.13, 2925.14, 2925.141, 2925.22, 2925.23, 2925.24, 2925.36, 2925.55, 2925.56, 2927.12, or 3716.11 of the Revised Code;

(b) Felonious sexual penetration in violation of former section 2907.12 of the Revised Code;

(c) A violation of section 2905.04 of the Revised Code as it existed prior to July 1, 1996;

(d) A violation of section 2923.01, 2923.02, or 2923.03 of the Revised Code when the underlying offense that is the object of the conspiracy, attempt, or complicity is one of the offenses listed in divisions (A)(3)(a) to (c) of this section;

(e) A violation of an existing or former municipal ordinance or law of this state, any other state, or the United States that is substantially equivalent to any of the offenses listed in divisions (A)(3)(a) to (d) of this section.

(4) On receipt of a request pursuant to section 2151.86 of the Revised Code, a completed form prescribed pursuant to division (C)(1) of this section, and a set of fingerprint impressions obtained in the manner described in division (C)(2) of this section, the superintendent of the bureau of criminal identification and investigation shall conduct a criminal records check in the manner described in division (B) of this section to determine whether any information exists that indicates that the person who is the subject of the request previously has been convicted of or pleaded guilty to any of the following:

(a) A violation of section 959.13, 2903.01, 2903.02, 2903.03, 2903.04, 2903.11, 2903.12, 2903.13, 2903.15, 2903.16, 2903.21, 2903.22, 2903.34, 2905.01, 2905.02, 2905.05, 2907.02, 2907.03, 2907.04, 2907.05, 2907.06, 2907.07, 2907.08, 2907.09, 2907.21, 2907.22, 2907.23, 2907.25, 2907.31, 2907.32, 2907.321, 2907.322, 2907.323, 2909.02, 2909.03, 2909.22, 2909.23, 2909.24, 2911.01, 2911.02, 2911.11, 2911.12, 2913.49, 2917.01, 2917.02, 2919.12, 2919.22, 2919.24, 2919.25, 2923.12, 2923.13, 2923.161, 2925.02, 2925.03, 2925.04, 2925.05, 2925.06, 2927.12, or 3716.11 of the Revised Code, a violation of section 2905.04 of the Revised Code as it existed prior to July 1, 1996, a violation of section 2919.23 of the Revised Code that would have been a violation of section 2905.04 of the Revised Code as it existed prior to July 1, 1996, had the violation been committed prior to that date, a violation of section 2925.11 of the Revised Code that is not a minor drug possession offense, two or more OVI or OVUAC violations committed within the three years immediately preceding the submission of the application or petition that is the basis of the request, or felonious sexual penetration in violation of former section 2907.12 of the Revised Code;

(b) A violation of an existing or former law of this state, any other state, or the United States that is substantially equivalent to any of the offenses listed in division (A)(4)(a) of this section.

(5) Upon receipt of a request pursuant to section 5104.013 of the Revised Code, a completed form prescribed pursuant to division (C)(1) of this section, and a set of fingerprint impressions obtained in the manner described in division (C)(2) of this section, the superintendent of the bureau of criminal identification and investigation shall conduct a criminal records check in the manner described in division (B) of this section to determine whether any information exists that indicates that the person who is the subject of the request previously has been convicted of or pleaded guilty to any of the following:

(a) A violation of section 2151.421, 2903.01, 2903.02, 2903.03, 2903.04, 2903.11, 2903.12, 2903.13, 2903.16, 2903.21, 2903.22, 2903.34, 2905.01, 2905.02, 2905.05, 2905.32, 2907.02, 2907.03, 2907.04, 2907.05, 2907.06, 2907.07, 2907.08, 2907.09, 2907.19, 2907.21, 2907.22, 2907.23, 2907.25, 2907.29, 2907.31, 2907.32, 2907.321, 2907.322, 2907.323, 2909.02, 2909.03, 2909.22, 2909.23, 2909.24, 2911.01, 2911.02, 2911.11, 2911.12, 2913.49, 2917.01, 2917.02, 2919.12, 2919.22, 2919.24, 2919.25, 2923.12, 2923.13, 2923.161, 2925.02, 2925.03, 2925.04, 2925.05, 2925.06, 2927.12, or 3716.11 of the Revised Code, a violation of section 2905.04 of the Revised Code as it existed prior to July 1, 1996, a violation of section 2919.23 of the Revised Code that would have been a violation of section 2905.04 of the Revised Code as it existed prior to July 1, 1996, had the violation been committed prior to that date, a violation of section 2925.11 of the Revised Code that is not a minor drug possession offense, two or more OVI or OVUAC violations committed within the three years immediately preceding the submission of the application or petition that is the basis of the request, or felonious sexual penetration in violation of former section 2907.12 of the Revised Code;
2923.13, 2923.161, 2925.02, 2925.03, 2925.04, 2925.05, 2925.06, or 3716.11 of the Revised Code, felonious sexual penetration in violation of former section 2907.12 of the Revised Code, a violation of section 2905.04 of the Revised Code as it existed prior to July 1, 1996, a violation of section 2919.23 of the Revised Code that would have been a violation of section 2905.04 of the Revised Code as it existed prior to July 1, 1996, had the violation been committed prior to that date, a violation of section 2925.11 of the Revised Code that is not a minor drug possession offense, a violation of section 2923.02 or 2923.03 of the Revised Code that relates to a crime specified in this division, or a second violation of section 4511.19 of the Revised Code within five years of the date of application for licensure or certification.

(b) A violation of an existing or former law of this state, any other state, or the United States that is substantially equivalent to any of the offenses or violations described in division (A)(5)(a) of this section.

(6) Upon receipt of a request pursuant to section 5153.111 of the Revised Code, a completed form prescribed pursuant to division (C)(1) of this section, and a set of fingerprint impressions obtained in the manner described in division (C)(2) of this section, the superintendent of the bureau of criminal identification and investigation shall conduct a criminal records check in the manner described in division (B) of this section to determine whether any information exists that indicates that the person who is the subject of the request previously has been convicted of or pleaded guilty to any of the following:

(a) A violation of section 2903.01, 2903.02, 2903.03, 2903.04, 2903.11, 2903.12, 2903.13, 2903.16, 2903.21, 2903.34, 2905.01, 2905.02, 2905.05, 2907.02, 2907.03, 2907.04, 2907.05, 2907.06, 2907.07, 2907.08, 2907.09, 2907.21, 2907.22, 2907.23, 2907.25, 2907.31, 2907.32, 2907.321, 2907.322, 2907.323, 2909.02, 2909.03, 2911.01, 2911.02, 2911.11, 2911.12, 2919.12, 2919.22, 2919.24, 2919.25, 2923.12, 2923.13, 2923.161, 2925.02, 2925.03, 2925.04, 2925.05, 2925.06, or 3716.11 of the Revised Code, felonious sexual penetration in violation of former section 2907.12 of the Revised Code, a violation of section 2905.04 of the Revised Code as it existed prior to July 1, 1996, a violation of section 2919.23 of the Revised Code that would have been a violation of section 2905.04 of the Revised Code as it existed prior to July 1, 1996, had the violation been committed prior to that date, or a violation of section 2925.11 of the Revised Code that is not a minor drug possession offense;

(b) A violation of an existing or former law of this state, any other state, or the United States that is substantially equivalent to any of the offenses listed in division (A)(6)(a) of this section.

(7) On receipt of a request for a criminal records check from an individual pursuant to section 4749.03 or 4749.06 of the Revised Code, accompanied by a completed copy of the form prescribed in division (C)(1) of this section and a set of fingerprint impressions obtained in a manner described in division (C)(2) of this section, the superintendent of the bureau of criminal identification and investigation shall conduct a criminal records check in the manner described in division (B) of this section to determine whether any information exists indicating that the person who is the subject of the request has been convicted of or pleaded guilty to a felony in this state or in any other state. If the individual indicates that a firearm will be carried in the course of business, the superintendent shall require information from the federal bureau of investigation as described in division (B)(2) of this section. Subject to division (F) of this section, the superintendent shall report the findings of the criminal records check and any information the federal bureau of investigation provides to the director of public safety.

(8) On receipt of a request pursuant to section 1321.37, 1321.53, 1321.531, 1322.03, 1322.031, or 4763.05 of the Revised Code, a completed form prescribed pursuant to division (C)(1) of this section, and a set of fingerprint impressions obtained in a manner described in division (C)(2) of this section, the superintendent of the bureau of criminal identification and investigation shall conduct a criminal records check with respect to any person who has applied for a license, permit, or certification from the department of commerce or a division in the
department. The superintendent shall conduct the criminal records check in the manner described in division (B) of this section to determine whether any information exists that indicates that the person who is the subject of the request previously has been convicted of or pleaded guilty to any of the following: a violation of section 2913.02, 2913.11, 2913.31, 2913.51, or 2925.03 of the Revised Code; any other criminal offense involving theft, receiving stolen property, embezzlement, forgery, fraud, passing bad checks, money laundering, or drug trafficking, or any criminal offense involving money or securities, as set forth in Chapters 2909., 2911., 2913., 2915., 2921., 2923., and 2925 of the Revised Code; or any existing or former law of this state, any other state, or the United States that is substantially equivalent to those offenses.

(9) On receipt of a request for a criminal records check from the treasurer of state under section 113.041 of the Revised Code or from an individual under section 4701.08, 4715.101, 4717.061, 4725.121, 4725.501, 4729.071, 4730.101, 4730.14, 4730.28, 4731.081, 4731.15, 4731.171, 4731.222, 4731.281, 4731.296, 4731.531, 4732.091, 4734.202, 4740.061, 4741.10, 4747.051, 4753.061, 4755.70, 4757.101, 4759.061, 4760.032, 4760.06, 4761.051, 4762.031, 4762.06, 4774.031, 4774.06, 4776.021, 4778.04, 4778.07, 4779.091, or 4783.04 of the Revised Code, accompanied by a completed form prescribed under division (C)(1) of this section and a set of fingerprint impressions obtained in the manner described in division (C)(2) of this section, the superintendent of the bureau of criminal identification and investigation shall conduct a criminal records check in the manner described in division (B) of this section to determine whether any information exists that indicates that the person who is the subject of the request has been convicted of or pleaded guilty to any criminal offense in this state or any other state. Subject to division (F) of this section, the superintendent shall send the results of a check requested under section 113.041 of the Revised Code to the treasurer of state and shall send the results of a check requested under any of the other listed sections to the licensing board specified by the individual in the request.

(10) On receipt of a request pursuant to section 1121.23, 1315.141, 1733.47, or 1761.26 of the Revised Code, a completed form prescribed pursuant to division (C)(1) of this section, and a set of fingerprint impressions obtained in the manner described in division (C)(2) of this section, the superintendent of the bureau of criminal identification and investigation shall conduct a criminal records check in the manner described in division (B) of this section to determine whether any information exists that indicates that the person who is the subject of the request previously has been convicted of or pleaded guilty to any criminal offense under any existing or former law of this state, any other state, or the United States.

(11) On receipt of a request for a criminal records check from an appointing or licensing authority under section 3772.07 of the Revised Code, a completed form prescribed under division (C)(1) of this section, and a set of fingerprint impressions obtained in the manner prescribed in division (C)(2) of this section, the superintendent of the bureau of criminal identification and investigation shall conduct a criminal records check in the manner described in division (B) of this section to determine whether any information exists that indicates that the person who is the subject of the request previously has been convicted of or pleaded guilty or no contest to any offense under any existing or former law of this state, any other state, or the United States that is a disqualifying offense as defined in section 3772.07 of the Revised Code or substantially equivalent to such an offense.

(12) On receipt of a request pursuant to section 2151.33 or 2151.412 of the Revised Code, a completed form prescribed pursuant to division (C)(1) of this section, and a set of fingerprint impressions obtained in the manner described in division (C)(2) of this section, the superintendent of the bureau of criminal identification and investigation shall conduct a criminal records check with respect to any person for whom a criminal records check is required under that section. The superintendent shall conduct the criminal records check in the manner described in division (B) of this section to determine whether any information exists that
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indications that the person who is the subject of the request previously has been convicted of or pleaded guilty to any of the following:

(a) A violation of section 2903.01, 2903.02, 2903.03, 2903.04, 2903.11, 2903.12, 2903.13, 2903.16, 2903.21, 2903.34, 2905.01, 2905.02, 2905.11, 2905.12, 2907.02, 2907.03, 2907.05, 2907.06, 2907.07, 2907.08, 2907.09, 2907.12, 2907.25, 2907.31, 2907.32, 2907.321, 2907.322, 2907.323, 2911.01, 2911.02, 2911.11, 2911.12, 2913.02, 2913.03, 2913.04, 2913.11, 2913.21, 2913.31, 2913.40, 2913.43, 2913.47, 2913.51, 2919.25, 2921.36, 2923.12, 2923.13, 2923.161, 2925.02, 2925.03, 2925.11, 2925.13, 2925.22, 2925.23, or 3716.11 of the Revised Code;

(b) An existing or former law of this state, any other state, or the United States that is substantially equivalent to any of the offenses listed in division (A)(12)(a) of this section.

(13) On receipt of a request pursuant to section 3796.12 of the Revised Code, a completed form prescribed pursuant to division (C)(1) of this section, and a set of fingerprint impressions obtained in a manner described in division (C)(2) of this section, the superintendent of the bureau of criminal identification and investigation shall conduct a criminal records check in the manner described in division (B) of this section to determine whether any information exists that indicates that the person who is the subject of the request previously has been convicted of or pleaded guilty to the following:

(a) A disqualifying offense as specified in rules adopted under division (B)(2)(b) of section 3796.03 of the Revised Code if the person who is the subject of the request is an administrator or other person responsible for the daily operation of, or an owner or prospective owner, officer or prospective officer, or board member or prospective board member of, an entity seeking a license from the department of commerce under Chapter 3796 of the Revised Code;

(b) A disqualifying offense as specified in rules adopted under division (B)(2)(b) of section 3796.04 of the Revised Code if the person who is the subject of the request is an administrator or other person responsible for the daily operation of, or an owner or prospective owner, officer or prospective officer, or board member or prospective board member of, an entity seeking a license from the state board of pharmacy under Chapter 3796 of the Revised Code.

(14) On receipt of a request required by section 3796.13 of the Revised Code, a completed form pursuant to division (C)(1) of this section, and a set of fingerprint impressions obtained in a manner described in division (C)(2) of this section, the superintendent of the bureau of criminal identification and investigation shall conduct a criminal records check in the manner described in division (B) of this section to determine whether any information exists that indicates that the person who is the subject of the request previously has been convicted of or pleaded guilty to the following:

(a) A disqualifying offense as specified in rules adopted under division (B)(8)(a) of section 3796.03 of the Revised Code if the person who is the subject of the request is seeking employment with an entity licensed by the department of commerce under Chapter 3796 of the Revised Code;

(b) A disqualifying offense as specified in rules adopted under division (B)(14)(a) of section 3796.04 of the Revised Code if the person who is the subject of the request is seeking employment with an entity licensed by the state board of pharmacy under Chapter 3796 of the Revised Code.

(B) Subject to division (F) of this section, the superintendent shall conduct any criminal records check to be conducted under this section as follows:

(1) The superintendent shall review or cause to be reviewed any relevant information gathered and compiled by the bureau under division (A) of section 109.57 of the Revised Code that relates to the person who is the subject of the criminal records check, including, if the criminal records check was requested under section 113.041, 121.08, 173.27, 173.38, 173.381,
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1121.23, 1315.141, 1321.37, 1321.53, 1321.531, 1322.03, 1322.031, 1733.47, 1761.26, 2151.86, 3301.32, 3301.541, 3319.39, 3701.881, 3712.09, 3721.121, 3772.07, 3796.12, 3796.13, 4749.03, 4749.06, 4763.05, 5104.013, 5164.34, 5164.341, 5164.342, 5123.081, 5123.169, or 5153.111 of the Revised Code, any relevant information contained in records that have been sealed under section 2953.32 of the Revised Code;

(2) If the request received by the superintendent asks for information from the federal bureau of investigation, the superintendent shall request from the federal bureau of investigation any information it has with respect to the person who is the subject of the criminal records check, including fingerprint-based checks of national crime information databases as described in 42 U.S.C. 671 if the request is made pursuant to section 2151.86 or 5104.013 of the Revised Code or if any other Revised Code section requires fingerprint-based checks of that nature, and shall review or cause to be reviewed any information the superintendent receives from that bureau. If a request under section 3319.39 of the Revised Code asks only for information from the federal bureau of investigation, the superintendent shall not conduct the review prescribed by division (B)(1) of this section.

(3) The superintendent or the superintendent's designee may request criminal history records from other states or the federal government pursuant to the national crime prevention and privacy compact set forth in section 109.571 of the Revised Code.

(4) The superintendent shall include in the results of the criminal records check a list or description of the offenses listed or described in division (A)(1), (2), (3), (4), (5), (6), (7), (8), (9), (10), (11), (12), (13), or (14) of this section, whichever division requires the superintendent to conduct the criminal records check. The superintendent shall exclude from the results any information the dissemination of which is prohibited by federal law.

(5) The superintendent shall send the results of the criminal records check to the person to whom it is to be sent not later than the following number of days after the date the superintendent receives the request for the criminal records check, the completed form prescribed under division (C)(1) of this section, and the set of fingerprint impressions obtained in the manner described in division (C)(2) of this section:

(a) If the superintendent is required by division (A) of this section (other than division (A)(3) of this section) to conduct the criminal records check, thirty;

(b) If the superintendent is required by division (A)(3) of this section to conduct the criminal records check, sixty.

(C)(1) The superintendent shall prescribe a form to obtain the information necessary to conduct a criminal records check from any person for whom a criminal records check is to be conducted under this section. The form that the superintendent prescribes pursuant to this division may be in a tangible format, in an electronic format, or in both tangible and electronic formats.

(2) The superintendent shall prescribe standard impression sheets to obtain the fingerprint impressions of any person for whom a criminal records check is to be conducted under this section. Any person for whom a records check is to be conducted under this section shall obtain the fingerprint impressions at a county sheriff's office, municipal police department, or any other entity with the ability to make fingerprint impressions on the standard impression sheets prescribed by the superintendent. The office, department, or entity may charge the person a reasonable fee for making the impressions. The standard impression sheets the superintendent prescribes pursuant to this division may be in a tangible format, in an electronic format, or in both tangible and electronic formats.

(3) Subject to division (D) of this section, the superintendent shall prescribe and charge a reasonable fee for providing a criminal records check under this section. The person requesting the criminal records check shall pay the fee prescribed pursuant to this section. In the case of a request under section 1121.23, 1155.03, 1163.05, 1315.141, 1733.47, 1761.26,
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2151.33, 2151.412, or 5164.34 of the Revised Code, the fee shall be paid in the manner specified in that section.

(4) The superintendent of the bureau of criminal identification and investigation may prescribe methods of forwarding fingerprint impressions and information necessary to conduct a criminal records check, which methods shall include, but not be limited to, an electronic method.

(D) The results of a criminal records check conducted under this section, other than a criminal records check specified in division (A)(7) of this section, are valid for the person who is the subject of the criminal records check for a period of one year from the date upon which the superintendent completes the criminal records check. If during that period the superintendent receives another request for a criminal records check to be conducted under this section for that person, the superintendent shall provide the results from the previous criminal records check of the person at a lower fee than the fee prescribed for the initial criminal records check.

(E) When the superintendent receives a request for information from a registered private provider, the superintendent shall proceed as if the request was received from a school district board of education under section 3319.39 of the Revised Code. The superintendent shall apply division (A)(1)(c) of this section to any such request for an applicant who is a teacher.

(F)(1) Subject to division (F)(2) of this section, all information regarding the results of a criminal records check conducted under this section that the superintendent reports or sends under division (A)(7) or (9) of this section to the director of public safety, the treasurer of state, or the person, board, or entity that made the request for the criminal records check shall relate to the conviction of the subject person, or the subject person's plea of guilty to, a criminal offense.

(2) Division (F)(1) of this section does not limit, restrict, or preclude the superintendent's release of information that relates to the arrest of a person who is eighteen years of age or older, to an adjudication of a child as a delinquent child, or to a criminal conviction of a person under eighteen years of age in circumstances in which a release of that nature is authorized under division (E)(2), (3), or (4) of section 109.57 of the Revised Code pursuant to a rule adopted under division (E)(1) of that section.

(G) As used in this section:

(1) "Criminal records check" means any criminal records check conducted by the superintendent of the bureau of criminal identification and investigation in accordance with division (B) of this section.

(2) "Minor drug possession offense" has the same meaning as in section 2925.01 of the Revised Code.

(3) "OVI or OVUAC violation" means a violation of section 4511.19 of the Revised Code or a violation of an existing or former law of this state, any other state, or the United States that is substantially equivalent to section 4511.19 of the Revised Code.

(4) "Registered private provider" means a nonpublic school or entity registered with the superintendent of public instruction under section 3310.41 of the Revised Code to participate in the autism scholarship program or section 3310.58 of the Revised Code to participate in the Jon Peterson special needs scholarship program.

109.575 Providing volunteers notice of fingerprinting or criminal background checks.

At the time of a person's initial application to an organization or entity to be a volunteer in a position in which the person on a regular basis will have unsupervised access to a child, the organization or entity shall inform the person that, at any time, the person might be required to provide a set of impressions of the person's fingerprints and a criminal records check might be conducted with respect to the person. Not later than thirty days after the effective date of this section, each organization or entity shall notify each current volunteer who is in a position in which the person on a regular basis has unsupervised access to a child that, at any time, the
volunteer might be required to provide a set of impressions of the volunteer's fingerprints and a criminal records check might be conducted with respect to the volunteer.

**109.576 Notifying parent or guardian of volunteer’s conviction.**

(A) If a person has applied to an organization or entity to be a volunteer in a position in which the person on a regular basis has unsupervised access to a child, if the organization or entity subjects the person to a criminal records check, if the report of the results of the criminal records check indicates that the person has been convicted of or pleaded guilty to any of the offenses described in division (A)(1) of section 109.572 of the Revised Code, and if the organization or entity accepts the person as a volunteer in a position in which the person on a regular basis has unsupervised access to a child, the organization or entity shall notify the parent or guardian of each child for whom it provides services that the volunteer has been convicted of one or more of those offenses but that, nonetheless, the person will be serving the organization or entity in that position. The notification required by this division shall be in writing, and the organization or entity shall send the notice to the parent or guardian on the date the organization or entity commences providing services to the child or on the date the organization or entity decides to accept the person as a volunteer after receiving the report of the results of the criminal records check, whichever is later.

(B) If a person is serving an organization or entity as a volunteer in a position in which the person on a regular basis has unsupervised access to a child, if the organization or entity subjects the person to a criminal records check, if the report of the results of the criminal records check indicates that the person has been convicted of or pleaded guilty to any of the offenses described in division (A)(1) of section 109.572 of the Revised Code, and if the organization or entity retains the person as a volunteer in the same position or in any other position in which the person on a regular basis has unsupervised access to a child, the organization or entity shall notify the parent or guardian of each child for whom it provides services that the volunteer has been convicted of one or more of those offenses but that, nonetheless, the person will be retained by the organization or entity in that position. The notification required by this division shall be in writing, and the organization or entity shall send the notice to the parent or guardian on the date the organization or entity commences providing services to the child or on the date the organization or entity decides to retain the person after receiving the report of the results of the criminal records check, whichever is later.

(C) A notification to a parent or guardian of a child that is required by division (A) or (B) of this section shall identify by name the person who is accepted or retained as a volunteer in a position in which the person on a regular basis has unsupervised access to a child, shall state the fact that the person has been convicted of or pleaded guilty to one or more of the offenses described in division (A)(1) of section 109.572 of the Revised Code, but shall not identify the offense or offenses in question.

(D) Divisions (A) to (C) of this section apply regarding any criminal records check performed by the bureau of criminal identification and investigation pursuant to section 109.57, section 109.572, or rules adopted under division (E) of section 109.57 of the Revised Code, any criminal records check performed in any manner by the organization or entity or any of its officers or employees, or any criminal records check performed in any manner by any person upon the request of the organization or entity or any of its officers or employees.

**109.577 Volunteer criminal records check and organization immunity.**

(A) If an organization or entity uses a volunteer in a position in which the person on a regular basis has unsupervised access to a child and if the volunteer has been subjected to a criminal records check performed by the bureau of criminal identification and investigation
pursuant to section 109.57, section 109.572, or rules adopted under division (E) of section 109.57 of the Revised Code, the organization or entity, and its officials and employees, are immune from civil liability that might otherwise be incurred or imposed for any death or any injury or loss to person or property that is caused by any act or omission of the volunteer and that results from or is related to the volunteer having unsupervised access to a child on a regular basis. This immunity does not apply to a person, organization, or entity that has immunity from civil liability in accordance with section 9.86, 2744.02, or 2744.03 of the Revised Code for the good faith compliance, attempted compliance, or failure to comply.

(B) This section does not create a new cause of action or substantive legal right against a person, organization, or entity and does not affect any immunities from civil liability or defenses established by another section of the Revised Code or available at common law, to which a person, organization, or entity may be entitled under circumstances not covered by this section.

2151.86 Criminal records check regarding out-of-home child care.

(A)(1) The appointing or hiring officer of any entity that appoints or employs any person responsible for a child’s care in out-of-home care shall request the superintendent of BCII to conduct a criminal records check with respect to any person who is under final consideration for appointment or employment as a person responsible for a child’s care in out-of-home care, except that section 3319.39 of the Revised Code shall apply instead of this section if the out-of-home care entity is a public school, educational service center, or chartered nonpublic school.

(2) At the times specified in this division, the administrative director of an agency, or attorney, who arranges an adoption for a prospective adoptive parent shall request the superintendent of BCII to conduct a criminal records check with respect to that prospective adoptive parent and a criminal records check with respect to all persons eighteen years of age or older who reside with the prospective adoptive parent. The administrative director or attorney shall request a criminal records check pursuant to this division at the time of the initial home study, every four years after the initial home study at the time of an update, and at the time that an adoptive home study is completed as a new home study.

(3) Before a recommending agency submits a recommendation to the department of job and family services on whether the department should issue a certificate to a foster home under section 5103.03 of the Revised Code, and every four years thereafter prior to a recertification under that section, the administrative director of the agency shall request that the superintendent of BCII conduct a criminal records check with respect to the prospective foster caregiver and a criminal records check with respect to all other persons eighteen years of age or older who reside with the foster caregiver.

(B)(1) If a person subject to a criminal records check under division (A)(1) of this section does not present proof that the person has been a resident of this state for the five-year period immediately prior to the date upon which the criminal records check is requested or does not provide evidence that within that five-year period the superintendent of BCII has requested information about the person from the federal bureau of investigation in a criminal records check, the appointing or hiring officer shall request that the superintendent of BCII obtain information from the federal bureau of investigation as a part of the criminal records check, including fingerprint-based checks of national crime information databases as described in 42 U.S.C. 671. If a person subject to a criminal records check under division (A)(1) of this section presents proof that the person has been a resident of this state for that five-year period, the appointing or hiring officer or attorney may request that the superintendent of BCII include information from the federal bureau of investigation in the criminal records check, including fingerprint-based checks of national crime information databases as described in 42 U.S.C. 671.
a prospective parent requests, at the time of the initial home study, a criminal records check for a person pursuant to division (A)(2) of this section, the administrative director or attorney shall request that the superintendent of BCII obtain information from the federal bureau of investigation as part of the criminal records check, including fingerprint-based checks of national crime information databases as described in 42 U.S.C. 671, for the person subject to the criminal records check. In all other cases in which the administrative director of an agency, or attorney, who arranges an adoption for a prospective parent requests a criminal records check for a person pursuant to division (A)(2) of this section, the administrative director or attorney may request that the superintendent of BCII include information from the federal bureau of investigation in the criminal records check, including fingerprint-based checks of national crime information databases as described in 42 U.S.C. 671.

When the administrative director of a recommending agency requests, before submitting a recommendation to the department of job and family services on whether the department should issue a certificate to a foster home under section 5103.03 of the Revised Code, a criminal records check for a person pursuant to division (A)(3) of this section, the administrative director shall request that the superintendent of BCII obtain information from the federal bureau of investigation as part of a criminal records check, including fingerprint-based checks of national crime information databases as described in 42 U.S.C. 671, for the person subject to the criminal records check. In all other cases in which the administrative director of a recommending agency requests a criminal records check for a person pursuant to division (A)(3) of this section, the administrative director may request that the superintendent of BCII include information from the federal bureau of investigation in the criminal records check, including fingerprint-based checks of national crime information databases as described in 42 U.S.C. 671.

Prior to a hearing on a final decree of adoption or interlocutory order of adoption by a probate court, the administrative director of an agency, or an attorney, who arranges an adoption for a prospective parent shall provide to the clerk of the probate court either of the following:

(a) Any information received pursuant to a request made under this division from the superintendent of BCII or the federal bureau of investigation as part of the criminal records check, including fingerprint-based checks of national crime information databases as described in 42 U.S.C. 671, for the person subject to the criminal records check;

(b) Written notification that the person subject to a criminal records check pursuant to this division failed upon request to provide the information necessary to complete the form or failed to provide impressions of the person's fingerprints as required under division (B)(2) of this section.

(2) An appointing or hiring officer, administrative director, or attorney required by division (A) of this section to request a criminal records check shall provide to each person subject to a criminal records check a copy of the form prescribed pursuant to division (C)(1) of section 109.572 of the Revised Code and a standard impression sheet to obtain fingerprint impressions prescribed pursuant to division (C)(2) of section 109.572 of the Revised Code, obtain the completed form and impression sheet from the person, and forward the completed form and impression sheet to the superintendent of BCII at the time the criminal records check is requested.

Any person subject to a criminal records check who receives pursuant to this division a copy of the form prescribed pursuant to division (C)(1) of section 109.572 of the Revised Code and a copy of an impression sheet prescribed pursuant to division (C)(2) of that section and who is requested to complete the form and provide a set of fingerprint impressions shall complete the form or provide all the information necessary to complete the form and shall provide the impression sheet with the impressions of the person's fingerprints. If a person subject to a criminal records check, upon request, fails to provide the information necessary to complete the
form or fails to provide impressions of the person's fingerprints, the appointing or hiring officer shall not appoint or employ the person as a person responsible for a child's care in out-of-home care, a probate court may not issue a final decree of adoption or an interlocutory order of adoption making the person an adoptive parent, and the department of job and family services shall not issue a certificate authorizing the prospective foster caregiver to operate a foster home.

(C)(1) No appointing or hiring officer shall appoint or employ a person as a person responsible for a child's care in out-of-home care, the department of job and family services shall not issue a certificate under section 5103.03 of the Revised Code authorizing a prospective foster caregiver to operate a foster home, and no probate court shall issue a final decree of adoption or an interlocutory order of adoption making a person an adoptive parent if the person or, in the case of a prospective foster caregiver or prospective adoptive parent, any person eighteen years of age or older who resides with the prospective foster caregiver or prospective adoptive parent previously has been convicted of or pleaded guilty to any of the violations described in division (A)(4) of section 109.572 of the Revised Code, unless the person meets rehabilitation standards established in rules adopted under division (F) of this section.

(2) The appointing or hiring officer may appoint or employ a person as a person responsible for a child's care in out-of-home care conditionally until the criminal records check required by this section is completed and the officer receives the results of the criminal records check. If the results of the criminal records check indicate that, pursuant to division (C)(1) of this section, the person subject to the criminal records check does not qualify for appointment or employment, the officer shall release the person from appointment or employment.

(3) Prior to certification or recertification under section 5103.03 of the Revised Code, the prospective foster caregiver subject to a criminal records check under division (A)(3) of this section shall notify the recommending agency of the revocation of any foster home license, certificate, or other similar authorization in another state occurring within the five years prior to the date of application to become a foster caregiver in this state. The failure of a prospective foster caregiver to notify the recommending agency of any revocation of that type in another state that occurred within that five-year period shall be grounds for denial of the person's foster home application or the revocation of the person's foster home certificate, whichever is applicable. If a person has had a revocation in another state within the five years prior to the date of the application, the department of job and family services shall not issue a foster home certificate to the prospective foster caregiver.

(D) The appointing or hiring officer, administrative director, or attorney shall pay to the bureau of criminal identification and investigation the fee prescribed pursuant to division (C)(3) of section 109.572 of the Revised Code for each criminal records check conducted in accordance with that section upon a request pursuant to division (A) of this section. The officer, director, or attorney may charge the person subject to the criminal records check a fee for the costs the officer, director, or attorney incurs in obtaining the criminal records check. A fee charged under this division shall not exceed the amount of fees the officer, director, or attorney pays for the criminal records check. If a fee is charged under this division, the officer, director, or attorney shall notify the person who is the applicant at the time of the person's initial application for appointment or employment, an adoption to be arranged, or a certificate to operate a foster home of the amount of the fee and that, unless the fee is paid, the person who is the applicant will not be considered for appointment or employment or as an adoptive parent or foster caregiver.

(E) The report of any criminal records check conducted by the bureau of criminal identification and investigation in accordance with section 109.572 of the Revised Code and pursuant to a request made under division (A) of this section is not a public record for the purposes of section 149.43 of the Revised Code and shall not be made available to any person other than the following:
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(1) The person who is the subject of the criminal records check or the person's representative;

(2) The appointing or hiring officer, administrative director, or attorney requesting the criminal records check or the officer's, director's, or attorney's representative;

(3) The department of job and family services, a county department of job and family services, or a public children services agency;

(4) Any court, hearing officer, or other necessary individual involved in a case dealing with the denial of employment, a final decree of adoption or interlocutory order of adoption, or a foster home certificate.

(F) The director of job and family services shall adopt rules in accordance with Chapter 119 of the Revised Code to implement this section. The rules shall include rehabilitation standards a person who has been convicted of or pleaded guilty to an offense listed in division (A)(4) of section 109.572 of the Revised Code must meet for an appointing or hiring officer to appoint or employ the person as a person responsible for a child's care in out-of-home care, a probate court to issue a final decree of adoption or interlocutory order of adoption making the person an adoptive parent, or the department to issue a certificate authorizing the prospective foster caregiver to operate a foster home or not revoke a foster home certificate for a violation specified in section 5103.0328 of the Revised Code.

(G) An appointing or hiring officer, administrative director, or attorney required by division (A) of this section to request a criminal records check shall inform each person who is the applicant, at the time of the person's initial application for appointment or employment, an adoption to be arranged, or a foster home certificate, that the person subject to the criminal records check is required to provide a set of impressions of the person's fingerprints and that a criminal records check is required to be conducted and satisfactorily completed in accordance with section 109.572 of the Revised Code.

(H) As used in this section:

(1) "Children's hospital" means any of the following:

(a) A hospital registered under section 3701.07 of the Revised Code that provides general pediatric medical and surgical care, and in which at least seventy-five per cent of annual inpatient discharges for the preceding two calendar years were individuals less than eighteen years of age;

(b) A distinct portion of a hospital registered under section 3701.07 of the Revised Code that provides general pediatric medical and surgical care, has a total of at least one hundred fifty registered pediatric special care and pediatric acute care beds, and in which at least seventy-five per cent of annual inpatient discharges for the preceding two calendar years were individuals less than eighteen years of age;

(c) A distinct portion of a hospital, if the hospital is registered under section 3701.07 of the Revised Code as a children's hospital and the children's hospital meets all the requirements of division (H)(1)(a) of this section.

(2) "Criminal records check" has the same meaning as in section 109.572 of the Revised Code.

(3) "Person responsible for a child's care in out-of-home care" has the same meaning as in section 2151.011 of the Revised Code, except that it does not include a prospective employee of the department of youth services or a person responsible for a child's care in a hospital or medical clinic other than a children's hospital.

(4) "Person subject to a criminal records check" means the following:

(a) A person who is under final consideration for appointment or employment as a person responsible for a child's care in out-of-home care;

(b) A prospective adoptive parent;

(c) A prospective foster caregiver;

(d) A person eighteen years old or older who resides with a prospective foster caregiver.
or a prospective adoptive parent.

(5) “Recommending agency” means a public children services agency, private child placing agency, or private noncustodial agency to which the department of job and family services has delegated a duty to inspect and approve foster homes.

(6) “Superintendent of BCII” means the superintendent of the bureau of criminal identification and investigation.

2953.25 Certificate of qualification for employment; immunity.

(A) As used in this section:

(1) “Collateral sanction” means a penalty, disability, or disadvantage that is related to employment or occupational licensing, however denominated, as a result of the individual's conviction of or plea of guilty to an offense and that applies by operation of law in this state whether or not the penalty, disability, or disadvantage is included in the sentence or judgment imposed.

“Collateral sanction” does not include imprisonment, probation, parole, supervised release, forfeiture, restitution, fine, assessment, or costs of prosecution.

(2) “Decision-maker” includes, but is not limited to, the state acting through a department, agency, board, commission, or instrumentality established by the law of this state for the exercise of any function of government, a political subdivision, an educational institution, or a government contractor or subcontractor made subject to this section by contract, law, or ordinance.

(3) “Department-funded program” means a residential or nonresidential program that is not a term in a state correctional institution, that is funded in whole or part by the department of rehabilitation and correction, and that is imposed as a sanction for an offense, as part of a sanction that is imposed for an offense, or as a term or condition of any sanction that is imposed for an offense.

(4) “Designee” means the person designated by the deputy director of the division of parole and community services to perform the duties designated in division (B) of this section.

(5) “Division of parole and community services” means the division of parole and community services of the department of rehabilitation and correction.

(6) “Offense” means any felony or misdemeanor under the laws of this state.

(7) “Political subdivision” has the same meaning as in section 2969.21 of the Revised Code.

(8) “Discretionary civil impact,” “licensing agency,” and “mandatory civil impact” have the same meanings as in section 2961.21 of the Revised Code.

(B)(1) An individual who is subject to one or more collateral sanctions as a result of being convicted of or pleading guilty to an offense and who either has served a term in a state correctional institution for any offense or has spent time in a department-funded program for any offense may file a petition with the designee of the deputy director of the division of parole and community services for a certificate of qualification for employment.

(2) An individual who is subject to one or more collateral sanctions as a result of being convicted of or pleading guilty to an offense and who is not in a category described in division (B)(1) of this section may file for a certificate of qualification for employment by doing either of the following:

(a) In the case of an individual who resides in this state, filing a petition with the court of common pleas of the county in which the person resides or with the designee of the deputy director of the division of parole and community services;

(b) In the case of an individual who resides outside of this state, filing a petition with the court of common pleas of any county in which any conviction or plea of guilty from which the individual seeks relief was entered or with the designee of the deputy director of the division of parole and community services.
parole and community services.

(3) A petition under division (B)(1) or (2) of this section shall be made on a copy of the form prescribed by the division of parole and community services under division (J) of this section and shall contain all of the information described in division (F) of this section.

(4)(a) Except as provided in division (B)(4)(b) of this section, an individual may file a petition under division (B)(1) or (2) of this section at any time after the expiration of whichever of the following is applicable:

(i) If the offense that resulted in the collateral sanction from which the individual seeks relief is a felony, at any time after the expiration of one year from the date of release of the individual from any period of incarceration in a state or local correctional facility that was imposed for that offense and all periods of supervision imposed after release from the period of incarceration or, if the individual was not incarcerated for that offense, at any time after the expiration of one year from the date of the individual's final release from all other sanctions imposed for that offense.

(ii) If the offense that resulted in the collateral sanction from which the individual seeks relief is a misdemeanor, at any time after the expiration of six months from the date of release of the individual from any period of incarceration in a local correctional facility that was imposed for that offense and all periods of supervision imposed after release from the period of incarceration or, if the individual was not incarcerated for that offense, at any time after the expiration of six months from the date of the final release of the individual from all sanctions imposed for that offense including any period of supervision.

(b) The department of rehabilitation and correction may establish criteria by rule adopted under Chapter 119 of the Revised Code that, if satisfied by an individual, would allow the individual to file a petition before the expiration of six months or one year from the date of final release, whichever is applicable under division (B)(4)(a) of this section.

(5)(a) A designee that receives a petition for a certificate of qualification for employment from an individual under division (B)(1) or (2) of this section shall review the petition to determine whether it is complete. If the petition is complete, the designee shall forward the petition, and any other information the designee possesses that relates to the petition, to the court of common pleas of the county in which the individual resides if the individual submitting the petition resides in this state or, if the individual resides outside of this state, to the court of common pleas of the county in which the conviction or plea of guilty from which the individual seeks relief was entered.

(b) A court of common pleas that receives a petition for a certificate of qualification for employment under division (B)(2) of this section, or that is forwarded a petition for such a certificate under division (B)(5)(a) of this section, shall attempt to determine all other courts in this state in which the individual was convicted of or pleaded guilty to an offense other than the offense from which the individual is seeking relief. The court that receives or is forwarded the petition shall notify all other courts in this state that it determines under this division were courts in which the individual was convicted of or pleaded guilty to an offense other than the offense from which the individual is seeking relief that the individual has filed the petition and that the court may send comments regarding the possible issuance of the certificate.

A court of common pleas that receives a petition for a certificate of qualification for employment under division (B)(2) of this section shall notify the county's prosecuting attorney that the individual has filed the petition.

A court of common pleas that receives a petition for a certificate of qualification for employment under division (B)(2) of this section, or that is forwarded a petition for qualification under division (B)(5)(a) of this section may direct the clerk of court to process and record all notices required in or under this section.

(C)(1) Upon receiving a petition for a certificate of qualification for employment filed by
an individual under division (B)(2) of this section or being forwarded a petition for such a certificate under division (B)(5)(a) of this section, the court shall review the individual's petition, the individual's criminal history, all filings submitted by the prosecutor or by the victim in accordance with rules adopted by the division of parole and community services, the applicant's military service record, if applicable, and whether the applicant has an emotional, mental, or physical condition that is traceable to the applicant's military service in the armed forces of the United States and that was a contributing factor in the commission of the offense or offenses, and all other relevant evidence. The court may order any report, investigation, or disclosure by the individual that the court believes is necessary for the court to reach a decision on whether to approve the individual's petition for a certificate of qualification for employment.

(2) Upon receiving a petition for a certificate of qualification for employment filed by an individual under division (B)(2) of this section or being forwarded a petition for such a certificate under division (B)(5)(a) of this section, except as otherwise provided in this division, the court shall decide whether to issue the certificate within sixty days after the court receives or is forwarded the completed petition and all information requested for the court to make that decision. Upon request of the individual who filed the petition, the court may extend the sixty-day period specified in this division.

(3) Subject to division (C)(5) of this section, a court that receives an individual's petition for a certificate of qualification for employment under division (B)(2) of this section or that is forwarded a petition for such a certificate under division (B)(5)(a) of this section may issue a certificate of qualification for employment, at the court's discretion, if the court finds that the individual has established all of the following by a preponderance of the evidence:

(a) Granting the petition will materially assist the individual in obtaining employment or occupational licensing.
(b) The individual has a substantial need for the relief requested in order to live a law-abiding life.
(c) Granting the petition would not pose an unreasonable risk to the safety of the public or any individual.

(4) The submission of an incomplete petition by an individual shall not be grounds for the designee or court to deny the petition.

(5) A certificate of qualification for employment shall not create relief from any of the following collateral sanctions:

(a) Requirements imposed by Chapter 2950 of the Revised Code and rules adopted under sections 2950.13 and 2950.132 of the Revised Code;
(b) A driver's license, commercial driver's license, or probationary license suspension, cancellation, or revocation pursuant to section 4510.037, 4510.07, 4511.19, or 4511.191 of the Revised Code if the relief sought is available pursuant to section 4510.021 or division (B) of section 4510.13 of the Revised Code;
(c) Restrictions on employment as a prosecutor or law enforcement officer;
(d) The denial, inelegibility, or automatic suspension of a license that is imposed upon an individual applying for or holding a license as a health care professional under Title XLVII of the Revised Code if the individual is convicted of, pleads guilty to, is subject to a judicial finding of eligibility for intervention in lieu of conviction in this state under section 2951.041 of the Revised Code, or is subject to treatment or intervention in lieu of conviction for a violation of section 2903.01, 2903.02, 2903.03, 2903.11, 2905.01, 2907.02, 2907.03, 2907.05, 2909.02, 2911.01, 2911.11, or 2919.123 of the Revised Code;
(e) The immediate suspension of a license, certificate, or evidence of registration that is imposed upon an individual holding a license as a health care professional under Title XLVII of the Revised Code pursuant to division (C) of section 3719.121 of the Revised Code;
(f) The denial or inelegibility for employment in a pain clinic under division (B)(4) of section 4729.552 of the Revised Code;
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(g) The mandatory suspension of a license that is imposed on an individual applying for or holding a license as a health care professional under Title XLVII of the Revised Code pursuant to section 3123.43 of the Revised Code.

(6) If a court that receives an individual's petition for a certificate of qualification for employment under division (B)(2) of this section or that is forwarded a petition for such a certificate under division (B)(5)(a) of this section denies the petition, the court shall provide written notice to the individual of the court's denial. The court may place conditions on the individual regarding the individual's filing of any subsequent petition for a certificate of qualification for employment. The written notice must notify the individual of any conditions placed on the individual's filing of a subsequent petition for a certificate of qualification for employment.

If a court of common pleas that receives an individual's petition for a certificate of qualification for employment under division (B)(2) of this section or that is forwarded a petition for such a certificate under division (B)(5)(a) of this section denies the petition, the individual may appeal the decision to the court of appeals only if the individual alleges that the denial was an abuse of discretion on the part of the court of common pleas.

(D)(1) A certificate of qualification for employment issued to an individual lifts the automatic bar of a collateral sanction, and a decision-maker shall consider on a case-by-case basis whether to grant or deny the issuance or restoration of an occupational license or an employment opportunity, notwithstanding the individual's possession of the certificate, without, however, reconsidering or rejecting any finding made by a designee or court under division (C)(3) of this section.

(2) The certificate constitutes a rebuttable presumption that the person's criminal convictions are insufficient evidence that the person is unfit for the license, employment opportunity, or certification in question. Notwithstanding the presumption established under this division, the agency may deny the license or certification for the person if it determines that the person is unfit for issuance of the license.

(3) If an employer that has hired a person who has been issued a certificate of qualification for employment applies to a licensing agency for a license or certification and the person has a conviction or guilty plea that otherwise would bar the person's employment with the employer or licensure for the employer because of a mandatory civil impact, the agency shall give the person individualized consideration, notwithstanding the mandatory civil impact, the mandatory civil impact shall be considered for all purposes to be a discretionary civil impact, and the certificate constitutes a rebuttable presumption that the person's criminal convictions are insufficient evidence that the person is unfit for the employment, or that the employer is unfit for the license or certification, in question.

(E) A certificate of qualification for employment does not grant the individual to whom the certificate was issued relief from the mandatory civil impacts identified in division (A)(1) of section 2961.01 or division (B) of section 2961.02 of the Revised Code.

(F) A petition for a certificate of qualification for employment filed by an individual under division (B)(1) or (2) of this section shall include all of the following:

(1) The individual's name, date of birth, and social security number;
(2) All aliases of the individual and all social security numbers associated with those aliases;
(3) The individual's residence address, including the city, county, and state of residence and zip code;
(4) The length of time that the individual has resided in the individual's current state of residence, expressed in years and months of residence;
(5) A general statement as to why the individual has filed the petition and how the certificate of qualification for employment would assist the individual;
(6) A summary of the individual's criminal history with respect to each offense that is a
disqualification from employment or licensing in an occupation or profession, including the years
de each conviction or plea of guilty for each of those offenses;

(7) A summary of the individual's employment history, specifying the name of, and dates
of employment with, each employer;

(8) Verifiable references and endorsements;

(9) The name of one or more immediate family members of the individual, or other
persons with whom the individual has a close relationship, who support the individual's reentry
plan;

(10) A summary of the reason the individual believes the certificate of qualification for
employment should be granted;

(11) Any other information required by rule by the department of rehabilitation and
correction.

(G)(1) In a judicial or administrative proceeding alleging negligence or other fault, a
certificate of qualification for employment issued to an individual under this section may be
introduced as evidence of a person's due care in hiring, retaining, licensing, leasing to, admitting
to a school or program, or otherwise transacting business or engaging in activity with the
individual to whom the certificate of qualification for employment was issued if the person knew
of the certificate at the time of the alleged negligence or other fault.

(2) In any proceeding on a claim against an employer for negligent hiring, a certificate of
qualification for employment issued to an individual under this section shall provide immunity for
the employer as to the claim if the employer knew of the certificate at the time of the alleged
negligence.

(3) If an employer hires an individual who has been issued a certificate of qualification
for employment under this section, if the individual, after being hired, subsequently
demonstrates dangerousness or is convicted of or pleads guilty to a felony, and if the employer
retains the individual as an employee after the demonstration of dangerousness or the
conviction or guilty plea, the employer may be held liable in a civil action that is based on or
relates to the retention of the individual as an employee only if it is proved by a preponderance
of the evidence that the person having hiring and firing responsibility for the employer had actual
knowledge that the employee was dangerous or had been convicted of or pleaded guilty to the
felony and was willful in retaining the individual as an employee after the demonstration of
dangerousness or the conviction or guilty plea of which the person has actual knowledge.

(H) A certificate of qualification for employment issued under this section shall be
revoked if the individual to whom the certificate of qualification for employment was issued is
convicted of or pleads guilty to a felony offense committed subsequent to the issuance of the
certificate of qualification for employment. The department of rehabilitation and correction shall
periodically review the certificates listed in the database described in division (K) of this section
to identify those that are subject to revocation under this division. Upon identifying a certificate
of qualification for employment that is subject to revocation, the department shall note in the
database that the certificate has been revoked, the reason for revocation, and the effective
date of revocation, which shall be the date of the conviction or plea of guilty subsequent to the
issuance of the certificate.

(I) A designee's forwarding, or failure to forward, a petition for a certificate of qualification
for employment to a court or a court's issuance, or failure to issue, a petition for a certificate of
qualification for employment to an individual under division (B) of this section does not give rise
to a claim for damages against the department of rehabilitation and correction or court.

(J) The division of parole and community services shall adopt rules in accordance with
Chapter 119 of the Revised Code for the implementation and administration of this section and
shall prescribe the form for the petition to be used under division (B)(1) or (2) of this section.
The form for the petition shall include places for all of the information specified in division (F) of
this section.
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(K) The department of rehabilitation and correction shall maintain a database that identifies granted certificates and revoked certificates and tracks the number of certificates granted and revoked, the industries, occupations, and professions with respect to which the certificates have been most applicable, and the types of employers that have accepted the certificates. The department shall annually create a report that summarizes the information maintained in the database and shall make the report available to the public on its internet web site.

2961.22 Certificate of achievement and employability.

(A)(1) Any prisoner serving a prison term in a state correctional institution who satisfies all of the following is eligible to apply to the department of rehabilitation and correction at a time specified in division (A)(2) of this section and in accordance with division (D) of this section for a certificate of achievement and employability:

   (a) The prisoner has satisfactorily completed one or more in-prison vocational programs approved by rule by the department of rehabilitation and correction.
   (b) The prisoner has demonstrated exemplary performance as determined by completion of one or more cognitive or behavioral improvement programs approved by rule by the department while incarcerated in a state correctional institution, while under supervision, or during both periods of time.
   (c) The prisoner has completed community service hours.
   (d) The prisoner shows other evidence of achievement and rehabilitation while under the jurisdiction of the department.

(2) An eligible prisoner may apply to the department of rehabilitation and correction under division (A)(1) of this section for a certificate of achievement and employability no earlier than one year prior to the date scheduled for the release of the prisoner from department custody and no later than the date of release of the prisoner.

(B)(1) Any prisoner who has been released from a state correctional institution, who is under supervision on parole or under a post-release control sanction, and who satisfies all of the criteria set forth in division (A)(1) of this section is eligible to apply to the adult parole authority at a time specified in division (B)(2) of this section and in accordance with division (D) of this section for a certificate of achievement and employability.

(2) An eligible prisoner may apply to the adult parole authority under division (B)(1) of this section for a certificate of achievement and employability at any time while the prisoner is under supervision on parole or under a post-release control sanction.

(2) Upon application by a prisoner in accordance with division (C)(1) of this section, the department of rehabilitation and correction or the adult parole authority, whichever is applicable, shall consider the application and all objections to the issuance of a certificate of achievement and employability to the prisoner, if any, that were made by a licensing agency under division
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2961.23 Certificate of achievement and employability; immunity.

(A)(1) If a person who has been issued a certificate of achievement and employability under section 2961.22 of the Revised Code applies to a licensing agency for a license or certificate and the person has a conviction or guilty plea that otherwise would bar licensure or certification for the person because of a mandatory civil impact, the agency shall give the person individualized consideration for the license or certification, notwithstanding the mandatory civil impact, the mandatory civil impact shall be considered for all purposes to be a discretionary civil impact, and the certificate constitutes a rebuttable presumption that the person's criminal convictions are insufficient evidence that the person is unfit for the license or certification in question. Notwithstanding the presumption established under this division, the agency may deny the license or certification for the person if it determines that the person is unfit for issuance of the license.

(2) If an employer that has hired a person who has been issued a certificate of achievement and employability under section 2961.22 of the Revised Code applies to a licensing agency for a license or certification and the person has a conviction or guilty plea that otherwise would bar the person's employment with the employer or licensure for the employer because of a mandatory civil impact, the agency shall give the person individualized consideration, notwithstanding the mandatory civil impact, the mandatory civil impact shall be considered for all purposes to be a discretionary civil impact, and the certificate constitutes a rebuttable presumption that the person's criminal convictions are insufficient evidence that the person is unfit for the employment, or that the employer is unfit for the license or certification, in question. Notwithstanding the presumption established under this division, the agency may deny the license or certification for the employer if it determines that the person is unfit for the employment or that the employer is unfit for the license or certification.

(B) If an employer hires a person who has been issued a certificate of achievement and employability under section 2961.22 of the Revised Code and if the person presents the employer with a copy of the certificate, all of the following apply:
(1) If a subsequent civil action against the employer alleges that the employer was negligent in hiring the person and if the civil action includes as an element of the alleged negligence that the employer had actual or constructive knowledge of the incompetence or dangerousness of the person, the person’s presentation of the certificate to the employer is an absolute defense for the employer to the element of the employer’s actual or constructive knowledge of the incompetence or dangerousness of the person.

(2) If the person, after being hired, subsequently demonstrates dangerousness and if the employer retains the person as an employee after the demonstration of dangerousness, the employer may be held liable in a civil action that is based on or relates to the retention of the person as an employee only if it is proved by a preponderance of the evidence that the person having hiring and firing responsibility for the employer had actual knowledge that the employee was dangerous and was willful in retaining the person as an employee after the demonstration of dangerousness of which the person had actual knowledge.

3701.881 Criminal records check for home health agency employment applicants.

(A) As used in this section:
(1) “Applicant” means a person who is under final consideration for employment with a home health agency in a full-time, part-time, or temporary position that involves providing direct care to an individual or is referred to a home health agency by an employment service for such a position.

(2) “Community-based long-term care provider” means a provider as defined in section 173.39 of the Revised Code.

(3) “Community-based long-term care subcontractor” means a subcontractor as defined in section 173.38 of the Revised Code.

(4) “Criminal records check” has the same meaning as in section 109.572 of the Revised Code.

(5) “Direct care” means any of the following:
(a) Any service identified in divisions (A)(8)(a) to (f) of this section that is provided in a patient's place of residence used as the patient's home;
(b) Any activity that requires the person performing the activity to be routinely alone with a patient or to routinely have access to a patient's personal property or financial documents regarding a patient;
(c) For each home health agency individually, any other routine service or activity that the chief administrator of the home health agency designates as direct care.

(6) “Disqualifying offense” means any of the offenses listed or described in divisions (A)(3)(a) to (e) of section 109.572 of the Revised Code.

(7) “Employee” means a person employed by a home health agency in a full-time, part-time, or temporary position that involves providing direct care to an individual and a person who works in such a position due to being referred to a home health agency by an employment service.

(8) “Home health agency” means a person or government entity, other than a nursing home, residential care facility, hospice care program, or pediatric respite care program, that has the primary function of providing any of the following services to a patient at a place of residence used as the patient's home:
(a) Skilled nursing care;
(b) Physical therapy;
(c) Speech-language pathology;
(d) Occupational therapy;
(e) Medical social services;
(f) Home health aide services.
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(9) “Home health aide services” means any of the following services provided by an employee of a home health agency:
(a) Hands-on bathing or assistance with a tub bath or shower;
(b) Assistance with dressing, ambulation, and toileting;
(c) Catheter care but not insertion;
(d) Meal preparation and feeding.

(10) “Hospice care program” and “pediatric respite care program” have the same meanings as in section 3712.01 of the Revised Code.

(11) “Medical social services” means services provided by a social worker under the direction of a patient’s attending physician.

(12) “Minor drug possession offense” has the same meaning as in section 2925.01 of the Revised Code.

(13) “Nursing home,” “residential care facility,” and “skilled nursing care” have the same meanings as in section 3721.01 of the Revised Code.

(14) “Occupational therapy” has the same meaning as in section 4755.04 of the Revised Code.

(15) “Physical therapy” has the same meaning as in section 4755.40 of the Revised Code.

(16) “Social worker” means a person licensed under Chapter 4757 of the Revised Code to practice as a social worker or independent social worker.

(17) “Speech-language pathology” has the same meaning as in section 4753.01 of the Revised Code.

(18) “Waiver agency” has the same meaning as in section 5164.342 of the Revised Code.

(B) No home health agency shall employ an applicant or continue to employ an employee in a position that involves providing direct care to an individual if any of the following apply:

(1) A review of the databases listed in division (D) of this section reveals any of the following:
(a) That the applicant or employee is included in one or more of the databases listed in divisions (D)(1) to (5) of this section;
(b) That there is in the state nurse aide registry established under section 3721.32 of the Revised Code a statement detailing findings by the director of health that the applicant or employee abused, neglected, or exploited a long-term care facility or residential care facility resident or misappropriated property of such a resident;
(c) That the applicant or employee is included in one or more of the databases, if any, specified in rules adopted under this section and the rules prohibit the home health agency from employing an applicant or continuing to employ an employee included in such a database in a position that involves providing direct care to an individual.

(2) After the applicant or employee is provided, pursuant to division (E)(2)(a) of this section, a copy of the form prescribed pursuant to division (C)(1) of section 109.572 of the Revised Code and the standard impression sheet prescribed pursuant to division (C)(2) of that section, the applicant or employee fails to complete the form or provide the applicant’s or employee’s fingerprint impressions on the standard impression sheet.

(3) Except as provided in rules adopted under this section, the applicant or employee is found by a criminal records check required by this section to have been convicted of, pleaded guilty to, or been found eligible for intervention in lieu of conviction for a disqualifying offense.

(C) Except as provided by division (F) of this section, the chief administrator of a home health agency shall inform each applicant of both of the following at the time of the applicant’s initial application for employment or referral to the home health agency by an employment service for a position that involves providing direct care to an individual:
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(1) That a review of the databases listed in division (D) of this section will be conducted to determine whether the home health agency is prohibited by division (B)(1) of this section from employing the applicant in the position;

(2) That, unless the database review reveals that the applicant may not be employed in the position, a criminal records check of the applicant will be conducted and the applicant is required to provide a set of the applicant's fingerprint impressions as part of the criminal records check.

(D) As a condition of employing any applicant in a position that involves providing direct care to an individual, the chief administrator of a home health agency shall conduct a database review of the applicant in accordance with rules adopted under this section. If rules adopted under this section so require, the chief administrator of a home health agency shall conduct a database review of an employee in accordance with the rules as a condition of continuing to employ the employee in a position that involves providing direct care to an individual. However, the chief administrator is not required to conduct a database review of an applicant or employee if division (F) of this section applies. A database review shall determine whether the applicant or employee is included in any of the following:

(1) The excluded parties list system that is maintained by the United States general services administration pursuant to subpart 9.4 of the federal acquisition regulation and available at the federal web site known as the system for award management;

(2) The list of excluded individuals and entities maintained by the office of inspector general in the United States department of health and human services pursuant to the “Social Security Act,” sections 1128 and 1156, 42 U.S.C. 1320a-7 and 1320c-5;

(3) The registry of developmental disabilities employees established under section 5123.52 of the Revised Code;

(4) The internet-based sex offender and child-victim offender database established under division (A)(11) of section 2950.13 of the Revised Code;

(5) The internet-based database of inmates established under section 5120.66 of the Revised Code;

(6) The state nurse aide registry established under section 3721.32 of the Revised Code;

(7) Any other database, if any, specified in rules adopted under this section.

(E)(1) As a condition of employing any applicant in a position that involves providing direct care to an individual, the chief administrator of a home health agency shall request the superintendent of the bureau of criminal identification and investigation to conduct a criminal records check of the applicant. If rules adopted under this section so require, the chief administrator of a home health agency shall request the superintendent to conduct a criminal records check of an employee at times specified in the rules as a condition of continuing to employ the employee in a position that involves providing direct care to an individual. However, the chief administrator is not required to request the criminal records check of the applicant or the employee if division (F) of this section applies or the home health agency is prohibited by division (B)(1) of this section from employing the applicant or continuing to employ the employee in a position that involves providing direct care to an individual. If an applicant or employee for whom a criminal records check request is required by this section does not present proof of having been a resident of this state for the five-year period immediately prior to the date upon which the criminal records check is requested or does not provide evidence that within that five-year period the superintendent has requested information about the applicant from the federal bureau of investigation in a criminal records check, the chief administrator shall request that the superintendent obtain information from the federal bureau of investigation as a part of the criminal records check. Even if an applicant or employee for whom a criminal records check request is required by this section presents proof that the applicant or employee has been a resident of this state for that five-year period, the chief administrator may request that the
superintendent include information from the federal bureau of investigation in the criminal records check.

(2) The chief administrator shall do all of the following:
   (a) Provide to each applicant and employee for whom a criminal records check request is required by this section a copy of the form prescribed pursuant to division (C)(1) of section 109.572 of the Revised Code and a standard impression sheet prescribed pursuant to division (C)(2) of that section;
   (b) Obtain the completed form and standard impression sheet from each applicant and employee;
   (c) Forward the completed form and standard impression sheet to the superintendent at the time the chief administrator requests the criminal records check.

(3) A home health agency shall pay to the bureau of criminal identification and investigation the fee prescribed pursuant to division (C)(3) of section 109.572 of the Revised Code for each criminal records check the agency requests under this section. A home health agency may charge an applicant a fee not exceeding the amount the agency pays to the bureau under this section if both of the following apply:
   (a) The home health agency notifies the applicant at the time of initial application for employment of the amount of the fee and that, unless the fee is paid, the applicant will not be considered for employment.
   (b) The medicaid program does not reimburse the home health agency for the fee it pays to the bureau under this section.

(F) Divisions (C) to (E) of this section do not apply with regard to an applicant or employee if the applicant or employee is referred to a home health agency by an employment service that supplies full-time, part-time, or temporary staff for positions that involve providing direct care to an individual and both of the following apply:
   (1) The chief administrator of the home health agency receives from the employment service confirmation that a review of the databases listed in division (D) of this section was conducted with regard to the applicant or employee.
   (2) The chief administrator of the home health agency receives from the employment service, applicant, or employee a report of the results of a criminal records check of the applicant or employee that has been conducted by the superintendent within the one-year period immediately preceding the following:
      (a) In the case of an applicant, the date of the applicant's referral by the employment service to the home health agency;
      (b) In the case of an employee, the date by which the home health agency would otherwise have to request a criminal records check of the employee under division (E) of this section.

(G)(1) A home health agency may employ conditionally an applicant for whom a criminal records check request is required by this section before obtaining the results of the criminal records check if the agency is not prohibited by division (B) of this section from employing the applicant in a position that involves providing direct care to an individual and either of the following applies:
   (a) The chief administrator of the home health agency requests the criminal records check in accordance with division (E) of this section not later than five business days after the applicant begins conditional employment.
   (b) The applicant is referred to the home health agency by an employment service, the employment service or the applicant provides the chief administrator of the agency a letter that is on the letterhead of the employment service, the letter is dated and signed by a supervisor or another designated official of the employment service, and the letter states all of the following:
      (i) That the employment service has requested the superintendent to conduct a criminal records check regarding the applicant;
(ii) That the requested criminal records check is to include a determination of whether the applicant has been convicted of, pleaded guilty to, or been found eligible for intervention in lieu of conviction for a disqualifying offense;

(iii) That the employment service has not received the results of the criminal records check as of the date set forth on the letter;

(iv) That the employment service promptly will send a copy of the results of the criminal records check to the chief administrator of the home health agency when the employment service receives the results.

(2) If a home health agency employs an applicant conditionally pursuant to division (G)(1)(b) of this section, the employment service, on its receipt of the results of the criminal records check, promptly shall send a copy of the results to the chief administrator of the agency.

(3) A home health agency that employs an applicant conditionally pursuant to division (G)(1)(a) or (b) of this section shall terminate the applicant's employment if the results of the criminal records check, other than the results of any request for information from the federal bureau of investigation, are not obtained within the period ending sixty days after the date the request for the criminal records check is made. Regardless of when the results of the criminal records check are obtained, if the results indicate that the applicant has been convicted of, pleaded guilty to, or been found eligible for intervention in lieu of conviction for a disqualifying offense, the home health agency shall terminate the applicant's employment unless circumstances specified in rules adopted under this section that permit the agency to employ the applicant exist and the agency chooses to employ the applicant. Termination of employment under this division shall be considered just cause for discharge for purposes of division (D)(2) of section 4141.29 of the Revised Code if the applicant makes any attempt to deceive the home health agency about the applicant's criminal record.

(H) The report of any criminal records check conducted by the bureau of criminal identification and investigation in accordance with section 109.572 of the Revised Code and pursuant to a request made under this section is not a public record for the purposes of section 149.43 of the Revised Code and shall not be made available to any person other than the following:

(1) The applicant or employee who is the subject of the criminal records check or the applicant's or employee's representative;

(2) The home health agency requesting the criminal records check or its representative;

(3) The administrator of any other facility, agency, or program that provides direct care to individuals that is owned or operated by the same entity that owns or operates the home health agency that requested the criminal records check;

(4) The employment service that requested the criminal records check;

(5) The director of health and the staff of the department of health who monitor a home health agency's compliance with this section;

(6) The director of aging or the director's designee if either of the following apply:

(a) In the case of a criminal records check requested by a home health agency, the home health agency also is a community-based long-term care provider or community-based long-term care subcontractor;

(b) In the case of a criminal records check requested by an employment service, the employment service makes the request for an applicant or employee the employment service refers to a home health agency that also is a community-based long-term care provider or community-based long-term care subcontractor.

(7) The medicaid director and the staff of the department of medicaid who are involved in the administration of the medicaid program if either of the following apply:

(a) In the case of a criminal records check requested by a home health agency, the home health agency also is a waiver agency;

(b) In the case of a criminal records check requested by an employment service, the
employment service makes the request for an applicant or employee the employment service refers to a home health agency that also is a waiver agency.

(8) Any court, hearing officer, or other necessary individual involved in a case dealing with any of the following:
   (a) A denial of employment of the applicant or employee;
   (b) Employment or unemployment benefits of the applicant or employee;
   (c) A civil or criminal action regarding the medicaid program.

   (I) In a tort or other civil action for damages that is brought as the result of an injury, death, or loss to person or property caused by an applicant or employee who a home health agency employs in a position that involves providing direct care to an individual, all of the following shall apply:
      (1) If the home health agency employed the applicant or employee in good faith and reasonable reliance on the report of a criminal records check requested under this section, the agency shall not be found negligent solely because of its reliance on the report, even if the information in the report is determined later to have been incomplete or inaccurate.
      (2) If the home health agency employed the applicant in good faith on a conditional basis pursuant to division (G) of this section, the agency shall not be found negligent solely because it employed the applicant prior to receiving the report of a criminal records check requested under this section.
      (3) If the home health agency in good faith employed the applicant or employee according to the personal character standards established in rules adopted under this section, the agency shall not be found negligent solely because the applicant or employee had been convicted of, pleaded guilty to, or been found eligible for intervention in lieu of conviction for a disqualifying offense.

   (J) The director of health shall adopt rules in accordance with Chapter 119 of the Revised Code to implement this section.
      (1) The rules may do the following:
         (a) Require employees to undergo database reviews and criminal records checks under this section;
         (b) If the rules require employees to undergo database reviews and criminal records checks under this section, exempt one or more classes of employees from the requirements;
         (c) For the purpose of division (D)(7) of this section, specify other databases that are to be checked as part of a database review conducted under this section.
      (2) The rules shall specify all of the following:
         (a) The procedures for conducting database reviews under this section;
         (b) If the rules require employees to undergo database reviews and criminal records checks under this section, the times at which the database reviews and criminal records checks are to be conducted;
         (c) If the rules specify other databases to be checked as part of the database reviews, the circumstances under which a home health agency is prohibited from employing an applicant or continuing to employ an employee who is found by a database review to be included in one or more of those databases;
         (d) Circumstances under which a home health agency may employ an applicant or employee who is found by a criminal records check required by this section to have been convicted of, pleaded guilty to, or been found eligible for intervention in lieu of conviction for a disqualifying offense but meets personal character standards.

3712.09 Criminal records check regarding hospice care.

   (A) As used in this section:
      (1) “Applicant” means a person who is under final consideration for employment with a
hospice care program or pediatric respite care program in a full-time, part-time, or temporary position that involves providing direct care to an older adult or pediatric respite care patient. “Applicant” does not include a person who provides direct care as a volunteer without receiving or expecting to receive any form of remuneration other than reimbursement for actual expenses.

(2) “Criminal records check” has the same meaning as in section 109.572 of the Revised Code.

(3) “Older adult” means a person age sixty or older.

(B)(1) Except as provided in division (I) of this section, the chief administrator of a hospice care program or pediatric respite care program shall request that the superintendent of the bureau of criminal identification and investigation conduct a criminal records check of each applicant. If an applicant for whom a criminal records check request is required under this division does not present proof of having been a resident of this state for the five-year period immediately prior to the date the criminal records check is requested or provide evidence that within that five-year period the superintendent has requested information about the applicant from the federal bureau of investigation in a criminal records check, the chief administrator shall request that the superintendent obtain information from the federal bureau of investigation as part of the criminal records check of the applicant. Even if an applicant for whom a criminal records check request is required under this division presents proof of having been a resident of this state for the five-year period, the chief administrator may request that the superintendent include information from the federal bureau of investigation in the criminal records check.

(2) A person required by division (B)(1) of this section to request a criminal records check shall do both of the following:

(a) Provide to each applicant for whom a criminal records check request is required under that division a copy of the form prescribed pursuant to division (C)(1) of section 109.572 of the Revised Code and a standard fingerprint impression sheet prescribed pursuant to division (C)(2) of that section, and obtain the completed form and impression sheet from the applicant;

(b) Forward the completed form and impression sheet to the superintendent of the bureau of criminal identification and investigation.

(3) An applicant provided the form and fingerprint impression sheet under division (B)(2)(a) of this section who fails to complete the form or provide fingerprint impressions shall not be employed in any position for which a criminal records check is required by this section.

(C)(1) Except as provided in rules adopted by the director of health in accordance with division (F) of this section and subject to division (C)(2) of this section, no hospice care program or pediatric respite care program shall employ a person in a position that involves providing direct care to an older adult or pediatric respite care patient if the person has been convicted of or pleaded guilty to any of the following:

(a) A violation of section 2903.01, 2903.02, 2903.03, 2903.04, 2903.11, 2903.12, 2903.13, 2903.16, 2903.21, 2903.34, 2905.01, 2905.02, 2905.11, 2905.12, 2907.02, 2907.03, 2907.05, 2907.06, 2907.07, 2907.08, 2907.09, 2907.12, 2907.25, 2907.31, 2907.32, 2907.321, 2907.322, 2907.323, 2911.01, 2911.02, 2911.11, 2911.12, 2911.13, 2913.02, 2913.03, 2913.04, 2913.11, 2913.21, 2913.31, 2913.40, 2913.43, 2913.47, 2913.51, 2919.25, 2921.36, 2923.12, 2923.13, 2923.161, 2925.02, 2925.03, 2925.11, 2925.13, 2925.22, 2925.23, or 3716.11 of the Revised Code.

(b) A violation of an existing or former law of this state, any other state, or the United States that is substantially equivalent to any of the offenses listed in division (C)(1)(a) of this section.

(2)(a) A hospice care program or pediatric respite care program may employ conditionally an applicant for whom a criminal records check request is required under division (B) of this section prior to obtaining the results of a criminal records check regarding the individual, provided that the program shall request a criminal records check regarding the individual in accordance with division (B)(1) of this section not later than five business days after
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the individual begins conditional employment. In the circumstances described in division (I)(2) of this section, a hospice care program or pediatric respite care program may employ conditionally an applicant who has been referred to the hospice care program or pediatric respite care program by an employment service that supplies full-time, part-time, or temporary staff for positions involving the direct care of older adults or pediatric respite care patients and for whom, pursuant to that division, a criminal records check is not required under division (B) of this section.

(b) A hospice care program or pediatric respite care program that employs an individual conditionally under authority of division (C)(2)(a) of this section shall terminate the individual's employment if the results of the criminal records check requested under division (B) of this section or described in division (I)(2) of this section, other than the results of any request for information from the federal bureau of investigation, are not obtained within the period ending thirty days after the date the request is made. Regardless of when the results of the criminal records check are obtained, if the results indicate that the individual has been convicted of or pleaded guilty to any of the offenses listed or described in division (C)(1) of this section, the program shall terminate the individual's employment unless the program chooses to employ the individual pursuant to division (F) of this section. Termination of employment under this division shall be considered just cause for discharge for purposes of division (D)(2) of section 4141.29 of the Revised Code if the individual makes any attempt to deceive the program about the individual's criminal record.

(D)(1) Each hospice care program or pediatric respite care program shall pay to the bureau of criminal identification and investigation the fee prescribed pursuant to division (C)(3) of section 109.572 of the Revised Code for each criminal records check conducted pursuant to a request made under division (B) of this section.

(2) A hospice care program or pediatric respite care program may charge an applicant a fee not exceeding the amount the program pays under division (D)(1) of this section. A program may collect a fee only if both of the following apply:

(a) The program notifies the person at the time of initial application for employment of the amount of the fee and that, unless the fee is paid, the person will not be considered for employment;

(b) The medicaid program does not reimburse the program the fee it pays under division (D)(1) of this section.

(E) The report of a criminal records check conducted pursuant to a request made under this section is not a public record for the purposes of section 149.43 of the Revised Code and shall not be made available to any person other than the following:

(1) The individual who is the subject of the criminal records check or the individual's representative;

(2) The chief administrator of the program requesting the criminal records check or the administrator's representative;

(3) The administrator of any other facility, agency, or program that provides direct care to older adults or pediatric respite care patients that is owned or operated by the same entity that owns or operates the hospice care program or pediatric respite care program;

(4) A court, hearing officer, or other necessary individual involved in a case dealing with a denial of employment of the applicant or dealing with employment or unemployment benefits of the applicant;

(5) Any person to whom the report is provided pursuant to, and in accordance with, division (I)(1) or (2) of this section.

(F) The director of health shall adopt rules in accordance with Chapter 119 of the Revised Code to implement this section. The rules shall specify circumstances under which a hospice care program or pediatric respite care program may employ a person who has been convicted of or pleaded guilty to an offense listed or described in division (C)(1) of this section.
but meets personal character standards set by the director.

(G) The chief administrator of a hospice care program or pediatric respite care program shall inform each individual, at the time of initial application for a position that involves providing direct care to an older adult or pediatric respite care patient, that the individual is required to provide a set of fingerprint impressions and that a criminal records check is required to be conducted if the individual comes under final consideration for employment.

(H) In a tort or other civil action for damages that is brought as the result of an injury, death, or loss to person or property caused by an individual who a hospice care program or pediatric respite care program employs in a position that involves providing direct care to older adults or pediatric respite care patients, all of the following shall apply:

(1) If the program employed the individual in good faith and reasonable reliance on the report of a criminal records check requested under this section, the program shall not be found negligent solely because of its reliance on the report, even if the information in the report is determined later to have been incomplete or inaccurate;

(2) If the program employed the individual in good faith on a conditional basis pursuant to division (C)(2) of this section, the program shall not be found negligent solely because it employed the individual prior to receiving the report of a criminal records check requested under this section;

(3) If the program in good faith employed the individual according to the personal character standards established in rules adopted under division (F) of this section, the program shall not be found negligent solely because the individual prior to being employed had been convicted of or pleaded guilty to an offense listed or described in division (C)(1) of this section.

(I)(1) The chief administrator of a hospice care program or pediatric respite care program is not required to request that the superintendent of the bureau of criminal identification and investigation conduct a criminal records check of an applicant if the applicant has been referred to the program by an employment service that supplies full-time, part-time, or temporary staff for positions involving the direct care of older adults or pediatric respite care patients and both of the following apply:

(a) The chief administrator receives from the employment service or the applicant a report of the results of a criminal records check regarding the applicant that has been conducted by the superintendent within the one-year period immediately preceding the applicant's referral;

(b) The report of the criminal records check demonstrates that the person has not been convicted of or pleaded guilty to an offense listed or described in division (C)(1) of this section, or the report demonstrates that the person has been convicted of or pleaded guilty to one or more of those offenses, but the hospice care program or pediatric respite care program chooses to employ the individual pursuant to division (F) of this section.

(2) The chief administrator of a hospice care program or pediatric respite care program is not required to request that the superintendent of the bureau of criminal identification and investigation conduct a criminal records check of an applicant and may employ the applicant conditionally as described in this division, if the applicant has been referred to the program by an employment service that supplies full-time, part-time, or temporary staff for positions involving the direct care of older adults or pediatric respite care patients and if the chief administrator receives from the employment service or the applicant a letter from the employment service that is on the letterhead of the employment service, dated, and signed by a supervisor or another designated official of the employment service and that states that the employment service has requested the superintendent to conduct a criminal records check regarding the applicant, that the requested criminal records check will include a determination of whether the applicant has been convicted of or pleaded guilty to any offense listed or described in division (C)(1) of this section, that, as of the date set forth on the letter, the employment service had not received the results of the criminal records check, and that, when the employment service receives the results of the criminal records check, it promptly will send a
copy of the results to the hospice care program or pediatric respite care program. If a hospice care program or pediatric respite care program employs an applicant conditionally in accordance with this division, the employment service, upon its receipt of the results of the criminal records check, promptly shall send a copy of the results to the hospice care program or pediatric respite care program, and division (C)(2)(b) of this section applies regarding the conditional employment.

3721.121 Criminal records check regarding nursing home or adult day care.

(A) As used in this section:
(1) “Adult day-care program” means a program operated pursuant to rules adopted by the director of health under section 3721.04 of the Revised Code and provided by and on the same site as homes licensed under this chapter.
(2) “Applicant” means a person who is under final consideration for employment with a home or adult day-care program in a full-time, part-time, or temporary position that involves providing direct care to an older adult. “Applicant” does not include a person who provides direct care as a volunteer without receiving or expecting to receive any form of remuneration other than reimbursement for actual expenses.
(3) “Community-based long-term care services provider” means a provider as defined in section 173.39 of the Revised Code.
(4) “Criminal records check” has the same meaning as in section 109.572 of the Revised Code.
(5) “Home” means a home as defined in section 3721.10 of the Revised Code.
(6) “Older adult” means a person age sixty or older.
(B)(1) Except as provided in division (I) of this section, the chief administrator of a home or adult day-care program shall request that the superintendent of the bureau of criminal identification and investigation conduct a criminal records check of each applicant. If an applicant for whom a criminal records check request is required under this division does not present proof of having been a resident of this state for the five-year period immediately prior to the date the criminal records check is requested or provide evidence that within that five-year period the superintendent has requested information about the applicant from the federal bureau of investigation in a criminal records check, the chief administrator shall request that the superintendent obtain information from the federal bureau of investigation as part of the criminal records check of the applicant. Even if an applicant for whom a criminal records check request is required under this division presents proof of having been a resident of this state for the five-year period, the chief administrator may request that the superintendent include information from the federal bureau of investigation in the criminal records check.
(2) A person required by division (B)(1) of this section to request a criminal records check shall do both of the following:
(a) Provide to each applicant for whom a criminal records check request is required under that division a copy of the form prescribed pursuant to division (C)(1) of section 109.572 of the Revised Code and a standard fingerprint impression sheet prescribed pursuant to division (C)(2) of that section, and obtain the completed form and impression sheet from the applicant;
(b) Forward the completed form and impression sheet to the superintendent of the bureau of criminal identification and investigation.
(C) An applicant provided the form and fingerprint impression sheet under division (B)(2)(a) of this section who fails to complete the form or provide fingerprint impressions shall not be employed in any position for which a criminal records check is required by this section.
(C)(1) Except as provided in rules adopted by the director of health in accordance with division (F) of this section and subject to division (C)(2) of this section, no home or adult day-care program shall employ a person in a position that involves providing direct care to an older
adult if the person has been convicted of or pleaded guilty to any of the following:

(a) A violation of section 2903.01, 2903.02, 2903.03, 2903.04, 2903.11, 2903.12, 2903.13, 2903.16, 2903.21, 2903.34, 2905.01, 2905.02, 2905.11, 2905.12, 2907.02, 2907.03, 2907.05, 2907.06, 2907.07, 2907.08, 2907.09, 2907.12, 2907.25, 2907.31, 2907.32, 2907.321, 2907.322, 2907.323, 2911.01, 2911.02, 2911.11, 2911.12, 2911.13, 2913.02, 2913.03, 2913.04, 2913.11, 2913.21, 2913.31, 2913.40, 2913.43, 2913.47, 2913.51, 2919.25, 2921.36, 2923.12, 2923.13, 2923.161, 2925.02, 2925.03, 2925.11, 2925.13, 2925.22, 2925.23, or 3716.11 of the Revised Code.

(b) A violation of an existing or former law of this state, any other state, or the United States that is substantially equivalent to any of the offenses listed in division (C)(1)(a) of this section.

(2)(a) A home or an adult day-care program may employ conditionally an applicant for whom a criminal records check request is required under division (B) of this section prior to obtaining the results of a criminal records check regarding the individual, provided that the home or program shall request a criminal records check regarding the individual in accordance with division (B)(1) of this section not later than five business days after the individual begins conditional employment. In the circumstances described in division (I)(2) of this section, a home or adult day-care program may employ conditionally an applicant who has been referred to the home or adult day-care program by an employment service that supplies full-time, part-time, or temporary staff for positions involving the direct care of older adults and for whom, pursuant to that division, a criminal records check is not required under division (B) of this section.

(b) A home or adult day-care program that employs an individual conditionally under authority of division (C)(2)(a) of this section shall terminate the individual’s employment if the results of the criminal records check requested under division (B) of this section or described in division (I)(2) of this section, other than the results of any request for information from the federal bureau of investigation, are not obtained within the period ending thirty days after the date the request is made. Regardless of when the results of the criminal records check are obtained, if the results indicate that the individual has been convicted of or pleaded guilty to any of the offenses listed or described in division (C)(1) of this section, the home or program shall terminate the individual’s employment unless the home or program chooses to employ the individual pursuant to division (F) of this section. Termination of employment under this division shall be considered just cause for discharge for purposes of division (D)(2) of section 4141.29 of the Revised Code if the individual makes any attempt to deceive the home or program about the individual’s criminal record.

(D)(1) Each home or adult day-care program shall pay to the bureau of criminal identification and investigation the fee prescribed pursuant to division (C)(3) of section 109.572 of the Revised Code for each criminal records check conducted pursuant to a request made under division (B) of this section.

(2) A home or adult day-care program may charge an applicant a fee not exceeding the amount the home or program pays under division (D)(1) of this section. A home or program may collect a fee only if both of the following apply:

(a) The home or program notifies the person at the time of initial application for employment of the amount of the fee and that, unless the fee is paid, the person will not be considered for employment;

(b) The medicaid program does not reimburse the home or program the fee it pays under division (D)(1) of this section.

(E) The report of any criminal records check conducted pursuant to a request made under this section is not a public record for the purposes of section 149.43 of the Revised Code and shall not be made available to any person other than the following:

(1) The individual who is the subject of the criminal records check or the individual’s representative;
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(2) The chief administrator of the home or program requesting the criminal records check or the administrator's representative;

(3) The administrator of any other facility, agency, or program that provides direct care to older adults that is owned or operated by the same entity that owns or operates the home or program;

(4) A court, hearing officer, or other necessary individual involved in a case dealing with a denial of employment of the applicant or dealing with employment or unemployment benefits of the applicant;

(5) Any person to whom the report is provided pursuant to, and in accordance with, division (I)(1) or (2) of this section;

(6) The board of nursing for purposes of accepting and processing an application for a medication aide certificate issued under Chapter 4723 of the Revised Code;

(7) The director of aging or the director's designee if the criminal records check is requested by the chief administrator of a home that is also a community-based long-term care services provider.

(F) In accordance with section 3721.11 of the Revised Code, the director of health shall adopt rules to implement this section. The rules shall specify circumstances under which a home or adult day-care program may employ a person who has been convicted of or pleaded guilty to an offense listed or described in division (C)(1) of this section but meets personal character standards set by the director.

(G) The chief administrator of a home or adult day-care program shall inform each individual, at the time of initial application for a position that involves providing direct care to an older adult, that the individual is required to provide a set of fingerprint impressions and that a criminal records check is required to be conducted if the individual comes under final consideration for employment.

(H) In a tort or other civil action for damages that is brought as the result of an injury, death, or loss to person or property caused by an individual who a home or adult day-care program employs in a position that involves providing direct care to older adults, all of the following shall apply:

(1) If the home or program employed the individual in good faith and reasonable reliance on the report of a criminal records check requested under this section, the home or program shall not be found negligent solely because of its reliance on the report, even if the information in the report is determined later to have been incomplete or inaccurate;

(2) If the home or program employed the individual in good faith on a conditional basis pursuant to division (C)(2) of this section, the home or program shall not be found negligent solely because it employed the individual prior to receiving the report of a criminal records check requested under this section;

(3) If the home or program in good faith employed the individual according to the personal character standards established in rules adopted under division (F) of this section, the home or program shall not be found negligent solely because the individual prior to being employed had been convicted of or pleaded guilty to an offense listed or described in division (C)(1) of this section.

(I)(1) The chief administrator of a home or adult day-care program is not required to request that the superintendent of the bureau of criminal identification and investigation conduct a criminal records check of an applicant if the applicant has been referred to the home or program by an employment service that supplies full-time, part-time, or temporary staff for positions involving the direct care of older adults and both of the following apply:

(a) The chief administrator receives from the employment service or the applicant a report of the results of a criminal records check regarding the applicant that has been conducted by the superintendent within the one-year period immediately preceding the applicant's referral;

(b) The report of the criminal records check demonstrates that the person has not been
convicted of or pleaded guilty to an offense listed or described in division (C)(1) of this section, or the report demonstrates that the person has been convicted of or pleaded guilty to one or more of those offenses, but the home or adult day-care program chooses to employ the individual pursuant to division (F) of this section.

(2) The chief administrator of a home or adult day-care program is not required to request that the superintendent of the bureau of criminal identification and investigation conduct a criminal records check of an applicant and may employ the applicant conditionally as described in this division, if the applicant has been referred to the home or program by an employment service that supplies full-time, part-time, or temporary staff for positions involving the direct care of older adults and if the chief administrator receives from the employment service or the applicant a letter from the employment service that is on the letterhead of the employment service, dated, and signed by a supervisor or another designated official of the employment service and that states that the employment service has requested the superintendent to conduct a criminal records check regarding the applicant, that the requested criminal records check will include a determination of whether the applicant has been convicted of or pleaded guilty to any offense listed or described in division (C)(1) of this section, that, as of the date set forth on the letter, the employment service had not received the results of the criminal records check, and that, when the employment service receives the results of the criminal records check, it promptly will send a copy of the results to the home or adult day-care program. If a home or adult day-care program employs an applicant conditionally in accordance with this division, the employment service, upon its receipt of the results of the criminal records check, promptly shall send a copy of the results to the home or adult day-care program, and division (C)(2)(b) of this section applies regarding the conditional employment.

4729-9-26 Criminal records check for pain management clinics.

Pursuant to division (B) of section 4729.552 of the Revised Code, a new terminal distributor of dangerous drug license with a pain management clinic classification will not be issued until the physician owner(s), or, if incorporated, the physician officers of the pain management clinic submit fingerprints to the Ohio bureau of criminal identification and investigation (BCI&I) for a criminal records check. Additionally, a criminal records check is required every time there is a change in ownership for each new owner(s) or officer(s). All criminal records checks conducted in accordance with this rule shall consist of both a BCI&I criminal records check and a federal bureau of investigations (FBI) records check. The results of the criminal records check must be sent directly to the Ohio state board of pharmacy from BCI&I. To be considered valid, the criminal records check must have been performed within the past twelve months. After the board receives the results of all of the required criminal records checks the license process will proceed. The physician owner(s) or physician officers must submit electronic fingerprint impressions as described in rule 4729-5-12 of the Administrative Code.

Physician owner(s) or physician officers are required to have all employees submit to a BCI&I and FBI criminal records check to ensure that no person has been previously convicted of, or pleaded guilty to a theft offense that would constitute a felony as described in division (K)(3) of section 2913.01 of the Revised Code or a felony drug abuse offense as defined in section 2925.01 of the Revised Code. BCI&I shall send the results of the BCI&I criminal records check directly to the employer or potential employer. BCI&I shall provide a letter regarding the FBI criminal records check to the employer or potential employer stating that there is either no record of any conviction or a letter stating that the request may not meet the criteria. When an employer or potential employer receives a letter stating that the request may not meet the criteria, they may share this information with the employee or potential employee. In order to complete the criminal records check, the employee or potential employee must then complete a
“Request for Release-FBI Rapsheet” and send it to BCI&I to request a copy of the FBI criminal record results be sent directly to the employee or potential employee. The employee or potential employee must provide the results to the employer or potential employer. The employee or potential employee must provide the results to the employer or potential employer in the original sealed envelope received from BCI&I. The criminal records check shall be based on electronic fingerprint impressions that are submitted directly to BCI&I from a “WebCheck” provider agency located in Ohio. The employer may accept the results of a criminal records check based on ink impressions from a “WebCheck” provider agency only in the event that readable electronic fingerprint impressions cannot be obtained.

Nursing Homes, Hospice and Adult Care

3701-13-01 Offenses, older adults; definitions.

As used in this chapter:

(A) "Applicant" means a person who is under final consideration for employment with a direct care provider (DCP) in a full-time, part-time, or temporary position that involves providing direct care to an older adult. "Applicant" does not include a person who provides direct care as a volunteer without receiving or expecting to receive any form of remuneration other than reimbursement for actual expenses.

(B) "BCII" means the bureau of criminal identification and investigation.

(C) "Chief administrator" means the individual in charge of the daily operation of the DCP or any employee of the DCP whom the chief administrator has designated as his representative pursuant to paragraph (B) of rule 3701-13-03 of the Administrative Code.

(D) "Criminal records check" means any criminal records check conducted by the superintendent of BCII in accordance with division (B) of section 109.572 of the Revised Code.

(E) "Department" means the department of health.

(F) "Direct care" means the provision of a service to an older adult or group of older adults that involves one or more of the following:

(1) Coordination of, direct supervision of, or provision of personal care, nursing, or health related services;

(2) Routine contact, such as face-to-face, hands-on physical assistance, verbal cuing, reminding, standing by or monitoring of activities;

(3) Activity that requires the person to be routinely alone with older adults or to routinely have access to older adults' personal property or financial documents;

(4) Any routine service or activity designated as direct care by the chief administrator; and

(5) In the case of a hospice care program, any service provided in an older adult's place of residence.

(G) "Direct care provider" or "DCP" means:

(1) An "adult day-care program" operated by and on the same site as a nursing home, residential care facility, home for the aging, or the Ohio veterans' home;

(2) A county home or district home operated under Chapter 5155 of the Revised Code;

(3) A "hospice care program" defined under section 3712.01 of the Revised Code;

(4) A hospital unit certified as a nursing facility or skilled nursing facility under Title XVIII or XIX of the "Social Security Act," 49 STAT. 620 (1935), 42 U.S.C.A. 301 as amended (1981); and

(5) A nursing home, residential care facility, or home for the aging as defined in section 3721.01 of the Revised Code and the Ohio veterans' homes.

(H) "Director" means the director of health or any division, bureau, agency, official or employee of the department to which the director has delegated his authority or duties.
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(I) "FBI" means the federal bureau of investigation.

(J) "Offense of violence" means any of the following:
1. A violation of section 2903.01 (aggravated murder), 2903.02 (murder), 2903.03 (voluntary manslaughter), 2903.04 (involuntary manslaughter), 2903.11 (felonious assault), 2903.12 (aggravated assault), 2903.13 (assault), 2903.21 (aggravated menacing), 2905.01 (kidnapping), 2905.02 (abduction), 2905.11 (extortion), 2905.02 (rape), 2907.03 (sexual battery), 2907.05 (gross sexual imposition), 2911.01 (aggravated robbery), 2911.02 (robbery), 2911.11 (aggravated burglary), 2911.12 (burglary), 2919.25 (domestic violence), 2923.161 (improperly discharging firearm at or into habitation or school) or former section 2907.12 (felonious sexual penetration) of the Revised Code;
2. A violation of an existing or former law of this or any other state or the United States, substantially equivalent to any section or division or offense listed in paragraph (J)(1) of this rule;
3. An offense, listed or described in rule 3701-13-05 of the Administrative Code or an offense under an existing or former law of this or any other state or the United States that is substantially equivalent to any of those offenses, committed purposefully or knowingly, and involving physical harm to persons or a risk of serious physical harm to persons.

(K) "Older adult" means a person age sixty or older.

(L) "PASSPORT agency" means a public or private entity that provides home and community-based services to older adults through the PASSPORT program created under section 173.52 of the Revised Code.

(M) "Repeat theft related offender" means a person who has been convicted of or pleaded guilty to the commission of any of the theft related offenses, listed or described in paragraph (R) of this rule, in two or more separate criminal actions. Convictions or guilty pleas resulting from or connected with the same act, or resulting from offenses committed at the same time, shall be counted as one conviction or guilty plea.

(N) "Repeat violent offender" means a person who has been convicted of or pleaded guilty to the commission of any of the offenses of violence, listed or described in paragraph (J) of this rule, in two or more separate criminal actions. Convictions or guilty pleas resulting from or connected with the same act, or resulting from offenses committed at the same time, shall be counted as one conviction or guilty plea.

(O) "Sexually oriented offense" means any of the following offenses:
1. Regardless of the age of the victim of the offense, a violation of section 2907.02 (rape), 2907.03 (sexual battery), or 2907.05 (gross sexual imposition) of the Revised Code, or former 2907.12 (felonious sexual penetration) of the Revised Code;
2. Any of the following offenses involving a minor in the circumstances specified:
   a. A violation of section 2905.01 (kidnapping) or 2905.02 (abduction) of the Revised Code when the victim is under eighteen years of age;
   b. A violation of division (A)(1) or (A)(3) of section 2907.321 (pandering obscenity involving a minor) or 2907.322 (pandering sexually oriented matter involving a minor) of the Revised Code;
   c. A violation of division (A)(1) or (A)(2) of section 2907.323 (illegal use of a minor in nudity-oriented material or performance) of the Revised Code;
3. Regardless of the age of the victim of the offense, a violation of section 2903.01 (aggravated murder), 2903.02 (murder), 2903.11 (felonious assault), or 2905.01 (kidnapping) of the Revised Code, or of division (A) of section 2903.04 (involuntary manslaughter) of the Revised Code with a purpose to gratify the sexual needs or desires of the offender;
4. A sexually violent offense as defined in paragraph (P) of this rule;
5. A violation of any former law of this state that was substantially equivalent to any offense listed in paragraphs (O)(1) to (O)(4) of this rule;
6. A violation of an existing or former law of another state or the United States, or a
violation under the law applicable in a military court, that is or was substantially equivalent to any offense listed in paragraphs (O)(1) to (O)(5) of this rule;

(P) "Sexually violent offense" means a violent sex offense, or a designated homicide, assault, or kidnapping offense for which the offender also was convicted of or pleaded guilty to a sexual motivation specification.

(1) "Designated homicide, assault, or kidnapping offense" means a violation of section 2903.01 (aggravated murder), 2903.02 (murder), 2903.11 (felonious assault), or 2905.01 (kidnapping) of the Revised Code or a violation of division (A) of section 2903.04 (involuntary manslaughter) of the Revised Code;

(2) "Sexual motivation" means a purpose to gratify the sexual needs or desires of the offender.

(3) "Sexual motivation specification" means a specification, as described in section 2941.147 of the Revised Code, that charges that a person charged with a designated homicide assault or kidnapping offense committed the offense with a sexual motivation.

(4) "Violent sex offense" means any of the following:

(a) A violation of section 2907.02 (rape), 2907.03 (sexual battery), or division (A)(4) of section 2907.05 (gross sexual imposition when victim is under thirteen years of age) of the Revised Code or felonious sexual penetration in violation of former section 2907.12 of the Revised Code;

(b) A felony violation of a former law of this state that is substantially equivalent to a violation listed in paragraph (P)(4)(a) of this rule.

(Q) "Superintendent" means superintendent of BCII.

(R) "Theft related offense" means a violation of any of the following sections of the Revised Code: 2911.01 (aggravated robbery), 2911.02 (robbery), 2911.11 (aggravated burglary), 2911.12 (burglary), 2911.13 (breaking and entering), 2913.02 (theft, aggravated theft), 2913.03 (unauthorized use of a vehicle), 2913.04 (unauthorized use of property - computer, cable, or telecommunication property), 2913.11 (passing bad checks), 2913.21 (misuse of credit cards), 2913.31 (forging identification cards or selling or distributing forged identification cards), 2913.40 (medicaid fraud), 2913.43 (securing writings by deception), 2913.47 (insurance fraud), or 2913.51 (receiving stolen property).

3701-13-02 Persons subject to checks.

(A) Chapter 3701-13 of the Administrative Code applies only to persons who apply for employment in a position involving the provision of direct care to an older adult on or after January 27, 1997, including:

(1) A person who is paid directly by the DCP;

(2) A person who contracts as an independent contractor with the DCP to provide direct care on behalf of the DCP;

(3) A person who provides direct care on behalf of the DCP pursuant to a contract between the DCP and another business entity; and

(4) A person referred to the DCP by an employment service, temporary employment service or staffing pool.

(B) A DCP shall request a criminal records check on any person employed by the DCP in a position other than direct care prior to January 27, 1997, who then applies and is under final consideration for a position within the DCP that requires the provision of direct care to an older adult.

(C) The DCP is not required to request a criminal records check for a person, as described in paragraph (A)(1) of this rule, who was employed in a direct care position by the entity prior to January 27, 1997 and continues to be employed by the entity in a position involving the provision of direct care to an older adult.
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3701-13-03 Criminal records check.

(A) Except as otherwise provided in paragraph (H) of this rule, the chief administrator shall request that the superintendent conduct a criminal records check with respect to each applicant.

(B) The chief administrator of an DCP may designate a representative such as a director of nursing, medical director, facility manager, or personnel officer to carry out the requirements of this rule on the chief administrator's behalf. The chief administrator shall remain ultimately responsible for complying with the requirements of this rule.

(C) Residency requirement.

(1) If the applicant does not present proof of having been a resident of this state for the five-year period immediately prior to the date the criminal records check is requested or provide evidence that within that five year period the superintendent has requested information about the applicant from the FBI in a criminal records check, the chief administrator of the DCP shall request that the superintendent obtain information from the FBI as part of the criminal records check of the applicant.

(2) Even if the applicant presents proof of having been a resident of this state for the five-year period or proof of a FBI criminal records check as specified in paragraph (C)(1) of this rule, the DCP may request that the superintendent include information from the FBI in the criminal records check.

(D) Investigation fee.

(1) A DCP shall pay to the BCII the fee prescribed pursuant to division (C)(3) of section 109.572 of the Revised Code for each criminal records check conducted pursuant to that section.

(2) A DCP may charge an applicant a fee not exceeding the amount the DCP pays under paragraph (D)(1) of this rule. A DCP may collect a fee only if both of the following apply:

   (a) The DCP notifies the person at the time of the initial application for employment of the amount of the fee and that, unless the fee is paid by the person, the person will not be considered for employment;

   (b) The medicaid program established under Chapter 5162 of the Revised Code does not reimburse the DCP for the fee it pays under paragraph (D)(1) of this rule.

(E) Notification to the applicant. The chief administrator of the DCP shall inform each individual, at the time of initial application for a position that involves providing direct care to an older adult:

   (1) That the individual is required to provide a set of fingerprint impressions and that a criminal records check is required to be conducted if the individual comes under final consideration for employment;

   (2) If applicable, the information required under paragraph (D)(2)(a) of this rule; and

   (3) Any fees authorized under division (C)(2) of section 109.572 of the Revised Code that are associated with obtaining fingerprint impressions.

(F) Criminal records check forms. The chief administrator of a DCP required by this rule to request a criminal records check shall do all of the following:

   (1) Provide each applicant a copy of the form(s) prescribed pursuant to division (C)(1) of section 109.572 of the Revised Code and a standard fingerprint impression sheet, or instructions for acquiring a standard fingerprint impression sheet prescribed pursuant to division (C)(2) of that section.

   (a) An applicant who meets the residency requirement shall be provided a copy of the BCII "civilian identification" form for fingerprint impressions; in addition, if the DCP chooses to do so, the applicant may also be provided an FBI "applicant" fingerprint impression form.

   (b) An applicant who does not meet the residency requirement, specified in paragraph (C) of this rule, shall be provided both the BCII and FBI fingerprint impression forms.
(2) Obtain the completed form(s) and fingerprint impression sheet(s) from the applicant.

(3) Forward the completed form(s) and fingerprint impression sheet(s) to the superintendent.

(a) The DCP shall submit the completed forms in the method prescribed by BCII.

(b) The DCP shall submit all applicable fees with completed forms or arrange for payment in a method prescribed by BCII prior to submitting forms for processing.

(G) An applicant provided the forms and fingerprint impression sheets under paragraph (F) (1) of this rule, who fails to complete the forms or to provide fingerprint impressions, shall not be employed in any position for which a criminal records check is required by this rule.

(H) Exception to criminal records check requirement. The DCP is not required to request that the superintendent conduct a criminal records check of an applicant if the applicant has been referred to the DCP by an employment service that supplies full-time, part-time, or temporary staff for positions involving the direct care of older adults if the requirements of this paragraph or of paragraph (B) of rule 3701-13-04 of the Administrative Code are met:

(1) The chief administrator receives from the employment service, or the applicant, a report of the results of a criminal records check regarding the applicant that has been conducted by the superintendent within the one-year period immediately preceding the applicant's referral; and

(2) The report of the criminal records check demonstrates that the person has not been convicted of or pleaded guilty to an offense listed or described in paragraph (A) of rule 3701-13-05 of the Administrative Code.

(I) In addition to or in conjunction with any request that is required to be made under this rule with respect to an individual who has applied for employment in a position that involves providing direct care to an older adult, the chief administrator of a DCP may request that the superintendent conduct a criminal records check with respect to any individual who has applied on or after January 27, 1997, for employment in a position that does not involve providing direct care to an older adult.

3701-13-04 Conditional employment and termination.

(A) A DCP may employ conditionally an applicant for whom a criminal records check request is required under rule 3701-13-02 of the Administrative Code prior to obtaining the results of a criminal records check regarding the applicant if the following requirements are met:

(1) The DCP shall not employ an applicant prior to obtaining the completed form(s) and fingerprint impression sheet(s) from the applicant as required in paragraph (F) of rule 3701-13-03 of the Administrative Code. For purposes of this prohibition, the applicant cannot perform or participate in any job related activity pertaining to a position involving the provision of direct care to an older adult that places the applicant in an active pay status.

(2) The DCP shall request a criminal records check in accordance with paragraph (F) of rule 3701-13-03 of the Administrative Code by submitting the request to BCII not later than five business days after the individual begins conditional employment.

(B) The DCP may employ conditionally an applicant for whom a criminal records check is required under rule 3701-13-02 of the Administrative Code if all of the following requirements are met:

(1) The applicant has been referred to the DCP by an employment service that supplies full-time, part-time, or temporary staff positions involving the direct care of older adults; and

(2) The chief administrator receives from the employment service a letter that:

(a) Is on the letterhead of the employment service;

(b) Is dated and signed by a supervisor or another designated official of the employment service;
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(c) States that the employment service has requested the superintendent to conduct a criminal records check regarding the applicant;
(d) States that the requested criminal records check will include a determination of whether the applicant has been convicted or pleaded guilty to any offense listed or described in rule 3701-13-05 of the Administrative Code;
(e) States that, as of the date set forth on the letter, the employment service had not received the results of the criminal records check; and
(f) States that, when the employment service receives the results of the criminal records check, it will promptly send a copy of the results to the DCP.

(C) If a DCP employs an applicant conditionally under paragraph (B) of this rule, the employment service, upon its receipt of the results of the criminal records check, shall prompt send a copy of the results to the DCP, and paragraph (D) of this rule shall apply regarding the conditional employment.

(D) The DCP shall terminate the individual's conditional employment if:
(1) The results of the criminal records check, other than the results of any request for information from the FBI, are not obtained within thirty days after the date the request is made; or
(2) The results of any part of the records check indicate that the individual has been convicted of or pleaded guilty to any of the offenses listed or described in paragraph (A) of rule 3701-13-05 of the Administrative Code, unless the DCP chooses to employ the applicant pursuant to rule 3701-13-06 of the Administrative Code.

(E) Termination under paragraph (D) of this rule shall be considered just cause for discharge for purposes of division (D)(2) of section 4141.29 of the Revised Code if the individual makes any attempt to deceive the DCP about the individual's criminal record.

3701-13-05 Criminal offenses.

(A) Except as provided in rule 3701-13-06 of the Administrative Code no DCP shall employ a person in a position that involves providing direct care to an older adult if the person has been convicted of or pleaded guilty to:
(1) A violation of any of the following sections of the Revised Code:
   (a) 2903.01--Aggravated murder;
   (b) 2903.02--Murder
   (c) 2903.03--Voluntary manslaughter
   (d) 2903.04--Involuntary manslaughter
   (e) 2903.11--Felonious assault
   (f) 2903.12--Aggravated assault
   (g) 2903.13--Assault
   (h) 2903.16--Failing to provide for a functionally impaired person
   (i) 2903.21--Aggravated menacing
   (j) 2903.34--Patient abuse or neglect
   (k) 2905.01--Kidnapping
   (l) 2905.02--Abduction
   (m) 2905.11--Extortion
   (n) 2905.12--Coercion
   (o) 2907.02--Rape
   (p) 2907.03--Sexual battery
   (q) 2907.05--Gross sexual imposition
   (r) 2907.06--Sexual imposition
   (s) 2907.07--Importuning
   (t) 2907.08--Voyeurism
(u) 2907.09--Public indecency
(v) Former 2907.12--Felonious sexual penetration
(w) 2907.25--Prostitution; after positive HIV test
(x) 2907.31--Disseminating matter harmful to juveniles
(y) 2907.32--Pandering obscenity
(z) 2907.321--Pandering obscenity involving a minor
(aa) 2907.322--Pandering sexually oriented matter involving a minor
(bb) 2907.323--Illegal use of a minor in nudity-oriented material or performance
(cc) 2911.01--Aggravated robbery
(dd) 2911.02--Robbery
(ee) 2911.11--Aggravated burglary
(ff) 2911.12--Burglary
(gg) 2911.13--Breaking and entering
(hh) 2913.02--Theft
(ii) 2913.03--Unauthorized use of a vehicle
(jj) 2913.04--Unauthorized use of property; computer, cable, or telecommunication property
(kk) 2913.11--Passing bad checks
(ll) 2913.21--Misuse of credit cards
(mm) 2913.31--Forgery; identification card offenses
(nn) 2913.40--Medicaid fraud
(oo) 2913.43--Securing writings by deception
(pp) 2913.47--Insurance fraud
(qq) 2913.51--Receiving stolen property
(rr) 2919.25--Domestic violence
(ss) 2921.36--Illegal conveyance of weapons or prohibited items onto grounds of detention facility or institution
(tt) 2923.12--Carrying concealed weapons
(uu) 2923.13--Having weapons while under disability
(vv) 2923.161--Improperly discharging firearm at or into habitation or school safety zone
(ww) 2925.02--Corrupting another with drugs
(xx) 2925.03--Trafficking in drugs
(yy) 2925.11--Possession of drugs
(zz) 2925.13--Permitting drug abuse
(aaa) 2925.22--Deception to obtain a dangerous drug
(bbb) 2925.23--Illegal processing of drug documents
(ccc) 3716.11--Placing harmful objects in food or confection
(2) A violation of an existing or former law of this state, any other state or the United States that is substantially equivalent to any of the offenses or violations listed in paragraph (A)(1) of this rule.

(B) Pardons. A conviction of or a plea of guilty to an offense listed or described in paragraph (A) of this rule shall not prevent an applicant's employment under any of the following circumstances:

(1) The applicant has been granted an unconditional pardon for the offense pursuant to Chapter 2967 of the Revised Code;

(2) The applicant has been granted an unconditional pardon for the offense pursuant to an existing or former law of the this state, any other state, or the United States, if the law is substantially equivalent to Chapter 2967 of the Revised Code;

(3) The conviction or guilty plea has been set aside pursuant to law; or
(4) The applicant has been granted a conditional pardon for the offense pursuant to Chapter 2967 of the Revised Code, and the conditions under which the pardon was granted have been satisfied.

3701-13-06 Personal character standards.

(A) A DCP may employ an applicant who has been convicted of or pleaded guilty to an offense listed in paragraph (A) of rule 3701-13-05 of the Administrative Code in a position involving direct care to an older adult, if all of the following standards are met:

(1) The applicant is not a repeat theft related offender as defined in paragraph (M) of rule 3701-13-01 of the Administrative Code;
(2) The applicant is not a repeat violent offender as defined in paragraph (N) of rule 3701-13-01 of the Administrative Code;
(3) The offense is not a sexually oriented offense as defined in paragraph (O) of rule 3701-13-01 of the Administrative Code;
(4) The offense is not a violation of any of the following sections of the Revised Code or a violation of an existing or former law of this state, any other state, or the United States, if the offense is substantially equivalent to the offenses or violations described in the following sections of the Revised Code: 2903.01 (aggravated murder), 2903.02 (murder), 2903.03 (voluntary manslaughter), 2903.34 (patient abuse or neglect), or 3716.11 (placing harmful objects in food or confection);
(5) If the offense is an offense of violence as defined in paragraph (J) of rule 3701-13-01 of the Administrative Code, other than one listed in paragraph (A)(4) of this rule; and
   (a) The victim of the offense was not an older adult; and
   (b) At least five years have elapsed since the applicant was fully discharged from imprisonment, probation and parole; or
(6) If the offense is not an offense of violence as defined in paragraph (J) of rule 3701-13-01 of the Administrative Code or an offense listed in paragraph (A)(4) of this rule; and
   (a) The applicant is either discharged from imprisonment, sentenced to probation, is fined or is on parole; and
   (b) The applicant provides proof that all conditions regarding fulfillment of sentencing requirements are being met.
(7) The applicant's character is such that it is unlikely that the applicant will harm an older adult. In making that determination, the chief administrator shall consider the following factors for each offense:
   (a) The applicant's age at the time of the offense;
   (b) Regardless of whether the applicant knew the victim prior to the committing of the offense, the age and mental capacity of the victim;
   (c) The nature and seriousness of the offense;
   (d) The number of previous offenses or length of time since the most recent conviction or guilty plea;
   (e) The degree to which the applicant participated in the offense and the degree to which the victim contributed to or provoked the offense;
   (f) The likelihood that the circumstances leading to the offense will reoccur;
   (g) The applicant's employment record;
   (h) The applicant's efforts at rehabilitation and the results of those efforts;
   (i) If known, whether the applicant has been convicted of or pleaded guilty to any violation of an existing or former municipal ordinance substantially equivalent to any offense listed or described in rule 3701-13-05 of the Administrative Code;
   (j) Whether any criminal proceedings are pending; and
(k) Any other factors related to the position that the chief administrator considers relevant to the performance of job duties.

(B) If the applicant fails to provide proof that the personal character standards listed in this rule are met, or if the DCP determines that the proof offered by the applicant is inconclusive, the applicant shall not be employed in a position that involves providing direct care to older adults.

3701-13-07 Records and disclosure.

(A) Criminal records check disclosure. The report of the criminal records check conducted pursuant to a request made under rule 3701-13-03 of the Administrative Code is not a public record for the purposes of section 149.43 of the Revised Code and shall not be made available to any person other than the following:

(1) The individual who is the subject of the criminal records check or the individual's representative;
(2) The chief administrator of the DCP requesting the criminal records check or the administrator's representative;
(3) The chief administrator of the DCP, any other DCP, home health agency defined under section 3701.881 of the Revised Code, or PASSPORT agency that provides direct care to older adults that is owned or operated by the same entity that owns or operates the DCP;
(4) Any court, hearing officer, or other necessary individual involved in a case dealing with the denial of employment of the applicant or dealing with employment or unemployment benefits.
(5) Any person to whom a report is provided pursuant to paragraph (H) of rule 3701-13-03 of the Administrative Code or paragraph (B) of 3701-13-04 of the Administrative Code.

(B) Personnel record. The DCP shall maintain the criminal records report in a confidential manner either sealed within, or separate from but a part of, the personnel record.

(C) Attestation. The DCP shall, upon request, provide to the director written confirmation of compliance with the provisions of this rule in a format that is specified by the director and is consistent with state law.

(D) Documentation of compliance. The DCP shall maintain an applicant log separate from the personnel record that shall be accessible to the director and shall contain the following information:

(1) The name of each applicant;
(2) Application date;
(3) The date the applicant starts work;
(4) The date the criminal records check request is submitted to BCII;
(5) The type(s) of criminal records checks requested (BCII, FBI, or both);
(6) The date(s) the BCII and FBI checks are received or, for referred applicants or applicants employed pursuant to a contract, the date a copy of the report of the criminal records check is provided to the DCP for its records;
(7) The date the report is completed by BCII, "date of original record check";
(8) Whether the applicant was hired pursuant to the personal character standards listed in rule 3701-13-06 of the Administrative Code;
(9) Final disposition of the applicant; and
(10) Whether the applicant was terminated pursuant to paragraph (D)(1), paragraph (D)(2) or paragraph (E) of rule 3701-13-04 of the Administrative Code.
3701-13-08 Liability.

In a tort or other civil action for damages that is brought as the result of an injury, death, or loss to person or property caused by an individual who a DCP employs in a position that involves providing direct care to older adults, the following shall apply:

(A) If the DCP employed the individual in good faith and reasonable reliance on the report of a criminal records check requested under this chapter, the DCP shall not be found negligent solely because of its reliance on the report, even if the information in the report is determined later to have been incomplete or inaccurate;

(B) If the DCP employed the individual in good faith on a conditional basis pursuant to rule 3701-13-04 of the Administrative Code, the DCP shall not be found negligent solely because it employed the individual prior to receiving the report of a criminal records check requested under this chapter;

(C) If the DCP in good faith employed the individual according to the personal character standards adopted under rule 3701-13-06 of the Administrative Code, the DCP shall not be negligent solely because the individual prior to being employed had been convicted of or pleaded guilty to an offense listed or described in rule 3701-13-05 of the Administrative Code.

Home Health Agencies

3701-60-02 Applicability.

(A) Chapter 3701-60 of the Administrative Code applies only to applicants to a home health agency for a position providing direct care, and to employees of a home health agency who provide direct care, including:

(1) A person who is paid directly by the home health agency;

(2) A person who contracts as an independent contractor to provide direct care on behalf of the home health agency;

(3) A person who provides direct care on behalf of a home health agency pursuant to a contract between the home health agency and another business entity;

(4) A person referred to the home health agency by an employment service or staffing pool.

(B) The home health agency shall conduct a criminal records check on any applicant for a position providing direct care and on an employee who provides direct care on or after January 1, 2013.

(C) The home health agency is not required to update the criminal records check as required by paragraph (B) of rule 3701-60-04 of the Administrative Code, for employees who are direct care staff, but who work in the office and do not see individuals in their homes on a routine basis.

3701-60-03 State and national database check.

(A) Except as provided for in paragraph (H) of rule 3701-60-04 of the Administrative Code, and prior to conducting a criminal records check, the chief administrator or his designee of a home health agency shall conduct, with respect to each applicant for a position involving the provision of direct care and each employee who provides direct care, a check of the following databases:

(1) The "System for Award Management" maintained by the United States general services administration, available at http://www.sam.gov/;

(2) The list of excluded individuals and entities maintained by the office of inspector general in the United States department of health and human services, available at
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http://exclusions.oig.hhs.gov/;

(3) The registry of employees guilty of abuse, neglect, or misappropriation maintained by the Ohio department of developmental disabilities, available at https://its.prodapps.dodd.ohio.gov/ABR_Default.aspx;


(5) The database of inmates maintained by the Ohio department of rehabilitation and correction, available at https://appgateway.drc.ohio.gov/OffenderSearch; and

(6) The Ohio nurse aide registry, maintained by the Ohio department of health, available at https://odhgateway.odh.ohio.gov/nar/nar_registry_search.aspx. If an applicant does not present proof of having been a resident of this state for the five year period immediately prior to the date of the database review, the chief administrator of a home health agency or his designee shall conduct a database review of the nurse aide registry in the state or states in which the applicant has lived.

(B) Except as provided for in rule 3701-60-07 of the Administrative Code, no home health agency shall employ a person in a position involving the provision of direct care if a review of the databases listed in paragraphs (A)(1) to (A)(5) of this rule discloses disqualifying information regarding the applicant or employee or if a review of the database listed in paragraph (A)(6) of this rule discloses a statement detailing findings by the director of health that the applicant or employee neglected or abused a long-term care facility or residential care facility resident or misappropriated property of such a resident.

(C) If the review of the free databases listed in paragraph (A) of this rule discloses disqualifying information about an applicant or employee, the home health agency shall inform the applicant or employee of the disqualifying information.

(D) The chief administrator of a home health agency shall conduct a check of the databases listed in paragraph (A) of this rule prior to requesting an update to the background check required in paragraph (B) of rule 3701-60-04 of the Administrative Code.

(E) The home health agency is not required to review the free databases listed under paragraph (A) of this rule if the applicant or employee was referred to the home health agency by an employment service that refers applicants to employers to fill full-time, part-time, or temporary positions involving direct care if the employment service provides the home health agency with the letter required by paragraph (A)(4) of rule 3701-60-05 of the Administrative Code.

3701-60-04 Requirements for criminal records check.

(A) The chief administrator of a home health agency or his designee shall request that the superintendent conduct a criminal records check with respect to each applicant for a direct care position.

(B) The chief administrator of a home health agency or his designee shall conduct a criminal background check on employees who provide direct care as follows:

(1) For employees hired prior to January 1, 2008, no later than thirty days after the anniversary of the employee's date of hire and at least every five years thereafter; or

(2) For employees hired on or after January 1, 2008, no later than thirty days after the fifth anniversary of the employee's date of hire and at least every five years thereafter.

(C) Residency requirement.

(1) If the applicant does not present proof of having been a resident of this state for the five year period immediately prior to the date the criminal records check is requested or provide evidence that within that five year period the superintendent has requested information about the applicant from the United States federal bureau of investigation in a criminal records check, the chief administrator of the home health agency shall request that the superintendent obtain
information from the United States federal bureau of investigation as part of the criminal records check of the applicant.

(2) Even if the applicant presents proof of having been a resident of this state for the five year period or proof of an United States federal bureau of investigation criminal records check as specified in paragraph (C)(1) of this rule, the home health agency may request that the superintendent include information from the United States federal bureau of investigation in the criminal records check.

(D) Notification to the applicant. The chief administrator of the home health agency or his designee shall notify each applicant and employee of the following:

(1) That the individual is required to provide a set of fingerprint impressions and that a criminal records check is required to be conducted if the individual comes under final consideration for employment, or, in the case of an employee, that a criminal records check will be conducted as a condition of continued employment;

(2) If applicable, the fee required under paragraph (E)(2) of this rule; and

(3) Any fees authorized under division (C)(2) of section 109.572 of the Revised Code that are associated with obtaining fingerprint impressions.

(E) Investigation fee.

(1) A home health agency shall pay to the bureau of criminal identification and investigation the fee prescribed pursuant to division (C)(3) of section 109.572 of the Revised Code for each criminal records check conducted pursuant to this rule.

(2) A home health agency may charge an applicant a fee not exceeding the amount the home health agency pays under paragraph (D)(1) of this rule. A home health agency may collect a fee only if both of the following apply:

(a) The home health agency notifies the person at the time of the initial application for employment of the amount of the fee and that, unless the fee is paid by the person, the person will not be considered for employment;

(b) The medicaid program established under Chapter 5162 of the Revised Code does not reimburse the home health agency for the fee it pays under paragraph (D)(1) of this rule.

(F) Criminal records check forms. The chief administrator of a home health agency required by this rule to request a criminal records check shall do all of the following:

(1) Provide each applicant and employee a copy of the form or forms prescribed by division (C)(1) of section 109.572 of the Revised Code and a standard fingerprint impression sheet, or instructions for acquiring a standard fingerprint impression sheet prescribed pursuant to division (C)(2) of that section.

(a) An applicant who meets the residency requirement shall be provided a copy of the bureau of criminal identification and investigation "civilian identification" form for fingerprint impressions; in addition, if the home health agency chooses to do so, the applicant may also be provided an United States federal bureau of investigation "applicant" fingerprint impression form;

(b) An applicant who does not meet the residency requirement, specified in paragraph (C) of this rule, shall be provided both the bureau of criminal identification and investigation and United States federal bureau of investigation fingerprint impression forms.

(2) Obtain the completed form or forms and standard fingerprint impression sheet or sheets from the applicant;

(3) Forward the completed form or forms and standard fingerprint impression sheet or sheets to the superintendent.

(a) The home health agency shall submit the completed forms in the method prescribed by bureau of criminal identification and investigation.

(b) The home health agency shall submit all applicable fees with completed forms or arrange for payment in a method prescribed by bureau of criminal identification and investigation prior to submitting forms for processing.
(G) An applicant or employee provided the forms and standard fingerprint impression sheets under paragraph (F)(1) of this rule, who fails to complete the forms or to provide fingerprint impressions, shall not be employed in any position for which a criminal records check is required by this rule.

(H) If an applicant or employee has been the subject of a criminal records check pursuant to division (D) of section 109.572 of the Revised Code within the previous twelve months, the chief administrator of the home health agency may request and accept a reverification of that criminal records check. A reverification of a criminal records check does not relieve the home health agency of the requirements under paragraph (C) of this rule if the applicant or employee has not been a resident of this state for the five year period immediately prior to the date the criminal records check.

(I) Exception to criminal records check requirement. The home health agency is not required to request that the superintendent conduct a criminal records check of an applicant if the applicant has been referred to the home health agency by an employment service that supplies full-time, part-time, or temporary staff for positions involving the direct care to an individual if all of the following apply:

1. The chief administrator receives from the employment service confirmation that a review of the databases required by rule 3701-60-03 of the Administrative Code was conducted with regard to the applicant or employee;

2. The chief administrator receives from the employment service confirmation that a report of the results of a criminal records check regarding the applicant or employee has been conducted by the superintendent within the one-year period immediately preceding the following:
   a. In the case of an applicant, the date of the applicant's referral by the employment service to the home health agency;
   b. In the case of an employee, the date by which the home health agency would otherwise have to request a criminal records check of the employee pursuant to this rule; and

   3. The report of both the database review and the criminal records check demonstrates that the applicant or employee has not been convicted of or pleaded guilty to an offense listed or described in paragraph (A) of rule 3701-60-06 of the Administrative Code.

3701-60-05 Conditional employment.

(A) A home health agency may employ an applicant conditionally prior to obtaining a criminal records check regarding the applicant if the:

1. Review of the state and national databases required by rule 3701-60-03 of the Administrative Code does not reveal any disqualifying information;

2. The applicant provides the home health agency with a completed fingerprint impression sheet before the commencement of the applicant's conditional employment; and

3. Chief administrator of the home health agency requests the criminal records check required by rule 3701-60-04 of the Administrative Code not later than five business days after the applicant begins conditional employment; or

4. Applicant is referred to the home health agency by an employment service, the employment service or the applicant provides the chief administrator of the agency a letter that is on the letterhead of the employment service, the letter is dated and signed by a supervisor or another designated official of the employment service, and the letter states all of the following:
   a. That the employment service has requested the superintendent to conduct a criminal records check regarding the applicant;

   b. That the requested criminal records check is to include a determination of whether the applicant has been convicted of, pleaded guilty to, or been found eligible for intervention in lieu of conviction for a disqualifying offense;
(c) That the employment service has not received the results of the criminal records check as of the date set forth on the letter; and
(d) That the employment service promptly will send a copy of the results of the criminal records check to the chief administrator of the home health agency when the employment service receives the results.

(B) If a home health agency employs an applicant conditionally pursuant to paragraph (A)(2) of this rule, the employment service, on its receipt of the results of the criminal records check, promptly shall send a copy of the results to the chief administrator of the agency.
(C) The home health agency shall not employ an applicant prior to obtaining the completed form or forms and standard fingerprint impression sheet or sheets from the applicant as required in paragraph (F) of rule 3701-60-04 of the Administrative Code. For purposes of this prohibition, the applicant cannot perform or participate in any job related activity pertaining to a position involving the provision of direct care to an individual that places the applicant in an active pay status.
(D) The home health agency shall terminate the individual's conditional employment if:
(1) In the case of an applicant for a position providing direct care to an individual, the results of the records check, other than the results of any request for information from the United States federal bureau of investigation, are not obtained within sixty days after the date the request is made; or
(2) The results or any part of the records check indicate that the individual has been convicted of or pleaded guilty to any of the offenses listed or described in paragraph (A) of rule 3701-60-06 of the Administrative Code, unless the home health agency chooses to employ the applicant pursuant to rule 3701-60-07 of the Administrative Code.
(E) Termination under paragraph (D) of this rule shall be considered just cause for discharge for purposes of division (D)(2) of section 4141.29 of the Revised Code if the individual makes any attempt to deceive the home health agency about the individual's criminal record.

3701-60-06 Criminal records check; disqualifying offenses.

(A) Except as provided in rule 3701-60-07 of the Administrative Code, no employer shall employ or continue to employ a person in a position that involves providing direct care to an individual if the person has been convicted of:
(1) A violation of any of the following sections of the Revised Code:
(a) 959.13 (cruelty to animals);
(b) 959.131 (prohibitions concerning companion animals);
(c) 2903.01 (aggravated murder);
(d) 2903.02 (murder);
(e) 2903.03 (voluntary manslaughter);
(f) 2903.04 (involuntarymanslaughter);
(g) 2903.041 (reckless homicide);
(h) 2903.11 (felonious assault);
(i) 2903.12 (aggravated assault);
(j) 2903.13 (assault);
(k) 2903.15 (permitting child abuse);
(l) 2903.16 (failing to provide for a functionally impaired person);
(m) 2903.21 (aggravated menacing);
(n) 2903.211 (menacing by stalking);
(o) 2903.22 (menacing);
(p) 2903.34 (patient abuse and neglect);
(q) 2903.341 (patient endangerment);
(r) 2905.01 (kidnapping);
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(s) 2905.02 (abduction);
(t) 2905.04 (child stealing, as it existed before July 1, 1996);
(u) 2905.05 (criminal child enticement);
(v) 2905.11 (extortion);
(w) 2905.12 (coercion);
(x) 2905.32 (trafficking in persons);
(y) 905.33 (unlawful conduct with respect to documents);
(z) 2907.02 (rape);
(aa) 2907.03 (sexual battery);
(bb) 2907.04 (unlawful sexual conduct with a minor, formerly corruption of a minor);
(cc) 2907.05 (gross sexual imposition);
(dd) 2907.06 (sexual imposition);
(ee) 2907.07 (importuning);
(ff) 2907.08 (voyerism);
(gg) 2907.09 (public indecency);
(hh) 2907.12 (felonious sexual penetration, as it existed before July 1, 1996);
(ii) 2907.21 (compelling prostitution);
(jj) 2907.22 (promoting prostitution);
(kk) 2907.23 (enticement or solicitation to patronize a prostitute; procurement of a
prostitute for another);
(ll) 2907.24 (soliciting after positive HIV test);
(mm) 2907.25 (prostitution);
(nn) 2907.31 (disseminating matter harmful to juveniles);
(oo) 2907.32 (pandering obscenity);
(pp) 2907.321 (pandering obscenity involving a minor);
(qq) 2907.322 (pandering sexually oriented matter involving a minor);
(rr) 2907.323 (illegal use of a minor in nudity-oriented material or performance);
(ss) 2907.33 (deception to obtain matter harmless to juveniles);
(tt) 2909.02 (aggravated arson);
(uu) 2909.03 (arson);
(vv) 2909.04 (disrupting public services);
(ww) 2909.22 (soliciting or providing support for act of terrorism);
(xx) 2909.23 (making terroristic threat);
(yy) 2909.24 (terrorism);
.zz) 2911.01 (aggravated robbery);
(aaa) 2911.02 (robbery);
(bbb) 2911.11 (aggravated burglary);
(ccc) 2911.12 (burglary);
(ddd) 2911.13 (breaking and entering);
(eee) 2913.02 (theft);
(fff) 2913.03 (unauthorized use of a vehicle);
(ggg) 2913.04 (unauthorized use of property, computer, cable, or telecommunication
property);
(hhh) 2913.05 (telecommunications fraud);
(iii) 2913.11 (passing bad checks);
(jj) 2913.21 (misuse of credit cards);
(kkk) 2913.31 (forging identification cards);
(ll) 2913.32 (criminal simulation);
(mmm) 2913.40 (medicaid fraud);
(nn) 2913.41 (defrauding a rental agency or hostelry);
(ooo) 2913.42 (tampering with records);
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(ppp) 2913.43 (securing writings by deception);
(qqq) 2913.44 (personating an officer);
(rrr) 2913.441 (unlawful display of law enforcement emblem);
(sss) 2913.45 (defrauding creditors);
(ttt) 2913.46 (illegal use of SNAP or WIC program benefits);
(uuu) 2913.47 (insurance fraud);
(vvv) 2913.48 (workers’ compensation fraud);
(www) 2913.49 (identify fraud);
(xxx) 2913.51 (receiving stolen property);
(yy) 2917.01 (inciting to violence);
(zzz) 2917.02 (aggravated riot);
(aaaa) 2917.03 (riot);
(bbbb) 2917.31 (inducing panic);
(cccc) 2919.12 (unlawful abortion);
(dddd) 2919.121 (unlawful abortion upon minor);
(eeee) 2919.123 (unlawful distribution of an abortion-inducing drug);
(ffff) 2919.22 (endangering children);
(gggg) 2919.23 (interference with custody);
(hhhh) 2919.24 (contributing to unruliness or delinquency of child);
(iii) 2919.25 (domestic violence);
(jjjj) 2921.03 (intimidation);
(kkkk) 2921.11 (perjury);
(llll) 2921.12 (tampering with evidence);
(mmmm) 2921.13 (falsification - in theft offense- to purchase firearm);
(nnnn) 2921.21 (compounding a crime);
(oooo) 2921.24 (disclosure of confidential information);
(pppp) 2921.32 (obstructing justice);
(qqqq) 2921.321 (assaulting or harassing a police dog, horse, or service animal);
(rrrr) 2921.34 (escape);
(ssss) 2921.35 (aiding escape or resistance to lawful authority);
(tttt) 2921.36 (illegal conveyance of weapons, drugs or other prohibited items onto
grounds of detention facility or institution);
(uuuu) 2921.51 (impersonation of peace officer);
(vvvv) 2923.12 (carrying concealed weapon);
(wwww) 2923.122 (illegal conveyance or possession of deadly weapon or dangerous
ordinance in a school safety zone, illegal possession of an object indistinguishable from a
firearm in a school safety zone);
(xxxx) 2923.123 (illegal conveyance, possession, or control of deadly weapon or
ordinance into a courthouse);
yyyy 2923.13 (having weapons while under disability);
zzzz 2923.161 (improperly discharging a firearm at or into a habitation or school);
(aaaa) 2923.162 (discharge of firearm on or near prohibited premises);
bbbbbb 2923.21 (improperly furnishing firearms to minor);
(cccc) 2923.32 (engaging in a pattern of corrupt activity);
(dddd) 2923.42 (participating in criminal gang);
(eeee) 2925.02 (corrupting another with drugs);
(ffff) 2925.03 (trafficking in drugs);
(ggggg) 2925.04 (illegal manufacture of drugs or cultivation of marijuana);
(hhhhh) 2925.041 (illegal assembly or possession of chemicals for the manufacture of
drugs);
(iiiii) 2925.05 (funding of drug or marijuana trafficking);
(jijjj) 2925.06 (illegal administration or distribution of anabolic steroids);
(kkkkk) 2925.09 (illegal administration, dispensing, distribution, manufacture, possession, selling, or using of any dangerous veterinary drug);
(lllll) 2925.11 (possession of drugs);
(mmmmm) 2925.13 (permitting drug abuse);
(nnnnn) 2925.14 (illegal use, possession, dealing, selling, or advertising of drug paraphernalia);
(ooooo) 2925.141 (illegal use or possession of marihuana drug paraphernalia);
(ppppp) 2925.22 (deception to obtain dangerous drugs);
(qqqqq) 2925.23 (illegal processing of drug documents);
(rrrrr) 2925.24 (tampering with drugs);
(sssss) 2925.36 (dispensing drug samples);
(ttttt) 2925.55 (unlawful purchase of pseudoephedrine product);
(uuuuu) 2925.56 (unlawful sale of pseudoephedrine product);
(vvvvv) 2927.12 (ethnic intimidation);
(wwwww) 3716.11 (placing harmful objects in food or confection);
(2) If related to an offense listed under paragraph (A)(1) of this rule, 2923.01 (conspiracy), 2923.02 (attempt), or 2923.03 (complicity); or
(3) A violation of an existing or former municipal ordinance or law of this state, any other state, or the United States that is substantially equivalent to any of the offenses or violations described in paragraphs (A)(1)(a) to (A)(1)(wwww) of this rule.

3701-60-07 Disqualifying offense exclusionary periods; certificated pardons.

(A) Disqualifying offense exclusionary periods: Except as set forth in paragraphs (B), (C) and (D) of this rule, a home health agency may employ an applicant or continue to employ an employee who has been convicted of or pleaded guilty to an offense listed in rule 3701-60-06 of the Administrative Code in a position involving providing direct care to an individual pursuant to the following exclusionary periods:

(1) Tier I: Permanent exclusion: No home health agency shall employ an applicant or continue to employ an employee in a position involving providing direct care to an individual who has been convicted of, or pleaded guilty to, an offense in any of the following sections of the Revised Code:

(a) 2903.01 (aggravated murder);
(b) 2903.02 (murder);
(c) 2903.03 (voluntary manslaughter);
(d) 2903.11 (felonious assault);
(e) 2903.15 (permitting child abuse);
(f) 2903.16 (failing to provide for a functionally-impaired person);
(g) 2903.34 (patient abuse or neglect);
(h) 2903.341 (patient endangerment);
(i) 2905.01 (kidnapping);
(j) 2905.02 (abduction);
(k) 2905.32 (human trafficking);
(l) 2905.33 (unlawful conduct with respect to documents);
(m) 2907.02 (rape);
(n) 2907.03 (sexual battery);
(o) 2907.04 (unlawful sexual conduct with a minor, formerly corruption of a minor);
(p) 2907.05 (gross sexual imposition);
(q) 2907.06 (sexual imposition);
(r) 2907.07 (importuning);
(s) 2907.08 (voyeurism);
(t) 2907.12 (felonious sexual penetration);
(u) 2907.31 (disseminating matter harmful to juveniles);
(v) 2907.32 (pandering obscenity);
(w) 2907.321 (pandering obscenity involving a minor);
(x) 2907.322 (pandering sexually-oriented matter involving a minor);
(y) 2907.323 (illegal use of a minor in nudity-oriented material or performance);
(z) 2909.22 (soliciting or providing support for an act of terrorism);
(aa) 2909.23 (making terrorist threats);
(bb) 2909.24 (terrorism);
(cc) 2913.40 (medicaid fraud);
(dd) If related to another offense under paragraph (A)(1) of this rule, 2923.01
(conspiracy), 2923.02 (attempt), or 2923.03 (complicity);
(ee) A conviction related to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct involving a federal or state-funded program, excluding the disqualifying offenses set forth in section 2913.46 (illegal use of SNAP or WIC program benefits); or,
(ff) A violation of an existing or former municipal ordinance or law of this state, any other state, or the United States that is substantially equivalent to any of the offenses or violations described in paragraphs (A)(1)(a) to (A)(1)(ee) of this rule.

(2) Tier II: Ten-year exclusionary period:
(a) No home health agency shall employ an applicant or continue to employ an employee in a position providing direct care to an individual for a period of ten years from the date the applicant or employee was fully discharged from all imprisonment, probation, or parole, if the applicant or employee has been convicted of, or pleaded guilty to, an offense in any of the following sections of the Revised Code:
   (i) 2903.04 (involuntary manslaughter);
   (ii) 2903.041 (reckless homicide);
   (iii) 2905.04 (child stealing, as it existed prior to July 1, 1996);
   (iv) 2905.05 (child enticement);
   (v) 2905.11 (extortion);
   (vi) 2907.21 (compelling prostitution);
   (vii) 2907.22 (promoting prostitution);
   (viii) 2907.23 (enticement or solicitation to patronize a prostitute; procurement of a prostitute for another.);
   (ix) 2909.02 (aggravated arson);
   (x) 2909.03 (arson);
   (xi) 2911.01 (aggravated robbery);
   (xii) 2911.11 (aggravated burglary);
   (xiii) 2913.46 (illegal use of SNAP or WIC program benefits);
   (xiv) 2913.48 (worker's compensation fraud);
   (xv) 2913.49 (identity fraud);
   (xvi) 2917.02 (aggravated riot);
   (xvii) 2923.12 (carrying concealed weapons);
   (xviii) 2923.122 (illegal conveyance or possession of deadly weapon or dangerous ordnance in a school safety zone, illegal possession of an object indistinguishable from a firearm in a school safety zone);
   (xix) 2923.123 (illegal conveyance, possession, or control of deadly weapon or ordnance into a courthouse);
   (xx) 2923.13 (having weapons while under disability);
   (xxi) 2923.161 (improperly discharging a firearm at or into a habitation or school);
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(xxii) 2923.162 (discharge of firearm on or near prohibited premises);  
(xxiii) 2923.21 (improperly furnishing firearms to a minor);  
(xxiv) 2923.32 (engaging in a pattern of corrupt activity);  
(xxv) 2923.42 (participating in a criminal gang);  
(xxvi) 2925.02 (corrupting another with drugs);  
(xxvii) 2925.03 (trafficking in drugs);  
(xxviii) 2925.04 (illegal manufacture of drugs or cultivation of marijuana);  
(xxix) 2925.041 (illegal assembly or possession of chemicals for the manufacture of drugs)  
(xxx) 3716.11 (placing harmful or hazardous objects in food or confection);  
(xxxi) If related to another offense under paragraph (A)(2)(a) of this rule, 2923.01 (conspiracy), 2923.02 (attempt), or 2923.03 (complicity); or,  
(xxxii) A violation of an existing or former municipal ordinance or law of this state, any other state, or the United States that is substantially equivalent to any of the offenses or violations described under paragraphs (A)(2)(a)(i) to (A)(2)(a)(xxxii) of this rule.

(b) If an applicant or employee has been convicted of multiple disqualifying offenses, including an offense listed in paragraph (A)(2)(a) of this rule, and another offense or offenses listed in paragraph (A)(2)(a), (A)(3)(a), or (A)(4)(a) of this rule, and if the multiple disqualifying offenses are not the result of, or connected to, the same act, the applicant or employee is subject to a fifteen-year exclusionary period.

(3) Tier III: Seven-year exclusionary period:  
(a) No employer shall employ an applicant or continue to employ an employee in a position providing direct care to an individual for a period of seven years from the date the applicant or employee was fully discharged from all imprisonment, probation, or parole, if the applicant or employee has been convicted of, or pleaded guilty to, any offense in any of the following sections of the Revised Code:  
(i) 959.13 (cruelty to animals);  
(ii) 959.131 (prohibitions concerning companion animals);  
(iii) 2903.12 (aggravated assault);  
(iv) 2903.21 (aggravated menacing);  
(v) 2903.211 (menacing by stalking);  
(vi) 2905.12 (coercion);  
(vii) 2909.04 (disrupting public services);  
(viii) 2911.02 (robbery);  
(ix) 2911.12 (burglary);  
(x) 2913.47 (insurance fraud);  
(xi) 2917.01 (inciting to violence);  
(xii) 2917.03 (riot);  
(xiii) 2917.31 (inducing panic);  
(xiv) 2919.22 (endangering children);  
(xv) 2919.25 (domestic violence);  
(xvi) 2921.03 (intimidation);  
(xvii) 2921.11 (perjury);  
(xviii) 2921.13 (falsification, falsification in a theft offense, falsification to purchase a firearm, or falsification to obtain a concealed handgun license);  
(xix) 2921.34 (escape);  
(xx) 2921.35 (aiding escape or resistance to lawful authority);  
(xxi) 2921.36 (illegal conveyance of weapons, drugs, or other prohibited items onto the grounds of a detention facility or institution);  
(xxii) 2925.05 (funding drug trafficking);  
(xxiii) 2925.06 (illegal administration of distribution of anabolic steroids);
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(b) If an applicant or employee has been convicted of multiple disqualifying offenses, including an offense listed in paragraph (A)(3)(a) of this rule, and another offense or offenses listed in paragraph (A)(3)(a) or (A)(4)(a) of this rule, and if the multiple disqualifying offenses are not the result of, or connected to, the same act, the applicant or employee is subject to a ten-year exclusionary period.

(4) Tier IV: Five-year exclusionary period:

(a) No home health agency shall employ and applicant or continue to employ an employee in a position providing direct care to an individual for a period of five years from the date the applicant or employee was fully discharged from all imprisonment, probation, or parole, if the applicant or employee has been convicted of, or pleaded guilty to, and offense in any of the following sections of the Revised Code:

(i) 2903.13 (assault);
(ii) 2903.22 (menacing);
(iii) 2907.09 (public indecency);
(iv) 2907.24 (soliciting);
(v) 2907.25 (prostitution);
(vi) 2907.33 (deception to obtain matter harmful to juveniles);
(vii) 2911.13 (breaking and entering);
(viii) 2913.02 (theft);
(ix) 2913.03 (unauthorized use of a vehicle);
(x) 2913.04 (unauthorized use of computer, cable, or telecommunication property);
(xi) 2913.05 (telecommunications fraud);
(xii) 2913.11 (passing bad checks);
(xiii) 2913.21 (misuse of credit cards);
(xiv) 2913.31 (forgery, forging identification cards);
(xv) 2913.32 (criminal simulation);
(xvi) 2913.41 (defrauding a rental agency or hostelry);
(xvii) 2913.42 (tampering with records);
(xviii) 2913.43 (securing writings by deception);
(xix) 2913.44 (personating an officer);
(xx) 2913.441 (unlawful display of law enforcement emblem);
(xxi) 2913.45 (defrauding creditors);
(xxii) 2913.51 (receiving stolen property);
(xxiii) 2919.12 (unlawful abortion);
(xxiv) 2919.121 (unlawful abortion upon minor);
(xxv) 2919.123 (unlawful distribution of an abortion-inducing drug);
(xxvi) 2919.23 (interference with custody);
(xxvii) 2919.24 (contributing to the unruliness or delinquency of a child);
(xxviii) 2921.12 (tampering with evidence);
(xxix) 2921.21 (compounding a crime);
(xxx) 2921.24 (disclosure of confidential information);
(xxxi) 2921.32 (obstructing justice);
(xxxii) 2921.321 (assaulting or harassing a police dog, horse, or service animal);
(xxxiii) 2921.51 (impersonation of peace officer);
(xxxiv) 2925.09 (illegal administration, dispensing, distribution, manufacture, possession, selling, or using of any dangerous veterinary drug);

(xxxv) 2925.11 (drug possession, other than a minor drug possession offense);

(xxxvi) 2925.13 (permitting drug abuse);

(xxxvii) 2925.22 (deception to obtain a dangerous drug);

(xxxviii) 2925.23 (illegal processing of drug documents);

(xxxix) 2925.36 (illegal dispensing of drug samples);

(xl) 2925.55 (unlawful sale of pseudophedrine product);

(xli) 2925.56 (unlawful sale of pseudophedrine product); or,

(xlii) If related to another offense under paragraph (A)(4)(a) of this rule, 2923.01 (conspiracy), 2923.02 (attempt), or 2923.03 (complicity); or,

(xliii) A violation of an existing or former municipal ordinance or law of this state, any other state, or the United States that is substantially equivalent to any of the offenses or violations described under paragraphs (A)(4)(a)(i) to (A)(4)(a)(xlii) of this rule.

(b) If an applicant or employee has been convicted of multiple disqualifying offenses listed in paragraph (A)(4)(a) of this rule, and if the multiple disqualifying offenses are not the result of, or connected to, the same act, the applicant or employee is subject to a seven-year exclusionary period.

(5) Tier V: No exclusionary period: A home health agency may employ an applicant or continue to employ an employee in a position providing direct care to an individual who has been convicted of, or pleaded guilty to, any of the following offenses:

(a) 2925.11 (drug possession that is a minor drug possession offense);

(b) 2925.14 (illegal use, possession, dealing, selling, or advertising of drug paraphernalia);

(c) 2925.141 (illegal use or possession of marihuana drug paraphernalia); or

(d) A violation of an existing or former municipal ordinance or law of this state, any other state, or the United States that is substantially equivalent to any of the offenses or violations described under paragraph (A)(5) of this rule.

(B) Certificates: Except for individual with a disqualifying offense listed in paragraph (A)(1) of this rule, a home health agency may hire an applicant or continue to employ an employee who has been issued either a:

(1) Certificate of qualification for employment issued by a court of common pleas with competent jurisdiction pursuant to section 2953.25 of the Revised Code; or,

(2) Certificate of achievement and employability in a home and community-based service-related field, issued by the department of rehabilitation and corrections pursuant to section 2961.22 of the Revised Code.

(C) Limited grandfathering: A home health agency may continue to employ an employee who is otherwise excluded by paragraph (A)(4) of this rule if:

(1) The offense or offenses are listed in paragraph (A)(4) of this rule;

(2) The employee was hired prior to January 1, 2013;

(3) The conviction or plea of guilt occurred prior to January 1, 2013;

(4) The home health agency has considered the nature and seriousness of the offense or offenses and attests, in writing prior to April 1, 2013, to the employee's character and fitness based on their demonstrated work performance.

(D) Pardons: A conviction or a plea of guilty to an offense listed or described in rule 3701-60-06 of the Administrative Code shall not prevent an applicant's employment or an employee's continued employment under any of the following circumstances:

(1) The applicant or employee has been granted an unconditional pardon for the offense pursuant to Chapter 2967 of the Revised Code;
(2) The applicant or employee has been granted an unconditional pardon for the offense pursuant to an existing or former law of this state, any other state, or the United States, if the law is substantially equivalent to Chapter 2967 of the Revised Code;

(3) The conviction or guilty plea has been set aside pursuant to law; or,

(4) The applicant or employee has been granted a conditional pardon for the offense pursuant to Chapter 2967 of the Revised Code, and the conditions under which the pardon was granted have been satisfied.

3701-60-08 Records and reports.

(A) Criminal record check disclosure. The report of the criminal records check conducted pursuant to a request made under this chapter is not a public record for the purposes of section 149.43 of the Revised Code and shall not be made available to any person other than the following:

(1) The applicant or employee who is the subject of the criminal records check or the applicant or employee's representative;

(2) The chief administrator of the home health agency requesting the criminal records check or the administrator's representative;

(3) The administrator of any other facility, agency, or program that provides direct care to individuals that is owned or operated by the same entity that owns or operates the home health agency that requested the criminal records check;

(4) The employment service that requested the check;

(5) The director of health or the director's designee;

(6) The director of aging or the director's designee if either of the following apply:

(a) In the case of a criminal records check requested by a home health agency, the home health agency also is a community-based long-term care agency; or

(b) In the case of a criminal records check requested by an employment service, the employment service makes the request for an applicant or employee the employment service refers to a home health agency that also is a community-based long-term care agency;

(7) The director of job and family services and the staff of the department of job and family services who are involved in the administration of the medicaid program if either of the following apply:

(a) In the case of a criminal records check requested by a home health agency, the home health agency also is a waiver agency;

(b) In the case of a criminal records check requested by an employment service, the employment service makes the request for an applicant or employee the employment service refers to a home health agency that also is a waiver agency;

(8) Any court, hearing officer or other necessary individual involved in a case dealing any of the following:

(a) A denial of employment of the applicant or dealing with employment employee;

(b) Employment or unemployment benefits of the applicant or employee;

(c) A civil or criminal action regarding the medicaid program.

(B) Personnel record. The home health agency shall maintain, in a confidential manner either sealed within, or separate from, but a part of the personnel record:

(1) The criminal records report; and

(2) Any disqualifying information discovered during the state and national database check required by rule 3701-60-03 of the Administrative Code.

(C) Documentation of compliance. The home health agency shall maintain a roster of applicants and employees, accessible by the director, which includes, but is not limited to:

(1) The name of each applicant or employee;
(2) The date the criminal records check request is submitted to the bureau of criminal
identification and investigation;
(3) The date the criminal records check request is received from the bureau of criminal
identification and investigation;
(4) A determination of whether the results of the check revealed that the applicant or
employee committed a disqualifying offense(s); and
(5) The date the employee starts work.
(D) Attestation. The home health agency shall, upon request, provide to the director
written confirmation of compliance with the provisions of this chapter in a format that is specified
by the director and is consistent with state law.

3701-60-09 Liability; compliance action.

(A) In a tort or other civil action for damages that is brought as the result of an injury,
death or loss to person or property caused by an applicant or employee who a home health
agency employs in a position that involves providing direct care to an individual, the following
shall apply:
(1) If the home health agency employed the applicant or employee in good faith and
reasonable reliance on the report of a criminal records check requested under this chapter, the
home health agency shall not be found negligent solely because of its reliance on the report,
even if the information in the report is determined later to have been incomplete or inaccurate;
(2) If the home health agency employed the applicant in good faith on a conditional basis
pursuant to rule 3701-60-05 of the Administrative Code, the home health agency shall not be
found negligent solely because it employed the individual prior to receiving the report of a
criminal records check requested under this chapter;
(3) If the home health agency in good faith employed the applicant or employ-
ee according to the personal character standards adopted under rule 3701-60-07 of the
Administrative Code, the home health agency shall not be negligent solely because the
applicant or employee, prior to being employed, had been convicted of, pleaded guilty to a
disqualifying offense listed or described in rule 3701-60-06 of the Administrative Code.
(B) As authorized by the applicable state laws and rules governing the specific home
health agency, the department may take appropriate action against a home health agency that
violates the requirements of Chapter 3701-60 of the Administrative Code and the authorizing
sections of the Revised Code applicable to the specific home health agency.

Part III. False Claims, Fraud, and Whistleblowers

2913.40 Fraudulent use of Medicaid funds.

(A) As used in this section:
(1) “Statement or representation” means any oral, written, electronic, electronic impulse,
or magnetic communication that is used to identify an item of goods or a service for which
reimbursement may be made under the medicaid program or that states income and expense
and is or may be used to determine a rate of reimbursement under the medicaid program.
(2) “Provider” means any person who has signed a provider agreement with the
department of medicaid to provide goods or services pursuant to the medicaid program or any
person who has signed an agreement with a party to such a provider agreement under which
the person agrees to provide goods or services that are reimbursable under the medicaid
program.
(3) “Provider agreement” has the same meaning as in section 5164.01 of the Revised Code.

(4) “Recipient” means any individual who receives goods or services from a provider under the medicaid program.

(5) “Records” means any medical, professional, financial, or business records relating to the treatment or care of any recipient, to goods or services provided to any recipient, or to rates paid for goods or services provided to any recipient and any records that are required by the rules of the medicaid director to be kept for the medicaid program.

(B) No person shall knowingly make or cause to be made a false or misleading statement or representation for use in obtaining reimbursement from the medicaid program.

(C) No person, with purpose to commit fraud or knowing that the person is facilitating a fraud, shall do either of the following:

(1) Contrary to the terms of the person's provider agreement, charge, solicit, accept, or receive for goods or services that the person provides under the medicaid program any property, money, or other consideration in addition to the amount of reimbursement under the medicaid program and the person's provider agreement for the goods or services and any cost-sharing expenses authorized by section 5162.20 of the Revised Code or rules adopted by the medicaid director regarding the medicaid program.

(2) Solicit, offer, or receive any remuneration, other than any cost-sharing expenses authorized by section 5162.20 of the Revised Code or rules adopted by the medicaid director regarding the medicaid program, in cash or in kind, including, but not limited to, a kickback or rebate, in connection with the furnishing of goods or services for which whole or partial reimbursement is or may be made under the medicaid program.

(D) No person, having submitted a claim for or provided goods or services under the medicaid program, shall do either of the following for a period of at least six years after a reimbursement pursuant to that claim, or a reimbursement for those goods or services, is received under the medicaid program:

(1) Knowingly alter, falsify, destroy, conceal, or remove any records that are necessary to fully disclose the nature of all goods or services for which the claim was submitted, or for which reimbursement was received, by the person;

(2) Knowingly alter, falsify, destroy, conceal, or remove any records that are necessary to disclose fully all income and expenditures upon which rates of reimbursements were based for the person.

(E) Whoever violates this section is guilty of medicaid fraud. Except as otherwise provided in this division, medicaid fraud is a misdemeanor of the first degree. If the value of property, services, or funds obtained in violation of this section is one thousand dollars or more and is less than seven thousand five hundred dollars, medicaid fraud is a felony of the fifth degree. If the value of property, services, or funds obtained in violation of this section is seven thousand five hundred dollars or more and is less than one hundred fifty thousand dollars, medicaid fraud is a felony of the fourth degree. If the value of the property, services, or funds obtained in violation of this section is one hundred fifty thousand dollars or more, medicaid fraud is a felony of the third degree.

(F) Upon application of the governmental agency, office, or other entity that conducted the investigation and prosecution in a case under this section, the court shall order any person who is convicted of a violation of this section for receiving any reimbursement for furnishing goods or services under the medicaid program to which the person is not entitled to pay to the applicant its cost of investigating and prosecuting the case. The costs of investigation and prosecution that a defendant is ordered to pay pursuant to this division shall be in addition to any other penalties for the receipt of that reimbursement that are provided in this section, section 5164.35 of the Revised Code, or any other provision of law.
(G) The provisions of this section are not intended to be exclusive remedies and do not preclude the use of any other criminal or civil remedy for any act that is in violation of this section.

2913.42 Falsifying records.

(A) No person, knowing the person has no privilege to do so, and with purpose to defraud or knowing that the person is facilitating a fraud, shall do any of the following:
   (1) Falsify, destroy, remove, conceal, alter, deface, or mutilate any writing, computer software, data, or record;
   (2) Utter any writing or record, knowing it to have been tampered with as provided in division (A)(1) of this section.

(B) (1) Whoever violates this section is guilty of tampering with records.
   (2) Except as provided in division (B)(4) of this section, if the offense does not involve data or computer software, tampering with records is whichever of the following is applicable:
      (a) If division (B)(2)(b) of this section does not apply, a misdemeanor of the first degree;
      (b) If the writing or record is a will unrevoked at the time of the offense, a felony of the fifth degree.

(3) Except as provided in division (B)(4) of this section, if the offense involves a violation of division (A) of this section involving data or computer software, tampering with records is whichever of the following is applicable:
   (a) Except as otherwise provided in division (B)(3)(b), (c), or (d) of this section, a misdemeanor of the first degree;
   (b) If the writing, data, or computer software involved in the offense or the loss to the victim is five hundred dollars or more and is less than five thousand dollars, a felony of the fifth degree;
   (c) If the writing, data, or computer software involved in the offense or the loss to the victim is five thousand dollars or more and is less than one hundred thousand dollars, a felony of the fourth degree;
   (d) If the writing, data, or computer software involved in the offense or the loss to the victim is one hundred thousand dollars or more or if the offense is committed for the purpose of devising or executing a scheme to defraud or to obtain property or services and the value of the property or services or the loss to the victim is five thousand dollars or more, a felony of the third degree.

(4) If the writing, data, computer software, or record is kept by or belongs to a local, state, or federal governmental entity, a felony of the third degree.

2913.47 Fraudulent use of insurance.

(A) As used in this section:
   (1) "Data" has the same meaning as in section 2913.01 of the Revised Code and additionally includes any other representation of information, knowledge, facts, concepts, or instructions that are being or have been prepared in a formalized manner.
   (2) "Deceptive" means that a statement, in whole or in part, would cause another to be deceived because it contains a misleading representation, withholds information, prevents the acquisition of information, or by any other conduct, act, or omission Creates, confirms, or perpetuates a false impression, including, but not limited to, a false impression as to law, value, state of mind, or other objective or subjective fact.
   (3) "Insurer" means any person that is authorized to engage in the business of insurance in this state under Title XXXIX of the Revised Code, the Ohio fair plan underwriting association
created under section 3929.43 of the Revised Code, any health insuring corporation, and any legal entity that is self-insured and provides benefits to its employees or members.

(4) "Policy" means a policy, certificate, contract, or plan that is issued by an insurer.

(5) "Statement" includes, but is not limited to, any notice, letter, or memorandum; proof of loss; bill of lading; receipt for payment; invoice, account, or other financial statement; estimate of property damage; bill for services; diagnosis or prognosis; prescription; hospital, medical, or dental chart or other record; x-ray, photograph, videotape, or movie film; test result; other evidence of loss, injury, or expense; computer-generated document; and data in any form.

(B) No person, with purpose to defraud or knowing that the person is facilitating a fraud, shall do either of the following:

(1) Present to, or cause to be presented to, an insurer any written or oral statement that is part of, or in support of, an application for insurance, a claim for payment pursuant to a policy, or a claim for any other benefit pursuant to a policy, knowing that the statement, or any part of the statement, is false or deceptive;

(2) Assist, aid, abet, solicit, procure, or conspire with another to prepare or make any written or oral statement that is intended to be presented to an insurer as part of, or in support of, an application for insurance, a claim for payment pursuant to a policy, or a claim for any other benefit pursuant to a policy, knowing that the statement, or any part of the statement, is false or deceptive.

(C) Whoever violates this section is guilty of insurance fraud. Except as otherwise provided in this division, insurance fraud is a misdemeanor of the first degree. If the amount of the claim that is false or deceptive is five hundred dollars or more and is less than five thousand dollars, insurance fraud is a felony of the fifth degree. If the amount of the claim that is false or deceptive is five thousand dollars or more and is less than one hundred thousand dollars, insurance fraud is a felony of the fourth degree. If the amount of the claim that is false or deceptive is one hundred thousand dollars or more, insurance fraud is a felony of the third degree.

(D) This section shall not be construed to abrogate, waive, or modify division (A) of section 2317.02 of the Revised Code.

2913.48 Fraudulent use of workers’ compensation.

(A) No person, with purpose to defraud or knowing that the person is facilitating a fraud, shall do any of the following:

(1) Receive workers’ compensation benefits to which the person is not entitled;

(2) Make or present or cause to be made or presented a false or misleading statement with the purpose to secure payment for goods or services rendered under Chapter 4121, 4123, 4127, or 4131 of the Revised Code or to secure workers’ compensation benefits;

(3) Alter, falsify, destroy, conceal, or remove any record or document that is necessary to fully establish the validity of any claim filed with, or necessary to establish the nature and validity of all goods and services for which reimbursement or payment was received or is requested from, the bureau of workers’ compensation, or a self-insuring employer under Chapter 4121, 4123, 4127, or 4131 of the Revised Code;

(4) Enter into an agreement or conspiracy to defraud the bureau or a self-insuring employer by making or presenting or causing to be made or presented a false claim for workers’ compensation benefits;

(5) Make or present or cause to be made or presented a false statement concerning manual codes, classification of employees, payroll, paid compensation, or number of personnel, when information of that nature is necessary to determine the actual workers’ compensation premium or assessment owed to the bureau by an employer;
(6) Alter, forge, or create a workers' compensation certificate to falsely show current or correct workers' compensation coverage;
(7) Fail to secure or maintain workers' compensation coverage as required by Chapter 4123 of the Revised Code with the intent to defraud the bureau of workers' compensation.

(B) Whoever violates this section is guilty of workers' compensation fraud. Except as otherwise provided in this division, a violation of this section is a misdemeanor of the first degree. If the value of premiums and assessments unpaid pursuant to actions described in division (A)(5), (6), or (7) of this section, or of goods, services, property, or money stolen is five hundred dollars or more and is less than five thousand dollars, a violation of this section is a felony of the fifth degree. If the value of premiums and assessments unpaid pursuant to actions described in division (A)(5), (6), or (7) of this section, or of goods, services, property, or money stolen is five thousand dollars or more and is less than one hundred thousand dollars, a violation of this section is a felony of the fourth degree. If the value of premiums and assessments unpaid pursuant to actions described in division (A)(5), (6), or (7) of this section, or of goods, services, property, or money stolen is one hundred thousand dollars or more, a violation of this section is a felony of the third degree.

(C) Upon application of the governmental body that conducted the investigation and prosecution of a violation of this section, the court shall order the person who is convicted of the violation to pay the governmental body its costs of investigating and prosecuting the case. These costs are in addition to any other costs or penalty provided in the Revised Code or any other section of law.

(D) The remedies and penalties provided in this section are not exclusive remedies and penalties and do not preclude the use of any other criminal or civil remedy or penalty for any act that is in violation of this section.

(E) As used in this section:
(1) "False" means wholly or partially untrue or deceptive.
(2) "Goods" includes, but is not limited to, medical supplies, appliances, rehabilitative equipment, and any other apparatus or furnishing provided or used in the care, treatment, or rehabilitation of a claimant for workers' compensation benefits.
(3) "Services" includes, but is not limited to, any service provided by any health care provider to a claimant for workers' compensation benefits and any and all services provided by the bureau as part of workers' compensation insurance coverage.
(4) "Claim" means any attempt to cause the bureau, an independent third party with whom the administrator or an employer contracts under section 4121.44 of the Revised Code, or a self-insuring employer to make payment or reimbursement for workers' compensation benefits.
(5) "Employment" means participating in any trade, occupation, business, service, or profession for substantial gainful remuneration.
(6) "Employer," "employee," and "self-insuring employer" have the same meanings as in section 4123.01 of the Revised Code.
(7) "Remuneration" includes, but is not limited to, wages, commissions, rebates, and any other reward or consideration.
(8) "Statement" includes, but is not limited to, any oral, written, electronic, electronic impulse, or magnetic communication notice, letter, memorandum, receipt for payment, invoice, account, financial statement, or bill for services; a diagnosis, prognosis, prescription, hospital, medical, or dental chart or other record; and a computer generated document.
(9) "Records" means any medical, professional, financial, or business record relating to the treatment or care of any person, to goods or services provided to any person, or to rates paid for goods or services provided to any person, or any record that the administrator of workers' compensation requires pursuant to rule.
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(10) "Workers’ compensation benefits" means any compensation or benefits payable under Chapter 4121, 4123, 4127, or 4131 of the Revised Code.

3701.91 ODH patient safety telephone line.

The department of health shall make available to the public a toll-free patient safety telephone line. The department may make the toll-free patient safety telephone line available by maintaining a toll-free telephone line specifically for accepting calls regarding patient safety or by using a toll-free telephone line that the department maintains for accepting calls regarding other matters.

The department shall accept calls placed through the toll-free patient safety telephone line by any person seeking to report an action or failure to act in the provision of health care that the person in good faith believes has resulted in or is likely to result in harm to a patient. This section shall not be used by the department to accept calls pertaining to a home, as defined in section 3721.10 of the Revised Code.

A person who makes a report under this section is not required to provide any information to the department that could reveal the person’s identity. Information provided by a person under this section is not a public record as defined in section 149.43 of the Revised Code.

3701.981 Submission of plans, assessments, and other information to department by boards of health and tax-exempt hospitals.

(A) As used in this section:
(1) “Assessment” means either of the following:
(a) A hospital community health needs assessment that meets the requirements set forth in 26 C.F.R. 1.501(r)-3(b);
(b) An assessment of community health conducted by a board of health.
(2) “Board of health” means the board of health of a city or general health district or the authority having the duties of a board of health under section 3709.05 of the Revised Code.
(3) “Plan” means either of the following:
(a) A hospital implementation strategy that meets the requirements set forth in 26 C.F.R. 1.501(r)-3(c);
(b) A plan regarding improving community health created by a board of health.
(4) “Tax-exempt hospital” means a nonprofit hospital or government-owned hospital that is exempt from income tax under section 501(c)(3) of the Internal Revenue Code of 1986, 26 U.S.C. 1, as amended, and that under federal law is a hospital organization required to meet community health needs assessment requirements set forth in 26 C.F.R. 1.501(r)-3.

(B)(1) Not later than July 1, 2017, each board of health and tax-exempt hospital shall submit to the department of health any existing plans and assessments for the most recent assessment and planning period.
(2) Beginning January 1, 2020, each board of health and tax-exempt hospital shall complete assessments and plans in alignment on a three-year interval established by the department. Not later than October 1, 2020, each board of health and tax-exempt hospital shall submit to the department plans and related assessments covering years 2020 through 2022. Beginning October 1, 2023, and every three years thereafter, each board of health and tax-exempt hospital shall submit subsequent plans and related assessments to the department. The department shall provide guidance regarding submitting plans and assessments and shall provide an online repository for the plans and assessments.
(3) Not later than July 1, 2017, and annually thereafter, each tax-exempt hospital shall submit information to the department as follows:
(a) If the hospital is not a government-owned hospital, the hospital shall submit a copy of the hospital's schedule H (form 990) submitted to the internal revenue service for the preceding fiscal year, including corresponding attachments and reporting on financial assistance and means-tested government programs and community building activities in parts I and II of schedule H. Subsequent annual schedule H filings shall be submitted to the department not later than thirty days after filing with the internal revenue service.

(b) If the hospital is a government-owned hospital, the hospital shall submit information that is equivalent to the information that is submitted by a hospital under division (C)(1)(a) of this section.

(2) The department shall provide an online repository for schedule H and equivalent information submitted by tax-exempt hospitals.

**3999.22 Prohibited referrals; anti-kickback.**

(A) As used in this section:

(1) "Claim" means any attempt to cause a health care insurer to make payment of a health care benefit.

(2) "Health care benefit" means the right under a contract or a certificate or policy of insurance to have a payment made by a health care insurer for a specified health care service.

(3) "Health care insurer" means any person that is authorized to do the business of sickness and accident insurance, any health insuring corporation, and any legal entity that is self-insured and provides health care benefits to its employees or members.

(B) No person shall knowingly solicit, offer, pay, or receive any kickback, bribe, or rebate, directly or indirectly, overtly or covertly, in cash or in kind, in return for referring an individual for the furnishing of health care services or goods for which whole or partial reimbursement is or may be made by a health care insurer, except as authorized by the health care or health insurance contract, policy, or plan. This division does not apply to any of the following:

(1) Deductibles, copayments, or similar amounts owed by the person covered by the health care or health insurance contract, policy, or plan;

(2) Discounts or similar reductions in prices;

(3) Any amount paid within a bona fide legal entity, or within legal entities under common ownership or control, including any amount paid to an employee in a bona fide employment relationship;

(4) Any amount paid as part of a bona fide lease, management, or other business contract.

(C) Nothing in this section shall be construed to apply to any of the following:

(1) A provider who provides goods or services requested by an individual that are not covered by the individual's health care or health insurance contract, policy, or plan;

(2) A provider who, in good faith, provides goods or services ordered by another health care provider;

(3) A provider who, in good faith, resubmits a claim previously submitted that has not been paid or denied within thirty days of the original submission, if the provider notifies the payor or returns any duplicate payment within sixty days after receipt of the duplicate payment;

(4) A provider who, in good faith, makes a diagnosis that differs from the interpretation of a diagnosis reached by a health care insurer in the payment of claims.

(D) Whoever violates this section is guilty of a felony of the fifth degree on a first offense and a felony of the fourth degree on each subsequent offense.
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4113.51 Ohio whistleblower protections; definitions.

As used in sections 4113.51 to 4113.53 of the Revised Code:
(A) "Employee" means any person who performs a service for wages or other remuneration for an employer.
(B) "Employer" means any person who has one or more employees. "Employer" includes an agent of an employer, the state or any agency or instrumentality of the state, and any municipal corporation, county, township, school district, or other political subdivision or any agency or instrumentality thereof.
(C) "Person" has the same meaning as in section 1.59 of the Revised Code and also includes a public agency or any other legal entity.
(D) "Peace officer" has the same meaning as in section 2935.01 of the Revised Code.
(E) "Political subdivision" has the same meaning as in division (F) of section 2744.01 of the Revised Code.
(F) "Prosecuting authority" means the prosecuting attorney of a county or the director of law, village solicitor, or similar chief legal officer of a municipal corporation.
(G) "Inspector general" means the inspector general appointed under section 121.48 of the Revised Code.

4113.512 Ohio whistleblower protections; notice to employees and reports.

The employer of an employee whose duties include providing health care or supervising an individual who provides health care may make information available to the employee explaining the employee's duty to make reports pursuant to section 4113.52 of the Revised Code, as well as the employee's opportunity to make reports regarding patient safety pursuant to section 3701.91 of the Revised Code.

4121.44 Workers' compensation qualified health plan program; prohibition against excess charges.

(A) The administrator of workers' compensation shall oversee the implementation of the Ohio workers' compensation qualified health plan system as established under section 4121.442 of the Revised Code.
(B) The administrator shall direct the implementation of the health partnership program administered by the bureau as set forth in section 4121.441 of the Revised Code. To implement the health partnership program and to ensure the efficiency and effectiveness of the public services provided through the program, the bureau:
(1) Shall certify one or more external vendors, which shall be known as “managed care organizations,” to provide medical management and cost containment services in the health partnership program for a period of two years beginning on the date of certification, consistent with the standards established under this section;
(2) May recertify managed care organizations for additional periods of two years; and
(3) May integrate the certified managed care organizations with bureau staff and existing bureau services for purposes of operation and training to allow the bureau to assume operation of the health partnership program at the conclusion of the certification periods set forth in division (B)(1) or (2) of this section;
(4) May enter into a contract with any managed care organization that is certified by the bureau, pursuant to division (B)(1) or (2) of this section, to provide medical management and cost containment services in the health partnership program.
(C) A contract entered into pursuant to division (B)(4) of this section shall include both of the following:
(1) Incentives that may be awarded by the administrator, at the administrator's discretion, based on compliance and performance of the managed care organization;
(2) Penalties that may be imposed by the administrator, at the administrator's discretion, based on the failure of the managed care organization to reasonably comply with or perform terms of the contract, which may include termination of the contract.

(D) Notwithstanding section 119.061 of the Revised Code, a contract entered into pursuant to division (B)(4) of this section may include provisions limiting, restricting, or regulating any marketing or advertising by the managed care organization, or by any individual or entity that is affiliated with or acting on behalf of the managed care organization, under the health partnership program.

(E) No managed care organization shall receive compensation under the health partnership program unless the managed care organization has entered into a contract with the bureau pursuant to division (B)(4) of this section.

(F) Any managed care organization selected shall demonstrate all of the following:
(1) Arrangements and reimbursement agreements with a substantial number of the medical, professional and pharmacy providers currently being utilized by claimants.
(2) Ability to accept a common format of medical bill data in an electronic fashion from any provider who wishes to submit medical bill data in that form.
(3) A computer system able to handle the volume of medical bills and willingness to customize that system to the bureau's needs and to be operated by the managed care organization's staff, bureau staff, or some combination of both staffs.
(4) A prescription drug system where pharmacies on a statewide basis have access to the eligibility and pricing, at a discounted rate, of all prescription drugs.
(5) A tracking system to record all telephone calls from claimants and providers regarding the status of submitted medical bills so as to be able to track each inquiry.
(6) Data processing capacity to absorb all of the bureau's medical bill processing or at least that part of the processing which the bureau arranges to delegate.
(7) Capacity to store, retrieve, array, simulate, and model in a relational mode all of the detailed medical bill data so that analysis can be performed in a variety of ways and so that the bureau and its governing authority can make informed decisions.
(8) Wide variety of software programs which translate medical terminology into standard codes, and which reveal if a provider is manipulating the procedures codes, commonly called "unbundling."
(9) Necessary professional staff to conduct, at a minimum, authorizations for treatment, medical necessity, utilization review, concurrent review, post-utilization review, and have the attendant computer system which supports such activity and measures the outcomes and the savings.
(10) Management experience and flexibility to be able to react quickly to the needs of the bureau in the case of required change in federal or state requirements.

(G)(1) The administrator may decertify a managed care organization if the managed care organization does any of the following:
(a) Fails to maintain any of the requirements set forth in division (F) of this section;
(b) Fails to reasonably comply with or to perform in accordance with the terms of a contract entered into under division (B)(4) of this section;
(c) Violates a rule adopted under section 4121.441 of the Revised Code.
(2) The administrator shall provide each managed care organization that is being decertified pursuant to division (G)(1) of this section with written notice of the pending decertification and an opportunity for a hearing pursuant to rules adopted by the administrator.

(H)(1) Information contained in a managed care organization's application for certification in the health partnership program, and other information furnished to the bureau by a managed care organization for purposes of obtaining certification or to comply with
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performance and financial auditing requirements established by the administrator, is for the
exclusive use and information of the bureau in the discharge of its official duties, and shall not
be open to the public or be used in any court in any proceeding pending therein, unless the
bureau is a party to the action or proceeding, but the information may be tabulated and
published by the bureau in statistical form for the use and information of other state departments
and the public. No employee of the bureau, except as otherwise authorized by the administrator,
shall divulge any information secured by the employee while in the employ of the bureau in
respect to a managed care organization’s application for certification or in respect to the
business or other trade processes of any managed care organization to any person other than
the administrator or to the employee’s superior.

(2) Notwithstanding the restrictions imposed by division (H)(1) of this section, the
governor, members of select or standing committees of the senate or house of representatives,
the auditor of state, the attorney general, or their designees, pursuant to the authority granted in
this chapter and Chapter 4123 of the Revised Code, may examine any managed care
organization application or other information furnished to the bureau by the managed care
organization. None of those individuals shall divulge any information secured in the exercise of
that authority in respect to a managed care organization’s application for certification or in
respect to the business or other trade processes of any managed care organization to any person.

(I) On and after January 1, 2001, a managed care organization shall not be an insurance
company holding a certificate of authority issued pursuant to Title XXXIX of the Revised Code or
a health insuring corporation holding a certificate of authority under Chapter 1751 of the
Revised Code.

(J) The administrator may limit freedom of choice of health care provider or supplier by
requiring, beginning with the period set forth in division (B)(1) or (2) of this section, that
claimants shall pay an appropriate out-of-plan copayment for selecting a medical provider not
within the health partnership program as provided for in this section.

(K) The administrator, six months prior to the expiration of the bureau’s certification or
recertification of the managed care organizations as set forth in division (B)(1) or (2) of this
section, may certify and provide evidence to the governor, the speaker of the house of
representatives, and the president of the senate that the existing bureau staff is able to match or
exceed the performance and outcomes of the managed care organizations and that the bureau
should be permitted to internally administer the health partnership program upon the expiration
of the certification or recertification as set forth in division (B)(1) or (2) of this section.

(L) The administrator shall establish and operate a bureau of workers’ compensation
health care data program. The administrator shall develop reporting requirements from all
employees, employers, medical providers, managed care organizations, and plans that
participate in the workers’ compensation system. The administrator shall do all of the following:

(1) Utilize the collected data to measure and perform comparison analyses of costs,
quality, appropriateness of medical care, and effectiveness of medical care delivered by all
components of the workers’ compensation system.

(2) Compile data to support activities of the selected managed care organizations and to
measure the outcomes and savings of the health partnership program.

(3) Publish and report compiled data on the measures of outcomes and savings of the
health partnership program and submit the report to the president of the senate, the speaker of
the house of representatives, and the governor with the annual report prepared under division
(F)(3) of section 4121.12 of the Revised Code. The administrator shall protect the confidentiality
of all proprietary pricing data.

(M) Any rehabilitation facility the bureau operates is eligible for inclusion in the Ohio
workers’ compensation qualified health plan system or the health partnership program under the
same terms as other providers within health care plans or the program.
(N) In areas outside the state or within the state where no qualified health plan or an inadequate number of providers within the health partnership program exist, the administrator shall permit employees to use a nonplan or nonprogram health care provider and shall pay the provider for the services or supplies provided to or on behalf of an employee for an injury or occupational disease that is compensable under this chapter or Chapter 4123., 4127., or 4131 of the Revised Code on a fee schedule the administrator adopts.

(O) No health care provider, whether certified or not, shall charge, assess, or otherwise attempt to collect from an employee, employer, a managed care organization, or the bureau any amount for covered services or supplies that is in excess of the allowed amount paid by a managed care organization, the bureau, or a qualified health plan.

(P) The administrator shall permit any employer or group of employers who agree to abide by the rules adopted under this section and sections 4121.441 and 4121.442 of the Revised Code to provide services or supplies to or on behalf of an employee for an injury or occupational disease that is compensable under this chapter or Chapter 4123., 4127., or 4131 of the Revised Code through qualified health plans of the Ohio workers’ compensation qualified health plan system pursuant to section 4121.442 of the Revised Code or through the health partnership program pursuant to section 4121.441 of the Revised Code. No amount paid under the qualified health plan system pursuant to section 4121.442 of the Revised Code by an employer who is a state fund employer shall be charged to the employer’s experience or otherwise be used in merit-rating or determining the risk of that employer for the purpose of the payment of premiums under this chapter, and if the employer is a self-insuring employer, the employer shall not include that amount in the paid compensation the employer reports under section 4123.35 of the Revised Code.

(Q) The administrator, in consultation with the health care quality assurance advisory committee created by the administrator or its successor committee, shall develop and periodically revise standards for maintaining an adequate number of providers certified by the bureau for each service currently being used by claimants. The standards shall ensure both of the following:

1. That a claimant has access to a choice of providers for similar services within the geographic area that the claimant resides;
2. That the providers within a geographic area are actively accepting new claimants as required in rules adopted by the administrator.

5160-1-29 False claims and fraud.

(A) For purposes of this rule, the following definitions apply:

1. “Fraud” is defined as an intentional deception, false statement, or misrepresentation made by a person with the knowledge that the deception, false statement, or misrepresentation could result in some unauthorized benefit to oneself or another person. It includes any act that constitutes fraud under applicable federal or state law.
2. “Waste and abuse” are defined as practices that are inconsistent with professional standards of care; medical necessity; or sound fiscal, business, or medical practices; and that constitute an overutilization of medicaid covered services and result in an unnecessary cost to the medicaid program.

(B) The Ohio department of medicaid (ODM) shall have in effect a program to prevent and detect fraud, waste, and abuse in the medicaid program. Where cases of suspected fraud to obtain payment from the medicaid program are detected, providers will be subject to a review by ODM and the case will be referred to the attorney general's medicaid fraud control unit and/or the appropriate enforcement officials. If waste and abuse are suspected or apparent, ODM and/or the office of the attorney general will take action to gain compliance and recoup
inappropriate or excess payments in accordance with rule 5160-1-27 or 5160-26-06 of the Administrative Code.

(C) Cases of provider fraud, waste, and abuse may include, but are not limited to, the following:
(1) A pattern of duplicate billing by a provider to obtain reimbursement to which the provider is not entitled.
(2) Misrepresentation as to services provided, quantity provided, date of service, who performed the service or to whom services were provided.
(3) Billing for services not provided.
(4) A pattern of billing, certifying, prescribing, or ordering services that are not medically necessary or reimbursable in accordance with rule 5160-1-01 of the Administrative Code, not clinically proven and effective, and not consistent with medicaid program rules and regulations.
(5) Differing charges for the same services to medicaid versus non-medicaid consumers.

For inpatient hospital services billed by hospitals reimbursed on a prospective payment basis, ODM will not pay, in the aggregate, more than the provider's customary and prevailing charges for comparable services.

(6) Violation of a provider agreement by requesting or obtaining additional payment for covered medicaid services from either the consumer or consumer's family, other than medicaid co-payments as designated in rule 5160-1-09 of the Administrative Code.

(7) Collusive activities involving the medicaid program between a medicaid provider and any person or business entity.

(8) Misrepresentation of cost report data so as to maximize reimbursement and/or misrepresent gains or losses.

(9) Billing for services that are outside the current license limitations, scope of practice, or specific practice parameters of the person supplying the service.

(10) Misrepresenting by commission or omission any information on the provider enrollment and revalidation application, provider agreement, or any documentation supplied by the provider to ODM.

(11) Ordering excessive quantities of medical supplies, drugs and biologicals, or other services.


(D) ODM will not pay for services prescribed, ordered, or rendered by a provider, when those services were prescribed, ordered, or rendered by that provider after the date the provider was terminated under the medicaid program in accordance with rule 5160-1-17.6 of the Administrative Code.

(E) In instances when a provider suspects that there may be fraud, waste, or abuse by a consumer, the provider should contact the local county department of job and family services (CDJFS). Cases of consumer fraud, waste, and abuse may include, but are not limited to:
(1) Alteration, sale, or lending of the medicaid card to others for securing medical services, or other related criminal activities.

(2) Receiving excessive medical visits and services.

(3) Obtaining services not personally needed and used by the consumer.

(F) Providers must assume responsibility for the business practices of employees. In accordance with rule 5160-1-17.2 of the Administrative Code, the Ohio medicaid provider agreement requires each provider to comply with the terms of the provider agreement, Revised Code, Administrative Code, and federal statutes and rules. Providers shall take the necessary time to thoroughly acquaint themselves and their employees with all rules relative to their participation in the medicaid program. Ignorance of medicaid program rules will not be an acceptable justification for violation of department rules.
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2923.1210 Concealed carry in employee's or invitee's motor vehicle.

(A) A business entity, property owner, or public or private employer may not establish, maintain, or enforce a policy or rule that prohibits or has the effect of prohibiting a person who has been issued a valid concealed handgun license from transporting or storing a firearm or ammunition when both of the following conditions are met:

(1) Each firearm and all of the ammunition remains inside the person's privately owned motor vehicle while the person is physically present inside the motor vehicle, or each firearm and all of the ammunition is locked within the trunk, glove box, or other enclosed compartment or container within or on the person's privately owned motor vehicle;

(2) The vehicle is in a location where it is otherwise permitted to be.

(B) A business entity, property owner, or public or private employer that violates division (A) of this section may be found liable in a civil action for injunctive relief brought by any individual injured by the violation. The court may grant any injunctive relief it finds appropriate.

(C) No business entity, property owner, or public or private employer shall be held liable in any civil action for damages, injuries, or death resulting from or arising out of another person's actions involving a firearm or ammunition transported or stored pursuant to division (A) of this section including the theft of a firearm from an employee's or invitee's automobile, unless the business entity, property owner, or public or private employer intentionally solicited or procured the other person's injurious actions.

2923.126 Concealed carry permits; requirements.

(A) A concealed handgun license that is issued under section 2923.125 of the Revised Code shall expire five years after the date of issuance. A licensee who has been issued a license under that section shall be granted a grace period of thirty days after the licensee's license expires during which the licensee's license remains valid. Except as provided in divisions (B) and (C) of this section, a licensee who has been issued a concealed handgun license under section 2923.125 or 2923.1213 of the Revised Code may carry a concealed handgun anywhere in this state if the licensee also carries a valid license and valid identification when the licensee is in actual possession of a concealed handgun. The licensee shall give notice of any change in the licensee's residence address to the sheriff who issued the license within forty-five days after that change.

If a licensee is the driver or an occupant of a motor vehicle that is stopped as the result of a traffic stop or a stop for another law enforcement purpose and if the licensee is transporting or has a loaded handgun in the motor vehicle at that time, the licensee shall promptly inform any law enforcement officer who approaches the vehicle while stopped that the licensee has been issued a concealed handgun license and that the licensee currently possesses or has a loaded handgun; the licensee shall not knowingly disregard or fail to comply with lawful orders of a law enforcement officer given while the motor vehicle is stopped, knowingly fail to remain in the motor vehicle while stopped, or knowingly fail to keep the licensee's hands in plain sight after any law enforcement officer begins approaching the licensee while stopped and before the officer leaves, unless directed otherwise by a law enforcement officer; and the licensee shall not knowingly have contact with the loaded handgun by touching it with the licensee's hands or fingers, in any manner in violation of division (E) of section 2923.16 of the Revised Code, after any law enforcement officer begins approaching the licensee while stopped and before the officer leaves. Additionally, if a licensee is the driver or an occupant of a commercial motor vehicle that is stopped by an employee of the motor carrier enforcement unit for the purposes
defined in section 5503.34 of the Revised Code and if the licensee is transporting or has a loaded handgun in the commercial motor vehicle at that time, the licensee shall promptly inform the employee of the unit who approaches the vehicle while stopped that the licensee has been issued a concealed handgun license and that the licensee currently possesses or has a loaded handgun.

If a licensee is stopped for a law enforcement purpose and if the licensee is carrying a concealed handgun at the time the officer approaches, the licensee shall promptly inform any law enforcement officer who approaches the licensee while stopped that the licensee has been issued a concealed handgun license and that the licensee currently is carrying a concealed handgun; the licensee shall not knowingly disregard or fail to comply with lawful orders of a law enforcement officer given while the licensee is stopped or knowingly fail to keep the licensee's hands in plain sight after any law enforcement officer begins approaching the licensee while stopped and before the officer leaves, unless directed otherwise by a law enforcement officer; and the licensee shall not knowingly remove, attempt to remove, grasp, or hold the loaded handgun or knowingly have contact with the loaded handgun by touching it with the licensee's hands or fingers, in any manner in violation of division (B) of section 2923.12 of the Revised Code, after any law enforcement officer begins approaching the licensee while stopped and before the officer leaves.

(B) A valid concealed handgun license does not authorize the licensee to carry a concealed handgun in any manner prohibited under division (B) of section 2923.12 of the Revised Code or in any manner prohibited under section 2923.16 of the Revised Code. A valid license does not authorize the licensee to carry a concealed handgun into any of the following places:

(1) A police station, sheriff's office, or state highway patrol station, premises controlled by the bureau of criminal identification and investigation; a state correctional institution, jail, workhouse, or other detention facility; any area of an airport passenger terminal that is beyond a passenger or property screening checkpoint or to which access is restricted through security measures by the airport authority or a public agency; or an institution that is maintained, operated, managed, and governed pursuant to division (A) of section 5119.14 of the Revised Code or division (A)(1) of section 5123.03 of the Revised Code;

(2) A school safety zone if the licensee's carrying the concealed handgun is in violation of section 2923.122 of the Revised Code;

(3) A courthouse or another building or structure in which a courtroom is located, in violation of section 2923.123 of the Revised Code;

(4) Any premises or open air arena for which a D permit has been issued under Chapter 4303 of the Revised Code if the licensee's carrying the concealed handgun is in violation of section 2923.121 of the Revised Code;

(5) Any premises owned or leased by any public or private college, university, or other institution of higher education, unless the handgun is in a locked motor vehicle or the licensee is in the immediate process of placing the handgun in a locked motor vehicle or unless the licensee is carrying the concealed handgun pursuant to a written policy, rule, or other authorization that is adopted by the institution's board of trustees or other governing body and that authorizes specific individuals or classes of individuals to carry a concealed handgun on the premises;

(6) Any church, synagogue, mosque, or other place of worship, unless the church, synagogue, mosque, or other place of worship posts or permits otherwise;

(7) Any building that is a government facility of this state or a political subdivision of this state and that is not a building that is used primarily as a shelter, restroom, parking facility for motor vehicles, or rest facility and is not a courthouse or other building or structure in which a courtroom is located that is subject to division (B)(3) of this section, unless the governing body
with authority over the building has enacted a statute, ordinance, or policy that permits a
licensee to carry a concealed handgun into the building;

(8) A place in which federal law prohibits the carrying of handguns.

(C)(1) Nothing in this section shall negate or restrict a rule, policy, or practice of a private
employer that is not a private college, university, or other institution of higher education
concerning or prohibiting the presence of firearms on the private employer's premises or
property, including motor vehicles owned by the private employer. Nothing in this section shall
require a private employer of that nature to adopt a rule, policy, or practice concerning or
prohibiting the presence of firearms on the private employer's premises or property, including
motor vehicles owned by the private employer.

(2)(a) A private employer shall be immune from liability in a civil action for any injury,
death, or loss to person or property that allegedly was caused by or related to a licensee
bringing a handgun onto the premises or property of the private employer, including motor
vehicles owned by the private employer, unless the private employer acted with malicious
purpose. A private employer is immune from liability in a civil action for any injury, death, or loss
to person or property that allegedly was caused by or related to the private employer's decision
to permit a licensee to bring, or prohibit a licensee from bringing, a handgun onto the premises
or property of the private employer.

(b) A political subdivision shall be immune from liability in a civil action, to the extent and
in the manner provided in Chapter 2744 of the Revised Code, for any injury, death, or loss to
person or property that allegedly was caused by or related to a licensee bringing a handgun
onto any premises or property owned, leased, or otherwise under the control of the political
subdivision. As used in this division, "political subdivision" has the same meaning as in section
2744.01 of the Revised Code.

(c) An institution of higher education shall be immune from liability in a civil action for any
injury, death, or loss to person or property that allegedly was caused by or related to a licensee
bringing a handgun onto the premises of the institution, including motor vehicles owned by the
institution, unless the institution acted with malicious purpose. An institution of higher education
is immune from liability in a civil action for any injury, death, or loss to person or property that
allegedly was caused by or related to the institution's decision to permit a licensee or class of
licensees to bring a handgun onto the premises of the institution.

(3)(a) Except as provided in division (C)(3)(b) of this section, the owner or person in
control of private land or premises, and a private person or entity leasing land or premises
owned by the state, the United States, or a political subdivision of the state or the United States,
may post a sign in a conspicuous location on that land or on those premises prohibiting persons
from carrying firearms or concealed firearms on or onto that land or those premises. Except as
otherwise provided in this division, a person who knowingly violates a posted prohibition of that
nature is guilty of criminal trespass in violation of division (A)(4) of section 2911.21 of the
Revised Code and is guilty of a misdemeanor of the fourth degree. If a person
knowingly violates a posted prohibition of that nature and the posted land or premises primarily was a
parking lot or other parking facility, the person is not guilty of criminal trespass under section
2911.21 of the Revised Code or under any other criminal law of this state or criminal law,
ordinance, or resolution of a political subdivision of this state, and instead is subject only to a
civil cause of action for trespass based on the violation.

If a person knowingly violates a posted prohibition of the nature described in this division
and the posted land or premises is a child day-care center, type A family day-care home, or type
B family day-care home, unless the person is a licensee who resides in a type A family day-care
home or type B family day-care home, the person is guilty of aggravated trespass in violation of
section 2911.211 of the Revised Code. Except as otherwise provided in this division, the
offender is guilty of a misdemeanor of the first degree. If the person previously has been
convicted of a violation of this division or of any offense of violence, if the weapon involved is a
firearm that is either loaded or for which the offender has ammunition ready at hand, or if the weapon involved is dangerous ordnance, the offender is guilty of a felony of the fourth degree.

(b) A landlord may not prohibit or restrict a tenant who is a licensee and who on or after September 9, 2008, enters into a rental agreement with the landlord for the use of residential premises, and the tenant’s guest while the tenant is present, from lawfully carrying or possessing a handgun on those residential premises.

(c) As used in division (C)(3) of this section:
   (i) “Residential premises” has the same meaning as in section 5321.01 of the Revised Code, except “residential premises” does not include a dwelling unit that is owned or operated by a college or university.
   (ii) “Landlord,” “tenant,” and “rental agreement” have the same meanings as in section 5321.01 of the Revised Code.

(D) A person who holds a valid concealed handgun license issued by another state that is recognized by the attorney general pursuant to a reciprocity agreement entered into pursuant to section 109.69 of the Revised Code or a person who holds a valid concealed handgun license under the circumstances described in division (B) of section 109.69 of the Revised Code has the same right to carry a concealed handgun in this state as a person who was issued a concealed handgun license under section 2923.125 of the Revised Code and is subject to the same restrictions that apply to a person who carries a license issued under that section.

(E)(1) A peace officer has the same right to carry a concealed handgun in this state as a person who was issued a concealed handgun license under section 2923.125 of the Revised Code. For purposes of reciprocity with other states, a peace officer shall be considered to be a licensee in this state.

   (2) An active duty member of the armed forces of the United States who is carrying a valid military identification card and documentation of successful completion of firearms training that meets or exceeds the training requirements described in division (G)(1) of section 2923.125 of the Revised Code has the same right to carry a concealed handgun in this state as a person who was issued a concealed handgun license under section 2923.125 of the Revised Code and is subject to the same restrictions as specified in this section.

(F)(1) A qualified retired peace officer who possesses a retired peace officer identification card issued pursuant to division (F)(2) of this section and a valid firearms requalification certification issued pursuant to division (F)(3) of this section has the same right to carry a concealed handgun in this state as a person who was issued a concealed handgun license under section 2923.125 of the Revised Code and is subject to the same restrictions that apply to a person who carries a license issued under that section. For purposes of reciprocity with other states, a qualified retired peace officer who possesses a retired peace officer identification card issued pursuant to division (F)(2) of this section and a valid firearms requalification certification issued pursuant to division (F)(3) of this section shall be considered to be a licensee in this state.

   (2)(a) Each public agency of this state or of a political subdivision of this state that is served by one or more peace officers shall issue a retired peace officer identification card to any person who retired from service as a peace officer with that agency, if the issuance is in accordance with the agency’s policies and procedures and if the person, with respect to the person’s service with that agency, satisfies all of the following:
      (i) The person retired in good standing from service as a peace officer with the public agency, and the retirement was not for reasons of mental instability.
      (ii) Before retiring from service as a peace officer with that agency, the person was authorized to engage in or supervise the prevention, detection, investigation, or prosecution of, or the incarceration of any person for, any violation of law and the person had statutory powers of arrest.
(iii) At the time of the person's retirement as a peace officer with that agency, the person was trained and qualified to carry firearms in the performance of the peace officer's duties.

(iv) Before retiring from service as a peace officer with that agency, the person was regularly employed as a peace officer for an aggregate of fifteen years or more, or, in the alternative, the person retired from service as a peace officer with that agency, after completing any applicable probationary period of that service, due to a service-connected disability, as determined by the agency.

(b) A retired peace officer identification card issued to a person under division (F)(2)(a) of this section shall identify the person by name, contain a photograph of the person, identify the public agency of this state or of the political subdivision of this state from which the person retired as a peace officer and that is issuing the identification card, and specify that the person retired in good standing from service as a peace officer with the issuing public agency and satisfies the criteria set forth in divisions (F)(2)(a)(i) to (iv) of this section. In addition to the required content specified in this division, a retired peace officer identification card issued to a person under division (F)(2)(a) of this section may include the firearms requalification certification described in division (F)(3) of this section, and if the identification card includes that certification, the identification card shall serve as the firearms requalification certification for the retired peace officer. If the issuing public agency issues credentials to active law enforcement officers who serve the agency, the agency may comply with division (F)(2)(a) of this section by issuing the same credentials to persons who retired from service as a peace officer with the agency and who satisfy the criteria set forth in divisions (F)(2)(a)(i) to (iv) of this section, provided that the credentials so issued to retired peace officers are stamped with the word “RETIRED.”

(c) A public agency of this state or of a political subdivision of this state may charge persons who retired from service as a peace officer with the agency a reasonable fee for issuing to the person a retired peace officer identification card pursuant to division (F)(2)(a) of this section.

(3) If a person retired from service as a peace officer with a public agency of this state or of a political subdivision of this state and the person satisfies the criteria set forth in divisions (F)(2)(a)(i) to (iv) of this section, the public agency may provide the retired peace officer with the opportunity to attend a firearms requalification program that is approved for purposes of firearms requalification required under section 109.801 of the Revised Code. The retired peace officer may be required to pay the cost of the course.

If a retired peace officer who satisfies the criteria set forth in divisions (F)(2)(a)(i) to (iv) of this section attends a firearms requalification program that is approved for purposes of firearms requalification required under section 109.801 of the Revised Code, the retired peace officer's successful completion of the firearms requalification program requalifies the retired peace officer for purposes of division (F) of this section for five years from the date on which the program was successfully completed, and the requalification is valid during that five-year period. If a retired peace officer who satisfies the criteria set forth in divisions (F)(2)(a)(i) to (iv) of this section satisfactorily completes such a firearms requalification program, the retired peace officer shall be issued a firearms requalification certification that identifies the retired peace officer by name, identifies the entity that taught the program, specifies that the retired peace officer successfully completed the program, specifies the date on which the course was successfully completed, and specifies that the requalification is valid for five years from that date of successful completion. The firearms requalification certification for a retired peace officer may be included in the retired peace officer identification card issued to the retired peace officer under division (F)(2) of this section.

A retired peace officer who attends a firearms requalification program that is approved for purposes of firearms requalification required under section 109.801 of the Revised Code may be required to pay the cost of the program.
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(G) As used in this section:

(1) “Qualified retired peace officer” means a person who satisfies all of the following:
(a) The person satisfies the criteria set forth in divisions (F)(2)(a)(i) to (v) of this section.
(b) The person is not under the influence of alcohol or another intoxicating or hallucinatory drug or substance.
(c) The person is not prohibited by federal law from receiving firearms.
(2) “Retired peace officer identification card” means an identification card that is issued pursuant to division (F)(2) of this section to a person who is a retired peace officer.
(3) “Government facility of this state or a political subdivision of this state” means any of the following:
(a) A building or part of a building that is owned or leased by the government of this state or a political subdivision of this state and where employees of the government of this state or the political subdivision regularly are present for the purpose of performing their official duties as employees of the state or political subdivision;
(b) The office of a deputy registrar serving pursuant to Chapter 4503 of the Revised Code that is used to perform deputy registrar functions.
(4) “Governing body” has the same meaning as in section 154.01 of the Revised Code.

2923.1210 Concealed carry in employee’s or invitee’s motor vehicle.

(A) A business entity, property owner, or public or private employer may not establish, maintain, or enforce a policy or rule that prohibits or has the effect of prohibiting a person who has been issued a valid concealed handgun license from transporting or storing a firearm or ammunition when both of the following conditions are met:
(1) Each firearm and all of the ammunition remains inside the person's privately owned motor vehicle while the person is physically present inside the motor vehicle, or each firearm and all of the ammunition is locked within the trunk, glove box, or other enclosed compartment or container within or on the person's privately owned motor vehicle;
(2) The vehicle is in a location where it is otherwise permitted to be.
(B) A business entity, property owner, or public or private employer that violates division (A) of this section may be found liable in a civil action for injunctive relief brought by any individual injured by the violation. The court may grant any injunctive relief it finds appropriate.
(C) No business entity, property owner, or public or private employer shall be held liable in any civil action for damages, injuries, or death resulting from or arising out of another person's actions involving a firearm or ammunition transported or stored pursuant to division (A) of this section including the theft of a firearm from an employee's or invitee's automobile, unless the business entity, property owner, or public or private employer intentionally solicited or procured the other person's injurious actions.

2933.52 Intercepting electronic communications.

(A) No person purposely shall do any of the following:
(1) Intercept, attempt to intercept, or procure another person to intercept or attempt to intercept a wire, oral, or electronic communication;
(2) Use, attempt to use, or procure another person to use or attempt to use an interception device to intercept a wire, oral, or electronic communication, if either of the following applies:
(a) The interception device is affixed to, or otherwise transmits a signal through, a wire, cable, satellite, microwave, or other similar method of connection used in wire communications;
(b) The interception device transmits communications by radio, or interferes with the transmission of communications by radio.
(3) Use, or attempt to use, the contents of a wire, oral, or electronic communication, knowing or having reason to know that the contents were obtained through the interception of a wire, oral, or electronic communication in violation of sections 2933.51 to 2933.66 of the Revised Code.

(B) This section does not apply to any of the following:

(1) The interception, disclosure, or use of the contents, or evidence derived from the contents, of an oral, wire, or electronic communication that is obtained pursuant to an order that is issued or an interception that is made in accordance with section 802 of the "Omnibus Crime Control and Safe Streets Act of 1968," 82 Stat. 237, 254, 18 U.S.C. 2510 to 2520 (1968), as amended, the "Electronic Communications Privacy Act of 1986," 100 Stat. 1848-1857, 18 2510-2521 [sic.] (1986), as amended, or the “Foreign Intelligence Surveillance Act,” 92 Stat. 1783, 50 U.S.C. 1801.11 (1978), as amended;

(2) An operator of a switchboard, or an officer, employee, or agent of a provider of wire or electronic communication service, whose facilities are used in the transmission of a wire or electronic communication to intercept, disclose, or use that communication in the normal course of employment while engaged in an activity that is necessary to the rendition of service or to the protection of the rights or property of the provider of that service, except that a provider of wire or electronic communication service to the public shall not utilize service observing or random monitoring except for mechanical or service quality control checks;

(3) A law enforcement officer who intercepts a wire, oral, or electronic communication, if the officer is a party to the communication or if one of the parties to the communication has given prior consent to the interception by the officer;

(4) A person who is not a law enforcement officer and who intercepts a wire, oral, or electronic communication, if the person is a party to the communication or if one of the parties to the communication has given the person prior consent to the interception, and if the communication is not intercepted for the purpose of committing a criminal offense or tortious act in violation of the laws or Constitution of the United States or this state or for the purpose of committing any other injurious act;

(5) A police, fire, or emergency communication system to intercept wire communications coming into and going out of the communications system of a police department, fire department, or emergency center, if both of the following apply:

(a) The telephone, instrument, equipment, or facility is limited to the exclusive use of the communication system for administrative purposes;

(b) At least one telephone, instrument, equipment, or facility that is not subject to interception is made available for public use at each police department, fire department, or emergency center.

(9) The interception or accessing of an electronic communication made through an electronic communication system that is configured so that the electronic communication is readily accessible to the general public.

(10) The interception of a radio communication that is transmitted by any of the following:

(a) A station for the use of the general public;
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(b) Governmental, law enforcement, civil defense, private land mobile, or public safety communications system, including a police or fire system, that is readily accessible to the general public;
(c) A station operating on an authorized frequency within the bands allocated to the amateur, citizen band, or general mobile radio services;
(d) A marine or aeronautical communications system.
(11) The interception of a radio communication that relates to a ship, aircraft, vehicle, or person in distress.
(12) The interception of a wire or electronic communication the transmission of which is causing harmful interference to a lawfully operating station or consumer electronic equipment, to the extent necessary to identify the source of that interference.
(13) Other users of the same frequency to intercept a radio communication made through a system that utilizes frequencies monitored by individuals engaged in the provision or the use of that system, if the communication is not scrambled or encrypted.
(C) Whoever violates this section is guilty of interception of wire, oral, or electronic communications, a felony of the fourth degree.

4112.02 Discriminatory practices unlawful.

It shall be an unlawful discriminatory practice:
(A) For any employer, because of the race, color, religion, sex, military status, national origin, disability, age, or ancestry of any person, to discharge without just cause, to refuse to hire, or otherwise to discriminate against that person with respect to hire, tenure, terms, conditions, or privileges of employment, or any matter directly or indirectly related to employment.
(B) For an employment agency or personnel placement service, because of race, color, religion, sex, military status, national origin, disability, age, or ancestry, to do any of the following:
(1) Refuse or fail to accept, register, classify properly, or refer for employment, or otherwise discriminate against any person;
(2) Comply with a request from an employer for referral of applicants for employment if the request directly or indirectly indicates that the employer fails to comply with the provisions of sections 4112.01 to 4112.07 of the Revised Code.
(C) For any labor organization to do any of the following:
(1) Limit or classify its membership on the basis of race, color, religion, sex, military status, national origin, disability, age, or ancestry;
(2) Discriminate against, limit the employment opportunities of, or otherwise adversely affect the employment status, wages, hours, or employment conditions of any person as an employee because of race, color, religion, sex, military status, national origin, disability, age, or ancestry.
(D) For any employer, labor organization, or joint labor-management committee controlling apprentice training programs to discriminate against any person because of race, color, religion, sex, military status, national origin, disability, or ancestry in admission to, or employment in, any program established to provide apprentice training.
(E) Except where based on a bona fide occupational qualification certified in advance by the commission, for any employer, employment agency, personnel placement service, or labor organization, prior to employment or admission to membership, to do any of the following:
(1) Elicit or attempt to elicit any information concerning the race, color, religion, sex, military status, national origin, disability, age, or ancestry of an applicant for employment or membership;
(2) Make or keep a record of the race, color, religion, sex, military status, national origin, disability, age, or ancestry of any applicant for employment or membership;

(3) Use any form of application for employment, or personnel or membership blank, seeking to elicit information regarding race, color, religion, sex, military status, national origin, disability, age, or ancestry; but an employer holding a contract containing a nondiscrimination clause with the government of the United States, or any department or agency of that government, may require an employee or applicant for employment to furnish documentary proof of United States citizenship and may retain that proof in the employer's personnel records and may use photographic or fingerprint identification for security purposes;

(4) Print or publish or cause to be printed or published any notice or advertisement relating to employment or membership indicating any preference, limitation, specification, or discrimination, based upon race, color, religion, sex, military status, national origin, disability, age, or ancestry;

(5) Announce or follow a policy of denying or limiting, through a quota system or otherwise, employment or membership opportunities of any group because of the race, color, religion, sex, military status, national origin, disability, age, or ancestry of that group;

(6) Utilize in the recruitment or hiring of persons any employment agency, personnel placement service, training school or center, labor organization, or any other employee-referring source known to discriminate against persons because of their race, color, religion, sex, military status, national origin, disability, age, or ancestry.

(F) For any person seeking employment to publish or cause to be published any advertisement that specifies or in any manner indicates that person's race, color, religion, sex, military status, national origin, disability, age, or ancestry, or expresses a limitation or preference as to the race, color, religion, sex, military status, national origin, disability, age, or ancestry of any prospective employer.

(G) For any proprietor or any employee, keeper, or manager of a place of public accommodation to deny to any person, except for reasons applicable alike to all persons regardless of race, color, religion, sex, military status, national origin, disability, age, or ancestry, the full enjoyment of the accommodations, advantages, facilities, or privileges of the place of public accommodation.

(H) Subject to section 4112.024 of the Revised Code, for any person to do any of the following:

(1) Refuse to sell, transfer, assign, rent, lease, sublease, or finance housing accommodations, refuse to negotiate for the sale or rental of housing accommodations, or otherwise deny or make unavailable housing accommodations because of race, color, religion, sex, military status, familial status, ancestry, disability, or national origin;

(2) Represent to any person that housing accommodations are not available for inspection, sale, or rental, when in fact they are available, because of race, color, religion, sex, military status, familial status, ancestry, disability, or national origin;

(3) Discriminate against any person in the making or purchasing of loans or the provision of other financial assistance for the acquisition, construction, rehabilitation, repair, or maintenance of housing accommodations, or any person in the making or purchasing of loans or the provision of other financial assistance that is secured by residential real estate, because of race, color, religion, sex, military status, familial status, ancestry, disability, or national origin or because of the racial composition of the neighborhood in which the housing accommodations are located, provided that the person, whether an individual, corporation, or association of any type, lends money as one of the principal aspects or incident to the person's principal business and not only as a part of the purchase price of an owner-occupied residence the person is selling nor merely casually or occasionally to a relative or friend;

(4) Discriminate against any person in the terms or conditions of selling, transferring, assigning, renting, leasing, or subleasing any housing accommodations or in furnishing facilities,
services, or privileges in connection with the ownership, occupancy, or use of any housing accommodations, including the sale of fire, extended coverage, or homeowners insurance, because of race, color, religion, sex, military status, familial status, ancestry, disability, or national origin or because of the racial composition of the neighborhood in which the housing accommodations are located;

(5) Discriminate against any person in the terms or conditions of any loan of money, whether or not secured by mortgage or otherwise, for the acquisition, construction, rehabilitation, repair, or maintenance of housing accommodations because of race, color, religion, sex, military status, familial status, ancestry, disability, or national origin or because of the racial composition of the neighborhood in which the housing accommodations are located;

(6) Refuse to consider without prejudice the combined income of both husband and wife for the purpose of extending mortgage credit to a married couple or either member of a married couple;

(7) Print, publish, or circulate any statement or advertisement, or make or cause to be made any statement or advertisement, relating to the sale, transfer, assignment, rental, lease, sublease, or acquisition of any housing accommodations, or relating to the loan of money, whether or not secured by mortgage or otherwise, for the acquisition, construction, rehabilitation, repair, or maintenance of housing accommodations, that indicates any preference, limitation, specification, or discrimination based upon race, color, religion, sex, military status, familial status, ancestry, disability, or national origin, or an intention to make any such preference, limitation, specification, or discrimination;

(8) Except as otherwise provided in division (H)(8) or (17) of this section, make any inquiry, elicit any information, make or keep any record, or use any form of application containing questions or entries concerning race, color, religion, sex, military status, familial status, ancestry, disability, or national origin in connection with the sale or lease of any housing accommodations or the loan of any money, whether or not secured by mortgage or otherwise, for the acquisition, construction, rehabilitation, repair, or maintenance of housing accommodations. Any person may make inquiries, and make and keep records, concerning race, color, religion, sex, military status, familial status, ancestry, disability, or national origin for the purpose of monitoring compliance with this chapter.

(9) Include in any transfer, rental, or lease of housing accommodations any restrictive covenant, or honor or exercise, or attempt to honor or exercise, any restrictive covenant;

(10) Induce or solicit, or attempt to induce or solicit, a housing accommodations listing, sale, or transaction by representing that a change has occurred or may occur with respect to the racial, religious, sexual, military status, familial status, or ethnic composition of the block, neighborhood, or other area in which the housing accommodations are located, or induce or solicit, or attempt to induce or solicit, a housing accommodations listing, sale, or transaction by representing that the presence or anticipated presence of persons of any race, color, religion, sex, military status, familial status, ancestry, disability, or national origin, in the block, neighborhood, or other area will or may have results including, but not limited to, the following:

(a) The lowering of property values;

(b) A change in the racial, religious, sexual, military status, familial status, or ethnic composition of the block, neighborhood, or other area;

(c) An increase in criminal or antisocial behavior in the block, neighborhood, or other area;

(d) A decline in the quality of the schools serving the block, neighborhood, or other area.

(11) Deny any person access to or membership or participation in any multiple-listing service, real estate brokers' organization, or other service, organization, or facility relating to the business of selling or renting housing accommodations, or discriminate against any person in the terms or conditions of that access, membership, or participation, on account of race, color, religion, sex, military status, familial status, national origin, disability, or ancestry;
(12) Coerce, intimidate, threaten, or interfere with any person in the exercise or enjoyment of, or on account of that person's having exercised or enjoyed or having aided or encouraged any other person in the exercise or enjoyment of, any right granted or protected by division (H) of this section;

(13) Discourage or attempt to discourage the purchase by a prospective purchaser of housing accommodations, by representing that any block, neighborhood, or other area has undergone or might undergo a change with respect to its religious, racial, sexual, military status, familial status, or ethnic composition;

(14) Refuse to sell, transfer, assign, rent, lease, sublease, or finance, or otherwise deny or withhold, a burial lot from any person because of the race, color, sex, military status, familial status, age, ancestry, disability, or national origin of any prospective owner or user of the lot;

(15) Discriminate in the sale or rental of, or otherwise make unavailable or deny, housing accommodations to any buyer or renter because of a disability of any of the following:

(a) The buyer or renter;

(b) A person residing in or intending to reside in the housing accommodations after they are sold, rented, or made available;

(c) Any individual associated with the person described in division (H)(15)(b) of this section.

(16) Discriminate in the terms, conditions, or privileges of the sale or rental of housing accommodations to any person or in the provision of services or facilities to any person in connection with the housing accommodations because of a disability of any of the following:

(a) That person;

(b) A person residing in or intending to reside in the housing accommodations after they are sold, rented, or made available;

(c) Any individual associated with the person described in division (H)(16)(b) of this section.

(17) Except as otherwise provided in division (H)(17) of this section, make an inquiry to determine whether an applicant for the sale or rental of housing accommodations, a person residing in or intending to reside in the housing accommodations after they are sold, rented, or made available, or any individual associated with that person has a disability, or make an inquiry to determine the nature or severity of a disability of the applicant or such a person or individual. The following inquiries may be made of all applicants for the sale or rental of housing accommodations, regardless of whether they have disabilities:

(a) An inquiry into an applicant's ability to meet the requirements of ownership or tenancy;

(b) An inquiry to determine whether an applicant is qualified for housing accommodations available only to persons with disabilities or persons with a particular type of disability;

(c) An inquiry to determine whether an applicant is qualified for a priority available to persons with disabilities or persons with a particular type of disability;

(d) An inquiry to determine whether an applicant currently uses a controlled substance in violation of section 2925.11 of the Revised Code or a substantively comparable municipal ordinance;

(e) An inquiry to determine whether an applicant at any time has been convicted of or pleaded guilty to any offense, an element of which is the illegal sale, offer to sell, cultivation, manufacture, other production, shipment, transportation, delivery, or other distribution of a controlled substance.

(18)(a) Refuse to permit, at the expense of a person with a disability, reasonable modifications of existing housing accommodations that are occupied or to be occupied by the person with a disability, if the modifications may be necessary to afford the person with a disability full enjoyment of the housing accommodations. This division does not preclude a
landlord of housing accommodations that are rented or to be rented to a disabled tenant from conditioning permission for a proposed modification upon the disabled tenant's doing one or more of the following:

(i) Providing a reasonable description of the proposed modification and reasonable assurances that the proposed modification will be made in a workerlike manner and that any required building permits will be obtained prior to the commencement of the proposed modification;

(ii) Agreeing to restore at the end of the tenancy the interior of the housing accommodations to the condition they were in prior to the proposed modification, but subject to reasonable wear and tear during the period of occupancy, if it is reasonable for the landlord to condition permission for the proposed modification upon the agreement;

(iii) Paying into an interest-bearing escrow account that is in the landlord's name, over a reasonable period of time, a reasonable amount of money not to exceed the projected costs at the end of the tenancy of the restoration of the interior of the housing accommodations to the condition they were in prior to the proposed modification, but subject to reasonable wear and tear during the period of occupancy, if the landlord finds the account reasonably necessary to ensure the availability of funds for the restoration work. The interest earned in connection with an escrow account described in this division shall accrue to the benefit of the disabled tenant who makes payments into the account.

(b) A landlord shall not condition permission for a proposed modification upon a disabled tenant's payment of a security deposit that exceeds the customarily required security deposit of all tenants of the particular housing accommodations.

(19) Refuse to make reasonable accommodations in rules, policies, practices, or services when necessary to afford a person with a disability equal opportunity to use and enjoy a dwelling unit, including associated public and common use areas;

(20) Fail to comply with the standards and rules adopted under division (A) of section 3781.111 of the Revised Code;

(21) Discriminate against any person in the selling, brokering, or appraising of real property because of race, color, religion, sex, military status, familial status, ancestry, disability, or national origin;

(22) Fail to design and construct covered multifamily dwellings for first occupancy on or after June 30, 1992, in accordance with the following conditions:

(a) The dwellings shall have at least one building entrance on an accessible route, unless it is impractical to do so because of the terrain or unusual characteristics of the site.

(b) With respect to dwellings that have a building entrance on an accessible route, all of the following apply:

(i) The public use areas and common use areas of the dwellings shall be readily accessible to and usable by persons with a disability.

(ii) All the doors designed to allow passage into and within all premises shall be sufficiently wide to allow passage by persons with a disability who are in wheelchairs.

(iii) All premises within covered multifamily dwelling units shall contain an accessible route into and through the dwelling; all light switches, electrical outlets, thermostats, and other environmental controls within such units shall be in accessible locations; the bathroom walls within such units shall contain reinforcements to allow later installation of grab bars; and the kitchens and bathrooms within such units shall be designed and constructed in a manner that enables an individual in a wheelchair to maneuver about such rooms.

For purposes of division (H)(22) of this section, "covered multifamily dwellings" means buildings consisting of four or more units if such buildings have one or more elevators and ground floor units in other buildings consisting of four or more units.

(l) For any person to discriminate in any manner against any other person because that person has opposed any unlawful discriminatory practice defined in this section or because that
person has made a charge, testified, assisted, or participated in any manner in any
investigation, proceeding, or hearing under sections 4112.01 to 4112.07 of the Revised Code.

(J) For any person to aid, abet, incite, compel, or coerce the doing of any act declared by
this section to be an unlawful discriminatory practice, to obstruct or prevent any person from
complying with this chapter or any order issued under it, or to attempt directly or indirectly to
commit any act declared by this section to be an unlawful discriminatory practice.

(K) Nothing in divisions (A) to (E) of this section shall be construed to require a person
with a disability to be employed or trained under circumstances that would significantly increase
the occupational hazards affecting either the person with a disability, other employees, the
general public, or the facilities in which the work is to be performed, or to require the
employment or training of a person with a disability in a job that requires the person with a
disability routinely to undertake any task, the performance of which is substantially and
inherently impaired by the person's disability.

(L) An aggrieved individual may enforce the individual's rights relative to discrimination
on the basis of age as provided for in this section by instituting a civil action, within one hundred
eighty days after the alleged unlawful discriminatory practice occurred, in any court with
jurisdiction for any legal or equitable relief that will effectuate the individual's rights.

A person who files a civil action under this division is barred, with respect to the
practices complained of, from instituting a civil action under section 4112.14 of the Revised
Code and from filing a charge with the commission under section 4112.05 of the Revised Code.

(M) With regard to age, it shall not be an unlawful discriminatory practice and it shall not
constitute a violation of division (A) of section 4112.14 of the Revised Code for any employer,
employment agency, joint labor-management committee controlling apprenticeship training
programs, or labor organization to do any of the following:

(1) Establish bona fide employment qualifications reasonably related to the particular
business or occupation that may include standards for skill, aptitude, physical capability,
intelligence, education, maturation, and experience;

(2) Observe the terms of a bona fide seniority system or any bona fide employee benefit
plan, including, but not limited to, a retirement, pension, or insurance plan, that is not a
subterfuge to evade the purposes of this section. However, no such employee benefit plan shall
excuse the failure to hire any individual, and no such seniority system or employee benefit plan
shall require or permit the involuntary retirement of any individual, because of the individual's
age except as provided for in the “Age Discrimination in Employment Act Amendment of 1978,”
92 Stat. 189, 29 U.S.C.A. 623, as amended by the “Age Discrimination in Employment Act

(3) Retire an employee who has attained sixty-five years of age who, for the two-year
period immediately before retirement, is employed in a bona fide executive or a high
policymaking position, if the employee is entitled to an immediate nonforfeitable annual
retirement benefit from a pension, profit-sharing, savings, or deferred compensation plan, or any
combination of those plans, of the employer of the employee, which equals, in the aggregate, at
least forty-four thousand dollars, in accordance with the conditions of the “Age Discrimination in
amended;

(4) Observe the terms of any bona fide apprenticeship program if the program is
registered with the Ohio apprenticeship council pursuant to sections 4139.01 to 4139.06 of the
Revised Code and is approved by the federal committee on apprenticeship of the United States
department of labor.

(N) Nothing in this chapter prohibiting age discrimination and nothing in division (A) of
section 4112.14 of the Revised Code shall be construed to prohibit the following:
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(1) The designation of uniform age the attainment of which is necessary for public employees to receive pension or other retirement benefits pursuant to Chapter 145., 742., 3307., 3309., or 5505 of the Revised Code;
(2) The mandatory retirement of uniformed patrol officers of the state highway patrol as provided in section 5505.16 of the Revised Code;
(3) The maximum age requirements for appointment as a patrol officer in the state highway patrol established by section 5503.01 of the Revised Code;
(4) The maximum age requirements established for original appointment to a police department or fire department in sections 124.41 and 124.42 of the Revised Code;
(5) Any maximum age not in conflict with federal law that may be established by a municipal charter, municipal ordinance, or resolution of a board of township trustees for original appointment as a police officer or firefighter;
(6) Any mandatory retirement provision not in conflict with federal law of a municipal charter, municipal ordinance, or resolution of a board of township trustees pertaining to police officers and firefighters;
(7) Until January 1, 1994, the mandatory retirement of any employee who has attained seventy years of age and who is serving under a contract of unlimited tenure, or similar arrangement providing for unlimited tenure, at an institution of higher education as defined in the “Education Amendments of 1980,” 94 Stat. 1503, 20 U.S.C.A. 1141(a).

(O)(1)(a) Except as provided in division (O)(1)(b) of this section, for purposes of divisions (A) to (E) of this section, a disability does not include any physiological disorder or condition, mental or psychological disorder, or disease or condition caused by an illegal use of any controlled substance by an employee, applicant, or other person, if an employer, employment agency, personnel placement service, labor organization, or joint labor-management committee acts on the basis of that illegal use.

(b) Division (O)(1)(a) of this section does not apply to an employee, applicant, or other person who satisfies any of the following:
(i) The employee, applicant, or other person has successfully completed a supervised drug rehabilitation program and no longer is engaging in the illegal use of any controlled substance, or the employee, applicant, or other person otherwise successfully has been rehabilitated and no longer is engaging in that illegal use.
(ii) The employee, applicant, or other person is participating in a supervised drug rehabilitation program and no longer is engaging in the illegal use of any controlled substance.
(iii) The employee, applicant, or other person is erroneously regarded as engaging in the illegal use of any controlled substance, but the employee, applicant, or other person is not engaging in that illegal use.

(2) Divisions (A) to (E) of this section do not prohibit an employer, employment agency, personnel placement service, labor organization, or joint labor-management committee from doing any of the following:
(a) Adopting or administering reasonable policies or procedures, including, but not limited to, testing for the illegal use of any controlled substance, that are designed to ensure that an individual described in division (O)(1)(b)(i) or (ii) of this section no longer is engaging in the illegal use of any controlled substance;
(b) Prohibiting the illegal use of controlled substances and the use of alcohol at the workplace by all employees;
(c) Requiring that employees not be under the influence of alcohol or not be engaged in the illegal use of any controlled substance at the workplace;
(d) Requiring that employees behave in conformance with the requirements established under “The Drug-Free Workplace Act of 1988,” 102 Stat. 4304, 41 U.S.C.A. 701, as amended;
(e) Holding an employee who engages in the illegal use of any controlled substance or who is an alcoholic to the same qualification standards for employment or job performance, and
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the same behavior, to which the employer, employment agency, personnel placement service, labor organization, or joint labor-management committee holds other employees, even if any unsatisfactory performance or behavior is related to an employee's illegal use of a controlled substance or alcoholism;

(f) Exercising other authority recognized in the “Americans with Disabilities Act of 1990,” 104 Stat. 327, 42 U.S.C.A. 12101, as amended, including, but not limited to, requiring employees to comply with any applicable federal standards.

(3) For purposes of this chapter, a test to determine the illegal use of any controlled substance does not include a medical examination.

(4) Division (O) of this section does not encourage, prohibit, or authorize, and shall not be construed as encouraging, prohibiting, or authorizing, the conduct of testing for the illegal use of any controlled substance by employees, applicants, or other persons, or the making of employment decisions based on the results of that type of testing.

(P) This section does not apply to a religious corporation, association, educational institution, or society with respect to the employment of an individual of a particular religion to perform work connected with the carrying on by that religious corporation, association, educational institution, or society of its activities.

The unlawful discriminatory practices defined in this section do not make it unlawful for a person or an appointing authority administering an examination under section 124.23 of the Revised Code to obtain information about an applicant's military status for the purpose of determining if the applicant is eligible for the additional credit that is available under that section.

4112.14 Age discrimination by employers; civil action.

(A) No employer shall discriminate in any job opening against any applicant or discharge without just cause any employee aged forty or older who is physically able to perform the duties and otherwise meets the established requirements of the job and laws pertaining to the relationship between employer and employee.

(B) Any person aged forty or older who is discriminated against in any job opening or discharged without just cause by an employer in violation of division (A) of this section may institute a civil action against the employer in a court of competent jurisdiction. If the court finds that an employer has discriminated on the basis of age, the court shall order an appropriate remedy which shall include reimbursement to the applicant or employee for the costs, including reasonable attorney's fees, of the action, or to reinstate the employee in the employee's former position with compensation for lost wages and any lost fringe benefits from the date of the illegal discharge and to reimburse the employee for the costs, including reasonable attorney's fees, of the action. The remedies available under this section are coexistent with remedies available pursuant to sections 4112.01 to 4112.11 of the Revised Code; except that any person instituting a civil action under this section is, with respect to the practices complained of, thereby barred from instituting a civil action under division (L) of section 4112.02 of the Revised Code or from filing a charge with the Ohio civil rights commission under section 4112.05 of the Revised Code.

(C) The cause of action described in division (B) of this section and any remedies available pursuant to sections 4112.01 to 4112.11 of the Revised Code shall not be available in the case of discharges where the employee has available to the employee the opportunity to arbitrate the discharge or where a discharge has been arbitrated and has been found to be for just cause.

4123.54 Workers' compensation; drug and alcohol testing.

(A) Except as otherwise provided in this division or divisions (I) and (K) of this section, every employee, who is injured or who contracts an occupational disease, and the dependents
of each employee who is killed, or dies as the result of an occupational disease contracted in the course of employment, wherever the injury has occurred or occupational disease has been contracted, is entitled to receive the compensation for loss sustained on account of the injury, occupational disease, or death, and the medical, nurse, and hospital services and medicines, and the amount of funeral expenses in case of death, as are provided by this chapter. The compensation and benefits shall be provided, as applicable, directly from the employee’s self-insuring employer as provided in section 4123.35 of the Revised Code or from the state insurance fund. An employee or dependent is not entitled to receive compensation or benefits under this division if the employee’s injury or occupational disease is either of the following:

1. Purposely self-inflicted;
2. Caused by the employee being intoxicated, under the influence of a controlled substance not prescribed by a physician, or under the influence of marihuana if being intoxicated, under the influence of a controlled substance not prescribed by a physician, or under the influence of marihuana was the proximate cause of the injury.

(B) For the purpose of this section, provided that an employer has posted written notice to employees that the results of, or the employee’s refusal to submit to, any chemical test described under this division may affect the employee’s eligibility for compensation and benefits pursuant to this chapter and Chapter 4121 of the Revised Code, there is a rebuttable presumption that an employee is intoxicated, under the influence of a controlled substance not prescribed by the employee’s physician, or under the influence of marihuana and that being intoxicated, under the influence of a controlled substance not prescribed by the employee’s physician, or under the influence of marihuana is the proximate cause of an injury under either of the following conditions:

1. When any one or more of the following is true:
   a. The employee, through a qualifying chemical test administered within eight hours of an injury, is determined to have an alcohol concentration level equal to or in excess of the levels established in divisions (A)(1)(b) to (i) of section 4511.19 of the Revised Code.
   b. The employee, through a qualifying chemical test administered within thirty-two hours of an injury, is determined to have a controlled substance not prescribed by the employee’s physician or marihuana in the employee’s system at a level equal to or in excess of the cutoff concentration level for the particular substance as provided in section 40.87 of Title 49 of the Code of Federal Regulations, 49 C.F.R. 40.87, as amended.
   c. The employee, through a qualifying chemical test administered within thirty-two hours of an injury, is determined to have barbiturates, benzodiazepines, or methadone in the employee’s system that tests above levels established by laboratories certified by the United States department of health and human services.
2. When the employee refuses to submit to a requested chemical test, on the condition that the employee is or was given notice that the refusal to submit to any chemical test described in division (B)(1) of this section may affect the employee’s eligibility for compensation and benefits under this chapter and Chapter 4121 of the Revised Code.

(C)(1) For purposes of division (B) of this section, a chemical test is a qualifying test if it is administered to an employee after an injury under at least one of the following conditions:

1. When the employee’s employer had reasonable cause to suspect that the employee may be intoxicated, under the influence of a controlled substance not prescribed by the employee’s physician, or under the influence of marihuana;
   a. At the request of a police officer pursuant to section 4511.191 of the Revised Code, and not at the request of the employee’s employer;
   b. At the request of a licensed physician who is not employed by the employee’s employer, and not at the request of the employee’s employer.
(2) As used in division (C)(1)(a) of this section, “reasonable cause” means, but is not limited to, evidence that an employee is or was using alcohol, a controlled substance, or marihuana drawn from specific, objective facts and reasonable inferences drawn from these facts in light of experience and training. These facts and inferences may be based on, but are not limited to, any of the following:

(a) Observable phenomena, such as direct observation of use, possession, or distribution of alcohol, a controlled substance, or marihuana, or of the physical symptoms of being under the influence of alcohol, a controlled substance, or marihuana, such as but not limited to slurred speech; dilated pupils; odor of alcohol, a controlled substance, or marihuana; changes in affect; or dynamic mood swings;

(b) A pattern of abnormal conduct, erratic or aberrant behavior, or deteriorating work performance such as frequent absenteeism, excessive tardiness, or recurrent accidents, that appears to be related to the use of alcohol, a controlled substance, or marihuana, and does not appear to be attributable to other factors;

(c) The identification of an employee as the focus of a criminal investigation into unauthorized possession, use, or trafficking of a controlled substance or marihuana;

(d) A report of use of alcohol, a controlled substance, or marihuana provided by a reliable and credible source;

(e) Repeated or flagrant violations of the safety or work rules of the employee's employer, that are determined by the employee's supervisor to pose a substantial risk of physical injury or property damage and that appear to be related to the use of alcohol, a controlled substance, or marihuana and that do not appear attributable to other factors.

(D) Nothing in this section shall be construed to affect the rights of an employer to test employees for alcohol or controlled substance abuse.

(E) For the purpose of this section, laboratories certified by the United States department of health and human services or laboratories that meet or exceed the standards of that department for laboratory certification shall be used for processing the test results of a qualifying chemical test.

(F) The written notice required by division (B) of this section shall be the same size or larger than the proof of workers' compensation coverage furnished by the bureau of workers' compensation and shall be posted by the employer in the same location as the proof of workers' compensation coverage or the certificate of self-insurance.

(G) If a condition that pre-existed an injury is substantially aggravated by the injury, and that substantial aggravation is documented by objective diagnostic findings, objective clinical findings, or objective test results, no compensation or benefits are payable because of the pre-existing condition once that condition has returned to a level that would have existed without the injury.

(H)(1) Whenever, with respect to an employee of an employer who is subject to and has complied with this chapter, there is possibility of conflict with respect to the application of workers' compensation laws because the contract of employment is entered into and all or some portion of the work is or is to be performed in a state or states other than Ohio, the employer and the employee may agree to be bound by the laws of this state or by the laws of some other state in which all or some portion of the work of the employee is to be performed. The agreement shall be in writing and shall be filed with the bureau of workers' compensation within ten days after it is executed and shall remain in force until terminated or modified by agreement of the parties similarly filed. If the agreement is to be bound by the laws of this state and the employer has complied with this chapter, then the employee is entitled to compensation and benefits regardless of where the injury occurs or the disease is contracted and the rights of the employee and the employee's dependents under the laws of this state are the exclusive remedy against the employer on account of injury, disease, or death in the course of and arising out of the employee's employment. If the agreement is to be bound by the laws of another state
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and the employer has complied with the laws of that state, the rights of the employee and the
employee's dependents under the laws of that state are the exclusive remedy against the
employer on account of injury, disease, or death in the course of and arising out of the
employee's employment without regard to the place where the injury was sustained or the
disease contracted. If an employer and an employee enter into an agreement under this
division, the fact that the employer and the employee entered into that agreement shall not be
construed to change the status of an employee whose continued employment is subject to the
will of the employer or the employee, unless the agreement contains a provision that expressly
changes that status.

(2) If an employee or the employee's dependents receive an award of compensation or
benefits under this chapter or Chapter 4121., 4127., or 4131 of the Revised Code for the same
injury, occupational disease, or death for which the employee or the employee's dependents
previously pursued or otherwise elected to accept workers' compensation benefits and received
decision on the merits as defined in section 4123.542 of the Revised Code under the laws of
another state or recovered damages under the laws of another state, the claim shall be
disallowed and the administrator or any self-insuring employer, by any lawful means, may
collect from the employee or the employee's dependents any of the following:

(a) The amount of compensation or benefits paid to or on behalf of the employee or the
employee's dependents by the administrator or a self-insuring employer pursuant to this chapter
or Chapter 4121., 4127., or 4131 of the Revised Code for that award;

(b) Any interest, attorney's fees, and costs the administrator or the self-insuring employer
incurs in collecting that payment.

(3) If an employee or the employee's dependents receive an award of compensation or
benefits under this chapter or Chapter 4121., 4127., or 4131 of the Revised Code and
subsequently pursue or otherwise elect to accept workers' compensation benefits or damages
under the laws of another state for the same injury, occupational disease, or death the claim
under this chapter or Chapter 4121., 4127., or 4131 of the Revised Code shall be disallowed.
The administrator or a self-insuring employer, by any lawful means, may collect from the
employee or the employee's dependents or other-states' insurer any of the following:

(a) The amount of compensation or benefits paid to or on behalf of the employee or the
employee's dependents by the administrator or the self-insuring employer pursuant to this
chapter or Chapter 4121., 4127., or 4131 of the Revised Code for that award;

(b) Any interest, costs, and attorney's fees the administrator or the self-insuring employer
incurs in collecting that payment;

(c) Any costs incurred by an employer in contesting or responding to any claim filed by
the employee or the employee's dependents for the same injury, occupational disease, or death
that was filed after the original claim for which the employee or the employee's dependents
received a decision on the merits as described in section 4123.542 of the Revised Code.

(4) If the employee's employer pays premiums into the state insurance fund, the
administrator shall not charge the amount of compensation or benefits the administrator collects
pursuant to division (H)(2) or (3) of this section to the employer's experience. If the administrator
collects any costs incurred by an employer in contesting or responding to any claim pursuant to
division (H)(2) or (3) of this section, the administrator shall forward the amount collected to that
employer. If the employee's employer is a self-insuring employer, the self-insuring employer
shall deduct the amount of compensation or benefits the self-insuring employer collects
pursuant to this division from the paid compensation the self-insuring employer reports to the
administrator under division (L) of section 4123.35 of the Revised Code.

(5) If an employee is a resident of a state other than this state and is insured under the
workers' compensation law or similar laws of a state other than this state, the employee and the
employee's dependents are not entitled to receive compensation or benefits under this chapter,
on account of injury, disease, or death arising out of or in the course of employment while
temporarily within this state, and the rights of the employee and the employee's dependents
under the laws of the other state are the exclusive remedy against the employer on account of
the injury, disease, or death.

(6) An employee, or the dependent of an employee, who elects to receive compensation
and benefits under this chapter or Chapter 4121., 4127., or 4131 of the Revised Code for a
claim may not receive compensation and benefits under the workers' compensation laws of any
state other than this state for that same claim. For each claim submitted by or on behalf of an
employee, the administrator or, if the employee is employed by a self-insuring employer, the
self-insuring employer, shall request the employee or the employee's dependent to sign an
election that affirms the employee's or employee's dependent's acceptance of electing to
receive compensation and benefits under this chapter or Chapter 4121., 4127., or 4131 of the
Revised Code for that claim that also affirmatively waives and releases the employee's or the
employee's dependent's right to file for and receive compensation and benefits under the laws
of any state other than this state for that claim. The employee or employee's dependent shall
sign the election form within twenty-eight days after the administrator or self-insuring employer
submits the request or the administrator or self-insuring employer shall dismiss that claim.

In the event a workers' compensation claim has been filed in another jurisdiction on
behalf of an employee or the dependents of an employee, and the employee or dependents
subsequently elect to receive compensation, benefits, or both under this chapter or Chapter
4121., 4127., or 4131 of the Revised Code, the employee or dependent shall withdraw or refuse
acceptance of the workers' compensation claim filed in the other jurisdiction in order to pursue
compensation or benefits under the laws of this state. If the employee or dependents were
awarded workers' compensation benefits or had recovered damages under the laws of the other
state, any compensation and benefits awarded under this chapter or Chapter 4121., 4127., or
4131 of the Revised Code shall be paid only to the extent to which those payments exceed the
amounts paid under the laws of the other state. If the employee or dependent fails to withdraw
or to refuse acceptance of the workers' compensation claim in the other jurisdiction within
twenty-eight days after a request made by the administrator or a self-insuring employer, the
administrator or self-insuring employer shall dismiss the employee's or employee's dependents'
claim made in this state.

(I) If an employee who is covered under the federal "Longshore and Harbor Workers'
Compensation Act," 98 Stat. 1639, 33 U.S.C. 901 et seq., is injured or contracts an occupational
disease or dies as a result of an injury or occupational disease, and if that employee's or that
employee's dependents' claim for compensation or benefits for that injury, occupational disease,
or death is subject to the jurisdiction of that act, the employee or the employee's dependents are
not entitled to apply for and shall not receive compensation or benefits under this chapter and
Chapter 4121 of the Revised Code. The rights of such an employee and the employee's
dependents under the federal "Longshore and Harbor Workers' Compensation Act," 98 Stat.
1639, 33 U.S.C. 901 et seq., are the exclusive remedy against the employer for that injury,
occupational disease, or death.

(J) Compensation or benefits are not payable to a claimant or a dependent during the
period of confinement of the claimant or dependent in any state or federal correctional
institution, or in any county jail in lieu of incarceration in a state or federal correctional institution,
whether in this or any other state for conviction of violation of any state or federal criminal law.

(K) An employer, upon the approval of the administrator, may provide for workers'
compensation coverage for the employer's employees who are professional athletes and
coaches by submitting to the administrator proof of coverage under a league policy issued
under the laws of another state under either of the following circumstances:

(1) The employer administers the payroll and workers' compensation insurance for a
professional sports team subject to a collective bargaining agreement, and the collective
bargaining agreement provides for the uniform administration of workers’ compensation benefits and compensation for professional athletes.

(2) The employer is a professional sports league, or is a member team of a professional sports league, and all of the following apply:

(a) The professional sports league operates as a single entity, whereby all of the players and coaches of the sports league are employees of the sports league and not of the individual member teams.

(b) The professional sports league at all times maintains workers’ compensation insurance that provides coverage for the players and coaches of the sports league.

(c) Each individual member team of the professional sports league, pursuant to the organizational or operating documents of the sports league, is obligated to the sports league to pay to the sports league any workers’ compensation claims that are not covered by the workers’ compensation insurance maintained by the sports league.

If the administrator approves the employer’s proof of coverage submitted under division (K) of this section, a professional athlete or coach who is an employee of the employer and the dependents of the professional athlete or coach are not entitled to apply for and shall not receive compensation or benefits under this chapter and Chapter 4121 of the Revised Code. The rights of such an athlete or coach and the dependents of such an athlete or coach under the laws of the state where the policy was issued are the exclusive remedy against the employer for the athlete or coach if the athlete or coach suffers an injury or contracts an occupational disease in the course of employment, or for the dependents of the athlete or the coach if the athlete or coach is killed as a result of an injury or dies as a result of an occupational disease, regardless of the location where the injury was suffered or the occupational disease was contracted.
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339.78 Physicians report of tuberculosis to county or district TB control unit.

(A) When a physician completes diagnostic studies confirming that an individual has tuberculosis, the physician shall report the confirmed case of tuberculosis to the county or district tuberculosis control unit. A physician shall make a report to the tuberculosis control unit prior to completion of diagnostic studies if the signs and symptoms demonstrated by an individual are sufficient for the physician to suspect that the individual has tuberculosis. At any time it is determined that an individual's tuberculosis is resistant to one or more drugs, the physician shall make a report to the unit.

The physician attending an individual with tuberculosis shall document the individual's adherence to the treatment regimen that the physician prescribes and make a report to the tuberculosis control unit if the individual does not adhere to the regimen.

In each report made under this division, the physician shall provide all information that the tuberculosis control unit requests. The information shall be provided at intervals specified by the tuberculosis control unit.

(B) In addition to accepting reports made by physicians under division (A) of this section, a county or district tuberculosis control unit shall accept reports made as follows:

1. The administrator of a hospital, clinic, or other facility that is providing services to an individual who is confirmed to have or is suspected of having tuberculosis shall report the case to the tuberculosis control unit;

2. The administrator of a laboratory that performs tests for tuberculosis on human specimens shall report to the tuberculosis control unit each positive tuberculosis test result obtained;

3. Any person who suspects that an individual has tuberculosis may report that suspicion to the tuberculosis control unit.

3701.13 Authority of Department of Health.

The department of health shall have supervision of all matters relating to the preservation of the life and health of the people and have ultimate authority in matters of quarantine and isolation, which it may declare and enforce, when neither exists, and modify, relax, or abolish, when either has been established. The department may approve methods of immunization against the diseases specified in section 3313.671 of the Revised Code for the purpose of carrying out the provisions of that section and take such actions as are necessary to encourage vaccination against those diseases.

The department may make special or standing orders or rules for preventing the use of fluoroscopes for nonmedical purposes that emit doses of radiation likely to be harmful to any person, for preventing the spread of contagious or infectious diseases, for governing the receipt and conveyance of remains of deceased persons, and for such other sanitary matters as are best controlled by a general rule. Whenever possible, the department shall work in cooperation with the health commissioner of a general or city health district. The department may make and enforce orders in local matters or reassign substantive authority for mandatory programs from a general or city health district to another general or city health district when an emergency exists, or when the board of health of a general or city health district has neglected or refused to act with sufficient promptness or efficiency, or when such board has not been established as
provided by sections 3709.02, 3709.03, 3709.05, 3709.06, 3709.11, 3709.12, and 3709.14 of the Revised Code. In such cases, the necessary expense incurred shall be paid by the general health district or city for which the services are rendered.

The department of health may require general or city health districts to enter into agreements for shared services under section 9.482 of the Revised Code. The department shall prepare and offer to boards of health a model contract and memorandum of understanding that are easily adaptable for use by boards of health when entering into shared services agreements. The department also may offer financial and other technical assistance to boards of health to encourage the sharing of services.

As a condition precedent to receiving funding from the department of health, the director of health may require general or city health districts to apply for accreditation by July 1, 2018, and be accredited by July 1, 2020, by an accreditation body approved by the director. The director of health, by July 1, 2016, shall conduct an evaluation of general and city health district preparation for accreditation, including an evaluation of each district's reported public health quality indicators as provided for in section 3701.98 of the Revised Code.

The department may make evaluative studies of the nutritional status of Ohio residents, and of the food and nutrition-related programs operating within the state. Every agency of the state, at the request of the department, shall provide information and otherwise assist in the execution of such studies.

3701.14 Director of health special duties.

(A) The director of health shall investigate or make inquiry as to the cause of disease or illness, including contagious, infectious, epidemic, pandemic, or endemic conditions, and take prompt action to control and suppress it. The reports of births and deaths, the sanitary conditions and effects of localities and employments, the personal and business habits of the people that affect their health, and the relation of the diseases of man and beast, shall be subjects of study by the director. The director may make and execute orders necessary to protect the people against diseases of lower animals, and shall collect and preserve information in respect to such matters and kindred subjects as may be useful in the discharge of the director's duties, and for dissemination among the people. When called upon by the state or local governments, or the board of health of a general or city health district, the director shall promptly investigate and report upon the water supply, sewerage, disposal of excreta of any locality, and the heating, plumbing, and ventilation of a public building.

(B) Information obtained during an investigation or inquiry that the director currently is conducting pursuant to division (A) of this section and that is not yet complete is confidential during the course of that investigation or inquiry and shall not be released except pursuant to division (D) or (J) of this section or under one of the following conditions:

(1) The confidential information is released pursuant to a search warrant or subpoena issued by or at the request of a grand jury or prosecutor, as defined in section 2935.01 of the Revised Code.

(2) The director has entered into a written agreement to share or exchange the information with a person or government entity, and that agreement requires the person or entity to comply with the confidentiality requirements established under this section.

(3) The information is contained in a preliminary report released by the director pursuant to division (G)(1) of this section.

(C) Division (B) of this section applies during any investigation or inquiry the director makes pursuant to division (A) of this section, notwithstanding any other provision of the Revised Code that establishes the manner of maintaining confidentiality or the release of information, except that the confidentiality and release of protected health information under section 3701.17 of the Revised Code is governed by that section.
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(D) Nothing in this section bars the release of information that is in summary, statistical, or aggregate form and that does not identify a person. Information that is in summary, statistical, or aggregate form and that does not identify a person is a public record under section 149.43 of the Revised Code.

(E) Nothing in this section authorizes the director to conduct an independent criminal investigation without the consent of each local law enforcement agency with jurisdiction to conduct the criminal investigation.

(F) Except for information released pursuant to division (G) or (J) of this section, any disclosure pursuant to this section shall be in writing and accompanied by a written statement that includes the following or substantially similar language: "This information has been disclosed to you from confidential records protected from disclosure by state law. If this information has been released to you in other than a summary, statistical, or aggregate form, you shall make no further disclosure of this information without the specific, written, and informed release of the person to whom it pertains, or as otherwise permitted by state law. A general authorization for the release of medical or other information is not sufficient for the release of information pursuant to this section."

(G)(1) If an investigation or inquiry the director currently is conducting pursuant to division (A) of this section is not completed within six months after the date of commencement, the director shall prepare and release a report containing preliminary findings. Every six months thereafter, the director shall prepare and release a supplementary preliminary report until such time as the investigation or inquiry is completed.

(2) Upon completion of an investigation or inquiry conducted pursuant to division (A) of this section, the director shall prepare and release a final report containing the director's findings.

(H) No report prepared by the director pursuant to this section shall contain protected health information, as defined in section 3701.17 of the Revised Code.

(I) The director shall adopt, in accordance with Chapter 119 of the Revised Code, rules establishing the manner in which the reports prepared by the director pursuant to this section are to be released.

(J) The director shall release information obtained during an investigation or inquiry that the director currently is conducting pursuant to division (A) of this section and that is not yet complete, if the director determines the release of the information is necessary, based on an evaluation of relevant information, to avert or mitigate a clear threat to an individual or to the public health. Information released pursuant to this division shall be limited to the release of the information to those persons necessary to control, prevent, or mitigate disease or illness.

3701.17 Maintaining confidential health information; releasing information.

(A) As used in this section:

(1) "Prosecutor" has the same meaning as in section 2935.01 of the Revised Code.

(2) "Protected health information" means information, in any form, including oral, written, electronic, visual, pictorial, or physical that describes an individual's past, present, or future physical or mental health status or condition, receipt of treatment or care, or purchase of health products, if either of the following applies:

(a) The information reveals the identity of the individual who is the subject of the information.

(b) The information could be used to reveal the identity of the individual who is the subject of the information, either by using the information alone or with other information that is available to predictable recipients of the information.

(B) Protected health information reported to or obtained by the director of health, the department of health, or a board of health of a city or general health district is confidential and
shall not be released without the written consent of the individual who is the subject of the information unless the information is released pursuant to division (C) of this section or one of the following applies:

(1) The release of the information is necessary to provide treatment to the individual and the information is released pursuant to a written agreement that requires the recipient of the information to comply with the confidentiality requirements established under this section.

(2) The release of the information is necessary to ensure the accuracy of the information and the information is released pursuant to a written agreement that requires the recipient of the information to comply with the confidentiality requirements established under this section.

(3) The information is released pursuant to a search warrant or subpoena issued by or at the request of a grand jury or prosecutor in connection with a criminal investigation or prosecution.

(4) The director determines the release of the information is necessary, based on an evaluation of relevant information, to avert or mitigate a clear threat to an individual or to the public health. Information may be released pursuant to this division only to those persons or entities necessary to control, prevent, or mitigate disease.

(C) Information that does not identify an individual is not protected health information and may be released in summary, statistical, or aggregate form. Information that is in a summary, statistical, or aggregate form and that does not identify an individual is a public record under section 149.43 of the Revised Code and, upon request, shall be released by the director.

(D) Except for information released pursuant to division (B)(4) of this section, any disclosure pursuant to this section shall be in writing and accompanied by a written statement that includes the following or substantially similar language: "This information has been disclosed to you from confidential records protected from disclosure by state law. If this information has been released to you in other than a summary, statistical, or aggregate form, you shall make no further disclosure of this information without the specific, written, and informed release of the individual to whom it pertains, or as otherwise permitted by state law. A general authorization for the release of medical or other information is not sufficient for the release of information pursuant to this section."

3701.22 Maintaining a public health laboratory.

The department of health shall maintain a public health laboratory for the following:

(A) Examination of public water supplies and the effluent of sewage purification works;

(B) Diagnosis of, screening for, or confirmation of diseases or pathogens as it deems necessary;

(C) Performance of biological, chemical, or radiological analyses or examinations as it deems necessary;

(D) Analysis of patient specimens and food samples necessary for investigation of food-borne illnesses. In food-borne illness investigations, the laboratory shall cooperate and consult with the director of agriculture acting pursuant to section 3715.02 of the Revised Code.

3701.232 Pharmacy or pharmacist’s duty to report.

(A) As used in this section:

(1) "Bioterrorism" means the intentional use of any microorganism, virus, infectious substance, or biological product that may be engineered as a result of biotechnology, or any naturally occurring or bioengineered component of a microorganism, virus, infectious substance, or biological product, to cause death, disease, or other biological malfunction in a human, animal, plant, or other living organism as a means of influencing the conduct of government or intimidating or coercing a population.
(2) “Pharmacist” means an individual licensed under Chapter 4729 of the Revised Code to engage in the practice of pharmacy as a pharmacist.

(3) “Pharmacy” and “prescription” have the same meanings as in section 4729.01 of the Revised Code.

(B) The director of health shall adopt rules in accordance with Chapter 119 of the Revised Code under which a pharmacy or pharmacist is required to report significant changes in medication usage that may be caused by bioterrorism, epidemic or pandemic disease, or established or novel infectious agents or biological toxins posing a risk of human fatality or disability. Rules adopted under this section may require a report of any of the following:

(1) An unexpected increase in the number of prescriptions for antibiotics;
(2) An unexpected increase in the number of prescriptions for medication to treat fever or respiratory or gastrointestinal complaints;
(3) An unexpected increase in sales of, or the number of requests for information on, over-the-counter medication to treat fever or respiratory or gastrointestinal complaints;
(4) Any prescription for medication used to treat a disease that is relatively uncommon and may have been caused by bioterrorism.

(C) No person shall fail to comply with any reporting requirement established in rules adopted under division (B) of this section.

(D) Information reported under this section that is protected health information pursuant to section 3701.17 of the Revised Code shall be released only in accordance with that section. Information that does not identify an individual may be released in summary, statistical, or aggregate form.

3701.352 Violation of health department pandemic, epidemic, bioterrorism rule.

No person shall violate any rule the director of health or department of health adopts or any order the director or department of health issues under this chapter to prevent a threat to the public caused by a pandemic, epidemic, or bioterrorism event.

3701.85 Automated external defibrillator.

(A) As used in this section:

(1) “Automated external defibrillation” has the same meaning as in section 2305.235 of the Revised Code.
(2) “Emergency medical services organization” has the same meaning as in section 4765.01 of the Revised Code.

(B) A person who possesses an automated external defibrillator shall do both of the following:

(1) Encourage expected users to complete successfully a course in automated external defibrillation and cardiopulmonary resuscitation that is offered or approved by a nationally recognized organization and includes instruction on psychomotor skills and national evidence-based emergency cardiovascular guidelines that are current;
(2) Maintain and test the defibrillator according to the manufacturer's guidelines.

(C) It is recommended, but not required, that a person who possesses an automated external defibrillator notify an emergency medical services organization of the location of the defibrillator.

(D) Any person may perform automated external defibrillation. Training in automated external defibrillation and cardiopulmonary resuscitation is recommended but not required.

A person who performs automated external defibrillation shall make a good faith effort to activate or have another person activate an emergency medical services system as soon as possible unless the person is performing automated external defibrillation as part of an
Part II. Animal Bite

3701-3-28 Reporting dog/mammal bite.

(A) Whenever an individual is bitten by a dog or other non-human mammal, report of such bite shall be made within twenty-four hours to the health commissioner of the district in which such bite occurred. The report herein required shall be made by any health care provider, or by any licensed doctor of veterinary medicine with knowledge of the bite, or by the individual bitten.

(B) Local health districts are required to submit information regarding non-human mammalian bites occurring in their district to the Ohio department of health annually. This report for non-human mammalian bites occurring in the previous calendar year shall be submitted by March first.

3701-3-29 Reporting and confining biting animal.

(A) Biting dog, cat, or ferret.

(1) Whenever it is reported to the health commissioner of a health district that any dog, cat, or ferret has bitten or otherwise exposed an individual to rabies, that dog, cat, or ferret shall be quarantined under an order issued by the health commissioner of the health district in which the bite or exposure occurred.

(a) The dog, cat, or ferret shall be quarantined by its owner or by a harborer, or shall be quarantined in a pound or kennel.

(b) In all cases, said quarantine shall be under the supervision of the health commissioner and shall be at the expense of the owner or harborer.

(c) Any sign of illness in the quarantined dog, cat or ferret must be reported immediately to the health commissioner.

(d) Quarantine shall continue until the health commissioner of the health district in which the bite was inflicted determines pursuant to paragraph (A)(1)(f) of this rule that the dog, cat, or ferret is not afflicted with rabies.

(e) The quarantine period hereby required shall not be less than ten days from the date on which the person was bitten.

(f) If at any time during the quarantine, the health commissioner requires the dog, cat, or ferret to be examined for symptoms of rabies, then the examination shall be by a licensed doctor of veterinary medicine. The licensed doctor of veterinary medicine shall report to the health commissioner the conclusions reached as a result of the examinations. The examination by a licensed doctor of veterinary medicine shall be at the expense of the owner or harborer.

(g) No dog, cat, or ferret shall be released from the required quarantine unless and until it has a current rabies vaccination status as demonstrated by a rabies vaccination certificate signed by a licensed doctor of veterinary medicine.

(2) If any quarantined dog, cat, or ferret dies before the quarantine period expires, then the head of the dog, cat, or ferret shall be submitted to the Ohio department of health's bureau of public health laboratory for rabies examination.

(3) If the owner or harborer of the dog, cat, or ferret is unknown, the health commissioner may direct that the dog, cat, or ferret be humanely killed in which case the head of the dog, cat, or ferret shall be submitted to the Ohio department of health's bureau of public health laboratory for rabies examination.
(B) Other biting mammals including hybrids.

(1) Whenever it is reported to the health commissioner of the health district that any other mammal that is known to transmit rabies has bitten or otherwise exposed an individual to rabies, under an order issued by the health commissioner of the health district in which the bite or exposure occurred, the health commissioner may direct the immediate killing of said mammal by a suitable humane method.

(2) The brain of said mammal shall then be submitted to the Ohio department of health's bureau of public health laboratory for rabies examination.

(C) Any non-human mammal bitten by a known rabid mammal, or that had reasonable probability to have been bitten by a wild carnivorous mammal or bat that is not available for rabies testing shall be regarded as having been exposed to the rabies virus.

(1) Dogs, cats, ferrets not currently vaccinated against the rabies virus or when vaccination cannot be verified shall be humanely killed; or if sufficient justification for preserving the animal exists, the exposed dog, cat, ferret shall be quarantined in strict isolation under an order issued by the health commissioner of the health district in which the bite was inflicted. Isolation in this context refers to confinement in an enclosure that precludes direct contact with people and other animals.

(a) In all cases, said quarantine shall be under the supervision of the health commissioner and shall be at the expense of the owner or harborer. Any signs of illness in the dog, cat, or ferret must be reported immediately to the health commissioner.

(b) The quarantine period shall be for not less than six months. The dog, cat, or ferret shall be vaccinated against rabies by a licensed doctor of veterinary medicine upon entry into quarantine or up to twenty-eight days before the end of the quarantine period required by this paragraph.

(2) Mammals with a current rabies vaccination shall be given a booster rabies vaccination immediately and quarantined under an order issued by the health commissioner of the health district in which the bite was inflicted.

(a) In all cases, said quarantine shall be under the supervision of the health commissioner and shall be at the expense of the owner or harborer. Any signs of illness in the dog, cat, or ferret must be reported immediately to the health commissioner.

(b) The quarantine period shall be for not less than forty-five days.

(3) Whenever it is known by the health commissioner of the health district that any other non-human mammal has been exposed to rabies, the health commissioner, at his or her discretion may direct the quarantine or immediate euthanizing of said mammal by a suitable humane method.

3701-3-30 Reporting suspected rabid mammal.

Any licensed doctor of veterinary medicine or other person who examines, treats, owns, harbors, or otherwise cares for any mammal which exhibits symptoms or behavior suggestive of rabies, shall confine and isolate such mammal in suitable quarters and shall report such fact within twenty-four hours after the symptoms or behaviors are observed or known to the health commissioner of the health district wherein such mammal is confined. Such mammal shall be confined until it has been determined that it is not afflicted with rabies. If it is determined that the mammal is rabid, the health commissioner shall take such action as is necessary to prevent the occurrence of rabies in individuals or mammals known or presumed to have been exposed to such rabid mammal.
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3701.19 Poison prevention and treatment center; definitions.

As used in sections 3701.19 to 3701.201 of the Revised Code:
(A) "Poison prevention and treatment center" means an entity designated as a poison prevention and treatment center by the director of health under section 3701.20 of the Revised Code.
(B) "Harm" means injury, death, or loss to person or property.
(C) "Tort action" means a civil action for damages for injury, death, or loss to person or property. "Tort action" includes a product liability claim that is subject to sections 2307.71 to 2307.80 of the Revised Code, but does not include a civil action for a breach of contract or another agreement between persons.
(D)(1) Subject to division (D)(2) of this section, "volunteer" means a trustee, officer, or agent of a poison prevention and treatment center, or another person associated with such a center, who satisfies both of the following:
   (a) Performs services for or on behalf of, and under the authority or auspices of, the center;
   (b) Does not receive compensation, either directly or indirectly, for performing those services.
(2) For purposes of division (D)(1) of this section, "compensation" does not include any of the following:
   (a) Actual and necessary expenses that are incurred by a volunteer in connection with the services performed for a center, and that are reimbursed to the volunteer or otherwise paid;
   (b) Insurance premiums paid on behalf of a volunteer, and amounts paid or reimbursed, pursuant to division (E) of section 1702.12 of the Revised Code;
   (c) Modest perquisites.

3701.20 Establishing, promoting, and maintaining poison control network.

(A) In accordance with rules adopted under division (C) of this section, the director of health shall establish, promote, and maintain the Ohio poison control network; designate regions within the network; and designate poison prevention and treatment centers within each region. The purposes of the network are to:
   (1) Reduce the mortality resulting from and the expenditures incurred because of accidental, homicidal, suicidal, occupational, or environmental poisoning;
   (2) Educate the public and health care professionals concerning the prevention and treatment of exposure to poison;
   (3) Organize poison prevention and treatment activities on a regional basis to avoid duplication and waste.
(B) To be eligible for designation as a poison prevention and treatment center and to retain the designation, a center must maintain compliance with the standards established by the director pursuant to division (C) of this section. A poison prevention and treatment center may be operated by an individual, hospital, institution of higher education, political subdivision, association, corporation, or public or private agency.
(C) In accordance with Chapter 119 of the Revised Code, the director shall adopt rules that do the following:
   (1) Establish guidelines, based on population density and other relevant factors, and procedures to be followed in designating poison control network regions and centers;
   (2) Establish standards for the operation of poison prevention and treatment centers;
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(3) Establish standards and procedures to be followed in making grants to poison prevention and treatment centers;
(4) Establish procedures, other than those prescribed by Chapter 119 of the Revised Code, for reconsideration, at the request of the entity affected, of the denial or revocation of a designation as a poison prevention and treatment center.
(D) In accordance with rules adopted under division (C) of this section, the director of health shall make grants to poison prevention and treatment centers. A center is not eligible for a grant unless, prior to receiving the grant, the entity that operates the center agrees in writing that the level of the total funds, labor, and services devoted by the entity to the center during the period of the grant will approximate, as determined by the director of health, the level of the total funds, labor, and services devoted to the center by that entity in the fiscal year preceding the fiscal year in which the grant begins.
(E) Each poison prevention and treatment center shall do all of the following:
   (1) Maintain and staff a twenty-four-hour per day, toll-free, telephone line to respond to inquiries and provide information about poison prevention and treatment and available services;
   (2) Provide specialized treatment, consultation, information, and educational programs to health care professionals and the public;
   (3) Compile information on the types and frequency of treatment it provides.
   A center may provide the services described in divisions (E)(1) and (2) of this section either directly or through contract with other facilities, as the director of health considers appropriate. Each center shall take measures to ensure the confidentiality of information about individuals to whom treatment or services are provided.
(F) The director of health may revoke the designation of a poison treatment and control center, or deny an application for designation, if the center or applicant fails to meet or maintain the standards established in rules adopted under division (C) of this section. The entity seeking the designation may have the revocation or denial reconsidered in accordance with rules adopted under division (C) of this section.
(G)(1) A poison prevention and treatment center, its officers, employees, volunteers, or other persons associated with the center, and a person, organization, or institution that advises or assists a poison prevention and treatment center are not liable in damages in a tort action for harm that allegedly arises from advice or assistance rendered to any person unless the advice or assistance is given in a manner that constitutes willful or wanton misconduct or intentionally tortious conduct.
   (2) This section does not create, and shall not be construed as creating, a new cause of action or substantive legal right against a poison prevention and control center, its officers, employees, volunteers, or other persons associated with the center, or a person, organization, or institution that advises or assists a poison prevention and treatment center. This section does not affect, and shall not be construed as affecting, any immunities from civil liability or defenses conferred by any other section of the Revised Code or available at common law, to which a poison prevention and treatment center, its officers, employees, volunteers, or other persons associated with the center or a person, organization, or institution that advises or assists a poison prevention and treatment center may be entitled under circumstances not specified by this section.
   (H) The director shall annually report to the general assembly findings and recommendations concerning the effectiveness, impact, and benefits of the poison prevention and treatment centers.

3701.201 Reporting by poison control centers; bioterrorism.

   (A) As used in this section, “bioterrorism” has the same meaning as in section 3701.232 of the Revised Code.
(B) The director of health shall adopt rules in accordance with Chapter 119 of the Revised Code under which a poison prevention and treatment center or other health-related entity is required to report events that may be caused by bioterrorism, epidemic or pandemic disease, or established or novel infectious agents or biological or chemical toxins posing a risk of human fatality or disability. Rules adopted under this section may require a report of any of the following:

1. An unexpected pattern or increase in the number of telephone inquiries or requests to provide information about poison prevention and treatment and available services;
2. An unexpected pattern or increase in the number of requests to provide specialized treatment, consultation, information, and educational programs to health care professionals and the public;
3. An unexpected pattern or increase in the number of requests for information on established or novel infectious agents or biological or chemical toxins posing a risk of human fatality or disability that is relatively uncommon and may have been caused by bioterrorism.

(C) Each poison prevention and treatment center and other health-related entity shall comply with any reporting requirement established in rules adopted under division (B) of this section.

(D) Information reported under this section that is protected health information pursuant to section 3701.17 of the Revised Code shall be released only in accordance with that section. Information that does not identify an individual may be released in summary, statistical, or aggregate form.

3701-3-14 Reporting by poison control centers.

(A) For the purpose of this rule

1. "Biological or chemical toxins" mean poisonous compounds produced by a microorganism or a poisonous chemical compound that pose a risk of human fatality or disability.
2. "Novel infectious agents" mean agents that are unusual that pose a risk of human fatality or disability.
3. "Other health-related entity" means an entity that employs health care providers, but that does not have an obligation to report events to the health district having jurisdiction in accordance with the requirements of Chapters 3701 and 3707 of the Revised Code.

(B) A poison control prevention and treatment center or other health-related entity shall report the following events:

1. An unexpected pattern or increase in the number of telephone inquiries or requests to provide information about poison prevention and treatment and available services;
2. An unexpected pattern or increase in the number of requests to provide specialized treatment, consultation, information, and educational programs to health care professionals and the public;
3. An unexpected pattern or increase in the number of requests for information on established or novel infectious agents or biological or chemical toxins posing a risk of human fatality or disability that is relatively uncommon and may have been caused by bioterrorism.

(C) Unless provided otherwise, all reports required by paragraph (B) of this rule shall be submitted to both the Ohio department of health and the health commissioner of the health district having jurisdiction over the event. Poison control prevention and treatment centers and other health-related entities shall immediately report an event as specified in rule 3701-3-02 of the Administrative Code, to the extent known or suspected, or upon the request from the director in the manner specified in paragraph (B) of rule 3701-3-03 of the Administrative Code.

(D) As required by division (C) of section 3701.201 of the Revised Code, poison control prevention and treatment centers and other health-related entities shall report information
Part IV. AIDS and HIV

3701.24 Reporting infectious diseases; AIDS; HIV.

(A) As used in this section and sections 3701.241 to 3701.249 of the Revised Code:
(1) “AIDS” means the illness designated as acquired immunodeficiency syndrome.
(2) “HIV” means the human immunodeficiency virus identified as the causative agent of AIDS.
(3) “AIDS-related condition” means symptoms of illness related to HIV infection, including AIDS-related complex, that are confirmed by a positive HIV test.
(4) “HIV test” means any test for the antibody or antigen to HIV that has been approved by the director of health under division (B) of section 3701.241 of the Revised Code.
(5) “Health care facility” has the same meaning as in section 1751.01 of the Revised Code.
(6) “Director” means the director of health or any employee of the department of health acting on the director's behalf.
(7) “Physician” means a person who holds a current, valid certificate issued under Chapter 4731 of the Revised Code authorizing the practice of medicine or surgery and osteopathic medicine and surgery.
(8) “Nurse” means a registered nurse or licensed practical nurse who holds a license or certificate issued under Chapter 4723 of the Revised Code.
(9) “Anonymous test” means an HIV test administered so that the individual to be tested can give informed consent to the test and receive the results by means of a code system that does not link the identity of the individual tested to the request for the test or the test results.
(10) “Confidential test” means an HIV test administered so that the identity of the individual tested is linked to the test but is held in confidence to the extent provided by sections 3701.24 to 3701.248 of the Revised Code.
(11) “Health care provider” means an individual who provides diagnostic, evaluative, or treatment services. Pursuant to Chapter 119 of the Revised Code, the director may adopt rules further defining the scope of the term “health care provider.”
(12) “Significant exposure to body fluids” means a percutaneous or mucous membrane exposure of an individual to the blood, semen, vaginal secretions, or spinal, synovial, pleural, peritoneal, pericardial, or amniotic fluid of another individual.
(13) “Emergency medical services worker” means all of the following:
   (a) A peace officer;
   (b) An employee of an emergency medical service organization as defined in section 4765.01 of the Revised Code;
   (c) A firefighter employed by a political subdivision;
   (d) A volunteer firefighter, emergency operator, or rescue operator;
   (e) An employee of a private organization that renders rescue services, emergency medical services, or emergency medical transportation to accident victims and persons suffering serious illness or injury.
(14) “Peace officer” has the same meaning as in division (A) of section 109.71 of the Revised Code, except that it also includes a sheriff and the superintendent and troopers of the state highway patrol.
   (B) Persons designated by rule adopted by the director under section 3701.241 of the Revised Code shall report promptly every case of AIDS, every AIDS-related condition, and every confirmed positive HIV test to the department of health on forms and in a manner...
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prescribed by the director. In each county the director shall designate the health commissioner of a health district in the county to receive the reports.

(C) No person shall fail to comply with the reporting requirements established under division (B) of this section.

(D) Information reported under this section that identifies an individual is confidential and may be released only with the written consent of the individual except as the director determines necessary to ensure the accuracy of the information, as necessary to provide treatment to the individual, as ordered by a court pursuant to section 3701.243 or 3701.247 of the Revised Code, or pursuant to a search warrant or a subpoena issued by or at the request of a grand jury, prosecuting attorney, city director of law or similar chief legal officer of a municipal corporation, or village solicitor, in connection with a criminal investigation or prosecution. Information that does not identify an individual may be released in summary, statistical, or aggregate form.

3701.242 Informed consent for HIV test.

(A) An HIV test may be performed by or on the order of a health care provider who, in the exercise of the provider's professional judgment, determines the test to be necessary for providing diagnosis and treatment to the individual to be tested, if the individual or the individual's parent or guardian has given consent to the provider for medical or other health care treatment. The health care provider shall inform the individual of the individual's right under division (D) of this section to an anonymous test.

(B) A minor may consent to be given an HIV test. The consent is not subject to disaffirmance because of minority. The parents or guardian of a minor giving consent under this division are not liable for payment and shall not be charged for an HIV test given to the minor without the consent of a parent or the guardian.

(C) The health care provider ordering an HIV test shall provide post-test counseling for an individual who receives an HIV-positive test result. The director of health may adopt rules in accordance with Chapter 119 of the Revised Code specifying the information to be provided in post-test counseling.

(D) An individual shall have the right to an anonymous test. A health care facility or health care provider that does not provide anonymous testing shall refer an individual requesting an anonymous test to a site where it is available.

(E) Divisions (B) to (D) of this section do not apply to the performance of an HIV test in any of the following circumstances:

(1) When the test is performed in a medical emergency by a nurse or physician and the test results are medically necessary to avoid or minimize an immediate danger to the health or safety of the individual to be tested or another individual, except that post-test counseling shall be given to the individual if the individual receives an HIV-positive test result;

(2) When the test is performed for the purpose of research if the researcher does not know and cannot determine the identity of the individual tested;

(3) When the test is performed by a person who procures, processes, distributes, or uses a human body part from a deceased person donated for a purpose specified in Chapter 2108 of the Revised Code, if the test is medically necessary to ensure that the body part is acceptable for its intended purpose;

(4) When the test is performed on a person incarcerated in a correctional institution under the control of the department of rehabilitation and correction if the head of the institution has determined, based on good cause, that a test is necessary;

(5) When the test is performed in accordance with section 2907.27 of the Revised Code;

(6) When the test is performed on an individual after the infection control committee of a health care facility, or other body of a health care facility performing a similar function determines that a health care provider, emergency medical services worker, or peace officer,
while rendering health or emergency care to an individual, has sustained a significant exposure to the body fluids of that individual, and the individual has refused to give consent for testing.

3701.243 Disclosure of HIV information.

(A) Except as provided in this section or section 3701.248 of the Revised Code, no person or agency of state or local government that acquires the information while providing any health care service or while in the employ of a health care facility or health care provider shall disclose or compel another to disclose any of the following:

(1) The identity of any individual on whom an HIV test is performed;
(2) The results of an HIV test in a form that identifies the individual tested;
(3) The identity of any individual diagnosed as having AIDS or an AIDS-related condition.

(B)(1) Except as provided in divisions (B)(2), (C), (D), and (F) of this section, the results of an HIV test or the identity of an individual on whom an HIV test is performed or who is diagnosed as having AIDS or an AIDS-related condition may be disclosed only to the following:

(a) The individual who was tested or the individual's legal guardian, and the individual's spouse or any sexual partner;
(b) A person to whom disclosure is authorized by a written release, executed by the individual tested or by the individual's legal guardian and specifying to whom disclosure of the test results or diagnosis is authorized and the time period during which the release is to be effective;
(c) Any physician who treats the individual;
(d) The department of health or a health commissioner to which reports are made under section 3701.24 of the Revised Code;
(e) A health care facility or provider that procures, processes, distributes, or uses a human body part from a deceased individual, donated for a purpose specified in Chapter 2108 of the Revised Code, and that needs medical information about the deceased individual to ensure that the body part is medically acceptable for its intended purpose;
(f) Health care facility staff committees or accreditation or oversight review organizations conducting program monitoring, program evaluation, or service reviews;
(g) A health care provider, emergency medical services worker, or peace officer who sustained a significant exposure to the body fluids of another individual, if that individual was tested pursuant to division (E)(6) of section 3701.242 of the Revised Code, except that the identity of the individual tested shall not be revealed;
(h) To law enforcement authorities pursuant to a search warrant or a subpoena issued by or at the request of a grand jury, a prosecuting attorney, a city director of law or similar chief legal officer of a municipal corporation, or a village solicitor, in connection with a criminal investigation or prosecution.

(2) The results of an HIV test or a diagnosis of AIDS or an AIDS-related condition may be disclosed to a health care provider, or an authorized agent or employee of a health care facility or a health care provider, if the provider, agent, or employee has a medical need to know the information and is participating in the diagnosis, care, or treatment of the individual on whom the test was performed or who has been diagnosed as having AIDS or an AIDS-related condition.

This division does not impose a standard of disclosure different from the standard for disclosure of all other specific information about a patient to health care providers and facilities. Disclosure may not be requested or made solely for the purpose of identifying an individual who has a positive HIV test result or has been diagnosed as having AIDS or an AIDS-related condition in order to refuse to treat the individual. Referral of an individual to another health care provider or facility based on reasonable professional judgment does not constitute refusal to
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treat the individual.

(3) Not later than ninety days after November 1, 1989, each health care facility in this state shall establish a protocol to be followed by employees and individuals affiliated with the facility in making disclosures authorized by division (B)(2) of this section. A person employed by or affiliated with a health care facility who determines in accordance with the protocol established by the facility that a disclosure is authorized by division (B)(2) of this section is immune from liability to any person in a civil action for damages for injury, death, or loss to person or property resulting from the disclosure.

(C)(1) Any person or government agency may seek access to or authority to disclose the HIV test records of an individual in accordance with the following provisions:

(a) The person or government agency shall bring an action in a court of common pleas requesting disclosure of or authority to disclose the results of an HIV test of a specific individual, who shall be identified in the complaint by a pseudonym but whose name shall be communicated to the court confidentially, pursuant to a court order restricting the use of the name. The court shall provide the individual with notice and an opportunity to participate in the proceedings if the individual is not named as a party. Proceedings shall be conducted in chambers unless the individual agrees to a hearing in open court.

(b) The court may issue an order granting the plaintiff access to or authority to disclose the test results only if the court finds by clear and convincing evidence that the plaintiff has demonstrated a compelling need for disclosure of the information that cannot be accommodated by other means. In assessing compelling need, the court shall weigh the need for disclosure against the privacy right of the individual tested and against any disservice to the public interest that might result from the disclosure, such as discrimination against the individual or the deterrence of others from being tested.

(c) If the court issues an order, it shall guard against unauthorized disclosure by specifying the persons who may have access to the information, the purposes for which the information shall be used, and prohibitions against future disclosure.

(2) A person or government agency that considers it necessary to disclose the results of an HIV test of a specific individual in an action in which it is a party may seek authority for the disclosure by filing an in camera motion with the court in which the action is being heard. In hearing the motion, the court shall employ procedures for confidentiality similar to those specified in division (C)(1) of this section. The court shall grant the motion only if it finds by clear and convincing evidence that a compelling need for the disclosure has been demonstrated.

(3) Except for an order issued in a criminal prosecution or an order under division (C)(1) or (2) of this section granting disclosure of the result of an HIV test of a specific individual, a court shall not compel a blood bank, hospital blood center, or blood collection facility to disclose the result of HIV tests performed on the blood of voluntary donors in a way that reveals the identity of any donor.

(4) In a civil action in which the plaintiff seeks to recover damages from an individual defendant based on an allegation that the plaintiff contracted the HIV virus as a result of actions of the defendant, the prohibitions against disclosure in this section do not bar discovery of the results of any HIV test given to the defendant or any diagnosis that the defendant suffers from AIDS or an AIDS-related condition.

(D) The results of an HIV test or the identity of an individual on whom an HIV test is performed or who is diagnosed as having AIDS or an AIDS-related condition may be disclosed to a federal, state, or local government agency, or the official representative of such an agency, for purposes of the medicaid program, the medicare program, or any other public assistance program.

(E) Any disclosure pursuant to this section shall be in writing and accompanied by a written statement that includes the following or substantially similar language: “This information has been disclosed to you from confidential records protected from disclosure by state law. You
shall make no further disclosure of this information without the specific, written, and informed release of the individual to whom it pertains, or as otherwise permitted by state law. A general authorization for the release of medical or other information is not sufficient for the purpose of the release of HIV test results or diagnoses.”

(F) An individual who knows that the individual has received a positive result on an HIV test or has been diagnosed as having AIDS or an AIDS-related condition shall disclose this information to any other person with whom the individual intends to make common use of a hypodermic needle or engage in sexual conduct as defined in section 2907.01 of the Revised Code. An individual's compliance with this division does not prohibit a prosecution of the individual for a violation of division (B) of section 2903.11 of the Revised Code.

(G) Nothing in this section prohibits the introduction of evidence concerning an HIV test of a specific individual in a criminal proceeding.

3701.244 Liability.

(A) As used in this section, “violation” means an occasion of noncompliance involving a single injured individual.

(B) A person or an agency of state or local government that knowingly violates division (A) of section 3701.242, division (A) of section 3701.243, or division (E) of section 3701.248 of the Revised Code may be found liable in a civil action; the action may be brought by any individual injured by the violation. Except as otherwise provided in division (C) or (D) of this section, the court may award compensatory damages and any equitable relief, including injunctive relief, it finds appropriate. If an award is made in favor of the plaintiff, the judge may award reasonable attorney's fees to the plaintiff after a hearing to determine the amount of the fees.

(C) No person shall be held liable for damages or attorney's fees in an action based on a violation of section 3701.243 of the Revised Code by his employee or agent unless the person knew or should have known of the violation.

(D) A person who acts in good faith in accordance with section 3701.242, 3701.243, or 3701.248 of the Revised Code is not liable for damages in a civil action brought pursuant to this section.

(E) A civil action under this section is barred unless the action is commenced within one year after the cause of action accrued. A cause of action does not survive the death of the individual injured by the violation unless a civil action based on the cause of action is commenced prior to the death of that individual.

(F) The remedies in this section are the exclusive civil remedies for an individual injured by noncompliance with section 3701.242, 3701.243, or division (E) of section 3701.248 of the Revised Code.

(G) Nothing in this section shall be construed to impose civil liability on a person for the disclosure of an HIV test result, a diagnosed case of AIDS, or a diagnosed AIDS-related condition in accordance with a reporting requirement of the department of health or any federal agency.

(H) No person with knowledge that an individual other than himself has or may have AIDS, and AIDS-related condition, or a positive HIV test shall be held liable for failing to disclose that information to any person unless disclosure is expressly required by law. 3701.246 Testing of anatomical gifts or blood donations for HIV

3701.246 Anatomical gifts and blood donations; testing for HIV.

Any human body part donated for transplantation, including an organ, tissue, eye, bone, artery, or other part, and any body fluid donated for transfusion or injection into another person,
including blood, plasma, a blood product, semen, or other fluid, shall be given an HIV test before being transplanted, transfused, or injected to determine that the part or fluid is not infected with the HIV virus unless, in an emergency, the recipient of the donation or his guardian, after consultation with the recipient's physician, consents to a waiver of this requirement.

3701.247 Compelling HIV test.

(A)(1) Any of the following persons may bring an action in a probate court for an order compelling another person to undergo HIV testing:
   (a) A person who believes the person may have been exposed to HIV infection while rendering health or emergency care to the other person;
   (b) A peace officer who believes the peace officer may have been exposed to HIV infection while dealing with the other person in the performance of official duties.
   (2) The complaint in the action shall be accompanied by an affidavit in which the plaintiff attests to all of the following:
      (a) While rendering health or emergency care to the defendant, or while dealing with the defendant in the performance of the plaintiff's duties, the plaintiff sustained a significant exposure to body fluids of the defendant that are known to transmit HIV;
      (b) The plaintiff has reason to believe the defendant may have an HIV infection;
      (c) The plaintiff made a reasonable attempt to have the defendant submit to HIV testing in accordance with section 3701.242 of the Revised Code, and notified the defendant that the plaintiff would bring an action under this section on the defendant's refusal or failure to be tested, but the defendant has not been tested;
      (d) Within seven days after the exposure, the plaintiff took an HIV test.

In the complaint, the defendant shall be identified by a pseudonym and the defendant's name communicated to the court confidentially pursuant to a court order restricting the use of the name. Proceedings shall be conducted in chambers unless the defendant agrees to a hearing in open court.

(B) The court shall hold a hearing on the complaint at the earliest possible time but not later than the third business day after the day the defendant is served with the complaint and notice of the hearing. The court shall enter judgment on the complaint on the day the hearing is concluded.

(C) Notwithstanding division (A) of section 3701.242 of the Revised Code, the court may order the defendant to undergo HIV testing if it finds by clear and convincing evidence that the plaintiff has proved the matters attested to in the plaintiff's affidavit and has demonstrated that the plaintiff has a compelling need for the results of the test and no other means exist to accommodate the need. If granted, the order shall guard against unauthorized disclosure of the test results by specifying the persons and governmental entities that may have access to the results and by limiting further disclosure. The court shall require that the defendant be given test results and, if the defendant's test results are HIV-positive, that post-test counseling be provided the defendant in accordance with division (C) of section 3701.242 of the Revised Code. The court may order the plaintiff to pay the cost of the defendant's testing and counseling.

3701.248 Exposed EMS or funeral services worker.

(A) As used in this section:
   (1) "Contagious or infectious disease" means a disease specified in rules adopted by the director of health pursuant to division (F) of this section.
   (2) "Patient" means either of the following:
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(a) A person, whether alive or dead, who has been treated, or handled, or transported for medical care by an emergency medical services worker;
(b) A deceased person whose body is handled by a funeral services worker.

(3) “Significant exposure” means:
(a) A percutaneous or mucous membrane exposure of an individual to the blood, semen, vaginal secretions, or spinal, synovial, pleural, peritoneal, pericardial, or amniotic fluid of another person;
(b) Exposure to a contagious or infectious disease.

(4) “Funeral services worker” means a person licensed as a funeral director or embalmer under Chapter 4717 of the Revised Code or an individual responsible for the direct final disposition of a deceased person.

(B)(1) An emergency medical services worker or funeral services worker who believes that significant exposure has occurred through the worker’s contact with a patient may submit to the health care facility or coroner that received the patient a written request to be notified of the results of any test performed on the patient to determine the presence of a contagious or infectious disease. The request shall include:
(a) The name, address, and telephone number of the individual submitting the request;
(b) The name of the individual’s employer, or, in the case of a volunteer emergency medical services worker, the entity for which the worker volunteers, and the individual’s supervisor;
(c) The date, time, location, and manner of the exposure.

(2) The request for notification that is submitted by an emergency medical services worker pursuant to division (B)(1) of this section is valid for ten days after it is made. If at the end of that ten-day period no test has been performed to determine the presence of a contagious or infectious disease, no diagnosis has been made, or the result of the test is negative, the health care facility or coroner shall notify the emergency medical services worker. The notification shall not include the name of the patient. If necessary, the request may be renewed in accordance with the same procedures and requirements as the original request.

(3) A health care facility or coroner shall respond immediately to a request for notification submitted pursuant to division (B)(1) of this section by a funeral services worker. If no test has been performed to determine the presence of a contagious or infectious disease, no diagnosis has been made, or the result of a test that was performed is negative, the health care facility or coroner shall immediately notify the funeral services worker. The notification shall not include the name of the patient.

On receipt of notification that no test has been performed to determine the presence of a contagious or infectious disease in a patient, the funeral services worker may have a test performed on the patient. The test shall be performed in accordance with rules adopted by the department of health pursuant to division (G) of this section.

The consent of the patient’s family is not required for performance of a test pursuant to division (B)(3) of this section.

(C) The health care facility or coroner that receives a written request for notification shall give an oral notification of the presence of a contagious or infectious disease, or of a confirmed positive test result, if known, to the person who made the request and the person’s supervisor and to the infection control committee or other body described in division (E)(6) of section 3701.242 of the Revised Code within two days after determining the presence of a contagious or infectious disease or after a confirmed positive test result. A written notification shall follow oral notification within three days. If a contagious or infectious disease is present, or the test results are confirmed positive, both the oral and written notification shall include the name of the disease, its signs and symptoms, the date of exposure, the incubation period, the mode of transmission of the disease, the medical precautions necessary to prevent transmission to other persons, and the appropriate prophylaxis, treatment, and counseling for the disease. The
notification shall not include the name of the patient.

If the request is made by an emergency medical services worker and the information is not available from the health care facility to which the request is made because the patient has been transferred from that health care facility, the facility shall assist the emergency medical services worker in locating the patient and securing the requested information from the health care facility that treated or is treating the patient. If the patient has died, the health care facility shall give the emergency medical services worker the name and address of the coroner who received the patient.

(D) Each health care facility and coroner shall develop written procedures to implement the notification procedures required by this section. A health care facility or coroner may take measures in addition to those required in this section to notify emergency medical services workers and funeral services workers of possible exposure to a contagious or infectious disease as long as the confidentiality of the information is maintained.

(E) No person shall knowingly fail to comply with division (C) of this section.

(F) The director of health shall adopt rules in accordance with Chapter 119 of the Revised Code that specify the diseases that are reasonably likely to be transmitted by air or blood during the normal course of duties performed by an emergency medical services worker or funeral services worker. In adopting such rules, the director shall consider the types of contact that typically occur between patients and emergency medical services workers and funeral services workers.

(G) The department of health shall adopt rules in accordance with Chapter 119 of the Revised Code specifying the procedures a funeral services worker must follow when having a test performed on a patient pursuant to division (B)(3) of this section. The rules shall specify how and by whom the test is to be performed. The rules shall require the funeral services worker or the funeral services worker's employer to pay the cost of the test. No health care facility shall be required to perform the test.

3701.249 Employer immunity.

(A) As used in this section, "employer" and "employee" have the same meanings as in section 4112.01 of the Revised Code.

(B) The employer of a person with HIV infection is immune from liability to any person in a civil action for damages for injury, death, or loss to person or property on a claim arising out of transmission of the human immunodeficiency virus from the infected employee to another employee or to any other person, unless the transmission occurs as a result of the reckless conduct of the employer.

(C) An employer is immune from liability to an employee on a claim asserted under any provision of the Revised Code or in a civil action for damages for injury, death, or loss to person or property if the claim arises from an illness or injury to the employee that is stress-related and results from the employee being required to work with an individual who has received a positive result on an HIV test or has been diagnosed as having AIDS or an AIDS-related condition.

3701-3-10 HIV tests approval.

(A) In approving tests to be used to determine whether an individual has human immunodeficiency virus infection under division (B)(1) of section 3701.241 of the Revised Code, the director of health shall consider:

(1) Whether the test has been approved by the United States food and drug administration.

(2) The recommendations of the United States centers for disease control and prevention.
(B) The director shall define a confirmed positive test result as:
(1) Two or more reactive enzyme immunoassay tests;
(2) A positive culture of the human immunodeficiency virus;
(3) A positive reaction to an human immunodeficiency virus antigen test licensed by the United States food and drug administration;
(4) Identification of the human immunodeficiency virus by the use of nucleic acid amplification probe to detect the presence of human immunodeficiency virus;
(5) The director may define other confirmed positive test results after consideration of the recommendations of the United States centers for disease control and prevention.

(C) In developing guidelines for interpreting test results, the director shall consider interpretation criteria established by the United States centers for disease control and prevention.

3701-3-11 Requirements related to HIV testing.

(A) A human immunodeficiency virus (HIV) test may be performed by or on the order of the health care provider who, in the exercise of the provider's professional judgment and within the provider's scope of practice, determines the test to be necessary for providing diagnosis and treatment to the individual to be tested if the individual or the individual's parent or guardian has given consent. Prior to performing or ordering an HIV test, the health care provider shall inform the individual to be tested of the individual's right to an anonymous test as set forth in section 3701.242 of the Revised Code and paragraph (C) of this rule.

(B) Pursuant to division (B) of section 3701.242 of the Revised Code, a minor may consent to be given an HIV test. The consent is not subject to disaffirmance because of minority. The parents or guardian of a minor giving consent under this paragraph are not responsible for payments for an HIV test given to the minor without the consent of a parent or the guardian.

(C) Any individual seeking an HIV test shall have the right, on the individual's request, to an anonymous test. A health care facility or health care provider that does not provide anonymous testing shall refer the individual requesting an anonymous test to a site where anonymous testing is available.

(D) If an individual tests positive for HIV, the health care provider who performed or ordered the test shall provide post-test counseling. Post-test counseling is suggested for all individuals seeking testing. Post-test counseling may be verbal or in writing and shall include,

(1) An explanation of the HIV test result. If, at the time of the HIV test, the result is preliminarily positive, the health care provider must explain the next step to confirm the test result;
(2) The nature of HIV disease;
(3) A list of resources for medical treatment, social services and, when necessary, a referral for further counseling to help that individual cope with the emotional consequences of learning of the test result;
(4) The individual will be provided information about the importance of following safer sex practices to protect themselves from sexually transmitted diseases, as well as how to protect others from being infected; and
(5) The individual will be provided information about Ohio's HIV disclosure laws.

(E) The requirements of paragraphs (B) to (D) of this rule do not apply to the performance of an HIV test in any of the following circumstances:

(1) When the test is performed in a medical emergency by a nurse or physician and the test results are medically necessary to avoid or minimize an immediate danger to the health or safety of the individual to be tested or another individual. Post-test counseling shall be given to
the individual if the individual received an HIV positive test result as soon as possible after the emergency is over;

(2) When the test is performed for the purpose of research if the researcher does not know and cannot determine the identity of the individual tested;

(3) When the test is performed by a person who procures, processes, distributes, or uses a human body part from deceased person donated for a purpose specified in Chapter 2108 of the Revised Code, if the test is medically necessary to ensure that the body part is acceptable for its intended purpose;

(4) When the test is performed on a person incarcerated in a penal institution if the head of the institution has determined, based on good cause, that a test is necessary; or

(5) When the test is performed on an individual after the infection control committee of a health care facility, or other body of a health care facility performing a similar function determines that a health care provider, emergency medical service worker, or peace officer, when rendering health or emergency care to an individual, has sustained significant exposure to the body fluids that are known to transmit HIV of that individual, and the individual has refused to give consent for testing.

(F) The consent of the individual to be tested is not required, and the individual or guardian may not elect to have an anonymous test, when the test is ordered by a court in connection with a criminal investigation.

3701-3-12 HIV test results.

(A) As used in this rule:

(1) “AIDS” has the same meaning as in section 3701.24 of the Revised Code.

(2) “ARC” is a historic term having the same meaning as in section 3701.24 of the Revised Code.

(3) “A CD4 count” means a count of lymphocytes containing the CD4 epitope as determined by the results of lymphocyte phenotyping.

(4) “Health care facility” has the same meaning as in section 3701.24 of the Revised Code.

(5) “Health care provider” has the same meaning as in section 3701.23 of the Revised Code.

(6) “HIV” has the same meaning as in section 3701.24 of the Revised Code.

(7) “HIV infection” means a disease of the human immune system caused by infection with the human immunodeficiency virus.

(8) “HIV test” has the same meaning as in section 3701.24 of the Revised Code.

(9) “HIV viral load” means concentration of HIV virus in blood.

(B) Persons required to report cases of AIDS, ARC, HIV, confirmed positive tests for HIV, and HIV infections pursuant to divisions (B) and (C) of section 3701.24 of the Revised Code and this rule are as follows:

(1) Health care providers shall report every case of HIV infection, including AIDS, for persons under their treatment and care. In an institutional or health care facility setting, a designated agent, including, but not limited to, an infection preventionist may make the report for the diagnosing or treating health care provider.

(2) The individual in charge of the laboratory shall report all positive or repeatedly reactive results from antigen detection, nucleic acid detection, detection of antibody confirmed with a supplemental test, or positive cultures used in the diagnosis of HIV infection, CD4 counts and percentages when performed to monitor the progression of HIV disease, and detectable and undetectable viral load results when performed to monitor the efficacy of HIV treatment. If a second laboratory is used for additional or supplemental HIV testing, the person in charge of the laboratory first receiving the specimen shall report the results of the supplemental testing.
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(C) Every health care provider attending a newborn infant or child born to an HIV infected mother shall report every instance of perinatal exposure to HIV and any subsequent test results on every such exposed newborn infant or child until such time that either an HIV infection or a sero status that is negative is confirmed. In an institutional or health care facility setting, a designated agent, including, but not limited to, an infection preventionist, may make the report for the diagnosing or treating health care provider.

(D) Persons designated by paragraphs (B) and (C) of this rule shall report every case of HIV infection, including AIDS, every instance of perinatal exposure to HIV, and HIV test as described in paragraph (B)(2) of this rule to the department of health as follows (in each county the director shall designate the health commissioner of a health district in the county to receive the reports):

1. Health care provider shall provide the following information:
   a. Case information: name, diagnosis, date of birth, sex, ethnicity, race, and street address including city, state, and zip code.
   b. Health care provider information: name, telephone number, and street address including city, state, and zip code.
   c. Laboratory test information: specimen collection date, specimen type, test name, test result, and reference range, where applicable.
   d. Supplementary information as needed to complete official surveillance forms provided or set forth by the director.
   e. A health care provider may submit electronic reports in the manner approved by the director.

2. Person in charge of a laboratory shall provide the following information:
   a. Case information: name, diagnosis, date of birth, sex, ethnicity, race, and street address including city, state, and zip code.
   b. Health care provider information: name, telephone number, and street address including city, state, and zip code.
   c. Laboratory information: name, telephone number, and street address including city, state, and zip code.
   d. Laboratory test information: specimen collection date, specimen type, test name, test result, and reference range, where applicable.
   e. A laboratory may submit electronic reports in the manner approved by the director.

3. Health care providers and laboratories shall report in the following manner:
   a. Persons designated in paragraph (B)(1) of this rule shall report to the local health district in which the case resides, or if the residence is unknown, to the Ohio department of health no later than five calendar days from the date of diagnosis or specimen collection date, whichever is later.
   b. Persons designated in paragraph (B)(2) of this rule shall report to the local health district in which the case resides, or if the residence is unknown, to the Ohio department of health no later than five calendar days from the test result.
   c. Persons designated in paragraph (C) of this rule shall report to the local health district in which the infant was born, or if unknown, to the Ohio department of health no later than five calendar days from the infant's date of birth.

Part V. Cancer

3701.261 Ohio cancer incidence surveillance system.

(A) As used in this section, "state university" has the same meaning as in section 3345.011 of the Revised Code.
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(B) The director of health shall:
(1) Establish a population-based cancer registry, which shall be known as the Ohio cancer incidence surveillance system, to monitor the incidence of various types of malignant diseases in Ohio, make appropriate epidemiologic studies to determine any causal relations of such diseases with occupational, nutritional, environmental, or infectious conditions, and alleviate or eliminate any such conditions;
(2) Advise, consult, cooperate with, and assist, by contract or otherwise, agencies of the state and federal government, agencies of the governments of other states, agencies of political subdivisions of this state, universities, private organizations, corporations, and associations for the purposes of division (B)(1) of this section;
(3) Accept and administer grants from the federal government or other sources, public or private, for carrying out any of the functions enumerated in divisions (B)(1) and (2) of this section.

(C) The Ohio cancer incidence surveillance system shall follow a model of cancer data collection as set forth by the survey epidemiology and end results system (SEERS).

(D) The department may, by contract, designate a state university as an agent to implement some or all of this section and section 3701.262 of the Revised Code and the rules adopted under those sections.

3701.262 Reporting and research.

(A) As used in this section:
(1) “Physician” means a person who holds a valid certificate issued under Chapter 4731 of the Revised Code authorizing the person to practice medicine and surgery or osteopathic medicine and surgery.
(2) “Dentist” means a person who is licensed under Chapter 4715 of the Revised Code to practice dentistry.
(3) “Hospital” has the same meaning as in section 3727.01 of the Revised Code.
(4) “Cancer” includes those diseases specified by rule of the director of health under division (B)(2) of this section.

(B) The director of health shall adopt rules in accordance with Chapter 119 of the Revised Code to do all of the following:
(1) Establish the Ohio cancer incidence surveillance system required by section 3701.261 of the Revised Code;
(2) Specify the types of cancer and other tumorous and precancerous diseases to be reported to the department of health under division (D) of this section;
(3) Establish reporting requirements for information concerning diagnosed cancer cases as the director considers necessary to conduct epidemiologic surveys of cancer in this state;
(4) Establish standards that must be met by research projects to be eligible to receive information concerning individual cancer patients from the department of health.

(C) The department of health shall record in the registry all reports of cancer received by it. In the development and administration of the cancer registry the department may use information compiled by public or private cancer registries and may contract for the collection and analysis of, and research related to, the information recorded under this section.

(D)(1) Each physician, dentist, hospital, or person providing diagnostic or treatment services to patients with cancer shall report each case of cancer to the department. Any person required to report pursuant to this section may elect to report to the department through an existing cancer registry if the registry meets the reporting standards established by the director and reports to the department.

(2) No person shall fail to make the cancer reports required by division (D)(1) of this section.
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(E) All physicians, dentists, hospitals, or persons providing diagnostic or treatment services to patients with cancer shall grant to the department or its authorized representative access to all records that identify cases of cancer or establish characteristics of cancer, the treatment of cancer, or the medical status of any identified cancer patient.

(F) The Arthur G. James cancer hospital and Richard J. Solove research institute of the Ohio state university, shall analyze and evaluate the cancer reports collected pursuant to this section. The department shall publish and make available to the public reports summarizing the information collected. Reports shall be made on a calendar year basis and published not later than ninety days after the end of each calendar year.

(G) Furnishing information, including records, reports, statements, notes, memoranda, or other information, to the department of health, either voluntarily or as required by this section, or to a person or governmental entity designated as a medical research project by the department, does not subject a physician, dentist, hospital, or person providing diagnostic or treatment services to patients with cancer to liability in an action for damages or other relief for furnishing the information.

(H) This section does not affect the authority of any person or facility providing diagnostic or treatment services to patients with cancer to maintain facility-based tumor registries, in addition to complying with the reporting requirements of this section.

3701.60 Uterine cytologic examination.

Every hospital agency, as defined in section 140.01 of the Revised Code, may offer a uterine cytologic examination for cancer to every female in-patient twenty-one years of age or over unless contrary orders are given by the attending physician or unless the examination has been performed within the preceding year. Any female in-patient may refuse the examination. If the examination is offered, the hospital agency shall maintain records to show the examination results or that the examination was refused.

3701-4-01 Cancer incidence surveillance system; definitions.

As used in rules 3701-4-01 to 3701-4-03 of the Administrative Code:

(A) “Cancer” means the types of cancer and other tumorous and precancerous diseases to be reported to the department and which includes:

(1) Any primary in situ or invasive malignant neoplasm (with the exception of basal cell and squamous cell carcinoma in situ of the cervix); and

(2) Benign and borderline intracranial and central nervous system neoplasms.

(B) “Dentist” means a person who is licensed under section 4715.12 or 4715.15 of the Revised Code to practice dentistry.

(C) “Department” means the department of health.

(D) “Director” means the director of health.

(E) “Hospital” has the same meaning as in section 3727.01 of the Revised Code.

(F) “Ohio cancer incidence surveillance system” means a population based cancer registry maintained at the department pursuant to section 3701.261 of the Revised Code to monitor the incidence of various types of malignant diseases in Ohio, make appropriate epidemiologic studies to determine any causal relations of such disease with occupational, nutritional, environmental, or infectious conditions, and alleviate or eliminate any such conditions.

(G) “Person providing diagnostic or treatment services to patients with cancer” means a person who diagnoses a patient as having cancer or provides treatment services (with the exception of end of life care) to patients for a cancer diagnosis in a health care facility including, but not limited to, an ambulatory surgical treatment center, a freestanding cancer treatment
center, a radiation therapy center, a chemotherapy treatment center, a nursing home, an oncology or dermatology clinic, a laboratory, or any other facility which provides diagnostic or treatment services to patients with cancer.

(H) "Physician" means a person who holds a valid certificate issued under Chapter 4731 of the Revised Code.

(I) "Protected health information" has the same meaning as in section 3701.17 of the Revised Code.

3701-4-02 Cancer information reporting.

(A) Each physician, dentist, hospital, or person providing diagnostic or treatment services to patients with cancer shall report each case of cancer to the department in a manner approved by the director. Reports shall be made for all patients diagnosed or treated in Ohio, regardless of the patient's state of residence. The report shall contain information regarding the patient which includes but is not limited to the following:

(1) Last name of patient;
(2) First name of patient;
(3) Middle initial of patient;
(4) Social security number of patient (if available);
(5) County of residence at diagnosis;
(6) City of residence at diagnosis;
(7) Street address of residence at diagnosis;
(8) State of residence at diagnosis;
(9) Zip code of residence at diagnosis;
(10) Date of birth;
(11) Sex;
(12) Race;
(13) Hispanic origin;
(14) Age in years at diagnosis;
(15) Date of diagnosis;
(16) Date of first contact for this patient for this cancer at this facility;
(17) Type of reporting source;
(18) Primary site;
(19) Laterality;
(20) Sequence number;
(21) Histology;
(22) Grade;
(23) Diagnostic confirmation;
(24) First course of treatment;
(25) Date treatment began;
(26) Class of case;
(27) Tobacco use;
(28) Date of last contact (or death);
(29) Managing physician's name;
(30) Stage at diagnosis;
(31) Primary site supporting text;
(32) Histology supporting text;
(33) Stage at diagnosis supporting text; and
(34) First course of treatment supporting text.

Any person required to report pursuant to this paragraph may elect to report to the department through an existing cancer registry if the registry submits the information in
accordance with the requirements of this rule.

(B) Each and every physician, dentist, hospital, and other person who diagnose patients as having cancer will report the patient's cancer within six months of the date of diagnosis. Facilities or persons providing treatment services to patients for a cancer diagnosis will report the patient's cancer within six months of the date of first contact with the patient.

(C) All physicians, dentists, hospitals or other persons who diagnose patients as having cancer or provide treatment services to patients for a cancer diagnosis shall grant to the department or its authorized representative access to all records that identify cases of cancer or establish characteristics of cancer, the treatment of cancer, or the medical status of any identified cancer patient.

3701-4-03 Confidentiality.

(A) Any information, data, and reports with respect to a case of cancer which are furnished to, or procured by, the department shall be confidential and shall be used only for public health surveillance and research for the purposes of reducing the morbidity or mortality of cancer.

(B) A person involved with a research project may be given access to confidential information if all the following conditions are met and if the research project is approved by the department's institutional review board:

(1) The person conducting the research submits verification of his credentials and of the credentials of other individuals involved in conducting the research;

(2) The person conducting the research provides written information about the purpose of the research project, the nature of the data to be collected and how the researcher intends to analyze it, the records the researcher seeks to review, and the safeguards the researcher will take to protect the identity of patients whose records the researcher will be reviewing;

(3) The proposed safeguards are adequate to protect the identity of each patient whose records will be reviewed. Safeguards for the protection of the identity of patients shall include, but are not limited to, provisions to limit access to identifying data to only those individuals who during the course of the project need access to such information for research purposes and provisions for the maintenance and/or destruction of identifying information after the termination of the project;

(4) An agreement is executed between the department and the researcher that specifies the terms of the researcher's use of the records. The agreement will prohibit the publication or release of protected health information.

(C) Notwithstanding paragraphs (A) and (B) of this rule, a researcher may, with the approval of the department's institutional review board, contact individual cancer patients to request additional information for research purposes or to solicit a patient's participation in a research project. The researcher shall first notify the patient's managing physician of the intent to contact the patient. Unless the patient's managing physician informs the researcher within a reasonable time that the patient should not be contacted, the researcher may contact the patient. The researcher shall obtain the patient's verbal or written consent prior to requesting additional information or including the patient in a research project.

(D) Notwithstanding paragraphs (A) and (B) of this rule the department may release confidential information concerning individual cancer patients who are not Ohio residents to the cancer registry of the patient's state of residence at diagnosis.

(E) Nothing in this rule prevents the release to any person of summary, statistical, or aggregate information that does not identify individual cancer patients.
3701.048 Authority to issue drugs during emergency

(A) As used in this section:

(1) “Board of health” means the board of health of a city or general health district or the authority having the duties of a board of health under section 3709.05 of the Revised Code.

(2) “Controlled substance” has the same meaning as in section 3719.01 of the Revised Code.

(3) “Drug,” “dangerous drug,” and “licensed health professional authorized to prescribe drugs” have the same meanings as in section 4729.01 of the Revised Code.

(4) “Registered volunteer” has the same meaning as in section 5502.281 of the Revised Code.

(B) In consultation with the appropriate professional regulatory boards of this state, the director of health shall develop one or more protocols that authorize the following individuals to administer, deliver, or distribute drugs, other than schedule II and III controlled substances, during a period of time described in division (E) of this section, notwithstanding any statute or rule that otherwise prohibits or restricts the administration, delivery, or distribution of drugs by such individuals:

(1) A physician authorized under Chapter 4731 of the Revised Code to practice medicine and surgery, osteopathic medicine and surgery, or podiatric medicine and surgery;

(2) A physician assistant licensed under Chapter 4730 of the Revised Code;

(3) A dentist or dental hygienist licensed under Chapter 4715 of the Revised Code;

(4) A registered nurse licensed under Chapter 4723 of the Revised Code, including an advanced practice registered nurse, as defined in section 4723.01 of the Revised Code;

(5) A licensed practical nurse licensed under Chapter 4723 of the Revised Code;

(6) An optometrist licensed under Chapter 4725 of the Revised Code;

(7) A pharmacist or pharmacy intern licensed under Chapter 4729 of the Revised Code;

(8) A respiratory care professional licensed under Chapter 4761 of the Revised Code;

(9) An emergency medical technician-basic, emergency medical technician-intermediate, or emergency medical technician-paramedic who holds a certificate to practice issued under Chapter 4765 of the Revised Code;

(10) A veterinarian licensed under Chapter 4741 of the Revised Code.

(C) In consultation with the executive director of the emergency management agency, the director of health shall develop one or more protocols that authorize employees of boards of health and registered volunteers to deliver or distribute drugs, other than schedule II and III controlled substances, during a period of time described in division (E) of this section, notwithstanding any statute or rule that otherwise prohibits or restricts the delivery or distribution of drugs by such individuals.

(D) In consultation with the state board of pharmacy, the director of health shall develop one or more protocols that authorize pharmacists and pharmacy interns to dispense, during a period of time described in division (E) of this section, limited quantities of dangerous drugs, other than schedule II and III controlled substances, without a written, oral, or electronic prescription from a licensed health professional authorized to prescribe drugs or without a record of a prescription, notwithstanding any statute or rule that otherwise prohibits or restricts the dispensing of drugs without a prescription or record of a prescription.

(E) On the governor’s declaration of an emergency that affects the public health, the director of health may issue an order to implement one or more of the protocols developed pursuant to division (B), (C), or (D) of this section. At a minimum, the director’s order shall identify the one or more protocols to be implemented and the period of time during which the protocols shall be in effect.
one or more protocols are to be effective.

(F)(1) An individual who administers, delivers, distributes, or dispenses a drug or dangerous drug in accordance with one or more of the protocols implemented under division (E) of this section is not liable for damages in any civil action unless the individual's acts or omissions in performing those activities constitute willful or wanton misconduct.

(2) An individual who administers, delivers, distributes, or dispenses a drug or dangerous drug in accordance with one or more of the protocols implemented under division (E) of this section is not subject to criminal prosecution or professional disciplinary action under any chapter in Title XLVII of the Revised Code.

3701.138 ODH to prepare influenza vaccine information.

(A) As used in this section, “older adult” means an individual who is sixty years of age or older.

(B) The department of health shall prepare an influenza vaccine information sheet that pertains to older adults. The information sheet shall contain all of the following:

(1) A description of influenza, including its causes, symptoms, and methods of transmission;

(2) A discussion of the health risks that influenza poses to older adults;

(3) A discussion of the influenza vaccine, including its availability, the methods of administration, and its effectiveness in preventing influenza and lessening symptoms and complications of influenza;

(4) A recommendation that each older adult consult with a health care professional to determine whether annual vaccination against influenza is appropriate for the older adult.

(C) The information sheet may contain any other information regarding influenza and the influenza vaccine that the department considers necessary, including the following:

(1) The rates of influenza-associated hospitalizations and deaths among older adults;

(2) The benefits to older adults from annual vaccination against influenza, especially to those living in close proximity to other older adults;

(3) The entities, facilities, or health care professionals providing influenza vaccinations to older adults.

(D) The department shall periodically review and update the information sheet. The department shall make the information sheet available on its internet web site in a format suitable for printing.

3701.23 Reporting of diseases.

(A) As used in this section, “health care provider” means any person or government entity that provides health care services to individuals. “Health care provider” includes, but is not limited to, hospitals, medical clinics and offices, special care facilities, medical laboratories, physicians, pharmacists, dentists, physician assistants, registered and licensed practical nurses, laboratory technicians, emergency medical service organization personnel, and ambulance service organization personnel.

(B) Boards of health, health authorities or officials, health care providers in localities in which there are no health authorities or officials, and coroners or medical examiners shall report promptly to the department of health the existence of any of the following:

(1) Asiatic cholera;

(2) Yellow fever;

(3) Diphtheria;

(4) Typhus or typhoid fever;

(5) As specified by the director of health, other contagious or infectious diseases,
illnesses, health conditions, or unusual infectious agents or biological toxins posing a risk of human fatality or disability.

(C) No person shall fail to comply with the reporting requirements established under division (B) of this section.

(D) The reports required by this section shall be submitted on forms, as required by statute or rule, and in the manner the director of health prescribes.

(E) Information reported under this section that is protected health information pursuant to section 3701.17 of the Revised Code shall be released only in accordance with that section. Information that does not identify an individual may be released in summary, statistical, or aggregate form.

3701.25 Occupational diseases; duty to report.

(A) Every physician attending on or called in to visit a patient whom the physician believes to be suffering from poisoning from lead, cadmium, phosphorus, arsenic, brass, wood alcohol, mercury, or their compounds, or from compressed air illness and such other occupational diseases and ailments as the department of health shall require to be reported, shall within forty-eight hours from the time of first attending such patient send to the director of health a report stating:

1. Name, address, and occupation of patient;
2. Name, address, and business of employer;
3. Nature of disease;
4. Such other information as may be reasonably required by the department.

(B) No person shall fail to comply with the reporting requirements established under division (A) of this section.

(C) The reports required by this section shall be made on, or in conformity with, the standard schedule blanks provided for in section 3701.26 of the Revised Code. The mailing of the report, within the time required, in a stamped envelope addressed to the office of the director, shall be in compliance with this section.

(D) Such reports shall not be evidence of the facts therein stated in any action arising out of the disease therein reported.

(E) Information reported under this section that is protected health information pursuant to section 3701.17 of the Revised Code shall be released only in accordance with that section. Information that does not identify an individual may be released in summary, statistical, or aggregate form.

3701.56 Quarantine and isolation orders.

Boards of health of a general or city health district, health authorities and officials, officers of state institutions, police officers, sheriffs, constables, and other officers and employees of the state or any county, city, or township, shall enforce quarantine and isolation orders, and the rules the department of health adopts.

3701.571 Fines for not reporting.

(A) The director of health shall adopt rules pursuant to Chapter 119 of the Revised Code that establish a graduated system of fines based on the scope and severity of violations and the history of compliance, not to exceed seven hundred fifty dollars per incident, and in an adjudication under Chapter 119 of the Revised Code, may impose a fine against any person who violates division (C) of section 3701.23, division (C) of section 3701.232, division (C) of section 3701.24, division (B) of section 3701.25, or division (B) of section 3707.06 of the
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Revised Code or against any poison prevention and treatment center or other health-related entity that fails to comply with division (C) of section 3701.201 of the Revised Code.

(B) On request of the director, the attorney general shall bring and prosecute to judgment a civil action to collect any fine imposed under division (A) of this section that remains unpaid.

(C) All fines collected under this section shall be deposited into the state treasury to the credit of the general operations fund created under section 3701.83 of the Revised Code.

3701.81 Exposing others to disease.

(A) No person, knowing or having reasonable cause to believe that he is suffering from a dangerous, contagious disease, shall knowingly fail to take reasonable measures to prevent exposing himself to other persons, except when seeking medical aid.

(B) No person, having charge or care of a person whom he knows or has reasonable cause to believe is suffering from a dangerous, contagious disease, shall recklessly fail to take reasonable measures to protect others from exposure to the contagion, and to inform health authorities of the existence of the contagion.

(C) No person, having charge of a public conveyance or place of public accommodation, amusement, resort, or trade, and knowing or having reasonable cause to believe that persons using such conveyance or place have been or are being exposed to a dangerous, contagious disease, shall negligently fail to take reasonable measures to protect the public from exposure to the contagion, and to inform health authorities of the existence of the contagion.

3707.06 Communicable diseases to be reported.

(A) Each physician or other person called to attend a person suffering from cholera, plague, yellow fever, typhus fever, diphtheria, typhoid fever, or any other disease dangerous to the public health, or required by the department of health to be reported, shall report to the health commissioner within whose jurisdiction the sick person is found the name, age, sex, and color of the patient, and the house and place in which the sick person may be found. In like manner, the owner or agent of the owner of a building in which a person resides who has any of the listed diseases, or in which are the remains of a person having died of any of the listed diseases, and the head of the family, immediately after becoming aware of the fact, shall give notice thereof to the health commissioner.

(B) No person shall fail to comply with the reporting requirements of division (A) of this section.

(C) Information reported under this section that is protected health information pursuant to section 3701.17 of the Revised Code shall be released only in accordance with that section. Information that does not identify an individual may be released in summary, statistical, or aggregate form.

3727.19 Hospitals must offer flu and pneumonia vaccine to patients.

(A) As used in this section:

(1) "Advisory committee" means the advisory committee on immunization practices of the United States centers for disease control and prevention or its successor agency.

(2) "Physician" means an individual authorized under Chapter 4731 of the Revised Code to practice medicine and surgery or osteopathic medicine and surgery.

(B) Each hospital shall offer to each patient who is admitted to the hospital, in accordance with guidelines issued by the advisory committee, vaccination against influenza, unless a physician has determined that vaccination of the patient is medically inappropriate. The
vaccine shall be of a form approved by the advisory committee for that calendar year. A patient may refuse vaccination.

(C) Each hospital shall offer to each patient who is admitted to the hospital, in accordance with guidelines issued by the advisory committee, vaccination against pneumococcal pneumonia, unless a physician has determined that vaccination of the patient is medically inappropriate. Each vaccine shall be of a form approved by the advisory committee for that calendar year. A patient may refuse vaccination.

(D) The director of health may adopt rules under Chapter 119 of the Revised Code as the director considers appropriate to implement this section.

3727.20 Hospital to offer long-acting reversible contraceptive after delivery.

(A) Except as provided in division (B) of this section, each hospital that has a maternity unit licensed under Chapter 3711 of the Revised Code shall modify operational processes not later than three months after the effective date of this section or three months after commencing operations, as applicable, to ensure that a woman giving birth in the hospital has the option of having a long-acting reversible contraceptive placed after delivery and before the woman is discharged.

(B) A hospital is exempt from the requirement in division (A) of this section if the hospital notifies the department of health in writing that it has a faith-based objection to the requirement.

5502.281 Registration and immunity of registered volunteers in public emergency.

(A) The executive director of the emergency management agency, jointly with the director of health, shall do both of the following:

(1) Advise, assist, consult with, and cooperate with agencies and political subdivisions of this state to establish and maintain a statewide system for recruiting, registering, training, and deploying the types of volunteers reasonably necessary to respond to an emergency declared by the state or a political subdivision;

(2) Establish fees, procedures, standards, and requirements necessary for recruiting, registering, training, and deploying the volunteers as required under this section.

(B)(1) A registered volunteer's status as a volunteer, and any information presented in summary, statistical, or aggregate form that does not identify an individual, is a public record pursuant to section 149.43 of the Revised Code.

(2) Information related to a registered volunteer's specific and unique responsibilities, assignments, or deployment plans, including but not limited to training, preparedness, readiness, or organizational assignment, is a security record for purposes of section 149.433 of the Revised Code.

(3) Information related to a registered volunteer's personal information, including but not limited to contact information, medical information, or information related to family members or dependents, is not a public record pursuant to section 149.43 of the Revised Code.

(C) A volunteer registered under this section is not liable in damages to any person or government entity in tort or other civil action, including an action upon a medical, dental, chiropractic, optometric, or other health-related claim or veterinary claim, for injury, death, or loss to person or property that may arise from an act or omission of that volunteer. This division applies to a registered volunteer while providing services within the scope of the volunteer's responsibilities during an emergency declared by the state or political subdivision or in disaster-related exercises, testing, or other training activities, if the volunteer's act or omission does not constitute willful or wanton misconduct.

(D) As used in this section:

(1) "Registered volunteer" means any individual registered as a volunteer pursuant to
procedures established under this section and who serves without pay or other consideration, other than the reasonable reimbursement or allowance for expenses actually incurred or the provision of incidental benefits related to the volunteer's service, such as meals, lodging, and child care.

(2) "Political subdivision" means a county, township, or municipal corporation in this state.

5502.29 Political subdivision mutual assistance agreements; tort liability and immunity.

(A) As used in this section, “political subdivision” has the same meaning as in section 5502.41 of the Revised Code.

(B) Political subdivisions, in collaboration with other public and private agencies within this state, may develop mutual assistance or aid agreements for reciprocal emergency management assistance or aid for purposes of preparing for, responding to, and recovering from an incident, disaster, exercise, training activity, planned event, or emergency, any of which requires additional resources. In time of any incident, disaster, exercise, training activity, planned event, or emergency, any of which requires additional resources, each political subdivision may render assistance in accordance with such mutual assistance or aid agreements. Such mutual assistance or aid agreements shall not in any manner relieve the chief elected official of any political subdivision of the responsibility for providing emergency management.

(C) Political subdivisions, in collaboration with political subdivisions in adjacent states, may develop agreements for mutual assistance or aid for purposes of preparing for, responding to, and recovering from an incident, disaster, exercise, training activity, planned event, or emergency, any of which requires additional resources. Each political subdivision may render assistance in accordance with the mutual assistance or aid agreements. A mutual assistance or aid agreement with political subdivisions in adjacent states shall be approved by the chief elected officials of the agreeing political subdivisions or their designees and shall be prepared in accordance with the laws, regulations, ordinances, and resolutions applicable to the agreeing political subdivisions.

(D) When engaged in preparation for, response to, or recovery from an incident, disaster, exercise, training activity, planned event, or emergency, any of which requires additional resources, and in accordance with the applicable mutual assistance or aid agreement, personnel from political subdivisions outside this state shall be permitted to provide services within this state in accordance with this section and the terms of the mutual assistance or aid agreement.

(E) Personnel of the responding political subdivision shall continue under their local command and control structure, but shall be under the operational control of the appropriate officials within the incident management system of the political subdivision receiving the assistance or aid.

(F) Nothing in this section shall be construed to prohibit a private company or its employees from participating in the provision of mutual assistance or aid, if the responding political subdivision approves the participation and the contract between the political subdivision and the private company permits the participation.

(G) Nothing in this section shall be construed to prohibit personnel of political subdivisions in this state from responding to a request for mutual assistance or aid resulting from an incident, disaster, exercise, training activity, planned event, or emergency, any of which requires additional resources, when the personnel are responding as part of a regional response team that is under the operational control of the incident command structure.

(H) Whenever a person from outside this state who is subject to a mutual assistance or aid agreement authorized by this section holds a license, certificate, or other permit issued by
any state evidencing qualification for professional, mechanical, or other skills, such license, certificate, or other permit shall be recognized by this state as authorizing the person to render assistance or aid in this state involving such skill to meet the request for assistance or aid, so long as the person is acting within the scope of the person's license, certificate, or other permit.

(I) Personnel rendering assistance or aid pursuant to a mutual assistance or aid agreement authorized by this section remain employees or agents of their respective political subdivisions, including for purposes of tort liability and immunity from tort liability, and nothing in this section or any mutual assistance or aid agreement entered into pursuant to this section creates an employment relationship between the political subdivision requesting aid and the employees or agents of the political subdivision rendering aid.

(J) Responding political subdivisions and the personnel of that political subdivision, while rendering assistance or aid under this section, or while in route to or from rendering assistance or aid under this section, in a political subdivision in an adjacent state under an agreement authorized by this section, shall be deemed to be exercising governmental functions as defined in section 2744.01 of the Revised Code, shall have the defenses to and immunities from civil liability provided in sections 2744.02 and 2744.03 of the Revised Code, and shall be entitled to all applicable limitations on recoverable damages under section 2744.05 of the Revised Code.

(K) All pension, disability, death benefits, workers' compensation, and other benefits enjoyed by personnel rendering interstate or intrastate mutual assistance or aid shall extend to the services they perform outside their respective political subdivisions to the same extent as while acting within the boundaries of the political subdivisions, and personnel are entitled to the rights and benefits of Chapter 4123. to the same extent as while performing service within the boundaries of the political subdivisions.

5502.30 Emergency management; immunity.

(A) The state, any political subdivision, any municipal agency, any emergency management volunteer, another state, or an emergency management agency thereof or of the federal government or of another country or province or subdivision thereof performing emergency management services in this state pursuant to an arrangement, agreement, or compact for mutual aid and assistance, or any agency, member, agent, or representative of any of them, or any individual, partnership, corporation, association, trustee, or receiver, or any of the agents thereof, in good faith carrying out, complying with, or attempting to comply with any state or federal law or any arrangement, agreement, or compact for mutual aid and assistance, or any order issued by federal or state military authorities relating to emergency management, is not liable for any injury to or death of persons or damage to property as the result thereof during training periods, test periods, practice periods, or other emergency management operations, or false alerts, as well as during any hazard,actual or imminent, and subsequent to the same except in cases of willful misconduct. As used in this division, "emergency management volunteer" means only an individual who is authorized to assist any agency performing emergency management during a hazard.

(B) The state, any political subdivision, any individual, partnership, corporation, association, trustee, or receiver, or any agent, agency, representative, officer, or employee of any of them that owns, maintains, occupies, operates, or controls all or part of any building, structure, or premises shall not be liable for any injury or death sustained by any person or damage caused to any property while that person or property is in the building, structure, or premises for duty, training, or shelter purposes during a hazard, drill, test, or false warning, or is entering therein for such purposes or departing therefrom, or for any injury, death, or property damage as the result of any condition in or on the building, structure, or premises or of any act or omission with respect thereto, except a willful act intended to cause injury or damage.

(C) This section does not affect the right of any person to receive benefits to which he
may be entitled under Chapter 4123 of the Revised Code or any pension law, nor the rights of
any person to receive any benefits or compensation under any act of congress or under any law
of this state.

5502.41 Intrastate mutual aid; immunity; reimbursement.

(A) As used in this section:

(1) “Chief executive of a participating political subdivision” means the elected chief
executive of a participating political subdivision or, if the political subdivision does not have an
elected chief executive, a member of the political subdivision’s governing body or an employee
of the political subdivision appointed by the governing body’s members to be its representative
for purposes of the intrastate mutual aid program created pursuant to this section.

(2) “Countywide emergency management agency” means a countywide emergency
management agency established under section 5502.26 of the Revised Code.

(3) “Emergency” means any period during which the congress of the United States, a
chief executive as defined in section 5502.21 of the Revised Code, or a chief executive of a
participating political subdivision has declared or proclaimed that an emergency exists.

(4) “Participating
political subdivision” means each political subdivision in this state
except a political subdivision that enacts or adopts, by appropriate legislation, ordinance,
resolution, rule, bylaw, or regulation signed by its chief executive, a decision not to partici-
pate in
the intrastate mutual aid program created by this section and that provides a copy of the
legislation, ordinance, resolution, rule, bylaw, or regulation to the state emergency management
agency and to the countywide emergency management agency, regional authority for
emergency management, or program for emergency management within the political
subdivision.

(5) “Planned event” means a scheduled nonemergency activity as defined by the
national incident management system adopted under section 5502.28 of the Revised Code as
the state’s standard procedure for incident management. “Planned event” includes, but is not
limited to, a sporting event, concert, or parade.

(6) “Political subdivision” or “subdivision” has the same meaning as in section 2744.01 of
the Revised Code and also includes a health district established under Chapter 3709 of the
Revised Code.

(7) “Program for emergency management within a political subdivision” means a
program for emergency management created by a political subdivision under section 5502.271
of the Revised Code.

(8) “Regional authority for emergency management” means a regional authority for
emergency management established under section 5502.27 of the Revised Code.

(9) “Regional response team” means a group of persons from participating political
subdivisions who provide mutual assistance or aid in preparation for, response to, or recovery
from an incident, disaster, exercise, training activity, planned event, or emergency, any of which
requires additional resources. “Regional response team” includes, but is not limited to, an
incident management team, hazardous materials response team, water rescue team, bomb
team, or search and rescue team.

(B) There is hereby created the intrastate mutual aid program to be known as “the
intrastate mutual aid compact” to complement existing mutual aid agreements. The program
shall have two purposes:

(1) Provide for mutual assistance or aid among the participating political subdivisions for
purposes of preparing for, responding to, and recovering from an incident, disaster, exercise,
training activity, planned event, or emergency, any of which requires additional resources;

(2) Establish a method by which a participating political subdivision may seek assistance
or aid that resolves many of the common issues facing political subdivisions before, during, and
after an incident, disaster, exercise, training activity, planned event, or emergency, any of which requires additional resources, and that ensures, to the extent possible, eligibility for available state and federal disaster assistance or other funding.

(C) Each countywide emergency management agency, regional authority for emergency management, and program for emergency management within a political subdivision, in coordination with all departments, divisions, boards, commissions, agencies, and other instrumentalities within that political subdivision, shall establish procedures or plans that, to the extent possible, accomplish both of the following:

(1) Identify hazards that potentially could affect the participating political subdivisions served by that agency, authority, or program;

(2) Identify and inventory the current services, equipment, supplies, personnel, and other resources related to the preparedness, response, and recovery activities of the participating political subdivisions served by that agency, authority, or program.

(D)(1) The executive director of the state emergency management agency shall coordinate with the countywide emergency management agencies, regional authorities for emergency management, and programs for emergency management within a political subdivision in identifying and formulating appropriate procedures or plans to resolve resource shortfalls.

(2) During and after the formulation of the procedures or plans to resolve resource shortfalls, there shall be ongoing consultation and coordination among the executive director of the state emergency management agency; the countywide emergency management agencies, regional authorities for emergency management, and programs for emergency management within a political subdivision; and all departments, divisions, boards, commissions, agencies, and other instrumentalities of, and having emergency response functions within, each participating political subdivision, regarding this section, local procedures and plans, and the resolution of the resource shortfalls.

(E)(1) A participating political subdivision that is impacted by an incident, disaster, exercise, training activity, planned event, or emergency, any of which requires additional resources, may request mutual assistance or aid by doing either of the following:

(a) Declaring a state of emergency and issuing a request for assistance or aid by doing either of the following:

(b) Issuing to another participating political subdivision a verbal or written request for assistance or aid. If the request is made verbally, a written confirmation of the request shall be made not later than seventy-two hours after the verbal request is made.

(2) Requests for assistance or aid made under division (E)(1) of this section shall be made through the emergency management agency of a participating political subdivision or an official designated by the chief executive of the participating political subdivision from which the assistance or aid is requested and shall provide the following information:

(a) A description of the incident, disaster, exercise, training activity, planned event, or emergency;

(b) A description of the assistance or aid needed;

(c) An estimate of the length of time the assistance or aid will be needed;

(d) The specific place and time for staging of the assistance or aid and a point of contact at that location.

(F) A participating political subdivision shall provide assistance or aid to another participating political subdivision that is impacted by an incident, disaster, exercise, training activity, planned event, or emergency, any of which requires additional resources. The provision of the assistance or aid is subject to the following conditions:

(1) The responding political subdivision may withhold resources necessary to provide for its own protection.

(2) Personnel of the responding political subdivision shall continue under their local
command and control structure, but shall be under the operational control of the appropriate
officials within the incident management system of the participating political subdivision
receiving assistance or aid.

(3) Responding law enforcement officers acting pursuant to this section have the same
authority to enforce the law as when acting within the territory of their regular employment.

(G)(1) Nothing in this section shall do any of the following:
(a) Alter the duties and responsibilities of emergency response personnel;
(b) Prohibit a private company from participating in the provision of mutual assistance or
aid pursuant to the compact created pursuant to this section if the participating political
subdivision approves the participation and the contract with the private company allows for the
participation;
(c) Prohibit employees of participating political subdivisions from responding to a request
for mutual assistance or aid precipitated by an incident, disaster, exercise, training activity,
planned event, or emergency, any of which requires additional resources, when the employees
are responding as part of a regional response team that is under the operational control of the
incident command structure;
(d) Authorize employees of participating political subdivisions to respond to an incident,
disaster, exercise, training activity, planned event, or emergency, any of which requires
additional resources, without a request from a participating political subdivision.

(2) This section does not preclude a participating political subdivision from entering into
a mutual aid or other agreement with another political subdivision, and does not affect any other
agreement to which a participating political subdivision may be a party, or any request for
assistance or aid that may be made, under any other section of the Revised Code, including,
but not limited to, any mutual aid arrangement under this chapter, any fire protection or
emergency medical services contract under section 9.60 of the Revised Code, sheriffs’ requests
for assistance to preserve the public peace and protect persons and property under section
311.07 of the Revised Code, any agreement for mutual assistance or aid in police protection
under section 737.04 of the Revised Code, any agreement for law enforcement services
between universities and colleges and political subdivisions under section 3345.041 or 3345.21
of the Revised Code, and mutual aid agreements among emergency planning districts for
hazardous substances or chemicals response under sections 3750.02 and 3750.03 of the
Revised Code.

(H)(1) Personnel of a responding participating political subdivision who suffer injury or
death in the course of, and arising out of, their employment while rendering assistance or aid
under this section to another participating political subdivision are entitled to all applicable
benefits under Chapters 4121 and 4123 of the Revised Code.

(2) Personnel of a responding participating political subdivision shall be considered,
while rendering assistance or aid under this section in another participating political subdivision,
to be agents of the responding political subdivision for purposes of tort liability and immunity
from tort liability under the law of this state.

(3)(a) A responding participating political subdivision and the personnel of that political
subdivision, while rendering assistance or aid under this section, or while in route to or from
rendering assistance or aid under this section, in another participating political subdivision, shall
be deemed to be exercising governmental functions as defined in section 2744.01 of the
Revised Code, shall have the defenses to and immunities from civil liability provided in sections
2744.02 and 2744.03 of the Revised Code, and shall be entitled to all applicable limitations on
recoverable damages under section 2744.05 of the Revised Code.

(b) A participating political subdivision requesting assistance or aid and the personnel of
that political subdivision, while requesting or receiving assistance or aid under this section from
any other participating political subdivision, shall be deemed to be exercising governmental
functions as defined in section 2744.01 of the Revised Code, shall have the defenses to and

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immunities from civil liability provided in sections 2744.02 and 2744.03 of the Revised Code, and shall be entitled to all applicable limitations on recoverable damages under section 2744.05 of the Revised Code.

(I) If a person holds a license, certificate, or other permit issued by a participating political subdivision evidencing qualification in a professional, mechanical, or other skill, and if the assistance or aid of that person is asked for under this section by a participating political subdivision, the person shall be deemed to be licensed or certified in or permitted by the participating political subdivision receiving the assistance or aid to render the assistance or aid, subject to any limitations and conditions the chief executive of the participating political subdivision receiving the assistance or aid may prescribe by executive order or otherwise.

(J)(1) Subject to division (K) of this section and except as provided in division (J)(2) of this section, any participating political subdivision rendering assistance or aid under this section in another participating political subdivision shall be reimbursed by the participating political subdivision receiving the assistance or aid for any loss or damage to, or expense incurred in the operation of, any equipment used in rendering the assistance or aid, for any expense incurred in the provision of any service used in rendering the assistance or aid, and for all other costs incurred in responding to the request for assistance or aid. To avoid duplication of payments, insurance proceeds available to cover any loss or damage to equipment of a participating political subdivision rendering assistance or aid shall be considered in the reimbursement by the participating political subdivision receiving the assistance or aid.

(2) A participating political subdivision rendering assistance or aid under this section to another participating political subdivision shall not be reimbursed for either of the following:
   (a) The first eight hours of mutual assistance or aid it provides to the political subdivision receiving the assistance or aid;
   (b) Expenses the participating political subdivision incurs under division (H)(1) of this section.

(K) A participating political subdivision rendering assistance or aid under this section may do any of the following:
   (1) Assume, in whole or in part, any loss, damage, expense, or cost the political subdivision incurs in rendering the assistance or aid;
   (2) Loan, without charge, any equipment, or donate any service, to the political subdivision receiving the assistance or aid;
   (3) Enter into agreements with one or more other participating political subdivisions to establish different allocations of losses, damages, expenses, or costs among such political subdivisions.

3701-3-01 Communicable diseases; definitions.

As used in Chapter 3701-3 of the Administrative Code:
   (A) “Antimicrobial” means an agent that kills microorganisms or suppresses microorganism multiplication or growth.
   (B) “Arthropod” means an organism of the phylum Arthropoda, such as an insect, spider, mite or tick.
   (C) “Board of health” means the board of health of the city or general health district established by section 3709.01 of the Revised Code, or the authority having the duties of a board of health in any city as authorized by section 3709.05 of the Revised Code.
   (D) “Bioterrorism” means the intentional use of any microorganism, virus, infectious substance, or biological product that may be engineered as a result of biotechnology, or any naturally occurring or bioengineered component of a microorganism, virus, infectious substance, or biological product, to cause death, disease, or other biological malfunction in a human, animal, plant, or other living organism as a means of influencing the conduct of government or

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Epidemic or "outbreak" means the occurrence of cases of disease in numbers greater than expected in a particular population or for a particular period of time.

J) “Epidemic” or “outbreak” means the occurrence of cases of disease in numbers greater than expected in a particular population or for a particular period of time.

K) “Exclude” means to bar from participation.

L) “Event” means an important happening or occurrence that results from an actual or suspected act of bioterrorism, epidemic or pandemic disease, established or novel infectious agents, or biological or chemical toxins.

M) “Food handler” means a person who prepares or serves food intended for human consumption.

N) “Health care provider” means any person or government entity that provides health care services to individuals. “Health care provider” includes, but is not limited to, hospitals, medical clinics and offices, special care facilities, medical laboratories, physicians, dentists, physician assistants, registered and licensed practical nurses, emergency medical service organization personnel, and ambulance service personnel.

O) “Health district” means a city or general health district as created by Chapter 3709 of the Revised Code.

P) “Incidence” means the number of new cases of a disease occurring during a specified interval of time in a defined population.

Q) “Infected individual” means a person whose body harbors a specific microorganism capable of producing disease, whether or not the person is experiencing signs or symptoms of the disease.

R) “Isolation” means the separation of an infected individual from others during the period of disease communicability in such a way that prevents, as far as possible, the direct or indirect conveyance of an infectious agent to those who are susceptible to infection or who may spread the agent to others.

S) “Pandemic” means an epidemic disease that is occurring throughout a very wide area, usually several countries or continents, and usually affecting a large proportion of the population.

T) “Quarantine” means the restriction of the movements or activities of a well individual or animal who has been exposed to a communicable disease during the period of communicability of that disease and in such a manner that transmission of the disease may have occurred. The duration of the quarantine ordered shall be equivalent to the usual incubation period of the disease to which the susceptible person or animal was exposed.

X) “Sensitive occupation” means direct food handling, direct patient care, the handling
of food or provision of direct care to children in a child care center, or any other occupation which provides significant opportunity for an infected individual to transmit infectious disease agents.

(Y) “Sexually-transmitted disease” or “venereal disease” is an infectious disease commonly contracted through sexual contact such as chancroid, chlamydia, gonococcal infection, granuloma inguinale, human immunodeficiency virus infection, lymphogranuloma venereum, or syphilis.

(Z) “Surveillance” means, in the public health service, the systematic collection, analysis, interpretation, and dissemination, of health data on an on-going basis, to gain knowledge of the pattern of disease occurrence and potential in a community in order to control and prevent disease in the community.

(AA) “Susceptible person” means a person that, when exposed to an infectious microorganism, may not possess sufficient resistance to prevent contracting the infection or disease.

3701-3-02 Reportable diseases.

The diseases listed in this rule and classified as class “A”, class “B”, and class “C” are declared to be dangerous to the public health and are reportable. The occurrence of cases or suspected cases of a disease classified as class “A”, class “B”, or class “C” shall be reported, in detail, by health care providers and laboratories to the board of health on forms as prescribed and provided by the director and shall be reported in accordance with this rule and Chapter 3701-3 of the Administrative Code.

(A) Due to the severity of disease or the potential for epidemic spread, diseases of major public health concern are classified as class “A.” The following diseases are classified as class “A” and shall be reported immediately via telephone in accordance with rules 3701-3-03, 3701-3-04, and 3701-3-05 of the Administrative Code:

1. Anthrax;
2. Botulism, foodborne;
3. Cholera;
4. Diphtheria;
5. Influenza “A” - novel virus infection;
6. Measles;
7. Meningococcal disease;
8. Middle east respiratory syndrome (MERS);
9. Plague;
10. Rabies, human;
11. Rubella (not congenital);
12. Severe acute respiratory syndrome (SARS);
13. Smallpox;
14. Tularemia;
15. Viral hemorrhagic fever (VHF), including Ebola virus disease, Lassa fever, Marburg hemorrhagic fever, and Crimean-Congo hemorrhagic fever;
16. Yellow fever; and
17. Any unexpected pattern of cases, suspected cases, deaths or increased incidence of any other disease of major public health concern, because of the severity of disease or potential for epidemic spread, which may indicate a newly recognized infectious agent, outbreak, epidemic, related public health hazard or act of bioterrorism.

(B) Due to the potential for epidemic spread, diseases of significant public health concern are classified as class “B.” The following diseases are classified as class “B” and shall be reported in accordance with this rule and rules 3701-3-03, 3701-3-04, and 3701-3-05 of the
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Administrative Code:
(1) Amebiasis;
(2) Arboviral neuroinvasive and non-neuroinvasive diseases:
   (a) Chikungunya virus infection;
   (b) Eastern equine encephalitis virus disease;
   (c) LaCrosse virus disease (other California serogroup virus disease);
   (d) Powassan virus disease;
   (e) St. Louis encephalitis virus disease;
   (f) West Nile virus infection;
   (g) Western equine encephalitis virus disease;
   (h) Zika virus infection;
   (i) Other Arthropod-borne diseases;
(3) Babesiosis;
(4) Botulism:
   (a) Infant;
   (b) Wound;
(5) Brucellosis;
(6) Campylobacteriosis;
(7) Chancroid;
(8) Chlamydia trachomatis infections;
(9) Coccidioidomycosis;
(10) Creutzfeldt-Jakob disease (CJD);
(11) Cryptosporidiosis;
(12) Cyclosporiasis;
(13) Dengue;
(14) E. coli O157:H7 and Shiga toxin-producing E. coli (STEC);
(15) Ehrlichiosis/anaplasmosis;
(16) Giardiasis;
(17) Gonorrhea (Neisseria gonorrhoeae);
(18) Haemophilus influenzae (invasive disease);
(19) Hantavirus;
(20) Hemolytic uremic syndrome (HUS);
(21) Hepatitis A;
(22) Hepatitis B (non-perinatal);
(23) Hepatitis B (perinatal);
(24) Hepatitis C;
(25) Hepatitis D (delta hepatitis);
(26) Hepatitis E;
(27) Influenza-associated hospitalization;
(28) Influenza-associated pediatric mortality;
(29) Legionnaires' disease;
(30) Leprosy (Hansen disease);
(31) Leptospirosis;
(32) Listeriosis;
(33) Lyme disease;
(34) Malaria;
(35) Meningitis:
   (a) Aseptic (viral);
   (b) Bacterial;
(36) Mumps;
(37) Pertussis;
(38) Poliomyelitis (including vaccine-associated cases);
(39) Psittacosis;
(40) Q fever;
(41) Rubella (congenital);
(42) Salmonellosis;
(43) Shigellosis;
(44) Spotted Fever Rickettsiosis, including Rocky Mountain spotted fever (RMSF);
(45) Staphylococcus aureus, with resistance or intermediate resistance to vancomycin (VRSA, VISA);
(46) Streptococcal disease, group A, invasive (IGAS);
(47) Streptococcal disease, group B, in newborn;
(48) Streptococcal toxic shock syndrome (STSS);
(49) Streptococcus pneumoniae, invasive disease (ISP);
(50) Syphilis;
(51) Tetanus;
(52) Toxic shock syndrome (TSS);
(53) Trichinellosis;
(54) Tuberculosis (TB), including multi-drug resistant tuberculosis (MDR-TB);
(55) Typhoid fever;
(56) Varicella;
(57) Vibriosis; and
(58) Yersiniosis.

(C) The following are classified as class “C” and shall be reported by the end of the next business day in accordance with this rule and rules 3701-3-03, 3701-3-04, and 3701-3-05 of the Administrative Code unless paragraph (C)(7) of this rule applies - outbreak, unusual incidence, or epidemic of other infectious diseases from the following sources:

(1) Community;
(2) Foodborne;
(3) Healthcare-associated;
(4) Institutional;
(5) Waterborne; and
(6) Zoonotic;

(7) If the outbreak, unusual incidence, or epidemic, including but not limited to, histoplasmosis, pediculosis, scabies, and staphylococcal infections, has an unexpected pattern of cases, suspected cases, deaths, or increased incidence of disease that is of a major public health concern pursuant to paragraph (A)(16) of this rule, then such outbreak, unusual incidence, or epidemic shall be reported in accordance with paragraph (A) of rule 3701-3-05 of the Administrative Code.

3701-3-02.1 Reporting occupational diseases.

(A) Every physician attending on or called in to visit a patient whom the physician believes to be suffering from any of the occupational diseases or occupationally related ailments listed in paragraph (B) of this rule shall submit a report to the director of health within forty-eight hours from the time of first attending the patient. This report shall be made on, or in conformity with, the standard schedule blanks which the director is required to provide physicians pursuant to section 3701.26 of the Revised Code and shall contain the following information:

(1) The name, address, and occupation of the patient;
(2) The name, address, and business of the patient’s employer;
(3) The nature of the disease or ailment; and
(4) Name, address and telephone number of the physician.
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The mailing of the report, within the time required by this paragraph shall constitute compliance with section 3701.25 the Revised Code and this rule.

(B) The following occupational diseases and ailments are required to be reported:
(1) Poisoning from phosphorous, brass, arsenic, mercury, wood alcohol or their compounds;
(2) Compressed air illness;
(3) Poisoning from lead and cadmium.

3701-3-02.2 Exposed EMS workers.

(A) Section 3701.248 of the Revised Code allows an emergency medical services worker to ask a health care facility or coroner to notify them of the results of tests for certain diseases, if the worker believes that he or she had a significant exposure through contact with a patient. The diseases subject to this procedure are contagious or infectious diseases that are specified as reasonably likely to be transmitted by air or blood during the normal course of an emergency medical services worker's duties. The diseases listed in paragraph (B) of this rule are specified for purposes of section 3701.248 of the Revised Code.

(B) The following diseases are specified as reasonably likely to be transmitted by air or blood during the normal course of an emergency medical worker's duties:
(1) Crimean-Congo hemorrhagic fever;
(2) Diphtheria;
(3) Ebola hemorrhagic fever;
(4) Fifth disease (human parvovirus infection);
(5) Hansen disease (leprosy);
(6) Acute or chronic infection with hepatitis B virus;
(7) Acute or chronic infection with hepatitis C virus;
(8) Infection with hepatitis D virus (delta hepatitis);
(9) Human immunodeficiency virus (HIV) infection, including acquired immunodeficiency syndrome (AIDS);
(10) Infection with human t-lymphotropic virus (HTLV-1 and HTLV-2);
(11) Lassa fever;
(12) Leishmaniasis, visceral (Kala-Azar);
(13) Leptospirosis;
(14) Marburg hemorrhagic fever;
(15) Measles (rubeola);
(16) Meningococcal disease (Neisseria meningitidis);
(17) Mumps (infectious parotitis);
(18) Pertussis (whooping cough);
(19) Pneumonic plague (Yersinia pestis);
(20) Rabies;
(21) Rubella (German measles);
(22) Severe acute respiratory syndrome (SARS)
(23) Tuberculosis; and
(24) Varicella (herpes zoster) infection, including chickenpox and shingles.

3701-3-03 Reporting communicable diseases.

(A) A health care provider with knowledge of a case or suspect case of a disease which is required by law to be reported, including all class “A”, class “B”, and class “C” categories of disease designated as reportable under rule 3701-3-02 of the Administrative Code, shall submit a case report in the manner set forth in rule 3701-3-05 of the Administrative Code.
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(1) A health care provider may submit electronic reports in the manner approved by the director.

(2) Unless otherwise demonstrated, a health care provider who submits electronic reports in the manner approved by the director shall be presumed compliant with section 3701.23 of the Revised Code and rules 3701-3-02, 3701-3-04, and 3701-3-05 of the Administrative Code.

(B) Reports of cases and suspect cases shall include, but not limited to, the following:

(1) Case or suspect case information: name, diagnosis or suspected diagnosis, date of birth, sex, telephone number, and street address including city, state, and zip code.

(2) Health care provider information: name, telephone number, and street address including city, state, and zip code.

(3) Supplementary information as needed to complete official surveillance forms provided or set forth by the director.

(C) Any individual having knowledge of a person suffering from a disease suspected of being communicable is authorized to report to public health authorities all known facts relating to the case or incident.

3701-3-04 Laboratory reporting.

(A) The person in charge of any laboratory that examines specimens of human origin for evidence of diseases designated as reportable by rule 3701-3-02 of the Administrative Code shall report all positive results of such examinations in the manner set forth in rule 3701-3-05 of the Administrative Code.

(B) A positive result of a laboratory examination for a reportable disease shall be considered reason to suspect that a person is infected by that disease. Upon receipt of a laboratory report of a positive result for a reportable disease, the city or general health district in which the suspect case resides shall make an inquiry through the appropriate health care provider to determine if the suspected case exists.

(C) A laboratory report shall include, but not be limited to, the following:

(1) Case information: name, date of birth, sex, and street address including city, state, and zip code.

(2) Laboratory test information: specimen identification number, specimen collection date, specimen type, test name, test result, and if applicable, the organism and serotype.

(3) Health care provider information: name, telephone number, street address including city, state, and postal zip code.

3701-3-05 When to report.

Reports by health care providers, as specified in rule 3701-3-03 of the Administrative Code, and reports by laboratories of positive results, as specified in rule 3701-3-04 of the Administrative Code, shall be provided in the manner set forth by the director according to the following time and method of reporting:

(A) Cases, suspect cases, and positive laboratory results for diseases specified as class “A” in paragraph (A) of rule 3701-3-02 of the Administrative Code shall be initially and immediately provided by telephone to the local health jurisdiction in which the case or suspected case resides, or if the residence is unknown, to the Ohio department of health. Follow up reports shall be provided in the manner set forth by the director. If cases, suspect cases, and positive laboratory results for diseases specified as class “A” are reported to a local health district, such local health jurisdiction shall immediately notify the Ohio department of health in the manner set forth by the director.

(B) Case and suspect case reports and reports of positive laboratory results for diseases
specified as class “B” in paragraph (B) of rule 3701-3-02 of the Administrative Code shall be provided by the end of the next business day.

(C) Reports related to an actual or suspected outbreak, unusual incident, or epidemic of any disease specified as class “C” in paragraph (C) of rule 3701-3-02 of the Administrative Code shall be provided by the end of the next business day, unless the unexpected pattern of cases, suspect cases, deaths, or increased incidence of disease is of major public health concern pursuant to paragraph (A) of rule 3701-3-02 of the Administrative Code, then such reports shall be made according to paragraph (A) of this rule.

3701-3-06 Local health reports to state health department.

A board of health that receives a report of a case, suspected case or positive laboratory result pursuant to rules 3701-3-02, 3701-3-03, 3701-3-04, and 3701-3-05 of the Administrative Code shall report the same report to the department as follows:

(A) Diseases specified as class “A” in paragraph (A) of rule 3701-3-02 of the Administrative Code shall be reported by telephone immediately after the existence of such case or suspect case is known to the board of health.

(B) Diseases specified as class “B” in paragraph (B) of rule 3701-3-02 of the Administrative Code shall be reported by the end of the next business day after the existence of such case or suspect case or positive laboratory result is known to the board of health.

(C) Outbreaks, unusual incidence, or epidemics of diseases specified as class “C” in paragraph (C) of rule 3701-3-02 of the Administrative Code shall be reported by the end of the next business day after the outbreak, unusual incidence, or epidemic is known to the board of health.

3701-3-08 Medical records access and confidentiality.

Any person, hospital, clinic, agency or other institution or facility providing care or treatment to an individual suffering from a communicable disease which is required to be reported under Chapter 3701 of the Revised Code and the rules adopted by the director of health, or a disease that the director requires special inquiry be made under sections 3701.13 and 3701.14 of the Revised Code, shall, upon written request by the director provide access to the patient's medical record to the director during an investigation of such disease.

3701-3-13 Isolation of infected persons.

A person infected with one of the following specified diseases or conditions shall be isolated as set forth in this rule:

(A) Amebiasis: a person with amebiasis who attends a child care center or works in a sensitive occupation shall be excluded from the child care center or work in the sensitive occupation and may return after diarrhea has ceased and three follow-up stool specimens are negative for Entamoeba histolytica.

(B) Campylobacteriosis: a person with campylobacteriosis who attends a child care center or works in a sensitive occupation shall be excluded from the child care center or work in the sensitive occupation and may return when the following conditions are met:

1. A child may return to a child care center after his or her diarrhea has ceased.
2. A person may return to work in a sensitive occupation after diarrhea has ceased, provided the person's duties do not include food handling.
3. A food handler may return to work only after diarrhea has ceased and one of the following conditions are met:
   a. Forty-eight hours of effective antimicrobial therapy; or
(b) Two consecutive follow-up stool specimens are negative for Campylobacter.

(C) Chickenpox: a person with chickenpox shall be isolated, including exclusion from school, child care center, and public places until the sixth day after onset of rash, or until all lesions are dry. Contagiousness may be prolonged in patients with altered immunity. Persons with chickenpox shall avoid contact with susceptible persons.

(D) Cholera: a person with cholera who attends a child care center or works in a sensitive occupation shall be excluded from the child care center or work in the sensitive occupation and may return when the following conditions are met:

(1) A child may return to a child care center after diarrhea has ceased.

(2) A person may return to work in a sensitive occupation after diarrhea has ceased, provided that his or her duties do not include food handling.

(3) A food handler may return to work after diarrhea has ceased and two consecutive follow-up stool specimens are negative for Vibrio cholerae.

(E) Conjunctivitis, purulent: a person with purulent conjunctivitis who attends or works in a child care center shall be excluded from the child care center and may return twenty-four hours after the initiation of effective antimicrobial therapy.

(F) Cryptosporidiosis: a person with cryptosporidiosis who attends a child care center or works in a sensitive occupation shall be excluded from the child care center or work in the sensitive occupation and may return when the following conditions are met:

(1) The child may return to the child care center after diarrhea has ceased.

(2) A person may return to work in a sensitive occupation after diarrhea has ceased, provided that his or her duties do not include food handling.

(3) A food handler may return to work after diarrhea has ceased and after three consecutive follow-up stool specimens are negative for Cryptosporidium.

(G) Cyclosporiasis: a person with cyclosporiasis who attends a child care center or works in a sensitive occupation shall be excluded from the child care center or work in the sensitive occupation and may return after diarrhea has ceased and effective antimicrobial therapy has begun.

(H) Diarrhea, infectious or of unknown cause: a person with diarrhea, of infectious or unknown cause, who attends a child care center or works in a sensitive occupation shall be excluded from the child care center or work in the sensitive occupation and may return only after diarrhea has ceased. A person with infectious diarrhea of known cause shall be isolated in accordance with the provisions of the rule set forth for the specified disease.

(I) Diphtheria: a person with diphtheria shall be isolated until two cultures, from both throat and nose, and additionally, in the case of cutaneous diphtheria, a culture from skin lesions, are negative for diphtheria bacilli. Cultures shall be taken not less than twenty-four hours apart, and not less than twenty-four hours after cessation of antimicrobial therapy. If culturing is unavailable or impractical, isolation may be ended after fourteen days of effective antimicrobial therapy.

(J) Escherichia coli (E. coli) O157:H7, other enterohemorrhagic (Shiga toxin-producing) E. coli or hemolytic uremic syndrome (HUS): a person with Escherichia coli (E. coli) O157:H7, other enterohemorrhagic (Shiga toxin-producing) E. coli or hemolytic uremic syndrome (HUS) who attends a child care center or works in a sensitive occupation shall be excluded from the child care center or work in the sensitive occupation and may return after his or her diarrhea has ceased and after two consecutive follow-up stool specimens are negative for E. coli O157:H7 or other enterohemorrhagic (Shiga toxin-producing) E. coli.

(K) Giardiasis: a person with giardiasis who attends a child care center or works in a sensitive occupation shall be excluded from the child care center or work in the sensitive occupation and may return after diarrhea has ceased and one of the following conditions have been met:

(1) Seventy-two hours of effective antimicrobial therapy; or
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(2) Three consecutive follow-up stool specimens are negative for Giardia.

(L) Hepatitis A: a person with hepatitis A who attends a child care center or works in a sensitive occupation shall be excluded from the child care center or work in the sensitive occupation until ten days after initial onset of symptoms.

(M) Measles: a person with measles shall be isolated, including exclusion from school or child care center, for four days following the onset of rash. Contagiousness may be prolonged in patients with altered immunity.

(N) Meningitis, aseptic, and viral meningoencephalitis, but not including arthropod-borne disease: a person with aseptic meningitis or viral meningoencephalitis shall be excluded from school or child care center until he or she is afebrile.

(O) Meningococcal disease: a person with meningococcal disease shall be isolated until twenty-four hours after the initiation of effective antimicrobial therapy.

(P) Mumps: a person with mumps shall be isolated, including exclusion from school or child care center, for five days after the onset of parotid swelling.

(Q) Pediculosis: a person with body lice shall be excluded from school or child care center until twenty-four hours after application of an effective pediculicide. A person with head lice shall be excluded from school or child care center until after the first treatment with an effective pediculicide.

(R) Pertussis (whooping cough): a person with pertussis, who is not treated with effective antimicrobial therapy, shall be isolated, including exclusion from school or child care center, until three weeks after the onset of paroxysms. If effective antimicrobial therapy is given, the person shall be isolated for five days after initiation of antimicrobial therapy.

(S) Plague: a person with plague shall be placed in droplet isolation until completion of forty-eight hours of effective antimicrobial therapy.

(T) Rubella: a person with rubella shall be isolated, including exclusion from school or child care center, for seven days after the onset of the rash. Persons with congenital rubella shall be isolated until they are one year old unless nasopharyngeal and urine cultures after three months of age are repeatedly negative for rubella.

(U) Salmonellosis: a person with salmonellosis who attends a child care center or works in a sensitive occupation shall be excluded from the child care center or work in the sensitive occupation and may return if diarrhea has ceased and after two consecutive follow-up stool specimens are negative for Salmonella.

(V) SARS (severe acute respiratory distress syndrome): a person with confirmed or suspected SARS shall be placed in airborne isolation until no longer considered infectious.

(W) Scabies: a person with scabies shall be isolated for twenty-four hours following initial treatment with an effective scabicide. A person with the manifestation of scabies known as “crusted scabies” shall be isolated until the mite can no longer be demonstrated on a scabies preparation.

(X) Shigellosis: a person with shigellosis who attends a child care center or works in a sensitive occupation shall be excluded from the child care center or work in the sensitive occupation and may return if diarrhea has ceased and after two consecutive follow-up stool specimens are negative for Shigella.

(Y) Smallpox: a person with confirmed or suspected smallpox shall be placed in airborne isolation in a facility designated by the director. The patient's release from the facility can occur when all scabs have fallen off.

(Z) Streptococcal infection: a person with a streptococcal infection shall be excluded from school or child care center for twenty-four hours after the initiation of effective antimicrobial
therapy.

(AA) Tuberculosis (TB): a person with infectious tuberculosis shall be isolated according to Chapter 3701-15 of the Administrative Code until the person has three negative AFB sputum smear results, collected eight to twenty-four hours apart (with at least one being an early morning specimen) and the person has responded clinically to an antituberculosis treatment regimen consistent with the results of any susceptibility testing performed and until the local authorized TB authority, as set out in section 339.72 of the Revised Code, or his or her designee approves that person's removal from isolation.

(BB) Typhoid fever person works in a sensitive occupation shall be excluded from work and may return after the person is asymptomatic and after three consecutive follow-up stool specimens are negative for Salmonella Typhi.

(CC) Typhus: a louse infested person with typhus shall be isolated until twenty-four hours after application of an effective pediculicide for body lice and clothing and environment are free of body lice.

(DD) Viral hemorrhagic fever (VHF): a person with confirmed or suspected viral hemorrhagic fever shall be placed in airborne isolation until no longer considered infectious.

(EE) Yellow fever: a person with confirmed or suspected yellow fever shall be isolated to prevent access of mosquitoes to the patient for at least five days after onset of disease.

(FF) Yersiniosis: a person with yersiniosis who attends a child care center or works in a sensitive occupation shall be excluded from the child care center or work in the sensitive occupation and may return when the following conditions are met:

1. A child may return to the child care center after diarrhea has ceased.
2. A person may return to work in a sensitive occupation after diarrhea has ceased, provided that his or her duties do not include food handling.
3. A food handler may return to work after diarrhea has ceased and two consecutive follow-up stool specimens are negative for Yersinia.

3701-3-15 Reporting by pharmacies and pharmacists; bioterrorism.

(A) As used in this rule:

1. "Pharmacist" means an individual licensed under Chapter 4729 of the Revised Code to engage in the practice of pharmacy as a pharmacist.
2. "Pharmacy," means the same as defined in division (A) of section 4729.01 of the Revised Code.
3. "Prescription" means the same as defined in division (H) of section 4729.01 of the Revised Code.
4. "Significant changes" means observations or occurrences of or related to medication usage that is, based on professional experience and judgment, too closely correlated to be attributed to chance.
5. "Unexpected increase" means, based on past experience, an unforeseen change in the types, urgency, or volume of sales, inquiries or requests specified in this rule.

(B) All pharmacies and pharmacists shall immediately report information by telephone or electronically to the health commissioner of the health district having jurisdiction:

1. Any prescription for medication used to treat a disease that is relatively uncommon and may have been caused by bioterrorism, or
2. Significant changes in medication usage that may be caused by bioterrorism, epidemic or pandemic disease, or established or novel infectious agents or biological toxins posing a risk of human fatality or disability, or
3. An unexpected increase in:
   a. The number of prescriptions issued for antibiotics;
   b. The number of prescriptions issued for medications to treat fever or respiratory or
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gastrointestinal complaints;
(c) The sales of or the number of requests for over-the-counter medication to treat fever, respiratory, or gastrointestinal complaints.
(C) Pharmacies and pharmacists shall submit reports required by this rule using forms and formats approved by the director. A pharmacy or pharmacist using an electronic reporting system or systems, to the extent approved by the director, is deemed to comply with the reporting requirements of this rule until such use is no longer considered active by the director.
(D) All health commissioners shall immediately report information received from pharmacies or pharmacists to the director.
(1) Health commissioner reports shall be submitted by telephone or by electronic means approved by the director.
(2) If a pharmacy has submitted an electronic report for over the counter medication sales as authorized by this rule and so advises the health commissioner, no further report is required.
(E) Upon receipt of a request from a health commissioner of the health district having jurisdiction, each pharmacy in the jurisdiction and for each location within the jurisdiction shall:
(1) Within ten business days of receiving such a request, identify an employee or employees of the pharmacy or a pharmacist or pharmacists employed at the pharmacy of who will be the point of contact for purposes of this rule.
(2) Within ten business days advise the health commissioner having jurisdiction of any change in the information of who will be responsible for being the point of contact for purposes of this rule.
(F) In consultation with the Ohio board of pharmacy, the director may publish a list of antibiotics and other medications that are required to be included in reports of significant changes in medication usage required by this rule.
(G) A pharmacy or pharmacist shall report information regarding events as specified in this rule. A pharmacy or pharmacist that does not report events in compliance with this rule is subject to an administrative fine as specified in rule 3701-73-02 of the Administrative Code.

Part VII. Epinephrine to Treat Anaphylaxis

3728.01 Administration of epinephrine.

As used in this chapter:
(A) “Administer epinephrine” means to inject an individual with epinephrine using an autoinjector in a manufactured dosage form.
(B) “Prescriber” means an individual who is authorized by law to prescribe drugs or dangerous drugs or drug therapy related devices in the course of the individual's professional practice, including only the following:
(1) A clinical nurse specialist, certified nurse-midwife, or certified nurse practitioner who holds a certificate to prescribe issued under section 4723.48 of the Revised Code;
(2) A physician authorized under Chapter 4731 of the Revised Code to practice medicine and surgery, osteopathic medicine and surgery, or podiatric medicine and surgery;
(3) A physician assistant who is licensed under Chapter 4730 of the Revised Code, holds a valid prescriber number issued by the state medical board, and has been granted physician-delegated prescriptive authority.
(C) “Qualified entity” means any public or private entity that is associated with a location where allergens capable of causing anaphylaxis may be present, including child day-care centers, colleges and universities, places of employment, restaurants, amusement parks, recreation camps, sports playing fields and arenas, and other similar locations, except that
“qualified entity” does not include either of the following:
   (1) A chartered or nonchartered nonpublic school; community school; science, technology, engineering, and mathematics school; or a school operated by the board of education of a city, local, exempted village, or joint vocational school district;
   (2) A camp described in section 5101.76 of the Revised Code.

3728.03 Epinephrine autoinjector supply.

   (A) A qualified entity may acquire and maintain a supply of epinephrine autoinjectors that, in accordance with section 4723.483, 4730.433,1 or 4731.96 of the Revised Code, are personally furnished by a prescriber or obtained pursuant to a prescription issued by a prescriber.
   (B) Epinephrine autoinjectors acquired pursuant to this section shall be stored in a location readily accessible in an emergency and maintained in accordance with the manufacturer’s instructions and any additional requirements that may be established by the department of health under section 3728.11 of the Revised Code.
   (C) A qualified entity that acquires epinephrine autoinjectors pursuant to this section shall designate one or more individuals who are employees or agents of the entity and have successfully completed anaphylaxis training in accordance with section 3728.04 of the Revised Code to be responsible for oversight of the epinephrine autoinjectors, including storage, maintenance, and control. The qualified entity may authorize those individuals and other individuals who have successfully completed the anaphylaxis training to administer epinephrine.

3728.04 Epinephrine training.

   (A) The anaphylaxis training required by section 3728.03 of the Revised Code may be any of the following:
      (1) Training conducted by a nationally recognized organization that has experience in providing training in emergency health care to individuals who are not health care professionals;
      (2) Training by individuals or organizations approved by the department of health under section 3728.11 of the Revised Code;
      (3) Classes approved by the department under section 3728.11 of the Revised Code.
   (B) Training may be completed in person or through an online system. The training must cover all of the following and may include any other material the organization or individual conducting it or the department considers appropriate:
      (1) Ways of recognizing the signs and symptoms of severe allergic reactions, including anaphylaxis;
      (2) Standards and procedures for administration of epinephrine and storage of epinephrine autoinjectors;
      (3) Emergency follow-up procedures.
   (C) An individual must successfully complete training before being authorized to administer epinephrine under section 3728.03 of the Revised Code and every two years thereafter. A qualified entity may authorize an individual to administer epinephrine only if the individual provides the entity with a certificate issued by the organization or individual conducting the training attesting to successful completion. The certificate must be on a form developed by the department of health under section 3728.11 of the Revised Code.

3728.05 Authorized epinephrine administration.

   (A) An individual who has completed the anaphylaxis training required by section 3728.03 of the Revised Code and is authorized by a qualified entity may use an epinephrine
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autoinjector from a supply maintained under section 3728.03 of the Revised Code to do either of the following:

(1) Administer epinephrine to an individual believed in good faith to be experiencing anaphylaxis;

(2) Provide, for immediate administration, an epinephrine autoinjector to an individual believed in good faith to be experiencing anaphylaxis or to the parent, guardian, or caregiver of such an individual.

(B) Epinephrine may be administered under this section regardless of whether the individual believed to be experiencing anaphylaxis has a prescription for an epinephrine autoinjector or has previously been diagnosed with an allergy.

3728.09 Limited immunity for administration of epinephrine.

(A) The following are not liable in damages in a civil action for injury, death, or loss to person or property that allegedly arises from an act or omission associated with administering epinephrine or acquiring, maintaining, accessing, or using an epinephrine autoinjector under this chapter, unless the act or omission constitutes willful or wanton misconduct:

(1) A qualified entity that maintains a supply of epinephrine autoinjectors as authorized in accordance with section 3728.03 of the Revised Code, and any employees or agents of the qualified entity;

(2) A trained individual who administers epinephrine or accesses an epinephrine autoinjector as authorized in accordance with section 3728.05 of the Revised Code;

(3) An individual or organization that conducts anaphylaxis training in accordance with section 3728.04 of the Revised Code.

(B) This section does not eliminate, limit, or reduce any other immunity or defense a person may be entitled to under any other provision of the Revised Code or under the common law of this state.

(C) A person located in this state is not liable for injury, death, or loss to person or property that allegedly arises from an act or omission associated with acquiring, maintaining, accessing, or using an epinephrine autoinjector outside of this state if either of the following is the case:

(1) The person would not have been liable had the act or omission occurred within this state;

(2) The person is not liable under the law of the state in which the act or omission occurred.

3728.10 Reporting administration of epinephrine.

A qualified entity that maintains and makes available epinephrine autoinjectors as authorized in accordance with this chapter shall annually report to the department of health, on a form developed by the department, each administration of epinephrine or provision of an epinephrine autoinjector under section 3728.05 of the Revised Code.

3728.11 ODH to develop epinephrine form; issue report; approve training; adopt rules.

(A) The department of health shall do all of the following:

(1) Develop a form to be used by an individual or organization to certify successful completion of anaphylaxis training under section 3728.04 of the Revised Code;

(2) Develop a form to be used to report each administration of epinephrine or provision of an epinephrine autoinjector as required by section 3728.10 of the Revised Code;

(3) Annually publish a report summarizing and analyzing all reports received by the
department under section 3728.10 of the Revised Code in the previous year.  
(B) The department may do either of the following:  
(1) Approve individuals or organizations to conduct anaphylaxis training under section 3728.04 of the Revised Code or approve certain classes offered by an individual or organization;  
(2) Adopt rules in accordance with Chapter 119 of the Revised Code specifying standards and procedures for storage and maintenance of epinephrine autoinjectors acquired pursuant to section 3728.03 of the Revised Code.
Chapter 11. Environmental, Radiation and Workplace

Part I. Clean Air and Waste

[Editor's Note: Additional statutes and regulations governing air, water, and land pollution are available at www.epa.state.oh.us.]

3704.036 Title V clean air act permit program.

(A) The director of environmental protection shall develop and administer a federally approvable Title V permit program and shall take all necessary and appropriate action to implement, through the issuance of Title V permits, applicable requirements of the federal Clean Air Act. Title V permits shall be required only for major sources and affected sources, as defined in 40 C.F.R. 70.2, and solid waste incineration units required to obtain a permit under section 129(e) of the federal Clean Air Act unless the administrator extends the obligation to obtain a Title V permit to other sources.

The Title V permit program does not apply to research and development sources whose emissions do not exceed the requirements of 40 C.F.R. 70.3(a)(1) or any facility or air contaminant source authorized by 40 C.F.R. 70.3(b) to be exempt from the obligation to obtain a Title V permit. A source that obtains a Title V permit shall not be required to obtain any other operating permit under this chapter and rules adopted under it.

Federally enforceable requirements shall be identified separately in Title V permits. The director may include in those permits reasonable and lawful terms and conditions necessary to ensure compliance with this chapter and rules adopted under it that are not federally enforceable requirements, provided that those terms and conditions are clearly separated from federally enforceable requirements and the Title V permits state that those terms and conditions are not federally enforceable.

(B) The director shall adopt, and may amend, suspend, and rescind, rules to facilitate the implementation, supervision, administration, and operation of the Title V permit program that are consistent with, and no more stringent than, the requirements of Title V of the federal Clean Air Act and 40 C.F.R. part 70. The rules shall establish at least all of the following:

(1) Definitions of the following terms, which shall be consistent with and no more stringent than the definitions in 40 C.F.R. part 70: "administrative permit amendment," "affected source," "applicable requirement," "emergency," "emissions unit," "fugitive emissions," "major source," "major stationary source," "potential to emit," "regulated air pollutant," and "stationary source;"

(2) Provisions for minor modifications and operational flexibility that minimize administrative burdens on a source and ensure maximum operational flexibility consistent with the federal Clean Air Act and regulations adopted under it;

(3) Provisions for administrative Title V permit amendments. The rules shall require the director to approve or disapprove an administrative permit amendment in accordance with all of the following:

(a) The director shall take not more than sixty days from receipt of a request for an administrative permit amendment to issue a final action on the request in accordance with the procedures specified in 40 C.F.R. 70.7(d).

(b) Chapter 119 and sections 3704.04 and 3745.07 of the Revised Code do not apply to administrative permit amendments under division (B)(3) of this section.

(c) The director's determination under division (B)(3) of this section is a final action appealable to the environmental review appeals commission under section 3745.04 of the
Revised Code.

(4) Provisions for exemption of insignificant air contaminant sources from inclusion in the Title V permit program. To the extent consistent with the federal Clean Air Act, the exemptions shall include, at a minimum, all source categories that are excluded from the requirements to obtain installation permits and operating permits pursuant to divisions (F) and (G) of section 3704.03 of the Revised Code and any source categories specifically exempted under 40 C.F.R. part 70 and also shall include, to the extent consistent with the federal Clean Air Act, any air contaminant sources with the potential to emit not more than five tons per year of a federally regulated air pollutant other than hazardous air pollutants and not more than twenty per cent of an applicable major source threshold under the federal Clean Air Act.

(5) Provisions to implement the permit shield permitted by the Federal Clean Air Act to the extent consistent with that act and regulations adopted under it, including at least provisions by which a Title V permit applicant may request the director to make a determination whether a provision or class of requirements of that act is applicable to the applicant's air contaminant source. Any such determination made by the director shall be specified in the applicant's Title V permit.

The director may adopt, amend, suspend, and rescind such other rules as are necessary for a federally approvable Title V permit program, which shall be consistent with, and no more stringent than, the requirements of Title V of the federal Clean Air Act and 40 C.F.R. part 70.

(C) Applications for initial Title V permits shall be submitted not less than one year after the director adopts rules under division (B) of this section for the implementation of the Title V permit program. New facilities that are required to obtain a Title V permit shall submit a complete Title V permit application not later than one year after the date of commencement of operation.

Title V permits shall not become effective prior to approval of the Title V permit program by the administrator pursuant to section 502 of the federal Clean Air Act.

Title V permits, except for permits that contain acid rain provisions pursuant to Title IV of the federal Clean Air Act and permits issued for solid waste incineration units combusting municipal waste that are subject to section 129 (e) of the federal Clean Air Act, may be issued for a period determined by the director not to exceed five years, are renewable, and are transferable. Title V permits that contain acid rain provisions pursuant to Title IV of the federal Clean Air Act shall be issued for a fixed term of five years. Title V permits for solid waste incineration units combusting municipal waste that are subject to section 129 (e) of the federal Clean Air Act may be issued for a period to be determined by the director not to exceed twelve years and are renewable. If such permits are issued for a period longer than five years, they shall be reviewed by the director at least once every five years to determine compliance with the permit requirements and to incorporate any new requirements established during the previous five years.

(D) A complete Title V permit application is one that contains all the information, consistent with 40 C.F.R. 70.5 (c), needed to begin processing the application and a certification by a responsible official of the truth, accuracy, and completeness of the information in the application, based upon information and belief formed after reasonable inquiry by the responsible official. Unless the director determines within sixty days after receipt of the application that the application is not complete, the application shall be deemed to be complete.

If, during the processing of an application before or after it has been determined or deemed to be complete, the director determines that additional information is necessary in order to evaluate or take final action on the application, the director may request that information in writing from the applicant. Any such request by the director shall identify the information requested with reasonable specificity and shall provide a reasonable time, not less than fifteen days, for the applicant's submission of the requested information.

If an applicant fails to make a good faith and timely response to a request for additional
information under this division with regard to an application that the director believes to be incomplete, the director shall offer to meet with the applicant within seven days after issuance of a letter for failure to submit the requested information. If the meeting or meeting offer fails to obtain a complete application from the applicant, the director, without prior hearing, shall make a final determination that the application is not complete. Any such determination shall not become effective until twenty days after notice of the determination is sent to the applicant by certified mail. An incompleteness determination by the director may be appealed in accordance with section 3745.04 of the Revised Code, except that if the notice of appeal is timely filed and is accompanied by an application for stay, the stay shall become effective upon filing and shall continue until such time as the environmental review appeals commission rules on the merits of the stay. The commission shall conduct an immediate hearing and determination on the application for stay without interruption by continuances, other than for unavoidable circumstances. If the commission grants the stay, it immediately shall conduct the hearing on the merits and determine the appeal without interruption by continuances, other than for unavoidable circumstances.

(E) The director expressly shall include permit shield provisions for each Title V permit in accordance with the following requirements:

(1) Except as provided in this section, the director shall expressly include in a Title V permit a provision stating that compliance with the conditions of the permit shall be deemed to be compliance with any applicable requirements as of the date of permit issuance, provided that either:

(a) The applicable requirements are included and are specifically identified in the permit;
(b) The director, in acting on the permit application or revision, determines in writing that other requirements specifically identified are not applicable to the facility, and the permit includes the determination or a concise summary of it.

(2) Nothing in division (E) of this section or in any Title V permit shall alter or affect any of the following:

(a) The provisions of section 303 of the federal Clean Air Act, including the authority of the administrator under that section;
(b) The liability of an owner or operator of a facility for any violation of applicable requirements prior to or at the time of permit issuance;
(c) The applicable requirements of the acid rain program, consistent with section 408 (a) of the federal Clean Air Act;
(d) The ability of the administrator to obtain information from a facility pursuant to section 114 of the federal Clean Air Act.

(F) (1) Title V permit applications shall be acted upon by the director in accordance with Chapters 119 and 3745 of the Revised Code and with 40 C.F.R. 70.8. If a Title V permit expires after a complete and timely renewal application has been filed with the director, all provisions and authorizations of the expired permit shall remain in effect until the director's final action on the pending renewal application. The director's failure to take action on a Title V permit application or permit renewal or modification application within the deadlines specified in the federal Clean Air Act or in 40 C.F.R. part 70 shall be a final action appealable to the environmental review appeals commission under section 3745.04 of the Revised Code.

(2) The director shall not issue a Title V permit if the administrator timely objects to its issuance under 40 C.F.R. 70.8 (c) or (d).

(3) The director may modify, revoke, or revoke and reissue a Title V permit for cause. The director shall modify, revoke, or revoke and reissue a Title V permit if requested to do so by the administrator under 40 C.F.R. 70.8 (d).

(G) A Title V permit applicant may request a single permit for a stationary source with multiple Title V emissions units or may request separate permits for any one or more emissions units at the same stationary source required to have a Title V permit. The director shall honor all
Upon written request of a Title V permit applicant, the director shall make a
determination of the applicability or inapplicability of any provision or class of requirements
under the federal Clean Air Act to an emissions unit or stationary source and shall include that
determination or a concise summary of it in the applicant's Title V permit.

(H) A Title V permit applicant may request a permit that accommodates multiple
operating scenarios and anticipated changes in emissions during the term of a permit at a
specified facility. The director shall include in a Title V permit all operating scenarios and
anticipated changes in emissions for which an application has been made unless the operating
scenarios or emissions are prohibited by federally enforceable requirements. The director may
include in a Title V permit such monitoring and recordkeeping requirements as may be
reasonably necessary to verify that any authorized operating scenario complies with federally
enforceable requirements. In imposing any such requirements, the director shall consider and
minimize, to the extent practicable, the administrative burdens that the monitoring will impose on
the source.

(I) The director, by rule or order on a class of similar permit applications, may issue a
general permit covering numerous similar facilities or air contaminant sources. Any such general
permit shall comply with all substantive requirements applicable to conventional Title V permits.
A general permit shall apply to the owner or operator of a facility or air contaminant source only
upon application of the owner or operator to the director.

(J) The director may issue a single Title V permit authorizing emissions from similar
operations at multiple temporary locations within the state, provided that the permit ensures
compliance with all federally enforceable requirements and with 40 C.F.R. 70.6 (e) at all
authorized locations. Any such permit shall require the owner or operator to notify the director in
advance of each change in location.

(K) A Title V permit shall address all existing federally enforceable requirements
applicable to the permitted facility and shall not impose new substantive requirements beyond
the federally enforceable requirements except for terms and conditions that are identified as not
federally enforceable as provided in division (A) of this section. A Title V permit shall specify the
regulatory citation for federal requirements addressed in the permit and shall identify any
difference in form as compared to the federally enforceable requirement on which it is based.

If the applicant for a Title V permit proposes an alternative emission limit as provided
under division (E) of section 3704.03 of the Revised Code, and if the director determines that
the alternative emission limit is equivalent to an emission limit adopted under that division, the
alternative emission limit shall be included in the Title V permit together with provisions to
ensure that any resulting emission limit has been demonstrated to be quantifiable, accountable,
enforceable, and based on replicable procedures. Any such alternative emission limit shall not
take effect if the administrator timely objects to it in accordance with division (F)(2) of this
section.

(L) The director shall take all necessary and appropriate action to do both of the
following:

(1) Issue Title V permits for affected sources consistent with the requirements of Title IV
of the federal Clean Air Act;

(2) Implement, through Title V permits, applicable requirements of section 112 of the
federal Clean Air Act.

(M) The director shall develop procedures for the Title V permit program such that the
program shall minimize procedural burdens and maximize source operational flexibility to the
extent consistent with the federal Clean Air Act.

(N) A Title V permit shall not apply to a physical, operational, or other change that is not
a change within a permitted facility. A Title V permittee shall provide simultaneous written notice
to the director and the administrator of each such off-permit change that is not addressed or prohibited by the federally enforceable portion of the Title V permit, except that no notice is required for off-permit changes that qualify as insignificant under rules adopted under division (B)(4) of this section.

(O) The director shall adopt rules doing both of the following:

(1) Establishing procedures under which any air contaminant source may assume federally enforceable restrictions on its emissions rates, operating rates, hours of operation, or other parameters that are more stringent than those limitations that ordinarily would apply to the source in order to limit the potential of the source to emit;

(2) To the maximum extent possible consistent with federal law, allowing such a source to impose the limitations described in division (O)(1) of this section on its operations unilaterally without further action by the director or approval from the United States environmental protection agency and otherwise minimizing the time required to effectuate such federally enforceable limits.

Until the director adopts rules under division (O) of this section, the owner or operator of an air contaminant source or sources may submit an application for a permit or permit modification pursuant to division (G) of section 3704.03 of the Revised Code with federally enforceable terms and conditions to limit the potential to emit of the source or sources to less than the major source emission thresholds defined in 40 C.F.R. 70.2. The application shall identify both an annual limit and a short-term limit of not more than thirty days for each pollutant to be restricted together with adequate methods for establishing compliance with the limits. Upon submission of the application, the limits shall be federally enforceable against the applicant. The application shall be signed by a responsible official and submitted simultaneously to the director and the administrator. The director shall act on the application in accordance with Chapters 119 and 3745 of the Revised Code.

3734.01 Infectious and other waste; definitions.

As used in this chapter:

(A) “Board of health” means the board of health of a city or general health district or the authority having the duties of a board of health in any city as authorized by section 3709.05 of the Revised Code.

(B) “Director” means the director of environmental protection.

(C) “Health district” means a city or general health district as created by or under authority of Chapter 3709 of the Revised Code.

(D) “Agency” means the environmental protection agency.

(E) “Solid wastes” means such unwanted residual solid or semisolid material as results from industrial, commercial, agricultural, and community operations, excluding earth or material from construction, mining, or demolition operations, or other waste materials of the type that normally would be included in demolition debris, nontoxic fly ash and bottom ash, including at least ash that results from the combustion of coal and ash that results from the combustion of coal in combination with scrap tires where scrap tires comprise not more than fifty per cent of heat input in any month, spent nontoxic foundry sand, nontoxic, nonhazardous, unwanted fired and unfired, glazed and unglazed, structural products made from shale and clay products, and slag and other substances that are not harmful or inimical to public health, and includes, but is not limited to, garbage, scrap tires, combustible and noncombustible material, street dirt, and debris. “Solid wastes” does not include any material that is an infectious waste or a hazardous waste.

(F) “Disposal” means the discharge, deposit, injection, dumping, spilling, leaking, emitting, or placing of any solid wastes or hazardous waste into or on any land or ground or surface water or into the air, except if the disposition or placement constitutes storage or
treatment or, if the solid wastes consist of scrap tires, the disposition or placement constitutes a beneficial use or occurs at a scrap tire recovery facility licensed under section 3734.81 of the Revised Code.

(G) “Person” includes the state, any political subdivision and other state or local body, the United States and any agency or instrumentality thereof, and any legal entity defined as a person under section 1.59 of the Revised Code.

(H) “Open burning” means the burning of solid wastes in an open area or burning of solid wastes in a type of chamber or vessel that is not approved or authorized in rules adopted by the director under section 3734.02 of the Revised Code or, if the solid wastes consist of scrap tires, in rules adopted under division (V) of this section or section 3734.73 of the Revised Code, or the burning of treated or untreated infectious wastes in an open area or in a type of chamber or vessel that is not approved in rules adopted by the director under section 3734.021 of the Revised Code.

(I) “Open dumping” means the depositing of solid wastes into a body or stream of water or onto the surface of the ground at a site that is not licensed as a solid waste facility under section 3734.05 of the Revised Code or, if the solid wastes consist of scrap tires, as a scrap tire collection, storage, monocell, monofill, or recovery facility under section 3734.81 of the Revised Code; the depositing of solid wastes that consist of scrap tires onto the surface of the ground at a site or in a manner not specifically identified in divisions (C)(2) to (5), (7), or (10) of section 3734.85 of the Revised Code; the depositing of untreated infectious wastes into a body or stream of water or onto the surface of the ground; or the depositing of treated infectious wastes into a body or stream of water or onto the surface of the ground at a site that is not licensed as a solid waste facility under section 3734.05 of the Revised Code.

(J) “Hazardous waste” means any waste or combination of wastes in solid, liquid, semisolid, or contained gaseous form that in the determination of the director, because of its quantity, concentration, or physical or chemical characteristics, may do either of the following:

1. Cause or significantly contribute to an increase in mortality or an increase in serious irreversible or incapacitating reversible illness;
2. Pose a substantial present or potential hazard to human health or safety or to the environment when improperly stored, treated, transported, disposed of, or otherwise managed.


(K) “Treat” or “treatment,” when used in connection with hazardous waste, means any method, technique, or process, including neutralization, designed to change the physical, chemical, or biological character or composition of any hazardous waste so as to neutralize the waste; recover energy or material resources from the waste; render the waste nonhazardous or less hazardous, safer to transport, store, or dispose of, or amenable for recovery or storage; or reduce the volume of the waste. When used in connection with infectious wastes, “treat” or “treatment” means any method, technique, or process that renders the wastes noninfectious so that it is no longer an infectious waste and is no longer an infectious substance as defined in applicable federal law, including, without limitation, steam sterilization and incineration, and, in the instance of wastes identified in division (R)(7) of this section, to substantially reduce or eliminate the potential for the wastes to cause lacerations or puncture wounds.

(L) “Manifest” means the form used for identifying the quantity, composition, origin, routing, and destination of hazardous waste during its transportation from the point of generation to the point of disposal, treatment, or storage.

(M) “Storage,” when used in connection with hazardous waste, means the holding of hazardous waste for a temporary period in such a manner that it remains retrievable and substantially unchanged physically and chemically and, at the end of the period, is treated;
disposed of; stored elsewhere; or reused, recycled, or reclaimed in a beneficial manner. When used in connection with solid wastes that consist of scrap tires, “storage” means the holding of scrap tires for a temporary period in such a manner that they remain retrievable and, at the end of that period, are beneficially used; stored elsewhere; placed in a scrap tire monocolll or monofill facility licensed under section 3734.81 of the Revised Code; processed at a scrap tire recovery facility licensed under that section or a solid waste incineration or energy recovery facility subject to regulation under this chapter; or transported to a scrap tire monocolll, monofill, or recovery facility, any other solid waste facility authorized to dispose of scrap tires, or a facility that will beneficially use the scrap tires, that is located in another state and is operating in compliance with the laws of the state in which the facility is located.

(N) “Facility” means any site, location, tract of land, installation, or building used for incineration, composting, sanitary landfilling, or other methods of disposal of solid wastes or, if the solid wastes consist of scrap tires, for the collection, storage, or processing of the solid wastes; for the transfer of solid wastes; for the treatment of infectious wastes; or for the storage, treatment, or disposal of hazardous waste.

(O) “Closure” means the time at which a hazardous waste facility will no longer accept hazardous waste for treatment, storage, or disposal, the time at which a solid waste facility will no longer accept solid wastes for transfer or disposal or, if the solid wastes consist of scrap tires, for storage or processing, or the effective date of an order revoking the permit for a hazardous waste facility or the registration certificate, permit, or license for a solid waste facility, as applicable. “Closure” includes measures performed to protect public health or safety, to prevent air or water pollution, or to make the facility suitable for other uses, if any, including, but not limited to, the removal of processing residues resulting from solid wastes that consist of scrap tires; the establishment and maintenance of a suitable cover of soil and vegetation over cells in which hazardous waste or solid wastes are buried; minimization of erosion, the infiltration of surface water into such cells, the production of leachate, and the accumulation and runoff of contaminated surface water; the final construction of facilities for the collection and treatment of leachate and contaminated surface water runoff, except as otherwise provided in this division; the final construction of air and water quality monitoring facilities, except as otherwise provided in this division; the final construction of methane gas extraction and treatment systems; or the removal and proper disposal of hazardous waste or solid wastes from a facility when necessary to protect public health or safety or to abate or prevent air or water pollution. With regard to a solid waste facility that is a scrap tire facility, “closure” includes the final construction of facilities for the collection and treatment of leachate and contaminated surface water runoff and the final construction of air and water quality monitoring facilities only if those actions are determined to be necessary.

(P) “Premises” means either of the following:

(1) Geographically contiguous property owned by a generator;
(2) Noncontiguous property that is owned by a generator and connected by a right-of-way that the generator controls and to which the public does not have access. Two or more pieces of property that are geographically contiguous and divided by public or private right-of-way or rights-of-way are a single premises.

(Q) “Post-closure” means that period of time following closure during which a hazardous waste facility is required to be monitored and maintained under this chapter and rules adopted under it, including, without limitation, operation and maintenance of methane gas extraction and treatment systems, or the period of time after closure during which a scrap tire monocolll or monofill facility licensed under section 3734.81 of the Revised Code is required to be monitored and maintained under this chapter and rules adopted under it.

(R) “Infectious wastes” means any wastes or combination of wastes that include cultures and stocks of infectious agents and associated biologicals, human blood and blood products, and substances that were or are likely to have been exposed to or contaminated with or are
likely to transmit an infectious agent or zoonotic agent, including all of the following:

1. Laboratory wastes;
2. Pathological wastes;
3. Animal blood and blood products;
4. Animal carcasses and parts;
5. Waste materials from the rooms of humans, or the enclosures of animals, that have been isolated because of diagnosed communicable disease that are likely to transmit infectious agents. Such waste materials from the rooms of humans do not include any wastes of patients who have been placed on blood and body fluid precautions under the universal precaution system established by the centers for disease control in the public health service of the United States department of health and human services, except to the extent specific wastes generated under the universal precautions system have been identified as infectious wastes by rules adopted under division (R)(7) of this section.
6. Sharp wastes used in the treatment, diagnosis, or inoculation of human beings or animals;
7. Any other waste materials generated in the diagnosis, treatment, or immunization of human beings or animals, in research pertaining thereto, or in the production or testing of biologicals, that the director of health, by rules adopted in accordance with Chapter 119 of the Revised Code, identifies as infectious wastes after determining that the wastes present a substantial threat to human health when improperly managed because they are contaminated with, or are likely to be contaminated with, infectious agents.

As used in this division, “blood products” does not include patient care waste such as bandages or disposable gowns that are lightly soiled with blood or other body fluids unless those wastes are soiled to the extent that the generator of the wastes determines that they should be managed as infectious wastes.

(S) “Infectious agent” means a type of microorganism, pathogen, virus, or proteinaceous infectious particle that can cause or significantly contribute to disease in or death of human beings.

(T) “Zoonotic agent” means a type of microorganism, pathogen, or virus that causes disease in vertebrate animals, is transmissible to human beings, and can cause or significantly contribute to disease in or death of human beings.

(U) “Solid waste transfer facility” means any site, location, tract of land, installation, or building that is used or intended to be used primarily for the purpose of transferring solid wastes that were generated off the premises of the facility from vehicles or containers into other vehicles for transportation to a solid waste disposal facility. “Solid waste transfer facility” does not include any facility that consists solely of portable containers that have an aggregate volume of fifty cubic yards or less nor any facility where legitimate recycling activities are conducted.

(V) “Beneficially use” includes:
1. With regard to scrap tires, to use a scrap tire in a manner that results in a commodity for sale or exchange or in any other manner authorized as a beneficial use in rules adopted by the director in accordance with Chapter 119 of the Revised Code;
2. With regard to material from a horizontal well that has come in contact with a refined oil-based substance and that is not technologically enhanced naturally occurring radioactive material, to use the material in any manner authorized as a beneficial use in rules adopted by the director under section 3734.125 of the Revised Code.
3. “Commercial car,” “commercial tractor,” “farm machinery,” “motor bus,” “vehicles,” “motor vehicle,” and “semitrailer” have the same meanings as in section 4501.01 of the Revised Code.

(X) “Construction equipment” means road rollers, traction engines, power shovels, power cranes, and other equipment used in construction work, or in mining or producing or processing aggregates, and not designed for or used in general highway transportation.
(Y) “Motor vehicle salvage dealer” has the same meaning as in section 4738.01 of the Revised Code.
(Z) “Scrap tire” means an unwanted or discarded tire.
(AA) “Scrap tire collection facility” means any facility that meets all of the following qualifications:
   (1) The facility is used for the receipt and storage of whole scrap tires from the public prior to their transportation to a scrap tire storage, monocell, monofill, or recovery facility licensed under section 3734.81 of the Revised Code; a solid waste incineration or energy recovery facility subject to regulation under this chapter; a premises within the state where the scrap tires will be beneficially used; or a scrap tire storage, monocell, monofill, or recovery facility, any other solid waste disposal facility authorized to dispose of scrap tires, or a facility that will beneficially use the scrap tires, that is located in another state, and that is operating in compliance with the laws of the state in which the facility is located.
   (2) The facility exclusively stores scrap tires in portable containers.
   (3) The aggregate storage of the portable containers in which the scrap tires are stored does not exceed five thousand cubic feet.
(BB) “Scrap tire monocell facility” means an individual site within a solid waste landfill that is used exclusively for the environmentally sound storage or disposal of whole scrap tires or scrap tires that have been shredded, chipped, or otherwise mechanically processed.
(CC) “Scrap tire monofill facility” means an engineered facility used or intended to be used exclusively for the storage or disposal of scrap tires, including at least facilities for the submergence of whole scrap tires in a body of water.
(DD) “Scrap tire recovery facility” means any facility, or portion thereof, for the processing of scrap tires for the purpose of extracting or producing usable products, materials, or energy from the scrap tires through a controlled combustion process, mechanical process, or chemical process. “Scrap tire recovery facility” includes any facility that uses the controlled combustion of scrap tires in a manufacturing process to produce process heat or steam or any facility that produces usable heat or electric power through the controlled combustion of scrap tires in combination with another fuel, but does not include any solid waste incineration or energy recovery facility that is designed, constructed, and used for the primary purpose of incinerating mixed municipal solid wastes and that burns scrap tires in conjunction with mixed municipal solid wastes, or any tire retreading business, tire manufacturing finishing center, or tire adjustment center having on the premises of the business a single, covered scrap tire storage area at which not more than four thousand scrap tires are stored.
(EE) “Scrap tire storage facility” means any facility where whole scrap tires are stored prior to their transportation to a scrap tire monocell, monofill, or recovery facility licensed under section 3734.81 of the Revised Code; a solid waste incineration or energy recovery facility subject to regulation under this chapter; a premises within the state where the scrap tires will be beneficially used; or a scrap tire storage, monocell, monofill, or recovery facility, any other solid waste disposal facility authorized to dispose of scrap tires, or a facility that will beneficially use the scrap tires, that is located in another state, and that is operating in compliance with the laws of the state in which the facility is located.
(FF) “Used oil” means any oil that has been refined from crude oil, or any synthetic oil, that has been used and, as a result of that use, is contaminated by physical or chemical impurities. “Used oil” includes only those substances identified as used oil by the United States environmental protection agency under the “Used Oil Recycling Act of 1980,” 94 Stat. 2055, 42 U.S.C.A. 6901a, as amended.
(GG) “Accumulated speculatively” has the same meaning as in rules adopted by the director under section 3734.12 of the Revised Code.
(HH) “Horizontal well” has the same meaning as in section 1509.01 of the Revised Code.
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(II) “Technologically enhanced naturally occurring radioactive material” has the same meaning as in section 3748.01 of the Revised Code.

3734.02 Infectious and other waste treatment facilities.

(A) The director of environmental protection, in accordance with Chapter 119 of the Revised Code, shall adopt and may amend, suspend, or rescind rules having uniform application throughout the state governing solid waste facilities and the inspections of and issuance of permits and licenses for all solid waste facilities in order to ensure that the facilities will be located, maintained, and operated, and will undergo closure and post-closure care, in a sanitary manner so as not to create a nuisance, cause or contribute to water pollution, create a health hazard, or violate 40 C.F.R. 257.3-2 or 40 C.F.R. 257.3-8, as amended. The rules may include, without limitation, financial assurance requirements for closure and post-closure care and corrective action and requirements for taking corrective action in the event of the surface or subsurface discharge or migration of explosive gases or leachate from a solid waste facility, or of ground water contamination resulting from the transfer or disposal of solid wastes at a facility, beyond the boundaries of any area within a facility that is operating or is undergoing closure or post-closure care where solid wastes were disposed of or are being disposed of. The rules shall not concern or relate to personnel policies, salaries, wages, fringe benefits, or other conditions of employment of employees of persons owning or operating solid waste facilities. The director, in accordance with Chapter 119 of the Revised Code, shall adopt and may amend, suspend, or rescind rules governing the issuance, modification, revocation, suspension, or denial of variances from the director's solid waste rules, including, without limitation, rules adopted under this chapter governing the management of scrap tires.

Variance shall be issued, modified, revoked, suspended, or rescinded in accordance with this division, rules adopted under it, and Chapter 3745 of the Revised Code. The director may order the person to whom a variance is issued to take such action within such time as the director may determine to be appropriate and reasonable to prevent the creation of a nuisance or a hazard to the public health or safety or the environment. Applications for variances shall contain such detail plans, specifications, and information regarding objectives, procedures, controls, and other pertinent data as the director may require. The director shall grant a variance only if the applicant demonstrates to the director's satisfaction that construction and operation of the solid waste facility in the manner allowed by the variance and any terms or conditions imposed as part of the variance will not create a nuisance or a hazard to the public health or safety or the environment. In granting any variance, the director shall state the specific provision or provisions whose terms are to be varied and also shall state specific terms or conditions imposed upon the applicant in place of the provision or provisions.

The director may hold a public hearing on an application for a variance or renewal of a variance at a location in the county where the operations that are the subject of the application for the variance are conducted. The director shall give not less than twenty days' notice of the hearing to the applicant by certified mail or by another type of mail accompanied by a receipt and shall publish at least one notice of the hearing in a newspaper with general circulation in the county where the hearing is to be held. The director shall make available for public inspection at the principal office of the environmental protection agency a current list of pending applications for variances and a current schedule of pending variance hearings. The director shall make a complete stenographic record of testimony and other evidence submitted at the hearing.

Within ten days after the hearing, the director shall make a written determination to issue, renew, or deny the variance and shall enter the determination and the basis for it into the record of the hearing. The director shall issue, renew, or deny an application for a variance or renewal of a variance within six months of the date upon which the director receives a complete application with all pertinent information and data required. No variance shall be issued,
revoked, modified, or denied until the director has considered the relative interests of the applicant, other persons and property affected by the variance, and the general public. Any variance granted under this division shall be for a period specified by the director and may be renewed from time to time on such terms and for such periods as the director determines to be appropriate. No application shall be denied and no variance shall be revoked or modified without a written order stating the findings upon which the denial, revocation, or modification is based. A copy of the order shall be sent to the applicant or variance holder by certified mail or by another type of mail accompanied by a receipt.

(B) The director shall prescribe and furnish the forms necessary to administer and enforce this chapter. The director may cooperate with and enter into agreements with other state, local, or federal agencies to carry out the purposes of this chapter. The director may exercise all incidental powers necessary to carry out the purposes of this chapter.

(C) Except as provided in this division and divisions (N)(2) and (3) of this section, no person shall establish a new solid waste facility or infectious waste treatment facility, or modify an existing solid waste facility or infectious waste treatment facility, without submitting an application for a permit with accompanying detail plans, specifications, and information regarding the facility and method of operation and receiving a permit issued by the director, except that no permit shall be required under this division to install or operate a solid waste facility for sewage sludge treatment or disposal when the treatment or disposal is authorized by a current permit issued under Chapter 3704 or 6111 of the Revised Code.

No person shall continue to operate a solid waste facility for which the director has disapproved plans and specifications required to be filed by an order issued under division (A)(3) of section 3734.05 of the Revised Code, after the date prescribed for commencement of closure of the facility in the order issued under division (A)(4) of that section denying the permit application or approval.

On and after the effective date of the rules adopted under division (A) of this section and division (D) of section 3734.12 of the Revised Code governing solid waste transfer facilities, no person shall establish a new, or modify an existing, solid waste transfer facility without first submitting an application for a permit with accompanying engineering detail plans, specifications, and information regarding the facility and its method of operation to the director and receiving a permit issued by the director.

No person shall establish a new compost facility or continue to operate an existing compost facility that accepts exclusively source separated yard wastes without submitting a completed registration for the facility to the director in accordance with rules adopted under divisions (A) and (N)(3) of this section.

This division does not apply to a generator of infectious wastes that does any of the following:

(1) Treats, by methods, techniques, and practices established by rules adopted under division (B)(2)(a) of section 3734.021 of the Revised Code, any of the following:
   (a) Infectious wastes that are generated on any premises that are owned or operated by the generator;
   (b) Infectious wastes that are generated by a generator who has staff privileges at a hospital as defined in section 3727.01 of the Revised Code;
   (c) Infectious wastes that are generated in providing care to a patient by an emergency medical services organization as defined in section 4765.01 of the Revised Code.

(2) Holds a license or renewal of a license to operate a crematory facility issued under Chapter 4717 and a permit issued under Chapter 3704 of the Revised Code;

(3) Treats or disposes of dead animals or parts thereof, or the blood of animals, and is subject to any of the following:
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(b) Chapter 918 of the Revised Code;
(c) Chapter 953 of the Revised Code.
(D) Neither this chapter nor any rules adopted under it apply to single-family residential
premises; to infectious wastes generated by individuals for purposes of their own care or
treatment; to the temporary storage of solid wastes, other than scrap tires, prior to their
collection for disposal; to the storage of one hundred or fewer scrap tires unless they are stored
in such a manner that, in the judgment of the director or the board of health of the health district
in which the scrap tires are stored, the storage causes a nuisance, a hazard to public health or
safety, or a fire hazard; or to the collection of solid wastes, other than scrap tires, by a political
subdivision or a person holding a franchise or license from a political subdivision of the state; to
composting, as defined in section 1511.01 of the Revised Code, conducted in accordance with
section 1511.022 of the Revised Code; or to any person who is licensed to transport raw
rendering material to a compost facility pursuant to section 953.23 of the Revised Code.
(E)(1) As used in this division:
(a) “On-site facility” means a facility that stores, treats, or disposes of hazardous waste
that is generated on the premises of the facility.
(b) “Off-site facility” means a facility that stores, treats, or disposes of hazardous waste
that is generated off the premises of the facility and includes such a facility that is also an on-
site facility.
(c) “Satellite facility” means any of the following:
(i) An on-site facility that also receives hazardous waste from other premises owned by
the same person who generates the waste on the facility premises;
(ii) An off-site facility operated so that all of the hazardous waste it receives is generated
on one or more premises owned by the person who owns the facility;
(iii) An on-site facility that also receives hazardous waste that is transported
uninterruptedly and directly to the facility through a pipeline from a generator who is not the
owner of the facility.
(2) Except as provided in division (E)(3) of this section, no person shall establish or
operate a hazardous waste facility, or use a solid waste facility for the storage, treatment, or
disposal of any hazardous waste, without a hazardous waste facility installation and operation
permit issued in accordance with section 3734.05 of the Revised Code and subject to the
payment of an application fee not to exceed one thousand five hundred dollars, payable upon
application for a hazardous waste facility installation and operation permit and upon application
for a renewal permit issued under division (H) of section 3734.05 of the Revised Code, to be
credited to the hazardous waste facility management fund created in section 3734.18 of the
Revised Code. The term of a hazardous waste facility installation and operation permit shall not
exceed ten years.
In addition to the application fee, there is hereby levied an annual permit fee to be paid
by the permit holder upon the anniversaries of the date of issuance of the hazardous waste
facility installation and operation permit and of any subsequent renewal permits and to be
credited to the hazardous waste facility management fund. Annual permit fees totaling forty
thousand dollars or more for any one facility may be paid on a quarterly basis with the first
quarterly payment each year being due on the anniversary of the date of issuance of the
hazardous waste facility installation and operation permit and of any subsequent renewal
permits. The annual permit fee shall be determined for each permit holder by the director in
accordance with the following schedule:

<table>
<thead>
<tr>
<th>TYPE OF BASIC MANAGEMENT UNIT</th>
<th>TYPE OF FACILITY</th>
<th>FEE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Storage facility using:</td>
<td>On-site, off-site, and</td>
<td></td>
</tr>
<tr>
<td>Containers</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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A hazardous waste disposal facility that disposes of hazardous waste by deep well injection and that pays the annual permit fee established in section 6111.046 of the Revised Code is not subject to the permit fee established in this division for disposal facilities using deep well injection unless the director determines that the facility is not in compliance with applicable requirements established under this chapter and rules adopted under it.

In determining the annual permit fee required by this section, the director shall not require additional payments for multiple units of the same method of storage, treatment, or disposal or for individual units that are used for both storage and treatment. A facility using more than one method of storage, treatment, or disposal shall pay the permit fee indicated by the schedule for each such method.

The director shall not require the payment of that portion of an annual permit fee of any permit holder that would apply to a hazardous waste management unit for which a permit has been issued, but for which construction has not yet commenced. Once construction has commenced, the director shall require the payment of a part of the appropriate fee indicated by

<table>
<thead>
<tr>
<th>Waste Management Method</th>
<th>On-site, off-site, and satellite</th>
<th>On-site</th>
<th>Off-site</th>
<th>Satellite</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tanks</td>
<td></td>
<td>$500</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Waste pile</td>
<td></td>
<td>$3,000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Surface impoundment</td>
<td></td>
<td>$8,000</td>
<td></td>
<td>$10,000</td>
</tr>
<tr>
<td>Disposal facility using:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Deep well injection</td>
<td></td>
<td>$15,000</td>
<td></td>
<td>$25,000</td>
</tr>
<tr>
<td>Landfill</td>
<td></td>
<td>$25,000</td>
<td></td>
<td>$40,000</td>
</tr>
<tr>
<td>Land application</td>
<td></td>
<td>$2,500</td>
<td></td>
<td>$5,000</td>
</tr>
<tr>
<td>Surface impoundment</td>
<td></td>
<td>$10,000</td>
<td></td>
<td>$20,000</td>
</tr>
<tr>
<td>Treatment facility using:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tanks</td>
<td></td>
<td></td>
<td></td>
<td>$700</td>
</tr>
<tr>
<td>Surface impoundment</td>
<td></td>
<td></td>
<td></td>
<td>$8,000</td>
</tr>
<tr>
<td>Incinerator</td>
<td></td>
<td></td>
<td></td>
<td>$5,000</td>
</tr>
<tr>
<td>Other forms of treatment</td>
<td></td>
<td></td>
<td></td>
<td>$1,000</td>
</tr>
</tbody>
</table>
the schedule that bears the same relationship to the total fee that the number of days remaining until the next anniversary date at which payment of the annual permit fee is due bears to three hundred sixty-five.

The director, by rules adopted in accordance with Chapters 119 and 3745 of the Revised Code, shall prescribe procedures for collecting the annual permit fee established by this division and may prescribe other requirements necessary to carry out this division.

(3) The prohibition against establishing or operating a hazardous waste facility without a hazardous waste facility installation and operation permit does not apply to either of the following:

(a) A facility that is operating in accordance with a permit renewal issued under division (H) of section 3734.05 of the Revised Code, a revision issued under division (I) of that section as it existed prior to August 20, 1996, or a modification issued by the director under division (I) of that section on and after August 20, 1996;

(b) Except as provided in division (J) of section 3734.05 of the Revised Code, a facility that will operate or is operating in accordance with a permit by rule, or that is not subject to permit requirements, under rules adopted by the director. In accordance with Chapter 119 of the Revised Code, the director shall adopt, and subsequently may amend, suspend, or rescind, rules for the purposes of division (E)(3)(b) of this section. Any rules so adopted shall be consistent with and equivalent to regulations pertaining to interim status adopted under the “Resource Conservation and Recovery Act of 1976,” 90 Stat. 2806, 42 U.S.C.A. 6921, as amended, except as otherwise provided in this chapter.

If a modification is requested or proposed for a facility described in division (E)(3)(a) or (b) of this section, division (I)(7) of section 3734.05 of the Revised Code applies.

(F) No person shall store, treat, or dispose of hazardous waste identified or listed under this chapter and rules adopted under it, regardless of whether generated on or off the premises where the waste is stored, treated, or disposed of, or transport or cause to be transported any hazardous waste identified or listed under this chapter and rules adopted under it to any other premises, except at or to any of the following:

(1) A hazardous waste facility operating under a permit issued in accordance with this chapter;

(2) A facility in another state operating under a license or permit issued in accordance with the “Resource Conservation and Recovery Act of 1976,” 90 Stat. 2806, 42 U.S.C.A. 6921, as amended;

(3) A facility in another nation operating in accordance with the laws of that nation;


(5) A hazardous waste facility as described in division (E)(3)(a) or (b) of this section.

(G) The director, by order, may exempt any person generating, collecting, storing, treating, disposing of, or transporting solid wastes, infectious wastes, or hazardous waste, or processing solid wastes that consist of scrap tires, in such quantities or under such circumstances that, in the determination of the director, are unlikely to adversely affect the public health or safety or the environment from any requirement to obtain a registration certificate, permit, or license or comply with the manifest system or other requirements of this chapter. Such an exemption shall be consistent with and equivalent to any regulations adopted by the administrator of the United States environmental protection agency under the “Resource Conservation and Recovery Act of 1976,” 90 Stat. 2806, 42 U.S.C.A. 6921, as amended, except as otherwise provided in this chapter.

(H) No person shall engage in filling, grading, excavating, building, drilling, or mining on land where a hazardous waste facility, or a solid waste facility, was operated without prior authorization from the director, who shall establish the procedure for granting such authorization by rules adopted in accordance with Chapter 119 of the Revised Code.
A public utility that has main or distribution lines above or below the land surface located on an easement or right-of-way across land where a solid waste facility was operated may engage in any such activity within the easement or right-of-way without prior authorization from the director for purposes of performing emergency repair or emergency replacement of its lines; of the poles, towers, foundations, or other structures supporting or sustaining any such lines; or of the appurtenances to those structures, necessary to restore or maintain existing public utility service. A public utility may enter upon any such easement or right-of-way without prior authorization from the director for purposes of performing necessary or routine maintenance of those portions of its existing lines; of the existing poles, towers, foundations, or other structures sustaining or supporting its lines; or of the appurtenances to those structures, located on or above the land surface on any such easement or right-of-way. Within twenty-four hours after commencing any such emergency repair, replacement, or maintenance work, the public utility shall notify the director or the director's authorized representative of those activities and shall provide such information regarding those activities as the director or the director's representative may request. Upon completion of the emergency repair, replacement, or maintenance activities, the public utility shall restore any land of the solid waste facility disturbed by those activities to the condition existing prior to the commencement of those activities.

(I) No owner or operator of a hazardous waste facility, in the operation of the facility, shall cause, permit, or allow the emission therefrom of any particulate matter, dust, fumes, gas, mist, smoke, vapor, or odorous substance that, in the opinion of the director, unreasonably interferes with the comfortable enjoyment of life or property by persons living or working in the vicinity of the facility, or that is injurious to public health. Any such action is hereby declared to be a public nuisance.

(J) Notwithstanding any other provision of this chapter, in the event the director finds an imminent and substantial danger to public health or safety or the environment that creates an emergency situation requiring the immediate treatment, storage, or disposal of hazardous waste, the director may issue a temporary emergency permit to allow the treatment, storage, or disposal of the hazardous waste at a facility that is not otherwise authorized by a hazardous waste facility installation and operation permit to treat, store, or dispose of the waste. The emergency permit shall not exceed ninety days in duration and shall not be renewed. The director shall adopt, and may amend, suspend, or rescind, rules in accordance with Chapter 119 of the Revised Code governing the issuance, modification, revocation, and denial of emergency permits.

(K) Except for infectious wastes generated by a person who produces fewer than fifty pounds of infectious wastes at a premises during any one month, no owner or operator of a sanitary landfill shall knowingly accept for disposal, or dispose of, any infectious wastes that have not been treated to render them noninfectious.

(L) The director, in accordance with Chapter 119 of the Revised Code, shall adopt, and may amend, suspend, or rescind, rules having uniform application throughout the state establishing a training and certification program that shall be required for employees of boards of health who are responsible for enforcing the solid waste and infectious waste provisions of this chapter and rules adopted under them and for persons who are responsible for the operation of solid waste facilities or infectious waste treatment facilities. The rules shall provide all of the following, without limitation:

(1) The program shall be administered by the director and shall consist of a course on new solid waste and infectious waste technologies, enforcement procedures, and rules;
(2) The course shall be offered on an annual basis;
(3) Those persons who are required to take the course under division (L) of this section shall do so triennially;
(4) Persons who successfully complete the course shall be certified by the director;
(5) Certification shall be required for all employees of boards of health who are responsible for enforcing the solid waste or infectious waste provisions of this chapter and rules adopted under them and for all persons who are responsible for the operation of solid waste facilities or infectious waste treatment facilities;

(6)(a) All employees of a board of health who, on the effective date of the rules adopted under this division, are responsible for enforcing the solid waste or infectious waste provisions of this chapter and the rules adopted under them shall complete the course and be certified by the director not later than January 1, 1995;

(b) All employees of a board of health who, after the effective date of the rules adopted under division (L) of this section, become responsible for enforcing the solid waste or infectious waste provisions of this chapter and rules adopted under them and who do not hold a current and valid certification from the director at that time shall complete the course and be certified by the director within two years after becoming responsible for performing those activities.

No person shall fail to obtain the certification required under this division.

(M) The director shall not issue a permit under section 3734.05 of the Revised Code to establish a solid waste facility, or to modify a solid waste facility operating on December 21, 1988, in a manner that expands the disposal capacity or geographic area covered by the facility, that is or is to be located within the boundaries of a state park established or dedicated under Chapter 1546 of the Revised Code, a state park purchase area established under section 1546.06 of the Revised Code, any unit of the national park system, or any property that lies within the boundaries of a national park or recreation area, but that has not been acquired or is not administered by the secretary of the United States department of the interior, located in this state, or any candidate area located in this state and identified for potential inclusion in the national park system in the edition of the "national park system plan" submitted under paragraph (b) of section 8 of “The Act of August 18, 1970,” 84 Stat. 825, 16 U.S.C.A. 1a-5, as amended, current at the time of filing of the application for the permit, unless the facility or proposed facility is or is to be used exclusively for the disposal of solid wastes generated within the park or recreation area and the director determines that the facility or proposed facility will not degrade any of the natural or cultural resources of the park or recreation area. The director shall not issue a variance under division (A) of this section and rules adopted under it, or issue an exemption order under division (G) of this section, that would authorize any such establishment or expansion of a solid waste facility within the boundaries of any such park or recreation area, state park purchase area, or candidate area, other than a solid waste facility exclusively for the disposal of solid wastes generated within the park or recreation area when the director determines that the facility will not degrade any of the natural or cultural resources of the park or recreation area.

(N)(1) The rules adopted under division (A) of this section, other than those governing variances, do not apply to scrap tire collection, storage, monofill, and recovery facilities. Those facilities are subject to and governed by rules adopted under sections 3734.70 to 3734.73 of the Revised Code, as applicable.

(2) Division (C) of this section does not apply to scrap tire collection, storage, monofill, and recovery facilities. The establishment and modification of those facilities are subject to sections 3734.75 to 3734.78 and section 3734.81 of the Revised Code, as applicable.

(3) The director may adopt, amend, suspend, or rescind rules under division (A) of this section creating an alternative system for authorizing the establishment, operation, or modification of a solid waste compost facility in lieu of the requirement that a person seeking to establish, operate, or modify a solid waste compost facility apply for and receive a permit under division (C) of this section and section 3734.05 of the Revised Code and a license under division (A)(1) of that section. The rules may include requirements governing, without limitation, the classification of solid waste compost facilities, the submittal of operating records for solid waste compost facilities, and the creation of a registration or notification system in lieu of the
issuance of permits and licenses for solid waste compost facilities. The rules shall specify the applicability of divisions (A)(1) and (2)(a) of section 3734.05 of the Revised Code to a solid waste compost facility.

(O)(1) As used in this division, “secondary aluminum waste” means waste material or byproducts, when disposed of, containing aluminum generated from secondary aluminum smelting operations and consisting of dross, salt cake, baghouse dust associated with aluminum recycling furnace operations, or dry-milled wastes.

(2) The owner or operator of a sanitary landfill shall not dispose of municipal solid waste that has been commingled with secondary aluminum waste.

(3) The owner or operator of a sanitary landfill may dispose of secondary aluminum waste, but only in a monocell or monofill that has been permitted for that purpose in accordance with this chapter and rules adopted under it.

(P)(1) As used in divisions (P) and (Q) of this section:

(a) “Natural background” means two picocuries per gram or the actual number of picocuries per gram as measured at an individual solid waste facility, subject to verification by the director of health.

(b) “Drilling operation” includes a production operation as defined in section 1509.01 of the Revised Code.

(2) The owner or operator of a solid waste facility shall not accept for transfer or disposal technologically enhanced naturally occurring radioactive material if that material contains or is contaminated with radium-226, radium-228, or any combination of radium-226 and radium-228 at concentrations equal to or greater than five picocuries per gram above natural background.

(3) The owner or operator of a solid waste facility may receive and process for purposes other than transfer or disposal technologically enhanced naturally occurring radioactive material that contains or is contaminated with radium-226, radium-228, or any combination of radium-226 and radium-228 at concentrations equal to or greater than five picocuries per gram above natural background, provided that the owner or operator has obtained and maintains all other necessary authorizations, including any authorization required by rules adopted by the director of health under section 3748.04 of the Revised Code.

(4) The director of environmental protection may adopt rules in accordance with Chapter 119 of the Revised Code governing the receipt, acceptance, processing, handling, management, and disposal by solid waste facilities of material that contains or is contaminated with radioactive material, including, without limitation, technologically enhanced naturally occurring radioactive material that contains or is contaminated with radium-226, radium-228, or any combination of radium-226 and radium-228 at concentrations less than five picocuries per gram above natural background. Rules adopted by the director may include at a minimum both of the following:

(a) Requirements in accordance with which the owner or operator of a solid waste facility must monitor leachate and ground water for radium-226, radium-228, and other radionuclides;

(b) Requirements in accordance with which the owner or operator of a solid waste facility must develop procedures to ensure that technologically enhanced naturally occurring radioactive material accepted at the facility neither contains nor is contaminated with radium-226, radium-228, or any combination of radium-226 and radium-228 at concentrations equal to or greater than five picocuries per gram above natural background.

(Q) Notwithstanding any other provision of this section, the owner or operator of a solid waste facility shall not receive, accept, process, handle, manage, or dispose of technologically enhanced naturally occurring radioactive material associated with drilling operations without first obtaining representative analytical results to determine compliance with divisions (P)(2) and (3) of this section and rules adopted under it.
3734.021 Infectious waste generators and transporters.

(A) Infectious wastes shall be segregated, managed, treated, and disposed of in accordance with rules adopted under this section.

(B) The director of environmental protection, in accordance with Chapter 119 of the Revised Code, shall adopt rules necessary or appropriate to protect human health or safety or the environment that do both of the following:

1. Establish standards for generators of infectious wastes that include, without limitation, the following requirements and authorizations that:
   a. All generators of infectious wastes:
      i. Either treat all specimen cultures and cultures of viable infectious agents on the premises where they are generated to render them noninfectious by methods, techniques, or practices prescribed by rules adopted under division (B)(2)(a) of this section before they are transported off that premises for disposal or ensure that such wastes are treated to render them noninfectious at an infectious waste treatment facility off that premises prior to disposal of the wastes;
   ii. Transport and dispose of infectious wastes, if a generator produces fewer than fifty pounds of infectious wastes during any one month that are subject to and packaged and labeled in accordance with federal requirements, in the same manner as solid wastes. Such generators who treat specimen cultures and cultures of viable infectious agents on the premises where they are generated shall not be considered treatment facilities as “treatment” and “facility” are defined in section 3734.01 of the Revised Code.
   iii. Dispose of infectious wastes subject to and treated in accordance with rules adopted under division (B)(1)(a)(i) of this section in the same manner as solid wastes;
   iv. May take wastes generated in providing care to a patient by an emergency medical services organization, as defined in section 4765.01 of the Revised Code, to and leave them at a hospital, as defined in section 3727.01 of the Revised Code, for treatment at a treatment facility owned or operated by the hospital or, in conjunction with infectious wastes generated by the hospital, at another treatment facility regardless of whether the wastes were generated in providing care to the patient at the scene of an emergency or during the transportation of the patient to a hospital;
   v. May take wastes generated by an individual for purposes of the individual's own care or treatment to and leave them at a hospital, as defined in section 3727.01 of the Revised Code, for treatment at a treatment facility owned or operated by the hospital or, in conjunction with infectious wastes generated by the hospital, at another treatment facility.

   (B) Each generator of fifty pounds or more of infectious wastes during any one month:
   i. Register with the environmental protection agency as a generator of infectious wastes and obtain a registration certificate. The fee for issuance of a generator registration certificate is one hundred forty dollars payable at the time of application. The registration certificate applies to all the premises owned or operated by the generator in this state where infectious wastes are generated and shall list the address of each such premises. If a generator owns or operates facilities for the treatment of infectious wastes it generates, the certificate shall list the address and method of treatment used at each such facility.

   A generator registration certificate is valid for three years from the date of issuance and shall be renewed for a term of three years upon the generator's submission of an application for renewal and payment of a one hundred forty dollar renewal fee.

   The rules may establish a system of staggered renewal dates with approximately one-third of such certificates subject to renewal each year. The applicable renewal date shall be prescribed on each registration certificate. Registration fees shall be prorated according to the time remaining in the registration cycle to the nearest year.

   The registration and renewal fees collected under division (B)(1)(b)(i) of this section shall
be deposited in the state treasury to the credit of the waste management fund created in section 3734.061 of the Revised Code.

(ii) Segregate infectious wastes from other wastes at the point of generation. Nothing in this section and rules adopted under it prohibits a generator of infectious wastes from designating and managing any wastes, in addition to those defined as infectious wastes under section 3734.01 of the Revised Code, as infectious wastes. After designating any such other wastes as infectious, the generator shall manage those wastes in compliance with the requirements of this chapter and rules adopted under it applicable to the management of infectious wastes.

(iii) Either treat the infectious wastes that it generates at a facility owned or operated by the generator by methods, techniques, or practices prescribed by rules adopted under division (B)(2)(a) of this section to render them noninfectious, or designate the wastes for treatment off that premises at an infectious waste treatment facility holding a license issued under division (B) of section 3734.05 of the Revised Code, at an infectious waste treatment facility that is located in another state that is in compliance with applicable state and federal laws, or at a treatment facility authorized by rules adopted under division (B)(2)(d) of this section, prior to disposal of the wastes. After being treated to render them noninfectious, the wastes shall be disposed of at a solid waste disposal facility holding a license issued under division (A) of section 3734.05 of the Revised Code or at a disposal facility in another state that is in compliance with applicable state and federal laws.

(iv) Not compact or grind any type of infectious wastes prior to treatment in accordance with rules adopted under division (B)(2)(a) of this section;

(v) May discharge untreated liquid or semiliquid infectious wastes consisting of blood, blood products, body fluids, and excreta into a disposal system, as defined in section 6111.01 of the Revised Code, unless the discharge of those wastes into a disposal system is inconsistent with the terms and conditions of the permit for the system issued under Chapter 6111 of the Revised Code;

(vi) May transport or cause to be transported infectious wastes that have been treated to render them noninfectious in the same manner as solid wastes are transported.

(2) Establish standards for owners and operators of infectious waste treatment facilities that include, without limitation, the following requirements and authorizations that:

(a) Require treatment of all wastes received to be performed in accordance with methods, techniques, and practices approved by the director;

(b) Govern the location, design, construction, and operation of infectious waste treatment facilities. The rules adopted under division (B)(2)(b) of this section shall require that a new infectious waste incineration facility be located so that the incinerator unit and all areas where infectious wastes are handled on the premises where the facility is proposed to be located are at least three hundred feet inside the property line of the tract of land on which the facility is proposed to be located and are at least one thousand feet from any domicile, school, prison, or jail that is in existence on the date on which the application for the permit to establish the incinerator is submitted under division (B)(2)(b) of section 3734.05 of the Revised Code.

(c) Establish quality control and testing procedures to ensure compliance with the rules adopted under division (B)(2)(b) of this section.

(d) Authorize infectious wastes to be treated at a facility that holds a license or renewal of a license to operate a crematory facility issued under Chapter 4717., and a permit issued under Chapter 3704., of the Revised Code to the extent that the treatment of those wastes is consistent with that permit and its terms and conditions. The rules adopted under divisions (B)(2)(b) and (c) of this section do not apply to a facility holding such a license and permit.

In adopting the rules required by divisions (B)(2)(a) to (d) of this section, the director shall consider and, to the maximum feasible extent, utilize existing standards and guidelines established by professional and governmental organizations having expertise in the fields of
infection control and infectious wastes management.

(e) Require shipping papers to accompany shipments of wastes that have been treated to render them noninfectious. The shipping papers shall include only the following elements:
   (i) The name of the owner or operator of the facility where the wastes were treated and the address of the treatment facility;
   (ii) A certification by the owner or operator of the treatment facility where the wastes were treated indicating that the wastes have been treated by the methods, techniques, and practices prescribed in rules adopted under division (B)(2)(a) of this section.

(C) This section and rules adopted under it do not apply to the treatment or disposal of wastes consisting of dead animals or parts thereof, or the blood of animals:
   (1) By the owner of the animal after slaughter by the owner on the owner's premises to obtain meat for consumption by the owner and the members of the owner's household;
   (2) In accordance with Chapter 941 of the Revised Code; or
   (3) By persons who are subject to any of the following:
      (b) Chapter 918 of the Revised Code;
      (c) Chapter 953 of the Revised Code.

(D) As used in this section, “generator” means a person who produces infectious wastes at a specific premises.

(E) Rules adopted under this section shall not concern or relate to personnel policies, salaries, wages, fringe benefits, or other conditions of employment of employees of persons owning or operating infectious waste treatment facilities.

(F)(1) The director, in accordance with Chapter 119 of the Revised Code, shall adopt rules governing the issuance, modification, revocation, suspension, and denial of variances from the rules adopted under division (B) of this section. Variances shall be issued, modified, revoked, suspended, or denied in accordance with division (F) of this section, rules adopted under it, and Chapter 3745 of the Revised Code.

(2) A person who desires to obtain a variance or renew a variance from the rules adopted under division (B) of this section shall submit to the director an application as prescribed by the director. The application shall contain detail plans, specifications, and information regarding objectives, procedures, controls, and any other information that the director may require. The director shall issue, renew, or deny a variance or renewal of a variance within six months of the date on which the director receives a complete application with all required information and data.

(3) The director may hold a public hearing on an application submitted under division (F) of this section for a variance at a location in the county in which the operations that are the subject of the application for a variance or renewal of variance are conducted. Not less than twenty days before the hearing, the director shall provide to the applicant notice of the hearing by certified mail or by another type of mail that is accompanied by a receipt and shall publish notice of the hearing at least once in a newspaper of general circulation in the county in which the hearing is to be held. The director shall make a complete stenographic record of testimony and other evidence submitted at the hearing. Not later than ten days after the hearing, the director shall make a written determination to issue, renew, or deny the variance and shall enter the determination and the basis for it into the record of the hearing.

(4) A variance shall not be issued, modified, revoked, or denied under division (F) of this section until the director has considered the relative interests of the applicant, other persons and property that will be affected by the variance, and the general public. The director shall grant a variance only if the applicant demonstrates to the director's satisfaction that the requested action will not create a nuisance or a hazard to the health or safety of the public or to the environment. In granting a variance, the director shall state the specific provision or provisions
whose terms are to be varied and also shall state specific terms or conditions imposed on the applicant in place of the provision or provisions.

(5) A variance granted under division (F) of this section shall be for a period specified by the director and may be renewed from time to time on terms and for periods that the director determines to be appropriate. The director may order the person to whom a variance has been issued to take action within the time that the director determines to be appropriate and reasonable to prevent the creation of a nuisance or a hazard to the health or safety of the public or to the environment.

(6) An application submitted under division (F) of this section shall not be denied and a variance shall not be revoked or modified under that division without a written order of the director stating the findings on which the denial, revocation, or modification is based. A copy of the order shall be sent to the applicant or holder of a variance by certified mail or by another type of mail that is accompanied by a receipt.

(7) The director shall make available for public inspection at the principal office of the environmental protection agency a current list of pending applications for variances submitted under division (F) of this section and a current schedule of pending variance hearings under it.

3734.023 Treatment facility defined.

As used in sections 3734.024, 3734.025, and 3734.026 of the Revised Code, "off-site infectious waste treatment facility" and "treatment facility" mean an infectious waste treatment facility for which a license is required under division (B) of section 3734.05 of the Revised Code. "Off-site infectious waste treatment facility" and "treatment facility" also include a solid waste incineration facility for which the license issued under division (A)(1) of section 3734.05 of the Revised Code includes the notation authorizing the treatment of infectious wastes made pursuant to division (B)(3) of that section.

3734.027 Low-level radioactive waste.

(A) No person shall commingle with any type of solid wastes, hazardous waste, or infectious wastes any low-level radioactive waste whose treatment, recycling, storage, or disposal is governed under division (B) of section 3748.10 of the Revised Code.

(B) Except as authorized by the director of health under Chapter 3748 of the Revised Code and rules adopted under it, no owner or operator of a solid waste facility, infectious waste treatment facility, or hazardous waste facility shall accept for transfer, storage, treatment, or disposal or shall transfer, store, treat, or dispose of any radioactive waste specified in division (A) of this section.

3734.05 Licensure of infectious and other treatment facilities.

(A)(1) Except as provided in divisions (A)(6) and (7) of this section, no person shall operate or maintain a solid waste facility without a license issued under this division by the board of health of the health district in which the facility is located or by the director of environmental protection when the health district in which the facility is located is not on the approved list under section 3734.08 of the Revised Code.

During the month of December, but before the first day of January of the next year, every person proposing to continue to operate an existing solid waste facility shall procure a license under this division to operate the facility for that year from the board of health of the health district in which the facility is located or, if the health district is not on the approved list under section 3734.08 of the Revised Code, from the director. The application for such a license
shall be submitted to the board of health or to the director, as appropriate, on or before the last
day of September of the year preceding that for which the license is sought. In addition to the
application fee prescribed in division (A)(2) of this section, a person who submits an application
after that date shall pay an additional ten per cent of the amount of the application fee for each
week that the application is late. Late payment fees accompanying an application submitted to
the board of health shall be credited to the special fund of the health district created in division
(B) of section 3734.06 of the Revised Code, and late payment fees accompanying an
application submitted to the director shall be credited to the general revenue fund. A person who
has received a license, upon sale or disposition of a solid waste facility, and upon consent of the
board of health and the director, may have the license transferred to another person. The board
of health or the director may include such terms and conditions in a license or revision to a
license as are appropriate to ensure compliance with this chapter and rules adopted under it.
The terms and conditions may establish the authorized maximum daily waste receipts for the
facility. Limitations on maximum daily waste receipts shall be specified in cubic yards of volume
for the purpose of regulating the design, construction, and operation of solid waste facilities.
Terms and conditions included in a license or revision to a license by a board of health shall be
consistent with, and pertain only to the subjects addressed in, the rules adopted under division
(A) of section 3734.02 and division (D) of section 3734.12 of the Revised Code.  
(2)(a) Except as provided in divisions (A)(2)(b), (6), and (7) of this section, each person
proposing to open a new solid waste facility or to modify an existing solid waste facility shall
submit an application for a permit with accompanying detail plans and specifications to the
environmental protection agency for required approval under the rules adopted by the director
pursuant to division (A) of section 3734.02 of the Revised Code and applicable rules adopted
under division (D) of section 3734.12 of the Revised Code at least two hundred seventy days
before proposed operation of the facility and shall concurrently make application for the
issuance of a license under division (A)(1) of this section with the board of health of the health
district in which the proposed facility is to be located.  
(b) On and after the effective date of the rules adopted under division (A) of section
3734.02 of the Revised Code and division (D) of section 3734.12 of the Revised Code
governing solid waste transfer facilities, each person proposing to open a new solid waste
transfer facility or to modify an existing solid waste transfer facility shall submit an application for
a permit with accompanying engineering detail plans, specifications, and information regarding
the facility and its method of operation to the environmental protection agency for required
approval under those rules at least two hundred seventy days before commencing proposed
operation of the facility and concurrently shall make application for the issuance of a license
under division (A)(1) of this section with the board of health of the health district in which the
facility is located or proposed.  
(c) Each application for a permit under division (A)(2)(a) or (b) of this section shall be
accompanied by a nonrefundable application fee of four hundred dollars that shall be credited to
the general revenue fund. Each application for an annual license under division (A)(1) or (2) of
this section shall be accompanied by a nonrefundable application fee of one hundred dollars. If
the application for an annual license is submitted to a board of health on the approved list under
section 3734.08 of the Revised Code, the application fee shall be credited to the special fund of the
health district created in division (B) of section 3734.06 of the Revised Code. If the
application for an annual license is submitted to the director, the application fee shall be credited
to the general revenue fund. If a permit or license is issued, the amount of the application fee
paid shall be deducted from the amount of the permit fee due under division (Q) of section
3745.11 of the Revised Code or the amount of the license fee due under division (A)(1), (2), (3),
(4), or (5) of section 3734.06 of the Revised Code.  
(d) As used in divisions (A)(2)(d), (e), and (f) of this section, “modify” means any of the
following:
(i) Any increase of more than ten per cent in the total capacity of a solid waste facility;
(ii) Any expansion of the limits of solid waste placement at a solid waste facility;
(iii) Any increase in the depth of excavation at a solid waste facility;
(iv) Any change in the technique of waste receipt or type of waste received at a solid
waste facility that may endanger human health, as determined by the director by rules adopted
in accordance with Chapter 119 of the Revised Code.

Not later than forty-five days after submitting an application under division (A)(2)(a) or (b)
of this section for a permit to open a new or modify an existing solid waste facility, the applicant,
in conjunction with an officer or employee of the environmental protection agency, shall hold a
public meeting on the application within the county in which the new or modified solid waste
facility is or is proposed to be located or within a contiguous county. Not less than thirty days
before holding the public meeting on the application, the applicant shall publish notice of the
meeting in each newspaper of general circulation that is published in the county in which the
facility is or is proposed to be located. If no newspaper of general circulation is published in the
county, the applicant shall publish the notice in a newspaper of general circulation in the county.
The notice shall contain the date, time, and location of the public meeting and a general
description of the proposed new or modified facility. Not later than five days after publishing the
notice, the applicant shall send by certified mail a copy of the notice and the date the notice was
published to the director and the legislative authority of each municipal corporation, township,
and county, and to the chief executive officer of each municipal corporation, in which the facility
is or is proposed to be located. At the public meeting, the applicant shall provide information and
describe the application and respond to comments or questions concerning the application, and
the officer or employee of the agency shall describe the permit application process. At the public
meeting, any person may submit written or oral comments on or objections to the application.
Not more than thirty days after the public meeting, the applicant shall provide the director with a
copy of a transcript of the full meeting, copies of any exhibits, displays, or other materials
presented by the applicant at the meeting, and the original copy of any written comments
submitted at the meeting.

(e) Except as provided in division (A)(2)(f) of this section, prior to taking an action, other
than a proposed or final denial, upon an application submitted under division (A)(2)(a) of this
section for a permit to open a new or modify an existing solid waste facility, the director shall
hold a public information session and a public hearing on the application within the county in
which the new or modified solid waste facility is or is proposed to be located or within a
contiguous county. If the application is for a permit to open a new solid waste facility, the
director shall hold the hearing not less than fourteen days after the information session. If the
application is for a permit to modify an existing solid waste facility, the director may hold both
the information session and the hearing on the same day unless any individual affected by the
application requests in writing that the information session and the hearing not be held on the
same day, in which case the director shall hold the hearing not less than fourteen days after the
information session. The director shall publish notice of the public information session or public
hearing not less than thirty days before holding the information session or hearing, as
applicable. The notice shall be published in each newspaper of general circulation that is
published in the county in which the facility is or is proposed to be located. If no newspaper of
general circulation is published in the county, the director shall publish the notice in a
newspaper of general circulation in the county. The notice shall contain the date, time, and
location of the information session or hearing, as applicable, and a general description of the
proposed new or modified facility. At the public information session, an officer or employee of
the environmental protection agency shall describe the status of the permit application and be
available to respond to comments or questions concerning the application. At the public hearing,
any person may submit written or oral comments on or objections to the approval of the
application. The applicant, or a representative of the applicant who has knowledge of the
location, construction, and operation of the facility, shall attend the information session and public hearing to respond to comments or questions concerning the facility directed to the applicant or representative by the officer or employee of the environmental protection agency presiding at the information session and hearing.

(f) The solid waste management policy committee of a county or joint solid waste management district may adopt a resolution requesting expeditious consideration of a specific application submitted under division (A)(2)(a) of this section for a permit to modify an existing solid waste facility within the district. The resolution shall make the finding that expedited consideration of the application without the public information session and public hearing under division (A)(2)(e) of this section is in the public interest and will not endanger human health, as determined by the director by rules adopted in accordance with Chapter 119 of the Revised Code. Upon receiving such a resolution, the director, at the director's discretion, may issue a final action upon the application without holding a public information session or public hearing pursuant to division (A)(2)(e) of this section.

(3) The director may issue an order in accordance with Chapter 3745 of the Revised Code to the owner or operator of a solid waste facility requiring the person to submit to the director updated engineering detail plans, specifications, and information regarding the facility and its method of operation for approval under rules adopted under division (A) of section 3734.02 of the Revised Code and applicable rules adopted under division (D) of section 3734.12 of the Revised Code if, in the director's judgment, conditions at the facility constitute a substantial threat to public health or safety or are causing or contributing to or threatening to cause or contribute to air or water pollution or soil contamination. Any person who receives such an order shall submit the updated engineering detail plans, specifications, and information to the director within one hundred eighty days after the effective date of the order.

(4) The director shall act upon any updated engineering plans, specifications, and information submitted under division (A)(3) of this section within one hundred eighty days after receiving them. If the director issues an order disapproving the plans, specifications, and information submitted under division (A)(3) of this section, the order shall include all of the following requirements:

(a) That the owner or operator submit a plan for closure and post-closure care of the facility to the director for approval within six months after issuance of the order;
(b) That the owner or operator cease accepting solid wastes for disposal or transfer at the facility; and
(c) The owner or operator commence closure of the facility not later than one year after issuance of the order.

If the director determines that closure of the facility within that one-year period would result in the unavailability of sufficient solid waste management facility capacity within the county or joint solid waste management district in which the facility is located to dispose of or transfer the solid waste generated within the district, the director in the order of disapproval may postpone commencement of closure of the facility for such period of time as the director finds necessary for the board of county commissioners or directors of the district to secure access to or for there to be constructed within the district sufficient solid waste management facility capacity to meet the needs of the district, provided that the director shall certify in the director's order that postponing the date for commencement of closure will not endanger ground water or any property surrounding the facility, allow methane gas migration to occur, or cause or contribute to any other type of environmental damage.

If an emergency need for disposal capacity that may affect public health and safety exists as a result of closure of a facility under division (A)(4) of this section, the director may issue an order designating another solid waste facility to accept the wastes that would have been disposed of at the facility to be closed.

(5) If the director determines that standards more stringent than those applicable in rules
adopted under division (A) of section 3734.02 of the Revised Code and division (D) of section 3734.12 of the Revised Code, or standards pertaining to subjects not specifically addressed by those rules, are necessary to ensure that a solid waste facility constructed at the proposed location will not cause a nuisance, cause or contribute to water pollution, or endanger public health or safety, the director may issue a permit for the facility with such terms and conditions as the director finds necessary to protect public health and safety and the environment. If a permit is issued, the director shall state in the order issuing it the specific findings supporting each such term or condition.

(6) Divisions (A)(1) and (2)(a) of this section do not apply to a solid waste compost facility that accepts exclusively source separated yard wastes and that is registered under division (C) of section 3734.02 of the Revised Code or, unless otherwise provided in rules adopted under division (N)(3) of section 3734.02 of the Revised Code, to a solid waste compost facility if the director has adopted rules establishing an alternative system for authorizing the establishment, operation, or modification of a solid waste compost facility under that division.

(7) Divisions (A)(1) to (5) of this section do not apply to scrap tire collection, storage, monowell, monofill, and recovery facilities. The approval of plans and specifications, as applicable, and the issuance of registration certificates, permits, and licenses for those facilities are subject to sections 3734.75 to 3734.78 of the Revised Code, as applicable, and section 3734.81 of the Revised Code.

(B)(1) No person shall operate or maintain an infectious waste treatment facility without a license issued by the board of health of the health district in which the facility is located or by the director when the health district in which the facility is located is not on the approved list under section 3734.08 of the Revised Code.

(2)(a) During the month of December, but before the first day of January of the next year, every person proposing to continue to operate an existing infectious waste treatment facility shall procure a license to operate the facility for that year from the board of health of the health district in which the facility is located or, if the health district is not on the approved list under section 3734.08 of the Revised Code, from the director. The application for such a license shall be submitted to the board of health or to the director, as appropriate, on or before the last day of September of the year preceding that for which the license is sought. In addition to the application fee prescribed in division (B)(2)(c) of this section, a person who submits an application after that date shall pay an additional ten per cent of the amount of the application fee for each week that the application is late. Late payment fees accompanying an application submitted to the board of health shall be credited to the special infectious waste fund of the health district created in division (C) of section 3734.06 of the Revised Code, and late payment fees accompanying an application submitted to the director shall be credited to the general revenue fund. A person who has received a license, upon sale or disposition of an infectious waste treatment facility and upon consent of the board of health and the director, may have the license transferred to another person. The board of health or the director may include such terms and conditions in a license or revision to a license as are appropriate to ensure compliance with the infectious waste provisions of this chapter and rules adopted under them.

(b) Each person proposing to open a new infectious waste treatment facility or to modify an existing infectious waste treatment facility shall submit an application for a permit with accompanying detail plans and specifications to the environmental protection agency for required approval under the rules adopted by the director pursuant to section 3734.021 of the Revised Code two hundred seventy days before proposed operation of the facility and concurrently shall make application for a license with the board of health of the health district in which the facility is or is proposed to be located. Not later than ninety days after receiving a complete application under division (B)(2)(b) of this section for a permit to open a new infectious waste treatment facility or modify an existing infectious waste treatment facility to expand its treatment capacity, or receiving a complete application under division (A)(2)(a) of this section for
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a permit to open a new solid waste incineration facility, or modify an existing solid waste incineration facility to also treat infectious wastes or to increase its infectious waste treatment capacity, that pertains to a facility for which a notation authorizing infectious waste treatment is included or proposed to be included in the solid waste incineration facility's license pursuant to division (B)(3) of this section, the director shall hold a public hearing on the application within the county in which the new or modified infectious waste or solid waste facility is or is proposed to be located or within a contiguous county. Not less than thirty days before holding the public hearing on the application, the director shall publish notice of the hearing in each newspaper that has general circulation and that is published in the county in which the facility is or is proposed to be located. If there is no newspaper that has general circulation and that is published in the county, the director shall publish the notice in a newspaper of general circulation in the county. The notice shall contain the date, time, and location of the public hearing and a general description of the proposed new or modified facility. At the public hearing, any person may submit written or oral comments on or objections to the approval or disapproval of the application. The applicant, or a representative of the applicant who has knowledge of the location, construction, and operation of the facility, shall attend the public hearing to respond to comments or questions concerning the facility directed to the applicant or representative by the officer or employee of the environmental protection agency presiding at the hearing.

(c) Each application for a permit under division (B)(2)(b) of this section shall be accompanied by a nonrefundable application fee of four hundred dollars that shall be credited to the general revenue fund. Each application for an annual license under division (B)(2)(a) of this section shall be accompanied by a nonrefundable application fee of one hundred dollars. If the application for an annual license is submitted to a board of health on the approved list under section 3734.08 of the Revised Code, the application fee shall be credited to the special infectious waste fund of the health district created in division (C) of section 3734.06 of the Revised Code. If the application for an annual license is submitted to the director, the application fee shall be credited to the general revenue fund. If a permit or license is issued, the amount of the application fee paid shall be deducted from the amount of the permit fee due under division (Q) of section 3745.11 of the Revised Code or the amount of the license fee due under division (C) of section 3734.06 of the Revised Code.

(d) The director may issue an order in accordance with Chapter 3745 of the Revised Code to the owner or operator of an infectious waste treatment facility requiring the person to submit to the director updated engineering detail plans, specifications, and information regarding the facility and its method of operation for approval under rules adopted under section 3734.021 of the Revised Code if, in the director's judgment, conditions at the facility constitute a substantial threat to public health or safety or are causing or contributing to or threatening to cause or contribute to air or water pollution or soil contamination. Any person who receives such an order shall submit the updated engineering detail plans, specifications, and information to the director within one hundred eighty days after the effective date of the order.

(e) The director shall act on any updated engineering plans, specifications, and information submitted under division (B)(2)(d) of this section within one hundred eighty days after receiving them. If the director disapproves any such updated engineering plans, specifications, and information, the director shall include in the order disapproving the plans the requirement that the owner or operator cease accepting infectious wastes for treatment at the facility.

(3) Division (B) of this section does not apply to a generator of infectious wastes that meets any of the following conditions:

(a) Treats, by methods, techniques, and practices established by rules adopted under division (B)(2)(a) of section 3734.021 of the Revised Code, any of the following wastes:

(i) Infectious wastes that are generated on any premises that are owned or operated by the generator;
(ii) Infectious wastes that are generated by a generator who has staff privileges at a hospital as defined in section 3727.01 of the Revised Code;

(iii) Infectious wastes that are generated in providing care to a patient by an emergency medical services organization as defined in section 4765.01 of the Revised Code.

(b) Holds a license or renewal of a license to operate a crematory facility issued under Chapter 4717 and a permit issued under Chapter 3704 of the Revised Code;

(c) Treats or disposes of dead animals or parts thereof, or the blood of animals, and is subject to any of the following:


(ii) Chapter 918 of the Revised Code;

(iii) Chapter 953 of the Revised Code.

Nothing in division (B) of this section requires a facility that holds a license issued under division (A) of this section as a solid waste facility and that also treats infectious wastes by the same method, technique, or process to obtain a license under division (B) of this section as an infectious waste treatment facility. However, the solid waste facility license for the facility shall include the notation that the facility also treats infectious wastes.

The director shall not issue a permit to open a new solid waste incineration facility unless the proposed facility complies with the requirements for the location of new infectious waste incineration facilities established in rules adopted under division (B)(2)(b) of section 3734.021 of the Revised Code.

(C) Except for a facility or activity described in division (E)(3) of section 3734.02 of the Revised Code, a person who proposes to establish or operate a hazardous waste facility shall submit a complete application for a hazardous waste facility installation and operation permit and accompanying detail plans, specifications, and such information as the director may require to the environmental protection agency at least one hundred eighty days before the proposed beginning of operation of the facility. The applicant shall notify by certified mail the legislative authority of each municipal corporation, township, and county in which the facility is proposed to be located of the submission of the application within ten days after the submission or at such earlier time as the director may establish by rule. If the application is for a proposed new hazardous waste disposal or thermal treatment facility, the applicant also shall give actual notice of the general design and purpose of the facility to the legislative authority of each municipal corporation, township, and county in which the facility is proposed to be located at least ninety days before the permit application is submitted to the environmental protection agency.

In accordance with rules adopted under section 3734.12 of the Revised Code, prior to the submission of a complete application for a hazardous waste facility installation and operation permit, the applicant shall hold at least one meeting in the township or municipal corporation in which the facility is proposed to be located, whichever is geographically closer to the proposed location of the facility. The meeting shall be open to the public and shall be held to inform the community of the proposed hazardous waste management activities and to solicit questions from the community concerning the activities.

(D)(1) Except as provided in section 3734.123 of the Revised Code, upon receipt of a complete application for a hazardous waste facility installation and operation permit under division (C) of this section, the director shall consider the application and accompanying information to determine whether the application complies with agency rules and the requirements of division (D)(2) of this section. After making a determination, the director shall issue either a draft permit or a notice of intent to deny the permit. The director, in accordance with rules adopted under section 3734.12 of the Revised Code or with rules adopted to implement Chapter 3745 of the Revised Code, shall provide public notice of the application and the draft permit or the notice of intent to deny the permit, provide an opportunity for public comments, and, if significant interest is shown, schedule a public meeting in the county in which
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the facility is proposed to be located and give public notice of the date, time, and location of the public meeting in a newspaper of general circulation in that county.

(2) The director shall not approve an application for a hazardous waste facility installation and operation permit or an application for a modification under division (I)(3) of this section unless the director finds and determines as follows:
(a) The nature and volume of the waste to be treated, stored, or disposed of at the facility;
(b) That the facility complies with the director's hazardous waste standards adopted pursuant to section 3734.12 of the Revised Code;
(c) That the facility represents the minimum adverse environmental impact, considering the state of available technology and the nature and economics of various alternatives, and other pertinent considerations;
(d) That the facility represents the minimum risk of all of the following:
(i) Fires or explosions from treatment, storage, or disposal methods;
(ii) Release of hazardous waste during transportation of hazardous waste to or from the facility;
(iii) Adverse impact on the public health and safety.
(e) That the facility will comply with this chapter and Chapters 3704 and 6111 of the Revised Code and all rules and standards adopted under them;
(f) That if the owner of the facility, the operator of the facility, or any other person in a position with the facility from which the person may influence the installation and operation of the facility has been involved in any prior activity involving transportation, treatment, storage, or disposal of hazardous waste, that person has a history of compliance with this chapter and Chapters 3704 and 6111 of the Revised Code and all rules and standards adopted under them, the “Resource Conservation and Recovery Act of 1976,” 90 Stat. 2806, 42 U.S.C.A. 6921, as amended, and all regulations adopted under it, and similar laws and rules of other states if any such prior operation was located in another state that demonstrates sufficient reliability, expertise, and competency to operate a hazardous waste facility under the applicable provisions of this chapter and Chapters 3704 and 6111 of the Revised Code, the applicable rules and standards adopted under them, and terms and conditions of a hazardous waste facility installation and operation permit, given the potential for harm to the public health and safety and the environment that could result from the irresponsible operation of the facility. For off-site facilities, as defined in section 3734.41 of the Revised Code, the director may use the investigative reports of the attorney general prepared pursuant to section 3734.42 of the Revised Code as a basis for making a finding and determination under division (D)(2)(f) of this section.
(g) That the active areas within a new hazardous waste facility where acute hazardous waste as listed in 40 C.F.R. 261.33 (e), as amended, or organic waste that is toxic and is listed under 40 C.F.R. 261, as amended, is being stored, treated, or disposed of and where the aggregate of the storage design capacity and the disposal design capacity of all hazardous waste in those areas is greater than two hundred fifty thousand gallons, are not located or operated within any of the following:
(i) Two thousand feet of any residence, school, hospital, jail, or prison;
(ii) Any naturally occurring wetland;
(iii) Any flood hazard area if the applicant cannot show that the facility will be designed, constructed, operated, and maintained to prevent washout by a one-hundred-year flood.
Division (D)(2)(g) of this section does not apply to the facility of any applicant who demonstrates to the director that the limitations specified in that division are not necessary because of the nature or volume of the waste and the manner of management applied, the facility will impose no substantial danger to the health and safety of persons occupying the structures listed in division (D)(2)(g)(i) of this section, and the facility is to be located or operated...
in an area where the proposed hazardous waste activities will not be incompatible with existing land uses in the area.

(h) That the facility will not be located within the boundaries of a state park established or dedicated under Chapter 1546 of the Revised Code, a state park purchase area established under section 1546.06 of the Revised Code, any unit of the national park system, or any property that lies within the boundaries of a national park or recreation area, but that has not been acquired or is not administered by the secretary of the United States department of the interior, located in this state, or any candidate area located in this state identified for potential inclusion in the national park system in the edition of the "national park system plan" submitted under paragraph (b) of section 8 of "The Act of August 18, 1970," 84 Stat. 825, 16 U.S.C.A. 1a-5, as amended, current at the time of filing of the application for the permit, unless the facility will be used exclusively for the storage of hazardous waste generated within the park or recreation area in conjunction with the operation of the park or recreation area. Division (D)(2)(h) of this section does not apply to the facility of any applicant for modification of a permit unless the modification application proposes to increase the land area included in the facility or to increase the quantity of hazardous waste that will be treated, stored, or disposed of at the facility.

(3) Not later than one hundred eighty days after the end of the public comment period, the director, without prior hearing, shall issue or deny the permit in accordance with Chapter 3745 of the Revised Code. If the director approves an application for a hazardous waste facility installation and operation permit, the director shall issue the permit, upon such terms and conditions as the director finds are necessary to ensure the construction and operation of the hazardous waste facility in accordance with the standards of this section.

(E) No political subdivision of this state shall require any additional zoning or other approval, consent, permit, certificate, or condition for the construction or operation of a hazardous waste facility authorized by a hazardous waste facility installation and operation permit issued pursuant to this chapter, nor shall any political subdivision adopt or enforce any law, ordinance, or rule that in any way alters, impairs, or limits the authority granted in the permit.

(F) The director may issue a single hazardous waste facility installation and operation permit to a person who operates two or more adjoining facilities where hazardous waste is stored, treated, or disposed of if the application includes detail plans, specifications, and information on all facilities. For the purposes of this section, "adjoining" means sharing a common boundary, separated only by a public road, or in such proximity that the director determines that the issuance of a single permit will not create a hazard to the public health or safety or the environment.

(G) No person shall falsify or fail to keep or submit any plans, specifications, data, reports, records, manifests, or other information required to be kept or submitted to the director by this chapter or the rules adopted under it.

(H)(1) Each person who holds an installation and operation permit issued under this section and who wishes to obtain a permit renewal shall submit a completed application for an installation and operation permit renewal and any necessary accompanying general plans, detail plans, specifications, and such information as the director may require to the director no later than one hundred eighty days prior to the expiration date of the existing permit or upon a later date prior to the expiration of the existing permit if the permittee can demonstrate good cause for the late submittal. The director shall consider the application and accompanying information, inspection reports of the facility, results of performance tests, a report regarding the facility's compliance or noncompliance with the terms and conditions of its permit and rules adopted by the director under this chapter, and such other information as is relevant to the operation of the facility and shall issue a draft renewal permit or a notice of intent to deny the renewal permit. The director, in accordance with rules adopted under this section or with rules adopted to implement Chapter 3745 of the Revised Code, shall give public notice of the
application and draft renewal permit or notice of intent to deny the renewal permit, provide for the opportunity for public comments within a specified time period, schedule a public meeting in the county in which the facility is located if significant interest is shown, and give public notice of the public meeting.

(2) Within sixty days after the public meeting or close of the public comment period, the director, without prior hearing, shall issue or deny the renewal permit in accordance with Chapter 3745 of the Revised Code. The director shall not issue a renewal permit unless the director determines that the facility under the existing permit has a history of compliance with this chapter, rules adopted under it, the existing permit, or orders entered to enforce such requirements that demonstrates sufficient reliability, expertise, and competency to operate the facility henceforth under this chapter, rules adopted under it, and the renewal permit. If the director approves an application for a renewal permit, the director shall issue the permit subject to the payment of the annual permit fee required under division (E) of section 3734.02 of the Revised Code and upon such terms and conditions as the director finds are reasonable to ensure that continued operation, maintenance, closure, and post-closure care of the hazardous waste facility are in accordance with the rules adopted under section 3734.12 of the Revised Code.

(3) An installation and operation permit renewal application submitted to the director that also contains or would constitute an application for a modification shall be acted upon by the director in accordance with division (I) of this section in the same manner as an application for a modification. In approving or disapproving the renewal portion of a permit renewal application containing an application for a modification, the director shall apply the criteria established under division (H)(2) of this section.

(4) An application for renewal or modification of a permit that does not contain an application for a modification as described in divisions (I)(3)(a) to (d) of this section shall not be subject to division (D)(2) of this section.

(1)(1) As used in this section, “modification” means a change or alteration to a hazardous waste facility or its operations that is inconsistent with or not authorized by its existing permit or authorization to operate. Modifications shall be classified as Class 1, 2, or 3 modifications in accordance with rules adopted under division (K) of this section. Modifications classified as Class 3 modifications, in accordance with rules adopted under that division, shall be further classified by the director as either Class 3 modifications that are to be approved or disapproved by the director under divisions (I)(3)(a) to (d) of this section or as Class 3 modifications that are to be approved or disapproved by the director under division (I)(5) of this section. Not later than thirty days after receiving a request for a modification under division (I)(4) of this section that is not listed in Appendix I to 40 C.F.R. 270.42 or in rules adopted under division (K) of this section, the director shall classify the modification and shall notify the owner or operator of the facility requesting the modification of the classification. Notwithstanding any other law to the contrary, a modification that involves the transfer of a hazardous waste facility installation and operation permit to a new owner or operator for any off-site facility as defined in section 3734.41 of the Revised Code shall be classified as a Class 3 modification. The transfer of a hazardous waste facility installation and operation permit to a new owner or operator for a facility that is not an off-site facility shall be classified as a Class 1 modification requiring prior approval of the director.

(2) Except as provided in section 3734.123 of the Revised Code, a hazardous waste facility installation and operation permit may be modified at the request of the permittee or upon the written request of the permittee only if any of the following applies:

(a) The permittee desires to accomplish alterations, additions, or deletions to the permitted facility or to undertake alterations, additions, deletions, or activities that are inconsistent with or not authorized by the existing permit;

(b) New information or data justify permit conditions in addition to or different from those in the existing permit;
(c) The standards, criteria, or rules upon which the existing permit is based have been changed by new, amended, or rescinded standards, criteria, or rules, or by judicial decision after the existing permit was issued, and the change justifies permit conditions in addition to or different from those in the existing permit;
(d) The permittee proposes to transfer the permit to another person.
(3) The director shall approve or disapprove an application for a modification in accordance with division (D)(2) of this section and rules adopted under division (K) of this section for all of the following categories of Class 3 modifications:
   (a) Authority to conduct treatment, storage, or disposal at a site, location, or tract of land that has not been authorized for the proposed category of treatment, storage, or disposal activity by the facility's permit;
   (b) Modification or addition of a hazardous waste management unit, as defined in rules adopted under section 3734.12 of the Revised Code, that results in an increase in a facility's storage capacity of more than twenty-five per cent over the capacity authorized by the facility's permit, an increase in a facility's treatment rate of more than twenty-five per cent over the rate so authorized, or an increase in a facility's disposal capacity over the capacity so authorized. The authorized disposal capacity for a facility shall be calculated from the approved design plans for the disposal units at that facility. In no case during a five-year period shall a facility's storage capacity or treatment rate be modified to increase by more than twenty-five per cent in the aggregate without the director's approval in accordance with division (D)(2) of this section. Notwithstanding any provision of division (I) of this section to the contrary, a request for modification of a facility's annual total waste receipt limit shall be classified and approved or disapproved by the director under division (I)(5) of this section.
   (c) Authority to add any of the following categories of regulated activities not previously authorized at a facility by the facility's permit: storage at a facility not previously authorized to store hazardous waste, treatment at a facility not previously authorized to treat hazardous waste, or disposal at a facility not previously authorized to dispose of hazardous waste; or authority to add a category of hazardous waste management unit not previously authorized at the facility by the facility's permit. Notwithstanding any provision of division (I) of this section to the contrary, a request for authority to add or to modify an activity or a hazardous waste management unit for the purposes of performing a corrective action shall be classified and approved or disapproved by the director under division (I)(5) of this section.
   (d) Authority to treat, store, or dispose of waste types listed or characterized as reactive or explosive, in rules adopted under section 3734.12 of the Revised Code, or any acute hazardous waste listed in 40 C.F.R. 261.33(e), as amended, at a facility not previously authorized to treat hazardous waste, treatment at a facility not previously authorized to treat hazardous waste, or disposal at a facility not previously authorized to dispose of hazardous waste; or authority to add a category of hazardous waste management unit not previously authorized at the facility by the facility's permit. Notwithstanding any provision of division (I) of this section to the contrary, a request for authority to add or to modify an activity or a hazardous waste management unit for the purposes of performing a corrective action shall be classified and approved or disapproved by the director under division (I)(5) of this section.
(4) A written request for a modification from the permittee shall be submitted to the director and shall contain such information as is necessary to support the request. Requests for modifications shall be acted upon by the director in accordance with this section and rules adopted under it.
(5) Class 1 modification applications that require prior approval of the director, as provided in division (I)(1) of this section or as determined in accordance with rules adopted under division (K) of this section, Class 2 modification applications, and Class 3 modification applications that are not described in divisions (I)(3)(a) to (d) of this section shall be approved or disapproved by the director in accordance with rules adopted under division (K) of this section. The board of county commissioners of the county, the board of township trustees of the
township, and the city manager or mayor of the municipal corporation in which a hazardous waste facility is located shall receive notification of any application for a modification for that facility and shall be considered as interested persons with respect to the director's consideration of the application.

As used in division (I) of this section:
(a) “Owner” means the person who owns a majority or controlling interest in a facility.
(b) “Operator” means the person who is responsible for the overall operation of a facility.

The director shall approve or disapprove an application for a Class 1 modification that requires the director's approval within sixty days after receiving the request for modification. The director shall approve or disapprove an application for a Class 2 modification within three hundred days after receiving the request for modification. The director shall approve or disapprove an application for a Class 3 modification within three hundred sixty-five days after receiving the request for modification.

(6) The approval or disapproval by the director of a Class 1 modification application is not a final action that is appealable under Chapter 3745 of the Revised Code. The approval or disapproval by the director of a Class 2 modification or a Class 3 modification is a final action that is appealable under that chapter. In approving or disapproving a request for a modification, the director shall consider all comments pertaining to the request that are received during the public comment period and the public meetings. The administrative record for appeal of a final action by the director in approving or disapproving a request for a modification shall include all comments received during the public comment period relating to the request for modification, written materials submitted at the public meetings relating to the request, and any other documents related to the director's action.

(7) Notwithstanding any other provision of law to the contrary, a change or alteration to a hazardous waste facility described in division (E)(3)(a) or (b) of section 3734.02 of the Revised Code, or its operations, is a modification for the purposes of this section. An application for a modification at such a facility shall be submitted, classified, and approved or disapproved in accordance with divisions (I)(1) to (6) of this section in the same manner as a modification to a hazardous waste facility installation and operation permit.

(J)(1) Except as provided in division (J)(2) of this section, an owner or operator of a hazardous waste facility that is operating in accordance with a permit by rule under rules adopted by the director under division (E)(3)(b) of section 3734.02 of the Revised Code shall submit either a hazardous waste facility installation and operation permit application for the facility or a modification application, whichever is required under division (J)(1)(a) or (b) of this section, within one hundred eighty days after the director has requested the application or upon a later date if the owner or operator demonstrates to the director good cause for the late submittal.

(a) If the owner or operator does not have a hazardous waste facility installation and operation permit for any hazardous waste treatment, storage, or disposal activities at the facility, the owner or operator shall submit an application for such a permit to the director for the activities authorized by the permit by rule. Notwithstanding any other provision of law to the contrary, the director shall approve or disapprove the application for the permit in accordance with the procedures governing the approval or disapproval of permit renewals under division (H) of this section.

(b) If the owner or operator has a hazardous waste facility installation and operation permit for hazardous waste treatment, storage, or disposal activities at the facility other than those authorized by the permit by rule, the owner or operator shall submit to the director a request for modification in accordance with division (I) of this section. Notwithstanding any other provision of law to the contrary, the director shall approve or disapprove the modification application in accordance with division (I)(5) of this section.

(2) The owner or operator of a boiler or industrial furnace that is conducting thermal
treatment activities in accordance with a permit by rule under rules adopted by the director under division (E)(3)(b) of section 3734.02 of the Revised Code shall submit a hazardous waste facility installation and operation permit application if the owner or operator does not have such a permit for any hazardous waste treatment, storage, or disposal activities at the facility or, if the owner or operator has such a permit for hazardous waste treatment, storage, or disposal activities at the facility other than thermal treatment activities authorized by the permit by rule, a modification application to add those activities authorized by the permit by rule, whichever is applicable, within one hundred eighty days after the director has requested the submission of the application or upon a later date if the owner or operator demonstrates to the director good cause for the late submittal. The application shall be accompanied by information necessary to support the request. The director shall approve or disapprove an application for a hazardous waste facility installation and operation permit in accordance with division (D) of this section and approve or disapprove an application for a modification in accordance with division (I)(3) of this section, except that the director shall not disapprove an application for the thermal treatment activities on the basis of the criteria set forth in division (D)(2)(g) or (h) of this section.

(3) As used in division (J) of this section:
(a) “Modification application” means a request for a modification submitted in accordance with division (I) of this section.
(b) “Thermal treatment,” “boiler,” and “industrial furnace” have the same meanings as in rules adopted under section 3734.12 of the Revised Code.

(K) The director shall adopt, and may amend, suspend, or rescind, rules in accordance with Chapter 119 of the Revised Code in order to implement divisions (H) and (I) of this section. Except when in actual conflict with this section, rules governing the classification of and procedures for the modification of hazardous waste facility installation and operation permits shall be substantively and procedurally identical to the regulations governing hazardous waste facility permitting and permit modifications adopted under the “Resource Conservation and Recovery Act of 1976,” 90 Stat. 2806, 42 U.S.C.A. 6921, as amended.

3734.12 EPA to issue hazardous and solid waste rules.


The director of environmental protection shall adopt rules in accordance with Chapter 119 of the Revised Code, which shall be consistent with and equivalent to the regulations adopted under the Resource Conservation and Recovery Act except for rules adopted under divisions (D) and (F) of this section governing solid waste facilities and except as otherwise provided in this chapter, doing all of the following:

(A) Adopting the criteria and procedures established under the Resource Conservation and Recovery Act for identifying hazardous waste. The director shall prepare, revise when appropriate, and publish a list of substances or categories of substances identified to be hazardous using the criteria specified in 40 C.F.R. 261, as amended, which shall be composed of at least those substances identified as hazardous pursuant to section 3001(B) of that act. The director shall not list any waste that the administrator of the United States environmental protection agency delisted or excluded by an amendment to the federal regulations, any waste that the administrator declined to list by publishing a denial of a rulemaking petition or by withdrawal of a proposed listing in the United States federal register after May 18, 1980, or any waste oil or polychlorinated biphenyl not listed by the administrator.

(B) Establishing standards for generators of hazardous waste necessary to protect human health or safety or the environment in accordance with this chapter, including, but not limited to, requirements respecting all of the following:
(1) Record-keeping practices that accurately identify the quantities of hazardous waste generated, the constituents that are significant in quantity or in potential harm to human health or safety or the environment, and the disposition of the waste;

(2) Labeling of containers used for storage, transportation, or disposal of hazardous waste to identify the waste accurately;

(3) Use of appropriate containers for hazardous waste;

(4) Providing information on the general chemical composition of hazardous waste to persons transporting, treating, storing, or disposing of the waste;

(5) A manifest system requiring a manifest consistent with that prescribed under the Resource Conservation and Recovery Act requiring a manifest for any hazardous waste transported off the premises where generated and assuring that all hazardous waste that is transported off the premises where generated is designated for treatment, storage, or disposal in facilities for which a permit has been issued or in the other facilities specified in division (F) of section 3734.02 of the Revised Code;

(6) Submission of such reports to the director as the director determines necessary;

(7) Establishment of quality control and testing procedures that ensure compliance with the rules adopted under this section;

(8) Obtainment of a United States environmental protection agency identification number.

(C) Establishing standards for transporters of hazardous waste necessary to protect human health or safety or the environment in accordance with this chapter, including, but not limited to, requirements respecting all of the following:

(1) Record-keeping concerning hazardous waste transported, including source and delivery points;

(2) Submission of such reports to the director as the director determines necessary;

(3) Transportation of only properly labeled waste;

(4) Compliance with the manifest system required by division (B) of this section;

(5) Transportation of hazardous waste only to the treatment, storage, or disposal facility that the shipper designates on the manifest to be a facility holding a permit or another facility specified in division (F) of section 3734.02 of the Revised Code;

(6) Contingency plans to minimize unanticipated damage from transportation of hazardous waste;

(7) Financial responsibility, including, but not limited to, provisions requiring a financial mechanism to cover the costs of spill cleanup and liability for sudden accidental occurrences that result in damage to persons, property, or the environment;

(8) Obtainment of a United States environmental protection agency identification number.

In the case of any hazardous waste that is subject to the “Hazardous Materials Transportation Act,” 88 Stat. 2156 (1975), 49 U.S.C.A. 1801, as amended, the rules shall be consistent with that act and regulations adopted under it.

(D) Establishing performance standards for owners and operators of hazardous waste facilities and owners and operators of solid waste facilities, necessary to protect human health or safety or the environment in accordance with this chapter, including, but not limited to, requirements respecting all of the following:

(1) Maintaining records of all hazardous waste that is treated, stored, or disposed of and of the manner in which the waste was treated, stored, or disposed of or records of all solid wastes transferred or disposed of and of the manner in which the wastes were disposed of;

(2) Submission of such reports to the director as the director determines necessary;

(3) Reporting, monitoring, inspection, and, except with respect to solid waste facilities, compliance with the manifest system referred to in division (B) of this section;

(4) Treatment, storage, or disposal of all hazardous waste received by methods,
techniques, and practices approved by the director and disposal or transfer of all solid wastes received by methods, techniques, and practices approved by the director;

(5) Location, design, and construction of hazardous waste facilities and location, design, and construction of solid waste facilities;

(6) Contingency plans for effective action to minimize unanticipated damage from treatment, storage, or disposal of hazardous waste and the disposal or transfer of solid wastes;

(7) Ownership, continuity of operation, training for personnel, and financial responsibility, including the filing of closure and post-closure financial assurance, if applicable. No private entity shall be precluded by reason of these requirements from the ownership or operation of facilities providing hazardous waste treatment, storage, or disposal services if the entity can provide assurances of financial responsibility and continuity of operation consistent with the degree and duration of risks associated with the treatment, storage, or disposal of specified hazardous waste.

(8) Closure and post-closure care of a hazardous waste facility where hazardous waste will no longer be treated, stored, or disposed of and of a solid waste facility where solid wastes will no longer be disposed of or transferred;

(9) Establishment of quality control and testing procedures that ensure compliance with the rules adopted under this section;

(10) Obtainment of a United States environmental protection agency identification number for each hazardous waste treatment, storage, or disposal facility;

(11) Trial burns and land treatment demonstrations.

The rules adopted under divisions (D) and (F) of this section pertaining to solid waste facilities do not apply to scrap tire collection, storage, monocell, monofill, and recovery facilities. Those facilities are subject to and governed by rules adopted under sections 3734.70 to 3734.73 of the Revised Code, as applicable.

(E) Governing the issuance, modification, revocation, suspension, withdrawal, and denial of installation and operation permits, draft permits, and transportation certificates of registration;

(F) Specifying information required to be included in applications for hazardous waste facility installation and operation permits and solid waste permits, including, but not limited to, detail plans, specifications, and information respecting all of the following:

(1) The composition, quantities, and concentrations of hazardous waste and solid wastes to be stored, treated, transported, or disposed of and such other information as the director may require regarding the method of operation;

(2) The facility to which the waste will be transported or where it will be stored, treated, or disposed of;

(3) The closure and post-closure care of a facility where hazardous waste will no longer be treated, stored, or disposed of and of a solid waste facility where solid wastes will no longer be disposed of or transferred.

(G) Establishing procedures ensuring that all information entitled to protection as trade secrets disclosed to the director or the director’s authorized representative is not disclosed without the consent of the owner, except that such information may be disclosed, upon request, to authorized representatives of the United States environmental protection agency, or as required by law. As used in this section, “trade secrets” means any formula, plan, pattern, process, tool, mechanism, compound, procedure, production date, or compilation of information that is not patented, that is known only to certain individuals within a commercial concern who are using it to fabricate, produce, or compound an article, trade, or service having commercial value, and that gives its user an opportunity to obtain a business advantage over competitors who do not know or use it.

(H) Prohibiting the disposal of specified hazardous wastes in this state if the director has determined both of the following:

(1) The potential impacts on human health or safety or the environment are such that
disposal of those wastes should not be allowed.

(2) A technically feasible and environmentally sound alternative is reasonably available, either within or outside this state, for processing, recycling, fixation of, neutralization of, or other treatment of those wastes. Such reasonable availability shall not be determined without a consideration of the costs to the generator of implementing the alternatives.

The director shall adopt, and may amend, suspend, or rescind, rules to specify hazardous wastes that shall not be disposed of in accordance with this division. Nothing in this division, either prior to or after adoption of those rules, shall preclude the director from prohibiting the disposal of specified hazardous wastes at particular facilities under the terms or conditions of a permit or by order.

(i)(1)(a) Governing the following that may be more stringent than the regulations adopted under the Resource Conservation and Recovery Act when the director determines that such more stringent rules are reasonable in order to protect human health or safety or the environment:

(i) Specific wastes that the director determines, because of their physical, chemical, or biological characteristics, are so extremely hazardous that the storage, treatment, or disposal of the wastes in compliance with those regulations would present an imminent danger to human health or safety or the environment;

(ii) The use of only properly designed, operated, and approved transfer facilities;

(iii) Preventing illegitimate activities relating to the reuse, recycling, or reclaiming of hazardous waste, including record-keeping, reporting, and manifest requirements.

(b) In adopting such more stringent rules, the director shall give consideration to and base the rules on evidence concerning factors including, but not limited to, the following insofar as pertinent:

(i) Geography of the state;

(ii) Geology of the state;

(iii) Hydrogeology of the state;

(iv) Climate of the state;

(v) Engineering and technical feasibility;

(vi) Availability of alternative technologies or methods of storage, treatment, or disposal.

(2) The director may require from generators and transporters of hazardous waste and from owners or operators of treatment, storage, or disposal facilities, the submission of reports in addition to those required under regulations adopted under the Resource Conservation and Recovery Act to the extent that such reports contain information that the generator, transporter, or facility owner or operator is required to obtain in order to comply with the regulations adopted by the administrator of the United States environmental protection agency under the Resource Conservation and Recovery Act or to the extent that such reports are required by the director to meet the requirements of division (B)(7), (D)(9), or (H) of this section or section 3734.121 of the Revised Code.

(J) Governing the storage, treatment, or disposal of hazardous waste in, and the permitting, design, construction, operation, monitoring, inspection, closure, and post-closure care of, hazardous waste underground injection wells, surface impoundments, waste piles other than those composed of materials removed from the ground as part of coal or mineral extraction or cleaning processes, land treatment facilities, thermal treatment facilities, and landfills that may be more stringent than the regulations adopted under the Resource Conservation and Recovery Act whenever the director reasonably determines that federal regulations will not adequately protect the public health or safety or the environment of this state with respect to the subject matter of the more stringent rules. Such more stringent rules shall be developed to achieve a degree of protection, as determined by the director, consistent with the degree of hazard potentially posed by the various wastes or categories of wastes to be treated, stored, or disposed of and the types of facilities at which they are to be treated, stored, or disposed of. In
adoption of such more stringent rules, the director shall give consideration to and base the rules on evidence concerning factors including, but not limited to, the following insofar as pertinent:

(1) Geography of the state;
(2) Geology of the state;
(3) Hydrogeology of the state;
(4) Climate of the state;
(5) Engineering and technical feasibility;
(6) Availability of alternative technologies or methods of storage, treatment, or disposal.

(K) Establishing performance standards and other requirements necessary to protect public health and the environment from hazards associated with used oil, including, without limitation, standards and requirements respecting all of the following:

(1) Material that is subject to regulation as used oil;
(2) Generation of used oil;
(3) Used oil collection centers and aggregation points;
(4) Transportation of used oil;
(5) Processing and re-refining of used oil;
(6) Burning of used oil;
(7) Marketing of used oil;
(8) Disposal of used oil;
(9) Use of used oil as a dust suppressant.

(L) Establishing any other requirements, standards, or criteria that are consistent with and equivalent to the Resource Conservation and Recovery Act governing any matter not specifically addressed by divisions (A) to (K) of this section.

3734.16 Liability of hazardous waste generator.

A generator of hazardous waste who violates any of the rules adopted by the director of environmental protection in accordance with divisions (B) and (I) of section 3734.12 of the Revised Code shall be liable for any damage or injury caused by the violation and for the costs of rectifying the violation and conditions caused by the violation in addition to any civil penalties or criminal fines imposed for the violation under section 3734.13 or 3734.99 of the Revised Code.

3750.01 Emergency planning; definitions.

As used in this chapter:

(A) "Confidential business information" means the types or categories of information identified in rules adopted under division (B)(1)(h) of section 3750.02 of the Revised Code.

(B) "Extremely hazardous substance" means a substance identified or listed by the rules adopted under division (B)(1)(a) or (C)(5) of section 3750.02 of the Revised Code.

(C) "Emergency planning district" means an emergency planning district or joint emergency planning district designated under section 3750.03 of the Revised Code or a joint interstate emergency planning district established by agreement under that section.

(D) "Facility" means all buildings, equipment, structures, and other stationary items that are located on a single site or on contiguous or adjacent sites and that are owned or operated by the same person or by any person who controls, is controlled by, or is under common control with such person. For the purposes of section 3750.06 of the Revised Code, the term also includes motor vehicles, rolling stock, and aircraft.

(E) "Fire department" means a fire department of a municipal corporation or township, a township fire district, a joint township fire district, a private fire company or volunteer fire company that has entered into an agreement for the use and operation of fire-fighting
equipment with a municipal corporation, township, township fire district, or joint township fire
district or, in a municipal corporation or township where no such fire department or district exists
and no such agreement is in effect, the fire prevention officer of the municipal corporation or
township.

(F) "First response equipment" means equipment, other than emergency response and
firefighting vehicles, designed primarily for the purpose of facilitating the safe and efficient
response to unanticipated and unauthorized releases of hazardous substances and extremely
hazardous substances.

(G) "Hazardous chemical" has the meaning given to that term in 29 C.F.R. 1910. 1200
(c). The term also includes chemicals identified or listed in rules adopted under division (C)(5) of
section 3750.02 of the Revised Code, but does not include any of the following:

1. Any food, food additive, color additive, drug, or cosmetic regulated by the food and
drug administration of the United States department of health and human services;
2. Any substance present as a solid in any manufactured item, to the extent that
exposure to the substance does not occur under normal conditions of use;
3. Any substance to the extent it is used for personal, family, or household purposes, or
is present in the same form and concentration as a product packaged for distribution and use by
the general public, including, without limitation, household and consumer products that are
stored prior to or displayed for distribution to the consumer when in the same form and
concentration and products that are not intended for distribution to the general public and are in
the same form and concentration as products packaged for distribution and use by the
general public, unless the chemical is subject to a reporting requirement for which a variance
has been issued under division (B) or (C) of section 3750.11 of the Revised Code;
4. Any substance to the extent it is used in a research laboratory or a hospital or other
medical facility under the direct supervision of a technically qualified individual;
5. Any substance to the extent it is used in routine agricultural operations or is a
fertilizer held for sale by a retailer to the ultimate customer.

(H) "Hazardous substance" means a substance identified or listed by the rules adopted
under division (B)(1)(c) or (C)(5) of section 3750.02 of the Revised Code.

(I) "Local emergency planning committee" means the local emergency planning
committee of an emergency planning district, joint emergency planning district, or joint interstate
planning district established under section 3750.03 of the Revised Code.

(J) "Oil" means oil of any kind or in any form including, without limitation, petroleum, fuel
oil, sludge, oil refuse, and oil mixed with wastes other than dredged spoil.

(K) "Person" means the state, any political subdivision, any other state or local body, the
United States and any agency or instrumentality thereof, and any person as defined in section
1.59 of the Revised Code.

(L) "Release" means any spilling, leaking, pumping, pouring, emitting, emptying,
discharging, injecting, escaping, leaching, dumping, or disposing of into the environment,
including, without limitation, the abandonment or discarding of barrels, containers, and other
closed receptacles that contained any oil, hazardous chemical, hazardous substance, or
extremely hazardous substance. The term does not include any discharge, emission, injection,
or disposal into the environment of any oil, hazardous chemical, hazardous substance, or
extremely hazardous substance that is in compliance with Chapter 1509, 3704, 3734, or 6111 of
the Revised Code, rules adopted thereunder, the terms or conditions of a current and valid
permit or license, or order, issued thereunder, or a plan approval made thereunder.

(M) "Vessel" means every watercraft or other artificial contrivance used or capable of
being used as a means of transportation on water.
Facility and emergency planning.

(A) Each facility that has an extremely hazardous substance present in an amount that exceeds the threshold planning quantity for the substance established by rules adopted under division (B)(1)(a) or (C)(5) of section 3750.02 of the Revised Code is subject to this section and section 3750.04 of the Revised Code. Upon the written request of the local emergency planning committee of the emergency planning district in which a facility is located, the emergency response commission may, by issuance of an order in accordance with section 3750.18 of the Revised Code, designate an additional facility as being subject to the requirements of this section and section 3750.04 of the Revised Code if the commission determines from the request that, due to the size of the facility, the nature of its operations, or its proximity to a residential area or an area where significant numbers of people work or congregate, participation in the emergency planning process under this section and section 3750.04 of the Revised Code is necessary or appropriate to protect the public health or safety or the environment. At least forty-five days before issuance of such an order the commission shall mail written notice to the owner or operator of the facility by certified mail, return receipt requested, and shall notify the public, by the publication of notice in a newspaper of general circulation in the county where the facility is located, of the commission's intention to approve the request and to issue the order and that the public may submit written comments to the commission regarding approval of the request during that time. The commission shall not issue any such order unless at least sixty per cent of the voting members of the commission vote to approve the request and issuance of the order. Designations under this division shall be made on the basis of individual facilities rather than on a categorical basis.

(B) Within thirty days after the committee of a district is appointed under section 3750.03 of the Revised Code, the owner or operator of any facility located in the district and identified under division (A) of this section shall select a facility representative and provide the name of the representative to the committee. The facility representative is the person who will participate in the district's emergency planning process as the facility emergency coordinator. If the owner or operator changes its facility emergency coordinator, the owner or operator shall promptly provide the name of the new facility emergency coordinator to the committee.

If an extremely hazardous substance first becomes present at a facility on or after the effective date of this section in an amount that exceeds the threshold planning quantity established for the substance in rules adopted under division (B)(1)(a) of section 3750.02 of the Revised Code, or if, after rules have been adopted under division (C)(5) of section 3750.02 of the Revised Code, an extremely hazardous substance becomes present at a facility in an amount that exceeds the threshold planning quantity for the extremely hazardous substance, the owner or operator of the facility shall notify the emergency response commission and the local emergency planning committee of the emergency planning district in which the facility is located that the facility is subject to this section and section 3750.04 of the Revised Code within sixty days after first acquiring the substance. If rules are adopted under division (C)(5) of section 3750.02 of the Revised Code, or if rules adopted under division (B)(1)(a) or (C)(5) of that section are amended, and a facility has present an extremely hazardous substance in an amount exceeding the threshold planning quantity for the extremely hazardous substance established in those rules or amended rules, the owner or operator of the facility shall notify the commission and the local emergency planning committee of the emergency planning district in which the facility is located that the facility is subject to this section and section 3750.04 of the Revised Code within sixty days after adoption or amendment of the rules. If the owner or operator had not previously been required to select a facility emergency coordinator under this division, he shall select one and provide his name to the committee within sixty days after first acquiring the extremely hazardous substance or within sixty days after adoption or amendment of the rule, as appropriate.
(C) Upon the request of the committee having jurisdiction, the owner or operator of a facility identified in division (A) of this section shall promptly provide to the committee the information necessary for developing and implementing the chemical emergency response and preparedness plan for the district.

(D) An agricultural producer who has complied with section 302 of the “Emergency Planning and Community Right-To-Know Act of 1986,” 100 Stat. 1730, 42 U.S.C.A. 11002, and divisions (B) and (C) of this section is not subject to the requirements of sections 3750.07 and 3750.08 of the Revised Code nor to the payment of filing fees under division (A) of section 3750.13 of the Revised Code with respect to his agricultural production activities.

(E) No owner or operator of a facility shall fail to comply with this section or an order issued under division (A) of this section.

3750.06 Notice of hazardous release.

(A) The owner or operator of a facility where a hazardous chemical is produced, used, or stored and from which a release of an extremely hazardous substance or hazardous substance occurs in an amount equal to or exceeding the reportable quantity prescribed in rules adopted under division (B)(1)(c) or (C)(5) of section 3750.02 of the Revised Code shall provide the notices required by divisions (C) and (D) of this section. The owner or operator of any facility from which a release of oil occurs in an amount equal to or exceeding the reportable quantity prescribed in rules adopted under division (B)(3) of section 3750.02 of the Revised Code shall provide the notices required by divisions (C) and (D) of this section.

(B) The owner or operator of a vessel from which a release of a hazardous substance or an extremely hazardous substance occurs in an amount equal to or exceeding the reportable quantity prescribed in rules adopted under division (B)(1)(c) or (C)(5) of section 3750.02 of the Revised Code, or from which a release of oil occurs in an amount equal to or exceeding the reportable quantity prescribed in rules adopted under division (B)(3) of section 3750.02 of the Revised Code, shall provide the notices required by divisions (C) and (D) of this section, except that those notices need be provided to only the director of environmental protection or his designated representative. Upon receiving a verbal emergency notice under this division, the director or his representative shall immediately notify the community emergency coordinator of the emergency planning district in which the release occurred of the release. Upon receipt of a written follow-up emergency notice or revised written follow-up emergency notice under division (D) of this section, the director or his representative shall immediately send a copy of it to that community emergency coordinator.

(C) Except as provided in division (E) of this section, if any release described in division (A) or (B) of this section occurs, the owner or operator of the facility or vessel from which the release occurred shall immediately notify verbally, by telephone, radio, or in person, the community emergency coordinator of each emergency planning district that contains an area likely to be affected by the release, the fire department having jurisdiction where the release occurred, and the director of environmental protection or his designated representative. Upon receiving a verbal emergency notice under this division, the director or his representative shall immediately notify the community emergency coordinator of the emergency planning district in which the release occurred of the release. Upon receipt of a written follow-up emergency notice or revised written follow-up emergency notice under division (D) of this section, the director or his representative shall immediately send a copy of it to that community emergency coordinator.

(1) The location of the release;
(2) The chemical name or identity of any substance involved in the release and whether the substance is an extremely hazardous substance;
(3) An estimate of the quantity of any substance released into the environment;
(4) The time and duration of the release;
(5) The environmental medium or media into which the substance was released;
(6) Any known or anticipated acute or chronic health risks associated with the release and, if known to the informant, advice regarding medical attention necessary for individuals exposed to the substance released;

(7) Proper precautions to take as a result of the release, including evacuation and other proposed response actions, unless that information is readily available to the community emergency coordinator pursuant to the plan of the district prepared under section 3750.04 of the Revised Code;

(8) The name and telephone number of the person or persons to be contacted for further information;

(9) Such other information as may be required by rules adopted under division (B)(1)(f) of section 3750.02 of the Revised Code.

(D) As soon as practicable but not later than thirty days after the release, the owner or operator of a facility or vessel from which a release described in division (A) or (B) of this section occurred shall submit to the committee of the district in which the release occurred and to the director or his designated representative a written, follow-up emergency notice of the release setting forth and updating the information provided in the verbal notice given under division (C) of this section and including all of the following additional information:

(1) Actions taken to respond to and contain the release;

(2) Any known or anticipated acute or chronic health risks associated with the release;

(3) Where appropriate, advice regarding medical attention necessary for individuals exposed to the substance released;

(4) A summary of all actions taken by the owner or operator to prevent a recurrence of the release. Any information submitted pursuant to division (D)(4) of this section is subject to Evidence Rule 407.

(5) Such other information as is required by rules adopted under division (B)(1)(f) of section 3750.02 of the Revised Code.

If significant additional information about a release becomes known during the period between submission of the written report required by this division and one year after the release, the owner or operator shall submit to the committee and the director or his authorized representative an updated written notice within three days after learning the additional information.

(E) This section does not apply to any release of an extremely hazardous substance, hazardous substance, or oil from a facility that results in exposure to persons solely within the site or sites on which the facility is located.

(F) No person shall fail to provide any verbal or written release notification or to update a written release notification required by this section and by rules adopted under division (B)(1)(f) of section 3750.02 of the Revised Code.

3750.07 Reporting of hazardous chemicals.

(A) Except as otherwise authorized in division (E) of this section, any person who owns or operates a facility and is required to prepare or have available a material safety data sheet for a hazardous chemical under the "Occupational Safety and Health Act of 1970," 84 Stat. 1590, 29 U.S.C.A. 651, as amended, and regulations adopted under it shall, within thirty days after the effective date of this section, submit to the local emergency planning committee of the emergency planning district in which the facility is located, the emergency response commission, and the fire department having jurisdiction over the facility, a list of any hazardous chemicals that are produced, used, or stored at the facility in an amount that equals or exceeds the threshold quantity applicable to the hazardous chemical established by rules adopted under division (B)(1)(b) of section 3750.02 of the Revised Code. The hazardous chemicals shall be grouped together on any such list by the categories of health and physical hazards prescribed in.
rules adopted under that division. The list shall include all of the following:

(1) A listing of the hazardous chemicals in the manner prescribed by rules adopted under division (B)(1)(d) of section 3750.02 of the Revised Code including chemical abstract service numbers and alphabetical groupings of the chemicals;

(2) The chemical name or common name of each such chemical and any hazardous component thereof;

(3) Any hazardous component of each hazardous chemical on the list that comprises more than one per cent by weight of the hazardous chemical or, if the hazardous component is a carcinogen, comprises more than one-tenth of one per cent by weight of the hazardous chemical;

(4) For each hazardous chemical, an indication as to whether the owner or operator chooses to withhold information about it from disclosure as a trade secret and, if so, whether the owner or operator has filed a claim with the administrator of the United States environmental protection agency for protection of that information as a trade secret pursuant to rules adopted under division (B)(2)(d) of section 3750.02 of the Revised Code or with the commission pursuant to rules adopted under division (B)(5) of that section, as appropriate;

(5) Any other information required by rules adopted under division (B)(1)(d) of section 3750.02 of the Revised Code.

(B) The owner or operator of a facility may meet the requirements of division (A) of this section for a hazardous chemical that consists of a mixture of hazardous chemicals by doing either of the following:

(1) Providing the information required by division (A) of this section for each component in the mixture that is a hazardous chemical. If the owner or operator reports on this basis, the quantity of each hazardous chemical in the mixture shall be determined by multiplying by the weight of the mixture the concentration of the hazardous chemical in the mixture that comprises more than one per cent of the mixture by weight or, if the chemical is a carcinogen, more than one-tenth of one per cent by weight.

(2) Providing the information required by division (A) of this section on the mixture itself, provided that the owner's or operator's reporting of mixtures on this basis is consistent with his reporting of mixtures under section 3750.08 of the Revised Code. If the owner or operator reports on this basis, the total quantity of the mixture shall be reported.

(C) Upon the request of the committee of the district in which a facility is located or the commission, the owner or operator of a facility subject to this section shall, within thirty days after receiving the request, submit to the committee or commission the material safety data sheet for any hazardous chemical on the list submitted by the owner or operator under division (A), (D), or (E) of this section. Upon the request of any person, a committee shall make available to that person the material safety data sheet for any hazardous chemical identified in a list submitted to the committee under division (A), (D), or (E) of this section. If the committee does not have the requested material safety data sheet, it shall request the sheet from the owner or operator of the facility who listed the chemical for which the sheet was requested. The owner or operator shall submit the sheet to the commission or committee within thirty days after receiving the commission's or committee's request. Upon receiving the sheet, the committee shall make it available to the person who requested it. When making material safety data sheets available to persons requesting them, the committee shall protect from disclosure trade secret information that is subject to protection under division (B)(14) of section 3750.02 of the Revised Code and rules adopted under divisions (B)(1)(i) and (B)(2)(d) of that section.

(D) Except as otherwise authorized in division (E) of this section, within three months after the discovery of new information about a hazardous chemical identified in the list required by division (A) of this section, within three months after obtaining a hazardous chemical for which reporting is required by division (A) of this section, or within three months after adoption of a rule under division (C)(5) of section 3750.02 of the Revised Code identifying or listing an
additional hazardous chemical which is produced, used, or stored at his facility in an amount equal to or exceeding the threshold quantity for the hazardous chemical established by those rules, the owner or operator of a facility shall prepare and submit to the commission and to the committee and fire department having jurisdiction over the facility a revised list that meets the requirements of that division and contains the new information. If the owner or operator submits a revised list due to discovery of new information about a hazardous chemical on the current list for which the committee or the commission had requested a material safety data sheet, the owner or operator shall also submit a revised material safety data sheet to the committee or commission, as appropriate.

(E) The owner or operator of any facility at which no more than ten hazardous chemicals are produced, used, or stored in an amount that exceeds the threshold quantity applicable to the hazardous chemical established by rules adopted under division (B)(1)(b) or (C)(5) of section 3750.02 of the Revised Code may submit to the commission and the committee and fire department having jurisdiction over the facility the material safety data sheets applicable to those chemicals instead of the list required under division (A) of this section. If an owner or operator who submitted material safety data sheets under this division discovers new information about a hazardous chemical for which a material safety data sheet was so submitted, he shall submit a revised material safety data sheet for the hazardous chemical to the commission, committee, and fire department within three months after discovery of the new information. If an owner or operator who has submitted material safety data sheets for nine or fewer hazardous chemicals under this division obtains a hazardous chemical for which reporting is required under division (A) of this section or, pursuant to division (D) of this section, is first required to report a hazardous chemical identified or listed by rules adopted under division (C)(5) of section 3750.02 of the Revised Code, he shall submit a material safety data sheet for it to the commission, committee, and fire department within three months after obtaining the hazardous chemical or adoption of the rule identifying or listing the hazardous chemical. If an owner or operator who has submitted material safety data sheets for ten hazardous chemicals under this division obtains a hazardous chemical for which reporting is required under division (A) of this section or is first required under division (D) of this section, he shall, within three months after obtaining the hazardous chemical or adoption of the rule identifying or listing the hazardous chemical, prepare and submit a list containing the information required in that division for all of the hazardous chemicals stored, handled, or processed at the facility for which reporting is required under that division.

(F) No owner or operator of a facility where a hazardous chemical is stored, handled, or processed in an amount that exceeds the threshold quantity for the hazardous chemical established in rules adopted under division (B)(1)(b) or (C)(5) of section 3750.02 of the Revised Code shall fail to:

(1) Submit either the list of hazardous chemicals required to be submitted and containing the information required by division (A) of this section or to submit material safety data sheets for the hazardous chemicals in compliance with division (E) of this section;

(2) Comply with a request to provide a material safety data sheet as required by division (B) of this section;

(3) Submit either a revised list of hazardous chemicals or a revised material safety data sheet as required by division (D) of this section or to submit a list, material safety data sheet, or revised material safety data sheet in compliance with division (E) of this section.

3750.08 Inventory form for hazardous chemicals.

(A) Each owner or operator of a facility who is required to prepare or have available a material safety data sheet for a hazardous chemical under the "Occupational Safety and Health Act of 1970," 84 Stat. 1590, 29 U.S.C.A. 651, as amended, and regulations adopted under it, or
who is required to submit a list under division (A), (D), or (E), or is authorized to submit material safety data sheets instead of that list under division (E), of section 3750.07 of the Revised Code and who had present at the facility during the preceding calendar year an amount of a hazardous chemical exceeding the applicable threshold quantity established by rules adopted under division (B)(1)(b) or (C)(5) of section 3750.02 of the Revised Code, shall annually by the first day of March submit to the local emergency planning committee of the emergency planning district in which the facility is located, the emergency response commission, and the fire department having jurisdiction over the facility an emergency and hazardous chemical inventory form containing tier I information as prescribed in divisions (A)(1) to (4) of this section. The owner or operator may instead submit an inventory form containing tier II information as prescribed in divisions (B)(1) to (7) of this section for any hazardous chemical present at the facility. If the commission, committee, or fire department having jurisdiction over a facility has requested under division (B) of this section that the owner or operator of a facility submit an inventory form containing tier II information as prescribed in that division, the owner or operator shall by the first day of March of each year subsequent to that request submit to the commission, committee, and fire department an inventory form containing tier II information as prescribed in divisions (B)(1) to (7) of this section instead of an inventory form containing the tier I information prescribed in this division, until such time as the commission authorizes the owner or operator to resume the annual submission of an inventory form containing tier I information. An owner or operator who has been so required to annually submit an inventory form containing tier II information may, at any time, request the commission to authorize the owner or operator to resume annual submission of an inventory form containing tier I information.

The emergency and hazardous chemical inventory form shall include as tier I information all of the following information with respect to each hazardous chemical that was present at the facility during the preceding calendar year in an amount exceeding the applicable threshold quantity:

1. An estimate of the maximum amount in pounds of the hazardous chemicals in each category established in rules adopted under division (B)(1)(b) or (C)(5) of section 3750.02 of the Revised Code that were present at the facility at any time during the preceding calendar year. The estimate for each such category shall be provided in the appropriate reporting range established by those rules.
2. An estimate of the average daily amount in pounds of the hazardous chemicals in each such category that were present at the facility during the preceding calendar year. The estimate for each such category shall be provided in the appropriate reporting range established by those rules.
3. The general location at the facility of hazardous chemicals in each category;
4. Any other information required by rules adopted under division (B)(1)(e) of section 3750.02 of the Revised Code.

(B) Upon the request of the commission or the committee or fire department having jurisdiction over the facility, the owner or operator of a facility that is subject to this section shall submit an emergency and hazardous chemical inventory form containing tier II information as prescribed in divisions (B)(1) to (7) of this section within thirty days after receiving the request.

An emergency and hazardous chemical inventory form shall include as tier II information the following additional information for each hazardous chemical that was present at the facility during the preceding calendar year in an amount exceeding the applicable threshold quantity:

1. The chemical name or common name of the hazardous chemical as provided on the material safety data sheet and its chemical abstract service number;
2. An estimate of the maximum amount in pounds of the hazardous chemical that was present at the facility at any time during the preceding calendar year. The estimate shall be provided in the appropriate reporting range established by rules adopted under division (B)(1)(b) of section 3750.02 of the Revised Code.
(3) An estimate in pounds of the average daily amount of the hazardous chemical that was present at the facility during the preceding calendar year. The estimate shall be provided in the appropriate reporting range established by those rules.

(4) A brief description of the manner of storage of the hazardous chemical;

(5) The location at the facility of the hazardous chemical;

(6) An indication as to whether the owner or operator chooses to withhold information about the hazardous chemical from disclosure as a trade secret and, if so, whether he has filed a claim with the administrator of the United States environmental protection agency for protection of that information as a trade secret pursuant to rules adopted under division (B)(2)(d) of section 3750.02 of the Revised Code or with the commission pursuant to rules adopted under division (B)(5) of that section, as appropriate;

(7) Any other information required by rules adopted under division (B)(1)(e) of section 3750.02 of the Revised Code.

If the commission has not prescribed emergency and hazardous chemical inventory forms, the owner or operator shall submit the information required by divisions (A)(1) to (4) or (B)(1) to (7) of this section to the commission by letter.

(C) No owner or operator of a facility where a hazardous chemical is produced, used, or stored in an amount that exceeds the threshold quantity for the chemical established in rules adopted under division (B)(1)(b) or (C)(5) of section 3750.02 of the Revised Code shall fail to submit:

(1) An emergency and hazardous chemical inventory form containing tier I information as required by division (A) of this section;

(2) An emergency and hazardous chemical inventory form containing tier II information in compliance with division (B) of this section when requested to do so under that division or when required to do so under division (A) of this section.

3750.081 Satisfying filing mandate.

(A) Notwithstanding any provision in this chapter to the contrary, an owner or operator of a facility that is regulated under Chapter 1509 of the Revised Code shall be deemed to have satisfied all of the inventory requirements established under this chapter, except for the release reporting requirements established under section 3750.06 of the Revised Code, by complying with the requirements established in section 1509.231 of the Revised Code.

(B) The emergency response commission and every local emergency planning committee and fire department in this state shall establish a means by which to access, view, and retrieve information from the electronic database maintained by the division of oil and gas resources management in the department of natural resources in accordance with section 1509.231 of the Revised Code. With respect to facilities regulated under Chapter 1509 of the Revised Code, the database shall be the means of providing and receiving the information described in division (A) of this section.

6109.32 EPA violations and penalties; director's investigation.

The director of environmental protection may on the director's own initiative investigate or make inquiries into any suspected violation of section 6109.31 of the Revised Code.

The attorney general, upon written request by the director, shall bring an action for injunction or other appropriate civil action or criminal prosecution against any person violating or threatening to violate that section. In an action for injunction to enforce any final order of the director, the finding by the director, after hearing, is prima-facie evidence of the facts found therein.
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6109.99 EPA violations; penalties.

(A) Except as provided in division (C) of this section, whoever recklessly violates section 6109.31 of the Revised Code is guilty of a misdemeanor and, notwithstanding section 2929.28 of the Revised Code, shall be fined not more than ten thousand dollars or imprisoned for not more than four years, or both. Each day of violation constitutes a separate offense.

(B) Whoever knowingly violates division (B), (C), or (D) of section 6109.31 of the Revised Code is guilty of a felony and, notwithstanding section 2929.18 of the Revised Code, shall be fined not more than twenty-five thousand dollars or imprisoned for not more than four years, or both. Each day of violation constitutes a separate offense.

(C) Whoever recklessly or knowingly violates division (A) of section 6109.31 of the Revised Code is guilty of a felony if the violation poses a significant threat to or causes significant harm to public health and, notwithstanding section 2929.18 of the Revised Code, shall be fined not more than twenty-five thousand dollars or imprisoned for not more than four years, or both. Each day of violation constitutes a separate offense.

6111.02 EPA violations and penalties; definitions.

As used in this section and sections 6111.021 to 6111.028 of the Revised Code:

(A) “Category 1 wetland,” “category 2 wetland,” or “category 3 wetland” means a category 1 wetland, category 2 wetland, or category 3 wetland, respectively, as described in rule 3745-1-54 of the Administrative Code, as that rule existed on July 17, 2001, and as determined to be a category 1, category 2, or category 3 wetland, respectively, through application of the “Ohio rapid assessment method for wetlands version 5.0,” including the Ohio rapid assessment method for wetlands version 5.0 quantitative score calibration dated August 15, 2000, unless an application for a section 401 water quality certification was submitted prior to February 28, 2001, in which case the applicant for the permit may elect to proceed in accordance with Ohio rapid assessment method for wetlands version 4.1.

(B) “Creation” means the establishment of a wetland where one did not formerly exist and that involves wetland construction on nonhydric soils.

(C) “Enhancement” means activities conducted in an existing wetland to improve or repair existing or natural wetland functions and values of that wetland.

(D) “Fill material” means any material that is used to fill an aquatic area, to replace an aquatic area with dry land, or to change the bottom elevation of a wetland for any purpose and that consists of suitable material that is free from toxic contaminants in other than trace quantities. “Fill material” does not include either of the following:

1. Material resulting from normal farming, silviculture, and ranching activities, such as plowing, cultivating, seeding, and harvesting, for the production of food, fiber, and forest products;

2. Material placed for the purpose of maintenance of existing structures, including emergency reconstruction of recently damaged parts of currently serviceable structures such as dikes, dams, levees, groins, riprap, breakwaters, causeways, and bridge abutments or approaches, and transportation structures.

(E) “Filling” means the addition of fill material into a wetland for the purpose of creating upland, changing the bottom elevation of the wetland, or creating impoundments of water. “Filling” includes, without limitation, the placement of the following in wetlands: fill material that is necessary for the construction of any structure; structures or impoundments requiring rock, sand, dirt, or other material for its construction; site-development fills for recreational, industrial, commercial, residential, or other uses; causeways or road fills; dams and dikes; artificial islands, property protection, or reclamation devices such as riprap, groins, seawalls, breakwalls, and bulkheads and fills; beach nourishment; levees; sanitary landfills; fill material for structures such
as sewage treatment facilities, intake and outfall pipes associated with power plants, and underwater utility lines; and artificial reefs.

(F) “Isolated wetland” means a wetland that is not subject to regulation under the Federal Water Pollution Control Act.

(G) “Mitigation” means the restoration, creation, enhancement, or, in exceptional circumstances, preservation of wetlands expressly for the purpose of compensating for wetland impacts.

(H) “Mitigation bank service area” means the designated area where a mitigation bank can reasonably be expected to provide appropriate compensation for impacts to wetlands and other aquatic resources and that is designated as such in accordance with the process established in 33 C.F.R. 332.8 and 40 C.F.R. 230.98.

(I) “Off-site mitigation” means wetland restoration, creation, enhancement, or preservation occurring farther than one mile from a project boundary, but within the same watershed.

(J) “On-site mitigation” means wetland restoration, creation, enhancement, or preservation occurring within and not more than one mile from the project boundary and within the same watershed.

(K) “Practicable” means available and capable of being executed with existing technology and without significant adverse effect on the economic feasibility of the project in light of the overall project purposes and in consideration of the relative environmental benefit.

(L) “Preservation” means the long-term protection of ecologically important wetlands through the implementation of appropriate legal mechanisms to prevent harm to the wetlands. “Preservation” may include protection of adjacent upland areas as necessary to ensure protection of a wetland.

(M) “Restoration” means the reestablishment of a previously existing wetland at a site where it has ceased to exist.

(N) “State isolated wetland permit” means a permit issued in accordance with sections 6111.02 to 6111.027 of the Revised Code authorizing the filling of an isolated wetland.

(O) “Watershed” means an eight-digit hydrologic unit.

(P) “Wetlands” means those areas that are inundated or saturated by surface or ground water at a frequency and duration that are sufficient to support, and that under normal circumstances do support, a prevalence of vegetation typically adapted for life in saturated soil conditions. “Wetlands” includes swamps, marshes, bogs, and similar areas that are delineated in accordance with the 1987 United States army corps of engineers wetland delineation manual and any other procedures and requirements adopted by the United States army corps of engineers for delineating wetlands.

(Q) “Wetland mitigation bank” means a site where wetlands have been restored, created, enhanced, or, in exceptional circumstances, preserved expressly for the purpose of providing mitigation for impacts to wetlands and that has been approved in accordance with the process established in 33 C.F.R. 332.8 and 40 C.F.R. 230.98.

(R) “Eight-digit hydrologic unit” means a common surface drainage area corresponding to one from the list of thirty-seven adapted from the forty-four cataloging units as depicted on the hydrologic unit map of Ohio, United States geological survey, 1988, and as described in division (F)(2) of rule 3745-1-54 of the Administrative Code or as otherwise shown on map number 1 found in rule 3745-1-54 of the Administrative Code. “Eight-digit hydrologic unit” is limited to those parts of the cataloging units that geographically lie within the borders of this state.

(S) “In-lieu fee mitigation” means a payment made by an applicant to satisfy a wetland mitigation requirement established in sections 6111.02 to 6111.027 of the Revised Code.
3750-25-25 Release notification requires.

[Editor’s Note: The “Comment” portion of the following regulation is part of the official provision.]

[Comment: For dates of non-regulatory government publications, publications of recognized organizations and associations, federal rules, and federal statutory provisions referenced in this rule, see paragraph (YY) of rule 3750-1-01 of the Administrative Code titled “Referenced materials.”]

(A) An owner or operator of a facility or vessel where a hazardous chemical is stored and from which a release of a hazardous substance, extremely hazardous substance, or discharge of oil into the environment has occurred in an amount equal to or exceeding the reportable quantity as set forth under rules 3750-20-50, 3750-20-30, and 3750-25-20 of the Administrative Code in any twenty-four hour period has occurred, shall provide both verbal and written notices in accordance with paragraphs (A)(1) and (A)(2) of this rule.

(1) Verbal release notification requirements:

(a) Except as provided in paragraph (B) of rule 3750-25-01 of the Administrative Code, if a release or discharge as described in paragraph (A) of this section occurs, the owner or operator of the facility from which the release or discharge has occurred shall immediately notify verbally, by telephone, radio, or in person, the community emergency coordinator of each local emergency planning district that contains an area likely to be affected by the release or discharge, the fire department having jurisdiction where the release occurred, and the Ohio EPA environmental response unit at 800-282-9378 or 614-224-0946. For facilities regulated pursuant to Chapter 1509 of the Revised Code, the reporting person, as defined by rule 1501:9-8-01 of the Administrative Code shall provide verbal notification to 1-844-OHCALL1. The verbal notification shall be given within thirty minutes after a person at the facility has knowledge of the release or discharge, unless notification within that time is impracticable under the circumstances. In the event a committee does not exist for that emergency planning district in which the release or discharge occurred, notification shall be provided under this section to the Ohio EPA environmental response unit at 800-282-9378 or 614-224-0946, or to 1-844-OHCALL1 for facilities regulated pursuant to Chapter 1509 of the Revised Code, and to the fire department having jurisdiction over the facility. Ohio EPA or Ohio department of natural resources may provide notification to the appropriate local emergency response personnel.

(b) An owner or operator of a vessel from which a release of a hazardous substance, extremely hazardous substance, or discharge of oil has occurred in an amount equal to or exceeding the reportable quantity as set forth under rules 3750-20-50, 3750-20-30 and 3750-25-20 of the Administrative Code shall provide verbal notice within thirty minutes after a person aboard the vessel has knowledge of the release or discharge to the Ohio EPA environmental response unit at 800-282-9378 or 614-224-0946. Upon receiving verbal notification, the Ohio EPA environmental response unit shall immediately notify the community emergency coordinator of the emergency planning district in which the release or discharge occurred. In the event a committee does not exist for the emergency planning district in which the release or discharge occurred, the Ohio EPA environmental response unit may provide notification to the appropriate local emergency response personnel.

(c) An owner or operator, or reporting person as defined by rule 1501:9-8-01 of the Administrative Code for facilities regulated pursuant to Chapter 1509 of the Revised Code, of a facility from which there is a transportation-related release of a hazardous substance, extremely hazardous substance or discharge of oil in an amount equal to or exceeding the reportable quantity as set forth under rules 3750-20-50, 3750-20-30, and 3750-25-20 of the Administrative Code shall provide verbal notice within thirty minutes after a person at the facility has knowledge of the release or discharge to the Ohio EPA, environmental response unit at 800-282-9378 or 614-224-0946 or to 1-844-OHCALL1 for facilities regulated pursuant to Chapter 1509 of the
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Revised Code, and to the 911 operator, or in the absence of a 911 emergency telephone number, to the operator. The Ohio EPA environmental response unit or Ohio department of natural resources, as applicable, may immediately notify the community emergency coordinator of the emergency planning district in which the release or discharge occurred. In the event a committee does not exist for the emergency planning district in which the release or discharge occurred, the Ohio EPA environmental response unit or Ohio department of natural resources, as applicable, may provide notification to the appropriate local emergency response personnel.

For purposes of this rule, “transportation related releases” means a release or discharge during transportation, or storage, incidental to transportation if the stored substance is moving under active shipping papers and has not reached the ultimate consignee.

(d) The verbal notification required under this rule shall be given within thirty minutes after a person at the facility or aboard a vessel has knowledge of the release or discharge, unless notification is impracticable under the circumstances. To the extent known at the time notice is given and that response to the release or discharge will not be delayed, the verbal notice shall include all of the following information:

(i) The location and source of the release or discharge.

(ii) The chemical name or identity of any substance involved in the release or discharge and whether the substance is an extremely hazardous substance.

(iii) An estimate of the quantity (in gallons or pounds) of any substance released or discharged into the environment.

(iv) The time and duration of the release or discharge.

(v) The environmental medium or media into which the substance was released or discharged and the extent of the release or discharge.

(vi) Any known or anticipated acute or chronic health risks associated with the release or discharge and, if known to the informant, advice regarding medical attention necessary for individuals exposed to the substance released or discharge.

(vii) Proper precautions to take as a result of the release or discharge, including evacuation and other proposed response actions, unless that information is readily available to the community emergency coordinator pursuant to the plan of the district prepared under section 3750.04 of the Revised Code.

(viii) The name and telephone number of the person or persons to be contacted for further information.

(2) Written release notification requirements:

(a) As soon as practicable but no later than thirty days after the release, the owner or operator, or reporting person as defined by rule 1501:9-8-01 of the Administrative Code for facilities regulated pursuant to Chapter 1509 of the Revised Code, of a facility from which a release or discharge occurred who was required to provide verbal notice under paragraph (A)(1) of this rule, shall submit to the Ohio EPA, or Ohio department of natural resources for facilities regulated pursuant to Chapter 1509 of the Revised Code, and to the committee of the planning district in which the release or discharge occurred, a written follow-up emergency notice for the release or discharge.

An owner or operator of a vessel from which a release or discharge occurred who was required to provide verbal notice under paragraph (A)(1)(b) of this rule shall submit a written follow-up emergency notice to the Ohio EPA pursuant to this rule. After the receipt of written follow-up emergency notice or revised written follow-up emergency notice, the Ohio EPA shall immediately send a copy of it to that community emergency coordinator for that emergency planning district in which the release or discharge occurred.

(b) The written follow-up emergency notice shall set forth and update the verbal notice given under paragraph (A)(1)(d) of this rule and shall include all of the following additional information (mandatory information):

(i) Complete name, mailing address, and telephone number of the owner or operator of
the facility from which the release occurred.

(ii) Actual time, date and duration of the release or discharge.

(iii) Actual time and date of discovery of the release or discharge.

(iv) Actions taken to respond to and contain the release or discharge.

(v) Indicate the Ohio EPA spill number and the national response center case number on submitted information.

(vi) Location of the facility from which the release or discharge occurred (street or mailing address).

(vii) Location of the release or discharge (street, county, township, city). Longitude and latitude, if known, or distance and direction from the nearest intersection or milepost if transportation related release or discharge.

(viii) Chemical name (common name or technical name) and chemical abstracts service registry number of the substance involved in the release or discharge.

(ix) Specifically identify all of the environmental medium or media impacted and the extent of impact:

(a) Name of waterway and length of area affected.

(b) If no water was affected then indicate surface area in square feet or yards.

(c) If the release or discharge was monitored, indicate the method of detection, concentrations, and wind direction and speed if the release was airborne.

(d) Amount recovered or neutralized. If neutralized, describe the method of neutralization.

(e) Describe any actions taken to reduce the impact of the release or discharge.

(x) Provide a chronological summary of the incident. Include a chronology of communications with state and local government agencies.

(xi) Provide manifest, bills of lading, laboratory analyses which were generated by the owner and operator of the facility and are germane to the incident.

(xii) Describe any extenuating circumstances which caused the release or discharge.

(xiii) Describe any known or anticipated acute or chronic health risks associated with the release or discharge.

(xiv) Where appropriate, advice regarding medical attention necessary for individuals exposed to the substance released or discharged.

(xv) A summary of all actions taken by the owner or operator to prevent a recurrence of the release or discharge.

(xvi) An owner or operator of a facility or vessel from which a release or discharge occurred may submit the following additional information (voluntary information) in the written follow up emergency notice as provided pursuant to paragraph (A)(2) of this rule.

(a) Indicate any air, water or other permit numbers which may be pertinent to this incident and to the efficient/emission limitations which may apply.

(b) To the extent information is available, identify damage to wildlife or vegetation.

(c) To the extent information is available, identify impact to human health and safety (evacuations, human exposure, death, or seen as injuries).

(d) Economic impact.

(i) Estimate the dollar value, if any, of the released or discharged product.

(ii) Estimate the replacement or repair cost of the of equipment replacement or repair.

(iii) Estimate the costs of cleanup.

(c) If significant additional information regarding the mandatory or voluntary information submitted about a release or discharge becomes known during the period between submission of the written report required by this section and one year after the release or discharge, the owner or operator shall submit to the committee and the Ohio EPA or Ohio department of natural resources for facilities regulated pursuant to Chapter 1509 of the Revised Code an updated written notice within three days after learning of the additional information.
(B) No person shall fail to provide verbal or written release notification or to update a written release notification as required by this rule. Failure to report under this rule may subject any person to civil or criminal penalties as provided under sections 3750.20 and 3750.99 of the Revised Code.

3750-30-01 Facilities subject to hazardous chemical reporting requirements.

[Editor’s Note: The “Comment” portion of the following regulation is part of the official provision.]

[Comment: For dates of non-regulatory government publications, publications of recognized organizations and associations, federal rules, and federal statutory provisions referenced in this rule, see paragraph (YY) of rule 3750-1-01 of the Administrative Code titled “Referenced materials.”]

(A) A facility that meets both of the following criteria is subject to hazardous chemical reporting under rules 3750-30-15 and 3750-30-20 of the Administrative Code:

(1) Any facility whose owner or operator is required to prepare or have available a “Material Safety Data Sheet (MSDS)” for a hazardous chemical under the Occupational Safety and Health Act of 1970, 29 USC 651 to 678, as amended, and regulations adopted thereunder.

(2) The facility has present an amount of any one or more hazardous chemical equal to or exceeding the threshold quantity established under rule 3750-30-27 of the Administrative Code.

(B) An agricultural producer, as defined in paragraph (B) of rule 3750-1-01 of the Administrative Code, who has complied with section 302 of the Emergency Planning and Community Right-To-Know Act of 1986, and divisions (B) and (C) of section 3750.05 of the Revised Code, is not a facility subject to this rule with respect to the producer’s agricultural activities.

(C) This chapter does not apply to the transportation, including the storage incident to such transportation, of any substance or chemical subject to the requirements of this chapter, including transportation and distribution of natural gas.

(D) A retail gas station, which is engaged in selling gasoline or diesel fuel principally to the general public for motor vehicle use on land, with gasoline or diesel fuel stored entirely underground, in compliance with all applicable underground storage (UST) requirements and with quantities of gasoline and/or diesel fuel that do not exceed the quantities specified in rule 3750-30-27 of the Administrative Code is not a facility subject to the reporting requirements under rules 3750-30-15 and 3750-30-20 of the Administrative Code.

(E) An owner or operator of a facility regulated under 1509, of the Revised Code and that is an oil and gas extraction storage facility as defined in paragraph (BB) of rule 3750-1-01 of the Administrative Code shall prepare and submit to the chief of the division of oil and gas resources management, Ohio department of natural resources, on or before the first day of March of each year, information that shall contain the information consistent with the information that is required to be submitted under the “Emergency Planning and Community Right-to-Know Act of 1986 and regulations adopted thereunder, for the last preceding calendar year. An owner or operator of such a facility who has reported the information to the chief of the division of oil and gas resources management as directed under 1509.231 of the Revised Code shall be deemed to have satisfied the reporting requirements under section 3750.07 and 3750.08 of the Revised Code, but is still subject to the reporting requirements under sections 3750.06 and 3750.13 of the Revised Code.

3750-30-20 Facility emergency and hazardous chemical inventory form.

[Editor’s Note: The “Comment” portion of the following regulation is part of the official provision.]
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[Comment: For dates of non-regulatory government publications, publications of recognized organizations and associations, federal rules, and federal statutory provisions referenced in this rule, see paragraph (YY) of rule 3750-1-01 of the Administrative Code titled “Referenced materials.”]

(A) Each owner or operator of a facility that is subject to rule 3750-30-01 of the Administrative Code shall annually prepare a facility emergency and hazardous chemical inventory report containing the information as defined in paragraphs (B) to (D) of this rule using either forms prescribed by the commission or via electronic submission as prescribed by the commission. The owner or operator of a facility subject to this rule shall annually submit this report on or before of March first of each year to each of the following:

(1) The local emergency planning committee of the emergency planning district in which the facility is located.
(2) The commission.
(3) The fire department having jurisdiction over the facility.
[Comment: Ohio's commission has adopted a resolution requesting the submission of tier II information on Ohio's approved forms. In addition to the requirements in paragraph (A) of this rule, each owner or operator must submit an annual inventory filing fee and facility annual chemical inventory fee worksheet (EPA 0320) as prescribed in rule 3750-50-01 of the Administrative Code to the commission.]

(B) An owner or operator of a facility that is subject to rule 3750-30-01 of the Administrative Code shall submit facility identification information that includes, but is not limited to, the following:

(1) The calendar year of the reporting period.
(2) An indication whether the information being reported on page one of the form is identical to that submitted last year.
(3) The complete name and address of the location of the facility (include the full street address or state road, city, county, state and zip code), latitude and longitude.
(4) An indication if the location of the facility is manned or unmanned.
(5) An estimate of the maximum number of occupants present at any one time. If the location of the facility is unmanned, check the box marked N/A, not applicable.
(6) The phone number of your facility (optional).
(7) The “North American Industry Classification System (NAICS)” code for your facility.
(8) The “Dun & Bradstreet” number of your facility.
(9) Facility identification numbers assigned under the “Toxic Release Inventory (TRI)” and risk management program. If the facility has not been assigned an identification number under these programs or if the facility is not subject to reporting under these programs, check the box marked N/A, not applicable.
(10) An indication if the facility is subject to the emergency planning notification requirement under section 3750.05 of the Revised Code.
(11) An indication whether the facility is subject to the chemical accident prevention requirements under section 112(r) of the Clean Air Act (CAA), codified in 40 CFR part 68, chemical accident prevention provisions, also known as the risk management program.
(12) The name, mailing address, phone number and email address of the owner or operator of the facility.
(13) The name, title, phone number, twenty four-hour phone number and email address of the facility emergency coordinator, if applicable.
(14) The name, title, phone number and email address of the person to contact regarding information contained in the tier II form.
(15) The name, title, phone number and email address of at least one local individual that can act as a referral if emergency responders need assistance in responding to a chemical
accident at the facility. An emergency phone number which will be available twenty four hours a
day, every day shall also be provided.

(16) A certification signed by owner or operator or an officially designated representative
who certifies that the information submitted on this document has been personally examined
and that the representative is familiar with the information submitted on this document and
based upon inquiry of those individuals responsible for obtaining the information, it is believed
that the submitted information is true, accurate and complete as follows: “I certify under penalty
of law that I have personally examined and am familiar with the information and based on my
inquiry of those individuals responsible for obtaining the information, I believe that the submitted
information is true, accurate and complete.” This certification shall be accompanied by the full
name, official title, signature, date signed, and total number of pages in the submission. All other
pages shall also contain the signature or signature stamp, the date the certification was signed,
and the total number of pages in the submission.

(C) In addition to the above listed information in paragraph (B) of this rule, an owner or
operator is requested to submit the following additional information applicable to the facility:

(1) The name, mailing address, phone number, “Dun & Bradstreet” number and e-mail of
the facility’s parent company.

(2) Any Ohio EPA identification number assigned to a facility, as may be required
pursuant to the “Resource Conservation and Recovery Act” (RCRA), contained in 42 USC
Section 6901 to 6992K.

(3) Any permit held by a facility under the “National Pollution Discharge Elimination
System” (NPDES) issued pursuant to state or federal authority under the “Clean Water Act”
contained in 33 USC Section 1251 to 1387 and Chapter 6111 of the Revised Code.

(4) Any state wastewater facility permit number designated to the facility pursuant to
Chapter 6111 of the Revised Code.

(5) Any pretreatment identification number designated to the facility pursuant to Chapter
6111 of the Revised Code.

(6) Any air permit facility number designated to the facility pursuant to Chapter
3704 of the Revised Code.

(D) In addition to the above information in paragraphs (B) and (C) of this rule, an owner
or operator shall submit the following information as applicable to the facility:

(1) An indication whether the information being reported is identical to that submitted last
year.

(2) For each hazardous chemical required to be reported, the following:

(a) Pure chemical: Provide the chemical name (or the common name of the chemical) as
provided on the “Material Safety Data Sheet (MSDS)” and provide the “Chemical Abstract
Service (CAS)” registry number of the chemical provided on the MSDS.

(b) Indicate whether the chemical is a solid, liquid, or gas; and whether the chemical is
an “Extremely Hazardous Substance (EHS).”

(c) Mixture: If reporting a mixture, enter the mixture name, product name or trade name
as provided on the MSDS and provide the CAS registry number of the mixture provided on the
MSDS. If there is no CAS number provided or it is not known, check the box “Not Available.”
(d) If the mixture being reported contains EHS; provide the name of each EHS in the
mixture. The owner or operator also has an option to report the non-EHS hazardous
components in the mixture.

(e) Pure chemical or mixture: Indicate which hazard categories apply to the chemical or
the mixture. The two hazard categories are established in rule 3750-30-25 of the Administrative
Code.

(f) Provide an estimate (in ranges) of the maximum amount of the hazardous chemical
present at the facility on any single day during the preceding calendar year. If you are reporting
a mixture, provide an estimate of the total amount of the mixture present at the facility on any
single day during the preceding calendar year. If the mixture contains any EHS, provide the total amount of each EHS in that mixture. The range value codes as listed in the rule or in actual pounds rounded up to two significant figures shall be used.

(g) Provide an estimate (in ranges) of the average daily amount of the hazardous chemical present at the facility during the preceding calendar year. If reporting a mixture, provide an estimate of the average daily amount of the mixture. The range value codes as listed in this rule or in actual pounds rounded up to two significant figures shall be used.

(h) Provide the maximum number of days that the hazardous chemical or mixture was present at the facility during the preceding calendar year.

(i) Provide the type of storage for the hazardous chemical or the mixture containing the hazardous chemical at the facility. Examples for types of storage: above-ground tank, plastic or non-metallic drum, steel drum, cylinder, or rail car.

(j) Provide the storage conditions for the hazardous chemical or the mixture containing the hazardous chemical at the facility. Examples for types of storage conditions: ambient pressure, ambient temperature, less than ambient temperature/pressure, or cryogenic conditions.

(k) Provide a brief description of the precise location of the hazardous chemical or the mixture at your facility.

(3) The estimated amount shall be reported either in actual pounds rounded up to two significant figures or in appropriate reporting ranges as follows:

<table>
<thead>
<tr>
<th>Range Value</th>
<th>Weight Range in Pounds From.....</th>
<th>Weight Range in Pounds To .....</th>
</tr>
</thead>
<tbody>
<tr>
<td>01</td>
<td>0</td>
<td>99</td>
</tr>
<tr>
<td>02</td>
<td>100</td>
<td>499</td>
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<td>03</td>
<td>500</td>
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<td>07</td>
<td>25,000</td>
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</tr>
<tr>
<td>12</td>
<td>1,000,000</td>
<td>9,999,999</td>
</tr>
<tr>
<td>13</td>
<td>10,000,000</td>
<td>Greater than 10 million</td>
</tr>
</tbody>
</table>

(4) The general location of each hazardous chemical present at the facility.

(a) An owner or operator shall submit a map indicating the following:

(i) Fixed and stationary items.

(ii) The storage locations of those hazardous chemicals present at the facility in quantities equal to or greater than the threshold quantity established under rule 3750-30-27 of the Administrative Code or those extremely hazardous substances present at the facility equal to or exceeding the threshold planning quantities established under rules 3750-30-27 and 3750-20-30 of the Administrative Code or five hundred pounds as reported on the annual inventory form.

(b) A map shall identify the facility buildings located at the site or on contiguous property
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Part I. Clean Air and Waste

including the following:

(i) Buildings.
(ii) Building openings.
(iii) Building or rooms including location.
(iv) Building floors.
(v) Only those buildings or rooms used for chemical storage shall be identified.
(vi) If a room or building is used as a warehouse, the map shall identify such area by labeling the room as a "warehouse."
(vii) For purposes of this rule "warehouse" means any area where chemicals are moved frequently to accommodate storage incidental to shipping.

(c) A map shall identify the facility's surrounding areas including the following:
(i) Drive through gates.
(ii) Bordering streets.
(iii) Access roads.
(iv) Surrounding land uses.
(v) Waterways.
(d) A map shall identify any storage structures or areas including the following:
(i) Inside storage tanks.
(ii) Outside storage tanks.
(iii) Inside storage areas.
(iv) Outside storage areas.

For purposes of this rule, "tank" means a totally enclosed container.
(e) A map shall identify portable containers stored in a single large areas as other storage.

For purposes of this rule, "portable containers" means any container which is not stored in a permanent place.

(f) A map shall indicate compass direction and scale representations.
(g) A map shall include the facility's name and address.
(h) The information required in paragraphs (B) to (D) of this rule shall be submitted to the commission, committee and fire department having jurisdiction over the facility unless otherwise negotiated and agreed to by the committee or the fire department. The negotiated information shall be approved by the committee or fire department and provided in a letter indicating approval to the commission, attached to the map.

(5) An owner or operator of a facility may indicate that the storage location of any hazardous chemical present at a facility as reported on a Tier II inventory form or electronic submission and a map shall not be disclosed to any person who is not an officer or employee of the state or political subdivision acting in an official capacity.

(6) An owner or operator may choose to withhold information about any hazardous chemical present at the facility from disclosure as a trade secret, if so, the owner or operator shall indicate whether a claim has been filed with the administrator of the United States environmental protection agency for protection of that information as a trade secret pursuant to the rules adopted under division (B)(2)(d) of section 3750.02 of the Revised Code or has filed a claim with the commission pursuant to rules adopted under section 3750.09 of the Revised Code.

(7) A certification signed by the owner or operator or an officially designated representative which certifies that the information has been personally examined and that such owner, operator, or representative is familiar with this document and attached map, and that based on an inquiry of those individuals responsible for obtaining the information, it is believed that the submitted information is true, accurate, and complete.

E) The committee and fire department having jurisdiction over a facility may, after assessing the information obtained from an owner or operator's previous Tier II inventory form
or on a state Tier II inventory form or electronic submission as adopted by the commission, may request any other information otherwise agreeable to the committee and fire department and the owner or operator of the facility. The confidential business information and trade secret provisions under Chapter 3750 of the Revised Code are applicable to the information submitted pursuant to this paragraph.

(1) The committee and fire department having jurisdiction over a facility shall determine the scope of information to be submitted pursuant to this paragraph by evaluating the information on the basis of the following factors:
(a) The information reported shall aid to reduce the extraordinary risk injury to public health and safety or to the environment.
(b) The information reported shall aid to reduce the extraordinary risk to injury to responding emergency management personnel in the event of a release of hazardous substances from the facility considering the following:
(i) The specific characteristics and degree and nature of the hazards posed by the release of the hazardous substances.
(ii) The proximity of the facility to a residential area, or area with significantly large numbers of people are employed or otherwise congregate; and to environmental resources that are subject to injury.
(iii) The quantities of extremely hazardous substances and hazardous chemicals that are routinely present at the facility.
(iv) The frequency in which the extremely hazardous substances and hazardous chemicals are present at the facility.

(2) An owner or operator subject to this rule shall continue to annually prepare and submit an inventory form or electronic submission as required under paragraphs (B) to (D) of this rule in addition to the information as agreed upon under paragraph (E) of this rule.

(3) A committee and fire department acquiring additional information pursuant to paragraph (E) of this rule shall notify the commission of such an agreement.

(F) An owner or operator of a facility subject to rule 3750-30-01 of the Administrative Code may submit chemical inventory information on forms prescribed by the administrator of the USEPA under section 312 of the Emergency Planning and Community Right-To-Know Act of 1986 (federal form) or on a state form adopted by the commission or on commission approved software to collect information required by paragraphs (B) to (D) of this rule.

(G) No owners or operators of a facility where any hazardous chemical is stored in an amount that exceeds the threshold quantity established in rule 3750-30-27 of the Administrative Code shall fail to submit one of the following:
(1) A state inventory form containing tier II information as prescribed in paragraphs (B) to (D) of this rule.
(2) A federal inventory form containing tier II information.
(3) Commission approved electronic software.

(H) An owner or operator of a facility who has previously submitted an inventory form pursuant to this rule, in the event there are no changes to the reported information including any facility map submitted, may send, in lieu of the reports otherwise required under this rule only the facility information prescribed in paragraphs (B) and (C) of this rule with a marked “no change (from last year's)” to the commission, committee and fire department having jurisdiction over the facility. An owner or operator shall submit a new inventory form and facility map every three years even if no changes have occurred at the facility.

(I) The owner or operator of the facility under paragraph (H) of this rule shall submit an annual inventory filing fee and worksheet form prescribed in rule 3750-50-01 of the Administrative Code to the commission.

Infectious Waste
**3745-27-01 Definitions (including “infectious waste”).**

[Editor’s Note: The “Comment” portion of the following regulation is part of the official provision.]

(A)

(1) “Airport” means any airport certified by the federal aviation administration and open to the public without prior permission and without restrictions within the physical capabilities of the available facilities.

(2) “Alteration” means a change to a facility from the requirements specified in the facility’s authorizing document which is at least equivalent to rule requirements, other than a “modification” as that term is defined in rule 3745-27-02 of the Administrative Code, which requires written concurrence by Ohio EPA.

[Comment: If the change is not equivalent to rule requirements, approval through a permit, variance, or exemption would be necessary.]

(3) “Animal waste” means animal excreta, bedding, wash waters, waste feed, and silage drainage.

(4) “Applicant” means any person who has applied for a registration certificate, permit to install, an alternative infectious waste treatment technology approval, or an operating license in accordance with Chapter 3745-27, 3745-29, 3745-30, or 3745-37 of the Administrative Code.

(5) “Aquifer” means a consolidated or unconsolidated geologic formation or series of formations that are hydraulically interconnected and that have the ability to receive, store, or transmit water to wells or springs.

(6) “Aquifer system” means one or more geological units or formations that are wholly or partially saturated with water and are able to store, transmit, and yield significant amounts of water to wells or springs.

(7) “Assets” means all existing and all probable future economic benefits obtained or controlled by a particular entity.

(8) “Authorized maximum daily waste receipt” means the maximum amount of solid waste a solid waste disposal facility may receive at the gate in any calendar day. The waste receipt limit shall be expressed in tons per day for facilities utilizing scales or cubic yards per day at the gate for all other facilities. The conversion factor between tons and cubic yards shall be one ton to three cubic yards unless the solid waste is baled, in which case a one-ton to one-cubic-yard conversion factor shall be used.

(B)

(1) “Beneficial use” means to use a scrap tire in a manner that results in a commodity for sale or exchange or in any other manner authorized as a beneficial use in accordance with rule 3745-27-78 of the Administrative Code. The use of a scrap tire at a scrap tire recovery facility is not a “beneficial use” of scrap tires, for the purposes of Chapter 3745-27 of the Administrative Code. “Beneficial use” does not apply to products manufactured from scrap tires and sold to a customer, including tire derived fuel as defined in this rule.

(2) “Biomass fuels” are defined in rule 3745-27-03 of the Administrative Code.

(3) “Bird hazard” means an increase in the likelihood of bird/aircraft collisions that may cause damage to the aircraft or injury to the occupants of the aircraft.

(4) “Board of directors of a joint district” means a collective body of the boards of county commissioners of the counties establishing a joint solid waste management district as specified in section 343.01 of the Revised Code.

(5) “Board of health” means the board of health of a city or general health district, or the authority having the duties of a board of health in any city as authorized by section 3709.05 of the Revised Code.

(C)

(1) “Closed unit” means any unit of a sanitary landfill facility for which the owner or
operator is required to complete, or has completed, all closure activities in accordance with rule 3745-27-11 of the Administrative Code.

(2) "Commingled yard waste" means yard waste that has been commingled with other solid wastes. Commingled yard waste does include containerized source-separated yard waste including, but not limited to, yard waste in paper or plastic bags where such bags are commingled with other solid wastes.

(3) "Composting" means the process of biological decomposition of solid wastes under controlled conditions resulting in compost. Controlled conditions include but are not limited to grinding, shredding, piling, physical turning, aerating, adding moisture, or other processing of solid wastes.

(4) “Composting facility” means a site, location, tract of land, installation, or building used for composting of solid waste in accordance with Chapter 3734 of the Revised Code and rules adopted thereunder.

(5) "Current assets" means cash or other assets or resources commonly identified as those which are reasonably expected to be realized in cash or sold or consumed during the normal operating cycle of the business.

(6) "Current corrective measures cost estimate" means the most recent of the estimates prepared in accordance with rule 3745-27-18 of the Administrative Code.


(8) “Current transporter cost estimate” means the most recent of the estimates prepared in accordance with rule 3745-27-15, 3745-27-54, or 3745-27-56 of the Administrative Code.

(9) "Current liabilities" means obligations whose liquidation is reasonably expected to require either the use of existing resources properly classifiable as current assets or the creation of other current liabilities.

(10) “Current post-closure care cost estimate” means the most recent of the estimates prepared in accordance with rule 3745-27-16 or 3745-27-73 of the Administrative Code.

(D)

(1) “Daily design input capacity” or “DDIC” means the weight of scrap tires that can be processed at a scrap tire recovery facility per day. The DDIC is expressed in tons and shall be calculated as an averaged daily processing amount for all operating days in a calendar month.

(2) “Developed spring” means any spring which has been permanently modified by the addition of pipes or a collection basin to facilitate the collection and use of the spring water.

(3) “Director” means the director of environmental protection or the director’s authorized representative.

(E)

(1) “Execute” means to complete and sign a document acceptable to the director for the purpose of establishing a financial assurance instrument.

(2) “Existing unit” means any unit of a sanitary landfill facility that is receiving solid waste on or before June 1, 1994, and is a geographically contiguous area within the limits of waste placement of the sanitary landfill facility, as the limits of waste placement existed on June 1, 1994.

(F)

(1) “Final slope” means the slope of a landfill when it has reached final grade and includes but is not limited to the composite cap system, the waste, the composite liner system and the subsurface.

(2) “Fire break” means the area around individual scrap tire storage piles that is maintained free of combustible and vegetative material. The width of the fire break shall be as specified in the applicable rule of Chapter 3745-27 of the Administrative Code. The fire break may include well mowed grass if the fire break also includes a gravel or paved fire lane twenty
feet wide.

(3) “Foundry sand” is defined in rule 3745-30-01 of the Administrative Code.

(G)

(1) “Ground water” means any water below the surface of the earth in a zone of saturation.

(H)

(1) “Hazardous waste” means waste that is listed specifically as hazardous waste or exhibits one or more characteristics of hazardous waste as defined in Chapter 3745-51 of the Administrative Code.

(2) “Health commissioner” means the individual occupying the office created by sections 3709.11 and 3709.14 of the Revised Code, or the health commissioner’s authorized representative.

(3) “Health district” means a city or general health district as created by or under authority of Chapter 3709 of the Revised Code.

(4) “Household hazardous waste” means solid waste originally generated by individual households that is listed specifically as hazardous waste or exhibits one or more characteristics of hazardous waste as defined in rule 3745-51-03 of the Administrative Code. Household hazardous waste is excluded from regulation as a hazardous waste pursuant to paragraph (B)(1) of rule 3745-51-04 of the Administrative Code.

(I)

(1) “Incinerator” means any equipment, machine, device, article, contrivance, structure, or part of a structure used to burn solid or infectious wastes to ash.

(2) “Independently audited” refers to an audit performed by an independent certified public accountant in accordance with generally accepted accounting standards, or for a publicly-owned facility, an equivalent comprehensive audit performed by the auditor of the state of Ohio pursuant to Chapter 117 of the Revised Code.

(3) “Industrial solid waste” is defined in rule 3745-29-01 of the Administrative Code.

(4) “Industrial solid waste landfill facility” is defined in rule 3745-29-01 of the Administrative Code.

(5) “Infectious agent” means a type of microorganism, pathogen, virus, or proteinaceous infectious particle that can cause or significantly contribute to disease in or death of human beings.

(6) “Infectious wastes” means any wastes or combination of wastes that include cultures and stocks of infectious agents and associated biologicals, human blood and blood products, and substances that were or are likely to have been exposed to or contaminated with or are likely to transmit an infectious agent or zoonotic agent, including the following:

(a) Laboratory wastes;

(b) Pathological wastes, including human and animal tissues, organs, body parts, and body fluids and excreta that are contaminated with or are likely to be contaminated with infectious agents or zoonotic agents;

(c) Animal blood and blood products;

(d) Animal carcasses and parts;

(e) Waste materials from the rooms of humans, or the enclosures of animals, that have been isolated because of diagnosed communicable disease that are likely to transmit infectious agents. Also included are waste materials from the rooms of patients who have been placed on blood and body fluid precautions under the universal precaution system established by the “Centers for Disease Control” in the public health service of the United States department of health and human services, if specific wastes generated under the universal precautions system have been identified as infectious wastes by rules referred to in paragraph (I)(6)(g) of this rule;

(f) Sharp wastes used in the treatment, diagnosis, or inoculation of human beings or animals;
(g) Any other waste materials generated in the diagnosis, treatment, or immunization of human beings or animals, in research pertaining thereto, or in the production of testing of biologicals, that the public health council created in section 3701.33 of the Revised Code, by rules adopted in accordance with Chapter 119 of the Revised Code, identifies as infectious wastes after determining that the wastes present a substantial threat to human health when improperly managed because they are contaminated with, or are likely to be contaminated with, infectious agents. As used in this rule, “blood products” does not include patient care waste such as bandages or disposable gowns that are lightly soiled with blood or other body fluids unless those wastes are soiled to the extent that the generator of the wastes determines that they should be managed as infectious wastes.

(h) Any other waste materials that the generator designates as infectious waste.

(7) “Infectious waste handling area” means any area where infectious wastes are stored, loaded, unloaded, prepared for treatment, or treated. Infectious waste handling areas also include areas where vehicles or containers are decontaminated, areas where transportation of infectious wastes within the facility premises occurs, and areas where treated infectious wastes are unloaded, stored, and loaded.

(8) “Infectious waste treatment unit” or “treatment unit” means the apparatus responsible for the attainment of the performance standard for treatment and for the reduction in microorganisms that is part of the treatment process. A free standing shredder or grinder is not considered a treatment unit.

[Comment: If the treatment process is contained within a single, enclosed piece of equipment, then the treatment unit and treatment process are considered one and the same.]

(9) “Interim slope” means the slope of a landfill as a result of daily filling or when a phase, cell or unit has reached its limits and includes but is not limited to daily cover, intermediate cover, transitional cover, waste, the composite liner system and the subsurface.

(10) “Internal slope” means the slope as excavated or constructed and includes but is not limited to the leachate collection layer, protective material, select waste, composite liner system and the subsurface.

(J) [Reserved.]

(K) [Reserved.]

(L)

(1) “Leachate” means liquid that has come in contact with or been released from solid waste.

(2) “Legitimate recycling facility” means an engineered facility or site where recycling of material other than scrap tires is the primary objective of the facility.

For the purposes of Chapters 3745-27 and 3745-37 of the Administrative Code, legitimate recycling facilities are either of the following:

(a) Facilities that accept only source separated recyclables, except scrap tires, or commingled recyclables which are currently recoverable utilizing existing technology.

(b) Facilities that meet all of the following:

(i) Accept mixed or source separated solid waste streams.

(ii) Recover for beneficial use not less than sixty per cent of the weight of solid wastes brought to the facility each month (as averaged monthly) for not less than eight months in each calendar year.

(iii) Dispose of not more than forty per cent of the total weight of solid wastes brought to the facility each month (as averaged monthly) for not less than eight months in each calendar year.

For purposes of Chapters 3745-27 and 3745-37 of the Administrative Code, legitimate recycling facility does not include any facility identified as a solid waste disposal facility as “solid waste” is defined in this rule, nor does it include any facility identified as a scrap tire collection, storage, monofil, monocell, or recovery facility or any premises at which the beneficial use of
scrap tires occurs.

(3) “Liabilities” means probable future sacrifices of economic benefits arising from present obligations to transfer assets or provide services to other entities in the future as a result of past transactions or events.

(4) “Lime sludge” is defined in rule 3745-27-03 of the Administrative Code.

(5) “Limestone quarry” means an excavation resulting from a mining operation where limestone is the principal material excavated for commercial sale or use in another location. This term does not include excavations of limestone resulting from the construction of the sanitary landfill facility.

(6) “Limits of waste placement” means the horizontal and vertical boundaries of a sanitary landfill facility within which the owner or operator has been authorized to dispose of solid waste.

(7) “Lower explosive limit” means the lowest per cent by volume of a mixture of explosive gases in air that will propagate a flame at twenty-five degrees Celsius and atmospheric pressure.

(M)

(1) “Maximum horizontal acceleration in lithified earth material” means the maximum expected horizontal acceleration depicted on a seismic hazard map, with a ninety per cent or greater probability that the acceleration will not be exceeded in two hundred fifty years, or the maximum expected horizontal acceleration based on a site-specific seismic risk assessment.

(2) “Modification” is defined in rule 3745-27-02 of the Administrative Code.

(3) “Monocell” means a discrete volume for solid waste, which is provided isolation from other solid wastes, where a segregated waste stream is exclusively disposed within the limits of waste placement of a sanitary landfill facility.

(4) “Monofill” means a specialized sanitary landfill facility where a single segregated waste stream is exclusively disposed.

(5) “Municipal solid waste” is a type of solid waste generated from community, commercial, and agricultural operations, including, but not limited to, the following:

(a) Solid waste generated by community operations, i.e. wastes derived from households (including single and multiple household residences, hotels, motels, bunkhouses, ranger stations, crew quarters, campgrounds, picnic grounds, and day-use recreation areas).

(b) Solid waste generated by commercial operations (including stores, offices, restaurants, warehouses, and other non-manufacturing activities).

(c) Solid waste generated from agricultural operations (including single-family and commercial farms, greenhouses, and nurseries).

(d) Sludge from municipal, commercial or industrial waste water treatment plants, water treatment plants, and air pollution control facilities that is co-disposed with wastes specified in paragraph (M)(6)(a), (M)(6)(b), (M)(6)(c) or (M)(6)(e) of this rule in a sanitary landfill facility.

(e) Fly ash and bottom ash generated from the incineration of municipal solid waste provided the fly ash and bottom ash are not regulated as hazardous wastes.

(N)

(1) “Net working capital” means current assets minus current liabilities.

(2) “Net worth” means total assets minus total liabilities and is equivalent to owner's equity.

(3) “New tire” means a tire that has never been installed on a vehicle or trailer, or any tire that is part of a new vehicle or trailer when the motor vehicle or trailer is manufactured or initially received in this state. New tire does not include any used or retreaded tire.

(4) “New unit” means any unit of a sanitary landfill facility that did not receive solid waste prior to June 1, 1994, and that has not been designated an existing unit by the owner or operator. A new unit may be contiguous or noncontiguous.

(5) “Nonputrescible solid wastes” is defined in rule 3745-27-12 of the Administrative Code.
"Nuisance" means anything which is injurious to human health or offensive to the senses; interferes with the comfortable enjoyment of life or property; and affects a community, neighborhood, or any considerable number of persons (although the extent of annoyance or damage inflicted upon individual persons may be unequal).

(1) "Occupied structure" is defined in rule 3745-27-12 of the Administrative Code.

(2) "Open burning" means the burning of solid wastes in an open area or burning of solid wastes in a type of chamber or vessel that is not approved or authorized in rules adopted by the director under section 3734.02 of the Revised Code or, if the solid wastes consist of scrap tires, in rules adopted by the director under section 3734.73 of the Revised Code, or the burning of treated or untreated infectious wastes in an open area or vessel that is not approved in rules adopted by the director under section 3734.021 of the Revised Code.

(3) "Open dump" means a site where solid wastes or untreated infectious wastes have been disposed without a license.

(4) "Open dumping" means the following:

(a) The deposition of solid wastes, other than scrap tires, into waters of the state, and also means the final deposition of solid wastes on or into the ground at any place other than a solid waste facility operated in accordance with Chapter 3734 of the Revised Code, and Chapters 3745-27, 3745-29, 3745-30, and 3745-37 of the Administrative Code.

(b) The deposition of solid wastes that consist of scrap tires into waters of the state, and also means the final deposition of scrap tires on or into the ground at any place other than a scrap tire collection, storage, monofill, monocell, or recovery facility licensed under section 3734.81 of the Revised Code, or at a site or in a manner not specifically identified in division (C)(2), (C)(3), (C)(4), (C)(5), (C)(7), or (C)(10) of section 3734.85 of the Revised Code, or at any licensed solid waste facility if the deposition is not in accordance with Chapters 3745-27 and 3745-37 of the Administrative Code.

(c) The deposition of solid wastes that consist of scrap tires in buildings, trailers, or other vehicles at locations other than a scrap tire transporter's registered business location, a licensed scrap tire facility, or an unregistered scrap tire facility operating in accordance with rule 3745-27-61 of the Administrative Code (such as pre-positioned trailers in accordance with paragraph (C)(8) of rule 3745-27-56 of the Administrative Code) for longer than fourteen days. The scrap tires in trailers or vehicles shall be considered open dumped unless written prior notification is given to the local health department and Ohio EPA that the vehicle or trailer requires mechanical repairs which will take longer than fourteen days to complete and that the repairs are being completed in a timely manner.

(d) The deposition of untreated or treated infectious wastes into waters of the state, and also means the final deposition of untreated infectious wastes on or into the ground at any place other than a licensed solid waste facility operated in accordance with Chapter 3734 of the Revised Code, and Chapters 3745-27 and 3745-37 of the Administrative Code.

(5) “Operator” or “facility operator” means the person responsible for the on-site supervision of technical operations and maintenance of a solid or infectious waste facility, or any parts thereof, which may affect the performance of the facility and its potential environmental impact or any person who has authority to make discretionary decisions concerning the daily operations of the solid or infectious waste facility. "Operator" also means the person responsible for the supervision of technical operations of a scrap tire transportation business.

(6) “Original scrap tire generator” or “original owner” means the person or business who purchased a new, retread, or used tire for use on a wheel or rim. Original scrap tire generator or original owner does not include anyone who has accepted a tire other than a new or retreaded tire, for the purposes of transportation, collection, storage, processing, or disposal.

(7) “Owner” or “property owner” means the person who holds title to the property on
which the solid waste facility, infectious waste treatment facility, or scrap tire transportation business is located.

(P)
(1) “Parent corporation” means a corporation, or the ultimate corporation, which directly owns at least fifty per cent of the voting stock of the corporation which holds a permit or license issued in accordance with section 3734.05 of the Revised Code and Chapter 3745-27, 3745-29, or 3745-30 of the Administrative Code; the latter corporation is deemed a “subsidiary” of the parent corporation.

(2) “Permittee” means a person to whom a permit to install has been issued.

(3) “Person” means the state, any political subdivision, public or private corporation, individual, partnership, or other entity.

(4) “Phase” means a discrete area of a sanitary landfill facility, which has been designated to facilitate the systematic construction, operation, and closure of the sanitary landfill facility. For a sanitary landfill facility, other than an industrial solid waste landfill facility or residual solid waste landfill facility, a phase is a discrete area that is part of a unit.

(5) “Portable solid waste container” or “portable container” is a container used for solid waste transfer that is not part of the permanent structure of a transport vehicle, can be removed from the transporting vehicle without compromising the container’s or the transporting vehicle’s structural integrity, and can be removed from the transporting vehicle without utilizing destructive measures. Portable containers include trailers used to store and transport solid wastes.

(6) “Premises” means one of the following:
   (a) Geographically contiguous property owned by an entity.
   (b) Noncontiguous property that is owned by an entity and connected by a right-of-way that the entity controls and to which the public does not have access. Two or more pieces of property that are geographically contiguous and divided by public or private right-of-way or rights-of-way are a single premises.

(7) “Processed tire” or “processed scrap tire” means a scrap tire that has been altered through a mechanical, chemical, thermal, or controlled combustion process so that the resulting material is a marketable product or is suitable for storage or disposal in a scrap tire monofill facility. For the purpose of disposal, processed tires shall be defined as a solid waste or a scrap tire based on the following:
   (a) Processed tires that are readily identifiable as scrap tires or pieces of scrap tires by visual inspection shall be disposed of as scrap tires.
   (b) Processed tires that are not readily identifiable as scrap tires or pieces of scrap tires by visual inspection when disposed may be disposed of as solid waste rather than scrap tires.
   (c) Items manufactured from processed tires and scrap tire material which is a by-product of a manufacturing process when disposed may be disposed of as solid waste.
   (d) “Processed tire” includes, but is not limited to, cut, split, and shredded tires. Baled tires are only considered “processed tires” for the purpose of disposal at a scrap tire monofill or monofill.

(8) “Public water supply well” means any well connected to a public water system as defined by division (A) of section 6109.01 of the Revised Code.

(9) “Public well field” means any system of wells which is connected to a public water system as defined by division (A) of section 6109.01 of the Revised Code.

(Q)
(1) “Qualified ground water scientist” means a scientist or engineer who has received a baccalaureate or post-graduate degree in the natural sciences or engineering and has at least five years relevant experience in ground water hydrology and related fields to enable that individual to make sound professional judgments regarding ground water monitoring, contaminant fate and transport, and corrective measures.
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(R) 
(1) "Recycling" means the process of collecting, sorting, cleansing, treating, and reconstituting solid waste that would otherwise be disposed in a solid waste disposal facility and returning reconstituted materials to commerce as commodities for use or exchange.

(2) “Regional aquifer” means the aquifer used as a primary source of water to wells within one mile of the solid waste disposal facility.

(3) “Registrant” means any person to whom a registration certificate has been issued.

(4) "Regulatory floodplain" means an area covered by a one hundred year flood as depicted on a flood insurance rate map published by the federal emergency management agency.

(5) “Residual solid waste” or “residual waste” is defined in rule 3745-30-01 of the Administrative Code.

(6) “Residual waste landfill facility” or “residual waste landfill” is defined in rule 3745-30-01 of the Administrative Code.

(7) “Retention time” means the average time for gases to pass through a chamber. The residence time is equivalent to retention time.

(8) “Rough tire shreds” or “rough shredded scrap tires” means tire shreds or cut tire pieces that have any dimension greater than four inches.

(S) 
(1) “Salvaging” means the extracting or removing of materials from the solid waste stream at the working face of a solid waste disposal facility for the intended purpose of recycling or for removal to a salvage facility regulated by Chapter 4737 of the Revised Code and rules promulgated thereunder.

(2) "Sand or gravel pit" means an excavation resulting from a mining operation where the removal of sand or gravel is undertaken for commercial sale or use in another location. This term does not include excavations of sand or gravel resulting from the construction of the sanitary landfill facility.

(3) "Sandstone quarry" means an excavation resulting from a mining operation where sandstone is the principal material excavated for commercial sale or use in another location. This term does not include excavations of sandstone resulting from the construction of a sanitary landfill facility.

(4) “Sanitary landfill facility” means an engineered facility where the final deposition of solid waste on or into the ground is practiced in accordance with Chapter 3745-27, 3745-29 or 3745-30, as appropriate, and 3745-37 of the Administrative Code, and includes the units within the limits of waste placement, all ground water monitoring and control system structures, buildings, explosive gas monitoring, control, and extraction system structures, surface water run-on and runoff control structures, sedimentation ponds, liner systems, and leachate management system structures. The sanitary landfill facility includes all portions of the facility described above and those areas within three hundred feet of the limits of waste placement unless an alternate setback is deemed acceptable by the director. If the owner or operator has not obtained approval of a permit to install, which delineates the setback from the limits of waste placement, submitted in accordance with section 3734.05 of the Revised Code, the sanitary landfill facility includes all portions of the facility described above and those areas within three hundred feet of the limits of waste placement unless the property line of the facility is less than three hundred feet from the limits of waste placement, in which case the sanitary landfill facility includes those areas within the property line.

(5) “Scavenging” means the removal by unauthorized personnel of materials from the solid waste stream at waste handling areas of a solid waste disposal facility or solid waste transfer facility.

(6) “Scrap tire” is a type of solid waste and means any unwanted or discarded tire, regardless of size, that has been removed from its original use. “Scrap tire” includes all whole
scrap tires and pieces of scrap tires which are readily identifiable as parts of scrap tires by visual inspection.

For purposes of this definition, “unwanted” means the original scrap tire generator, original owner or manufacturer of the tire no longer wants to use, or is unable to use the tire for its original purpose, and “discarded” means the original scrap tire generator, original owner, or manufacturer of the tire has otherwise managed the tire in such a manner that disposal has occurred.

“Scrap tire” does not include the following:

(a) A tire after it has been retreaded or regrooved for resale or reuse, unless it has been declared defective or has been returned to the seller or manufacturer for warranty adjustment.
(b) A tire that is mounted and installed on a vehicle or trailer, or carried on the vehicle or trailer as the spare tire. Trucks with more than four wheels or with different size wheels or tires may carry more than one spare tire.

For purposes of this definition “installed” means placing the mounted wheel and tire assembly at any of the positions on a vehicle or trailer where a wheel and tire assembly was initially placed on the vehicle or trailer during manufacture and includes the position normally used for a spare tire or tires.

For purposes of this definition “mounted” means placing a tire on a wheel rim so that it can be installed on a vehicle. A mounted tire may be a scrap tire unless it is also installed.
(c) Tires from non-motorized vehicles such as bicycles, or tires from small equipment such as lawn mowers, wheelbarrows, etc.

[Comment: Tires from non-motorized vehicles may be recycled, disposed of as scrap tires, or may be disposed of as solid waste.]
(d) Only at a retreading business, a retreadable casing stored in an enclosed building or stored in a manner otherwise authorized or exempted by the director that the retreading business has inspected and individually labeled or marked the casing as suitable for retreading.
(e) Tire derived fuel (TDF) or tire derived chips (TDC) as defined in this rule after the TDF or TDC has been transported from the scrap tire recovery facility for use as a fuel or for an authorized beneficial use.
(f) Non-pneumatic, hard, pressed tires, such as forklift tires.
(7) “Scrap tire collection facility” means a type of facility for scrap tire storage that meets the following:
(a) The facility is used for the receipt and storage of whole scrap tires from the public prior to the transportation of the scrap tires to one of the destinations listed in rule 3745-27-65 of the Administrative Code.
(b) The facility exclusively stores scrap tires in portable containers.
(c) The aggregate storage of the portable containers in which the scrap tires are stored does not exceed five thousand cubic feet.

[Comment: If the facility does not meet the above definition for a scrap tire collection facility, then the facility may be a scrap tire storage facility. If the facility includes any equipment for processing (e.g. cutting or shredding equipment) the scrap tires to produce a usable product, then the facility is a scrap tire recovery facility.]

(8) “Scrap tire facility” is a generic term that includes but is not limited to the following: scrap tire collection facility, scrap tire storage facility, scrap tire recovery facility, scrap tire monofill facility, scrap tire monocell facility, and scrap tire submergence facility as those terms are defined in this rule.

(9) “Scrap tire generator” means any person or business that generates scrap tires. Scrap tire generator includes the original scrap tire generator, as defined in this rule, and any business which removes tires from vehicles and accepts scrap tires in the normal course of business such as tire retail dealers and tire retreaders.

[Comment: A scrap tire generator or original scrap tire generator who stores more than
one hundred scrap tires and who does not qualify for one of the exclusions from registration in rule 3745-27-61 or permitting in rule 3745-27-63 of the Administrative Code may also be a scrap tire collection, storage, or recovery facility.]

(10) “Scrap tire handling area” means any area of a scrap tire collection, storage, monocell, monofill, or recovery facility where scrap tires are stored, loaded, unloaded, sorted, baled, shredded, prepared for processing, or otherwise processed. A scrap tire handling area includes the scrap tire storage area but does not include vehicle staging areas, vehicle storage areas, or buildings not used for the processing or storage of scrap tires. Scrap tire handling area also includes that portion of a scrap tire transporter’s business location where scrap tires are unloaded, sorted, and loaded.

(11) “Scrap tire monocell facility” means a type of “monocell,” as that term is defined in this rule, that is used or intended to be used exclusively for the environmentally sound storage or disposal of scrap tires that have been shredded, chipped, or otherwise mechanically processed.

(12) “Scrap tire monofill facility” means a type of “monofill,” as that term is defined in this rule, that is used or intended to be used exclusively for the environmentally sound storage or disposal of scrap tires that have been shredded, chipped, or otherwise mechanically processed.

(13) “Scrap tire recovery facility” means any site, location, tract of land, installation, or building that is used or intended to be used for the processing of scrap tires for the purpose of extracting or producing usable products, materials, or energy from the scrap tires. Processing includes but is not limited to: a controlled combustion process, mechanical process, thermal process, or chemical process that uses whole, split, or shredded scrap tires as a raw material. Scrap tire recovery facility includes any facility that uses the controlled combustion of scrap tires in a manufacturing process to produce process heat or steam or any facility that produces usable heat or electric power through the controlled combustion of scrap tires in combination with another fuel.

(a) A “mobile scrap tire recovery facility” is a type of scrap tire recovery facility owned or operated by a person not otherwise licensed as a class I or class II scrap tire recovery facility in Ohio and means any unit for processing tires which is designed by the manufacturer for the regular movement from one operating site to another and which the owner or operator has used at more than one location during the prior year. “Mobile scrap tire recovery facility” specifically includes any tire cutting, baling, or shredding equipment that is moved from site to site for the purpose of processing scrap tires into a useable product at the site or before the scrap tires are removed from the site.

(b) A “class I scrap tire recovery facility” means a scrap tire recovery facility with a permitted daily design input capacity of two hundred tons of scrap tires per day or greater.

(c) A “class II scrap tire recovery facility” means a scrap tire recovery facility with a registered daily design input capacity of less than two hundred tons of scrap tires per day.

(14) “Scrap tire storage area” means that part of a premises including but not limited to a scrap tire collection, storage, or recovery facility where whole scrap tires are stored. At a scrap tire recovery facility the scrap tire storage area also means that part of the premises where processed scrap tires are stored.

(15) “Scrap tire storage facility” means any facility where whole scrap tires are stored prior to the scrap tires being transported to one of the destinations listed in paragraph (D)(8) of rule 3745-27-65 of the Administrative Code. A “class I scrap tire storage facility” means a scrap tire storage facility that has a permitted capacity of more than ten thousand square feet of effective scrap tire storage. A “class II scrap tire storage facility” means a scrap tire storage facility that has a registered capacity of not greater than ten thousand square feet of effective scrap tire storage.

[Comment: Division (C) of section 3734.71 of the Revised Code specifies that the owner or operator of a class I scrap tire storage facility must also be the owner or operator of a
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licensed scrap tire monocell, monofill, or recovery facility in Ohio, or a solid waste or scrap tire monocell, monofill, or recovery facility located in another state and operating in compliance with the laws of that state.]

(16) “Scrap tire storage pile” means an area where scrap tires are stored either indoors or outdoors on the floor, on the ground, or in racks. The dimensions of a scrap tire storage pile are determined by the location of fire breaks of at least the width specified in Chapter 3745-27 of the Administrative Code around the storage pile. A scrap tire storage pile may consist of one or more separate racks. A scrap tire storage pile may consist of a combination of racks and on the floor or on ground storage of scrap tires.

(17) “Scrap tire submergence facility” is a type of scrap tire monofill facility and means a facility where only whole scrap tires are submerged in water in an engineered structure.

(18) “Scrap tire transporter” or “transporter” means the registrant for the scrap tire transportation business or anyone in the registrant's employ who signs the scrap tire shipping papers or operates the registrant's scrap tire transportation vehicles.

(19) “Seismic impact zone” means an area where the maximum horizontal acceleration in lithified earth material exceeds 0.10g.

(20) “Sewage sludge” is defined in rule 3745-27-03 of the Administrative Code.

(21) “Sharp objects” means any object that has the potential to puncture or lacerate, including but not limited to nails, sewing needles, straight pins, staples, metal screws, hard plastic, glass, broken ceramics, and infectious waste “sharps.”

(22) “Significant zone of saturation” means a zone of saturation that may act as a preferential pathway of migration away from the limits of solid waste placement.

(23) “Solid waste” means such unwanted residual solid or semisolid material, including but not limited to garbage, scrap tires, combustible and noncombustible material, street dirt and debris, as results from industrial, commercial, agricultural, and community operations, excluding earth or material from construction, mining, or demolition operations, or other waste materials of the type that normally would be included in demolition debris, nontoxic fly ash and bottom ash, including at least ash that results from combustion of coal, biomass fuels, and ash that results from the combustion of coal in combination with scrap tires where scrap tires comprise not more than fifty per cent of heat input in any month, spent nontoxic foundry sand, and slag and other substances that are not harmful or inimical to public health, and includes but is not limited to garbage, scrap tires, combustible and noncombustible material, street dirt, and debris. Solid waste does not include any material that is an infectious waste or a hazardous waste.

(24) “Solid waste disposal facility” means any site, location, tract of land, installation, or building used for incineration, composting, sanitary landfilling, or other approved methods of disposal of solid wastes.

(25) “Solid waste energy recovery facility” means any site location, tract of land, installation, or building where mixed solid waste or select solid waste streams, including scrap tires, is used as or intends to be used as fuel to produce energy, heat, or steam.

[Comment: A “solid waste energy recovery facility”, which exclusively uses scrap tires and other approved rubber waste as fuel, may be regulated as a “scrap tire recovery facility.”]

(26) “Solid waste management district” means a county which has established a resolution, or joint counties which have entered into an agreement, for the purposes of preparing, adopting, submitting, and implementing a solid waste management plan for the county or joint counties and for the purposes of providing for, or causing to be provided for, the safe and sanitary management of solid wastes within all of the incorporated and unincorporated territory of the county or joint counties and in compliance with Chapters 343 and 3734 of the Revised Code.

(27) “Solid waste management policy committee” means a committee established and convened by the board of county commissioners of a county solid waste management district or the board of directors of a joint solid waste management district to prepare the solid waste...
management plan of the solid waste management district and in compliance with division (B) of section 3734.54 of the Revised Code.

(28) “Solid waste transfer facility” or “transfer facility” means any site, location, tract of land, installation, or building that is used or intended to be used primarily for the purpose of transferring solid wastes that are generated off the premises of the facility from vehicles or containers into other vehicles or containers for transportation to a solid waste disposal facility. The term does not include any facility that consists solely of portable containers that have an aggregate volume of fifty cubic yards or less nor any facility where legitimate recycling activities are conducted. The term does not include any facility that accepts scrap tires other than scrap tires which are accepted incidental to a mixed solid waste shipment.

(29) “Source-separated yard waste” means yard waste that has been separated at the point of generation or at the point of collection from other solid wastes. Source separation includes, but is not limited to, such measures as placing yard waste in portable containers and compartments of portable containers dedicated to yard waste collection, and in vehicles dedicated to yard waste collection.

(30) “Surface water” means any water on the surface of the earth.

(T)

(1) “Tangible net worth” means the tangible assets that remain after deducting liabilities; such assets would not include such intangibles as goodwill and rights to patents or royalties.

(2) “Tire” for purposes of fee collection only is defined in section 3734.90 of the Revised Code. “Tire” and “scrap tire” as used in Chapter 3745-27 of the Administrative Code and the definitions in this rule are not restricted to motor vehicle tires but includes all pneumatic tires. [Comment: The definition of “tire” found in section 3734.90 of the Revised Code applies only to the collection of the state fee on the sale of new tires by a wholesaler.]

(3) “Tire adjustment center” means a premises to which defective new tires and tires returned for warranty adjustment are shipped for analysis of failure and final disposition.

(4) “Tire derived fuel” (TDF) or “tire derived chips” (TDC) means a uniformly shredded product obtained from whole tires where the maximum size of ninety-five per cent of the shreds are less than four inches in any dimension. TDC may be used as a civil engineering material or as feedstock for the manufacturing of crumb rubber or other tire derived material. TDC is defined using the ASTM “Standard Practice for Use of Scrap Tires in Civil Engineering Applications,” (D6270-98) (www.astm.org), section 3.1.29, for x-minus classified, size reduced scrap tires.

(5) “Tire manufacturing finishing center” means premises where tires are manufactured, inspected, and processed to either finished stock or scrap.

(6) “Tire retreading business” means premises where scrap tires are recycled by processing the scrap tire and attaching a new tread to the used tire casing.

(7) “Tire sidewall” means the flat circular part of a tire left after the tread has been cut away. Tire sidewall does not include a bagel cut tire or any cut tire where a portion of the tread remains attached to the sidewall.

(8) “Treat” or “treatment” when used in connection with infectious wastes, means any method, technique, or process that renders the wastes noninfectious so that it is no longer an infectious waste and is no longer an infectious substance as defined in applicable federal law, including, without limitation, steam sterilization and incineration and, in the instance of wastes identified in division (R)(7) of section 3734.01 of the Revised Code, to substantially reduce or eliminate the potential for the wastes to cause lacerations or puncture wounds.

(U)

(1) “Unit” means a discrete area within the limits of waste placement of a sanitary landfill facility, for which the owner or operator is authorized to dispose of solid waste, that is delineated by the owner or operator for the purpose of complying with the siting, construction, operational, closure or post-closure care ground water monitoring, and financial assurance requirements of
Chapter 3745-27 of the Administrative Code.

(2) “Unstable area” means a location that is susceptible to natural or human induced events or forces capable of impairing the integrity of some or all of the structural components of a landfill that are responsible for preventing releases from the landfill and can include areas where on-site or local soil conditions result in significant differential settling; areas where the downslope movement of soil or rock due to gravitational influence occurs; or areas where the lowering or collapse of the land surface occurs either locally or over broad regional areas.

(3) “Used tire” means a whole scrap tire. A used tire remains a scrap tire until it has been reused by being installed on a vehicle or trailer.

(V)

(1) “Vertical expansion” means the extension of the vertical boundary of waste placement that occurs prior to beginning, or being required to begin, closure activities in accordance with rule 3745-27-11 of the Administrative Code. A vertical expansion is a “modification” as that term is defined in rule 3745-27-02 of the Administrative Code. A vertical expansion is not a “unit.”

(W)

(1) “Waste handling area” means any area of a solid waste facility where solid wastes are stored, loaded, unloaded, baled, shredded, crushed, compacted, or otherwise processed or subjected to salvaging activities. Waste handling areas do not include vehicle staging or vehicle storage areas.

[Comment: For definitions of other types of waste handling areas please see “infectious waste handling area” and “scrap tire handling area.”]

(2) “Water pollution” means the unpermitted release of sediment from disturbed areas, solid waste or waste-derived constituents, or leachate to the waters of the state.

(3) “Waters of the state” means all streams, lakes, ponds, marshes, watercourses, waterways, wells, springs, irrigation systems, drainage systems, and all other bodies or accumulations of water, surface and underground, natural or artificial, which are situated wholly or partly within, or border upon, this state or are within its jurisdiction, except those private waters which do not combine or effect a junction with natural surface or underground waters.

(4) “Wetland” means any area that is inundated or saturated by surface or ground water at a frequency and duration sufficient to support, and that under normal circumstances does support, a prevalence of vegetation typically adapted for life in saturated soil conditions. Wetlands generally include swamps, marshes, bogs, and similar areas.

(5) “Working face” means that portion of a sanitary landfill facility where solid wastes are unloaded for final deposition.

(X) [Reserved.]

(Y)

(1) “Yard waste” means solid waste that includes only leaves, grass clippings, brush, garden waste, tree trunks, tree stumps, holiday trees, and prunings from trees or shrubs and vegetative waste resulting from the use of commercial products, including but not limited to discarded flowers, potted flowers, or grave blankets that do not include plastic, metal, styrofoam, or other non-biodegradable material. Yard waste does not include industrial agricultural processing or food processing.

(Z)

(1) “Zone of saturation” means that part of the earth's crust, excluding the capillary zone, in which all voids are filled with water.

(2) “Zoonotic agent” means a type of microorganism, pathogen, virus, or proteinaceous infectious particle that causes disease in vertebrate animals, is transmissible to human beings and can cause or significantly contribute to disease in or death of human beings.
3745-27-30 Standards for generators of infectious waste.

[Editor’s Note: The “Comment” portion of the following regulation is part of the official provision.]

(A) Each generator of less than fifty pounds of infectious waste in any one month (small generator) shall:

1. Identify and separate infectious from non-infectious waste at the point of generation for the purposes of determining whether the generator must comply with paragraph (B) of this rule;

2. Place sharp infectious wastes in a “sharps” container.

3. Either treat all specimen cultures and cultures of viable infectious agents on the premises where they are generated to render them noninfectious by any of the methods, techniques, or practices prescribed by paragraph (B) of rule 3745-27-32 of the Administrative Code before they are transported off that premises for disposal; or

4. Ensure that such wastes are treated to render them noninfectious at a treatment facility off that premises that is owned or operated by the generator, a treatment facility that holds a license issued under division (B) of section 3734.05 of the Revised Code, a treatment facility that is authorized by rule 3745-27-32 of the Administrative Code, prior to disposal of the wastes, or a facility in another state operating in compliance with state and federal regulations.

5. Not be considered a treatment facility as “treatment” and “facility” are defined in section 3734.01 of the Revised Code when the generator treats specimen cultures and cultures of viable infectious agents on the premises where they are generated. Such treated cultures may be transported and disposed of in the same manner as solid wastes and need not comply with the disposal paper as described in rule 3745-27-33 of the Administrative Code;

6. Quantify the waste generation rate and keep records recorded in pounds. This generation rate and record shall pertain to the aggregate quantity of waste generated on the premise owned or operated by the generator on a calendar month basis. Upon request of the board of health or its authorized representative, the generator shall provide information regarding the infectious waste generation rate, the generator shall quantify and record the monthly generation rate. A monthly generation rate log shall display the month and the weight of all the infectious waste generated on the premises during that calendar month.

7. Determine by monthly records, required by paragraph (A)(5) of this rule, if fifty pounds or more of infectious waste is generated. If fifty pounds or more of infectious waste is generated in any one month the generator shall register with the Ohio environmental protection agency as a generator of infectious waste on the forms prescribed by the director and as outlined in paragraph (A) of rule 3745-27-36 of the Administrative Code. Generator registration certificates shall apply to premises and shall not include emergency vehicles or public safety vehicles; and

8. Comply with paragraph (C) of this rule.

A generator who complies with paragraph (A)(2) of this rule and who generates less than fifty pounds of infectious wastes each month and does not hold a certificate of registration as a generator of infectious wastes may dispose of infectious wastes in the same manner as solid wastes.

(B) Each generator of infectious wastes holding a certificate of registration under paragraph (A) of rule 3745-27-36 of the Administrative Code, and any other person who generates fifty pounds or more of infectious wastes in any one month (large generator), shall:

1. Segregate infectious wastes from other wastes at the point of generation. At a minimum, infectious wastes shall be placed in separate containers, from other wastes until rendered non-infectious;
(2) Place sharp infectious wastes in a “sharps” container;

(3) Not grind any sharp infectious wastes, not compact any such wastes until after the wastes have been treated in accordance with rule 3745-27-32 of the Administrative Code and not compact or grind any other type of infectious wastes until after the wastes have been treated in accordance with rule 3745-27-32 of the Administrative Code;

(4) Dispose of the infectious wastes at a solid waste disposal facility holding a license issued under division (A) of section 3734.05 of the Revised Code, after being treated to render them non infectious by either:
   (a) Treating the infectious waste that is generated at a facility owned or operated by the generator by any of the methods, techniques, or practices prescribed by paragraph (A) of rule 3745-27-32 of the Administrative Code to render them non-infectious; or
   (b) Designating the wastes for treatment off that premises at an infectious waste treatment facility holding a license issued under division (B) of section 3734.05 of the Revised Code, or to a facility that holds a license issued under section 4717.17, and a permit issued under Chapter 3704 of the Revised Code to the extent that the treatment of those wastes is consistent with that permit and its terms and conditions prior to disposal of the wastes, or a facility in another state operating in compliance with state and federal regulations.

(5) Provide information on the major components of the infectious wastes, any method of treatment of the wastes to render them non-infectious, and the generator’s system for distinguishing between waste containers that contain treated and untreated wastes to persons with whom the generator has entered into an arrangement to treat or dispose of the wastes upon receiving a written request from those persons;

(6) Ensure that all treated infectious wastes that are transported off the premises where they are generated are accompanied by a disposal paper that meets the requirements of rule 3745-27-33 of the Administrative Code.

(C) All generators of infectious wastes shall comply with the following provisions:

(1) A generator of infectious wastes, who also generates wastes consisting of any instrument designed to pierce or lacerate used in the body adornment of human beings, that have come in contact with blood or other body fluids, including, but not limited to needles, syringes with an attached needle, or any other type of instrument designed for the purpose to pierce or lacerate, shall manage such instruments in the same manner as sharp infectious wastes;

(2) Nothing in this rule prohibits a generator of infectious wastes from designating and managing wastes, in addition to infectious wastes, as infectious wastes when, in the judgment of the generator, those other wastes should be managed as infectious wastes because they are, or are likely to be, contaminated with infectious agents. After designating any such other wastes as infectious, the generator shall manage those wastes in compliance with the requirements of this rule;

(3) Generators of infectious wastes may discharge untreated liquid or semiliquid infectious wastes consisting of blood, blood products, body fluids, and excreta into a disposal system, as defined in section 6111.01 of the Revised Code, unless the discharge of those wastes into a disposal system is inconsistent with the terms and conditions of any permit for the system issued under Chapter 6111 of the Revised Code;

(4) A generator holding a license issued under section 4717.17 of the Revised Code shall not consider the weight of blood, blood products, other body fluids, or embalming fluids that are discharged on the site of their generation into a disposal system, as defined in section 6111.01 of the Revised Code, when determining the quantity of infectious wastes produced by that generator or the monthly generation rate;

(5) A generator of infectious wastes may transport or cause to be transported infectious wastes that have been treated to render them noninfectious in accordance with paragraph (B) of rule 3745-27-32 of the Administrative Code in the same manner as noninfectious wastes are
Infectious Waste transported;
   (6) No wastes consisting of dead animals or parts thereof shall be considered when determining the quantity of infectious wastes produced by any generator if the dead animals or parts meet all of the following:
   (a) Were not intentionally exposed to infectious agents during research, production of biologicals, or testing of pharmaceutical;
   (b) Were produced by a veterinarian holding a license issued under Chapter 4741 of the Revised Code; or
   (c) Were treated or disposed of by a person holding a license issued under Chapter 953 of the Revised Code.
(7) Any infectious waste or infectious waste mixture that meets the definition of hazardous waste as specified in rule 3745-51-03 of the Administrative Code shall be managed as a hazardous waste in accordance with Chapters 3745-50 to 3745-69 of the Administrative Code. No generator of infectious waste shall transport, or cause to be transported, wastes deemed hazardous in accordance with rule 3745-51-03 of the Administrative Code to an infectious waste treatment facility licensed in accordance with section 3734.05 of the Revised Code;
(8) A generator of infectious waste who produces infectious waste that is also radioactive waste shall:
   (a) Manage the waste in accordance with applicable Ohio department of health and U.S. nuclear regulatory commission regulations; and
   (b) Use a monitoring instrument, calibrated at least annually, to verify that infectious waste that is also radioactive is no longer required to be managed in accordance with Ohio department of health and U.S. nuclear regulatory commission regulations; and
   (c) Not transport, or cause to be transported, any infectious waste that is also radioactive to an infectious waste treatment facility licensed under section 3734.05 of the Revised Code unless the monitoring instrument indicates that the levels of radioactivity do not exceed Ohio department of health and U.S. nuclear regulatory commission regulations for managing as a non-regulated material or waste.
[Comment: The purpose of this paragraph is to clarify the interaction between this rule and the statutory requirements of the Ohio department of health, Chapter 3748 of the Revised Code and rules promulgated thereunder, and the U.S. nuclear regulatory commission when materials are both infectious waste and radioactive waste.]
   (d) Infectious waste that is also radioactive but no longer required to be managed in accordance with Ohio department of health or U.S. nuclear regulatory commission regulations shall be handled in accordance with rule 3745-27-35 of the Administrative Code.
[Comment: The intent of this regulation is to have the generator of the wastes verify that the contents have decayed to a sufficient level that the wastes are no longer regulated as radioactive wastes or materials.]
(9) A generator, that is a hospital as defined in section 3727.01 of the Revised Code, may accept for treatment or storage prior to treatment the following wastes:
   (a) Sharp infectious wastes and all unused discarded hypodermic needles, syringes, and scalpel blades that are in containers securely closed to prevent leaks or punctures that are generated by a generator of less than fifty pounds in any one month and who has staff privileges at the hospital;
   (b) Infectious wastes generated by an individual for purposes of their own care or treatment; and
   (c) Infectious wastes generated in providing care to a patient by an emergency medical services organization as defined in section 4765.01 of the Revised Code.
(10) An emergency medical services organization, as defined in section 4765.01 of the Revised Code, shall not be required to quantify the infectious waste that is accepted by a
generator that is a hospital as defined in section 3727.01 of the Revised Code;
(11) A generator shall handle all infectious wastes in accordance with rule 3745-27-35 of the Administrative Code.

3745-27-32 Standards for operation of infectious waste treatment facilities.

[Editor’s Note: The “Comment” portion of the following regulation is part of the official provision.]

(A) The owner or operator of an infectious waste treatment facility shall treat all infectious wastes in accordance with an approved infectious waste treatment method. Infectious waste treatment facilities are licensed infectious waste treatment facilities and all large generators who treat infectious wastes on-site. Treatment shall occur in accordance with all paragraphs in this rule applicable to that particular treatment technology and paragraph (I) of this rule. The following is a list of infectious waste treatment methods approved in the state of Ohio:

(1) Incineration, as specified in paragraphs (C) and (I) of this rule;
(2) Autoclaving, as specified in paragraphs (D) and (I) of this rule;
(3) Chemical treatment utilizing a sodium hypochlorite solution for cultures, as specified in paragraphs (E) and (I) of this rule;
(4) Applied heat encapsulation for sharps, as specified in paragraphs (F) and (I) of this rule;
(5) Chemical treatment utilizing peracetic acid and grinding, as specified in paragraphs (G) and (I) of this rule; and
(6) Alternative treatment technologies approved by the director. The owner or operator of any infectious waste treatment facility utilizing either a statewide or a site-specific alternative infectious waste treatment technology approved by the director in accordance with rule 3745-27-38 of the Administrative Code shall comply with the director’s approval letter for that treatment technology and paragraph (I) of this rule.

(B) All small generators who choose to treat infectious wastes on the premises where they are generated shall comply with the following applicable paragraphs in this rule. Treatment shall occur using an approved infectious waste treatment method and in accordance with paragraph (C)(1), (D)(1), (E)(1), (F)(1) or (G)(1) of this rule or in accordance with a director’s approval letter issued in accordance with rule 3745-27-38 of the Administrative Code.

(C) Incineration. The owner or operator of any infectious waste treatment facility utilizing incineration as a treatment technology shall comply with the following:

(1) Methodology. The owner or operator shall use methods, techniques, and practices for the treatment of infectious wastes in accordance with the following:
(a) All incineration shall occur in a multi-chamber incinerator which provides complete combustion of the wastes, excluding metallic, glass, and ceramic items;
(b) A minimum temperature of one thousand two hundred degrees Fahrenheit in the primary chamber and a minimum of one thousand six hundred degrees Fahrenheit with a minimum one second residence time in the secondary chamber shall be maintained;
[Comment: Additional temperature, residence time, and compliance testing requirements may be necessary to achieve appropriate air emission standards in accordance with Chapter 3704 of the Revised Code.]
(c) Each incinerator shall be equipped with a mechanical process(es) to prevent the charging of infectious wastes into the incinerator until the minimum temperatures required in paragraph (C)(1)(b) of this rule are achieved;
(d) Incinerators shall have automatic auxiliary burners that are capable, excluding the heat content of the wastes, of independently maintaining the secondary chamber temperature at the minimum of one thousand six hundred degrees Fahrenheit;
(e) Incinerators shall not be charged beyond either:
   (i) The maximum hourly waste capacity. For the purposes of this rule, the maximum hourly waste capacity is the same as the hourly capacity as stated in the permit to operate issued by Ohio EPA, division of air pollution control; or
   (ii) The design capacity as determined by the manufacturer, if no permit to operate is issued by Ohio EPA, division of air pollution control.
(f) Wastes not combusted to ash, except for metallic, glass, and ceramic items, shall be handled and treated as infectious wastes and may be reincinerated.

(2) Specific operational criteria. The owner or operator shall design, construct, and operate the equipment for the treatment of infectious wastes in accordance with the following:
   (a) Store all ash from the incinerator in a leakproof, closed container. The ash shall be free of liquids before disposal;
   (b) Any ash spilled outside of the treatment unit shall be managed as treated infectious wastes unless the owner or operator has reason to manage such wastes as hazardous waste;
   (c) The owner or operator shall:
      (i) Characterize the ash resulting from the treatment of infectious wastes as either a solid waste or a hazardous waste by:
         (a) Separately testing fly ash and bottom ash for metals, and;
         (b) Obtaining representative samples of bottom and fly ash utilizing the “simple random sampling method” described in the “U.S. EPA Test Methods for Evaluating Solid Waste, third edition (SW846),” chapter nine. The samples shall be collected and tested quarterly, or more frequently as required by Ohio EPA, for the toxicity characteristic leaching procedure (TCLP) for metals utilizing an independent analytical laboratory using the methodology specified in the “hazardous waste rules” as defined in paragraph (A) of 3745-50-10 of the Administrative Code.
         (ii) Manage the ash in accordance with the applicable solid waste or hazardous waste requirements in Chapter 3734 of the Revised Code and the rules adopted thereunder.
   [Comment: Pursuant to paragraph (I) of this rule, the owner or operator of an incinerator must maintain for a three year period the date and permanent recordings of primary and secondary chamber temperatures, documentation of calibration or replacement of the temperature measuring or recording devices, results of Bacillus species spore testing, if so required, and the results of fly and bottom ash testing.]
   (3) Quality assurance. The owner or operator of the infectious waste treatment technology shall use the following quality assurance testing requirements to demonstrate that the treatment unit is capable of attaining the performance standard as specified in this rule for the treatment of infectious wastes:
      (a) Produce and maintain a permanent record of primary and secondary chamber temperatures utilizing continuous temperature recorders. Chamber temperatures shall also be displayed for visual monitoring. In the event of a temperature recorder failure the owner or operator shall:
         (i) Manually record the chamber temperature(s). The chamber temperature(s) shall be manually recorded immediately after each charge of infectious waste and, at a maximum, once every ten minutes thereafter until the burn down cycle is initiated. Manual recording of the temperature(s) shall continue until repair of the recording device. The operator shall demonstrate proof that repair parts have been ordered if requested by Ohio EPA or approved health department; and
         [Comment: Temperature recordings taken after a charge of infectious waste that occurred sooner than ten minutes from the previous charge of infectious waste fulfills the maximum ten minute temperature recording requirement.]
         (ii) Discontinue use of the incinerator, until repaired, for the treatment of infectious wastes if failure has occurred in the temperature measuring device, such as a thermocouple or thermocouple wiring.
(b) Utilize an independent company to calibrate, repair or replace primary and secondary chamber temperature recording devices or temperature measuring devices in accordance with the following:

(i) The manufacturer’s maintenance schedule, specifications, or recommendations; or

(ii) A calibration schedule as determined by the facility, with, at a minimum, annual calibrations, if the manufacturer’s specifications are not available.

(c) Sample, upon written notification by Ohio EPA, stack gas and the resulting bottom ash after the addition of Bacillus species spores to a load of infectious waste. Sampling shall be accomplished in accordance with the protocol provided by Ohio EPA.

(4) Comply with paragraph (l) of this rule.

(D) Autoclaving. The owner or operator of any infectious waste treatment facility utilizing autoclaving as a treatment technology shall comply with the following:

(1) Methodology. The owner or operator shall use methods, techniques, and practices for the treatment of infectious wastes in accordance with the following:

(a) All autoclaves shall operate at a minimum temperature of one hundred twenty-one degrees Centigrade or two hundred fifty degrees Fahrenheit at a minimum of fifteen pounds per square inch gauge pressure for a minimum of sixty minutes during a treatment cycle; or

(b) The owner or operator of an autoclave who uses combinations during the treatment cycle, other than the minimum time, temperature, and pressure requirements, as specified in paragraph (D)(1)(a) of this rule, to treat infectious wastes may do so provided that achievement of the performance standard is demonstrated by validation testing, as outlined in paragraph (D)(4) of this rule, prior to use for the treatment of infectious wastes; and

[Comment: Although autoclaving has been approved for statewide use pursuant to section 3734.021 of the Revised Code, the capability of autoclave units to treat infectious wastes is variable. The variability is due to a number of factors such as: type of wastes treated; the size and density of the waste load; the packaging of the waste; gravity versus vacuum displacement of the air in the chamber; and steam quality. Hence, this rule provides for a process by which autoclaves that are capable of treating infectious wastes at operating parameters below the specified minimum parameters may be approved for use at the lower operating parameters.]

(c) For the purposes of this rule, the treatment cycle is that combination of time, temperature, and pressure needed to achieve the performance standard of a four log (base ten) reduction in Bacillus stearothermophilus spores. The treatment cycle does not include the time needed to bring the chamber up to the operating temperature or pressure nor the time it takes for the autoclave to exhaust and allow opening of the chamber; and

(d) The total treatable volume of infectious wastes used in either the validation or quality assurance testing shall be the total volume of wastes that can be treated per treatment cycle. The total treatable volume of infectious wastes may be calculated by using any one of the following:

(i) The manufacturer’s specification for the total volume of the autoclave; or

(ii) A lesser estimate based upon the manufacturer’s specification of the total volume of the autoclave; or

(iii) An actual calculation of the total treatable volume at each validation or quality assurance test. The total treatable volume shall be calculated by listing the number of bags, boxes, or sharps containers of infectious wastes used during the testing, and adding the volumes of those containers.

[Comment: an example to actually calculate the total treatable volume. The autoclave test load consisted of three bags, four boxes, and six sharps containers. The volume of each container is: bag = 3 cubic feet, box = 2.5 cubic feet, sharps container = 0.21 cubic feet. Therefore, the total treatable volume of wastes in the quality assurance test load and hence, the maximum amount of wastes that can be treated at any one time is]
[(3)(3) + (4)(2.5) + (6)(0.21)] = 20.26 cubic feet.

(e) Autoclaves shall not be loaded beyond the total treatable volume of infectious wastes, as defined in paragraph (D)(1)(d) of this rule; and

(f) Autoclaves shall not treat pathological wastes, including without limitation, human and animal tissues, organs, and body parts, that are contaminated with or are likely to be contaminated with infectious agents, removed or obtained during surgery or autopsy or for diagnostic evaluation and gross anatomical wastes such as human or animal limbs and sections containing bone, and animal carcases, except small sections of tissue that are only several cells wide used for microscopic evaluation, utilizing autoclaving unless the owner or operator:

(i) Submits a protocol to Ohio EPA for approval prior to validation testing to demonstrate that the autoclave unit can effectively achieve the performance standard of a minimum four \(10\log\) (base ten) reduction of a challenge population of Bacillus stearothermophilus spores;

(ii) Demonstrates, through the use of a protocol acceptable to Ohio EPA, that the autoclave unit can effectively achieve the performance standard of a minimum four \(\log\) (base ten) reduction of a challenge population of Bacillus stearothermophilus spores within such wastes; and

(iii) Receives approval from Ohio EPA to operate the unit to treat pathological wastes.

(2) Specific operational criteria. The owner or operator shall design, construct, and operate the equipment for the treatment of infectious wastes in accordance with the following:

(a) Produce and maintain a permanent record of the chamber temperature utilizing a temperature recording device permanently connected to the unit. The device shall permanently record a data point at a maximum of every two minutes. The temperature shall be displayed for visual monitoring. In the event of a temperature recording device failure, the owner or operator shall:

(i) Manually record the chamber temperature, at a maximum, once every ten minutes until the exhaust cycle is initiated. The temperature shall be manually recorded for no longer than the time necessary to repair the mechanical failure. The operator shall demonstrate proof that repair parts have been ordered if requested by Ohio EPA or approved health department; and

(ii) Discontinue use of the autoclave for the treatment of infectious wastes if failure or malfunction occurs in the temperature measuring device, such as a thermocouple or thermocouple wiring.

(b) Demonstrate the achievement of the performance standard by the treatment unit for the treatment of infectious wastes. The owner or operator shall perform this by checking the daily operation of the pressure and temperature monitoring devices in the following manner:

(i) Record into the daily log, as required in paragraph (I) of this rule, the actual gauge readings of temperature and pressure and not the manual settings of the treatment unit, during the treatment cycle of a load of infectious wastes; and

(ii) Use the gauge pressure versus temperature of saturated steam table in the appendix to this rule to confirm that the temperature or pressure readings obtained from the gauges are within either +2 degrees or +2 pounds per square inch (psi) from either the temperature or pressure readings in the referenced table. If the temperature or pressure monitoring devices are not within +2 degrees or +2 pounds per square inch (psi) in accordance with the gauge pressure versus temperature of saturated steam table located in the appendix to this rule, then the owner or operator shall select one of the following options. The owner or operator may continue use of the autoclave until such time that the autoclave is repaired or calibrated in accordance with paragraph (D)(2)(c) of this rule:

(a) Discontinue use of the autoclave for the treatment of infectious wastes; or

(b) Perform weekly (every seventh day that the autoclave is used for treatment) quality assurance testing in accordance with paragraph (D)(3) of this rule. If the weekly quality assurance testing fails, discontinue use of the autoclave for the treatment of infectious wastes.
until the autoclave is able to operate in accordance with the gauge pressure versus temperature of saturated steam table located in the appendix to this rule. Infectious wastes placed within the unit during and after the failed spore testing shall not be considered treated and shall be handled as infectious wastes.

[Comment: Any autoclave that does not operate within the gauge pressure versus temperature of saturated steam table parameters located in the appendix to this rule and fails the weekly quality assurance testing is to be calibrated. See paragraph (D)(2)(b) of this rule.]

(c) Utilize an independent company to calibrate or repair the autoclave chamber pressure gauge, temperature recording device, or temperature measuring device in accordance with the following:

(i) The manufacturer's maintenance schedule, specifications, or recommendations; or
(ii) A calibration schedule as determined by the facility, with, at a minimum, annually, if the manufacturer's specifications are not available.

[Comment: A direct relationship exists between the pressure and temperature of saturated steam. If either the temperature recording or pressure device begins to give false readings, then the autoclave owner or operator will be able to note this since the published known values will no longer match the observed values. However, the owner or operator will not know if the pressure or temperature value is incorrect and may have to have both instruments evaluated by an independent company.]

(3) Quality assurance. The owner or operator shall perform quality assurance testing to demonstrate the capability of the autoclave to achieve the performance standard of a minimum four \(10^{\log_{10}}\) reduction of Bacillus stearothermophilus spores. The quality assurance testing for autoclaves shall be performed monthly, in accordance with the following provisions:

(a) Perform monthly quality assurance testing every calendar month in which the autoclave is used for the treatment of infectious wastes to ensure the capability of the autoclave to achieve the performance standard of a minimum four \(10^{\log_{10}}\) reduction of Bacillus stearothermophilus spores;

(b) Use a challenge population of spores as either spore strips with a population of at least \(1.0 \times 10^4\) Bacillus stearothermophilus spores, ampules containing at least \(1.0 \times 10^4\) Bacillus stearothermophilus spores per milliliter or a commercially available steam pack which contains a population of at least \(1.0 \times 10^4\) Bacillus stearothermophilus spores. The owner or operator shall ensure that the Bacillus stearothermophilus spore testing methodology does not result in the denaturation of the proteins within the inoculating media;

[Comment: For quality assurance testing, Ohio EPA has set the performance standard for the treatment of infectious wastes by autoclaving to be a four \(10^{\log_{10}}\) reduction of Bacillus stearothermophilus spores. The quality assurance is designed to be a qualitative (growth or no growth) system. If the owner or operator uses strips or ampules with a greater spore population, then the treatment unit must still achieve a complete kill of all spores.]

(c) Compose the waste load of containers of both infectious wastes and non-infectious wastes. The majority of the waste load may consist of infectious wastes. However, at least three test containers shall consist of material such as newspaper, plastic backed absorbent pads, or general refuse placed into either boxes, bags, or sharps containers representative of normal or anticipated use for that autoclave unit. A spore strip or ampule shall be placed in the center of each test container. In the event that the autoclave will not hold three containers of wastes, then each test container shall contain a spore strip or ampule. Alternatively, commercially available steam packs may be placed into the three representative containers instead of the newspaper, plastic backed absorbent pads, or general refuse;

(d) Treat the waste load containing the challenge population of spores in the same manner as the daily operation of the autoclave for the treatment of infectious wastes. This would include the same temperature, pressure, time, and total treatable volume. The quality assurance testing shall be performed at the same combinations of temperature, pressure, and time, as the
validation testing;
(e) Record the following information during the monthly quality assurance testing:
   (i) The date;
   (ii) The time the treatment cycle started, as specified in paragraph (D)(1) of this rule;
   (iii) The time the treatment cycle ended, as specified in paragraph (D)(1) of this rule;
   (iv) The chart or graph of the chamber temperature produced by the permanently connected temperature recording device;
   (v) The name of the person who loaded the autoclave and the name of the person performing laboratory analysis of the challenge population of spores;
   (vi) A diagram depicting the pattern of infectious waste loading and location of the challenge population of spores during the testing except those units which have rotating treatment chambers are not required to diagram the pattern of waste loading;
   (vii) The total treatable volume of infectious wastes used during the quality assurance testing as defined in paragraph (D)(1) of this rule;
   (viii) The autoclave chamber pressure, as displayed by the permanently connected gauge, during the treatment cycle as specified in paragraph (D)(1) of this rule;
   (ix) The incubation temperature and time (in days) of the challenge population of spores, in accordance with the manufacturer's recommendation for optimal growth; and
   (x) The results of spore growth during incubation for a period of seven days or for the maximum period of time as specified by the manufacturer of the spore test. The results of spore growth shall be recorded as indicated by the development of turbidity in the growth media. The development of turbidity in the growth media is indicative of growth of the challenge population of spores present unless other morphological or metabolic testing indicates that the growth is due to a contaminating microorganism.
(f) Remove and incubate the challenge population of spores used in the quality assurance testing for either seven days or for the maximum period of time as specified by the manufacturer of the spore test. If any of the challenge population of spores used to perform the testing are positive for growth at any time during the incubation period, the unit has failed to achieve the performance standard required for treatment. Infectious wastes placed within the unit during and after the spore testing shall not be considered treated and shall be handled as infectious wastes. The autoclave unit shall not be used for further treatment of infectious wastes until the problem has been determined and rectified and another successful quality assurance test performed. The rectification may require the operator to increase the minimum temperature or pressure requirements or cycle time; and
(g) Perform the quality assurance testing, upon request by, and in the presence of, Ohio EPA or approved health department to verify that the written operating procedures as located in the facility management plan are sufficient to meet the performance standard of a four 10log (base ten) reduction in Bacillus stearothermophilus spores. If so directed, the owner or operator shall use twice as many spore tests in the same location in the autoclave and permit Ohio EPA or approved health department to remove and separately incubate one-half of the spore tests.
[Comment: autoclave owners or operators treating infectious wastes in accordance with the specifications in this rule must maintain, for a three year period, the dated permanent recordings of autoclave chamber temperatures, documentation of the calibrations of the temperature measuring devices performed by an independent company, documentation of the monthly checks on the measuring device, and the results of the monthly quality assurance testing using a challenge population of spores.]
(4) Validation testing. The owner or operator shall perform validation testing to demonstrate the capability of the autoclave to achieve the performance standard of a minimum four 10log (base ten) reduction of Bacillus stearothermophilus spores. The validation testing for autoclaves shall be performed in accordance with the following provisions:
[Comment: Validation testing is performed prior to use for treatment by an operator who
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wishes to use an alternative combination to the time, temperature, and pressure requirements specified in paragraph (D)(1)(a) of this rule. Validation testing is a check to ensure that the alternate combination will result in the achievement of the performance standard for treatment. Quality assurance testing is an on-going monitor, performed monthly, of the autoclave’s continuing ability to attain the performance standard for treatment.]

(a) Perform validation testing to ensure that the autoclave, using combinations of temperature, pressure, and time other than the minimums specified in paragraph (D)(1)(a) of this rule, is capable of achieving the performance standard of a minimum four 10log (base ten) reduction of Bacillus stearothermophilus spores;

(b) Use a challenge population of spores as either spore strips with a population of at least 1.0 x 10^4 Bacillus stearothermophilus spores, ampules containing at least 1.0 x 10^4 Bacillus stearothermophilus spores per milliliter or a commercially available steam pack which contains a population of at least 1.0 x 10^4 Bacillus stearothermophilus spores. The owner or operator shall ensure that the Bacillus stearothermophilus spore testing methodology does not result in the denaturation of the proteins within the inoculating media;

[Comment: For validation testing, Ohio EPA has set the performance standard for the treatment of infectious wastes by autoclaving to be a four 10log (base ten) reduction of Bacillus stearothermophilus spores. The validation testing is designed to be a qualitative (growth or no growth) system. If the owner or operator uses strips or ampules with a greater spore population, then the treatment unit must still achieve a complete kill of all spores.]

(c) Compose the validation testing waste load of containers of non-infectious wastes. The waste load for testing shall consist of materials other than infectious wastes, such as newspaper, plastic backed absorbent pads, or general refuse placed into boxes, bags, or sharps containers which are representative of the normal or anticipated use for that autoclave unit. A challenge population of spores shall be placed in the center of each test container;

(d) Treat the waste load containing the challenge population of spores in the same manner as the autoclave will be used during daily operations for the treatment of infectious wastes. This would include the same temperature, pressure, time, and total treatable volume;

(e) Record the following information during the validation testing:

(i) A written statement indicating the autoclave pressure, temperature, and treatment cycle time that the facility owner or operator is attempting to validate for the treatment of infectious wastes;

(ii) The date;

(iii) The time the treatment cycle started, as specified in paragraph (D)(1) of this rule;

(iv) The time the treatment cycle ended, as specified in paragraph (D)(1) of this rule;

(v) The chart or graph of the chamber temperature produced by the permanently connected temperature recording device;

(vi) The name of the person who loaded the autoclave and the name of the person performing laboratory analysis of the challenge population of spores;

(vii) A diagram depicting the pattern of infectious waste loading and location of the challenge population of spores during the validation testing. Those units which have rotating treatment chambers are not required to diagram the pattern of waste loading;

(viii) The total treatable volume of infectious wastes used during the validation testing as defined in paragraph (D)(1) of this rule. Once a total treatable volume of infectious wastes that an autoclave has been validated to treat has been established, infectious waste loads of lesser than the established total treatable volume may be treated without further validation;

(ix) The autoclave chamber pressure, as recorded by the permanently connected gauge, during the treatment cycle as specified in paragraph (D)(1) of this rule;

(x) The challenge population of spores shall be incubated in accordance with the manufacturer’s recommendation for optimal growth; and

(xi) The results of spore growth during incubation shall be recorded daily, for a period of
seven days or for the maximum period of time as specified by the manufacturer of the spore test. The results of spore growth shall be recorded as indicated by the development of turbidity in the growth media. The development of turbidity in the growth media is indicative of growth of the challenge population of spores unless other morphological or metabolic testing indicates that the growth is due to a contaminating microorganism.

(f) Remove and incubate the challenge population of spores used in the validation testing for either seven days or for the maximum period of time as specified by the manufacturer of the spore test. If any of the challenge population of spores used to perform the testing are positive for growth at any time during the incubation period, the unit has failed to achieve the performance standard required for treatment of infectious wastes. In order to utilize the autoclave for the treatment of infectious wastes using combinations of temperature, pressure and time other than the minimums specified in paragraph (D)(1) of this rule, the operator shall either:

(i) Change the treatment cycle temperature, pressure, or time requirements and again perform the validation testing until the performance standard is achieved. Rectification may require the operator to increase the minimum treatment cycle temperature, pressure or time requirements; or

(ii) Operate the autoclave at the minimum operation parameters of one hundred twenty-one degrees Centigrade or two hundred fifty degrees Fahrenheit, fifteen pounds per square inch gauge pressure for sixty minutes.

(g) Perform validation testing, upon request by, and in the presence of, Ohio EPA or approved health department to verify that the written operating procedures as located in the facility management plan are sufficient to meet the performance standard of a four 10log (base ten) reduction in Bacillus stearothermophilus spores. If so directed, the owner or operator shall use twice as many spore tests in the same location in the autoclave and permit Ohio EPA or approved health department to remove and separately incubate one-half of the spore tests.

[Comment: Autoclave owners or operators treating infectious wastes in accordance with the specifications in this rule must maintain, for a three year period, the dated permanent recordings of autoclave chamber temperatures, documentation of the calibrations of the temperature measuring devices performed by an independent company, documentation of the monthly checks on the measuring device, and the results of the validation testing using a challenge population of spores.]

(5) Comply with paragraph (I) of this rule.

(E) Chemical treatment with sodium hypochlorite solution for cultures. The owner or operator of any infectious waste treatment facility utilizing chemical treatment with sodium hypochlorite solution for cultures shall comply with the following:

[Comment: The use of chemical treatment with sodium hypochlorite solution for cultures is intended for those cultures either with surface colonies or in suspension as the chemical must come in direct contact with the cultures to effectively treat the microorganisms.]

(1) Methodology. The owner or operator shall use methods, techniques, and practices for the treatment of infectious wastes in accordance with the following:

(a) The approved chemical treatment solution shall contain, volume per volume, fifteen per cent sodium hypochlorite (household grade bleach);

[Comment: The specific solutions stated in the rule are percent solutions of household bleach not per cent solutions of the active ingredient, sodium hypochlorite. The hypochlorite concentration of household bleaches ranges from 3.00 to 5.25 per cent. The resulting hypochlorite concentration of the treatment solution ranges from 0.45 to 0.79 per cent (or four thousand five hundred to seven thousand eight hundred seventy-five parts per million). To make one gallon of treatment solution, mix 2.4 cups of household bleach and 3.4 quarts (13.6 cups) of water.]

(b) All cultures shall be submerged for a minimum of twenty minutes, in the chemical
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Treatment solution specified in this rule;
(c) Cultures of infectious agents that are recommended by the centers for disease control to be handled in accordance with biosafety level 3 or 4 practices shall not be treated by a non-mechanical chemical treatment method;
(d) Mix the treatment solution immediately prior to use and discard after use; and
(e) Decant or absorb excess treatment solution from the cultures before disposal.
(2) Comply with paragraph (I) of this rule.
(F) Applied heat encapsulation for sharps. The owner or operator of any infectious waste treatment facility utilizing applied heat encapsulation for sharps shall comply with the following:
(1) Methodology. The owner or operator shall use methods, techniques, and practices for the treatment of infectious wastes in accordance with the following:
(a) Process only waste loads of sharps that consist of at least seventy per cent by weight of plastic material;
(b) Process only waste loads of sharps in a heating chamber within the treatment unit for a minimum treatment time of thirty minutes at a minimum temperature of three hundred thirty degrees Fahrenheit;
(c) Process sharps that are not totally encapsulated within a solid plastic mass as sharp infectious wastes;
(d) Treat only sharps as defined in rule 3745-27-01 of the Administrative Code and as specified in division (A)(1)(a) of section 3734.021 of the Revised Code. No other infectious wastes shall be treated using this treatment technology; and
(e) Treat only sharps that contain no more than “residual liquid”. “Residual liquid”, for the purposes of this rule, is defined as that liquid which remains in the waste item after being emptied or in the case of a syringe after the plunger has been fully depressed.
(2) Specific operational criteria. The owner or operator shall design, construct, and operate the equipment for the treatment of infectious wastes in accordance with the following:
(a) Maintain the following documentation for a period of three years for each treatment unit:
(i) A quality assurance log as specified in this rule;
(ii) A daily operating log which permanently maintains a record of the following:
(a) The date of each treatment cycle;
(b) The time of day each treatment cycle was started and ended; and
(c) The name of the person operating the treatment unit for each treatment cycle.
(b) If the treatment of sharps is interrupted as a result of a malfunction of the treatment unit due to such occurrences as jamming, overloading, electrical, or mechanical reasons, all sharps contained within the unit shall be managed as infectious wastes. Infectious wastes may be maintained within the unit until the problem is corrected unless the wastes become putrescent or become a food source or breeding place for insects or rodents; and
(c) Treat only sharps that are not contaminated with chemicals that volatilize or are contaminated with antineoplastic agents.
(3) Quality assurance. The owner or operator shall perform quality assurance testing to demonstrate the capability of the applied heat encapsulation system to achieve the performance standard of a minimum four 10log (base ten) reduction of Bacillus subtilis spores. The owner or operator of the applied heat encapsulation system shall perform quality assurance testing in accordance with the following provisions:
(a) Perform quality assurance testing semi-annually or after every fifty cycles whichever comes first to ensure that the applied heat encapsulation system is capable of achieving the performance standard of a minimum four 10log (base ten) reduction of Bacillus subtilis spores;
(b) Prepare a challenge population of spores using a spore strip, still within the glassine envelope, containing at least a minimum population of 1.0 x 104 Bacillus subtilis spores by:
(i) Wrapping the spore strip in aluminum foil and placing it at the bottom of the heating
chapter, prior to adding sharps and initiation of the treatment cycle, so that the folded seams are placed on the outside of the resulting solid mass; or

(ii) Placing the aluminum foil wrapped spore strip directly into the heating chamber without the addition of any waste, for technologies that utilize a system where the foil wrapped strip would become part of the encapsulated material.

[Comment: For quality assurance testing, Ohio EPA has set the performance standard for the treatment of infectious wastes to be a four 10log (base ten) reduction of Bacillus subtilis spores. The quality assurance is designed to be a qualitative (growth or no growth) system. If the treatment unit owner or operator uses strips with a greater spore population, then the treatment unit must still achieve a complete kill of all spores.]

(c) Compose the waste load of sharp infectious wastes;

(d) Treat the sharp waste load containing the challenge population of spores in the same manner as the daily operation of the applied heat encapsulation system for the treatment of sharps as specified in paragraph (F) of this rule;

(e) Aseptically remove the spore strip from the wrapped foil and glassine envelope, upon completion of the treatment cycle;

(f) Incubate the challenge population of spores used in the quality assurance testing for either seven days or for the maximum period of time as specified by the manufacturer of the spore strip. If any of the challenge population of spores used to perform the testing are positive for growth at any time during the incubation period, the unit has failed to achieve the performance standard required for treatment. Infectious wastes placed within the unit during and after the spore testing shall not be considered treated and shall be handled as infectious wastes. The applied heat encapsulation system shall not be used for further treatment of infectious wastes until the problem has been determined and rectified and another successful quality assurance test performed;

(g) Maintain a quality assurance log that provides a written record of the results of the quality assurance testing performed. Record the following information during the quality assurance testing:

(i) The date;

(ii) The time the treatment cycle started, as specified in paragraph (F) of this rule;

(iii) The time the treatment cycle ended, as specified in paragraph (F) of this rule;

(iv) The heating chamber temperature;

(v) The name of the person who loaded the heating chamber and the name of the person performing laboratory analysis of the challenge population of spores;

(vi) The challenge population of spores shall be incubated in accordance with the manufacturer's recommendation for optimal growth; and

(vii) The results of spore growth during incubation for a period of seven days or for the maximum period of time as specified by the manufacturer of the spore test. The results of spore growth shall be recorded as indicated by the development of turbidity in the growth media. The development of turbidity in the growth media is indicative of growth of the challenge population of spores present unless other morphological or metabolic testing indicates that the growth is due to a contaminating microorganism.

(h) Perform the quality assurance testing, upon request by, and in the presence of, Ohio EPA or approved health department to verify that the written operating procedures as located in the facility management plan are sufficient to meet the performance standard of a four 10log (base ten) reduction in Bacillus subtilis spores. If so directed, the owner or operator shall use twice as many spore strips in the same location in the heating chamber and permit Ohio EPA or approved health department to remove and separately incubate one-half of the spore strips.

(4) Comply with paragraph (I) of this rule.

(G) Chemical treatment with peracetic acid and grinding. The owner or operator of any infectious waste treatment facility utilizing chemical treatment with peracetic acid and grinding
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shall comply with the following:

(1) Methodology. The owner or operator shall use methods, techniques, and practices for the treatment of infectious wastes in accordance with the following:
   (a) Process each waste load using the appropriate concentration of peracetic acid, as specified in paragraph (G)(1)(f) of this rule;
   (b) Operate all treatment units at a minimum of ten minutes per treatment cycle using the following parameters: the grinding cycle shall operate for a minimum of three minutes at the beginning of the treatment cycle. The chemical soak portion of the treatment cycle shall operate for a minimum of seven minutes;
   (c) Mark the canister to indicate the volume of blood present. The person(s) filling the canister with infectious wastes shall mark the canister to indicate that the canister contains less than one hundred milliliters of blood or that the canister contains at least one hundred milliliters but less than one thousand milliliters of blood. The generator shall also separately indicate the approximate volume of blood contained within the canister on the daily operating log as prescribed by Ohio EPA;
   (d) Not process waste loads containing volumes of blood greater than one thousand milliliters or one liter;
   (e) Not process wastes contaminated with non-incidental quantities of chemicals, body parts containing bone, organs, whole carcasses, quantities of gauze or rubber or latex that may become entangled around the rotors or blades, or heavy metal items;
   (f) Use a minimum of 17.1 milliliters of thirty-five per cent peracetic acid when the infectious waste load contains less than or equal to one hundred milliliters of blood. Use a minimum of 79.8 milliliters of thirty-five per cent peracetic acid when the infectious waste load contains greater than one hundred milliliters but less than or equal to one thousand milliliters (one liter) of blood;
   (g) Examine the specifically designed indicator disk upon completion of the treatment cycle and before the waste is dewatered and bagged. The entire indicator on the disk shall have a visible color change as an indication that peracetic acid was used during the process; and
   (h) If there is not a complete color change, then the wastes are not considered treated and shall be treated again with either a new charge of the appropriate concentration of peracetic acid and a new indicator disk or using another approved treatment method in accordance with this rule.

(2) Specific operational criteria. The owner or operator shall design, construct, and operate the equipment for the treatment of infectious wastes in accordance with the following:
   (a) Use rotating blades contained within the specialized canister to grind the infectious wastes;
   (b) Operate all treatment units using a specially designed canister that sets down inside the machine cabinetry and contains internal grinding blades;
   (c) Record the peracetic acid dosage used for each treatment cycle in a daily operating log. The unit operator shall complete the operating log as prescribed by Ohio EPA;
   (d) Keep the cap on the canister when the canister is in use as an infectious waste receptacle. The cap shall not be removed prior to arrival at the treatment area. The collection cap is to be removed before treatment;
   (e) Disinfect the canister cap after each use using any one of the following disinfectants:
      (i) An U.S. EPA registered hospital disinfectant that is also tuberculocidal, for a contact time as specified by the manufacturer; or
      (ii) A unexpired dated stabilized bleach product that is an U.S. EPA registered hospital disinfectant that is also tuberculocidal, for a contact time as specified by the manufacturer; or
      (iii) A minimum ten per cent sodium hypochlorite solution prepared immediately prior to use with a minimum of thirty minutes of contact time.
   (f) If treatment occurs outside the parameters as outlined in this rule, as a result of a
malfunction of the unit due to such occurrences as jamming, overloading, electrical, or mechanical reasons, all wastes contained within the unit shall be managed as infectious wastes. Infectious wastes may be temporarily maintained within the unit unless the wastes becomes putrescent or becomes a food source or breeding ground for insects or rodents.

(3) Quality assurance. The owner or operator shall perform quality assurance testing to demonstrate the capability of the chemical treatment with peracetic acid and grinding unit to achieve the performance standard of a minimum four log10 reduction of Bacillus subtilis spores. The quality assurance testing for the chemical treatment with peracetic acid and grinding unit for the treatment of infectious wastes is specified as follows:

(a) Produce and maintain for a period of three years a permanent record of the daily operational and maintenance activities for the infectious waste treatment technology in the facility management plan as follows:

(i) Utilize a daily operating log form, as prescribed by Ohio EPA for each unit for each day that infectious wastes are treated in the unit. All daily operating logs for a treatment unit shall be grouped together and arranged by date within the grouping; and

(ii) Conduct preventative maintenance checks and services as stated in the operating manual.

(b) Repair the treatment unit in the event of a malfunction of the chemical treatment using peracetic acid and grinding. The unit shall not be used for the treatment of infectious wastes until repaired; and

(c) Perform quality assurance testing, upon request of Ohio EPA, for each unit. This testing shall demonstrate the unit's capability to achieve a minimum four 10 log (base ten) reduction of Bacillus subtilis spores.

(4) Comply with paragraph (I) of this rule; and

(5) Comply with requirements as specified in the director’s approval letter issued in accordance with rule 3745-27-38 of the Administrative Code.

(H) Mobile treatment methods (reserved).

(I) General facility requirements. All owners and operators of a infectious waste treatment facility shall comply with the following:

(1) Retain all records for three years. Retention periods are extended during the course of any unresolved litigation, or when requested by Ohio EPA. The three-year period for records retention shall start from the date of recording, sample, or measurement and is applicable to all records included in the facility management plan;

(2) Develop and maintain in one area on the premises of the infectious waste treatment unit a facility management plan, excluding generators who utilize chemical treatment of cultures or applied heat encapsulation for sharps, in accordance with this rule:

[Comment: The facility management plan may be composed of several volumes, binders, or computer disks.]

(a) The facility management plan shall contain copies of the following information and documentation:

(i) Applicable environmental regulations regarding infectious wastes, solid wastes, surface water, and air pollution control;

(ii) Applicable infectious wastes, solid wastes, surface water, and air authorizing documents (such as licenses, registrations, or permits) for the treatment facility;

(iii) Manufacturer's equipment specifications, owner's manual for the treatment unit, and maintenance schedule;

(iv) Monitor and recording device calibration or replacement schedule;

(v) Maintenance and repair log for each treatment unit;

(vi) Facility contingency plan;

(vii) Results of quality assurance and applicable validation testing requirements;

(viii) Procedures for treatment unit start-up, loading, operating, shut down, and
equipment malfunction;
   (ix) Emergency telephone numbers including, at a minimum: the facility emergency coordinator, the fire department, any existing local emergency management office, the local health department, the police department, and Ohio EPA district office;
   (x) The permanently recorded daily logs as specified in paragraph (I)(3) of this rule. A daily log shall be maintained for each treatment unit for a period of three years;
   (xi) All strip charts, graphs, or manually produced temperature records. Each chart, graph, or record shall be dated and maintained for a period of three years;
   (xii) Disposal shipping papers for the infectious wastes treated; and
   (xiii) A training certification statement, as required in paragraph (I)(3) of this rule, shall be maintained for each employee who operates the infectious waste treatment unit or loads infectious wastes into the infectious wastes treatment unit. Each training certification statement shall be maintained for the duration of such employment.

[Comment: The training certificate statement is not required to be maintained for an employee who no longer works for the organization or whose job responsibilities no longer include and will not include operating or loading the infectious waste treatment unit.]

(b) All of the current calendar year’s information is to be located in this same area such as an office or work area. The two previous calendar year’s information may be maintained in other accessible areas or multiple rooms depending on the amount of available space at the facility. A notation shall be made in the current year’s facility management plan regarding the location of any past calendar year’s information; and

(c) Documents and information contained in paragraph (I)(2)(a) of this rule of the facility management plan shall be accessible to employees during working hours.

[Comment: Nothing in this rule prohibits the facility management plan or parts thereof from being copied and located in other areas of the facility for the purpose of easy access for employees. However, there shall be only one official facility management plan that shall be located in one general area and accessible during working hours.]

(3) Provide training on the contents of the facility management plan for each employee who will operate the infectious waste treatment unit or load the infectious waste treatment unit before the employee is responsible for operating or loading the infectious waste treatment unit. A written certification statement attesting that the employee received the specified training shall be signed and dated by each employee and the owner or operator of the facility;

(4) Use a daily log of operation to record charging of the infectious waste treatment unit. A printout produced by the treatment unit may substitute for the daily log provided all the information required is present on the printout. Unless already required to keep a charging log in accordance with rule 3745-75-04 of the Administrative Code, permanently record in a daily log of operation the following, as applicable:

   (a) The date;
   (b) The time the first load or batch of infectious wastes was charged into each treatment unit;
   (c) The time the last load or batch of infectious wastes were charged into each treatment unit for the day;
   (d) Name(s) of the person(s) operating each infectious waste treatment unit and the time of day the operator started the unit;
   (e) The time the treatment unit was unloaded;
   (f) Whether the load was for validation, quality assurance or usual treatment; and
   (g) The actual daily autoclave pressure and temperature reading.

[Comment: A printout containing partial information may be used when attached to a daily log containing the remaining required information.]

(5) Provide, in the immediate area of the infectious waste treatment unit and readily available to the personnel operating the treatment unit, the operating and loading procedures for

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the treatment unit;

(6) If the treatment of infectious wastes occurs outside the treatment parameters established in each methodology paragraph of this rule specific to the type of treatment technology in use and as a result of a malfunction of the unit due to such occurrences as jamming, overloading, electrical, or mechanical reasons, then all wastes contained within the unit shall be managed as infectious wastes. The infectious wastes may be maintained within the treatment unit until the problem is corrected unless the wastes become putrescent or become a food source or breeding place for insects or rodents;

(7) Conduct all construction and operations at the facility in strict compliance with the applicable authorizing document(s), including permit(s) to install issued under Chapter 3745-27 of the Administrative Code, plan approval(s), and alteration(s) concurred with in writing by Ohio EPA; the license issued under Chapter 3745-37 of the Administrative Code; court orders; and findings and orders issued by the director;

(8) Construct and maintain all-weather access roads in such a manner as will withstand the anticipated degree of use and allow passage of vehicles with minimum erosion and dust generation;

(9) Construct and maintain non-absorbent floors in all infectious waste handling areas. Such areas shall not be overlaid with an absorbent covering;

[Comment: Nothing in this paragraph prohibits the overlaying of the concrete or asphalt floors with a cleanable non-absorbent covering.]

(10) Conduct loading operations into any treatment unit in such a manner as not to compact or puncture the containers of infectious wastes;

(11) Do not charge infectious wastes into the treatment unit during periods of precipitation unless the wastes to be loaded and the waste loading operations are protected from the elements of weather;

(12) Discharge into a disposal system in accordance with Chapter 6111 of the Revised Code or absorb and handle as infectious wastes, any wastewater resulting from a spill of infectious wastes or the cleanup of a spill of infectious wastes from all infectious waste handling areas. Such wastewater shall not be disposed into a storm sewer;

(13) Construct and maintain proper slopes and drainage to prevent the ponding of liquids in infectious waste handling areas;

[Comment: Methods of drainage are not limited to systems consisting of underground pipes.]

(14) Restrict infectious waste handling areas to authorized personnel, utilizing signs or a locking mechanism;

(15) Shall not treat wastes for which such treatment or disposal is prohibited by the Ohio department of health or the U.S. nuclear regulatory commission;

(16) Shall not accept wastes for which such storage, treatment or disposal is prohibited in the “hazardous wastes rules” as defined in paragraph (A) of rule 3745-50-10 of the Administrative Code;

[Comment: The “hazardous wastes rules” as defined in paragraph (A) of rule 3745-50-10 of the Administrative Code contain the regulations for the proper handling of hazardous wastes. For technical information regarding the designation, handling, treatment, and disposal of hazardous waste, please contact the division of hazardous waste management at the appropriate Ohio EPA district office.]

(17) The owner or operator of a licensed infectious waste treatment facility shall submit an annual report to Ohio EPA central office and the approved health district no later than February first of each year. The annual report shall consist, at a minimum, of the following:

(a) The name, address, telephone number, and contact person for the facility;
(b) Hours of operation for the facility;
(c) Monthly total of infectious wastes treated at the facility for each state or country of
origin; and
(d) Any quality assurance results that do not demonstrate achievement of the performance standard.

(18) Infectious wastes that have been treated in accordance with the provisions of this rule shall be handled in the same manner as solid wastes. Such treated infectious wastes shall be disposed in a licensed solid waste disposal facility, or a facility in another state operating in compliance with state and federal regulations. Shipments of treated infectious wastes shall be accompanied by disposal papers as required by rule 3745-27-33 of the Administrative Code; [Comment: Small generators of infectious wastes who treat the infectious wastes that they generate are not required to comply with the disposal shipping paper requirements of rule 3745-27-33 of the Administrative Code.]

(19) All “sharps” shall be managed in a manner to eliminate the potential of those wastes to cause lacerations or puncture wounds during handling and disposal;
(20) Perform quality assurance testing to demonstrate the ability of the treatment unit to achieve the performance standard if the unit has not been used for the treatment of infectious wastes for more than one year;
(21) Any large generator who treats infectious wastes on-site and any infectious waste treatment facility licensed to treat infectious wastes, who intends to discontinue treating infectious wastes at any facility or premise, shall comply with rules 3745-27-36 and 3745-27-39 of the Administrative Code;
(22) Apply for and obtain an operating license from the board of health of the health district where the facility will be located, or from the director if the director has assumed the licensing function, unless the facility currently holds an operating license; and
(23) The following infectious waste treatment facilities are exempt from the permitting and licensing requirements stated in division (C) of section 3734.02 and division (B) of section 3734.05 of the Revised Code:
   (a) An infectious waste treatment facility that is owned or operated by the generator of the wastes and exclusively treats wastes that are produced by that generator at any premises owned or operated by that generator, by methods established under this rule; and
   (b) Hospitals as defined in section 3727.01 of the Revised Code, that accept for treatment infectious wastes generated by any of the following:
      (i) Generators who produce fewer than fifty pounds of infectious wastes during any one month and who are not listed on a registration certificate as a generator of infectious wastes and who have staff privileges at that hospital; or
      (ii) An emergency medical service organization, as defined in section 4765.01 of the Revised Code, regardless of whether the wastes were generated in providing care to the patient at the scene of an emergency or during the transportation of the patient to the hospital; or
      (iii) An individual for purposes of his own care or treatment.

3745-27-33 Disposal paper system.

(A) The disposal paper shall accompany treated infectious wastes from the treatment facility to the disposal facility. The disposal paper shall:
   (1) Be produced from a form prescribed by or approved by Ohio EPA;
   (2) Be legible and complete;
   (3) Be kept on file for a minimum of three years;
   (4) Be prepared by:
      (a) The infectious waste treatment facility responsible for treating the wastes when a shipment of treated wastes is transported to a solid waste disposal facility; and
      (b) The generator if the infectious waste treatment facility is owned or operated by the generator.
(5) Be signed, dated, and given to the transporter by the infectious waste treatment facility before the wastes are removed from the premises;

(6) Contain the following information:
   (a) The name of the owner or operator of the facility where the wastes were treated and the address of the treatment facility;
   (b) A certification by the owner or operator of the treatment facility where the wastes were treated indicating that the wastes have been treated by the methods, techniques, and practices prescribed by paragraph (A) of rule 3745-27-32 of the Administrative Code.

(7) Not apply to generators who do not hold a registration certificate as a generator of fifty pounds or more of infectious waste in any one month;

(8) Not be kept by a transfer facility but shall continue to accompany the treated infectious wastes to the solid waste disposal facility.

(B) Records retention periods shall be extended during the course of any unresolved litigation, or when so requested by Ohio EPA. The three-year period for retention of records shall start from the date of sample, measurement, or report.

3745-27-35 Standards for handling infectious wastes.

(A) For the purposes of this rule, a storage area means an area used to collect containers that are sealed, or bags that are sealed or otherwise closed, and tied, or closed sharps containers prior to treatment. Generators and treatment facilities, as defined under Chapter 3734 of the Revised Code, shall adhere to the following handling requirements for all in-use and stored containers of infectious waste:
   (1) Handle infectious waste containers in a manner and location that maintains the integrity of the container;
   (2) Lock outside storage areas containing infectious wastes containers to prevent unauthorized access;
   (3) Designate infectious waste storage areas. Those storage areas that are not locked, shall be visibly labeled with a sign stating "warning: infectious waste" or displaying the international biohazard symbol at all points of access.

(B) Generators and treatment facilities, as defined under Chapter 3734 of the Revised Code, shall adhere to the following regulations for the management of the infectious wastes within containers:
   (1) Maintain infectious wastes in a nonputrescent state, using refrigeration or freezing when necessary; and
   (2) If infectious waste becomes putrescent, then the waste must be immediately refrigerated or frozen and shall be treated and disposed of as soon as possible regardless of any storage time frame;
   (3) Maintain infectious wastes in a manner that affords protection from animals and does not provide a breeding place or a food source for insects or rodents.

(C) Infectious waste treatment facilities shall adhere to the following storage regulations:
   (1) No infectious waste may be stored more than fourteen days at any facility;
   (2) No more than seven times the treatment facility's total maximum daily throughput capacity of all incinerators and/or autoclaves shall be stored for treatment;
   (3) All facilities shall formulate a contingency plan. At a minimum the plan shall:
      (a) Address compliance with the requirements set forth in paragraphs (A) and (B) of this rule, and shall provide for the removal of infectious wastes to an alternate treatment facility;
      (b) Be maintained at the treatment facility as a part of the facility management plan in accordance with rule 3745-27-32 of the Administrative Code;
      (c) Designate an emergency coordinator and an alternate emergency coordinator; and
      (d) Contain all of the following:
(i) Table of contents, and
(ii) Facility identification, and
(iii) Purpose statement, and
(iv) Emergency response equipment, and
(v) A designation of alternative treatment facilities, and
(vi) Responsibilities of emergency coordinator, and
(vii) Storage procedures, and
(viii) Handling procedures, and
(ix) Refrigeration and freezing requirements in accordance with rule 3745-27-35 of the
Administrative Code, and
(x) Implementation of response, and
(xi) Internal notification, and
(xii) Provide a posting of emergency procedures.
(4) If the treatment facility exceeds or reasonably anticipates exceeding storage
capacity, then the treatment facility shall implement its contingency plan and notify on the same
or next business day the appropriate health department and Ohio EPA district office of the
implementation of the contingency plan;
(5) A generator who also treats infectious wastes generated on premises owned or
operated by the generator shall be subject to the requirements of paragraph (C) of this rule
when the untreated infectious wastes are in a centralized storage area directly prior to
treatment; and
(6) Other storage methods approved by the director.
(D) For the purposes of this rule, a treatment facility may utilize a trailer as a storage
area only if the trailer is equipped in such a manner as to prevent the spillage of infectious
wastes or liquids outside of the trailer.
(E) Generators that collect and store infectious wastes, produced by multiple infectious
waste generators in a centralized location, shall store and handle the infectious wastes in
accordance with this rule.

3745-27-36 Registration requirements for generators of infectious waste.

(A) Generator registration requirements.
(1) All persons who generate fifty pounds or more of infectious waste in any one month
at any one location shall register with Ohio EPA as follows:
(a) Not later than thirty days after the last day of the month in which fifty pounds or more
of infectious waste were generated, the generator must submit to Ohio EPA an application for a
registration certificate accompanied by an application fee of one hundred forty dollars. The
application fee is non-refundable and the check for the application fee shall be made payable to
the "Treasurer-State of Ohio." A certificate is valid for three years.
(b) A registration certificate shall include all premises owned or operated by the
generator which generates fifty pounds or more of infectious waste in any one month or treats
infectious waste.
(c) A registration certificate is not transferable to another generator.
(2) Amendments. Any generator who holds a valid registration certificate under this rule
shall ensure that all information that is contained on the registration certificate is correct and up
to date by submitting an amended registration application form and obtaining an amended
registration certificate that reflects any changes to current registrant information, premises
information, or treatment method. No additional fee shall be charged to amend a registration
certificate. An amended registration shall not alter the expiration date of the original registration
certificate.
(3) Renewals. All generators who hold a valid registration certificate under this rule shall,
at least thirty days prior to the expiration of the valid registration certificate, do one of the following:

(a) Submit an application to renew the registration.
(b) Submit to Ohio EPA a reversion to small generator application which states that fifty pounds or more of infectious waste in any one month is no longer generated by the generator at any premises operated by the generator.

The generator shall provide verification that no more than fifty pounds of infectious waste were generated in any one month during the six months prior to expiration, at a minimum. In addition, if untreated liquid infectious waste is disposed of on the premises, the generator shall include a monthly log of the amount produced.

(4) Upon written notification that an application is incomplete the applicant shall, within fifteen days of receipt of the notification, correct noted deficiencies and resubmit the form or application. A registration cycle shall not be considered to be extended in the event of a deficiency notification or late submittal of an application.

(5) The applicant, owner, or operator signing a document in accordance with this rule shall be one of the following:

(a) A person as defined in sections 3734.01 and 1.59 of the Revised Code.
(b) In the case of a corporation, a principal executive officer of at least the level of vice-president or a duly authorized representative, who is responsible for the overall operation of a facility where infectious waste is generated.
(c) In the case of a partnership, a general partner.
(d) In the case of sole proprietorship, the owner.
(e) In the case of a municipal, state, federal, or other governmental facility, the principal executive officer, the ranking elected official, or other duly authorized employee.
(f) In the case of a limited liability company, a manager, member, or other duly authorized representative of the limited liability company, if such representative is responsible for the overall operation of the facility.

(6) Persons, who as part of their business activities engage in the designation and segregation of infectious wastes at places including but not limited to crime or accident scenes, and who generate fifty pounds or more of infectious wastes per month are subject to the requirements of this rule.

Environmental Audit

3745.70 Environmental audit; definitions.

As used in sections 3745.70 to 3745.73 of the Revised Code:
(A) "Environmental audit" means a voluntary, thorough, and discrete self-evaluation of one or more activities at one or more facilities or properties that is documented; is designed to improve compliance, or identify, correct, or prevent noncompliance, with environmental laws; and is conducted by the owner or operator of a facility or property or the owner's or operator's employee or independent contractor. An environmental audit may be conducted by the owner or operator of a facility or property, the owner's or operator's employees, or independent contractors. Once initiated, an audit shall be completed within a reasonable time, not to exceed six months, unless a written request for an extension is approved by the head officer of the governmental agency, or division or office thereof, with jurisdiction over the activities being audited based on a showing of reasonable grounds. An audit shall not be considered to be initiated until the owner or operator or the owner's or operator's employee or independent contractor actively has begun the self-evaluation of environmental compliance.
(B) "Activity" means any process, procedure, or function that is subject to environmental laws.
(C) “Voluntary” means, with respect to an environmental audit of a particular activity, that both of the following apply when the audit of that activity commences:

(1) The audit is not required by law, prior litigation, or an order by a court or a government agency;

(2) The owner or operator who conducts the audit does not know or have reason to know that a government agency has commenced an investigation or enforcement action that concerns a violation of environmental laws involving the activity or that such an investigation or enforcement action is imminent.

(D) “Environmental audit report” means interim or final data, documents, records, or plans that are necessary to an environmental audit and are collected, developed, made, and maintained in good faith as part of the audit, and may include, without limitation:

(1) Analytical data, laboratory reports, field notes and records of observations, findings, opinions, suggestions, conclusions, drafts, memoranda, drawings, photographs, computer-generated or electronically recorded information, maps, charts, graphs, and surveys;

(2) Reports that describe the scope, objectives, and methods of the environmental audit, audit management policies, the information gained by the environmental audit, and conclusions and recommendations together with exhibits and appendices;

(3) Memoranda, documents, records, and plans analyzing the environmental audit report or discussing implementation, prevention, compliance, and remediation issues associated with the environmental audit.

“Environmental audit report” does not mean corrective or remedial action taken pursuant to an environmental audit.

(E) “Environmental laws” means sections 939.02 and 1531.29, Chapters 3704., 3734., 3745., 3746., 3750., 3751., 3752., 6109., and 6111 of the Revised Code, and any other sections or chapters of the Revised Code the principal purpose of which is environmental protection; any federal or local counterparts or extensions of those sections or chapters; rules adopted under any such sections, chapters, counterparts, or extensions; and terms and conditions of orders, permits, licenses, license renewals, variances, exemptions, or plan approvals issued under such sections, chapters, counterparts, or extensions.

3745.71 Environmental audit; privileged information.

(A) Except as otherwise provided in division (C) of this section, the owner or operator of a facility or property who conducts an environmental audit of one or more activities at the facility or property has a privilege with respect to both of the following:

(1) The contents of an environmental audit report that is based on the audit;

(2) The contents of communications between the owner or operator and employees or contractors of the owner or operator, or among employees or contractors of the owner or operator, that are necessary to the audit and are made in good faith as part of the audit after the employee or contractor is notified that the communication is part of the audit.

(B) Except as otherwise provided in or ordered pursuant to this section, information that is privileged under this section is not admissible as evidence or subject to discovery in any civil or administrative proceeding and a person who possesses such information as a result of conducting or participating in an environmental audit shall not be compelled to testify in any civil or administrative proceeding concerning the privileged portions of the environmental audit.

(C) The privilege provided in this section does not apply to criminal investigations or proceedings. Where an audit report is obtained, reviewed, or used in a criminal proceeding, the privilege provided in this section applicable to civil or administrative proceedings is not waived or eliminated. Furthermore, the privilege provided in this section does not apply to particular information under any of the following circumstances:

(1) The privilege is not asserted with respect to that information by the owner or operator
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to whom the privilege belongs.

(2) The owner or operator to whom the privilege belongs voluntarily testifies, or has provided written authorization to an employee, contractor, or agent to testify on behalf of the owner or operator, as to that information.

(3) A court of record in a civil proceeding or the tribunal or presiding officer in an administrative proceeding finds, pursuant to this section, that the privilege does not apply to that information.

(4) The information is required by law to be collected, developed, maintained, reported, disclosed publicly, or otherwise made available to a government agency.

(5) The information is obtained from a source other than an environmental audit report, including, without limitation, observation, sampling, monitoring, a communication, a record, or a report that is not part of the audit on which the audit report is based.

(6) The information is collected, developed, made, or maintained in bad faith or for a fraudulent purpose.

(7) The owner or operator to whom the privilege belongs waives the privilege, in whole or in part, explicitly or by engaging in conduct that manifests a clear intent that the information not be privileged. If an owner or operator introduces part of an environmental audit report into evidence in a civil or administrative proceeding to prove that the owner or operator did not violate, or is no longer violating, any environmental laws, the privilege provided by this section is waived with respect to all information in the audit report that is relevant to that issue.

(8)(a) The information shows evidence of noncompliance with environmental laws and the owner or operator fails to do any of the following:

(i) Promptly initiate reasonable efforts to achieve compliance upon discovery of the noncompliance through an environmental audit;

(ii) Pursue compliance with reasonable diligence;

(iii) Achieve compliance within a reasonable time.

(b) "Reasonable diligence" includes, without limitation, compliance with section 3745.72 of the Revised Code.

(9) The information contains evidence that a government agency federally authorized, approved, or delegated to enforce environmental laws has reasonable cause to believe is necessary to prevent imminent and substantial endangerment or harm to human health or the environment.

(10) Any circumstance in which both of the following apply:

(a) The information contains evidence regarding an alleged violation of environmental laws and a government agency charged with enforcing any of those laws has a substantial need for the information to protect public health or safety or to prevent substantial harm to property or the environment.

(b) The government agency is unable to obtain the substantial equivalent of the information by other means without unreasonable delay or expense.

(11) The information consists of personal knowledge of an individual who did not obtain that information as part of an environmental audit.

(12) The information is not clearly identified as part of an environmental audit report. For purposes of this section, clear identification of information as part of an environmental audit report includes, without limitation, either of the following:

(a) The information is contained in a document and the front cover, the first page, or a comparable part of the document is prominently labeled with "environmental audit report: privileged information" or substantially comparable language.

(b) The information is contained in an electronic record and the record is programmed to display or print prominently "environmental audit report: privileged information" or substantially comparable language before the privileged information is displayed or printed.

(13) The information existed prior to the initiation of the environmental audit under
division (A) of section 3745.70 of the Revised Code.

(D) If the privilege provided in this section belongs to an owner or operator who is not an individual, the privilege may be asserted or waived, in whole or in part, on behalf of the owner or operator only by an officer, manager, partner, or other comparable person who has a fiduciary relationship with the owner or operator and is authorized generally to act on behalf of the owner or operator or is a person who is authorized specifically to assert or waive the privilege.

(E) A person asserting the privilege provided in this section has the burden of proving the applicability of the privilege by a preponderance of the evidence. If a person seeking disclosure of information with respect to which a privilege is asserted under this section shows evidence of noncompliance with environmental laws pursuant to division (C)(8) of this section, the person asserting the privilege also has the burden of proving by a preponderance of the evidence that reasonable efforts to achieve compliance with those laws were initiated promptly and that compliance was pursued with reasonable diligence and achieved within a reasonable time.

(F) When determining whether the privilege provided by this section applies to particular information, a court of record that is not acting pursuant to division (G) of this section, or the tribunal or presiding officer in an administrative proceeding, shall conduct an in camera review of the information in a manner consistent with applicable rules of procedure.

(G)(1) The prosecuting attorney of a county or the attorney general, having probable cause to believe, based on information obtained from a source other than an environmental audit report, that a violation has been committed under environmental laws for which a civil or administrative action may be initiated, may obtain information with respect to which a privilege is asserted under this section pursuant to a search warrant, subpoena, or discovery under the Rules of Civil Procedure. The prosecuting attorney or the attorney general immediately shall place the information under seal and shall not review or disclose its contents.

(2) Not later than sixty days after receiving an environmental audit report under division (G)(1) of this section, the prosecuting attorney or the attorney general may file with the court of common pleas of a county in which there is proper venue to bring a civil or administrative action pertaining to the alleged violation a petition requesting an in camera hearing to determine if the information described in division (G)(1) of this section is subject to disclosure under this section. Failure to file such a petition shall cause the information to be released to the owner or operator to whom it belongs.

(3) Upon the filing of a petition under division (G)(2) of this section, the court shall issue an order scheduling an in camera hearing, not later than forty-five days after the filing of the petition, to determine if any or all of the information described in division (G)(1) of this section is subject to disclosure under this section. The order shall allow the prosecuting attorney or the attorney general to remove the seal from the report in order to review it and shall place appropriate limitations on distribution and review of the report to protect against unnecessary disclosure.

(4) The prosecuting attorney or the attorney general may consult with government agencies regarding the contents of the report to prepare for the in camera hearing. Information described in division (G)(1) of this section that is used by the prosecuting attorney or the attorney general to prepare for the in camera hearing shall not be used by the prosecuting attorney, the attorney general, an employee or agent of either of them, or an agency described in division (G)(4) of this section in any investigation or proceeding against the respondent, and otherwise shall be kept confidential, unless the information is subject to disclosure under this section.

(5) The parties may stipulate that information contained in an environmental audit report is or is not subject to disclosure under this section.

(6) If the court determines that information described in division (G)(1) of this section is subject to disclosure under this section, the court shall compel disclosure under this section of
only the information that is relevant to the proceeding described in division (G)(1) of this section.

(H) Nothing in this section affects the nature, scope, or application of any privilege of confidentiality or nondisclosure recognized under another section of the Revised Code or the common law of this state, including, without limitation, the work product doctrine and attorney-client privilege.

(I) The privilege provided by this section applies only to information and communications that are part of environmental audits initiated after March 13, 1997, in accordance with the time frames specified in division (A) of section 3745.70 of the Revised Code.

3745.72 Environmental audits immunity and liability; exceptions.

(A) The owner or operator of a facility or property who conducts an environmental audit of the facility or property and promptly and voluntarily discloses information contained in or derived from an audit report that is based on the audit and concerns an alleged violation of environmental laws to the director of the state agency that has jurisdiction over the alleged violation is immune from any administrative and civil penalties for the specific violation disclosed, except that where the disclosed violation has resulted in significant economic benefit to the owner or operator of the facility or property, there is no immunity for the economic benefit component of the administrative and civil penalties for that violation. An owner or operator asserting entitlement to such immunity has the burden of proving that entitlement by a preponderance of the evidence.

(B) For the purposes of this section, a disclosure of information is voluntary with respect to an alleged violation of environmental laws only if all of the following apply:

(1) The disclosure is made promptly after the information is obtained through the environmental audit by the owner or operator who conducts the environmental audit.

(2) A reasonable, good faith effort is made to achieve compliance as quickly as practicable with environmental laws applicable to the information disclosed.

(3) Compliance with environmental laws applicable to the information disclosed is achieved as quickly as practicable or within such period as is reasonably ordered by the director of the state agency that has jurisdiction over the alleged violation.

(4) The owner or operator cooperates with the director of the state agency that has jurisdiction over the alleged violation in investigating the cause, nature, extent, and effects of the noncompliance.

(5) The disclosure is not required by law, prior litigation, or an order by a court or a government agency.

(6) The owner or operator who makes the disclosure does not know or have reason to know that a government agency charged with enforcing environmental laws has commenced an investigation or enforcement action that concerns a violation of such laws involving the activity.

(C) For the purposes of this section, a disclosure shall be in writing, dated, and hand delivered or sent by certified mail to the director of the state agency that has jurisdiction over the alleged violation, and shall contain all of the following in a printed letter attached to the front of the disclosure:

(1) The name, address, and telephone number of the owner or operator making the disclosure;

(2) The name, title, address, and telephone number of one or more persons associated with the owner or operator who may be contacted regarding the disclosure;

(3) A brief summary of the alleged violation of environmental laws, including, without limitation, the nature, date, and location of the alleged violation to the extent that the information is known by the owner or operator;

(4) A statement that the information is part of an environmental audit report and is being disclosed under section 3745.72 of the Revised Code in order to obtain the immunity provided
by that section.

(D) This section does not provide immunity from the payment of damages for harm to persons, property, or the environment; the payment of reasonable costs incurred by a government agency in responding to a disclosure; or responsibility for the remediation or cleanup of environmental harm under environmental laws.

(E) The immunity provided by this section does not apply under any of the following circumstances:

(1) Within the three-year period prior to disclosure, the owner or operator of a facility or property has committed significant violations that constitute a pattern of continuous or repeated violations of environmental laws, environmental related settlement agreements, or environmental related judicial orders and that arose from separate and distinct events. For the purposes of division (E)(1) of this section, a pattern of continuous or repeated violations also may be demonstrated by multiple settlement agreements related to substantially the same alleged significant violations that occurred within the three-year period immediately prior to the voluntary disclosure. Determination of whether a person has a pattern of continuous or repeated violations under division (E)(1) of this section shall be based on the compliance history of the property or specific facility at issue.

(2) With respect to a specific violation, the violation resulted in serious harm or in imminent and substantial endangerment to human health or the environment.

(3) With respect to a specific violation, the violation is of a specific requirement of an administrative or judicial order.

(F) The immunity provided by this section applies only to disclosures made concerning environmental audits initiated after March 13, 1997, in accordance with the time frames specified in division (A) of section 3745.70 of the Revised Code.

(G) The immunity provided by this section applies to a person who makes a good faith disclosure to a state agency under this section even though another state agency is determined to have jurisdiction over an alleged violation of environmental laws indicated in the disclosure.

(H) Each state agency that receives a disclosure under this section promptly shall record receipt of the disclosure, determine whether it has jurisdiction over the alleged violation of environmental laws indicated in the disclosure, and, if it does not have such jurisdiction, deliver the disclosure documents to the director of a state agency that has jurisdiction over the alleged violation. If a disclosure indicates alleged violations of environmental laws that are under the jurisdiction of more than one state agency, the state agency that first receives the disclosure and has jurisdiction over any of the alleged violations promptly shall notify the director of each state agency that has jurisdiction over any of such alleged violations. The director of each state agency that receives a disclosure under this section, or is notified by another state agency that the director's agency has jurisdiction over an alleged violation of environmental laws indicated in the disclosure, promptly shall deliver written notice of that fact by certified mail to the owner or operator who made the disclosure. The notice shall identify the state agency that sends the notice; state the name, title, address, and telephone number of a person in the agency whom the owner or operator may contact regarding the disclosure; and state the name, address, and telephone number of the director of any other state agency notified about the disclosure because that agency has jurisdiction over an alleged violation of environmental laws indicated in the disclosure.

EPA Confidentiality

3745-48-04 Confidentiality statutes.

[Editor’s Note: The “Comment” portion of the following regulation is part of the official provision.]
The following federal statutes or regulations or state statutes and administrative rules make personal information maintained by the agency confidential and identify the confidential personal information within this chapter:

(A) Social security numbers pursuant to 5 U.S.C. 522a., unless the individual was told that the number would be disclosed.

(B) Bureau of criminal investigation and information criminal records check results pursuant to section 4776.04 of the Revised Code.

(C) Medical records pursuant to division (A) of section 149.43 of the Revised Code.

(D) Any other personal information that is considered confidential pursuant to section 149.43 of the Revised Code.

[Comment: For dates of non-regulatory government publications, publications of recognized organizations and associations, federal rules, and federal statutory provisions referenced in this rule, see the “Incorporation by Reference” section in paragraph (B) of rule 3745-48-01 of the Administrative Code.]

Part II. Fire Marshal and Petroleum Underground Storage

Underground Storage Tanks

[Editor’s Note: Additional statutes and regulations governing underground storage tanks are available at http://www.com.state.oh.us/fire/]

3737.87 Definitions; underground storage tanks.

As used in sections 3737.87 to 3737.98 of the Revised Code:

(A) “Accidental release” means any sudden or nonsudden release of petroleum that was neither expected nor intended by the owner or operator of the applicable underground storage tank system and that results in the need for corrective action or compensation for bodily injury or property damage.

(B) “Corrective action” means any action necessary to protect human health and the environment in the event of a release of petroleum into the environment, including, without limitation, any action necessary to monitor, assess, and evaluate the release. In the instance of a suspected release, “corrective action” includes, without limitation, an investigation to confirm or disprove the occurrence of the release. In the instance of a confirmed release, “corrective action” includes, without limitation, the initial corrective action taken under section 3737.88 or 3737.882 of the Revised Code and rules adopted or orders issued under those sections and any action taken consistent with a remedial action to clean up contaminated ground water, surface water, soils, and subsurface material and to address the residual effects of a release after the initial corrective action is taken.

(C) “Eligible lending institution” means a financial institution that is eligible to make commercial loans, is a public depository of state funds under section 135.03 of the Revised Code, and agrees to participate in the petroleum underground storage tank linked deposit program provided for in sections 3737.95 to 3737.98 of the Revised Code.

(D) “Eligible owner” means any person that owns six or fewer petroleum underground storage tanks comprising a petroleum underground storage tank or underground storage tank system.

(E) “Installer” means a person who supervises the installation of, performance of major repairs on site to, abandonment of, or removal of underground storage tank systems.

(F) “Major repair” means the restoration of a tank or an underground storage tank system component that has caused a release of a product from the underground storage tank.
system. “Major repair” does not include modifications, upgrades, or routine maintenance for normal operational upkeep to prevent an underground storage tank system from releasing a product.

(G) “Operator” means the person in daily control of, or having responsibility for the daily operation of, an underground storage tank system.

(H) “Owner” means:

1. In the instance of an underground storage tank system in use on November 8, 1984, or brought into use after that date, the person who owns the underground storage tank system;

2. In the instance of an underground storage tank system in use before November 8, 1984, that was no longer in use on that date, the person who owned the underground storage tank system immediately before the discontinuation of its use.

“Owner” includes any person who holds, or, in the instance of an underground storage tank system in use before November 8, 1984, but no longer in use on that date, any person who held immediately before the discontinuation of its use, a legal, equitable, or possessory interest of any kind in an underground storage tank system or in the property on which the underground storage tank system is located, including, without limitation, a trust, vendor, vendee, lessor, or lessee. “Owner” does not include any person who, without participating in the management of an underground storage tank system and without otherwise being engaged in petroleum production, refining, or marketing, holds indicia of ownership in an underground storage tank system primarily to protect the person's security interest in it.

(I) “Person,” in addition to the meaning in section 3737.01 of the Revised Code, means the United States and any department, agency, or instrumentality thereof.

(J) “Petroleum” means petroleum, including crude oil or any fraction thereof, that is a liquid at the temperature of sixty degrees Fahrenheit and the pressure of fourteen and seven-tenths pounds per square inch absolute. “Petroleum” includes, without limitation, motor fuels, jet fuels, distillate fuel oils, residual fuel oils, lubricants, petroleum solvents, and used oils.

(K) “Petroleum underground storage tank linked deposit” means a certificate of deposit placed by the treasurer of state with an eligible lending institution pursuant to sections 3737.95 to 3737.98 of the Revised Code.

(L) “Regulated substance” means petroleum or any substance identified or listed as a hazardous substance in rules adopted under division (D) of section 3737.88 of the Revised Code.

(M) “Release” means any spilling, leaking, emitting, discharging, escaping, leaching, or disposing of from an underground storage tank system into ground or surface water or subsurface soils or otherwise into the environment.

(N) Notwithstanding division (F) of section 3737.01 of the Revised Code, “responsible person” means the person who is the owner or operator of an underground storage tank system.

(O) “Tank” means a stationary device designed to contain an accumulation of regulated substances that is constructed of manufactured materials.

(P) “Underground storage tank” means one or any combination of tanks, including the underground pipes connected thereto, that are used to contain an accumulation of regulated substances the volume of which, including the volume of the underground pipes connected thereto, is ten per cent or more beneath the surface of the ground.

“Underground storage tank” does not include any of the following or any pipes connected to any of the following:


2. Farm or residential tanks of one thousand one hundred gallons or less capacity used for storing motor fuel for noncommercial purposes;
(3) Tanks used for storing heating fuel for consumptive use on the premises where stored;
(4) Surface impoundments, pits, ponds, or lagoons;
(5) Storm or waste water collection systems;
(6) Flow-through process tanks;
(7) Storage tanks located in underground areas, including, without limitation, basements, cellars, mine workings, drifts, shafts, or tunnels, when the tanks are located on or above the surface of the floor;
(8) Septic tanks;
(9) Liquid traps or associated gathering lines directly related to oil or gas production and gathering operations.

(Q) “Underground storage tank system” means an underground storage tank and the connected underground piping, underground ancillary equipment, and containment system, if any.

(R) “Revenues” means all fees, premiums, and charges paid by owners and operators of petroleum underground storage tanks to the petroleum underground storage tank release compensation board created in section 3737.90 of the Revised Code; proceeds received by the board from any insurance, condemnation, or guaranty; the proceeds of petroleum underground storage tank revenue bonds; and the income and profits from the investment of any such revenues.

(S) “Revenue bonds,” unless the context indicates a different meaning or intent, means petroleum underground storage tank revenue bonds and petroleum underground storage tank revenue refunding bonds that are issued by the petroleum underground storage tank release compensation board pursuant to sections 3737.90 to 3737.948 of the Revised Code.

(T) “Class C release” means a release of petroleum occurring or identified from an underground storage tank system subject to sections 3737.87 to 3737.89 of the Revised Code for which the responsible person for the release is specifically determined by the fire marshal not to be a viable person capable of undertaking or completing the corrective actions required under those sections for the release. “Class C release” also includes any release designated as a “class C release” in accordance with rules adopted under section 3737.88 of the Revised Code.

3737.88 UST program under state fire marshal.

(A)(1) The fire marshal shall have responsibility for implementation of the underground storage tank program and corrective action program for releases of petroleum from underground storage tanks established by the “Resource Conservation and Recovery Act of 1976,” 90 Stat. 2795, 42 U.S.C.A. 6901, as amended. To implement the programs, the fire marshal may adopt, amend, and rescind such rules, conduct such inspections, require annual registration of underground storage tanks, issue such citations and orders to enforce those rules, enter into environmental covenants in accordance with sections 5301.80 to 5301.92 of the Revised Code, and perform such other duties, as are consistent with those programs. The fire marshal, by rule, may delegate the authority to conduct inspections of underground storage tanks to certified fire safety inspectors.

(2) In the place of any rules regarding release containment and release detection for underground storage tanks adopted under division (A)(1) of this section, the fire marshal, by rule, shall designate areas as being sensitive for the protection of human health and the environment and adopt alternative rules regarding release containment and release detection methods for new and upgraded underground storage tank systems located in those areas. In designating such areas, the fire marshal shall take into consideration such factors as soil conditions, hydrogeology, water use, and the location of public and private water supplies. Not
later than July 11, 1990, the fire marshal shall file the rules required under this division with the
secretary of state, director of the legislative service commission, and joint committee on agency
rule review in accordance with divisions (B) and (C) of section 119.03 of the Revised Code.

(3) Notwithstanding sections 3737.87 to 3737.89 of the Revised Code, a person who is
not a responsible person, as determined by the fire marshal pursuant to this chapter, may
conduct a voluntary action in accordance with Chapter 3746 of the Revised Code and rules
adopted under it for either of the following:

(a) A class C release;

(b) A release, other than a class C release, that is subject to the rules adopted by the fire
marshal under division (B) of section 3737.882 of the Revised Code pertaining to a corrective
action, provided that both of the following apply:

(i) The voluntary action also addresses hazardous substances or petroleum that is not
subject to the rules adopted under division (B) of section 3737.882 of the Revised Code
pertaining to a corrective action.

(ii) The fire marshal has not issued an administrative order concerning the release or
referred the release to the attorney general for enforcement.

The director of environmental protection, pursuant to section 3746.12 of the Revised
Code, may issue a covenant not to sue to any person who properly completes a voluntary
action with respect to any such release in accordance with Chapter 3746 of the Revised Code
and rules adopted under it.

(B) Before adopting any rule under this section or section 3737.881 or 3737.882 of the
Revised Code, the fire marsh shall file written notice of the proposed rule with the chairperson
of the state fire council, and, within sixty days after notice is filed, the council may file responses
to or comments on and may recommend alternative or supplementary rules to the fire marshal.
At the end of the sixty-day period or upon the filing of responses, comments, or
recommendations by the council, the fire marshal may adopt the rule filed with the council or
any alternative or supplementary rule recommended by the council.

(C) The state fire council may recommend courses of action to be taken by the fire
marshal in carrying out the fire marshal's duties under this section. The council shall file its
recommendations in the office of the fire marshal, and, within sixty days after the
recommendations are filed, the fire marshal shall file with the chairperson of the council
comments on, and proposed action in response to, the recommendations.

(D) For the purpose of sections 3737.87 to 3737.89 of the Revised Code, the fire
marshal shall adopt, and may amend and rescind, rules identifying or listing hazardous
substances. The rules shall be consistent with and equivalent in scope, coverage, and content
to regulations identifying or listing hazardous substances adopted under the “Comprehensive
9602, as amended, except that the fire marshal shall not identify or list as a hazardous
substance any hazardous waste identified or listed in rules adopted under division (A) of section
3734.12 of the Revised Code.

(E) Except as provided in division (A)(3) of this section, the fire marshal shall have
exclusive jurisdiction to regulate the storage, treatment, and disposal of petroleum contaminated
soil generated from corrective actions undertaken in response to releases of petroleum from
underground storage tank systems. The fire marshal may adopt, amend, or rescind such rules
as the fire marshal considers to be necessary or appropriate to regulate the storage, treatment,
or disposal of petroleum contaminated soil so generated.

(F) The fire marshal shall adopt, amend, and rescind rules under sections 3737.88 to
3737.883 of the Revised Code in accordance with Chapter 119 of the Revised Code.
Chapter 11. Environmental, Radiation and Workplace
Part II. Fire Marshal and Petroleum Underground Storage

1301:7-9-02 Underground storage tank definitions.

(A) Purpose.
For the purpose of prescribing rules pursuant to sections 3737.88 to 3737.883 of the Revised Code, the state fire marshal hereby adopts this rule to establish definitions of words and phrases related to underground storage tanks. This rule is adopted by the state fire marshal in accordance with Chapter 119 of the Revised Code and shall not be considered a part of the "Ohio Fire Code."

(B) Definitions.
When used in this chapter of the Administrative Code, the following terms shall have the following meanings:

(1) "Accredited laboratory" means a laboratory accredited to perform laboratory analyses as outlined in this chapter of the Administrative Code using prescribed United States environmental protection agency test methods through one of the following programs:
   (a) Ohio environmental protection agency division of drinking and ground waters;
   (b) Ohio environmental protection agency voluntary action program;
   (c) National environmental laboratory accreditation program;
   (d) American association of laboratory accreditation; or,
   (e) Another state environmental protection agency program approved by the state fire marshal.

(2) "Airport hydrant fuel distribution system (also called airport hydrant system)" means an UST system which fuels aircraft and operates under high pressure with large diameter piping that typically terminates into one or more hydrants (fill stands). The airport hydrant system begins where fuel enters one or more tanks from an external source such as a pipeline, barge, rail car, or other motor fuel carrier.

(3) "Ancillary equipment" means any devices including, without limitation, such devices as piping, fittings, flanges, valves, and pumps used to distribute, meter, or control the flow of regulated substances to and from an UST.

(4) "Beneath the surface of the ground" means beneath the ground surface or otherwise covered with earthen materials.

(5) "Cathodic protection" is a technique to prevent corrosion of a metal surface by making that surface the cathode of an electrochemical cell. An UST system can be cathodically protected, without limitation, through the application of either galvanic anodes or impressed current.

(6) "Cathodic protection tester" means a person who can demonstrate an understanding of the principles and measurements of all common types of cathodic protection systems as applied to buried or submerged metal piping and UST systems. At a minimum, such persons shall have education and experience in soil resistivity, stray current, structure-to-soil potential, and component electrical isolation measurements of buried metal piping and UST systems.

(7) "Certified installer" or "installer" means an individual certified by the state fire marshal under the requirements of rule 1301:7-9-11 of the Administrative Code to supervise the installation of, performance of major repairs on site to, closure-in-place of, removal of, performance of modifications of, placing out of service for more than ninety days of, or the change in service of UST systems.

(8) "Certified UST inspector" means an individual certified by the state fire marshal under the requirements of rule 1301:7-9-15 of the Administrative Code to inspect the installation of, performance of major repairs on site to, closure-in-place of, removal of, performance of modifications of, placing out of service for more than ninety days of, or the change in service of UST systems.
“Change in service” means a change in the substances managed in the UST system from regulated substances to non-regulated substances, without closure in place or permanent removal of the UST system.

“Change of product” means a change in the substances stored in the UST system from one regulated substance to another regulated substance containing greater than ten percent ethanol or containing greater than twenty percent biodiesel.

“Closure-in-place” or “close-in-place” means the abandonment of an UST system by permanently taking an UST system out of service but not out of the ground in compliance with this chapter of the Administrative Code.

“Compatible” means the ability of two or more substances to maintain their respective physical and chemical properties upon contact with one another for the design life of the UST system under conditions likely to be encountered in the UST.

“Connected piping” means all underground piping including valves, elbows, joints, flanges, and flexible connectors attached to an UST system through which regulated substances flow. For the purpose of determining how much piping is connected to any individual UST system, the piping that joins two UST systems should be allocated equally between them.

“Consumptive use” with respect to heating fuel means consumed on the premises.

“Containment sump” means a liquid-tight container that protects the environment by containing leaks and spills of regulated substances from piping, dispensers, pumps and related components in the containment area. Containment sumps may be single walled or secondarily contained and located at the top of tank (tank top or submersible turbine pump sump), underneath the dispenser (under-dispenser containment sump), or at other points in the piping run (transition or intermediate sump).

“Corrective action” means any action necessary to protect human health and the environment in the event of a release of petroleum into the environment, including, without limitation, any action necessary to monitor, assess, and evaluate the release. In the instance of a suspected release, the term includes, without limitation, an investigation to confirm or disprove the occurrence of the release. In the instance of a confirmed release, the term includes, without limitation, the initial corrective action taken under section 3737.88 or 3737.882 of the Revised Code, or orders issued under those sections, and any initial corrective action taken under this chapter of the Administrative Code and any action taken consistent with a remedial action to clean up contaminated groundwater, surface water, soils, and subsurface material and to address the residual effects of a release after the initial corrective action is taken.

“Corrosion expert” means a person who, by reason of thorough knowledge of the physical sciences and the principles of engineering and mathematics acquired by a professional education and related practical experience, is qualified to engage in the practice of corrosion control on buried or submerged metal piping systems and metal tanks. Such a person shall be accredited or certified as being qualified by the national association of corrosion engineers or be a registered professional engineer who has certification or licensing that includes education and experience in corrosion control of buried or submerged metal piping systems and metal tanks.

“Dielectric material” means a material that does not conduct direct electrical current. Dielectric coatings are used to electrically isolate UST systems from the surrounding soils. Dielectric bushings are used to electrically isolate portions of the UST system.

“Electrical equipment” means underground equipment that contains dielectric fluid that is necessary for the operation of equipment such as transformers and buried electrical cable.

“Excavation zone” means the volume containing the UST system and backfill material bounded by the ground surface, walls, and floor of the pit and trenches into which the UST system is placed at the time of installation.
(21) “Existing UST system” means an UST system used to contain an accumulation of regulated substances or for which installation has commenced on or before the effective date of this rule. Installation is considered to have commenced if:

(a) The owner or operator has obtained all federal, state, and local approvals or permits necessary to begin physical construction of the site or installation of the UST system; and if,

(b) One of the following has occurred:

(i) A continuous on-site physical construction or installation program has begun; or,

(ii) The owner or operator has entered into contractual obligations, which cannot be cancelled or modified without substantial loss, for physical construction at the site or installation of the UST system to be completed within a reasonable time.

(22) “Farm tank” is a tank located on a tract of land devoted to the production of crops or raising animals, including fish, and associated residences and improvements. A farm tank shall be located on the farm property. “Farm” includes fish hatcheries, rangeland and nurseries with growing operations.

(23) “Field-constructed tank” means an UST constructed on site in the field, such as an UST constructed of concrete that is poured in the field, or a steel or fiberglass UST primarily fabricated in the field.

(24) “Flow-through process tank” is a tank that forms an integral part of a production process through which there is a steady, variable, recurring, or intermittent flow of materials during the operation of the process. Flow-through process tanks do not include tanks used for the storage of materials prior to their introduction into the production process or for the storage of finished products or by-products from the production process.

(25) “Free product” means a separate liquid hydrocarbon phase that has a measured thickness of greater than one one-hundredth of a foot.

(26) “Gathering lines” means any pipeline, equipment, facility, or building used in the transportation of oil or gas during oil or gas production or gathering operations.

(27) “Hazardous substance” means any substance listed in rule 1301:7-9-03 of the Administrative Code, but not including any substance regulated as a hazardous waste under Chapters 3745-50 to 3745-69 of the Administrative Code, or any mixture of such substance and petroleum which is not contained in a petroleum UST system.

(28) “Hazardous substance UST system” means an underground storage tank system that contains a hazardous substance.

(29) “Heating fuel” means petroleum that is No. 1, No 2, No. 4-light, No. 4-heavy, No. 5-light, No. 5-heavy, and No. 6 technical grades of fuel oil; other residual fuel oils including, without limitation, Navy Special Fuel Oil and Bunker C; and other fuels when used as substitutes for one of these fuel oils. Heating fuel is typically used in the operation of heating equipment, boilers, or furnaces.

(30) “Hydraulic lift tank” means a tank holding hydraulic fluid for a closed-loop mechanical system that uses compressed air or hydraulic fluid to operate lifts, elevators, and other similar devices.

(31) “Liquid trap” means sumps, well cellars, and other traps used in association with oil and gas production, gathering, and extraction operations including gas production plants, for the purpose of collecting oil, water, and other liquids. These liquid traps may temporarily collect liquids for subsequent disposition or reinjection into a production or pipeline stream, or may collect and separate liquids from a gas stream.

(32) “Maintenance” means the normal operational upkeep to prevent an underground storage tank system from releasing product.

(33) “Major repair” means the restoration of a tank or an underground storage tank system component that has caused a release of a product from the underground storage tank system. “Major repair” does not include modifications, upgrades, or routine maintenance for
normal operational upkeep to prevent an underground storage tank system from releasing a product.

(34) “Modification” means work performed on UST system components that have not leaked such as adding, altering, replacing, or retrofitting the following:

(a) USTs and any components fixed to UST openings;
(b) Containment sumps located over USTs, under dispensers, or at intermediate points;
(c) Piping components that routinely contain regulated substances;
(d) Underground vent lines excluding stage two vapor recovery components;
(e) Flexible connector lines;
(f) UST system lining components;
(g) Release detection systems; and
(h) Shear valves (any portion).

(35) “Motor fuel” means a complex blend of hydrocarbons typically used in the operation of a motor engine, such as motor gasoline, aviation gasoline, racing fuel, No. 1 or No. 2 diesel fuel, or any blend containing one or more of these substances (for example, motor gasoline blended with alcohol.).

(36) “Native soils” means any soil or other materials outside of the backfill material used at the time of the original installation of the UST system.

(37) “New UST system” means an UST system that will be used to contain an accumulation of regulated substances and for which installation has commenced after the effective date of this rule.

(38) “Noncommercial purposes” with respect to motor fuel means not for resale.

(39) “On the premises where stored” with respect to heating oil means UST systems located on the same property where the stored heating oil is used.

(40) “Operational life” refers to the period beginning when installation of the UST system has commenced until the time the UST system is properly closed under this chapter.

(41) “Operator” means the person in daily control of, or having responsibility for the daily operation of, the UST system.

(42) “Out of service” means the normal operation and use of the UST system or any portion of the UST system is discontinued.

(43) “Overfill” is a release that occurs when an UST is filled beyond its capacity, resulting in a discharge of the regulated substance to the environment.

(44) “Owner” means:

(a) In the instance of an underground storage tank system in use on November 8, 1984, or brought into use after that date, the person who owns the underground storage tank system;
(b) In the instance of an underground storage tank system in use before November 8, 1984, but no longer in use on that date, the person who owned the underground storage tank system immediately before the discontinuation of its use.

The term includes any person who holds, or, in the instance of an underground storage tank in use before November 8, 1984, but no longer in use on that date, any person who held immediately before the discontinuation of its use, a legal, equitable, or possessory interest of any kind in an underground storage tank system or in the property on which the underground storage tank system is located, including, without limitation, a trust, vendor, vendee, lessor, or lessee. The term does not include any person who, without participating in the management of an underground storage tank system and without otherwise being engaged in petroleum production, refining, or marketing, holds indicia of ownership in an underground storage tank system primarily to protect the person’s security interest in it.

(45) “Permanent removal” means permanently taking an UST system or any of its components out of service by taking it out of the ground in compliance with this chapter.

(46) “Person”, in addition to the meaning in section 3737.01 of the Revised Code, means the United States and any department, agency, or instrumentality thereof.
(47) “Petroleum” means petroleum, including crude oil or any fraction thereof, that is a liquid at the temperature of sixty degrees Fahrenheit and the pressure of 14.7 pounds per square inch absolute. The term includes, without limitation, motor fuels, jet fuels, distillate fuel oils, residual fuel oils, lubricants, petroleum solvents, and used oils.

(48) “Petroleum UST system” means an underground storage tank system that contains petroleum or a mixture of petroleum with de minimis quantities of other regulated substances.

(49) “Pipe” or “piping” means a hollow cylinder or tubular conduit that is constructed of man-made materials.

(50) “Pipeline facilities” are new and existing pipe rights-of-way and any associated equipment, including, without limitation, gathering lines; facilities; or buildings.

(51) “Political subdivision” means a municipal corporation, township, county, school district, or other body corporate and politic responsible for governmental activities in a geographic area smaller than that of the state.

(52) “Regulated substance” means:
(a) Any hazardous substance; and
(b) Petroleum.

(53) “Release” means any spilling, leaking, emitting, discharging, escaping, leaching or disposing of a petroleum product from an UST system into groundwater, a surface water body, subsurface soil or otherwise into the environment.

(54) “Release detection” means determining whether a release of a regulated substance has occurred from the UST system into the environment or a leak has occurred into the interstitial space between the UST system and its secondary barrier or secondary containment around it.

(55) “Residential tank” is a tank located on property used primarily for dwelling purposes such as homes, apartments, nursing homes, and assisted living facilities.

(56) “Routine maintenance or normal operational upkeep” means work performed to maintain or to prevent an underground storage tank system from releasing a regulated substance. Work on the following components shall constitute routine maintenance or normal operational upkeep on existing UST systems provided that the component has not caused a release:
(a) Drop tubes;
(b) Overfill prevention devices;
(c) Spill prevention equipment;
(d) Fill caps and adapters;
(e) Cathodic protection components;
(f) Stage one vapor recovery components;
(g) Submersible pump components; and
(h) Individual leak detection monitoring units, probes, sensors or line leak detectors that are maintained with like components.

(57) “Secondary containment” or “secondarily contained” means a release prevention and release detection system for an UST or piping. This system has an inner and outer barrier with an interstitial space that is monitored for leaks. This term includes containment sumps when used for interstitial monitoring of piping.

(58) “Septic tank” is a water-tight covered receptacle designed to receive or process, through liquid separation or biological digestion, the sewage discharged from a building sewer. The effluent from such receptacle is distributed for disposal through the soil and settled solids and scum from the tank are pumped out periodically and hauled to a treatment facility.

(59) “Sole source aquifer” means any aquifer which has been so designated by the administrator of the United States environmental protection agency pursuant to section 1424(e) of the Safe Drinking Water Act (42 U.S.C.A. 300h, as amended through January 16, 2014).

(60) “Spill” means;
(a) A release resulting from improper transfer practices to an UST system including, without limitation, the disconnecting of a delivery hose from a tank's fill pipe before the hose has drained completely, or
(b) Any spilling, leaking, emitting, discharging, escaping, or disposal of a petroleum product into groundwater, a surface water body, subsurface soil or otherwise into the environment while transferring or attempting to transfer petroleum products into an UST system.
(61) “Spill prevention equipment” means a spill containment manhole or spill bucket installed at a fill pipe that catches and holds drips and spills of regulated substance that can occur when a delivery hose is removed from the fill pipe after delivery of a regulated substance to an UST.
(62) “State” means the state of Ohio, including, without limitation, the general assembly, the supreme court, the offices of all elected state officers, and all departments, boards, offices, commissions, agencies, colleges, universities, institutions, and other instrumentalities of the state of Ohio. “State” does not include political subdivisions.
(63) “Storm water or wastewater collection system” means piping, pumps, conduits, and any other equipment necessary to collect and transport the flow of surface water run-off resulting from precipitation, or domestic, commercial, or industrial wastewater to and from retention areas or any areas where treatment is designated to occur. The collection of storm water and wastewater does not include treatment except where incidental to conveyance.
(64) “Supervise” means being physically on site and having the authority to direct other persons engaged in carrying out the installation of, making major repairs on site to, closure-in-place of, removal of, performance of modifications of, placing out of service for more than ninety days of, or the change in service of UST systems as well as having the authority to exercise independent judgment regarding the recommendation of activities to such other persons.
(65) “Surface impoundment” is a natural topographic depression, man-made excavation, or diked area formed primarily of earthen materials, although it may be lined with man-made materials, that is not an injection well.
(66) “Tank” is a stationary device designed to contain an accumulation of regulated substances that is constructed of man-made materials.
(67) “Temporarily out of service” means the normal operation and use of the UST system is deliberately, but temporarily, discontinued for ninety days or less.
(68) “Underground area” means an underground room, such as a basement, cellar, shaft, or vault, providing enough space for physical inspection of the exterior of the tank situated on or above the surface of the floor.
(69) “Underground storage tank” or “UST” means one or any combination of tanks, including the underground pipes connected thereto, that are used to contain an accumulation of regulated substances the volume of which, including the volume of the underground pipes connected thereto, is ten per cent or more beneath the surface of the ground.

The term does not include any of the following:
(b) Farm or residential tanks of one thousand one hundred gallons or less capacity used for storing motor fuel for noncommercial purposes;
(c) Tanks used for storing heating fuel for consumptive use on the premises where stored;
(d) Surface impoundments, pits, ponds, or lagoons;
(e) Storm or waste water collection systems;
(f) Flow-through process tanks;
(g) Storage tanks located in underground areas, including without limitation, basements, cellars, mine workings, drifts, shafts, or tunnels, when the tanks are located on or above the surface of the floor;
As used in this chapter:

(A) “Byproduct material” means either of the following:
   (1) Any radioactive material, except special nuclear material, yielded in or made radioactive by exposure to radiation incident to the process of producing or utilizing special nuclear material;
   (2) The tailings or wastes produced by the extraction or concentration of uranium or thorium from any ore processed primarily for its source material content.

(B) “Certified radiation expert” means an individual who has complied with all of the following:
   (1) Applied to the director of health for certification as a radiation expert under section 3748.12 of the Revised Code;
   (2) Met minimum education and experience requirements established in rules adopted under division (C) of section 3748.04 of the Revised Code;
   (3) Been granted a certificate as a radiation expert by the director under section 3748.12 of the Revised Code.

(C) “Closure” or “site closure” refers to a facility for the disposal of low-level radioactive waste or a byproduct material site, as “byproduct material” is defined in division (A)(2) of this section, and means all activities performed at a licensed operation, such as stabilization and contouring, to ensure that the site where the operation occurred is in a stable condition so that only minor custodial care, surveillance, and monitoring are necessary at the site following the termination of the licensed operation.

(D) “Decommissioning” means to safely remove any licensed operation from service and reduce residual radioactivity to a level that permits release of the licensee's property for unrestricted use. With regard to a facility for the disposal of low-level radioactive waste or a byproduct material site, as “byproduct material” is defined in division (A)(2) of this section, “decommissioning” does not include the reduction of residual radioactivity to a level that permits release of the facility for unrestricted use.

(E) “Director of health” includes a designee or authorized representative of the director.

(F) “Disposal,” with regard to low-level radioactive waste, means the permanent isolation of that waste in accordance with requirements established by the United States nuclear regulatory commission or the licensing agreement state.

(G) “Disposal site” means that portion of a facility that is used for the disposal of low-
level radioactive waste and that consists of disposal units and a buffer zone. “Disposal unit” means a discrete portion of such a facility into which low-level radioactive waste is placed for disposal.

(H)(1) Except as provided in division (H)(2) of this section, “facility” means the state, any political subdivision, person, public or private institution, or group, or any unit of one of those entities, but does not include the federal government or any of its agencies.

(2) For the purposes of the disposal of low-level radioactive waste, “facility” has the same meaning as in section 3747.01 of the Revised Code.

(I) “Handle” means receive, possess, use, store, transfer, install, service, or dispose of sources of radiation unless possession is solely for the purpose of transportation.

(J) “Handler” means a facility that handles sources of radiation unless possession is solely for the purpose of transportation.

(K) “Inspection” means an official review, examination, or observation, including, without limitation, tests, surveys, and monitoring, that is used to determine compliance with rules, orders, requirements, and conditions of the department of health and that is conducted by the director of health.

(L) “Low-level radioactive waste” has the same meaning as in section 3747.01 of the Revised Code with regard to the disposal of low-level radioactive waste. In regard to regulatory control at locations other than a disposal facility, “low-level radioactive waste” has the same meaning as in 42 U.S.C.A. 2021b.

(M) “Quality assurance program” means a program providing for verification by written procedures such as testing, auditing, and inspection to ensure that deficiencies, deviations, defective equipment, or unsafe practices, or a combination thereof, relating to the use, disposal, management, or manufacture of radiation sources are identified, promptly corrected, and reported to the appropriate regulatory authorities.

(N) “Radiation” means ionizing and nonionizing radiation.

(1) “Ionizing radiation” means gamma rays and X-rays, alpha and beta particles, high-speed electrons, neutrons, protons, and other nuclear particles, but does not include sound or radio waves or visible, infrared, or ultraviolet light.

(2) “Nonionizing radiation” means any electromagnetic radiation, other than ionizing electromagnetic radiation, or any sonic, ultrasonic, or infrasonic wave.

(O) “Radioactive material” means any solid, liquid, or gaseous material that emits ionizing radiation spontaneously. “Radioactive material” includes accelerator-produced and naturally occurring materials and byproduct, source, and special nuclear material.

(P) “Radiation-generating equipment” means any manufactured product or device, or component of such a product or device, or any machine or system that during operation can generate or emit radiation, except those that emit radiation only from radioactive material.

“Radiation-generating equipment” does not include either of the following:

(1) Diathermy machines;

(2) Microwave ovens, including food service microwave ovens used for commercial and industrial uses, television receivers, electric lamps, and other household appliances and products that generate very low levels of radiation.

(Q) “Source material” means uranium, thorium, or any combination thereof in any physical or chemical form, or any ores that contain by weight at least one-twentieth of one percent of uranium, thorium, or any combination thereof. “Source material” does not include special nuclear material.

(R) “Source of radiation” means radioactive material or radiation-generating equipment.

(S) “Special nuclear material” means either of the following:

(1) Plutonium, uranium 233, uranium enriched in the isotope 233 or in the isotope 235, and any other material that the United States nuclear regulatory commission determines to be special nuclear material, but does not include source material pursuant to section 51 of the

(2) Except for any source material, any material artificially enriched by any of the materials identified in division (S)(1) of this section.

(T) “Storage” means the retention of radioactive materials, including low-level radioactive waste, prior to disposal in a manner that allows for surveillance, control, and subsequent retrieval.

(U) “Medical practitioner” means a person who is authorized pursuant to Chapter 4715 of the Revised Code to practice dentistry; pursuant to Chapter 4731 of the Revised Code to practice medicine and surgery, osteopathic medicine and surgery, or podiatric medicine and surgery; or pursuant to Chapter 4734 of the Revised Code to practice chiropractic.

(V) “Medical-practitioner group” means a corporation, partnership, or other business entity, other than a hospital as defined in section 3727.01 of the Revised Code, consisting of medical practitioners.

(W) “Naturally occurring radioactive material” means material that contains any nuclide that is radioactive in its natural physical state. “Naturally occurring radioactive material” does not include source material, byproduct material, or special nuclear material.

(X) “Technologically enhanced naturally occurring radioactive material” means naturally occurring radioactive material with radionuclide concentrations that are increased by or as a result of past or present human activities. “Technologically enhanced naturally occurring radioactive material” does not include drill cuttings, natural background radiation, byproduct material, or source material.

(Y) “Drill cuttings” means the soil, rock fragments, and pulverized material that are removed from a borehole and that may include a de minimus amount of fluid that results from a drilling process.

3748.06 License required.

(A) No facility shall handle radioactive material or radiation-generating equipment for which licensure or registration, respectively, by its handler is required by rules adopted under section 3748.04 of the Revised Code unless the facility has obtained a license or certificate of registration from the department of health.

(B) No facility shall handle radioactive material or radiation-generating equipment except in accordance with rules adopted under section 3748.04 of the Revised Code.

3748.07 License application.

(A) Every facility that proposes to handle radioactive material or radiation-generating equipment for which licensure or registration, respectively, by its handler is required shall apply in writing to the director of health on forms prescribed and provided by the director for licensure or registration. Terms and conditions of licenses and certificates of registration may be amended in accordance with rules adopted under section 3748.04 of the Revised Code or orders issued by the director pursuant to section 3748.05 of the Revised Code.

(B)(1) An applicant proposing to handle radioactive material shall pay for a license or renewal of a license the appropriate fee specified in rules adopted under section 3748.04 of the Revised Code and listed on an invoice provided by the director. The applicant shall pay the fee on receipt of the invoice.

(2)(a) Except as provided in division (B)(2)(b) of this section, until fees are established in rules adopted under division (A)(8)(b) of section 3748.04 of the Revised Code, an applicant proposing to handle radiation-generating equipment shall pay for a certificate of registration or renewal of a certificate a biennial registration fee of two hundred sixty-two dollars.

Except as provided in division (B)(2)(b) of this section, on and after the effective date of
the rules in which fees are established under division (A)(8)(b) of section 3748.04 of the Revised Code, an applicant proposing to handle radiation-generating equipment shall pay for a certificate of registration or renewal of a certificate the appropriate fee established in those rules.

The applicant shall pay the fees described in division (B)(2)(a) of this section at the time of applying for a certificate of registration or renewal of a certificate.

(b) An applicant that is, or is operated by, a medical practitioner or medical-practitioner group and proposes to handle radiation-generating equipment shall pay for a certificate of registration or renewal of a certificate a biennial registration fee of two hundred sixty-two dollars. The applicant shall pay the fee at the time of applying for a certificate of registration or renewal of the certificate.

(C) All fees collected under this section shall be deposited in the state treasury to the credit of the general operations fund created in section 3701.83 of the Revised Code. The fees shall be used solely to administer and enforce this chapter and rules adopted under it.

(D) Any fee required under this section that remains unpaid on the ninety-first day after the original invoice date shall be assessed an additional amount equal to ten per cent of the original fee.

(E) The director shall grant a license or registration to any applicant who has paid the required fee and is in compliance with this chapter and rules adopted under it.

(F) Except as provided in division (B)(2) of this section, licenses and certificates of registration shall be effective for the applicable period established in rules adopted under section 3748.04 of the Revised Code. Licenses and certificates of registration shall be renewed in accordance with the renewal procedure established in rules adopted under section 3748.04 of the Revised Code.

3748.13 Hospital quality assurance program; fees.

(A) The director of health shall inspect sources of radiation for which licensure or registration by the handler is required, and the sources’ shielding and surroundings, according to the schedule established in rules adopted under division (D) of section 3748.04 of the Revised Code. In accordance with rules adopted under section 3748.04 of the Revised Code, the director shall inspect all records and operating procedures of handlers that install or service sources of radiation and all sources of radiation for which licensure of radioactive material or registration of radiation-generating equipment by the handler is required. The director may make other inspections upon receiving complaints or other evidence of a violation of this chapter or rules adopted under it.

The director shall require any hospital registered under division (A) of section 3701.07 of the Revised Code to develop and maintain a quality assurance program for all sources of radiation-generating equipment. A certified radiation expert shall conduct oversight and maintenance of the program and shall file a report of audits of the program with the director on forms prescribed by the director. The audit reports shall become part of the inspection record.

(B)(1) Except as provided in division (B)(2) of this section, a facility shall pay inspection fees for radioactive material and radiation-generating equipment according to the schedule and categories established in rules adopted under division (A)(9) of section 3748.04 of the Revised Code.

(2) A facility that is, or is operated by, a medical practitioner or medical-practitioner group shall pay inspection fees for radiation-generating equipment according to the following schedule and categories:

<p>| First dental x-ray tube | $155.00 |</p>
<table>
<thead>
<tr>
<th>Service Description</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>Each additional dental x-ray tube at the same location</td>
<td>$77.00</td>
</tr>
<tr>
<td>First medical x-ray tube</td>
<td>$307.00</td>
</tr>
<tr>
<td>Each additional medical x-ray tube at the same location</td>
<td>$163.00</td>
</tr>
<tr>
<td>Each unit of ionizing radiation-generating equipment capable of operating at or above 250 kilovoltage peak</td>
<td>$610.00</td>
</tr>
<tr>
<td>First nonionizing radiation-generating equipment of any kind</td>
<td>$307.00</td>
</tr>
<tr>
<td>Each additional nonionizing radiation-generating equipment of any kind at the same location</td>
<td>$163.00</td>
</tr>
</tbody>
</table>

(C)(1) Except as provided in division (C)(2) of this section, the fee for the inspection of a facility that proposes to handle radioactive material or radiation-generating equipment and is not licensed or registered, and for which no license or registration application is pending at the time of inspection, is four hundred seventy-four dollars plus the applicable fee specified in rules adopted under division (A)(9) of section 3748.04 of the Revised Code.

(2) For a facility that is, or is operated by, a medical practitioner or medical-practitioner group and proposes to handle radiation-generating equipment, the fee for an inspection if the facility is not licensed or registered, and no license or registration is pending at the time of inspection, is four hundred seventy-four dollars plus the fee applicable under the schedule in division (B)(2) of this section.

(D)(1) Except as provided in division (D)(2) of this section, for a facility that handles radioactive material or radiation-generating equipment, the fee for an inspection to determine whether violations cited in a previous inspection have been corrected is the amount specified in rules adopted under division (A)(9) of section 3748.04 of the Revised Code.

(2) For a facility that is, or is operated by, a medical practitioner or medical-practitioner group and handles radiation-generating equipment, the fee for an inspection to determine whether violations cited in a previous inspection have been corrected is fifty per cent of the applicable fee under the schedule in division (B)(2) of this section.

(E) The director may conduct a review of shielding plans or the adequacy of shielding on the request of a licensee or registrant or an applicant for licensure or registration or during an inspection when the director considers a review to be necessary.

(1) Except as provided in division (E)(2) of this section, the fee for the review is the applicable amount specified in rules adopted under division (A)(9) of section 3748.04 of the Revised Code.

(2) For a facility that is, or is operated by, a medical practitioner or medical-practitioner group and handles or proposes to handle radiation-generating equipment, the fee for the review is seven hundred sixty-two dollars for each room where a source of radiation is used and is in addition to any other fee applicable under the schedule in division (B)(2) of this section.

(F) All fees shall be paid to the department of health no later than thirty days after the invoice for the fee is mailed. Fees shall be deposited in the general operations fund created in section 3701.83 of the Revised Code. The fees shall be used solely to administer and enforce this chapter and rules adopted under it.

(G) Any fee required under this section that remains unpaid on the ninety-first day after the original invoice date shall be assessed an additional amount equal to ten per cent of the original fee.

(H) If the director determines that a board of health of a city or general health district is
qualified to conduct inspections of radiation-generating equipment, the director may delegate to the board, by contract, the authority to conduct such inspections. In making a determination of the qualifications of a board of health to conduct those inspections, the director shall evaluate the credentials of the individuals who are to conduct the inspections of radiation-generating equipment and the radiation detection and measuring equipment available to them for that purpose. If a contract is entered into, the board shall have the same authority to make inspections of radiation-generating equipment as the director has under this chapter and rules adopted under it. The contract shall stipulate that only individuals approved by the director as qualified shall be permitted to inspect radiation-generating equipment under the contract’s provisions. The contract shall provide for such compensation for services as is agreed to by the director and the board of health of the contracting health district. The director may reevaluate the credentials of the inspection personnel and their radiation detecting and measuring equipment as often as the director considers necessary and may terminate any contract with the board of health of any health district that, in the director’s opinion, is not satisfactorily performing the terms of the contract.

(I) The director may enter at all reasonable times upon any public or private property to determine compliance with this chapter and rules adopted under it.

3748.22 Radiation program must be self-sufficient.

Fees for administrative, regulatory, and enforcement programs established under this chapter shall be sufficient to pay all costs of those programs.

4773.03 Licenses for healthcare workers with exposure to radiation.

(A) Each individual seeking a license to practice as a general x-ray machine operator, radiographer, radiation therapy technologist, or nuclear medicine technologist shall apply to the department of health on a form the department shall prescribe and provide. The application shall be accompanied by the appropriate license application fee established in rules adopted under section 4773.08 of the Revised Code.

(B) The department shall review all applications received and issue the appropriate general x-ray machine operator, radiographer, radiation therapy technologist, or nuclear medicine technologist license to each applicant who meets all of the following requirements:

1. Is eighteen years of age or older;
2. Is of good moral character;
3. Except as provided in division (C) of this section, passes the examination administered under section 4773.04 of the Revised Code for the applicant’s area of practice;
4. Complies with any other licensing standards established in rules adopted under section 4773.08 of the Revised Code.

(C) An applicant is not required to take a licensing examination if one of the following applies to the applicant:

1. The individual is applying for a license as a general x-ray machine operator and holds certification in that area of practice from the American registry of radiologic technologists or the American chiropractic registry of radiologic technologists.
2. The individual is applying for a license as a radiographer and holds certification in that area of practice from the American registry of radiologic technologists.
3. The individual is applying for a license as a radiation therapy technologist and holds certification in that area of practice from the American registry of radiologic technologists.
4. The individual is applying for a license as a nuclear medicine technologist and holds certification in that area of practice from the American registry of radiologic technologists or the nuclear medicine technology certification board.
(5) The individual holds a conditional license issued under section 4773.05 of the Revised Code and has completed the continuing education requirements established in rules adopted under section 4773.08 of the Revised Code.

(6) The individual holds a license, certificate, or other credential issued by another state that the department determines uses standards for radiologic professions that are at least equal to those established under this chapter.

(D) A license issued under this section expires biennially on the license holder's birthday, except for an initial license which expires on the license holder's birthday following two years after it is issued. For an initial license, the fee established in rules adopted under section 4773.08 of the Revised Code may be increased in proportion to the amount of time beyond two years that the license may be valid.

A license may be renewed. To be eligible for renewal, the license holder must complete the continuing education requirements specified in rules adopted by the department under section 4773.08 of the Revised Code. Applications for license renewal shall be accompanied by the appropriate renewal fee established in rules adopted under section 4773.08 of the Revised Code. Renewals shall be made in accordance with the standard renewal procedure established under Chapter 4745 of the Revised Code.

(E)(1) A license that has lapsed or otherwise become inactive may be reinstated. An individual seeking reinstatement of a license shall apply to the department on a form the department shall prescribe and provide. The application shall be accompanied by the appropriate reinstatement fee established in rules adopted under section 4773.08 of the Revised Code.

(2) To be eligible for reinstatement, both of the following apply:

(a) An applicant must continue to meet the conditions for receiving an initial license, including the examination or certification requirements specified in division (B) or (C) of this section. In the case of an applicant seeking reinstatement based on having passed an examination administered under section 4773.04 of the Revised Code, the length of time that has elapsed since the examination was passed is not a consideration in determining whether the applicant is eligible for reinstatement.

(b) The applicant must complete the continuing education requirements for reinstatement established in rules adopted under section 4773.08 of the Revised Code.

(F) The department shall refuse to issue, renew, or reinstate and may suspend or revoke a general x-ray machine operator, radiographer, radiation therapy technologist, or nuclear medicine technologist license if the applicant or license holder does not comply with the applicable requirements of this chapter or rules adopted under it.


Terms defined in rule 3701:1-38-01 of the Administrative Code shall have the same meaning when used in this chapter except terms redefined within a given rule for use within that rule only. Additionally, the following terms as used in this chapter are defined as follows:

(A) “Access control” means a system for allowing only approved individuals to have unescorted access to the security zone and for ensuring that all other individuals are subject to escorted access.

(B) “Act” means the Atomic Energy Act of 1954 (68 Stat. 919), including any amendments thereto.

(C) “Aggregated” means accessible by the breach of a single physical barrier that would allow access to radioactive material in any form, including any devices that contain the radioactive material, when the total activity equals or exceeds a category two quantity of radioactive material.

(D) “Approved individual” means an individual whom the licensee has determined to be
trustworthy and reliable for unescorted access in accordance with rules 3701:1-37-07 to 3701:1-37-13 of the Administrative Code and who has completed the training required by paragraph (C) of rule 3701:1-37-15 of the Administrative Code.

(E) “Background investigation” means the investigation conducted by a licensee or applicant to support the determination of trustworthiness and reliability.

(F) “Carrier” means a person engaged in the transportation of passengers or property by land or water as a common, contract, or private carrier, or by civil aircraft.

(G) “Category one quantity of radioactive material” means a quantity of radioactive material meeting or exceeding the category one threshold in Table 1 of Appendix A to this rule. This is determined by calculating the ratio of the total activity of each radionuclide to the category one threshold for that radionuclide and adding the ratios together. If the sum is equal to or exceeds one, the quantity would be considered a category one quantity. Category one quantities of radioactive material do not include the radioactive material contained in any fuel assembly, subassembly, fuel rod, or fuel pellet.

(H) “Category two quantity of radioactive material” means a quantity of radioactive material meeting or exceeding the category two threshold but less than the category one threshold in Table 1 of Appendix A to this rule. This is determined by calculating the ratio of the total activity of each radionuclide to the category two threshold for that radionuclide and adding the ratios together. If the sum is equal to or exceeds one, the quantity would be considered a category two quantity. Category two quantities of radioactive material do not include the radioactive material contained in any fuel assembly, subassembly, fuel rod, or fuel pellet.

(I) “Commission” means the U.S. nuclear regulatory commission or its duly authorized representatives.

(J) “Diversion” means the unauthorized movement of radioactive material subject to this chapter to a location different from the material's authorized destination inside or outside of the site at which the material is used or stored.

(K) “Escorted access” means accompaniment while in a security zone by an approved individual who maintains continuous direct visual surveillance at all times over an individual who is not approved for unescorted access.

(L) “Fingerprint orders” means the orders issued by the U.S. nuclear regulatory commission or the legally binding requirements issued by agreement states that require fingerprints and criminal history records checks for individuals with unescorted access to category one and category two quantities of radioactive material or safeguards information-modified handling.

(M) “Government agency” means any executive department, commission, independent establishment, corporation, wholly or partly owned by the United States of America which is an instrumentality of the United States, or any board, bureau, division, service, office, officer, authority, administration, or other establishment in the executive branch of the government.

(N) “License issuing authority” means the licensing agency that issued the license, i.e. the U.S. nuclear regulatory commission or the appropriate agency of an agreement state.

(O) “Local law enforcement agency” or “LLEA” means a public or private organization that has been approved by a federal, state, or local government to carry firearms and make arrests, and is authorized and has the capability to provide an armed response in the jurisdiction where the licensed category one or category two quantity of radioactive material is used, stored, or transported.

(P) “Mobile device” means a piece of equipment containing licensed radioactive material that is either mounted on wheels or casters, or otherwise equipped for moving without a need for disassembly or dismounting; or designed to be hand carried. Mobile devices do not include stationary equipment installed in a fixed location.

(Q) “Movement control center” means an operations center that is remote from transport activity and that maintains position information on the movement of radioactive material.
receives reports of attempted attacks or thefts, provides a means for reporting these and other problems to appropriate agencies and can request and coordinate appropriate aid.

(R) “No-later-than arrival time” means the date and time that the shipping licensee and receiving licensee have established as the time at which an investigation will be initiated if the shipment has not arrived at the receiving facility. The no-later-than-arrival time may not be more than six hours after the estimated arrival time for shipments of category two quantities of radioactive material.

(S) “Reviewing official” means the individual who shall make the trustworthiness and reliability determination of an individual to determine whether the individual may have, or continue to have, unescorted access to the category one or category two quantities of radioactive materials that are possessed by the licensee.

(T) “Sabotage” means deliberate damage, with malevolent intent, to a category one or category two quantity of radioactive material, a device that contains a category one or category two quantity of radioactive material, or the components of the security system.

(U) “Safe haven” means a readily recognizable and readily accessible site at which security is present or from which, in the event of an emergency, the transport crew can notify and wait for the local law enforcement authorities.

(V) “Security zone” means any temporary or permanent area determined and established by the licensee for the physical protection of category one or category two quantities of radioactive material.

(W) “State” means a state of the United States, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Commonwealth of the Northern Mariana Islands.

(X) “Telemetric position monitoring system” means a data transfer system that captures information by instrumentation and/or measuring devices about the location and status of a transport vehicle or package between the departure and destination locations.

(Y) “Trustworthiness and reliability” are characteristics of an individual considered dependable in judgment, character, and performance, such that unescorted access to category one or category two quantities of radioactive material by that individual does not constitute an unreasonable risk to the public health and safety or security. A determination of trustworthiness and reliability for this purpose is based upon the results from a background investigation.

(Z) “Unescorted access” means solitary access to an aggregated category one or category two quantity of radioactive material or the devices that contain the material.

(AA) “United States”, when used in a geographical sense, includes Puerto Rico and all territories and possessions of the United States.

3701:1-37-03 Scope of radioactive materials licensing program.

(A) Rules 3701:1-37-07 to 3701:1-37-22 of the Administrative Code apply to any person who, under the rules of this chapter, possesses or uses at any site, an aggregated category one or category two quantity of radioactive material.

(B) Rules 3701:1-37-23 to 3701:1-37-28 of the Administrative Code apply to any person who, under the rules of this chapter:

1. Transports or delivers to a carrier for transport in a single shipment, a category one or category two quantity of radioactive material; or
2. Imports or exports a category one or category two quantity of radioactive material; the provisions only apply to the domestic portion of the transport.

3701:1-37-05 Immediate notification regarding radioactive materials.

Immediate notifications required by this chapter shall be made by telephone to the Ohio
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department of health at (614) 644-2727.

3701:1-37-22 Reporting of radioactive material attempted or actual theft, sabotage, or diversion.

(A) The licensee shall immediately notify the LLEA after determining that an unauthorized entry resulted in an actual or attempted theft, sabotage, or diversion of a category one or category two quantity of radioactive material. As soon as possible after initiating a response, but not at the expense of causing delay or interfering with the LLEA response to the event, the licensee shall notify the director in accordance with rule 3701:1-37-05 of the Administrative Code. In no case shall the notification to the director be later than four hours after the discovery of any attempted or actual theft, sabotage, or diversion.

(B) The licensee shall assess any suspicious activity related to possible theft, sabotage, or diversion of category one or category two quantities of radioactive material and notify the LLEA as appropriate. As soon as possible but not later than four hours after notifying the LLEA, the licensee shall notify the director in accordance with rule 3701:1-37-05 of the Administrative Code.

(C) The initial telephonic notification to the director required by paragraph (A) of this rule must be followed within a period of thirty days by a written report submitted to the director by an appropriate method listed in rule 3701:1-37-04 of the Administrative Code. The report must include sufficient information for director analysis and evaluation, including identification of any necessary corrective actions to prevent future instances.

3701:1-38-02 Fees for inspection, application, amendment, and renewal of radioactive material sources of radiation.

[Editor’s Note: Fees and inspection schedulers are listed in the appendices, available at http://www.odh.ohio.gov/rules/final/finalrules.aspx.]

(A) As used in this rule, “facility” has the meaning defined in division (H) of section 3748.01 of the Revised Code and the following:

1. All buildings, equipment, structures, and other stationary items that are located on a single site or on contiguous or adjacent sites and that are operated by the same person and have common corporate or business interests; and
2. Portions of a building or structure which are operated by the same person and have common corporate or business interests.

(B) Notwithstanding the definition of “facility,” the director may consider sites that are not contiguous or adjacent as one facility provided that:

1. The sites are operated by the same person;
2. The sites are in the same license category or categories;
3. The applicant for a license provides for one radiation safety officer, and if applicable, one radiation safety committee, as responsible for all sites; and
4. The director is reasonably satisfied from the information provided in the application that the applicant will adequately control radioactive material at all sites listed in the application.

(a) Unless the director has information of violations of Chapter 3748 of the Revised Code or the rules adopted thereunder at one or more sites, the director shall presume the applicant will adequately control radioactive material at all sites if the sites are located not more than twenty miles driving distance apart as documented by the licensee, and if all sites are within a twenty mile radius from the main site as designated on the license.

(b) The director shall continue to renew a license issued under this paragraph that contains all the sites listed thereon provided the licensee demonstrates continued compliance.
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with this paragraph, Chapter 3748 of the Revised Code, and the rules adopted thereunder.

(C) Every facility that handles radioactive material in any license category as specified in appendix A to this rule for which licensure is required shall apply for a license, license amendment, or license renewal in accordance with this rule. Application for a license, license amendment, or license renewal shall be made on any format prescribed and provided by the director. Licenses shall be issued in accordance with the requirements of Chapter 3748 of the Revised Code, and the rules adopted thereunder. Except as otherwise provided in this rule, a license shall expire five years from the date of issuance.

(1) As used in this paragraph, site means an address of use listed on the license. Temporary job sites are exempted.

(a) Any individual applying for a new license with one or more additional sites or a current licensee amending a license to add one or more additional sites that are located more than twenty miles from the main site shall pay an additional site fee for each such site as follows:

(i) The additional site fee(s) shall be seventy-five percent of the applicable annual fee, as those fees are set forth in paragraphs (D), (F), and (J) of this rule.

(ii) Additional site fees will be invoiced annually with the annual fee.

(b) Broad scope licensees are exempt from paragraph (C)(1)(a) of this rule.

(2) As used in this paragraph, “service” means activities performed by a person, other than a worker as defined in rule 3701:1-38-01 of the Administrative Code, pursuant to an agreement with the facility to perform activities that deal with sources of radiation for the facility.

(a) These activities include, but are not limited to the following:

(i) Conduct leak tests;

(ii) Calibrate survey instruments;

(iii) Provide quality control tests;

(iv) Conduct surveys, characterization, and/or remediation activities;

(v) Manage the disposal of radioactive waste for other persons; or

(vi) Install sources or devices or change sources within a device.

(b) License categories affected are:

(i) 3219 - decontamination services;

(ii) 3220 - leak test service;

(iii) 3221 - instrument calibration service only - source less than 3.7 terabecquerels (one hundred curies);

(iv) 3222 - instrument calibration service only - source equal to or greater than 3.7 terabecquerels (one hundred curies);

(v) 3223 - leak test and instrument calibration - source less than 3.7 terabecquerels (one hundred curies);

(vi) 3224 - leak test and instrument calibration - source equal to or greater than 3.7 terabecquerels (one hundred curies);

(vii) 3225 - other services - including teletherapy, irradiator, and gauge service;

(viii) 3232 - waste disposal service prepackaged only;

(ix) 3233 - waste disposal service - incineration; and

(x) 3234 - waste disposal service processing and/or repackaging.

(D) A radioactive materials license issued by the department may, at the discretion of the director, have more than one license category on any one specific license. A licensee may have more than one radioactive materials license. Except as otherwise provided in paragraph (J) of this rule, the annual fee for a radioactive material license shall be in an amount in accordance with appendix A to this rule.

(1) Upon receipt of an application for a new radioactive material license, the department will issue an invoice for the appropriate fee specified in appendix A to this rule or paragraph (J) of this rule. Annual fees will be invoiced based on the month of the license expiration date and
the invoice will state that the fee is due thirty days after the date of the invoice. License fees are not refundable.

(2) An applicant for a new or a renewal or amendment of a radioactive material license must submit a complete application before the director will finalize the review of the application. A complete application is one in which the applicant has provided all the information requested by the director, including any additional information requested after receipt of the application package.

(3) Upon receipt of an application for a license amendment, the department will issue an invoice for the appropriate fee for the proposed amendment as specified in appendix A to this rule. If the amendment is to change the license from operational phase to storage of sealed sources only incident to disposal of the sources, after the amendment the annual fee for the license shall be reduced to fifty per cent of the fee for the operational phase of the license, provided that the sources continue to be in safe storage and leak tested as provided by license condition for the specific sources in storage. The inspection frequency will remain the same as that for the operational phase of the license until after source disposal.

(4) The applicant for a new, or renewal or amendment of a radioactive materials license shall provide to the director all additional information requested within sixty days from the date of the information request. If the director does not receive the requested information within the stated time period, the director may consider the application abandoned. Any further consideration of a new license, or a renewal or amendment of a license shall be pursuant to another application.

(5) The director shall grant a new license, license amendment, or license renewal to any applicant who has submitted a complete application and is in compliance with Chapter 3748 of the Revised Code and the rules adopted thereunder.

(6) When an amendment to a license results in a change to a license category with a higher fee, the licensee will be charged the higher of the two amendment fees for that category. The annual fee for the licensee will escalate to the new category fee on the date of the next annual invoice.

(7) The director shall charge a fee for minor license amendments that do not require review by members of the technical staff at a rate of one hundred dollars per amendment provided that no licensee shall be required to pay more than one thousand dollars for minor amendments in any calendar year. Minor amendments include, but are not limited to, adding a new gauge of the same type already licensed unless that additional gauge increases the license or inspection fee, a corporate name change if the corporate ownership does not change, adding a user name that does not require review of education and experience, and corporate address change if the location of the use of the radioactive material does not change. Amendments to change the radiation safety officer or the chair or members of the radiation safety committee that require review of education or experience are not minor amendments.

(8) License terminations shall be handled as follows:
   (a) Except as provided in paragraph (D)(8)(c) of this rule, a termination fee of five hundred dollars or fifty per cent of the annual fee, whichever is less, will be invoiced upon written request from the licensee for termination of the license. This fee is not refundable.
   (b) Except as provided in paragraph (D)(8)(c) of this rule, if the termination cost, as determined by paragraph (M) of this rule, exceeds the termination fee in paragraph (D)(8)(a) of this rule, the remainder of the termination expense will be assessed at full cost.
   (c) If the license termination would be covered under paragraph (D)(9) of this rule, that paragraph will be used for the termination process.
   (d) The license termination process will not be completed until the licensee is in compliance with all rules, including payment of fees.

(9) Licenses, and other approvals related to the licensed activity requiring decommissioning, decontamination, reclamation, site restoration, or long-term care due to the
continued presence of radioactive materials shall be charged an annual fee based on the
approved decommissioning funding plan as specified in appendix B to this rule.
   (a) A decommissioning plan must be approved by the department. Prior to approval of
the decommissioning plan the licensee must submit an amendment requesting
decommissioning. Until the amendment is approved the licensee’s annualized license fee will be
reduced by fifty per cent. After approval of the amendment containing the decommissioning
plan, the licensee will be invoiced at the annual fee specified in appendix B to this rule.
   (b) The annual fee specified in appendix B to this rule is based on the cost of
decommissioning. The fee is payable within thirty days of mailing of an invoice by the
department.
   (c) Routine decommissioning oversight by the department will be charged against the
annual amount received and additional invoices will not be issued unless the cost of activities
exceeds the annual amount in any given year.
   (d) The facility shall receive a monthly statement of items and amounts charged against
the annual fee.
   (e) If the cost of additional activities arise that require use of additional staff, including
any consulting service that exceeds the amount of the annual fee paid by the licensee, these
additional costs will be included in any invoice as separate items invoiced for the full cost of the
oversight by additional staff or consultants. Oversight activities will be performed at a frequency
which adequately monitors health, safety, and the environment.
   (f) When the approved decommissioning plan is less than one hundred thousand dollars,
the licensee will remain in the current license category and continue to pay the required annual
fee specified in appendix A to this rule during decommissioning. Inspections of these licensees
will be done as non-routine inspections. Non-routine inspection fees will not be applied until the
number of decommissioning inspections performed exceed the inspections that would have
been performed if the licensee had not chosen the decommissioning option.
   (g) When the licensee has completed the decommissioning, and the director has
determined that the licensee cannot terminate the license as provided by the Administrative
Code, Chapter 3748 of the Revised Code or the rules adopted thereunder, but the licensee has
successfully completed the decommissioning of the operation as required by the approved
decommissioning plan, the director will amend the license to a decommissioning/possession
only license. The annual fee for a decommissioning/possession only license is provided in
appendix B to this rule.
   (E) Licenses shall be renewed in accordance with the standard renewal procedure
established in Chapter 4745 of the Revised Code, except that a licensee, other than a broad
scope licensee, shall apply for renewal of the license ninety days prior to the expiration date of
the current license and broad scope licensees shall apply for renewal of their license one
hundred eighty days prior to expiration.
   (F) The annual fee is listed in appendix A to this rule “column 5” for a new license or
“column 6” for a renewal license. To recover the costs of oversight activities where radioactive
material is found in the public domain and there is no evident individual that is determined to be
responsible, a surcharge of 5.25 per cent has been included in the annual fee listed in “column
5” and “column 6” of appendix A to this rule.
   (G) The department shall charge an inspection fee for all non-routine inspections. A non-
routine inspection is defined as any inspection that the department conducts in addition to the
scheduled routine inspections and one follow-up inspection if necessary. Non-routine
inspections include, without limitation:
   (1) An inspection performed as a result of an incident;
   (2) Any pre-license inspections for a new license applicant when the director determines
that an inspection is necessary to assess the adequacy of the information provided in the
application;
(3) Inspections prior to license amendment, category change, or termination;
(4) An inspection performed at a facility that results in the issuance of an adjudication order by the director; or
(5) Other enforcement or regulatory inspections, not specified above, that the director determines is necessary to assess compliance with Chapter 3748 of the Revised Code.

(H) The fee for a non-routine inspection shall be based on the actual cost for conducting the inspection which shall include:
(1) An hourly charge of seventy dollars per staff person assigned to the inspection, except staff participating as training will not be included in the charges;
(2) An administrative fee of three hundred thirty dollars;
(3) All necessary laboratory analysis costs for samples collected by department personnel; and
(4) Any staff travel costs which shall be calculated in accordance with rule 126-01-02 of the Administrative Code.

(I) All fees invoiced as provided within this rule, including full cost, routine, and non-routine inspection fees, shall be paid within thirty days of the invoice date specified on the invoice. In accordance with sections 3748.07 and 3748.13 of the Revised Code, any fee that remains unpaid on the ninety-first day after the original invoice date shall be assessed an additional amount equal to ten per cent of the original fee.

(1) The department shall mail invoices by ordinary U.S. mail to the most recent address provided by the licensee.
(2) The department shall maintain a list of the invoices issued and date mailed.

(J) Notwithstanding paragraph (D) of this rule, the department shall charge the following types of licensees reduced license fees in the following specified amounts:
(1) A private entity that provides services, does not engage in manufacturing, and that has three hundred fifty thousand to two million dollars in gross annual receipts, shall pay a total license fee of seventy-five per cent of the amount specified for that use of radioactive materials in appendix A to this rule.
(2) A private entity that provides services, does not engage in manufacturing, and that has less than three hundred fifty thousand dollars in gross annual receipts shall pay a total license fee of fifty per cent of the amount specified for that use of radioactive material in appendix A to this rule.
(3) A private entity that engages in manufacturing and that has thirty-five to two hundred employees, irrespective of gross annual receipts, shall pay a total license fee of seventy-five per cent of the amount specified for that use of radioactive material in appendix A to this rule.
(4) A private entity that engages in manufacturing and that has less than thirty-five employees, irrespective of gross annual receipts, shall pay a total license fee of fifty per cent of the amount specified for that use of radioactive material in appendix A to this rule.
(5) A nonprofit entity that has gross annual receipts of three hundred fifty thousand dollars or less shall pay a total license fee of seventy-five per cent of the amount specified for that use of radioactive material as specified in appendix A to this rule.
(6) A nonprofit entity that has gross annual receipts of less than three hundred fifty thousand dollars shall pay a total license fee of fifty per cent of the amount specified for that use of radioactive material as specified in appendix A to this rule.
(7) A government jurisdiction or district with a population of twenty thousand to fifty thousand shall pay a total license fee of seventy-five per cent of the amount specified for that use of radioactive material as specified in appendix A to this rule.
(8) A government jurisdiction or district with a population of less than twenty thousand shall pay a total license fee of fifty per cent of the amount specified for that use of radioactive materials as specified in appendix A to this rule.
(9) A health district as defined in section 3709.01 of the Revised Code shall pay a total
license fee of twenty-five per cent of the amount specified in appendix A to this rule.

(10) An accredited private or public college or university possessing or using radioactive material in a sealed or unsealed source solely as a part of a college or university course supported by tuition and leading to an accredited degree, but excluding clinical training, shall pay a total license fee as set forth for category “1129” as that amount is specified in appendix A to this rule.

The reduced annual fees specified in this paragraph do not apply to any other fees that a licensee may be required to pay under Chapter 3748 of the Revised Code or rules adopted thereunder. Licensees shall provide certification of their compliance with the provisions of paragraphs (J)(1) to (J)(6) of this rule upon initial application and renewal.

(K) The director may modify the inspection frequency of licensed facilities based upon the performance of the facility.

(L) In accordance with section 3748.22 of the Revised Code, the department shall charge fees sufficient to cover all costs of regulatory, administrative, and enforcement activities conducted pursuant to Chapter 3748 of the Revised Code. The director shall recommend to the radiation advisory council and the public health council changes in the radioactive materials fees if the director finds that fees do not meet the requirements of section 3748.22 of the Revised Code.

(M) Fees for those categories listed as “full cost” such as decommissioning activities, for either partial, building or selected area of a licensed site, or full decommissioning leading to license amendment, category change, or termination and for review of sources and/or devices shall be specified as “full cost” and shall be calculated as the sum of the seventy dollar hourly charge per staff member for the number of hours spent on document review and preparation, licensing, inspection, meetings, teleconferences, in travel, administrative time, the cost of any special contractors as determined necessary by the director, any environmental monitoring for radioactive materials and laboratory analysis, any other associated activities. The administrative fee from paragraph (H)(2) of this rule shall be used for administrative time. Travel expenses shall also be invoiced and shall be calculated at the rate determined by rule 126-1-02 of the Administrative Code. These fees will be invoiced monthly.

(N)

(1) Reciprocity to engage in activities in the state of Ohio which involve radioactive materials may be authorized provided:

(a) The person requesting reciprocity possesses a valid radioactive materials license issued by another agreement state or the United States nuclear regulatory commission which authorizes the same activities proposed to be conducted in Ohio;

(b) The request for reciprocity is made by submission of a completed reciprocity application provided by the director, a copy of the person’s radioactive materials license, and payment of the reciprocity fee specified in appendix A to this rule;

(c) The duration of activities to be performed in Ohio under reciprocity does not exceed one hundred eighty days in any one calendar year.

(2) A person who has been granted reciprocity in Ohio shall notify the director at least three business days in advance of each time the person proposes to begin a new use of radioactive materials in the state of Ohio, with the notification made on a form provided by the director.

(3) Activities conducted in Ohio under reciprocity are subject to inspection by the department at any time and the department shall invoice a reciprocity inspection fee of one thousand dollars for each inspection of a person’s authorized reciprocity activities.

(4) Reciprocity is authorized for one calendar year, beginning on January first or later date when reciprocity is initially applied for, and ending on December thirty-first.

(5) A person who is authorized reciprocity shall apply for an Ohio radioactive materials license at least thirty days prior to exceeding one hundred eighty days of activities in Ohio.
(O) Requests for safety evaluation of devices, products, or sealed sources used for radioactive materials either for commercial distribution or manufactured in accordance with the unique specifications of, and for use by, a single applicant shall be submitted to the director on a form provided by the director for that review prior to manufacture or commercial distribution.

(1) The application shall specify a license amendment for one of the areas listed below:
   (a) Safety evaluation of sealed sources or devices or products containing NARM, byproduct material, source material, or special nuclear material (less than critical mass) for commercial distribution.
   (b) Safety evaluation of sealed sources or devices or products containing NARM, byproduct material, source material, or special nuclear material (less than critical mass) manufactured in accordance with the unique specifications of, and for use by, a single applicant.

(2) The amendment fee for a source or device review shall be “full cost” as outlined in paragraph ((M) of this rule.

(3) The amendment fee in appendix A to this rule for categories under manufacturing and distribution shall be for amendments other than source or device reviews.

(4) Licensees for categories 3211, 3212, 3213, 3214, and 22162 shall pay an annual surcharge of six hundred fifty dollars to cover administrative costs of overall maintenance activities associated with source or device data submitted to the United States nuclear regulatory commission. This surcharge is included in the annual fee for the above listed categories in “column 5” and “column 6” of appendix A to this rule.

(P) When considered necessary by the director, the director may conduct a review of shielding plans or the adequacy of shielding. The director may also conduct such a review upon the request of the licensee or the applicant for a license. The applicant or licensee shall pay a fee for review of shielding plans or adequacy of shielding as specified in paragraph (M) of this rule.

(Q) Individuals with implanted pacemakers that have a radioactive source will not be charged an annual fee as an individual because of the necessity of possessing the device. Unless the director determines other provisions are required, the medical institution that implanted the device shall hold the license for the individual.

(R) If, because of the complexity of a review, such as that for a sealed source or device, decommissioning, license, or incident, it is necessary to obtain the services of a consultant to assist in a final determination, the licensee or applicant will be invoiced for the consulting services.

(S) Licensees with general licenses requiring an annual report to the director shall submit the report with a fee of four hundred twenty dollars within thirty days of mailing an invoice by the department and are subject to late penalties in paragraph (I) of this rule. If a facility has a specific license which is in a category that would include the generally licensed material, the facility may add the generally licensed material to the specific license and will not be charged the additional fee for that generally licensed material. Annual reports are required for devices under a general license containing radionuclides at or above activities listed in paragraph (C)(13) of rule 3701:1-46-05 of the Administrative Code.

3701:1-38-03 Application and renewal of registrations for handlers of radiation-generating equipment.

(A) As used in this rule, “facility” means the state, any political subdivision, person, public or private institution, or group, or any unit of one of those entities, but does not include the federal government agencies, and includes the following:

(1) All buildings, equipment, structures and other stationary items that are located on a single site or on contiguous or adjacent sites and that are operated by the same person and have common corporate or business purposes; and
(2) Portions of a building or structure which are operated by the same person and have common corporate or business purposes.

(B) Notwithstanding the definition of “facility,” the director may consider sites that are not contiguous or adjacent as one facility provided that:

(1) The sites are operated by the same person;

(2) The sites are of the same facility type as categorized in paragraph (B) of rule 3701:1-38-04 of the Administrative Code;

(3) The applicant for a registration provides for one individual responsible for radiation protection and implementing quality assurance procedures and policies necessary for effective compliance with Chapter 3748 of the Revised Code and rules adopted thereunder, and if applicable, one quality assurance committee, as responsible for all sites; and

(4) The director is reasonably satisfied from the information provided in the application that the applicant will adequately control the radiation-generating equipment at all sites listed in the application. Unless the director has information of violations of Chapter 3748 of the Revised Code or the rules adopted thereunder at one or more sites, he or she shall presume the applicant will adequately control the radiation-generating equipment at all sites if the sites are located not more than five miles apart.

The director shall continue to renew a registration issued under this paragraph that contains all the sites listed thereon provided the registrant demonstrates continued compliance with this paragraph, Chapter 3748 of the Revised Code, and the rules adopted thereunder.

(C) Except as provided in paragraph (D) of this rule, every facility that proposes to handle radiation-generating equipment shall apply for a registration at least thirty days prior to handling the equipment. Registration is required for dental, medical, therapeutic, and non-medical radiation-generating equipment. Application for a registration or renewal thereof shall be made on a form prescribed and provided by the director and shall be accompanied by a non-refundable registration fee in accordance with section 3748.07 of the Revised Code. The application shall include the name and qualifications of the individual designated as responsible and readily available for radiation protection and implementing quality assurance policy and procedures necessary for assuring compliance with Chapter 3748 of the Revised Code and rules adopted thereunder. Registrations shall expire two years from the date of issuance.

Registration certificates are not transferable. If a facility is sold or otherwise transferred to another person after a certificate of registration has been issued, the new handler is required to apply and receive a new registration certificate for the radiation-generating equipment.

(D) Facilities do not need to register the following types of radiation-generating equipment:

(1) Electronic equipment that produces ionizing radiation incidental to its operation for other purposes, if the exposure rate averaged over an area of ten square centimeters does not exceed one-half milliroentgen per hour at a distance of five centimeters from any accessible surface of such equipment; or

(2) Radiation-generating equipment that is already registered under Chapter 3748 of the Revised Code by its possessor.

(E) An applicant for a registration shall submit to the director a complete application for registration on a form provided by the director together with the required registration fee. The application shall contain all the information required on the form and accompanying instructions. The applicant for a registration shall provide to the director within thirty days of receipt of the request, all additional requested information. If the director does not receive the requested information within the thirty days, the director may consider the application abandoned. Any further consideration for a new registration shall be pursuant to another application accompanied by another nonrefundable registration fee.

(F) The director shall grant a new registration or renewal to any applicant who has submitted a complete application, paid the registration fee, and is in compliance with applicable
rules adopted under Chapter 3748 of the Revised Code.

(G) Registrations shall be renewed in accordance with the standard renewal procedure established in Chapter 4745 of the Revised Code. The registrant shall apply for renewal at least thirty days prior to the expiration of the registration.

(H) Any handler that assembles, installs, or disposes of radiation-generating equipment within this state shall notify the director, in writing, at least quarterly of such actions.

Each report shall contain the name and address of the facility that received equipment; the manufacturer, model, and serial number of the x-ray tube or x-ray generator transferred, disposed of, or installed; and the date of transfer, disposal, or installation of the radiation-generating equipment.

The state copy of the United States department of health and human services, food and drug administration “Report of Assembly of a Diagnostic X-ray System” form, used for reporting diagnostic x-ray systems which contain certified components, may be used to meet the notification requirements for this rule.

(I) No handler shall transfer, service, or install radiation-generating equipment or the components used in connection with such equipment unless such components and equipment, when properly placed in operation and used, meet the requirements of this chapter and all applicable requirements of Chapter 3701:1-66 or 3701:1-67 of the Administrative Code.

(J) The registrant shall notify the director, in writing, fifteen days prior to making any change which would render the information contained in the application for registration or registration certificate no longer accurate.

(K) Notwithstanding any other requirements of this rule, out-of-state owners of radiation-generating equipment who:

1. Operate the radiation-generating equipment within Ohio are required to:
   (a) Possess a valid Ohio registration;
   (b) Provide written notification three days prior to the dates when the radiation-generating equipment will be used in Ohio; and
   (c) Assure that the operation of the radiation-generating equipment complies with all applicable rules in Chapters 3701:1-38, 3701:1-66, 3701:1-67, and 3701-72 of the Administrative Code.

2. Solely transport the radiation-generating equipment to an Ohio facility to be operated by the Ohio facility are not required to register. The Ohio facility using the radiation-generating equipment shall:
   (a) Possess a valid Ohio registration;
   (b) Provide written notification three days prior to the dates when the radiation-generating equipment will be used in Ohio; and
   (c) Verify that the operation of the radiation-generating equipment complies with all applicable rules in Chapters 3701:1-38, 3701:1-66, 3701:1-67, and 3701-72 of the Administrative Code.

(L) Any facility found as an unregistered handler shall be notified by the director that registration is required pursuant to the requirements of paragraph (C) of this rule. Any such facility that does not apply for registration within ten business days of receiving a notice to register shall be inspected by the department. The unregistered handler shall pay the fee required by section 3748.13 of the Revised Code.

A facility that handles radiation-generating equipment and engages in activities involving the use of radiation-generating equipment that does not obtain an Ohio registration as required by this rule is subject to the fee for the inspection of an unregistered handler specified in section 3748.13 of the Revised Code.
3701:1-38-04 Radiation generating equipment inspection schedule and inspection fee.

[Editor’s Note: Fees and inspection schedules are listed in the appendices, available at http://www.odh.ohio.gov/rules/final/finalrules.aspx.]

(A) Each handler shall afford the director, at all reasonable times, opportunity to inspect radiation-generating equipment and equipment shielding, surroundings, records and other equipment and devices used in connection with handling radiation-generating equipment. Each handler also shall perform, as requested by the director, such tests as the director determines may be necessary for the handler to demonstrate compliance with the requirements of Chapter 3748 of the Revised Code and rules adopted thereunder and to evaluate the extent of radiation hazards that may be present.

(B) The director shall routinely inspect radiation-generating equipment unless that equipment is registered as in storage and rendered inoperable. Routine inspections shall be conducted according to the schedule by facility category listed in appendix A to this rule.

(C) Notwithstanding the inspection frequencies specified in paragraph (B) of this rule, radiation-generating equipment capable of operating at or above two hundred fifty kilovoltage peak may be inspected every twelve months irrespective of facility category.

(D) The director may modify the inspection frequency of a registered facility based upon the performance of the facility.

(E) In addition to any inspections required under this rule, inspections of new or newly installed radiation-generating equipment may be performed within twelve months of installation of the equipment.

(F) Non-routine or special inspections of facilities may be conducted by the director upon receiving complaints or other evidence of violation of the requirements of Chapter 3748 of the Revised Code or rules adopted thereunder, or orders of the director issued pursuant thereto.

(G) Any handler of radiation-generating equipment that is a medical practitioner or a corporation, partnership, or other business entity consisting of medical practitioners, other than a hospital as defined in section 3727.01 of the Revised Code, shall pay to the department of health an inspection fee according to the schedule and categories listed in appendix B to this rule. For purposes of this section “medical practitioner” means a person authorized to practice dentistry pursuant to Chapter 4715 of the Revised Code; medicine and surgery, osteopathic medicine and surgery, or podiatry pursuant to Chapter 4731 of the Revised Code; or chiropractic pursuant to Chapter 4734 of the Revised Code.

(H) Except as otherwise provided in paragraph (G) of this rule, all handlers of radiation-generating equipment shall pay an inspection fee according to the schedule listed in appendix C to this rule.

(I) In accordance with division (B) of section 3748.13 of the Revised Code, the fee for the inspection of a facility that does not possess or that has not applied for registration and for which registration is required, shall pay the amount required in division (B) of section 3748.13 of the Revised Code plus any required amount specified under paragraph (G) or (H) of this rule.

(J) In accordance with section 3748.13 of the Revised Code, the fee for any inspection to determine whether notice of violations cited in a previous inspection have been corrected is fifty per cent of the fee specified in paragraphs (G) and (H) of this rule. Inspections to determine compliance with a notice of violation issued pursuant to paragraph (A) of rule 3701:1-38-06 of the Administrative Code may include, but is not limited to, compliance reviews done off-site.

3701:1-38-09 Inspection and investigation.

(A) Each licensee or registrant shall afford to the department at all reasonable times, the opportunity to inspect materials, machines, activities, facilities, premises, and records and any
other matters relative to the handling of radioactive material or radiation-generating equipment.

(1) During an inspection, department inspectors may consult privately with workers as specified in paragraph (B) of this rule. The licensee or registrant may accompany department inspectors at any other time during the inspection.

(2) If, at the time of inspection, an individual has been authorized by the workers to represent them during department inspections, the licensee or registrant shall notify the inspector of such authorization and shall give the worker’s representative an opportunity to accompany the inspector during the inspection of physical working conditions. Each worker’s representative shall be routinely engaged in licensed or registered activity under control of the licensee or registrant and shall have received instructions as to the provisions specified in paragraph (B) of rule 3701:1-38-10 of the Administrative Code. Different representatives of licensees or registrants and workers may accompany the inspectors during different phases of an inspection if there is no resulting interference with the conduct of the inspection. However, only one worker’s representative at a time may accompany an inspector.

(3) With the approval of the licensee or registrant and the worker’s representative, an individual who is not routinely engaged in work under control of the licensee or registrant, for example, a consultant to the licensee or registrant or to the worker’s representative, shall be afforded the opportunity to accompany the department inspector during the inspection of physical working conditions.

(4) Notwithstanding any other provision in paragraph (A) of this rule, a department inspector may refuse to permit accompaniment by any individual who deliberately interferes with a fair and orderly inspection. With regard to areas containing information classified by an agency of the United States government in the interest of national security, an individual who accompanies an inspector may have access to such information only if properly authorized. With regard to any area containing proprietary information or trade secrets, the worker’s representative for that area shall be an individual previously authorized by the licensee or registrant to enter that area.

(B) Private consultation between a department inspector and a worker during inspections shall be subject to the following:

(1) A department inspector may consult privately with workers concerning matters of occupational radiation protection and other matters related to applicable provisions of a license condition, order, or rules adopted pursuant to Chapter 3748 of the Revised Code.

(2) During the course of an inspection, any worker privately may bring to the attention of a department inspector, either orally or in writing, any past or present condition which the worker has reason to believe may have contributed to or caused any violation of rules adopted pursuant to Chapter 3748 of the Revised Code, license condition, order, or any unnecessary exposure of an individual to sources of radiation under the licensee’s or registrant’s control. Any such notice in writing shall comply with the requirements specified in paragraph (C) of this rule. The provisions of this paragraph shall not be interpreted as authorization to disregard instructions pursuant to paragraph (B) of rule 3701:1-38-10 of the Administrative Code.

(C) Requests by workers for a department inspection shall be in accordance with the following:

(1) Any worker or representative of workers believing that a violation of Chapter 3748 of the Revised Code or rules adopted thereunder, license condition or order, or any unnecessary exposure of an individual to sources of radioactive material or radiation-generating equipment under the licensee’s or registrant’s control has occurred in the handling of radioactive material or radiation-generating equipment relative to working conditions may request an inspection by giving notice of the alleged violation to the director. Any such notice shall be in writing, shall set forth the specific grounds for the notice, and shall be signed by the worker or representative of the workers. A copy shall be provided to the licensee or registrant by the department no later than at the time of inspection except that, upon the request of the worker giving such notice,
such worker's name and the name of individuals referred to therein shall not appear in such copy or on any record published, released, or made available by the department, except for good cause shown.

(2) If, upon receipt of such notice, the director determines that the written complaint meets the requirements specified in paragraph (C)(1) of this rule and that the director determines that there are reasonable grounds to believe that the alleged violation exists or has occurred or that further investigation is necessary, the department shall inspect the facility as soon as practicable to determine if such alleged violation exists or has occurred. Any such inspection is not limited to matters referred to in the written complaint.

(3) The department shall notify the complainant in writing of the results of the investigation. The complainant may resubmit the written complaint without prejudice.

(D) If the department determines under paragraph (C) of this rule that an inspection is not warranted by a written complaint, such determination shall be in accordance with the following:

(1) If the department determines that an inspection is not warranted because there are no reasonable grounds to believe that a violation exists or has occurred, the department shall notify the complainant in writing of such determination. The complainant may obtain review of such determination by submitting a written statement of position with the department. The department will provide the licensee or registrant with a copy of such statement, excluding, at the request of the complainant, the name of the complainant. The licensee or registrant may submit an opposing written statement of position with the department. The department will provide any opposing statement to the complainant.

(2) Upon the request of the complainant, the director may hold an informal conference in which the complainant and the licensee or registrant may orally present their views. An informal conference may also be held at the request of the licensee or registrant, but disclosure of the identity of the complainant will be made only following receipt of written authorization from the complainant. The director shall consider all written and oral views presented and shall notify the parties in writing of his or her decision on whether an inspection is warranted and the reason therefore.

(E) No licensee or registrant, or contractor or subcontractor of a licensee or registrant shall instruct any employee to withhold information from a department inspector or retaliate or discriminate against any employee or former employee for exercising rights or engaging in activities protected under rules adopted pursuant to Chapter 3748 of the Revised Code.

3701:1-38-10 Notices, instructions, and reports to workers.

(A) Posting of notices to workers.

(1) Each licensee or registrant shall post current copies of the following documents:

(a) All applicable rules promulgated pursuant to Chapters 3748 and 4773 of the Revised Code;

(b) The license or certificate of registration, including, any conditions or documents incorporated by reference into a license and amendments thereto;

(c) The safe operating procedures applicable to activities under the license or registration; and

(d) Any notice of violation involving radiological working conditions, proposed imposition of civil or administrative monetary penalty, or order issued pursuant to rule 3701:1-38-06 of the Administrative Code and any response from the licensee or registrant. Such document shall be posted within five working days after receipt of the document. The licensee’s or registrant’s response, if any, shall be posted within five working days after dispatch of the document to the director. Such documents shall remain posted for a minimum of five working days or until action correcting the violation has been completed, whichever is later.
(e) The Ohio department of health, bureau of radiation protection issued form titled “Notice to Employees.”

(2) If posting of a document specified in paragraphs (A)(1)(a) to (A)(1)(c) of this rule is not practical, the licensee or registrant may post a notice which describes the document and states where it may be readily examined.

(3) Documents, notices, or forms posted pursuant to paragraph (A) of this rule shall appear in a sufficient number of places to permit individuals engaged in licensed or registered activity under the license or registration to observe them on the way to or from any particular work location to which the document applies, shall be conspicuous, and shall be replaced if defaced or altered.

(B) Instruction to workers.

(1) The licensee or registrant shall, with respect to all individuals likely to receive an annual TEDE occupational dose in excess of one millisievert (one hundred millirem): 
   (a) Keep such individuals informed of the storage, transfer, or use of sources of radiation in the licensee's or registrant's workplace;
   (b) Instruct such individuals in the health effects associated with exposure to radiation or radioactive material to the individual and potential offspring, in precautions or procedures to minimize exposure, and in the purposes and functions of protective devices employed;
   (c) Instruct such individuals in, and instruct such individuals to observe, to the extent within the individual's control, the applicable provisions of rules promulgated under Chapter 3748 of the Revised Code and any license conditions for the protection of personnel from exposures to radiation or radioactive material;
   (d) Instruct each such individual of his or her responsibility to report promptly to the licensee or registrant any condition which may constitute, lead to, or cause a violation of Chapter 3748 of the Revised Code, the rules promulgated thereunder, any license condition, or order, and any unnecessary exposure to radiation or radioactive material;
   (e) Instruct such individuals in the appropriate response to warnings made in the event of any unusual occurrence or malfunction that may involve exposure to radiation or radioactive material; and
   (f) Advise such individuals of any radiation exposure reports furnished pursuant to paragraph (C) of this rule.

(2) In determining those individuals subject to the requirements of paragraph (B)(1) of this rule, licensees and registrants shall take into consideration assigned activities during normal and abnormal situations involving exposure to radiation and radioactive materials which can reasonably be expected to occur during the life of the facility. The extent of these instructions shall be commensurate with potential radiological health protection problems present in the workplace.

(C) Notifications and reports to individuals.

(1) Radiation exposure data for an individual and the results of any measurements, analyses, and calculations of radioactive material deposited or retained in the body of an individual shall be reported to the individual as specified in this rule. The information reported shall include data and results obtained pursuant to Chapter 3748 of the Revised Code or rules adopted thereunder, an order, or license condition as shown in records maintained by the licensee or registrant pursuant to paragraph (H) of rule 3701:1-38-20 of the Administrative Code. Each notification and report shall:
   (a) Be in writing;
   (b) Include appropriate identifying data such as the name of the licensee or registrant, the name of the individual, and the individual's identification number, preferably social security number;
   (c) Include the individual's exposure information; and
   (d) Contain the statement: “This report is furnished to you under the provisions of rule
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3701:1-38-10 of the Administrative Code. You should preserve this report for further reference.

(2) Each licensee or registrant shall make dose information available to workers as shown in records maintained by the licensee under the provisions of paragraph (H) of rule 3701:1-38-20 of the Administrative Code. The licensee or registrant shall provide an annual report to each individual monitored under rule 3701:1-38-14 of the Administrative Code, of the dose received in that monitoring year if:

(a) The individual's occupational dose exceeds one millisievert (one hundred millirem) TEDE or one millisievert (one hundred millirem) to any individual organ or tissue; or
(b) The individual requests his or her annual dose report.

(3) Each licensee or registrant shall furnish reports to workers.

(a) At the request of a worker formerly engaged in activities controlled by the licensee or registrant, each licensee or registrant shall furnish to the worker a report of the worker's exposure to sources of radiation:

(i) As shown in records maintained by the licensee or registrant pursuant to rule 3701:1-38-20 of the Administrative Code for each year the worker was required to be monitored under the provisions of rule 3701:1-38-14 of the Administrative Code; and
(ii) For each year the worker was required to be monitored under the monitoring requirements in effect prior to August 31, 1999.

(b) This report must be furnished within thirty days from the time the request is made or within thirty days after the exposure of the individual has been determined by the licensee or registrant, whichever is later. This report must cover the period of time that the worker's activities involved exposure to sources of radiation licensed or registered by the director and must include the dates and locations of licensed or registered activities in which the worker participated during this period.

(4) When a licensee or registrant is required pursuant to paragraphs (A) to (C) of rule 3701:1-38-21 of the Administrative Code to report to the director any exposure of an individual to sources of radiation, the licensee or the registrant shall also provide the individual a written report on the exposure data included in the report to the director. This report must be transmitted no later than the transmittal to the director.

(5) At the request of a worker who is terminating employment with the licensee or registrant that involved exposure to sources of radiation during the current calendar quarter or the current year, each licensee or registrant shall provide at termination to each worker, or to the worker's designee, a written report regarding the radiation dose received by that worker from operations of the licensee or registrant during the current calendar year or fraction thereof. If the most recent individual monitoring results are not available at that time, a written estimate of the dose must be provided together with a clear indication that this is an estimate.

3701:1-38-13 Dose limits for individual members of the public.

(A) Each licensee or registrant shall conduct operations so that:

(1) The total effective dose equivalent to individual members of the public from the licensed or registered operation does not exceed one millisievert (0.1 rem) in a year, exclusive of the dose contribution from the following:

(a) Background radiation;
(b) Radiation attributable to any medical administration the individual has received;
(c) Exposure to an individual that was administered radioactive materials and has been released in accordance with rule 3701:1-58-30 of the Administrative Code or equivalent United States nuclear regulatory agency or agreement state regulations;
(d) Voluntary participation in medical research programs;
(e) The licensee's disposal of radioactive material into sanitary sewerage in accordance with paragraph (D) of rule 3701:1-38-19 of the Administrative Code; and
(2) The dose in any unrestricted area from external sources, exclusive of the dose contribution from patients administered radioactive material and released in accordance with rule 3701:1-58-30 of the Administrative Code or equivalent United States nuclear regulatory agency or agreement state regulations, does not exceed 0.02 millisievert (0.002 rem) in any one hour.

(B) If the licensee or registrant permits members of the public to have access to controlled or restricted areas, the limits for members of the public continue to apply to those individuals.

(C) A licensee, registrant, or an applicant for a license or registration may apply for prior department authorization to operate up to an annual dose limit for an individual member of the public of five millisievert (0.5 rem). This application shall include the following information:

(1) Demonstration of the need for and the expected duration of operation in excess of the limit set forth in paragraph (A) of this rule;
(2) The licensee’s or registrant’s program to assess and control dose within the five millisievert (0.5 rem) annual limit; and
(3) The procedures that the registrant or licensee will follow to maintain the dose ALARA.

(D) In addition to the requirements of paragraphs (A) and (B) of this rule:

(1) A licensee subject to the provisions of the United States environmental protection agency’s generally applicable environmental radiation standards in 40 C.F.R. 190, as published in the July 1, 2014 Code of Federal Regulations, shall also comply with those standards.

(2) The department may impose additional restrictions on radiation levels in unrestricted areas and on the total quantity of radionuclides that a licensee may release in effluents in order to restrict the collective dose.

(E) The licensee or registrant shall demonstrate compliance with dose limits for individual members of the public.

(1) The licensee or registrant shall make or cause to be made surveys of radiation levels in unrestricted and controlled areas and radioactive materials in effluents released to unrestricted and controlled areas to demonstrate compliance with the dose limits for individual members of the public in paragraph (A) of this rule.

(2) A licensee or registrant shall show compliance with the annual dose limit in paragraph (A) of this rule by:

(a) Demonstrating by measurement or calculation that the total effective dose equivalent to the individual likely to receive the highest dose from the licensed or registered operation does not exceed the annual dose limit; or

(b) Demonstrating that:

(i) The annual average concentrations of radioactive material released in gaseous and liquid effluents at the boundary of the unrestricted area do not exceed the values specified in appendix C to rule 3701:1-38-12 of the Administrative Code; and

(ii) If an individual were continuously present in an unrestricted area, the dose from external sources would not exceed 0.02 millisievert (0.002 rem) in an hour and 0.5 millisievert (0.05 rem) in a year.

(3) Upon approval from the department, the licensee may adjust the effluent concentration values in appendix C to rule 3701:1-38-12 of the Administrative Code for members of the public, to take into account the actual physical and chemical characteristics of
the effluents, such as aerosol size distribution, solubility, density, radioactive decay equilibrium, or chemical form.


(A) A licensee shall dispose of licensed radioactive material in accordance with this rule. Licensed material shall be disposed of in one of the following manners:
   (1) By transfer to an authorized recipient as provided in this chapter, Chapter 3701:1-40 of the Administrative Code, or to the United States department of energy;
   (2) By decay in storage provided that the radionuclide has a half-life of one hundred twenty days or less, or as otherwise permitted by the license;
   (3) By release in effluents within the limits set forth in rule 3701:1-38-13 of the Administrative Code; or
   (4) As authorized pursuant to paragraphs (B) to (F) of this rule.

(B) A person shall be specifically licensed to receive waste containing licensed material from another person for:
   (1) Treatment prior to disposal;
   (2) Treatment or disposal by incineration;
   (3) Decay in storage;
   (4) Disposal at a land disposal facility licensed pursuant to rules 3701:1-54-06 to 3701:1-54-12 of the Administrative Code or equivalent United States nuclear regulatory commission or agreement state regulations; or
   (5) Storage until transfer to a storage or disposal facility authorized to receive the waste.

(C) A licensee or applicant for a license may apply to the director for approval of proposed disposal procedures that are not otherwise authorized in these rules for the disposal of licensed material generated in the licensee’s operations. Each application shall include:
   (1) A description of the waste containing licensed material to be disposed of, including the physical and chemical properties that have an impact on risk evaluation, and the proposed manner and conditions of waste disposal;
   (2) An analysis and evaluation of pertinent information on the nature of the environment;
   (3) The nature and location of other potentially affected facilities; and
   (4) An analysis and procedures to ensure that doses are maintained ALARA and within the dose limits in rules 3701:1-38-12 and 3701:1-38-13 of the Administrative Code.

(D) A licensee may discharge licensed material into sanitary sewerage as follows:
   (1) The material is readily soluble in water or is a biological material that is readily dispersible in water;
   (2) The quantity of licensed or other radioactive material that the licensee releases into the sewer in one month divided by the average monthly volume of water released into the sewer by the licensee does not exceed the concentration listed in table III of appendix C to rule 3701:1-38-12 of the Administrative Code; and
   (3) If more than one radionuclide is to be released, the following conditions must also be satisfied:
      (a) The licensee shall determine the fraction of the limit in table III of appendix C to rule 3701:1-38-12 of the Administrative Code represented by discharges into sanitary sewerage by dividing the actual monthly average concentration of each radionuclide released by the licensee into the sewer by the concentration of that radionuclide listed in table III of appendix C to rule 3701:1-38-12 of the Administrative Code; and
      (b) The sum of the fractions for each radionuclide required by paragraph (D)(3)(a) of this rule does not exceed unity.
   (4) The total quantity of licensed and other radioactive material that the licensee releases into the sanitary sewerage in a year does not exceed one hundred eighty-five
gigabecquerels (five curies) of hydrogen-3, thirty-seven gigabecquerels (one curie) of carbon-
14, and thirty-seven gigabecquerels (one curie) of all other radioactive materials combined.

(5) Excreta from an individual undergoing medical diagnosis or therapy with radioactive
material is not subject to the limitations contained in paragraph (D) of this rule.

(E) A licensee may dispose of licensed material by decay in storage. A licensee may
hold radioactive material with a physical half-life of one hundred twenty days or less for decay-
in-storage before disposal as non-radioactive material provided the licensee does the following:
(1) Monitors the material at the container surface prior to disposal and determines that
the radioactivity cannot be distinguished from the background radiation level with an appropriate
radiation detection survey meter set on its most sensitive scale and with no interposing
shielding;
(2) Removes or obliterates all radiation caution labels and symbols, unless otherwise
specified in the license; and
(3) Retains a record of the disposal for three years.

(F) A licensee may treat or dispose of licensed material by incineration only in the form
and concentration specified in paragraph (G) of this rule or as specifically approved by the
director pursuant to paragraph (C) of this rule.

(G) A licensee may dispose of the following licensed material as if it were not
radioactive. The licensee shall maintain records in accordance with paragraph (K) of rule

(1) 1.85 kilobecquerels (0.05 microcurie) or less, of hydrogen-3 or carbon-14 per gram of
medium used for liquid scintillation counting; or
(2) 1.85 kilobecquerels (0.05 microcurie) or less, of hydrogen-3 or carbon-14 per gram of
animal tissue, averaged over the weight of the entire animal. A licensee shall not dispose of
tissue pursuant to this paragraph in a manner that would permit its use either as food for
humans or as animal feed.

(H) A licensee shall transfer and dispose of licensed material in accordance with the
following:
(1) For transfer of radioactive waste intended for disposal at a licensed radioactive waste
disposal facility, establish a manifest tracking system, and supplement existing requirements
concerning transfers and recordkeeping for those wastes. Each shipment of radioactive waste
designated for disposal at a licensed radioactive waste disposal facility shall be accompanied by
a shipment manifest as specified in appendix A to this rule.
(2) Each shipment manifest shall include a certification by the waste generator in
accordance with appendix A to this rule.
(3) Each person involved in the transfer of waste for disposal or in the disposal of waste,
including the waste generator, waste collector, waste processor, and disposal facility operator,
shall comply with the requirements specified in appendix A to this rule.

(I) Nothing in this rule relieves a licensee from complying with other applicable federal,
state and local regulations governing any other toxic or hazardous properties of materials that
may be disposed of under this rule.

3701:1-38-21 Reports.

(A) The licensee or registrant shall report stolen, lost, or missing licensed or registered
sources of radiation to the director in accordance with the following:
(1) Telephone reports shall be made as follows:
(a) To the bureau of radiation protection point of contact (POC) in accordance with the
form "Notice to Employees" issued by the director.
(b) In the case of a licensee, he or she shall make contact:
(i) Immediately after the licensee determines that licensed radioactive material is stolen,
lost, or missing in an aggregate quantity equal to or greater than one hundred times the quantity specified in appendix A to rule 3701:1-38-18 of the Administrative Code under such circumstances that it appears to the licensee that an exposure could result to individuals in unrestricted areas;

(ii) Within thirty days after its occurrence becomes known to the licensee, lost, stolen, or missing licensed radioactive material in an aggregate quantity greater than ten times the quantity specified in appendix A to rule 3701:1-38-18 of the Administrative Code that is still missing.

(c) In the case of a registrant, he or she shall make contact immediately after it becomes known that radiation-generating equipment has been stolen, lost, or is missing.

(2) Written reports shall be made as follows:

(a) Each licensee or registrant required to make a report pursuant to paragraph (A)(1) of this rule shall, within thirty days after making the telephone report, make a written report to the director setting forth the following information, where applicable:

(i) A description of the licensed or registered source of radiation involved, including, for radioactive material, the kind, quantity, and chemical and physical form, and in the case of radiation-generating equipment, the manufacturer, model and serial number, type and maximum energy of the radiation emitted;

(ii) A description of the circumstances under which the loss or theft occurred;

(iii) A statement of disposition, or probable disposition, of the licensed or registered source of radiation involved;

(iv) Exposures of individuals to radiation, circumstances under which the exposures occurred, and the possible total effective dose equivalent to persons in unrestricted areas;

(v) Actions that have been taken, or will be taken, to recover the source of radiation; and

(vi) Procedures or measures that have been, or will be, adopted to ensure against a recurrence of the loss or theft of licensed or registered sources of radiation.

(b) Subsequent to filing the written report, the licensee or registrant shall also report additional substantive information on the loss or theft within thirty days after the licensee or registrant learns of such information.

(c) The licensee or registrant shall prepare any report filed with the director pursuant to this rule so that names of individuals who may have received exposure to radiation are stated in a separate and detachable portion of the report.

(B) Notification of incidents shall be made as follows:

(1) Excluding prescribed medical doses to patients, each licensee or registrant shall immediately report each event involving a source of radiation possessed by the licensee or registrant that may have caused or threatens to cause any of the following conditions:

(a) An individual receiving:

(i) A total effective dose equivalent of 0.25 sievert (twenty-five rem) or more;

(ii) A lens dose equivalent of 0.75 sievert (seventy-five rem) or more; or

(iii) A shallow dose equivalent to the skin or extremities or a total organ dose equivalent of 2.5 sievert (two hundred fifty rem) or more; or

(b) The release of radioactive material, inside or outside of a restricted area that, had an individual been present for twenty-four hours, the individual could have received an intake five times the occupational ALI. This provision does not apply to locations where personnel are not normally stationed during routine operations, such as hot-cells or process enclosures.

(2) Each licensee or registrant shall report to the director, within twenty-four hours of discovery, each event involving loss of control of a licensed or registered source of radiation possessed by the licensee or registrant that may have caused, or threatens to cause, any of the following:

(a) An individual to receive, in a period of twenty-four hours:

(i) A total effective dose equivalent exceeding 0.05 sievert (five rem);
(ii) An lens dose equivalent exceeding 0.15 sievert (fifteen rem); or
(iii) A shallow dose equivalent to the skin or extremities or a total organ dose equivalent
exceeding 0.5 sievert (fifty rem); or
(b) The release of radioactive material, inside or outside of a restricted area that, had an
individual been present for twenty-four hours, the individual could have received an intake in
excess of one occupational ALI. This provision does not apply to locations where personnel are
not normally stationed during routine operations, such as hot-cells or process enclosures.
(3) Licensees or registrants shall make the reports required by paragraphs (B)(1) and
(B)(2) of this rule to the POC by telephone to the department and shall confirm the initial contact
by telegram, mailgram, electronic mail, or facsimile to the director.
(4) The licensee or registrant shall prepare each report filed with the director pursuant to
this rule so that names of individuals who have received exposure to sources of radiation are
stated in a separate and detachable portion of the report.
(5) The provisions of paragraph (B) of this rule do not apply to doses that result from
planned special exposures, provided such doses are within the limits for planned special
exposures and are reported in accordance with this paragraph.
(C) Reports of exposures, radiation levels, and concentrations of radioactive material
exceeding the limits shall be made by the licensee or registrant as follows:
(1) Reportable events that are specified in this paragraph shall, in addition to the
notification requirements in paragraph (B) of this rule, be reported to the director in writing within
thirty days after learning of any of the following occurrences:
(a) Incidents for which notification is required by paragraph (B) of this rule and with
doses in excess of any of the following:
(i) The occupational dose limits for adults in paragraphs (A)(1) and (A)(2) of rule 3701:1-38-12 of the Administrative Code;
(ii) The occupational dose limits for a minor in paragraph (G) of rule 3701:1-38-12 of the
Administrative Code;
(iii) The limits for an embryo or fetus of a declared pregnant woman in paragraph (H) of
rule 3701:1-38-12 of the Administrative Code;
(iv) The limits for an individual member of the public in paragraph (A) of rule 3701:1-38-13 of the
Administrative Code;
(v) Any applicable limit in the license or registration; or
(vi) The ALARA constraints for air emissions established under paragraph (D)(4) of rule
3701:1-38-11 of the Administrative Code; or
(b) Levels of radiation or concentrations of radioactive material in:
(i) A restricted area in excess of applicable limits in the license or registration; or
(ii) An unrestricted area in excess of ten times the applicable limit set forth in this chapter
or in the license or registration, whether or not involving exposure of any individual in excess of
the limits in paragraph (A) of rule 3701:1-38-13 of the Administrative Code; or
(c) For licensees subject to the provisions of the United States environmental protection
agency generally applicable environmental radiation standards in 40 C.F.R. 190, levels of
radiation or releases of radioactive material in excess of those standards, or of license
conditions related to those standards.
(2) Each report required by this rule shall describe the extent of exposure of individuals
to radiation and radioactive material, including, as appropriate:
(a) Estimates of each individual's dose, the level of radiation and concentration of
radioactive material involved, and the cause of the elevated exposure, dose rate, or
concentration; and
(b) Corrective steps taken or planned to ensure against a recurrence, including the
schedule for achieving conformance with applicable limits, ALARA constraints, generally
applicable environmental standards, and associated license or registration conditions.
(3) Each report filed pursuant to this rule shall include, for each occupationally overexposed individual, the name, social security account number, and date of birth of the individual. In the case of the limit for an embryo or fetus in paragraph (H) of rule 3701:1-38-12 of the Administrative Code, the identifiers should be those of the declared pregnant woman. The report shall be prepared so that information on each individual is stated in a separate and detachable portion of the report.

(4) All licensees or registrants who make reports pursuant to this rule shall submit the report in writing to the director.

(D) Reports of planned special exposures shall be submitted by the licensee in a written report to the director within thirty days following any planned special exposure conducted in accordance with paragraph (F) of rule 3701:1-38-12 of the Administrative Code, informing the director that a planned special exposure was conducted and indicating the date the planned special exposure occurred and the information required by paragraph (G) of rule 3701:1-38-20 of the Administrative Code.

(E) When a licensee or registrant is required pursuant to paragraph (C) or (D) of this rule to report to the director any exposure of an identified occupationally exposed individual, or an identified member of the public, to radiation or radioactive material, the licensee or registrant shall also provide the individual a report on his or her exposure data included in the report to the director. This report shall be transmitted no later than the transmittal to the director, and shall comply with the provisions of paragraph (C)(1) of rule 3701:1-38-10 of the Administrative Code.

(F) A report of a leaking or contaminated sealed source shall be filed by the licensee with the director within five days of the test results, if the test reveals the presence of one hundred eighty-five becquerels (0.005 microcurie) or more of removable contamination. The report shall include the equipment involved, the test results and the corrective action taken.

3701:1-38-25 Reports of transactions involving nationally tracked sources.

Each licensee who manufactures, transfers, receives, disassembles, or disposes of a nationally tracked source shall complete and submit a national source tracking transaction report as specified in paragraphs (A) to (E) of this rule for each type of transaction.

(A) Each licensee who manufactures a nationally tracked source shall complete and submit a national source tracking transaction report. The report must include the following information:

(1) The name, address, and license number of the reporting licensee;
(2) The name of the individual preparing the report;
(3) The manufacturer, model, and serial number of the source;
(4) The radioactive material in the source;
(5) The initial source strength in becquerels (curies) at the time of manufacture; and
(6) The manufacture date of the source.

(B) Each licensee that transfers a nationally tracked source to another person shall complete and submit a national source tracking transaction report. The report must include the following information:

(1) The name, address, and license number of the reporting licensee;
(2) The name of the individual preparing the report;
(3) The name and license number of the recipient facility and the shipping address;
(4) The manufacturer, model, and serial number of the source or, if not available, other information to uniquely identify the source;
(5) The radioactive material in the source;
(6) The initial or current source strength in becquerels (curies);
(7) The date for which the source strength is reported;
(8) The shipping date;
(9) The estimated arrival date; and
(10) For nationally tracked sources transferred as waste under a uniform low-level radioactive waste manifest, the waste manifest number and the container identification of the container with the nationally tracked source.

(C) Each licensee that receives a nationally tracked source shall complete and submit a national source tracking transaction report. The report must include the following information:
(1) The name, address, and license number of the reporting licensee;
(2) The name of the individual preparing the report;
(3) The name, address, and license number of the person that provided the source;
(4) The manufacturer, model, and serial number of the source or, if not available, other information to uniquely identify the source;
(5) The radioactive material in the source;
(6) The initial or current source strength in becquerels (curies);
(7) The date for which the source strength is reported;
(8) The date of receipt; and
(9) For material received under a uniform low-level radioactive waste manifest, the waste manifest number and the container identification with the nationally tracked source.

(D) Each licensee that disassembles a nationally tracked source shall complete and submit a national source tracking transaction report. The report must include the following information:
(1) The name, address, and license number of the reporting licensee;
(2) The name of the individual preparing the report;
(3) The manufacturer, model, and serial number of the source or, if not available, other information to uniquely identify the source;
(4) The radioactive material in the source;
(5) The initial or current source strength in becquerels (curies);
(6) The date for which the source strength is reported; and
(7) The disassemble date of the source.

(E) Each licensee who disposes of a nationally tracked source shall complete and submit a national source tracking transaction report. The report must include the following information:
(1) The name, address, and license number of the reporting licensee;
(2) The name of the individual preparing the report;
(3) The waste manifest number;
(4) The container identification with the nationally tracked source;
(5) The date of disposal; and
(6) The method of disposal.

(F) The reports discussed in paragraphs (A) to (E) of this rule must be submitted by the close of the next business day after the transaction. A single report may be submitted for multiple sources and transactions. The reports must be submitted to the national source tracking system by using:
(1) The on-line national source tracking system;
(2) Electronically using a computer readable format;
(3) By facsimile;
(4) By mail to the address on the national source tracking transaction report form (NRC form 748); or
(5) By telephone with followup by facsimile or mail.

(G) Each licensee shall correct any error in previously filed reports or file a new report for any missed transaction within five business days of the discovery of the error or missed transaction. Such errors may be detected by a variety of methods such as administrative reviews or by physical inventories required by regulation. In addition, each licensee shall
reconcile the inventory of nationally tracked sources possessed by the licensee against that licensee's data in the national source tracking system. The reconciliation must be conducted during the month of January in each year. The reconciliation process must include resolving any discrepancies between the national source tracking system and the actual inventory by filing the reports identified by paragraphs (A) to (E) of this rule. By January thirty-first, of each year, each licensee must submit to the national source tracking system confirmation that the data in the national source tracking system is correct.

3701:1-40-20 Reporting requirements.

(A) Except as provided in paragraph (D) of this rule, each licensee shall notify the department as soon as possible, but not later than four hours after the discovery of an event that prevents immediate protective action necessary to avoid exposure to radiation or radioactive material that could exceed regulatory limits, or a release of licensed material that could exceed regulatory limits. An event that requires such an immediate report may include a fire, explosion, or toxic gas release.

(B) Each licensee shall notify the department within twenty-four hours after the discovery of any of the following events involving licensed material:

(1) An unplanned contamination event that involves:
   (a) Access to the contaminated area, by workers or the public, to be restricted for more than twenty-four hours by imposing additional radiological controls or by prohibiting entry into the area;
   (b) A quantity of material greater than five times the lowest annual limit on intake specified in the appendices to rule 3701:1-38-12 of the Administrative Code; and
   (c) Access to the area restricted for a reason other than to allow radionuclides with a half-life of less than twenty-four hours to decay prior to decontamination.

(2) An event in which equipment is disabled or fails to function as designed when:
   (a) The equipment is required by regulation or license condition to prevent a release exceeding regulatory limits, to prevent exposure to radiation or radioactive material exceeding regulatory limits, or to mitigate the consequences of an accident;
   (b) The equipment is required to be available and operable when it is disabled or fails to function; and
   (c) No redundant equipment is available and operable to perform the required safety function.

(3) An event that requires unplanned medical treatment of an individual with spreadable radioactive contamination on the individual's clothing or body.

(4) An unplanned fire or explosion damaging any licensed material or any device, container, or equipment containing licensed material when:
   (a) The quantity of material involved is greater than five times the lowest annual limit on intake specified in the appendices to rule 3701:1-38-12 of the Administrative Code; and
   (b) The damage affects the integrity of the licensed material or its container.

(C) The licensee shall prepare and submit a report in response to the requirements of this rule as follows:

(1) Licensees shall make reports required by paragraphs (A) and (B) of this rule by telephone, to the department at the telephone number listed in the notice to employees required by paragraph (A)(1)(e) of rule 3701:1-38-10 of the Administrative Code. To the extent that the information is available at the time of notification, the information provided in these reports must include:
   (a) The caller's name and call back telephone number;
   (b) A description of the event, including date and time;
   (c) The exact location of the event;
(d) The radionuclides, quantities, and chemical and physical form of the licensed material involved; and

(e) Any personnel radiation exposure data available.

(2) Each licensee who makes a report required by paragraph (A) or (B) of this rule shall submit a written follow-up report within thirty days of the initial report. Written reports prepared pursuant to other regulations may be submitted to fulfill this requirement if the report contains all of the necessary information and the appropriate distribution is made. These written reports shall be sent to the department in the manner specified in rule 3701:1-40-04 of the Administrative Code. The report must include the following:

- A description of the event, including the probable cause and the manufacturer and model number, if applicable, of any equipment that failed or malfunctioned;
- The exact location of the event;
- The radionuclides, quantities, and chemical and physical form of the licensed material involved;
- Date and time of the event;
- Corrective actions taken or planned and the results of any evaluations or assessments; and
- The extent of exposure of individuals to radiation or to radioactive materials without identification of individuals by name.

(D) This rule applies to all licensees possessing material licensed under rule 3701:1-38-02 of the Administrative Code. This rule does not apply to material under a license subject to the notification requirements in 10 C.F.R. 50.72, as published in the January 1, 2013, Code of Federal Regulations.

(E) An applicant for a license or a licensee shall notify the department within two working days of information identified by the applicant or licensee as having for the regulated activity, an active adverse impact on equipment or personnel readily obvious by human observation or instrumentation, or a radiological impact on personnel or the environment in excess of regulatory limits. An applicant or licensee violates this paragraph only if the applicant or licensee fails to notify the director of information that the applicant or licensee has or should have identified.

3701:1-54-02 Generator reporting and fee requirements.

(A) Except as otherwise provided in paragraph (D) of this rule, on or before the thirtieth day of April each year, each generator shall submit to the director, on forms provided by the director at least ninety days prior, an annual report containing the following information for the previous calendar year:

- The name, address, and telephone number of the generator, including the name of the person responsible for low-level radioactive waste management;
- The types and amounts of low-level radioactive waste generated during the previous calendar year;
- The types and amounts of low-level radioactive waste first placed in storage during the previous calendar year, and the types and amounts of wastes remaining in storage from previous calendar years;
- The types and amounts of low-level radioactive waste shipped during the previous calendar year, including carrier or broker, and the means of shipment;
- A statement indicating whether or not additional low-level radioactive waste was stored or shipped or both and not reported to the director during the previous report period;
- A description of the methods used to treat, store, and dispose of low-level radioactive waste;
- A description of any actions taken or planned to be taken to reduce the low-level radioactive waste; and
- A description of any actions taken or planned to be taken to reduce the low-level radioactive waste.
radioactive waste volume or production; and

(8) The types and amounts of low-level radioactive waste expected to be generated or placed in storage during the next calendar year.

(B) Except as otherwise provided in paragraphs (C) and (D) of this rule, within thirty days after the director issues an invoice, all generators shall pay a fee as follows:

(1) At least fifty dollars if any low-level radioactive waste was generated, or three dollars and fifty cents per cubic foot of low-level radioactive waste that was generated during the previous calendar year, whichever is greater, except that for waste generated by a uranium enrichment facility, the generator shall pay seventy-five cents per cubic foot rather than three dollars and fifty cents per cubic foot for such wastes; and

(2) Three dollars and fifty cents per cubic foot of low-level radioactive waste that was stored or held in storage for more than forty-two months, except that for such waste held in storage by a uranium enrichment facility, the generator shall pay seventy-five cents rather than three dollars and fifty cents per cubic foot for such wastes; and

(3) In addition to the minimum charge and the per cubic foot charge provided in paragraphs (B)(1) and (B)(2) of this rule, a generator shall pay a per cubic foot surcharge based on the activity of the waste as classified in rule 3701:1-54-10 of the Administrative Code. There is no surcharge for class A waste. The surcharge for class B waste is an additional fifty per cent of the amount charged under paragraph (B)(1) or (B)(2) of this rule. The per cubic foot surcharge for class C waste is an additional one hundred per cent of the amount charged under paragraph (B)(1) or (B)(2) of this rule.

(C) Notwithstanding paragraph (B) of this rule, if the low-level radioactive waste is high-volume radioactive waste which contains soil, building debris, or rubble typically resulting from decommissioning or decontamination efforts, in an amount containing at least fifty cubic feet, the fee shall be one dollar per cubic yard for such wastes generated during the previous calendar year or for such wastes that have been stored for more than twelve months.

(D) Notwithstanding paragraph (B) of this rule, radioactive waste generated and disposed of in accordance with paragraphs (D) to (G) of rule 3701:1-38-19 of the Administrative Code shall be exempt from the requirements of this rule.

(E) If the low-level radioactive waste is treated by the generator, the fees specified in paragraphs (B) and (C) of this rule shall be determined based on the volume of waste that remains after treatment. The generator shall certify on a form provided by the director the amount of waste that was sent to a processor and the amount of waste sent back to the generator or disposed of on behalf of the generator.

(F) Paragraphs (B) and (C) of this rule shall be applicable to low-level radioactive waste generated or first placed in storage on or after January 1, 1998. The director shall include a notice on each invoice that the generator may appeal the determination of the fees, provided the generator requests a hearing within thirty days of the date of the invoice.

(G) In accordance with division (H) of section 3748.04 of the Revised Code, any fee that remains unpaid on the ninety-first day after the original invoice date shall be assessed an additional amount equal to ten per cent of the original fee.

(H) The director may annually review, at the generator's location, documentation and information that the generator used to prepare the report and the certification required by paragraphs (A) and (E) of this rule. If the director determines that the documentation and information that the generator used to prepare the report is inadequate to determine the accuracy of the report, the director may issue an order pursuant to division (B)(4) of section 3748.05 of the Revised Code to require the generator to amend the report so that the report is accurate.

(I) Any generator shall, upon the request of the director, provide additional information as required.

(J) Reports generated in accordance with this rule must be maintained by the licensee.
for a period of five years after being submitted to the director.

3701:1-58-06 License required.

(A) A person may manufacture, produce, acquire, receive, possess, prepare, use, or transfer radioactive material for medical use only in accordance with a specific license issued by the director, United States nuclear regulatory commission, an agreement state, or as allowed in paragraph (B)(1) or (B)(2) of this rule.

(B) A specific license is not needed for an individual who:

1. Receives, possesses, uses, or transfers radioactive material in accordance with the regulations in this chapter under the supervision of an authorized user as provided in rule 3701:1-58-14 of the Administrative Code, unless prohibited by license condition; or

2. Prepares unsealed radioactive material for medical use in accordance with the regulations in this chapter under the supervision of an authorized nuclear pharmacist or authorized user as provided in rule 3701:1-58-14 of the Administrative Code, unless prohibited by license condition.


(A) A licensee shall report any event, except for an event that results from patient intervention, in which the administration of radioactive material or radiation from radioactive material results in:

1. A dose that differs from the prescribed dose or dose that would have resulted from the prescribed dosage by more than 0.05 sievert (five rem) effective dose equivalent, 0.5 sievert (fifty rem) to an organ or tissue, or 0.5 sievert (fifty rem) shallow dose equivalent to the skin; and

   a. The total dose delivered differs from the prescribed dose by twenty per cent or more;

   b. The total dosage delivered differs from the prescribed dosage by twenty per cent or more or falls outside the prescribed dosage range; or

   c. The fractionated dose delivered differs from the prescribed dose, for a single fraction, by fifty per cent or more.

2. A dose that exceeds 0.05 sievert (five rem) effective dose equivalent, 0.5 sievert (fifty rem) to an organ or tissue, or 0.5 sievert (fifty rem) shallow dose equivalent to the skin from any of the following:

   a. An administration of a wrong radioactive drug containing radioactive material;

   b. An administration of a radioactive drug containing radioactive material by the wrong route of administration;

   c. An administration of a dose or dosage to the wrong individual or human research subject;

   d. An administration of a dose or dosage delivered by the wrong mode of treatment; or

   e. A leaking sealed source; or

3. A dose to the skin or an organ or tissue other than the treatment site that exceeds by 0.5 sievert (fifty rem) to an organ or tissue and fifty per cent or more of the dose expected from the administration defined in the written directive (excluding, for permanent implants, seeds that were implanted in the correct site but migrated outside the treatment site).

(B) A licensee shall report any event resulting from intervention of a patient or human research subject in which the administration of radioactive material or radiation from radioactive material results or will result in unintended permanent functional damage to an organ or a physiological system, as determined by a physician.

(C) The licensee shall notify by telephone the Ohio department of health, bureau of radiation protection no later than the next calendar day after discovery of the medical event.

(D) The licensee shall submit a written report to the Ohio department of health, bureau of
radiation protection to the address listed in listed in rule 3701:1-40-04 of the Administrative Code within fifteen days after discovery of the medical event.

(1) The written report must include:
   (a) The licensee's name;
   (b) The name of the prescribing physician;
   (c) A brief description of the event;
   (d) Why the event occurred;
   (e) The effect, if any, on the individual(s) who received the administration;
   (f) What actions, if any, have been taken or are planned to prevent recurrence; and
   (g) Certification that the licensee notified the individual (or the individual's personal representative), and if not, why not.

(2) The report may not contain the individual's name or any other information that could lead to identification of the individual.

(E) The licensee shall provide notification of the event to the referring physician and also notify the individual who is the subject of the medical event no later than twenty-four hours after its discovery, unless the referring physician personally informs the licensee either that he or she will inform the individual or that, based on medical judgment, telling the individual would be harmful to the individual. The licensee is not required to notify the individual without first consulting the referring physician. If the referring physician or the affected individual cannot be reached within twenty-four hours, the licensee shall notify the individual as soon as possible thereafter. The licensee may not delay any appropriate medical care for the individual, including any necessary remedial care as a result of the medical event, because of any delay in notification. To meet the requirements of this paragraph, the notification of the individual who is the subject of the medical event may be made instead to that individual's personal representative. If a verbal notification is made, the licensee shall inform the individual, or appropriate personal representative, that a written description of the event can be obtained from the licensee upon request. The licensee shall provide such a written description if requested.

(F) Aside from the notification requirement, nothing in this section affects any rights or duties of licensees and physicians in relation to each other, to individuals affected by the medical event, or to that individual's personal representative.

(G) A licensee shall:
   (1) Annotate a copy of the report provided to the Ohio department of health, bureau of radiation protection with the:
      (a) Name of the individual who is the subject of the event; and
      (b) Social security number or other identification number, if one has been assigned, of the individual who is the subject of the event; and
   (2) Provide a copy of the annotated report to the referring physician, if other than the licensee, no later than fifteen days after the discovery of the event.

3701:1-58-102 Report of radioactive dose or radiation to fetus or nursing child.

(A) A licensee shall report any dose to an embryo/fetus that is greater than fifty millisievert (five rem) dose equivalent that is a result of an administration of radioactive material or radiation from radioactive material to a pregnant individual unless the dose to the embryo/fetus was specifically approved, in advance, by the authorized user.

(B) A licensee shall report any dose to a nursing child that is a result of an administration of radioactive material to a breast-feeding individual that:
   (1) Is greater than fifty millisievert (five rem) total effective dose equivalent; or
   (2) Has resulted in unintended permanent functional damage to an organ or a physiological system of the child, as determined by a physician.

(C) The licensee shall notify by telephone the Ohio department of health, bureau of radiation protection to the address listed in listed in rule 3701:1-40-04 of the Administrative Code within fifteen days after discovery of the medical event.

(1) The written report must include:
   (a) The licensee's name;
   (b) The name of the prescribing physician;
   (c) A brief description of the event;
   (d) Why the event occurred;
   (e) The effect, if any, on the individual(s) who received the administration;
   (f) What actions, if any, have been taken or are planned to prevent recurrence; and
   (g) Certification that the licensee notified the individual (or the individual's personal representative), and if not, why not.

(2) The report may not contain the individual's name or any other information that could lead to identification of the individual.

(E) The licensee shall provide notification of the event to the referring physician and also notify the individual who is the subject of the medical event no later than twenty-four hours after its discovery, unless the referring physician personally informs the licensee either that he or she will inform the individual or that, based on medical judgment, telling the individual would be harmful to the individual. The licensee is not required to notify the individual without first consulting the referring physician. If the referring physician or the affected individual cannot be reached within twenty-four hours, the licensee shall notify the individual as soon as possible thereafter. The licensee may not delay any appropriate medical care for the individual, including any necessary remedial care as a result of the medical event, because of any delay in notification. To meet the requirements of this paragraph, the notification of the individual who is the subject of the medical event may be made instead to that individual's personal representative. If a verbal notification is made, the licensee shall inform the individual, or appropriate personal representative, that a written description of the event can be obtained from the licensee upon request. The licensee shall provide such a written description if requested.

(F) Aside from the notification requirement, nothing in this section affects any rights or duties of licensees and physicians in relation to each other, to individuals affected by the medical event, or to that individual's personal representative.

(G) A licensee shall:
   (1) Annotate a copy of the report provided to the Ohio department of health, bureau of radiation protection with the:
      (a) Name of the individual who is the subject of the event; and
      (b) Social security number or other identification number, if one has been assigned, of the individual who is the subject of the event; and
   (2) Provide a copy of the annotated report to the referring physician, if other than the licensee, no later than fifteen days after the discovery of the event.
radiation protection no later than the next calendar day after discovery of a dose to the embryo/fetus or nursing child that requires a report in paragraph (A) or (B) in this rule.

(D) The licensee shall submit a written report to the appropriate address listed in rule 3701:1-40-04 of the Administrative Code within fifteen days after discovery of a dose to the embryo/fetus or nursing child that requires a report in paragraph (A) or (B) in this rule.

(1) The written report must include:
   (a) The licensee's name;
   (b) The name of the prescribing physician;
   (c) A brief description of the event;
   (d) Why the event occurred;
   (e) The effect, if any, on the embryo/fetus or the nursing child;
   (f) What actions, if any, have been taken or are planned to prevent recurrence; and
   (g) Certification that the licensee notified the pregnant individual or mother (or the mother's or child's personal representative), and if not, why not.

(2) The report must not contain the individual's or child's name or any other information that could lead to identification of the individual or child.

(E) The licensee shall provide notification of the event to the referring physician and also notify the pregnant individual or mother, both hereafter referred to as the mother, no later than twenty-four hours after discovery of an event that would require reporting under paragraph (A) or (B) of this rule, unless the referring physician personally informs the licensee either that he or she will inform the mother or that, based on medical judgment, telling the mother would be harmful to the mother. The licensee is not required to notify the mother without first consulting with the referring physician. If the referring physician or mother cannot be reached within twenty-four hours, the licensee shall make the appropriate notifications as soon as possible thereafter. The licensee may not delay any appropriate medical care for the embryo/fetus or for the nursing child, including any necessary remedial care as a result of the event, because of any delay in notification. To meet the requirements of this paragraph, the notification may be made to the mother's or child's personal representative instead of the mother. If a verbal notification is made, the licensee shall inform the mother, or the mother's or child's personal representative, that a written description of the event can be obtained from the licensee upon request. The licensee shall provide such a written description if requested.

(F) A licensee shall:
   (1) Annotate a copy of the report provided to the director with the:
      (a) Name of the pregnant individual or the nursing child who is the subject of the event; and
      (b) Social security number or other identification number, if one has been assigned, of the pregnant individual or the nursing child who is the subject of the event; and
   (2) Provide a copy of the annotated report to the referring physician, if other than the licensee, no later than fifteen days after the discovery of the event.

3701:1-58-103 Leaking radioactive material report to ODH.

A licensee shall file a report within five days if a leak test required by rule 3701:1-58-27 of the Administrative Code reveals the presence of one hundred eighty-five becquerels (0.005 microcurie) or more of removable contamination. The report must be filed with the address listed in rule 3701:1-40-04 of the Administrative Code. The written report must include the model number and serial number if assigned, of the leaking source; the radionuclide and its estimated activity; the results of the test; the date of the test; and the action taken.
3701:1-67-12 Unintended treatment deviations and notifications of medical events.

(A) Any unintended treatment deviation from the written directive or approved treatment plan shall be identified, evaluated, documented and appropriate action taken by the handler.
(B) A handler shall report any medical event resulting from intervention of a human patient or human research subject in which the administration of radiation from therapy equipment results, or will result, in unintended permanent functional damage to an organ or a physiological system as determined by a physician.
(C) A handler shall report, as a medical event, any treatment deviation, except for a treatment deviation that results from intervention by a human patient or human research subject in which the administration of radiation from therapy equipment involves:
   (1) The wrong patient; where wrong patient means administration of radiation to an individual using a treatment plan intended for another patient or human research subject; or
   (2) The wrong treatment; where wrong treatment means administration of radiation to a human patient or human research subject that does not conform to the written directive and the approved treatment plan; and
      (a) The administered dose over the entire treatment course differs from the prescribed dose as stated in the written directive by more than ten per cent for treatment courses consisting of three or fewer fractions; or
      (b) The administered dose over the entire treatment course differs from the prescribed dose by more than twenty per cent for treatment courses consisting of more than three fractions; or
      (c) The administered dose over any five consecutive fractions differs from the prescribed dose by more than thirty per cent; or
      (d) The administered dose to any critical structure:
         (i) Exceeds the critical dose limit established in the written directive or approved treatment plan by twenty per cent or more; and
         (ii) Has the potential to cause serious harm according to the current published recommendations from a recognized national professional organization with expertise in radiation oncology.
   (D) For purposes of paragraphs (C)(2)(a), (C)(2)(b) and (C)(2)(c) of this rule, “administered dose” means:
      (1) The D95 (minimum dose to ninety-five per cent of the prescribed volume) for computer treatment plans; or
      (2) The dose to the prescription point for treatments prescribed to a point.
   (E) The handler shall notify the department by telephone no later than the next calendar day after the handler ascertains that a medical event occurred.
   (F) The handler shall submit a written report to the department within fifteen days after the initial report of the medical event. The written report must include:
      (1) The handler or registrant name;
      (2) The name of the prescribing physician;
      (3) A brief description of the event;
      (4) Why the event occurred;
      (5) The effect, if any, on the individual who received the medical event;
      (6) Actions, if any, that have been taken, or are planned, to prevent recurrence; and
      (7) Certification that the handler notified the individual, or the individual's responsible relative or guardian, and if not, why not.
   (G) The report shall not contain the individual's name or any other information that could lead to the identification of the individual.
   (H) The handler shall provide notification of the medical event to the referring physician no later than twenty-four hours after its discovery. The handler shall also notify the individual
who is the subject of the medical event no later than twenty-four hours after the initial notification, unless the authorized user or referring physician determines that, based on their medical judgment, informing the individual would be harmful. The handler is not required to notify the individual without first consulting the referring physician. If the referring physician or the affected individual cannot be reached within twenty-four hours, the handler shall notify the individual as soon as possible thereafter. The handler may not delay any appropriate medical care for the individual, including any necessary remedial care as a result of the medical event, because of any delay in notification. To meet the requirements of this paragraph, the notification of the individual who is the subject of the medical event may be made instead to that individual's responsible relative or guardian. If a verbal notification is made, the handler shall inform the individual or appropriate responsible relative or guardian that a written description of the event can be obtained from the handler upon request. The handler shall provide such a written description if requested.

(I) Aside from the notification requirement, nothing in this section affects any rights or duties of handlers, registrants and physicians in relation to each other, to individuals affected by the medical event, or to that individual's responsible relatives or guardians.

(J) The handler shall retain a record of each unintended deviation in accordance with paragraph (J) of this rule. If the unintended deviation is a medical event, a copy of the record shall be provided to the referring physician if other than the handler within fifteen days after its discovery.

(K) The handler shall retain a record of each unintended deviation for three years. The record must contain the following:

(1) The handler or registrant's name and the names of the individuals involved;
(2) The social security number or other identification number, if one has been assigned, of the individual who is the subject of the unintended deviation;
(3) A brief description of the event; why it occurred; the effect, if any, on the individual;
(4) The actions, if any, taken or planned to prevent recurrence; and
(5) Whether the handler or the registrant notified the individual, or the individual's responsible relative or guardian; and, if not, whether such failure to notify was based on guidance from the referring physician.

Part IV. Workplace

Hospital Nurse Staffing

3727.50 Hospital nurse staffing definitions.

As used in this section and sections 3727.51 to 3727.57 of the Revised Code:

(A) “Direct patient care” means care provided by a nurse with direct responsibility to carry out medical regimens or nursing care for one or more patients.

(B) “Inpatient care unit” means a hospital unit, including an operating room or other inpatient care area, in which nursing care is provided to patients who have been admitted to the hospital.

(C) “Nurse” means a person who is licensed to practice as a registered nurse under Chapter 4723 of the Revised Code or, if the hospital employs licensed practical nurses, a person who is licensed to practice as a licensed practical nurse under that chapter.

3727.51 Hospital nursing care committee.

(A) Each hospital shall convene a hospital-wide nursing care committee not later than
ninety days after the effective date of this section or, if the hospital is not treating patients on the effective date of this section, ninety days after the hospital begins to treat patients. The hospital shall select the members of the committee, subject to all of the following:

(1) The hospital’s chief nursing officer shall be included as a member of the committee.
(2) At least fifty per cent of the committee’s membership shall consist of registered nurses who provide direct patient care in the hospital.
(3) The number of registered nurses included as members of the committee shall be sufficient to provide adequate representation of all types of nursing care services provided in the hospital.

(B) The committee member who is the hospital’s chief nursing officer shall establish a mechanism for obtaining input from nurses in all inpatient care units who provide direct patient care regarding what the nursing services staffing plan recommendations described in division (B) of section 3727.52 of the Revised Code should include.

3727.52 Activities of hospital nursing care committee.

A hospital-wide nursing care committee convened pursuant to section 3727.51 of the Revised Code shall do both of the following:

(A) If one exists, evaluate the hospital’s current nursing services staffing plan;
(B) Recommend a nursing services staffing plan that is, at a minimum, consistent with current standards established by private accreditation organizations or governmental entities and addresses all of the following:

(1) The selection, implementation, and evaluation of minimum staffing levels for all inpatient care units that ensure that the hospital has a staff of competent nurses with the specialized skills needed to meet patient needs in accordance with evidence-based safe nurse staffing standards;
(2) The complexity of complete care, assessment on patient admission, volume of patient admissions, discharges and transfers, evaluation of the progress of a patient’s problems, the amount of time needed for patient education, ongoing physical assessments, planning for a patient’s discharge, assessment after a change in patient condition, and assessment of the need for patient referrals;
(3) Patient acuity and the number of patients for whom care is being provided;
(4) The need for ongoing assessments of a unit’s patients and its nursing staff levels;
(5) The hospital’s policy for identifying additional nurses who can provide direct patient care when patients’ unexpected needs exceed the planned workload for direct care staff.

3727.53 Creation of hospital nursing services staffing plan.

(A) In accordance with division (B) of this section, each hospital shall create an evidence-based written nursing services staffing plan guiding the assignment of nurses hospital-wide. The staffing plan shall be implemented not later than ninety days after the hospital-wide nursing care committee is convened pursuant to section 3727.51 of the Revised Code, except that if the hospital’s next fiscal year starts not later than one hundred eighty days after the date on which the committee convenes, implementation may be delayed until the first day of that fiscal year.

(B) The staffing plan created under this section shall, at a minimum, reflect current standards established by private accreditation organizations or governmental entities. The plan shall be based on multiple nurse and patient considerations that yield minimum staffing levels for inpatient care units that ensure that the hospital has a staff of competent nurses with specialized skills needed to meet patient needs. These considerations shall include both of the following:
(1) The recommendations of the hospital-wide nursing care committee made under section 3727.52 of the Revised Code, which shall be given significant consideration;
(2) All of the matters listed in divisions (B)(1) to (5) of section 3727.52 of the Revised Code.

3727.54 Review of hospital nurse staffing plan.

(A) At least once every two years, the hospital-wide nursing care committee convened pursuant to section 3727.51 of the Revised Code shall do both of the following:
   (1) Review how the nursing services staffing plan in effect at the time of the review does all of the following:
       (a) Affects inpatient care outcomes;
       (b) Affects clinical management;
       (c) Facilitates a delivery system that provides, on a cost-effective basis, quality nursing care consistent with acceptable and prevailing standards of safe nursing care and evidence-based guidelines established by national nursing organizations.
   (2) Make recommendations, based on the review conducted under division (A)(1) of this section, regarding how the nursing services staffing plan should be revised, if at all.
(B) For the purpose of maintaining a repository for public access, beginning in 2018, a hospital shall submit to the department of health, by March 1 of each even-numbered year, a copy of the hospital's nursing services staffing plan in effect at that time. The copy of the plan is a public record under section 149.43 of the Revised Code.

3727.55 Model for adjusting hospital nurse staffing plan.

To provide staffing flexibility to meet patient needs, every hospital shall identify a model for adjusting the nursing services staffing plan created under section 3727.53 of the Revised Code for each inpatient care unit.

3727.56 Availability of copies of staffing plan.

(A) A hospital shall provide copies of its nursing services staffing plan created under section 3727.53 of the Revised Code, in accordance with both of the following:
   (1) Free of charge, a copy of the staffing plan and subsequent changes to the plan shall be provided to each member of the hospital's nursing staff.
   (2) For a fee not to exceed actual copying costs, a copy of the staffing plan shall be provided to any person who requests it.
(B) In a conspicuous location in the hospital, a notice shall be posted informing the public of the availability of the staffing plan. The notice shall specify the appropriate person, office, or department to be contacted to review or obtain a copy of the staffing plan.

Wages and Overtime

4111.01 Ohio minimum wage; definitions.

As used in this chapter:
(A) “Wage” means compensation due to an employee by reason of employment, payable in legal tender of the United States or checks on banks convertible into cash on demand at full face value, subject to the deductions, charges, or allowances permitted by rules of the director of commerce under section 4111.05 of the Revised Code. “Wage” includes an employee's commissions of which the employee's employer keeps a record, but does not
include gratuities, except as provided by rules issued under section 4111.05 of the Revised Code.

“Wage” also includes the reasonable cost to the employer of furnishing to an employee board, lodging, or other facilities, if the board, lodging, or other facilities are customarily furnished by the employer to the employer's employees. The cost of board, lodging, or other facilities shall not be included as part of wage to the extent excluded therefrom under the terms of a bona fide collective bargaining agreement applicable to the employee.

(B) “Occupation” means any occupation, service, trade, business, industry, or branch or group of industries or employment or class of employment in which individuals are employed.

**4111.02 Ohio minimum wage; director to adjust wage rates.**

Every employer, as defined in Section 34a of Article II, Ohio Constitution, shall pay each of the employer's employees at a wage rate of not less than the wage rate specified in Section 34a of Article II, Ohio Constitution.

The director of commerce annually shall adjust the wage rate as specified in Section 34a of Article II, Ohio Constitution.

No political subdivision shall establish a minimum wage rate different from the wage rate required under this section.

As used in this section, “employee” has the same meaning as in section 4111.14 of the Revised Code.

**4111.03 Overtime pay.**

(A) An employer shall pay an employee for overtime at a wage rate of one and one-half times the employee's wage rate for hours worked in excess of forty hours in one workweek, in the manner and methods provided in and subject to the exemptions of section 7 and section 13 of the “Fair Labor Standards Act of 1938,” 52 Stat. 1060, 29 U.S.C.A. 207, 213, as amended.

Any employee employed in agriculture shall not be covered by the overtime provision of this section.

(B) If a county employee elects to take compensatory time off in lieu of overtime pay, for any overtime worked, compensatory time may be granted by the employee's administrative superior, on a time and one-half basis, at a time mutually convenient to the employee and the administrative superior within one hundred eighty days after the overtime is worked.

(C) A county appointing authority with the exception of the county department of job and family services may, by rule or resolution as is appropriate, indicate the authority's intention not to be bound by division (B) of this section, and to adopt a different policy for the calculation and payment of overtime than that established by that division. Upon adoption, the alternative overtime policy prevails. Prior to the adoption of an alternative overtime policy, a county appointing authority with the exception of the county department of job and family services shall give a written notice of the alternative policy to each employee at least ten days prior to its effective date.

(D) As used in this section:

1. “Employ” means to suffer or to permit to work.
2. “Employer” means the state of Ohio, its instrumentalities, and its political subdivisions and their instrumentalities, any individual, partnership, association, corporation, business trust, or any person or group of persons, acting in the interest of an employer in relation to an employee, but does not include an employer whose annual gross volume of sales made for business done is less than one hundred fifty thousand dollars, exclusive of excise taxes at the retail level which are separately stated.
3. “Employee” means any individual employed by an employer but does not include:
(a) Any individual employed by the United States;
(b) Any individual employed as a baby-sitter in the employer's home, or a live-in companion to a sick, convalescing, or elderly person whose principal duties do not include housekeeping;
(c) Any individual engaged in the delivery of newspapers to the consumer;
(d) Any individual employed as an outside salesperson compensated by commissions or employed in a bona fide executive, administrative, or professional capacity as such terms are defined by the "Fair Labor Standards Act of 1938," 52 Stat. 1060, 29 U.S.C.A. 201, as amended;
(e) Any individual who works or provides personal services of a charitable nature in a hospital or health institution for which compensation is not sought or contemplated;
(f) A member of a police or fire protection agency or student employed on a part-time or seasonal basis by a political subdivision of this state;
(g) Any individual in the employ of a camp or recreational area for children under eighteen years of age and owned and operated by a nonprofit organization or group of organizations described in Section 501 (c)(3) of the "Internal Revenue Code of 1954," and exempt from income tax under Section 501 (a) of that code;
(h) Any individual employed directly by the house of representatives or directly by the senate.

Public Employment Risk Reduction Advisory Commission

4167-3-01 Incorporation by reference.

Pursuant to section 4167.07 of the Revised Code, the following occupational safety and health standards promulgated by the United States secretary of labor are adopted as Ohio employment risk reduction standards:


(B) The Code of Federal Regulations, Title 29, Subtitle b, Chapter XVII, Part 1910 occupational safety and health standards Subpart C to and including Subpart T and Subpart Z.

(C) The standards of Part 1926, Subpart C to and including Subpart X, with the exclusion of standards 29 CFR 1910.96, 1910.97, 1926.53, and 1926.54.


4167-3-02 Adoption of standards.

(A) An emergency temporary Ohio employment risk reduction standard shall be issued if the superintendent finds both of the following:

(1) Public employees are exposed to grave danger from exposure to substances or agents determined to be toxic or physically harmful or from new hazards; and

(2) The emergency standard is necessary to protect employees from the danger.

(B) The emergency standard shall take effect immediately upon publication in newspapers of general circulation in Cleveland, Columbus, Cincinnati, and Toledo.

(1) Such emergency standard shall be in effect no longer than fifteen days, unless the administrator approves the standard, in which case the standard shall be in effect no longer than one hundred twenty days after issuance by the superintendent.
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(2) The superintendent may renew an emergency standard approved by the administrator for a time period not to exceed one hundred days if the conditions prompting the emergency standard continue to exist.

(C) The administrator, with the advice and consent of the board of directors, shall adopt a permanent Ohio public employment risk reduction standard to replace the emergency standard on or before the final expiration date of the temporary emergency standard if the conditions prompting the emergency standard are expected to persist.

4167-3-03 Amending of existing standards.

(A) The administrator, with the advice and consent of the bureau of workers’ compensation board of directors, has the authority to amend Ohio employment risk reduction standards.

(B) The Ohio employment risk reduction standards are amended as referenced by:


4167-3-05 Ohio specific safety standards.

(A) Radiation standards.

(1) Ionizing radiation: Any use of ionizing radiation is to comply with the standards for protection against radiation promulgated by the United States nuclear regulatory commission set forth in 10 C.F.R. 20. For purposes of this section, radiation includes alpha particles, beta particles, gamma rays, x-rays, neutrons, high speed electrons, high speed protons, and other atomic particles, but does not include sound or radio waves, visible light, infrared or ultraviolet light.

(2) Nonionizing radiation:

Any use of nonionizing radiation, specifically electromagnetic radiation, is to comply with the recommended standards of the American conference of governmental industrial hygienists.

(B) Traffic control standards.

Any use of traffic control devices by a public employer must comply with the Ohio manual of uniform traffic control devices promulgated by the Ohio department of transportation pursuant to section 4511.09 of the Revised Code.

(C) Bloodborne pathogen standards.

Each public employer of health care workers shall do the following:

(1) Include as a part of the employer's engineering and work practice controls, needleless systems, sharps that are manufactured with engineered sharps injury protection, and other devices that comply with the United States occupational safety and health administration's bloodborne pathogen standards as set forth in 29 C.F.R. 1910.1030.

(2) Develop and implement a written exposure control plan that is consistent with the employment risk reduction standards for bloodborne pathogens as set forth in rules 4167-3-01 and 4167-3-03 of the Administrative Code, and update such plan at least once a year.
(3) Ensure that all public health care workers are trained in the use of engineering and
work practice controls before undertaking any task with potential for exposure incidents.
(4) Maintain accurate records of health care exposure incidents, as required by rule
4167-6-11 of the Administrative Code.

4167-6-01 Recording and reporting occupational injuries and illnesses.

(A) Each public employer shall maintain records and make reports to the superintendent
in accordance with this rule.
   (1) All records and reports shall be maintained and submitted on forms prescribed by the
   superintendent, or equivalent records that meet the following requirements, as determined by
   the superintendent:
      (a) The records must contain the same information contained on the form prescribed by
          the superintendent;
      (b) The records must be as readable and comprehensible as the form prescribed by the
          superintendent;
      (c) The records must be completed in as much detail as required by the instructions for
          the form prescribed by the superintendent.
   (2) Records shall be established on a calendar year basis.
   (3) The superintendent may issue a citation for failure to comply with this rule.
   (4) If a false statement, representation, or certification of these records is knowingly
given, the administrator may seek an injunction, restraining order, or any other appropriate relief
against the public employer pursuant to section 4167.17 of the Revised Code.

(B) Records retention and access to records.
   (1) All records and reports required under this chapter shall be retained for five years at
the establishment following the end of the year to which they relate.
   (2) Each employer shall make any records required under this rule available to the
superintendent upon the superintendent's request.
   (3) The log and summary of all recordable occupational injuries and illnesses required
under paragraph (C) of this rule shall be made available by the employer to any employee,
former employee, or employee representatives for examination, and copying in a recordable
manner and at reasonable times.

(C) Log and summary of work-related injuries and illnesses.
   (1) Each employer shall maintain, for each establishment, a separate log and summary
of all work-related injuries and illnesses for that establishment.
   (2) Each recordable injury and illness must be entered on the log and summary as early
as practicable but no later than six working days after receiving information that a recordable
injury or illness has occurred.

(D) Injury and illness report.
   (1) In addition to the log and summary of work-related injuries and illnesses required
under paragraph (C) of this rule, each public employer shall have available for inspection at
each establishment within six working days after receiving information that a recordable
accident case has occurred, an injury and illness report for each occupational injury or illness
associated with that establishment.

(E) Annual summary.
   (1) Each annual summary shall include the employer's policy (risk) number.
   (2) The annual summary shall be submitted to the public employment risk reduction
program by February first for the previous calendar year. The annual summary shall be
submitted in a manner prescribed by the superintendent. An employer with five or fewer
employees that has had no recordable injuries is exempted from this submission requirement.
(3) The highest ranking authority for each public employer, or the highest ranking management official at the employer's establishment, shall certify that the annual summary of occupational injuries and illnesses is true and complete.

(4) Each public employer shall post a copy of each establishment's annual summary at each establishment from February first through April thirtieth of the year after the year to which the summary pertains. The annual summary must be posted in the same manner that notices are required to be posted under rule 4167-4-01 of the Administrative Code.

(F) Bureau of labor statistics, United States department of labor.

A public employer who receives a “Survey of Occupational Injuries and Illnesses” form from the bureau of labor statistics (BLS), United States department of labor or a BLS designee, shall promptly complete the survey and return it following the instructions contained on the survey form.
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Part I. Nurses

General Provisions and Licensing

[Editor's Note: Licensed professionals are also referenced elsewhere in this Handbook, as listed in the Index. Statutes pertaining to licensed professionals are listed at http://codes.ohio.gov/orc/47.]

4723.01 Nursing and nurses; definitions.

As used in this chapter:
(A) “Registered nurse” means an individual who holds a current, valid license issued under this chapter that authorizes the practice of nursing as a registered nurse.
(B) “Practice of nursing as a registered nurse” means providing to individuals and groups nursing care requiring specialized knowledge, judgment, and skill derived from the principles of biological, physical, behavioral, social, and nursing sciences. Such nursing care includes:
   (1) Identifying patterns of human responses to actual or potential health problems amenable to a nursing regimen;
   (2) Executing a nursing regimen through the selection, performance, management, and evaluation of nursing actions;
   (3) Assessing health status for the purpose of providing nursing care;
   (4) Providing health counseling and health teaching;
   (5) Administering medications, treatments, and executing regimens authorized by an individual who is authorized to practice in this state and is acting within the course of the individual's professional practice;
   (6) Teaching, administering, supervising, delegating, and evaluating nursing practice.
(C) “Nursing regimen” may include preventative, restorative, and health-promotion activities.
(D) “Assessing health status” means the collection of data through nursing assessment techniques, which may include interviews, observation, and physical evaluations for the purpose of providing nursing care.
(E) “Licensed practical nurse” means an individual who holds a current, valid license issued under this chapter that authorizes the practice of nursing as a licensed practical nurse.
(F) “The practice of nursing as a licensed practical nurse” means providing to individuals and groups nursing care requiring the application of basic knowledge of the biological, physical, behavioral, social, and nursing sciences at the direction of a registered nurse or any of the following who is authorized to practice in this state: a physician, physician assistant, dentist, podiatrist, optometrist, or chiropractor. Such nursing care includes:
   (1) Observation, patient teaching, and care in a diversity of health care settings;
   (2) Contributions to the planning, implementation, and evaluation of nursing;
   (3) Administration of medications and treatments authorized by an individual who is authorized to practice in this state and is acting within the course of the individual's professional practice on the condition that the licensed practical nurse is authorized under section 4723.17 of the Revised Code to administer medications;
(4) Administration to an adult of intravenous therapy authorized by an individual who is authorized to practice in this state and is acting within the course of the individual's professional practice, on the condition that the licensed practical nurse is authorized under section 4723.18 or 4723.181 of the Revised Code to perform intravenous therapy and performs intravenous therapy only in accordance with those sections;

(5) Delegation of nursing tasks as directed by a registered nurse;

(6) Teaching nursing tasks to licensed practical nurses and individuals to whom the licensed practical nurse is authorized to delegate nursing tasks as directed by a registered nurse.

(G) “Certified registered nurse anesthetist” means an advanced practice registered nurse who holds a current, valid license issued under this chapter and is designated as a certified registered nurse anesthetist in accordance with section 4723.42 of the Revised Code and rules adopted by the board of nursing.

(H) “Clinical nurse specialist” means an advanced practice registered nurse who holds a current, valid license issued under this chapter and is designated as a clinical nurse specialist in accordance with section 4723.42 of the Revised Code and rules adopted by the board of nursing.

(I) “Certified nurse-midwife” means an advanced practice registered nurse who holds a current, valid license issued under this chapter and is designated as a certified nurse-midwife in accordance with section 4723.42 of the Revised Code and rules adopted by the board of nursing.

(J) “Certified nurse practitioner” means an advanced practice registered nurse who holds a current, valid license issued under this chapter and is designated as a certified nurse practitioner in accordance with section 4723.42 of the Revised Code and rules adopted by the board of nursing.

(K) “Physician” means an individual authorized under Chapter 4731 of the Revised Code to practice medicine and surgery or osteopathic medicine and surgery.

(L) “Collaboration” or “collaborating” means the following:

(1) In the case of a clinical nurse specialist or a certified nurse practitioner, that one or more podiatrists acting within the scope of practice of podiatry in accordance with section 4731.51 of the Revised Code and with whom the nurse has entered into a standard care arrangement or one or more physicians with whom the nurse has entered into a standard care arrangement are continuously available to communicate with the clinical nurse specialist or certified nurse practitioner either in person or by electronic communication;

(2) In the case of a certified nurse-midwife, that one or more physicians with whom the certified nurse-midwife has entered into a standard care arrangement are continuously available to communicate with the certified nurse-midwife either in person or by electronic communication.

(M) “Supervision,” as it pertains to a certified registered nurse anesthetist, means that the certified registered nurse anesthetist is under the direction of a podiatrist acting within the podiatrist’s scope of practice in accordance with section 4731.51 of the Revised Code, a dentist acting within the dentist’s scope of practice in accordance with Chapter 4715 of the Revised Code, or a physician, and, when administering anesthesia, the certified registered nurse anesthetist is in the immediate presence of the podiatrist, dentist, or physician.

(N) “Standard care arrangement” means a written, formal guide for planning and evaluating a patient's health care that is developed by one or more collaborating physicians or podiatrists and a clinical nurse specialist, certified nurse-midwife, or certified nurse practitioner and meets the requirements of section 4723.431 of the Revised Code.

(O) “Advanced practice registered nurse” means an individual who holds a current, valid license issued under this chapter that authorizes the practice of nursing as an advanced practice registered nurse and is designated as any of the following:
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(1) A certified registered nurse anesthetist;
(2) A clinical nurse specialist;
(3) A certified nurse-midwife;
(4) A certified nurse practitioner.

(P) “Practice of nursing as an advanced practice registered nurse” means providing to individuals and groups nursing care that requires knowledge and skill obtained from advanced formal education, training, and clinical experience. Such nursing care includes the care described in section 4723.43 of the Revised Code.

(Q) “Dialysis care” means the care and procedures that a dialysis technician or dialysis technician intern is authorized to provide and perform, as specified in section 4723.72 of the Revised Code.

(R) “Dialysis technician” means an individual who holds a current, valid certificate to practice as a dialysis technician issued under section 4723.75 of the Revised Code.

(S) “Dialysis technician intern” means an individual who holds a current, valid certificate to practice as a dialysis technician intern issued under section 4723.75 of the Revised Code.

(T) “Certified community health worker” means an individual who holds a current, valid certificate as a community health worker issued under section 4723.85 of the Revised Code.

(U) “Medication aide” means an individual who holds a current, valid certificate issued under this chapter that authorizes the individual to administer medication in accordance with section 4723.67 of the Revised Code;

(V) “Nursing specialty” means a specialty in practice as a certified registered nurse anesthetist, clinical nurse specialist, certified nurse-midwife, or certified nurse practitioner.

4723.011 Registered nurse.

As used in this chapter, unless otherwise specified, “registered nurse” includes a registered nurse who is also licensed under this chapter as an advanced practice registered nurse.

4723.03 Nursing and nurses; unlicensed practice.

(A) No person shall engage in the practice of nursing as a registered nurse, represent the person as being a registered nurse, or use the title “registered nurse,” the initials “R.N.,” or any other title implying that the person is a registered nurse, for a fee, salary, or other consideration, or as a volunteer, without holding a current, valid license as a registered nurse under this chapter.

(B) No person shall knowingly do any of the following without holding a current, valid license to practice nursing as an advanced practice registered nurse issued under this chapter:
(1) Engage in the practice of nursing as an advanced practice registered nurse;
(2) Represent the person as being an advanced practice registered nurse;
(3) Use the title “advanced practice registered nurse,” the initials “A.P.R.N.,” or any other title implying that the person is an advanced practice registered nurse, for a fee, salary, or other consideration, or as a volunteer.

(C) No person who is not otherwise authorized to do so shall knowingly prescribe or personally furnish drugs or therapeutic devices without holding a current, valid license to practice nursing as an advanced practice registered nurse issued under this chapter and being designated as a clinical nurse specialist, certified nurse-midwife, or certified nurse practitioner under section 4723.42 of the Revised Code;

(D) No person shall engage in the practice of nursing as a licensed practical nurse, represent the person as being a licensed practical nurse, or use the title “licensed practical nurse,” the initials “L.P.N.,” or any other title implying that the person is a licensed practical
nurse, for a fee, salary, or other consideration, or as a volunteer, without holding a current, valid license as a practical nurse under this chapter.

(E) No person shall use the titles or initials "graduate nurse," "G.N.,” "professional nurse,” "P.N.,” "graduate practical nurse,” "G.P.N.,” "practical nurse,” "P.N.,” "trained nurse,” "T.N.,” or any other statement, title, or initials that would imply or represent to the public that the person is authorized to practice nursing in this state, except as follows:

(1) A person licensed under this chapter to practice nursing as a registered nurse may use that title and the initials “R.N.”;
(2) A person licensed under this chapter to practice nursing as a licensed practical nurse may use that title and the initials “L.P.N.”;
(3) A person licensed under this chapter to practice nursing as an advanced practice registered nurse and designated as a certified registered nurse anesthetist may use that title or the initials “A.P.R.N.-C.R.N.A.”;
(4) A person licensed under this chapter to practice nursing as an advanced practice registered nurse and designated as a clinical nurse specialist may use that title or the initials “A.P.R.N.-C.N.S.”;
(5) A person licensed under this chapter to practice nursing as an advanced practice registered nurse and designated as a certified nurse-midwife may use that title or the initials “A.P.R.N.-C.N.M.”;
(6) A person licensed under this chapter to practice nursing as an advanced practice registered nurse and designated as a certified nurse practitioner may use that title or the initials “A.P.R.N.-C.N.P.”;

(7) A person licensed under this chapter to practice nursing as an advanced practice registered nurse may use the title “advanced practice registered nurse” or the initials “A.P.R.N.”

(F) No person shall employ a person not licensed as a registered nurse under this chapter to engage in the practice of nursing as a registered nurse.

No person shall knowingly employ a person not licensed as an advanced practice registered nurse under this chapter to engage in the practice of nursing as an advanced practice registered nurse.

No person shall employ a person not licensed as a practical nurse under this chapter to engage in the practice of nursing as a licensed practical nurse.

(G) No person shall sell or fraudulently obtain or furnish any nursing diploma, license, certificate, renewal, or record, or aid or abet such acts.

4723.09 Nursing and nurses; license application; temporary permit.

(A)(1) An application for licensure by examination to practice as a registered nurse or as a licensed practical nurse shall be submitted to the board of nursing in the form prescribed by rules of the board. The application shall include all of the following:

(a) Evidence that the applicant has met the educational requirements described in division (C) of this section;
(b) Any other information required by rules of the board;
(c) The application fee required by section 4723.08 of the Revised Code.
(2) The board shall grant a license to practice nursing as a registered nurse or as a licensed practical nurse if the conditions of divisions (A)(2)(a) to (d) have been met:

(a) The applicant passes the examination accepted by the board under section 4723.10 of the Revised Code.
(b) In the case of an applicant who entered a prelicensure nursing education program on or after June 1, 2003, the results of a criminal records check conducted in accordance with section 4723.091 of the Revised Code demonstrate that the applicant is not ineligible for licensure as specified in section 4723.092 of the Revised Code.
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(c) The board determines that the applicant has not committed any act that is grounds for disciplinary action under section 3123.47 or 4723.28 of the Revised Code or determines that an applicant who has committed any act that is grounds for disciplinary action under either section has made restitution or has been rehabilitated, or both.

(d) The applicant is not required to register under Chapter 2950 of the Revised Code or a substantially similar law of another state, the United States, or another country.

(3) The board is not required to afford an adjudication to an individual to whom it has refused to grant a license because of that individual's failure to pass the examination.

(B)(1) An application for licensure by endorsement to practice nursing as a registered nurse or as a licensed practical nurse shall be submitted to the board in the form prescribed by rules of the board. The application shall include all of the following:

(a) Evidence that the applicant holds a current, valid, and unrestricted license or equivalent authorization from another jurisdiction granted after passing an examination approved by the board of that jurisdiction that is equivalent to the examination requirements under this chapter for a license to practice nursing as a registered nurse or licensed practical nurse;

(b) Any other information required by rules of the board;

(c) The application fee required by section 4723.08 of the Revised Code.

(2) The board shall grant a license by endorsement to practice nursing as a registered nurse or as a licensed practical nurse if the conditions of divisions (B)(2)(a) to (f) have been met:

(a) The applicant provides evidence satisfactory to the board that the applicant has met the educational requirements described in division (C) of this section.

(b) The examination, at the time it is successfully completed, is equivalent to the examination requirements in effect at that time for applicants who were licensed by examination in this state.

(c) The board determines there is sufficient evidence that the applicant completed two contact hours of continuing education directly related to this chapter or the rules adopted under it.

(d) The results of a criminal records check conducted in accordance with section 4723.091 of the Revised Code demonstrate that the applicant is not ineligible for licensure as specified in section 4723.092 of the Revised Code.

(e) The applicant has not committed any act that is grounds for disciplinary action under section 3123.47 or 4723.28 of the Revised Code, or the board determines that an applicant who has committed any act that is grounds for disciplinary action under either of those sections has made restitution or has been rehabilitated, or both.

(f) The applicant is not required to register under Chapter 2950 of the Revised Code, or a substantially similar law of another state, the United States, or another country.

(C)(1) To be eligible for licensure by examination or endorsement, an applicant seeking a license to practice nursing as a registered nurse must successfully complete either of the following:

(a) A nursing education program approved by the board under division (A) of section 4723.06 of the Revised Code;

(b) A nursing education program approved by a board of another jurisdiction that is a member of the national council of state boards of nursing.

(2) To be eligible for licensure by examination or endorsement, an applicant seeking a license to practice nursing as a licensed practical nurse must successfully complete one of the following:

(a) A nursing education program approved by the board under division (A) of section 4723.06 of the Revised Code;

(b) A nursing education program approved by a board of another jurisdiction that is a
member of the national council of state boards of nursing;
  (c) A practical nurse course offered or approved by the United States army;
  (d) A practical nurse education program approved by the United States air force as either of the following:
    (i) The community college of the air force associate degree in practical nursing technology;
    (ii) The allied health program, for students who graduated that program prior to 2016.
(D) The board may grant a nonrenewable temporary permit to practice nursing as a registered nurse or as a licensed practical nurse to an applicant for license by endorsement if the board is satisfied by the evidence that the applicant holds a current, valid, and unrestricted license or equivalent authorization from another jurisdiction. Subject to earlier automatic termination as described in this paragraph, the temporary permit shall expire at the earlier of one hundred eighty days after issuance or upon the issuance of a license by endorsement. The temporary permit shall terminate automatically if the criminal records check completed by the bureau of criminal identification and investigation as described in section 4723.091 of the Revised Code regarding the applicant indicates that the applicant is ineligible for licensure as specified in section 4723.092 of the Revised Code. An applicant whose temporary permit is automatically terminated is permanently prohibited from obtaining a license to practice nursing in this state as a registered nurse or as a licensed practical nurse.

4723.151 Practice of medicine by nurse prohibited.

  (A) Medical diagnosis, prescription of medical measures, and the practice of medicine or surgery or any of its branches by a nurse are prohibited.
  (B) Division (A) of this section does not prohibit a certified registered nurse anesthetist, clinical nurse specialist, certified nurse-midwife, or certified nurse practitioner from practicing within the nurse’s scope of practice in accordance with section 4723.43 of the Revised Code.
  (C) Notwithstanding division (B) of this section, nothing in this chapter shall be construed as authorizing any nurse to prescribe any drug or device to perform or induce an abortion, or to otherwise perform or induce an abortion.

4723.17 Medications administered by LPN.

  The board of nursing shall authorize a licensed practical nurse to administer medications if the nurse supplies evidence satisfactory to the board that either of the following is the case:
  (A) The nurse successfully completed, within a practical nurse prelicensure education program approved by the board or by another jurisdiction’s agency that regulates the practice of nursing, a course in basic pharmacology.
  (B) The nurse successfully completed a postlicensure course in basic pharmacology that is acceptable to the board.

4723.18 Intravenous therapy by LPN.

  (A) The board of nursing shall authorize a licensed practical nurse to administer to an adult intravenous therapy if the nurse supplies evidence satisfactory to the board that the conditions of divisions (A)(1) to (3) of this section have been met:
    (1) The nurse holds a current, valid license issued under this chapter to practice nursing as a licensed practical nurse.
    (2) The nurse has been authorized under section 4723.17 of the Revised Code to administer medications.
    (3) The nurse successfully completed either of the following:
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(a) A course of study in the safe performance of intravenous therapy approved by the board pursuant to section 4723.19 of the Revised Code or by an agency in another jurisdiction that regulates the practice of nursing and has requirements for intravenous therapy course approval that are substantially similar to the requirements in division (B) of section 4723.19 of the Revised Code, as determined by the board;

(b) A continuing education course or program approved by the board pursuant to section 4723.06 of the Revised Code that includes all of the following:

(i) The curriculum established by rules adopted by the board;

(ii) Training in the anatomy and physiology of the cardiovascular system, signs and symptoms of local and systemic complications in the administration of fluids and antibiotic additives, and guidelines for management of these complications;

(iii) Any other training or instruction the board considers appropriate;

(iv) A testing component that requires the nurse to perform a successful demonstration of the intravenous procedures, including all skills needed to perform them safely.

(B) Except as provided in section 4723.181 of the Revised Code and subject to the restrictions in division (D) of this section, a licensed practical nurse may perform intravenous therapy on an adult patient only if authorized by the board pursuant to division (A) of this section and only at the direction of one of the following:

(1) A physician, physician assistant, dentist, optometrist, or podiatrist who is authorized to practice in this state and, except as provided in division (C)(2) of this section, is present and readily available at the facility where the intravenous therapy procedure is performed;

(2) A registered nurse in accordance with division (C) of this section.

(C)(1) Except as provided in division (C)(2) of this section and section 4723.181 of the Revised Code, when a licensed practical nurse authorized by the board to perform intravenous therapy performs an intravenous therapy procedure at the direction of a registered nurse, the registered nurse or another registered nurse shall be readily available at the site where the intravenous therapy is performed, and before the licensed practical nurse initiates the intravenous therapy, the registered nurse shall personally perform an on-site assessment of the adult patient who is to receive the intravenous therapy.

(2) When a licensed practical nurse authorized by the board to perform intravenous therapy performs an intravenous therapy procedure in a home as defined in section 3721.10 of the Revised Code, or in an intermediate care facility for individuals with intellectual disabilities as defined in section 5124.01 of the Revised Code, at the direction of a registered nurse or licensed1 a physician, physician assistant, dentist, optometrist, or podiatrist who is authorized to practice in this state, a registered nurse shall be on the premises of the home or facility or accessible by some form of telecommunication.

(D) No licensed practical nurse shall perform any of the following intravenous therapy procedures:

(1) Initiating or maintaining any of the following:

(a) Blood or blood components;

(b) Solutions for total parenteral nutrition;

(c) Any cancer therapeutic medication including, but not limited to, cancer chemotherapy or an anti-neoplastic agent;

(d) Solutions administered through any central venous line or arterial line or any other line that does not terminate in a peripheral vein, except that a licensed practical nurse authorized by the board to perform intravenous therapy may maintain the solutions specified in division (D)(6)(a) of this section that are being administered through a central venous line or peripherally inserted central catheter;

(e) Any investigational or experimental medication.

(2) Initiating intravenous therapy in any vein, except that a licensed practical nurse authorized by the board to perform intravenous therapy may initiate intravenous therapy in
accordance with this section in a vein of the hand, forearm, or antecubital fossa;
    (3) Discontinuing a central venous, arterial, or any other line that does not terminate in a peripheral vein;
    (4) Initiating or discontinuing a peripherally inserted central catheter;
    (5) Mixing, preparing, or reconstituting any medication for intravenous therapy, except that a licensed practical nurse authorized by the board to perform intravenous therapy may prepare or reconstitute an antibiotic additive;
    (6) Administering medication via the intravenous route, including all of the following activities:
        (a) Adding medication to an intravenous solution or to an existing infusion, except that a licensed practical nurse authorized by the board to perform intravenous therapy may do any of the following:
            (i) Initiate an intravenous infusion containing one or more of the following elements: dextrose 5%, normal saline, lactated ringers, sodium chloride .45%, sodium chloride 0.2%, sterile water;
            (ii) Hang subsequent containers of the intravenous solutions specified in division (D)(6)(a)(i) of this section that contain vitamins or electrolytes, if a registered nurse initiated the infusion of that same intravenous solution;
            (iii) Initiate or maintain an intravenous infusion containing an antibiotic additive.
        (b) Injecting medication via a direct intravenous route, except that a licensed practical nurse authorized by the board to perform intravenous therapy may inject heparin or normal saline to flush an intermittent infusion device or heparin lock including, but not limited to, bolus or push.
    (7) Changing tubing on any line including, but not limited to, an arterial line or a central venous line, except that a licensed practical nurse authorized by the board to perform intravenous therapy may change tubing on an intravenous line that terminates in a peripheral vein;
    (8) Programming or setting any function of a patient controlled infusion pump.
    (E) Notwithstanding divisions (A) and (D) of this section, at the direction of a physician or a registered nurse, a licensed practical nurse authorized by the board to perform intravenous therapy may perform the following activities for the purpose of performing dialysis:
        (1) The routine administration and regulation of saline solution for the purpose of maintaining an established fluid plan;
        (2) The administration of a heparin dose intravenously;
        (3) The administration of a heparin dose peripherally via a fistula needle;
        (4) The loading and activation of a constant infusion pump;
        (5) The intermittent injection of a dose of medication that is administered via the hemodialysis blood circuit and through the patient's venous access.
    (F) No person shall employ or direct a licensed practical nurse to perform an intravenous therapy procedure without first verifying that the licensed practical nurse is authorized by the board to perform intravenous therapy.

4723.181 LPN intravenous therapy.

    (A) A licensed practical nurse may perform on any person any of the intravenous therapy procedures specified in division (B) of this section without receiving authorization to perform intravenous therapy from the board of nursing under section 4723.18 of the Revised Code, if both of the following apply:
        (1) The licensed practical nurse acts at the direction of a registered nurse or a licensed physician, dentist, optometrist, or podiatrist and the registered nurse, physician, dentist, optometrist, or podiatrist is on the premises where the procedure is to be performed or
accessible by some form of telecommunication.

(2) The licensed practical nurse can demonstrate the knowledge, skills, and ability to perform the procedure safely.

(B) The intravenous therapy procedures that a licensed practical nurse may perform pursuant to division (A) of this section are limited to the following:

1. Verification of the type of peripheral intravenous solution being administered;
2. Examination of a peripheral infusion site and the extremity for possible infiltration;
3. Regulation of a peripheral intravenous infusion according to the prescribed flow rate;
4. Discontinuation of a peripheral intravenous device at the appropriate time;
5. Performance of routine dressing changes at the insertion site of a peripheral venous or arterial infusion, peripherally inserted central catheter infusion, or central venous pressure subclavian infusion.

4723.24 Nursing and nurses; license renewal.

(A)(1) Except as otherwise provided in this chapter, all of the following apply with respect to the schedules for renewal of licenses and certificates issued by the board of nursing:

(a) An active license to practice nursing as a registered nurse is subject to renewal in odd-numbered years. An application for renewal of the license is due on the fifteenth day of September of the renewal year. A late application may be submitted before the license lapses. If a license is not renewed or classified as inactive, the license lapses on the first day of November of the renewal year.

(b) An active license to practice nursing as a licensed practical nurse is subject to renewal in even-numbered years. An application for renewal of the license is due on the fifteenth day of September of the renewal year. A late application may be submitted before the license lapses. If a license is not renewed or classified as inactive, the license lapses on the first day of November of the renewal year.

(c) An active license to practice nursing as an advanced practice registered nurse is subject to renewal in odd-numbered years. An application for renewal of the license is due on the fifteenth day of September of the renewal year. A late application may be submitted before the license lapses. If a license is not renewed or classified as inactive, the license lapses on the first day of November of the renewal year.

(d) All other active licenses and certificates issued under this chapter are subject to renewal according to a schedule established by the board in rules adopted under section 4723.07 of the Revised Code.

(2) The board shall provide an application for renewal to every holder of an active license or certificate, except when the board is aware that an individual is ineligible for license or certificate renewal for any reason, including pending criminal charges in this state or another jurisdiction, failure to comply with a disciplinary order from the board or the terms of a consent agreement entered into with the board, failure to pay fines or fees owed to the board, or failure to provide on the board’s request documentation of having completed the continuing nursing education requirements specified in division (C) of this section.

If the board provides a renewal application by mail, the application shall be addressed to the last known post-office address of the license or certificate holder and mailed before the date the application is due. Failure of the license or certificate holder to receive an application for renewal from the board shall not excuse the holder from the requirements contained in this section, except as provided in section 5903.10 of the Revised Code.

(3) A license or certificate holder seeking renewal of the license or certificate shall complete the renewal application and submit it to the board with the renewal fee established under section 4723.08 of the Revised Code. If a renewal application is submitted after the date the application is due, but before the date the license or certificate lapses, the applicant shall
include with the application the fee established under section 4723.08 of the Revised Code for processing a late application for renewal.

With the renewal application, the applicant shall report any conviction, plea, or judicial finding regarding a criminal offense that constitutes grounds for the board to impose sanctions under section 4723.28 of the Revised Code since the applicant last submitted an application to the board.

(4) On receipt of the renewal application, the board shall verify whether the applicant meets the renewal requirements. If the applicant meets the requirements, the board shall renew the license or certificate.

(B) Every license or certificate holder shall give written notice to the board of any change of name or address within thirty days of the change. The board shall require the holder to document a change of name in a manner acceptable to the board.

(C)(1) Except in the case of a first renewal after licensure by examination, to be eligible for renewal of an active license to practice nursing as a registered nurse or licensed practical nurse, each individual who holds an active license shall, in each two-year period specified by the board, complete continuing nursing education as follows:

(a) For renewal of a license that was issued for a two-year renewal period, twenty-four hours of continuing nursing education;

(b) For renewal of a license that was issued for less than a two-year renewal period, the number of hours of continuing nursing education specified by the board in rules adopted in accordance with Chapter 119 of the Revised Code;

(c) Of the hours of continuing nursing education completed in any renewal period, at least one hour of the education must be directly related to the statutes and rules pertaining to the practice of nursing in this state.

(2) To be eligible for renewal of an active license to practice nursing as an advanced practice registered nurse, each individual who holds an active license shall, in each two-year period specified by the board, complete continuing education as follows:

(a) For renewal of a license that was issued for a two-year renewal period, twenty-four hours of continuing nursing education;

(b) For renewal of a license that was issued for less than a two-year renewal period, the number of hours of continuing nursing education specified by the board in rules adopted in accordance with Chapter 119 of the Revised Code, including the number of hours of continuing education in advanced pharmacology;

(c) In the case of an advanced practice registered nurse who is designated as a clinical nurse specialist, certified nurse-midwife, or certified nurse practitioner, of the hours of continuing nursing education completed in any renewal period, at least twelve hours of the education must be in advanced pharmacology and be received from an accredited institution recognized by the board.

(d) The continuing education required by division (C)(2)(a) or (b) of this section is in addition to the continuing education required by division (C)(1)(a) or (b) of this section.

(3) The board shall adopt rules establishing the procedure for a license holder to certify to the board completion of the required continuing nursing education. The board may conduct a random sample of license holders and require that the license holders included in the sample submit satisfactory documentation of having completed the requirements for continuing nursing education. On the board’s request, a license holder included in the sample shall submit the required documentation.

(4) An educational activity may be applied toward meeting the continuing nursing education requirement only if it is obtained through a program or course approved by the board or a person the board has authorized to approve continuing nursing education programs and courses.

(5) The continuing education required of a certified registered nurse anesthetist, clinical
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nurse specialist, certified nurse-midwife, or certified nurse practitioner to maintain certification by a national certifying organization shall be applied toward the continuing education requirements for renewal of the following if the continuing education is obtained through a program or course approved by the board or a person the board has authorized to approve continuing nursing education programs and courses:

(a) A license to practice nursing as a registered nurse;
(b) A license to practice nursing as an advanced practice registered nurse.

(D) Except as otherwise provided in section 4723.28 of the Revised Code, an individual who holds an active license to practice nursing as a registered nurse or licensed practical nurse and who does not intend to practice in Ohio may send to the board written notice to that effect on or before the date the license lapses, and the board shall classify the license as inactive. During the period that the license is classified as inactive, the holder may not engage in the practice of nursing as a registered nurse or licensed practical nurse in Ohio and is not required to pay the renewal fee.

The holder of an inactive license to practice nursing as a registered nurse or licensed practical nurse or an individual who has failed to renew the individual's license to practice nursing as a registered nurse or licensed practical nurse may have the license reactivated or reinstated upon doing the following, as applicable to the holder or individual:

(1) Applying to the board for license reactivation or reinstatement on forms provided by the board;
(2) Meeting the requirements for reactivating or reinstating licenses established in rules adopted under section 4723.07 of the Revised Code or, if the individual did not renew because of service in the armed forces of the United States or a reserve component of the armed forces of the United States, including the Ohio national guard or the national guard of any other state, as provided in section 5903.10 of the Revised Code;
(3) If the license has been inactive for at least five years from the date of application for reactivation or has lapsed for at least five years from the date of application for reinstatement, submitting a request to the bureau of criminal identification and investigation for a criminal records check and check of federal bureau of investigation records pursuant to section 4723.091 of the Revised Code.

(E) Except as otherwise provided in section 4723.28 of the Revised Code, an individual who holds an active license to practice nursing as an advanced practice registered nurse and does not intend to practice in Ohio as an advanced practice registered nurse may send to the board written notice to that effect on or before the renewal date, and the board shall classify the license as inactive. During the period that the license is classified as inactive, the holder may not engage in the practice of nursing as an advanced practice registered nurse in Ohio and is not required to pay the renewal fee.

The holder of an inactive license to practice nursing as an advanced practice registered nurse or an individual who has failed to renew the individual's license to practice nursing as an advanced practice registered nurse may have the license reactivated or reinstated upon doing the following, as applicable to the holder or individual:

(1) Applying to the board for license reactivation or reinstatement on forms provided by the board;
(2) Meeting the requirements for reactivating or reinstating licenses established in rules adopted under section 4723.07 of the Revised Code or, if the individual did not renew because of service in the armed forces of the United States or a reserve component of the armed forces of the United States, including the Ohio national guard or the national guard of any other state, as provided in section 5903.10 of the Revised Code.
4723.26 Retired nurses and free clinic.

(A)(1) As used in this section:
(a) “Free clinic” has the same meaning as in section 3701.071 of the Revised Code.
(b) “Indigent and uninsured person” and “operation” have the same meanings as in section 2305.234 of the Revised Code.
(2) For the purposes of this section, a person shall be considered retired from practice if the person's license has expired with the intention of ceasing to practice nursing as a registered nurse, licensed practical nurse, or advanced practice registered nurse for remuneration.
(B) The board of nursing may issue, without examination, a volunteer's certificate to a qualified person who is retired from practice so that the person may provide nursing services to indigent and uninsured persons at any location, including a free clinic.
(C) Except as provided in division (D) of this section, an application for a volunteer's certificate shall include all of the following:
(1) A copy or other evidence of the applicant's degree from a school of registered nursing, practical nursing, or advanced practice registered nursing;
(2) One of the following, as applicable:
(a) A copy or other evidence of the applicant's most recent license to practice nursing as a registered nurse, licensed practical nurse, or advanced practice registered nurse issued by a jurisdiction in the United States that licenses persons to practice nursing as a registered nurse, licensed practical nurse, or advanced practice registered nurse;
(b) A copy or other evidence of the applicant's most recent license equivalent to a license to practice nursing as a registered nurse, licensed practical nurse, or advanced practice registered nurse in one or more branches of the United States armed services that the United States government issued.
(D) For an applicant retired from practice for at least ten years, the applicant shall do both of the following:
(1) Certify to the board completion of continuing nursing education that meets the requirements of section 4723.24 of the Revised Code and the rules adopted under that section;
(2) Submit a request to the bureau of criminal identification and investigation for a criminal records check and check of federal bureau of investigation records pursuant to section 4723.091 of the Revised Code.
(E) The holder of a volunteer's certificate may provide nursing services only to indigent and uninsured persons, but may do so at any location, including a free clinic. The holder shall not accept any form of remuneration for providing nursing services while in possession of the certificate. The board may suspend or revoke a volunteer's certificate on receiving proof satisfactory to the board that the holder has engaged in practice in this state outside the scope of the holder's certificate or that there are grounds for action against the person under section 4723.28 of the Revised Code. In revoking a certificate, the board may specify that the revocation is permanent.
(F)(1) A volunteer's certificate shall be valid for a period of two years, and may be renewed upon the application of the holder, unless the certificate is suspended or revoked under division (E) of this section. The board shall maintain a record of all persons who hold volunteer's certificates. The board shall not charge a fee for issuing or renewing a certificate.
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pursuant to this section.

(2) To be eligible for renewal of a volunteer's certificate, the holder of the certificate shall certify to the board completion of continuing nursing education that meets the requirements of section 4723.24 of the Revised Code and the rules adopted under that section. The board may not renew a certificate if the holder has not complied with the appropriate continuing education requirements. Any entity for which the holder provides nursing services may pay for or reimburse the holder for any costs incurred in obtaining the required continuing education hours.

(3) The holder of a volunteer's certificate issued pursuant to this section is subject to the immunity provisions regarding the provision of services to indigent and uninsured persons in section 2305.234 of the Revised Code.

(G) The board shall adopt rules in accordance with Chapter 119 of the Revised Code to administer and enforce this section.

4723.28 Disciplinary actions and sanctions.

(A) The board of nursing, by a vote of a quorum, may impose one or more of the following sanctions if it finds that a person committed fraud in passing an examination required to obtain a license or dialysis technician certificate issued by the board or to have committed fraud, misrepresentation, or deception in applying for or securing any nursing license or dialysis technician certificate issued by the board: deny, revoke, suspend, or place restrictions on any nursing license or dialysis technician certificate issued by the board; reprimand or otherwise discipline a holder of a nursing license or dialysis technician certificate; or impose a fine of not more than five hundred dollars per violation.

(B) The board of nursing, by a vote of a quorum, may impose one or more of the following sanctions: deny, revoke, suspend, or place restrictions on any nursing license or dialysis technician certificate issued by the board; reprimand or otherwise discipline a holder of a nursing license or dialysis technician certificate; or impose a fine of not more than five hundred dollars per violation. The sanctions may be imposed for any of the following:

(1) Denial, revocation, suspension, or restriction of authority to engage in a licensed profession or practice a health care occupation, including nursing or practice as a dialysis technician, for any reason other than a failure to renew, in Ohio or another state or jurisdiction;

(2) Engaging in the practice of nursing or engaging in practice as a dialysis technician, having failed to renew a nursing license or dialysis technician certificate issued under this chapter, or while a nursing license or dialysis technician certificate is under suspension;

(3) Conviction of, a plea of guilty to, a judicial finding of guilt of, a judicial finding of guilt resulting from a plea of no contest to, or a judicial finding of eligibility for a pretrial diversion or similar program or for intervention in lieu of conviction for, a misdemeanor committed in the course of practice;

(4) Conviction of, a plea of guilty to, a judicial finding of guilt of, a judicial finding of guilt resulting from a plea of no contest to, or a judicial finding of eligibility for a pretrial diversion or similar program or for intervention in lieu of conviction for, any felony or of any crime involving gross immorality or moral turpitude;

(5) Selling, giving away, or administering drugs or therapeutic devices for other than legal and legitimate therapeutic purposes; or conviction of, a plea of guilty to, a judicial finding of guilt of, a judicial finding of guilt resulting from a plea of no contest to, or a judicial finding of eligibility for a pretrial diversion or similar program or for intervention in lieu of conviction for, violating any municipal, state, county, or federal drug law;

(6) Conviction of, a plea of guilty to, a judicial finding of guilt of, a judicial finding of guilt resulting from a plea of no contest to, or a judicial finding of eligibility for a pretrial diversion or similar program or for intervention in lieu of conviction for, an act in another jurisdiction that would constitute a felony or a crime of moral turpitude in Ohio;
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(7) Conviction of, a plea of guilty to, a judicial finding of guilt of, a judicial finding of guilt resulting from a plea of no contest to, or a judicial finding of eligibility for a pretrial diversion or similar program or for intervention in lieu of conviction for, an act in the course of practice in another jurisdiction that would constitute a misdemeanor in Ohio;

(8) Self-administering or otherwise taking into the body any dangerous drug, as defined in section 4729.01 of the Revised Code, in any way that is not in accordance with a legal, valid prescription issued for that individual, or self-administering or otherwise taking into the body any drug that is a schedule I controlled substance;

(9) Habitual or excessive use of controlled substances, other habit-forming drugs, or alcohol or other chemical substances to an extent that impairs the individual's ability to provide safe nursing care or safe dialysis care;

(10) Impairment of the ability to practice according to acceptable and prevailing standards of safe nursing care or safe dialysis care because of the use of drugs, alcohol, or other chemical substances;

(11) Impairment of the ability to practice according to acceptable and prevailing standards of safe nursing care or safe dialysis care because of a physical or mental disability;

(12) Assaulting or causing harm to a patient or depriving a patient of the means to summon assistance;

(13) Misappropriation or attempted misappropriation of money or anything of value in the course of practice;

(14) Adjudication by a probate court of being mentally ill or mentally incompetent. The board may reinstate the person's nursing license or dialysis technician certificate upon adjudication by a probate court of the person's restoration to competency or upon submission to the board of other proof of competency.

(15) The suspension or termination of employment by the United States department of defense or department of veterans affairs for any act that violates or would violate this chapter;

(16) Violation of this chapter or any rules adopted under it;

(17) Violation of any restrictions placed by the board on a nursing license or dialysis technician certificate;

(18) Failure to use universal and standard precautions established by rules adopted under section 4723.07 of the Revised Code;

(19) Failure to practice in accordance with acceptable and prevailing standards of safe nursing care or safe dialysis care;

(20) In the case of a registered nurse, engaging in activities that exceed the practice of nursing as a registered nurse;

(21) In the case of a licensed practical nurse, engaging in activities that exceed the practice of nursing as a licensed practical nurse;

(22) In the case of a dialysis technician, engaging in activities that exceed those permitted under section 4723.72 of the Revised Code;

(23) Aiding and abetting a person in that person's practice of nursing without a license or practice as a dialysis technician without a certificate issued under this chapter;

(24) In the case of an advanced practice registered nurse, except as provided in division (M) of this section, either of the following:

(a) Waiving the payment of all or any part of a deductible or copayment that a patient, pursuant to a health insurance or health care policy, contract, or plan that covers such nursing services, would otherwise be required to pay if the waiver is used as an enticement to a patient or group of patients to receive health care services from that provider;

(b) Advertising that the nurse will waive the payment of all or any part of a deductible or copayment that a patient, pursuant to a health insurance or health care policy, contract, or plan that covers such nursing services, would otherwise be required to pay.

(25) Failure to comply with the terms and conditions of participation in the chemical
dependency monitoring program established under section 4723.35 of the Revised Code;

(26) Failure to comply with the terms and conditions required under the practice intervention and improvement program established under section 4723.282 of the Revised Code;

(27) In the case of an advanced practice registered nurse:
   (a) Engaging in activities that exceed those permitted for the nurse's nursing specialty under section 4723.43 of the Revised Code;
   (b) Failure to meet the quality assurance standards established under section 4723.07 of the Revised Code.

(28) In the case of an advanced practice registered nurse other than a certified registered nurse anesthetist, failure to maintain a standard care arrangement in accordance with section 4723.431 of the Revised Code or to practice in accordance with the standard care arrangement;

(29) In the case of an advanced practice registered nurse who is designated as a clinical nurse specialist, certified nurse-midwife, or certified nurse practitioner, failure to prescribe drugs and therapeutic devices in accordance with section 4723.481 of the Revised Code;

(30) Prescribing any drug or device to perform or induce an abortion, or otherwise performing or inducing an abortion;

(31) Failure to establish and maintain professional boundaries with a patient, as specified in rules adopted under section 4723.07 of the Revised Code;

(32) Regardless of whether the contact or verbal behavior is consensual, engaging with a patient other than the spouse of the registered nurse, licensed practical nurse, or dialysis technician in any of the following:
   (a) Sexual contact, as defined in section 2907.01 of the Revised Code;
   (b) Verbal behavior that is sexually demeaning to the patient or may be reasonably interpreted by the patient as sexually demeaning.

(33) Assisting suicide, as defined in section 3795.01 of the Revised Code;

(34) Failure to comply with the requirements in section 3719.061 of the Revised Code before issuing for a minor a prescription for an opioid analgesic, as defined in section 3719.01 of the Revised Code;

(35) Failure to comply with section 4723.487 of the Revised Code, unless the state board of pharmacy no longer maintains a drug database pursuant to section 4729.75 of the Revised Code;

(36) The revocation, suspension, restriction, reduction, or termination of clinical privileges by the United States department of defense or department of veterans affairs or the termination or suspension of a certificate of registration to prescribe drugs by the drug enforcement administration of the United States department of justice.

(C) Disciplinary actions taken by the board under divisions (A) and (B) of this section shall be taken pursuant to an adjudication conducted under Chapter 119 of the Revised Code, except that in lieu of a hearing, the board may enter into a consent agreement with an individual to resolve an allegation of a violation of this chapter or any rule adopted under it. A consent agreement, when ratified by a vote of a quorum, shall constitute the findings and order of the board with respect to the matter addressed in the agreement. If the board refuses to ratify a consent agreement, the admissions and findings contained in the agreement shall be of no effect.

(D) The hearings of the board shall be conducted in accordance with Chapter 119 of the Revised Code, the board may appoint a hearing examiner, as provided in section 119.09 of the Revised Code, to conduct any hearing the board is authorized to hold under Chapter 119 of the Revised Code.

In any instance in which the board is required under Chapter 119 of the Revised Code to give notice of an opportunity for a hearing and the applicant, licensee, or certificate holder does
not make a timely request for a hearing in accordance with section 119.07 of the Revised Code, the board is not required to hold a hearing, but may adopt, by a vote of a quorum, a final order that contains the board's findings. In the final order, the board may order any of the sanctions listed in division (A) or (B) of this section.

(E) If a criminal action is brought against a registered nurse, licensed practical nurse, or dialysis technician for an act or crime described in divisions (B)(3) to (7) of this section and the action is dismissed by the trial court other than on the merits, the board shall conduct an adjudication to determine whether the registered nurse, licensed practical nurse, or dialysis technician committed the act on which the action was based. If the board determines on the basis of the adjudication that the registered nurse, licensed practical nurse, or dialysis technician committed the act, or if the registered nurse, licensed practical nurse, or dialysis technician fails to participate in the adjudication, the board may take action as though the registered nurse, licensed practical nurse, or dialysis technician had been convicted of the act.

If the board takes action on the basis of a conviction, plea, or a judicial finding as described in divisions (B)(3) to (7) of this section that is overturned on appeal, the registered nurse, licensed practical nurse, or dialysis technician may, on exhaustion of the appeal process, petition the board for reconsideration of its action. On receipt of the petition and supporting court documents, the board shall temporarily rescind its action. If the board determines that the decision on appeal was a decision on the merits, it shall permanently rescind its action. If the board determines that the decision on appeal was not a decision on the merits, it shall conduct an adjudication to determine whether the registered nurse, licensed practical nurse, or dialysis technician committed the act on which the original conviction, plea, or judicial finding was based. If the board determines on the basis of the adjudication that the registered nurse, licensed practical nurse, or dialysis technician committed such act, or if the registered nurse, licensed practical nurse, or dialysis technician does not request an adjudication, the board shall reinstate its action; otherwise, the board shall permanently rescind its action.

Notwithstanding the provision of division (C)(2) of section 2953.32 of the Revised Code specifying that if records pertaining to a criminal case are sealed under that section the proceedings in the case shall be deemed not to have occurred, sealing of the following records on which the board has based an action under this section shall have no effect on the board's action or any sanction imposed by the board under this section: records of any conviction, guilty plea, judicial finding of guilt resulting from a plea of no contest, or a judicial finding of eligibility for a pretrial diversion program or intervention in lieu of conviction.

The board shall not be required to seal, destroy, redact, or otherwise modify its records to reflect the court's sealing of conviction records.

(F) The board may investigate an individual's criminal background in performing its duties under this section. As part of such investigation, the board may order the individual to submit, at the individual's expense, a request to the bureau of criminal identification and investigation for a criminal records check and check of federal bureau of investigation records in accordance with the procedure described in section 4723.091 of the Revised Code.

(G) During the course of an investigation conducted under this section, the board may compel any registered nurse, licensed practical nurse, or dialysis technician or applicant under this chapter to submit to a mental or physical examination, or both, as required by the board and at the expense of the individual, if the board finds reason to believe that the individual under investigation may have a physical or mental impairment that may affect the individual's ability to provide safe nursing care. Failure of any individual to submit to a mental or physical examination when directed constitutes an admission of the allegations, unless the failure is due to circumstances beyond the individual's control, and a default and final order may be entered without the taking of testimony or presentation of evidence.

If the board finds that an individual is impaired, the board shall require the individual to submit to care, counseling, or treatment approved or designated by the board, as a condition for...
initial, continued, reinstated, or renewed authority to practice. The individual shall be afforded an opportunity to demonstrate to the board that the individual can begin or resume the individual's occupation in compliance with acceptable and prevailing standards of care under the provisions of the individual's authority to practice.

For purposes of this division, any registered nurse, licensed practical nurse, or dialysis technician or applicant under this chapter shall be deemed to have given consent to submit to a mental or physical examination when directed to do so in writing by the board, and to have waived all objections to the admissibility of testimony or examination reports that constitute a privileged communication.

(H) The board shall investigate evidence that appears to show that any person has violated any provision of this chapter or any rule of the board. Any person may report to the board any information the person may have that appears to show a violation of any provision of this chapter or rule of the board. In the absence of bad faith, any person who reports such information or who testifies before the board in any adjudication conducted under Chapter 119 of the Revised Code shall not be liable for civil damages as a result of the report or testimony.

(I) All of the following apply under this chapter with respect to the confidentiality of information:

1. Information received by the board pursuant to a complaint or an investigation is confidential and not subject to discovery in any civil action, except that the board may disclose information to law enforcement officers and government entities for purposes of an investigation of either a licensed health care professional, including a registered nurse, licensed practical nurse, or dialysis technician, or a person who may have engaged in the unauthorized practice of nursing or dialysis care. No law enforcement officer or government entity with knowledge of any information disclosed by the board pursuant to this division shall divulge the information to any other person or government entity except for the purpose of a government investigation, a prosecution, or an adjudication by a court or government entity.

2. If an investigation requires a review of patient records, the investigation and proceeding shall be conducted in such a manner as to protect patient confidentiality.

3. All adjudications and investigations of the board shall be considered civil actions for the purposes of section 2305.252 of the Revised Code.

4. Any board activity that involves continued monitoring of an individual as part of or following any disciplinary action taken under this section shall be conducted in a manner that maintains the individual's confidentiality. Information received or maintained by the board with respect to the board's monitoring activities is not subject to discovery in any civil action and is confidential, except that the board may disclose information to law enforcement officers and government entities for purposes of an investigation of a licensee or certificate holder.

(J) Any action taken by the board under this section resulting in a suspension from practice shall be accompanied by a written statement of the conditions under which the person may be reinstated to practice.

(K) When the board refuses to grant a license or certificate to an applicant, revokes a license or certificate, or refuses to reinstate a license or certificate, the board may specify that its action is permanent. An individual subject to permanent action taken by the board is forever ineligible to hold a license or certificate of the type that was refused or revoked and the board shall not accept from the individual an application for reinstatement of the license or certificate or for a new license or certificate.

(L) No unilateral surrender of a nursing license, certificate of authority, or dialysis technician certificate issued under this chapter shall be effective unless accepted by majority vote of the board. No application for a nursing license, certificate of authority, or dialysis technician certificate issued under this chapter may be withdrawn without a majority vote of the board. The board's jurisdiction to take disciplinary action under this section is not removed or limited when an individual has a license or certificate classified as inactive or fails to renew a
license or certificate.

(M) Sanctions shall not be imposed under division (B)(24) of this section against any licensee who waives deductibles and copayments as follows:

(1) In compliance with the health benefit plan that expressly allows such a practice. Waiver of the deductibles or copayments shall be made only with the full knowledge and consent of the plan purchaser, payer, and third-party administrator. Documentation of the consent shall be made available to the board upon request.

(2) For professional services rendered to any other person licensed pursuant to this chapter to the extent allowed by this chapter and the rules of the board.

4723.281 Mandatory suspension; orders.

(A) As used in this section, with regard to offenses committed in Ohio, "aggravated murder," "murder," "voluntary manslaughter," "felonious assault," "kidnapping," "rape," "sexual battery," "gross sexual imposition," "aggravated arson," "aggravated robbery," and "aggravated burglary" mean such offenses as defined in Title XXIX of the Revised Code; with regard to offenses committed in other jurisdictions, the terms mean offenses comparable to offenses defined in Title XXIX of the Revised Code.

(B) When there is clear and convincing evidence that continued practice by an individual licensed under this chapter presents a danger of immediate and serious harm to the public, as determined on consideration of the evidence by the president and the executive director of the board of nursing, the president and director shall impose on the individual a summary suspension without a hearing. An individual serving as president or executive director in the absence of the president or executive director may take any action that this section requires or authorizes the president or executive director to take.

Immediately following the decision to impose a summary suspension, the board shall issue a written order of suspension and cause it to be delivered by certified mail or in person in accordance with section 119.07 of the Revised Code. The order shall not be subject to suspension by the court during the pendency of any appeal filed under section 119.12 of the Revised Code. If the individual subject to the suspension requests an adjudication, the date set for the adjudication shall be within fifteen days but not earlier than seven days after the individual makes the request, unless another date is agreed to by both the individual and the board. The summary suspension shall remain in effect, unless reversed by the board, until a final adjudication order issued by the board pursuant to this section and Chapter 119 of the Revised Code becomes effective.

The board shall issue its final adjudication order within ninety days after completion of the adjudication. If the board does not issue a final order within the ninety-day period, the summary suspension shall be void, but any final adjudication order issued subsequent to the ninety-day period shall not be affected.

(C) The license or certificate issued to an individual under this chapter is automatically suspended on that individual's conviction of, plea of guilty to, or judicial finding with regard to any of the following: aggravated murder, murder, voluntary manslaughter, felonious assault, kidnapping, rape, sexual battery, gross sexual imposition, aggravated arson, aggravated robbery, or aggravated burglary. The suspension shall remain in effect from the date of the conviction, plea, or finding until an adjudication is held under Chapter 119 of the Revised Code. If the board has knowledge that an automatic suspension has occurred, it shall notify the individual subject to the suspension. If the individual is notified and either fails to request an adjudication within the time periods established by Chapter 119 of the Revised Code or fails to participate in the adjudication, the board shall enter a final order permanently revoking the person's license or certificate.
4723.282 Program for practice intervention and improvement.

(A) As used in this section, "practice deficiency" means any activity that does not meet acceptable and prevailing standards of safe and effective nursing care or dialysis care.

(B) The board of nursing may abstain from taking disciplinary action under section 4723.28 of the Revised Code against the holder of a license or certificate issued under this chapter who has a practice deficiency that has been identified by the board through an investigation conducted under section 4723.28 of the Revised Code. The board may abstain from taking action only if the board has reason to believe that the individual's practice deficiency can be corrected through remediation, and if the individual enters into an agreement with the board to seek remediation as prescribed by the board, complies with the terms and conditions of the remediation, and successfully completes the remediation. If an individual fails to complete the remediation or the board determines that remediation cannot correct the individual's practice deficiency, the board shall proceed with disciplinary action in accordance with section 4723.28 of the Revised Code.

(C) To implement its authority under this section to abstain from taking disciplinary action, the board shall establish a practice intervention and improvement program. The board shall designate an administrator to operate the program and, in accordance with Chapter 119 of the Revised Code, adopt rules for the program that establish the following:

1. Criteria for use in identifying an individual's practice deficiency;
2. Requirements that an individual must meet to be eligible for remediation and the board's abstention from disciplinary action;
3. Standards and procedures for prescribing remediation that is appropriate for an individual's identified practice deficiency;
4. Terms and conditions that an individual must meet to be successful in completing the remediation prescribed;
5. Procedures for the board's monitoring of the individual's remediation;
6. Procedures for maintaining confidential records regarding individuals who participate in remediation;
7. Any other requirements or procedures necessary to develop and administer the program.

(D) All records held by the board for purposes of the program shall be confidential, are not public records for purposes of section 149.43 of the Revised Code, and are not subject to discovery by subpoena or admissible as evidence in any judicial proceeding. The administrator of the program shall maintain all records in the board's office in accordance with the board's record retention schedule.

(E) When an individual begins the remediation prescribed by the board, the individual shall sign a waiver permitting any entity that provides services related to the remediation to release to the board information regarding the individual's progress. An entity that provides services related to remediation shall report to the board if the individual fails to complete the remediation or does not make satisfactory progress in remediation.

In the absence of fraud or bad faith, an entity that reports to the board regarding an individual's practice deficiency, or progress or lack of progress in remediation, is not liable in damages to any person as a result of making the report.

(F) An individual participating in remediation prescribed under this section is responsible for all financial obligations that may arise from obtaining or completing the remediation.

4723.29 Subpoenas.

In addition to the powers conferred upon the board of nursing by Chapter 119 of the Revised Code, the board may subpoena witnesses and require their attendance, require the
testimony of witnesses and require the production by witnesses of books, papers, public
records, and other documentary evidence, and examine them as it may require in relation to any
matter which it has authority to investigate, inquire into, or hear.

A subpoena for patient record information shall be issued only upon approval of the
executive director of the board, and the president or another member of the board designated
by the president, in consultation with the office of the attorney general. Before issuance of any
such subpoena, the executive director and the office of the attorney general shall determine
whether there is probable cause to believe that the complaint filed alleges a violation of this
chapter or any rule of the board, that the records sought are relevant to the alleged violation and
material to the investigation, and that the records cover a reasonable period of time surrounding
the alleged violation.

Upon failure to comply with any subpoena issued by the board and after reason-
able notice to the person being subpoenaed, the board may move for an order compelling the
production of persons or records pursuant to Ohio Rules of Civil Procedure.

Each officer who serves such subpoena shall receive the same fees as a sheriff, and
each witness who appears, in obedience to a subpoena, before the board, shall receive the fees
and mileage provided for under section 119.094 of the Revised Code.

4723.32 Licensing exemptions.

This chapter does not prohibit any of the following:
(A) The practice of nursing by a student currently enrolled in and actively pursuing
completion of a prelicensure nursing education program, if all of the following are the case:
(1) The student is participating in a program located in this state and approved by the
board of nursing or participating in this state in a component of a program located in another
jurisdiction and approved by a board that is a member of the national council of state boards of
nursing;
(2) The student’s practice is under the auspices of the program;
(3) The student acts under the supervision of a registered nurse serving for the program
as a faculty member or teaching assistant.
(B) The rendering of medical assistance to a licensed physician, licensed dentist, or
licensed podiatrist by a person under the direction, supervision, and control of such licensed
physician, dentist, or podiatrist;
(C) The activities of persons employed as nursing aides, attendants, orderlies, or other
auxiliary workers in patient homes, nurseries, nursing homes, hospitals, home health agencies,
or other similar institutions;
(D) The provision of nursing services to family members or in emergency situations;
(E) The care of the sick when done in connection with the practice of religious tenets of
any church and by or for its members;
(F) The practice of nursing as an advanced practice registered nurse by a student
currently enrolled in and actively pursuing completion of a program of study leading to initial
authorization by the board of nursing to practice nursing as an advanced practice registered
nurse in a designated specialty, if all of the following are the case:
(1) The program qualifies the student to sit for the examination of a national certifying
organization approved by the board under section 4723.46 of the Revised Code or the program
prepares the student to receive a master’s or doctoral degree in accordance with division (A)(2)
of section 4723.41 of the Revised Code;
(2) The student’s practice is under the auspices of the program;
(3) The student acts under the supervision of an advanced practice registered nurse
serving for the program as a faculty member, teaching assistant, or preceptor.
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(G) The activities of an individual who currently holds a license to practice nursing or equivalent authorization from another jurisdiction, if the individual's authority to practice has not been revoked, the individual is not currently under suspension or on probation, the individual does not represent the individual as being licensed under this chapter, and one of the following is the case:

1. The individual is engaging in the practice of nursing by discharging official duties while employed by or under contract with the United States government or any agency thereof;
2. The individual is engaging in the practice of nursing as an employee of an individual, agency, or corporation located in the other jurisdiction in a position with employment responsibilities that include transporting patients into, out of, or through this state, as long as each trip in this state does not exceed seventy-two hours;
3. The individual is consulting with an individual licensed in this state to practice any health-related profession;
4. The individual is engaging in activities associated with teaching in this state as a guest lecturer at or for a nursing education program, continuing nursing education program, or in-service presentation;
5. The individual is conducting evaluations of nursing care that are undertaken on behalf of an accrediting organization, including the national league for nursing accrediting committee, the joint commission on accreditation of healthcare organizations, or any other nationally recognized accrediting organization;
6. The individual is providing nursing care to an individual who is in this state on a temporary basis, not to exceed six months in any one calendar year, if the nurse is directly employed by or under contract with the individual or a guardian or other person acting on the individual's behalf;
7. The individual is providing nursing care during any disaster, natural or otherwise, that has been officially declared to be a disaster by a public announcement issued by an appropriate federal, state, county, or municipal official;
8. The individual is providing nursing care at a free-of-charge camp accredited by the SeriousFun children's network that specializes in providing therapeutic recreation, as defined in section 2305.231 of the Revised Code, for individuals with chronic diseases, if all of the following are the case:
   a. The individual provides documentation to the medical director of the camp that the individual holds a current, valid license to practice nursing or equivalent authorization from another jurisdiction.
   b. The individual provides nursing care only at the camp or in connection with camp events or activities that occur off the grounds of the camp.
   c. The individual is not compensated for the individual's services.
   d. The individual provides nursing care within this state for not more than thirty days per calendar year.
   e. The camp has a medical director who holds an unrestricted license to practice medicine issued in accordance with Chapter 4731 of the Revised Code.

(H) The administration of medication by an individual who holds a valid medication aide certificate issued under this chapter, if the medication is administered to a resident of a nursing home, residential care facility, or ICF/IID authorized by section 4723.64 of the Revised Code to use a certified medication aide and the medication is administered in accordance with section 4723.67 of the Revised Code.

4723.33 Retaliatory protection.

A registered nurse, licensed practical nurse, dialysis technician, community health worker, or medication aide who in good faith makes a report under this chapter or any other
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provision of the Revised Code regarding a violation of this chapter or any other provision of the Revised Code, or participates in any investigation, administrative proceeding, or judicial proceeding resulting from the report, has the full protection against retaliatory action provided by sections 4113.51 to 4113.53 of the Revised Code.

4723.34 Nursing and nurses; reports to board.

(A) A person or governmental entity that employs, or contracts directly or through another person or governmental entity for the provision of services by, registered nurses, licensed practical nurses, dialysis technicians, medication aides, or certified community health workers and that knows or has reason to believe that a current or former employee or person providing services under a contract who holds a license or certificate issued under this chapter engaged in conduct that would be grounds for disciplinary action by the board of nursing under this chapter or rules adopted under it shall report to the board of nursing the name of such current or former employee or person providing services under a contract. The report shall be made on the person's or governmental entity's behalf by an individual licensed by the board who the person or governmental entity has designated to make such reports.

A prosecutor in a case described in divisions (B)(3) to (5) of section 4723.28 of the Revised Code, or in a case where the trial court issued an order of dismissal upon technical or procedural grounds of a charge of a misdemeanor committed in the course of practice, a felony charge, or a charge of gross immorality or moral turpitude, who knows or has reason to believe that the person charged is licensed under this chapter to practice nursing as a registered nurse or as a licensed practical nurse or holds a certificate issued under this chapter to practice as a dialysis technician shall notify the board of nursing of the charge. With regard to certified community health workers and medication aides, the prosecutor in a case involving a charge of a misdemeanor committed in the course of employment, a felony charge, or a charge of gross immorality or moral turpitude, including a case dismissed on technical or procedural grounds, who knows or has reason to believe that the person charged holds a community health worker or medication aide certificate issued under this chapter shall notify the board of the charge.

Each notification from a prosecutor shall be made on forms prescribed and provided by the board. The report shall include the name and address of the license or certificate holder, the charge, and the certified court documents recording the action.

(B) If any person or governmental entity fails to provide a report required by this section, the board may seek an order from a court of competent jurisdiction compelling submission of the report.

4723.341 Immunities for reporting.

(A) As used in this section, “person” has the same meaning as in section 1.59 of the Revised Code and also includes the board of nursing and its members and employees; health care facilities, associations, and societies; insurers; and individuals.

(B) In the absence of fraud or bad faith, no person reporting to the board of nursing or testifying in an adjudication conducted under Chapter 119 of the Revised Code with regard to alleged incidents of negligence or malpractice or matters subject to this chapter or sections 3123.41 to 3123.50 of the Revised Code and any applicable rules adopted under section 3123.63 of the Revised Code shall be subject to either of the following based on making the report or testifying:

(1) Liability in damages in a civil action for injury, death, or loss to person or property;
(2) Discipline or dismissal by an employer.

(C) An individual who is disciplined or dismissed in violation of division (B)(2) of this section has the same rights and duties accorded an employee under sections 4113.52 and
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4113.53 of the Revised Code.

(D) In the absence of fraud or bad faith, no professional association of registered nurses, advanced practice registered nurses, licensed practical nurses, dialysis technicians, community health workers, or medication aides that sponsors a committee or program to provide peer assistance to individuals with substance abuse problems, no representative or agent of such a committee or program, and no member of the board of nursing shall be liable to any person for damages in a civil action by reason of actions taken to refer a nurse, dialysis technician, community health worker, or medication aide to a treatment provider or actions or omissions of the provider in treating a nurse, dialysis technician, community health worker, or medication aide.

4723.431 Advanced practice nurse standard care arrangement.

(A) An advanced practice registered nurse who is designated as a clinical nurse specialist, certified nurse-midwife, or certified nurse practitioner may practice only in accordance with a standard care arrangement entered into with each physician or podiatrist with whom the nurse collaborates. A copy of the standard care arrangement shall be retained on file by the nurse’s employer. Prior approval of the standard care arrangement by the board of nursing is not required, but the board may periodically review it for compliance with this section.

A clinical nurse specialist, certified nurse-midwife, or certified nurse practitioner may enter into a standard care arrangement with one or more collaborating physicians or podiatrists. Not later than thirty days after first engaging in the practice of nursing as a clinical nurse specialist, certified nurse-midwife, or certified nurse practitioner, the nurse shall submit to the board the name and business address of each collaborating physician or podiatrist. Thereafter, the nurse shall notify the board of any additions or deletions to the nurse’s collaborating physicians or podiatrists. Except as provided in division (E) of this section, the notice must be provided not later than thirty days after the change takes effect.

Each collaborating physician or podiatrist must be authorized to practice in this state and, except as provided in division (D) of this section, practice in a specialty that is the same as or similar to the nurse’s nursing specialty. If a collaborating physician or podiatrist enters into standard care arrangements with more than five nurses, the physician or podiatrist shall not collaborate at the same time with more than five nurses in the prescribing component of their practices.

(B) A standard care arrangement shall be in writing and shall contain all of the following:

(1) Criteria for referral of a patient by the clinical nurse specialist, certified nurse-midwife, or certified nurse practitioner to a collaborating physician or podiatrist;

(2) A process for the clinical nurse specialist, certified nurse-midwife, or certified nurse practitioner to obtain a consultation with a collaborating physician or podiatrist;

(3) A plan for coverage in instances of emergency or planned absences of either the clinical nurse specialist, certified nurse-midwife, or certified nurse practitioner or a collaborating physician or podiatrist that provides the means whereby a physician or podiatrist is available for emergency care;

(4) The process for resolution of disagreements regarding matters of patient management between the clinical nurse specialist, certified nurse-midwife, or certified nurse practitioner and a collaborating physician or podiatrist;

(5) Any other criteria required by rule of the board adopted pursuant to section 4723.07 or 4723.50 of the Revised Code.

(C)(1) A standard care arrangement entered into pursuant to this section may permit a clinical nurse specialist, certified nurse-midwife, or certified nurse practitioner to supervise services provided by a home health agency as defined in section 3701.881 of the Revised Code.
(2) A standard care arrangement entered into pursuant to this section may permit a clinical nurse specialist, certified nurse-midwife, or certified nurse practitioner to admit a patient to a hospital in accordance with section 3727.06 of the Revised Code.

(D) A collaborating physician who enters into a standard care arrangement with a clinical nurse specialist whose nursing specialty is mental health or psychiatric mental health, as determined by the board, must practice in one of the following specialties:

(1) A specialty that is the same as or similar to the nurse's nursing specialty;
(2) Pediatrics;
(3) Primary care or family practice.

(E)(1) Except as provided in division (E)(2) of this section, if a physician or podiatrist terminates the collaboration between the physician or podiatrist and a certified nurse-midwife, certified nurse practitioner, or clinical nurse specialist before their standard care arrangement expires, all of the following apply:

(a) The physician or podiatrist must give the nurse written or electronic notice of the termination.
(b) Once the nurse receives the termination notice, the nurse must notify the board of nursing of the termination as soon as practicable by submitting to the board a copy of the physician's or podiatrist's termination notice.
(c) Notwithstanding the requirement of section 4723.43 of the Revised Code that the nurse practice in collaboration with a physician or podiatrist, the nurse may continue to practice under the existing standard care arrangement without a collaborating physician or podiatrist for not more than one hundred twenty days after submitting to the board a copy of the termination notice.

(2) In the event that the collaboration between a physician or podiatrist and a certified nurse-midwife, certified nurse practitioner, or clinical nurse specialist terminates because of the physician's or podiatrist's death, the nurse must notify the board of the death as soon as practicable. The nurse may continue to practice under the existing standard care arrangement without a collaborating physician or podiatrist for not more than one hundred twenty days after notifying the board of the physician's or podiatrist's death.

(F) Nothing in this section prohibits a hospital from hiring a clinical nurse specialist, certified nurse-midwife, or certified nurse practitioner as an employee and negotiating standard care arrangements on behalf of the employee as necessary to meet the requirements of this section. A standard care arrangement between the hospital's employee and the employee's collaborating physician is subject to approval by the medical staff and governing body of the hospital prior to implementation of the arrangement at the hospital.

4723.44 Unauthorized practice of advanced practice registered nurse.

(A) No person shall knowingly do any of the following unless the person holds a current, valid license issued by the board of nursing under this chapter to practice nursing as an advanced practice registered nurse in the specialty indicated by the designation:

(1) Engage in the practice of nursing as an advanced practice registered nurse for a fee, salary, or other consideration, or as a volunteer;
(2) Represent the person as being an advanced practice registered nurse, including representing the person as being a certified registered nurse anesthetist, clinical nurse specialist, certified nurse-midwife, or certified nurse practitioner;
(3) Use any title or initials implying that the person is an advanced practice registered nurse, including using any title or initials implying the person is a certified registered nurse anesthetist, clinical nurse specialist, certified nurse-midwife, or certified nurse practitioner.

(B) No advanced practice registered nurse shall knowingly do any of the following:

(1) Engage, for a fee, salary, or other consideration, or as a volunteer, in the practice of
a nursing specialty other than the specialty designated on the nurse's current, valid license
issued by the board under this chapter to practice nursing as an advanced practice registered
nurse;
(2) Represent the person as being authorized to practice any nursing specialty other
than the specialty designated on the current, valid license to practice nursing as an advanced
practice registered nurse;
(3) Use the title "certified registered nurse anesthetist" or the initials "N.A." or "C.R.N.A.,”
the title "clinical nurse specialist" or the initials “C.N.S.”, the title "certified nurse-midwife" or the
initials “C.N.M.”, the title "certified nurse practitioner" or the initials “C.N.P.”, the title “advanced
practice registered nurse” or the initials “A.P.R.N.”, or any other title or initials implying that the
nurse is authorized to practice any nursing specialty other than the specialty designated on the
nurse's current, valid license to practice nursing as an advanced practice registered nurse;
(4) Except as provided in division (D) of section 4723.431 of the Revised Code, enter
into a standard care arrangement with a physician or podiatrist whose practice is not the same
as or similar to the nurse’s nursing specialty;
(5) Prescribe drugs or therapeutic devices in a manner that does not comply with section
4723.481 of the Revised Code;
(6) Prescribe any drug or device to perform or induce an abortion, or otherwise perform
or induce an abortion.
(C) No person shall knowingly employ a person to engage in the practice of nursing as
an advanced practice registered nurse unless the person so employed holds a current, valid
license and designation issued by the board under this chapter to practice as an advanced
practice registered nurse in the specialty indicated by the designation.
(D) A document certified by the executive director of the board, under the official seal of
the board, to the effect that it appears from the records of the board that no license to practice
nursing as an advanced practice registered nurse has been issued to the person specified in the
document, or that a license to practice nursing as an advanced practice registered nurse, if
issued, has been revoked or suspended, shall be received as prima-facie evidence of the record
of the board in any court or before any officer of the state.

4723.48 Advanced practice nursing delegation.

(A) A clinical nurse specialist, certified nurse-midwife, or certified nurse practitioner who
holds a license to practice nursing issued under section 4723.42 of the Revised Code may
delegate to a person not otherwise authorized to administer drugs the authority to administer to
a specified patient a drug, unless the drug is a controlled substance or is listed in the formulary
established in rules adopted under section 4723.50 of the Revised Code. The delegation shall
be in accordance with division (B) of this section and standards and procedures established in
rules adopted under division (O) of section 4723.07 of the Revised Code.
(B) Prior to delegating the authority, the nurse shall do both of the following:
(1) Assess the patient and determine that the drug is appropriate for the patient;
(2) Determine that the person to whom the authority will be delegated has met the
conditions specified in division (D) of section 4723.489 of the Revised Code.

4723.481 Scope of practice for advanced practice nurse.

This section establishes standards and conditions regarding the authority of an
advanced practice registered nurse who is designated as a clinical nurse specialist, certified
nurse-midwife, or certified nurse practitioner to prescribe and personally furnish drugs and
therapeutic devices under a license issued under section 4723.42 of the Revised Code.
(A) Except as provided in division (F) of this section, a clinical nurse specialist, certified
nurse-midwife, or certified nurse practitioner shall not prescribe or furnish any drug or therapeutic device that is listed on the exclusionary formulary established in rules adopted under section 4723.50 of the Revised Code.

(B) The prescriptive authority of a clinical nurse specialist, certified nurse-midwife, or certified nurse practitioner shall not exceed the prescriptive authority of the collaborating physician or podiatrist, including the collaborating physician's authority to treat chronic pain with controlled substances and products containing tramadol as described in section 4731.052 of the Revised Code.

(C)(1) Except as provided in division (C)(2) or (3) of this section, a clinical nurse specialist, certified nurse-midwife, or certified nurse practitioner may prescribe to a patient a schedule II controlled substance only if all of the following are the case:
   (a) The patient has a terminal condition, as defined in section 2133.01 of the Revised Code.
   (b) A physician initially prescribed the substance for the patient.
   (c) The prescription is for an amount that does not exceed the amount necessary for the patient's use in a single, seventy-two-hour period.

(2) The restrictions on prescriptive authority in division (C)(1) of this section do not apply if a clinical nurse specialist, certified nurse-midwife, or certified nurse practitioner issues the prescription to the patient from any of the following locations:
   (a) A hospital registered under section 3701.07 of the Revised Code;
   (b) An entity owned or controlled, in whole or in part, by a hospital or by an entity that owns or controls, in whole or in part, one or more hospitals;
   (c) A health care facility operated by the department of mental health and addiction services or the department of developmental disabilities;
   (d) A nursing home licensed under section 3721.02 of the Revised Code or by a political subdivision certified under section 3721.09 of the Revised Code;
   (e) A county home or district home operated under Chapter 5155 of the Revised Code that is certified under the medicare or medicaid program;
   (f) A hospice care program, as defined in section 3712.01 of the Revised Code;
   (g) A community mental health services provider, as defined in section 5122.01 of the Revised Code;
   (h) An ambulatory surgical facility, as defined in section 3702.30 of the Revised Code;
   (i) A freestanding birthing center, as defined in section 3702.141 of the Revised Code;
   (j) A federally qualified health center, as defined in section 3701.047 of the Revised Code;
   (k) A federally qualified health center look-alike, as defined in section 3701.047 of the Revised Code;
   (l) A health care office or facility operated by the board of health of a city or general health district or the authority having the duties of a board of health under section 3709.05 of the Revised Code;
   (m) A site where a medical practice is operated, but only if the practice is comprised of one or more physicians who also are owners of the practice; the practice is organized to provide direct patient care; and the clinical nurse specialist, certified nurse-midwife, or certified nurse practitioner providing services at the site has a standard care arrangement and collaborates with at least one of the physician owners who practices primarily at that site;
   (n) A residential care facility, as defined in section 3721.01 of the Revised Code.

(3) A clinical nurse specialist, certified nurse-midwife, or certified nurse practitioner shall not issue to a patient a prescription for a schedule II controlled substance from a convenience care clinic even if the clinic is owned or operated by an entity specified in division (C)(2) of this section.

(D) A pharmacist who acts in good faith reliance on a prescription issued by a clinical
nurse specialist, certified nurse-midwife, or certified nurse practitioner under division (C)(2) of this section is not liable for or subject to any of the following for relying on the prescription: damages in any civil action, prosecution in any criminal proceeding, or professional disciplinary action by the state board of pharmacy under Chapter 4729 of the Revised Code.

(E) A clinical nurse specialist, certified nurse-midwife, or certified nurse practitioner shall comply with section 3719.061 of the Revised Code if the nurse prescribes for a minor, as defined in that section, an opioid analgesic, as defined in section 3719.01 of the Revised Code.

(F) Until the board of nursing establishes a new formulary in rules adopted under section 4723.50 of the Revised Code, a clinical nurse specialist, certified nurse-midwife, or certified nurse practitioner who prescribes or furnishes any drug or therapeutic device shall do so in accordance with the formulary established by the board prior to the effective date of this amendment.

4723.483 Authorization to prescribe and use epinephrine autoinjectors.

(A)(1) Subject to division (A)(2) of this section, and notwithstanding any provision of this chapter or rule adopted by the board of nursing, a clinical nurse specialist, certified nurse-midwife, or certified nurse practitioner who holds a certificate to prescribe issued under section 4723.48 of the Revised Code may do either of the following without having examined an individual to whom epinephrine may be administered:

(a) Personally furnish a supply of epinephrine autoinjectors for use in accordance with sections 3313.7110, 3313.7111, 3314.143, 3326.28, 3328.29, 3728.03 to 3728.05, and 5101.76 of the Revised Code;

(b) Issue a prescription for epinephrine autoinjectors for use in accordance with sections 3313.7110, 3313.7111, 3314.143, 3326.28, 3328.29, 3728.03 to 3728.05, and 5101.76 of the Revised Code.

(2) An epinephrine autoinjector personally furnished or prescribed under division (A)(1) of this section must be furnished or prescribed in such a manner that it may be administered only in a manufactured dosage form.

(B) A nurse who acts in good faith in accordance with this section is not liable for or subject to any of the following for any action or omission of an entity to which an epinephrine autoinjector is furnished or a prescription is issued: damages in any civil action, prosecution in any criminal proceeding, or professional disciplinary action.

4723.488 Advanced practice nurse authorization for issuing naloxone.

(A) Notwithstanding any provision of this chapter or rule adopted by the board of nursing, an advanced practice registered nurse who is designated as a clinical nurse specialist, certified nurse-midwife, or certified nurse practitioner may personally furnish a supply of naloxone, or issue a prescription for naloxone, without having examined the individual to whom it may be administered if both of the following conditions are met:

(1) The naloxone supply is furnished to, or the prescription is issued to and in the name of, a family member, friend, or other individual in a position to assist an individual who there is reason to believe is at risk of experiencing an opioid-related overdose.

(2) The advanced practice registered nurse instructs the individual receiving the naloxone supply or prescription to summon emergency services as soon as practicable either before or after administering naloxone to an individual apparently experiencing an opioid-related overdose.

(B) An advanced practice registered nurse who under division (A) of this section in good faith furnishes a supply of naloxone or issues a prescription for naloxone is not liable for or subject to any of the following for any action or omission of the individual to whom the naloxone
is furnished or the prescription is issued: damages in any civil action, prosecution in any criminal proceeding, or professional disciplinary action.

4723.489 Advance practice nurse may delegate drug administration.

A person not otherwise authorized to administer drugs may administer a drug to a specified patient if all of the following conditions are met:

(A) The authority to administer the drug is delegated to the person by an advanced practice registered nurse who is a clinical nurse specialist, certified nurse-midwife, or certified nurse practitioner and holds a license issued under section 4723.42 of the Revised Code.

(B) The drug is not listed in the formulary established in rules adopted under section 4723.50 of the Revised Code, is not a controlled substance, and is not to be administered intravenously.

(C) The drug is to be administered at a location other than a hospital inpatient care unit, as defined in section 3727.50 of the Revised Code; a hospital emergency department or a freestanding emergency department; or an ambulatory surgical facility, as defined in section 3702.30 of the Revised Code.

(D) The person has successfully completed education based on a recognized body of knowledge concerning drug administration and demonstrates to the person's employer the knowledge, skills, and ability to administer the drug safely.

(E) The person's employer has given the advanced practice registered nurse access to documentation, in written or electronic form, showing that the person has met the conditions specified in division (D) of this section.

(F) The advanced practice registered nurse is physically present at the location where the drug is administered.

4723.4810 Immunity for advanced practice nurse issuing certain drugs.

(A)(1) Notwithstanding any conflicting provision of this chapter or rule adopted by the board of nursing, a clinical nurse specialist, certified nurse-midwife, or certified nurse practitioner who holds a license to practice nursing as an advanced practice registered nurse issued under section 4723.42 of the Revised Code may issue a prescription for or personally furnish a complete or partial supply of a drug to treat chlamydia, gonorrhea, or trichomoniasis, without having examined the individual for whom the drug is intended, if all of the following conditions are met:

(a) The individual is a sexual partner of the nurse's patient.

(b) The patient has been diagnosed with chlamydia, gonorrhea, or trichomoniasis.

(c) The patient reports to the nurse that the individual is unable or unlikely to be evaluated or treated by a health professional.

(2) A prescription issued under this section shall include the individual's name and address, if known. If the nurse is unable to obtain the individual's name and address, the prescription shall include the patient's name and address and the words “expedited partner therapy” or the letters “EPT.”

(3) A nurse may prescribe or personally furnish a drug under this section for not more than a total of two individuals who are sexual partners of the nurse's patient.

(B) For each drug prescribed or personally furnished under this section, the nurse shall do all of the following:

(1) Provide the patient with information concerning the drug for the purpose of sharing the information with the individual, including directions for use of the drug and any side effects, adverse reactions, or known contraindications associated with the drug;

(2) Recommend to the patient that the individual seek treatment from a health
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(3) Document all of the following in the patient's record:
(a) The name of the drug prescribed or furnished and its dosage;
(b) That information concerning the drug was provided to the patient for the purpose of sharing the information with the individual;
(c) If known, any adverse reactions the individual experiences from treatment with the drug.

(C) A nurse who prescribes or personally furnishes a drug under this section may contact the individual for whom the drug is intended.
(1) If the nurse contacts the individual, the nurse shall do all of the following:
(a) Inform the individual that the individual may have been exposed to chlamydia, gonorrhea, or trichomoniasis;
(b) Encourage the individual to seek treatment from a health professional;
(c) Explain the treatment options available to the individual, including treatment with a prescription drug, directions for use of the drug, and any side effects, adverse reactions, or known contraindications associated with the drug;
(d) Document in the patient's record that the nurse contacted the individual.
(2) If the nurse does not contact the individual, the nurse shall document that fact in the patient's record.

(D) A nurse who in good faith prescribes or personally furnishes a drug under this section is not liable for or subject to any of the following:
(1) Damages in any civil action;
(2) Prosecution in any criminal proceeding;
(3) Professional disciplinary action.

4723.99 Penalties for unauthorized practice.

(A) Except as provided in division (B) of this section, whoever violates section 4723.03, 4723.44, 4723.653, or 4723.73 of the Revised Code is guilty of a felony of the fifth degree on a first offense and a felony of the fourth degree on each subsequent offense.

(B) Each of the following is guilty of a minor misdemeanor:
(1) A registered nurse, advanced practice registered nurse, or licensed practical nurse who violates division (A), (B), (C), or (D) of section 4723.03 of the Revised Code by reason of a license to practice nursing that has lapsed for failure to renew or by practicing nursing after a license has been classified as inactive;
(2) A medication aide who violates section 4723.653 of the Revised Code by reason of a medication aide certificate that has lapsed for failure to renew or by administering medication as a medication aide after a certificate has been classified as inactive.

4723-4-01 Competent nursing practice for licensed nurses; definitions.

(A) The purpose of this chapter is to establish:
(1) Minimal acceptable standards of safe and effective nursing practice for a registered nurse and a licensed practical nurse in any setting;
(2) Minimal acceptable standards of safe and effective practice for a certified nurse-midwife, certified nurse practitioner, certified registered nurse anesthetist, and clinical nurse specialist in any setting. Additional standards for practice as a certified nurse-midwife, certified nurse practitioner, certified registered nurse anesthetist, and clinical nurse specialist are established in Chapters 4723-8 and 4723-9 of the Administrative Code;

(B) For purposes of this chapter, the following definitions shall apply:
(1) “Certified nurse-midwife” means a registered nurse who has met the requirements of
section 4723.41 of the Revised Code, and who holds a current valid certificate of authority issued by the board under section 4723.42 of the Revised Code.

(2) “Certified nurse practitioner” means a registered nurse who has met the requirements of section 4723.41 of the Revised Code, and who holds a current valid certificate of authority issued by the board under section 4723.42 of the Revised Code.

(3) “Certified registered nurse anesthetist” means a registered nurse who has met the requirements of section 4723.41 of the Revised Code, and who holds a current valid certificate of authority issued by the board under section 4723.42 of the Revised Code.

(4) “Clinical judgment” is the application of the nurse's knowledge and reasoning within the context of the clinical environment in making decisions about patient care.

(5) “Clinical nurse specialist” means a registered nurse who has met the requirements of section 4723.41 of the Revised Code, and who holds a current valid certificate of authority issued by the board under section 4723.42 of the Revised Code.

(6) “Direction” means communicating a plan of care to a licensed practical nurse. Direction by a registered nurse is not meant to imply the registered nurse is supervising the licensed practical nurse in the employment context.

(7) “Licensed nurse” means a registered nurse or a licensed practical nurse who holds a current valid license to practice nursing in Ohio.

(8) “Nursing diagnosis” means the identification of a patient's needs or problems which are amenable to nursing intervention.

(9) “Patient” means the recipient of nursing care, which may include an individual, a group, or a community.

4723-4-03 Registered nurse scope of practice.

(A) A registered nurse shall provide nursing care within the scope of practice of nursing for a registered nurse as set forth in division (B) of section 4723.01 of the Revised Code and the rules of the board.

(B) A registered nurse shall maintain current knowledge of the duties, responsibilities, and accountabilities for safe nursing practice.

(C) A registered nurse shall demonstrate competence and accountability in all areas of practice in which the nurse is engaged including:

(1) Consistent performance of all aspects of nursing care; and

(2) Recognition, referral or consultation, and intervention, when a complication arises.

(D) A registered nurse may provide nursing care that is beyond basic nursing preparation for a registered nurse, provided:

(1) The nurse obtains education that emanates from a recognized body of knowledge relative to the nursing care to be provided;

(2) The nurse demonstrates knowledge, skills, and abilities necessary to provide the nursing care;

(3) The nurse maintains documentation satisfactory to the board of meeting the requirements set forth in paragraphs (D)(1) and (D)(2) of this rule;

(4) When the nursing care to be provided according to division (B)(5) of section 4723.01 of the Revised Code, the nurse has a specific current order from an individual who is authorized to practice in this state and is acting within the course of the individual's professional practice; and

(5) The nursing care does not involve a function or procedure that is prohibited by any other law or rule.

(E) A registered nurse shall, in a timely manner:

(1) Implement any order for a patient unless the registered nurse believes or should have reason to believe the order is:
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(a) Inaccurate;
(b) Not properly authorized;
(c) Not current or valid;
(d) Harmful, or potentially harmful to a patient; or
(e) Contraindicated by other documented information; and
(2) Clarify any order for a patient when the registered nurse believes or should have reason to believe the order is:
(a) Inaccurate;
(b) Not properly authorized;
(c) Not current or valid;
(d) Harmful, or potentially harmful to a patient; or
(e) Contraindicated by other documented information.
(F) When clarifying an order, the registered nurse shall, in a timely manner:
(1) Consult with an appropriate licensed practitioner;
(2) Notify the ordering practitioner when the registered nurse makes the decision not to follow the order or administer the medication or treatment as prescribed;
(3) Document that the practitioner was notified of the decision not to follow the order or administer the medication or treatment, including the reason for not doing so; and
(4) Take any other action needed to assure the safety of the patient.
(G) A registered nurse shall, in a timely manner, report to and consult as necessary with other nurses or other members of the health care team and make referrals as necessary.
(H) A registered nurse shall maintain the confidentiality of patient information. The registered nurse shall communicate patient information with other members of the health care team for health care purposes only, shall access patient information only for purposes of patient care, or for otherwise fulfilling the nurse's assigned job responsibilities, and shall not disseminate patient information for purposes other than patient care, or for otherwise fulfilling the nurse's assigned job responsibilities, through social media, texting, emailing or any other form of communication.
(I) To the maximum extent feasible, identifiable patient health care information shall not be disclosed by a registered nurse unless the patient has consented to the disclosure of identifiable patient health care information. A registered nurse shall report individually identifiable patient information without written consent in limited circumstances only and in accordance with an authorized law, rule, or other recognized legal authority.
(J) The registered nurse shall use acceptable standards of safe nursing care as a basis for any observation, advice, instruction, teaching, or evaluation and shall communicate information which is consistent with acceptable standards of safe nursing care.
(K) When a registered nurse provides direction to a licensed practical nurse the registered nurse shall first assess:
(1) The condition of the patient who needs nursing care, including, but not limited to, the stability of the patient;
(2) The type of nursing care the patient requires;
(3) The complexity and frequency of the nursing care needed;
(4) The training, skill, and ability of the licensed practical nurse who will be performing the specific function or procedure, to perform the specific function or procedure; and
(5) The availability and accessibility of resources necessary to safely perform the specific function or procedure.

4723-4-04 Licensed practical nurse scope of practice.

(A) A licensed practical nurse shall function within the scope of practice of nursing for a licensed practical nurse as set forth in division (F) of section 4723.01 of the Revised Code and
the rules of the board.

(B) A licensed practical nurse shall maintain current knowledge of the duties, responsibilities, and accountabilities for safe nursing practice.

(C) A licensed practical nurse shall demonstrate competence and accountability in all areas of practice in which the nurse is engaged which includes, but is not limited to, the following:

(1) Consistent performance of all aspects of nursing care; and

(2) Recognition, referral or consultation, and intervention, when a complication arises.

(D) A licensed practical nurse may provide nursing care in accordance with division (F) of section 4723.01 of the Revised Code that is beyond basic preparation for a licensed practical nurse provided:

(1) The nurse obtains education that emanates from a recognized body of knowledge relative to the nursing care to be provided;

(2) The nurse demonstrates knowledge, skills, and abilities necessary to perform the nursing care;

(3) The nurse maintains documentation satisfactory to the board of meeting the requirements set forth in paragraphs (D)(1) and (D)(2) of this rule;

(4) When the nursing care to be provided according to division (F)(3) of section 4723.01 of the Revised Code, the nurse has a specific current valid order or direction from an individual who is authorized to practice in this state and is acting within the course of the individual's professional practice; and

(5) The nursing care does not involve a function or procedure that is prohibited by any other law or rule.

(E) A licensed practical nurse shall, in a timely manner:

(1) Implement any order or direction for a patient unless the licensed practical nurse believes or should have reason to believe the order or direction is:

(a) Inaccurate;

(b) Not properly authorized;

(c) Not current or valid;

(d) Harmful, or potentially harmful to a patient; or

(e) Contraindicated by other documented information; and

(2) Clarify any order or direction for a patient when the licensed practical nurse believes or should have reason to believe the order or direction is:

(a) Inaccurate;

(b) Not properly authorized;

(c) Not current or valid;

(d) Harmful, or potentially harmful to a patient; or

(e) Contraindicated by other documented information.

(F) When clarifying an order or direction, the licensed practical nurse shall, in a timely manner:

(1) Consult with an appropriate licensed practitioner or directing registered nurse;

(2) Notify the ordering practitioner or directing registered nurse when the licensed practical nurse makes the decision not to follow the order or direction or administer the medication or treatment as prescribed;

(3) Document that the practitioner or directing registered nurse was notified of the decision not to follow the direction or order, or administer the medication or treatment, including the reason for not doing so; and

(4) Take any other action needed to assure the safety of the patient.

(G) A licensed practical nurse shall, in a timely manner report to and consult as necessary with other nurses or other members of the health care team and make referrals as necessary.
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(H) A licensed practical nurse shall maintain the confidentiality of patient information obtained in the course of nursing practice. The licensed practical nurse shall communicate patient information with other members of the health care team for health care purposes only, shall access patient information only for purposes of patient care, or for otherwise fulfilling the nurse's assigned job responsibilities, and shall not disseminate patient information for purposes other than patient care, or for otherwise fulfilling the nurse's assigned job responsibilities, through social media, texting, emailing or any other form of communication.

(I) To the maximum extent feasible, identifiable patient health care information shall not be disclosed by a licensed practical nurse unless the patient has consented to the disclosure of identifiable patient health care information. A licensed practical nurse shall report individually identifiable patient information without written consent in limited circumstances only, and in accordance with an authorized law, rule, or other recognized legal authority.

(J) When a licensed practical nurse is directed to observe, advise, instruct, or evaluate the performance of a nursing task, the licensed practical nurse shall use acceptable standards of safe nursing care as a basis for that observation, advice, instruction, teaching, or evaluation and shall communicate information that is consistent with acceptable standards of safe nursing care.

4723-4-05 Certified nurse-midwife, certified nurse practitioner, certified registered nurse anesthetist, or clinical nurse specialist; scope of practice.

(A) A certified nurse-midwife, certified nurse practitioner, certified registered nurse anesthetist, or clinical nurse specialist shall do all of the following:
   (1) Function within the scope of practice of nursing for a registered nurse as set forth in division (B) of section 4723.01 of the Revised Code and the rules of the board.
   (2) Function within the nurse's applicable scope of practice as set forth in section 4723.43 of the Revised Code and the rules of the board.
   (3) Practice according to section 4723.481 of the Revised Code and Chapter 4723-9 of the Administrative Code if the individual holds a certificate to prescribe.

(B) When the practice of a certified nurse-midwife, certified nurse practitioner, or clinical nurse specialist is evaluated, the evaluation shall be provided by a collaborating licensed physician or podiatrist, or a nurse holding a current, valid certificate of authority that is the same as the individual being evaluated.

(C) When the practice of a certified registered nurse anesthetist is evaluated, the evaluation shall be provided by a supervising licensed physician, podiatrist, dentist or a certified registered nurse anesthetist whose certificate is current and valid.

(D) A certified nurse-midwife, certified nurse practitioner, certified registered nurse anesthetist, or clinical nurse specialist may provide care within their specialty provided:
   (1) The nurse obtains education that emanates from a recognized body of knowledge relative to the nursing care to be provided;
   (2) The nurse demonstrates knowledge, skills, and abilities necessary to provide the nursing care; and
   (3) The nurse maintains documentation satisfactory to the board of meeting the requirements set forth in paragraphs (D)(1) and (D)(2) of this rule.

4723-4-06 Nursing practice.

(A) At all times when a licensed nurse is providing direct nursing care to a patient the licensed nurse shall display the applicable title or initials set forth in division (C) of section 4723.03 of the Revised Code to identify the nurse's relevant licensure as a registered nurse or as a licensed practical nurse.
(B) At all times when a certified nurse-midwife, certified nurse practitioner, certified registered nurse anesthetist, or clinical nurse specialist is providing direct nursing care to a patient, the nurse shall display the applicable title or initials set forth in division (C) of section 4723.03 of the Revised Code to identify relevant approval either as a certified nurse-midwife, certified nurse practitioner, certified registered nurse anesthetist, or clinical nurse specialist.

(C) At all times when a licensed nurse is engaged in nursing practice and interacting with the patient, or health care providers on behalf of the patient, through any form of telecommunication, the licensed nurse shall identify to each patient or health care provider the nurse's title or initials set forth in division (C) of section 4723.03 of the Revised Code to identify applicable licensure or approval as a registered nurse, licensed practical nurse, certified nurse-midwife, certified nurse practitioner, certified registered nurse anesthetist, or clinical nurse specialist.

(D) A licensed nurse shall delegate a nursing task, including medication administration, only in accordance with Chapter 4723-13, 4723-23, 4723-26, or 4723-27 of the Administrative Code.

(E) A licensed nurse shall, in a complete, accurate, and timely manner, report and document nursing assessments or observations, the care provided by the nurse for the patient, and the patient's response to that care.

(F) A licensed nurse shall, in an accurate and timely manner, report to the appropriate practitioner errors in or deviations from the current valid order.

(G) A licensed nurse shall not falsify any patient record or any other document prepared or utilized in the course of, or in conjunction with, nursing practice. This includes, but is not limited to, case management documents or reports or time records, reports, and other documents related to billing for nursing services.

(H) A licensed nurse shall implement measures to promote a safe environment for each patient.

(I) A licensed nurse shall delineate, establish, and maintain professional boundaries with each patient.

(J) At all times when a licensed nurse is providing direct nursing care to a patient the licensed nurse shall:

1. Provide privacy during examination or treatment and in the care of personal or bodily needs; and
2. Treat each patient with courtesy, respect, and with full recognition of dignity and individuality.

(K) A licensed nurse shall not:

1. Engage in behavior that causes or may cause physical, verbal, mental, or emotional abuse to a patient;
2. Engage in behavior toward a patient that may reasonably be interpreted as physical, verbal, mental, or emotional abuse.

(L) A licensed nurse shall not misappropriate a patient's property or:

1. Engage in behavior to seek or obtain personal gain at the patient's expense;
2. Engage in behavior that may reasonably be interpreted as behavior to seek or obtain personal gain at the patient's expense;
3. Engage in behavior that constitutes inappropriate involvement in the patient's personal relationships or financial matters; or
4. Engage in behavior that may reasonably be interpreted as inappropriate involvement in the patient's personal relationships or financial matters.

For the purpose of this paragraph, the patient is always presumed incapable of giving free, full, or informed consent to the behaviors by the nurse set forth in this paragraph.

(M) A licensed nurse shall not:

1. Engage in sexual conduct with a patient;
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(2) Engage in conduct in the course of practice that may reasonably be interpreted as sexual;
(3) Engage in any verbal behavior that is seductive or sexually demeaning to a patient; or
(4) Engage in verbal behavior that may reasonably be interpreted as seductive, or sexually demeaning to a patient.

For the purpose of this paragraph, the patient is always presumed incapable of giving free, full, or informed consent to sexual activity with the nurse.

(N) A licensed nurse, when functioning in an administrative role, shall verify that each nurse, dialysis technician, or medication aide under the nurse administrator has:
(1) A current valid license to practice nursing in Ohio or a current valid certificate to practice as a dialysis technician or medication aide in Ohio; and
(2) If applicable, other documents of approval or certification as required by the board.

(O) When nursing practice, as set forth in section 4723.01 of the Revised Code, is supervised or evaluated:
(1) Only a registered nurse shall supervise or evaluate the practice of nursing, as set forth in Chapter 4723 of the Revised Code and the rules of the board, performed by other registered nurses and licensed practical nurses; or
(2) In matters other than the practice of nursing, a non-nursing supervisor may evaluate a nurse employee.

(3) Supervision or evaluation by a registered nurse does not require that the registered nurse be present on-site on a routine basis, but at minimum:
(a) Supervision requires that the registered nurse be continuously available through some form of telecommunication with the supervised nurse, and take all action necessary, including but not limited to conducting periodic on-site visits, to insure that the supervised nurse is practicing in accordance with acceptable and prevailing standards of safe nursing care as set forth in Chapter 4723 of the Revised Code and the rules of the board; and
(b) Evaluation requires that the registered nurse conduct periodic on-site visits sufficient to enable the evaluating nurse to evaluate the evaluated nurse's performance.

Nothing in this paragraph shall be construed to authorize a licensed practical nurse to practice without direction, as required by division (F) of section 4723.01 of the Revised Code.

Nothing in this paragraph shall be construed to prohibit a licensed practical nurse from participating in activities that contribute to the delivery of patient care services. Such participation may include, but is not limited to, scheduling of coverage for nursing services and observation and documentation by a licensed practical nurse regarding care provided by assistive personnel.

(P) A licensed nurse shall not make any false, misleading, or deceptive statements, or submit or cause to be submitted any false, misleading or deceptive information, or documentation to:
(1) The board or any representative of the board;
(2) Current employers;
(3) Prospective employers when applying for positions requiring a nursing license;
(4) Facilities in which, or organizations for whom, the nurse is working a temporary, agency, or locus tenens assignment;
(5) Other members of the patient's health care team; or
(6) Law enforcement personnel.

(Q) For purposes of paragraphs (I), (J), (K), (L), and (M) of this rule, a nurse shall not use social media, texting, emailing, or other forms of communication with, or about a patient, for non-health care purposes or for purposes other than fulfilling the nurse's assigned job responsibilities.
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4723-4-07 Registered nurse standards.

(A) A registered nurse shall apply the nursing process in the practice of nursing as set forth in division (B) of section 4723.01 of the Revised Code and in the rules of the board. The nursing process is cyclical in nature and requires that the nurse’s actions respond to the patient’s changing status throughout the process. The following standards shall be used by a registered nurse, using clinical judgment, in applying the nursing process for each patient under the registered nurse’s care:

1. **Assessment of health status:**
   - The registered nurse shall, in an accurate and timely manner:
     a. Collect data. This includes:
        i. Collection of subjective and objective data from the patient, family, significant others, or other members of the health care team. The registered nurse may direct or delegate the performance of data collection; and
        ii. Documentation of the collected data.

2. **Analysis and reporting:**
   - The registered nurse shall, in an accurate and timely manner:
     a. Identify, organize, assimilate and interpret data;
     b. Establish, accept, or modify a nursing diagnosis that is to be addressed with applicable nursing interventions; and
     c. Report the patient’s health status and nursing diagnosis as necessary to other members of the health care team;

3. **Planning:**
   - The registered nurse shall, in an accurate and timely manner:
     a. Develop, establish, maintain, or modify the nursing plan of care consistent with current nursing science, including the nursing diagnosis, desired patient outcomes or goals, and nursing interventions; and
     b. Communicate the nursing plan of care and all modifications of the plan to members of the health care team;

4. **Implementation:**
   - The registered nurse shall, in an accurate and timely manner implement the current nursing plan of care which may include:
     a. Executing the nursing regimen;
     b. Implementing the current valid order authorized by an individual who is authorized to practice in this state and is acting within the course of the individual’s professional practice;
     c. Providing nursing care commensurate with the documented education, knowledge, skills, and abilities of the registered nurse;
     d. Assisting and collaborating with other health care providers in the care of the patient;
     e. Delegating nursing tasks, including medication administration, only in accordance with Chapter 4723-13, 4723-23, 4723-26, or 4723-27 of the Administrative Code;

5. **Evaluation:**
   - The registered nurse shall, in an accurate and timely manner:
     a. Evaluate, document, and report the patient’s:
        i. Response to nursing interventions; and
        ii. Progress towards expected outcomes; and
     b. Reassess the patient’s health status, and establish or modify any aspect of the nursing plan as set forth in this rule.

(B) For purposes of this rule, standards for implementing the nursing process also apply to a certified nurse-midwife, certified nurse practitioner, certified registered nurse anesthetist, or clinical nurse specialist.
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4723-4-08 Licensed practical nurse standards.

(A) The licensed practical nurse shall contribute to the nursing process in the practice of nursing as set forth in division (F) of section 4723.01 of the Revised Code and in the rules of the board. The nursing process is cyclical in nature so that the nurse's actions respond to the patient's changing status throughout the process. The licensed practical nurse is directed in providing nursing care by the established nursing plan. The following standards shall be used by a licensed practical nurse in utilization of the nursing process:

1. Contribution to assessment of patient health status:
The licensed practical nurse shall contribute to the nursing assessment of the patient. The licensed practical nurse shall, in an accurate and timely manner:
   (a) Collect and document objective and subjective data related to the patient's health status; and
   (b) Report objective and subjective data to the directing registered nurse or health care provider, and other members of the health care team;

2. Planning:
The licensed practical nurse shall, in an accurate and timely manner:
   (a) Contribute to the development, maintenance, or modification of the nursing component of the care plan;
   (b) Communicate the nursing plan of care and all authorized modifications of the plan to members of the health care team;

3. Implementation:
The licensed practical nurse shall, in an accurate and timely manner, implement the nursing plan of care, which may include:
   (a) Providing nursing interventions;
   (b) Collecting and reporting patient data as directed;
   (c) Administering medications and treatments prescribed by an individual who is authorized to practice in this state and is acting within the course of the individual's professional practice;
   (d) Providing basic nursing care as directed by a registered nurse, advanced practice registered nurse, or licensed physician, dentist, optometrist, chiropractor or podiatrist;
   (e) Collaborating with other nurses and other members of the health care team;
   (f) Delegating nursing tasks as directed, including medication administration, only in accordance with Chapter 4723-13, 4723-23, 4723-26, or 4723-27 of the Administrative Code; and

4. Contributing to evaluation:
The licensed practical nurse shall, in an accurate and timely manner:
   (a) Contribute to the evaluation of the patient's response to nursing interventions;
   (b) Document the patient's responses to nursing interventions;
   (c) Communicate the patient's responses to nursing interventions to the directing registered nurse or health care provider, and members of the health care team; and
   (d) Contribute to the reassessment of the patient's health status and to the modifications of any aspect of the nursing plan of care as set forth in this rule.

4723-17-03 LPN intravenous therapy.

(A) Except as provided in paragraph (B) of this rule, a licensed practical nurse shall not perform any of the following intravenous therapy procedures:

1. Initiate or maintain any of the following:
   (a) Blood or blood components;
   (b) Solutions for total parenteral nutrition;
(c) Cancer therapeutic medications including, but not limited to, cancer chemotherapy or an anti-neoplastic agents;
(d) Investigational or experimental medications;
(e) Solutions administered through any central venous line or arterial line or any other line that does not terminate in a peripheral vein, except as provided in paragraph (B)(1) of this rule;
(f) An intravenous piggyback infusion, except as provided in paragraph (B)(3) of this rule.
(2) Discontinue a central venous, arterial, or any other line that does not terminate in a peripheral vein;
(3) Initiate or discontinue a peripherally inserted central catheter, or any catheter that is longer than three inches;
(4) Program or set any function of a patient controlled analgesic;
(5) Mix, prepare or reconstitute any medication for intravenous therapy, except as provided in paragraph (B)(4) of this rule;
(6) Administer medications by an intravenous route, except as provided in paragraph (B)(3) of this rule;
(7) Inject medications by a direct intravenous route, except as provided in paragraph (B)(5) of this rule;
(8) Change tubing on an arterial line, a central venous line, or on any line that does not terminate in a peripheral vein;
(9) Change an intermittent infusion device, unless the tip of the connected intravenous catheter terminates in a peripheral vein.

(B) A licensed practical nurse authorized by the board to perform intravenous therapy procedures, may perform the following procedures only for individuals aged eighteen or older and only when directed to do so by a licensed physician, dentist, optometrist, podiatrist, or registered nurse in accordance with section 4723.18 of the Revised Code:
(1) Administer the following solutions, or combinations of the solutions, through a venous line:
   (a) five per cent dextrose and water;
   (b) five per cent dextrose and lactated ringers;
   (c) five per cent dextrose and normal saline;
   (d) Normal saline;
   (e) Lactated ringers;
   (f) 0.45 per cent sodium chloride and water;
   (g) 0.2 per cent sodium chloride and water;
   (h) 0.3 per cent sodium chloride and water.
(2) Administer any of the solutions set forth in paragraph (B)(1) of this rule that contain vitamins or electrolytes after a registered nurse initiates the first infusion of the solution containing vitamins or electrolytes.
(3) Initiate or maintain an intermittent or secondary intravenous infusion containing an antibiotic;
(4) Prepare or reconstitute an antibiotic additive to be administered through an intravenous infusion;
(5) Inject heparin or normal saline to flush an intermittent infusion device or heparin lock, including, but not limited to, bolus or push;
(6) Change tubing on an intermittent infusion device and on an intravenous line if the line terminates in a peripheral vein;
(7) Place a venous access catheter, no longer than three inches in length, in the hand, forearm or antecubital space, followed by the placement of a saline or heparin lock, either for purposes of intermittent infusions, or to initiate infusions of any of the solutions set forth in paragraph (B)(1) of this rule; or
(8) Stop an infusion of blood or blood component, or turn off the function of a patient-controlled analgesic device when a complication arises.

(C) A licensed practical nurse authorized by the board to perform intravenous therapy procedures may perform the procedures set forth in paragraph (B) of this rule only if one of the following requirements are met:

(1) The licensed practical nurse is directed to perform intravenous therapy by a licensed physician, dentist, optometrist, or podiatrist who is present and readily available at the facility where the intravenous therapy procedure is performed;

(2) The licensed practical nurse is directed to perform intravenous therapy by a registered nurse who has personally performed an on-site assessment of the individual to receive intravenous therapy, and that registered nurse or another registered nurse is readily available at the site where the intravenous therapy procedure is performed; or

(3) If the intravenous therapy procedures are performed in a home as defined in section 3721.10 of the Revised Code, or in an intermediate care facility for individuals with intellectual disabilities as defined in section 5124.01 of the Revised Code, a registered nurse who directs the authorized licensed practical nurse to perform intravenous therapy is either:

   (a) On the premises of the home or facility; or
   (b) Accessible by some form of telecommunication.

(D) A licensed practical nurse may perform any of the intravenous therapy procedures specified in paragraph (E) of this rule without receiving authorization to perform intravenous therapy from the board of nursing under section 4723.18 of the Revised Code, if both of the following apply:

   (1) The licensed practical nurse acts at the direction of a registered nurse or a licensed physician, dentist, optometrist, or podiatrist and the registered nurse, physician, dentist, optometrist, or podiatrist is on the premises where the procedure is to be performed or accessible by some form of telecommunication; and

   (2) The licensed practical nurse can demonstrate the knowledge, skills, and ability necessary to perform the procedure safely.

(E) The intravenous therapy procedures that a licensed practical nurse may perform in accordance with paragraph (D) of this rule are limited to the following:

   (1) Verification of the type of peripheral intravenous solution being administered;
   (2) Examination of a peripheral infusion site and the extremity for possible infiltration;
   (3) Regulation of a peripheral intravenous infusion according to the prescribed flow rate;
   (4) Discontinuation of a peripheral intravenous device at the appropriate time; and
   (5) Performance of routine dressing changes at the insertion site of a peripheral venous or arterial infusion, peripherally inserted central catheter infusion, or central venous pressure subclavian infusion.

4723-20-01 Infection control; definitions.

For the purposes of this chapter, the following definitions shall apply:

(A) “Aseptic technique” means practices used to reduce or eliminate microorganisms.

(B) “Exposure-prone activity” means an activity in which there is a risk of disease transmission by virtue of any of the following:

   (1) Direct contact with a disease source that includes:
       (a) Airborne transmission or droplet;
       (b) Eating or drinking contaminated food or water;
       (c) Being bitten by an insect or other disease carrying agent;
   (2) Invasive procedure;
   (3) Any other direct contact with disease source, including bodily contact; or
   (4) Contact with contaminated environmental surfaces.
(C) “Hand washing” as that term is used in division (K)(1) of section 4723.07 of the Revised Code is a component of hand hygiene achieved by washing and rinsing hands with non-antimicrobial soap or antimicrobial soap and water, or by using alcohol-based waterless hand sanitizers or other antimicrobial agents.

(D) “Invasive procedure” means any procedure involving manual or instrumental contact with, or entry into, any blood, body fluid, cavity, internal organ, subcutaneous tissue, mucous membrane or percutaneous wound of the human body. If percutaneous injury occurs to a licensee or certificate holder during an exposure-prone activity, the licensee's or certificate holder's blood is likely to contact the patient's body cavity, subcutaneous tissues, or mucous membranes.

(E) “Respiratory hygiene” is an element of standard precautions that requires the licensee or certificate holder to engage in source control practices to control the spread of respiratory infection, including but not limited to:
   (1) Covering coughs or sneezes, promptly disposing of used tissues, and performing hand hygiene;
   (2) Source control measures, including but not limited to using masks on a coughing patient when tolerated and appropriate; or
   (3) Spatial separation of patients and other persons with respiratory infections in common waiting areas when possible.

(F) “Universal and standard precautions” are infection prevention practices that apply to all patients, regardless of suspected or confirmed infection status, in any setting in which healthcare is delivered, and include but are not limited to the following:
   (1) Practices used to mitigate exposure to disease-causing agents when exposure-prone activity occurs;
   (2) Hand hygiene;
   (3) Disinfection and sterilization of equipment;
   (4) Appropriate handling and disposal of needles and other sharp instruments; and
   (5) Appropriate use of personal protective equipment, including wearing and disposal of gloves and other protective barriers or devices.

4723-20-02 Practices to control infection and minimize exposure to disease.

During the delivery of healthcare, licensees and certificate holders shall be familiar with, observe, and rigorously adhere to the acceptable and prevailing standard precautions to minimize exposure to disease causing agents and prevent infection, including at least the following:
   (A) Appropriate use of hand hygiene;
   (B) Appropriate use of respiratory hygiene;
   (C) Effective disinfection and sterilization of equipment;
   (D) Safe injection practices;
   (E) Safe handling and disposal of needles and other sharp instruments;
   (F) Safe handling and disposal of blood and body fluid; and
   (G) Appropriate use of personal protective equipment, including wearing and disposal of gloves and other protective garments and devices.

4723-20-03 Hand washing.

During the delivery of healthcare, licensees and certificate holders shall follow acceptable and prevailing standard precautions for hand hygiene, including but not limited to the following:
   (A) Appropriate handwashing prior to performing or participating in an exposure-prone activity.
activity and after performing or participating in an exposure-prone activity;

(B) Washing the hands and other skin surfaces immediately and thoroughly when hands have had contact with mucous membranes, blood or body fluids, secretions or excretions, or after touching contaminated items; and

(C) Washing the hands immediately after the gloves are removed; and

(D) For the purposes of this chapter, hand washing may include the use of alcohol-based waterless hand sanitizers or other antimicrobial agents. If contact with spores, such as C. difficile or bacillus anthracis, has likely occurred, the physical action of washing and rinsing hands with antimicrobial soap and water is the recommended standard precaution.

4723-20-04 Disinfection and sterilization.

An instrument or other reusable equipment used by a licensee or certificate holder who performs or participates in an exposure-prone activity shall be appropriately disinfected and sterilized according to acceptable and prevailing standards for disinfection and sterilization which shall include at least the following:

(A) Equipment and devices that enter a normally sterile area of the body shall be sterilized before being used for each client; and

(B) Equipment and devices that touch an intact mucous membrane but do not penetrate the client's body surfaces shall be sterilized when possible, or undergo high-level disinfection if the equipment or device cannot be sterilized before being used for each client.

(C) A licensee or certificate holder shall use aseptic technique, as appropriate.

4723-20-05 Sharps and waste.

(A) To prevent injury, a licensee or certificate holder performing or participating in an exposure-prone activity shall not recap a needle, or purposely bend or break a needle or other sharp instrument or item by hand.

(B) After a licensee or certificate holder, who is performing or participating in an exposure-prone activity, uses a disposable needle, syringe, scalpel blade or other sharp item, the licensee or certificate holder shall place the disposable sharp item used in a puncture-resistant container for disposal. The puncture-resistant container shall be located as close as practicable to the use area.

(C) In addition to the requirements of this rule, any sharp instrument, needle or contaminated waste shall be handled and disposed in accordance with all requirements established by the licensee or certificate holder's employer, facilities or organizations in which the licensee or certificate holder is providing care, and requirements established for independent providers by the Ohio department of job and family services for the delivery of home care.

4723-20-06 Personal protection equipment.

During the delivery of healthcare, licensees and certificate holders shall follow acceptable and prevailing standards precautions regarding the use of personal protective equipment, including at least the following:

(A) Gloves:

(1) A licensee or certificate holder shall wear disposable gloves when performing or participating in an exposure-prone invasive procedure;

(2) The licensee's or certificate holder's hands shall be washed when gloves are removed;

(3) Before performing or participating in an exposure-prone invasive procedure on
another client, the licensee or certificate holder shall wash hands and reglove with another pair of disposable gloves;

(4) If a glove is torn or a needlestick or other injury occurs, the glove shall be removed and a new glove put on as promptly as client safety permits. The needle or instrument involved in the incident shall be removed from the sterile field;

(B) Masks and protective eyewear. A licensee or certificate holder shall use personal protective equipment such as masks and protective eyewear during patient procedures and activities that are likely to generate splashes or sprays of blood, body fluids and excretions; and

(C) Gowns or aprons. A gown or apron made of material that provides an effective barrier shall be worn by a licensee or certificate holder who is performing or participating in an exposure-prone activity if during the procedure there is a possibility of spattering or splashing of blood or other body fluid.

4723-20-07 Failure to follow universal precautions.

During the delivery of healthcare, a licensee or certificate holder who fails to follow universal and standard precautions when engaging in exposure-prone activity, as set forth in rules 4723-20-01 to 4723-20-06 of the Administrative Code, may be subject to disciplinary action according to section 4723.28 of the Revised Code.

Chemical Dependency

4723.35 Chemical dependency program.

(A) As used in this section, “chemical dependency” means either of the following:

(1) The chronic and habitual use of alcoholic beverages to the extent that the user no longer can control the use of alcohol or endangers the user’s health, safety, or welfare or that of others;

(2) The use of a controlled substance as defined in section 3719.01 of the Revised Code, a harmful intoxicant as defined in section 2925.01 of the Revised Code, or a dangerous drug as defined in section 4729.01 of the Revised Code, to the extent that the user becomes physically or psychologically dependent on the substance, intoxicant, or drug or endangers the user's health, safety, or welfare or that of others.

(B) The board of nursing may abstain from taking disciplinary action under section 4723.28 or 4723.86 of the Revised Code against an individual with a chemical dependency if it finds that the individual can be treated effectively and there is no impairment of the individual's ability to practice according to acceptable and prevailing standards of safe care. The board shall establish a chemical dependency monitoring program to monitor the registered nurses, licensed practical nurses, dialysis technicians, and certified community health workers against whom the board has abstained from taking action. The board shall develop the program, select the program's name, and designate a coordinator to administer the program.

(C) Determinations regarding an individual's eligibility for admission to, continued participation in, and successful completion of the monitoring program shall be made by the board's supervising member for disciplinary matters in accordance with rules adopted under division (D) of this section.

(D) The board shall adopt rules in accordance with Chapter 119 of the Revised Code that establish the following:

(1) Eligibility requirements for admission to and continued participation in the monitoring program;

(2) Terms and conditions that must be met to participate in and successfully complete the program;
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(3) Procedures for keeping confidential records regarding participants;
(4) Any other requirements or procedures necessary to establish and administer the program.

(E)(1) As a condition of being admitted to the monitoring program, an individual shall surrender to the program coordinator the license or certificate that the individual holds. While the surrender is in effect, the individual is prohibited from engaging in the practice of nursing, engaging in the provision of dialysis care, or engaging in the provision of services that were being provided as a certified community health worker.

If the board's supervising member for disciplinary matters determines that a participant is capable of resuming practice according to acceptable and prevailing standards of safe care, the program coordinator shall return the participant's license or certificate. If the participant violates the terms and conditions of resumed practice, the coordinator shall require the participant to surrender the license or certificate as a condition of continued participation in the program. The coordinator may require the surrender only on the approval of the board's supervising member for disciplinary matters.

The surrender of a license or certificate on admission to the monitoring program or while participating in the program does not constitute an action by the board under section 4723.28 or 4723.86 of the Revised Code. The participant may rescind the surrender at any time and the board may proceed by taking action under section 4723.28 or 4723.86 of the Revised Code.

(2) If the program coordinator determines that a participant is significantly out of compliance with the terms and conditions for participation, the coordinator shall notify the board's supervising member for disciplinary matters and the supervising member shall determine whether to temporarily suspend the participant's license or certificate. The board shall notify the participant of the suspension by certified mail sent to the participant's last known address and shall refer the matter to the board for formal action under section 4723.28 or 4723.86 of the Revised Code.

(F) All of the following apply with respect to the receipt, release, and maintenance of records and information by the monitoring program:

(1) The program coordinator shall maintain all program records in the board's office, and for each participant, shall retain the records for a period of two years following the participant's date of successful completion of the program.

(2) When applying to participate in the monitoring program, the applicant shall sign a waiver permitting the board to receive and release information necessary to determine whether the individual is eligible for admission. After being admitted, the participant shall sign a waiver permitting the board to receive and release information necessary to determine whether the individual is eligible for continued participation in the program. Information that may be necessary for the board's supervising member for disciplinary matters to determine eligibility for admission or continued participation in the monitoring program includes, but is not limited to, information provided to and by employers, probation officers, law enforcement agencies, peer assistance programs, health professionals, and treatment providers. No entity with knowledge that the information has been provided to the monitoring program shall divulge that knowledge to any other person.

(3) Except as provided in division (F)(4) of this section, all records pertaining to an individual's application for or participation in the monitoring program, including medical records, treatment records, and mental health records, shall be confidential. The records are not public records for the purposes of section 149.43 of the Revised Code and are not subject to discovery by subpoena or admissible as evidence in any judicial proceeding.

(4) The board may disclose information regarding a participant's progress in the program to any person or government entity that the participant authorizes in writing to be given the
information. In disclosing information under this division, the board shall not include any information that is protected under section 5119.27 of the Revised Code or any federal statute or regulation that provides for the confidentiality of medical, mental health, or substance abuse records.

(G) In the absence of fraud or bad faith, the board as a whole, its individual members, and its employees and representatives are not liable for damages in any civil action as a result of disclosing information in accordance with division (F)(4) of this section. In the absence of fraud or bad faith, any person reporting to the program with regard to an individual's chemical dependence, or the progress or lack of progress of that individual with regard to treatment, is not liable for damages in any civil action as a result of the report.

4723-6-01 Chemical dependency program; definitions.

As used in this chapter:

(A) “Agreement” means a voluntary, written contract between an individual and the board's alternative program for chemical dependency in which the board abstains from taking disciplinary action against the individual for violation of Chapter 4723 of the Revised Code and the individual agrees to be monitored by the board according to the terms and conditions of the program specified in section 4723.35 of the Revised Code, this chapter, and any other terms and conditions determined necessary by the program to ensure that the individual is able to practice in accordance with acceptable standards of safe care.

(B) “Approved treatment program” means an alcoholism or drug treatment program which is either certified by the appropriate state agency or is accredited by the “Joint Commission on Accreditation of Health Care Organizations” or JCAHO.

(C) “Chemical dependency” means either of the following:

(1) The chronic and habitual use of alcoholic beverages to the extent that the user no longer can control the use of alcohol; or the user's health, safety, or welfare or that of others is endangered; or

(2) The use of a drug of abuse, to the extent that the user becomes physically or psychologically dependent on the drug; or the user's health, safety, or welfare or that of others is endangered.

For purposes of section 4723.35 of the Revised Code and Chapter 4723-6 of the Administrative Code, the term “chemical dependency” includes or may otherwise be referred to as a “substance use disorder” to the extent the disorder involves dependency and not abuse.

(D) “Drug of abuse” has the same meaning as in section 3719.011 of the Revised Code, and includes any controlled substance as defined in section 3719.01 of the Revised Code, any harmful intoxicant as defined in section 2925.01 of the Revised Code, or any dangerous drug as defined in section 4729.01 of the Revised Code.

(E) “Person” includes, without limitation, a natural person, a corporation, whether nonprofit or for profit, a partnership, a limited liability company, an unincorporated society or association, or two or more persons having a joint or common interest.

(F) “Practitioner” means a healthcare professional who is authorized by law to prescribe drugs, dangerous drugs, or drug therapy related devices in the course of the professional's practice and is licensed under Chapter 4715., 4723., 4725., 4731., or 4730., of the Revised Code and authorized by law to write prescription's for drugs or dangerous drugs.

(G) “Program” means the unit of the board responsible for administering the alternative program for chemical dependency established by section 4723.35 of the Revised Code.

(H) “Random alcohol and drug screen” means a laboratory or breathalyzer test administered at an irregular interval not known in advance by the individual to be tested to detect the presence of alcohol, drugs of abuse, or other mood altering substances in the individual's body fluids, breath, hair, or nails.
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(I) “Support group” means individuals who hold licenses or certificates issued under Chapter 4723 of the Revised Code who meet regularly to discuss practice issues related to recovery and to provide substance use disorder support for its members.

(J) “Treatment provider” means a licensed healthcare provider, with demonstrated expertise in substance use disorder, who provides alcoholism or drug treatment in an approved treatment program to an individual participating in the alternative program for chemical dependency.

(K) “Twelve-step meeting” means a meeting sponsored by a group such as alcoholics anonymous, narcotics anonymous, or a related organization which addresses substance use disorders and promotes sobriety and recovery through peer group support, self-help, and anonymity, and which is based on an abstinence model of recovery.

4723-6-02 Participation in chemical dependency program.

(A) An individual may participate in the program if the board supervising member for disciplinary matters determines that all of the following conditions are met:

(1) The individual holds a current, valid license to practice nursing as either a registered nurse or a licensed practical nurse in Ohio, or a current, valid certificate or intern certificate to practice as a dialysis technician or community health worker in Ohio;

(2) The individual requests and the board provides the individual a program application, which includes temporary license or surrender form, located at http://www.nursing.ohio.gov/forms.htm (revised 2014). Within ten business days of the date the application was mailed by the board to the individual, the individual submits a completed voluntary temporary license or certificate surrender form to the board;

(3) The individual submits to the program a completed program application within sixty days of the date the application was mailed by the board to the individual. The completed application shall be accompanied by all of the following:

(a) A substance use disorder assessment that:

(i) Includes a bio-psycho-social evaluation performed by a licensed healthcare provider with demonstrated expertise in the treatment of substance use disorders; and

(ii) Documents a diagnosis of substance use disorder and sets forth an organized plan for treatment.

(b) Signed waivers giving the program consent to receive and release information necessary for purposes of determining program eligibility. This includes, but is not limited to, information to and from employers, probation officers, law enforcement agencies, peer assistance programs, and any treatment providers or health care practitioners. No person with knowledge of any information disclosed by the program pursuant to this paragraph shall divulge the information to any other person. The information contained in the completed application shall indicate to the board supervising member for disciplinary matters all of the following:

(i) The individual may be effectively treated for the substance use disorder;

(ii) The individual may be effectively monitored for compliance with program requirements; and

(iii) The individual is not subject to the prohibitions in paragraph (B) of this rule.

(B) An individual may not participate in the program if the board receives information indicating that the individual’s compliance with the program may not be effectively monitored while participating in the program. This information includes, but is not limited to, the following:

(1) The individual is currently using or being prescribed a drug of abuse, as defined in paragraph (D) of rule 4723-6-01 of the Administrative Code;

(2) The individual has a medical and/or psychiatric condition, diagnosis, or disorder, other than a substance use disorder, in which the manifest symptoms are not adequately controlled;
(3) The individual has attempted or completed two or more substance use disorder treatment programs as of the date of the application, not including the individual's current substance use disorder treatment plan and related treatment currently submitted for purposes of program eligibility;

(4) The individual has substituted or tampered with a substance or drug of abuse;

(5) The board has taken action against the individual's license to practice nursing as either a registered nurse or a licensed practical nurse in Ohio or certificate or intern certificate to practice as a dialysis technician or community health worker in Ohio;

(6) A board regulating nurses, dialysis technicians or community health workers in another jurisdiction has taken action against the individual's license to practice nursing as either a registered nurse or a licensed practical nurse in that jurisdiction or certificate or intern certificate to practice as a dialysis technician or community health worker in that jurisdiction;

(7) The individual has completed the program or a similar program in another jurisdiction;

(8) The individual has been terminated from the program or from a similar program in another jurisdiction;

(9) The individual was admitted to, but did not complete or is no longer in good standing, a similar program in another jurisdiction;

(10) The individual has been convicted of, pled guilty to (other than a plea resulting in a finding of eligibility for intervention in lieu of conviction), had a judicial finding of eligibility for diversion for, or had a judicial finding of guilt resulting from a plea of no contest to any felony or an act in another jurisdiction that would constitute a felony in Ohio;

(11) The board determines that the public may not be adequately protected from unsafe practice if the individual enters the program; or

(12) The individual has failed or refused to cooperate with a board investigation.

4723-6-03 Completion of chemical dependency program.

(A) The participant shall enter into an agreement with the program and shall comply with all of the terms and conditions of the participant's agreement for the time period specified in the agreement.

(B) The agreement may include the following:

(1) A requirement that the participant:

(a) Enter substance use disorder treatment in an approved treatment program no later than thirty days from the execution of the agreement; and

(b) Comply with all requirements of the participant's substance use disorder treatment plan;

(2) A requirement that the participant cause the treatment provider to submit documentation acceptable to the program of the participant's compliance with the participant's chemical dependency treatment plan;

(3) A requirement that the participant abstain from the use of alcohol, drugs of abuse, and controlled substances, except for the participant's time limited use of drugs of abuse and controlled substances prescribed by the participant's treating practitioner with knowledge of the participant's substance use disorder and treatment plan;

(4) A requirement that the participant cause all treating healthcare providers who authorize, prescribe or administer medication with respect to the participant, including but not limited to drugs of abuse, to submit documentation regarding the medication to the program, in the manner specified in the agreement;

(5) A requirement that the participant, when using medications according to paragraphs (B)(3) and (B)(4) of this rule, cease working in any position that requires a nursing license or dialysis technician certificate or intern certificate, or as a certified community health worker.
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(6) A requirement that the participant inform any and all treating healthcare practitioners of the participant's substance use disorder and recovery status prior to receiving treatment and prescriptions;

(7) A requirement that the participant cause any and all healthcare practitioners, substance use disorder treatment providers, and counselors to provide progress reports to the program at the intervals specified in the participant's agreement;

(8) A requirement that the participant submit to random alcohol and drug screens when requested by the program, and that the participant comply with all requirements of random alcohol and drug screening as specified in the agreement;

(9) A requirement that the participant attend support, peer group, or twelve-step group meetings as specified in the participant's agreement, and that the participant verify attendance at these meetings by signature of a group leader or meeting representative and submit such signatures to the program using the meeting form provided by the program;

(10) A requirement that the participant comply with the employment restrictions specified by the participant's participatory agreement and terms and conditions of employment as executed at the time of employment approval by the program. The restrictions may include, but are not limited to:

(a) Work schedule restrictions;
(b) Work site supervision restrictions, such as work site monitors;
(c) Restrictions against administering and having access to alcohol or products containing alcohol, excluding topically applied alcohol-based products used for disinfection purposes, controlled substances, and drugs of abuse; and
(d) Practice setting or client restrictions;

(11) A requirement that the participant sign waivers required by division (E) of section 4723.35 of the Revised Code, and that the participant also sign waivers permitting the program to receive or release information necessary to properly facilitate the monitoring of the participant's progress in their recovery from substance use disorder and their compliance with their program requirements. The information may be released to or received from persons, including, but not limited to, employers, probation officers, law enforcement agencies, peer assistance programs, substance use disorder treatment providers, healthcare practitioners, government agencies, or court officials. No person with knowledge of any information disclosed by the program pursuant to this paragraph shall divulge the information to any other person.

(12) A requirement that the participant return to employment in a position that requires a nursing license or dialysis technician certificate or intern certificate, or as a community health worker, while under the terms of the agreement, and continue in that employment, or other employment requiring licensure or certification, for an aggregate period of at least one year of full-time employment, prior to being considered for release from the terms and conditions of the agreement;

(13) A requirement that the participant be responsible for all costs to the participant resulting from the participant's program requirements. All costs incurred by the participant resulting from the participant's participation in the program are wholly between the participant and any person providing the services according to the program requirements. None of the costs incurred by the participant shall be charged to the program and the program assumes no liability for any costs incurred by the participant in paying all costs;

(14) A requirement that the participant submit a written personal report to the program at the intervals specified by the participant's agreement;

(15) A requirement that the participant meet in person with a program representative at the intervals specified by the participant's agreement;

(16) A requirement that the participant obey all federal, state, and local laws and rules including, but not limited to, all laws and rules regulating the practice of nursing or dialysis care in Ohio; and
(17) A requirement that the participant comply with all requirements specified in the participant's agreement that the program determines are necessary to ensure effective monitoring of the participant's compliance with program requirements and that the public is adequately protected from unsafe practice.

4723-6-04 Successful completion of chemical dependency program.

(A) A participant successfully completes the program when the participant complies with the terms and conditions of the program specified in section 4723.35 of the Revised Code, this chapter, and the participant's agreement for the time period specified in the agreement.

(B) When a participant successfully completes the program as indicated in paragraph (A) of this rule, the program shall notify the participant of such successful completion in writing. Once the participant receives this written notification of successful completion from the program, the participant shall no longer be required to comply with the terms and conditions of the program specified in section 4723.35 of the Revised Code, this chapter, and the participant's agreement.

(C) When making a decision regarding disciplinary action for violations of Chapter 4723 of the Revised Code or the rules of the board, the board will be notified by a written communication from board staff, marked as confidential according to division (F) of section 4723.35 of the Revised Code, if the individual who is the subject of proposed board action previously successfully completed the program.

(D) A participant who successfully completes the program shall not be reported to the national council of state boards of nursing's disciplinary data bank or the federally mandated healthcare integrity and protection data bank unless the board imposes disciplinary action against the participant.

4723-6-05 Termination from chemical dependency program.

Participation in the program may be terminated for any of the following reasons:

(A) The participant fails to comply with any of the terms and conditions of the program specified in section 4723.35 of the Revised Code and this chapter;

(B) The participant fails to comply with any provision of the participant's agreement;

(C) The participant is unable to practice according to acceptable and prevailing standards of safe care; or

(D) The program receives information which, after investigation, indicates that the participant may have committed an additional violation of a provision of Chapter 4723 of the Revised Code or any rules of the board.

4723-6-06 Confidentiality.

(A) Admission and ongoing monitoring shall be conducted in a manner that maintains the confidentiality of the individual.

(B) According to division (F)(3) of section 4723.35 of the Revised Code, all records regarding an individual's application to or participation in the program are confidential and are not public records. The records include, but are not limited to:

(1) Medical records;
(2) Substance use disorder records;
(3) Mental health records;
(4) Treatment records;
(5) Reports required by the participant's agreement;
(6) Waivers and releases required by the participant's agreement;
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(7) Alcohol and drug screen results;  
(8) Verification of attendance at support, peer group or twelve-step meetings; and  
(9) Internal program documentation concerning participants in the program, including program assessments and recommendations;  
(10) Applications submitted to the program, records related to review of program eligibility, and participant agreements.

(C) According to division (E)(4) of section 4723.35 of the Revised Code, a participant may authorize in writing the release of information regarding his or her progress in the program.

(D) All program records shall be maintained in a secure storage area for a period of two years following the participant's date of successful completion of the program, or for a period of two years following a determination that an applicant is not eligible for participation.

4723-7-10 Volunteer's certificate.

[Editor’s Note: The “Comment” portion of the following regulation is part of the official provision.]

[Comment: Information regarding the availability and effective date of the materials incorporated by reference in this rule can be found in paragraph (G) of rule 4723-1-03 of the Administrative Code.]

(A) For purposes of division (A)(2) of section 4723.26 of the Revised Code, “expired” means “lapsed” as defined in paragraph (H) of rule 4723-7-01 of the Administrative Code.

(B) An individual who holds a lapsed license to practice, as a licensed practical nurse or registered nurse, or lapsed certificate of authority to practice as an advanced practice registered nurse, issued by the board or by a jurisdiction of the national council of state boards of nursing, may be issued a volunteer's certificate if:

(1) The requirements set forth in section 4723.26 of the Revised Code are met;

(2) The applicant has completed and submitted a “Volunteer’s Certificate Application”; and

(3) The applicant has provided documentation satisfactory to the board of twenty-four contact hours of continuing education, completed in the twenty-four month period immediately before the application date, that meets the requirements of Chapter 4723-14 of the Administrative Code, and includes:

(a) Two contact hours of category A with learning outcomes that address standards of safe practice and nursing delegation;

(b) One contact hour that includes content in patient abuse, patient rights, and professional boundaries;

(c) Two contact hours that include content in the scope of practice of the licensed practical nurse and the registered nurse;

(d) Two contact hours in nursing documentation;

(e) Three contact hours in principles of pain management;

(f) One contact hour that addresses the application of the nursing process and critical thinking related to patient care;

(g) One contact hour that includes content in maintaining patient confidentiality;

(h) Four contact hours in patient assessment and wound care;

(i) Four contact hours in medication administration and preventing medication errors; and

(j) Four contact hours relevant to the nurse’s anticipated practice setting.

(C) No fee shall be charged in order to obtain a volunteer's certificate.

(D) A volunteer's certificate is valid, unless suspended or revoked by the board, for a period of two years from the date the board issues the certificate, and may be renewed according to paragraph (O) of rule 4723-7-09 of the Administrative Code.
(E) An individual holding a current, valid volunteer’s certificate issued by the board:

1. Shall only provide nursing services to indigent and uninsured persons, as defined in section 2305.234 of the Revised Code;
2. Shall not accept any form of remuneration for providing nursing services; and
3. Shall at all times while engaging in nursing practice display identification that clearly identifies the person as holding a volunteer's certificate, and shall not represent themselves as, sign documents as, or use titles indicating that the person is licensed as a licensed practical nurse, registered nurse or advanced practice registered nurse, without also referencing the volunteer's certificate status. Volunteer's certificate status may be abbreviated in nursing documentation as “V.C.”

(F) A certificate holder may place a volunteer's certificate on inactive status by submitting a written request to the board. To reactivate an inactive certificate or reinstate a lapsed certificate, the holder must submit a completed “Volunteer's Reactivation and Reinstatement Application,” with all required records, and provide documentation of continuing education as set forth in paragraph (K) of rule 4723-14-03 of the Administrative Code. If the applicant has been lapsed or inactive for at least five years from the date of the application, the requirements set forth in division (D) of section 4723.24 of the Revised Code must be met in order to be eligible to reactivate or reinstate the certificate.

(G) A certificate holder engaged in active military duty may be eligible for an extension of time to complete continuing education as provided in rule 4723-2-04 of the Administrative Code.

(H) The provisions of section 4723.28 of the Revised Code apply to a volunteer's certificate issued by the board:

1. A volunteer's certificate holder shall be subject to disciplinary action for any of the grounds set forth in section 4723.28 of the Revised Code;
2. A certificate holder who continues to practice nursing in Ohio with a lapsed or inactive certificate, who fails to comply with the scope of practice and other provisions set forth in section 4723.26 of the Revised Code, or who violates the provisions of this rule, shall be subject to disciplinary action according to section 4723.28 of the Revised Code.

4723.43 Advanced practice nurses.

A certified registered nurse anesthetist, clinical nurse specialist, certified nurse-midwife, or certified nurse practitioner may provide to individuals and groups nursing care that requires knowledge and skill obtained from advanced formal education and clinical experience. In this capacity as an advanced practice registered nurse, a certified nurse-midwife is subject to division (A) of this section, a certified registered nurse anesthetist is subject to division (B) of this section, a certified nurse practitioner is subject to division (C) of this section, and a clinical nurse specialist is subject to division (D) of this section.

(A) A nurse authorized to practice as a certified nurse-midwife, in collaboration with one or more physicians, may provide the management of preventive services and those primary care services necessary to provide health care to women antepartally, intrapartally, postpartally, and gynecologically, consistent with the nurse's education and certification, and in accordance with rules adopted by the board of nursing.

No certified nurse-midwife may perform version, deliver breech or face presentation, use forceps, do any obstetric operation, or treat any other abnormal condition, except in emergencies. Division (A) of this section does not prohibit a certified nurse-midwife from performing episiotomies or normal vaginal deliveries, or repairing vaginal tears. A certified nurse-midwife may, in collaboration with one or more physicians, prescribe drugs and therapeutic devices in accordance with section 4723.481 of the Revised Code.
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(B) A nurse authorized to practice as a certified registered nurse anesthetist, with the supervision and in the immediate presence of a physician, podiatrist, or dentist, may administer anesthesia and perform anesthesia induction, maintenance, and emergence, and may perform with supervision preanesthetic preparation and evaluation, postanesthesia care, and clinical support functions, consistent with the nurse’s education and certification, and in accordance with rules adopted by the board.

The physician, podiatrist, or dentist supervising a certified registered nurse anesthetist must be actively engaged in practice in this state. When a certified registered nurse anesthetist is supervised by a podiatrist, the nurse’s scope of practice is limited to the anesthesia procedures that the podiatrist has the authority under section 4731.51 of the Revised Code to perform. A certified registered nurse anesthetist may not administer general anesthesia under the supervision of a podiatrist in a podiatrist’s office. When a certified registered nurse anesthetist is supervised by a dentist, the nurse’s scope of practice is limited to the anesthesia procedures that the dentist has the authority under Chapter 4715 of the Revised Code to perform.

(C) A nurse authorized to practice as a certified nurse practitioner, in collaboration with one or more physicians or podiatrists, may provide preventive and primary care services, provide services for acute illnesses, and evaluate and promote patient wellness within the nurse’s nursing specialty, consistent with the nurse’s education and certification, and in accordance with rules adopted by the board. A certified nurse practitioner may, in collaboration with one or more physicians or podiatrists, prescribe drugs and therapeutic devices in accordance with section 4723.481 of the Revised Code.

When a certified nurse practitioner is collaborating with a podiatrist, the nurse’s scope of practice is limited to the procedures that the podiatrist has the authority under section 4731.51 of the Revised Code to perform.

(D) A nurse authorized to practice as a clinical nurse specialist, in collaboration with one or more physicians or podiatrists, may provide and manage the care of individuals and groups with complex health problems and provide health care services that promote, improve, and manage health care within the nurse’s nursing specialty, consistent with the nurse’s education and in accordance with rules adopted by the board. A clinical nurse specialist may, in collaboration with one or more physicians or podiatrists, prescribe drugs and therapeutic devices in accordance with section 4723.481 of the Revised Code.

When a clinical nurse specialist is collaborating with a podiatrist, the nurse’s scope of practice is limited to the procedures that the podiatrist has the authority under section 4731.51 of the Revised Code to perform.

4723-8-01 Certified nurse practitioners; clinical nurse specialists; definitions.

As used in this chapter:
(A) “Advanced practice registered nurse” means a certified registered nurse anesthetist, clinical nurse specialist, certified nurse-midwife, or certified nurse practitioner as provided in division (O) of section 4723.01 of the Revised Code.
(B) “Certificate of authority” means the certificate issued by the board and held by an advanced practice registered nurse who has fulfilled all requirements of the board set forth in section 4723.41 of the Revised Code and this chapter.
(C) “Certified registered nurse anesthetist” means a registered nurse who has met the requirements of section 4723.41 of the Revised Code, and who holds a current valid certificate of authority issued by the board under section 4723.42 of the Revised Code.
(D) “Clinical nurse specialist” means a registered nurse who has met the requirements of section 4723.41 of the Revised Code, and who holds a current valid certificate of authority issued by the board under section 4723.42 of the Revised Code.
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(E) “Certified nurse-midwife” means a registered nurse who has met the requirements of section 4723.41 of the Revised Code, and who holds a current valid certificate of authority issued by the board under section 4723.42 of the Revised Code.

(F) “Certified nurse practitioner” means a registered nurse who has met the requirements of section 4723.41 of the Revised Code, and who holds a current valid certificate of authority issued by the board under section 4723.42 of the Revised Code.

(G) “Collaboration” or “collaborating” means:

1. In the case of a certified nurse practitioner or a clinical nurse specialist, except as provided in paragraph (G)(2) of this rule, that a podiatrist or physician has entered into a standard care arrangement with the nurse and is continuously available to communicate with the clinical nurse specialist or certified nurse practitioner either in person, or by radio, telephone, or other form of telecommunication;

2. In the case of a clinical nurse specialist whose nursing specialty is mental health or psychiatric mental health, that a physician is continuously available to communicate with the nurse either in person, or by radio, telephone, or other form of telecommunication;

3. In the case of a certified nurse-midwife, that a physician has entered into a standard care arrangement with the nurse and is continuously available to communicate with the nurse either in person, or by radio, telephone, or other form of telecommunication.

(H) “Dentist” means an individual holding a license issued under Chapter 4715 of the Revised Code to practice dentistry, and who is practicing in Ohio.

(I) “Physician” means an individual holding a certificate issued under Chapter 4731 of the Revised Code authorizing the practice of medicine and surgery or osteopathic medicine and surgery, and who is practicing in Ohio.

(J) “Podiatrist” means an individual holding a certificate issued under Chapter 4731 of the Revised Code authorizing the practice of podiatric medicine, and who is practicing in Ohio.

(K) “Standard care arrangement” means a written, formal guide for planning and evaluating a patient's health care that is developed by a collaborating physician or podiatrist and a certified nurse-midwife, certified nurse practitioner, or clinical nurse specialist, and that meets the requirements of section 4723.431 of the Revised Code and this chapter.

(L) “Supervision” means that a certified registered nurse anesthetist is under the direction of a podiatrist, a dentist, or a physician, and, when administering anesthesia, the certified registered nurse anesthetist is in the immediate presence of the podiatrist, dentist, or physician.

4723-8-02 Requirements and scope of practice.

(A) An advanced practice registered nurse shall provide to patients nursing care that requires knowledge and skill obtained from advanced formal education, which includes a clinical practicum, and clinical experience as specified in sections 4723.41 and 4723.43 of the Revised Code and this chapter.

(B) Except as otherwise precluded by law or rule, each advanced practice registered nurse shall practice in accordance with the following:

1. The advanced practice registered nurse’s education and clinical experience;

2. The advanced practice registered nurse's national certification as provided in section 4723.41 of the Revised Code; and

3. Chapter 4723 of the Revised Code and rules adopted under that chapter.

(C) Only a certified nurse-midwife, certified nurse practitioner, or clinical nurse specialist authorized under section 4723.48 of the Revised Code may prescribe drugs.

(D) Each certified nurse-midwife, certified nurse practitioner, and clinical nurse specialist shall utilize and incorporate into the nurse's practice, knowledge of Chapter 4731 of the Revised Code and rules adopted under that chapter that govern the practice of the nurse's collaborating
physician or podiatrist. Each certified registered nurse anesthetist shall utilize and incorporate into the nurse’s practice, knowledge of Chapters 4715 and 4731 of the Revised Code and rules adopted under these chapters that govern the practice of the nurse’s supervising podiatrist, dentist, or physician.

(E) Nothing in this rule precludes an advanced practice registered nurse from practicing as a registered nurse in accordance with section 4723.01 of the Revised Code and the rules of the board.

4723-8-04 Standard care arrangement.

(A) Prior to engaging in practice, a standard care arrangement shall be entered into with each physician or podiatrist with whom the certified nurse-midwife, certified nurse practitioner, or clinical nurse specialist collaborates.

(1) The standard care arrangement shall be revised to reflect the addition or deletion of a physician or podiatrist with whom the nurse collaborates within that employment setting. Under these circumstances, a new standard care arrangement is not necessary.

(2) A new standard care arrangement shall be executed when the nurse is employed at a different setting and engages in practice with a different collaborating physician or podiatrist.

(B) A certified nurse-midwife, certified nurse practitioner, or clinical nurse specialist engaged in the practice of the nurse’s specialty, shall enter into a written standard care arrangement with one or more collaborating physicians or podiatrists whose practice is the same or similar to the nurse’s practice. In accordance with division (D) of section 4723.431 of the Revised Code, a clinical nurse specialist without a certificate to prescribe whose nursing specialty is mental health or psychiatric mental health is not required to enter into a standard care arrangement.

(C) The standard care arrangement shall include at least:

(1) The signatures of each nurse, and each collaborating physician, or the physician’s designated representative, or each podiatrist with whom the certified nurse-midwife, certified nurse practitioner, or clinical nurse specialist primarily collaborates indicating review of and agreement to abide by the terms of the standard care arrangement. For purposes of this rule, a physician’s designated representative means a physician who serves as the department or unit director or chair, within the same institution, organization or facility department or unit, and within the same practice specialty, that the nurse practices, and with respect to whom the physician has executed a legal authorization to enter collaborating agreements on the physician’s behalf;

(2) The date when the arrangement is initially executed;

(3) The date of the most recent review of the arrangement;

(4) The complete name, specialty and practice area, business address, and business phone number or number at which the individual can be reached at any time for:

(a) Each collaborating physician or podiatrist with whom the certified nurse-midwife, certified nurse practitioner, or clinical nurse specialist primarily collaborates and who is a party to the standard care arrangement; and

(b) Each certified nurse-midwife, certified nurse practitioner, or clinical nurse specialist who is a party to the standard care arrangement;

(5) A statement of services offered by the certified nurse-midwife, certified nurse practitioner, or clinical nurse specialist consistent with section 4723.43 of the Revised Code and this chapter. For holders of a certificate to prescribe, there shall also be a description of the scope of prescriptive practice.

(6) A plan for incorporation of new technology or procedures consistent with the applicable scope of practice as set forth in section 4723.43 of the Revised Code and this chapter;
(7) Quality assurance provisions, including at least:
(a) Every two years, review and reapproval of the standard care arrangement. The standard care arrangement shall be reviewed at least every two years. Each nurse who is a party to the arrangement and at least one collaborating physician or podiatrist shall sign and date the biennial review of the standard care arrangement;
(b) Criteria for referral of a patient by the certified nurse-midwife, certified nurse practitioner, or clinical nurse specialist to a collaborating physician or podiatrist, including, for the certified nurse-midwife, a plan for referral of breech or face presentation or any other abnormal condition identified as such in the standard care arrangement;
(c) A process for the certified nurse-midwife, certified nurse practitioner, or clinical nurse specialist to obtain consultation from a physician or podiatrist;
(d) A procedure for regular review of referrals made by the certified nurse-midwife, certified nurse practitioner, or clinical nurse specialist to other health care professionals, and the care outcomes for a representative sample of all patients seen by the nurse; and
(e) A process for chart review in accordance with rule 4723-8-05 of the Administrative Code if the nurse's practice includes any direct patient care, education, or management;
(8) A policy for care of infants up to age one and recommendations for collaborating physician visits for children from birth to age three, if the nurse is providing services to infants;
(9) A plan for coverage of patients in instances of emergency or planned absences of either the certified nurse-midwife, certified nurse practitioner, or clinical nurse specialist, or the collaborating physician or podiatrist;
(10) A process for resolution of disagreements regarding matters of patient management; and
(11) An arrangement regarding reimbursement under the medical assistance program as set forth in Chapter 5162 of the Revised Code and in accordance with any rules adopted under division (B) of section 5164.02 of the Revised Code.
(12) For nurses with a current valid certificate to prescribe, the following quality assurance provisions shall include at least:
(a) Provisions to ensure timely direct, personal evaluation of the patient with a collaborating physician or the physician's designee when indicated;
(b) Additional prescribing parameters for those drugs or therapeutic devices established in the formulary, http://www.nursing.ohio.gov/Practice-CTP.htm (effective 2015), including:
(i) Provisions for use of drugs with non-food and drug administration (FDA) approved indications;
(ii) Provisions for use of drugs approved by the FDA and reviewed by the committee on prescriptive governance subsequent to the date of the standard care arrangement;
(iii) Provisions for use of drugs previously reviewed by the committee on prescriptive governance but approved by the FDA for new indications subsequent to the date of the standard care arrangement; and
(iv) Provisions for the use of schedule II controlled substances.
(v) If the nurse is prescribing to minors, as defined in division (A) of section 3719.061 of the Revised Code, provisions for complying with section 3719.061 of the Revised Code when prescribing an opioid analgesic to a minor; and
(c) A procedure for the nurse and the collaborating physician, or a designated member of a quality assurance committee, composed of at least one physician, of the institution, organization, or agency where the nurse has practiced during the period covered by the review, to conduct a periodic review, at least semiannually, of:
(i) A representative sample of prescriptions written by the nurse;
(ii) A representative sample of schedule II prescriptions written by the nurse; and

(d) Provisions to ensure that the nurse is meeting all the requirements of rule 4723-9-12 of the Administrative Code related to review of a patient's OARRS report, consultation with the collaborating physician prior to prescribing based on the OARRS report and signs of drug abuse or diversion as set forth in rule 4723-9-12 of the Administrative Code, and documentation of receipt and assessment of OARRS report information in the patient's record.

(13) Quality assurance standards consistent with rule 4723-8-05 of the Administrative Code.

(D) The most current copy of the standard care arrangement, and any legal authorization signed by a physician according to paragraph (C)(1) of this rule, shall be retained and be available upon request at each site where practice of the certified nurse-midwife, certified nurse practitioner, or clinical nurse specialist occurs. Upon request of the board, the certified nurse-midwife, certified nurse practitioner, or clinical nurse specialist shall immediately provide a copy of the standard care arrangement to the board.

(E) Copies of previously effective standard care arrangements shall be retained by the nurse for three years and provided to the board upon request.

(F) When a hospital negotiates a standard care arrangement in accordance with division (E) of section 4723.431 of the Revised Code and this chapter, the standard care arrangement shall be developed in accordance with paragraph (C) of this rule. Review and approval of the standard care arrangement shall be in accordance with the policies and procedures of the hospital governing body and the bylaws, policies, and procedures of the hospital medical staff.

(G) A certified nurse-midwife, certified nurse practitioner, or clinical nurse specialist shall notify the board of the identity of a collaborating physician or podiatrist not later than thirty days after engaging in practice.

(H) A certified nurse-midwife, certified nurse practitioner, or clinical nurse specialist shall notify the board of any change in the name and business address of a collaborating physician or podiatrist not later than thirty days after the change takes effect.

(I) A clinical nurse specialist who does not hold a certificate to prescribe and whose nursing specialty is mental health or psychiatric mental health is exempt from the requirement of executing a standard care arrangement in accordance with division (D)(1) of section 4723.431 of the Revised Code. The clinical nurse specialist who does not hold a certificate to prescribe and whose nursing specialty is mental health or psychiatric mental health shall identify one or more physicians with whom the nurse collaborates in accordance with division (D)(1) of section 4723.431 of the Revised Code.

(J) A clinical nurse specialist who holds a certificate to prescribe and whose nursing specialty is mental health or psychiatric mental health shall enter into a standard care arrangement in accordance with division (D)(2) of section 4723.431 of the Revised Code.

4723-8-05 Quality assurance.

(A) A holder of a current valid certificate of authority shall comply with all continuing education requirements for registered nurse license renewal set forth in division (C) of section 4723.24 of the Revised Code and national certification requirements set forth in sections 4723.41 and 4723.42 of the Revised Code and this chapter.

(B) The certified nurse-midwife, certified nurse practitioner, or clinical nurse specialist and the collaborating physician or podiatrist shall jointly review each effective standard care arrangement at least once every two years. Such review shall be documented with the date and signature of each nurse who is party to the arrangement and at least one collaborating physician or podiatrist.

(C) Each certified nurse-midwife, certified nurse practitioner, and clinical nurse specialist who is a party to a standard care arrangement shall comply with all quality assurance provisions
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of the standard care arrangement in accordance with this chapter. Failure to provide, enter into, or to practice in accordance with a standard care arrangement may result in disciplinary action in accordance with section 4723.28 of the Revised Code.

(D) Each practicing advanced practice registered nurse shall participate in a quality assurance process and shall immediately provide documentation satisfactory to the board of such participation upon request of the board. The quality assurance process shall include at a minimum:

(1) Periodic random chart review at least annually by a collaborating or supervising physician, podiatrist, dentist, or a designated member of a quality assurance committee, composed of at least one physician, of the institution, organization, or agency where the nurse has practiced during the period covered by the review. If the nurse holds prescriptive authority, the process shall include a procedure for periodic review, at least semi-annually, of prescriptions written and prescribing patterns for the holder of a certificate to prescribe;

(2) Subsequent to each chart review, a conference shall be held between a collaborating or supervising physician, podiatrist, dentist, or a designated member of a quality assurance committee of the institution, organization, or agency and the advanced practice registered nurse; and

(3) A process for patient evaluation of care.

(E) Documentation of participation in an ongoing, systematic quality assurance process at an institution, organization, or agency shall satisfy the requirements of paragraph (D) of this rule, provided there is a plan to utilize the results of the quality assurance process to maintain or improve care delivery.

(F) Every two years, each certified nurse-midwife, certified nurse practitioner, and clinical nurse specialist shall verify the licensure status of each collaborating physician or podiatrist with whom the nurse has an effective standard care arrangement. Verification of licensure status may be obtained online from the Ohio e-license center. The nurse shall document that such verification was obtained.

(G) The board may audit, review or investigate, at any time, whether an advanced practice registered nurse has complied with the quality assurance standards set forth in this rule.

4723-8-11 Youth concussion assessment and clearance.

(A) For purposes of this rule:

(1) “Interscholastic athletics” means an athletic activity, that is an interscholastic extracurricular activity as defined in section 3313.535 of the Revised Code, that a school or school district sponsors or participates in and that includes participants from more than one school or school district.

(2) “Youth” means an individual between the ages of four and nineteen who participated in youth sports organization or interscholastic athletics and was removed from practice or competition under division (D) of section 3707.511 of the Revised Code or division (D) of section 3313.539 of the Revised Code, based on exhibiting signs, symptoms or behaviors consistent with having sustained a concussion or head injury while participating in practice or competition.

(3) “Youth sports organization” has the same meaning as in section 3707.51 of the Revised Code and means a public or nonpublic entity that organizes an athletic activity in which the athletes are not more than nineteen years of age and are required to pay a fee to participate in the athletic activity or whose cost to participate is sponsored by a business or nonprofit organization.

(4) “Zurich Guidelines” means the “Consensus Statement on Concussion in Sport: the 4th International Conference on Concussion in Sport held in Zurich, November 2012.”
(B) A clinical nurse specialist or certified nurse practitioner may assess and clear a youth to return to practice or competition if all of the following requirements are met:

1. The nurse's specialty must include care and treatment of patients aged four through nineteen years of age and the nurse must collaborate with a physician whose practice includes this age group;

2. The nurse has completed education and training in the detection of concussion, its clinical features, assessment techniques, and the principles of safe return to play protocols consistent with the “Zurich Guidelines”;

3. The nurse has maintained competency and completed continuing education in the detection of concussion, its clinical features, assessment techniques, and the principles of safe return to play protocols consistent with the “Zurich Guidelines”; and


4723-9-10 Formulary; standards of prescribing for advanced practice registered nurses.

(A) Definitions; for purposes of this rule and interpretation of the formulary, located at http://www.nursing.ohio.gov/Practice-Prescribing.htm (effective 2017):

1. “Acute pain” means pain that normally fades with healing, is related to tissue damage and significantly alters a patient's typical function, and is expected to be time-limited.

2. “Extended-release or long-acting opioid analgesic” means an opioid analgesic that:
   a. Has United States food and drug administration approved labeling indicating that it is an extended-release or controlled release formulation;
   b. Is administered via a transdermal route; or
   c. Contains methadone.

3. “Family member” means a spouse, parent, child, sibling or other individual with respect to whom a nurse's personal or emotional involvement may render the nurse unable to exercise detached professional judgment in reaching diagnostic or therapeutic decisions.

4. “Hospice care program” has the same meaning as in section 3712.01 of the Revised Code.

5. “ICD-10-CM code” means the disease code in the most current international classification of diseases, clinical modifications published by the United States department of health and human services.

6. “Opioid analgesic” has the same meaning as in section 3719.01 of the Revised Code, and means a controlled substance that has analgesic pharmacological activity at the opioid receptors of the central nervous system, including but not limited to the following drugs and their varying salt forms or chemical congeners: buprenorphine, butorphanol, codeine (including acetaminophen and other combination products), dihydrocodeine, fentanyl, hydrocodone (including acetaminophen combination products), hydromorphone, meperidine, methadone, morphine sulfate, oxycodone (including acetaminophen, aspirin, and other combination products), oxymorphone, tapentadol, and tramadol.

7. “Minor” has the same meaning as in section 3719.061 of the Revised Code.

8. “Morphine equivalent daily dose (MED)” means a conversion of various opioid analgesics to a morphine equivalent dose by the use of accepted conversion tables provided by the state board of pharmacy at: http://www.pharmacy.ohio.gov.MED (effective 2017).

9. “Palliative care” has the same meaning as in section 3712.01 of the Revised Code.

10. “Terminal condition” has the same meaning as in section 2133.01 of the Revised Code.

(B) The committee on prescriptive governance shall establish a recommended exclusionary formulary, located at http://www.nursing.ohio.gov/Practice-Prescribing.htm (effective 2017), that may specify the exclusion of therapeutic devices, individual drugs or
subtypes or individual drugs.

(C) The recommended exclusionary formulary shall not permit the prescribing or furnishing of any drug or device prohibited by federal or state law, or rules adopted by the board, including this rule.

(D) The formulary established by the committee on prescriptive governance shall be available on the Ohio board of nursing web site, located at http://www.nursing.ohio.gov/Practice-Prescribing.htm (effective 2017).

(E) The committee on prescriptive governance shall review the formulary, located at http://www.nursing.ohio.gov/Practice-Prescribing.htm (effective 2017), for additions or deletions at least twice a year.

(F) A clinical nurse specialist, certified nurse-midwife, or certified nurse practitioner may prescribe any drug or therapeutic device in any form or route of administration if:

(1) The ability to prescribe the drug or therapeutic device is within the scope of practice in the nurse's specialty area;

(2) The prescription is consistent with the terms of a standard care arrangement entered into with a collaborating physician;

(3) The prescription would not exceed the prescriptive authority of the collaborating physician, including restrictions imposed on the physician's practice by action of the United States drug enforcement administration or the state medical board, or by the state medical board rules, including but not limited to rule 4731-11-09 of the Administrative Code;

(4) The individual drug or subtype or therapeutic device is not one excluded by the formulary, located at http://www.nursing.ohio.gov/Practice-Prescribing.htm (effective 2017);

(5) The prescription meets the requirements of state and federal law, including but not limited to this rule, rule 4729-5-30 of the Administrative Code and rule 4729-5-13 of the Administrative Code;

(6) A valid prescriber-patient relationship exists. This relationship may include, but is not limited to:

(a) Obtaining a thorough history of the patient;

(b) Conducting a physical or mental examination of the patient;

(c) Rendering a diagnosis;

(d) Prescribing medication, ruling out the existence of any recognized contraindications;

(e) Consulting with the collaborating physician when necessary; and

(f) Properly documenting these steps in the patient's medical records;

(7) Notwithstanding paragraph (F)(6) of this rule, the nurse may prescribe or personally furnish a drug according to section 4723.4810 of the Revised Code to not more than a total of two individuals who are sexual partners of the nurse's patient.

(8) If the patient is a family member, acceptable and prevailing standards of safe nursing care require that a nurse maintain detached professional judgment. The nurse shall not prescribe to a family member unless:

(a) The nurse is able to exercise detached professional judgment in reaching diagnostic or therapeutic decisions;

(b) The prescription is documented in the patient's record;

(9) For drugs that are a controlled substance:

(a) The nurse has obtained a United States drug enforcement administration registration, except if not required to do so as provided in rule 4729-17-13 of the Administrative Code, and indicates the number on the prescription;

(b) The prescription indicates the ICD-10-CM code of the primary disease or condition that the controlled substance is being used to treat;

(c) The prescription indicates the intended days' supply of the controlled substance prescription. The intended days' supply is calculated by dividing the total quantity prescribed by the maximum intended number of tablets or doses per day;
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(d) The patient is not a family member; and
(e) The nurse shall not self-prescribe a controlled substance.

(G) Except as provided in paragraph (H) of this rule, a clinical nurse specialist, certified nurse-midwife, or certified nurse practitioner may prescribe a schedule II controlled substance only in situations where all of the following apply:

1. A patient has a terminal condition;
2. A physician initially prescribed the substance for the patient; and
3. The prescription is for a quantity that does not exceed the amount necessary for the patient's use in a single, seventy-two hour period.

(H) Subject to the requirements set forth in paragraphs (I) and (J) of this rule, a clinical nurse specialist, certified nurse-midwife, or certified nurse practitioner may prescribe a schedule II controlled substance, if not excluded by the formulary, located at http://www.nursing.ohio.gov/Practice-Prescribing.htm (effective 2017), if the nurse issues the prescription to the patient from any of the following locations:

1. A hospital registered under section 3701.07 of the Revised Code;
2. An entity owned or controlled, in whole or in part, by a hospital or by an entity that owns or controls, in whole or in part, one or more hospitals;
3. A health care facility operated by the department of mental health or the department of developmental disabilities;
4. A nursing home licensed under section 3721.02 of the Revised Code or by a political subdivision certified under section 3721.09 of the Revised Code;
5. A county home or district home operated under Chapter 5155 of the Revised Code that is certified under the medicare or medicaid program;
6. A hospice care program;
7. A community mental health agency, as defined in section 5122.01 of the Revised Code;
8. An ambulatory surgical facility, as defined in section 3702.30 of the Revised Code;
9. A freestanding birthing center, as defined in section 3702.141 of the Revised Code;
10. A federally qualified health center, as defined in section 3701.047 of the Revised Code;
11. A federally qualified health center look-alike, as defined in section 3701.047 of the Revised Code;
12. A health care office or facility operated by the board of health of a city or general health district or the authority having the duties of a board of health under section 3709.05 of the Revised Code;
13. A site where a medical practice is operated, but only if the practice is comprised of one or more physicians who also are owners of the practice; the practice is organized to provide direct patient care; and the clinical nurse specialist, certified nurse-midwife, or certified nurse practitioner providing services at the site has a standard care arrangement and collaborates with at least one of the physician owners who practices primarily at that site; or
14. A residential care facility, as defined in section 3721.01 of the Revised Code.

(I) A clinical nurse specialist, certified nurse-midwife, or certified nurse practitioner shall not issue to a patient a prescription for a schedule II controlled substance from a convenience care clinic even if the clinic is owned or operated by an entity specified in paragraph (H) of this rule.

(J) For the treatment of acute pain, a clinical nurse specialist, certified nurse-midwife, or certified nurse practitioner shall comply with the following:

1. Extended-release or long-acting opioid analgesics shall not be prescribed for the treatment of acute pain;
2. Before prescribing an opioid analgesic, the nurse shall first consider non-opioid treatment options. If opioid analgesic medications are required as determined by history and
physical examination, the prescription should be for the minimum quantity and potency needed to treat the expected duration of pain, with a presumption that a three-day supply or less is frequently sufficient;

(3) In all circumstances where opioid analgesics are prescribed for acute pain:
   (a) Except as provided in paragraph (J)(3)(a)(iii) of this rule, the duration of the first opioid analgesic prescription for the treatment of an episode of acute pain shall be:
      (i) For adults, not more than a seven-day supply with no refills;
      (ii) For minors, not more than a five-day supply with no refills. As set forth in section 4723.481 of the Revised Code, a nurse shall comply with section 3719.061 of the Revised Code, including but not limited to obtaining the parent or guardian's written consent prior to prescribing an opioid analgesic to a minor;
      (iii) The seven-day limit for adults and five-day limit for minors may be exceeded for pain that is expected to persist for longer than seven days based on the pathology causing the pain. In this circumstance, the reason that the limits are being exceeded and the reason that a non-opioid analgesic medication was not appropriate to treat the patient's condition shall be documented in the patient's medical record; and
      (iv) If a patient is intolerant of or allergic to an opioid medication initially prescribed, a prescription for a different opioid medication may be issued at any time during the initial seven-day or five-day dosing period, and the new prescription shall be subject to the requirements of this rule. The patient's intolerance or allergy shall be documented in the patient's medical record, and the patient advised to safely dispose of the unused medication;
   (b) The patient, or a minor's parent or guardian, shall be advised of the benefits and risks of the opioid analgesic, including the potential for addiction, and the advice shall be documented in the patient's medical record; and
   (c) The total morphine equivalent dose (MED) of a prescription for opioid analgesics for treatment of acute pain shall not exceed an average of thirty MED per day.

(K) The requirements of paragraph (J) of this rule apply to treatment of acute pain, and do not apply when an opioid analgesic is prescribed:
   (1) To an individual who is a hospice patient or in a hospice care program;
   (2) To an individual who is receiving palliative care;
   (3) To an individual who has been diagnosed with a terminal condition; or
   (4) To an individual who has cancer or a condition associated with the individual's cancer or history of cancer.

(L) The requirements of paragraph (J) of this rule do not apply to:
   (1) Prescriptions for opioid analgesics for the treatment of opioid addiction utilizing a controlled substance that is approved by the FDA for opioid detoxification or maintenance treatment; or
   (2) Inpatient prescriptions as defined in rule 4729-17-01 of the Administrative Code.

(M) Drugs approved by the FDA but not yet reviewed and approved by the committee on prescriptive governance may be prescribed, unless later disapproved by the committee on prescriptive governance, if:
   (1) The drug type or subtype is not excluded on the formulary, located at http://www.nursing.ohio.gov/Practice.htm (effective 2017); and
   (2) The collaborating physician has agreed in the standard care arrangement that the nurse may prescribe drugs approved by the FDA, that meet the criteria set forth in paragraphs (M)(1) and (M)(2) of this rule, that have not yet been reviewed and approved by the committee on prescriptive governance.

(N) As specified in section 4723.44 of the Revised Code, a clinical nurse specialist, certified nurse-midwife, or certified nurse practitioner shall not prescribe any drug or device to perform or induce an abortion.

(O) As specified in section 4723.488 of the Revised Code, notwithstanding the
requirements of this rule, a clinical nurse specialist, certified nurse-midwife, or certified nurse practitioner may prescribe or personally furnish naloxone.

4723-9-12 Standards and procedures for review of OARRS.

(A) Definitions; for purposes of this rule:
(1) “APRN” means a clinical nurse specialist, certified nurse midwife, or certified nurse practitioner who holds a current, valid certificate to prescribe issued by the board.
(2) “Delegate” means an authorized representative who is registered to obtain an OARRS report on behalf of an APRN.
(3) “OARRS” means the Ohio automated RX reporting system established and maintained according to section 4729.75 of the Revised Code.
(4) “OARRS report” means a report of information related to a specified patient generated by the drug database established maintained by the state board of pharmacy pursuant to section 4729.75 of the Revised Code.
(5) “Reported drugs” means all drugs listed in rule 4729-37-02 of the Administrative Code that are required to be reported to the drug database established and maintained according to section 4729.75 of the Revised Code, including controlled substance schedules II, III, IV and V.

(B) Standards of care: in addition to the requirements set forth in rule 4723-9-08 and rule 4723-9-09 of the Administrative Code, accepted and prevailing standards of care require that when prescribing or personally furnishing a reported drug, an APRN shall taking into account the potential for abuse of the reported drug, the possibility that the reported drug may lead to dependence, the possibility the patient will obtain the reported drug for a nontherapeutic use or distribute it to other persons, and the potential existence of an illicit market for the reported drug. When considering these circumstances in the course of determining whether to prescribe or personally furnish a reported drug to a patient, the APRN shall use sound clinical judgment and consider obtaining and reviewing an OARRS report, consistent with the requirements of this rule.

(C) Red flags: an APRN shall obtain and review an OARRS report when any of the following red flags pertain to the patient:
(1) Selling prescription drugs;
(2) Forging or altering a prescription;
(3) Stealing or borrowing reported drugs;
(4) Increasing the dosage of reported drugs in amounts that exceed the prescribed amount;
(5) Suffering an overdose, intentional or nonintentional;
(6) Having a drug screen result that is inconsistent with the treatment plan or refusing to participate in a drug screen;
(7) Having been arrested, convicted, or received diversion, or intervention in lieu of conviction for a drug-related offense while under the APRN’s care;
(8) Receiving reported drugs from multiple prescribers, without clinical basis;
(9) Traveling with a group of other patients to the APRN’s office, where all or most of the patients request controlled substances prescriptions;
(10) Traveling an extended distance or from out of state to the APRN’s office;
(11) Having a family member, friend, law enforcement officer or health care professional express concern related to the patient’s use of illegal or reported drugs;
(12) A known history of chemical abuse or dependency;
(13) Appearing impaired or overly sedated during an office visit or examination;
(14) Requesting reported drugs by specific name, street name, color, or identifying marks;
(15) Frequently requesting early refills of reported drugs;
(16) Frequently losing prescriptions for reported drugs;
(17) A history of illegal drug use;
(18) Sharing reported drugs with another person; or
(19) Recurring visits to non-coordinated sites of care, such as emergency departments, urgent care facilities, or walk-in clinics to obtain reported drugs.

(D) OARRS review; opioid analgesics and benzodiazepines.

(1) Except as provided in paragraph (G) of this rule, an APRN shall:
(a) Obtain and review an OARRS report before initially prescribing to a patient a reported drug that is an opioid analgesic or benzodiazepine;
(b) If the patient continues to receive opioid analgesics or benzodiazepines for more than ninety days after the initial report is requested, the APRN shall obtain and review OARRS reports for the patient at intervals not exceeding ninety days, determined according to the date the initial request was made, and until the course of treatment has ended; and
(c) In obtaining and reviewing OARRS reports, comply with paragraph (F) of this rule.

(E) OARRS review; reported drugs that are not opioid analgesics or benzodiazepines.

(1) Except as provided in paragraph (G) of this rule, an APRN shall:
(a) Obtain and review an OARRS report following a course of treatment for a period of more than ninety days if the treatment includes the prescribing or personally furnishing of reported drugs that are not opioid analgesics or benzodiazepines;
(b) Obtain and review an OARRS report at least annually thereafter until the course of treatment utilizing these reported drugs has ended; and
(c) In obtaining and reviewing OARRS reports, comply with paragraph (F) of this rule.

(F) OARRS reports; time period; adjoining state: for purposes of paragraphs (C), (D), and (E) of this rule:
(1) OARRS reports may be requested by the APRN's delegate but must be personally reviewed by the APRN;
(2) Receipt and assessment of the OARRS report information, including consultation with the collaborating physician that occurred based on the OARRS report information or as required by paragraph (H) of this rule, shall be documented in the patient record;
(3) Initial reports requested shall cover at least twelve months immediately preceding the date of the request;
(4) If the APRN practices in a county of this state that adjoins another state, the APRN or the APRN's delegate shall also request a report of any information available in the drug database that pertains to prescriptions issued or drugs furnished to the patient in the state adjoining the county; and
(5) If an OARRS report regarding the patient is not available, the APRN shall document in the patient's record the reason that the report is not available and any efforts made in follow-up to obtain the requested information.

(G) OARRS report exceptions: an APRN shall not be required to review and assess an OARRS report when prescribing or personally furnishing a reported drug under the following circumstances, unless the APRN believes or has reason to believe that the patient may be abusing or diverting reported drugs:
(1) The reported drug is prescribed or personally furnished to a hospice patient in a hospice care program as those terms are defined in section 3712.01 of the Revised Code, or any other patient diagnosed as terminally ill;
(2) The reported drug is prescribed for administration in a hospital, nursing home, or residential care facility;
(3) The reported drug is prescribed or personally furnished in an amount indicated for a period not to exceed seven days; or
(4) The reported drug is prescribed for treatment of cancer or another condition
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associated with cancer.

(H) Physician consultation: an APRN who prescribes or personally furnishes a reported
drug to a patient following review of an OARRS report under paragraph (C), (D), or (E) of this
rule, and determines, based on the OARRS report or red flags described in paragraph (C) of
this rule that the patient may be abusing or diverting reported drugs, shall first consult with their
collaborating physician prior to personally furnishing or prescribing a reported drug at the
patient’s next visit.

(1) Consultation shall include and result in:
(a) Review and documentation of the reasons why the APRN believes or has reason to
believe that the patient may be abusing or diverting drugs;
(b) Review and documentation of the patient’s progress toward treatment objectives over
the course of treatment; and
(c) Review and documentation of the functional status of the patient, including activities
for daily living, adverse effects, analgesia and aberrant behavior over the course of treatment.

(2) Consultation may include and result in:
(a) Utilization of a patient treatment agreement that includes more frequent and periodic
review of OARRS reports, more frequent office visits, different treatment options, drug screens,
use of one pharmacy, use of one provider for the prescription or personally furnishing of
reported drugs, and consequences for non-compliance with the terms of the agreement. The
patient treatment agreement shall be maintained as part of the patient record; and
(b) Consultation with or referral to a substance use disorder specialist.

4723-13-01 Delegation; definitions.

For the purposes of this chapter, the following definitions shall apply:

(A) “Board” means the Ohio board of nursing.
(B) “Delegation” means the transfer of responsibility for the performance of a selected
nursing task from a licensed nurse authorized to perform the task to an individual who does not
otherwise have the authority to perform the task.
(C) “Delegating nurse” means the nurse who delegates a nursing task or assumes
responsibility for individuals who are receiving delegated nursing care.
(D) “Dialysis technician” means an individual who holds a current valid certificate issued
under Chapter 4723 of the Revised Code that authorizes the provision of dialysis care.
(E) “Direction” means communicating a plan of care to a licensed practical nurse.
Direction by a registered nurse is not meant to imply the registered nurse is supervising the
licensed practical nurse in the employment context.
(F) “Licensed nurse” means a registered nurse or a licensed practical nurse licensed to
practice nursing in Ohio.
(G) “Medication aide” means an individual who holds a current valid certificate issued
under Chapter 4723 of the Revised Code that authorizes the individual to administer
medications in nursing homes or residential care facilities
(H) “DODD” means the Ohio department of developmental disabilities.
(I) “Nursing tasks” means those activities that constitute the practice of nursing as a
licensed nurse and may include, but are not limited to, assistance with activities of daily living
that are performed to maintain or improve the client’s well-being, when the client is unable to
perform that activity for him or herself.
(J) “Unlicensed person” means an individual, not currently licensed by the board as a
registered nurse or licensed practical nurse, or an individual who does not hold a current valid
certificate to practice as a dialysis technician or administer medications as a medication aide.
4723-13-02 Delegation.

(A) A nursing task may be delegated to an unlicensed person only by a licensed nurse who shall delegate in accordance with this chapter.

(B) Nothing in this chapter shall be construed to prevent any person registered, certified, licensed, or otherwise legally authorized in this state under any law from engaging in the practice for which such person is registered, certified, licensed, or authorized.

“Otherwise legally authorized” may include, but is not limited to, authorization for medication administration pursuant to section 3313.713 of the Revised Code, DODD personnel authorized to perform tasks or activities pursuant to sections 5123.41 to 5123.47 of the Revised Code, and individuals authorized to administer medications or perform tasks pursuant to Title 47 of the Revised Code.

(C) Nothing in this chapter shall prohibit an unlicensed person from assisting an individual who can safely self direct his or her own care, including, helping the individual with self-administration of medications in a facility where the substantial purpose of the setting is other than the provision of health care. An unlicensed person assisting with self-administration of medications may do only the following:

(1) Remind an individual when to take the medication and observe to ensure that the individual follows the directions on the container;

(2) Assist an individual in the self-administration of medication by taking the medication in its container from the area where it is stored and handing the container with the medication in it to the individual. If the individual is physically unable to open the container, the unlicensed person may open the container for the individual;

(3) Assist upon request by or with the consent of, a physically impaired but mentally alert individual, in removing oral or topical medication from the container and in taking or applying the medication. If an individual is physically unable to place a dose of medicine in the individual’s mouth without spilling or dropping it, an unlicensed person may place the dose in another container and place that container to the mouth of the individual; or

(4) Assisting an individual with self-administration does not mean that an unlicensed person can administer medication to an individual, whether orally, by injection, or by any other route.

(D) Nothing in this chapter shall prohibit an unlicensed person from administering medication under the following circumstances:

(1) The giving of oral or the applying of topical medication in accordance with sections 5123.41 to 5123.47 of the Revised Code and in accordance with rules 5123:2-6-01 to 5123:2-6-07 of the Administrative Code;

(2) When medication is administered by an individual employed by a board of education, or a school charted by the state board of education, who has been designated according to section 3313.713 of the Revised Code to administer to a student a drug prescribed by an authorized prescriber; or

(3) In accordance with any other law or rule that authorizes an unlicensed person to administer medications.

4723-13-03 Delegation prohibitions.

(A) No person to whom a nursing task is delegated shall delegate the nursing task to any other person.

(B) An unlicensed person who performs a nursing task and does not comply with all the provisions as set forth in this chapter, and who is not otherwise excepted from licensure pursuant to section 4723.32 of the Revised Code, or otherwise legally authorized, shall be
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engaging in the unauthorized practice of nursing, which is prohibited by section 4723.03 of the Revised Code.

(C) Nothing in this chapter shall be construed to allow an unlicensed person to perform a delegated nursing task on any individual other than the individual specified by the delegating nurse.

4723-13-05 Delegation to a trained unlicensed person.

(A) A registered nurse may delegate a nursing task to an unlicensed person if all the conditions for delegation set forth in this chapter are met.

(B) A licensed practical nurse may delegate to an unlicensed person only at the direction of the registered nurse and if all the conditions for delegation set forth in this chapter are met.

(C) An advanced practice registered nurse may delegate the administration of medication to an unlicensed person in accordance with the requirements set forth in division (C) of section 4723.48 of the Revised Code and section 4723.489 of the Revised Code.

(D) Except as otherwise authorized by law or this chapter, a licensed nurse may delegate to an unlicensed person the administration of only the following medications:

(1) Over-the-counter topical medications to be applied to intact skin for the purpose of improving a skin condition or providing a barrier; and

(2) Over-the-counter eye drop, ear drop, and suppository medications, foot soak treatments, and enemas.

(E) Prior to delegating a nursing task to an unlicensed person, the delegating nurse shall determine each of the following:

(1) That the nursing task is within the scope of practice of the delegating nurse as set forth in section 4723.01 of the Revised Code.

(2) That the nursing task is within the knowledge, skill, and ability of the nurse delegating the nursing task;

(3) That the nursing task is within the training, ability, and skill of the unlicensed person who will be performing the delegated nursing task;

(4) That appropriate resources and support are available for the performance of the task and management of the outcome; and

(5) That adequate and appropriate supervision by a licensed nurse of the performance of the nursing task is available in accordance with rule 4732-13-07 of the Administrative Code.

(F) Prior to delegating a nursing task, the delegating nurse shall:

(1) Identify:

(a) The individual on whom the nursing task may be performed; and

(b) A specific time frame during which the delegated nursing task may be performed.

(2) Complete an evaluation of the conditions that relate to the delegation of the nursing task to be performed, including:
(a) An evaluation of the individual who needs nursing care;
(b) The types of nursing care the individual requires;
(c) The complexity and frequency of the nursing care needed;
(d) The stability of the individual who needs nursing care; and
(e) A review of the evaluations performed by other licensed health care professionals.
(G) The delegating nurse shall be accountable for the decision to delegate nursing tasks to an unlicensed person.
(H) If a licensed nurse determines that an unlicensed person is not correctly performing a delegated nursing task, the licensed nurse shall immediately intervene.

4723-13-06 Teaching a delegable nursing task.

A licensed nurse shall include all of the following when teaching an unlicensed person to perform a nursing task:
(A) Presentation of information on infection control and universal precautions;
(B) Presentation of information and directions on the concepts underlying the nursing task;
(C) Presentation of information and direction on how to correctly perform the specific nursing task according to current standards of practice following step-by-step directions readily available to the unlicensed person;
(D) Demonstration of the nursing task; and
(E) Observation and documentation of a satisfactory return demonstration by the unlicensed person of the nursing task.

4723-13-07 Supervision.

(A) When a licensed nurse delegates a nursing task to an unlicensed person in accordance with this chapter, supervision of the performance of the nursing task by the unlicensed person shall be provided by the delegating nurse. For purposes of this rule, supervision includes initial and ongoing direction, procedural guidance, and evaluation, and may include direct observation of the performance of the nursing task. The delegating nurse shall evaluate the performance by the unlicensed person of the delegated nursing task, the need for further instruction, and the need to withdraw the delegation.
(B) If the substantial purpose of the setting, institution, or agency where a delegated nursing task is being performed is the provision of health care services, the supervision provided by the delegating nurse shall be on-site direct supervision.
(C) If the substantial purpose of the setting, institution, or agency where a delegated nursing task is being performed is other than the provision of health care services, the supervision provided by the delegating nurse may be on-site direct supervision, or indirect supervision provided by the delegating nurse who is always accessible through some form of telecommunication. Prior to the delegation of any nursing task in a setting, institution, or agency where the substantial purpose of the setting, institution, or agency is other than the provision of health care, a registered nurse shall conduct an assessment. The assessment and the following factors shall be used by the delegating nurse to determine the supervision required by the delegating nurse.
   (1) The number of individuals who require nursing care and the health status of the individuals;
   (2) The types and number of nursing tasks that will be delegated;
   (3) The continuity, dependability, and reliability of the unlicensed person who will be performing the delegated nursing task;
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(4) If the delegating nurse is assuming responsibility for more than one setting, the distance between settings, the accessibility of each setting, and any unusual problems that may be encountered in reaching each setting; and
(5) The availability of emergency aid should the nurse be too far from the setting to arrive at the setting in a timely manner.

4723-27-02 Standards of safe medication administration by a certified medication aide.

(A) A certified medication aide shall administer prescription medications only at the delegation of a nurse according to section 4723.67 of the Revised Code, Chapter 4723-13 of the Administrative Code, and this chapter, to residents of nursing homes and residential care facilities.

(B) Except as provided in paragraphs (C) and (D) of this rule, a certified medication aide to whom the task of medication administration is delegated, may administer the following types of prescription medications:
   (1) Oral medications;
   (2) Topical medications;
   (3) Medications administered as nasal spray, or as drops, or ointment to a resident's eye, ear, or nose;
   (4) Rectal and vaginal medications; or
   (5) Inhalants delivered by inhalers, nebulizers, or aerosols, that allow for a single dose of a fixed, pre-measured amount of medication.

(C) A certified medication aide shall not administer medications in the following categories:
   (1) Medications containing a schedule II controlled substance, as defined in section 3719.01 of the Revised Code;
   (2) Medications, including inhalants delivered by inhalers, nebulizers, or aerosols, requiring dosage calculations;
   (3) Medications that are not approved drugs;
   (4) Medications being administered as part of clinical research; or
   (5) Oxygen.

(D) A certified medication aide shall not administer medications by any of the following methods:
   (1) Injection;
   (2) Intravenous therapy procedures;
   (3) Splitting pills for purposes of changing the dose being given; or
   (4) Through jejunostomy, gastrostomy, nasogastric, or oral gastric tubes.

(E) In addition to the prohibitions in paragraphs (C) and (D) of this rule, a certified medication aide shall not:
   (1) Receive, transcribe or alter a medication order;
   (2) Administer the initial dose of a medication ordered for a resident;
   (3) Administer medications to a person other than a resident of a nursing home or residential care facility as provided in paragraph (A) of this rule;
   (4) Administer any medication without the task having been delegated by a nurse;
   (5) Administer medications to pediatric residents; or
   (6) Access schedule II controlled substances.

(F) A certified medication aide shall maintain knowledge of the duties, responsibilities, and accountabilities of a certified medication aide and shall act in accordance with the laws pertaining to the administration of medication by a certified medication aide as set forth in Chapter 4723 of the Revised Code and the rules adopted under that chapter.

(G) A certified medication aide shall display the title "certified medication aide” at all
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times when administering medications to residents of a nursing home or residential care facility.

(H) A certified medication aide shall demonstrate competence and accountability in the task of medication administration, including appropriate recognition, referral, and consultation with the delegating nurse.

(I) Immediately after administering a medication, a certified medication aide shall accurately document in the resident's record, the following information:

(1) The name of the medication and the dosage administered;
(2) The route of administration;
(3) The date and time of administration;
(4) The name of the certified medication aide administering the medication; and
(5) Refusal by a resident to comply with medication administration.

(J) A certified medication aide shall implement measures to promote a safe environment for nursing home or residential care facility residents.

(K) A certified medication aide shall take measures to ensure the safety of the resident including but not limited to:

(1) Reporting to a nurse in a timely manner all of the following:
   (a) The potential need of a resident for the administration of an as-needed medication, as evidenced by an expression of discomfort from the resident or other indication;
   (b) Refusal by a resident to comply with medication administration;
   (c) Any deviation from the delegated medication administration;
   (d) Any unanticipated reaction by the resident to the medication administration; or
   (e) Anything about the condition of a resident that should cause concern to the certified medication aide.

(2) Preparing and storing medications in accordance with instructions of the manufacturer or the pharmacist;

(3) Removing medications only from a dispensed and properly labeled container that includes all of the following:
   (a) Medication name;
   (b) Medication dose;
   (c) Name of the resident to whom the medication is dispensed, unless:
      (i) The medication is a contingency drug stored and supplied in accordance with Chapter 4729-17 of the Administrative Code and is supplied to the certified medication aide by the delegating nurse; or
      (ii) Medication that is available over the counter and bears the original manufacturer's label and has been purchased and prescribed for the resident;
   (d) Expiration date of the medication;
   (4) Verifying the identity of the resident to whom the medication is to be administered;
   (5) Witnessing the resident swallowing an oral medication that is to be ingested, or otherwise taking a medication in accordance with its prescribed route;
   (6) Immediately documenting and reporting medication errors to a nurse;
   (7) Utilizing only the medication delivery process currently in use in the nursing home or residential care facility; and
   (8) Administering medications in accordance with standards set forth in the medication aide training curriculum established according to division (B)(6) of section 4723.69 of the Revised Code and this chapter.

(L) A certified medication aide shall not accept a resident care assignment that would interrupt or conflict with the administration of medications or the performance of other tasks and activities that are directly related to the administration of medications. A certified medication aide may perform other resident care activities during such times that the certified medication aide is not engaged in, or scheduled to be engaged in, the administration of medications.

(M) A certified medication aide shall maintain the confidentiality of resident information.
obtained in the course of the certified medication aide's duties and responsibilities, shall access resident information only for purposes of resident care or for otherwise fulfilling the aide's assigned job responsibilities, and shall not disseminate resident information for purposes other than resident care or for otherwise fulfilling the aide's assigned job responsibilities through social media, texting, emailing, or any other form of communication.

(N) A certified medication aide to whom the administration of medication has been delegated shall not delegate the task of medication administration to any other person.

(O) A certified medication aide shall not falsify any resident record or any other document prepared or utilized in the course of, or in conjunction with, the administration of medications.

(P) A certified medication aide shall delineate, establish, and maintain professional boundaries with each resident.

(Q) At all times when a certified medication aide is administering medications to residents in a nursing home or residential care facility the certified medication aide shall:
   1. Take reasonable measures to assure the privacy of the resident; and
   2. Treat each resident with courtesy, respect, and with full recognition of dignity and individuality.

(R) A certified medication aide shall not:
   1. Engage in behavior that causes or may cause physical, verbal, mental, or emotional abuse to a resident; or
   2. Engage in behavior toward a resident that may reasonably be interpreted as physical, verbal, mental, or emotional abuse.

(S) A certified medication aide shall not misappropriate a resident's property or:
   1. Engage in behavior to seek or obtain personal gain at the expense of a resident or that may reasonably be interpreted as behavior to seek or obtain personal gain at the expense of a resident; or
   2. Engage in behavior that constitutes inappropriate involvement in the personal relationships of a resident or that may reasonably be interpreted as inappropriate involvement in the personal relationships of a resident.

   For purposes of this paragraph, the resident is always presumed incapable of giving free, full, or informed consent to the behaviors by the certified medication aide set forth in this paragraph.

(T) A certified medication aide shall not:
   1. Engage in sexual conduct with a resident or conduct that may reasonably be interpreted as sexual; or
   2. Engage in any verbal behavior that is seductive or sexually demeaning to a resident, or that may reasonably be interpreted as seductive, or sexually demeaning to a resident.

   For purposes of this paragraph, the resident is always presumed incapable of giving free, full, or informed consent to sexual activity with a certified medication aide.

(U) A certified medication aide shall not make any false, misleading or deceptive statements, or submit or cause to be submitted any false, misleading, or deceptive information, or documentation to:
   1. The board or any representative of the board;
   2. Current employers;
   3. Prospective employers for positions requiring certification as a medication aide;
   4. Facilities in which, or organizations for whom, the medication aide is working a temporary or agency assignment;
   5. Other members of the client's health care team; or
   6. Law enforcement personnel.

   For purposes of paragraphs (P), (Q), (R), (S), and (T) of this rule, a certified medication aide shall not use social media, texting, emailing, or other forms of communication.
with, or about, a resident, for non-health care purposes or for purposes other than fulfilling the aide’s assigned job responsibilities.

4723-27-03 Delegation of medication administration to certified medication aides.

(A) A registered nurse or a licensed practical nurse acting at the direction of a registered nurse, who provides nursing care to residents in nursing homes or residential care facilities, may delegate the task of medication administration to a certified medication aide according to section 4723.67 of the Revised Code, Chapter 4723-13 of the Administrative Code, and this chapter.

(B) A registered nurse may delegate the administration of medications to a certified medication aide only if the registered nurse holds a current, valid license issued under Chapter 4723 of the Revised Code that is not subject to restrictions relating to the administration of medications imposed under section 4723.28 of the Revised Code, or imposed by agreement entered under section 4723.282 or 4723.35 of the Revised Code.

(C) A licensed practical nurse, acting at the direction of a registered nurse, may delegate the administration of medications to a certified medication aide only if all of the following apply:

1. The registered nurse at whose direction the licensed practical nurse is delegating the administration of medications is authorized to delegate the administration of medications to a certified medication aide according to paragraph (B) of this rule;
2. The licensed practical nurse is authorized to administer medications according to division (F)(3) of section 4723.01 of the Revised Code; and
3. The licensed practical nurse holds a current, valid license issued under Chapter 4723 of the Revised Code that is not subject to restrictions relating to the administration of medications imposed under section 4723.28 of the Revised Code, or imposed by agreement entered under section 4723.282 or 4723.35 of the Revised Code.

(D) A nurse who delegates to a certified medication aide responsibility for the administration of prescription medications to residents in nursing homes or residential care facilities shall not withdraw the delegation on an arbitrary basis or for any purpose not related to resident safety.

(E) Prior to delegating the task of medication administration to a certified medication aide, a nurse shall evaluate the following:

1. The resident and the medication needs of the resident, including:
   a. The resident's mental and physical stability;
   b. The medication to be administered;
   c. The timeframe during which the medication is to be administered;
   d. The route or method by which the medication is to be administered; and
2. The ability of the certified medication aide to safely administer the medication being delegated.

(F) When delegating the task of medication administration to a certified medication aide, the nurse shall communicate the following:

1. The residents to whom the certified medication aide shall administer medications;
2. The medications the certified medication aide shall administer;
3. The timeframes during which the medications are to be administered; and
4. Any special instructions concerning the administration of medications to specific residents.

(G) A nurse who is on site may delegate the administration of as-needed medications to a certified medication aide if:

1. A registered nurse has completed a nursing assessment of the resident to whom the as-needed medication is to be administered;
2. A nursing regimen based on the nursing assessment is established that contains
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interventions including the administration of the as-needed medication according to the medication order;
(3) The nurse determines the resident's need for the medication based on information collected from sources that include but are not limited to:
   (a) Direct observation of the resident;
   (b) The nursing regimen established for the resident;
   (c) The resident's record; and
(4) The nurse determines the as-needed medication may be safely administered by the certified medication aide.

(H) If a nurse is not on site, the nurse may delegate the administration of as-needed medications to a certified medication aide if:
   (1) A registered nurse has completed a nursing assessment of the resident to whom the as-needed medication is to be administered;
   (2) A nursing regimen based on the nursing assessment is established that contains interventions including the administration of the as-needed medication according to the medication order;
   (3) A nurse is immediately available by telecommunication and determines the resident's need for the medication based on but not limited to the following:
       (a) Current knowledge of the resident's health status and the resident's nursing regimen;
       (b) The resident's record; and
       (c) Data conveyed by the certified medication aide who is directly engaged in the administration of medications to the resident.
   (4) The as-needed medication is available for over the counter purchase; and
   (5) The nurse determines the as-needed medication may be safely administered by the certified medication aide.

(I) In a nursing home or residential care facility that utilizes certified medication aides, a nurse remains responsible for all of the following:
   (1) Reviewing the medication delivery process to assure there have been no errors in stocking or preparing the medications;
   (2) Accepting, transcribing, and reviewing resident medication orders;
   (3) Monitoring residents to whom medications are administered for side effects or changes in health status; and
   (4) Reviewing documentation completed by a certified medication aide, including the medication administration record.

(J) A nurse shall supervise the certified medication aides as follows:
   (1) In a nursing home, a nurse shall provide on-site supervision of a certified medication aide.
   (2) In a residential care facility, supervision of a certified medication aide shall be provided by a nurse who is either on-site or is immediately and continuously available through some form of telecommunication.

(K) A nurse may not delegate the administration of prescription medications in the following categories, by the following routes, or under the following circumstances, to a certified medication aide:
   (1) Medications containing a schedule II controlled substance, as defined in section 3719.01 of the Revised Code;
   (2) Medications, including inhalants delivered by inhalers, nebulizers, or aerosols, requiring dosage calculations;
   (3) Medications that are not approved drugs;
   (4) Medications being administered as part of clinical research;
   (5) Administration of medications via injection;
   (6) Administration of medications via intravenous therapy procedures;
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(7) Administration of medications via splitting pills for purposes of changing the dose being given;
(8) Administration of medications through jejunostomy, gastrostomy, nasogastric, or oral gastric tubes;
(9) Administration of medications to pediatric residents;
(10) Administration of the initial dose of any medication ordered for a resident;
(11) Administration of oxygen.

A registered nurse or a licensed practical nurse acting at the direction of a registered nurse, who delegates the administration of medications to a certified medication aide according to section 4723.67 of the Revised Code and this chapter, shall not be liable in damages to any person or government entity in a civil action for injury, death, or loss to person or property that allegedly arises from an action or omission of the certified medication aide in the administration of the medications.

4723-27-04 Certification as a medication aide.

[Editor's Note: The “Comment” portion of the following regulation is part of the official provision.]

[Comment: Information regarding the availability and effective date of the materials incorporated by reference in this rule can be found in paragraph (G) of rule 4723-1-03 of the Administrative Code.]

(A) To be issued a medication aide certificate the following requirements must be met:
(1) The applicant must be at least eighteen years of age;
(2) The applicant must have a high school diploma or a high school equivalence diploma as described in section 5107.40 of the Revised Code;
(3) If the applicant is to function as a certified medication aide in a nursing home, the applicant must be a nurse aide who satisfies the requirements of division (A)(1), (A)(2), (A)(3), (A)(4), (A)(5), (A)(6), or (A)(8) of section 3721.32 of the Revised Code;
(4) If the applicant is to function as a certified medication aide in a residential care facility the applicant must be either:
   (a) A nurse aide who satisfies the requirements of division (A)(1), (A)(2), (A)(3), (A)(4), (A)(5), (A)(6), or (A)(8) of section 3721.32 of the Revised Code; or
   (b) The applicant must have at least one year of direct care experience in a residential care facility;
(5) The applicant must submit a completed "Medication Aide Application";
(6) The board must receive the results of a criminal records check conducted according to section 4723.091 of the Revised Code that indicates the individual is not ineligible for certification as specified in section 4723.092 of the Revised Code;
(7) The applicant is not required to register under Chapter 2950 of the Revised Code or a substantially similar law of another state, the United States, or another country;
(8) The board must receive written verification that the applicant has successfully completed an approved medication aide training program, and documentation indicating applicant passed a board approved examination. The minimum passing grade on the written component of a board-approved examination shall be eighty per cent. A student must successfully complete each of the skills evaluation tasks included in the clinical component of a board-approved examination in order to pass; and
(9) The applicant shall submit to the board the fee for a medication aide certificate required by paragraph (A)(1) of rule 4723-27-10 of the Administrative Code.

(B) The holder of a medication aide certificate who is not a state tested nurse aide but who qualifies for a medication aide certificate under paragraph (A)(4)(b) of this rule, may only function as a certified medication aide in residential care facilities.
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(1) If the certificate holder has, following certification, satisfied the requirements of division (A)(1), (A)(2), (A)(3), (A)(4), (A)(5), (A)(6), or (A)(8) of section 3721.32 of the Revised Code, the holder may submit documentation to the board and a written request that the holder’s certification be amended to allow the holder to function as a medication aide in nursing home facilities or residential care facilities.

(2) If the board determines that the certificate holder has submitted valid documentation, the board shall amend website verification to reflect the amended status of the certificate holder.

(C) Medication aide certificates shall be renewed biennially according to rule 4723-27-05 of the Administrative Code, and shall be valid from May first of even numbered years until April thirtieth of the following even numbered year.

(D) If a medication aide certificate is issued by the board on or after February first of an even numbered year, the certificate shall be valid, unless the certificate is made inactive or if disciplinary action has rendered it invalid, through April thirtieth of the next even numbered year.

(E) An individual who holds a current, valid medication aide certificate issued by the board under section 4723.651 of the Revised Code and this chapter, may use the title “medication aide-certified” and the initials “MA-C.”

(F) If an applicant fails to meet the requirements for certification within one year of receipt of their application, the application is void and the fee forfeited. The application form shall state the circumstances under which this forfeiture may occur.

(G) The board shall not endorse applicants who have been licensed or certified as medication aides in jurisdictions other than Ohio.

4723-27-05 Renewal of a medication aide certificate.

[Editor’s Note: The “Comment” portion of the following regulation is part of the official provision.]

[Comment: Information regarding the availability and effective date of the materials incorporated by reference in this rule can be found in paragraph (G) of rule 4723-1-03 of the Administrative Code.]

(A) Medication aide certificates shall be renewed biennially on or before April thirtieth of even numbered years.

(1) The board shall provide access to an on-line “Medication Aide Renewal Application,” to every holder of a current, valid certificate, except when the board is aware that the individual may be ineligible for certificate renewal for any reason, including those reasons set forth in section 4723.092 of the Revised Code.

(2) To renew a medication aide certificate, a holder of a current, valid certificate shall:

(a) Submit a completed “Medication Aide Renewal Application”;

(b) Submit the renewal fee required by rule 4723-27-10 of the Administrative Code; and

(c) Verify successful completion of the continuing education requirements set forth in rule 4723-27-06 of the Administrative Code.

(B) A certified medication aide with a current, valid certificate who does not intend to practice as a medication aide in Ohio may request that the certificate be placed on inactive status at any time by submitting to the board a written statement or electronic request asking that the certificate be placed on inactive status.

(C) If a medication aide certificate is not renewed by April thirtieth of each even numbered year and the certificate holder fails by that time to request that the certificate be placed on inactive status, the certificate shall lapse.

(D) If a medication aide certificate is inactive or lapsed for two years or less, the board may reactivate or reinstate the certificate if the individual submits to the board within two years from the date the certificate was made inactive or lapsed, all of the following:

(1) A completed “Medication Aide Reactivation and Reinstatement Application”;
(2) The applicable fee set forth in paragraph (A) of rule 4723-27-10 of the Administrative Code; and

(3) Documentation of successful completion of the continuing education requirements for renewal of a certified medication aide required by rule 4723-27-06 of the Administrative Code.

(E) If a medication aide certificate is inactive or lapsed for more than two years, it shall not be reactivated or reinstated unless the applicant submits to the board all of the following:

(1) A completed “Medication Aide Reactivation and Reinstatement Application”;

(2) The applicable fee set forth in paragraph (A) of rule 4723-27-10 of the Administrative Code; and

(3) Written verification from an approved medication aide training program that the applicant has, within six months prior to submission of the application, successfully completed the medication aide training program.

(F) A certificate holder who has placed a medication aide certificate on inactive status is not required to pay a renewal fee unless the holder seeks to reactivate the certificate. If the certificate holder placed a certificate on inactive status on or after March first of the year in which the certificate was to be renewed, and then notifies the board on or before April thirtieth of the same renewal year of the intent to reactivate, the certificate holder must still pay the late processing fee required by paragraph (A)(3) of rule 4723-27-10 of the Administrative Code.

(G) During the time that an individual's certification as a medication aide is either inactive or lapsed, the holder may not administer medications as a certified medication aide.

(H) An individual who administers medications as a certified medication aide or represents to the public that the individual holds a current valid medication aide certificate, who has failed to renew a medication aide certificate issued under this chapter, or while the certificate is under suspension, inactive or lapsed, may be subject to disciplinary action under rule 4723-27-09 of the Administrative Code.

(I) A medication aide certificate holder who is a service member or veteran, as defined in rule 4723-2-01 of the Administrative Code, or who is the spouse or surviving spouse of a service member or veteran, may be eligible for a waiver of the late application fee and the reinstatement fee according to rule 4723-2-03 of the Administrative Code.

### 4723-27-10 Fees.

(A) The board may impose fees in accordance with division (B)(1) of section 4723.69 of the Revised Code, including the following:

(1) For applications to obtain a medication aide certificate, fifty dollars;

(2) For biennial renewal of a medication aide certificate submitted on or before March first of even numbered years, fifty dollars;

(3) For biennial renewal of a medication aide certificate submitted after March first and before May first of even numbered years, one-hundred dollars;

(4) Except as provided in section 5903.10 of the Revised Code, for reinstatement of a lapsed medication aide certificate, one hundred dollars;

(5) For reactivation of an inactive medication aide certificate, fifty dollars;

(6) For verification of a medication aide certificate to another jurisdiction, fifteen dollars;

(7) For providing a replacement copy of a medication aide certificate suitable for framing, twenty-five dollars;

(8) For applications for approval to operate a medication aide training program, one thousand dollars;

(9) For applications for re-approval of a medication aide training program, five hundred dollars; or

(10) For processing a check returned to the board by a financial institution for insufficient funds, twenty-five dollars.
(B) All payments of fees shall be in the form required by the board.
(C) Except for duplicate payments, all fees are nonrefundable.
(D) An applicant whose initial payment is returned to the board before the renewal deadline may reissue payment to the board without jeopardizing the status of the applicant's certificate.

**Practice Intervention and Improvement Program**

**4723-18-01 Practice Intervention and Improvement program; definitions.**

As used in this chapter:

(A) “Certificate holder” means an individual holding either:

1. A current, valid certificate of authority issued by the board to practice as a certified nurse-midwife, certified nurse practitioner, certified registered nurse anesthetist, or clinical nurse specialist;

2. A current, valid certificate issued by the board to provide dialysis care as a dialysis technician.

(B) “Educational intervention” means the following:

1. One or more learning activities that meet the requirements of rule 4723-18-06 of the Administrative Code, with content and objectives that address a participant's prescribed learning needs;

2. An activity with content and objectives that meet a participant's prescribed learning needs provided by the participant's employer through a registered nurse who meets the qualifications set forth in rule 4723-18-06 of the Administrative Code.

(C) “Employer” means any person for whom a participant works, or may work in the future, or any institution that grants practice privileges enabling an individual to practice at the institution, while participating in the practice intervention and improvement program.

(D) “Licensee” means any individual holding a current valid license issued by the board to practice nursing as a registered nurse or licensed practical nurse.

(E) “Participant” means a licensee or certificate holder undergoing a remedial process in the practice intervention and improvement program.

(F) “Participatory agreement” means a voluntary, written contract between an individual and the board's practice intervention and improvement program (PIIP) in which the board abstains from taking disciplinary action against an individual for violation of Chapter 4723 of the Revised Code and the individual agrees to be monitored by the board and remediated according to the terms and conditions of the program. The participatory agreement includes, but is not limited to, the following:

1. Stipulation by the individual to one or more identified practice deficiencies;

2. Agreement of the individual to completion of the remediation process required by the board;

3. Authorization by the individual to the release of records and information to PIIP by employers, workplace monitors and other parties involved in the individual's remediation process; and

4. Acknowledgment by the individual that their failure to comply with the terms and conditions of the participatory agreement will result in disciplinary action by the board.

(G) “Practice intervention and improvement program” or "PIIP" means the program authorized by section 4723.282 of the Revised Code that allows the board to abstain from taking disciplinary action against a licensee or certificate holder, who has a practice deficiency that has been identified by the board through an investigation conducted under section 4723.28 of the Revised Code.
(H) “Practice deficiency” means a practice activity that does not meet acceptable and prevailing standards of safe nursing care as set forth in Chapter 4723-4 of the Administrative Code, Chapter 4723-8 of the Administrative Code, Chapter 4723-9 of the Administrative Code, or the acceptable and prevailing standards of safe dialysis care set forth in Chapter 4723-23 of the Administrative Code.

(I) “Remediation” means a prescribed educational intervention that is designed to correct an individual's identified practice deficiency. Remediation includes, but is not limited to, successful demonstration by the individual that the learned knowledge and skills have been incorporated into the individual's practice.

(J) “Supervising member” means the board member elected to serve as the supervising member for disciplinary matters in accordance with section 4723.02 of the Revised Code.

(K) “Workplace monitor” means the individual who observes and evaluates, for a specified time period, the practice of a participant in PIIP to determine whether the participant has incorporated applicable learned knowledge and skills into workplace practice.

4723-18-02 Practice deficiency.

(A) The board shall investigate, according to section 4723.28 of the Revised Code, evidence that appears to show that a licensee or certificate holder has failed to practice in accordance with acceptable and prevailing standards of safe care as set forth in Chapter 4723-4 of the Administrative Code, Chapter 4723-8 of the Administrative Code, Chapter 4723-9 of the Administrative Code, or Chapter 4723-23 of the Administrative Code.

(B) The supervising member shall review the evidence obtained during the investigation to determine whether the individual's identified practice deficiency can be corrected through participation in the practice intervention and improvement program (PIIP) rather than through formal disciplinary action. Criteria to use when making this determination include, but are not limited to, the following:

1. Whether the public will be adequately protected from unsafe practice if the individual enters PIIP;
2. Whether the individual's practice deficiency resulted in harm or other untoward outcome for the patient;
3. The likelihood that the identified practice deficiency at issue is a deficiency that can be corrected through remediation;
4. The extent of the individual's cooperation with the board during the investigation;
5. Whether the individual's identified practice deficiency represented an intentional or willful commission or omission by the individual;
6. The frequency of the occurrence of the identified practice deficiency;
7. The adverse impact of the identified practice deficiency on others;
8. Whether the identified practice deficiency affected a particularly vulnerable patient;
9. Whether the individual is eligible for participation in PIIP as specified in rule 4723-18-03 of the Administrative Code; and
10. Whether the individual has a mental or physical impairment that contributed to the practice deficiency.

(C) When the supervising member has reason to believe, after an investigation and review of evidence, that the individual's identified practice deficiency can be successfully corrected through participation in PIIP, the board may abstain from taking disciplinary action provided the individual enters into an agreement with PIIP according to rule 4723-18-04 of the Administrative Code, complies with the terms and conditions of PIIP, and successfully completes PIIP.
4723-18-03 Eligibility requirements for participation.

An individual may participate in the practice intervention and improvement program if the supervising member determines that the public will be adequately protected from unsafe practice if the individual enters PIIP, and:

(A) The individual has not been the subject of formal disciplinary action by any regulatory board or entity located in Ohio or in another jurisdiction, unless the supervising member determines that the previous disciplinary action was for a violation that should not preclude participation in PIIP;

(B) The individual is not concurrently under investigation by the board for a violation of Chapter 4723 of the Revised Code or the rules of the board that does not constitute a practice deficiency;

(C) The supervising member determines that the nature of the individual's identified practice deficiency is such that it may be corrected through remediation;

(D) The individual holds a current valid, license or certificate issued by the board;

(E) The individual is otherwise eligible to renew the license or certificate issued by the board;

(F) At the time of PIIP eligibility determination by the supervising member, the individual is working in a position in the state of Ohio, whether as an employee or contractor, that requires a nursing license, if the individual is a licensed nurse, or a dialysis technician certificate, if the individual is a dialysis technician; and

(G) If the board has ordered the individual to submit to a mental or physical examination according to division (G) of section 4723.28 of the Revised Code, the supervising member has determined that the individual does not have any impairment as defined in rule 4723-3-02 of the Administrative Code.

4723-18-04 Participatory agreement.

(A) When an individual has been determined by the supervising member to be eligible for the practice intervention and improvement program, the individual shall execute a participatory agreement with PIIP that includes, but is not limited to, provisions that:

(1) Set forth the identified practice deficiencies;

(2) Identify the specific remediation including educational interventions the participant must complete;

(3) Specify the time frame for the participant to submit to PIIP copies of the educational intervention content and objectives that demonstrate it fulfills the prescribed education intervention requirements;

(4) Require the participant to pay all expenses the participant incurs as a result of the required remediation;

(5) Require the participant to provide the participatory agreement to a manager, or a person with administrative responsibilities equivalent to or higher than a manager, for all of the participant's employers or contracting entities with respect to which the participant provides nursing or dialysis care, and provide documentation to the board of the manager's receipt of the participatory agreement;

(6) Require a participant who is the holder of a certificate of authority issued under section 4723.41 of the Revised Code to provide a copy of the participatory agreement to the following, and submit documentation to the board of their receipt:

(a) The credentialing body of each institution at which the certificate holder provides advanced practice registered nursing services or nursing care;

(b) Each collaborating physician with whom the certificate holder works as a clinical nurse specialist, certified nurse practitioner, or certified nurse midwife;
(7) Require the participant to participate in workplace monitoring; 
(8) Require the participant to cooperate with any entity, including the educational 
provider and workplace monitor; 
(9) Require the participant to cause all workplace monitors, selected according to 
paragraph (B) of rule 4723-18-08 of the Administrative Code, and educational providers, 
selected according to rule 4723-18-06 of the Administrative Code, to provide remediation and to 
send written progress reports regarding the participant's progress in remediation to PIIP at 
specified intervals; 
(10) Require the participant to sign all waivers necessary to secure all reports required 
by PIIP; 
(11) Require the participant to submit a written personal progress report containing the 
information required by PIIP to PIIP at specified intervals; 
(12) Require the participant to meet in person with a PIIP representative at specified 
intervals; 
(13) Require the participant to obey all federal, state, and local laws, including all laws 
and rules regulating nursing practice or dialysis care in Ohio; 
(14) Specify that the prescribed educational intervention cannot be used to satisfy the 
continuing education requirements set forth in Chapter 4723 of the Revised Code and the rules 
of the board; 
(15) Specify the terms and conditions the participant must meet to successfully complete 
the remediation, including the time frames for successfully completing both the educational 
intervention and workplace monitoring components of the remediation; and 
(16) Set forth the grounds for termination from PIIP. 
(B) An individual determined by the supervising member to be eligible for PIIP who 
refuses to enter into the participatory agreement set forth in this rule within the time frame 
specified by PIIP may be subject to disciplinary action according to section 4723.28 of the 
Revised Code. 

4723-18-05 Termination from the PIIP. 

(A) A participant may be terminated from PIIP for any of the following: 
(1) Failure to comply with any term of the participatory agreement entered into by the 
participant; 
(2) Receipt of evidence from an employer educational intervention provider indicating 
that the participant has failed to progress through or to successfully complete the prescribed 
educational intervention in the manner and during the time frame prescribed by the supervising 
member; 
(3) Receipt of evidence from the workplace monitor indicating that the participant has 
failed to incorporate learned knowledge and skills into practice or has continued to demonstrate 
the practice deficiency; 
(4) Failure to complete the remediation including the educational intervention; or 
(5) Failure to maintain eligibility for PIIP. 
(B) When a licensee or certificate holder is terminated from PIIP for one of the reasons 
specified in paragraph (A) of this rule, the board shall proceed with disciplinary action according 
to section 4723.28 of the Revised Code. The board may consider an individual's termination 
from PIIP when determining the sanction to be imposed.
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4723-18-06 Requirements for educational providers.

(A) The practice intervention and improvement program shall utilize educational interventions that contain content and objectives that meet the participant's learning needs as prescribed by the supervising member.
(B) An educational intervention shall be one of the following:
   (1) A continuing education activity that meets the requirements of Chapter 4723-14 of the Administrative Code;
   (2) An activity conducted by a national certifying organization approved by the board according to section 4723.46 of the Revised Code;
   (3) A course provided by a post-secondary educational institution that is approved, authorized or registered by the board, the Ohio board of regents, the Ohio department of education, the state board of career colleges and schools, or a substantially similar authorizing body in another jurisdiction, for which academic credit is awarded to the participant; or
   (4) An activity that is provided by the participant's employer through an employed or contracted registered nurse who holds a master's degree and has at least two years experience in nursing education or adult education.
(C) According to section 4723.021 of the Revised Code, an entity that provides services related to remediation, including but not limited to a participant's educational intervention shall not be held liable in damages to any person as the result of any act, omission, proceeding, conduct, or decision related to official duties undertaken or performed pursuant to this chapter.
(D) Educational intervention shall not be used for purposes of satisfying the participant's continuing education requirements.

4723-18-07 Educational intervention.

(A) An individual shall be notified in writing of a determination by the supervising member that their identified practice deficiency may be remediated through participation in the practice intervention and improvement program.
(B) In order to participate in PIIP, an eligible licensee or certificate holder shall enter into the participatory agreement set forth in rule 4723-18-04 of the Administrative Code.
(C) The participant shall notify PIIP in writing of the educational intervention selected within the time frame specified in the participatory agreement. The written notification shall include a copy of the learning activity's content and objectives that demonstrate it meets the prescribed educational intervention requirements.
(D) When the participant's educational intervention is provided by an employer through an employed or contracted registered nurse, the participant shall provide the registered nurse with a copy of the participatory agreement and provide PIIP with documentation of the registered nurse's receipt of the agreement.
(E) The participant shall provide documentation acceptable to PIIP that all educational interventions have been successfully completed within the specified timeframe.
(F) According to rule 4723-18-08 of the Administrative Code, PIIP shall establish workplace monitoring requirements that a participant must meet in order to demonstrate that the learned knowledge and skills have been incorporated into the participant's practice and shall notify the participant and the participant's workplace monitor in writing of these requirements.
(G) Upon receipt of evidence that the participant has failed to successfully complete the remediation, PIIP shall immediately notify the supervising member.

4723-18-08 Monitoring of participant.

(A) A PIIP participant shall be monitored by PIIP to determine whether the participant
satisfactorily demonstrates that the learned knowledge and skills have been incorporated into
the participant's practice.

(B) A participant, in collaboration with his or her employer, shall identify one or more
individuals who meet the requirements of paragraph (D) of this rule who will act as a workplace
monitor of the participant's nursing or dialysis care.

(C) The workplace monitor shall:
   (1) As directed by PIIP, observe specific aspects of the participant's practice at the
       intervals identified by PIIP;
   (2) Evaluate specific aspects of the participant's practice and report to PIIP whether that
       practice, with respect to the identified practice deficiency, meets acceptable and prevailing
       standards of safe nursing care set forth in Chapter 4723-4 of the Administrative Code, Chapter
       4723-8 of the Administrative Code or Chapter 4723-9 of the Administrative Code, or the
       acceptable and prevailing standards of safe dialysis care set forth in Chapter 4723-23 of the
       Administrative Code;
   (3) Report the participant's progress in remediation to PIIP at the intervals required by
       PIIP; and
   (4) Maintain the confidentiality of the participant's participation in PIIP and of all records
       associated with the participant's remediation.

(D) A workplace monitor shall meet the following requirements:
   (1) When monitoring a licensed nurse the workplace monitor shall be a registered nurse
       with a current, valid license;
   (2) When monitoring an advanced practice registered nurse holding a certificate of
       authority issued under section 4723.41 of the Revised Code for an identified practice deficiency,
       the workplace monitor shall be an advanced practice registered nurse with a current, valid
       certificate of authority issued under section 4723.41 of the Revised Code, or a holder of a
       current, valid license issued under Chapter 4731 of the Revised Code to practice medicine and
       surgery or osteopathic medicine and surgery, or podiatric medicine and surgery;
   (3) When monitoring a dialysis technician, the workplace monitor shall be a registered
       nurse with a current, valid license or a holder of a current, valid license issued under Chapter
       4731 of the Revised Code to practice medicine and surgery or osteopathic medicine and
       surgery.

(E) In addition to meeting the requirements of paragraph (D) of this rule, a workplace
monitor shall:
   (1) Have no disciplinary action imposed on their license or certificate, or any disciplinary
       action with respect to a similar license or certificate issued by another jurisdiction;
   (2) Be in a position that enables the monitor to directly observe the participant's clinical
       performance;
   (3) Have a minimum of five years experience as a registered nurse, advanced practice
       registered nurse, physician, or podiatrist; and
   (4) Cooperate with the participant and PIIP to meet the requirements set forth in the
       participatory agreement entered into by the participant and PIIP.

(F) When the individual to be monitored is a licensed practical nurse, the workplace
monitor may direct a licensed practical nurse to observe specific tasks related to the identified
practice deficiency and to report those observations to the monitor.

(G) When the individual to be monitored is a dialysis technician, the workplace monitor
may direct an Ohio certified dialysis technician or licensed practical nurse to observe specific
tasks related to the identified practice deficiency and to report those observations to the monitor.

(H) For purposes of providing the remediation directed by the supervising member, a
workplace monitor shall be considered a representative of the board and, according to section
4723.021 of the Revised Code, shall not be held liable in damages to any person as the result
of any act, omission, proceeding, conduct, or decision related to official duties undertaken or
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performed pursuant to this chapter.

4723-18-09 Successful completion of PIIP.

(A) An individual eligible for the practice intervention and improvement program shall enter into a participatory agreement, as set forth in rule 4723-18-04 of the Administrative Code, and shall comply with all of the terms and conditions set forth in the agreement.

(B) A participant shall provide or cause to be provided all of the following to PIIP:

(1) Written verification acceptable to PIIP that the participant has successfully completed the educational intervention prescribed by the supervising member; and

(2) Written verification from a workplace monitor who meets the requirements set forth in rule 4723-18-08 of the Administrative Code that, at the time of verification with respect to the identified practice deficiency, the participant's practice meets the acceptable and prevailing standards of safe nursing care set forth in Chapter 4723-4 of the Administrative Code, Chapter 4723-8 of the Administrative Code, or Chapter 4723-9 of the Administrative Code, or the acceptable and prevailing standards of safe dialysis care set forth in Chapter 4723-23 of the Administrative Code.

(C) Upon receipt of the documents required by paragraph (B) of this rule, the supervising member shall review all information relevant to the participant's remediation to determine whether the participant's practice as a licensed nurse or dialysis technician meets the acceptable and prevailing standards of safe nursing care set forth in Chapter 4723-4 of the Administrative Code, Chapter 4723-8 of the Administrative Code, or Chapter 4723-9 of the Administrative Code, or the acceptable and prevailing standards of safe dialysis care set forth in Chapter 4723-23 of the Administrative Code.

(D) When the supervising member determines that the participant's identified practice deficiency has been sufficiently corrected so as to meet the acceptable and prevailing standards of safe care, the supervising member shall notify the participant in writing that remediation has been successfully completed and participation in PIIP is completed.

(E) When making a decision regarding disciplinary action for violations of Chapter 4723 of the Revised Code or the rules of the board, the board will be notified by written communication from board staff, marked as confidential according to division (D) of section 4723.282 of the Revised Code if the individual who is the subject of proposed board action previously successfully completed PIIP.

(F) A participant who successfully completes PIIP shall not be reported to the national council of state boards of nursing's disciplinary data bank or the federally mandated national practitioner data bank unless the board imposes disciplinary action against the participant.

(G) When the supervising member determines that remediation has not occurred or the participant has otherwise violated the terms and conditions of the participatory agreement, the board shall proceed with disciplinary action in accordance with section 4723.28 of the Revised Code.

4723-18-10 Confidentiality.

(A) Information and records obtained by the practice intervention and improvement program pursuant to an investigation conducted in accordance with section 4723.28 of the Revised Code shall be confidential and are not public records pursuant to division (I) of section 4723.28 of the Revised Code.

(B) All records regarding an individual's participation in PIIP are confidential and are not public records pursuant to division (I) of section 4723.28 of the Revised Code and division (D) of section 4723.282 of the Revised Code.
(C) All employers providing educational intervention and workplace monitors selected to provide remediation by a participant in PIIP shall, as representatives of the board, maintain the confidentiality of all records regarding the participant’s remediation.

(D) All PIIP records maintained by the board shall be kept in a secure storage area according to the board’s record retention schedule.

(E) Notwithstanding paragraphs (A) and (B) of this rule, PIIP may prepare public reports setting forth in general terms statistical information regarding the program as requested by the board.

Part II. Physician Assistants

[Editor’s Note: Complete statutes and regulations governing physician assistants are available at www.med.ohio.gov.]

4730.01 Physician assistants; definitions.

As used in this chapter:

(A) “Physician” means an individual who is authorized under Chapter 4731 of the Revised Code to practice medicine and surgery, osteopathic medicine and surgery, or podiatric medicine and surgery.

(B) “Health care facility” means any of the following:

(1) A hospital registered with the department of health under section 3701.07 of the Revised Code;

(2) A health care facility licensed by the department of health under section 3702.30 of the Revised Code;

(3) Any other facility designated by the state medical board in rules adopted pursuant to division (B) of section 4730.08 of the Revised Code.

(C) “Service” means a medical activity that requires training in the diagnosis, treatment, or prevention of disease.

4730.02 Requirements.

(A) No person shall hold that person out as being able to function as a physician assistant, or use any words or letters indicating or implying that the person is a physician assistant, without a current, valid license to practice as a physician assistant issued pursuant to this chapter.

(B) No person shall practice as a physician assistant without the supervision, control, and direction of a physician.

(C) No person shall practice as a physician assistant without having entered into a supervision agreement with a supervising physician under section 4730.19 of the Revised Code.

(D) No person acting as the supervising physician of a physician assistant shall authorize the physician assistant to perform services if either of the following is the case:

(1) The services are not within the physician’s normal course of practice and expertise;

(2) The services are inconsistent with the supervision agreement under which the physician assistant is being supervised, including, if applicable, the policies of the health care facility in which the physician and physician assistant are practicing.

(E) No person practicing as a physician assistant shall prescribe any drug or device to perform or induce an abortion, or otherwise perform or induce an abortion.

(F) No person shall advertise to provide services as a physician assistant, except for the
purpose of seeking employment.

(G) No person practicing as a physician assistant shall fail to wear at all times when on duty a placard, plate, or other device identifying that person as a “physician assistant.”

4730.08 Practice requirements.

(A) A license to practice as a physician assistant issued under this chapter authorizes the holder to practice as a physician assistant as follows:

(1) The physician assistant shall practice only under the supervision, control, and direction of a physician with whom the physician assistant has entered into a supervision agreement under section 4730.19 of the Revised Code.

(2) The physician assistant shall practice in accordance with the supervision agreement entered into with the physician who is responsible for supervising the physician assistant, including, if applicable, the policies of the health care facility in which the physician assistant is practicing.

(B) The state medical board may, subject to division (D) of section 4730.06 of the Revised Code, adopt rules designating facilities to be included as health care facilities that are in addition to the facilities specified in divisions (B)(1) and (2) of section 4730.01 of the Revised Code. Any rules adopted shall be adopted in accordance with Chapter 119 of the Revised Code.

4730.14 License renewal.

(A) A license to practice as a physician assistant shall expire biennially and may be renewed in accordance with this section. A person seeking to renew a license to practice as a physician assistant shall, on or before the thirty-first day of January of each even-numbered year, apply for renewal of the license. The state medical board shall provide renewal notices at least one month prior to the expiration date.

Applications shall be submitted to the board in a manner prescribed by the board. Each application shall be accompanied by a biennial renewal fee of two hundred dollars. The board shall deposit the fees in accordance with section 4731.24 of the Revised Code.

The applicant shall report any criminal offense that constitutes grounds for refusing to issue a license to practice under section 4730.25 of the Revised Code to which the applicant has pleaded guilty, of which the applicant has been found guilty, or for which the applicant has been found eligible for intervention in lieu of conviction, since last signing an application for a license to practice as a physician assistant.

(B) To be eligible for renewal of a license, an applicant is subject to all of the following:

(1) The applicant must certify to the board that the applicant has maintained certification by the national commission on certification of physician assistants or a successor organization that is recognized by the board by meeting the standards to hold current certification from the commission or its successor, including completion of continuing medical education requirements and passing periodic recertification examinations;

(2) Except as provided in division (F) of this section and section 5903.12 of the Revised Code, the applicant must certify to the board that the applicant has completed during the current licensure period not less than one hundred hours of continuing medical education acceptable to the board.

(3) The applicant must comply with the renewal eligibility requirements established under section 4730.49 of the Revised Code that pertain to the applicant.

(C) The board shall adopt rules in accordance with Chapter 119 of the Revised Code specifying the types of continuing medical education that must be completed to fulfill the board's requirements under division (B)(2) of this section. Except when additional continuing medical
education is required, as specified in section 4730.49 of the Revised Code, the board shall not adopt rules that require a physician assistant to complete in any licensure period more than one hundred hours of continuing medical education acceptable to the board. In fulfilling the board's requirements, a physician assistant may use continuing medical education courses or programs completed to maintain certification by the national commission on certification of physician assistants or a successor organization that is recognized by the board if the standards for acceptable courses and programs of the commission or its successor are at least equivalent to the standards established by the board.

(D) If an applicant submits a complete renewal application and qualifies for renewal pursuant to division (B) of this section, the board shall issue to the applicant a renewed license to practice as a physician assistant.

(E) The board may require a random sample of physician assistants to submit materials documenting certification by the national commission on certification of physician assistants or a successor organization that is recognized by the board and completion of the required number of hours of continuing medical education.

(F) The board shall provide for pro rata reductions by month of the number of hours of continuing education that must be completed for individuals who are in their first licensure period, who have been disabled due to illness or accident, or who have been absent from the country. The board shall adopt rules, in accordance with Chapter 119 of the Revised Code, as necessary to implement this division.

(G)(1) A license to practice that is not renewed on or before its expiration date is automatically suspended on its expiration date. Continued practice after suspension of the license shall be considered as practicin

(H) If an individual certifies that the individual has completed the number of hours and type of continuing medical education required for renewal or reinstatement of a license to practice as a physician assistant, and the board finds through a random sample conducted under division (E) of this section or through any other means that the individual did not complete the requisite continuing medical education, the board may impose a civil penalty of not more than five thousand dollars. A civil penalty imposed under this division may be in addition to or in lieu of any other action the board may take under section 4730.25 of the Revised Code. The board shall deposit civil penalties in accordance with section 4731.24 of the Revised Code. The board shall not conduct an adjudication under Chapter 119 of the Revised Code if the board imposes only a civil penalty.
4730.19 Medical board approval of plan.

(A) Before initiating supervision of one or more physician assistants licensed under this chapter, a physician shall enter into a supervision agreement with each physician assistant who will be supervised. A supervision agreement may apply to one or more physician assistants, but, except as provided in division (B)(2)(e) of this section, may apply to not more than one physician. The supervision agreement shall specify that the physician agrees to supervise the physician assistant and the physician assistant agrees to practice under that physician's supervision.

The agreement shall clearly state that the supervising physician is legally responsible and assumes legal liability for the services provided by the physician assistant. The agreement shall be signed by the physician and the physician assistant.

(B) A supervision agreement shall include either or both of the following:

(1) If a physician assistant will practice within a health care facility, the agreement shall include terms that require the physician assistant to practice in accordance with the policies of the health care facility.

(2) If a physician assistant will practice outside a health care facility, the agreement shall include terms that specify all of the following:

(a) The responsibilities to be fulfilled by the physician in supervising the physician assistant;

(b) The responsibilities to be fulfilled by the physician assistant when performing services under the physician's supervision;

(c) Any limitations on the responsibilities to be fulfilled by the physician assistant;

(d) The circumstances under which the physician assistant is required to refer a patient to the supervising physician;

(e) If the supervising physician chooses to designate physicians to act as alternate supervising physicians, the names, business addresses, and business telephone numbers of the physicians who have agreed to act in that capacity.

(C)(1) The supervising physician shall submit a copy of each supervision agreement to the board. The board may review the supervision agreement at any time for compliance with this section and for verification of licensure of the supervising physician and the physician assistant. All of the following apply to the submission and review process:

(a) If the board reviews a supervision agreement, the board shall notify the supervising physician of any way that the agreement fails to comply with this section.

(b) A supervision agreement becomes effective at the end of the fifth business day after the day the board receives the agreement unless the board notifies the supervising physician that the agreement fails to comply with this section.

(c) If a physician receives a notice under division (C)(1)(a) of this section, the physician may revise the supervision agreement and resubmit the agreement to the board. The board may review the agreement as provided in division (C)(1) of this section.

(D) A supervision agreement expires two years after the day it takes effect. The agreement may be renewed by submitting a copy of it to the board.

Before expiration, a supervision agreement may be amended by including one or more additional physician assistants. An amendment to a supervision agreement shall be submitted to the board for review in the manner provided for review of an initial agreement under division (C)(1) of this section. The amendment does not alter the agreement's expiration date.

(E)(1) The board may impose a civil penalty of not more than one thousand dollars if it finds through a review conducted under this section or through any other means either of the following:
(a) That a physician assistant has practiced in a manner that departs from, or fails to conform to, the terms of a supervision agreement entered into under this section;
(b) That a physician has supervised a physician assistant in a manner that departs from, or fails to conform to, the terms of a supervision agreement entered into under this section.
(2) The board's finding under division (A)(1) of this section shall be made pursuant to an adjudication conducted under Chapter 119 of the Revised Code. A civil penalty imposed under that division may be in addition to or in lieu of any other action the board may take under section 4730.25 or 4731.22 of the Revised Code.

4730.20 Physician assistant services.

(A) A physician assistant licensed under this chapter may perform any of the following services authorized by the supervising physician that are part of the supervising physician's normal course of practice and expertise:
(1) Ordering diagnostic, therapeutic, and other medical services;
(2) Prescribing physical therapy or referring a patient to a physical therapist for physical therapy;
(3) Ordering occupational therapy or referring a patient to an occupational therapist for occupational therapy;
(4) Taking any action that may be taken by an attending physician under sections 2133.21 to 2133.26 of the Revised Code, as specified in section 2133.211 of the Revised Code;
(5) Determining and pronouncing death in accordance with section 4730.202 of the Revised Code;
(6) Assisting in surgery;
(7) If the physician assistant holds a valid prescriber number issued by the state medical board and has been granted physician-delegated prescriptive authority, ordering, prescribing, personally furnishing, and administering drugs and medical devices;
(8) Any other services that are part of the supervising physician's normal course of practice and expertise.
(B) The services a physician assistant may provide under the policies of a health care facility are limited to the services the facility authorizes the physician assistant to provide for the facility. A facility shall not authorize a physician assistant to perform a service that is prohibited under this chapter. A physician who is supervising a physician assistant within a health care facility may impose limitations on the physician assistant's practice that are in addition to any limitations applicable under the policies of the facility.

4730.21 Physician supervisor's duties.

(A) The supervising physician of a physician assistant exercises supervision, control, and direction of the physician assistant. A physician assistant may practice in any setting within which the supervising physician has supervision, control, and direction of the physician assistant.
    In supervising a physician assistant, all of the following apply:
    (1) The supervising physician shall be continuously available for direct communication with the physician assistant by either of the following means:
        (a) Being physically present at the location where the physician assistant is practicing;
        (b) Being readily available to the physician assistant through some means of telecommunication and being in a location that is a distance from the location where the physician assistant is practicing that reasonably allows the physician to assure proper care of patients.
    (2) The supervising physician shall personally and actively review the physician
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assistant's professional activities.

(3) The supervising physician shall ensure that the quality assurance system established pursuant to division (F) of this section is implemented and maintained.

(4) The supervising physician shall regularly perform any other reviews of the physician assistant that the supervising physician considers necessary.

(B) A physician may enter into supervision agreements with any number of physician assistants, but the physician may not supervise more than three physician assistants at any one time. A physician assistant may enter into supervision agreements with any number of supervising physicians.

(C) A supervising physician may authorize a physician assistant to perform a service only if the physician is satisfied that the physician assistant is capable of competently performing the service. A supervising physician shall not authorize a physician assistant to perform any service that is beyond the physician's or the physician assistant's normal course of practice and expertise.

(D) In the case of a health care facility with an emergency department, if the supervising physician routinely practices in the facility's emergency department, the supervising physician shall provide on-site supervision of the physician assistant when the physician assistant practices in the emergency department. If the supervising physician does not routinely practice in the facility's emergency department, the supervising physician may, on occasion, send the physician assistant to the facility's emergency department to assess and manage a patient. In supervising the physician assistant's assessment and management of the patient, the supervising physician shall determine the appropriate level of supervision in compliance with the requirements of divisions (A) to (C) of this section, except that the supervising physician must be available to go to the emergency department to personally evaluate the patient and, at the request of an emergency department physician, the supervising physician shall go to the emergency department to personally evaluate the patient.

(E) Each time a physician assistant writes a medical order, including prescriptions written in the exercise of physician-delegated prescriptive authority, the physician assistant shall sign the form on which the order is written and record on the form the time and date that the order is written.

(F)(1) The supervising physician of a physician assistant shall establish a quality assurance system to be used in supervising the physician assistant. All or part of the system may be applied to other physician assistants who are supervised by the supervising physician. The system shall be developed in consultation with each physician assistant to be supervised by the physician.

(2) In establishing the quality assurance system, the supervising physician shall describe a process to be used for all of the following:

(a) Routine review by the physician of selected patient record entries made by the physician assistant and selected medical orders issued by the physician assistant;
(b) Discussion of complex cases;
(c) Discussion of new medical developments relevant to the practice of the physician and physician assistant;
(d) Performance of any quality assurance activities required in rules adopted by state medical board pursuant to any recommendations made by the physician assistant policy committee under section 4730.06 of the Revised Code;
(e) Performance of any other quality assurance activities that the supervising physician considers to be appropriate.

(3) The supervising physician and physician assistant shall keep records of their quality assurance activities. On request, the records shall be made available to the board.
4730.22 Physician assistants; liability.

(A) When performing authorized services, a physician assistant acts as the agent of the physician assistant's supervising physician. The supervising physician is legally responsible and assumes legal liability for the services provided by the physician assistant. The physician is not responsible or liable for any services provided by the physician assistant after their supervision agreement expires or is terminated.

(B) When a health care facility permits physician assistants to practice within that facility or any other health care facility under its control, the health care facility shall make reasonable efforts to explain to each individual who may work with a particular physician assistant the scope of that physician assistant's practice within the facility. The appropriate credentialing body within the health care facility shall provide, on request of an individual practicing in the facility with a physician assistant, a copy of the facility's policies on the practice of physician assistants within the facility and a copy of each supervision agreement applicable to the physician assistant.

An individual who follows the orders of a physician assistant practicing in a health care facility is not subject to disciplinary action by any administrative agency that governs that individual's conduct and is not liable in damages in a civil action for injury, death, or loss to person or property resulting from the individual's acts or omissions in the performance of any procedure, treatment, or other health care service if the individual reasonably believed that the physician assistant was acting within the proper scope of practice or was relaying medical orders from a supervising physician, unless the act or omission constitutes willful or wanton misconduct.

4730.26 Board investigations.

(A) The state medical board shall investigate evidence that appears to show that any person has violated this chapter or a rule adopted under it. In an investigation involving the practice or supervision of a physician assistant pursuant to the policies of a health care facility, the board may require that the health care facility provide any information the board considers necessary to identify either or both of the following:

1. The facility's policies for the practice of physician assistants within the facility;
2. The services that the facility has authorized a particular physician assistant to provide for the facility.

(B) Any person may report to the board in a signed writing any information the person has that appears to show a violation of any provision of this chapter or rule adopted under it. In the absence of bad faith, a person who reports such information or testifies before the board in an adjudication conducted under Chapter 119 of the Revised Code shall not be liable for civil damages as a result of reporting the information or providing testimony. Each complaint or allegation of a violation received by the board shall be assigned a case number and be recorded by the board.

(C) Investigations of alleged violations of this chapter or rules adopted under it shall be supervised by the supervising member elected by the board in accordance with section 4731.02 of the Revised Code and by the secretary as provided in section 4730.33 of the Revised Code. The president may designate another member of the board to supervise the investigation in place of the supervising member. A member of the board who supervises the investigation of a case shall not participate in further adjudication of the case.

(D) In investigating a possible violation of this chapter or a rule adopted under it, the board may administer oaths, order the taking of depositions, issue subpoenas, and compel the attendance of witnesses and production of books, accounts, papers, records, documents, and testimony, except that a subpoena for patient record information shall not be issued without
consultation with the attorney general's office and approval of the secretary and supervising member of the board. Before issuance of a subpoena for patient record information, the secretary and supervising member shall determine whether there is probable cause to believe that the complaint filed alleges a violation of this chapter or a rule adopted under it and that the records sought are relevant to the alleged violation and material to the investigation. The subpoena may apply only to records that cover a reasonable period of time surrounding the alleged violation.

On failure to comply with any subpoena issued by the board and after reasonable notice to the person being subpoenaed, the board may move for an order compelling the production of persons or records pursuant to the Rules of Civil Procedure.

A subpoena issued by the board may be served by a sheriff, the sheriff's deputy, or a board employee designated by the board. Service of a subpoena issued by the board may be made by delivering a copy of the subpoena to the person named therein, reading it to the person, or leaving it at the person's usual place of residence. When the person being served is a physician assistant, service of the subpoena may be made by certified mail, restricted delivery, return receipt requested, and the subpoena shall be deemed served on the date delivery is made or the date the person refuses to accept delivery.

A sheriff's deputy who serves a subpoena shall receive the same fees as a sheriff. Each witness who appears before the board in obedience to a subpoena shall receive the fees and mileage provided for under section 119.094 of the Revised Code.

(E) All hearings and investigations of the board shall be considered civil actions for the purposes of section 2305.252 of the Revised Code.

(F) Information received by the board pursuant to an investigation is confidential and not subject to discovery in any civil action.

The board shall conduct all investigations and proceedings in a manner that protects the confidentiality of patients and persons who file complaints with the board. The board shall not make public the names or any other identifying information about patients or complainants unless proper consent is given or, in the case of a patient, a waiver of the patient privilege exists under division (B) of section 2317.02 of the Revised Code, except that consent or a waiver is not required if the board possesses reliable and substantial evidence that no bona fide physician-patient relationship exists.

The board may share any information it receives pursuant to an investigation, including patient records and patient record information, with law enforcement agencies, other licensing boards, and other governmental agencies that are prosecuting, adjudicating, or investigating alleged violations of statutes or administrative rules. An agency or board that receives the information shall comply with the same requirements regarding confidentiality as those with which the state medical board must comply, notwithstanding any conflicting provision of the Revised Code or procedure of the agency or board that applies when it is dealing with other information in its possession. In a judicial proceeding, the information may be admitted into evidence only in accordance with the Rules of Evidence, but the court shall require that appropriate measures are taken to ensure that confidentiality is maintained with respect to any part of the information that contains names or other identifying information about patients or complainants whose confidentiality was protected by the state medical board when the information was in the board's possession. Measures to ensure confidentiality that may be taken by the court include sealing its records or deleting specific information from its records.

(G) The state medical board shall develop requirements for and provide appropriate initial and continuing training for investigators employed by the board to carry out its duties under this chapter. The training and continuing education may include enrollment in courses operated or approved by the Ohio peace officer training council that the board considers appropriate under conditions set forth in section 109.79 of the Revised Code.

(H) On a quarterly basis, the board shall prepare a report that documents the disposition
of all cases during the preceding three months. The report shall contain the following information for each case with which the board has completed its activities:

1. The case number assigned to the complaint or alleged violation;
2. The type of certificate, if any, held by the individual against whom the complaint is directed;
3. A description of the allegations contained in the complaint;
4. The disposition of the case.

The report shall state how many cases are still pending, and shall be prepared in a manner that protects the identity of each person involved in each case. The report shall be submitted to the physician assistant policy committee of the board and is a public record for purposes of section 149.43 of the Revised Code.

4730.32 Report to medical board required.

(A) Within sixty days after the imposition of any formal disciplinary action taken by a health care facility against any individual holding a valid license to practice as a physician assistant issued under this chapter, the chief administrator or executive officer of the facility shall report to the state medical board the name of the individual, the action taken by the facility, and a summary of the underlying facts leading to the action taken. Upon request, the board shall be provided certified copies of the patient records that were the basis for the facility's action. Prior to release to the board, the summary shall be approved by the peer review committee that reviewed the case or by the governing board of the facility.

The filing of a report with the board or decision not to file a report, investigation by the board, or any disciplinary action taken by the board, does not preclude a health care facility from taking disciplinary action against a physician assistant.

In the absence of fraud or bad faith, no individual or entity that provides patient records to the board shall be liable in damages to any person as a result of providing the records.

(B) A physician assistant, professional association or society of physician assistants, physician, or professional association or society of physicians that believes a violation of any provision of this chapter, Chapter 4731 of the Revised Code, or rule of the board has occurred shall report to the board the information upon which the belief is based. This division does not require any treatment provider approved by the board under section 4731.25 of the Revised Code or any employee, agent, or representative of such a provider to make reports with respect to a physician assistant participating in treatment or aftercare for substance abuse as long as the physician assistant maintains participation in accordance with the requirements of section 4731.25 of the Revised Code and the treatment provider or employee, agent, or representative of the provider has no reason to believe that the physician assistant has violated any provision of this chapter or rule adopted under it, other than being impaired by alcohol, drugs, or other substances. This division does not require reporting by any member of an impaired practitioner committee established by a health care facility or by any representative or agent of a committee or program sponsored by a professional association or society of physician assistants to provide peer assistance to physician assistants with substance abuse problems with respect to a physician assistant who has been referred for examination to a treatment program approved by the board under section 4731.25 of the Revised Code if the physician assistant cooperates with the referral for examination and with any determination that the physician assistant should enter treatment and as long as the committee member, representative, or agent has no reason to believe that the physician assistant has ceased to participate in the treatment program in accordance with section 4731.25 of the Revised Code or has violated any provision of this chapter or rule adopted under it, other than being impaired by alcohol, drugs, or other substances.

(C) Any professional association or society composed primarily of physician assistants

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that suspends or revokes an individual’s membership for violations of professional ethics, or for reasons of professional incompetence or professional malpractice, within sixty days after a final decision, shall report to the board, on forms prescribed and provided by the board, the name of the individual, the action taken by the professional organization, and a summary of the underlying facts leading to the action taken.

The filing or nonfiling of a report with the board, investigation by the board, or any disciplinary action taken by the board, shall not preclude a professional organization from taking disciplinary action against a physician assistant.

(D) Any insurer providing professional liability insurance to any person holding a valid license to practice as a physician assistant issued under this chapter or any other entity that seeks to indemnify the professional liability of a physician assistant shall notify the board within thirty days after the final disposition of any written claim for damages where such disposition results in a payment exceeding twenty-five thousand dollars. The notice shall contain the following information:

(1) The name and address of the person submitting the notification;
(2) The name and address of the insured who is the subject of the claim;
(3) The name of the person filing the written claim;
(4) The date of final disposition;
(5) If applicable, the identity of the court in which the final disposition of the claim took place.

(E) The board may investigate possible violations of this chapter or the rules adopted under it that are brought to its attention as a result of the reporting requirements of this section, except that the board shall conduct an investigation if a possible violation involves repeated malpractice. As used in this division, “repeated malpractice” means three or more claims for malpractice within the previous five-year period, each resulting in a judgment or settlement in excess of twenty-five thousand dollars in favor of the claimant, and each involving negligent conduct by the physician assistant.

(F) All summaries, reports, and records received and maintained by the board pursuant to this section shall be held in confidence and shall not be subject to discovery or introduction in evidence in any federal or state civil action involving a physician assistant, supervising physician, or health care facility arising out of matters that are the subject of the reporting required by this section. The board may use the information obtained only as the basis for an investigation, as evidence in a disciplinary hearing against a physician assistant or supervising physician, or in any subsequent trial or appeal of a board action or order.

The board may disclose the summaries and reports it receives under this section only to health care facility committees within or outside this state that are involved in credentialing or recredentialing a physician assistant or supervising physician or reviewing their privilege to practice within a particular facility. The board shall indicate whether or not the information has been verified. Information transmitted by the board shall be subject to the same confidentiality provisions as when maintained by the board.

(G) Except for reports filed by an individual pursuant to division (B) of this section, the board shall send a copy of any reports or summaries it receives pursuant to this section to the physician assistant. The physician assistant shall have the right to file a statement with the board concerning the correctness or relevance of the information. The statement shall at all times accompany that part of the record in contention.

(H) An individual or entity that reports to the board or refers an impaired physician assistant to a treatment provider approved by the board under section 4731.25 of the Revised Code shall not be subject to suit for civil damages as a result of the report, referral, or provision of the information.

(I) In the absence of fraud or bad faith, a professional association or society of physician assistants that sponsors a committee or program to provide peer assistance to a physician
Assistant with substance abuse problems, a representative or agent of such a committee or program, and a member of the state medical board shall not be held liable in damages to any person by reason of actions taken to refer a physician assistant to a treatment provider approved under section 4731.25 of the Revised Code for examination or treatment.

**4730.41 Certificate to prescribe.**

(A) A physician assistant who holds a valid prescriber number issued by the state medical board is authorized to prescribe and personally furnish drugs and therapeutic devices in the exercise of physician-delegated prescriptive authority.

(B) In exercising physician-delegated prescriptive authority, a physician assistant is subject to all of the following:

1. The physician assistant shall exercise physician-delegated prescriptive authority only to the extent that the physician supervising the physician assistant has granted that authority.

2. The physician assistant shall comply with all conditions placed on the physician-delegated prescriptive authority, as specified by the supervising physician who is supervising the physician assistant in the exercise of physician-delegated prescriptive authority.

3. If the physician assistant possesses physician-delegated prescriptive authority for controlled substances, the physician assistant shall register with the federal drug enforcement administration.

4. If the physician assistant possesses physician-delegated prescriptive authority for schedule II controlled substances, the physician assistant shall comply with section 4730.411 of the Revised Code.

5. If the physician assistant possesses physician-delegated prescriptive authority to prescribe for a minor an opioid analgesic, as those terms are defined in sections 3719.061 and 3719.01 of the Revised Code, respectively, the physician assistant shall comply with section 3719.061 of the Revised Code.

6. The physician assistant shall comply with the requirements of section 4730.44 of the Revised Code.

**4730.433 Physician assistant may prescribe epinephrine.**

(A) (1) Subject to division (A)(2) of this section, and notwithstanding any provision of this chapter or rule adopted by the state medical board, a physician assistant who holds a license issued under this chapter and a valid prescriber number issued by the state medical board and has been granted physician-delegated prescriptive authority may do either of the following without having examined an individual to whom epinephrine may be administered:

(a) Personally furnish a supply of epinephrine autoinjectors for use in accordance with sections 3313.7110, 3313.7111, 3314.143, 3326.28, 3328.29, 3728.03 to 3728.05, and 5101.76 of the Revised Code;

(b) Issue a prescription for epinephrine autoinjectors for use in accordance with sections 3313.7110, 3313.7111, 3314.143, 3326.28, 3328.29, 3728.03 to 3728.05, and 5101.76 of the Revised Code.

(2) An epinephrine autoinjector personally furnished or prescribed under division (A)(1) of this section must be furnished or prescribed in such a manner that it may be administered only in a manufactured dosage form.

(B) A physician assistant who acts in good faith in accordance with this section is not liable for or subject to any of the following for any action or omission of an entity to which an epinephrine autoinjector is furnished or a prescription is issued: damages in any civil action, prosecution in any criminal proceeding, or professional disciplinary action.
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4730-1-01 Physician assistant definitions.

(A) For purposes of agency-level 4730 of the Administrative Code:
(1) "Direct supervision" means that the supervising physician is physically present in the same room as the physician assistant, with the physician assistant in the actual sight of the supervising physician, when the physician assistant is performing the medical function, task, or service requiring direct supervision.
(2) "On-site supervision" means the supervising physician is required to be physically present in the same location as the physician assistant, but does not require the supervising physician's physical presence in the same room.
(3) "Off-site supervision" means the supervising physician must be continually available for direct communication with the physician assistant by such means as telephone or other real-time electronic, active communication, and must be in a location that under normal conditions is not more than sixty minutes travel time from the physician assistant's practice location.
(4) "Health care facility" means either of the following:
(a) A hospital registered with the department of health under section 3701.07 of the Revised Code;
(b) A health care facility licensed by the department of health under section 3702.30 of the Revised Code.
(5) "Office-based practice" means medical practice in a location other than a health care facility.
(6) "Service" means a medical function, task, or activity which requires training in the diagnosis, treatment and prevention of disease, including the use and administration of drugs.
(7) "Board" means the state medical board of Ohio.
(8) "Local anesthesia" means the injection of a drug or combination of drugs to stop or prevent a painful sensation in a circumscribed area of the body where a painful procedure is to be performed, and is limited to local infiltration anesthesia, digital blocks, and pudendal blocks. Local anesthesia does not include regional anesthesia or any systemic sedation.
(9) "Medical order" means one or more diagnostic or treatment directives generated by a physician or physician assistant that commands the execution of specific activities to be performed or delivered as part of a diagnostic or therapeutic regimen of a patient.
(10) "CME" means continuing medical education.
(11) "Licensure registration period" means the period between granting of the initial or renewed certificate to practice and the next scheduled renewal date for the certificate to practice.
(12) "Special services plan" means the portion of a supervisory plan that lists services not specified in division (A) of section 4730.09 of the Revised Code, that is either submitted for board approval as a portion of a supervisory plan or as an addendum to a supervisory plan that was previously approved.

(B) For purposes of Chapter 4730 of the Revised Code:
(1) "Setting in which the supervising physician routinely practices" means a practice environment in which the supervising physician ordinarily provides medical services.
(2) "Routine diagnostic procedure" means a diagnostic or therapeutic evaluation that is commonly performed, as indicated, within the scope of practice of the supervising physician.

4730-1-02 Physician assistant practice.

(A) A physician assistant shall practice under the supervision, control, and direction of a supervising physician with whom the physician assistant has a supervision agreement approved by the board.
(1) The physician assistant may enter into supervision agreements with any number of supervising physicians.

(2) The physician assistant’s practice shall be in a practice setting in which the supervising physician routinely practices.

(3) In a health care facility that includes an emergency department, the physician assistant who does not routinely practice in the emergency department, may, on occasion, be sent to the emergency department by a supervising physician who does not routinely practice in the emergency department for the purpose of assessing and managing a patient, provided the supervising physician is available to come to the emergency department upon request.

(4) The services a physician assistant is authorized to perform shall be services within the supervising physician's normal course of practice and expertise, and which are consistent with the board-approved physician supervisory plan or the policies of the health care facility in which the physician and physician assistant are practicing.

(B) The scope of practice of the physician assistant is determined as follows:

(1) In a health care facility:
   (a) The policies of the health care facility, as may be limited by the particular supervising physician who is providing the supervision, may authorize the physician assistant to provide any or all of the services listed in division (A) of section 4730.09 of the Revised Code;
   (b) The policies of the health care facility, as may be limited by the particular supervising physician who is providing supervision, may authorize the physician assistant to assist in surgery in the health care facility;
   (c) The policies of the health care facility, as may be limited by the particular supervising physician who is providing supervision, may authorize the physician assistant to provide any other services permitted by the policies of the health care facility, except where performance of a service is prohibited by any provision of Chapter 4730 of the Revised Code;
   (d) The policies of the health care facility, as may be limited by the particular supervising physician who is providing supervision, may authorize the physician assistant to order or direct the execution of procedures or techniques by a registered nurse or licensed practical nurse without the need for co-signature by the supervising physician;
   (e) The policies of the health care facility, as may be limited by the particular supervising physician who is providing supervision, may authorize the physician assistant to administer, monitor, or maintain local anesthesia as a component of a procedure the physician assistant is performing or as a separate service when the procedure requiring local anesthesia is to be performed by the physician assistant's supervising physician or another person; and
   (f) The policies of the health care facility, as may be limited by the particular supervising physician who is providing supervision, may authorize the physician assistant to perform routine visual screening, provide medical care prior to or following eye surgery, or assist in the care of diseases of the eye.

(2) In an office-based practice:
   (a) The board approved physician supervisory plan or the board approved special services plan for the particular supervising physician may authorize the physician assistant to provide any or all of the services listed in division (A) of section 4730.09 of the Revised Code;
   (b) The board approved physician supervisory plan or the board approved special services plan for the particular supervising physician may authorize the physician assistant to administer, monitor, or maintain local anesthesia as a component of a procedure the physician assistant is performing or as a separate service when the procedure requiring local anesthesia is to be performed by the physician assistant's supervising physician or another person; and
   (c) The board approved physician supervisory plan or the board approved special services plan for the particular supervising physician may authorize the physician assistant to order or direct the execution of procedures or techniques by a registered nurse or licensed practice nurse without the need for co-signature by the supervising physician;
(d) The board approved physician supervisory plan or the board approved special services plan for the particular supervising physician may authorize the physician assistant to perform routine visual screening, provide medical care prior to or following eye surgery, or assist in the care of diseases of the eye; and

(e) The board approved physician supervisory plan or the board approved special services plan for the particular supervising physician may authorize the physician assistant to provide any service approved by the board as a special service in the physician supervisory plan, pursuant to section 4730.17 of the Revised Code.

(3) A physician assistant shall not perform any of the following activities regardless of the practice setting:

(a) Prescribe any drug or device to perform or induce an abortion, or otherwise perform or induce an abortion;

(b) Administer, monitor, or maintain any form of anesthesia except for local anesthesia; or

(c) Engage in the practice of optometry, except to the extent of authorization to perform routine visual screening, provide medical care prior to or following eye surgery, or assist in the care of diseases of the eye.

(C) The physician assistant shall include the following information with each medical order written:

(1) The physician assistant shall sign the form on which the order or order set is written, and record the time and date that the order is written; and

(2) The physician assistant shall include the name of the physician under whose supervision the physician assistant was practicing at the time the order was written.

4730-1-03 Duties of supervising physician.

(A) The physician supervising a physician assistant assumes legal liability for the services provided by the physician assistant under a board-approved supervision agreement. A supervision agreement shall be terminated by one of the following means:

(1) The supervising physician fails to renew the supervision agreement;

(2) The physician notifies the board, in writing, that the supervision agreement has been terminated; or

(3) The certificate to practice held by either the physician or the physician assistant is inactive due to failure to renew or for any other reason.

(B) The supervising physician may enter into supervision agreements with any number of physician assistants, but shall not supervise more than two physician assistants at any one time.

(C) A supervising physician may authorize the physician assistant to perform a service only if all the following criteria are met:

(1) The supervising physician has a board-approved supervision agreement with the physician assistant;

(2) The service is listed on the board-approved physician supervisory plan or special services plan, if the practice is an office-based practice, or is in accordance with the policies of the health care facility in which the physician and physician assistant are practicing;

(3) The service is within the supervising physician's normal course of practice;

(4) The supervising physician is satisfied that the physician assistant is capable of competently performing the service; and

(5) The supervising physician is authorized to perform the service.

(D) When on-site supervision or direct supervision of the physician assistant is not required under rule 4730-1-04 of the Administrative Code, the supervisory plan or special services plan approved by the board, or the policies of the health care facility in which the
supervising physician and physician assistant are practicing, the supervising physician shall be continuously available for direct communication with the physician assistant by either of the following means:

1. Being physically present at the location where the physician assistant is practicing; or
2. Being in a location that under normal conditions is not more than sixty minutes travel time away from the practice location of the physician assistant and being readily available to the physician assistant through some means of telecommunication.

E The supervising physician shall perform all of the following supervisory activities:

1. Personally and actively review the physician assistant's professional activities;
2. Regularly review the condition of the patients treated by the physician assistant;
3. Regularly perform any other reviews of the physician assistant that the supervising physician considers necessary;
4. Establish, in consultation with each physician assistant supervised by the physician, implement, and maintain a quality assurance system, in accordance with the requirements of rule 4730-1-05 of the Administrative Code;
5. Only grant prescriptive authority to a physician assistant in compliance with the formulary adopted in rule by the board;
6. Supervise the physician assistant's provisional period of prescriptive authority in accordance with rule 4730-2-04 of the Administrative Code; and
7. Maintain a written record of the following:
   a. Any conditions placed upon a specific physician assistant's practice in an office-based practice.
   b. Any limitations imposed in addition to any limitations applicable under the policies of a health care facility.
8. Make the written record of conditions and/or limitations required in paragraph (E)(7) of this rule available upon request of the board or any health care professional working with the supervising physician and physician assistant.

F When a physician assistant is providing medical care precipitated by a disaster or emergency, as those terms are defined in section 4730.04 of the Revised Code, both of the following apply:

1. The physician supervising a physician assistant pursuant to a supervisory plan approved under section 4730.17 of the Revised Code is not required to be physically present at the disaster or emergency site or be readily available to the physician assistant through some means of telecommunication and being in a location that under normal conditions is not more than sixty minutes travel time away from the disaster or emergency site.
2. The physician designated as the medical director of the disaster or emergency may supervise the medical care provided by the physician assistant.

4730-1-04 Physician assistant supervision.

A A physician assistant's practice shall be under the on-site supervision of the supervising physician in the following instances:

1. For practice in a health care facility's emergency department when that is a routine practice location for the supervising physician and physician assistant;
2. During the first five hundred hours of a physician assistant's provisional period of physician delegated prescriptive authority;
3. When on-site supervision is specified as the supervision level in a special services plan or the policies of a health care facility; and
4. When a supervising physician specifies that on-site supervision is required as a condition for the physician assistant's performance of one or more identified services in the supervisory plan, special services plan, or policies of a health care facility.
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(B) A physician assistant's practice shall be under the direct supervision of the supervising physician in the following instances:
(1) When direct supervision is specified in a special services plan approved by the board; or
(2) When the supervising physician specifies that direct supervision is required as a condition for the physician assistant's performance of one or more identified services in a supervisory plan, special services plan, or the policies of a health care facility.
(C) Where paragraphs (A) and (B) of this rule do not apply, a physician assistant may practice under the off-site supervision of the supervising physician.

4730-1-05 Physician assistant quality assurance.

(A) A quality assurance system shall be developed to assess the physician assistant's performance.
(B) The quality assurance system shall describe the process to be used for all of the following:
(1) Review by the physician of selected patient record entries made by the physician assistant and selected medical orders issued by the physician assistant, to include, at a minimum, all of the following:
   (a) Assessment of the medical history and physical examination documented in the record;
   (b) Assessment of the appropriateness of the diagnosis and treatment plan based on the medical history and physical examination documented in the record;
   (c) Feedback to the physician assistant concerning appropriateness of the physician assistant's prescriptive decisions; and
   (d) Assessment of whether the physician assistant is practicing according to the supervisory plan or the policies of the health care facility, as applicable.
(2) Discussion of complex cases;
(3) Discussion of new medical developments relevant to the practice of the physician and physician assistant, including new pharmaceuticals;
(4) Performance of any other quality assurance activities that the supervising physician considers to be appropriate.
(C) The quality assurance assessment shall be conducted at least twice per year during the first year of a physician assistant's practice and at least once per year thereafter.
(D) Each supervising physician and physician assistant shall keep records of their quality assurance activities for at least seven years, and shall make the records available to the board and any health care professional working with the supervising physician and physician assistant.
(E) The quality assurance system developed pursuant to this rule shall not preclude a health care facility or other entity in which physician assistants practice from conducting quality assurance activities involving the assessment of physician assistant performance.
(F) This provision allows, and does not preclude, multiple supervising physicians to assign the quality assurance process to one supervising physician.

4730-1-07 Physician assistant standards for prescribing.

For purposes of Chapter 4730 of the Revised Code and Chapters 4730-1 and 4730-2 of the Administrative Code:
(A) An adjudication hearing held pursuant to the provisions of Chapter 119 of the Revised Code shall be conducted in conformance with the provisions of Chapter 4731-13 of the Administrative Code.
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(B) The provisions of Chapters 4731-13, 4731-14, 4731-15, 4731-16, 4731-17, 4731-18, 4731-19, 4731-21, 4731-26, and 4731-28 of the Administrative Code and rules 4731-11-01, 4731-11-02, 4731-11-03, 4731-11-04, 4731-11-05, 4731-11-06, 4731-11-07, 4731-11-08, and 4731-11-09 of the Administrative Code are applicable to the holder of a certificate to practice as a physician assistant issued pursuant to section 4730.12 of the Revised Code, as though fully set forth in Chapter 4730-1 or 4730-2 of the Administrative Code.

(C) A holder of a certificate to practice as a physician assistant issued pursuant to section 4730.12 of the Revised Code shall not assist in surgery in an office setting, except where such authority is specified in a special services plan approved by the board pursuant to section 4730.17 of the Revised Code. Where a board-approved special services plan specifically authorizes the physician assistant to assist in office-based surgery, the requirements of paragraph (B) of this rule and the provisions of Chapter 4731-25 of the Administrative Code apply, as though fully set forth in Chapter 4730-1 or 4730-2 of the Administrative Code.

4730-1-08 Physician assistant delegation of medical tasks and administration of drugs.

(A) As used in this rule:

(1) "Administer" means the direct application of a drug, whether by injection, inhalation, ingestion, or any other means to a person.

(2) "Delegate" means to transfer authority for the performance of a medical task or drug administration to an unlicensed person.

(3) "On-site supervision" means that the physical presence of the physician assistant is required in the same location (for example, the medical practice office suite) as the unlicensed person to whom the medical task or drug administration has been delegated while the medical task or drug administration is being performed. On-site supervision does not require the physician assistant's presence in the same room.

(4) "Physician" means an individual authorized by Chapter 4731 of the Revised Code to practice medicine and surgery, osteopathic medicine and surgery, or podiatric medicine and surgery.

(5) "Task" means a routine, medical service not requiring the special skills of a licensed provider.

(6) "Unlicensed person" means an individual who is not licensed or otherwise specifically authorized by the Revised Code to perform the delegated medical task or drug administration.

(7) "Drug" means the same as in division (E) of section 4729.01 of the Revised Code.

(8) "Supervision agreement" means the document signed by the supervising physician and physician assistant in compliance with section 4730.19 of the Revised Code.

(B) When acting pursuant to a supervision agreement, a physician assistant may delegate the performance of a medical task or, under the conditions specified in section 4730.203 of the Revised Code, the administration of a drug to an unlicensed person.

(1) The physician assistant shall comply with all of the requirements of section 4730.203 of the Revised Code and this rule when delegating a medical task or the administration of a drug.

(2) A physician assistant shall not authorize or permit an unlicensed person to whom a medical task or the administration of a drug is delegated to further delegate the performance of the task or administration to third person.

(3) The physician assistant shall provide on-site supervision of the unlicensed person to whom the medical task or administration of a drug is delegated.

(C) Prior to the delegation of the performance of a medical task or the administration of a drug, the physician assistant shall ensure that each of the following requirements is met:
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(1) That the supervision agreement and any applicable healthcare facility policies authorize the physician assistant to delegate the performance of a medical task or the administration of a drug;
(2) That the task or administration of the drug is within that physician assistant's practice authority;
(3) That the task or administration of the drug is indicated for the patient;
(4) That no law prohibits the delegation;
(5) That the unlicensed person to whom the task or drug administration will be delegated is competent to perform that service;
(6) That the task or drug administration itself is one that should be appropriately delegated when considering the following factors:
   (a) That the task or drug administration can be performed without requiring the exercise of judgment based on medical knowledge;
   (b) That results of the task or drug administration are reasonably predictable;
   (c) That the task or drug administration can safely be performed according to exact, unchanging directions;
   (d) That the task or drug administration can be performed without a need for complex observations or critical decisions;
   (e) That the task or drug administration can be performed without repeated medical assessments;
   (f) That the task or drug administration, if performed improperly, would not present life threatening consequences or the danger of immediate and serious harm to the patient; and
(7) That the delegation of the administration of a drug is in compliance with paragraph (D) of this rule.

(D) In addition to the requirements of paragraph (C) of this rule, prior to delegating the administration of a drug, the physician assistant shall ensure that all of the following requirements are met:
(1) The physician assistant holds a current license with a valid prescriber number issued under section 4730.11 of the Revised Code and has been granted physician-delegated prescriptive authority by the supervising physician.
(2) The drug is included in the formulary established under division (A) of section 4730.39 of the Revised Code;
(3) The drug is not a controlled substance;
(4) The drug will not be administered intravenously;
(5) The drug is not an anesthesia agent; and
(6) The drug will not be administered in any of the following locations:
   (a) A hospital inpatient care unit, as defined in section 3727.50 of the Revised Code;
   (b) A hospital emergency department;
   (c) A freestanding emergency department; or
   (d) An ambulatory surgical facility licensed under section 3702.30 of the Revised Code.

(E) Violations of this rule.

(1) A violation of any provision of this rule, as determined by the board, shall constitute “a departure from, or the failure to conform to, minimal standards of care of similar physician assistants under the same or similar circumstances regardless of whether actual injury to a patient is established,” as that clause is used in division (B)(19) of section 4730.25 of the Revised Code.
(2) A violation of any provision of this rule, as determined by the board, shall constitute “violating or attempting to violate, directly or indirectly, or assisting in or abetting the violation of, or conspiring to violate, any provision of this chapter, Chapter 4731 of the Revised Code, or the rules of the board,” as that clause is used in division (B)(3) of section 4730.25 of the Revised Code.
(3) A violation of any provision of this rule that pertains to the administration of drugs, as determined by the board, shall constitute “administering drugs for purposes other than those authorized under this chapter” as that clause is used in division (B)(6) of section 4730.25 of the Revised Code.

4730-3-02 Criminal records check.

(A) An applicant for an initial certificate to practice or for a restored certificate to practice pursuant to Chapter 4730 of the Revised Code, shall submit fingerprints, required forms, and required fees to BCI for completion of BCI and FBI criminal records checks.

(1) An applicant who is present in Ohio shall use the services of an entity that has been designated by the Ohio attorney general to participate in the “National WebCheck” program (available at http://www.ohioattorneygeneral.gov/) pay any processing fee charged by the entity, and cause the entity to submit both of the following to BCI, with the “State Medical Board of Ohio” designated to receive the results:

(a) The applicant's electronic fingerprints; and
(b) The applicant's payment of fees for the BCI and FBI criminal records checks.

(2) An applicant who resides in a state or jurisdiction other than Ohio shall either appear in Ohio in order to comply with the requirements of paragraph (A)(1) of this rule or request that the board send the forms required for the criminal records checks to the applicant’s address. Upon receipt of the forms, the applicant shall have their fingerprints processed, pay any processing fees charged by the entity and cause the entity to submit to BCI all of the following, with the “State Medical Board of Ohio” designated to receive the results:

(a) A fingerprint card bearing the prints of the applicant's ten fingers;
(b) The applicant's completed request for exemption from the electronic fingerprint submission requirement; and
(c) The applicant's payment of fees for BCI and FBI criminal records checks.

(B) The board shall maintain the criminal records check reports in a manner that ensures the confidentiality of the results, prevents disclosure pursuant to a public records request, and complies with applicable state and federal requirements.

(C) The board shall not accept the results of a criminal records check submitted by an entity other than BCI.

(D) In reviewing the results of criminal records checks to determine whether the applicant should be granted an initial or restored certificate to practice, the board may consider all of the following:

(1) The nature and seriousness of the crime;
(2) The extent of the applicant's past criminal activity;
(3) The age of the applicant when the crime was committed;
(4) The amount of time that has elapsed since the applicant’s last criminal activity;
(5) The conduct and work activity of the applicant before and after the criminal activity;
(6) Whether the applicant has completed the terms of any probation or deferred adjudication;
(7) Evidence of the applicant's rehabilitation;
(8) Whether the applicant fully disclosed the arrest or conviction to the board; and
(9) Any other factors the board considers relevant.
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4731.051 Universal blood and body fluid precautions.

[Editor’s Note: This version of the statute is effective until 1/20/2018. The version effective after that date is included subsequently.]

The state medical board shall adopt rules in accordance with Chapter 119 of the Revised Code establishing universal blood and body fluid precautions that shall be used by each person who performs exposure prone invasive procedures and is authorized to practice by this chapter or Chapter 4730., 4760., 4762., or 4774 of the Revised Code. The rules shall define and establish requirements for universal blood and body fluid precautions that include the following:

(A) Appropriate use of hand washing;
(B) Disinfection and sterilization of equipment;
(C) Handling and disposal of needles and other sharp instruments;
(D) Wearing and disposal of gloves and other protective garments and devices.

4731.051 Universal blood and body fluid precautions.

[Editor’s Note: This version of the statute is effective 1/21/2018. The version effective prior to that date is included previously.]

The state medical board shall adopt rules in accordance with Chapter 119 of the Revised Code establishing universal blood and body fluid precautions that shall be used by each person who performs exposure prone invasive procedures and is authorized to practice by this chapter or Chapter 4730., 4759., 4760., 4761., 4762., or 4774 of the Revised Code. The rules shall define and establish requirements for universal blood and body fluid precautions that include the following:

(A) Appropriate use of hand washing;
(B) Disinfection and sterilization of equipment;
(C) Handling and disposal of needles and other sharp instruments;
(D) Wearing and disposal of gloves and other protective garments and devices.

4731.052 Chronic pain.

(A) As used in this section:
(1) “Chronic pain” means pain that has persisted after reasonable medical efforts have been made to relieve the pain or cure its cause and that has continued, either continuously or episodically, for longer than three continuous months. “Chronic pain” does not include pain associated with a terminal condition or with a progressive disease that, in the normal course of progression, may reasonably be expected to result in a terminal condition.
(2) “Controlled substance” has the same meaning as in section 3719.01 of the Revised Code.
(3) “Physician” means an individual authorized under this chapter to practice medicine and surgery or osteopathic medicine and surgery.

(B) The state medical board shall adopt rules in accordance with Chapter 119 of the Revised Code that establish standards and procedures to be followed by physicians in the diagnosis and treatment of chronic pain, including standards for a physician’s consultation with one or more other physicians who specialize in the treatment of the area, system, or organ of the body perceived as the source of pain and managing chronic pain by prescribing, personally furnishing, or administering controlled substances or products containing tramadol.

(C) When a physician diagnoses a patient as having chronic pain, the physician may,
subject to division (D) of this section, treat the pain by managing it with controlled substances and products containing tramadol. The physician's diagnosis and treatment decisions shall be made according to accepted and prevailing standards for medical care. For the purpose of assisting with the diagnosis of chronic pain, the physician shall obtain and review all available medical records or detailed written summaries of the patient's treatment for chronic pain or the condition causing the chronic pain. It is recommended that the physician also consider having the patient evaluated by one or more other physicians who specialize in the treatment of the area, system, or organ of the body perceived as the source of the pain.

(D) For each patient a physician diagnoses as having chronic pain, the physician shall maintain a written record of all of the following:

(1) Medical history and physical examination of the patient;
(2) The diagnosis of chronic pain, including signs, symptoms, and causes;
(3) The plan of treatment proposed, the patient's response to treatment, and any modification to the plan of treatment, including all of the following:
   (a) Documentation that other medically reasonable treatments for relief of the patient's chronic pain have been offered or attempted without adequate or reasonable success;
   (b) Periodic assessment and documentation of the patient's functional status, including the ability to engage in work or other purposeful activities, the pain intensity and its interference with activities of daily living, quality of family life and social activities, and physical activity of the patient;
   (c) Periodic assessment and documentation of the patient's progress toward treatment objectives, including the intended role of controlled substances or products containing tramadol within the overall plan of treatment;
   (d) Periodic assessment and documentation for indicators of possible addiction, drug abuse, or drug diversion;
   (e) Notation of any adverse drug effects.
(4) The dates on which controlled substances or products containing tramadol were prescribed, furnished, or administered, the name and address of the patient to or for whom the controlled substances or products containing tramadol were prescribed, furnished, or administered, and the amounts and dosage forms for the controlled substances or products containing tramadol prescribed, furnished, or administered;
(5) A copy of any record or report made by another physician that was used or consulted for the purpose of diagnosing the patient's chronic pain or treating the patient for chronic pain.

(E) A physician shall not prescribe, personally furnish, or administer to a patient a controlled substance or product containing tramadol without taking into account the potential for abuse of the controlled substance or product, the possibility the controlled substance or product may lead to dependence, the possibility the patient will obtain the controlled substance or product for a nontherapeutic use or distribute it to other persons, and the potential existence of an illicit market for the controlled substance or product. In addition, the physician shall address with the patient the risks associated with protracted treatment with controlled substances or products containing tramadol, including informing the patient of the potential for dependence, tolerance, and addiction and the clinical or monitoring tools the physician may use if signs of addiction, drug abuse, or drug diversion are present.

(F) A physician who treats chronic pain by managing it with controlled substances or products containing tramadol is not subject to disciplinary action by the board under section 4731.22 of the Revised Code solely because the physician treated the chronic pain with controlled substances or products containing tramadol.

### 4731.053 Delegation of medical task.

(A) As used in this section, "physician" means an individual authorized by this chapter to
practice medicine and surgery, osteopathic medicine and surgery, or podiatric medicine and surgery.

(B) The state medical board shall adopt rules that establish standards to be met and procedures to be followed by a physician with respect to the physician’s delegation of the performance of a medical task to a person who is not licensed or otherwise specifically authorized by the Revised Code to perform the task. The rules shall be adopted in accordance with Chapter 119 of the Revised Code.

(C) To the extent that delegation applies to the administration of drugs, the rules adopted under this section shall provide for all of the following:

1. On-site supervision when the delegation occurs in an institution or other facility that is used primarily for the purpose of providing health care, unless the board establishes a specific exception to the on-site supervision requirement with respect to routine administration of a topical drug, such as the use of a medicated shampoo;

2. Evaluation of whether delegation is appropriate according to the acuity of the patient involved;

3. Training and competency requirements that must be met by the person administering the drugs;

4. Other standards and procedures the board considers relevant.

(D) The board shall not adopt rules that do any of the following:

1. Authorize a physician to transfer the physician’s responsibility for supervising a person who is performing a delegated medical task to a health professional other than another physician;

2. Authorize an individual to whom a medical task is delegated to delegate the performance of that task to another individual;

3. Except as provided in divisions (D)(4) to (7) of this section, authorize a physician to delegate the administration of anesthesia, controlled substances, drugs administered intravenously, or any other drug or category of drug the board considers to be inappropriate for delegation;

4. Prevent an individual from engaging in an activity performed for a handicapped child as a service needed to meet the educational needs of the child, as identified in the individualized education program developed for the child under Chapter 3323 of the Revised Code;

5. Conflict with any provision of the Revised Code that specifically authorizes an individual to perform a particular task;

6. Conflict with any rule adopted pursuant to the Revised Code that is in effect on the effective date of this section, as long as the rule remains in effect, specifically authorizing an individual to perform a particular task;

7. Prohibit a perfusionist from administering drugs intravenously while practicing as a perfusionist;

8. Authorize a physician assistant, anesthesiologist assistant, or any other professional regulated by the board to delegate tasks pursuant to this section.

4731.14 Certificate display and issuance.

(A) The state medical board shall review all applications submitted under section 4731.09 or 4731.296 of the Revised Code and determine whether each applicant meets the requirements for a license to practice medicine and surgery or osteopathic medicine and surgery. An affirmative vote of not fewer than six members of the board is necessary for the board to determine that an applicant meets the requirements for a license.

(B) If the board determines that the evidence submitted with an application is satisfactory and the applicant meets the requirements for a license, the board shall issue to the applicant a
license to practice medicine and surgery or osteopathic medicine and surgery, as applicable. If the applicant holds a medical degree other than the degree of doctor of medicine or doctor of osteopathic medicine, the license shall indicate that the applicant is authorized to practice medicine and surgery pursuant to the laws of this state. Each license issued by the board shall be signed by its president and secretary, and attested by its seal.

(C) The holder of a license to practice medicine and surgery issued under this chapter may use the titles "Dr.,” “doctor,” “M.D.,” or “physician.” The holder of a license to practice osteopathic medicine and surgery issued under this chapter may use the titles “Dr.,” “doctor,” “D.O.,” or “physician.”

(D) The holder of a license issued under this section shall either provide verification of licensure status from the board's internet website on request or prominently display a wall certificate in the license holder's office or place where the majority of the holder's practice is conducted.

4731.143 Duty to notify of no malpractice insurance.

(A) Each person holding a valid license issued under this chapter authorizing the license holder to practice medicine and surgery, osteopathic medicine and surgery, or podiatric medicine and surgery, who is not covered by medical malpractice insurance shall provide a patient with written notice of the license holder's lack of that insurance coverage prior to providing nonemergency professional services to the patient. The notice shall be provided alone on its own page. The notice shall provide space for the patient to acknowledge receipt of the notice, and shall be in the following form:

"N O T I C E:
Dr. ............... (here state the full name of the license holder) is not covered by medical malpractice insurance.

The undersigned acknowledges the receipt of this notice.

....................................................

(Patient's Signature)

....................................................

(Date)"

The license holder shall obtain the patient's signature, acknowledging the patient's receipt of the notice, prior to providing nonemergency professional services to the patient. The license holder shall maintain the signed notice in the patient's medical record.

(B) This section does not apply to any officer or employee of the state, as those terms are defined in section 9.85 of the Revised Code, who is immune from civil liability under section 9.86 of the Revised Code or is entitled to indemnification pursuant to section 9.87 of the Revised Code, to the extent that the person is acting within the scope of the person's employment or official responsibilities.

This section does not apply to a person who complies with division (B)(2) of section 2305.234 of the Revised Code.

(C) As used in this section, "medical malpractice insurance" means insurance coverage against the legal liability of the insured and against loss, damage, or expense incident to a claim arising out of the death, disease, or injury of any person as the result of negligence or malpractice in rendering professional service by any licensed physician, podiatrist, or hospital,
as those terms are defined in section 2305.113 of the Revised Code.

4731.22 Disciplinary actions.

(A) The state medical board, by an affirmative vote of not fewer than six of its members, may limit, revoke, or suspend a license or certificate to practice or certificate to recommend, refuse to grant a license or certificate, refuse to renew a license or certificate, refuse to reinstate a license or certificate, or reprimand or place on probation the holder of a license or certificate if the individual applying for or holding the license or certificate is found by the board to have committed fraud during the administration of the examination for a license or certificate to practice or to have committed fraud, misrepresentation, or deception in applying for, renewing, or securing any license or certificate to practice or certificate to recommend issued by the board.

(B) The board, by an affirmative vote of not fewer than six members, shall, to the extent permitted by law, limit, revoke, or suspend a license or certificate to practice or certificate to recommend, refuse to issue a license or certificate, refuse to renew a license or certificate, refuse to reinstate a license or certificate, or reprimand or place on probation the holder of a license or certificate for one or more of the following reasons:

(1) Permitting one's name or one's license or certificate to practice to be used by a person, group, or corporation when the individual concerned is not actually directing the treatment given;

(2) Failure to maintain minimal standards applicable to the selection or administration of drugs, or failure to employ acceptable scientific methods in the selection of drugs or other modalities for treatment of disease;

(3) Except as provided in section 4731.97 of the Revised Code, selling, giving away, personally furnishing, prescribing, or administering drugs for other than legal and legitimate therapeutic purposes or a plea of guilty to, a judicial finding of guilt of, or a judicial finding of eligibility for intervention in lieu of conviction of, a violation of any federal or state law regulating the possession, distribution, or use of any drug;

(4) Willfully betraying a professional confidence.

For purposes of this division, “willfully betraying a professional confidence” does not include providing any information, documents, or reports under sections 307.621 to 307.629 of the Revised Code to a child fatality review board; does not include providing any information, documents, or reports to the director of health pursuant to guidelines established under section 3701.70 of the Revised Code; does not include written notice to a mental health professional under section 4731.62 of the Revised Code; and does not include the making of a report of an employee’s use of a drug of abuse, or a report of a condition of an employee other than one involving the use of a drug of abuse, to the employer of the employee as described in division (B) of section 2305.33 of the Revised Code. Nothing in this division affects the immunity from civil liability conferred by section 2305.33 or 4731.62 of the Revised Code upon a physician who makes a report in accordance with section 2305.33 or notifies a mental health professional in accordance with section 4731.62 of the Revised Code. As used in this division, “employee,” “employer,” and “physician” have the same meanings as in section 2305.33 of the Revised Code.

(5) Making a false, fraudulent, deceptive, or misleading statement in the solicitation of or advertising for patients; in relation to the practice of medicine and surgery, osteopathic medicine and surgery, podiatric medicine and surgery, or a limited branch of medicine; or in securing or attempting to secure any license or certificate to practice issued by the board.

As used in this division, “false, fraudulent, deceptive, or misleading statement” means a statement that includes a misrepresentation of fact, is likely to mislead or deceive because of a failure to disclose material facts, is intended or is likely to create false or unjustified expectations
of favorable results, or includes representations or implications that in reasonable probability will cause an ordinarily prudent person to misunderstand or be deceived.

(6) A departure from, or the failure to conform to, minimal standards of care of similar practitioners under the same or similar circumstances, whether or not actual injury to a patient is established;

(7) Representing, with the purpose of obtaining compensation or other advantage as personal gain or for any other person, that an incurable disease or injury, or other incurable condition, can be permanently cured;

(8) The obtaining of, or attempting to obtain, money or anything of value by fraudulent misrepresentations in the course of practice;

(9) A plea of guilty to, a judicial finding of guilt of, or a judicial finding of eligibility for intervention in lieu of conviction for, a felony;

(10) Commission of an act that constitutes a felony in this state, regardless of the jurisdiction in which the act was committed;

(11) A plea of guilty to, a judicial finding of guilt of, or a judicial finding of eligibility for intervention in lieu of conviction for, a misdemeanor committed in the course of practice;

(12) Commission of an act in the course of practice that constitutes a misdemeanor in this state, regardless of the jurisdiction in which the act was committed;

(13) A plea of guilty to, a judicial finding of guilt of, or a judicial finding of eligibility for intervention in lieu of conviction for, a misdemeanor involving moral turpitude;

(14) Commission of an act involving moral turpitude that constitutes a misdemeanor in this state, regardless of the jurisdiction in which the act was committed;

(15) Violation of the conditions of limitation placed by the board upon a license or certificate to practice;

(16) Failure to pay license renewal fees specified in this chapter;

(17) Except as authorized in section 4731.31 of the Revised Code, engaging in the division of fees for referral of patients, or the receiving of a thing of value in return for a specific referral of a patient to utilize a particular service or business;

(18) Subject to section 4731.226 of the Revised Code, violation of any provision of a code of ethics of the American medical association, the American osteopathic association, the American podiatric medical association, or any other national professional organizations that the board specifies by rule. The state medical board shall obtain and keep on file current copies of the codes of ethics of the various national professional organizations. The individual whose license or certificate is being suspended or revoked shall not be found to have violated any provision of a code of ethics of an organization not appropriate to the individual's profession.

For purposes of this division, a “provision of a code of ethics of a national professional organization” does not include any provision that would preclude the making of a report by a physician of an employee's use of a drug of abuse, or of a condition of an employee other than one involving the use of a drug of abuse, to the employer of the employee as described in division (B) of section 2305.33 of the Revised Code. Nothing in this division affects the immunity from civil liability conferred by that section upon a physician who makes either type of report in accordance with division (B) of that section. As used in this division, “employee,” “employer,” and “physician” have the same meanings as in section 2305.33 of the Revised Code.

(19) Inability to practice according to acceptable and prevailing standards of care by reason of mental illness or physical illness, including, but not limited to, physical deterioration that adversely affects cognitive, motor, or perceptive skills.

In enforcing this division, the board, upon a showing of a possible violation, may compel any individual authorized to practice by this chapter or who has submitted an application pursuant to this chapter to submit to a mental examination, physical examination, including an HIV test, or both a mental and a physical examination. The expense of the examination is the responsibility of the individual compelled to be examined. Failure to submit to a mental or
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physical examination or consent to an HIV test ordered by the board constitutes an admission of the allegations against the individual unless the failure is due to circumstances beyond the individual's control, and a default and final order may be entered without the taking of testimony or presentation of evidence. If the board finds an individual unable to practice because of the reasons set forth in this division, the board shall require the individual to submit to care, counseling, or treatment by physicians approved or designated by the board, as a condition for initial, continued, reinstated, or renewed authority to practice. An individual affected under this division shall be afforded an opportunity to demonstrate to the board the ability to resume practice in compliance with acceptable and prevailing standards under the provisions of the individual's license or certificate. For the purpose of this division, any individual who applies for or receives a license or certificate to practice under this chapter accepts the privilege of practicing in this state and, by so doing, shall be deemed to have given consent to submit to a mental or physical examination when directed to do so in writing by the board, and to have waived all objections to the admissibility of testimony or examination reports that constitute a privileged communication.

(20) Except as provided in division (F)(1)(b) of section 4731.282 of the Revised Code or when civil penalties are imposed under section 4731.225 of the Revised Code, and subject to section 4731.226 of the Revised Code, violating or attempting to violate, directly or indirectly, or assisting in or abetting the violation of, or conspiring to violate, any provisions of this chapter or any rule promulgated by the board.

This division does not apply to a violation or attempted violation of, assisting in or abetting the violation of, or a conspiracy to violate, any provision of this chapter or any rule adopted by the board that would preclude the making of a report by a physician of an employee's use of a drug of abuse, or of a condition of an employee other than one involving the use of a drug of abuse, to the employer of the employee as described in division (B) of section 2305.33 of the Revised Code. Nothing in this division affects the immunity from civil liability conferred by that section upon a physician who makes either type of report in accordance with division (B) of that section. As used in this division, “employee,” “employer,” and “physician” have the same meanings as in section 2305.33 of the Revised Code.

(21) The violation of section 3701.79 of the Revised Code or of any abortion rule adopted by the director of health pursuant to section 3701.341 of the Revised Code;

(22) Any of the following actions taken by an agency responsible for authorizing, certifying, or regulating an individual to practice a health care occupation or provide health care services in this state or another jurisdiction, for any reason other than the nonpayment of fees: the limitation, revocation, or suspension of an individual's license to practice; acceptance of an individual's license surrender; denial of a license; refusal to renew or reinstate a license; imposition of probation; or issuance of an order of censure or other reprimand;

(23) The violation of section 2919.12 of the Revised Code or the performance or inducement of an abortion upon a pregnant woman with actual knowledge that the conditions specified in division (B) of section 2317.56 of the Revised Code have not been satisfied or with a heedless indifference as to whether those conditions have been satisfied, unless an affirmative defense as specified in division (H)(2) of that section would apply in a civil action authorized by division (H)(1) of that section;

(24) The revocation, suspension, restriction, reduction, or termination of clinical privileges by the United States department of defense or department of veterans affairs or the termination or suspension of a certificate of registration to prescribe drugs by the drug enforcement administration of the United States department of justice;

(25) Termination or suspension from participation in the medicare or medicaid programs by the department of health and human services or other responsible agency for any act or acts that also would constitute a violation of division (B)(2), (3), (6), (8), or (19) of this section;
(26) Impairment of ability to practice according to acceptable and prevailing standards of care because of habitual or excessive use or abuse of drugs, alcohol, or other substances that impair ability to practice.

For the purposes of this division, any individual authorized to practice by this chapter accepts the privilege of practicing in this state subject to supervision by the board. By filing an application for or holding a license or certificate to practice under this chapter, an individual shall be deemed to have given consent to submit to a mental or physical examination when ordered to do so by the board in writing, and to have waived all objections to the admissibility of testimony or examination reports that constitute privileged communications.

If it has reason to believe that any individual authorized to practice by this chapter or any applicant for licensure or certification to practice suffers such impairment, the board may compel the individual to submit to a mental or physical examination, or both. The expense of the examination is the responsibility of the individual compelled to be examined. Any mental or physical examination required under this division shall be undertaken by a treatment provider or physician who is qualified to conduct the examination and who is chosen by the board.

Failure to submit to a mental or physical examination ordered by the board constitutes an admission of the allegations against the individual unless the failure is due to circumstances beyond the individual's control, and a default and final order may be entered without the taking of testimony or presentation of evidence. If the board determines that the individual's ability to practice is impaired, the board shall suspend the individual's license or certificate or deny the individual's application and shall require the individual, as a condition for initial, continued, reinstated, or renewed licensure or certification to practice, to submit to treatment.

Before being eligible to apply for reinstatement of a license or certificate suspended under this division, the impaired practitioner shall demonstrate to the board the ability to resume practice in compliance with acceptable and prevailing standards of care under the provisions of the practitioner's license or certificate. The demonstration shall include, but shall not be limited to, the following:

(a) Certification from a treatment provider approved under section 4731.25 of the Revised Code that the individual has successfully completed any required inpatient treatment;
(b) Evidence of continuing full compliance with an aftercare contract or consent agreement;
(c) Two written reports indicating that the individual's ability to practice has been assessed and that the individual has been found capable of practicing according to acceptable and prevailing standards of care. The reports shall be made by individuals or providers approved by the board for making the assessments and shall describe the basis for their determination.

The board may reinstate a license or certificate suspended under this division after that demonstration and after the individual has entered into a written consent agreement.

When the impaired practitioner resumes practice, the board shall require continued monitoring of the individual. The monitoring shall include, but not be limited to, compliance with the written consent agreement entered into before reinstatement or with conditions imposed by board order after a hearing, and, upon termination of the consent agreement, submission to the board for at least two years of annual written progress reports made under penalty of perjury stating whether the individual has maintained sobriety.

(27) A second or subsequent violation of section 4731.66 or 4731.69 of the Revised Code;
(28) Except as provided in division (N) of this section:
(a) Waiving the payment of all or any part of a deductible or copayment that a patient, pursuant to a health insurance or health care policy, contract, or plan that covers the individual's services, otherwise would be required to pay if the waiver is used as an enticement to a patient or group of patients to receive health care services from that individual;
(b) Advertising that the individual will waive the payment of all or any part of a deductible or copayment that a patient, pursuant to a health insurance or health care policy, contract, or plan that covers the individual’s services, otherwise would be required to pay.

(29) Failure to use universal blood and body fluid precautions established by rules adopted under section 4731.051 of the Revised Code;

(30) Failure to provide notice to, and receive acknowledgment of the notice from, a patient when required by section 4731.143 of the Revised Code prior to providing nonemergency professional services, or failure to maintain that notice in the patient’s medical record;

(31) Failure of a physician supervising a physician assistant to maintain supervision in accordance with the requirements of Chapter 4730 of the Revised Code and the rules adopted under that chapter;

(32) Failure of a physician or podiatrist to enter into a standard care arrangement with a clinical nurse specialist, certified nurse-midwife, or certified nurse practitioner with whom the physician or podiatrist is in collaboration pursuant to section 4731.27 of the Revised Code or failure to fulfill the responsibilities of collaboration after entering into a standard care arrangement;

(33) Failure to comply with the terms of a consult agreement entered into with a pharmacist pursuant to section 4729.39 of the Revised Code;

(34) Failure to cooperate in an investigation conducted by the board under division (F) of this section, including failure to comply with a subpoena or order issued by the board or failure to answer truthfully a question presented by the board in an investigative interview, an investigative office conference, at a deposition, or in written interrogatories, except that failure to cooperate with an investigation shall not constitute grounds for discipline under this section if a court of competent jurisdiction has issued an order that either quashes a subpoena or permits the individual to withhold the testimony or evidence in issue;

(35) Failure to supervise an oriental medicine practitioner or acupuncturist in accordance with Chapter 4762 of the Revised Code and the board’s rules for providing that supervision;

(36) Failure to supervise an anesthesiologist assistant in accordance with Chapter 4760 of the Revised Code and the board’s rules for supervision of an anesthesiologist assistant;

(37) Assisting suicide, as defined in section 3795.01 of the Revised Code;

(38) Failure to comply with the requirements of section 2317.561 of the Revised Code;

(39) Failure to supervise a radiologist assistant in accordance with Chapter 4774 of the Revised Code and the board’s rules for supervision of radiologist assistants;

(40) Performing or inducing an abortion at an office or facility with knowledge that the office or facility fails to post the notice required under section 3701.791 of the Revised Code;

(41) Failure to comply with the standards and procedures established in rules under section 4731.054 of the Revised Code, unless the state board of pharmacy no longer maintains a drug database pursuant to section 4729.75 of the Revised Code;

(42) Failure to comply with the standards and procedures established in rules under section 4731.054 of the Revised Code for providing supervision, direction, and control of individuals at a pain management clinic;

(43) Failure to comply with the requirements of section 4729.79 or 4731.055 of the Revised Code, unless the state board of pharmacy no longer maintains a drug database pursuant to section 4729.75 of the Revised Code;

(44) Failure to comply with the requirements of section 2919.171, 2919.202, or 2919.203 of the Revised Code or failure to submit to the department of health in accordance with a court order a complete report as described in section 2919.171 or 2919.202 of the Revised Code;

(45) Practicing at a facility that is subject to licensure as a category III terminal distributor of dangerous drugs with a pain management clinic classification unless the person operating the facility has obtained and maintains the license with the classification;
(46) Owning a facility that is subject to licensure as a category III terminal distributor of dangerous drugs with a pain management clinic classification unless the facility is licensed with the classification;

(47) Failure to comply with the requirement regarding maintaining notes described in division (B) of section 2919.191 of the Revised Code or failure to satisfy the requirements of section 2919.191 of the Revised Code prior to performing or inducing an abortion upon a pregnant woman;

(48) Failure to comply with the requirements in section 3719.061 of the Revised Code before issuing for a minor a prescription for an opioid analgesic, as defined in section 3719.01 of the Revised Code;

(49) Failure to comply with the requirements of section 4731.30 of the Revised Code or rules adopted under section 4731.301 of the Revised Code when recommending treatment with medical marijuana;

(50) Practicing at a facility, clinic, or other location that is subject to licensure as a category III terminal distributor of dangerous drugs with an office-based opioid treatment classification unless the person operating that place has obtained and maintains the license with the classification;

(51) Owning a facility, clinic, or other location that is subject to licensure as a category III terminal distributor of dangerous drugs with an office-based opioid treatment classification unless that place is licensed with the classification.

(C) Disciplinary actions taken by the board under divisions (A) and (B) of this section shall be taken pursuant to an adjudication under Chapter 119 of the Revised Code, except that in lieu of an adjudication, the board may enter into a consent agreement with an individual to resolve an allegation of a violation of this chapter or any rule adopted under it. A consent agreement, when ratified by an affirmative vote of not fewer than six members of the board, shall constitute the findings and order of the board with respect to the matter addressed in the agreement. If the board refuses to ratify a consent agreement, the admissions and findings contained in the consent agreement shall be of no force or effect.

A telephone conference call may be utilized for ratification of a consent agreement that revokes or suspends an individual's license or certificate to practice or certificate to recommend. The telephone conference call shall be considered a special meeting under division (F) of section 121.22 of the Revised Code.

If the board takes disciplinary action against an individual under division (B) of this section for a second or subsequent plea of guilty to, or judicial finding of guilt of, a violation of section 2919.123 of the Revised Code, the disciplinary action shall consist of a suspension of the individual's license or certificate to practice for a period of at least one year or, if determined appropriate by the board, a more serious sanction involving the individual's license or certificate to practice. Any consent agreement entered into under this division with an individual that pertains to a second or subsequent plea of guilty to, or judicial finding of guilt of, a violation of that section shall provide for a suspension of the individual's license or certificate to practice for a period of at least one year or, if determined appropriate by the board, a more serious sanction involving the individual's license or certificate to practice.

(D) For purposes of divisions (B)(10), (12), and (14) of this section, the commission of the act may be established by a finding by the board, pursuant to an adjudication under Chapter 119 of the Revised Code, that the individual committed the act. The board does not have jurisdiction under those divisions if the trial court renders a final judgment in the individual's favor and that judgment is based upon an adjudication on the merits. The board has jurisdiction under those divisions if the trial court issues an order of dismissal upon technical or procedural grounds.

(E) The sealing of conviction records by any court shall have no effect upon a prior board order entered under this section or upon the board's jurisdiction to take action under this
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section if, based upon a plea of guilty, a judicial finding of guilt, or a judicial finding of eligibility for intervention in lieu of conviction, the board issued a notice of opportunity for a hearing prior to the court's order to seal the records. The board shall not be required to seal, destroy, redact, or otherwise modify its records to reflect the court's sealing of conviction records.

(F)(1) The board shall investigate evidence that appears to show that a person has violated any provision of this chapter or any rule adopted under it. Any person may report to the board in a signed writing any information that the person may have that appears to show a violation of any provision of this chapter or any rule adopted under it. In the absence of bad faith, any person who reports information of that nature or who testifies before the board in any adjudication conducted under Chapter 119 of the Revised Code shall not be liable in damages in a civil action as a result of the report or testimony. Each complaint or allegation of a violation received by the board shall be assigned a case number and shall be recorded by the board.

(2) Investigations of alleged violations of this chapter or any rule adopted under it shall be supervised by the supervising member elected by the board in accordance with section 4731.02 of the Revised Code and by the secretary as provided in section 4731.39 of the Revised Code. The president may designate another member of the board to supervise the investigation in place of the supervising member. No member of the board who supervises the investigation of a case shall participate in further adjudication of the case.

(3) In investigating a possible violation of this chapter or any rule adopted under this chapter, or in conducting an inspection under division (E) of section 4731.054 of the Revised Code, the board may question witnesses, conduct interviews, administer oaths, order the taking of depositions, inspect and copy any books, accounts, papers, records, or documents, issue subpoenas, and compel the attendance of witnesses and production of books, accounts, papers, records, documents, and testimony, except that a subpoena for patient record information shall not be issued without consultation with the attorney general's office and approval of the secretary and supervising member of the board.

(a) Before issuance of a subpoena for patient record information, the secretary and supervising member shall determine whether there is probable cause to believe that the complaint filed alleges a violation of this chapter or any rule adopted under it and that the records sought are relevant to the alleged violation and material to the investigation. The subpoena may apply only to records that cover a reasonable period of time surrounding the alleged violation.

(b) On failure to comply with any subpoena issued by the board and after reasonable notice to the person being subpoenaed, the board may move for an order compelling the production of persons or records pursuant to the Rules of Civil Procedure.

(c) A subpoena issued by the board may be served by a sheriff, the sheriff's deputy, or a board employee designated by the board. Service of a subpoena issued by the board may be made by delivering a copy of the subpoena to the person named therein, reading it to the person, or leaving it at the person's usual place of residence, usual place of business, or address on file with the board. When serving a subpoena to an applicant for or the holder of a license or certificate issued under this chapter, service of the subpoena may be made by certified mail, return receipt requested, and the subpoena shall be deemed served on the date delivery is made or the date the person refuses to accept delivery. If the person being served refuses to accept the subpoena or is not located, service may be made to an attorney who notifies the board that the attorney is representing the person.

(d) A sheriff's deputy who serves a subpoena shall receive the same fees as a sheriff. Each witness who appears before the board in obedience to a subpoena shall receive the fees and mileage provided for under section 119.094 of the Revised Code.

(4) All hearings, investigations, and inspections of the board shall be considered civil actions for the purposes of section 2305.252 of the Revised Code.
(5) A report required to be submitted to the board under this chapter, a complaint, or information received by the board pursuant to an investigation or pursuant to an inspection under division (E) of section 4731.054 of the Revised Code is confidential and not subject to discovery in any civil action.

The board shall conduct all investigations or inspections and proceedings in a manner that protects the confidentiality of patients and persons who file complaints with the board. The board shall not make public the names or any other identifying information about patients or complainants unless proper consent is given or, in the case of a patient, a waiver of the patient privilege exists under division (B) of section 2317.02 of the Revised Code, except that consent or a waiver of that nature is not required if the board possesses reliable and substantial evidence that no bona fide physician-patient relationship exists.

The board may share any information it receives pursuant to an investigation or inspection, including patient records and patient record information, with law enforcement agencies, other licensing boards, and other governmental agencies that are prosecuting, adjudicating, or investigating alleged violations of statutes or administrative rules. An agency or board that receives the information shall comply with the same requirements regarding confidentiality as those with which the state medical board must comply, notwithstanding any conflicting provision of the Revised Code or procedure of the agency or board that applies when it is dealing with other information in its possession. In a judicial proceeding, the information may be admitted into evidence only in accordance with the Rules of Evidence, but the court shall require that appropriate measures are taken to ensure that confidentiality is maintained with respect to any part of the information that contains names or other identifying information about patients or complainants whose confidentiality was protected by the state medical board when the information was in the board’s possession. Measures to ensure confidentiality that may be taken by the court include sealing its records or deleting specific information from its records.

(6) On a quarterly basis, the board shall prepare a report that documents the disposition of all cases during the preceding three months. The report shall contain the following information for each case with which the board has completed its activities:

(a) The case number assigned to the complaint or alleged violation;
(b) The type of license or certificate to practice, if any, held by the individual against whom the complaint is directed;
(c) A description of the allegations contained in the complaint;
(d) The disposition of the case.

The report shall state how many cases are still pending and shall be prepared in a manner that protects the identity of each person involved in each case. The report shall be a public record under section 149.43 of the Revised Code.

(G) If the secretary and supervising member determine both of the following, they may recommend that the board suspend an individual’s license or certificate to practice or certificate to recommend without a prior hearing:

(1) That there is clear and convincing evidence that an individual has violated division (B) of this section;
(2) That the individual’s continued practice presents a danger of immediate and serious harm to the public.

Written allegations shall be prepared for consideration by the board. The board, upon review of those allegations and by an affirmative vote of not fewer than six of its members, excluding the secretary and supervising member, may suspend a license or certificate without a prior hearing. A telephone conference call may be utilized for reviewing the allegations and taking the vote on the summary suspension.

The board shall issue a written order of suspension by certified mail or in person in accordance with section 119.07 of the Revised Code. The order shall not be subject to
suspension by the court during pendency of any appeal filed under section 119.12 of the Revised Code. If the individual subject to the summary suspension requests an adjudicatory hearing by the board, the date set for the hearing shall be within fifteen days, but not earlier than seven days, after the individual requests the hearing, unless otherwise agreed to by both the board and the individual.

Any summary suspension imposed under this division shall remain in effect, unless reversed on appeal, until a final adjudicative order issued by the board pursuant to this section and Chapter 119 of the Revised Code becomes effective. The board shall issue its final adjudicative order within seventy-five days after completion of its hearing. A failure to issue the order within seventy-five days shall result in dissolution of the summary suspension order but shall not invalidate any subsequent, final adjudicative order.

(H) If the board takes action under division (B)(9), (11), or (13) of this section and the judicial finding of guilt, guilty plea, or judicial finding of eligibility for intervention in lieu of conviction is overturned on appeal, upon exhaustion of the criminal appeal, a petition for reconsideration of the order may be filed with the board along with appropriate court documents. Upon receipt of a petition of that nature and supporting court documents, the board shall reinstate the individual's license or certificate to practice. The board may then hold an adjudication under Chapter 119 of the Revised Code to determine whether the individual committed the act in question. Notice of an opportunity for a hearing shall be given in accordance with Chapter 119 of the Revised Code. If the board finds, pursuant to an adjudication held under this division, that the individual committed the act or if no hearing is requested, the board may order any of the sanctions identified under division (B) of this section.

(I) The license or certificate to practice issued to an individual under this chapter and the individual's practice in this state are automatically suspended as of the date of the individual's second or subsequent plea of guilty to, or judicial finding of guilt of, a violation of section 2919.123 of the Revised Code. In addition, the license or certificate to practice or certificate to recommend issued to an individual under this chapter and the individual's practice in this state are automatically suspended as of the date the individual pleads guilty to, is found by a judge or jury to be guilty of, or is subject to a judicial finding of eligibility for intervention in lieu of conviction in this state or treatment or intervention in lieu of conviction in another jurisdiction for any of the following criminal offenses in this state or a substantially equivalent criminal offense in another jurisdiction: aggravated murder, murder, voluntary manslaughter, felonious assault, kidnapping, rape, sexual battery, gross sexual imposition, aggravated arson, aggravated robbery, or aggravated burglary. Continued practice after suspension shall be considered practicing without a license or certificate.

The board shall notify the individual subject to the suspension by certified mail or in person in accordance with section 119.07 of the Revised Code. If an individual whose license or certificate is automatically suspended under this division fails to make a timely request for an adjudication under Chapter 119 of the Revised Code, the board shall do whichever of the following is applicable:

(1) If the automatic suspension under this division is for a second or subsequent plea of guilty to, or judicial finding of guilt of, a violation of section 2919.123 of the Revised Code, the board shall enter an order suspending the individual's license or certificate to practice for a period of at least one year or, if determined appropriate by the board, imposing a more serious sanction involving the individual's license or certificate to practice.

(2) In all circumstances in which division (I)(1) of this section does not apply, enter a final order permanently revoking the individual's license or certificate to practice.

(J) If the board is required by Chapter 119 of the Revised Code to give notice of an opportunity for a hearing and if the individual subject to the notice does not timely request a hearing in accordance with section 119.07 of the Revised Code, the board is not required to hold a hearing, but may adopt, by an affirmative vote of not fewer than six of its members, a
final order that contains the board's findings. In that final order, the board may order any of the sanctions identified under division (A) or (B) of this section.

(K) Any action taken by the board under division (B) of this section resulting in a suspension from practice shall be accompanied by a written statement of the conditions under which the individual's license or certificate to practice may be reinstated. The board shall adopt rules governing conditions to be imposed for reinstatement. Reinstatement of a license or certificate suspended pursuant to division (B) of this section requires an affirmative vote of not fewer than six members of the board.

(L) When the board refuses to grant or issue a license or certificate to practice to an applicant, revokes an individual's license or certificate to practice, refuses to renew an individual's license or certificate to practice, or refuses to reinstate an individual's license or certificate to practice, the board may specify that its action is permanent. An individual subject to a permanent action taken by the board is forever thereafter ineligible to hold a license or certificate to practice and the board shall not accept an application for reinstatement of the license or certificate or for issuance of a new license or certificate.

(M) Notwithstanding any other provision of the Revised Code, all of the following apply:

(1) The surrender of a license or certificate issued under this chapter shall not be effective unless or until accepted by the board. A telephone conference call may be utilized for acceptance of the surrender of an individual's license or certificate to practice. The telephone conference call shall be considered a special meeting under division (F) of section 121.22 of the Revised Code. Reinstatement of a license or certificate surrendered to the board requires an affirmative vote of not fewer than six members of the board.

(2) An application for a license or certificate made under the provisions of this chapter may not be withdrawn without approval of the board.

(3) Failure by an individual to renew a license or certificate to practice in accordance with this chapter or a certificate to recommend in accordance with rules adopted under section 4731.301 of the Revised Code shall not remove or limit the board's jurisdiction to take any disciplinary action under this section against the individual.

(4) At the request of the board, a license or certificate holder shall immediately surrender to the board a license or certificate that the board has suspended, revoked, or permanently revoked.

(N) Sanctions shall not be imposed under division (B)(28) of this section against any person who waives deductibles and copayments as follows:

(1) In compliance with the health benefit plan that expressly allows such a practice. Waiver of the deductibles or copayments shall be made only with the full knowledge and consent of the plan purchaser, payer, and third-party administrator. Documentation of the consent shall be made available to the board upon request.

(2) For professional services rendered to any other person authorized to practice pursuant to this chapter, to the extent allowed by this chapter and rules adopted by the board.

(O) Under the board's investigative duties described in this section and subject to division (F) of this section, the board shall develop and implement a quality intervention program designed to improve through remedial education the clinical and communication skills of individuals authorized under this chapter to practice medicine and surgery, osteopathic medicine and surgery, and podiatric medicine and surgery. In developing and implementing the quality intervention program, the board may do all of the following:

(1) Offer in appropriate cases as determined by the board an educational and assessment program pursuant to an investigation the board conducts under this section;

(2) Select providers of educational and assessment services, including a quality intervention program panel of case reviewers;
(3) Make referrals to educational and assessment service providers and approve individual educational programs recommended by those providers. The board shall monitor the progress of each individual undertaking a recommended individual educational program.

(4) Determine what constitutes successful completion of an individual educational program and require further monitoring of the individual who completed the program or other action that the board determines to be appropriate;

(5) Adopt rules in accordance with Chapter 119 of the Revised Code to further implement the quality intervention program.

An individual who participates in an individual educational program pursuant to this division shall pay the financial obligations arising from that educational program.

4731.221 Practitioner with mental illness; incompetence.

If the state medical board has reason to believe that any person who has been granted a license or certificate under this chapter is mentally ill or mentally incompetent, it may file in the probate court of the county in which such person has a legal residence an affidavit in the form prescribed in section 5122.11 of the Revised Code and signed by the board secretary or a member of the board secretary's staff, whereupon the same proceedings shall be had as provided in Chapter 5122 of the Revised Code. The attorney general may represent the board in any proceeding commenced under this section.

If any person who has been granted a license or certificate under this chapter is adjudged by a probate court to be mentally ill or mentally incompetent, the person's license or certificate shall be automatically suspended until such person has filed with the state medical board a certified copy of an adjudication by a probate court of the person's subsequent restoration to competency or has submitted to such board proof, satisfactory to the board, that the person has been discharged as having a restoration to competency in the manner and form provided in section 5122.38 of the Revised Code. The judge of such court shall forthwith notify the state medical board of an adjudication of mental illness or mental incompetence, and shall note any suspension of a license or certificate in the margin of the court's record of such license or certificate.

4731.222 Restoration of certificate.

(A) This section applies to both of the following:

(1) An applicant seeking restoration of a license or certificate issued under this chapter that has been in a suspended or inactive state for any cause for more than two years;

(2) An applicant seeking issuance of a license or certificate pursuant to section 4731.17 or 4731.295 of the Revised Code who for more than two years has not been engaged in the practice of medicine and surgery, osteopathic medicine and surgery, or a limited branch of medicine as any of the following:

(a) An active practitioner;

(b) A participant in a program of graduate medical education, as defined in section 4731.04 of the Revised Code;

(c) A student in a college of podiatry determined by the state medical board to be in good standing;

(d) A student in a school, college, or institution giving instruction in a limited branch of medicine determined by the board to be in good standing under section 4731.16 of the Revised Code.

(B) Before restoring a license or certificate to good standing for or issuing a license or certificate to an applicant subject to this section, the state medical board may impose terms and conditions including any one or more of the following:
(1) Requiring the applicant to pass an oral or written examination, or both, to determine the applicant's present fitness to resume practice;
(2) Requiring the applicant to obtain additional training and to pass an examination upon completion of such training;
(3) Requiring an assessment of the applicant's physical skills for purposes of determining whether the applicant's coordination, fine motor skills, and dexterity are sufficient for performing medical evaluations and procedures in a manner that meets the minimal standards of care;
(4) Requiring an assessment of the applicant's skills in recognizing and understanding diseases and conditions;
(5) Requiring the applicant to undergo a comprehensive physical examination, which may include an assessment of physical abilities, evaluation of sensory capabilities, or screening for the presence of neurological disorders;
(6) Restricting or limiting the extent, scope, or type of practice of the applicant.

The board shall consider the moral background and the activities of the applicant during the period of suspension or inactivity, in accordance with section 4731.09, 4731.19, or 4731.52 of the Revised Code. The board shall not restore a license or certificate under this section unless the applicant complies with sections 4776.01 to 4776.04 of the Revised Code.

4731.224 Health care facility and insurer; duty to report.

[Editor's Note: This version of the statute is effective from 9/29/2017 to 1/20/2018. The version effective after that date is provided subsequently.]

(A) Within sixty days after the imposition of any formal disciplinary action taken by any health care facility, including a hospital, health care facility operated by a health insuring corporation, ambulatory surgical center, or similar facility, against any individual holding a valid license or certificate to practice issued pursuant to this chapter, the chief administrator or executive officer of the facility shall report to the state medical board the name of the individual, the action taken by the facility, and a summary of the underlying facts leading to the action taken. Upon request, the board shall be provided certified copies of the patient records that were the basis for the facility's action. Prior to release to the board, the summary shall be approved by the peer review committee that reviewed the case or by the governing board of the facility. As used in this division, "formal disciplinary action" means any action resulting in the revocation, restriction, reduction, or termination of clinical privileges for violations of professional ethics, or for reasons of medical incompetence, medical malpractice, or drug or alcohol abuse. "Formal disciplinary action" includes a summary action, an action that takes effect notwithstanding any appeal rights that may exist, and an action that results in an individual surrendering clinical privileges while under investigation and during proceedings regarding the action being taken or in return for not being investigated or having proceedings held. "Formal disciplinary action" does not include any action taken for the sole reason of failure to maintain records on a timely basis or failure to attend staff or section meetings.

The filing or nonfiling of a report with the board, investigation by the board, or any disciplinary action taken by the board, shall not preclude any action by a health care facility to suspend, restrict, or revoke the individual's clinical privileges.

In the absence of fraud or bad faith, no individual or entity that provides patient records to the board shall be liable in damages to any person as a result of providing the records.

(B) If any individual authorized to practice under this chapter or any professional association or society of such individuals believes that a violation of any provision of this chapter, Chapter 4730., 4760., 4762., 4774., or 4778 of the Revised Code, or any rule of the board has occurred, the individual, association, or society shall report to the board the
information upon which the belief is based. This division does not require any treatment provider approved by the board under section 4731.25 of the Revised Code or any employee, agent, or representative of such a provider to make reports with respect to an impaired practitioner participating in treatment or aftercare for substance abuse as long as the practitioner maintains participation in accordance with the requirements of section 4731.25 of the Revised Code, and as long as the treatment provider or employee, agent, or representative of the provider has no reason to believe that the practitioner has violated any provision of this chapter or any rule adopted under it, other than the provisions of division (B)(26) of section 4731.22 of the Revised Code. This division does not require reporting by any member of an impaired practitioner committee established by a health care facility or by any representative or agent of a committee or program sponsored by a professional association or society of individuals authorized to practice under this chapter to provide peer assistance to practitioners with substance abuse problems with respect to a practitioner who has been referred for examination to a treatment program approved by the board under section 4731.25 of the Revised Code if the practitioner cooperates with the referral for examination and with any determination that the practitioner should enter treatment and as long as the committee member, representative, or agent has no reason to believe that the practitioner has ceased to participate in the treatment program in accordance with section 4731.25 of the Revised Code or has violated any provision of this chapter or any rule adopted under it, other than the provisions of division (B)(26) of section 4731.22 of the Revised Code.

(C) Any professional association or society composed primarily of doctors of medicine and surgery, doctors of osteopathic medicine and surgery, doctors of podiatric medicine and surgery, or practitioners of limited branches of medicine that suspends or revokes an individual's membership for violations of professional ethics, or for reasons of professional incompetence or professional malpractice, within sixty days after a final decision shall report to the board, on forms prescribed and provided by the board, the name of the individual, the action taken by the professional organization, and a summary of the underlying facts leading to the action taken.

The filing of a report with the board or decision not to file a report, investigation by the board, or any disciplinary action taken by the board, does not preclude a professional organization from taking disciplinary action against an individual.

(D) Any insurer providing professional liability insurance to an individual authorized to practice under this chapter, or any other entity that seeks to indemnify the professional liability of such an individual, shall notify the board within thirty days after the final disposition of any written claim for damages where such disposition results in a payment exceeding twenty-five thousand dollars. The notice shall contain the following information:

(1) The name and address of the person submitting the notification;
(2) The name and address of the insured who is the subject of the claim;
(3) The name of the person filing the written claim;
(4) The date of final disposition;
(5) If applicable, the identity of the court in which the final disposition of the claim took place.

(E) The board may investigate possible violations of this chapter or the rules adopted under it that are brought to its attention as a result of the reporting requirements of this section, except that the board shall conduct an investigation if a possible violation involves repeated malpractice. As used in this division, “repeated malpractice” means three or more claims for medical malpractice within the previous five-year period, each resulting in a judgment or settlement in excess of twenty-five thousand dollars in favor of the claimant, and each involving negligent conduct by the practicing individual.

(F) All summaries, reports, and records received and maintained by the board pursuant to this section shall be held in confidence and shall not be subject to discovery or introduction in evidence in any federal or state civil action involving a health care professional or facility arising...
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out of matters that are the subject of the reporting required by this section. The board may use
the information obtained only as the basis for an investigation, as evidence in a disciplinary
hearing against an individual whose practice is regulated under this chapter, or in any
subsequent trial or appeal of a board action or order.

The board may disclose the summaries and reports it receives under this section only to
health care facility committees within or outside this state that are involved in credentialing or
recredentialing the individual or in reviewing the individual's clinical privileges. The board shall
indicate whether or not the information has been verified. Information transmitted by the board
shall be subject to the same confidentiality provisions as when maintained by the board.

    (G) Except for reports filed by an individual pursuant to division (B) of this section, the
board shall send a copy of any reports or summaries it receives pursuant to this section to the
individual who is the subject of the reports or summaries. The individual shall have the right to
file a statement with the board concerning the correctness or relevance of the information. The
statement shall at all times accompany that part of the record in contention.

    (H) An individual or entity that, pursuant to this section, reports to the board or refers an
impaired practitioner to a treatment provider approved by the board under section 4731.25 of
the Revised Code shall not be subject to suit for civil damages as a result of the report, referral,
or provision of the information.

    (I) In the absence of fraud or bad faith, no professional association or society of
individuals authorized to practice under this chapter that sponsors a committee or program to
provide peer assistance to practitioners with substance abuse problems, no representative or
agent of such a committee or program, and no member of the state medical board shall be held
liable in damages to any person by reason of actions taken to refer a practitioner to a treatment
provider approved under section 4731.25 of the Revised Code for examination or treatment.

4731.224 Health care facility and insurer; duty to report.

[Editor's Note: This version of the statute is effective 1/21/2018. The version effective prior to
that date is provided previously.]

    (A) Within sixty days after the imposition of any formal disciplinary action taken by any
health care facility, including a hospital, health care facility operated by a health insuring
corporation, ambulatory surgical center, or similar facility, against any individual holding a valid
license or certificate to practice issued pursuant to this chapter, the chief administrator or
executive officer of the facility shall report to the state medical board the name of the individual,
the action taken by the facility, and a summary of the underlying facts leading to the action
taken. Upon request, the board shall be provided certified copies of the patient records that
were the basis for the facility's action. Prior to release to the board, the summary shall be
approved by the peer review committee that reviewed the case or by the governing board of the
facility. As used in this division, "formal disciplinary action" means any action resulting in the
revocation, restriction, reduction, or termination of clinical privileges for violations of professional
ethics, or for reasons of medical incompetence, medical malpractice, or drug or alcohol abuse.
"Formal disciplinary action" includes a summary action, an action that takes effect
notwithstanding any appeal rights that may exist, and an action that results in an individual
surrendering clinical privileges while under investigation and during proceedings regarding the
action being taken or in return for not being investigated or having proceedings held. "Formal
disciplinary action" does not include any action taken for the sole reason of failure to maintain
records on a timely basis or failure to attend staff or section meetings.

The filing or nonfiling of a report with the board, investigation by the board, or any
disciplinary action taken by the board, shall not preclude any action by a health care facility to
suspend, restrict, or revoke the individual's clinical privileges.
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In the absence of fraud or bad faith, no individual or entity that provides patient records to the board shall be liable in damages to any person as a result of providing the records.

(B) If any individual authorized to practice under this chapter or any professional association or society of such individuals believes that a violation of any provision of this chapter, Chapter 4730., 4759., 4760., 4761., 4762., 4774., or 4778 of the Revised Code, or any rule of the board has occurred, the individual, association, or society shall report to the board the information upon which the belief is based. This division does not require any treatment provider approved by the board under section 4731.25 of the Revised Code or any employee, agent, or representative of such a provider to make reports with respect to an impaired practitioner participating in treatment or aftercare for substance abuse as long as the practitioner maintains participation in accordance with the requirements of section 4731.25 of the Revised Code, and as long as the treatment provider or employee, agent, or representative of the provider has no reason to believe that the practitioner has violated any provision of this chapter or any rule adopted under it, other than the provisions of division (B)(26) of section 4731.22 of the Revised Code. This division does not require reporting by any member of an impaired practitioner committee established by a health care facility or by any representative or agent of a committee or program sponsored by a professional association or society of individuals authorized to practice under this chapter to provide peer assistance to practitioners with substance abuse problems with respect to a practitioner who has been referred for examination to a treatment program approved by the board under section 4731.25 of the Revised Code if the practitioner cooperates with the referral for examination and with any determination that the practitioner should enter treatment and as long as the committee member, representative, or agent has no reason to believe that the practitioner has ceased to participate in the treatment program in accordance with section 4731.25 of the Revised Code or has violated any provision of this chapter or any rule adopted under it, other than the provisions of division (B)(26) of section 4731.22 of the Revised Code.

(C) Any professional association or society composed primarily of doctors of medicine and surgery, doctors of osteopathic medicine and surgery, doctors of podiatric medicine and surgery, or practitioners of limited branches of medicine that suspends or revokes an individual’s membership for violations of professional ethics, or for reasons of professional incompetence or professional malpractice, within sixty days after a final decision shall report to the board, on forms prescribed and provided by the board, the name of the individual, the action taken by the professional organization, and a summary of the underlying facts leading to the action taken.

The filing of a report with the board or decision not to file a report, investigation by the board, or any disciplinary action taken by the board, does not preclude a professional organization from taking disciplinary action against an individual.

(D) Any insurer providing professional liability insurance to an individual authorized to practice under this chapter, or any other entity that seeks to indemnify the professional liability of such an individual, shall notify the board within thirty days after the final disposition of any written claim for damages where such disposition results in a payment exceeding twenty-five thousand dollars. The notice shall contain the following information:

(1) The name and address of the person submitting the notification;
(2) The name and address of the insured who is the subject of the claim;
(3) The name of the person filing the written claim;
(4) The date of final disposition;
(5) If applicable, the identity of the court in which the final disposition of the claim took place.

(E) The board may investigate possible violations of this chapter or the rules adopted under it that are brought to its attention as a result of the reporting requirements of this section, except that the board shall conduct an investigation if a possible violation involves repeated malpractice. As used in this division, “repeated malpractice” means three or more claims for
medical malpractice within the previous five-year period, each resulting in a judgment or settlement in excess of twenty-five thousand dollars in favor of the claimant, and each involving negligent conduct by the practicing individual.

(F) All summaries, reports, and records received and maintained by the board pursuant to this section shall be held in confidence and shall not be subject to discovery or introduction in evidence in any federal or state civil action involving a health care professional or facility arising out of matters that are the subject of the reporting required by this section. The board may use the information obtained only as the basis for an investigation, as evidence in a disciplinary hearing against an individual whose practice is regulated under this chapter, or in any subsequent trial or appeal of a board action or order.

The board may disclose the summaries and reports it receives under this section only to health care facility committees within or outside this state that are involved in credentialing or recredentialing the individual or in reviewing the individual's clinical privileges. The board shall indicate whether or not the information has been verified. Information transmitted by the board shall be subject to the same confidentiality provisions as when maintained by the board.

(G) Except for reports filed by an individual pursuant to division (B) of this section, the board shall send a copy of any reports or summaries it receives pursuant to this section to the individual who is the subject of the reports or summaries. The individual shall have the right to file a statement with the board concerning the correctness or relevance of the information. The statement shall at all times accompany that part of the record in contention.

(H) An individual or entity that, pursuant to this section, reports to the board or refers an impaired practitioner to a treatment provider approved by the board under section 4731.25 of the Revised Code shall not be subject to suit for civil damages as a result of the report, referral, or provision of the information.

(I) In the absence of fraud or bad faith, no professional association or society of individuals authorized to practice under this chapter that sponsors a committee or program to provide peer assistance to practitioners with substance abuse problems, no representative or agent of such a committee or program, and no member of the state medical board shall be held liable in damages to any person by reason of actions taken to refer a practitioner to a treatment provider approved under section 4731.25 of the Revised Code for examination or treatment.

4731.227 Alternative medical treatments.

An individual authorized to practice medicine and surgery or osteopathic medicine and surgery may use alternative medical treatments if the individual has provided the information necessary to obtain informed consent from the patient and the treatment meets the standards enforced by the state medical board pursuant to section 4731.22 of the Revised Code and any rules adopted by the board.

As used in this section, “alternative medical treatment” means care that is complementary to or different from conventional medical care but is reasonable when the benefits and risks of the alternative medical treatment and the conventional medical care are compared. “Alternative medical treatment” does not include treatment with an investigational drug, product, or device under section 4731.97 of the Revised Code.

4731.228 Health care entity notice to patients of terminated physician.

(A) As used in this section:

1. “Federally qualified health center” has the same meaning as in section 3701.047 of the Revised Code.

2. “Federally qualified health center look-alike” has the same meaning as in section 3701.047 of the Revised Code.
(3) “Health care entity” means any of the following that employs a physician to provide physician services:
   (a) A hospital registered with the department of health under section 3701.07 of the Revised Code;
   (b) A corporation formed under division (B) of section 1701.03 of the Revised Code;
   (c) A corporation formed under Chapter 1702 of the Revised Code;
   (d) A limited liability company formed under Chapter 1705 of the Revised Code;
   (e) A health insuring corporation holding a certificate of authority under Chapter 1751 of the Revised Code;
   (f) A partnership;
   (g) A professional association formed under Chapter 1785 of the Revised Code.

(4) “Physician” means an individual authorized under this chapter to practice medicine and surgery, osteopathic medicine and surgery, or podiatric medicine and surgery.

(5) “Physician services” means direct patient care services provided by a physician pursuant to a certificate issued to the physician by the state medical board.

(6) “Termination” means the end of a physician’s employment with a health care entity for any reason.

(B) This section applies when a physician’s employment with a health care entity to provide physician services is terminated for any reason, unless the physician continues to provide medical services for patients of the health care entity on an independent contractor basis.

(C)(1) Except as provided in division (C)(2) of this section, a health care entity shall send notice of the termination of a physician’s employment to each patient who received physician services from the physician in the two-year period immediately preceding the date of employment termination. Only patients of the health care entity who received services from the physician are to receive the notice.

(2) If the health care entity provides to the physician a list of patients treated and patient contact information, the health care entity may require the physician to send the notice required by this section.

(D) The notice provided under division (C) of this section shall be provided not later than the date of termination or thirty days after the health care entity has actual knowledge of termination or resignation of the physician, whichever is later. The notice shall be provided in accordance with rules adopted by the state medical board under section 4731.05 of the Revised Code. The notice shall include at least all of the following:

   (1) A notice to the patient that the physician will no longer be practicing medicine as an employee of the health care entity;
   (2) Except in situations in which the health care entity has a good faith concern that the physician’s conduct or the medical care provided by the physician would jeopardize the health and safety of patients, the physician’s name and, if known by the health care entity, information provided by the physician that the patient may use to contact the physician;
   (3) The date on which the physician ceased or will cease to practice as an employee of the health care entity;
   (4) Contact information for an alternative physician or physicians employed by the health care entity or contact information for a group practice that can provide care for the patient;
   (5) Contact information that enables the patient to obtain information on the patient’s medical records.

(E) The requirements of this section do not apply to any of the following:

   (1) A physician rendering services to a patient on an episodic basis or in an emergency department or urgent care center, when it should not be reasonably expected that related medical services will be rendered by the physician to the patient in the future;
   (2) A medical director or other physician providing services in a similar capacity to a
medical director to patients through a hospice care program licensed pursuant to section 3712.04 of the Revised Code.

(3) Medical residents, interns, and fellows who work in hospitals, health systems, federally qualified health centers, and federally qualified health center look-alikes as part of their medical education and training.

(4) A physician providing services to a patient through a community mental health agency certified by the director of mental health under section 5119.611 of the Revised Code or an alcohol and drug addiction program certified by the department of alcohol and drug addiction services under section 3793.06 of the Revised Code.

(5) A physician providing services to a patient through a federally qualified health center or a federally qualified health center look-alike.

4731.25 Treatment of impaired practitioners; standards.

[Editor’s Note: This version of the statute is effective until 1/21/2018. The version effective subsequently is provided next.]

The state medical board, in accordance with Chapter 119 of the Revised Code, shall adopt and may amend and rescind rules establishing standards for approval of physicians and facilities as treatment providers for impaired practitioners who are regulated under this chapter or Chapter 4730., 4760., 4762., 4774., or 4778 of the Revised Code. The rules shall include standards for both inpatient and outpatient treatment. The rules shall provide that in order to be approved, a treatment provider must have the capability of making an initial examination to determine what type of treatment an impaired practitioner requires. Subject to the rules, the board shall review and approve treatment providers on a regular basis. The board, at its discretion, may withdraw or deny approval subject to the rules.

An approved impaired practitioner treatment provider shall:

(A) Report to the board the name of any practitioner suffering or showing evidence of suffering impairment as described in division (B)(5) of section 4730.25 of the Revised Code, division (B)(26) of section 4731.22 of the Revised Code, division (B)(6) of section 4760.13 of the Revised Code, division (B)(6) of section 4762.13 of the Revised Code, division (B)(6) of section 4774.13 of the Revised Code, or division (B)(6) of section 4778.14 of the Revised Code who fails to comply within one week with a referral for examination;

(B) Report to the board the name of any impaired practitioner who fails to enter treatment within forty-eight hours following the provider's determination that the practitioner needs treatment;

(C) Require every practitioner who enters treatment to agree to a treatment contract establishing the terms of treatment and aftercare, including any required supervision or restrictions of practice during treatment or aftercare;

(D) Require a practitioner to suspend practice upon entry into any required inpatient treatment;

(E) Report to the board any failure by an impaired practitioner to comply with the terms of the treatment contract during inpatient or outpatient treatment or aftercare;

(F) Report to the board the resumption of practice of any impaired practitioner before the treatment provider has made a clear determination that the practitioner is capable of practicing according to acceptable and prevailing standards of care;

(G) Require a practitioner who resumes practice after completion of treatment to comply with an aftercare contract that meets the requirements of rules adopted by the board for approval of treatment providers;

(H) Report the identity of any practitioner practicing under the terms of an aftercare contract to hospital administrators, medical chiefs of staff, and chairpersons of impaired
practitioner committees of all health care institutions at which the practitioner holds clinical privileges or otherwise practices. If the practitioner does not hold clinical privileges at any health care institution, the treatment provider shall report the practitioner's identity to the impaired practitioner committee of the county medical society, osteopathic academy, or podiatric medical association in every county in which the practitioner practices. If there are no impaired practitioner committees in the county, the treatment provider shall report the practitioner's identity to the president or other designated member of the county medical society, osteopathic academy, or podiatric medical association.

(I) Report to the board the identity of any practitioner who suffers a relapse at any time during or following aftercare.

Any individual authorized to practice under this chapter who enters into treatment by an approved treatment provider shall be deemed to have waived any confidentiality requirements that would otherwise prevent the treatment provider from making reports required under this section.

In the absence of fraud or bad faith, no person or organization that conducts an approved impaired practitioner treatment program, no member of such an organization, and no employee, representative, or agent of the treatment provider shall be held liable in damages to any person by reason of actions taken or recommendations made by the treatment provider or its employees, representatives, or agents.

4731.25 Treatment of impaired practitioners; standards.

[Editor's Note: This version of the statute is effective 1/21/2018. The version effective prior to that date is provided previously.]

The state medical board, in accordance with Chapter 119 of the Revised Code, shall adopt and may amend and rescind rules establishing standards for approval of physicians and facilities as treatment providers for impaired practitioners who are regulated under this chapter or Chapter 4730, 4759, 4760, 4761, 4762, 4774, or 4778 of the Revised Code. The rules shall include standards for both inpatient and outpatient treatment. The rules shall provide that in order to be approved, a treatment provider must have the capability of making an initial examination to determine what type of treatment an impaired practitioner requires. Subject to the rules, the board shall review and approve treatment providers on a regular basis. The board, at its discretion, may withdraw or deny approval subject to the rules.

An approved impaired practitioner treatment provider shall:

(A) Report to the board the name of any practitioner suffering or showing evidence of suffering impairment as described in division (B)(5) of section 4730.25 of the Revised Code, division (B)(26) of section 4731.22 of the Revised Code, division (A)(4) of section 4759.07 of the Revised Code, division (B)(6) of section 4760.13 of the Revised Code, division (B)(6) of section 4762.13 of the Revised Code, division (B)(6) of section 4774.13 of the Revised Code, or division (B)(6) of section 4778.14 of the Revised Code who fails to comply within one week with a referral for examination;

(B) Report to the board the name of any impaired practitioner who fails to enter treatment within forty-eight hours following the provider's determination that the practitioner needs treatment;

(C) Require every practitioner who enters treatment to agree to a treatment contract establishing the terms of treatment and aftercare, including any required supervision or restrictions of practice during treatment or aftercare;

(D) Require a practitioner to suspend practice upon entry into any required inpatient treatment;

(E) Report to the board any failure by an impaired practitioner to comply with the terms
of the treatment contract during inpatient or outpatient treatment or aftercare;
   (F) Report to the board the resumption of practice of any impaired practitioner before the
   treatment provider has made a clear determination that the practitioner is capable of practicing
   according to acceptable and prevailing standards of care;
   (G) Require a practitioner who resumes practice after completion of treatment to comply
   with an aftercare contract that meets the requirements of rules adopted by the board for
   approval of treatment providers;
   (H) Report the identity of any practitioner practicing under the terms of an aftercare
   contract to hospital administrators, medical chiefs of staff, and chairpersons of impaired
   practitioner committees of all health care institutions at which the practitioner holds clinical
   privileges or otherwise practices. If the practitioner does not hold clinical privileges at any health
   care institution, the treatment provider shall report the practitioner's identity to the impaired
   practitioner committee of the county medical society, osteopathic academy, or podiatric medical
   association in every county in which the practitioner practices. If there are no impaired
   practitioner committees in the county, the treatment provider shall report the practitioner's
   identity to the president or other designated member of the county medical society, osteopathic
   academy, or podiatric medical association.
   (I) Report to the board the identity of any practitioner who suffers a relapse at any time
   during or following aftercare.
   Any individual authorized to practice under this chapter who enters into treatment by an
   approved treatment provider shall be deemed to have waived any confidentiality requirements
   that would otherwise prevent the treatment provider from making reports required
   under this
   section.
   In the absence of fraud or bad faith, no person or organization that conducts an
   approved impaired practitioner treatment program, no member of such an organization, and no
   employee, representative, or agent of the treatment provider shall be held liable in damages to
   any person by reason of actions taken or recommendations made by the treatment provider or
   its employees, representatives, or agents.

4731.27 Standard care arrangement with collaborating nurse.

   (A) As used in this section, "collaboration," "physician," "standard care arrangement,"
   and "supervision" have the same meanings as in section 4723.01 of the Revised Code.
   (B) A physician or podiatrist shall enter into a standard care arrangement with each
   clinical nurse specialist, certified nurse-midwife, or certified nurse practitioner with whom the
   physician or podiatrist is in collaboration.
   The collaborating physician or podiatrist shall fulfill the responsibilities of collaboration,
   as specified in the arrangement and in accordance with division (A) of section 4723.431 of the
   Revised Code. A copy of the standard care arrangement shall be retained on file by the nurse's
   employer. Prior approval of the standard care arrangement by the state medical board is not
   required, but the board may periodically review it.
   A physician or podiatrist who terminates collaboration with a certified nurse-midwife,
   certified nurse practitioner, or clinical nurse specialist before their standard care arrangement
   expires shall give the nurse the written or electronic notice of termination required by division
   (E)(1) of section 4723.431 of the Revised Code.
   Nothing in this division prohibits a hospital from hiring a clinical nurse specialist, certified
   nurse-midwife, or certified nurse practitioner as an employee and negotiating standard care
   arrangements on behalf of the employee as necessary to meet the requirements of this section.
   A standard care arrangement between the hospital's employee and the employee's
   collaborating physician is subject to approval by the medical staff and governing body of the
   hospital prior to implementation of the arrangement at the hospital.
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(C) A physician or podiatrist shall cooperate with the board of nursing in any investigation the board conducts with respect to a clinical nurse specialist, certified nurse-midwife, or certified nurse practitioner who collaborates with the physician or podiatrist or with respect to a certified registered nurse anesthetist who practices with the supervision of the physician or podiatrist.

4731.281 Continuing education; registration; malpractice claims.

(A)(1) Each person holding a license issued under this chapter to practice medicine and surgery, osteopathic medicine and surgery, or podiatric medicine and surgery wishing to renew that license shall apply to the board for renewal. Applications shall be submitted to the board in a manner prescribed by the board. Each application shall be accompanied by a biennial renewal fee of three hundred five dollars. Applications shall be submitted according to the following schedule:

(a) Persons whose last name begins with the letters “A” through “B,” on or before the first day of July of every odd-numbered year;
(b) Persons whose last name begins with the letters “C” through “D,” on or before the first day of April of every odd-numbered year;
(c) Persons whose last name begins with the letters “E” through “G,” on or before the first day of January of every odd-numbered year;
(d) Persons whose last name begins with the letters “H” through “K,” on or before the first day of October of every even-numbered year;
(e) Persons whose last name begins with the letters “L” through “M,” on or before the first day of July of every even-numbered year;
(f) Persons whose last name begins with the letters “N” through “R,” on or before the first day of April of every even-numbered year;
(g) Persons whose last name begins with the letter “S,” on or before the first day of January of every even-numbered year;
(h) Persons whose last name begins with the letters “T” through “Z,” on or before the first day of October of every even-numbered year.

The board shall deposit the fee in accordance with section 4731.24 of the Revised Code, except that the board shall deposit twenty dollars of the fee into the state treasury to the credit of the physician loan repayment fund created by section 3702.78 of the Revised Code.

(2) The board shall provide to every person holding a license to practice medicine and surgery, osteopathic medicine and surgery, or podiatric medicine and surgery, a renewal notice or may provide the notice to the person through the secretary of any recognized medical, osteopathic, or podiatric society. The notice shall be provided to the person at least one month prior to the date on which the person's license expires.

(3) Failure of any person to receive a notice of renewal from the board shall not excuse the person from the requirements contained in this section.

(4) The board's notice shall inform the applicant of the renewal procedure. The board shall provide the application for renewal in a form determined by the board.

(5) The applicant shall provide in the application the applicant's full name; the applicant's residence address, business address, and electronic mail address; the number of the applicant's license to practice; and any other information required by the board.

(6)(a) Except as provided in division (A)(6)(b) of this section, in the case of an applicant who prescribes or personally furnishes opioid analgesics or benzodiazepines, as defined in section 3719.01 of the Revised Code, the applicant shall certify to the board whether the applicant has been granted access to the drug database established and maintained by the state board of pharmacy pursuant to section 4729.75 of the Revised Code.

(b) The requirement in division (A)(6)(a) of this section does not apply if any of the
following is the case:
   (i) The state board of pharmacy notifies the state medical board pursuant to section 4729.861 of the Revised Code that the applicant has been restricted from obtaining further information from the drug database.
   (ii) The state board of pharmacy no longer maintains the drug database.
   (iii) The applicant does not practice medicine and surgery, osteopathic medicine and surgery, or podiatric medicine and surgery in this state.
(c) If an applicant certifies to the state medical board that the applicant has been granted access to the drug database and the board finds through an audit or other means that the applicant has not been granted access, the board may take action under section 4731.22 of the Revised Code.
(7) The applicant shall indicate whether the applicant currently collaborates, as that term is defined in section 4723.01 of the Revised Code, with any clinical nurse specialists, certified nurse-midwives, or certified nurse practitioners.
(8) The applicant shall report any criminal offense to which the applicant has pleaded guilty, of which the applicant has been found guilty, or for which the applicant has been found eligible for intervention in lieu of conviction, since last submitting an application for a license to practice or renewal of a license.
(9) The applicant shall execute and deliver the application to the board in a manner prescribed by the board.

(B) The board shall renew a license under this chapter to practice medicine and surgery, osteopathic medicine and surgery, or podiatric medicine and surgery upon application and qualification therefor in accordance with this section. A renewal shall be valid for a two-year period.
(C) Failure of any license holder to renew and comply with this section shall operate automatically to suspend the holder's license to practice and if applicable, the holder's certificate to recommend issued under section 4731.30 of the Revised Code. Continued practice after the suspension shall be considered as practicing in violation of section 4731.41, 4731.43, or 4731.60 of the Revised Code.
If the license has been suspended pursuant to this division for two years or less, it may be reinstated. The board shall reinstate a license to practice suspended for failure to renew upon an applicant's submission of a renewal application and payment of a reinstatement fee of four hundred five dollars.
If the license has been suspended pursuant to this division for more than two years, it may be restored. Subject to section 4731.222 of the Revised Code, the board may restore a license to practice suspended for failure to renew upon an applicant's submission of a restoration application, payment of a restoration fee of five hundred five dollars, and compliance with sections 4776.01 to 4776.04 of the Revised Code. The board shall not restore to an applicant a license to practice unless the board, in its discretion, decides that the results of the criminal records check do not make the applicant ineligible for a license issued pursuant to section 4731.14 or 4731.56 of the Revised Code. Any reinstatement or restoration of a license to practice under this section shall operate automatically to renew the holder's certificate to recommend.
(D) The state medical board may obtain information not protected by statutory or common law privilege from courts and other sources concerning malpractice claims against any person holding a license to practice under this chapter or practicing as provided in section 4731.36 of the Revised Code.
(E) Each mailing sent by the board under division (A)(2) of this section to a person holding a license to practice medicine and surgery or osteopathic medicine and surgery shall inform the applicant of the reporting requirement established by division (H) of section 3701.79 of the Revised Code. At the discretion of the board, the information may be included on the

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application for renewal or on an accompanying page.

(F) Each person holding a license to practice medicine and surgery, osteopathic medicine and surgery, or podiatric medicine and surgery shall give notice to the board of a change in the license holder’s residence address, business address, or electronic mail address not later than thirty days after the change occurs.

**4731.291 Training certificates.**

(A) An individual seeking to pursue an internship, residency, or clinical fellowship program in this state, who does not hold a license to practice medicine and surgery or osteopathic medicine and surgery issued under this chapter, shall apply to the state medical board for a training certificate. The application shall be made on forms that the board shall furnish and shall be accompanied by an application fee of seventy-five dollars.

An applicant for a training certificate shall furnish to the board all of the following:

1. Evidence satisfactory to the board that the applicant is at least eighteen years of age and is of good moral character.
2. Evidence satisfactory to the board that the applicant has been accepted or appointed to participate in this state in one of the following:
   a. An internship or residency program accredited by either the accreditation council for graduate medical education of the American medical association or the American osteopathic association;
   b. A clinical fellowship program at an institution with a residency program accredited by either the accreditation council for graduate medical education of the American medical association or the American osteopathic association that is in a clinical field the same as or related to the clinical field of the fellowship program;
3. Information identifying the beginning and ending dates of the period for which the applicant has been accepted or appointed to participate in the internship, residency, or clinical fellowship program;
4. Any other information that the board requires.

(B) If no grounds for denying a license or certificate under section 4731.22 of the Revised Code apply, and the applicant meets the requirements of division (A) of this section, the board shall issue a training certificate to the applicant. The board shall not require an examination as a condition of receiving a training certificate.

A training certificate issued pursuant to this section shall be valid only for the period of three years, but may in the discretion of the board and upon application duly made, be renewed annually thereafter for up to two additional years. The fee for renewal of a training certificate shall be thirty-five dollars.

The board shall maintain a register of all individuals who hold training certificates.

(C) The holder of a valid training certificate shall be entitled to perform such acts as may be prescribed by or incidental to the holder's internship, residency, or clinical fellowship program, but the holder shall not be entitled otherwise to engage in the practice of medicine and surgery or osteopathic medicine and surgery in this state. The holder shall limit activities under the certificate to the programs of the hospitals or facilities for which the training certificate is issued. The holder shall train only under the supervision of the physicians responsible for supervision as part of the internship, residency, or clinical fellowship program.

A training certificate may be revoked by the board upon proof, satisfactory to the board, that the holder thereof has engaged in practice in this state outside the scope of the internship, residency, or clinical fellowship program for which the training certificate has been issued, or upon proof, satisfactory to the board, that the holder thereof has engaged in unethical conduct or that there are grounds for action against the holder under section 4731.22 of the Revised Code.
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4731.292 Limited certificate for non-citizen.

The state medical board may register, without examination, persons who are not citizens of the United States, but who hold the degree of doctor of medicine or the degree of doctor of osteopathic medicine and surgery, for the purpose of permitting such persons to practice in hospitals operated by the state. Registration pursuant to this section permits practice of medicine or osteopathic medicine and surgery in state operated institutions under the supervision of the medical staff of such institution until the next scheduled examination prescribed by the state medical board in its rules.

An applicant for a limited certificate to practice medicine or osteopathic medicine and surgery shall furnish proof, satisfactory to the board, that:

(A) The applicant has filed an application for naturalization and that such application has not been rejected or withdrawn, or if not yet eligible to file an application for naturalization, the applicant has filed a declaration of intention to become a citizen of the United States in an appropriate court of record.

(B) The applicant has successfully passed the educational council for foreign medical graduates test.

(C) The applicant is at least eighteen years of age and of good moral character.

(D) The applicant is a graduate of a medical or osteopathic school or college which is reputable and in good standing in the judgment of the board.

(E) The applicant will limit the applicant's practice and training within the physical confines of the institution for which the limited certificate to practice is granted.

(F) The medical staff of the institution for which the limited certificate to practice is granted has approved in writing the applicant's application for such certificate.

(G) The applicant will practice medicine or osteopathic medicine and surgery only under the supervision of the attending medical staff of the institution for which the limited certificate is granted.

(H) The applicant has made application to take the state medical board examination as provided by this section.

Registration pursuant to this section shall be valid until such time as the applicant takes the state medical board examination. If the applicant passes the examination, the applicant shall then be granted a limited certificate to practice medicine or osteopathic medicine and surgery. A holder of a limited certificate to practice, upon completion of the requisite training and upon receipt of United States citizenship, shall be entitled to receive an unlimited license to practice.

A limited certificate to practice issued pursuant to this section shall be valid for a period of one year only, but may be renewed, in the discretion of the board and upon application duly made, annually, with the written approval of the medical staff of the institution for which the limited certificate to practice has been issued, but no limited certificate shall be renewed more than four times. The fee to be paid to the board for the issuances of the pre-examination registration permit to engage in limited practice shall be one hundred dollars; the fee to be paid for each renewal of a limited certificate shall be ten dollars.

An applicant for a limited certificate to practice must take an examination prescribed by the board in its rules at the first reasonable opportunity. Failure to take the examination at the first reasonable opportunity authorizes the termination of the pre-examination registration permit to engage in a limited practice as defined in this section.

The holder of a valid limited certificate to practice may engage in the practice of medicine and surgery or osteopathic medicine and surgery only under the supervision of a member of the medical staff of the institution for which the limited certificate to practice has
been issued, and only within physical confines of the institution so named. A limited certificate to practice may be revoked by the board upon proof, satisfactory to the board, that the holder thereof has engaged in the practice of medicine and surgery or osteopathic medicine and surgery in this state outside the scope of the holder's certificate, or upon proof that the holder thereof has engaged in unethical conduct or has violated section 4731.22 of the Revised Code.

The board may promulgate such additional rules and regulations as the board finds necessary to effect the purpose of this section.

4731.295 Retired physicians and free clinics.

(A)(1) As used in this section:
   (a) "Free clinic" has the same meaning as in section 3701.071 of the Revised Code.
   (b) "Indigent and uninsured person" and "operation" have the same meanings as in section 2305.234 of the Revised Code.

   (2) For the purposes of this section, a person shall be considered retired from practice if the person's license has expired with the person's intention of ceasing to practice medicine and surgery or osteopathic medicine and surgery for remuneration.

   (B) The state medical board may issue, without examination, a volunteer's certificate to a person who is retired from practice so that the person may provide medical services to indigent and uninsured persons at any location, including a free clinic. The board shall deny issuance of a volunteer's certificate to a person who is not qualified under this section to hold a volunteer's certificate.

   (C) An application for a volunteer's certificate shall include all of the following:
      (1) A copy of the applicant's degree of medicine or osteopathic medicine.
      (2) One of the following, as applicable:
         (a) A copy of the applicant's most recent license authorizing the practice of medicine and surgery or osteopathic medicine and surgery issued by a jurisdiction in the United States that licenses persons to practice medicine and surgery or osteopathic medicine and surgery.
         (b) A copy of the applicant's most recent license equivalent to a license to practice medicine and surgery or osteopathic medicine and surgery in one or more branches of the United States armed services that the United States government issued.
      (3) Evidence of one of the following, as applicable:
         (a) That the applicant has maintained for at least ten years prior to retirement full licensure in good standing in any jurisdiction in the United States that licenses persons to practice medicine and surgery or osteopathic medicine and surgery.
         (b) That the applicant has practiced for at least ten years prior to retirement in good standing as a doctor of medicine and surgery or osteopathic medicine and surgery in one or more of the branches of the United States armed services.
      (4) A notarized statement from the applicant, on a form prescribed by the board, that the applicant will not accept any form of remuneration for any medical services rendered while in possession of a volunteer's certificate.

   (D) The holder of a volunteer's certificate may provide medical services only to indigent and uninsured persons, but may do so at any location, including a free clinic. The holder shall not accept any form of remuneration for providing medical services while in possession of the certificate. Except in a medical emergency, the holder shall not perform any operation or deliver babies. The board may revoke a volunteer's certificate on receiving proof satisfactory to the board that the holder has engaged in practice in this state outside the scope of the certificate.

   (E)(1) A volunteer's certificate shall be valid for a period of three years, unless earlier revoked under division (D) of this section or pursuant to section 4731.22 of the Revised Code. A volunteer's certificate may be renewed upon the application of the holder. The board shall
maintain a register of all persons who hold volunteer's certificates. The board shall not charge a fee for issuing or renewing a certificate pursuant to this section.

(2) To be eligible for renewal of a volunteer's certificate the holder of the certificate shall certify to the board completion of one hundred fifty hours of continuing medical education that meets the requirements of section 4731.282 of the Revised Code regarding certification by private associations and approval by the board. The board may not renew a certificate if the holder has not complied with the continuing medical education requirements. Any entity for which the holder provides medical services may pay for or reimburse the holder for any costs incurred in obtaining the required continuing medical education credits.

(3) The board shall issue a volunteer's certificate to each person who qualifies under this section for the certificate. The certificate shall state that the certificate holder is authorized to provide medical services pursuant to the laws of this state. The holder shall display the certificate prominently at the location where the holder primarily practices.

(4) The holder of a volunteer's certificate issued pursuant to this section is subject to the immunity provisions regarding the provision of services to indigent and uninsured persons in section 2305.234 of the Revised Code.

(F) The board shall adopt rules in accordance with Chapter 119 of the Revised Code to administer and enforce this section.

4731.296 Telemedicine.

(A) For the purposes of this section, “the practice of telemedicine” means the practice of medicine in this state through the use of any communication, including oral, written, or electronic communication, by a physician located outside this state.

(B) A person who wishes to practice telemedicine in this state shall file an application with the state medical board, together with a fee of three hundred five dollars and shall comply with sections 4776.01 to 4776.04 of the Revised Code. If the board, in its discretion, decides that the results of the criminal records check do not make the person ineligible for a telemedicine certificate, the board may issue, without examination, a telemedicine certificate to a person who meets all of the following requirements:

(1) The person holds a current, unrestricted license to practice medicine and surgery or osteopathic medicine and surgery issued by another state that requires license holders to complete at least fifty hours of continuing medical education every two years.

(2) The person's principal place of practice is in that state.

(3) The person does not hold a license issued under this chapter authorizing the practice of medicine and surgery or osteopathic medicine and surgery in this state.

(4) The person meets the same age, moral character, and educational requirements individuals must meet under sections 4731.09 and 4731.14 of the Revised Code and, if applicable, demonstrates proficiency in spoken English in accordance with section 4731.142 of the Revised Code.

(C) The holder of a telemedicine certificate may engage in the practice of telemedicine in this state. A person holding a telemedicine certificate shall not practice medicine in person in this state without obtaining a special activity certificate under section 4731.294 of the Revised Code.

(D) The board may revoke a certificate issued under this section or take other disciplinary action against a certificate holder pursuant to section 4731.22 of the Revised Code on receiving proof satisfactory to the board that the certificate holder has engaged in practice in this state outside the scope of the certificate or that there are grounds for action against the holder under section 4731.22 of the Revised Code.
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(E) A telemedicine certificate shall be valid for a period specified by the board, and the initial renewal shall be in accordance with a schedule established by the board. Thereafter, the certificate shall be valid for two years. A certificate may be renewed on application of the holder.

To be eligible for renewal, the holder of the certificate shall do both of the following:
(1) Pay a fee in the amount of the fee described in division (A)(1) of section 4731.281 of the Revised Code;
(2) Certify to the board compliance with the continuing medical education requirements of the state in which the holder's principal place of practice is located.

The board may require a random sample of persons holding a telemedicine certificate to submit materials documenting completion of the continuing medical education requirements described in this division.

(F) The board shall convert a telemedicine certificate to a license issued under section 4731.14 of the Revised Code on receipt of a written request from the certificate holder. Once the telemedicine certificate is converted, the holder is subject to all requirements and privileges attendant to a license issued under section 4731.14 of the Revised Code, including continuing medical education requirements.

4731.31 Rural hospital may employ physician.

(A) As used in this section:
(1) "Rural hospital" means a hospital agency, as defined in section 140.01 of the Revised Code, that meets all of the following criteria:
(a) Is in compliance with section 3727.02 of the Revised Code and the registration requirement of division (A) of section 3701.07 of the Revised Code;
(b) Is located in a county that has a population of less than one hundred twenty-five thousand.
(2) "Physician" means an individual authorized under Chapter 4731 of the Revised Code to practice medicine and surgery, osteopathic medicine and surgery, and podiatric medicine and surgery.

(B) Subject to division (C) of this section, a rural hospital or a health care facility that is owned or operated by a rural hospital may employ a physician. A hospital or facility that employs a physician in accordance with this section is not engaged in the practice of medicine and surgery, osteopathic medicine and surgery, or podiatric medicine and surgery in violation of section 4731.41, 4731.43, or 4731.60 of the Revised Code.

(C) No rural hospital or health care facility owned or operated by a rural hospital shall do either of the following:
(1) Control the professional clinical judgment exercised within accepted and prevailing standards of practice of a physician employed pursuant to this section in rendering care, treatment, or professional advice to an individual patient;
(2) Require that a physician be employed by the hospital or facility as a condition of granting the physician privileges to practice within the hospital or facility.

4731.34 Practice of medicine.

(A) A person shall be regarded as practicing medicine and surgery, osteopathic medicine and surgery, or podiatric medicine and surgery, within the meaning of this chapter, who does any of the following:
(1) Uses the words or letters, "Dr.," "Doctor," "M.D.," "physician," "D.O.," "D.P.M.," or any other title in connection with the person's name in any way that represents the person as engaged in the practice of medicine and surgery, osteopathic medicine and surgery, or podiatric medicine and surgery, in any of its branches;
(2) Advertises, solicits, or represents in any way that the person is practicing medicine and surgery, osteopathic medicine and surgery, or podiatric medicine and surgery, in any of its branches;

(3) In person or, regardless of the person's location, through the use of any communication, including oral, written, or electronic communication, does any of the following:
   (a) Examines or diagnoses for compensation of any kind, direct or indirect;
   (b) Prescribes, advises, recommends, administers, or dispenses for compensation of any kind, direct or indirect, a drug or medicine, appliance, mold or cast, application, operation, or treatment, of whatever nature, for the cure or relief of a wound, fracture or bodily injury, infirmity, or disease.

(B) The treatment of human ills through prayer alone by a practitioner of the Christian Science church, in accordance with the tenets and creed of such church, shall not be regarded as the practice of medicine, provided that sanitary and public health laws shall be complied with, no practices shall be used that may be dangerous or detrimental to life or health, and no person shall be denied the benefits of accepted medical and surgical practices.

(C) The use of words, letters, or titles in any connection or under any circumstances as to induce the belief that the person who uses them is engaged in the practice of medicine and surgery, osteopathic medicine and surgery, or podiatric medicine and surgery, in any of its branches, is prima-facie evidence of the intent of such person to represent the person as engaged in the practice of medicine and surgery, osteopathic medicine and surgery, or podiatric medicine and surgery, in any of its branches.

4731.341 Unlawfully practicing medicine.

(A) The practice of medicine in all of its branches or the treatment of human ailments without the use of drugs or medicines and without operative surgery by any person not at that time holding a valid and current license or certificate as provided by Chapter 4723., 4725., or 4731 of the Revised Code is hereby declared to be inimical to the public welfare and to constitute a public nuisance.

(B) The attorney general, the prosecuting attorney of any county in which the offense was committed or the offender resides, the state medical board, or any other person having knowledge of a person who either directly or by complicity is in violation of division (A) of this section, may on or after January 1, 1969, in accord with provisions of the Revised Code governing injunctions, maintain an action in the name of the state to enjoin any person from engaging either directly or by complicity in the unlawful activity by applying for an injunction in the Franklin county court of common pleas or any other court of competent jurisdiction.

Prior to application for such injunction, the secretary of the state medical board shall notify the person allegedly engaged either directly or by complicity in the unlawful activity by registered mail that the secretary has received information indicating that this person is so engaged. Said person shall answer the secretary within thirty days showing either that the person is properly licensed or certified for the stated activity or that the person is not in violation of Chapter 4723 or 4731 of the Revised Code. If the answer is not forthcoming within thirty days after notice by the secretary, the secretary shall request that the attorney general, the prosecuting attorney of the county in which the offense was committed or the offender resides, or the state medical board proceed as authorized in this section.

Upon the filing of a verified petition in court, the court shall conduct a hearing on the petition and shall give the same preference to this proceeding as is given all proceedings under Chapter 119 of the Revised Code, irrespective of the position of the proceeding on the calendar of the court.

Such injunction proceedings shall be in addition to, and not in lieu of, all penalties and other remedies provided in Chapters 4723 and 4731 of the Revised Code.
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4731.35 Anesthesia by CRNA.

(A) This chapter does not apply to or prohibit in any way the administration of anesthesia by a certified registered nurse anesthetist under the direction of and in the immediate presence of an individual authorized by this chapter to practice medicine and surgery, osteopathic medicine and surgery, or podiatric medicine and surgery.

(B) This chapter does not prohibit an individual from practicing as an anesthesiologist assistant in accordance with Chapter 4760 of the Revised Code.

4731.36 Exceptions to §§ 4731.01 to 4731.47.

(A) Sections 4731.01 to 4731.47 of the Revised Code shall not prohibit service in case of emergency, domestic administration of family remedies, or provision of assistance to another individual who is self-administering drugs.

Sections 4731.01 to 4731.47 of the Revised Code shall not apply to any of the following:

1. A commissioned medical officer of the armed forces of the United States or an employee of the veterans administration of the United States or the United States public health service in the discharge of the officer's or employee's professional duties;

2. A dentist authorized under Chapter 4715 of the Revised Code to practice dentistry when engaged exclusively in the practice of dentistry or when administering anesthetics in the practice of dentistry;

3. A physician or surgeon in another state or territory who is a legal practitioner of medicine or surgery therein when providing consultation to an individual holding a license to practice issued under this chapter who is responsible for the examination, diagnosis, and treatment of the patient who is the subject of the consultation, if one of the following applies:

   a. The physician or surgeon does not provide consultation in this state on a regular or frequent basis.

   b. The physician or surgeon provides the consultation without compensation of any kind, direct or indirect, for the consultation.

   c. The consultation is part of the curriculum of a medical school or osteopathic medical school of this state or a program described in division (A)(2) of section 4731.291 of the Revised Code.

4. A physician or surgeon in another state or territory who is a legal practitioner of medicine or surgery therein and provided services to a patient in that state or territory, when providing, not later than one year after the last date services were provided in another state or territory, follow-up services in person or through the use of any communication, including oral, written, or electronic communication, in this state to the patient for the same condition;

5. A physician or surgeon residing on the border of a contiguous state and authorized under the laws thereof to practice medicine and surgery therein, whose practice extends within the limits of this state. Such practitioner shall not either in person or through the use of any communication, including oral, written, or electronic communication, open an office or appoint a place to see patients or receive calls within the limits of this state.

6. A board, committee, or corporation engaged in the conduct described in division (A) of section 2305.251 of the Revised Code when acting within the scope of the functions of the board, committee, or corporation;

7. The conduct of an independent review organization accredited by the superintendent of insurance under section 3922.13 of the Revised Code for the purpose of external reviews conducted under Chapter 3922 of the Revised Code.

As used in division (A)(1) of this section, “armed forces of the United States” means the army, air force, navy, marine corps, coast guard, and any other military service branch that is designated by congress as a part of the armed forces of the United States.
(B)(1) Subject to division (B)(2) of this section, this chapter does not apply to a person who holds a current, unrestricted license to practice medicine and surgery or osteopathic medicine and surgery in another state when the person, pursuant to a written agreement with an athletic team located in the state in which the person holds the license, provides medical services to any of the following while the team is traveling to or from or participating in a sporting event in this state:

(a) A member of the athletic team;
(b) A member of the athletic team's coaching, communications, equipment, or sports medicine staff;
(c) A member of a band or cheerleading squad accompanying the athletic team;
(d) The athletic team's mascot.

(2) In providing medical services pursuant to division (B)(1) of this section, the person shall not provide medical services at a health care facility, including a hospital, an ambulatory surgical facility, or any other facility in which medical care, diagnosis, or treatment is provided on an inpatient or outpatient basis.

(C) Sections 4731.51 to 4731.61 of the Revised Code do not apply to any graduate of a podiatric school or college while performing those acts that may be prescribed by or incidental to participation in an accredited podiatric internship, residency, or fellowship program situated in this state approved by the state medical board.

(D) This chapter does not apply to an oriental medicine practitioner or acupuncturist who complies with Chapter 4762 of the Revised Code.

(E) This chapter does not prohibit the administration of drugs by any of the following:

(1) An individual who is licensed or otherwise specifically authorized by the Revised Code to administer drugs;
(2) An individual who is not licensed or otherwise specifically authorized by the Revised Code to administer drugs, but is acting pursuant to the rules for delegation of medical tasks adopted under section 4731.053 of the Revised Code;
(3) An individual specifically authorized to administer drugs pursuant to a rule adopted under the Revised Code that is in effect on April 10, 2001, as long as the rule remains in effect, specifically authorizing an individual to administer drugs.

(F) The exemptions described in divisions (A)(3), (4), and (5) of this section do not apply to a physician or surgeon whose license to practice issued under this chapter is under suspension or has been revoked or permanently revoked by action of the state medical board.

4731.41 Practice of medicine without appropriate certificate.

(A) No person shall practice medicine and surgery, or any of its branches, without the appropriate license or certificate from the state medical board to engage in the practice. No person shall advertise or claim to the public to be a practitioner of medicine and surgery, or any of its branches, without a license or certificate from the board. No person shall open or conduct an office or other place for such practice without a license or certificate from the board. No person shall conduct an office in the name of some person who has a license or certificate to practice medicine and surgery, or any of its branches. No person shall practice medicine and surgery, or any of its branches, after the person's license or certificate has been revoked, or, if suspended, during the time of such suspension.

A license or certificate signed by the secretary of the board to which is affixed the official seal of the board to the effect that it appears from the records of the board that no such license or certificate to practice medicine and surgery, or any of its branches, in this state has been issued to the person specified therein, or that a license or certificate to practice, if issued, has been revoked or suspended, shall be received as prima-facie evidence of the record of the board in any court or before any officer of the state.
(B) No license or certificate from the state medical board is required by a physician who comes into this state to practice medicine at a free-of-charge camp accredited by the SeriousFun children's network that specializes in providing therapeutic recreation, as defined in section 2305.231 of the Revised Code, for individuals with chronic illnesses as long as all of the following apply:

1. The physician provides documentation to the medical director of the camp that the physician is licensed and in good standing to practice medicine in another state;
2. The physician provides services only at the camp or in connection with camp events or camp activities that occur off the grounds of the camp;
3. The physician receives no compensation for the services;
4. The physician provides those services within this state for not more than thirty days per calendar year;
5. The camp has a medical director who holds an unrestricted license to practice medicine issued in accordance with division (A) of this section.

4731.43 Practice of osteopathy without appropriate certificate.

No person shall announce or advertise that person as an osteopathic physician and surgeon, or shall practice as such, without a license from the state medical board or without complying with all the provisions of law relating to such practice, or shall practice after such license has been revoked, or if suspended, during the time of such suspension.

A license certified by the secretary, under the official seal of the said board to the effect that it appears from the records of the board that no license to practice osteopathic medicine and surgery has been issued to any person specified therein, or that a license, if issued, has been revoked or suspended shall be received as prima-facie evidence of the record in any court or before any officer of the state.

4731.511 Hyperbaric oxygen therapy.

(A) As used in this section:
1. “Hyperbaric oxygen therapy” means the administration of pure oxygen in a pressurized room or chamber.
2. “Physician” means an individual authorized under this chapter to practice medicine and surgery or osteopathic medicine and surgery.

(B) A podiatrist may supervise hyperbaric oxygen therapy if all of the following conditions are met:
1. The podiatrist has consulted with a physician who has been authorized to perform hyperbaric oxygen therapy by the facility in which the hyperbaric oxygen room or chamber is located.
2. The podiatrist orders hyperbaric oxygen therapy only for treatment within the scope of practice of podiatry as described in section 4731.51 of the Revised Code.
3. The podiatrist is certified in advanced cardiovascular life support by a certifying organization recognized by the state medical board.
4. The podiatrist has completed, at a minimum, a forty-hour introductory course in hyperbaric medicine recognized by the American board of foot and ankle surgery or by the undersea and hyperbaric medical society.
5. The podiatrist is board-certified or board-qualified by the American board of foot and ankle surgery or the American board of podiatric medicine.

On the request of the state medical board, the podiatrist shall submit to the board evidence demonstrating that the podiatrist is certified in advanced cardiovascular life support and has completed a course in hyperbaric medicine as described in this section.
(C) When hyperbaric oxygen therapy is supervised under this section, both of the following apply:

1. The podiatrist must be immediately available throughout the performance of the therapy.
2. A physician who has been authorized to perform hyperbaric oxygen therapy by the facility in which the hyperbaric room or chamber is located must be readily available for consultation throughout the performance of the therapy to furnish assistance and direction in the event a complication occurs that is outside the scope of practice of podiatry as described in section 4731.51 of the Revised Code.

4731.73 Surgical guidance for mastectomy patients.

As used in this section, “NAPBC” means the national accreditation program for breast centers of the American college of surgeons. A surgeon who will perform a mastectomy in a hospital, or a person designated by the surgeon, shall guide the patient through provided or referred services in a manner that is consistent with NAPBC standards. If a surgeon who is to perform a mastectomy considers breast reconstruction appropriate for the patient, the surgeon or designated person shall offer the patient a preoperative referral to a reconstructive or plastic surgeon in accordance with NAPBC standards.

4731-11-11 Standards and procedures for review of “Ohio Automated Rx Reporting System” (OARRS)

(A) For purposes of this rule:
1. “Delegate” means an authorized representative who is registered with the Ohio board of pharmacy to obtain an OARRS report on behalf of a physician;
2. “OARRS” means the “Ohio Automated Rx Reporting System” drug database established and maintained pursuant to section 4729.75 of the Revised Code.
3. “OARRS report” means a report of information related to a specified patient generated by the drug database established and maintained pursuant to section 4729.75 of the Revised Code.
4. “Personally furnish” means the distribution of drugs by a prescriber to the prescriber’s patients for use outside the prescriber’s practice setting.
5. “Reported drugs” means all the drugs listed in rule 4729-37-02 of the Administrative Code that are required to be reported to the drug database established and maintained pursuant to section 4729.75 of the Revised Code, including controlled substances in schedules II, III, IV, and V.

(B) Standards of care:
1. The accepted and prevailing minimal standards of care require that when prescribing or personally furnishing a reported drug, a physician shall take into account all of the following:
   a. The potential for abuse of the reported drug;
   b. The possibility that use of the reported drug may lead to dependence;
   c. The possibility the patient will obtain the reported drug for a nontherapeutic use or distribute it to other persons; and
   d. The potential existence of an illicit market for the reported drug.
2. In considering whether a prescription for or the personally furnishing of a reported drug is appropriate for the patient, the physician shall use sound clinical judgment and obtain and review an OARRS report consistent with the provisions of this rule.
3. A physician shall obtain and review an OARRS report to help determine if it is appropriate to prescribe or personally furnish an opioid analgesic, benzodiazepine, or reported
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Drug to a patient as provided in this paragraph and paragraph (F) of this rule:

(1) A physician shall obtain and review an OARRS report before prescribing or personally furnishing an opiate analgesic or benzodiazepine to a patient, unless an exception listed in paragraph (G) of this rule is applicable.

(2) A physician shall obtain and review an OARRS report when a patient's course of treatment with a reported drug other than an opioid analgesic or benzodiazepine has lasted more than ninety days, unless an exception listed in paragraph (G) of this rule is applicable.

(3) A physician shall obtain and review an OARRS report when any of the following red flags pertain to the patient:

(a) Selling prescription drugs;
(b) Forging or altering a prescription;
(c) Stealing or borrowing reported drugs;
(d) Increasing the dosage of reported drugs in amounts that exceed the prescribed amount;
(e) Suffering an overdose, intentional or unintentional;
(f) Having a drug screen result that is inconsistent with the treatment plan or refusing to participate in a drug screen;
(g) Having been arrested, convicted, or received diversion or intervention in lieu of conviction for a drug related offense while under the physician's care;
(h) Receiving reported drugs from multiple prescribers, without clinical basis;
(i) Traveling with a group of other patients to the physician's office where all or most of the patients request controlled substance prescriptions;
(j) Traveling an extended distance or from out of state to the physician's office;
(k) Having a family member, friend, law enforcement officer, or health care professional express concern related to the patient's use of illegal or reported drugs;
(l) A known history of chemical abuse or dependency;
(m) Appearing impaired or overly sedated during an office visit or exam;
(n) Requesting reported drugs by street name, color, or identifying marks;
(o) Frequently requesting early refills of reported drugs;
(p) Frequently losing prescriptions for reported drugs;
(q) A history of illegal drug use;
(r) Sharing reported drugs with another person; or
(s) Recurring visits to non-coordinated sites of care, such as emergency departments, urgent care facilities, or walk-in clinics to obtain reported drugs.

(D) A physician who decides to utilize an opioid analgesic, benzodiazepine, or other reported drug in any of the circumstances within paragraphs (C)(2) and (C)(3) of this rule, shall take the following steps prior to issuing a prescription for or personally furnishing the opioid analgesic, benzodiazepine, or other reported drug:

(1) Review and document in the patient record the reasons why the physician believes or has reason to believe that the patient may be abusing or diverting drugs;
(2) Review and document in the patient's record the patient's progress toward treatment objectives over the course of treatment;
(3) Review and document in the patient record the functional status of the patient, including activities for daily living, adverse effects, analgesia, and aberrant behavior over the course of treatment;
(4) Consider using a patient treatment agreement including more frequent and periodic reviews of OARRS reports and that may also include more frequent office visits, different treatment options, drug screens, use of one pharmacy, use of one provider for the prescription or personally furnishing of reported drugs, and consequences for non-compliance with the terms of the agreement. The patient treatment agreement shall be maintained as part of the patient record; and
(5) Consider consulting with or referring the patient to a substance abuse specialist.

(E) Frequency for follow-up OARRS reports:

(1) For a patient whose treatment with an opioid analgesic or benzodiazepine lasts more than ninety days, a physician shall obtain and review and OARRS report for the patient at least every ninety days during the course of treatment, unless an exception listed in paragraph (G) of this rule is applicable.

(2) For a patient who is treated with a reported drug other than an opioid analgesic or benzodiazepine for a period lasting more than ninety days, the physician shall obtain and review and OARRS report for the patient at least annually following the initial OARRS report obtained and reviewed pursuant to paragraph (C)(2) of this rule until the course of treatment utilizing the reported drug has ended, unless an exception in paragraph (G) of this rule is applicable.

(F) When a physician or their delegate requests an OARRS report in compliance with this rule, a physician shall document receipt and review of the OARRS report in the patient record, as follows:

(1) Initial reports requested shall cover at least the twelve months immediately preceding the date of the request;

(2) Subsequent reports requested shall, at a minimum, cover the period from the date of the last report to present;

(3) If the physician practices primarily in a county of this state that adjoins another state, the physician or their delegate shall also request a report of any information available in the drug database that pertains to prescriptions issued or drugs furnished to the patient in the state adjoining that county; and

(4) If an OARRS report regarding the patient is not available, the physician shall document in the patient's record the reason that the report is not available and any efforts made in follow-up to obtain the requested information.

(G) A physician shall not be required to review and assess an OARRS report when prescribing or personally furnishing an opioid analgesic, benzodiazepine, or other reported drug under the following circumstances, unless a physician believes or has reason to believe that a patient may be abusing or diverting reported drugs:

(1) The reported drug is prescribed or personally furnished to a hospice patient in a hospice care program as those terms are defined in section 3712.01 of the Revised Code, or any other patient diagnosed as terminally ill;

(2) The reported drug is prescribed for administration in a hospital, nursing home, or residential care facility;

(3) The reported drug is prescribed or personally furnished in an amount indicated for a period not to exceed seven days;

(4) The reported drug is prescribed or personally furnished for the treatment of cancer or another condition associated with cancer; and

(5) The reported drug is prescribed or personally furnished to treat acute pain resulting from a surgical or other invasive procedure or a delivery.

4731-11-12 Office Based Opioid Treatment.

(A) For the purposes of this rule:

(1) “Office Based Opioid Treatment,” or “OBOT,” means treatment of opioid addiction utilizing a “Schedule III, IV, or V” controlled substance narcotic.

(2) “Board certified addictionologist or addiction psychiatrist” means a medical doctor or doctor of osteopathic medicine and surgery who holds one of the following certifications:

(a) Subspecialty board certification in addiction psychiatry from the American board of psychiatry and neurology;

(b) Board certification in addiction medicine from the American board of addiction
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(c) Certification from the American society of addiction medicine; or
(d) Board certification with additional qualification in addiction medicine from the American osteopathic association.

(B) A physician shall provide OBOT in compliance with all of the provisions of this rule.

(1) The physician shall comply with all federal and state laws applicable to OBOT;

(2) Prior to providing OBOT, the physician shall conduct an assessment meeting the following requirements:

(a) The assessment shall include, at a minimum, an appropriate history and physical, mental status exam, substance use history, appropriate lab tests, pregnancy test for women of childbearing years, toxicology tests for drugs and alcohol, and “hepatitis B” and “hepatitis C” screens.

(b) For other than the toxicology tests for drugs and alcohol, appropriate history, substance abuse history, hepatitis “B” and “C” screens and the pregnancy test, the physician may satisfy the assessment requirements by reviewing records from a physical examination of the patient that was conducted by a physician within a reasonable period of time prior to the visit. For purposes of this paragraph, “physician” means an individual holding a certificate under Chapter 4731 of the Revised Code to practice medicine and surgery, osteopathic medicine and surgery, or podiatric medicine and surgery and practicing within his or her scope of practice as defined by section 4731.51 of the Revised Code, or an individual practicing in another state where the individual holds an active and unrestricted license to practice medicine and surgery, osteopathic medicine and surgery, or podiatric medicine and surgery and practicing within his or her scope of practice.

(3) The physician shall practice in accordance with an acceptable treatment protocol for assessment, induction, stabilization, maintenance and tapering. Acceptable protocols are any of the following:

(a) "Clinical Guidelines For the Use of Buprenorphine in the Treatment of Opioid Addiction" protocol approved by the substance abuse and mental health services administration in 2004, (available from the substance abuse and mental health services administration website at http://samhsa.gov/);

(b) The low dose protocol approved by the Ohio department of alcohol and drug addiction services in or about 2011 (available from the Ohio department of mental health and addiction services website at http://mha.ohio.gov/); or

(c) Any protocol for OBOT approved by the Ohio department of mental health and addiction services website at http://mha.ohio.gov.

(4) The physician shall diagnose an opioid disorder utilizing the criteria contained in the diagnostic and statistical manual of mental disorders, 4th or 5th edition.

(5) The physician shall develop an individualized treatment plan for each patient

(6) The physician shall require each patient to actively participate in appropriate behavioral counseling or treatment for their addiction and shall document at each visit that the patient is attending sufficient behavioral health treatment.

(a) The physician shall maintain meaningful interactions with the qualified chemical dependency professional, addiction treatment provider, or other behavioral health professional who is treating the patient.

(b) If the physician is a psychiatrist, board certified addictionologist, or board certified addiction psychiatrist, the physician may personally provide behavioral health treatment for the addiction.

(c) If the physician determines that the patient cannot reasonably be required to obtain professional treatment or if the patient has successfully completed professional treatment, the physician shall require the patient to actively participate in a recovery care program such as
alcoholics anonymous, narcotics anonymous, or other appropriate twelve step program, and to document attendance at program meetings.

(i) For at least the first year the physician shall require the patient to attend the meetings at least three times weekly.

(ii) Following the first year, the physician shall determine the frequency with which the patient shall be required to attend the meetings.

(iii) The physician shall document in the patient record the reasons that the patient cannot reasonably be required to obtain professional treatment.

(7) The physician shall provide OBOT utilizing a drug product that has been specifically approved by the United States food and drug administration for use in maintenance and detoxification treatment. A physician shall not provide OBOT utilizing a drug product that has not been specifically approved by the United States food and drug administration for use in maintenance and detoxification treatment.

(8) The physician shall comply with all of the following:

(a) During the first twelve months of treatment, the physician shall not prescribe, personally furnish, or administer more than a thirty day supply of OBOT medications at one time.

(b) The physician shall personally meet with and evaluate the patient at each visit during the first twelve months of OBOT, and shall document an assessment and plan for continuing treatment.

(c) After twelve months of OBOT, the physician shall personally meet with and evaluate the patient at least every three months, unless more frequent meetings are indicated.

(9) The physician shall not provide OBOT to a patient whom the physician knows or should know is receiving other controlled substances for more than twelve consecutive weeks on an outpatient basis from any provider, without having consulted with a board certified addictionologist or addiction psychiatrist, who has recommended the patient receive OBOT. If the physician is a board certified addictionologist or addiction psychiatrist, the consultation is not required.

(10) The physician shall not prescribe, personally furnish, or administer greater than 16 milligrams of buprenorphine per day to a patient, except in one of the following situations:

(a) The dosage greater than 16 milligrams was established before the effective date of this rule;

(b) The physician is a board certified addictionologist or addiction psychiatrist and has determined that a dosage greater than 16 milligrams is required for the patient, and has documented patientspecific reasons for the need for a dosage greater than 16 milligrams in the patient's record; or

(c) The physician has consulted with a board certified addictionologist or addiction psychiatrist who has recommended a dosage greater than 16 milligrams and that fact is documented in the patient's medical record.

(11) The physician shall access OARRS for each patient no less frequently than every ninety days, and shall document receipt and assessment of the information received.

(12) The physician shall provide ongoing toxicological testing in compliance with all of the following:

(a) The physician shall assure that any inoffice kit used is “Clinical Laboratory Improvement Amendments” waived.

(b) The physician shall require toxicological testing be performed at least monthly for the first six months, then randomly at least once every three months thereafter.

(c) The physician may accept the results of toxicological testing performed by a treatment program or pursuant to a court order to satisfy the requirements of paragraph (B)(12)(b) of this rule.

(d) A screen is failed if the result is inconsistent with the treatment plan. A physician shall
address failed screens in a clinically appropriate manner.

(13) Each physician who provides OBOT shall complete at least eight hours of “Category I” continuing medical education relating to substance abuse and addiction every two years. Courses completed in compliance with this rule shall be accepted toward meeting the physician’s “Category I” continuing medical education requirement for biennial renewal of the physician’s certificate.

(C) Notwithstanding the provisions of this rule, a physician may provide OBOT to a pregnant patient during the term of her pregnancy and for two months thereafter, in compliance with the minimal standards of care.

(D) A violation of any provision of this rule, as determined by the board, shall constitute any or all of the following violations:

(1) “Failure to maintain minimal standards applicable to the selection or administration of drugs,” and “failure to employ acceptable scientific methods in the selection of drugs or other modalities for treatment of disease,” as those clauses are used in division (B)(2) of section 4731.22 of the Revised Code, and “a departure from, or the failure to conform to, minimal standards of care of similar physicians under the same or similar circumstances, whether or not actual injury to a patient is established,” as that clause is used in division (B)(6) of section 4731.22 of the Revised Code.

(2) A violation of paragraph (B)(7) of this rule shall further constitute “selling, prescribing, giving away, or administering drugs for other than legal and legitimate therapeutic purposes,” as that clause is used in division (B)(3) of section 4731.22 of the Revised Code.

4731-11-13 Prescribing of opiate analgesic for acute pain.

(A) For the treatment of acute pain, the physician shall comply with the following:

(1) Extended-release or long-acting opioid analgesics shall not be prescribed for treatment of acute pain;

(2) Before prescribing an opioid analgesic, the physician shall first consider non-opioid treatment options. If opioid analgesic medications are required as determined by a history and physical examination, the physician shall prescribe for the minimum quantity and potency needed to treat the expected duration of pain, with a presumption that a three-day supply or less is frequently sufficient and that limiting the duration of opioid use to the necessary period will decrease the likelihood of subsequent chronic use or dependence;

(3) In all circumstances where opioid analgesics are prescribed for acute pain:

(a) Except as provided in paragraph (B) of this rule, the duration of the first opioid analgesic prescription for the treatment of an episode of acute pain shall be:

(i) For adults, not more than a seven-day supply with no refills;

(ii) For minors, not more than a five-day supply with no refills. A physician shall comply with section 3719.061 of the Revised Code, including but not limited to obtaining from the parent, guardian, or another adult who is authorized to consent to the minor's medical treatment written consent prior to prescribing an opioid analgesic to a minor;

(iii) The seven-day limit for adults and five-day limit for minors may be exceeded for pain that is expected to persist for longer than seven days based on the pathology causing the pain. In this circumstance, the reason that the limits are being exceeded and the reason that a non-opioid medication was not appropriate to treat the patient's conditions shall be documented in the patient's medical record. The number of days of the prescription shall not exceed the amount required to treat the expected duration of the pain as noted in paragraph (A) (2) of this rule; and

(iv) If a patient is allergic to or otherwise unable to tolerate the initially prescribed opioid medication, a prescription for a different, appropriate opioid may be issued at any time during the initial seven or five-day dosing period and shall be subject to all other provisions of this rule.
The allergy and/or intolerance shall be documented in the patient's medical record. The patient or the minor patient's parent, guardian or another adult who is authorized to consent to the minor's medical treatment must be provided education of the safe disposal of the unused medication.

(b) The patient, or a minor's parent or guardian, shall be advised of the benefits and risks of the opioid analgesic, including the potential for addiction, and the advice shall be documented in the patient's medical record; and

(c) The total morphine equivalent dose (MED) of a prescription for opioid analgesics for treatment of acute pain shall not exceed an average of thirty MED per day, except when all of the following apply:

(i) The patient suffers from medical conditions, surgical outcomes or injuries of such severity that pain cannot be managed within the thirty MED average limit as determined by the treating physician based upon prevailing standards of medical care, such as:
   (a) Traumatic crushing of tissue;
   (b) Amputation;
   (c) Major orthopedic surgery;
   (d) Severe burns

(ii) The physician determines that exceeding the thirty MED average limit is necessary based on the physician's clinical judgment and the patient's needs.

(iii) The physician shall document in the patient's medical record the reason for exceeding the thirty MED average and the reason it is the lowest dose consistent with the patient's medical condition.

(iv) Only the prescribing physician for the conditions in paragraph (A)(3)(c)(i) of this rule may exceed the thirty MED average. The prescribing physician shall be held singularly accountable for prescriptions that exceed the thirty MED average.

(v) In circumstances when the thirty MED average is exceeded, the dose shall not exceed the dose required to treat the severity of the pain as noted in paragraph (A) (2) of this rule.

(d) Prescriptions that exceed the five or seven day supply or thirty MED average daily dose are subject to additional review by the state medical board. The dosage, days supplied, and condition for which the opioid analgesic is prescribed will be considered as part of this additional review.

(B) The requirements of paragraph (A) of this rule apply to treatment of acute pain and do not apply when an opioid analgesic is prescribed:

   (1) To an individual who is a hospice patient or in a hospice care program;
   (2) To an individual receiving palliative care;
   (3) To an individual who has been diagnosed with a terminal condition; or
   (4) To an individual who has cancer or another condition associated with the individual's cancer or history of cancer.

(C) This rule does not apply to prescriptions for opioid analgesics for the treatment of opioid addiction utilizing a schedule III, IV or V controlled substance narcotic that is approved by the federal drug administration for opioid detoxification or maintenance treatment.

(D) This rule does not apply to inpatient prescriptions as defined in Chapter 4729 of the Revised Code.

4731-15-01 Licensee reporting.

(A) Licensees of the board shall be required to report as listed below:

   (1) Subject to paragraph (B) of this rule, any individual licensed under Chapter 4731 of the Revised Code or any association or society of individuals licensed under Chapter 4731 of the Revised Code shall report to the board a belief that a violation of Chapter 4730, Chapter
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4731, Chapter 4760, Chapter 4762, or Chapter 4774 of the Revised Code, or any rule of the board has occurred.

(2) Subject to paragraph (B) of this rule, any physician assistant or any association or society of physician assistants shall report to the board a belief that a violation of Chapter 4730 or 4731 of the Revised Code, or any rule of the board has occurred.

(3) Subject to paragraph (B) of this rule, any anesthesiologist assistant or any association or society of anesthesiologist assistants shall report to the board a belief that a violation of Chapter 4731 or 4760 of the Revised Code, or any rule of the board has occurred.

(4) Subject to paragraph (B) of this rule, any acupuncturist or any association or society of acupuncturists shall report to the board a belief that a violation of Chapter 4731 or 4762 of the Revised Code, or any rule of the board has occurred.

(5) Subject to paragraph (B) of this rule, any radiologist assistant or any association of radiologist assistants shall report to the board a belief that a violation of Chapter 4731 or 4774 of the Revised Code, or any rule of the board has occurred.

(B) An individual, association or society shall be relieved of the obligation to report under paragraph (A) of this rule if one of the following requirements is met:

(1) The individual or organization is an approved treatment provider under section 4731.25 of the Revised Code or the individual is an employee, agent or representative of an approved treatment provider, and

(a) The practitioner maintains participation in treatment or aftercare in accordance with section 4731.25 of the Revised Code and any rules of the board adopted pursuant to that section; and

(b) There is no reason to believe that the practitioner has violated any provision of Chapter 4730, Chapter 4731, Chapter 4760, Chapter 4762, or Chapter 4774 of the Revised Code, or any rule of the board, other than impairment of ability to practice according to acceptable and prevailing standards of care because of habitual or excessive use or abuse of drugs, alcohol or other substances that impair ability to practice, as provided in division (B)(5) of section 4730.25 of the Revised Code, division (B)(26) of section 4731.22 of the Revised Code, division (B)(6) of section 4760.13 of the Revised Code, division (B)(6) of section 4762.13 of the Revised Code, or division (B)(6) of section 4774.13 of the Revised Code.

(2) The individual is a member of an impaired practitioner committee, or the equivalent, established by a hospital or its medical staff, or is a representative or agent of a committee or program sponsored by a professional association of individuals licensed under Chapter 4731 of the Revised Code to provide peer assistance to practitioners with substance abuse problems, and

(a) The practitioner has been referred for examination to an approved treatment program;

(b) The practitioner co-operates with the referral for examination and any determination that he or she should enter treatment; and

(c) There is no reason to believe that the practitioner has violated any provision of Chapter 4730, Chapter 4731, Chapter 4760, Chapter 4762, or Chapter 4774 of the Revised Code, or any rule of the board, other than impairment of ability to practice according to acceptable and prevailing standards of care because of habitual or excessive use or abuse of drugs, alcohol or other substances that impair ability to practice, as provided in division (B)(5) of section 4730.25 of the Revised Code, division (B)(26) of section 4731.22 of the Revised Code, division (B)(6) of section 4760.13 of the Revised Code, division (B)(6) of section 4762.13 of the Revised Code, or division (B)(6) of section 4774.13 of the Revised Code.

(3) The individual reasonably believes all of the following:

(a) The practitioner has been referred for examination to an approved treatment program;

(b) The practitioner co-operates with the referral for examination and any determination
that he or she should enter treatment; and

(c) There is no reason to believe that the practitioner has violated any provision of Chapter 4730, Chapter 4731, Chapter 4760, Chapter 4762, or Chapter 4774 of the Revised Code, or any rule of the board, other than impairment of ability to practice according to acceptable and prevailing standards of care because of habitual or excessive use or abuse of drugs, alcohol or other substances that impair ability to practice, as provided in division (B)(5) of section 4730.25 of the Revised Code, division (B)(26) of section 4731.22 of the Revised Code, division (B)(6) of section 4760.13 of the Revised Code, division (B)(6) of section 4762.13 of the Revised Code, or division (B)(6) of section 4774.13 of the Revised Code.

(4) The individual is a member of a review committee described in section 2305.25 of the Revised Code and the sole source for the belief that a violation has occurred and there has been evidence or other matters produced or presented during the proceedings of such committee.

(5) The individual is otherwise prohibited from reporting to the board by a superseding state or federal law.

(6) For purposes of this paragraph any individual licensed under Chapter 4730, Chapter 4731, Chapter 4760, Chapter 4762, or Chapter 4774 of the Revised Code, or any association or society of individuals so licensed, shall report a practitioner who has, at any time during or following treatment, experienced a relapse, as that term is defined in rule 4731-16-01 of the Administrative Code. The relapsing practitioner shall self-report the relapse.

(C) For purposes of paragraphs (B)(1)(b), (B)(2)(c), and (B)(3)(c) of this rule, violations of provisions of Chapter 4730, Chapter 4731, Chapter 4760, Chapter 4762, or Chapter 4774 of the Revised Code, or any rule of the board, other than impairment of ability to practice according to acceptable and prevailing standards of care because of habitual or excessive use or abuse of drugs, alcohol, or other substances that impair ability to practice, need not be reported if all of the following requirements are met, but if any or all of the following conditions are not met, the individual or organization shall report to the board all violations which are believed to have occurred:

(1) All acts or omissions by the practitioner which would otherwise have constituted violations occurred while the practitioner was impaired; and

(2) The practitioner has not been criminally convicted based on any such acts or omissions; and

(3) There is no reason to believe that such acts or omissions might have an adverse impact on other individuals.

(D) For purposes of section 4730.32, section 4731.224, section 4760.16, section 4762.16, or section 4774.16 of the Revised Code, and this rule, “reason to believe” or “belief” does not require absolute certainty or complete unquestioning acceptance, but only an opinion that a violation has occurred based upon firsthand knowledge or reliable information.

(E) Any report required under paragraph (A) of this rule shall be made to the board within forty-eight hours. Reporting of any belief that a violation has occurred to a review committee as described in section 2305.251 of the Revised Code or any entity other than the board does not discharge the duty or obligation to report to the board. In cases where the secretary and supervising member determined that peer review is being conducted by a review committee as described in section 2305.251 of the Revised Code for purposes of denying, determining, changing or modifying the scope of the licensee’s clinical privileges, they may defer further investigation by the board while awaiting the outcome of that peer review.

(F) Any individual licensed by the board or any association or society of individuals who are licensed by the board who reports to the board a belief that a violation of Chapter 4731, Chapter 4730, Chapter 4760, Chapter 4762, or Chapter 4774 of the Revised Code, or any rule of the board has occurred shall be considered to be reporting pursuant to the requirements of section 4730.32, 4731.224, 4760.16, 4762.16, or 4774.16 of the Revised Code and shall be
immune from civil liability as provided by division (H) of section 4730.32, division (H) of section 4731.224, division (H) of section 4760.16, division (H) of section 4762.16, or division (H) of section 4774.16 of the Revised Code and paragraph (A) of rule 4731-15-05 of the Administrative Code. The individual, association, or society may remain anonymous by complying with all of the following actions:

(1) The individual, association, or society shall request and shall be assigned a confidential identifying number by the board.
(2) The individual, association, or society shall be responsible for notifying the board that he or she is a licensee or is an association or society of licensees and shall be responsible for maintaining the confidential identifying number in order to verify compliance with the reporting obligations of section 4730.32 of the Revised Code, section 4731.224 of the Revised Code, section 4760.16 of the Revised Code, section 4762.16 of the Revised Code, or section 4774.16 of the Revised Code and this chapter.

(G) Each report pursuant to this rule shall include:
(1) The name of the practitioner or other individual in violation;
(2) The violation which is believed to have occurred; and
(3) The date(s) of and place(s) of occurrence(s), if known.

4731-15-02 Healthcare facility reporting.

(A) The chief administrator or executive officer of any healthcare facility as defined in section 3702.51 of the Revised Code, including a hospital, healthcare facility operated by a health insurance corporation, ambulatory surgical facility or similar facility, shall report to the board any formal disciplinary action against any individual licensed under Chapter 4730, 4731, 4760, 4762, or 4774 of the Revised Code within sixty days after its completion.

(B) “Formal disciplinary action” means any procedure resulting in the revocation, restriction, reduction, or termination of clinical privileges for violations of professional ethics, or for reasons of medical incompetence, medical malpractice, or drug or alcohol abuse. Clinical privileges means the authorization by the healthcare facility to a person licensed under Chapter 4730, 4731, 4760, 4762, or 4774 of the Revised Code for the provision of health care services.

(C) Formal disciplinary actions shall include:
(1) Summary actions, actions that take effect notwithstanding any appeal rights that may exist and actions that result in an individual surrendering clinical privileges while under investigation during proceedings regarding the action being taken or in return for not being investigated or having proceedings held, resulting in revocation, restriction, reduction, or termination of privileges for the violations or reasons set forth in paragraph (B) of this rule; and
(2) Actions resulting in refusal or denial of clinical privileges for the violations or reasons set forth in paragraph (B) of this rule;

(D) Formal disciplinary actions shall not include any action taken for the sole reason of failure to maintain records on a timely basis, failure to pay dues, or failure to attend staff, department or section meetings.

(E) Formal disciplinary actions need not be reported if:
(1) The practitioner has been referred for examination to an approved treatment program; and
(2) The practitioner cooperates with the referral for examination and any determination that he should enter treatment; and
(3) There is no reason to believe that the practitioner has violated any provision of Chapter 4730, Chapter 4731, Chapter 4760, Chapter 4762, or Chapter 4774 of the Revised Code, or any rule of the board, other than impairment of ability to practice according to acceptable and prevailing standards of care because of habitual or excessive use or abuse of drugs, alcohol, or other substances that impair ability to practice, as provided in division (B)(5)
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of section 4730.25 of the Revised Code, division (B)(26) of section 4731.22 of the Revised Code, division (B)(6) of section 4760.13 of the Revised Code, division (B)(6) of section 4762.13 of the Revised Code, or division (B)(6) of section 4774.13 of the Revised Code.

(F) Each report shall include:
(1) The name and address of the facility reporting;
(2) The practitioner's name and license number;
(3) The action taken by the facility;
(4) The date of the action taken by the facility;
(5) The effective date of the action taken by the facility; and
(6) A summary of the underlying facts leading to the action.

(G) A facility's timely filing with the board of a copy of the national practitioner data bank adverse action report shall satisfy the reporting requirement of this rule when, upon contact by the board, the reporting facility verifies that the filing of the report has been approved by the peer review committee which reviewed the case or by the governing board of the facility.

(H) Any request for patient records by the board as provided under division (A) of section 4730.32 of the Revised Code, division (A) of section 4731.224 of the Revised Code, division (A) of section 4760.16 of the Revised Code, division (A) of section 4762.16 of the Revised Code, or division (A) of section 4774.16 of the Revised Code shall be made by certified mail directed to the chief administrator or executive officer of the facility. Failure to provide the board with the requested certified copies of patient records within thirty days of receipt of that request shall constitute a failure to comply with the applicable reporting requirements, unless the board has granted a prior extension in writing.

4731-15-03 Insurer reporting.

(A) Any insurer providing professional liability insurance or any other entity that seeks to indemnify the professional liability of any person holding a valid certificate issued pursuant to Chapter 4730, 4731, 4760, 4762, or 4774 of the Revised Code shall notify the board within thirty days after the final disposition of any written claim for damages where such disposition results in a payment which exceeds twenty-five thousand dollars.

(B) For purposes of division (D) of section 4730.32 of the Revised Code, division (D) of section 4731.224 of the Revised Code, division (D) of section 4760.16 of the Revised Code, division (D) of section 4762.16 of the Revised Code, or division (D) of section 4774.16 of the Revised Code, this rule:
(1) The amount of payment shall mean the aggregate gross settlement, not including court costs or other litigation costs;
(2) The present value of future payments shall be utilized in calculating the aggregate gross settlement in cases of structured payments;
(3) In cases involving multiple defendants where payment exceeds twenty-five thousand dollars but no specific allocation is made in the disposition of the claim, a report shall be filed with the board for each of the defendants upon whose behalf the payment is made;
(4) Payments made solely for damages not arising from patient care need not be reported;
(5) The waiver of an outstanding debt is not construed as a payment.

(C) Each notification to the board shall include the following:
(1) The name and address of the person submitting the notification;
(2) The identity of the insurer or other indemnifying entity;
(3) The name and address of the insured who is the subject of the claim;
(4) The name of the person filing the written claim;
(5) The date of final disposition;
(6) The amount of payment;
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(7) If applicable, the identity of the court in which the final disposition took place.

(D) An insurer that reports a medical malpractice payment to the national practitioner
data bank may satisfy the reporting requirement of this rule by timely filing a copy of the national
practitioner data bank medical malpractice report with the board.

(E) The reports received under division (D) of section 4730.32 of the Revised Code,
division (D) of section 4731.224 of the Revised Code, division (D) of section 4760.16 of the
Revised Code, division (D) of section 4762.16 of the Revised Code, division (D) of section
4774.16 of the Revised Code, and this rule shall be listed for periodic review by the secretary
and supervising member at least once every three months. The review shall determine the need
to investigate possible violations of Chapter 4730, 4731, 4760, 4762, or 4774 of the Revised
Code or any rule of the board.

4731-15-05 Reporting; confidentiality; immunity.

(A) Any person, health care facility, association, society, or insurer who reports to the
board or who refers an impaired practitioner to an approved treatment program shall not be
subject to suit for civil damages as a result of the report, referral, or provision of information.

(B) The board shall provide, upon request, forms for reporting under the provisions of
section 4730.32 of the Revised Code, section 4731.224 of the Revised Code, section 4760.16
of the Revised Code, section 4762.16 of the Revised Code, section 4774.16 of the Revised
Code, and this chapter of the Administrative Code.

(C) When a national practitioner data bank report form is accepted by the board for the
purpose of satisfying the requirements of section 4731.224 of the Revised Code and this
chapter of the Administrative Code, the board shall redact the following information prior to
disclosing the report as authorized under section 4731.224 of the Revised Code and this
chapter of the Administrative Code:

1. National practitioner data bank identification number of the reporting entity, and
2. All national practitioner data bank references and federal form indicia.

(D) Summaries, reports, and records received and maintained by the board pursuant to
section 4730.32 of the Revised Code, section 4731.224 of the Revised Code, section 4760.16
of the Revised Code, section 4762.16 of the Revised Code, section 4774.16 of the Revised
Code and this chapter of the Administrative Code shall be held in confidence and shall not be
subject to discovery or introduction in evidence in any federal or state civil action involving a
health care professional or facility arising out of matters which are the subject of such reporting
to the board.

1. The board may only disclose the summaries and reports to hospital committees
which are involved in credentialing or recredentialing the practitioner or in reviewing the
practitioner’s clinical privileges, and in credentialing or recredentialing or reviewing the clinical
privileges of the supervising physician of a practitioner licensed pursuant to Chapter 4730,
4760, 4762, or 4774 of the Revised Code. Such disclosure may be made through an
independent credentialing service if the service merely communicates the information to the
hospital committees and maintains strict confidentiality as provided in a written agreement with
the board.

2. Reports filed by an individual licensee pursuant to division (B) of section 4730.32 of
the Revised Code, division (B) of section 4731.224 of the Revised Code, division (B) of section
4760.16 of the Revised Code, division (B) of section 4762.16 of the Revised Code, division (B)
of section 4774.16 of the Revised Code and rule 4731-16-01 of the Administrative Code shall
not be disclosed.

(E) Except for reports filed by an individual licensee pursuant to division (B) of section
4730.32 of the Revised Code, division (B) of section 4731.224 of the Revised Code, division (B)
of section 4760.16 of the Revised Code, division (B) of section 4762.16 of the Revised Code,
division (B) of section 4774.16 of the Revised Code and rule 4731-15-01 of the Administrative Code, a copy of any reports or summaries received by the board pursuant to section 4730.32 of the Revised Code, section 4731.224 of the Revised Code, section 4760.16 of the Revised Code, section 4762.16 of the Revised Code, section 4774.16 of the Revised Code and Chapter 4731-15 of the Administrative Code shall be sent to the practitioner by the board. The practitioner shall have the right to file a statement with the board concerning the correctness or relevance of the information. Such statement, upon receipt by the board, shall at all times accompany that part of the record in contention.

(F) The board need not accept reports, summaries, or statements that consist of or include proceedings or records of review committees as described in section 2305.25 of the Revised Code. If the board determines that materials submitted are unacceptable, it shall return those materials to the submitting individual or entity, and provide an opportunity for submission of appropriate materials.

4731-17-01 Definitions of exposure-prone invasive procedures.

For purposes of this chapter of the Administrative Code:
(A) "Licensee" means any person holding or practicing pursuant to a certificate issued by the board under Chapter 4730., 4731., 4760., 4762., or 4774 of the Revised Code.
(B) "Invasive procedure" means any of the following:
   (1) Surgical or procedural entry into tissues, cavities, or organs or repair of major traumatic injuries associated with any of the following: an operating or delivery room, emergency department, or outpatient setting, including physicians' offices; cardiac catheterization and angiographic procedures; a vaginal or cesarean delivery or other invasive obstetric procedure during which bleeding may occur; or the manipulation, cutting, or removal of any oral or perioral tissues, including tooth structure, during which bleeding occurs or the potential for bleeding exists.
   (2) Any entry into the hair follicle using an electric modality for the purpose of hair removal.
   (3) The practice of acupuncture as defined in section 4762.01 of the Revised Code.
   (4) The performance of fluoroscopic procedures pursuant to section 4774.08 of the Revised Code.
   (5) The performance of cosmetic procedures, such as the injection of botulinum toxin, dermal fillers, permanent makeup at a location that is not licensed under the rules in Chapter 3701-9 of the Administrative Code, laser hair removal, and hair replacement procedures.
(C) "FDA" means the United States food and drug administration.
(D) "EPA" means the United States environmental protection agency.

4731-17-02 Universal precautions.

Licensees who perform or participate in invasive procedures shall, in the performance of or participation in any such procedures or functions, be familiar with, observe and rigorously adhere to the acceptable and prevailing standards for universal blood and body fluid precautions to minimize the risk of being exposed to or exposing others to the hepatitis B virus (HBV), the hepatitis C virus (HCV), and the human immunodeficiency virus (HIV). The acceptable and prevailing universal blood and body fluid precautions which the licensee follows shall include at least the following:
(A) Appropriate use of hand washing;
(B) Effective disinfection and sterilization of equipment;
(C) Safe handling and disposal of needles and other sharp instruments; and
(D) Appropriate barrier techniques including wearing and disposal of gloves and other
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protected garments and devices.

4731-17-03 Hand washing.

Licensees who perform or participate in invasive procedures shall follow acceptable and prevailing standards for hand washing which shall include at least the following:

(A) Hands shall be washed appropriately prior to performing or participating in an invasive procedure and after performing or participating in an invasive procedure;
(B) Hands and other skin surfaces shall be washed immediately and thoroughly if contaminated with blood or other body fluids; and
(C) Hands shall be washed immediately after gloves are removed.

4731-17-04 Disinfection and sterilization.

Instruments and other equipment classified by the FDA as reusable, used by licensees who perform or participate in invasive procedures shall be appropriately disinfected and sterilized according to acceptable and prevailing standards for disinfection and sterilization which shall include at least the following:

(A) Instruments and devices that enter the patient's vascular system or other normally sterile areas of the body shall be sterilized before being used for each patient;
(B) Instruments and devices that touch intact mucous membranes but do not penetrate the patient's body surfaces shall be sterilized when possible, or undergo high-level disinfection if they cannot be sterilized before using for each patient;
(C) Instruments and devices that are able to withstand repeated exposure to heat shall be heat sterilized. Sterilization shall be accomplished by autoclave, dry heat, unsaturated chemical vapor, ethylene oxide, hydrogen peroxide gas plasma, or any other FDA/EPA-approved method;
(D) Instruments and items that cannot withstand heat sterilization shall be subjected to a high level disinfection process, including compliance with any manufacturer's instructions for disinfection;
(E) Heat sterilizing devices shall be tested for proper function on a weekly basis by means of a biological monitoring system that indicates microorganism kill. Documentation shall be maintained either in the form of a log reflecting dates and person(s) conducting the testing or copies of reports from an independent testing entity. The documentation shall be maintained for a period of at least two years. In the event of a positive biological spore test, the licensee must take immediate remedial action to ensure that heat sterilization is being accomplished;
(F) Surface disinfection:
(1) Environmental surfaces that are contaminated by blood or other body fluids shall be disinfected with a chemical germicide that is registered with the environmental protection agency as a “hospital disinfectant” or sodium hypochlorite and is mycobactericidal at use-dilution. The disinfection process shall be followed before each patient; and
(2) Impervious backed paper, aluminium foil or plastic wrap shall be used to cover surfaces that may be contaminated by blood or other body fluids and that are difficult or impossible to disinfect. The cover shall be removed, discarded and then replaced between patients.
(G) Single use items used in treating a patient, which have become contaminated by blood or other body fluids, shall be discarded and not reused, unless sterilized and reused in accordance with current guidelines established by the FDA. Single use items being reused in treating a patient shall be adequately cleaned and sterilized. Single use items shall not be reused if the items' physical characteristics and quality have been adversely affected or if the items are incapable of being reused safely and effectively for their intended use.
4731-17-05 Handling and disposal of sharps and wastes.

Licensees who perform or participate in invasive procedures shall follow acceptable and prevailing standards for hand washing which shall include at least the following:
(A) Hands shall be washed appropriately prior to performing or participating in an invasive procedure and after performing or participating in an invasive procedure;
(B) Hands and other skin surfaces shall be washed immediately and thoroughly if contaminated with blood or other body fluids; and
(C) Hands shall be washed immediately after gloves are removed.

4731-17-06 Barrier techniques.

All licensees who perform or participate in invasive procedures shall routinely use appropriate barrier precautions to prevent skin and mucous-membrane contact with blood and other body fluids of all patients. The barrier techniques to be followed are:
(A) All licensees shall wear disposable gloves when performing or participating in invasive procedures. Hands shall be washed when gloves are removed. Before performing or participating in invasive procedures on another patient, the licensee shall wash hands and reglove with another pair of disposable gloves. If a glove is torn or a needlestick or other injury occurs, the glove shall be removed and a new glove used as promptly as patient safety permits. The needle or instrument involved in the incident shall be removed from the sterile field. Disposable gloves shall not be washed or reused for any purpose.
(B) All licensees shall wear masks and protective eyewear when performing or participating in invasive procedures if during the procedure there is likely to be spattering or splashing of blood or other body fluids.
(C) Gowns or aprons made of materials that provide an effective barrier shall be worn by all licensees who are performing or participating in invasive procedures if during the procedure there is likely to be spattering or splashing of blood or other body fluids.

Impaired Medical Board Licensees

4731-16-01 Impaired practitioners; definitions.

As used in this chapter of the Administrative Code:
(A) “Impairment” means impairment of ability to practice according to acceptable and prevailing standards of care because of habitual or excessive use or abuse of drugs, alcohol, or other substances that impair ability to practice. Impairment includes inability to practice in accordance with such standards, and inability to practice in accordance with such standards without appropriate treatment, monitoring or supervision.
(B) “Relapse” means any use of, or obtaining for the purpose of using, alcohol or a drug or substance that may impair ability to practice, by someone who has received a diagnosis of and treatment for chemical dependency or abuse, except pursuant to the directions of a treating physician who has knowledge of the patient’s history and of the disease of addiction, or pursuant to the direction of a physician in a medical emergency. An instance of use that occurs during detoxification treatment or inpatient or residential treatment before a practitioner’s disease of addiction has been brought into remission does not constitute a relapse.
(C) “Approved treatment provider” means a treatment provider approved pursuant to section 4731.25 of the Revised Code and this chapter of the Administrative Code.
(D) “The board” means the state medical board of Ohio.
(E) “Sobriety” means abstinence from alcohol, and from drugs or substances that may impair ability to practice, except pursuant to the directions of a treating physician who has
knowledge of the patient's history and of the disease of addiction, or pursuant to the direction of a physician in a medical emergency.

(F) “Order” for a controlled substance or other drug means a preprinted order or standing order as defined in rule 4729-5-01 of the Administrative Code.

(G) “Impaired physician committee” includes health committees, physician assistance committees, peer support committees, and similar bodies.

(H) “Massage therapist or cosmetic therapist” means a person who holds or has applied for a certificate to practice massage therapy or cosmetic therapy, or both, and who does not currently hold or have a pending application for any other certificate issued by the board.

4731-16-02 Medical board impairment authority.

(A) Should the board have reason to believe that any licensee or applicant suffers from impairment, as that term is used in division (B)(5) of section 4730.25 of the Revised Code, division (B)(26) of section 4731.22 of the Revised Code, division (B)(6) of section 4760.13 of the Revised Code or division (B)(6) of section 4762.13 of the Revised Code, it may compel the individual to submit to a mental or physical examination, or both.

(1) Such examinations shall be undertaken by an approved treatment provider designated by the board.

(2) The notice issued ordering the individual to submit to examination shall delineate acts, conduct or behavior committed or displayed which establish reason to believe that the individual is impaired.

(3) Failure to submit to examination ordered by the board constitutes an admission of impairment unless the failure is due to circumstances beyond the individual's control.

(B) In cases where the only disciplinary action initiated against the individual is for violation of division (B)(5) of section 4730.25 of the Revised Code, division (B)(26) of section 4731.22 of the Revised Code, division (B)(6) of section 4760.13 of the Revised Code or division (B)(6) of section 4762.13 of the Revised Code the following general pattern of action shall be followed:

(1) Upon identification by the board of reason to believe that a licensee or applicant is impaired it may compel an examination or examinations as set forth in paragraph (A) of this rule. The examination must meet all requirements of rule 4731-16-05 of the Administrative Code.

(a) If the examination or examinations fail to disclose impairment, no action shall be initiated pursuant to division (B)(5) of section 4730.25 of the Revised Code, division (B)(26) of section 4731.22 of the Revised Code, division (B)(6) of section 4760.13 of the Revised Code or division (B)(6) of section 4762.13 of the Revised Code unless other investigation produces reliable, substantial, and probative evidence demonstrating impairment.

(b) If the examination or examinations disclose impairment, or if the board has other reliable, substantial and probative evidence demonstrating impairment, the board shall initiate proceedings to suspend the license or deny the applicant. The board may issue an order of summary suspension as provided in division (G) of section 4730.25 of the Revised Code, division (G) of section 4731.22 of the Revised Code, division (G) of section 4760.13 of the Revised Code or division (G) of section 4762.13 of the Revised Code.

(2) The presence of one or more of the following circumstances shall constitute independent proof of impairment and shall support license suspension or denial without the need for an examination:

(a) The individual has relapsed during or following treatment;

(b) The individual has applied for or requested treatment in lieu of conviction of a criminal charge or intervention in lieu of conviction of a criminal charge, or has applied for or requested entry into a similar diversion or drug intervention program;
(c) The individual has pled guilty to or has had a judicial finding of guilt of a criminal offense that involved the individual's personal use or abuse of any controlled substance.

(3) Before being eligible to apply for reinstatement of a license suspended under this paragraph the impaired individual must demonstrate to the board that the individual can resume practice in compliance with acceptable and prevailing standards of care under the provisions of the individual's certificate. Such demonstrations shall include but shall not be limited to the following:

(a) Certification from a treatment provider approved under section 4731.25 of the Revised Code that the individual has successfully completed all required treatment, as follows:

(i) Except as provided in paragraph (B)(3)(a)(ii) of this rule, the required treatment shall include inpatient or residential treatment that extends a minimum of twenty-eight days with the following exception: If the individual has previously completed an inpatient or residential treatment program of at least twenty-eight days and maintained sobriety for at least one year following completion of that inpatient or residential treatment, the treatment required shall be determined by the treatment provider.

(ii) If the impaired individual is a massage therapist or cosmetic therapist who does not meet the criteria set forth in paragraph (B)(3)(iii) of this rule, the required treatment shall include intensive outpatient treatment meeting the requirements of paragraph (A)(13) of rule 4731-16-08 of the Administrative Code. The required intensive outpatient treatment must include a minimum of twenty treatment sessions over no less than five consecutive weeks with the following exception: If the massage therapist or cosmetic therapist has previously completed an intensive outpatient treatment program of at least twenty treatment sessions over no less than five consecutive weeks and has maintained sobriety for at least one year following completion of that intensive outpatient treatment, the treatment required shall be determined by the treatment provider.

(iii) If the impaired individual is a massage therapist or cosmetic therapist who was investigated by the board for possible impairment as part of a previous application for or while holding any certificate issued by the board other than a certificate to practice massage therapy or cosmetic therapy, the required treatment shall be in compliance with paragraph (B)(3)(a)(i) of this rule.

(b) Evidence of continuing full compliance with an aftercare contract that meets the requirements of rule 4731-16-10 of the Administrative Code, and with any consent agreement or order of the board then in effect;

(c) Two written reports indicating that the individual's ability to practice has been assessed and that the individual has been found capable of practicing according to acceptable and prevailing standards of care. The reports shall be made by individuals or providers approved by the board for making such assessments and shall describe the basis for this determination. A physician who is the medical director of a treatment provider approved under section 4731.25 of the Revised Code and this chapter of the Administrative Code may perform such an assessment without prior board approval.

(4) Subject to the provisions of paragraph (D) of this rule, the board may reinstate a license suspended under this paragraph after the demonstration described in paragraph (B)(3) of this rule and after the individual has entered into a written consent agreement which conforms to the requirements set forth in rule 4731-16-06 of the Administrative Code, or after the board has issued a final order in lieu of a consent agreement.

(5) When the impaired individual resumes practice after license reinstatement, the board shall require continued monitoring of the individual. This monitoring shall include but not be limited to compliance with the written consent agreement entered into before reinstatement or compliance with conditions imposed by board order after a hearing, and, upon termination of the consent agreement, submission by the individual to the board, for at least two years, of annual
written progress reports made under penalty of perjury stating whether the license holder has maintained sobriety.

(C) In cases where the board has initiated a disciplinary action for violations of any provisions of Chapter 4731, Chapter 4730, Chapter 4760 or Chapter 4762 of the Revised Code or any of its rules in addition to division (B)(5) of section 4730.25 of the Revised Code, division (B)(26) of section 4731.22 of the Revised Code, division (B)(6) of section 4760.13 of the Revised Code or division (B)(6) of section 4762.13 of the Revised Code, the general pattern of action described in paragraph (B) of this rule will be followed with the following exceptions:

(1) If the board permanently revokes a license, the individual shall not be eligible for further consideration for licensure or license reinstatement;
(2) If the board imposes a period of ineligibility for licensure, the individual shall not be eligible for licensure or license reinstatement until the period of ineligibility has lapsed;
(3) If the board imposes an indefinite period of ineligibility, licensure or license reinstatement shall depend upon successful completion of the requirements in paragraphs (B)(3) and (B)(4) of this rule and determination by the board that the period of suspension or ineligibility served is commensurate with the violations found.

(D) Except as provided in this paragraph, an individual who has relapsed during or following treatment shall be ineligible to apply for reinstatement for at least ninety days following the date of license suspension for a first relapse, for at least one year following the date of license suspension for a second relapse, and for at least three years following the date of license suspension for a third relapse. An individual who suffers a relapse, as that term is defined in paragraph (B) of rule 4731-16-01 of the Administrative Code, will not be subjected to suspension or other board discipline based on that relapse if all of the following conditions are met:

(1) The relapse was the first ever suffered by the individual;
(2) The relapse occurred under circumstances that the board finds minimized the probability that the individual would either provide patient care while under influence of alcohol or drugs or leave patients without necessary care while under the influence of alcohol or drugs;
(3) The relapse involved a single occasion of use for less than one day;
(4) The individual self-reported the relapse within forty-eight hours in accordance with rule 4731-15-01 of the Administrative Code;
(5) The individual does not thereafter suffer another relapse;
(6) The board does not obtain evidence of acts, conduct or omissions that would support the imposition of discipline, apart from the relapse itself;
(7) The relapse does not lead to the individual being charged with any criminal offense;
(8) The individual reported the relapse to an approved treatment provider within forty-eight hours, submitted to evaluation as requested by the approved treatment provider, and obtained any additional treatment recommended;
(9) The individual suspended practice until the approved treatment provider reported in writing to the board that it had made a clear determination that the individual was capable of practicing according to acceptable and prevailing standards of care; and

(10) The approved treatment provider provides the board a full report of the evaluation, and the board's secretary and supervising member decide that there are not circumstances warranting the initiation of disciplinary action.

4731-16-05 Examinations of impaired practitioner.

(A) Any examination ordered by the board under division (F)(2) of section 4730.25 of the Revised Code, division (B)(26) of section 4731.22 of the Revised Code, division (F)(2) of section 4760.13 of the Revised Code or division (F)(2) of section 4762.13 of the Revised Code
in order to determine impairment, or any examination of an applicant for or a holder of a certificate issued under Chapter 4730, Chapter 4731, Chapter 4760 or Chapter 4762 of the Revised Code performed by an approved treatment provider shall include all of the following:

(1) Urine screening or blood alcohol testing, or both, with legal chain of custody and forensic capability protocol;

(2) Comprehensive evaluation pertinent to the reasons for referral, including:
   (a) Complete medical history and physical examination;
   (b) Psychiatric evaluation and mental status examination;
   (c) Comprehensive chemical use history; and

(3) One of the following assessment standards, as applicable:
   (a) Except as provided in paragraph (A)(3)(b) of this rule, observation of the individual in an inpatient setting for at least seventy-two consecutive hours, unless the approved treatment provider diagnoses the individual as chemically dependent and formulates a treatment plan in a shorter time period.

   (b) If the individual is a massage therapist or cosmetic therapist who does not meet the criteria set forth in paragraph (A)(3)(c) of this rule:
      (i) In-depth assessment, including use of a structured interview, by a physician, registered nurse or nurse practitioner who has specialized training in addiction medicine or treatment of addiction, or by a licensed independent chemical dependency counselor or licensed chemical dependency counselor III;
      (ii) Routine laboratory tests, to include complete blood count and liver function studies;
      (iii) Corroborating interviews of at least two persons who are close to the individual;
      (iv) Administration of the "Beck Depression Inventory" and the "Hamilton Anxiety Survey;"
      (v) Any other requirements as identified by the board or treatment provider. Psychiatric evaluation is not required in an examination administered under this paragraph unless the need for such an evaluation is identified by the board of the treatment provider.

   (c) If the individual is a massage therapist or cosmetic therapist who was investigated by the board for possible impairment as part of a previous application for or while holding any certificate issued by the board, observation of the individual in an inpatient setting for at least seventy-two consecutive hours, unless the approved treatment provider diagnoses the individual as chemically dependent and formulates a treatment plan in a shorter time period.

   (B) A diagnosis made by an approved treatment provider based on an examination ordered by the board under division (F)(2) of section 4730.25 of the Revised Code, division (B)(26) of section 4731.22 of the Revised Code, division (F)(2) of section 4760.13 of the Revised Code or division (F)(2) of section 4762.13 of the Revised Code shall be made solely for the purpose of providing evidence for use by the board. A licensee or applicant who undergoes an examination ordered by the board but who refuses to authorize the treatment provider to release reports or information to the board shall be deemed to have failed to submit to the examination due to circumstances within the individual's control, and a default and final order may be entered without the taking of testimony or presentation of evidence as provided in division (F)(2) of section 4730.25 of the Revised Code, division (B)(26) of section 4731.22 of the Revised Code, division (F)(2) of section 4760.13 of the Revised Code or division (F)(2) of section 4762.13 of the Revised Code.

   (C) The report issued pursuant to an examination ordered by the board shall be submitted to the board within five days following completion of the examination.

   (D) The board may require the certificate holder or applicant to submit to a drug toxicology screen at the time it serves its order to submit to an examination or at any time after it issues the examination order and before the examination is completed.

   (1) The drug toxicology screen shall be considered part of the examination.

   (2) Refusal to submit to the drug toxicology screen immediately upon such request shall
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constitute failure to submit to a mental or physical examination ordered by the board and shall constitute an admission of the allegations against the individual, unless the failure is due to circumstances beyond the individual's control. A default and final order may be entered without the taking of testimony or presentation of evidence.

(E) An individual ordered by the board to an examination who refuses to authorize the treatment provider to contact any person identified by the treatment provider as being appropriate for the purpose of conducting a corroborating interview as part of the examination shall be deemed to have failed to submit to the examination due to circumstances within the individual's control, and a default and final order may be entered into without the taking of testimony or presentation of evidence.

4731-16-06 Consent and reinstatement.

(A) The written consent agreement required under division (F)(2) of section 4730.25 of the Revised Code, division (B)(26) of section 4731.22 of the Revised Code, division (F)(2) of section 4760.13 of the Revised Code or division (F)(2) of section 4762.13 of the Revised Code and rule 4731-16-02 of the Administrative Code prior to reinstatement of a suspended license, or any board order entered in lieu of a consent agreement, shall require, at a minimum, the following probationary and limiting terms:

(1) Obedience of all federal, state, and local laws, and all rules governing practice in Ohio;

(2) Submission of quarterly declarations under penalty of perjury stating whether there has been compliance with all conditions of the consent agreement;

(3) Periodic appearances before the board or its representatives as requested;

(4) Notification to the board of departures or absences from Ohio. Periods of departure or absence shall not reduce the probationary term, unless otherwise determined by motion of the board for absences of three months or longer, or by the secretary or the supervising member of the board for absences of less than three months, in instances where the board can be assured that probationary monitoring is otherwise being performed;

(5) Maintenance of a log of all controlled substances, and other drugs as directed by the board, which the practitioner prescribes, orders, personally furnishes, or administers, where appropriate;

(6) Prohibition of authority to prescribe, administer, personally furnish, order, or possess controlled substances and, as directed by the board, other substances which may impair ability to practice, where appropriate;

(7) Abstinence from the use of alcohol;

(8) Abstinence from the use or personal possession of drugs, except those prescribed, administered, or dispensed by another person so authorized by law who has knowledge of the patient's history and of the disease of addiction;

(9) Submission of witnessed urine or blood samples upon request of the board, and without prior notice;

(10) Undertaking and maintaining participation in a self help support group acceptable to the board, such as alcoholics anonymous or narcotics anonymous, with evidence of compliance to be provided to the board in each quarterly report;

(11) Undertaking psychiatric evaluation, and, where appropriate, continuing treatment acceptable to the board, with evidence of compliance to be provided in each quarterly report;

(12) Monitoring of progress and status by a physician approved by the board, with reports to be provided to the board quarterly;

(13) Prior approval by the board of any practice arrangements or any health care field employment, where appropriate;
(14) Copies of the agreement to be provided by the individual to all of the following during the effective period of the agreement or board order:
   (a) All employers or prospective employers, entities with which the individual contracts or seeks to contract to provide health services or receive training, the chief of staff at each hospital where the individual has or applies for privileges, and all persons and entities that provide the individual chemical dependency treatment or monitoring; and
   (b) By certified mail, the proper licensing authority of any state or jurisdiction in which the individual holds or applies for any professional license.
(15) Contacting an appropriate impaired physicians committee, such as the physician health program, to arrange for assistance in recovery or aftercare;
(16) Continuing compliance with the terms of the aftercare contract entered into with the treatment provider, provided, that where terms of the aftercare contract conflict with the terms of the consent agreement or board order, the terms of the consent agreement or board order shall control;
(17) Continuing authorization, through appropriate written consent forms, for disclosure by the treatment provider to the board, to treating and monitoring physicians, and to others involved in the monitoring process, of information necessary for them to fulfill their respective duties and obligations;
(18) Minimum probationary term of at least five years, except that a practitioner who first applies for licensure or license restoration after receiving treatment for impairment may be given probation of less than five years if the practitioner demonstrates continuous current sobriety of more than one year but less than five years, and a practitioner who first applies for licensure or license restoration after receiving treatment for impairment may be licensed without probation if the practitioner demonstrates continuous current sobriety of at least five years;
(19) Periods during which the probationer is not in compliance with all probationary terms, or during which all probationary monitoring provisions have not yet been implemented, as determined by the secretary of the board, shall not reduce the term of probation;
(20) No requests by the probationer for modifications to probationary terms for at least one year; and
(21) Prohibition of consumption of poppy seeds or any other food or liquid that may produce false results in a toxicology screen.
(B) A violation of any term of the consent agreement or board order described in this rule shall constitute grounds to take disciplinary action in accordance with Chapter 119 of the Revised Code.

4731-16-13 Practitioner consent.

(A) Licensees, associations, and societies shall report to the board a belief that a licensee suffers from impairment according to rule 4731-15-01 of the Administrative Code. Where the duty to report is relieved pursuant to paragraph (B) of that rule, the following requirements apply:
   (1) In order to ascertain the status of the practitioner’s progress, the licensee, member, representative, or agent shall contact the approved treatment provider to ascertain the licensee’s progress at least once weekly during the first four weeks following referral, and at least once monthly thereafter, and
   (2) If at any time the approved treatment provider indicates that the licensee has not continued to participate in accordance with section 4731.25 of the Revised Code, or if the approved treatment provider refuses to release information, the member, representative, or agent shall report to the board all information that led to the belief that the licensee suffers from impairment.
(B) A licensee who has been referred to an approved treatment provider shall execute, and shall not revoke, appropriate release forms to allow the referring party to monitor his progress in treatment.

4731-16-16 Practice prohibition while under treatment.

(A) No individual licensed pursuant to Chapter 4730, 4731, 4760, or 4762 of the Revised Code shall practice while receiving a controlled substance for the treatment of opioid dependence. A violation of this section shall constitute "a departure from, or failure to conform to, minimal standards of care of similar practitioners under the same or similar circumstances whether or not actual injury to the patient is established" as that language is used in division (B)(6) of section 4731.22 of the Revised Code, division (B)(19) of section 4730.25 of the Revised Code, division (B)(4) of section 4760.13 of the Revised Code, and in division (B)(4) of section 4762.13 of the Revised Code.

4731-28-01 Inability to practice.

For the purposes of division (B)(4) of section 4730.25 of the Revised Code, division (B)(19) of section 4731.22 of the Revised Code, division (B)(5) of section 4760.13 of the Revised Code, division (B)(5) of section 4762.13 of the Revised Code, division (B)(5) of section 4774.13 of the Revised Code, and division (B)(5) of section 4778.14 of the Revised Code, the following definitions apply:

(A) “Mental illness” includes, but is not limited to, mental disorder; and

(B) “Inability to practice according to acceptable and prevailing standards of care by reason of mental illness or physical illness, including, but not limited to, physical deterioration that adversely affects cognitive, motor, or perceptive skills”, includes inability to practice in accordance with such standards without appropriate treatment, monitoring, or supervision.

Intractable Pain and Comfort

4731-18-01 Requirements for surgeon.

(A) The surgeon of record in an operative case shall personally:

1. Evaluate the patient sufficiently to formulate an appropriate preoperative diagnosis;

and

2. Select the operation to be performed in consultation with the patient or with a person authorized to act on his behalf; and

3. Determine, based on his own evaluation, and, as necessary, on consultation with other physicians involved in the patient’s care, that the patient is a fit candidate for the operation to be performed; and

4. Assure that the patient or a person authorized to act on his behalf gives informed consent before the surgery begins; and

5. Comply with division (B)(6) of section 4731.22 of the Revised Code; and

6. Perform or personally supervise the surgery, except those portions of the surgery, if any, which are performed or supervised by another qualified surgeon with the informed consent of the patient.

(B) Management of postoperative medical care is the responsibility of the surgeon of record. The surgeon of record shall fulfill this responsibility by:

1. Personally performing the postoperative medical care; or

2. Delegating postoperative medical care to another physician or physicians who are qualified by training and experience to provide the level of care required, provided that the
surgeon of record shall remain primarily responsible for the patient's overall care unless the patient and the other physician have agreed in advance to shift that responsibility to the other physician; or

(3) Delegating defined aspects of the postoperative medical care to appropriately trained and supervised allied health care personnel in compliance with applicable standards, provided that the surgeon of record shall retain personal responsibility for the quality of the care rendered by personnel who are under his supervision and control. The surgeon of record shall obtain the patient's fully informed consent, or the consent of a person authorized to act on the patient's behalf, in advance of surgery, before delegating aspects of patient care to allied health care personnel under this paragraph. The surgeon of record need not obtain the patient's informed consent for aspects of care to which the patient has already consented, such as consent to treatment and care by hospital personnel under an informed consent form signed upon the patient's admission to the hospital; or

(4) Delegating defined aspects of the postoperative medical care to licensees of other health regulatory boards who are licensed to independently provide the scope of practice and the level of care required, provided that the surgeon of record shall remain primarily responsible for the patient's overall care and must examine the patient during the postoperative period.

(C) This rule shall not be read to transfer any responsibility which currently rests with any other physician, allied health care provider, or institution to the surgeon of record.

(D) This rule shall not be read to prohibit or interfere with the appropriate training of medical students and physicians in post-graduate training programs, or other personnel.

(E) The provisions of this rule requiring consultation with or obtaining the informed consent of the patient or a person legally authorized to act on his behalf do not apply to the extent they would prevent the performance of surgery or other procedures under emergency circumstances.

4731-21-01 Intractable pain and related definitions.

As used in Chapter 4731-21 of the Administrative Code:

(A) “Addiction” means a compulsive disorder in which an individual becomes preoccupied with obtaining and using a substance, despite adverse social, psychological and/or physical consequences, the continued use of which results in a decreased quality of life. Physical dependence alone is not evidence of addiction.

(B) “Believes” or “has reason to believe” does not require absolute certainty or complete unquestioning acceptance, but only an opinion based on reasonable information that a patient is suffering from addiction or drug abuse or engaging in diversion of drugs.

(C) “Board” means the state medical board of Ohio.

(D) “Chronic pain” means pain that has persisted after reasonable medical efforts have been made to relieve the pain or cure its cause and that has continued, either continuously or episodically, for longer than three continuous months. “Chronic pain” does not include pain associated with a terminal condition or with a progressive disease that, in the normal course of progression, may reasonably be expected to result in a terminal condition.

(E) “Diversion” means the conveyance of a prescription drug to a person other than the person for whom the drug was prescribed or dispensed by a practitioner.

(F) “Drug abuse” means a maladaptive or inappropriate use or overuse of a medication.

(G) “Emergency” means an unforeseen combination of circumstances or the resulting state that calls for immediate action.

(H) “Pain” means an unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage.

(I) “Physical dependence” means a physiologic state of adaptation to a specific drug or medication characterized by the development of a withdrawal syndrome following abrupt
cessation of a drug or on administration of an antagonist.

(J) “Practitioner” means any of the following:
   (1) An individual holding a certificate to practice medicine and surgery or osteopathic
       medicine and surgery under Chapter 4731 of the Revised Code;
   (2) An individual holding a certificate to practice podiatric medicine and surgery under
       Chapter 4731 of the Revised Code and practicing within his or her scope of practice as defined
       in section 4731.51 of the Revised Code; or
   (3) An individual holding both of the following:
       (a) A certificate to practice as a physician assistant under Chapter 4730 of the Revised
           Code and practicing within his or her scope of practice in compliance with that chapter; and
       (b) A certificate to prescribe under Chapter 4730 of the Revised Code and exercising
           physician delegated prescriptive authority in compliance with that chapter.

(K) “Prescription drug” means a drug which under state or federal law may be
administered or dispensed only by or upon the order of a practitioner and includes the term
“dangerous drug” as defined by section 4729.02 of the Revised Code.

(L) “Protracted basis” means for a period in excess of twelve continuous weeks.

(M) “Terminal condition” means an irreversible, incurable, and untreatable condition
caused by disease, illness, or injury, which will likely result in death. A terminal condition is one
in which there can be no recovery, although there may be periods of remission.

A terminal condition shall be determined to a reasonable degree of medical certainty in
accordance with reasonable medical standards by a patient's attending medical doctor or doctor
of osteopathic medicine and one other individual holding a certificate under Chapter 4731 of the
Revised Code to practice medicine and surgery or osteopathic medicine and surgery who has
examined the patient.

(N) “Tolerance” means decreasing response to the same dosage of a prescription drug
over time as a result of physiologic adaptation to that drug.

(O) “Utilizing prescription drugs” means prescribing, administering, dispensing,
supplying, selling or giving a prescription drug.

**4731-21-02 Utilizing prescription drug for treatment of intractable pain.**

(A) When utilizing any prescription drug for the treatment of chronic pain, a practitioner
shall comply with accepted and prevailing standards of care which shall include, but not be
limited to, the following:
   (1) An initial evaluation of the patient shall be conducted and documented in the patient's
       record that includes a relevant history, including complete medical, pain, alcohol and substance
       abuse histories; an assessment of the impact of pain on the patient’s physical and psychological
       functions; a review of previous diagnostic studies and previously utilized therapies; an
       assessment of coexisting illnesses, diseases or conditions; and an appropriate physical
       examination;
   (2) A medical diagnosis shall be established and documented in the patient's medical
       record that indicates not only the presence of chronic pain but also the signs, symptoms, and
       causes and, if determinable, the nature of the underlying disease and pain mechanism;
   (3) An individualized treatment plan shall be formulated and documented in the patient's
       medical record. The treatment plan shall specify the treatment proposed, the patient's response
to treatment, and any modification to the treatment plan. The treatment plan shall include the
medical justification and the intended role of prescription drug therapy within the overall plan,
and documentation that other medically reasonable treatments for relief of the patient's chronic
pain have been offered or attempted without adequate or reasonable success. The prescription
drug therapy shall be tailored to the individual medical needs of each patient.

(4)
(a) The practitioner's diagnosis of chronic pain shall be made after having the patient evaluated by one or more other practitioners who specialize in the treatment of the anatomic area, system, or organ of the body perceived as the source of the pain. For purposes of this rule, a practitioner "specializes" if the practitioner limits the whole or part of his or her practice, and is qualified by advanced training or experience to so limit his or her practice, to the particular anatomic area, system, or organ of the body perceived as the source of the pain. The evaluation shall include review of all available medical records of prior treatment of the chronic pain or the condition underlying the chronic pain; a thorough history and physical examination; and testing as required by accepted and prevailing standards of care. The practitioner shall maintain a copy of any report made by any practitioner to whom referral for evaluation was made under this paragraph. A practitioner shall not provide an evaluation under this paragraph if that practitioner would be prohibited by sections 4731.65 to 4731.69 of the Revised Code or any other rule adopted by the board from providing a designated health service upon referral by the treating practitioner; and

(b) The practitioner shall not be required to obtain such an evaluation, if the practitioner obtains a copy of medical records or a detailed written summary thereof showing that the patient has been evaluated and treated within a reasonable period of time by one or more other practitioners who specialize in the treatment of the anatomic area, system, or organ of the body perceived as the source of the pain and the treating practitioner is satisfied that he or she can rely on that evaluation for purposes of meeting the further requirements of this chapter of the Administrative Code. The practitioner shall obtain and review all available medical records or detailed written summaries of prior treatment of the chronic pain or the condition underlying the chronic pain. The practitioner shall maintain a copy of any record or report of any practitioner on which the practitioner relied for purposes of meeting the requirements under this paragraph; and

(5) The practitioner shall ensure and document in the patient's record that the patient or other individual who has the authority to provide consent to treatment on behalf of that patient gives consent to treatment after being informed of the benefits and risks of receiving prescription drug therapy for chronic pain and after being informed of available treatment alternatives.

(B) Upon completion and satisfaction of the conditions prescribed in paragraph (A) of this rule, and upon a practitioner's judgment that the continued utilization of prescription drugs is medically warranted for the treatment of chronic pain, a practitioner may utilize prescription drugs provided that the practitioner continues to adhere to accepted and prevailing standards of care which shall include, but not be limited to, the following:

(1) Patients shall be seen by the practitioner at appropriate periodic intervals to assess the efficacy of treatment, assure that prescription drug therapy remains indicated, evaluate the patient's progress toward treatment objectives and note any adverse drug effects. During each visit, attention shall be given to changes in the patient's ability to function or to the patient's quality of life as a result of prescription drug usage, as well as indications of possible addiction, drug abuse or diversion. Compliance with this paragraph of the rule shall be documented in the patient's medical record;

(2) Some patients with chronic pain may be at risk of developing increasing prescription drug consumption without improvement in functional status. Subjective reports by the patient should be supported by objective data. Objective measures in the patient's condition are determined by an ongoing assessment of the patient's functional status, including the ability to engage in work or other gainful activities, the pain intensity and its interference with activities of daily living, quality of family life and social activities, and physical activity of the patient. Compliance with this paragraph of the rule shall be documented in the patient's medical record;

(3) Based on evidence or behavioral indications of addiction or drug abuse, the practitioner shall obtain a drug screen on the patient. It is within the practitioner's discretion to decide the nature of the screen and which type of drug(s) to be screened. If the practitioner
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obtains a drug screen for the reasons described in this paragraph, the practitioner shall document the results of the drug screen in the patient's medical record. If the patient refuses to consent to a drug screen ordered by the practitioner, the practitioner shall make a referral as provided in paragraph (C) of this rule;

(4) The practitioner shall document in the patient's medical record the medical necessity for utilizing more than one controlled substance in the management of a patient's chronic pain; and

(5) The practitioner shall document in the patient's medical record the name and address of the patient to or for whom the prescription drugs were prescribed, dispensed, or administered, the dates on which prescription drugs were prescribed, dispensed, or administered, and the amounts and dosage forms of the prescription drugs prescribed, dispensed, or administered, including refills.

(6) The practitioner shall, in accordance with the requirements set forth in section 4731.055 of the Revised Code and rule 4731-11-11 of the Administrative Code, request a report from "OARRS," or the successor drug database maintained by the board of pharmacy.

(C) If the practitioner believes or has reason to believe that the patient is suffering from addiction or drug abuse, the practitioner shall immediately consult with an addiction medicine specialist or other substance abuse professional to obtain formal assessment of addiction or drug abuse.

(1) For purposes of this rule:
(a) Addiction medicine specialist means a physician who is qualified by advanced formal training in addiction medicine or other substance abuse specialty, and includes a medical doctor or doctor of osteopathic medicine who is certified by a specialty examining board to so limit the whole or part of his or her practice.
(b) Substance abuse professional includes a psychologist licensed pursuant to Chapter 4732 of the Revised Code and certified as a clinical health psychologist, an independent chemical dependency counselor, or a chemical dependency counselor III.

(2) The practitioner shall do all of the following:
(a) Document the recommendations of the consultation in the patient's record;
(b) Continue to actively monitor the patient for signs and symptoms of addiction, drug abuse or diversion; and
(c) Maintain a copy of any written report made by the addiction medicine specialist or substance abuse professional to whom referral for evaluation was made under this paragraph.

(3) Prescription drug therapy may be continued consistent with the recommendations of the consultation. If the consulting addiction medicine specialist or other substance abuse professional believes the patient to be suffering from addiction or drug abuse, prompt referral shall be made to one of the following:
(a) An addiction medicine specialist or substance abuse professional; or
(b) An addiction medicine or substance abuse treatment facility.

4731-21-06 Intractable pain and comfort care.

(A) A practitioner who treats pain by utilizing prescription drugs is not subject to disciplinary action pursuant to this chapter of the Administrative Code under the following circumstances:
(1) The treatment of pain for a patient with a terminal condition;
(2) The treatment of pain associated with a progressive disease that, in the normal course of progression, may reasonably be expected to result in a terminal condition;
(3) Treatment utilizing only drugs that do not exert their effects at the central nervous system level; and
(4) Treatment utilizing only drugs that are not controlled substances and are classified as antidepressants.

(B) A practitioner who treats chronic pain by utilizing prescription drugs is not subject to disciplinary action by the board under section 4731.22 of the Revised Code solely because the practitioner treated the chronic pain with prescription drugs. The practitioner is subject to disciplinary action only if the prescription drugs are not utilized in accordance with section 4731.052 of the Revised Code and the rules adopted under this chapter of the Administrative Code.

(C) A medical doctor or doctor of osteopathic medicine who provides comfort care as described in division (E)(1) of section 2133.12 of the Revised Code to a patient with a terminal condition is not subject to disciplinary action by the board under section 4731.22 of the Revised Code if the treatment of pain for a patient with a terminal condition is provided pursuant to the requirements of section 2133.11 of the Revised Code.

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4731-23-01 Delegation of medical tasks; definitions.

As used in Chapter 4731-23 of the Administrative Code:

(A) “Administer” means the direct application of a drug, whether by injection, inhalation, ingestion, or any other means to a person.

(B) “Delegate” means to transfer authority for the performance of a medical task to an unlicensed person.

(C) “On-site supervision” means that the physical presence of the physician is required in the same location (e.g., the physician's office suite) as the unlicensed person to whom the medical task has been delegated while the medical task is being performed. “On-site supervision” does not require the physician's presence in the same room.

(D) “Physician” means an individual authorized by Chapter 4731 of the Revised Code to practice medicine and surgery, osteopathic medicine and surgery, or podiatric medicine and surgery.

(E) “Task” includes, but is not limited to, a routine medical service not requiring the special skills of a licensed provider.

(F) “Unlicensed person” means an individual who is not licensed or otherwise specifically authorized by the Revised Code to perform the delegated medical task.

(G) “Drug” means the same as in division (E) of section 4729.01 of the Revised Code.

4731-23-02 Delegation of medical task.

(A) A physician shall not delegate the performance of a medical task unless that physician has complied with all of the requirements of this chapter of the Administrative Code and the delegation otherwise conforms to minimal standards of care of similar physicians under the same or similar circumstances.

(B) Prior to a physician's delegation of the performance of a medical task, that physician shall determine each of the following:

(1) That the task is within that physician's authority;
(2) That the task is indicated for the patient;
(3) The appropriate level of supervision;
(4) That no law prohibits the delegation;
(5) That the person to whom the task will be delegated is competent to perform that task; and,
(6) That the task itself is one that should be appropriately delegated when considering
the following factors:
   (a) That the task can be performed without requiring the exercise of judgment based on medical knowledge;
   (b) That results of the task are reasonably predictable;
   (c) That the task can safely be performed according to exact, unchanging directions;
   (d) That the task can be performed without a need for complex observations or critical decisions;
   (e) That the task can be performed without repeated medical assessments; and,
   (f) That the task, if performed improperly, would not present life threatening consequences or the danger of immediate and serious harm to the patient.

(C) When a physician delegates the administration of drugs, that physician shall provide on-site supervision, except in the following situations:

1. When the physician has transferred responsibility for the on-site supervision of the unlicensed person who is administering the drug to another physician and that physician has knowingly accepted that responsibility on a patient-by-patient basis; or
2. In the routine administration of a topical drug, such as a medicated shampoo.
3. When delegation occurs pursuant to section 5126.36 of the Revised Code within the programs and services offered by a county board of developmental disabilities.
4. When delegation occurs pursuant to section 5123.42 of the Revised Code.
5. When written policies and procedures have been adopted for the distribution of drugs by an unlicensed person to individuals incarcerated in state correctional institutions as defined in division (A) of section 2796.01 of the Revised Code, other correctional facilities including county and municipal jails, workhouses, minimum security jails, halfway houses, community residential centers, regional jails and multi-county jails, or any other detention facility as defined in division (F) of section 2921.01 of the Revised Code.

(D) This chapter of the Administrative Code shall not apply if the rules contained herein:

1. Prevent an individual from engaging in an activity performed for a handicapped child as a service needed to meet the educational needs of the child, as identified in the individualized education program developed for the child under Chapter 3323 of the Revised Code;
2. Prevent delegation from occurring pursuant to section 5126.36 of the Revised Code within the programs and services offered by a county board of developmental disabilities;
3. Conflict with any provision of the Revised Code that specifically authorizes an individual to perform a particular task;
4. Conflict with any rule adopted pursuant to the Revised Code that is in effect on the effective date of this section, as long as the rule remains in effect, specifically authorizing an individual to perform a particular task;
5. Prohibit a perfusionist from administering drugs intravenously while practicing as a perfusionist.

4731-23-03 Limitation on delegation of medical tasks.

(A) A physician shall not delegate the practice of medicine as defined in section 4731.34 of the Revised Code unless specifically authorized to do so in the Revised Code or by an administrative rule adopted pursuant to the Revised Code and which became effective prior to April 10, 2001. Nothing in this chapter of the Administrative Code shall prohibit the performance of emergency medical tasks.

(B) A physician shall not delegate a task to an unlicensed person if the task is beyond that person's competence. In a hospital, as defined in section 3727.01 of the Revised Code, or an ambulatory care center affiliated with the hospital (if the center meets the same credentialing, quality assurance, and utilization review standards as the hospital) wherein unlicensed persons
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are employed or otherwise authorized by the governing authority of the institution to perform specific medical tasks, one factor the physician shall take into account is the policies by which the employer or the governing authority of the institution seeks to ensure that competent persons will be performing the delegated tasks.

(C) A physician shall not delegate a medical task that is not within the authority of that physician or is beyond the physician's training, expertise, or normal course of practice.

(D) A physician shall not transfer his or her responsibility for supervising an unlicensed person in the performance of a delegated medical task, except to another physician who has knowingly accepted that responsibility.

(E) A physician shall not authorize or permit an unlicensed person to whom a medical task is delegated to delegate the performance of that task to another person.

(F) Except as provided in divisions (D)(4) to (D)(8) of section 4731.053 of the Revised Code, a physician shall not delegate to an unlicensed person the administration of anesthesia, controlled substances, or drugs administered intravenously.

(G) The supervising physician retains responsibility for the manner in which the delegated task is carried out.

4731-27-01 Terminating physician patient relationship.

As used in section 4731.228 of the Revised Code and this chapter:

(A) “Health care entity” has the same meaning as in section 4731.228 of the Revised Code.

(B) “Termination” has the same meaning as in section 4731.228 of the Revised Code. Pursuant to division (B) of section 4731.228 of the Revised Code termination does not include a physician leaving employment with a health care entity but continuing to provide medical services for patients of the health care entity on an independent contractor basis.

(C) “Retiring” means the relinquishing of all clinical privileges and either expiration of medical liability insurance by lapse of the policy or conversion of the policy to extended reporting period coverage only.

(D) “Terminate” means to put an end to.

(E) “Resignation” as that term is used in division (D) of section 4731.228 of the Revised Code means the provision of notice by a physician to a health care entity that the physician will no longer be an employee of the health care entity as of the date stated in the notice or a determination by the health care entity that the physician has resigned.

4731-27-02 Dismissing a patient from the medical practice.

A physician-patient relationship is established when the physician provides service to a person to address medical needs, whether the service was provided by mutual consent or implied consent, or was provided without consent pursuant to a court order. Once a physician-patient relationship is established, a person remains a patient until the relationship is terminated.

(A) Except as provided in paragraph (B) of this rule, a physician shall comply with the following requirements in order to dismiss a patient from the medical practice:

(1) Send notice to the patient that includes all of the following:

(a) A statement that the physician-patient relationship is terminated;

(b) A statement that the physician will continue to provide emergency treatment and access to services for up to thirty days from the date the letter was mailed, to allow the patient to secure care from another licensee; and

(c) An offer to transfer records to a new provider upon the patient's signed authorization to do so.
(2) The notice shall be sent in one of the following ways:
   (a) A letter sent via certified mail, return receipt requested, to the last address for the patient on record, with a copy of the letter, the certified mail receipt, and the mail delivery receipt maintained in the patient record;
   (b) An electronic message sent via a HIPAA compliant electronic medical record system or HIPAA compliant electronic health record system that provides a means of electronic communication between the health care entity and the patient, is capable of sending the patient a notification that a message has been received and is in the patient's portal, and is capable of notifying the sender that a message has not been viewed or has been viewed;
   (c) If a notice sent via an electronic message as authorized in paragraph (A)(2)(b) of this rule is not viewed within ten days of having been sent, a letter sent in accordance with paragraph (A)(2)(a) of this rule.

(B) The requirements of paragraph (A) of this rule do not apply to the following:
   (1) The physician rendered me medical service to the person on an episodic basis or in an emergency setting and the physician should not reasonably expect that related medical service will be rendered to the patient in the future;
   (2) The physician formally transferred the patient's care to another health care provider who is not in the same practice group;
   (3) The physician is leaving a practice, selling a practice, retiring from medical practice, or whose employment with a health care entity has ended for any reason;
   (4) The patient terminated the relationship, either verbally or in writing, or has transferred care to another physician for the same or a related condition, and the physician maintains documentation in the patient record of the patient's action terminating the relationship.

(C) A physician assistant or anesthesiologist assistant may not independently dismiss a patient from a medical practice.

(D) A physician's dismissal of a patient from a medical practice other than in accordance with the provisions of this rule, as determined by the state medical board of Ohio, shall constitute "a departure from, or failure to conform to, minimal standards of care of similar practitioners under the same or similar circumstances, whether or not actual injury to a patient is established," as that clause is used in division (B)(6) of section 4731.22 of the Revised Code.

(E) Nothing in this rule shall limit the board's authority to investigate and take action under section 4731.22 of the Revised Code.

4731-27-03 Notice of termination of physician employment or physician leaving a practice, selling a practice, or retiring from the practice of medicine.

(A) When pursuant to section 4731.228 of the Revised Code a health care entity provides to patients a notice of the termination of a physician's employment, the notice shall be provided in one of the following ways:
   (1) A letter sent via regular mail to the last address for the patient on record, with the date of mailing of the letter documented;
   (2) An electronic message sent via a HIPAA compliant electronic medical record system or HIPAA compliant electronic health record system that provides a means of electronic communication between the health care entity and the patient and is capable of sending the patient a notification that a message has been received and is in the patient's portal.

(B) When pursuant to section 4731.228 of the Revised Code a health care entity provides the physician whose employment has been terminated for any reason with a list of patients treated and the patient contact information, the physician shall provide the notice required by section 4731.228 of the Revised Code by one of the ways authorized by paragraph (A)(1) or (A)(2) of this rule. In addition, the physician may, but is not required to, publish a notice in a newspaper of greatest circulation in the county in which the physician has practiced and in
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(1) The notice shall be sent to all patients who received physician services from the physician within the two-years immediately preceding the physician's last date for seeing patients;

(2) The notice shall be provided as authorized in paragraph (A)(1) or (A)(2) of this rule.

(a) The notice shall be sent no later than thirty days prior to the last date the physician will see patients or upon actual knowledge that the physician will be leaving, selling, or retiring from the health care entity, whichever is earlier.

(b) A physician shall make a good faith effort to comply with paragraph (C)(2)(a) of this rule. However, a physician who because of acute illness or unforeseen emergency is unable to provide the notice thirty days prior to the last date of seeing patients shall provide the notice required by paragraph (C) of this rule no later than thirty days after it is determined that the physician will not be returning to the health care entity.

(3) The notice shall include all of the following:

(a) A statement that the physician will no longer be practicing medicine at the health care entity;

(b) The date on which the physician ceased or will cease to provide medicine services at the health care entity;

(c) If the physician will be practicing medicine in another location, contact information for the physician subsequent to leaving the health care entity;

(d) Contact information for an alternative physician or physicians employed by the health care entity or contact information for a group practice that can provide care for the patient;

(e) Contact information that enables the patient to obtain information on the patient's medical records.

(D) The requirements of paragraphs (A), (B) and (C) of this rule do not apply to the following:

(1) A physician who rendered medical service to a person on an episodic basis or in an emergency department or urgent care center, when it should not be reasonably expected that related medical service will be rendered by the physician to the patient in the future;

(2) A medical director or other physician providing services in a similar capacity to a medical director to patients through a hospice care program licensed pursuant to section 3712.04 of the Revised Code;

(3) Medical residents, interns, and fellows who work in hospitals, health systems, federally qualified health centers, and federally qualified health center look-alikes as part of their medical education and training;

(4) A physician providing services to a patient through a community mental health agency certified by the director of mental health under section 5119.611 of the Revised Code or an alcohol and drug addiction program certified by the department of alcohol and drug addiction services under section 3793.06 of the Revised Code;

(5) A physician providing services to a patient through a federally qualified health center or a federally qualified health center look-alike.

(E) A physician's failure to provide notice in accordance with the provisions of paragraph (B) or (C) of this rule, as determined by the state medical board of Ohio, shall constitute "a departure from, or failure to conform to, minimal standards of care of similar practitioners under the same or similar circumstances, whether or not actual injury to a patient is established," as that clause is used in division (B)(6) of section 4731.22 of the Revised Code.

(F) Nothing in this rule shall limit the board's authority to investigate and take action
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under section 4731.22 of the Revised Code.

Referrals

4731.65 Patient referrals, group practice, clinical laboratory services; definitions.

As used in sections 4731.65 to 4731.71 of the Revised Code:
(A)(1) “Clinical laboratory services” means either of the following:
   (a) Any examination of materials derived from the human body for the purpose of providing information for the diagnosis, prevention, or treatment of any disease or impairment or for the assessment of health;
   (b) Procedures to determine, measure, or otherwise describe the presence or absence of various substances or organisms in the body.
(2) “Clinical laboratory services” does not include the mere collection or preparation of specimens.
(B) “Designated health services” means any of the following:
   (1) Clinical laboratory services;
   (2) Home health care services;
   (3) Outpatient prescription drugs.
(C) “Fair market value” means the value in arms-length transactions, consistent with general market value and:
   (1) With respect to rentals or leases, the value of rental property for general commercial purposes, not taking into account its intended use;
   (2) With respect to a lease of space, not adjusted to reflect the additional value the prospective lessee or lessor would attribute to the proximity or convenience to the lessor if the lessor is a potential source of referrals to the lessee.
(D) “Governmental health care program” means any program providing health care benefits that is administered by the federal government, this state, or a political subdivision of this state, including the medicare program, health care coverage for public employees, health care benefits administered by the bureau of workers’ compensation, and the medicaid program.
(E)(1) “Group practice” means a group of two or more holders of licenses or certificates under this chapter legally organized as a partnership, professional corporation or association, limited liability company, foundation, nonprofit corporation, faculty practice plan, or similar group practice entity, including an organization comprised of a nonprofit medical clinic that contracts with a professional corporation or association of physicians to provide medical services exclusively to patients of the clinic in order to comply with section 1701.03 of the Revised Code and including a corporation, limited liability company, partnership, or professional association described in division (B) of section 4731.226 of the Revised Code formed for the purpose of providing a combination of the professional services of optometrists who are licensed, certificated, or otherwise legally authorized to practice optometry under Chapter 4725 of the Revised Code, chiropractors who are licensed, certificated, or otherwise legally authorized to practice chiropractic or acupuncture under Chapter 4734 of the Revised Code, psychologists who are licensed, certificated, or otherwise legally authorized to practice psychology under Chapter 4732 of the Revised Code, registered or licensed practical nurses who are licensed, certificated, or otherwise legally authorized to practice nursing under Chapter 4723 of the Revised Code, pharmacists who are licensed, certificated, or otherwise legally authorized to practice pharmacy under Chapter 4729 of the Revised Code, physical therapists who are licensed, certificated, or otherwise legally authorized to practice physical therapy under sections 4755.40 to 4755.56 of the Revised Code, occupational therapists who are licensed, certificated, or otherwise legally authorized to practice occupational therapy under sections 4755.04 to 4755.13 of the Revised Code, mechanotherapists who are licensed, certificated, or otherwise...
Section 4731.66 Referrals and cross-referrals for designated health service; prohibitions.

(A) Except as provided in sections 4731.67 and 4731.68 of the Revised Code, no holder of a license under this chapter to practice medicine and surgery, osteopathic medicine and surgery, or podiatric medicine and surgery shall refer a patient to a person for a designated health service if the license holder, or a member of the license holder’s immediate family, has either of the following financial relationships with the person:

(1) An ownership or investment interest in the person whether through debt, equity, or other means;

(2) Any compensation arrangement involving any remuneration, directly or indirectly, overtly or covertly, in cash or in kind.

(B) No person to which a license holder has referred a patient in violation of division (A) of this section shall bill the patient, any third-party payer, any governmental health care program, or any other person or governmental entity for the designated health service rendered pursuant to the referral.

(C) No person shall knowingly enter into an arrangement or scheme, including a cross-
referral arrangement, that has a principal purpose of assuring referrals by a license holder to a particular person that, if the license holder directly made referrals to such person, would violate division (A) of this section.

**4731.67 Prohibitions on referrals; exceptions.**

Section 4731.66 of the Revised Code does not apply to any of the following referrals by the holder of a license under this chapter:

(A) Referrals for physicians' services that are performed by or under the personal supervision of a physician in the same group practice as the referring physician;

(B) Referrals for clinical laboratory services by a license holder specializing in the practice of pathology if those services are provided by or under the supervision of the pathologist pursuant to a consultation requested by another physician;

(C) Referrals for in-office ancillary services to which all of the following apply:
   (1) The services are furnished by the referring physician, a physician in the same group practice as the referring physician, or individuals who are employed by the referring physician or the group practice and who are supervised by the referring physician or a physician in the group practice, and are furnished either:
      (a) In a building in which the referring physician, or another physician in the same group practice as the referring physician, furnishes physicians' services unrelated to the furnishing of designated health services;
      (b) In another building used by the referring physician's group practice for the centralized provision of the group's designated health services.
   (2) The services are billed by the physician performing or supervising the services, the physician's group practice, or an entity wholly owned by the group practice.
   (3) The physician's ownership or investment interest in the services described in this division meets any other requirements that the state medical board applies in rules adopted under section 4731.70 of the Revised Code.

(D) Referrals for in-office ancillary services if the third-party payer is aware of and has agreed in writing to reimburse the services notwithstanding the financial arrangement between the physician and the provider of such ancillary services.

(E) Referrals for services furnished by a health insuring corporation to an enrollee of the corporation;

(F) Referrals to a hospital for designated health services, if all of the following apply:
   (1) The financial arrangement between the referring physician or immediate family member and the hospital consists of an ownership or investment interest described in division (A)(1) of section 4731.66 of the Revised Code and not a compensation arrangement described in division (A)(2) of that section.
   (2) The referring physician is authorized to perform services at the hospital.
   (3) The ownership or investment interest is in the hospital itself and not merely in a subdivision of the hospital.

(G) Referrals to a hospital with which the license holder's or immediate family member's financial relationship does not relate to the provision of designated health services;

(H) Referrals to a laboratory located in a rural area as defined in section 1886(d)(2)(D) of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 1395ww(d)(2)(D), as amended, if the financial relationship consists of an ownership or investment interest described in division (A)(1) of section 4731.66 of the Revised Code, and not a compensation arrangement described in division (A)(2) of that section;

(I) Any other referrals in which the financial relationship between the license holder or immediate family member and the person furnishing services has been specified in rules adopted by the state medical board under section 4731.70 of the Revised Code.
4731.68 Exceptions; permissible ownership of investment securities; permissible compensation arrangements.

(A) Ownership of investment securities in a corporation, including bonds, debentures, notes, other debt instruments, or shares, shall not be considered an ownership or investment interest described in division (A)(1) of section 4731.66 of the Revised Code if all of the following apply:

1. The securities were purchased on terms generally available to the public.
2. The corporation is listed for trading on the New York stock exchange or the American stock exchange or is a national market system security traded under an automated interdealer quotation system operated by the national association of securities dealers.
3. The corporation had, at the end of its most recent fiscal year, total assets exceeding one hundred million dollars.

(B) Payments for the rental or lease of office space shall not be considered a compensation arrangement described in division (A)(2) of section 4731.66 of the Revised Code if all of the following apply:

1. There is a written agreement signed by the parties for the rental or lease of the space that does all of the following:
   a. Specifies the space covered by the agreement and dedicated for the use of the lessee;
   b. Provides for a term of rental or lease of at least one year;
   c. Provides for payment on a periodic basis of an amount that is consistent with fair market value;
   d. Provides for an amount of aggregate payments that does not directly or indirectly vary based on the volume or value of any referrals of business between the parties;
   e. Would be commercially reasonable even if no referrals were made between the parties.
2. In the case of a rental or lease arrangement between a holder of a license under this chapter or member of the license holder’s immediate family and another person in which the license holder or family member also has an ownership or investment interest described in division (A)(1) of section 4731.66 of the Revised Code, the office space is in the same building as the building in which the license holder or the license holder’s group practice has a practice.
3. The arrangement meets any other requirements that the state medical board applies in rules adopted under section 4731.70 of the Revised Code.

(C) An arrangement between a hospital and a license holder or a member of the license holder’s immediate family for the employment of the license holder or family member or for the provision of administrative services shall not be considered a compensation arrangement described in division (A)(2) of section 4731.66 of the Revised Code if all of the following apply:

1. The arrangement is for identifiable services.
2. The amount of the remuneration under the arrangement is consistent with the fair market value of the services and is not determined in a manner that directly or indirectly takes into account the volume or value of any referrals by the license holder.
3. The remuneration is provided pursuant to an agreement that would be commercially reasonable even if the license holder made no referrals to the hospital.
4. The arrangement meets any other requirements that the state medical board applies in rules adopted under section 4731.70 of the Revised Code.

(D) Remuneration by a hospital of a license holder to induce the license holder to relocate to the geographic area served by the hospital in order to be a member of the hospital’s medical staff shall not be considered a compensation arrangement described in division (A)(2) of section 4731.66 of the Revised Code if all of the following apply:

1. The license holder is not required to refer patients to the hospital.
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(2) The amount of the remuneration is not determined in a manner that directly or indirectly takes into account the volume or value of any referrals by the license holder to the hospital.

(3) The arrangement meets any other requirements that the state medical board applies in rules adopted under section 4731.70 of the Revised Code.

(E) Remuneration of a license holder or member of the license holder’s immediate family by a person other than a hospital shall not be considered a compensation arrangement described in division (A)(2) of section 4731.66 of the Revised Code if all of the following apply:

(1) The remuneration is for any of the following:
(a) Specific, identifiable services as the medical director or a member of a medical advisory board of the person;
(b) Specific, identifiable physicians’ services furnished to an individual in a hospice if the physicians’ services are payable by the individual’s third-party payer only to the hospice;
(c) Specific, identifiable physicians’ services furnished to a nonprofit blood center;
(d) Specific, identifiable administrative services other than direct patient care services in circumstances specified in rules adopted by the state medical board under section 4731.70 of the Revised Code.

(2) The amount of the remuneration under the arrangement is consistent with the fair market value of the services and is not determined in a manner that directly or indirectly takes into account the volume or value of any referrals by the license holder.

(3) The remuneration is provided pursuant to an agreement that would be commercially reasonable even if the license holder made no referrals to the person.

(4) The arrangement meets any other requirements that the state medical board applies in rules adopted under section 4731.70 of the Revised Code.

(F) Isolated financial transactions, including a one-time sale of property, shall not be considered a compensation arrangement described in division (A)(2) of section 4731.66 of the Revised Code if all of the following apply:

(1) The amount of the remuneration under the arrangement is consistent with fair market value and is not determined in a manner that directly or indirectly takes into account the volume or value of any referrals by the license holder.

(2) The remuneration is provided pursuant to an agreement that would be commercially reasonable even if the license holder made no referrals to the person.

(3) The transaction meets any other requirements that the state medical board applies in rules adopted under section 4731.70 of the Revised Code.

(G) Payment of the salary of a license holder by the license holder’s group practice shall not be considered a compensation arrangement described in division (A)(2) of section 4731.66 of the Revised Code.

4731.69 Requirement to refund unlawfully collected amounts.

Any person who collects any amounts billed in violation of section 4731.66 of the Revised Code shall be liable to the individual, third-party payer, governmental health care program, or other person or governmental entity for and shall refund, on a timely basis, the amount so collected. No person shall fail to refund on a timely basis any amount due under this section.

4731.70 State Medical Board to adopt rules on implementing referral provisions.

The state medical board shall adopt rules in accordance with Chapter 119 of the Revised Code to implement sections 4731.65 to 4731.69 of the Revised Code. The rules shall include all of the following:
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4731.71 Detecting and reporting violations; auditor of state.

The auditor of state may implement procedures to detect violations of section 4731.66 or 4731.69 of the Revised Code within governmental health care programs administered by the state. The auditor of state shall report any violation of either section to the state medical board and shall certify to the attorney general in accordance with section 131.02 of the Revised Code the amount of any refund owed to a state-administered governmental health care program under section 4731.69 of the Revised Code as a result of a violation. If a refund is owed to the medicaid program, the auditor of state also shall report the amount to the department of medicaid.

The state medical board also may implement procedures to detect violations of section 4731.66 or 4731.69 of the Revised Code.

4731.81 Using general anesthetic; competent witness required.

No person shall knowingly administer a general anesthetic to another, unless at the time of administration a competent witness is present.

4731.99 Penalties for violations.

(A) Whoever violates section 4731.41, 4731.43, or 4731.60 of the Revised Code is guilty of a felony of the fifth degree on a first offense and a felony of the fourth degree on each subsequent offense.

(B) Whoever violates section 4731.49, 4731.50, or 4731.81 of the Revised Code is guilty of a misdemeanor of the fourth degree on a first offense and a misdemeanor of the first degree on each subsequent offense.

(C) Whoever violates section 4731.46 or 4731.47 of the Revised Code is guilty of a felony of the fifth degree.

(D) Whoever violates section 4731.48 of the Revised Code is guilty of a misdemeanor of the fourth degree.

(E) Whoever violates division (A), (B), (C), or (D) of section 4731.224 of the Revised Code is guilty of a minor misdemeanor on a first offense and a misdemeanor of the fourth degree on each subsequent offense, except that an individual guilty of a subsequent offense shall not be subject to imprisonment, but to a fine alone of up to one thousand dollars for each offense.

(F) Whoever violates section 4731.481 of the Revised Code is guilty of a misdemeanor
Part IV. Physical Therapists

4755-27-01 Physical therapy practice defined.

(A) In accordance with section 4755.48 of the Revised Code, only individuals licensed by the physical therapy section of the board may imply or claim to be able to practice physical therapy or provide physical therapy services.

(1) Only individuals licensed by the physical therapy section may use the words physical therapist, physical therapy, physical therapy services, physiotherapist, physiotherapy, physiotherapy services, physical therapy assistant, physical therapist assistant, physical therapy technician, or other words or insignia indicating or implying that the person is a physical therapist or physical therapist assistant.

(2) Only individuals licensed by the physical therapy section may use the letters PT, PhT, PTT, RPT, LPT, MPT, DPT, MSPT, PTA, or any other letters or insignia to indicate or imply that the person is licensed to practice as a physical therapist or physical therapist assistant.

(B) The practice of physical therapy, as used in Chapter 4755 of the Revised Code, means engaging in physical therapy, as defined in division (A) of section 4755.40 of the Revised Code, including providing consultative services.

(C) For the purpose of Chapters 4755-21 to 4755-29 of the Administrative Code, the following definitions shall apply:

(1) "Physical therapist" means an individual who performs the initial examination unless that physical therapist has transferred the responsibility for the management of the patient's care to another physical therapist and that physical therapist agrees to the transfer.

(2) "Physical therapist assistant" means an individual holding a valid license under sections 4755.40 to 4755.56 to assist in the provision of physical therapy treatments, including the provision of patient education and instruction under the supervision of a physical therapist.

(3) "Other licensed personnel" means any person holding an Ohio license to practice as a health care practitioner in a profession other than physical therapy, and not holding a valid license under sections 4755.40 to 4755.56 of the Revised Code, who is working under the direct supervision of a physical therapist or physical therapist assistant, as delegated by the physical therapist, and is performing tasks and duties related to the delivery of physical therapy.

(4) "Unlicensed personnel" means any person who is on the job trained and supports the delivery of physical therapy services by personally assisting the physical therapist, physical therapist assistant, student physical therapist and/or student physical therapist assistant while the physical therapist, physical therapist assistant, student physical therapist, and/or student physical therapist assistant is concurrently providing services to the same patient.

(5) "Student physical therapist" means a student enrolled in an accredited or candidacy status entry level physical therapist education program who is completing a required clinical education course.

(6) "Student physical therapist assistant" means a student enrolled in an accredited or candidacy status entry level physical therapist assistant education program who is completing a required clinical education course.

(7) "Supervising physical therapist" means the physical therapist who is available to supervise the physical therapist assistant, the student physical therapist or student physical therapist assistant, other licensed personnel, or unlicensed personnel. The supervising physical therapist may be the physical therapist who performed the initial examination or another physical therapist with whom that physical therapist has a formal or informal agreement.
(8) "Supervising physical therapist assistant" means the physical therapist assistant who is appropriately available to supervise the student physical therapist assistant, other licensed personnel, or unlicensed personnel.

(9) "Direct supervision" means the physical therapist or physical therapist assistant is in the same building and available to immediately respond to the needs of the patient. The physical therapist or physical therapist assistant shall have direct contact with the patient during each visit.

4755-27-02 Supervision of physical therapist assistant by physical therapist.

(A) The physical therapist assistant, defined in division (C) of section 4755.40 of the Revised Code, is a skilled, technical person who assists in physical therapy treatment and related duties as assigned by the physical therapist. These duties are carried out under the supervision of the physical therapist, as defined in division (D) of section 4755.40 of the Revised Code and rule 4755-27-04 of the Administrative Code. The duties assigned may vary in accordance with the setting and organizational structure of the service, the scope, size, and volume of the services, and the needs of the patients to be served. The physical therapist assistant may carry out patient related duties, as well as responsibilities appropriate to the established physical therapy services.

(B) Physical therapist assistants are not qualified to:

1. Interpret physician referrals;
2. Conduct initial patient evaluations;
3. Write initial or ongoing patient plans of care;
4. Conduct re-evaluations of the patient or make changes to the patient plan of care; or
5. Perform the discharge evaluation and complete the final discharge summary.

(C) The physical therapist assistant may review medical information and/or review the patient's medical history and past functional ability through verbal contact with medical persons, family or the patient. This information may then be used by the physical therapist to determine the need for a patient evaluation.

(D) The physical therapist assistant may progress a patient treatment program within the parameters of the plan of care as established by the supervising physical therapist.

(E) The physical therapist may assign treatment procedures beyond the scope of entry level physical therapist assistant practice in accordance with the physical therapist assistant's ability, provided that both the supervising physical therapist and the physical therapist assistant have documented training and demonstrated competency in the procedure.

4755-27-03 Delegation by physical therapist.

(A) Delegation in physical therapy is the sole responsibility of the physical therapist.

(B) The responsibility for physical therapy care rendered by the physical therapist assistant and other licensed personnel rests with the supervising physical therapist.

(C) The physical therapist performs the following, none of which may be delegated:

1. Interpreting available information concerning the referral;
2. Providing the initial evaluation;
3. Developing the plan of care, including the short term and long term goals;
4. Identifying and documenting precautions, special problems, contraindications, anticipated progress, and plans for reevaluation;
5. Selecting and delegating only appropriate tasks in the plan of care;
6. Designating or establishing channels of written and oral communication;
7. Assessing the competence of the physical therapist assistant, other licensed personnel, and unlicensed personnel to perform assigned tasks;
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(8) Directing and supervising the physical therapist assistant, other licensed personnel, and unlicensed personnel in delegated tasks; and

(9) Reevaluating and adjusting the plan of care, when necessary, and performing the final evaluation, determining discharge, and establishing the follow-up plan.

(D) The physical therapist may refer patients to another discipline, which is not considered delegation. A referral to another discipline, including a physician, shall be documented in the medical record.

(E) Delegation of duties or tasks to the physical therapist assistant must be done in accordance with the scope of practice of the physical therapist assistant.

(1) A physical therapist assistant may not initiate or alter the plan of care without prior evaluation by and approval of the supervising physical therapist.

(2) A physical therapist assistant may adjust a treatment procedure in accordance with a change in patient status within the established plan of care.

(3) A physical therapist assistant may respond to inquiries regarding patient status to appropriate parties within the healthcare system and within the protocol established by the supervising physical therapist.

(4) The physical therapist assistant shall refer inquiries regarding a patient's prognosis to the supervising physical therapist. The physical therapist assistant may reinforce the physical therapist's position regarding the patient's prognosis.

(5) The physical therapist assistant may gather historical information about a patient to perform a screening that may determine the need for physical therapy intervention. This type of screening does not include physical contact with the patient.

(6) The physical therapist assistant shall document in the medical record according to the established protocols. All documentation shall be co-signed by the supervising physical therapist.

(F) Delegation of tasks related to the operation and delivery of physical therapy to other licensed personnel must be done in accordance with the scope of practice of the other licensed personnel's professional license, education and training, the level of competence as determined by the supervising physical therapist, and in consideration of the patient's overall needs and medical status.

(1) The physical therapist or physical therapist assistant shall demonstrate involvement, in accordance with paragraph (F) of rule 4755-27-04 of the Administrative Code, in each treatment session in which a component of care is delegated.

(2) Documentation by the other licensed personnel is restricted to an accounting of the activities provided, which includes the patient's response to intervention. The remainder of the documentation is the responsibility of the supervising physical therapist or supervising physical therapist assistant.

(G) The unlicensed personnel may be assigned routine duties that assist in the delivery of physical therapy care and operations, such as:

(1) Maintenance and care of equipment and supplies;
(2) Preparation, maintenance, and cleaning of treatment areas;
(3) Transportation of patients;
(4) Office and clerical functions;
(5) Assisting patients preparing for, during, and at the conclusion of treatment (such as changing clothes, assisting during transfer, and altering position during treatment);

(6) Personally assisting the physical therapist, physical therapist assistant, student physical therapist, and/or student physical therapist assistant while the physical therapist, physical therapist assistant, student physical therapist, and/or student physical therapist assistant is concurrently providing services to the same patient.
4755-27-04 Supervision by physical therapist.

(A) The supervising physical therapist is accountable and responsible at all times for the direction of the actions of the persons supervised, including the:
   (1) Physical therapist assistant;
   (2) Student physical therapist;
   (3) Student physical therapist assistant;
   (4) Other licensed personnel; and
   (5) Unlicensed personnel.

(B) The supervising physical therapist assistant is accountable and responsible at all times for the direction of the actions of the persons supervised, including the:
   (1) Student physical therapist assistant;
   (2) Other licensed personnel; and
   (3) Unlicensed personnel.

(C) Supervision of the physical therapist assistant.
   (1) In accordance with division (C) of section 4755.40 of the Revised Code, a physical therapist assistant may only be supervised by a physical therapist and may not be supervised by any other person, including those persons licensed to practice in any other profession.
   (2) Supervision for a physical therapist assistant does not require the supervising physical therapist to be on-site or on location. The supervising physical therapist must be available by telecommunication at all times and able to respond appropriately to the needs of the patient.

(D) Supervision of the student physical therapist.
   (1) A student physical therapist may only be supervised by a physical therapist licensed pursuant to Chapter 4755 of the Revised Code.
   (2) The supervising physical therapist is required to be on-site and available to immediately respond to the needs of the patient whenever the student physical therapist is performing patient examinations, evaluations, and interventions.

(E) Supervision of the student physical therapist assistant.
   (1) A student physical therapist assistant may only be supervised by a physical therapist or physical therapist assistant licensed pursuant to Chapter 4755 of the Revised Code.
   (2) The supervising physical therapist or supervising physical therapist assistant is required to be on-site and available to immediately respond to the needs of the patient whenever the student physical therapist assistant is performing patient interventions.

(F) Supervision of other licensed personnel.
   Direct supervision from the supervising physical therapist or supervising physical therapist assistant is required whenever the other licensed personnel is performing patient interventions.

(G) Supervision of unlicensed personnel.
   Unlicensed personnel may be supervised by the student physical therapist or student physical therapist assistant who are being supervised in accordance with the laws and rules governing the practice of physical therapy.

4755-27-06 Reporting requirements.

A licensee shall self report to the physical therapy section, within thirty days, any of the items outlined in paragraphs (A) to (E) of this rule. Failure to comply with this rule may be grounds for disciplinary action pursuant to section 4755.47 of the Revised Code and in accordance with Chapter 119 of the Revised Code.

(A) Impairment by physical or mental illness, chemical use, or chemical dependency, that affects the applicant's or licensee's ability to practice with reasonable skill and safety.
(B) Conviction of a felony.
(C) Conviction of a misdemeanor when the act that constituted the misdemeanor occurred during the practice of physical therapy.
(D) The termination, revocation, or suspension of membership by a state or national physical therapy professional association.
(E) A positive drug and/or alcohol screening.
Additional Places to Find the Law

Ohio Law
Ohio Constitution:  https://www.legislature.ohio.gov/laws/ohio-constitution  
Ohio Revised Code (statutes):  http://codes.ohio.gov/orc  
Ohio Administrative Code (final regulations):  http://codes.ohio.gov/oac  
Ohio Judicial Decisions:  www.supremecourt.ohio.gov  
Ohio Register (proposed regulations):  www.registerofohio.state.oh.us/  
Pending Ohio Legislation:  www.legislature.state.oh.us  

Federal Law
Proposed New or Revised Regulations:  www.regulations.gov  
U.S. Supreme Court opinions:  www.supremecourtus.gov/  

Find the Law Web Sites
This web site may help you find and understand applicable law, as well as find related information.  http://lawcrawler.findlaw.com/
Google Scholar enables you to search for legal articles, documents and both state and federal court decisions: http://scholar.google.com

Health Information and the Law Website has pages specific to various states and legal issues: http://www.healthinfolaw.org/state/36
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