Rules & Policies Agenda for Board Meeting
March 10, 2021

A. Rule Review Update

B. Rules with CSI
   1. Hearing Rules
   2. Dietetics Rule 4759-4-04

C. Board of Nursing Consult Agreement Rules

D. Initial Circulation of Rules

E. Delegation FAQ’s

F. Light-Based Medical Device Rules

G. ODH Vaccine Protocol

H. Evaluation and Treatment Rules

I. Legislative Update
MEMORANDUM

TO:        Mark Bechtel, M.D., President  
           Members, State Medical Board of Ohio
FROM:      Kimberly C. Anderson, Chief Legal Counsel
RE:        Rule Review Updates
DATE:      February 24, 2021

Attached please find the updated rule schedule and rule spreadsheet.

Please let me know if you have any questions.

Action Requested: No Action Needed
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<th>Rule Number</th>
<th>Rule Description</th>
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<th>Board Approval to File with CSI</th>
<th>CSI filing</th>
<th>CSI recommendation</th>
<th>JCARR filing</th>
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**Legal Dept. Rules Schedule**  
As of 2/24/21

### March 2021 Board Meeting

**For approval to file with CSI**
- 4731-11-08
- 4731-14-01
- 4731-23-01
- 4731-23-02
- 4731-23-03
- 4731-23-04
- 4731-26-01
- 4731-26-02
- 4731-26-03
- 4730-1-07
- 4730-2-07
- 4731-35-01
- 4731-35-02

**For discussion re comments received**
- 4731 Chapter 13 Hearing Rules

### RULES AT CSI

**Comment Deadline 5/27/20**
- 4731-18 – Light Based Medical Device Rules

**Comment Deadline 10/19/20**
- 4731-11-02
- 4731-11-03
- 4731-11-04
- 4731-11-04.1
- 4731-11-07
- 4731-11-11

**Comment Deadline 11/6/20**
- 4731 Chapter 13 – 36 rules

**Comment Deadline 11/23/20**
- 4759-4-04
- 4759-4-08
- 4759-6-02

### RULES SENT FOR INITIAL CIRCULATION

**Comment Deadline – September 25, 2020**
- 4731-6-14

### RULES AT JCARR

**4731-10-CME Rules (amended to reflect HB442 changes)**

**Filed 2/11/21 – Hearing to be held 3/15/21**
- 4731-8-01
- 4731-8-02
- 4731-8-03
- 4731-8-04
- 4731-8-05
- 4731-8-06
- 4774-1-01
- 4774-1-02
- 4774-1-03
- 4774-1-04
- 4731-17-01
- 4731-17-02
- 4731-17-03
- 4731-17-04
- 4731-17-05
- 4731-17-06
- 4731-17-07
- 4731-36-04

**Filed 3/1/21 – Hearing to be held 3/15/21**
- 4731-10-02
- 4731-10-08

### Rules for review in 2021

- 4731-1-12-Examination-Due 11.30.21
- 4731-1-16-Massage Therapy Curriculum-Due 11.30.21
- 4731-11-08-Utilizing controlled substances for self and family members-Due 8.17.21
- 4731-14-01-Pronouncement of Death-Due 6.30.21
- 4731-23-01-Delegation of Medical Tasks-Definitions-Due 11.30.21
- 4731-23-02-Delegation of Medical Tasks-Due 11.30.21
- 4731-23-03-Delegation of Medical Tasks-Prohibitions-Due 8.17.21
- 4731-23-04-Violations-Due 8.17.21
- 4731-26-01-Sexual Misconduct Definitions-Due 6.30.21
- 4731-26-02-Prohibitions-Due 6.14.21
- 4731-26-03-Violations; Miscellaneous-Due 6.30.21

### Rules Needing Amendments Due to HB442

The following rules need to be amended or rescinded to remove references to cosmetic therapy and oriental medicine:

- 4731-1-01 Definition of terms
- 4731-1-02 Application of rules governing limited branches of medicine or surgery
- 4731-1-03 General prohibitions
### Rules Needing Amendments Due to HB442, con’t.

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<td>Eligibility of electrologists licensed by Ohio state board of cosmetology to obtain licensure as cosmetic therapists (rescind)</td>
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<td>Continuing cosmetic therapy education requirements (rescind)</td>
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<td>Cosmetic therapy curriculum requirements (rescind)</td>
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<td>Distance education</td>
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<td>Application and examination for certificate to practice cosmetic therapy</td>
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<td>4731-1-15</td>
<td>Determination of standing of school, college or institution</td>
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<td>Instructional staff in Ohio cosmetic therapy and massage therapy programs</td>
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<td>Grounds for suspension, revocation or denial of certificate of good standing</td>
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<td>General Procedures in Impairment cases</td>
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<td>Military Provisions Related to Education and Experience Requirements for Licensure</td>
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### Changes related to continuing education (volunteer hours and clinical research faculty certificate)

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### Changes related to massage therapy curriculum requirements

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<tr>
<td>4731-1-16</td>
<td>Massage therapy curriculum requirements</td>
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MEMORANDUM

TO: Mark Bechtel, M.D., President
       Members, State Medical Board of Ohio

FROM: Kimberly C. Anderson, Chief Legal Counsel

RE: Comments Received on Hearing Rules-CSI

DATE: February 12, 2021

The hearing rules are due for five year review in 2021. The rules were filed with the Common Sense Initiative (“CSI”) on October 23, 2020 with comments due on November 6, 2020. No comments were received. The hearing unit requested an amendment to Rule 4731-13-03 to allow for electronic hearings. The Board approved the amendment at the December Board meeting and an amended Business Impact Analysis was filed with CSI on January 5, 2021 with comments due on January 22, 2021. Two comments were received, which are attached for your review.

1. Bob Miller, D.O. requests that the option of paper filing remain available for individuals with unreliable internet access. It appears that Dr. Miller is referencing Rule 4731-13-08, OAC, in which electronic filing is an option but not a requirement. Therefore, it appears no changes are necessary.

2. Levi Tkach of Graff & McGovern objected to the provision in Rule 4731-13-03 which would allow an electronic hearing upon the motion of a hearing examiner. Mr. Tkach expresses concerns that the hearing examiner could unilaterally deny respondent of the right of confrontation. In addition, Mr. Tkach indicates that the Ohio State Bar Association is drafting model virtual hearing guidelines and that the rule should not move forward until those guidelines are completed. Mr. Tkach also objects to the amendment of Rule 4731-13-15 which increases the time for a party to request to address the Board on the Report and Recommendation from 5 days to 7 days. Mr. Tkach advocates for reducing the time to three days.

Regarding Rule 4731-13-03, any ruling of the hearing examiner, including procedural rulings, are subject to review by the Board and by the courts, on appeal. Since the request would be by motion, the parties would have an opportunity to file a memorandum contra to outline objections to having a virtual hearing. In addition, the parties are able to file objections or an appeal if unsatisfied with the hearing examiner and Board rulings. With respect to the OSBA guidelines, they are not yet complete and the rules are due for five year review now. Once the guidelines are issued, the Board should review and make any necessary amendments to the rules.
Regarding Rule 4731-13-15, the reason for the extension of time is to provide the materials to the Board in a timely manner. Failure of a party to timely request to address the Board in accordance with the rule will not bar the party from making that address. Section 4731.23(C), Ohio Revised Code, states that the Board, upon the favorable vote of three members, allow the parties or their counsel the opportunity to present oral arguments on the proposed findings of fact and conclusions of law of the hearing examiner prior to the Board’s final action. The Board regularly considers and approves late requests to address the Board and this would continue.

Based on the foregoing, I am not recommending any amendments to the hearing rules at this time.

**Recommended action: Determine whether to amend the rules based upon the comments received.**
Please see attached for filing today.

Very sincerely yours,

Levi J. Tkach
Administrative Agency Law Specialist
Certified by the Ohio State Bar Association
levi@grafflaw.com
Ph: 614-228-5800 Ext. 4;
Fax: (614) 228-8811

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January 22, 2021

Via email only at Judith.rodriguez@med.ohio.gov
State Medical Board of Ohio
Attn: Judy Rodriguez
30 East Broad Street, 3rd Floor
Columbus, OH 43215

And to CSIPublicComments@governor.ohio.gov
Ohio Governor
Common Sense Initiative Office

Re: Comment on Proposed Rule 4731-13

Dear Ms. Rodriguez and CIS:

Please allow this letter to serve as a formal comment to the above proposed rule. Graff & McGovern, LPA is a Columbus based law firm representing individuals and companies across the state. Graff & McGovern, LPA represents clients before many regulatory bodies in the state. Two of the nine attorneys certified as specialists in administrative agency law are at Graff & McGovern, LPA and the firm stands unique in its focus on administrative law.

These comments reflect the opinions and concerns of many of our clients who appear before the State Medical Board of Ohio at administrative hearings. All attorneys with formal association with Graff & McGovern, LPA have reviewed these comments and join in this submission. Finally, as outlined below, these proposed rule change will have an impact on tens of thousands of other individuals and entities currently hold and/or intend to apply for licensure by the State Medical Board of Ohio.

Proposed Rule OAC 4731-13-03(J)
We believe the proposed rule lacks specificity and could reasonably be interpreted to deprive an accused of their constitutional right to address the accuser. While, virtual hearings routinely make sense during a pandemic, a hearing officer should not possess the unilateral authority to deprive a licensee or applicant of the right to confrontation.

Moreover, this proposed rule is vague as it lacks any companion guidelines for the flow and administration of virtual hearings. Graff & McGovern, LPA is working with the Ohio State Bar Association, the Ohio Attorney General’s Office, and other interested stake holders on drafting a set of model virtual hearing guidelines. Any rule on virtual hearings should wait until it can be coupled with a vetted set of virtual hearing guidelines.

Proposed Rule OAC 4731-13-15(G)
Graff & McGovern LPA also expresses concern with the proposed extension of the deadline of the time to request a hearing before the Board. OAC 4731-13-15(G). The current rule sets the deadline
at 5 days prior to the Board Meeting. The proposed rule change (7 days) is a significant change and adversely impacts the due process rights of licensees and applicants. The decision to appear before the Board often involves a very complicated case-by-case analysis. In many cases, the decision cannot be made a week in advance of the meeting. Forcing the client to make a decision at the one week mark places an unnecessary burden on the client and fails to promote a fair and impartial hearing process, while there is no impact on the Board.

We request the outright rejection of the proposed revision to 7 days and instead request the current rule be modified to 3 days instead.

Sincerely,

GRAFF & McGOVERN, LPA

Levi J. Tkach, Esquire
Administrative Agency Law Specialist
Certified by the Ohio State Bar Association
levi@grafflaw.com
Ph: 614-228-5800 Ext. 4
My question is where it states electronic filing: should read electronic filing and/or paper/hard copy filing. My rationale for this is because those of us physician that live and practice in Southeastern Ohio have to struggle with Internet Dysfunction and unreliability. Thank you for the opportunity for me to voice my opinion.
Bob Miller DO

Sent from my iPhone

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Representatives; appearances.

(A) As used in this chapter of the Administrative Code:

(1) "Respondent" means a person who is requesting or has requested a hearing as provided in Chapter 119. of the Revised Code.

(2) "Representative of record" means one person designated by each party to be the party's agent for purposes of receipt of service pursuant to this chapter of the Administrative Code.

(3) "Hearing" means the adjudication hearing held pursuant to Chapter 119. of the Revised Code when a hearing is requested by an applicant or licensee for whom the Board has proposed formal action under section 4730.25, 4731.22, 4759.07, 4760.13, 4761.09, 4762.13, 4774.13, or 4778.14 of the Revised Code.

(4) "Summary Suspension" means the pre-hearing suspension of the license under division (G) of section 4730.25, 4731.22, 4759.07, 4760.13, 4761.09, 4762.13, 4774.13, or 4778.14 of the Revised Code.

(B) The respondent may represent himself or herself or may be represented by an attorney or attorneys who shall be admitted to the practice of law in Ohio. Each attorney representing the respondent shall enter his or her appearance in writing. The respondent may authorize his or her attorney or attorneys to represent the respondent in all facets of a hearing before the board.

(C) If the respondent is self represented, he or she shall be deemed the representative of record for purposes of service pursuant to this chapter of the Administrative Code. If the respondent is represented by one attorney, that attorney shall be deemed the representative of record for purposes of service pursuant to this chapter of the Administrative Code. If the respondent is represented by more than one attorney, the respondent shall designate one of those attorneys as the representative of record for purposes of service pursuant to this chapter of the Administrative Code.

(D) Each representative from the office of the attorney general shall enter his or her appearance in writing. The office of the attorney general shall identify one attorney from that office as the representative of record for purposes of service pursuant to this chapter of the Administrative Code.

(E) The respondent shall not be required to appear personally at any hearing provided he or she has not been subpoenaed. If a respondent has not been subpoenaed to appear at hearing, a respondent may present his or her position, arguments or contentions
in writing.

(F) An attorney who has filed notice of appearance with the board shall withdraw his or her representation of a respondent by filing a written notice of withdrawal with the board. A written notice of withdrawal should include (i) current address and telephone number of respondent, and (ii) an attestation from the attorney that the respondent has been provided copies of all filings and has been specifically notified of all dates and deadlines.

(G) An attorney who has been designated as a respondent's representative of record for purposes of service pursuant to this chapter of the Administrative Code shall remain the representative of record for that party until a representative of that party files a written notice designating another attorney or the respondent as the representative of record.

(H) Except as otherwise provided under Chapter 119 of the Revised Code, communications from the board or its hearing examiner shall be sent to the representative of record for each party.
4731-13-02  Filing request for hearing.

(A) In order to request a hearing pursuant to Chapter 119. of the Revised Code, the respondent or the respondent's attorney or attorneys shall file a written request for a hearing in accordance with rule 4731-13-08 of the Administrative Code. The request shall be filed within thirty days of the date of mailing of the board's notice of opportunity for hearing upon which service is perfected, of the date of personal service of the board's notice of opportunity for hearing or of the date of publication of the board's notice of opportunity for hearing in accordance with Chapter 119. of the Revised Code, whichever occurs first. The date of mailing of the board's notice of opportunity for hearing shall be the date postmarked on the certified mail receipt.

(B) A respondent properly filing a request for a hearing, whether personally or by attorney or attorneys, shall be entitled to such hearing within fifteen days but not sooner than seven days after such request has been filed unless both parties agree otherwise or a continuance is granted pursuant to section 119.09 of the Revised Code and rule 4731-13-06 of the Administrative Code.
4731-13-03. Authority and duties of hearing examiners

(A) Hearings shall be conducted before hearing examiner pursuant to section 4731.23 of the
Revised Code.

(B) All hearings shall be open to the public, but the hearing examiner conducting a hearing
may close the hearing to the extent necessary to protect compelling interests and rights or
to comply with statutory requirements. In the event the hearing examiner determines to
close the hearing, the hearing examiner shall state the reasons in the public record.

(C) The hearing examiner shall conduct hearings in such a manner as to prevent unnecessary
delay, maintain order and ensure the development of a clear and adequate record.

(D) The authority of the hearing examiner shall include, but not be limited to, authority to:

(1) Administer oaths and affirmations;

(2) Order issuance of subpoenas and subpoenas duces tecum to require the attendance
of witnesses at hearings and depositions in lieu of live testimony and to require the
production of evidence for hearings and depositions in lieu of live testimony;

(3) Examine witnesses and direct witnesses to testify;

(4) Make rulings on the admissibility of evidence;

(5) Make rulings on procedural motions, whether such motions are oral or written;

(6) Hold prehearing conferences;

(7) Request briefs before, during or following the hearing;

(8) Prepare entries, proposed findings, proposed orders or reports and recommendations
pursuant to rule 4731-13-15 of the Administrative Code;

(9) Make rulings on requests to broadcast, record, televise or photograph the hearing;

(10) Take such other actions as may be necessary to accomplish the purposes of
paragraph (C) of this rule; and

(11) Determine the order in which any hearing shall proceed.

(E) The authority of the hearing examiner shall not include authority to grant motions for
dismissal of charges, or modify, compromise or settle charges or allegations.

(F) The hearing examiner shall have such other powers, duties, and authority as are granted by
statutes or rules.

(G) All rulings on evidence and motions and on any other procedural matters shall be subject to
review by the board upon presentation of the proposed findings of facts and conclusions of
law of the hearing examiner. When such rulings warrant, the board may remand the matter to the attorney hearing examiner.

(H) The hearing examiner may assist the board by reviewing the evidence in matters that have been subject to a notice of opportunity for hearing but for which no timely hearing request has been filed. In such matters the hearing examiner may prepare proposed findings and a proposed order for the board's consideration.

(I) Briefs provided under paragraph (D)(7) of this rule shall comply with the requirements set forth in rule 4731-13-07.1 of the Administrative Code.

(J) Upon the motion of a party, or upon the hearing examiner’s own motion, the hearing examiner shall have the authority to conduct hearings by use of a live, real-time video-conferencing system. Such a system must provide a means, through the use of software that is widely accessible to the general public without charge, for the hearing examiner, attorneys, the respondent, witnesses, and a court reporter, along with any other necessary participants, to see and converse with each other and to display documentary and physical evidence. Further, the video-conferencing system must also provide a means by which members of the public may view and listen to the hearing.
Consolidation.

Upon motion by either party, or upon the initiative of the hearing examiner, the hearing examiner may consolidate two or more hearings into a single hearing, unless either party objects for good cause.
Intervention.

Petitions to intervene shall not be permitted.
Continuance of hearing.

(A) Except in matters of summary suspension, the board or the board through its hearing examiner, shall continue the initially scheduled hearing upon its own motion in order to more efficiently and effectively conduct its business unless the circumstances establish that a continuance would not serve the interest of justice. The new hearing date shall be set according to the case management schedule approved by the board for the type of violation alleged and available from the board's website at http://med.ohio.gov/. In setting the new hearing date, the hearing examiner shall make a reasonable attempt to obtain input from the parties. Upon motion of at least one of the parties demonstrating extraordinary circumstances, the hearing examiner may approve a special case management schedule.

(B) A hearing shall be continued only with the approval of the board or its hearing examiner based upon a written motion of a party or upon the initiative of the hearing examiner.

(C) A motion for a continuance shall not be granted unless good cause and proper diligence is demonstrated.

   (1) Before granting any continuance, consideration shall be given to harm to the public which may result from delay in proceedings.

   (2) In no event will a motion for a continuance requested less than fourteen days prior to the scheduled date of the hearing be granted unless it is demonstrated that good cause exists which would justify the granting of a continuance.

(D) No continuance of a hearing for a summary suspension shall be granted without the written agreement of the respondent or the respondent's attorney or attorneys and of the board through its secretary and supervising member.

(E) If a continuance is granted, the entry granting the continuance shall specify the dates to which the hearing is continued and shall be set in accordance with the case management schedule. Upon motion of at least one of the parties demonstrating extraordinary circumstances, the hearing examiner may approve a special case management schedule.

(F) Hearings shall not be continued due to the unavailability of a subpoenaed witness without approval of the hearing examiner.

   (1) The hearing examiner may hold the record open to accept a deposition in lieu of live testimony of a subpoenaed witness.
(2) The procedures set forth in rules 4731-13-20 and 4731-13-20.1 of the Administrative Code shall apply to any deposition in lieu of live testimony taken pursuant to this rule.
4731-13-07.1 Form and page limitations for briefs and memoranda.

(A) All hearing briefs provided under paragraph (D)(7) of rule 4731-13-03 of the Administrative Code and memoranda filed under rule 4731-13-07 of the Administrative Code shall be provided or filed subject to the following requirements:

1. The body text of a brief or memorandum shall be set in a legible typeface of at least twelve points, either single-spaced or double-spaced.

2. A brief or memorandum shall not exceed fifteen pages exclusive of the certificate of service and the appendix unless an exception is granted in advance pursuant to paragraph (A)(3) of this rule.

3. Upon motion by either party, or upon the initiative of the hearing examiner, the hearing examiner may authorize briefs or memoranda that exceed fifteen pages, up to a maximum of thirty pages exclusive of the certificate of service and the appendix, in matters that involve complex legal issues. Unless made upon the record at hearing, a motion for such a determination shall be filed no later than seven days prior to the deadline for filing the brief or memorandum.

4. If a reply memorandum is authorized pursuant to paragraph (C) of rule 4731-13-07 of the Administrative Code, that memorandum shall not exceed seven pages exclusive of the certificate of service and the appendix.

(B) Briefs and memoranda provided in contravention of the requirements set forth in paragraph (A) of this rule will be accepted for filing, however, pages beyond the fifteen page limit shall not be considered. Memoranda filed in contravention of the requirements set forth in paragraph (A) of this rule will be accepted for filing.
Motions.

(A) Except as otherwise provided under Chapter 4731-13 of the Administrative Code or Chapter 119. of the Revised Code, all motions, unless made upon the record at hearing, shall be made in writing. A written motion shall state with particularity the relief or order sought, shall be accompanied by a memorandum setting forth the grounds therefore, and shall be filed in compliance with rule 4731-13-08 of the Administrative Code. Except in cases of summary suspensions pursuant to division (G) of section 4731.22 of the Revised Code, all prehearing motions except motions for continuance pursuant to rule 4731-13-06 of the Administrative Code and motions to quash pursuant to paragraph (F) of rule 4731-13-13 of the Administrative Code, shall be made no later than fourteen days before the date of hearing unless express exception is granted by the hearing examiner or by this chapter.

(1) If filed by email, motions and supporting or opposing memoranda shall be filed as pdf attachments to emails, and not be incorporated into the body of the email itself.

(2) All supporting or opposing memoranda shall comply with rule 4731-13-07.1 of the Administrative Code.

(B) All motions, together with any supporting documentation, shall be served as provided in rule 4731-13-09 of the Administrative Code.

(C) Any response to a prehearing motion shall be filed within ten days after service of that motion, or at such other time as is fixed by the hearing examiner. A movant may reply to a response only with the permission of the hearing examiner.

(D) Before ruling upon a written motion, the hearing examiner shall consider all memoranda and supporting documents filed. The hearing examiner shall enter a written ruling and shall issue copies to each representative of record. The ruling on all motions made at hearing shall be included in the hearing transcript except where the hearing examiner elects to take the motion under advisement and issue a written ruling at a later time. The hearing examiner shall include in each written ruling on a motion a statement of the reasons therefore.

(E) Except as otherwise provided in this chapter or Chapter 119. of the Revised Code, rulings on all motions filed subsequent to the issuance of the report and recommendation shall be rendered by the board or, if the board is not in session, by its president or the vice president if the president is unavailable acting on its behalf.

(1) Responses to motions shall be filed no later than three days after service of the motion as set forth in the certificate of service attached to the served copy of
the motion. A movant may reply to a response only with the permission of the board through its president or vice president if the president is unavailable, and only under extraordinary circumstances, such as an assertion that a material inaccuracy of fact or law was provided in the response.

(2) Motions for extension of time for filing objections shall be filed on or prior to the deadline for filing the objections. A motion for extension of time for filing objections filed after the deadline will not be considered absent extraordinary circumstances, as determined by the board through its president or vice president if the president is unavailable.
4731-13-08  Filing.

(A) A document is "filed" when it is received and time stamped in the offices of the board. For documents received via e-mail or through any electronic filing system implemented by the board, the time stamp provided by the board's computer shall be the time of receipt. Documents received after five p.m. eastern standard time shall not be considered for filing until the next business day.

(B) An original of any document required to be served by Chapter 4731-13 of the Administrative Code shall be filed with the board not more than three days after service.

(C) All filings shall be addressed to the board to the attention of its hearing unit.
To be considered by the board and its hearing examiner, any document required by Chapter 4731-13 of the Administrative Code to be served shall:

(A) Be served either personally, by regular mail, by facsimile, **or by e-mail**, or through any electronic filing system which provides automatic notice to parties utilized by the board. Service is complete on the date of mailing, e-mailing, facsimile or personal service of the document.

(B) Contain the name, address, and telephone number of the person submitting the document and shall be appropriately captioned to indicate the name of the respondent.

(C) Have a certificate of service on it. A certificate of service shall be signed and contain the following:

(1) The date of service;

(2) The method by which service was made;

(3) The address where service was made; and

(4) The name of the person or authority who was served.
4731-13-10 **Computation and extension of time.**

(A) The date of occurrence of the event causing time to run is not counted in the computation of any time limit under Chapter 4731-13 of the Administrative Code. The last day of the period is included in the computation of the time limit. If the last day of a period is not a regular business day, the time period runs through the end of the next regularly scheduled business day.

(B) The board or its hearing examiner may extend the time for filing or responding to motions and briefs.

1. Requests for extension of time shall be made in writing and filed as provided in rule 4731-13-08 of the Administrative Code prior to the expiration of any applicable time limit.

2. Requests for extension of time shall be addressed to the attention of the board's hearing unit.

3. Requests for extension of time shall be served as provided in rule 4731-13-09 of the Administrative Code.
Notice of hearings.

Notice specifying the date, time and place set for hearing shall be mailed by certified mail to the representatives of record, except that notice of changes to the date, time or place set for hearing shall be mailed by regular mail, e-mail or facsimile if a representative of each party participated in the selection of the new date, time or place.
Transcripts.

(A) Duplicate transcripts of the stenographic record taken of hearings may be obtained directly from the court reporter at the requestor's expense prior to receipt of the original transcript by the board, except as otherwise restricted by 4731-13-31 of the Administrative Code.

(B) Upon request made to the board's hearing unit, a copy of the original hearing transcripts may be reviewed at the board offices. Additional copies may be prepared at the requestor's expense and shall be provided by the board within a reasonable period of time.

(C) Original transcripts shall not be removed from the board offices.

(D) Any portion of a hearing transcript which contains information that is required to be kept confidential pursuant to any state or federal law shall be sealed and made part of the hearing record. Confidential portions of hearing transcripts shall be provided only to agents of the parties for purposes of the administrative hearing and shall not be disseminated to any other persons.
Subpoenas for purposes of hearing.

(A) Upon written request, the board shall issue subpoenas for purposes of hearing to compel the attendance and testimony of witnesses and production of books, records and papers. Each subpoena shall indicate on whose behalf the witness is required to testify. Copies of such subpoenas shall be issued to each representative of record.

(B) For purposes of a hearing conducted pursuant to Chapter 119. of the Revised Code, subpoena requests shall specify the name and address of the individual to be served and the date and time at which the individual is to appear. With respect to the production of books, records and papers, such request shall set a compliance date in accordance with the exchange deadlines established by the hearing examiner in rule 4731-13-18, may not specify a date of compliance less than fourteen days prior to hearing.

(C) Except upon leave of the board or its hearing examiner, subpoena requests are to be filed with the board as provided in rule 4731-13-08 of the Administrative Code at least twenty-one days in advance of the requested date of compliance in order to allow sufficient time for preparation and service of the subpoenas.

(D) In the event that the number of subpoenas requested appears to be unreasonable, the board or its hearing examiner may require a showing of necessity therefore and, in the absence of such showing, may limit the number of subpoenas. Absent such a limitation, subpoenas shall be issued within seven days of request. Failure to issue subpoenas within this time may constitute sufficient grounds for the granting of a continuance.

(E) After the hearing has commenced the hearing examiner may order the issuance of subpoenas for purposes of hearing to compel the attendance and testimony of witnesses and production of books, records and papers. Copies of such subpoenas shall be issued to each representative of record.

(F) Upon motion and for good cause, the hearing examiner may order any subpoena be quashed. Motions to quash shall be made in the manner provided in rules 4731-13-07 and 4731-13-08 of the Administrative Code, except that motions to quash shall be filed at least seven days prior to the date of compliance. The non-moving party may file a response no later than five days after service of the motion to quash or at least one day prior to the date of compliance whichever is earlier. Unless a motion to quash has been granted, a witness shall attend the hearing to which he or she was subpoenaed. The board shall make a reasonable attempt to contact any witness whose subpoena has been quashed.

(G) Witnesses shall not be subpoenaed to prehearing conferences.
Mileage reimbursement and witness fees.

(A) Mileage shall be paid in the same manner as that allowed in the court of common pleas in criminal cases in the county of hearing.

(B) The respondent shall not subpoena him or her self.

(C) Mileage and witness fees shall be returned by anyone who fails to appear at the hearing for which he or she was subpoenaed.
(A) Within thirty days following the close of a hearing conducted under Chapter 119. of the Revised Code, the hearing examiner shall submit a written report setting forth proposed findings of fact and conclusions of law and a recommendation of the action to be taken by the board. The hearing shall not be considered closed until such time as the record is complete, as determined by the hearing examiner.

(B) A copy of such written report shall be issued to each representative of record. The copy issued to the respondent's representative of record shall be accompanied by notice of the date the report and recommendation is to be considered by the board.

(C) Either representative of record may, within ten days of receipt of the hearing examiner's report and recommendation, file written objections to the report and recommendation. Only those objections filed in a timely manner shall be considered by the board before approving, modifying, or disapproving the hearing examiner's recommendation, unless otherwise determined by the board.

(D) Upon written request, the board may grant extensions of the time within which to file objections to the report and recommendation. In the event that the board is not in session, the president of the board may grant such extensions.

(E) Unless otherwise determined by the board based upon written motion of a party, the board shall consider the hearing examiner's report and recommendation and any objections thereto at its next regularly scheduled meeting after the time for filing objections has passed. At that time, the board may do any or all of the following: order additional testimony to be taken; permit the introduction of further documentary evidence; or act upon the report and recommendation. For purposes of taking such additional testimony or documentary evidence, the board may remand to the hearing examiner.

(F) Any motion to reopen the hearing record for purposes of introducing newly discovered material evidence that with reasonable diligence, could not have been discovered and produced at the hearing shall be filed in the manner provided in rules 4731-13-07 and 4731-13-08 of the Administrative Code. Such motion to reopen shall be filed not later than fourteen days prior to the scheduled consideration by the board of the hearing examiner's report and recommendation, unless the newly discovered material evidence, with reasonable diligence, could not have been discovered earlier than fourteen days prior to the scheduled consideration by the board. The other party shall have an opportunity to file, not later than seven days prior to the scheduled consideration by the board of the hearing examiner's report and recommendation, a memorandum contra to said motion.

Any submission of documentation or evidence received by the board after the close of the record and prior to the date of consideration of the hearing examiner's report
and recommendation by the board shall be deemed a motion to reopen the record pursuant to this rule. If such motion is filed prior to the issuance of the hearing examiner’s report and recommendation, the hearing examiner shall rule on the motion. If such motion is filed subsequent to the issuance of the hearing examiner’s report and recommendation, the board shall rule on the motion. All submitted materials must be accompanied by an affidavit from the moving party that sets forth how the evidence is material, how the evidence is newly discovered, and why it could not have been produced at hearing. The affidavit must also show that the party made a reasonably diligent effort to obtain the material prior to hearing. Failure to comply with the requirements of this rule shall result in the exclusion of the submitted material unless the moving party shows good cause and the board votes to admit the document or evidence.

(G) Without leave of the board, no party shall be permitted to address the board at the time of consideration of the hearing examiner’s report and recommendation. Any request for such leave shall be filed by motion no less than five/seven days prior to the date the report and recommendation is to be considered by the board. No such leave shall be granted unless the opposing representative of record has been actually notified of the request, unless otherwise determined by the board.

(H) If a request to address the board is granted, the opposing party may also address the board.
Reinstatement or restoration of certificate.

Any disciplinary action taken by the board which results in a suspension from practice shall either lapse by its own terms or contain a written statement of the conditions under which the certificate may be reinstated or restored, unless terms for reinstatement or restoration are otherwise governed by statute.

Such conditions may include but are not limited to:

(A) Submission of a written application for reinstatement or restoration;

(B) Payment of all appropriate fees, civil penalties, and fines as provided in Chapter 4731. of the Revised Code;

(C) Mental or physical examination;

(D) Additional education or training;

(E) Reexamination;

(F) Practice limitations;

(G) Participation in counseling programs;

(H) Demonstration that the respondent can resume practice in compliance with acceptable and prevailing standards.
Settlements, dismissals, and voluntary surrenders.

(A) Settlement shall be negotiated on behalf of the board by the secretary and supervising member of the board. Any settlement agreement containing terms not in conformity with the disciplinary guidelines adopted by the board must have the concurrence of the board's president prior to execution.

(B) Any matter which is the subject of a hearing may be settled by the parties. If settlement negotiations continue after the final day of hearing, the parties shall, within ten days of the final day of hearing, jointly present the hearing examiner with written notice specifying a period of time, not to exceed thirty days, during which the record shall be held open for purposes of negotiation.

(1) If the hearing record has closed or closes during the period of time specified in the parties' joint notice, such notice shall toll the hearing examiner's thirty-day time period for issuance of findings of fact and conclusions of law pursuant to section 4731.23 of the Revised Code.

(2) If, at the conclusion of the time period specified by the parties' joint notice, the hearing examiner has not received appropriate written notice that a settlement agreement has been executed, the tolling of the hearing examiner's thirty-day period for issuance of findings of fact and conclusions of law shall cease, no further settlement negotiations shall be undertaken, and no settlement agreement shall be executed in lieu of the filing of a report and recommendation by the hearing examiner and the issuance of a final order by the board.

(C) Before being submitted to the board for ratification, all settlement agreements shall be in writing and shall be signed by the respondent and by the respondent's attorney, if any. Counsel for the board shall sign the settlement agreement as follows:

(1) If the settlement agreement was negotiated prior to the issuance of a notice of opportunity for hearing, an appropriate board staff attorney shall sign the agreement.

(2) If the settlement agreement was negotiated subsequent to the issuance of a notice of opportunity for hearing, an attorney from the office of the attorney general shall sign the agreement.

(D) Signed settlement agreements shall be submitted to the board for ratification.

(E) If the board ratifies a settlement agreement, the secretary and supervising member of the board shall sign the ratified agreement, following shall sign the ratified agreement.
agreement:

(1) The secretary and supervising member of the board shall sign the ratified agreement.

(2) If the settlement agreement was negotiated prior to the issuance of a notice of opportunity for hearing, an appropriate board staff attorney shall sign the ratified agreement.

(3) If the settlement was negotiated subsequent to the issuance of a notice of opportunity for hearing, an attorney from the office of the attorney general shall sign the ratified agreement.

(F) A notice of dismissal may be entered at any time prior to the filing of the report and recommendation. If negotiations continue after the final day of hearing, the procedures in paragraph (B) of this rule shall be followed. A notice of dismissal shall be authorized and signed by the board's secretary and supervising member.

(G) This rule shall neither apply to nor limit the authority granted the board under division (M) of section 4731.22 of the Revised Code with regard to the surrender of a license or certificate or the withdrawal of an application for a license or certificate.

(H) In the event that the board issues an amended notice of opportunity for hearing, the original notice of opportunity for hearing is automatically superseded by the amended notice. To request a hearing pursuant to Chapter 119. of the Revised Code, the respondent must file a new hearing request in response to the amended notice of opportunity for hearing. For purposes of this chapter of the Administrative Code, "amended cite" means a cite in which there has been a substantive alteration to one or more factual allegations or statutory charges, other than correction of a clerical or technical error, that relates to the allegations set forth in the original notice.
Exchange of documents and witness lists.

(A) At the time the hearing examiner schedules the hearing with input from the parties, a case management schedule shall be created which will include the deadline dates for each party to provide a list of both the witnesses and the documents intended to be introduced at hearing.

(B) Upon motion of any party, failure without good cause to provide the list of witnesses and documents by the deadline date established in the case management schedule may result in exclusion from the hearing of such testimony or documents.

(C) The hearing examiner shall set, in the case management schedule, the deadline dates by which the parties shall exchange hearing exhibits, identify lay and expert witnesses and exchange written reports from expert witnesses.

(1) Absent extraordinary circumstances, the failure of a party to produce an exhibit under the terms of the case management schedule shall result in the exclusion of that exhibit from evidence at hearing.

(2) Absent extraordinary circumstances, the failure of a party to identify a lay or expert witness under the terms of the case management schedule shall result in the exclusion of that witness' testimony at hearing.

(3) Absent extraordinary circumstances, the failure of a party to produce a written report from an expert witness under the terms of the case management schedule shall result in the exclusion of the witness' expert testimony at hearing.

(D) A party shall notify the hearing examiner of any deficiency in the materials provided by the other party within a reasonable period of time after discovery of the deficiency.

(E) A party shall notify the hearing examiner of any failure by the other party to comply with a deadline imposed pursuant to this rule within seven days of the failure to comply.

(F) Any witness who intends to testify as an expert, including the respondent, must submit a written report. A written report by an expert shall set forth the opinions to which the expert witness will testify and the bases for such opinions. This paragraph will not preclude the respondent from testifying as a fact witness.

(G) Any exhibit exchanged by the parties which is a patient record or which contains information that is required to be kept confidential pursuant to any state or federal
law may be provided only to agents of the parties for purposes of the administrative hearing and shall not be disseminated to any other person or entity.
4731-13-20.1 Electronic testimony.

(A) Upon written motion of any party, and upon service of that motion to the other party's representative of record, the hearing examiner may order that the testimony of a prospective witness be taken by telephonic or real-time video testimony. The hearing examiner may grant the motion if it appears probable that:

1. The prospective witness will be unavailable to attend or will be prevented from attending a hearing; and

2. The testimony of the prospective witness is material.

(B) The testimony shall be taken under such conditions and terms as the hearing examiner shall set forth. Moreover, the hearing examiner may order the production of any designated books, papers, documents or tangible objects, so long as not privileged, at the same time and place.

(C) The hearing examiner shall set the time and fix the place of telephonic or real-time video testimony.
Depositions in lieu of live testimony.

(A) Upon written motion of any party, and upon service of that motion to the other party's representative of record, the hearing examiner may order that the testimony of a prospective witness be taken by deposition in lieu of live testimony. The hearing examiner may grant the motion if it appears probable that:

(1) The prospective witness will be unavailable to attend or will be prevented from attending a hearing;

(2) The testimony of the prospective witness is material; and

(3) In the case of an expert witness, a showing of the unavailability of the expert to attend shall not be necessary for the hearing examiner's consideration of the motion to take a deposition in lieu of live testimony.

(B) The testimony shall be taken under such conditions and terms as the hearing examiner shall set forth. Moreover, the hearing examiner may order the production of any designated books, papers, documents or tangible objects, so long as not privileged, at the same time and place.

(C) The parties shall agree to the time and place for taking the deposition in lieu of live testimony. Depositions in lieu of live testimony shall be conducted in the same county in which the hearing is conducted unless otherwise agreed to by the parties. If the parties are unable to agree, the hearing examiner shall set the time or fix the place of deposition.

(D) At a deposition in lieu of live testimony taken under this rule, each party shall have the right, as at hearing, to fully examine witnesses.

(E) The transcript of a deposition in lieu of live testimony taken under this rule shall be offered into evidence at hearing. The cost of preparing a transcript of any testimony taken by deposition in lieu of live testimony which is submitted as evidence at the hearing shall be borne by the board.

(F) The expense of any video deposition shall be borne by the requestor.
Prior action by the state medical board.

The hearing examiner shall admit evidence of any prior action entered by the board against the respondent. Such evidence shall include a certified copy of the final order in that prior action, and may also include other certified documents pertaining to that action.
Parties may, by stipulation, agree on any or all facts involved in proceedings before the hearing examiner. The hearing examiner may thereafter require development of any fact the hearing examiner deems necessary.
Witnesses.

(A) All witnesses at any hearing before the hearing examiner shall testify under oath or affirmation.

(B) A witness may be accompanied and advised by legal counsel. Participation by counsel for a witness other than the respondent is limited to protection of that witness's rights, and that legal counsel may neither examine nor cross-examine any witnesses.

(C) The board may institute contempt proceedings pursuant to section 119.09 of the Revised Code, if a witness refuses to answer a question ruled proper at a hearing or disobeys a subpoena.

(D) For purposes of this chapter:

(1) A sitting board member is an individual who is currently a member of the board.

(2) A presiding board member is a sitting board member who has a decisive role in the outcome of the matter in question and who is neither the secretary nor the supervising member as appointed pursuant to Chapter 4731. of the Revised Code.

(3) A non-presiding board member is a sitting board member who does not have a decisive role in the outcome of the matter in question due to recusal, absence or other reason.

(4) A presiding hearing examiner is a hearing examiner who is assigned to the matter in question pursuant to section 4731.23 of the Revised Code.

(5) A non-presiding hearing examiner is a hearing examiner who is not assigned to the matter in question pursuant to section 4731.23 of the Revised Code.

(E) Neither a presiding board member nor a presiding hearing examiner shall be a competent witness in any adjudication proceeding. Evidence from other persons relating to the mental processes of a presiding board member or a presiding hearing examiner shall not be admissible.

(F) Unless the testimony of a non-presiding board member or a non-presiding hearing examiner is material to the factual allegations set forth in the notice of opportunity for hearing, neither a non-presiding board member nor a non-presiding hearing examiner shall be a competent witness in any adjudication proceeding.
(G) A sitting board member shall not be subpoenaed to provide expert testimony.

(H) Any party may move for a separation of witnesses. Expert witnesses shall not be separated.

(I) Upon commencement of a hearing, each party shall inform the hearing examiner of the identity of each potential witness for his or her cause who is present in the hearing room. Failure to so identify potential witnesses may be grounds for their later disqualification as witnesses.

(J) A witness may, in the discretion of the attorney hearing examiner, testify as to an ultimate issue of fact. An expert witness may testify regarding the appropriate treatment for impairment.
A certified copy of a plea of guilty to, or a judicial finding of guilt of any crime in a court of competent jurisdiction is conclusive proof of the commission of all of the elements of that crime.
Evidence.

(A) The "Ohio Rules of Evidence" may be taken into consideration by the board or its hearing examiner in determining the admissibility of evidence, but shall not be controlling. The "Ohio Rules of Evidence" are readily available to attorneys and may be found at libraries, bookstores and on the internet at www.supremecourt.ohio.gov/LegalResources/Rules/evidence/evidence.pdf.

(B) The hearing examiner may permit the use of electronic or photographic means for the presentation of evidence.
Broadcasting and photographing administrative hearings.

If the hearing examiner determines that broadcasting, televisual, recording or taking of photographs in the hearing room would not distract participants, impair the dignity of the proceedings or otherwise materially interfere with the achievement of a fair administrative hearing, the broadcasting, televisual, recording or taking of photographs during hearing proceedings open to the public may be permitted under the following conditions and upon request:

(A) Requests for permission for the broadcasting, televisual, recording or taking of photographs in the hearing room shall be made in writing to the hearing examiner prior to the commencement of the hearing, and shall be made a part of the record of the proceedings;

(B) Permission is expressly granted prior to commencement of the hearing in writing by the hearing examiner and is made a part of the record of the proceedings;

(C) If the permission is granted, the hearing examiner shall specify the place or places in the hearing room where operators and equipment are to be positioned;

(D) The filming, videotaping, recording or taking of photographs of witnesses who object thereto shall not be permitted.
Sexual misconduct evidence.

In those cases where sexual misconduct has been alleged:

(A) Evidence of specific instances of the victim's sexual activity, opinion evidence of the victim's sexual activity, and reputation evidence of the victim's sexual activity shall not be admitted unless it involves evidence of the origin of semen, pregnancy, or disease, or the victim's sexual activity with the offender, and only to the extent that the evidence is material to a fact at issue in the case and that its inflammatory or prejudicial nature does not outweigh its probative value.

(B) Prior to taking testimony or receiving evidence of any sexual activity of the victim, the hearing examiner shall resolve the admissibility of the proposed evidence in a closed hearing. The victim may be represented by counsel in that hearing or other proceedings to resolve the admissibility of evidence upon approval by the hearing examiner.

(C) Nothing in this rule shall be construed as limiting the authority of the hearing examiner to close a hearing as provided under paragraph (B) of rule 4731-13-03 of the Administrative Code.
Supervision of hearing examiners.

The hearing examiners shall perform their duties under the supervision and direction of the board's executive director, provided that the board, other than the secretary and supervising member, shall have exclusive authority to impose discipline based on the substance of the hearing examiners' reports and recommendations.
4731-13-30

Prehearing conference.

With or without written motion from any party, the hearing examiner may schedule a prehearing conference to address any matter related to preparation for or conduct of a hearing. The prehearing conference may be in person or by telephone. No witness testimony shall be taken during a prehearing conference. Any documents presented at the prehearing conference shall be made part of the hearing record. If a transcript of the proceeding is prepared, the transcript shall be made part of the hearing record.
Transcripts of prior testimony.

(A) Any transcript of prior testimony of a witness may be used for the purpose of refreshing the recollection, contradicting the testimony or impeaching the credibility of that witness. If only a part of a transcript is offered into evidence by a party, the other party may offer any other part.

(B) A transcript of testimony and exhibits from a prior proceeding may be introduced for any purpose if that prior proceeding concerns the basis for the board's allegations against the respondent. Upon offering part of a transcript or exhibit from a prior proceeding, the offering party may be required by the other party to present any other part of the offered item which should in fairness be considered contemporaneously with it.

(C) Nothing in this paragraph shall be construed to permit the taking of depositions for purposes other than those set forth in rule 4731-13-20 of the Administrative Code.

(D) Nothing in this rule shall be construed to limit the use of a prior statement by a respondent as set forth in rule 4731-13-32 of the Administrative Code.
Prior statements of the respondent shall not be excluded on the basis of hearsay.
The board or its hearing examiner may utilize the "Physicians' Desk Reference" (PDR) for information regarding the FDA approved labeling for dangerous drugs. The edition(s) of the PDR utilized shall be the edition(s) contemporaneous with the allegations set forth in the notice of opportunity for hearing upon which the hearing is based. The "PDR" is a well-known and readily available text. It may be found at libraries, bookstores or on the internet at www.pdr.net. The board or its hearing examiner may also utilize the US National Library of Medicine at medlineplus.gov.
Ex parte communication.

(A) The members of the board shall base their decisions on any matter subject to hearing only on the evidence of record. No information acquired by a member of the board in any way other than by review of the evidence of record shall be considered by such member in that member’s decision on a matter subject to hearing. The receipt of information about a matter subject to hearing outside the evidence of record shall not disqualify the member from participating in the decision on that matter unless the member excuses himself or herself from participation in the decision on the ground that he or she cannot restrict his or her decision on the matter to the evidence of record.

(B) Except as otherwise provided under this chapter or by statute, no hearing examiner or member of the board shall initiate or consider ex parte communications concerning a substantive matter related to a pending hearing. Nothing contained herein, however, shall preclude the hearing examiner from nonsubstantive ex parte communications on procedural matters and matters affecting the efficient conduct of adjudicatory hearings.

(C) The hearing examiner and members of the board shall disclose on the public record the source of any ex parte or attempted ex parte communications pertaining to a substantive issue. If the recipient of the ex parte communication determines that he or she can no longer render an impartial decision, the recipient shall recuse himself or herself from further participation in consideration of the matter.

(D) If requested by any party, the recipient of the ex parte communication shall file with the board an affidavit setting forth the substance of the ex parte communication. The affidavit shall be sealed, held as proffered material and maintained with the hearing record.
Severability.

(A) Except as otherwise provided under this chapter or by statute, a rule promulgated under this chapter shall apply only to those administrative proceedings for which the notice of opportunity for hearing was mailed to respondent, or his representative, on or after the effective date of the particular rule.

(B) If any provision of the rules in this chapter of the Administrative Code or if the application of any provision of the rules in this chapter of the Administrative Code is held invalid, the invalidity shall not affect any other provision of the rules in this chapter, or the application of any other provision of the rules in this chapter, that can be given effect without the invalid provision or application, and, to this end, the provisions of the rules in this chapter are hereby declared severable.
Disciplinary actions.

For purposes of Chapters 4730., 4731., 4759., 4760., 4761., 4762., 4774., and 4778. of the Revised Code and Chapters 4730., 4731., 4774., and 4778. of the Administrative Code:

(A) "Permanent revocation" means the permanent loss of a certificate to practice in Ohio and the inability, at any time, to reapply for or hold any certificate to practice in Ohio. An individual whose certificate has been permanently revoked shall forever thereafter be ineligible to hold any certificate to practice, and the board shall not accept from that individual an application for reinstatement or restoration of the certificate or for issuance of any new certificate.

(B) "Revocation" means the loss of a certificate to practice in Ohio. An individual whose certificate has been revoked shall be eligible to submit an application for a new certificate. The application for a new certificate shall be subject to all requirements for certification in effect at the time the application is submitted. In determining whether to grant such an application, the board may consider any violations of Chapters 4730., 4731., 4759., 4760., 4761., 4762., 4774., and 4778. of the Revised Code, whichever is applicable, that were committed by the individual before or after the revocation of the individual's certificate, including those that formed the basis for the revocation. All disciplinary action taken by the board against the revoked certificate shall be made a part of the board's records for any new certificate granted under this rule.

(C) "Suspension" means the temporary loss of a certificate to practice in Ohio. A suspension shall be imposed for either a definite term or an indefinite term.

(1) An order for a definite term of suspension shall specify the time period of the suspension. A certificate which has been suspended for a definite term shall be reinstated at the conclusion of the specified time period.

(2) An order for an indefinite term of suspension shall contain a written statement of the conditions under which the certificate may be reinstated. Such conditions may include, but are not limited to, the following:

(a) A minimum time period of suspension;

(b) Submission of a written application for reinstatement;

(c) Payment of all appropriate fees, civil penalties, and fines as provided in Chapters 4730., 4731., 4759., 4760., 4761., 4762., 4774., and 4778. of the Revised Code;
(d) Mental or physical examination;

(e) Additional education or training;

(f) Reexamination;

(g) Participation in counseling programs;

(h) Demonstration that the certificate holder can resume practice in compliance with acceptable and prevailing standards;

(i) Satisfactory completion of all terms, conditions or limitations placed upon the certificate holder through a board-approved consent agreement or board order;

(j) Passage of an examination to determine present fitness to resume practice, pursuant to section 4731.222 of the Revised Code; and

(k) Acceptance of conditions of probation or practice limitations.

(D) "Limitation" means to preclude the certificate holder from engaging in a particular conduct or activity, to impose conditions on the manner in which that conduct or activity may be performed, or to require the certificate holder to abide by specific conditions in order to continue practicing medicine. A limitation shall be either temporary or permanent.

(E) "Probation" means a situation whereby the certificate holder shall continue to practice only under conditions specified by the board. Failure of the certificate holder to comply with the conditions of probation may result in further disciplinary action being imposed by the board. The probation period shall be for either a definite or an indefinite term. If probation is for an indefinite term, the board shall establish a minimum probation period and the board shall release the certificate holder from the conditions of probation upon completion of the minimum probation period and upon the board's determination that the purpose of probation has been fulfilled.

(F) "Reprimand" means the certificate holder is formally and publicly reprimanded in writing.

(G) "No Further Action" means that the board finds that a violation occurred but declines to impose any disciplinary sanction. No further action shall be ordered by the board
under circumstances where the board finds that all necessary remedial measures have been completed by the certificate holder, future monitoring is unnecessary and reprimand is not warranted.

(H) "Dismissal" means that the board finds that no violation occurred.

(I) "Grant of Application for Certificate" means that the board grants an application for a certificate to practice. In matters where disciplinary violations have been alleged against an applicant for a certificate, the grant of an application for certificate may be accompanied by a suspension, limitation, probation, reprimand or no further action.

(J) "Permanent Denial" and "Permanent Refusal to Register or Reinstate" mean the permanent denial of an application for a certificate to practice in Ohio. An individual whose application for a certificate has been permanently denied shall forever thereafter be ineligible to apply to the board for any certificate to practice, and the board shall not accept from that individual an application for issuance of any certificate.

(K) "Denial" and "Refusal to Register to Reinstate" mean the denial of an application for a certificate to practice in Ohio. An individual whose application for a certificate has been denied shall be eligible to submit a new application for a certificate. The new application shall be subject to all requirements for certification in effect at the time the new application is submitted. In determining whether to grant a new application, the board may consider any violations of Chapters 4730., 4731., 4759., 4760., 4761., and 4778. of the Revised Code, whichever is applicable, that were committed by the individual before or after the denial of the individual's previous application, including those that formed the basis for the denial.
MEMORANDUM

TO:         Mark Bechtel, M.D., President
            Members, State Medical Board of Ohio

FROM:      Nathan T. Smith, Senior Legal and Policy Counsel

DATE:      March 4, 2021

RE:        Amended rule 4759-4-04 Continuing Education

On November 10, 2021, Medical Board staff filed Dietetics rules 4759-4-04, 4759-4-08, and 4759-6-02 with the Common Sense Initiative. These rules were posted on the Board’s website and emailed to interested parties on the same date.

The Medical Board received one comment from the Ohio Academy of Nutrition and Dietetics which is attached. OAND supported the amendments to 4759-4-08 and 4759-6-02, but suggested changes to the Continuing Education rule 4759-4-04. Specifically, OAND advocated for amending the rule so that non-registered licensed dietitians’ continuing education requirements would be even more similar to those of licensed registered dietitians by adding language requiring non-RD licensees to “use and document the PDP process as adopted by the commission on dietetic registration of self-reflection, planning based on individual learning needs assessment and competencies, and evaluation of learning outcomes when fulfilling continuing education requirements.”

Based on this comment, Board staff recommends the following addition to the rule in bold type:

- If licensee is not a registered dietitian, establish a five year continuing education cycle with the board, and adhere to that schedule for meeting requirements consistent with the options offered by "The commission on dietetic registration." certify the completion of thirty hours of continuing education completed during the two-year renewal period. At least one hour in each renewal period shall relate to ethics or laws, rules, and regulations governing the practice of dietetics. These continuing education hours shall be from activities approved by the commission on dietetic registration, academy of nutrition and dietetics, or the Ohio academy of nutrition and dietetics.

In addition for each biennial renewal period, a licensee that is not a registered dietitian shall use and document a learning process for that renewal period that is consistent with the commission on dietetic registration. Specifically, the licensee that is not a registered dietitian shall document the following: self-reflection on competencies and learning needs, development of a learning plan with goals to maintain and improve on existing competencies and/or develop competencies in new areas or areas of learning deficiency; and progress on the learning plan documented through successful completion of activities in the areas specified in the learning plan. This learning plan must be documented and available to the board upon request pursuant to the audit and disciplinary provisions of divisions (E) and (F) of section 4759.06 of the Revised Code.
For each five year cycle an individual learning plan shall be submitted and approved by the board and a log of learning activities maintained by the licensee. A copy of the log shall be submitted directly to the Ohio board of dietetics postmarked by June thirtieth of the year that the cycle ends, and shall demonstrate successful completion of at least seventy-five continuing professional education units.

Board staff recently met with OAND and they agreed that this additional language resolves their concerns. In addition, this amended rule still allows the Board to move to biennial continuing education reporting requirements for dietitians. Also, the Board will not be routinely reviewing non-RD licensee continuing education learning plans. Instead, the obligation is on the licensee to document the learning plan and produce it to the Board upon request in a continuing education audit.

**Action requested:** Approve this amended OAC rule 4759-4-04 to be re-filed with CSI. This rule will eventually be filed with JCARR as a new rule based on the extensive revisions to the rule.
4759-4-04 Continuing education.

(A) Each applicant for renewal or restoration of a license shall demonstrate compliance with the continuing education/professional development requirements of this rule.

(B) Each applicant for license renewal or restoration shall:

1. Be If licensee is a registered dietitian, certify completion of the continuing education required to hold current registration with the commission on dietetic registration, and complete one hour of ethics or laws, rules, and regulations governing the practice of dietetics in the two-year renewal period. These continuing education hours shall be from activities approved by the commission on dietetic registration, academy of nutrition and dietetics, or the Ohio academy of nutrition and dietetics; or

2. If licensee is not a registered dietitian, establish a five year continuing education cycle with the board, and adhere to that schedule for meeting requirements consistent with the options offered by "The commission on dietetic registration." certify the completion of thirty hours of continuing education completed during the two-year renewal period. At least one hour in each renewal period shall relate to ethics or laws, rules, and regulations governing the practice of dietetics. These continuing education hours shall be from activities approved by the commission on dietetic registration, academy of nutrition and dietetics, or the Ohio academy of nutrition and dietetics.

In addition for each biennial renewal period, a licensee that is not a registered dietitian shall use and document a learning process for that renewal period that is consistent with the commission on dietetic registration. Specifically, the licensee that is not a registered dietitian shall document the following: self-reflection on competencies and learning needs, development of a learning plan with goals to maintain and improve on existing competencies and/or develop competencies in new areas or areas of learning deficiency; and progress on the learning plan documented through successful completion of activities in the areas specified in the learning plan. This learning plan must be documented and available to the board upon request pursuant to the audit and disciplinary provisions of divisions (E) and (F) of section 4759.06 of the Revised Code.

For each five year cycle an individual learning plan shall be submitted and approved by the board and a log of learning activities maintained by the licensee. A copy of the log shall be submitted directly to the Ohio board of dietetics postmarked by June thirtieth of the year that the cycle ends, and shall demonstrate successful completion of at least seventy-five continuing professional education units.

(C) Beginning in two thousand-five, on odd numbered calendar years, each applicant for renewal, reactivation, or reinstatement of a license shall report to the board completion of at least one continuing education unit of board approved education in jurisprudence.

Board approved programs in jurisprudence shall include approved programs and activities relating to current laws, rules, and regulations dealing with the practice of dietetics and recent changes that have occurred to those laws, rules, and regulations. A list of approved programs and activities will be posted on the board’s web site.

(C) All licensees are subject to the audit and disciplinary provisions of divisions (E) and (F) of section 4759.06 of the Revised Code for failure to comply with this rule. Licensees are
responsible for retaining records of completion of the continuing education hours required.
Ms. Mavko,

Thank you for submitting comments on the proposed rules. All comments will be reviewed.

Sincerely,

Nathan T. Smith  
Senior Legal & Policy Counsel  
State Medical Board of Ohio  
30 East Broad St., 3rd Floor  
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From: Kay Mavko <kmavko@columbus.rr.com>  
Sent: Monday, November 23, 2020 12:29 PM  
To: Smith, Nathan <Nathan.Smith@med.ohio.gov>  
Subject: OAND Comments on Rules 4759-4-04, 4759-4-08, 4759-6-02;

Nate,

Attached are the comments OAND wishes to submit on rules 4759-4-04, 4759-4-08, and 4759-6-02.

In addition to the comments it was suggested by OAND’s President Mary Jon Ludy (DAC member) that we send a copy of the Academy’s Ethics Opinion on dietitians ethical obligation to maintain personal competence in practice. You will find it also attached. The opinion highlights the value of self reflection.

Thank you for the opportunity to review these rules and submit comments.
CAUTION: This is an external email and may not be safe. If the email looks suspicious, please do not click links or open attachments and forward the email to csc@ohio.gov or click the Phish Alert Button if available.
The Ohio Academy of Nutrition and Dietetics (OAND) would like to submit the following comments regarding Dietetics rules 4759-4-04 OAC, 4759-4-08 OAC and 4759-6-02 OAC currently proposed for amendment by the State Medical Board of Ohio (SMBO).

4759-4-04 OAC Continuing education.

Since 1987 when the dietetic practice act was enacted it was clearly the intent of the law that requirements for licensure of dietitians be equivalent or consistent with the education, pre-professional experience, and continuing education utilized to achieve the Registered Dietitian (RD) credential offered by the Commission on Dietetic Registration (CDR) - the credentialing arm of the Academy of Nutrition and Dietetics (Academy) *.

Ohio Revised Code 4759.05 (A) (5) authorizes the State Medical Board of Ohio to promulgate rules related to continuing education for licensed dietitians.

"4759.05 (A) The state medical board shall adopt, amend, or rescind rules pursuant to Chapter 119. of the Revised Code to carry out the provisions of this chapter, including rules governing the following:

***(5) Continuing education requirements for renewal of a license, including rules providing for pro rata reductions by month of the number of hours of continuing education that must be completed for license holders who have been disabled by illness or accident or have been absent from the country. Rules adopted under this division shall be consistent with the continuing education requirements adopted by the commission on dietetic registration. " (emphasis added)

Registered dietitians are not only required to complete 75 continuing education units (CEUs) per 5 years to maintain RD certification but must also utilize the Professional Development Portfolio (PDP) process when planning for, engaging in , and reporting continuing education to CDR. The PDP process includes self-reflection, learning needs assessment, developing a learning plan that addresses their needs and is based on competencies and performance indicators, and submitting the plan for approval. The RD logs attendance at approved educational activities, and at the conclusion of the 5 year cycle submits the log for evaluation of learning outcomes. If accepted, the RD may re-certify.

Most U.S. state licensure boards (including Ohio) accept re-certification / active RD status as fulfilling continuing education requirements for dietitians.

The public, accrediting agencies, and even legislators are concerned about competency of health professionals.¹ Since the 1990’s these groups have made recommendations for strengthening continuing education that include the importance of adopting needs assessments and evaluation of learning outcomes.²³ CDR led various healthcare professions by studying, validating, and becoming an
early adopter of the PDP process to support dietitian ethical practice, competence, continuing education, and professional development.

In Ohio, non-RD licensees currently are required to fulfill their continuing education in the same way as RD licensees – including use of the PDP process and completion of 15 CEUs per year (equivalent to 75 CEUs per 5 years). Non-RD licensees submit paper documentation directly to the licensure board when renewing/restoring a license – which is now every two years. The Commission on Dietetic Registration even lets non-RDs use its web based service now (for free). This is a courtesy to assist regulatory boards with collecting continuing education documentation.

The currently proposed amendment to 4759-4-04 (G) (2) OAC removes/strikes language requiring non-RD licensees to meet

*** “requirements (for continuing education) consistent with the options offered by the commission on dietetic registration” ***.

OAND opposes the amendment to 4759-4-04 (G) (2) OAC for the following reasons:

1. The change permits non-RD licensees to complete 30 CEUs per 2 year renewal cycle simply by attending continuing education events without requiring use of the PDP process of self-reflection, planning based on individual learning needs assessment and competencies, and evaluation of learning outcomes.

2. This change would be a step back for Ohio’s non-RD licensees, endangers their long term professional development and is not consistent with the 2-part continuing education process that RDs must complete in order to maintain RD certification and ultimately renew/restore their license in Ohio.

3. The changes made to 4759-4-04 (G) (2) conflict with 4759.05 ORC requirement that “Rules adopted under this division shall be consistent with the continuing education requirements adopted by the commission on dietetic registration.” (emphasis added)

4. The change also presents an enticement for Ohio RDs to avoid the PDP process required by CDR. The RD licensee can just drop their RD credential, stay licensed in Ohio, and continue to meet the proposed lower requirements that active RD licensees must meet.

5. The change entices RDs to avoid the costs associated with maintaining the RD credential. Any significant reductions in numbers of Registered Dietitians renewing RD credentials could result in adverse financial effects on CDR directly, and the Academy and OAND indirectly.

Recommendation:

OAND recommends that 4759-4-04 (G) (2) OAC be revised to re-insert language where appropriate in the paragraph requiring non-RD licensees to engage in continuing education “consistent with the
continuing education requirements adopted by the commission on dietetic registration” in order to correct the conflict that its removal creates; **OR**

Add specific language requiring non-RD licensees to “use and document the PDP process as adopted by the commission on dietetic registration of self-reflection, planning based on individual learning needs assessment and competencies, and evaluation of learning outcomes when fulfilling continuing education requirements” when engaging in continuing education.

**4759-4-08 OAC Limited Permit.**

OAND supports the amendments as proposed for this rule.

**4759-6-02 OAC Standards of Professional Performance.**

OAND supports the amendments as proposed for this rule.

Thank you for the opportunity to provide comments on these important dietitian licensure rules.

Sincerely,
Kay Mavko, MS, RDN, LD
State Regulatory Specialist
Ohio Academy of Nutrition and Dietetics

Patricia Mcknight, MS, RDN, LD
State Policy Representative
Ohio Academy of Nutrition and Dietetics

*The Academy of Nutrition and Dietetics was previously known as the American Dietetic Association and is used in Ohio’s enabling legislation for dietitian licensure in 1987.

References:


Registered Dietitian Nutritionists and Nutrition and Dietetics Technicians, Registered, Are Ethically Obligated to Maintain Personal Competence in Practice

An Ethics Opinion reflects the interpretation or application of the Academy of Nutrition and Dietetics/Commission on Dietetic Registration (CDR) Code of Ethics for the Profession of Dietetics by the Ethics Committee. This interpretation or application by the Ethics Committee is in response to a specific ethics issue facing the Registered Dietitian Nutritionist (RDN) or Nutrition and Dietetics Technician, Registered (NDTR), in practice.

An Ethics Opinion is an educational guide for RDN and NDTR conduct; it is meant to be a comprehensive review of the issue. The situations described are hypothetical.

Miller-Keane and O’Toole define competence as the ability to consistently deliver safe and reliable services. Registered dietitian nutritionists (RDNs) and nutrition and dietetics technicians, registered (NDTRs), who are competent use up-to-date knowledge and skills; make sound decisions based on appropriate data; communicate effectively with patients, customers, and other professionals; critically evaluate their own practice; and improve performance based on self-awareness, applied practice, and feedback from others.

More than 30 years ago, Houle noted that one of the distinguishing features of a profession is the recognition, by professionals as well as the public, of the necessity in keeping up-to-date with the latest advances in the field. A recent report by the Institute of Medicine reaffirmed the need to remain competent in a changing field by suggesting that professionals need to build on basic knowledge and skills learned in school, as well as continue to learn new techniques and the latest evidence-based information, and improve performance to provide quality services for current and future work settings. Professionals also must take responsibility to determine the limits of their competence; a professional who is considering entering a new area of practice or implementing a new treatment approach must become competent to practice in the new area. For example, nutrition and dietetics practitioners today may need to learn the latest social media techniques and legal and ethical issues in delivering information via social media, and professionals in the future may need to learn to interpret and communicate the results of complex nutrigenetic testing.

In recent years, various groups have specifically focused on the need for continuing competence of health professionals. For example, the Joint Commission requires institutions to assure that staff remain competent in their practice area by assessing and documenting competence every 3 years, or more frequently as determined by hospital policy. Consumer organizations, federal agencies, managed care organizations, and legislators are applying increasing pressure for licensure and certifying bodies to take steps to ensure the continuing competence of providers.

For example, the National Commission for Certifying Agencies approved new 2016 standards that require certifying agencies to promote continued competence through periodic recertification. Employers, the Academy, and the Commission on Dietetic Registration expect RDNs and NDTRs to remain competent throughout their careers.

For RDNs and NDTRs, the Code of Ethics for the Profession of Dietetics, Comprehensive Scope of Practice Resources for the RDN/NDTR, and Professional Development Portfolio work together to assure competence. The Code of Ethics defines ethical principles that support the best interests of persons in the society and provides guidelines on how RDNs and NDTRs should conduct business with clients, colleagues, and other professionals. Principle 14 states that “dietetics practitioners assume a long-life responsibility and accountability for personal competence in practice, consistent with accepted professional standards, continually striving to increase professional knowledge and skills and to apply them in practice.” Therefore, RDNs and NDTRs are ethically obligated to remain competent so that they can provide the best possible service to clients, customers, and society.

The Comprehensive Scope of Practice Resources for the RDN/NDTR explains safe and appropriate practice. The Standards of Practice and Standards of Professional Performance hold the individual practitioner responsible for continuing competence by participating in self-assessment and professional development to improve knowledge and skills. The Professional Development Portfolio process offers a framework to guide RDNs and NDTRs though the continuing professional education (CPE) process in order to help them achieve...
self-identified learning needs or practice competencies.13 The Scope of Practice Resources and the Professional Development Portfolio outline a similar process for maintaining continued competence and professional accountability. Both dietetics resources emphasize conducting regular self-assessments based on self-reflection and feedback from a variety of sources to identify gaps in practice competencies or needs for professional development. They also help the RDN or NDTR develop and implement a plan for professional growth and evaluate the effectiveness of the plan in maintaining competence. For this process to be effective, RDNs and NDTRs must accept responsibility for accurately assessing their learning needs, preparing and implementing a learning plan that appropriately addresses identified needs, applying new knowledge and skills to practice, and honestly evaluating whether they remain competent to practice.

When registration was first implemented in 1969, mandatory continuing education was established to promote continuing competence of registered dietitian nutritionists.14 As part of the Professional Development Portfolio process, RDNs and NDTRs must participate in CPE activities that are related to nutrition and dietetics. Dietetics is defined as “the integration, application and communication of principles derived from food, nutrition, social, business and basic sciences, to achieve and maintain optimal nutrition status of individuals through the development, provision and management of effective food and nutrition services in a variety of settings.”15 The purpose of CPE is to maintain or develop competence in specific areas of nutrition and dietetics. To be most effective, CPE activities should be based on needs assessments, be interactive, provide feedback, use multiple learning methods, provide adequate time to incorporate knowledge, and apply to the learner’s professional practice.16

However, participation in formal professional development activities such as workshops is not the only way professionals learn. Professional development during the years of active practice also occurs as the direct or indirect result of the work itself. RDNs and NDTRs who maintain a mind-set of continuous performance improvement through self-reflection and interaction with others will be more effective practitioners. For example, a nutrition and dietetics practitioner who would like to improve his or her ability to help clients solve nutrition-related problems may use critical self-analysis to revise his or her counseling approach. Or a dietetics manager may learn about more effective personnel management strategies through informal interactions with other managers in the institution. Other professional development opportunities in the workplace may include observation of role models, analysis of errors or unexpected results of one’s actions, or discussion of difficult clients or situations with colleagues.17-19 This informal learning in the workplace can help RDNs and NDTRs maintain competence to practice.

RDNs and NDTRs who fail to remain competent, or are not competent enough to practice, expose themselves to many professional risks, including the possibility that they may cause harm to clients or customers. For example, an RDN in clinical practice who writes orders for parenteral nutrition without extensive training may cause metabolic complications, a foodservice manager who does not remain current with procedures to prevent food-borne illness may risk causing injury or death to vulnerable clients, or an RDN in private practice may exacerbate a patient’s medical condition by recommending inappropriate diet restrictions. Incompetent practitioners may also become the subject of a lawsuit. For example, the family of a patient in a long-term care facility who dies of malnutrition may sue the nutrition and dietetics practitioner who failed to appropriately identify and recommend treatment for the patient. Other professional risks of practicing in an incompetent or less-than-competent manner include the possibility that the RDN or NDTR may lose his or her job or become the subject of a complaint to a state licensure board, to the Ethics Committee of the Academy, and the Commission on Dietetic Registration. Licensure boards and the Ethics Committee may suspend or revoke the individual’s registration10 or license to practice.

EVALUATION OF COMPETENCE

How does a professional know if he or she is competent to practice? Most professionals believe that they are competent to practice, but overconfidence or resistance to change may cloud their judgment. Both experienced professionals and those who are either considering entering a new area of practice or implementing a new treatment approach must be sure that they have the appropriate training and understand the scientific basis of practice. Professionals have the responsibility to identify the limits of their competence. Professionals may use a number of strategies to evaluate their competence.

Self-reflection, a key component of lifelong learning, is an important strategy for evaluating competence.11,18,20 Self-reflection may be defined as a “conscious and systematic approach to thinking about experiences with the aim of learning and changing behaviors.”21 Reflection is most effective when professionals pay careful attention to and maintain curiosity about their daily work, especially in complex, difficult, or emotionally challenging situations, and receive feedback about their performance.22-24 An example of an opportunity to use self-reflection to evaluate success in maintaining competence may occur when a professional experiences a critical incident.25 For example, an RDN or NDTR who writes a blog post about a controversial diet should evaluate his or her knowledge of research on the effectiveness of the diet after receiving critical comments about the post from other professionals. Effective analysis of critical incidents is based on sound and sufficient knowledge, the ability to transfer learning from one situation to another, and a willingness to change.23

Obtaining feedback on performance from a variety of sources including clients, supervisors, peers, and mentors, is another effective strategy to determine whether one is maintaining competence.18 These individuals, who are in a position to directly observe the RDN’s or NDTR’s behavior, can provide valuable evidence of competence. A nutrition and dietetics practitioner who observes incompetent practice by another practitioner has the ethical responsibility to confront the incompetent individual, and if the incompetent practice can harm the public, provide evidence to the state licensing board and the Ethics Committee.

Another strategy for nutrition and dietetics practitioners to estimate their level of competence is to compare their performance to evidence-based
practice guidelines. Evidence-based practice guidelines are developed from current research on the effectiveness of different approaches to practice. The resulting guidelines translate the research findings into the most appropriate strategies to use in practice. Thus, an RDN or NDTR who is following the guidelines appropriately should be providing high-quality services. For example, an RDN who uses clinical judgment to diagnose malnutrition in adult oncology patients should compare his or her criteria for diagnosis with the recommendations in the Academy’s Evidence Analysis Library, and an RDN or NDTR who provides nutrition education for children should evaluate his or her online program by comparing it with effective digital media programs using the US Department of Agriculture’s Nutrition Evidence Library.

The Standards of Practice and Standards of Professional Performance are designed to be self-evaluation tools for RDN and NDTR competence. In addition to these descriptions of the minimum competent level of practice and professional performance, published standards in at least 12 focus areas (available from www.eatright.org) represent expert opinion and consensus on the expectations for professional practice. For example, an RDN or NDTR who has been hired as a patient service manager may use the Standards of Professional Performance for Registered Dietitian Nutritionists in Management of Food and Nutrition Systems, and a clinical RDN who has taken on responsibility for renal patients may use the Standards of Practice and Standards of Professional Performance for Registered Dietitian Nutritionists in Nephrology Nutrition to identify gaps in practice competencies and develop goals for professional development.

Another way nutrition and dietetics practitioners can determine whether they are maintaining competence is to compare their performance in the worksite to the best practices identified in professional development activities. For example, a nutrition and dietetics practitioner who teaches nutrition to nursing students may attend a training session on effective strategies for distance education courses, and then determine whether the web-based course designed for his or her students incorporates the most effective strategies. Finally, some RDNs and NDTRs may evaluate competence by completing the requirements to achieve and maintain relevant certification. For example, an RDN may demonstrate application of knowledge and decision-making skills for the appropriate care of children by passing the examination to become a Board Certified Specialist in Pediatric Nutrition. Registered dietitian nutritionists may also become Board Certified Specialists in Renal Nutrition, Gerontological Nutrition, Oncology Nutrition, and Sports Dietics.

EXAMPLES OF THE NEED FOR PERSONAL COMPETENCE IN PRACTICE

The following three examples demonstrate the need for nutrition and dietetics practitioners to maintain personal competence in practice:

- Ben is an NDTR who has worked for 2 years as the manager of a school lunch program in a rural area. The local school board received a complaint that Ben’s department is not following acceptable financial practices. Upon further investigation, the board determines that Ben must update his knowledge and skills in budgeting, record keeping, and interpreting financial data, in order to remain employed. Ben agrees to complete a workshop on financial practices and to meet regularly with the school district’s chief financial officer for one year. If Ben had assumed responsibility for remaining competent to practice, he could have avoided the potential loss of his job.

- Maria was recently elected as an officer of the district dietetic association. Maria would like to become an effective officer, so she establishes a mentoring relationship with an experienced officer to develop her leadership and team-building skills. As a result of identifying and addressing a learning need, Maria has maintained competence as a professional.

- Jane is an RDN who has been out of the workforce for 10 years. When she decides to return to work, she accepts a position working with patients with diabetes. During her 10 years away from practice, Jane participated in CPE activities related to medical nutrition therapy; however, when she accepts the position Jane determines that she must identify opportunities to quickly update her knowledge and skills on the management of patients with diabetes. Jane purchases the Diabetes Mellitus Toolkit and works with a mentor to understand these evidence-based practice guidelines before then applying the guidelines to her practice and evaluating the effectiveness of the medical nutrition therapy that she provides to her clients. Jane has demonstrated that she is willing to assume responsibility and accountability for competence in practice.

CONCLUSION

All RDNs and NDTRs have an ethical responsibility to remain competent throughout their careers. Practitioners who are returning to the workforce, changing job responsibilities, or continuing to practice in the same position must all accept responsibility for learning and improving performance throughout their careers. Changing practitioner roles requires individuals to plan and implement learning experiences that will keep them ready to safely and effectively provide nutrition services. When each RDN or NDTR chooses the most appropriate learning strategy to train for his or her specific area of practice, the result will be a diverse group of competent nutrition and dietetics practitioners with a solid foundation of knowledge and skills. Participating in critical self-evaluation, gathering feedback from others, following evidence-based practice guidelines, adopting best practices, or obtaining certification will help RDNs and NDTRs evaluate how successful they are in maintaining competence.

References


AUTHOR INFORMATION

The Ethics Committee, Academy Board of Directors, HOD Leadership Team, and the Commission on Dietetic Registration approved the original Ethics Opinion on January 27, 2003. The Ethics Committee reaffirmed this opinion for updating on October 20, 2013. The Academy for Nutrition and Dietetics authorizes the republication of the Ethics Opinion in its entirety, provided full and proper credit are given. Request to use portions of the Ethics Opinion must be directed to Academy Headquarters at 800/877-1600, ext. 4896 or ethics@eatright.org.

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MEMORANDUM

TO:            Mark Bechtel, M.D., President
               Members, State Medical Board of Ohio

FROM:         Kimberly C. Anderson, Chief Legal Counsel

RE:           Board of Nursing-Consult Agreement Rules

DATE:         February 24, 2021

Pursuant to Section 4729.39(E)(3), the Ohio Board of Nursing is required to consult with the Medical Board and the Pharmacy Board regarding proposed rules for clinical nurse specialists, certified nurse-midwives and certified nurse practitioners entering into consult agreements with pharmacists. The rules mirror the Medical Board’s rules related to physician assistants.

Please review the rules and let me know if you have any concerns.

Action Requested: Identify any issues of concern and authorize communication to the Board of Nursing
Consult agreements for a certified nurse-midwife, certified nurse practitioner, and clinical nurse specialist.

(A) For purposes of this rule and rule 4723-8-13 of the Administrative Code, practitioner means an advanced practice registered nurse licensed under Chapter 4723 of the Revised Code and practicing in Ohio as a certified nurse-midwife, certified nurse practitioner, or clinical nurse specialist.

(B) Requirements of a consult agreement

(1) A consult agreement shall include all of the following:

(a) Identification of the practitioner(s) and pharmacist(s) authorized to enter the agreement. They may include:

(i) Individual names of the practitioner(s) and pharmacists;

(ii) Practitioner or pharmacist practice groups;

(iii) Identification based on institutional credentialing or privileging; or

(iv) If multiple practitioners are entering the consult agreement, identification of the primary practitioner for the patient.

(b) A description of the patient's consent to drug therapy management pursuant to the consult agreement in compliance with paragraph (E) of rule 4729:1-06-01 of the Administrative Code.

(c) The specific diagnoses and diseases being managed under the agreement, including whether each disease is primary or comorbid.

(d) A description of the drugs or drug categories managed as part of the agreement.

(e) A description of the procedures, decision criteria, and plan the managing pharmacist is to follow in acting under a consult agreement. Such a description should provide a reasonable set of parameters for the activities a managing pharmacist is allowed to perform under a consult agreement.

(f) A description of the types of tests permitted pursuant to section 4729.39 of the Revised Code that may be ordered and evaluated by the managing pharmacist as long as the tests relate directly to the management of drug therapy. This may include specific tests or categories of testing that may be ordered and evaluated.

(g) A description of how the managing pharmacist shall maintain a record of each action taken for each patient whose drug therapy is managed under
the agreement. All prescribing, administering, and dispensing of drugs shall be documented using positive identification pursuant to paragraph (N) of rule 4729-5-01 of the Administrative Code.

(h) A description of how communication between a managing pharmacist and practitioner acting under a consult agreement shall take place at regular intervals specified by the practitioner who authorized the agreement. The agreement may include a requirement that the managing pharmacist send a consult report to each consulting practitioner.

(i) A provision that allow a practitioner to override a decision made by the managing pharmacist when appropriate.

(j) An appropriate quality assurance mechanism to ensure that managing pharmacists only act within the scope authorized by the consult agreement.

(k) A description of a continuous quality improvement (CQI) program used to evaluate effectiveness of patient care and ensure positive patient outcomes. The CQI program shall be implemented pursuant to the agreement.

(l) The training and experience criteria for managing pharmacists. The criteria may include privileging or credentialing, board certification, continuing education or any other training requirements. The agreement shall include a process to verify that the managing pharmacists meet the specified criteria.

(m) A statement that the practitioner(s) and pharmacists shall meet minimal standards of care at all times.

(n) An effective date and expiration date.

(o) Any other requirements contained in rules 4729:1-6-01, 4729:1-6-02 and 4729:1-6-03 of the Administrative Code.

(2) Institutional or ambulatory outpatient facilities may implement a consult agreement and meet the requirements of paragraphs (A)(1)(c) to (A)(1)(f) of this rule through institutional credentialing standards or policies. Such standards or policies shall be referenced as part of the consult agreement and available to an agent of the board upon request.

(3) The consult agreement shall be signed by the primary practitioner and one of the following:

(a) The terminal distributor's responsible person, which may include the responsible person's designee if the designee meets the qualifications of
the responsible person pursuant to Chapter 4729. of the Revised Code; or

(b) A managing pharmacist licensed pursuant to Chapter 4729. of the Revised Code.

(4) All amendments to a consult agreement shall be signed and dated by the primary practitioner and one of the following:

(a) The terminal distributor's responsible person, which may include the responsible person's designee if the designee meets the qualifications of the responsible person pursuant to Chapter 4729. of the Revised Code; or

(b) A managing pharmacist licensed pursuant to Chapter 4729. of the Revised Code.

(c) Amendments to the consult agreement are required when the scope of the managing pharmacist's permitted procedures expands past what was contemplated in the original agreement.

(5) A consult agreement shall be valid for a period not to exceed two years.

(6) A practitioner may enter a consult agreement with an Ohio licensed pharmacist if the physician or podiatrist with whom the practitioner collaborates, with respect to patient(s) that are the proposed subjects of consult agreements, has authorized in the standard care agreement that the practitioner may enter consult agreements for those patient(s).

(C) Recordkeeping. The primary practitioner, practitioner group or institution as defined in agency 4729 of the Administrative Code shall maintain a copy of the original consult agreement, all amendments made to the agreement, and a record of actions made in consultation with the managing pharmacist regarding each patient's drug therapy. The records shall be maintained in such a manner that they are readily retrievable for at least three years from the date of the last action taken under the agreement. Consult agreements shall be considered confidential patient records.

(D) Managing drug therapy.

(1) For purposes of implementing the management of a patient's drug therapy by an authorized managing pharmacist acting pursuant to a consult agreement, the primary practitioner must:

(a) Provide the managing pharmacist with access to the patient's medical record;

(b) Establish the managing pharmacist's prescriptive authority as one or both
of the following:

(i) A prescriber authorized to issue a drug order in writing, orally, by a manually signed drug order sent via facsimile or by an electronic prescribing system for drugs or combinations or mixtures of drugs to be used by a particular patient as authorized by the consult agreement. For all prescriptions issued by a pharmacist pursuant to this paragraph, the pharmacist shall comply with rules 4729-5-30 and 4729-5-13 of the Administrative Code; and or

(ii) With respect to non-controlled dangerous drugs only, an agent of the consulting practitioner(s). As an agent of the consulting practitioner(s), a pharmacist is authorized to issue a drug order, on behalf of the consulting practitioner(s), in writing, orally, by a manually signed drug order sent via facsimile or by an electronic prescribing system for drugs or combinations or mixtures of drugs to be used by a particular patient as authorized by the consult agreement;

(c) Specifically authorize the managing pharmacist's ability to:

(i) Change the duration of treatment for the current drug therapy; adjust a drug's strength, dose, dosage form, frequency of administration, route of administration, discontinue a drug, or to prescribe new drugs; and or

(ii) Order tests related to the drug therapy being managed and to evaluate those results; and

(d) Identify the extent to which, and to whom, the managing pharmacist may delegate drug therapy management to other authorized pharmacists under the agreement.

(E) Review of consult agreements. Upon the request of the board, the practitioner shall immediately provide a copy of the consult agreement, amendments, and any related policies or documentation pursuant to this rule and section 4729.39 of the Revised Code. The board may prohibit the execution of a consult agreement, or subsequently void a consult agreement, if the board finds any of the following:

(1) The agreement does not meet the requirements set forth in section 4729.39 of the Revised Code or Chapter 4723. of the Administrative Code; or

(2) The consult agreement, if executed, would present a danger to patient safety.
Standards for managing drug therapy according to a consult agreement.

(A) A practitioner may elect to manage the drug therapy of an established patient by entering into a consult agreement with a pharmacist. The agreement is subject to but not limited by the following standards:

1. The primary practitioner must ensure that the managing pharmacist has access to the patient's medical record, the medical record is accurate, and that while transferring the medical record, the primary practitioner ensures the confidentiality of the medical record.

2. The practitioner must have an ongoing practitioner-patient relationship with the patient whose drug therapy is being managed, including an initial assessment and diagnosis by the practitioner prior to the commencement of the consult agreement.

3. With the exception of inpatient management of patient care at an institutional facility as defined in agency 4729 of the Administrative Code, the practitioner, prior to a pharmacist managing the patient's drug therapy, shall communicate the content of the proposed consult agreement to each patient whose drug therapy is managed under the agreement, in such a manner that the patient or the patient's representative understands the scope and role of the managing pharmacist, which includes the following:

   a. That a pharmacist may be utilized in the management of the patient's care;

   b. That the patient or an individual authorized to act on behalf of a patient has the right to elect to participate in and to withdraw from the consult agreement; and

   c. Consent may be obtained as part of the patient's initial consent to treatment.

4. The diagnosis by the practitioner must be within the practitioner's scope of practice.

5. The practitioner shall meet the minimal and prevailing standards of care.

6. The practitioner must ensure that the pharmacist managing the patient's drug therapy has the requisite training and experience related to the particular diagnosis for which the drug therapy is prescribed. Practitioners practicing at institutional or ambulatory outpatient facilities may meet this requirement through institutional credentialing standards or policies.

7. The practitioner shall review the records of all services provided to the patient under the consult agreement.
(B) Quality assurance mechanisms. The following quality assurance mechanisms shall be implemented to verify information contained within the consult agreement, and ensure the managing pharmacist's actions are authorized and meet the standards listed in paragraphs (A) and (B) of this rule:

1) Verification of ongoing practitioner-patient relationship. A practitioner-patient relationship can be established by detailing criteria set forth in paragraph (A)(2) of this rule within the consult agreement.

2) Verification that practitioner diagnosis is within the practitioner's scope of practice. Establishing that a diagnosis is within the practitioner scope of practice may be established by detailing the criteria set forth in paragraph (A)(4) of this rule within the consult agreement.

3) Verification that the pharmacist's training and experience is related to the drug therapy. Establishing that a pharmacist's requisite training and experience with a particular drug therapy is related to the diagnosis for which the drug therapy is prescribed may be established by detailing the criteria set forth in paragraph (A)(6) of this rule within the consult agreement.

(C) Continuous quality improvement program. The following should be included in the development of a continuous quality improvement program in order to evaluate the effectiveness of patient care and ensure positive patient outcome:

1) Notifications to the primary practitioner. The managing pharmacist must notify the primary practitioner of the following situations regarding any pharmacist authorized to manage drug therapy under the agreement:

   a) A pharmacist has had their pharmacist license revoked, suspended, or denied by the state board of pharmacy;

   b) If prescribing controlled substances, a pharmacist has failed to renew their controlled substance prescriber registration;

   c) If prescribing controlled substances, a pharmacist fails to obtain or maintain a valid D.E.A. registration;

(D) Overriding decisions of managing pharmacist. Any authorized practitioner identified under the consult agreement may override any decision, change, modification, evaluation or other action by any pharmacist acting pursuant to the consult agreement or under the direction of the managing pharmacist, that was made with respect to the management of the patient's drug therapy under the consult agreement.
MEMORANDUM

TO: Mark Bechtel, M.D., President
    Members, State Medical Board of Ohio

FROM: Kimberly C. Anderson, Chief Legal Counsel

RE: Initial Circulation of Rules

DATE: February 24, 2021

The following rules were circulated to interested parties on January 25, 2021 with comments due on February 12, 2021. One comment was received regarding Rule 4731-14-01, which is attached for your review. The comment from Steve Lanier is a comment on the history of Rule 4731-14-01 and that a funeral director was able to pronounce death in the 1980s or early 1990s. This comment does not address any substantive issues in the proposed rules. The next step in the process is to file with the Common Sense Initiative.

4731-11-08 Prescribing to Self and Family: Proposed no change;

4731-14-01 Pronouncement of Death: Edits to reflect statutory changes;

4731-23-01 Definitions: Proposed no change;

4731-23-02 Delegation of Medical Tasks Changes needed for sections dealing with DODD statutes which have been repealed. I have reached out to DODD for comments;

4731-23-03 Delegation of Medical Tasks: Prohibitions Proposed no change;

4731-23-04 Violations Proposed no change;

4731-26-01 Definitions Updated to add and delete license types to reflect statutory changes; updated language change to “license” from “certificate”;

4731-26-02 Prohibitions Updated statutory authority and amplifying statutes;

4731-26-03 Violations; Miscellaneous Updated to add and delete license types to reflect statutory changes; updated statutory authority and amplifying statutes

Requested action: Approve rules for filing with Common Sense initiative.
Please file with the comments on 4731-14-01. Thank you.

Kimberly C. Anderson  
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Kimberly.Anderson@med.ohio.gov  
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Hi Kimberly,

I just had to tell you that up until the late 80s or early 90s the person in the county that was in charge of pronouncing death was a FUNERAL DIRECTOR!

Always struck me as a conflict of interest.

Sorry to be a bother just saw the "Pronouncement of Death" below and remembered that situation.

Be Well,
Steve Lanier

On Monday, January 25, 2021, 04:08:09 PM EST, Judith.Rodriguez@med.ohio.gov <judith.rodriguez@med.ohio.gov> wrote:

PROPOSED RULES: Seeking comments on the Medical Board's initial review of rules
The State Medical Board of Ohio seeks public input on proposed rules several times during the rule-making process. Public input is sought after the Medical Board has conducted its initial review of rules, after rules are filed with the Common Sense Initiative Office, and at the public hearing that occurs after the rules are formally filed with the Joint Committee on Agency Rule Review.

The Medical Board’s initial review of rules may result in a proposal to amend current rules, rescind current rules, make no changes to current rules, and/or adopt new rules. Comments received will be reviewed and possibly result in changes to the initially proposed language before the rules are then filed with the Common Sense Initiative Office.

At this time, public comment is being sought on the proposed language for the following rules. Please see the rules attached.

4731-11-08 Utilizing Controlled Substances for Self & Family No change
4731-14-01 Pronouncement of Death Proposed Amendment
4731-23-01 Delegation of Medical Tasks; Definitions No Change
4731-23-02 Delegation of Medical Tasks Proposed Amendment
4731-23-03 Delegation of Medical Tasks; Prohibitions No change
4731-23-04 Violations No change
4731-26-01 Sexual Misconduct and Impropriety; Definitions Proposed Amendment
4731-26-02 Prohibitions No Change
4731-26-03 Violations; miscellaneous Proposed Amendment
4730-1-07 Miscellaneous Provisions Proposed Amendment
4730-2-07 Standards for Prescribing Proposed Amendment
4731-35-01 Consult Agreements Proposed Amendment
4731-35-02 Standards for Managing Drug Therapy Proposed Amendment

Deadline for submitting comments: February 12, 2021

Comments to: Kimberly Anderson
State Medical Board of Ohio
Kimberly.Anderson@med.ohio.gov

Judy Rodriguez
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CAUTION: This is an external email and may not be safe. If the email looks suspicious, please do not click links or open attachments and forward the email to csc@ohio.gov or click the Phish Alert Button if available.
4731-11-08 Utilizing controlled substances for self and family members.

(A) Accepted and prevailing standards of care presuppose a professional relationship between a patient and physician when the physician is utilizing controlled substances. By definition, a physician may never have such a relationship with himself or herself. Thus, a physician may not self-prescribe or self-administer controlled substances. This paragraph does not prohibit a physician from obtaining a schedule V controlled substance for personal use in conformance with state and federal laws, in the same manner that a non-physician may obtain a schedule V controlled substance.

(B) Accepted and prevailing standards of care require that a physician maintain detached professional judgment when utilizing controlled substances in the treatment of family members. A physician shall utilize controlled substances when treating a family member only in an emergency situation which shall be documented in the patient's record.

(C) For purposes of this rule, "family member" means a spouse, parent, child, sibling or other individual in relation to whom a physician's personal or emotional involvement may render that physician unable to exercise detached professional judgment in reaching diagnostic or therapeutic decisions.
(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 4730.202 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) A 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.
4731-23-01 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.
Delegation of medical tasks.

(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.

(E) Physician delegation is prohibited in all settings specified in section 5123.42 of the Revised Code.
(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 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.
4731-23-04  Violations.

(A) A violation of any provision of any rule in this chapter of the Administrative Code, as determined by the board, shall constitute "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," as that clause is used in division (B)(6) of section 4731.22 of the Revised Code.

(B) A violation of any provision of any rule in this chapter of the Administrative Code that pertains to the administration of drugs, as determined by the board, shall constitute "failure to maintain minimal standards applicable to the selection or administration of drugs," as that clause is used in division (B)(2) of section 4731.22 of the Revised Code.
For purposes of Chapter 4731-26 of the Administrative Code:

(A) “Licensee” means any of the following:

(1) An individual holding a certificate to practice as a physician assistant under Chapter 4730. of the Revised Code;

(2) An individual holding a certificate to practice medicine and surgery, osteopathic medicine and surgery, or podiatric medicine and surgery under Chapter 4731. of the Revised Code;

(3) An individual holding a certificate to practice a limited branch of medicine under Chapter 4731. of the Revised Code;

(4) An individual holding a license to practice dietetics under Chapter 4759 of the Revised Code.

(4)(5) An individual holding a certificate of registration as an anesthesiologist assistant under Chapter 4760. of the Revised Code;

(6) An individual holding a license or limited permit to practice respiratory care under Chapter 4761 of the Revised Code.

(5)(7) An individual holding a certificate to practice as an acupuncturist or an oriental medicine practitioner under Chapter 4762. of the Revised Code;

(6)(8) An individual holding a certificate to practice as a radiologist assistant under Chapter 4774. of the Revised Code; or

(7)(9) An individual holding a license to practice as a genetic counselor under Chapter 4778. of the Revised Code.

(B) “Health care services” means examination, consultation, health care, treatment, or other services provided by a licensee under the legal authority conferred by a license, certificate, or registration issued by the board.

(C) “Patient” means a person for whom the licensee has provided health care services, whether provided by mutual consent or implied consent, or provided without consent pursuant to a court order. Once a licensee-patient relationship is established, a person remains a patient until the relationship is terminated. Patient includes any of the following:
(1) A person who is receiving or has received health care services from the licensee without termination of the licensee-patient relationship; or

(2) A person who meets the criteria of a key third party, as that term is defined in paragraph (D) of this rule.

(D) “Key third party” means an individual closely involved in the patient’s decision-making regarding health care services, including but not limited to, the patient’s spouse or partner, parents, child, sibling, or guardian. For purposes of this chapter, an individual’s status as a key third party ceases upon the termination of the licensee-patient relationship or upon termination of the individual’s relationship with the patient.

(E) “Chaperone” means a third person who, with the patient’s consent, is present during a medical examination.

(F) “Former patient” means one of the following:

(1) A person for whom the licensee has not rendered health care services since the licensee-patient relationship was terminated; or

(2) A person who has otherwise been admitted, discharged, or referred to another licensee for care subsequent to receipt of health care services by a licensee in an emergency setting or on an episodic basis, and such action has been recorded in the person’s medical record or chart.

(G) “Intimate examination” means an examination of the pelvic area, genitals, rectum, breast, or prostate.

(H) “Sexual misconduct” means conduct that exploits the licensee-patient relationship in a sexual way, whether verbal or physical, and may include the expression of thoughts, feelings, or gestures that are sexual or that reasonably may be construed by a patient as sexual. Sexual misconduct includes sexual impropriety, sexual contact, or sexual interaction as follows:

(1) “Sexual impropriety” means conduct by the licensee that is seductive, sexually suggestive, disrespectful of patient privacy, or sexually demeaning to a patient, including but not limited to, the following:

   (a) Neglecting to employ disrobing or draping practices respecting the patient’s privacy;
(b) Subjecting a patient to an intimate examination in the presence of a third party, other than a chaperone, without the patient’s consent or in the event such consent has been withdrawn;

(c) Making comments that are not clinically relevant about or to the patient, including but not limited to, making sexual comments about a patient’s body or underclothing, making sexualized or sexually demeaning comments to a patient, criticizing the patient’s sexual orientation, or making comments about potential sexual performance;

(d) Soliciting a date or romantic relationship with a patient;

(e) Participation by the licensee in conversation regarding the sexual problems, sexual preferences, or sexual fantasies of the licensee;

(f) Requesting details of the patient’s sexual history, sexual problems, sexual preferences, or sexual fantasies when not clinically indicated for the type of health care services; and

(g) Failing to offer the patient the opportunity to have a third person or chaperone in the examining room during an intimate examination and/or failing to provide a third person or chaperone in the examining room during an intimate examination upon the request of the patient.

(2) “Sexual contact” includes, but is not limited to, the following:

(a) Touching a breast or any body part that has sexual connotation for the licensee or patient, for any purpose other than appropriate health care services, or where the patient has refused or has withdrawn consent; and

(b) Examining or touching of the patient’s genitals without the use of gloves.

(3) “Sexual interaction” means conduct between a licensee and patient, whether or not initiated by, consented to, or participated in by a patient, that is sexual or may be reasonably interpreted as sexual, including but not limited to, the following:

(a) Sexual intercourse, genital to genital contact;
(b) Oral to genital contact;

(c) Oral to anal contact, genital to anal contact;

(d) Kissing in a romantic or sexual manner;

(e) Encouraging the patient to masturbate in the presence of the licensee or masturbation by the licensee while the patient is present;

(f) Offering to provide health care services, such as drugs, in exchange for sexual favors; and

(g) Performing an intimate examination without clinical justification.

(h) Conduct that is sexually demeaning to a patient or which demonstrates a lack of respect for the patient’s privacy.

(4) Conduct described in paragraphs (H)(1)(a), (H)(1)(b), (H)(1)(g), and (H)(2)(b) of this rule does not constitute sexual misconduct when all of the following criteria are met:

(a) The conduct occurred during the rendering of health care services in an emergency setting;

(b) The health care services rendered were clinically necessary;

(c) The patient was unconscious or otherwise unable to consent to health care services; and

(d) The patient’s clinical condition required immediate action and the licensee’s violation of the provisions of paragraph (H)(1)(a), (H)(1)(b), (H)(1)(g), or (H)(2)(b) of this rule, as applicable, was due to circumstances not within the licensee’s control.

(I) “Emergency setting” means an emergency department.

(J) “Board” means the state medical board of Ohio.

(K) “Conduct” includes, but is not limited to the following:
(1) Behaviors, gestures, or expressions, whether verbal or physical; or

(2) The creation, receipt, exchange, saving, or sending of images or communications, whether verbal or written, via a telecommunications device.
Prohibitions.

Sexual misconduct, as that term is defined in paragraph (H) of rule 4731-26-01 of the Administrative Code, between a licensee and a patient is never diagnostic or therapeutic.

(A) A licensee shall not engage in sexual misconduct with a patient or key third party, as that term is defined in paragraph (C) of rule 4731-26-01 of the Administrative Code.

(B) Conduct included within the definition of sexual misconduct occurring between a licensee and a former patient constitutes sexual misconduct and is prohibited if it meets any of the following criteria:

1. The conduct occurred within ninety days after the licensee-patient relationship was terminated;

2. The conduct occurred between a psychiatrist and a person to whom the psychiatrist formerly provided psychiatric or mental health services, and the conduct is in violation of the code of ethics of the “American Psychiatric Association”; or

3. The board determines that the conduct constitutes sexual misconduct upon consideration of the following factors:
   (a) The duration of the licensee-patient relationship;
   (b) The nature of the health care services provided;
   (c) The lapse of time since the licensee-patient relationship ended;
   (d) The extent to which the former patient confided personal or private information to the licensee;
   (e) The degree of emotional dependence that the former patient has or had on the licensee; and
   (f) The extent to which the licensee used or exploited the trust, knowledge, emotions, or influence derived from the previous licensee-patient relationship.
Violations, miscellaneous.

(A) Except as provided in paragraph (C) of this rule, a violation of rule 4731-26-02 of the Administrative Code, as determined by the board, shall constitute the following:

(1) For a physician, massage therapist, or cosmetic therapist, “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,” as that clause is used in division (B)(6) of section 4731.22 of the Revised Code.

(2) For a physician assistant, “a departure from, or 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.

(3) For a dietitian, “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 (A)(11) of section 4759.07 of the Revised Code.

(4) For an anesthesiologist assistant, “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 clause is used in division (B)(4) of section 4760.13 of the Revised Code.

(5) For a respiratory care professional or limited permit holder, “a departure from, or a 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 (A)(10) of section 4761.09 of the Revised Code.

(6) For an acupuncturist or oriental medicine practitioner, 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 clause is used in division (B)(4) of section 4762.13 of the Revised Code.

(7) For a radiologist assistant, 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 clause is used in division (B)(4) of section 4774.13 of the Revised Code.
(6) For a genetic counselor, 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 clause is used in division (B)(4) of section 4778.14 of the Revised Code.

(B) Where the alleged conduct does not in itself constitute sexual misconduct, as defined in paragraph (H) of rule 4731-26-01 of the Administrative Code, the board may consider expert testimony or other evidence in making its determination as to whether the conduct of the licensee constitutes sexual misconduct.

(C) Nothing in this rule shall limit the board’s authority to investigate and take action under section 4730.25, 4731.22, 4759.07, 4760.13, 4761.09, 4762.13, 4774.13 or 4778.14 of the Revised Code.
4730-1-07

Miscellaneous provisions.

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.

(B) The provisions of Chapters 4731-4, 4731-11, 4731-13, 4731-14, 4731-15, 4731-16, 4731-17, 4731-18, 4731-23, 4731-25, 4731-26, 4731-28, and 4731-29, and 4731-35 of the Administrative Code are applicable to the holder of a physician assistant license 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.
Standards for prescribing.

(A) A physician assistant who holds a prescriber number and who has been granted physician-delegated prescriptive authority by a supervising physician may prescribe a drug or therapeutic device provided the prescription is in accordance with all of the following:

1. The extent and conditions of the physician-delegated prescriptive authority, granted by the supervising physician who is supervising the physician assistant in the exercise of the authority;

2. The requirements of Chapter 4730. of the Revised Code;

3. The requirements of Chapters 4730-1, 4730-2, 4730-4, and 4731-11, and 4731-35 of the Administrative Code; and

4. The requirements of state and federal law pertaining to the prescription of drugs and therapeutic devices.

(B) A physician assistant who holds a prescriber number who has been granted physician-delegated prescriptive authority by a supervising physician shall prescribe in a valid prescriber-patient relationship. This includes, but is not limited to:

1. Obtaining a thorough history of the patient;

2. Conducting a physical examination of the patient;

3. Rendering or confirming a diagnosis;

4. Prescribing medication, ruling out the existence of any recognized contraindications;

5. Consulting with the supervising physician when necessary; and

6. Properly documenting these steps in the patient's medical record.

(C) The physician assistant's prescriptive authority shall not exceed the prescriptive authority of the supervising physician under whose supervision the prescription is being written, including but not limited to, any restrictions imposed on the physician's practice by action of the United States drug enforcement administration or the state medical board of Ohio.
(D) A physician assistant holding a prescriber number and who has been granted physician-delegated prescriptive authority by a supervising physician to prescribe controlled substances shall apply for and obtain the United States drug enforcement administration registration prior to prescribing any controlled substances.

(E) A physician assistant holding prescriber number and who has been granted physician-delegated prescriptive authority by a supervising physician shall not prescribe any drug or device to perform or induce an abortion.

(F) A physician assistant holding prescriber number and who has been granted physician-delegated prescriptive authority by a supervising physician shall include on each prescription the physician assistant's license number, and, where applicable, shall include the physician assistant's DEA number.
Consult agreements.

(A) For purposes of this chapter, practitioner includes the following:

(1) Physician authorized to practice medicine and surgery or osteopathic medicine and surgery under chapter 4731 of the Revised Code.

(2) Physician assistant who is licensed to practice as a physician assistant 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.

(B) Requirements of a consult agreement.

(1) A consult agreement shall include all of the following:

(a) Identification of the physician practitioner(s) and pharmacist(s) authorized to enter into the agreement. They may include:

(i) Individual names of physicians practitioners and pharmacists;

(ii) Physician Practitioner or pharmacist practice groups; or

(iii) Identification based on institutional credentialing or privileging.

(b) A description of the patient’s consent to drug therapy management pursuant to the consult agreement as set forth in paragraphs (H) and (I) of rule 4729:1-06-01 of the Administrative Code.

(c) The specific diagnoses and diseases being managed under the agreement, including whether each disease is primary or comorbid.

(d) A description of the drugs or drug categories managed as part of the agreement.

(e) A description of the procedures, decision criteria, and plan the managing pharmacist is to follow in acting under a consult agreement. Such a description should provide a reasonable set of parameters of the activities a managing pharmacist is allowed to perform under a consult agreement.

(f) A description of the types of blood, urine or other tests permitted pursuant to section 4729.39 of the Revised Code that may be ordered and
evaluated by the managing pharmacist as long as the tests relate directly to the management of drug therapy. This may include specific tests or categories of testing that may be ordered and evaluated.

(g) A description of how the managing pharmacist shall maintain a record of each action taken for each patient whose drug therapy is managed under the agreement. All prescribing, administering, and dispensing of drugs shall be documented using positive identification pursuant to paragraph (N) of rule 4729-5-01 of the Administrative Code.

(h) A description of how communication between a managing pharmacist and physician practitioner acting under a consult agreement shall take place at regular intervals specified by the physician practitioner who authorized the agreement. The agreement may include a requirement that the managing pharmacist send a consult report to each consulting physician practitioner.

(i) A provision that allows a physician practitioner to override a decision made by the managing pharmacist when appropriate.

(j) An appropriate quality assurance mechanism to ensure that managing pharmacists only act within the scope authorized by the consult agreement.

(k) A description of a continuous quality improvement (CQI) program used to evaluate effectiveness of patient care and ensure positive patient outcomes. The CQI program shall be implemented pursuant to the agreement.

(l) The training and experience criteria for managing pharmacists. The criteria may include privileging or credentialing, board certification, continuing education or any other training requirements. The agreement shall include a process to verify that the managing pharmacists meet the specified criteria.

(m) A statement that the physician practitioners and pharmacists shall meet minimal and prevailing standards of care at all times.

(n) An effective date and expiration date.

(o) Any other requirements contained in rules 4729:1-6-01, 4729:1-6-02 and 4729:1-6-03 of the Administrative Code.
(2) Institutional or ambulatory outpatient facilities may implement a consult agreement and meet the requirements of paragraphs (A)(1)(c) to (A)(1)(f) of this rule through institutional credentialing standards or policies. Such standards or policies shall be referenced as part of the consult agreement and available to an agent of the board upon request.

(3) The agreement shall be signed by the primary physician practitioner, which may include a medical director or designee if the designee is licensed pursuant to Chapter 4731. of the Revised Code, and one of the following:

(a) The terminal distributor's responsible person, which may include the responsible person's designee if the designee meets the qualifications of the responsible person pursuant to Chapter 4729. of the Revised Code; or

(b) A managing pharmacist licensed pursuant to Chapter 4729. of the Revised Code, if that pharmacist is not practicing at a pharmacy or institutional facility licensed as a terminal distributor of dangerous drugs.

(4) All amendments to a consult agreement shall be signed and dated by the primary physician practitioner, which may include a medical director or designee if the designee is licensed pursuant to Chapter 4731. of the Revised Code, and one of the following:

(a) The terminal distributor's responsible person, which may include the responsible person's designee if the designee meets the qualifications of the responsible person pursuant to Chapter 4729. of the Revised Code; or

(b) A managing pharmacist licensed pursuant to Chapter 4729. of the Revised Code, if that pharmacist is not practicing at a pharmacy or institutional facility licensed as a terminal distributor of dangerous drugs.

(c) Amendments to the consult agreement are required when the scope of the managing pharmacist's permitted procedures expands past what was contemplated withing the agreement

(5) A consult agreement shall be valid for a period not to exceed two years.

(6) Only the following Ohio licensed physicians practitioners practicing in Ohio and Ohio licensed pharmacists may participate in a consult agreement pursuant to
(B)(C) Recordkeeping. The primary physician practitioner, physician practitioner group or institution as defined in agency 4729 of the Administrative Code shall maintain a copy of the original consult agreement, and all amendments made thereafter, and a record of actions made in consultation with the managing pharmacist regarding each patient’s drug therapy. These records shall be maintained in such a manner that they are readily retrievable for at least three years from the date of the last action taken under the agreement. Such consult agreements shall be considered confidential patient records.

(D) Managing drug therapy.

(1) For the purpose of implementing the management of a patient’s drug therapy by an authorized managing pharmacist acting pursuant to a consult agreement, the primary physician practitioner must:

(a) Provide the managing pharmacist with access to the patient’s medical record; and

(b) Establish the managing pharmacist’s prescriptive authority as one or both of the following:

(i) A prescriber authorized to issue a drug order in writing, orally, by a manually signed drug order sent via facsimile or by an electronic prescribing system for drugs or combinations or mixtures of drugs to be used by a particular patient as authorized by the consult agreement. For all prescriptions issued by a pharmacist pursuant to this paragraph, the pharmacist shall comply with rules 4729-5-30 and 4729-5-13 of the Administrative Code; and or

(ii) With respect to non-controlled dangerous drugs only, an agent of the consulting physician practitioner(s). As an agent of the consulting physician practitioner(s), a pharmacist is authorized to issue a drug order, on behalf of the consulting physician practitioner(s), in writing, orally, by a manually signed drug order sent via facsimile or by an electronic prescribing system.
system for drugs or combinations or mixtures of drugs to be used by a particular patient as authorized by the consult agreement, and

(c) Specifically authorize the managing pharmacist’s ability to:

(i) Change the duration of treatment for the current drug therapy; adjust a drug's strength, dose, dosage form, frequency of administration, route of administration, discontinue a drug, or to prescribe new drugs; and or

(ii) Order blood, urine and other tests related to the drug therapy being managed and to evaluate those results, and

(d) Identify the extent to which, and to whom, the managing pharmacist may delegate drug therapy management to other authorized pharmacists under the agreement.

(E) Review of consult agreements. Upon the request of the state medical board, the primary practitioner shall immediately provide a copy of the consult agreement, amendments, and any relating policies or documentation pursuant to this rule and section 4729.39 of the Revised Code. The state medical board may prohibit the execution of a consult agreement, or subsequently void a consult agreement, if the board finds any of the following:

(1) The agreement does not meet the requirements set forth in section 4729.39 of the Revised Code or this division of the administrative code; or

(2) The consult agreement, if executed, would present a danger to patient safety.
(A) A **physician practitioner** may elect to manage the drug therapy of an established patient by entering into a consult agreement with a pharmacist. The agreement is subject, but not limited to, the following standards:

1. The primary **physician practitioner** must ensure that the managing pharmacist has access to the patient’s medical record, the medical record is accurate, and that while transferring the medical record, the primary **physician practitioner** ensures the confidentiality of the medical record.

2. The **physician practitioner** must have an ongoing **physician practitioner**-patient relationship with the patient whose drug therapy is being managed, including an initial assessment and diagnosis by the **physician practitioner** prior to the commencement of the consult agreement.

3. With the exception of inpatient management of patient care at an institutional facility as defined in agency 4729 of the Administrative Code, the **physician practitioner**, prior to a pharmacist managing the patient’s drug therapy, shall communicate the content of the proposed consult agreement to each patient whose drug therapy is managed under the agreement, in such a manner that the patient or the patient’s representative understands scope and role of the managing pharmacist, which includes the following:

   a. That a pharmacist may be utilized in the management of the patient's care;

   b. That the patient or an individual authorized to act on behalf of a patient has the right to elect to participate in and to withdraw from the consult agreement.

   c. Consent may be obtained as part of the patient's initial consent to treatment.

4. The diagnosis by the **physician practitioner** must be within the **physician practitioner’s** scope of practice.

5. The **physician practitioner** shall meet the minimal and prevailing standards of care.

6. The **physician practitioner** must ensure that the pharmacist managing the patient’s drug therapy has the requisite training, and experience related to the particular diagnosis for which the drug therapy is prescribed. **Physicians Practitioners** practicing at institutional or ambulatory outpatient...
facilities may meet this requirement through institutional credentialing standards or policies.

(7) The physician practitioner shall review the records of all services provided to the patient under the consult agreement.

(B) Quality assurance mechanisms. The following quality assurance mechanisms shall be implemented to verify information contained within the consult agreement, and ensure the managing pharmacist’s actions are authorized and meet the standards listed in paragraphs (A) and (B) of this rule:

(1) Verification of ongoing physician practitioner-patient relationship. A physician practitioner-patient relationship can be established by detailing criteria set forth in paragraph (A)(2) of this rule, within the consult agreement.

(2) Verification that physician practitioner diagnosis is within the physician’s practitioner’s scope of practice. Establishing that a diagnosis is within the physician’s practitioner’s scope of practice may be established by detailing the criteria set forth in paragraph (A)(4) of this rule, within the consult agreement.

(3) Verification that pharmacist’s training and experience is related to the drug therapy. Establishing that a pharmacist’s requisite training and experience with a particular drug therapy is related to the diagnosis for which the drug therapy is prescribed, may be established by detailing the criteria set forth in paragraph (A)(6) of this rule, within the consult agreement.

(C) Continuous quality improvement program. The following should be included in the development of a continuous quality improvement program in order to evaluate the effectiveness of patient care and ensure positive patient outcomes:

(1) Notifications to primary physician practitioner. The managing pharmacist must notify the primary physician practitioner of the following situations regarding any pharmacist authorized to manage drug therapy under the agreement:

(a) A pharmacist has had their pharmacist license revoked, suspended, or denied by the state board of pharmacy;

(b) If prescribing controlled substances, a pharmacist has failed to renew their controlled substance prescriber registration;
(c) If prescribing controlled substances, a pharmacist fails to obtain or maintain a valid D.E.A. registration;

(D) Overriding decisions of managing pharmacist. Any authorized physician/practitioner identified under the consult agreement may override any decision, change, modification, evaluation or other action by any pharmacist acting pursuant to consult agreement or under the direction of the managing pharmacist, that was made with respect to the management of the patient’s drug therapy under the consult agreement.
MEMORANDUM

TO: Mark Bechtel, M.D., President
    Members, State Medical Board of Ohio

FROM: Kimberly C. Anderson, Chief Legal Counsel

RE: Draft FAQs-Delegation of Medical Tasks

DATE: February 26, 2021

Following up from discussion at the February Board meeting regarding a question from a hospital regarding nursing practice during orthopedic surgery, attached please find draft Frequently Asked Questions related to the delegation of medical tasks under the Board’s statute and rules.

Please let me know if you have questions or changes to the draft.

Action Requested: Finalize Frequently Asked Questions for posting on the Board’s website.
FREQUENTLY ASKED QUESTIONS: DELEGATION OF MEDICAL TASKS

1. Does the Medical Board have laws and rules regarding the delegation of medical tasks to unlicensed persons?

Yes. Section 4731.053 of the Ohio Revised Code requires the State Medical Board to adopt rules that establish standards to be met and procedures to be followed by a physician (MD, DO, DPM) 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 Ohio Revised Code to perform the task.

The Medical Board has adopted rules in Chapter 4731-23 of the Ohio Administrative Code.

2. What is a medical task?

Under Rule 4731-23-01, a task includes a routine medical service not requiring the special skills of a licensed provider.

3. What are the requirements for physicians delegating a medical task?

Under Rule 4731-23-02, OAC, a physician must determine the following prior to delegating the performance of a medical task:

(a) That the task is within that physician’s authority;
(b) That the task is indicated for the patient;
(c) The appropriate level of supervision;
(d) That no law prohibits the delegation;
(e) That the person to whom the task will be delegated is competent to perform that task; and
(f) That the task itself is one that should be appropriately delegated.

4. How does the physician determine that the task is one that should be appropriately delegated?

The physician determines whether the task is one that should be appropriately delegated by 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.

5. Are there additional requirements for physicians delegating the administration of drugs?

Yes. When a physician delegates the administration of drugs, the physician shall provide on-site supervision, except in certain circumstances. On-site supervision means that the physical presence of the physician is required in the same location as the unlicensed person while the medical task is being performed. On-site supervision does not require the physician’s presence in the same room as the person performing the medical task.

6. What are the circumstances where the physician is not required to provide on-site supervision for the person performing the administration of drugs?

The following are the circumstances where on-site physician supervision is not required for the person performing the administration of drugs:

(a) 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
(b) Routine administration of a topical drug, such as a medicated shampoo; or
(c) Delegation occurs pursuant to laws related to programs and services offered by a county board of developmental disabilities; or
(d) When written policies and procedures have been adopted for the distribution of drugs by an unlicensed person to individuals incarcerated in state correctional institutions and other correctional facilities, such as county and municipal jails, workhouses, minimum security jails, halfway houses, community residential centers, regional jails, multi-county jails or any other detention facility.

7. May a physician delegate medical tasks to a licensed person, such as a registered nurse, if the task is outside the scope of the individual’s licensed practice?

In certain circumstances, this may be permissible. The individual will be considered an unlicensed person for purposes of completion of the delegated task and the physician must meet all the requirements in Section 4731.053 and the rules under Chapter 4731-23. It is also recommended to check with the individual’s licensing board.

8. May a physician delegate the following specific surgical tasks to an unlicensed person under the direct supervision of a physician under the Board’s delegation rules?
(a) Pressing the trigger on a powered drill to fully insert a pin into a bone after the pin placement has already been started by the surgeon, while the surgeon maintains traction/fracture reduction on the bone;

(b) Tapping the tip of a bone cutting instrument with a hammer after the surgeon has placed the bone cutting instrument against the bone while the surgeon, by hand, manually feels and assesses the depth of the bone cut being made. The surgeon would then verbally tell the nurse or unlicensed person when to stop tapping the bone cutting instrument with the hammer based on his/her manual assessment; and

(c) Insert/advance orthopedic instrumentation via manual pressure or mallet while the surgeon maintains bone reduction on an implant that has been placed by the surgeon within or outside the bone and the surgeon maintains position of the implant while the nurse or unlicensed person inserts/advances the instrumentation.

Yes, an unlicensed person may complete these tasks under the direct supervision of a physician, so long as the physician is fully participating in the surgery and actively supervising the unlicensed person, who is acting as another set of hands and the physician meets all the requirements of Rule 4731-23-02(B), OAC. See FAQs #3 and 4.

9. What acts are prohibited under the delegation rules?

(a) A physician may not delegate the practice of medicine unless specifically authorized to do so by statute or rule;
(b) A physician may not delegate a task to an unlicensed person if the task is beyond that person’s competence;
(c) A physician may 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 may not transfer the 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) Except as permitted in section 4731.053(D)(4) to (D)(7) of the Ohio Revised Code, a physician may not delegate to an unlicensed person the administration of anesthesia, controlled substances or drugs administered intravenously.
(f) A physician may not authorize a physician assistant, anesthesiologist assistant, or any other professional regulated by the Medical Board to delegate tasks pursuant to section 4731.053 of the Ohio Revised Code.

10. What happens if a physician violates the delegation statute and rules?

Violations of the rules on delegation constitute a minimal standards violation under division (B)(6) of Section 4731.22 of the Revised Code. Any violation related to the administration of
drugs shall constitute a failure to maintain minimal standards applicable to the selection or administration of drugs in division (B)(2) of Section 4731.22 of the Revised Code.

11. What are exceptions to delegation statutes and rules?

The rules in Chapter 4731-23 do not apply to the following:

(a) Preventing 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 IEP developed for the child;
(b) Preventing delegation from occurring within programs and services offered by a county board of developmental disabilities;
(c) Conflicting with any provision of the Ohio Revised Code that specifically authorizes an individual to perform a particular task;
(d) Conflict with any rule that specifically authorizes an individual to perform a particular task; and
(e) Prohibit a perfusionist from administering drugs intravenously while practicing as a perfusionist.

Approved by the State Medical Board: (Date)
MEMORANDUM

TO: Mark Bechtel, M.D., President
Members, State Medical Board of Ohio

FROM: Kimberly C. Anderson, Chief Legal Counsel

RE: Light-Based Medical Device Rules, Chapter 4731-18, OAC

DATE: February 26, 2021

HB 442 which eliminates licensure for cosmetic therapists by the State Medical Board of Ohio becomes effective April 12, 2021. Under Section 4731.04, Ohio Revised Code, cosmetic therapy is defined as the permanent removal of hair from the human body using electric modalities approved by the state medical board for use in cosmetic therapy and may include the systematic friction, stroking, slapping, and kneading or tapping of the face, neck, scalp, or shoulders. In addition, cosmetic therapists are delegated the medical procedure of laser hair removal under Rule 4731-18-03, Ohio Administrative Code. The rule, along with the other rules in this chapter are pending at CSI.

For cosmetic therapists to be able to continue performing laser hair removal after the effective date of HB 442, three possible options exist:

1. Statutory change;
2. Emergency Rule, 4731-18-03;
3. Waiver of enforcement of Rule 4731-18-03.

I. Statutory change

The Board’s legislative staff has communicated to the sponsor of HB442 that the Board is supportive of reinstating Medical Board licensure for cosmetic therapists.

II. Emergency Rule, 4731-18-03, OAC

The April Board meeting is on April 14, 2021, after the effective date of HB 442, so it is necessary to reach some decisions on this matter at the March meeting. An emergency rule filing requires an Executive Order from Governor DeWine, and is effective for 120 days,
becoming invalid at the end of the 120th day. **Due to the expiration of the emergency rule, it will also be necessary to file the permanent rule at the same time the emergency rule is filed.**

A draft emergency rule is provided for your review. The rule makes the following changes to the current, existing rule 4731-18-03, OAC:

(A)(5)(a): Deletes language regarding a supplemental utilization plan for physician assistants and adds language “with whom the physician has an effective supervision agreement authorizing the service”. This is a necessary clean-up item since the supplemental utilization plans have not been required for many years;

(A)(5)(b): Changes the definition of cosmetic therapist from being currently licensed under Chapter 4731 to a cosmetic therapist who was licensed under 4731 on April 11, 2021;

(B): Deletes the language, “licensed pursuant to Chapter 4731. Of the Revised Code” following cosmetic therapist.

(B)(1): Changes the approval of the course in the use of light-based medical devices for the purpose of hair removal before the physician may provide off-site supervision from the Medical Board to the delegating physician.

(G): Deletes that violation of paragraph (C) of the rule constitutes a minimal standards of care violation under section 4731.22(B)(6) and adds that a violation of paragraphs (B) and (C) of the rule (failure to take or document necessary training for off-site supervision or failure to immediately report to the supervising physician any clinically significant side effect or failure of the treatment to progress as expected) constitutes the unauthorized practice of medicine under section 4731.41 of the Revised Code.

**Permanent Rule Amendments**

The permanent rules related to light-based medical devices are pending at CSI, and comments have been received from several individuals and entities. The rules and comments were reviewed at the December Policy Committee meeting and the January Physician Assistant Policy Committee meeting.

Some of the commenters and the members of the PAPC raised questions regarding Rules 4731-18-03(A)(3), (A)(4), (B)(3) and (B)(4) and 4731-18-04(B)(2) and (C)(2). In 4731-18-03(A)(3) and (B)(3), the rule requires the physician to see and evaluate the patient in person to determine whether the proposed application of the specific light-based medical device is appropriate. In 4731-18-03(A)(4), the physician must see and evaluate the patient in person following the initial application of the light-based medical device. The PAPC members asked about this requirement and if it could be completed by telemedicine or delegated to the physician assistant.
The PAPC also had questions about the language in 4731-18-04(B)(2) and 4731-18-04(C)(2), where the physician must see and personally evaluate the patient to determine whether the proposed application of phototherapy or photodynamic therapy may be completed via telemedicine or delegated to the physician assistant.

Please advise if any amendments are needed for these sections.

The following amendments are recommended:

Rule 4731-18-01(J): Adds language to clarify that vascular lasers are light-based medical devices. “Vascular laser” means light-based medical devices including lasers and intense pulsed light apparatuses whose primary cutaneous target structures are telangiectasia, venulectasia, and superficial cutaneous vascular structures. In general, these lasers have wavelengths that correspond to the hemoglobin absorption spectrum.

Rule 4731-18-02: No changes.

Rule 4731-18-03 (A)(6): Clarification that authorization by a physician for a physician assistant to apply a non-ablative vascular laser must meet the requirements of Chapter 4730.21, ORC. This addresses the education and training for the physician assistant by requiring the supervising physician to 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.

Section 4730.21 also addresses the supervision requirement in that the supervising physician must be continuously available for direct communication by being physically present at the location where the physician assistant is practicing and 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.

Section 4730.21 also indicates that the supervising physician may not supervise more than five physician assistants at any one time.

4731-18-03(A)(7): Clarifies that the education and training requirements for a registered nurse or licensed practical nurse must be met before they can apply a non-ablative vascular laser.

4731-18-03(A)(8): Clarifies that for registered nurse or licensed practical nurse, the physician must provide on-site supervision at all times during the application of the vascular laser.

4731-18-03(A)(9): Clarifies that for delegation to a registered nurse or licensed practical nurse, the physician may supervise no more than two persons at the same time.
4731-18-03(B)(5)(b): Since HB 442 eliminated the Medical Board’s authority to license cosmetic therapists, the rule is changed to allow delegation of laser hair removal to a cosmetic therapist who either was licensed by the Medical Board on April 11, 2021 or a cosmetic therapist who has completed a cosmetic therapy course of instruction for a minimum of 750 clock hours and received a passing score on the Certified Laser Hair Removal Professional® Examination administered by “The Society for Clinical and Medical Hair Removal”. **Note: this adds to the requirement in the draft emergency rule to allow for individuals who had not been previously licensed by the Medical Board to be able to meet the requirements.**

4731-18-03(B)(6): Amended to state that the authorization to a physician assistant to perform laser hair removal by the supervising physician must meet the requirements of Chapter 4730.21 of the Revised Code. As indicated above, this includes the education and training requirements, the supervision requirements by the supervising physician and the number of physician assistants that may be supervised by the supervising physician at one time.

4731-18-03(B)(7): Amended to clarify that the education and training requirements set out in this section apply to cosmetic therapists, registered nurses, and licensed practical nurses.

4731-18-03(B)(8): Amended to clarify that the on-site supervision requirements of that section apply to cosmetic therapists, registered nurses, and licensed practical nurses.

4731-18-03(B)(9): Amended to clarify that the provision that the physician may supervise no more than two persons performing laser hair removal at the same time applies to cosmetic therapists, registered nurses, and licensed practical nurses.

4731-18-03(C): Amended to remove the statement that a cosmetic therapist is licensed under Chapter 4731 of the Revised Code.

4731-18-03(H): Revise this paragraph which related to discipline of a cosmetic therapist who violates the rule to clarify that violation of the rule could constitute the unauthorized practice of medicine under section 4731.41 of the Revised Code.

4731-18-04(B)(4): Amended to state that the authorization to a physician assistant to perform phototherapy for treatment of hyperbilirubinemia in neonates by the supervising physician must meet the requirements of Chapter 4730.21 of the Revised Code. As indicated above, this includes the education and training requirements, the supervision requirements by the supervising physician and the number of physician assistants that may be supervised by the supervising physician at one time.

4731-18-04(B)(5) Amended to clarify that the requirement for on-site supervision at all times by the physician is applicable to the registered nurses, licensed practical nurses and certified medical assistants performing phototherapy for treatment of hyperbilirubinemia in neonates.
4731-18-04(C)(4): Amended to state that the authorization to a physician assistant to perform photodynamic therapy for dermatologic purposes by the supervising physician must meet the requirements of Chapter 4730.21 of the Revised Code. As indicated above, this includes the education and training requirements, the supervision requirements by the supervising physician and the number of physician assistants that may be supervised by the supervising physician at one time.

4731-18-04(C)(5): Amended to clarify that the requirement for training on photodynamic therapy is applicable to registered nurses and licensed practical nurses.

4731-18-04(C)(6): Amended to clarify that the requirement for on-site supervision is applicable to registered nurses and licensed practical nurses.

III. Waiver of enforcement

In addition to pursuing the emergency rule, the Board could also suspend enforcement of Rule 4731-18-03, OAC and related statutes and rules for physicians allowing cosmetic therapists to perform laser hair removal on or after April 12, 2021 and for cosmetic therapists performing laser hair removal under the delegation of physicians.

Requested action:

1. Recommend that staff explore the possibility of filing an emergency rule, with an Executive Order;
2. Approve the draft emergency rule language;
3. Approve amendments to the permanent rule, 4731-18-03, to update with CSI;
4. Approve filing the permanent rules 4731-18-01 through 4731-18-04, OAC as soon as released from CSI;
5. Delegate to Dr. Bechtel, Board President, the ability to make additional, necessary changes to the emergency rule or permanent rules, if needed between the March and April Board meetings.
6. If legislative change or an emergency rule are not finalized prior to April 12, 2021, approve the waiver of enforcement for Rule 4731-18-03 for physicians and cosmetic therapists.
4731-18-03 Delegation of the use of light based medical devices.

(A) A physician licensed pursuant to Chapter 4731. of the Revised Code may delegate the application of light based medical devices only for the purpose of hair removal and only if all the following conditions are met:

1. The light based medical device has been specifically approved by the United States food and drug administration for the removal of hair from the human body; and

2. The use of the light based medical device for the purpose of hair removal is within the physician's normal course of practice and expertise; and

3. The physician has seen and personally evaluated the patient to determine whether the proposed application of a light based medical device is appropriate; and,

4. The physician has seen and personally evaluated the patient following the initial application of a light based medical device, but prior to any continuation of treatment in order to determine that the patient responded well to that initial application; and,

5. The person to whom the delegation is made is one of the following:

(a) A physician assistant registered pursuant to Chapter 4730. of the Revised Code with whom the physician has an effective supervision agreement authorizing the service and the physician has a board approved supplemental utilization plan allowing such delegation; or,

(b) A cosmetic therapist who was licensed pursuant to Chapter 4731. of the Revised Code on April 11, 2021; or,

(C) A registered nurse or licensed practical nurse licensed pursuant to Chapter 4723. of the Revised Code; and,

6. The person to whom the delegation is made has received adequate education and training to provide the level of skill and care required; and,

7. The physician provides on-site supervision at all times the person to whom the delegation is made is applying the light based medical device; and,

8. The physician supervises no more than two persons pursuant to this rule at the same time.

(B) Notwithstanding paragraph (A)(7) of this rule, the physician may provide off-site supervision when the light based medical device is applied to an established patient if the person to whom the delegation is made pursuant to paragraph (A) of this rule is a cosmetic therapist licensed pursuant to Chapter 4731. of the Revised Code who meets all of the following criteria:

1. The cosmetic therapist has successfully completed a course in the use of light based medical devices for the purpose of hair removal that has been approved by the board delegating physician; and

2. The course consisted of at least fifty hours of training, at least thirty hours of which was clinical experience; and
(3) The cosmetic therapist has worked under the on-site supervision of the physician making the
delegation a sufficient period of time that the physician is satisfied that the cosmetic therapist is
capable of competently performing the service with off-site supervision.

The cosmetic therapist shall maintain documentation of the successful completion of the required
training.

(C) The cosmetic therapist, physician assistant, registered nurse or licensed practical nurse shall
immediately report to the supervising physician any clinically significant side effect following the
application of the light based medical device or any failure of the treatment to progress as was
expected at the time the delegation was made. The physician shall see and personally evaluate
the patient who has experienced the clinically significant side effect or whose treatment is not
progressing as expected as soon as practicable.

(D) For purposes of this rule, on-site supervision requires the physical presence of the
supervising physician in the same location (i.e., the physician's office suite) as the cosmetic
therapist, physician assistant, registered nurse or licensed practical nurse, but does not require
his or her presence in the same room.

(E) For purposes of this rule, off-site supervision means that the supervising physician shall be
continuously available for direct communication with the cosmetic therapist and must be in a
location that under normal conditions is not more than sixty minutes travel time from the
cosmetic therapist's location.

(F) A violation of paragraph (A) (B) or (C) of this rule by a physician shall constitute "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," as that
clause is used in division (B)(6) of section 4731.22 of the Revised Code. A violation of division
(A)(5) of this rule shall constitute "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," as that clause is used in division (B)(20) of
section 4731.22 of the Revised Code, to wit: section 4731.41 of the Revised Code.

(G) A violation of paragraphs (B) or (C) of this rule by a cosmetic therapist shall constitute the
unauthorized practice of medicine pursuant to section 4731.41 of the Revised Code "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," as that
clause is used in division (B)(6) of section 4731.22 of the Revised Code. A violation of paragraph
(C) of this rule by a physician assistant shall constitute a "departure from, or failure to conform
to, minimal standards of care of similar physician assistants under the same or similar
circumstances, regardless of whether actual injury to patient is established," as that clause is
used in division (B)(19) of section 4730.25 of the Revised Code.
Chapter 4731-18 Surgery Standards Light Based Procedures

4731-18-01 Standards for Surgery Definitions

(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 patient’s behalf; and

(3) Determine, based on his surgeon’s 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 patient’s 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 patient’s behalf do not apply to the extent they would prevent the performance of surgery or other procedures under emergency circumstances.

As used in this chapter of the Administrative Code:

(A) “Light based medical device” shall mean any device that can be made to produce or amplify electromagnetic radiation at wavelengths equal to or greater than one hundred eighty nm but less than or equal to 1.0 X 10^6 nm [ten to the sixth power] and that is manufactured, designed, intended or promoted for in vivo irradiation of any part of the human body for the purpose of affecting the structure or function of the body.

(B) “Phototherapy” means the following:

(1) For paragraph (A) of rule 4731-18-04 of the Administrative Code, phototherapy means the application of light for the treatment of hyperbilirubinemia in neonates.

(2) For paragraphs (B) and (C) of rule 4731-18-04 of the Administrative Code, phototherapy means the application of ultraviolet light for the treatment of psoriasis and similar skin diseases. This application can occur with any device cleared or approved by the United States food and drug administration for the indicated use that can be made to produce irradiation with broadband ultraviolet B (290-320nm), narrowband ultraviolet B (311-313 nm), excimer light based (308nm), ultraviolet A1 (340-400nm), or UVA (320-400nm) plus oral psoralen called PUVA.

(C) “Photodynamic therapy” means light therapy involving the activation of a photosensitizer by visible light in the presence of oxygen, resulting in the creation of reactive oxygen species, which selectively destroy the target tissue.

(D) “Ablative dermatologic procedure” means a dermatologic procedure that is expected to excise, burn, or vaporize the skin below the dermo-epidermal junction.

(E) “Non-ablative dermatologic procedure” means a dermatologic procedure that is not expected or intended to excise, burn, or vaporize the epidermal surface of the skin.
“Physician means a person authorized to practice medicine and surgery, osteopathic medicine and surgery, or podiatric medicine and surgery under Chapter 4731. and acting within the scope of their practice.

“Delegation” means the assignment of the performance of a service to a person who is not a physician.

“On-site supervision” means the physical presence of the supervising physician is required in the same location (i.e., the physician's office suite) as the delegate of the light based medical device but does not require the physician’s presence in the same room.

“Off-site supervision” means that the supervising physician shall be continuously available for direct communication with the cosmetic therapist and must be in a location that under normal conditions is not more than sixty minutes travel time from the cosmetic therapist's location.

“Vascular laser” means light-based medical devices including lasers and intense pulsed light apparatuses whose primary cutaneous target structures are telangiectasia, venul ectasia, and superficial cutaneous vascular structures. In general, these lasers have wavelengths that correspond to the hemoglobin absorption spectrum.

4731-18-02 Use of light based medical devices

(A) The application of light based medical devices to the human body is the practice of medicine and surgery, osteopathic medicine and surgery, or podiatric medicine and surgery.

(B) A physician shall not delegate the application of light based medical devices for ablative procedures.

(C) A physician may delegate the application of a vascular laser for non-ablative dermatologic procedures according to the requirements in paragraph (A) of rule 4731-18-03 of the Administrative Code.

(D) A physician may delegate the application of light based medical devices for the purpose of hair removal according to the respective requirements in paragraphs (B) and (C) of rule 4731-18-03 of the Administrative Code.

(E) A physician may delegate the application of phototherapy for the treatment of hyperbilirubinemia in neonates according to the requirements in paragraph (A) of rule 4731-18-04 of the Administrative Code.

(F) A physician may delegate the application of phototherapy and photodynamic therapy only for dermatologic purposes according to the requirements of paragraphs (B) and (C) of rule 4731-18-04 of the Administrative Code.

(G) A violation of paragraph (C)(B) of this rule shall constitute "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," as that clause is used in division (B)(6) of section 4731.22 of the Revised Code and "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," as that clause is used in division (B)(20) of section 4731.22 of the Revised Code, to wit: section 4731.41 of the Revised Code.

4731-18-03 Delegation of the use of light based medical devices for specified non-ablative procedures

(A) A physician may delegate the application of a vascular laser for non-ablative dermatologic procedures only if all the following conditions are met:

(1) The vascular laser has been specifically cleared or approved by the United States food and drug administration for the specific intended non-ablative dermatologic procedure;

(2) The use of the vascular laser for the specific non-ablative dermatologic use is within the physician's normal course of practice and expertise;

(3) The physician has seen and evaluated the patient in person to determine whether the proposed application of the specific vascular laser is appropriate;

(4) The physician has seen and evaluated the patient in person following the initial application of the specific vascular laser, but prior to any continuation of treatment in order to determine that the patient responded well to the initial application of the specific vascular laser;

(5) The person to whom the delegation is made is one of the following:

(a) A physician assistant licensed under Chapter 4730. of the Revised Code with whom the physician has an effective supervision agreement authorizing the service; or,

(b) A registered nurse or licensed practical nurse licensed under Chapter 4723. of the Revised Code;

(6) For a physician assistant, the authorization must meet the requirements of Chapter 4730.21 of the Revised Code.

(7) For a registered nurse or licensed practical nurse, the physician must ensure that the person to whom the delegation is made has received adequate education and training to provide the level of skill and care required including:

(a) Eight (8) hours of basic education that must include the following topics: light based procedure physics, tissue interaction in light based procedures, light based procedure safety including use of proper safety equipment, clinical application of light based procedures, pre and post-operative care of light based procedure patients, and reporting of adverse events;

(b) Observation of fifteen (15) procedures for each specific type of vascular laser non-ablative procedure delegated. The procedures observed must be performed by
a physician for whom the use of this specific vascular laser procedure is within the physician’s normal course of practice and expertise; and

c) Performance of twenty (20) procedures under the direct physical oversight of the physician on each specific type of vascular laser non-ablative procedure delegated. The physician overseeing the performance of these procedures must use this specific vascular laser procedure within the physician’s normal course of practice and expertise;

d) Satisfactory completion of training shall be documented and retained by each physician delegating and the delegate. The education requirement in (a) must only be completed once by the delegate regardless of the number of types of specific vascular laser procedures delegated and the number of delegating physicians. The training requirements in (b) and (c) must be completed by the delegate once for each specific type of vascular laser procedure delegated regardless of the number of delegating physicians;

(8) For delegation to a registered nurse or licensed practical nurse, the physician provides on-site supervision at all times that the person to whom the delegation is made is applying the vascular laser; and,

(9) For delegation to a registered nurse or licensed practical nurse, the physician supervises no more than two persons pursuant to this rule at the same time.

(B) A physician may delegate the application of light based medical devices only for the purpose of hair removal and only if all the following conditions are met:

1) The light based medical device has been specifically cleared or approved by the United States Food and Drug Administration for the removal of hair from the human body; and

2) The use of the light based medical device for the purpose of hair removal is within the physician's normal course of practice and expertise; and

3) The physician has seen and personally evaluated the patient in person to determine whether the proposed application of the specific light based medical device is appropriate; and,

4) The physician has seen and personally evaluated the patient in person following the initial application of the specific light based medical device, but prior to any continuation of treatment in order to determine that the patient responded well to that initial application of the specific light based medical device; and,

5) The person to whom the delegation is made is one of the following:
(a) A physician assistant registered pursuant to Chapter 4730. of the Revised Code and with whom the physician has a board approved supplemental utilization plan allowing such delegation an effective supervision agreement authorizing the service; or,

(b) A cosmetic therapist who was licensed pursuant to Chapter 4731. of the Revised Code on April 11, 2021 or who has completed a cosmetic therapy course of instruction for a minimum of 750 clock hours and received a passing score on the Certified Laser Hair Removal Professional® Examination administered by “The Society for Clinical and Medical Hair Removal”; or,

(c) A registered nurse or licensed practical nurse licensed pursuant to Chapter 4723. of the Revised Code; and,

(6) For a physician assistant, the authorization must meet the requirements of Chapter 4730.21 of the Revised Code;

(7) For cosmetic therapists, registered nurses and licensed practical nurses, the physician shall ensure the person to whom the delegation is made has received adequate education and training to provide the level of skill and care required including:

(a) Eight (8) hours of basic education that must include the following topics: light based procedure physics, tissue interaction in light based procedures, light based procedure safety including use of proper safety equipment, clinical application of light based procedures, pre and post-operative care of light based procedure patients, and reporting of adverse events;

(b) Observation of fifteen (15) procedures for each specific type of light based medical device procedure for hair removal delegated. The procedures observed must be performed by a physician for whom the use of this specific light based medical device procedure for hair removal is within the physician’s normal course of practice and expertise; and

(c) Performance of twenty (20) procedures under the direct physical oversight of the physician on each specific type of light based medical device procedure for hair removal delegated. The physician overseeing the performance of these procedures must use this specific light based medical device procedure for hair removal within the physician’s normal course of practice and expertise;

(d) Satisfactory completion of training shall be documented and retained by each physician delegating and the delegate. The education requirement in (a) must only be completed once by the delegate regardless of the number of types of specific light based medical device procedures for hair removal delegated and the number of delegating physicians. The training requirements of (b) and (c) must be completed by the delegate once for each specific type of light based medical device procedure for hair removal delegated regardless of the number of delegating physicians;
(e) Delegates who, prior to the effective date of this rule, have been applying a specific type of light based medical device procedure for hair removal for at least two (2) years through a lawful delegation by a physician, shall be exempted from the education and training requirements of (a), (b), and (c) for that type of procedure provided that they obtain a written certification from one of their current delegating physicians stating that the delegate has received sufficient education and training to competently apply that type of light based medical device procedure. This written certification must be completed no later than sixty (60) days after the effective date of this provision, and a copy of the certification shall be retained by each delegating physician and each delegate.

(8) For cosmetic therapists, registered nurses and licensed practical nurses, the physician provides on-site supervision at all times that the person to whom the delegation is made is applying the light based medical device; and,

(9) For cosmetic therapists, registered nurses and licensed practical nurses, the physician supervises no more than two persons pursuant to this rule at the same time.

(C) Notwithstanding paragraph (B)(8) of this rule, the physician may provide off-site supervision when the light based medical device is applied for the purpose of hair removal to an established patient if the person to whom the delegation is made pursuant to paragraph (A) (B) of this rule is a cosmetic therapist licensed pursuant to under Chapter 4731. of the Revised Code who meets all of the following criteria:

(1) The cosmetic therapist has successfully completed a course in the use of light based medical devices for the purpose of hair removal that has been approved by the delegating physician board; and

(2) The course consisted of at least fifty hours of training, at least thirty hours of which was clinical experience; and

(3) The cosmetic therapist has worked under the on-site supervision of the physician making the delegation a sufficient period of time that the physician is satisfied that the cosmetic therapist is capable of competently performing the service with off-site supervision.

The cosmetic therapist shall maintain documentation of the successful completion of the required training.

(D) The cosmetic therapist, physician assistant, registered nurse or licensed practical nurse shall immediately report to the supervising physician any clinically significant side effect following the application of the light based medical device or any failure of the treatment to progress as was expected at the time the delegation was made. The physician shall see and personally evaluate the patient who has experienced the clinically
significant side effect or whose treatment is not progressing as expected as soon as practicable.

(E) A violation of paragraph (A), (B), or (C), or (D) of this rule by a physician shall constitute "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," as that clause is used in division (B)(6) of section 4731.22 of the Revised Code.

(F) A violation of division (A)(5) or (B)(5) of this rule shall constitute "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," as that clause is used in division (B)(20) of section 4731.22 of the Revised Code, to wit: section 4731.41 of the Revised Code.

(G) A violation of paragraph (C) or (D) of this rule by a cosmetic therapist shall constitute the unauthorized practice of medicine pursuant to section 4731.41 "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," as that clause is used in division (B)(6) of section 4731.22 of the Revised Code.

(H) A violation of paragraph (D) of this rule by a physician assistant shall constitute "a departure from, or failure to conform to, minimal standards of care of similar physician assistants under the same or similar circumstances, regardless of whether actual injury to patient is established," as that clause is used in division (B)(19) of section 4730.25 of the Revised Code.

4731-18-04 Delegation of phototherapy and photodynamic therapy

(A) A physician authorized pursuant to Chapter 4731. of the Revised Code to practice medicine and surgery or osteopathic medicine and surgery may delegate to any appropriate person the application of light based medical devices cleared or approved by the United States food and drug administration for phototherapy in treatment of hyperbilirubinemia in neonates only if all the following conditions are met:

(1) The use of the light based medical device for this treatment is within the physician’s normal course of practice and expertise.

(2) The delegation and application of light based medical devices for phototherapy for this treatment is performed pursuant to hospital rules, regulations, policies, and protocols.

(B) A physician authorized pursuant to Chapter 4731. of the Revised Code to practice medicine and surgery or osteopathic medicine and surgery may delegate to any appropriate person the application of a light based medical device that is a fluorescent lamp phototherapy device that is cleared or approved by the United States food and drug
administration for treatment of psoriasis and similar skin diseases only if all the following conditions are met: A fluorescent lamp phototherapy device is a device that emits ultraviolet light through the use of one or more fluorescent bulbs and is approved by the United States food and drug administration for phototherapy in the treatment of psoriasis or similar skin diseases.

(1) The use of the light based medical device for this treatment is within the physician’s normal course of practice and expertise.

(2) The physician has seen and personally evaluated the patient to determine whether the proposed application of phototherapy is appropriate;

(3) The person to whom the delegation is made is one of the following:
   (a) A physician assistant licensed under Chapter 4730. of the Revised Code with whom the physician has an effective supervision agreement authorizing the service;
   (b) A registered nurse or licensed practical nurse licensed under Chapter 4723. of the Revised Code; or
   (c) A certified medical assistant who has successfully completed and documented the completion of basic training on psoriasis and similar skin diseases and clinical training in the administration of the phototherapy device for the specific skin disease being treated; and

(4) For physician assistants, the authorization shall meet the requirements of Section 4730.21 of the Revised Code;

(5) For registered nurses, licensed practical nurses, and certified medical assistants, the physician provides on-site supervision at all times that the person to whom the delegation is made is applying the phototherapy.

(C) A physician may delegate the application of light based medical devices cleared or approved by the United States food and drug administration for photodynamic therapy for dermatologic purposes only if all the following conditions are met:

(1) The use of the light based medical device for this treatment is within the physician’s normal course of practice and expertise.

(2) The physician has seen and personally evaluated the patient to determine whether the proposed application of photodynamic therapy is appropriate;

(3) The person to whom the delegation is made is one of the following:
   (a) A physician assistant licensed under Chapter 4730. of the Revised Code with whom the physician has an effective supervision agreement authorizing the service; or,
   (b) A registered nurse or licensed practical nurse licensed under Chapter 4723. of the Revised Code;

(4) For physician assistants, the authorization shall meet the requirements of Section 4730.21 of the Revised Code;

(5) For registered nurses and licensed practical nurses, the person to whom the delegation is made completes basic training on photodynamic therapy and clinical training in the administration of photodynamic therapy for the specific disease or disorder being treated and the completion of this training is documented by the person to whom the delegation is made; and
(6) **For registered nurses and licensed practical nurses,** the physician provides on-site supervision at all times that the person to whom the delegation is made is applying the photodynamic therapy.

(D) Any person to whom a lawful delegation of phototherapy or photodynamic therapy has been made shall immediately report to the supervising physician any clinically significant side effect following the application of the phototherapy or photodynamic therapy device or any failure of the treatment to progress as was expected at the time the delegation was made. The physician shall see and personally evaluate the patient who has experienced the clinically significant side effect or whose treatment is not progressing as expected as soon as practicable.

(E) A violation of paragraph (A), (B), (C), or (D) of this rule by a physician shall constitute "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," as that clause is used in division (B)(6) of section 4731.22 of the Revised Code. A violation of division (A)(2), (B)(2), or (C)(2) of this rule shall constitute "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," as that clause is used in division (B)(20) of section 4731.22 of the Revised Code, to wit: section 4731.41 of the Revised Code.

(F) A violation of paragraph (D) of this rule by a physician assistant shall constitute "a departure from, or failure to conform to, minimal standards of care of similar physician assistants under the same or similar circumstances, regardless of whether actual injury to patient is established," as that clause is used in division (B)(19) of section 4730.25 of the Revised Code.
MEMORANDUM

TO: Mark Bechtel, M.D., President
Members, State Medical Board of Ohio

FROM: Nathan T. Smith, Senior Legal and Policy Counsel

DATE: March 4, 2021

RE: Ohio Department of Health Vaccination protocols

On February 12, 2021, the Ohio Department of Health issued the attached Director Journal Entry In re COVID 19 Volunteer Vaccine Providers.

**Applicability to Medical Board and its Licensees**
This vaccination protocol authorizes physicians (M.D., D.O., and D.P.M.), physician assistants, and respiratory care professionals “within the scope of their respective licensure and according to the competencies set forth by their respective licensing board, unless otherwise stated herein, to administer, deliver, or distribute the drugs, other than schedule II and III controlled substances, set forth in this order during the COVID State of Emergency, notwithstanding any statute or rule that otherwise prohibits or restricts the administration, delivery, or distribution of drugs by these professionals. The only drugs set forth in the Order are the Pfizer and Moderna COVID-19 vaccines.

The Order further states that for it to apply to the professionals listed, “these individuals will need to be Registered Volunteers pursuant to Section 5502.281 of the Revised Code and actively deployed by a recognized Medical Reserve Corps (MRC) unit in support of points of dispensing.”

**Medical Students**
The Order also provides that “[p]harmacy interns, medical, and nursing students who are sufficiently advanced in their education at their respective professional schools with the necessary competencies, according to the manner set out by the appropriate licensing board, may also administer COVID vaccine if properly supervised and actively deployed by a recognized Medical Reserve Corps unit.”

**Training**
The Order requires that “[a]ll personnel administering vaccines must receive comprehensive, competency-based training on vaccine administration policies and procedures as well as training on the recognition and management of anaphylaxis BEFORE administering vaccines. Vaccinating personnel must comply with any competencies set forth by their respective licensing boards. If the board has not set a competency, vaccinating personnel may meet this training requirement through the e-training listed below. The free vaccine administration e-Learn is available that offers continuing education for health care personnel. The training can be found at the following links:”
• https://www2.cdc.gov/vaccines/ed/vaxadmin/va/ce.asp and
• https://www.foodallergy.org/recognizing-responding-anaphylaxis

**Procedure**
The remainder of the Order gives very detailed procedural instructions including assessment of persons in need of vaccination, screening persons for contraindications and precautions for the vaccines, recommended counseling for special populations, pre-vaccination information to be provided, preparation of the vaccines, administration of the vaccines, documentation of the vaccination, observation of the vaccine recipient, and emergency protocols for allergic reactions.

**Medical Board Options for Setting Competencies**
The Order tasks the Medical Board to set competencies for physicians, physician assistants, respiratory care professionals, as well as medical students for COVID-19 vaccinations. The Training portion of the order provides that if the board has not set a competency that the vaccinating personnel may meet the training requirement through the two e-training programs listed. The following competency options are presented for your consideration:

**Option 1**

Require that physicians, physician assistants, and respiratory care professionals have an active license in good standing with the Medical Board and not be under suspension or under a probation order and complete the e-training specified in the Order.

Require that medical students have completed at least two years of medical school and/or have medical school clinical experience within the last year giving a vaccination of any kind.

**Option 2**

No competencies beyond the e-training specified in the Order for M.D., D.O., D.P.M., PA, and RCP.

Require that medical students have completed at least two years of medical school and/or medical school clinical experience within the last year giving a vaccination of any kind.

**Option 3**

No competencies beyond the e-training specified in the Order for M.D., D.O., D.P.M., PA, RCP, and medical students.

**Requested Action:** Discuss and select one of the competency options presented or a suitable alternative.
DIRECTOR JOURNAL ENTRY

In re COVID 19 Volunteer Vaccine Providers.

WHEREAS, the Governor declared a State of Emergency on March 9th, 2020, due to novel Coronavirus (2019-nCoV, known as COVID-19), a disease of major public concern; and

WHEREAS, the United States Food and Drug Administration (FDA) has granted Emergency Use Authorizations (EUAs) to the COVID vaccines developed by Pfizer and Moderna; and

WHEREAS, a large-scale campaign will be needed to vaccinate all Ohioans who wish to be vaccinated once the vaccines become sufficiently available; and

WHEREAS, general and city health departments have plans to use points of dispensing and clinic locations to support a large-scale vaccination campaign; and

WHEREAS, Medical Reserve Units have been established throughout Ohio to support a large-scale vaccination campaign; and

WHEREAS, there may be an insufficient number of health professionals available to conduct a large-scale vaccination campaign; and

WHEREAS, Section 3701.048 of the Revised Code, allows the Director of Health to, in consultation with the appropriate professional regulatory boards of Ohio, develop protocols that authorize individuals to administer, deliver, or distribute drugs, other than schedule II and III controlled substances, during a period of time the Governor declares to be an emergency that affects the public’s health;

NOW THEREFORE, I, Stephanie McCloud, Director, Ohio Department of Health (ODH), in accordance with my authority set forth in Section 3701.048, HEREBY ORDER AND AUTHORIZE, the following professionals, within the scope of their respective licensure and according to the competencies set forth by their respective licensing board, unless otherwise stated herein, to administer, deliver, or distribute the
drugs, other than schedule II and III controlled substances, set forth in this order during this COVID State of Emergency, notwithstanding any statute or rule that otherwise prohibits or restricts the administration, delivery, or distribution of drugs by these professionals:

(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-intermediate (now known as an “Advanced EMT”) or emergency medical technician-paramedic (now known as a “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.

For this Order to apply, these individuals will need to be Registered Volunteers pursuant to Section 5502.281 of the Revised Code and actively deployed by a recognized Medical Reserve Corps (MRC) unit in support of points of dispensing.

Pharmacy interns, medical, and nursing students who are sufficiently advanced in their education at their respective professional schools with the necessary
competencies, according to the manner set out by the appropriate licensing board, may also administer COVID vaccine if properly supervised and actively deployed by a recognized Medical Reserve Corps unit.

**Training**

Proper vaccine administration is critical to ensure that vaccination is safe and effective. All personnel administering vaccines must receive comprehensive, competency-based training on vaccine administration policies and procedures as well as training on the recognition and management of anaphylaxis **BEFORE** administering vaccines. Vaccinating personnel must comply with any competencies set forth by their respective licensing boards. If the board has not set a competency, vaccinating personnel may meet this training requirement through the e-training listed below.

The free vaccine administration e-Learn is available that offers continuing education for health care personnel. The training can be found at the following links:

- [https://www2.cdc.gov/vaccines/ed/vaxadmin/va/ce.asp](https://www2.cdc.gov/vaccines/ed/vaxadmin/va/ce.asp)
- [https://www.foodallergy.org/recognizing-responding-anaphylaxis](https://www.foodallergy.org/recognizing-responding-anaphylaxis)

**Procedure**

1. Assess adults and adolescents in need of vaccination against the SARS-CoV-2 virus based on the following criteria:

   a. Must be 16 years and older for the Pfizer-BioNTech COVID-19 Vaccine (Pfizer) or 18 years of age and older for Moderna COVID-19 Vaccine (Moderna). Children and adolescents younger than age 16 are NOT authorized to receive Pfizer and children and adolescents younger than age 18 are NOT authorized to receive Moderna at this time.

   b. If the recipient has received a previous dose of Pfizer or Moderna, the second dose of the same brand should be administered.

   c. The vaccines are administered in a 2-dose series separated by at least 21 days for Pfizer and 28 days for Moderna. Individuals should be scheduled as close to the recommended interval as possible. For
Pfizer, if the second dose was given as early as 17 days after the first dose, the dose is considered valid. For Moderna if the second dose was given as early as 24 days, the dose is considered valid. The second dose of the vaccines may be administered up to 6 weeks (42 days) after the first dose. There is currently limited data on the efficacy if administered beyond that interval. If the second dose for either vaccine is administered beyond these intervals there is no need to restart the series. Also, doses inadvertently administered earlier than the grace period should not be repeated.

d. The Pfizer and Moderna should not be administered with any other vaccines. Best practice is to separate the Pfizer and Moderna from other vaccines by 14 days before or after administration of either vaccine.

2. Screen all adults and adolescents for contraindication and precautions for the mRNA COVID-19 (Pfizer or Moderna) vaccines.

a. Contraindications.

i. Under 16 years of age for Pfizer and under 18 years of age for Moderna.

ii. Do not give the mRNA COVID-19 vaccines to an individual who has experienced a serious reaction* (e.g., anaphylaxis) to a prior dose of mRNA COVID-19 vaccine or to any of the mRNA COVID-19 vaccine components. For more information on Pfizer vaccine components, refer to the Fact Sheet for Healthcare Providers at [https://www.fda.gov/media/144413/download](https://www.fda.gov/media/144413/download). For more information on the Moderna vaccine components, refer to the Fact Sheet for Healthcare Providers at [https://www.modernatx.com/covid19vaccine-eua/eua-fact-sheet-providers.pdf](https://www.modernatx.com/covid19vaccine-eua/eua-fact-sheet-providers.pdf)

iii. Do not give the mRNA COVID-19 vaccines to an individual who has had an immediate allergic reaction of any severity to a previous dose of any mRNA COVID-19 vaccine or any of its components (including polyethylene glycol [PEG])*.
iv. Do not give the mRNA COVID-19 vaccine to an individual who has had an immediate allergic reaction of any severity to polysorbate (due to potential cross-reactivity hypersensitivity with the vaccine ingredient PEG**).

*An immediate allergic reaction to a vaccine or medication is defined as any hypersensitivity-related signs or symptoms consistent with urticarial, angioedema, respiratory distress (e.g., wheezing, stridor), or anaphylaxis that occur within four hours following exposure to a previous dose of an mRNA COVID-19 vaccine or any of its components. For more information regarding contraindications and precautions when administering the mRNA COVID-19 vaccines, see Interim Clinical Considerations for Use of mRNA COVID-19 Vaccines Currently Authorized in the United States at https://www.cdc.gov/vaccines/covid-19/info-by-product/clinicalconsiderations.html#Contraindications.

** These individuals should not receive mRNA COVID-19 vaccines at this time unless they have been evaluated by an allergist-immunologist and it is determined that the person can safely receive the vaccine (e.g., under observation, in a setting with advanced medical care available).

b. Precautions

i. Moderate or severe acute illness with or without a fever.

ii. Severe allergic reaction** (e.g., anaphylaxis) to a previous dose of any vaccine (not including Pfizer-or Moderna as this would be a contraindication).

1. Action:

   a. Assess the risk of vaccination

   b. Observe patient for 30 minutes following vaccination.

iii. Severe allergic reaction** (e.g. Anaphylaxis) to a medication that is injectable.

1. Action:
a. Assess the risk of vaccination.

b. Observe patient for 30 minutes following vaccination.

iv. Delay vaccination in individuals in community or outpatient settings who have a known SARS-CoV-2 exposure until quarantine period has ended, unless individual resides in congregate healthcare setting or resident of other congregate settings (e.g., correctional facilities, homeless shelter)

v. Defer vaccination for both symptomatic and asymptomatic COVID-19 patients until they have met criteria to discontinue isolation

vi. Delay vaccination if the individual has had passive antibody therapy for COVID-19 until 90 days have passed from completion of said therapy

** Providers may consider deferring vaccination with the mRNA COVID-19 vaccines at this time until the individual has been evaluated by an allergist-immunologist and it is determined that the person can safely receive the vaccine (e.g., under observation, in a setting with advanced medical care available). Considerations that can be used to help the provider conduct a risk assessment for mRNA COVID-19 vaccinations include the risk of exposure to SARS-CoV-2 or risk of severe disease or death due to COVID-19. For further guidance, visit [https://www.cdc.gov/vaccines/covid-19/info-by-product/clinical-considerations.html#Contraindications](https://www.cdc.gov/vaccines/covid-19/info-by-product/clinical-considerations.html#Contraindications).

3. Special Populations for which special counseling is recommended.

   a. Pregnant females are recommended for vaccine depending on the following:

      i. Level of COVID-19 community transmission (risk of acquisition).

      ii. Personal risk of contracting COVID-19 to the person and potential risks to the fetus.
iii. The efficacy of the vaccine.

iv. The known side effects of the vaccine.

v. The lack of data about the vaccine during pregnancy.

b. Lactating (Breastfeeding) is not a contraindication to vaccination; however, there are no data on the safety of mRNA COVID-19 vaccines in lactating people or the effects of mRNA COVID-19 vaccines on the breastfed infant or milk production/excretion.

c. Immunocompromised persons

i. Immunocompromised persons are those with HIV infection, other immunocompromising conditions, or who take immunosuppressive medications or therapies.

ii. Data are not currently available to establish safety and efficacy of vaccine in these groups

iii. These individuals may still receive COVID-19 vaccine unless otherwise contraindicated

iv. Individuals should be counseled about:

1. Unknown vaccine safety and efficacy profiles in immunocompromised persons.

2. Potential for reduced immune responses and the need to continue to follow all current guidance to protect themselves against COVID-19.

4. Routine testing for pregnancy or COVID-19 antibody testing is not recommended prior to vaccination

5. Prior to vaccination, provide the person/legal representative the following:


i. Provide all -persons(or in the case of minors or incapacitated adults their legal representative) with a copy of the Emergency Authorization Fact Sheet. Provide non-English language if one
is available and desired; at The Pfizer EUA Fact Sheet for Healthcare Providers can be found at https://www.fda.gov/media/144413/download and for recipients and caregivers at https://www.fda.gov/media/144414/download. The Moderna EUA Fact Sheet for Healthcare Providers can be found at https://www.modernatx.com/covid19vaccine-eua/eua-fact-sheet-providers.pdf and for recipients and caregivers at https://www.fda.gov/media/144638/download.

b. Vaccine Information Statement (VIS).

i. Provide all persons (or in the case of minors or incapacitated adults their legal representative) with a copy of the most current federal Vaccine Information Statement (VIS). Provide non-English speaking patients with a copy of the VIS in their native language if one is available and desired; these can be found at www.immunize.org.

6. Prepare for Vaccination

a. Choose the correct needle length and gauge for an intramuscular injection

b. For persons 16 through 18 years of age: 1-inch needle is recommended

c. 19 years of age or older (see table):

<table>
<thead>
<tr>
<th>Gender and Weight of patient</th>
<th>Needle Gauge</th>
<th>Needle Length</th>
<th>Injection Site</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female or Male less than 130 pounds</td>
<td>22-25</td>
<td>5/8” – 1”</td>
<td>Intramuscular Deltoid</td>
</tr>
<tr>
<td>Female or Male 130-152 pounds</td>
<td>22-25</td>
<td>1”</td>
<td>Intramuscular Deltoid</td>
</tr>
<tr>
<td>Female 153-200 pounds</td>
<td>22-25</td>
<td>1”-1 ½”</td>
<td>Intramuscular Deltoid</td>
</tr>
<tr>
<td>Male 153-260 pounds</td>
<td>22-25</td>
<td>1”-1 ½”</td>
<td>Intramuscular Deltoid</td>
</tr>
</tbody>
</table>
d. Prepare the PfizerBioNTech COVID-19 vaccine

i. The vaccine must be thawed and mixed with diluent before administration. The vaccine can be thawed in the refrigerator for two to three hours between 36°F and 46°F or at room temperature for thirty minutes to two hours up to 77°F. Vials at room temperature must be mixed within 2 hours or returned to the refrigerator. Do not refreeze thawed vaccine.

ii. Perform hand hygiene before vaccine preparation. Remove vaccine from refrigerator and allow to come to room temperature. With the vaccine at room temperature, GENTLY invert vial 10 times.

iii. Using a sterile alcohol prep pad for each vial, wipe off the stoppers of the diluent and vaccine vials. Using a 21-gauge (or narrower) needle, withdraw 1.8 mL of 0.9% sodium chloride (normal saline, preservative-free) into a mixing syringe. Inject 1.8 mL 0.9% sodium chloride into the vaccine vial. Using the mixing syringe, remove 1.8 mL of air from the vaccine vial to equalize the pressure in the vial.

iv. GENTLY invert the vaccine and diluent vial 10 times. The vaccine will be off-white in color. Do not use if discolored or contains particulate matter.

v. Note the date and time the vaccine was mixed on the vial.

vi. Keep the mixed vaccine at room temperature (36°F to 77°F) and administer within 6 hours. Discard any unused vaccine after 6 hours.

vii. Due to production, a sixth dose may be available in the vaccine vial; however, any remaining vaccine that does not equal a full 0.3 mL dose should not be pooled with other remaining vaccine to obtain a full 0.3 mL dose.
e. Prepare the Moderna COVID-19 vaccine:

i. The vaccine must be thawed before administration. Do not mix the vaccine with a diluent. The vaccine can be thawed in the refrigerator for two hours and thirty minutes between 36°F and 46°F or at room temperature for one hour between 59°F and 77°F. Vials that have not been punctured may be kept between 46°F and 77°F for up to 12 hours. Do not refreeze thawed vaccine.

ii. Perform hand hygiene before vaccine preparation. With the vial upright, GENTLY swirl the vaccine.

iii. Examine the vaccine. It should be white to off white in color and may contain white particles. Do not use if liquid contains other particulate matter or is discolored.

iv. Using a sterile alcohol prep pad, wipe off the stopper of the vaccine vial before withdrawing a dose. Gently swirl the vaccine before withdrawing subsequent doses.

v. Note the date and time the vial was first punctured. Keep the vaccine between 36°F and 77°F for up to six hours. Discard any unused vaccine after six hours.

7. Administer the mRNA Vaccine (Pfizer or Moderna)

<table>
<thead>
<tr>
<th>Type of Vaccine</th>
<th>Age group</th>
<th>Dose</th>
<th>Route</th>
<th>Instruction</th>
<th>Dose Schedule</th>
</tr>
</thead>
<tbody>
<tr>
<td>Moderna</td>
<td>Adults 18 years of age and older</td>
<td>0.5mL</td>
<td>Intramuscular</td>
<td>Administer vaccine in deltoid muscle</td>
<td>Give dose # 2 at least 21 days from dose # 1 for Pfizer and dose #2 at least 28 days from dose #1 for Moderna.</td>
</tr>
<tr>
<td>Pfizer</td>
<td>Adolescents 16 years of age and older</td>
<td>0.3mL</td>
<td>Intramuscular</td>
<td>Administer vaccine in deltoid muscle</td>
<td></td>
</tr>
</tbody>
</table>

a. Patients who do not receive the 2nd vaccination dose at 21 days or 28 days should still receive the 2nd dose as soon as possible thereafter.

b. The second dose should be administered as close to the recommended interval as possible.
c. However, if it is not feasible to adhere to the recommended interval, the second dose of Pfizer and Moderna may be scheduled for administration 4 days before the 21 or 28 day intervals depending on product being administered and up to 6 weeks (42 days) after the first dose.

d. There are currently limited data on efficacy of mRNA COVID-19 vaccines administered beyond this window.

e. If the second dose is administered beyond these intervals, there is no need to restart the series.


a. Medical Record: Record the date and the vaccine that was administered, the manufacturer and lot number, the vaccination site and route, the vaccine dosage, and the name and title of the person administering the vaccine. Document the VIS given, and VIS publication date.

b. Immunization Record Card: Record the date of vaccination, product name/manufacturer, lot number and the name/location of the administering clinic or healthcare professional.

c. Documentation of the vaccination in Ohio's immunization information system - ImpactSIIS within 24 hours following vaccination.

9. Observe the Vaccine Recipient.

a. 30 minutes: Persons with a history of an immediate allergic reaction of any severity to a vaccine or injectable therapy and persons with a history of anaphylaxis due to any cause.

b. 15 minutes: All other persons.

10. Emergency Protocols

a. If a patient experiences itching and swelling confined to the injection site where the vaccination was given, apply a cold compress to the injection site. Observe patient closely for the development of generalized symptoms until symptoms subside.
b. If symptoms are generalized (generalized itching, redness, urticaria (hives); or include angioedema (swelling of the lips, face, or throat); shortness of breath; shock; or abdominal cramping; call 911 and notify the supervising healthcare professional. Notifications should be done by a second person while the primary healthcare professional assesses the airway, breathing, circulation and level of consciousness of the patient. Vital signs (heart rate, respirations and blood pressure, pulse ox) should be taken every 5 minutes.

i. First-line treatment of an anaphylactic reaction is to administer Epinephrine (1 mg/ml aqueous solution [1:1000 dilution]) intramuscularly.

ii. The adult dose is 0.3mg to 0.5mg with maximum dose of 0.5mg; or as auto-injector (0.3 mg)

iii. For hives or itching, you may also administer diphenhydramine (orally or intramuscular with a standard dose of 25-50mg.) or hydroxyzine (standard oral dose is 25mg -100mg or 0.5-1.0 mg/kg.

iv. Monitor the person closely until EMS arrives. Monitor blood pressure and pulse every 5 minutes.

v. If EMS has not arrived and symptoms are still present, repeat dose of epinephrine every 5-15 minutes for up to 3 doses depending on the person’s response.

vi. Record the person’s reaction to the vaccine (e.g., hives, anaphylaxis), all vital signs, and medications administered to theperson, including time dosage, response, and the name of the medical personnel who administered the medication and other relevant clinical information.

vii. Adverse events must be reported to the Vaccine Adverse Event Reporting System (VAERS) at https://vaers.hhs.gov/reportevent.html or call 1-800-822-7967.

viii. Report the adverse event to the person’s primary care provider.
Pursuant to R.C. 3701.352, this order is to prevent a threat to the public’s health; no person shall fail to follow this order.

Stephanie McCloud
Director of Health

2.12.2021
Date
MEMORANDUM

TO: Mark Bechtel, M.D., President
    Members, State Medical Board of Ohio

FROM: Kimberly C. Anderson, Chief Legal Counsel

RE: Updates to Evaluation and Treatment Rules

DATE: March 3, 2021

At the February meeting of the Compliance Committee, it was determined that the rules regarding the evaluation and treatment requirements for dietitians, respiratory care professionals, radiologist assistants and genetic counselors should be updated to allow for outpatient evaluation and treatment. Currently massage therapists and cosmetic therapists are eligible to have outpatient evaluations and treatment.

Attached you will find rules 4731-16-02, 4731-16-05, and 4731-16-08 with the proposed amendments. In addition, I have updated the statutory references and removed reference to cosmetic therapists who will not be licensed by the Medical Board after the effective date of HB442, April 12, 2021.

Action Requested: Approve rules for initial circulation
4731-16-02 General procedures in impairment cases.

(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 (A)(18) of section 4759.07 of the Revised Code, division (B)(6) of section 4760.13 of the Revised Code, division (A)(18) of section 4761.09 of the Revised Code, or 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 4778.14 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 (A)(18) of section 4759.07 of the Revised Code, division (B)(6) of section 4760.13 of the Revised Code, division (A)(18) of section 4761.09 of the Revised Code, or division (B)(6) of section 4762.13 of the Revised Code, division (B)(6) of section 474.13 of the Revised Code or division (B)(6) 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 (A)(18) of section 4759.07 of the Revised Code, division (B)(6) of section 4760.13 of the Revised Code, division (A)(18) of section 4761.09 of the Revised Code, or division (B)(6) of section 4762.13 of the Revised Code, division (B)(6) of section 474.13 of the Revised Code or division (B)(6) 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 (H) of section 4759.07 of the Revised Code, division (G) of section 4760.13 of the Revised Code, division (G) of section 4761.09 of the Revised Code, or division (G) of section 4762.13 of the Revised Code, division (G) of section 4774.13 of the Revised Code, or division (H) of section 4778.14 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, dietitian, respiratory care professional, radiologist assistant or genetic counselor 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, dietitian, respiratory care professional, radiologist assistant or genetic counselor 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, dietitian, respiratory care professional, radiologist assistant or genetic counselor 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, dietetics, respiratory care, as a radiologist assistant or as a genetic counselor 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
(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 4759., Chapter 4760., Chapter 4761., or Chapter 4762., Chapter 4774., or Chapter 4778. 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 (A)(18) of section 4759.07 of the Revised Code, division (B)(6) of section 4760.13 of the Revised Code, division (A)(18) of section 4761.09 of the Revised Code, or 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., 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.

Replaces: 4731-16-02
4731-16-05 Examinations.

(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 (G) of section 4759.07 of the Revised Code, division (F)(2) of section 4760.13 of the Revised Code, division (F) of section 4761.09 of the Revised Code, or division (F)(2) of section 4762.13 of the Revised Code, division (F)(2) of section 4774.13 of the Revised Code, or division (G)(2) of section 4778.14 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 4759., Chapter 4760., Chapter 4761., Chapter 4762., Chapter 4774., or Chapter 4778. 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, dietitian, respiratory care professional, radiologist assistant, or genetic counselor 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;" and
      (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, dietitian, respiratory care professional, radiologist assistant, or genetic counselor 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 (G) of section 4759.07 of the Revised Code, division
(F)(2) of section 4760.13 of the Revised Code, division (F) of section 4761.09 of the Revised Code,
or division (F)(2) of section 4762.13 of the Revised Code, division (F)(2) of section 4774.13 of the
Revised Code, or division (G)(2) of section 4778.14 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 (G) of section 4759.07 of the Revised Code, division (F)(2) of section 4760.13 of the
Revised Code, division (F)(2) of section 4761.09 of the Revised Code, or division (F)(2) of
section 4762.13 of the Revised Code, division (F)(2) of section 4774.13 of the Revised Code, or
division (G)(2) of section 4778.14 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 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.
4731-16-08 Criteria for approval.

(A) Criteria for approval of treatment providers shall include all of the following:

(1) The philosophy and individualized treatment plan of the program is based on the disease concept.

(2) The chemical dependency model of treatment is based on a twelve-step program such as alcoholics anonymous.

(3) The program provides specialized medical and nursing care during detoxification and appropriate health care professionals during treatment phase.

(4) The evaluation process is an objective, measurable program which uses tools and testing procedures to identify patterns, progression, and stages of recovery at appropriate times in the treatment program. The evaluation shall also emphasize patient self-assessment.

(5) The treatment provider has a network of referral agencies or professionals which meets the needs of the practitioner and significant others in the event that the needs go beyond the program's expertise or available facilities.

(6) The treatment provider has a variety of treatment plan options including inpatient detoxification treatment, inpatient or residential treatment, and outpatient services.

(7) The involvement and treatment of family and significant others is provided.

(8) The provider gives each patient who has been diagnosed as in need of treatment a written list of approved treatment providers from whom indicated inpatient or residential treatment, outpatient treatment, or aftercare can be obtained.

(9) The provider holds certification as an alcoholism program or drug treatment program by the Ohio department of alcohol and drug addiction services, or if located outside Ohio, holds appropriate certification or registration with an agency exercising a similar function in the state in which it is located.

(10) The provider provides advocacy services only at no cost to the patient, or provides such services only after obtaining the signature of the patient acknowledging that he or she has been notified:

(a) That advocacy is not treatment;

(b) That nothing in Chapter 4730., 4731., 4759., 4760., 4761., or 4774. or 4778. of the Revised Code or this chapter of the Administrative Code requires a practitioner to obtain aftercare, monitoring or advocacy from the provider of inpatient or extended residential treatment or intensive outpatient treatment, as applicable; and

(c) That the practitioner's refusal to obtain aftercare, monitoring, or advocacy services from the provider of inpatient treatment or intensive outpatient treatment, as applicable, shall not constitute grounds to report to the board so long as the practitioner demonstrates that the practitioner has contracted with another approved treatment provider to receive any further recommended treatment.
(11) The provider has the capability of making an initial examination to determine what type of treatment an impaired practitioner requires.

(12) The provider requires that each patient who is subject to the jurisdiction of the board, who is determined to be impaired, except as provided in paragraph (A)(13) of this rule, complete a minimum of twenty-eight days of inpatient or residential treatment, or a combination thereof, during which the patient shall be prohibited by the terms of the treatment contract from conducting any practice or practice related activities, and after which the provider shall evaluate the patient and determine the necessity for further treatment based solely on clinical grounds. The exceptions in paragraph (C) of this rule notwithstanding, the provider must personally provide the required inpatient or residential treatment and the assessment or must confirm that another approved treatment provider has provided the inpatient or residential treatment and the assessment before providing any outpatient treatment or aftercare. The inpatient or residential treatment program must have a continuing inpatient or residential patient census sufficient to provide an appropriate treatment milieu for patients receiving treatment in the inpatient or residential setting. This paragraph shall not apply to a patient who has previously completed an inpatient or residential treatment program of at least twenty-eight days if the patient was able to maintain sobriety for at least one year following completion of that inpatient or residential treatment.

(13) The provider requires that a massage therapist, dietitian, respiratory care professional, radiologist assistant, or genetic counselor cosmetic therapist who is determined to be impaired and who does not meet the criteria set forth in paragraph (A)(14) of this rule, complete a minimum of twenty treatment sessions over no less than five consecutive weeks of intensive outpatient treatment, after which the provider shall evaluate the patient and determine the necessity for further treatment based solely on clinical grounds. The intensive outpatient treatment must include:

(a) Witnessed toxicology screens with legal chain of custody and forensic capability performed weekly at therapy sessions;

(b) At least three twelve-step meetings weekly;

(c) All treatment sessions lasting a minimum of three hours, not including time spent watching videos or participating in twelve-step meetings;

(d) Family education lasting at least two hours weekly.

(14) The provider requires that a massage therapist, dietitian, respiratory care professional, radiologist assistant, or genetic counselor cosmetic therapist who was investigated by the board for possible impairment as part of a previous application or while holding any certificate by the board other than a certificate to practice as a massage therapist, dietitian, respiratory care professional, radiologist assistant or genetic counselor cosmetic therapist, complete the inpatient or residential treatment required in paragraph (A)(12) of this rule.

(15) If the provider did not hold approval under this chapter prior to January 1, 2001, the provider is accredited by the joint commission on accreditation of health care organizations or by CARF (commission on accreditation of rehabilitation facilities.)

(B) A treatment provider which does not meet the criteria of paragraph (A)(1) or (A)(2) of this rule may nonetheless be considered for approval if it establishes by evidence acceptable to the board that its philosophy, individualized treatment plan, or model of treatment is based on current scientific advances in the field of chemical dependency, and that its success in treatment is comparable or superior to that obtained by treatment providers which meet all the criteria of paragraph (A) of this rule.
(C) A treatment provider that does not meet the criteria of paragraph (A)(3) or (A)(6) of this rule because it does not offer all phases of treatment may nonetheless be considered for approval if it meets both of the following requirements.

(1) If it does not offer detoxification treatment, its policies and procedures are structured to assure that all patients who enter treatment have completed detoxification where detoxification is medically indicated.

(2) If it does not offer one or more required treatment phases (e.g. - inpatient treatment, intensive outpatient treatment, or extended residential treatment), it has affiliation agreements or working relationships with other treatment providers to which patients can be referred for any necessary treatment it does not offer.
Legislative Update: March 10, 2021

**Bills of high interest or with significant activity since the last board meeting:**

**SB 6 – Join Interstate Medical Licensure Compact (Sen. Roegner and Sen. Steve Huffman)**

*To enter into the Interstate Medical Licensure Compact*

**Areas of Interest:**

- Requires entrance into the Interstate Medical Licensure Compact (IMLC).
- Model compact language must be adopted as written and cannot be amended though amendments that do not require changes to the actual membership contract may be considered by the IMLC.
- Several stakeholders have offered testimony in support of this legislation including OSMA and OHA.
- The policy, legal and licensing team continue to research this issue. Several other states with introduced legislation and passed legislation were contacted when this language was introduced in the last General Assembly.
- Director Loucka and Chelsea Wonski attended an interested party meeting hosted by the bill sponsors and additional meetings with the sponsors are planned.

**Board Position:** Interested Party

**Status:** 1/27/2021 Introduced in the Senate. Second hearing in Senate Health, Human Services and Medicaid 2/3/2020

**HB 110 – State Operating Budget (Rep. Oelslager)**

*Creates appropriations for FY 2022-2023*

**Areas of Interest:**

- The Medical Board budget request was granted in the first version of the bill.
- Directed Loucka provided testimony before the House Finance Subcommittee on Health and Human Services on behalf of the Board regarding the relevant budget items on 2/18/2021.

**Board Position:** Support

**Status:** Introduced 2/16/2021 – Ongoing hearings
HB 122 – Telehealth (Rep. Fraizer)

To establish and modify requirements regarding the provision of telehealth services.

Areas of Interest:

- Permits specified health care professionals to provide telehealth services.
- Requires telehealth services provided by health care professionals to be done so according to specified conditions and standards.
- Permits certain health care licensing boards to adopt rules as necessary to carry out the bill’s provisions regarding telehealth services provided by health care professionals.

Board Position: Interested party

Status: Introduced in the House 2/16/2021 Second House committee hearing was held 3/3/2021

Bills that continue to be monitored but have not seen significant activity since the last board meeting:

SB 4 – Public Records (Sen. Roegner)

To exempt personal info of certain persons from public records law.

Areas of Interest:

- Includes emergency service telecommunicators and certain Ohio National Guard members as individuals whose residential and familial information is exempt from disclosure under the Public Records Law.

Board Position: Neutral

Status: Passed out of the Senate 2/17/2021 Introduced in the House: 2/24/2021

SB 9 – Regulations (Sen. McColley and Sen. Roegner)

To reduce regulatory restrictions in administrative rules

Areas of Interest:

- Requires certain agencies to reduce the number of regulatory restrictions in their administrative rules.
- This applies to administrative agencies only and does not currently impact the Medical Board.

Board Position: Neutral

Status: Reported out of Senate Committee 3/2/2021
SB 48 – Cultural Competency (Sen. Maharath and Sen. Antonio)

To require certain health care professionals to complete instruction in cultural competency.

Areas of Interest:

- Requires certain health care professionals to complete instruction in cultural competency and provide proof of completion at initial application for licensure and at renewal.
- Includes: dentists, nurses, pharmacists, physicians, psychologists, and social workers.

Board Position: Neutral

Status: Introduced in the Senate: 2/3/2021

SB 55 – Massage Therapy (Sen. Brenner) (companion bill HB 81)

To make changes to the laws governing massage establishments and massage therapy.

Areas of Interest:

- Requires any individual practicing massage within the state to obtain the current massage therapy license issued by the State Medical Board.

Board Position: Neutral

Status: Introduced in the Senate: 2/10/2021 Second Hearing in Senate Health 3/3/2021

HB 6 – Modify laws governing certain professions due to COVID-19 (Rep. Roemer)

To modify the laws governing certain health professionals and educator preparation programs due to COVID-19.

Areas of Interest:

- Allows pharmacists to administer immunization for influenza, COVID-19 and any other disease but only pursuant to prescription for persons seven or older.
- Allows pharmacists to administer immunizations for an disease for those 13 and older.
- Allows podiatrists to administer vaccinations for individuals seven and older for influenza and COVID-1.

Board Position: Neutral

Status: Passed out of the House 3/3/2021

To authorize the use of medical marijuana for autism spectrum disorder.

Areas of Interest:
- Allows autism spectrum disorder to be included in qualifying conditions.

Board Position: Opposed

Status: Introduced in the House 2/3/2021 First hearing in the House 2/9/2021

HB 64 – Regards fraudulent assisted reproduction (Rep. Powell)

To create the crime of fraudulent assisted reproduction and civil actions for an assisted reproduction procedure without consent.

Areas of Interest:
- Prohibits a health care professional from purposely or knowingly using human reproductive material from a donor while performing an assisted reproduction procedure if the person receiving the procedure has not expressly consented to the use of that donor's material.
- Creates the crime of fraudulent assisted reproduction, making it a third degree felony and allows for civil action against a fertility doctor within ten years of the offense.

Board Position: Neutral

Status: Introduced in the House 2/4/2021 First hearing in the House 2/25/2021


To make changes to the laws governing massage establishments and massage therapy.

Areas of Interest:
- Requires any individual practicing massage within the state to obtain the current massage therapy license issued by the State Medical Board.

Board Position: Neutral

Status: Introduced in the House 2/9/2021 First hearing in the House 2/17/2021
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<th>Name</th>
<th>Current Bill Status</th>
<th>Committee Assignment</th>
<th>Board Position</th>
<th>Bill Sponsor(s)</th>
<th>Date Introduced</th>
<th>Areas of Interest</th>
<th>Action Taken</th>
<th>Action Needed</th>
</tr>
</thead>
<tbody>
<tr>
<td>SB 4</td>
<td>Public Records</td>
<td>Passed out of the Senate</td>
<td>House Civil Justice</td>
<td>Neutral</td>
<td>Senator Kristina Roegner (R-27 Hudson)</td>
<td>1/19/2021</td>
<td>Includes emergency service telecommunicators and certain Ohio National Guard members as individuals whose residential and familial information is exempt from disclosure under the Public Records Law</td>
<td>Monitoring</td>
<td>None</td>
</tr>
</tbody>
</table>
| SB 6            | Enter into Interstate Medical Licensure Compact | Introduced 1/19/2021  
First Senate Hearing 1/27/2021  
Second Senate Hearing 2/3/2021 | Senate Health 1/26/2021  
Interested Party          | Neutral          | Senator Kristina Roegner (R-27 Hudson)  
and Senator Steve Huffman (R-5 Tipp City) | 1/19/2021 | Would make Ohio a member of the Interstate Medical Licensure Compact | Monitoring | Chelsea and Stephanie attended an interested party meeting hosted by the bills sponsors.  
- Interested party testimony was offered at the second committee hearing  
- Additional meetings with the bill sponsors are planned | Additional meetings with the bills sponsor and health committee chair are being scheduled. |
| SB 9            | Reduce regulatory restrictions in administrative rules | Reported out of the Senate Committee 3/2/2021  
Senate Government Oversight and Reform 1/26/2021 | Neutral - does not currently impact SMBO | Senator Rob McColley (R-1/21/2021  
1 Napoleon) and Senator Kristina Roegner (R-27 Hudson) | Requires certain agencies to reduce the number of regulatory restrictions in their administrative rules. | Monitoring | The policy team will continue to monitor this bill as it progresses through the legislative process. |
| SB 48           | Cultural Competency                        | Introduced 2/3/2021  
Senate Health 2/10/2021 | Neutral | Senator Tina Maharath (D-3 Canal Winchester)  
and Nickie Antonio (D-23 Lakewood) | 2/3/2021 | Require certain health care professionals to complete instruction in cultural competency. Includes:  
- Requires any individual practicing massage within the state to obtain the current massage therapy license issued by the State Medical Board. | Monitoring | The policy team will continue to monitor this bill as it progresses through the legislative process. |
| SB 55           | Massage Therapy (companion HB 81)         | Second hearing in Senate Committee 3/3/2021  
Senate Health 2/10/21 | Neutral | Senator Andrew Brenner (R-19) | 2/10/2021 | Requires any individual practicing massage within the state to obtain the current massage therapy license issued by the State Medical Board. | Monitoring | The policy team will continue to monitor this bill as it progresses through the legislative process. |
**HB 6**
Modify laws governing certain professions due to COVID-19
Passed out of the House 3/3/2021
House State & Local Government - Referred 2/4/2021
Rep Bill Roemer (R-38) 2/3/2021
- allows pharmacists to administer immunization for influenza, COVID-19 and any other disease but only pursuant to prescription for persons seven or older
- allows pharmacists to administer immunizations for an disease for those 13 and older
- allows podiatrists to administer vaccinations for individuals seven and older for influenza and COVID-19
Monitoring
The policy team will continue to monitor this bill as it progresses through the legislative process.

**HB 60**
Authorize medical marijuana for autism spectrum disorder
First House committee hearing 2/9/2021
House Health - referred 2/4/2021
- Opposed - the Board has already weighed in on the issue - petition review process is progress
Rep Juanita Brent (D-12) and Rep Bill Seitz (R-30) 2/3/2021
Adds autism spectrum disorder to qualifying conditions
Monitoring
The policy team will continue to monitor this bill as it progresses through the legislative process.

**HB 64**
Regards fraudulent assisted reproduction
First House committee hearing 2/25/2021
House Criminal Justice 2/4/2021
Neutral
Rep. Jena Powell (R-80) 2/3/2021
Prohibits a health care professional from purposely or knowingly using human reproductive material from a donor while performing an assisted reproduction procedure if the person
Monitoring
The policy team will continue to monitor this bill as it progresses through the legislative process.

**HB 81**
Revise laws governing massage establishments / massage therapy (Companion SB 55)
Introduced 2/9/2021
First House hearing held 2/17/2021
House Commerce and Labor 2/10/2021
Neutral
Rep. Phil Plummer (R-40) and Rep. Susan Manchester (R-84) 2/9/2021
Requires any individual practicing massage within the state to obtain the current massage therapy license issued by the State Medical Board.
Monitoring
The policy team will continue to monitor this bill as it progresses through the legislative process.

**HB 110**
State Budget
Introduced 2/16/2021
House Finance 2/17/2021
Support
Rep. Scott Oelslager (R-48) 2/16/2021
Stephanie provided testimony before the House Finance Health and Human Services Subcommittee on 2/18/2021
Monitoring
The policy team will continue to monitor this bill as it progresses through the legislative process.
<table>
<thead>
<tr>
<th>Bill</th>
<th>Description</th>
<th>Committee</th>
<th>Interested Party</th>
<th>Date</th>
<th>Summary</th>
</tr>
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<tbody>
<tr>
<td>HB 122</td>
<td>Telehealth</td>
<td>House Insurance Committee</td>
<td>Rep. Mark Fraizer (R-71) and Rep. Adam Holmes (R-97)</td>
<td>2/16/2021</td>
<td>Permits specified health care professionals to provide telehealth services. Requires telehealth services provided by health care professionals to be done so according to specified conditions and standards. Permits certain health care licensing boards to adopt rules as necessary to carry out the bill’s provisions regarding telehealth services provided by health care professionals.</td>
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<td>Committee on Health, Education, Labor and Pensions</td>
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<td>Monitoring</td>
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<tr>
<td>S. 155 / H.R. 688</td>
<td>Equal Access to Care Act</td>
<td>Senate Bill - Sen. Ted Cruz (R-TX)</td>
<td>2/2/2021</td>
<td>Would allow health care providers licensed in one jurisdiction to provide telemedicine to patients in another in which they are unlicensed during the COVID-19 public health emergency and for 180 days after the pandemic has ended.</td>
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<td>Committee on Health, Education, Labor and Pensions</td>
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<tr>
<td>H.R. 341</td>
<td>Ensuring Telehealth Expansion Act</td>
<td>Senate Bill - Rep. Roger Williams (R-TX)</td>
<td>1/15/2021</td>
<td>Would extend telehealth provisions from the CARES Act through 2025, including eliminating originating site restrictions, implementing payment parity</td>
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<td>Committee on Energy and Commerce</td>
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<td>Monitoring</td>
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<tr>
<td>Bill Number</td>
<td>Title</td>
<td>Referred To</td>
<td>Committee</td>
<td>Sponsorship</td>
<td>Status</td>
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<tr>
<td>H.R. 366</td>
<td>Protecting Access to Post-COVID–19 Telehealth Act of 2021</td>
<td>House Committee on Energy and Commerce</td>
<td>Rep. Mike Thompson (D-CA) and Rep. David Schweikert (R-AZ)</td>
<td>Would eliminate most geographic and originating site restrictions in Medicare, establish the patient's home as an eligible telehealth site, continue CMS telehealth reimbursement for 90 days beyond the end of the public health emergency (PHE), make permanent disaster waiver authority, and require a study on the use of telehealth during COVID, including telehealth utilization rates across state lines.</td>
<td>Monitoring</td>
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<tr>
<td>H.R. 596 / S. 57</td>
<td>ACCESS Act</td>
<td>House Committee on Appropriations; House Committee on Energy and Commerce</td>
<td>House Resolution - Rep. Janice Schakowsky (D-IL) and Rep. Gus Bilirakis (R-FL); Senate Bill - Sen. Amy Klobuchar (D-MN) and Sen. Bob Casey (D-PA)</td>
<td>Would authorize $50 million for the HHS' Telehealth Resource Center to assist nursing facilities to expand the use of telehealth and establish a grant program to support virtual visits in nursing homes during the pandemic.</td>
<td>Monitoring</td>
</tr>
</tbody>
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**Key**
- Monitoring
- Requires immediate action
- Enacted
- No Longer Active
House Bill 442 Implementation
Frequently Asked Questions

House Bill 442 was passed by the Ohio General Assembly on December 22, 2020. Effective as of April 12, 2021, this new legislation makes several changes that will impact licensees of the Medical Board.

The bill removes the authority of the State Medical Board to regulate cosmetic therapists and oriental medicine professionals as of the effective date of the bill; and

Decreases the required curriculum hours to obtain a massage therapy diploma or certificate and to apply for massage therapy licensure; and

Gives the Medical Board the authority to recognize any accrediting organization for physician assistant education programs; and increases the number of volunteer hours for continuing education hours for MD, DO and DPM professionals.

Below are some frequently asked questions that you may find helpful about the changes made in this legislation:

**Cosmetic Therapists**

The Medical Board is working to amend its Ohio Administrative Code rules to align with the legislative change to the unlicensed practice of cosmetic therapy while still preserving the ability of cosmetic therapists to perform laser hair removal under the delegation and supervision of a physician and with rigorous education, training, and supervision requirements to protect public safety.

The rules must go through the state administrative rulemaking process which may be lengthy. There will be opportunities for public comment, including when the rules are on the agenda of the state’s legislative Joint Committee on Agency Rule Review. The Medical Board is exploring temporary measures to prevent the interruption of cosmetic therapists’ ability to perform laser hair removal while the permanent rule is making its way through the rulemaking process and/or a legislative fix is made.

**Q:** Now that cosmetic therapists are no longer licensed by the Medical Board can I still practice?

**A:** The legislation in House Bill 442 does not allow for independent practice of cosmetic therapy. Individuals may practice cosmetic therapy in a salon if authorized by and according to rules made by the Ohio State Cosmetology and Barber Board. The definition of cosmetic therapy in the legislation does not include laser hair removal.

**Q:** Will I now be licensed by the Ohio Cosmetology and Barber Board?

**A:** No, as of April 12, 2021, cosmetic therapists will not be licensed by any board in Ohio.
Q: What happens to my license in the state’s eLicense system on April 12, 2021?
A: Beginning April 12, 2021, cosmetic therapists will no longer have the ability to apply for a license, but eLicense will retain the history of the cosmetic therapy licenses.

Q: My cosmetic therapist license does not expire until after April 12, 2021. Can I continue to practice using my license until it expires?
A: No, you may only practice under the license until April 12, 2021.

Q: If my license does not expire until after April 12, 2021 do I get a prorated refund?
A: No, the legislature did not include a refund or wind-down period for cosmetic therapist licensure in the new law.

Q: What happens if I am in school studying to become a cosmetic therapist?
A: You may continue your studies, but the new law means that you will be practicing in an unlicensed occupation in Ohio at the end of your education.

Q: Will the schools who teach cosmetic therapy still be accredited?
A: The Medical Board does not determine a school’s accreditation. However, the Medical Board will no longer be involved in determining the standing of cosmetic therapy schools because the new law does not allow Medical Board regulation of the practice of cosmetic therapy. For further information, please contact the schools or the accrediting organizations.

Q: Can I still perform laser hair removal?
A: Cosmetic therapists can still perform laser hair removal under the delegation and supervision of a physician according to the requirements of current Ohio Administrative Code rule 4731-18-03 until April 12, 2021. On and after April 12, 2021, the ability of cosmetic therapists to perform laser hair removal depends on further legislative or rulemaking action. The Medical Board is exploring temporary measures to prevent the interruption of cosmetic therapists’ ability to perform laser hair removal while the permanent rule is making its way through the rulemaking process and/or a legislative fix is made.

Q: Will the Medical Board still have any authority over laser hair removal performed by cosmetic therapists?
A: The Medical Board has the authority to regulate to whom and with what requirements a physician can delegate laser hair removal.

Q: Can the Medical Board still take enforcement actions on those who practice laser hair removal improperly?
A: The application of light-based medical devices for hair removal (i.e., laser hair removal) is the practice of medicine and surgery. If a cosmetic therapist does not comply with the requirements in Ohio Administrative Code rule 4731-18-03 that enable physician delegation of this portion of the practice of medicine, that cosmetic therapist could be found to be committing the offense of the unlicensed practice of medicine.
**Oriental Medicine**

**Q:** What happens to my license as of April 12, 2021?

**A:** All individuals who are currently licensed as an oriental medicine practitioner will have their license converted to an acupuncture license.

**Q:** Will I still be able to continue to practice oriental medicine if my license gets converted to an acupuncture license?

**A:** An oriental medicine practitioner whose license gets converted to acupuncture will be practicing under the acupuncture license. Therefore, that practitioner’s scope of practice is the scope of practice of acupuncture defined in R.C. 4762.01 and the practitioner’s license is regulated by the rules and laws regulating the practice of acupuncture.

**Q:** Can I still practice herbal therapy?

**A:** As of April 12, 2021, the new law has made the practice of herbal therapy an unlicensed and unregulated activity due to the removal of the oriental medicine license and regulation in House Bill 442. The Medical Board does not have any regulatory or enforcement authority over the practice of herbal therapy unless the method in which it is practiced constitutes the unlicensed practice of medicine or the unlicensed practice of any other health care profession that the Medical Board licenses and regulates.

**Q:** If my oriental medicine license is converted to an acupuncture license, will my renewal date change?

**A:** No, you will retain your current license renewal date and license number.

**Massage Therapy**

**Q:** Why are the number of required education hours for a massage therapy school diploma or certificate decreasing?

**A:** The Ohio General Assembly passed House Bill 442 which amended R.C. 4731.19 to set the number of hours required for a massage therapy diploma or certificate to meet the education requirement for massage therapy licensure. The amended statute sets the minimum hours in the following subject areas:

- 275 hours in anatomy and physiology and pathology; and
- 275 hours in massage theory and practical, including hygiene; and
- 25 hours in ethics; and
- 25 hours in business and law.

**Q:** What effect does the Medical Board's current or future Ohio Administrative Code rules have on the decrease in the number of hours required for a diploma or certificate from a massage therapy school?

**A:** While the board has had an administrative rule that sets the minimum number of hours, the newly passed law supersedes this rule and now sets the legal requirement at 600 hours with specific subject area requirements as outlined above. The board will go through the administrative rulemaking process to align its rule with the new law.
Q: How will the change in required curriculum hours impact my schooling?
A: The law change sets the minimum hours in specified subject matters that the board requires to consider a diploma or certificate from a massage therapy school to satisfy the education requirement for licensure. It is up to each school, college, or institution to determine what, if any, effect this minimum requirement will have on their current curriculum. A massage therapy school, college, or institution must stay in good standing with the Medical Board for a graduate’s diploma or certificate to be considered to meet the education requirement for licensure. For additional information, please contact your school.

Physician Assistant

Q: What change was made in HB 442?
A: The Medical Board has been given the authority to recognize any accrediting organization for physician assistant education programs rather than the current requirement that the education program be accredited by the Accreditation Review Commission on Education for the Physician Assistant.

Physicians (M.D., D.O and D.P.M) Continuing Education Change to Volunteer Hours

Q: What change was made in recent legislation regarding the number of volunteer hours that can be used for continuing education credit?
A: HB 442 amended state law to increase the number of volunteer hours that can be accrued for physician continuing education credit hours from three to ten. Licensees can, however, earn those hours at the rate of one credit hour for every five hours spent providing health care services as a volunteer.